



MISSOURI MEDICARE QUICK REFERENCE GUIDE
January 2012

Web Address: www.wellcare.com/provider/resources

Important Telephone Numbers

Provider Services Eligibility verification, Claims, Utilization Mgmt and Provider Complaints	(866) 687-8994	Nurse Advice Line Members may call this number to speak to a nurse 24 hours a day, 7 days a week.	(800) 581-9952
Case and Disease Management Referrals	(866) 635-7045	Risk Management WellCare's Fraud, Waste and Abuse Hotline	(866) 678-8355
TTY/TDD	(877) 247-6272		

Provider "How-To" Guide

Provider Resource Guide

Claim Submissions

Claim Payment Disputes

Claims Department **(866) 687-8994**
 Questions related to claim submissions

For inquiries related to your electronic submissions to WellCare, please contact our EDI team at EDI-Master@wellcare.com.

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.

Preferred EDI Partner **EDI Payor ID**
 RelayHealth (McKesson) 14163 **(877) 411-7271**

Mail or fax all claim payment disputes with supporting documentation to:

WellCare Health Plans, Inc. **Fax (877) 277-1808**
 Attn: Claim Payment Disputes
 PO Box 31370
 Tampa, FL 33631-3370

WellCare follows the Centers for Medicare and Medicaid Services' (CMS) guidelines for paper claim submissions. Since October 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 Payment Policy Disputes

Claim forms and guidelines may be found on our website:
www.wellcare.com/provider/resources

The Claims Payment Policy department has created a new mailbox for provider issues related strictly to payment policy issues. Disputes for payment policy related issues (Explanation of Payment Codes beginning with IHXXX, MKXXX or PDXXX) must be submitted to WellCare in writing within 90 days of the date of denial on the EOP.

Mail paper claim submissions to:

WellCare Health Plans, Inc.
 Claims Department
 PO Box 31372
 Tampa, FL 33631-3372

Mail all disputes related to payment policy issues to:

WellCare Health Plans, Inc. **Fax (877) 277-1808**
 Payment Policy Disputes Department
 PO Box 31426
 Tampa, FL 33631-3426

Appeals (Medical)

For pre-service appeals, providers may file an appeal on the member's behalf with the member's consent. A signed appointment of representative may be required. Providers may also seek an appeal through the Appeals department within 90 calendar days of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification.

Mail or fax medical appeals with supporting documentation to:

WellCare Health Plans, Inc. **Fax (866) 201-0657**
 Attn: Appeals Department
 PO Box 31368
 Tampa, FL 33631-3368

Medicare Appointment of Representative Form

Grievances

Member grievances may be filed verbally by contacting Customer Service or submitted via fax or mail. Providers may also file a grievance on behalf of the member with the member's written consent.

Mail or fax member grievances to:

WellCare Health Plans, Inc. **Fax (866) 388-1769**
 Attn: Grievance Department
 PO Box 31384
 Tampa, FL 33631-3384

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Pharmacy Services

Pharmacy Services (866) 653-0976
 Including After Hours / Weekends (WHI)

Specialty Pharmacy (866) 458-9246
wsp@wellcare.com TTY (866) 507-6135

Medication Appeals Fax (866) 388-1766

Mail all [medication appeal forms](#) with supporting documentation to:

WellCare Health Plans, Inc.
 Attn: Pharmacy Appeals Department
 PO Box 31383
 Tampa, FL 33631-3383

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

PDL Inclusions

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

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

Coverage Determination Requests Fax (866) 388-1767

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

[Coverage Determination Request Form](#)

[Medical Injectables – No Authorization Required List](#)

[Mail Order Pharmacy Prescription Form](#)

[Specialty Pharmacy Physician Referral Form](#)

Behavioral Health

[Magellan Behavioral Health](#) (888) 684-2026

- Authorization is not required for the first outpatient visit. **Prior approval is required for continued services.**
- Contact Magellan for **all** Mental Health and Substance Abuse services including Inpatient hospitalization **and** Outpatient counseling.
- Inpatient admission notification is required within 24 hours.

For real-time authorization responses, submit your secure request online at www.MagellanHealth.com/provider (select "Request Outpatient Authorization"). Complete your request for more sessions at least two weeks prior to the completion of the current authorized session(s).

Radiology Prior Authorization

CareCore National is our in-network Advanced Radiology services vendor for places of service (POS): 11, 22 & 24. Contact CareCore for all *authorization* related submissions for services rendered in locations listed above.

Urgent Authorizations and Provider Services (888) 333-8641
 Authorization Request Submissions Fax (866) 896-2152

Web submissions may be submitted via the [CareCore Provider Web Portal](#). A searchable [Authorization Lookup and Eligibility Tool](#) is also available online.

Contracted Networks

Dental (877) 468-5581
[DentaQuest](#)

Transportation (888) 332-8216
 Medical Transportation Management

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Prior Authorization (PA) Requirements

This WellCare Prior Authorization list supersedes any lists that have been distributed to our providers. Please ensure that older lists are replaced with this updated version. The authorization changes are denoted by a **Pa** symbol for easy identification. Requirements that have been edited for *clarification only* are denoted with an **i** symbol. There were no changes to authorization requirements on this list.

