Georgia Medicaid Provider Resource Guide

Thank you for being a star member of our provider team. WellCare of Georgia, Inc. (WellCare) understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks. WellCare has contracted with the Georgia Department of Community Health (DCH) to provide Medicaid services for Georgia Families®, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) managed care programs. This guide will explain the 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 Portal

The Provider Portal offers providers the convenience of exchanging health care service information directly with WellCare. The Provider Portal, which is offered at no cost, features:

- View member eligibility status, co-payments and benefit information
- Request authorizations and check status
- The ability to use PaySpan Health’s Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA)
- Submit claims, look up status, submit appeals, disputes and corrected claims
- 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 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. The Georgia QRG can be accessed on our website at www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.

Please see the Provider Handbook and/or Quick Reference Guide (QRG) for additional information.
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 be taken 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 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.

- Click the My Patients area.
- Enter the Member ID number.
- 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, 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 authorizations for certain services and procedures. Authorizations can be requested via the secure online Provider Portal, via fax or via telephone. For details regarding services that require authorization 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, and then select Create New Authorization.

For authorizations, please supply your phone and fax numbers. You can attach up to 10 clinical files. Your requests may not be visible in the Provider Portal inquiry until a final disposition has been determined. As a result, you may receive our fax response prior to seeing the determination online.

Via Fax
Complete the appropriate notification or authorization form for the type of care needed. Forms are online at www.wellcare.com/en/Georgia/Providers/Medicaid/Forms. 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 24 hours. Contact Provider Services at the phone number listed on the QRG to request an expedited authorization.

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.

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.

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 are displayed at the bottom of the page.
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:

- Your Vendor/Provider Identification Number (PIN) and TIN
- A valid email 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
- 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 a small deposit has been made to your bank account by PaySpan Health. This deposit amount will be used to confirm your electronic payments are properly set up. The deposit does not need to be returned 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 – a claim that has at least one line item designated as payable
- Pending 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
- Rejected claims – a claim that has 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.

Please see the Provider Handbook and/or Quick Reference Guide (QRG) for additional information.
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/Georgia/Providers/Medicaid/Claims/Electronic.

HIPAA Electronic Transactions and Code Sets
Please 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.

Fee-For-Service Clearinghouse Submitters
All Fee-for-Service (FFS) providers and vendors must send claims through a clearinghouse. WellCare has partnered with Change Healthcare (formerly known as RelayHealth) as our preferred EDI clearinghouse. WellCare only accepts electronic claims through Change Healthcare.

Call Change Healthcare for submitter/client connectivity services at 1-877-411-7271. Clearinghouses, practice management vendors or billing services should call 1-800-527-8133 for assistance with EDI transactions.

If your clearinghouse or billing system is not connected to Change Healthcare 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 |

If your clearinghouse or billing system is connected to Change Healthcare and uses their four-digit CPID, please use the following codes according to the file type (FFS or Encounters).

Change Healthcare CPIDs

| 1844 Fee-For-Service Professional | 3211 Encounters Professional |
| 8551 Fee-For-Service Institutional | 4949 Encounters Institutional |

Real-Time Services
Real-time HIPAA 270/271 eligibility transactions and 276/277 claim statuses are available to providers via the following vendors:

- AdministEP.com 1-888-751-3271
- Availity 1-800-282-4548
- Dorado Systems, LLC 1-855-770-8048 prompt 4
- Change Healthcare 1-877-363-3666 prompt 1
- TransUnion Healthcare 1-877-732-6853

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
• Low or 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 georgia.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.

Alternative Solutions – Change Healthcare’s ConnectCenter™

ConnectCenter™ for physicians offers a web browser for direct data entry (DDE) and the upload ability to submit electronically at no cost to you. To register, visit https://connect.relayhealth.com. For registry questions, the submitter/clients may contact Provider Connectivity Services at 1-877-411-7271. Any questions regarding functionality of ConnectCenter should be directed to the clearinghouse at 1-800-527-8133 (select option 2).

• Providers will be required to enter a credit card upon initial enrollment to verify them as a valid submitter.
• Only WellCare submissions are free of charge and please ensure you use vendor code 212750 when you register.

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/Wellcare/Georgia/Providers/Medicaid/Claims for complete paper claims submission guidelines.

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/Wellcare/Georgia/Providers/Medicaid. 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/Wellcare/Georgia/Providers/Medicaid/Claims.

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 Harmony in writing within 90 days of the date of denial on the EOP. Refer to the QRG for mailing address and fax number. Claim disputes may also be submitted through the Provider Portal.

Please see the Provider Handbook and/or Quick Reference Guide (QRG) for additional information.
**Encounters Submission**

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

- RelayHealth
- WellCare’s Secure FTP (SFTP) process
- WellCare’s Direct Data Entry (DDE)

For further details about Encounter Submissions, please refer to Encounter Reference guides located at [www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Claims](http://www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Claims).

**Strategic National Implementation Process (SNIP)**

All claims and encounter transactions submitted electronically, via paper or direct data entry (DDE) will be validated for transaction integrity/syntax based on the SNIP guidelines.

The SNIP validations used by WellCare are available at [www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Claims](http://www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Claims).

**Checking Claim Status Online**

WellCare encourages you to check the status of your claims online via our secure Provider Portal at [georgia.wellcare.com/login/provider](http://georgia.wellcare.com/login/provider).

Simply log in and access 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.

**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 or payment reductions 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 must be submitted in writing within 30 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.

You may file an appeal by mail or fax. To file an appeal, 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 30 calendar days of receipt of the appealed claim.

Quality care is a team effort. Thank you for playing a starring role!

Contacts

For important mailing addresses, phone numbers and fax numbers, refer to your state-specific QRG located at www.wellcare.com/Wellcare/Georgia/Providers/Medicaid.