QUICK REFERENCE INFORMATION FOR MEDICARE SERVICES

Background

WellCare Health Plans, Inc., provides integrated utilization management services in accordance with NCQA accreditation standards, and state and federal regulations. Medical/Behavioral Health utilization, Pharmacy, and Case Management teams work together to facilitate optimal treatment and member outcomes.

The Behavioral Health (BH) Department is structured to provide behavioral health services using an outlier management approach. This approach focuses clinical attention on high-risk, medically complex, and dually diagnosed individuals in higher levels of care who need services to be monitored and coordinated to facilitate the best possible individual clinical outcomes. Higher levels of care are closely monitored by BH Utilization Managers to ensure that these most vulnerable members get excellent and timely care, and receive effective discharge planning that provides the services and supports needed to lead to member success. Routine and targeted provider documentation audits, and program visits, will be used to determine provider strengths, identify and promote best practices, and identify any provider problems to offer technical assistance as part of our ongoing quality assurance program.

Frequently Asked Questions

Transition from Magellan

Question: What is the effective date of the transition of behavioral health services from Magellan to WellCare?

Answer: *The transition of behavioral health services from Magellan to the WellCare Behavioral Health Integrated Program is effective on December 1, 2013 for all markets with the exception of New York, which is effective December 15, 2013.*

Question: When should we stop filing claims to Magellan?

Answer: *Claims with a date of service up to and including November 30, 2013, (including a hospital admission that began on November 30, 2013) should be billed to Magellan. Claims with a date of service of December 1, 2013, or after should be sent to WellCare.*

Question: Will members who have Medicare keep Magellan? Will there be new treatment request forms with Magellan?

Answer: *Magellan will no longer manage benefits beginning December 1, 2013. WellCare will publish authorization request forms for services rendered beginning in November, on our website at* **www.wellcare.com**.

Question: How are emergency services handled?
Answer: *Members admitted on an emergency basis should be treated immediately for the emergency condition.*

In accordance with CMS requirements, prior authorization of emergency services is not required. WellCare expects and appreciates notice of emergency MHSA admissions within 24 hours or by the next business day. During business hours, notices of emergency admission can be completed via fax or phone (see the Quick Reference Guide *or the contact data on page 6).*

On the weekends or holidays, notices must be faxed or sent via the web only to the Intake Department. *(Faxes and Web submissions are received on a 365/24/7 basis, but the BH Intake phone line is available Monday–Friday 7 a.m. to 7 p.m. Only fax and Web UM submissions are available on weekends or holidays.) All notices of emergency services will be processed by the UM team within NCQA standards, and as soon as possible during business hours. The UM team business hours are:*

- ***Monday–Friday 7 a.m. to 7 p.m. and Saturday 2 p.m. to 6 p.m.***

Question: What do the WellCare BH benefits/covered services look like?
Answer: *WellCare uses the standard Medicare benefit structure which can be found on the CMS website. To clarify questions regarding Intensive Outpatient Services (IOP), IOP is not a covered benefit under Medicare and will not be authorized by or paid by WellCare.*

Question: What are the requirements for authorizations?
Answer: *In general, the prior authorization and concurrent review processes for Medicare programs will be very similar to our medical processes.*

- ***After a 30-day TOC period, Medicare members must be rendered by participating providers only.***
- *Authorizations need to be requested and received prior to the service being provided. For non-immediate services, we encourage you to request an authorization 14 days* ***PRIOR*** *to the service being delivered.*
- *The hospital must notify WellCare prior to admission, or by the next business day, of a WellCare member initiating an inpatient stay.*
- *The length of the authorization will depend on the medical necessity for the service requested. The authorization approval document will note the length of the authorization. We are requesting that providers submit continued stay authorization requests 14 days prior to the service being delivered.*
- *WellCare* ***will*** *use Behavioral Health InterQual Criteria and ASAM criteria to assess medical necessity.*
- *WellCare* ***will not*** *require a PCP referral for behavioral health services for Medicare members.*
- *WellCare* ***will not*** *require prior authorization for standard psychiatric services including psychiatric assessment/evaluation and medication management.*

