

**Overview**

The focus of the Claims department is to process claims timely, to investigate the basis for any issues and to correct their root causes. The Claims department partners with Provider Relations to better assist providers with any claim-related questions.

In addition, the Provider Hotline enables providers to use the automated telephone system to check the status of a claim. Providers may also check claims status at [www.wellcare.com](http://www.wellcare.com). Please refer to the **Quick Reference Guide** for the Provider Hotline telephone number.

**Timely  
Claim  
Submission**

Timely filing is six months from date of service to the primary payers and 90 days to the secondary payers unless otherwise specified in the provider's contractual or as required by law.

Refer to the **Quick Reference Guide** for the appropriate mailing address.

**Clean Claim**

Providers are required to submit clean claims. A clean claim is one that can be processed without obtaining additional information from the provider of service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity pursuant to 42 CFR 447.45.

**Prompt  
Payment**

Claims are considered received on the date received by the health plan at its designated claims receipt location.

Medicare:

Clean claims must be paid within the number of days specified in the contractual payment arrangement between the provider and health carrier. Interest is to be paid to the provider based on the number of days that have elapsed between the date payment is due based on the contractual payment arrangement entered into and the date payment is made.

Medicaid:

In pursuant to Florida § 641.3155 the prompt payment for electronically submitted clean claims are to be paid or denied within 20 days from receipt of the claim. Non-electronically (paper) submitted clean claims are to be paid or denied within 40 days of receipt of the claim. Interest is to be paid to the provider based on the number of days that have elapsed between the date payment is due and the date payment is made.

Provider fee schedules for covered services provided to eligible Florida *Medicaid/Healthy Kids* recipients can be accessed online at:

[http://portal.flmmis.com/FLPublic/Provider\\_ProviderSupport/Provider\\_ProviderSupport\\_FeeSchedules/tabId/44/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_ProviderSupport/Provider_ProviderSupport_FeeSchedules/tabId/44/Default.aspx)

Provider fee schedules for covered services provided to eligible Florida *Medicare* recipients can be accessed online at::

CMS

<http://www.cms.hhs.gov/home/medicare.asp>

First Coast (Part B, Labs, Carrier Priced Codes)

<http://medicare.fcso.com/Landing/135985.asp>

Cigna (DME)

<http://www.cignagovernmentservices.com/jc/index.html>

**Coordination of Benefits**

*Coordination of Benefits* (COB) is the procedure used to process health care payments when a member has coverage with more than one insurer.

Prior to submitting a claim to the Plan, providers must identify if any other payer has primary responsibility for payment of a claim.

If determination is made that another payer is primary:

- The primary payer should be billed prior to billing the Plan;

- Any balance due after receipt of payment from the primary payer should be submitted to the Plan for consideration; and
- The claim must include information verifying the payment amount received from the primary plan as well as a copy of the Explanation of Benefits.

Upon receiving the claim, the Plan will review using the COB rule or the Medicaid/Medicare Crossover rule, whichever is applicable.

**Coordination of Benefits (COB)**

All Submitters that adjudicate claims for the health plan or have COB information from other payers are required to send in all the Coordination of Benefits and Adjudication Loops as per the 837 Professional (004010X098A1) Implementation Guide as per Coordination of Benefits Section 1.4.2.

**Claim  
Submission  
Format**

Claims may be submitted to the Plan in one of the following formats:

- Electronic Claims Submission (EDI)
- CMS-1500 Form
- UB-04 Form

Claims should be submitted to the Plan according to the following standards. Failure to comply with these standards may result in delay of payment or the rejection (returned to provider as unprocessed) of the claim.

- Claims must contain the National Provider Identifier (NPI) for all primary and secondary provider fields on all electronic and paper claims (UB-04 and CMS-1500) submissions.
  - The NPI is a unique identification number for all health care providers mandated by the Health Insurance Portability and Accountability Act (HIPAA). This number is a 10-position, intelligence-free numeric identifier

(10-digit number).