Primary Care Physicians (PCPs) are required to obtain authorizations for all out-of-network requests. Requests for Point-of-Service benefits must be submitted and reviewed for authorization. Specialists must coordinate all services with the member's PCP. All other requests to utilize Point-of-Service benefits must be submitted and reviewed for authorization. The POS benefit is a HMO option that allows members of designated Plans the ability to receive care from non-participating providers for additional costs. With the exception of emergent/urgent services, the member will pay more to access services outside of the network. It is the responsibility of the provider rendering care to verify that the authorization request has been approved before services are rendered.

WellCare supports the concept of the PCP as the "medical home" for its members. PCPs may refer members to network specialists when services will be rendered in an office, clinic or free-standing facility (11, 50, 71 & 72)*. The specialist must document receipt of the request for a consultation and the reason for the referral in the medical record. No communication with the Plan is necessary.

WELLCARE'S PRIOR AUTHORIZATION (PA) LIST:

Urgent Authorization Requests and Admission Notifications – Call (866) 687-8994 and follow the prompts.

- Notify the Plan of unplanned inpatient hospital admissions and observations within the next business day (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information – by the next business day.
- Outpatient authorizations may be requested by phone for urgent and time sensitive services when warranted by the member's condition. Please add **CPT and ICD-9 codes** with your authorization request.

Standard Authorization Requests may be submitted online via wellcare.com or by fax.

NOTE: Place of service codes (POS)* are specified for some services.

***Place of Service Codes**

11 – Office	23 – Emergency Room	50 – FQHC	72 – Rural Health Clinic
12 – Home	24 – Ambulatory Surgery Center	61 – Inpatient Rehab	81 – Laboratory
20 – Urgent Care Facility	31 – Skilled Nursing Facility	62 – Outpatient Rehab	
21 – Inpatient Hospital	32 – Nursing Facility	65 – ESRD	
22 – Outpatient Hospital	33 – Custodial Care Facility	71 – Public Health Clinic	

PROCEDURES and SERVICES	Auth Required	No Auth Required	Comments
Pa = New or changed requirement i = Clarification of current requirement			
DME Services		Fax (877) 431-8859	
Durable Medical Equipment purchases i	X		DME purchases billed for less than \$200 per line item do not require authorization
Durable Medical Equipment rentals	X		Refer to Clinical Coverage Guidelines
Orthotics and Prosthetics i	X		DME purchases billed for less than \$200 per line item do not require authorization
Home Health Services		Fax (866) 886-4321	
Home health care services	X		
Inpatient Services		Fax (877) 431-8860	
Emergency behavioral health services		X	
Emergency room services (23)*		X	
Emergency transportation services		X	
Inpatient Hospital admissions (21)*	X		Clinical updates required for continued length of stay.
Observations (22)*	X		Notification is required.
Rehabilitation facility admissions (61)*	X		Clinical updates required for continued length of stay.
Skilled nursing facility admissions (31 & 32)*	X		Clinical updates required for continued length of stay.

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📄 = New or changed requirement ⓘ = Clarification of current requirement			
Outpatient Services		Fax (877) 899-2033	
Advanced Radiology services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, PET & SPECT scans (11, 22 & 24)*	X		Contact CareCore National for authorization. See Radiology Prior Authorization on page 2.
Air ambulance transportation (non-emergent)	X		
Ambulatory surgery center surgical procedures (24)*	X		No Authorization is required for CPT code range: 43200 – 43258, 44360 – 44397, 45300 - 45392
Cosmetic procedures (ALL)*	X		
Court-ordered services	X		
Cytogenetic, reproductive and molecular diagnostic laboratory testing	X		Refer to Clinical Coverage Guidelines
Diagnostic laboratory services (Routine)		X	Lab testing must be consistent with CLIA guidelines. Authorization is required for Cytogenetic, reproductive and molecular diagnostic testing.
Diagnostic tests and procedures considered by the Plan to be routine office treatment (11)*		X	
Diagnostic ultrasounds (ALL)*		X	
Domiciliary, rest home & custodial services (32 & 32)*	X		
Hearing services	X		
Hospice care services	X		
Investigational & experimental procedures and treatment	X		Experimental and Investigational Procedures and Devices Clinical Coverage Guideline
Mammograms (ALL)*		X	
Outpatient hospital surgical procedures (22)*	X		No Authorization is required for CPT code range: 43200 – 43258, 44360 – 44397, 45300 - 45392
Pain Management treatment (22)*	X		
PCP office visits and treatment		X	
Radiology Anesthesia		X	No authorization is required for CPT codes 01916 - 01936
Rehabilitation facility services (61 & 62)* ⓘ	X		
Routine radiology services (11 & 22)*		X	
Skilled nursing facility services (31 & 32)*	X		
Specialist office visits and treatment (11)*		X	
Urgent care services (20)*		X	
Skilled Therapy Services		Fax (877) 709-1698	
Occupational, Physical and Speech therapy services (22)*	X		Refer to Clinical Coverage Guidelines <i>No authorization is required for the first 3 visits.</i>

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