NEW JERSEY MEDICAID QUICK REFERENCE GUIDE
August 2019
Web Address: www.wellcare.com/New-Jersey/Providers/Medicaid

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Important Contact Information

Nurse Advice Line **1-800-919-8807**

Members may call this number to speak to a Nurse 24 hours a day, 7 days a week

Proficient Self Service Offerings

WellCare offers robust technology options to save you time. The fastest ways to get what you need are shown below.

WellCare Provider Portal

	Portal	CHAT	(IVR) Interactive Voice Response
Authorization Requirements	Fastest Result ✔	N/A	Available
Authorization Status	Fastest Result ✔	Available	Available
Authorizations Request	Fastest Result ✔	N/A	N/A
Benefit Information	Fastest Result ✔	Available	Available
Claims Status	Fastest Result ✔	Available	Available
Co-Payment	Fastest Result ✔	Available	Available
Eligibility Verification	Fastest Result ✔	Available	Available
Submit Appeals	Fastest Result ✔	N/A	N/A
Submit Claim Disputes	Fastest Result ✔	N/A	N/A
Submit Claims	Fastest Result ✔	N/A	N/A
Submit Corrected Claims	Fastest Result ✔	N/A	N/A

WellCare understands that having access to the right tools can help you and your staff streamline day-to-day administrative tasks.

The Provider Portal will help with those routine tasks.

Provider Portal Registration – click here **Provider Portal Training – click here**

Provider Services

Interactive Voice Response System **1-888-453-2534**

TTY **711**

WellCare Phone Numbers

Care Management Referrals (non-MLTSS members)

Phone: **1-866-635-7045** **TTY:** **711**

Fax: **1-866-287-3286** **Hours: M-F 8-7 p.m. Eastern**

Community Connections Help Line	**1-866-775-2192**
MCO Care Coordination (Special needs Members)	**1-866-635-7045**
Risk Management WellCare's Fraud, Waste and Abuse Hotline	**1-866-678-8355**

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable Plan coverage guidelines.

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Provider Resource Guide

Prior Authorization Contacts*

To check the status of a prior authorization (medical, behavioral, pharmacy, dental) or changes to a prior authorization, please call Provider Services at **1-888-453-2534** or visit **provider.wellcare.com**
For information regarding the status of a prior authorization for LTC (PCA, Medical Day Care, PDN, or HCBS) Please call **1-855 -642-6185.**

WellCare's process for prior authorization acknowledgement includes a response to the request and/or a request for additional information. There is no formal acknowledgement policy in place. However, providers may call Provider Services at **1-888-453-2534 to inquire on prior authorization requests not received within 15 days.*

MLTSS Contacts

Care Management: 1-855-642-6185

Nursing Facility Contacts

- For requesting authorization Eileen Urban, Care Coordinator, Senior, **1-855-642-6185** or **eileen.urban@wellcare.com**
- For claims, eligibility, enrollment and hospice issues: Katelyn Mignone, Network Management Specialist, **1-201-259-5934** or **katelyn.mignone@wellcare.com**
- For nursing facility providers to address questions regarding 835 files: **#edianalyst@wellcare.com**
- For a resident that is auto-assigned or self-selected the MCO and needs a NJ Choice Assessment performed: Teresa Howard, Supervisor Outpatient Care, **1-973-848-7031**, **teresa.howard@wellcare.com**
- For assistance with issues in a nursing facility in which a resident that elects hospice: Marion Lynn Smayda RNC, BSN, Manager, MLTSS Care Management, **1-609-620-7703** or **marion.smayda@wellcare.com**

Assisted Living Contact

- For claims, eligibility and enrollment issues: Katelyn Mignone, Network Management Specialist, **1-201-259-5934** or **katelyn.mignone@wellcare.com**

Hospice Services

- For claims, eligibility and enrollment issues: Consuelo Taveras, Manager Network Management, **1-973-274-2128** or **consuelo.taveras@wellcare.com**