- Information for obtaining a NPI is available by:

Telephone: (800) 465-3203 or

TTY: (800) 692-2326

E-mail: [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

Mail: NPI Enumerator

P.O. Box 6059

Fargo, ND 58108-6059

- Answers to frequently asked questions regarding NPI are available at [www.cms.gov](http://www.cms.gov).
- Claims must contain the Federal Tax ID (Employer Identification Number or Social Security number) for the provider of service or supplier.
- All data fields are to be completed.
- Claims should not be handwritten or altered in any way.
- Only current standard procedural terminology is acceptable for reimbursement per the following coding manuals:
  - Current Procedural Terminology (CPT) for physician procedural terminology.
  - International Classification of Diseases (ICD9-CM) for diagnostic coding.
  - Health Care Procedure Coding System (HCPC).
- CMS-1500 paper claim submissions must be submitted on form OMB-0938-0999(08-05) as noted on the document's footer.
- The Plan accepts the revised CMS-1500 and UB-04 forms printed in Flint OCR Red, J6983, (or exact match) ink.

- Although a copy of the CMS-1500 form can be downloaded from the CMS Web site, copies of the form cannot be used for submission of claims because your copy may not accurately replicate the scale or color of the form when scanned using Optical Character Recognition (OCR).
  - This scanning technology allows for the data contained on the form to be read while the actual form fields, headings and lines remain invisible to the scanner. OCR technology allows the Plan to record and process paper claims faster.
- 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 and the Companion Guide when provided by the Plan. HIPAA requires compliance with the Electronic Data Interchange (EDI) standards.
  - The National Electronic Data Interchange Transaction Set Implementation Guides for HIPAA transaction sets are available at [www.wpc-edi.com](http://www.wpc-edi.com).
  - All files submitted to the Plan must be in the ANSI ASC X12N format, version 4010A.
- For further instructions for both paper and EDI claim submission, including access to Plan EDI Companion Guides, visit [www.wellcare.com](http://www.wellcare.com).
- Refer to the **Quick Reference Guide** for claim mailing addresses.

**HIPAA  
Electronic  
Transactions**

*HIPAA Electronic Transactions and Code Sets* is a federal mandate that requires health care payers such as WellCare, as well as providers engaging in one or more of the identified transactions, to have the capability to send and receive all standard electronic transactions using the HIPAA designated content and format.

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Specific WellCare requirements for claims and encounter transactions, code sets, and SNIP validation are described as follows. *To promote consistency and efficiency for all claims and encounter submissions to the Plan, it is WellCare's policy that these requirements also apply to all paper and direct data entry (DDE) transactions.*

### Standard Guides

Available online or by calling Customer Service, providers may obtain the Plan's recommended transaction guidelines. These are:

- Electronic Data Interchange Transaction Set Implementation Guides
- Institutional Claims Companion Guide
- Institutional Encounter Companion Guide
- Professional Claims Companion Guide
- Professional Encounter Companion Guide

### Standard Transactions

Transactions, as defined by HIPAA, are activities involving the transfer of health care information for specific purposes, including claims and encounter information, payment and remittance advice, and claim status and inquiry. All providers who submit encounters and electronic claims to the Plan must do so in the formats established by HIPAA.

The following standard HIPAA electronic claim/encounter transactions must be submitted in the \*ANSI ASC X12N format, version 4010A1:

- 270/271–Health Insurance Eligibility/Benefit Inquiry & Response
- 276/277–Health Care Claim Status Request & Response
- 278–Health Care Services Review – Request for Review and Response

- 835–Health Care Claim Payment/Advice
- 837–Health Care Claims

**Standard Code Sets**

Standard Code Sets as required by HIPAA are the codes used to identify specific diagnosis and clinical procedures on claims and encounter forms. All providers are required to submit claims and encounters using current HIPAA compliant codes, which include the standard CMS codes for ICD9, CPT, HCPCS, NDC and CDT, as appropriate.

**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 Strategic National Implementation Process (SNIP) guidelines.

The SNIP validations used by the Plan to verify transaction integrity/syntax are available in the Forms section of this manual and on our Web site. The SNIP Validation Descriptions document may be a helpful resource to share with your billing agent or clearinghouse.

If your claim is rejected for lack of compliance to the Plan's claim and encounter submission requirements, please correct your claim and resubmit it to the Plan. For additional information, please contact your Provider Relations representative or the Customer Service department.

**Electronic  
Claim  
Submissions**

The Plan accepts electronic claim submissions through Electronic Data Interchange (EDI).

**Advantages of EDI**

- Submitting claims electronically is less costly than billing with paper.
- In most instances, the Plan can process your electronic claim in half the time of a paper claim.

