



MO HealthNet Provider Resource Guide

Thank you for being a star member of our provider team. Missouri Care 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 services that Missouri Care offers to assist with those routine tasks. In this guide you will find information related to:

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

Missouri Care Provider Web Portal

The Missouri Care Provider Web Portal offers providers the convenience of exchanging health care service information directly with Missouri Care. 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 Missouri Care
- Provider Web Portal news and alerts

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

missouricare SM
A WellCare Company



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/Missouri/Providers/Medicaid.

Create a New Account

Users can create an account by visiting our provider website: <https://provider.wellcare.com/missouricare>.

- 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:
 - Missouri Care Contract Name and ZIP Code OR
- If a Sub-Group for your medical group or facility exists, your Missouri Care-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 Missouri Care eligibility and enrollment information using the Provider Portal.

- Log in at <https://provider.wellcare.com/missouricare>
- 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 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.

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. 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 before seeing the determination online.

Via Fax

Complete the appropriate notification or authorization form for the type of care needed.

You can find the forms online at www.wellcare.com/Missouri/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 three business days. Contact Provider Services at the phone number listed on the QRG to request an expedited authorization.

Checking Authorization Status Online

Missouri Care encourages you to check the status of your authorization requests online via our secure Provider Portal at <https://provider.wellcare.com/missouricare>.

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)

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

Register for Electronic Funds Transfer at PaySpan Health

Create a New Account

Missouri Care 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 PaySpan Health 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 Missouri Care

General Definitions:

- **Paid claims** – claims that have at least one line item designated as payable
- **Pending claims** – require additional review
- **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 Missouri Care’s “front-end” edit process. You will need to correct the data and resubmit a new claim.

Electronic Claims

Missouri Care accepts electronic claims submission through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Missouri Care 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 Missouri Care, refer to the Claims/Encounter Companion Guides located at www.wellcare.com/Missouri/Providers/Medicaid/Claims.

Prompt Pay

Missouri Care adheres to the Missouri Prompt Pay Guidelines of processing 95% of all clean and unclean claims in 45 calendar days. Claims paid beyond the 45th day will have the current prevailing Missouri interest rate penalty applied.

Please note that individual participating provider agreements may contain provider-specific prompt pay and interest agreements that differ from state or federal requirements.

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. Missouri Care has partnered with Change Healthcare (formerly known as RelayHealth), a division of McKesson, as our preferred EDI clearinghouse. Missouri Care only accepts electronic claims through Change Healthcare.

Call Change Healthcare for submitter/client connectivity services at **1-877-411-7271**. All clearinghouses, practice management vendors or billing services may call Change Healthcare, formerly known as RelayHealth, at **1-800-527-8133** for connectivity services.

- ▶ 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).

Missouri Care Payer IDs

14163 Fee-For-Service – Professional or Institutional	59354 Encounters – Professional or Institutional
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- ▶ 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 **www.wellcare.com/Missouri**

Registered users can log in and directly enter professional and/or institutional claims and encounters into Missouri Care'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 – Change Healthcare's Connect Center

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://physician.connectcenter.changehealthcare.com>**. For registry questions, the submitter/clients may contact Provider Connectivity Services at **1-877-411-7271**. Direct any questions regarding functionality of ConnectCenter 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

Missouri Care 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/Missouri/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/Missouri/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/Missouri/Providers/Medicaid/Claims**.

Encounters Submission

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

- Change Healthcare
- Missouri Care's Secure FTP (SFTP) process
- Missouri Care's Direct Data Entry (DDE)

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 Missouri Care are available at www.wellcare.com/Missouri/Providers/Medicaid/Claims.

Checking Claim Status Online

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

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, Missouri Care 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 Missouri Care'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/Missouri/.

TIPS for using our IVR

Providers should have the following information available with each call:

- Missouri Care 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

Payment or Denial on Outlier and High Dollar Stoploss Claims

Missouri Care has retained Equian, LLC, a third party vendor, to assist with its claim adjudication obligations. During its claim adjudication review, Equian may identify line items that require an itemized statement to be submitted before the claim can be adjudicated. Effective January 1, 2016, the criteria is as follows:

- Inpatient & LTAC Claims - All DRG payments that hit an outlier in excess of \$2,500
- Inpatient Claims Paid on Percent of Billed Charges - If payment exceeds \$50,000



Claim Payment Disputes

The claim payment dispute process is designed to address claims when there is disagreement regarding reimbursement. Claim payment disputes can be submitted to Missouri Care in writing within 90 days of the date of denial on the EOP. Refer to the QRG for mailing address and fax number. Claims disputes may also be submitted through the Provider Portal.

Equian Appeals

If Equian identifies a billing discrepancy during its adjudication review, you will receive a Forensic Review Report that identifies each of the items in question. You may formally appeal Equian's findings directly to Equian at the following address:

Equian, LLC
Attention: Appeals Department
300 Union Boulevard, Suite 200
Lakewood, CO 80228

Please ensure correspondence clearly indicates that it is a formal appeal and include all explanations and documentation necessary to address the issues raised in the Forensic Review Report.

Appeals

Filing an Appeal

Providers have the right to file a request for review regarding provider payment or contractual decisions. 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

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.

You may file an appeal by mail, fax or through our secure portal. To file an appeal, refer to the QRG for applicable addresses and fax numbers. Claim appeals may also be submitted through the Provider Portal. Missouri Care will process and finalize an appealed claim to a paid or denied status within 30 calendar days of receipt of the appealed claim. Should the decision be to overturn the appeal and pay the claim, please allow 60–90 days for claims reprocessing.



Contacts

For important mailing addresses, phone numbers and fax numbers, refer to the QRG located at www.wellcare.com/Missouri/Providers/Medicaid.