Home and Community Based Services Contacts

- Call **1-855-642-6185** to be connected to your MLTSS Care Manager
- Non-medical based issues: Damaris Camilo, Sr. Network Management Specialist, **1-973-274-2106** or **damaris.camilo@wellcare.com**

Specialty Care Nursing Facility Contact

- For claims, eligibility and enrollment issues: Katelyn Mignone, Network Management Specialist, **1-201-259-5934** or **katelyn.mignone@wellcare.com**
- For a resident who is auto-assigned or self-selected the MCO and needs a NJ Choice Assessment performed: Teresa Howard, Supervisor Outpatient Care, **1-973-848-7031** or **teresa.howard@wellcare.com**
- For a SNF that has a resident that elects hospice: Teresa Howard, Supervisor Outpatient Care, **1-973-848-7031** or **teresa.howard@wellcare.com**

Behavioral Health Services

- For claims, eligibility and enrollment issues: Consuelo Taveras, Manager Network Management, **1-973-274-2128**, **consuelo.taveras@wellcare.com**
- For participating providers and services as well as authorization process: Hania Schwartz, Sr. Manager, Behavioral Health Programs, **1-973-274-2155**, **hania.schwartz@wellcare.com**

Home and Community Based Services

- For Chore Services and other non-traditional MLTSS services: Damaris Camilo, Sr. Network Management Specialist, **1-973-274-2106** or **damaris.camilo@wellcare.com**

Hospital Billing Contact

- For hospital billing staff to address questions regarding claim denials: Oscar Morales, Manager Hospital Contracting & Relations, **1-973-634-2640** or **oscar.morales@wellcare.com**

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Joining WellCare s Provider Network

To inquire whether WellCare is accepting new providers, or to check on an existing application:

- Call **1-973-274-2100,** option 2
- Email **NJPR@wellcare.com**

To submit an application for enrollment in WellCare's provider network:

- Contact Provider Relations:
  1. Call **1-973-274-2100**
  2. Visit **www.wellcare.com/en/New-Jersey/Become-a-Provider** for all counties and all provider types
  3. Send an email inquiry to **NJPR@wellcare.com**.
- Schedule a meeting
- Receive application
- Sign and return application including all up to date credentialing documents. All credentialing documents must not expire within the following 60 days after submission.

To submit application for network consideration:

- For Medical, Behavioral and HCBS – Mail to **550 Broad St. 12th Floor Newark, NJ 07102**
- For Dental – Contact Liberty Dental at **1-888-352-7924** to be added to the WellCare panel
- For Vision – Contact Superior Vision at **1-866-819-4298** to be added to the WellCare panel
- For Hearing – Contact HearUSA at **1-800-333-3389** to be added to the WellCare panel

*Completing the online form or sending an email is an inquiry for consideration and not an official registration. WellCare will review the request, and a representative will follow up and provide assistance through the formal application process.

Application process can take up to 90 days.

WellCare Website

Visit **www.wellcare.com/New-Jersey/Providers/Medicaid** to:

- Search for providers by county (includes visibility into open/closed panels) by clicking on "Find a Provider"
- Review the **Provider Resource Guide**
- **Access Claims/Encounter Guides and other Job Aids**
- **Access the secure Provider Portal**

Provider Portal

The secure Provider Portal offers 24-hour access to the following:

- Submit a claim
- Check status of a claim
- Check member eligibility and co-payment information
- Run reports e.g., Member Panel
- Submit and Check Care Gaps (PCPs)
- Request an authorization
- Check status of a prior authorization
- Access online training
- Catch up on provider news

Log onto the web portal at **https://provider.wellcare.com/**

To register to use the secure provider portal, an account will need to be created. The following is needed to create a new account:

- Name of Person to Access Account
- Primary Group or Physician address
- Phone Number for the Group or Physician

Additionally, the following actions need to be taken

- Provider must assign an Administrator whether there is one or many users
- Within 24 hours of registration, an email with a temporary password will be sent. Use this password (within 30 days) to log into the portal and create a permanent password to complete the registration process.
- Once access portal, there are training videos and materials on using it.