- Clearinghouses charge varying fees. The Plan has options with ACS, including connectivity and software that are free. Contact the EDI department to see if you qualify for this service. You may also contact your clearinghouse or billing software vendor to see if they offer free options.

There are six clearinghouses through which the Plan currently receives EDI transactions. Those companies are:

- Emdeon
- SSI Group Inc.
- Availity
- ACS EDI Gateway Inc.
- RelayHealth (McKesson)
- ZirMed

Since most clearinghouses can exchange data with one another, providers should work with their existing clearinghouse, if other than those listed, to establish EDI with the Plan.

If you do not have a clearinghouse or have been unsuccessful in submitting claims through your clearinghouse, please contact our EDI team. The EDI team contact information can be found on the **Quick Reference Guide**.

#### **Payer ID**

There are unique Payer IDs that must be used to identify our Plan on electronic claim submissions.

The appropriate Payer IDs for each of the six clearinghouses through which WellCare claims may be submitted are listed as follow:

#### **ACS EDI Gateway\***

- 77004

#### **Availity, Emdeon (WebMD®), SSI\*, RelayHealth (McKesson) and ZirMed**

- 14163

*\*Subject to Change*

For further instructions on EDI claim submission including access to Plan Companion Guides, please visit [www.wellcare.com](http://www.wellcare.com).

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

We have partnered with Payformance Corporation to offer you free Electronic Funds Transfer (EFT) and online Electronic Remittance Advice services (ERA, also known as electronic payment voucher) by registering with PaySpan Health®.

The benefits of enrolling for EFT/ERA through PaySpan Health include:

- A secure, self-service Web site;
- Absolutely no cost for participating;
- Improved cash flow through automated deposits;
- Convenient access to view remittance records online, at any time;
- Reporting mechanisms to access adjudicated claims information; and
- Ability to import payment data directly into your practice-management or patient-account system.

Online registration is simple and fast. PaySpan Health will mail a registration letter to network providers containing a unique registration code and PIN number.

Using the information contained in the registration letter, providers will proceed through an easy registration process that includes the following steps:

- Log on to PaySpan Health using the registration code and PIN number provided in the letter;
- Enter Tax ID number (for security purposes);

- Enter banking information and set up account administrators and users;
- Select payment and remittance preferences; and
- Confirm receipt of funds transfer into provider bank account.

When the funds transfer is confirmed, all payments will be sent via EFT.

Should a provider elect not to receive payments or vouchers electronically, they will continue to receive paper checks generated at the Payformance payment processing center.

For questions related to this service, please visit the PaySpan Health Web site at [www.payspanhealth.com](http://www.payspanhealth.com) or call the Customer Service, the number for which may be found on the Quick Reference Guide.

### **Prohibition on Billing Plan Members**

Your agreement with WellCare of Florida, Inc., d/b/a Staywell Health Plan of Florida for Medicaid, and HealthEase of Florida, Inc., (referred to collectively as WellCare), requires providers to accept payment directly from WellCare... Payment from WellCare constitutes payment in full, with the exception of applicable co-payments and any other amounts listed as member responsibility on the Explanation of Benefits/Provider Remittance Advice.

This means providers **cannot bill Plan members for:**

- The difference between actual charges and the contracted reimbursement amount;
- Services denied due to timely filing requirements;
- Covered services for which a claim has been returned and denied for lack of information;
- Remaining or denied charges for those services where the provider fails to notify the Plan of a service

that required prior authorization – payment for that service will be denied;

- Covered services that were not medically necessary, in the judgment of the Plan, unless prior to rendering the service the provider obtains the member's informed written consent and the member receives information that he/she will be financially responsible for the specific services.

#### **Non-Covered Services**

Plan members may be billed for non-covered services, such as cosmetic procedures and items of convenience (i.e., televisions).

#### **Paper Claim Submission Guidelines**

Paper claims must be completed in full and include:

- The Plan member's name and his or her relationship to the subscriber;
- The subscriber's name, address and Social Security number;
- Information on other insurance or coverage for the Plan member;
- The name, signature, place of service address, billing address and telephone number of the physician or provider performing the service;
- The tax ID number;
- Qualifiers

Each form of identification should be accompanied by a qualifier which will correctly allocate the information when transferred into our databases. Proper qualifiers for identification numbers submitted to the Plan are:

| <b>ID</b>  | <b>Qualifier</b> |
|------------|------------------|
| <b>NPI</b> | <b>XX</b>        |
| Tax ID     | 24               |
| Taxonomy   | ZZ               |

Notice that some form fields will include a box to submit the identification number's qualifier. In others, however, the box will not be available and the qualifier should be included by preceding the identification number with a hyphen (Ex. XX-XXXXXXXXX).