- *WellCare **will** require prior authorization for most therapy codes. The indicated codes (**90832, 90834, 90837, 90838, 90846, 90847, 90849, 90853, and 90887**) can be requested once a year, up to 20 combined, without any clinical data by submitting the Initial Outpatient Service Request Form. If additional services are needed, a BH IOP/OP Service Request Form which includes clinical information must be submitted.*

- *WellCare **will** require authorization for inpatient hospital services, partial hospital services, psychological testing and ECT. **Initial authorization requests should be done by filling out and faxing the correct WellCare form, or submitting it online**.*

- *Concurrent reviews can be done by faxing in new information or via phone as arranged with the WellCare Care Manager.*

- *Partial hospitalization, psychological testing, and ECT requests require PRIOR authorization. Initial authorizations will be requested by filling out and faxing the correct WellCare form or submitting it online (except testing requests which cannot be done online). Concurrent reviews can be done by faxing in new information or via phone as arranged with the WellCare Care Manager.*

Question: How are authorization responses given back to the provider? How will I receive my authorization number?

***Answer:** Providers will receive authorization numbers via fax after the authorization requests are approved. Information regarding authorizations can also be accessed on the secure, online portal at **www.wellcare.com/provider**.*

Question: What are the provider requirements?

Answer:

- *WellCare will require all BH providers to "re-contract" with WellCare directly. Providers will need to be credentialed by WellCare. Nothing contractually in their relationship with other vendors will "transfer" to WellCare. If the provider wants to continue to see WellCare members, they need to be in the WellCare network.*

- *WellCare has sent contracts out inviting all current providers in vendor networks to join the WellCare network.*

- *Providers must have a Medicare ID in order to provide services. Behavioral Health providers include: MD (psychiatrist), ARNP (Certified Psychiatric Nurse Practitioner), Clinical Ph.D. (Psychologist), LMSW (Licensed Master Social Worker), Physician Assistant, Clinical Nurse Specialist (CNS) and Independent Psychologist. Billing WellCare will require the proper Medicare ID of the rendering provider. LPC, LMHC and other types of BH licensure are **not recognized** by Medicare and will not be reimbursed by WellCare.*

- *WellCare has updated information on the contract, the provider manual and other communications available on the WellCare website.*

Questions about Claim Payment

Question: When resubmitting claims will we get denied for duplicates?

Answer: *If the claim is an exact duplicate, then yes. If you make changes to the claim, it should be submitted as a corrected claim using the appropriate frequency code (7).*

Question: When will I receive a fee schedule?

Answer: *All providers received their contracted fee schedule when they signed their agreement with WellCare. Provider fee schedules are located at the end of the Provider Agreement.*

Question: Will my EFT carry over or will I need to sign up with WellCare's EFT vendor?

Answer: *Providers need to sign up with PaySpan by calling* ***1-877-331-7154*** *or emailing* **providersupport@payspanhealth.com**.

Question: Will the Web portal allow adjustments, or void claims? Is there any way to make adjustments to claims that are submitted electronically or via Web portal?

Answer: *Yes. Once registered for WellCare's secure online portal, providers can submit corrections. We also accept corrected claims through electronic submission. Providers must indicate the correction by including the appropriate frequency code for a correction (7) or void (8).*

Question: We are currently billing all our WellCare claims through the Magellan website. Will we be able to continue or will we have to use the WellCare website?