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Claim Submission Information

Submission Inquiries

Provider Services **1-888-453-2534**

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

Electronic Funds Transfer & Electronic Remittance Advice:
Register online using the simplified, enhanced provider registration process:
PaySpan.com or call **1-877-331-7154.** For more details on PaySpan, please refer to your **Provider Manual**.

Clearinghouse Connectivity Setup & Connection Support:
WellCare has partnered with Change Healthcare, formerly known as Relay Health, as our preferred EDI Clearinghouse. You may connect directly to Change Healthcare or in some cases your existing clearinghouse, billing service, or trading partner may maintain existing reciprocal agreements with Change Healthcare. We encourage you to contact your claims vendor and determine if they have connectivity to Change Healthcare. If not, you may want to consider contacting Change Healthcare to establish free connectivity to WellCare for your EDI transactions.

Change Healthcare offers Submitter/client Connectivity Services at **1-877-411-7271**. All Clearinghouses, Practice Management Vendors or Billing Services may call Change Healthcare, formerly known as Relay Health, at **1-800-527-8133** for connectivity services.

Change Healthcare CPIDs: If your billing system is connected to Change Healthcare and requires a 4-digit Change Healthcare payer ID, please use the following according to the file type (Fee-For-Service or Encounters):

Claim Type	Fee for Service (CH-Chargeable) Submissions	Encounter (RP-Reporting only) Submissions
Professional	1844	3211
Institutional	8551	4949

WELLCARE PAYER IDS – If your clearinghouse or billing system is not connected to Change Healthcare and requires a five-digit Payer ID, please use the following according to the file type (Fee-For-Service or Encounters):

- **Fee For Service (FFS) is defined in the Transaction Type Code BHT06 as CH which means Chargeable, expecting adjudication.**
- **Encounters (ENC) is defined in the Transaction Type Code BHT06 as RP which means Reportable only, NOT expecting adjudication.**

Claim Type	Fee for Service (CH-Chargeable) Submissions	Encounter (RP-Reporting only) Submissions
Professional or Institutional	14163	59354

Free Direct Data Entry (DDE) and Small Batch File Solutions (use same WellCare Payer IDs defined above)

AdminisTEP offers a web browser for single submission direct data entry (DDE) or batch upload for professional and institutional submissions, claim status and reporting and inquiry functions **at no cost to you**. To sign up go to **http://www.administep.com/Signup.aspx** or call **1-888-751-3271**.

Connect Center™ for physicians offers a web browser for direct data entry (DDE) or batch upload capability **at no cost to you for you**. To sign up, go to **https://physician.connectcenter.changehealthcare.com**. For registry questions, submitter/clients may contact Provider Connectivity Services at **1-877-411-7271**. Direct questions regarding functionality of ConnectCenter to the Clearinghouse at **1-800-527-8133, opt 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.

WellCare follows the Centers for Medicare and Medicaid Services' (CMS) guidelines for paper claim submissions. Since Oct. 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. To download claim forms and guidelines and to check the status of an initial claim submission and/or adjusted and appealed claims, visit our website at: **www.wellcare.com/New-Jersey/Providers/Medicaid/Claims**

Paper claims (new and corrected) are verified by the provider portal.

Mail paper claim submissions to:

WellCare Health Plans, Inc. Claims Department
P.O. Box 31224
Tampa, FL 33631-3224

Claim Payment Disputes

The claim payment dispute process is designed to address claim denials for issues related to untimely filing, unlisted procedure codes and noncovered codes, etc. Claim payment disputes must be submitted in writing to WellCare within 90 days of the date on the EOP.