- Appropriate Bill Type
- Appropriate ICD-9 codes;
- Standard CMS procedure and NUBC/NUCC Documentation or service codes (e.g., CPT-4 procedure codes and HCPC-I,II; HIPPS and RUX codes with appropriate modifiers, revenue codes and Rates, where applicable);
- Number of service units rendered;
- Billed charges;
- Referring physician's name and NPI number;
- Date(s) of service;
- Place(s) of service and facility NPI (where applicable);
- Authorization Number (if applicable);
- NDC for drug therapy (if applicable); and
- Job related, auto or other accident information.

“Corrected Claims” should be stamped in “RED” ink at the top of the claim form and not to obscure any claim information.

**Encounter Data** Health care encounter data includes:

- All data captured during the course of a single health care encounter that specifies the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative,

maintenance or palliative), pharmaceuticals, medical devices and equipment associated with the member receiving services during the encounter;

- The identification of the member receiving and the provider(s) delivering the health care services during the single encounter;
- A unique, i.e., unduplicated, identifier for the single encounter.

**If a provider is paid on a capitated basis, encounter data must be submitted to the Plan according to the claim submission standards noted above.**

**Encounter Payer ID: 59354**

This requirement is mandated to meet the reporting requirements of the Plan, as well as those established by regulatory agencies and the Balanced Budget Act. Under capitation, encounter data is generally submitted in the form of a claim, and such claims are usually referred to as encounter data.

The Plan will record the encounter data received. The Plan recognizes these services as under a capitated contract and will not make payment to the provider.

**A capitated provider who does not submit encounter data is subject to corrective action measures and penalties under applicable state and federal law and could be terminated from the Plan.**

**Encounters Data that is submitted by Paper must be stamped “Encounter Claim” in RED ink at the top of the claim form and should not obscure any claim information.**

**Explanation of Payment**

An Explanation of Payment (EOP) is issued for each claim submitted. The EOP contains all of the information that was submitted on the claim form. The EOP will show all reimbursement information along with any specific messages regarding the claim.

**Overpayment  
Recovery**

WellCare strives for 100% payment quality but recognizes that a small percent of financial overpayments will occur while processing claims. An overpayment can occur because of reasons such as retroactive member termination, identification of a different primary insurance (COB/TPL), inappropriate coding, duplication of payments, non-authorized services, erroneous contract or fee schedule reimbursement.

WellCare will proactively identify and attempt to correct inappropriate payments. In situations when the inappropriate payment caused an overpayment, WellCare will limit its recovery effort to 30 months from the date of service. However, beginning November 1, 2008, WellCare will limit its recovery effort to 12 months from the date of service for professional claims (CMS-1500) and 30 months from the date of service for institutional claims (UB-04), with the exception for retro disenrollment, where institutional claims will also be limited to 12 months from the date of service. These time frames do not apply to fraudulent or abusive billing and there is no deadline for WellCare to seek recovery from the provider. In all cases, WellCare or one of its business partners will provide a written notice to the provider explaining the overpayment reason and amount, contact information and instructions on how to send the refund. The standard request notification provides 45 days for the provider to send in the refund or contact WellCare or its business partner for further information or to dispute the overpayment.

Failure by the provider to respond within the above timeframes will constitute acceptance of the terms in the letter and will result in offsets to future payments. Once the overpaid balance has been satisfied, a system-generated Explanation of Payment (EOP) will be issued. In situations where future billing is not enough to offset the entire overpaid amount, a system-generated EOP will not be sent identifying the negative balance. Instead, the provider will need to contact their provider representative for account information. In situations where the overpaid balance has aged more than three months, the provider may be contacted by WellCare or its business partner to arrange payment.

**Delegated  
Entities**

All participating providers or entities delegated for claims management are to use the same standards as defined in this section. Compliance is monitored on a monthly basis, and formal audits are conducted annually.