Answer: *As of December 1, 2013, all services, including direct data claims submission on the Web portal, will go through WellCare. Services rendered on November 30, 2013, and prior should be billed to Magellan. Services rendered on December 1, 2013, and forward should be billed to WellCare. For questions about Magellan claims, please call Magellan. Beginning December 1, 2013, providers will be able to bill individual claims via Direct Data Entry (DDE) directly through WellCare's secure Web portal. Batch claims submitted through EDI must be submitted through a clearinghouse. WellCare's preferred clearinghouse is RelayHealth.*

Question: When will the WellCare website be active to behavioral health providers?

Answer: *When you receive your provider ID number, you are eligible to register on the Web portal. Information specific to behavioral health has been updated to include a provider orientation, a prior authorization grid and service request forms. Please refer to the* ***Guidelines for Submitting Outpatient Service Requests*** *found on the WellCare website.*

Question: If we are already a Web user, do we have to re-register? Where do we obtain the information to access the WellCare website for authorization requests and claims?

Answer: *No. You do not need to re-register if you are already a WellCare Web user. New WellCare providers **will** need to go to* **www.wellcare.com/registration/provider** *to register as a provider to access the secure portion of the website. Information on how to access the Web portal for authorization requests will be given at the time a provider registers to access the secure portal. If you have additional questions about Web portal registration or access, please contact Provider Services from the number located on the* Quick Reference Guide *at* **www.wellcare.com/provider/resources**.

Question: What changes will there be in terms of rates and payment processes?

Answer:

- *Providers can bill for the same services they were billing for previously as long as they are working with the 2013 updates to co-pay/deductible as below:*
  The 2013 deductible and co-pays for inpatient hospital stays under are as follows:
  - *All plans: $0 deductible for each benefit period in 2013.*
  - *Value: Days 1–5: $320 co-pay per day of each benefit period in 2013. Days 6–90: $0 co-pay per per day of each benefit period in 2013.*
  - *Choice: Days 1–7: $250 co-pay per day of each benefit period in 2013. Days 8–90: $0 per day of each benefit period in 2013.*
  - *Access: $0 co-pay per day of each benefit period in 2013.*
- *Note: For zero-cost-share DSNPs, providers should bill Medicaid for the member cost shares listed above.*
- *Providers are required to follow Medicare guidelines when billing professional services and use appropriate CPT codes for provider type. Providers should use the 2013 CPT Professional code book for guidance.*
- *WellCare is contracting rates at a % of the Medicare fee schedule. The Medicare fee schedule is located on the CMS website. Providers are reimbursed according to their provider type and practice level. Reimbursement rates are listed in the Provider Agreement.*

Question: What communication with the PCP must occur?

***Answer:** WellCare will require BH Providers to communicate with the PCP to notify him or her that the member is in care with them and to coordinate care, medications and treatment services.*

Contact information

Inpatient, Partial Hospitalization, and Psychological/Neuropsychological Testing DO require a Prior Authorization. Please use the appropriate request form and fax the request to the appropriate number below:

For Inpatient and Partial Hospitalization Requests, please fax:

BH FL Care Inpatient	**(855) 710-0167**
BH IL Care Inpatient	**(855) 713-0592**
BH LA Care Inpatient	**(855) 710-0159**
BH MO Care Inpatient	**(855) 710-0161**
BH NJ Care Inpatient	**(855) 671-0257**
BH NY Care Inpatient	**(855) 713-0588**
BH OH Care Inpatient	**(855) 710-0163**
BH TX Care Inpatient	**(855) 671-0258**

For Outpatient Requests including Psych Testing Requests, please fax:

BH FL Care Outpatient	**(855) 710-0168**
BH IL Care Outpatient	**(855) 713-0593**
BH LA Care Outpatient	**(855) 710-0160**
BH MO Care Outpatient	**(855) 710-0162**
BH NJ Care Outpatient	**(855) 671-0256**
BH NY Care Outpatient	**(855) 713-0589**
BH OH Care Outpatient	**(855) 710-0164**
BH TX Care Outpatient	**(855) 671-0259**

Below is an additional link where you can find benefits information and other helpful information from CMS:

www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html