Submit all claims payment disputes with supporting documentation on our website**: https://provider.wellcare.com/**

Mail all claim payment disputes with supporting documentation to:

WellCare Health Plans, Inc.
Attn: Claim Payment Disputes
P.O. Box 31370
Tampa, FL 33631-3370

Note: Any appeals related to a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification must be sent to the Appeals (Medical) address in the section below. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC, however, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals PO Box with all substantiating information like a summary of the appeal, relevant medical records and member specific information.

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Claim Payment Policy Disputes

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 must be submitted to WellCare in writing within **90 days** of the date of denial on the EOP. Please provide all relevant documentation, which may include medical records, in order to facilitate the review. Submit all Claims Payment Policy Disputes related to Explanation of Payment Codes beginning with IHXXX, CEXXX or PDXXX on our website**:** **https://provider.wellcare.com/**

Mail all disputes related to Explanation of Payment Codes beginning with CEXXX, IHXXX, MKXXX or PDXXX to:	**WellCare Health Plans, Inc.** **Payment Policy Disputes Department** **P.O. Box 31426** **Tampa, FL 33631-3426**
Mail all medical records and first level disputes related to Explanation of Payment Codes beginning with CPIXX:	**By Mail (U.S. Postal Service)** **Phone: 1-844-458-6739** **OPTUM** **P.O. Box 52846** **Philadelphia, PA 19115** **By Delivery Services (FedEx, UPS)** **OPTUM** **458 Pike Road** **Huntingdon Valley, PA 19006**
Mail all disputes related to Explanation of Payment Codes LTXXX, RVLTX:	**WellCare Health Plans, Inc.** **CCR** **P.O. Box 31394** **Tampa, FL 33631-3394**

Recovery/Cost Containment Unit (CCU)

Refund(s) in response to a WellCare overpayment notification should include a copy of the overpayment notification as well as a copy of attachment(s) and sent to:	**WellCare Health Plans, Inc.** **Attn: CCU Recovery** **P.O Box 31584** **Tampa, FL 33631-3584**

If you do not agree with this proposed WellCare overpayment notification related to adjustments **RVXX** (**Except RV059** that should refer to the **Claim Payment Disputes** section above), you may request an Administrative Review by submitting your request in writing within **45 days** of the date of this letter. Your request should detail why you disagree with these findings and must include any supporting evidence/documentation you believe is pertinent to your position.

Mail or fax your Administrative Review request to:	**WellCare Health Plans, Inc.** **Fax: 813-283-3284** **Attn: CCU Recovery** **P.O Box 31658** **Tampa, FL 33631-3658**

Additional documentation received after your initial Administrative Review request will not be considered. A Final Determination will be rendered within **30 days** of the date of WellCare's receipt of your request. If you do not object or render payment within such time period, we will take action to recover the above listed amount as allowed by law, or applicable, the contract between you and WellCare.

Administrative Reviews related to Explanation of Payment Codes and Comments beginning with DN227, DN228, or RV213 must be submitted in writing and include at a minimum: a summary of the review request, the member's name, member's identification number, date of service(s), reason(s) why the denial should be reversed and copies of related documentation and all applicable medical records related to both stays to support appropriateness of the services rendered.

Mail or fax your dispute to:	**COTIVITI HEALTHCARE** **Fax: 1-203-202-6607** **Attn: WellCare Clinical Chart Validation** **Hillcrest III Building** **731 Arbor Way, Suite 150** **Blue Bell, PA 19422C**

Provider Identified Refund(s) without receiving overpayment notification should include the reason for overpayment as well as any details that assist in identifying the member and WellCare Claim ID.

Please submit to**:**	**WellCare Health Plans, Inc.** **Attn: CCU Recovery** **P.O. Box 31584** **Tampa, FL 33631-3584**

Note: For single claim checks, please use the **Refund Check Informational Sheet** to help Recovery post accurately and timely. For checks in excess of 25 claims, please complete the **Refund Referral Grid** and email all supporting documentation, including the grid, to **OverpaymentRefunds@wellcare.com** to assist with expedited posting. Please note that only check referrals will be accepted by this email box; anything other than check referrals will not be responded to and will be closed.

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Appeals (Medical)

Providers may file an appeal on behalf of the member with the member's written consent. 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. Examples include Explanation of Payment Codes DN001, DN004, DN0038, DN039, VSTEX, DMNNE, HRM16, and KYREC, however, this is not an all-encompassing list of Appeals codes. Anything else related to authorization, or medical necessity that is in question should be sent to the Appeals P.O. Box with all substantiating information like a summary of the appeal, relevant medical records and member specific information.

Mail or fax medical appeals with supporting documentation to:

WellCare Health Plans, Inc. **Fax 1-866-201-0657**
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

WellCare does not send an acknowledgement letter upon receipt of a provider appeal. However, a written resolution letter is sent to the provider.

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 1-866-388-1769**
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384

WellCare Partners

eviCore aka CareCore National

eviCore is our in-network vendor for the following programs and clinical criteria can be accessed through the corresponding program links: **Advanced Radiology**, **Cardiology**, **Lab Management**, **Pain Management**, **Physical and Occupational Therapy**, and **Sleep Diagnostics**.
Contact eviCore for all ***authorization***-related submissions for the services listed above rendered in outpatient places of service (including the home setting). Please click on the hyperlinks above for a listing of the specific services and related criteria included in the eviCore programs.

Web submissions are faster and if the procedure requested meets clinical criteria, the Web provides an immediate approval that can be printed for easy reference. Member eligibility and authorization requests may be submitted via the **eviCore Provider Web Portal**. A searchable **Authorization Lookup and Eligibility Tool** is also available online and criteria can be accessed through the program links above.

Urgent Authorizations and Provider Services **1-888-333-8641**

HealthHelp®

HealthHelp is our in-network vendor for the following programs and provider resources. The vendor can be accessed through the corresponding program links: **Radiation Therapy and Medical Oncology**.

Contact HealthHelp for all **authorization-related** submissions for the services listed above rendered in all outpatient places of service. Please click on the links above for a listing of the specific services and related resources included in the HealthHelp programs.

Member eligibility and authorization request materials may be accessed via the **HealthHelp Portal**. A searchable **Authorization Lookup** also available online to check the status of your authorization request and criteria can be accessed through the program links above.

Urgent Authorizations and Provider Services **1-888-210-3736**

Contracted Networks

Vision – Superior Vision	**Provider Services**	**1-866-819-4298**	**Hearing –**	**Hear USA**	**1-800-333-3389**

Transportation * **1-888-453-2534**

*Please confirm benefit coverage and limitations at member's plan level.

For your convenience, language on this QRG in bold, underlined fonts are hyperlinks to supporting WellCare Provider Job Aids, Resource Guides and forms when the Quick Reference Guide is viewed in an electronic format.
NOTE: This guide is not intended to be an all-inclusive list of covered services under WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions. Authorization does not guarantee claims payment. All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable Plan coverage guidelines.

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Dental Services

Liberty Dental Plan:

Provider Service Line: 1-888-352-7924
Fax: 800-268-0154
Email (Provider Relations Inquiry): prinquiries@libertydentalplan.com
Website Address and Link to Liberty Provider Manual:
https://www.libertydentalplan.com/Providers/Provider-Resource-Library.aspx
https://www.libertydentalplan.com/New-Jersey/LIBERTY-Dental-Plan-of-New-Jersey.aspx

Address:
Liberty Dental Plan
PO Box 26110
Santa Ana, CA 92799-6110

Provider Portal (i-Transact)
www.libertydentalplan.com

For claims submission address:
Liberty Dental Plan
Attn: Claims Department
PO Box 401086
Las Vegas, NV 89140

Treatment for dental emergencies (to include oral-facial trauma)

At the time emergency dental services are provided to a member/enrollee, member service department must be notified by telephone or fax.

- The Dental Director or his designee shall approve or disapprove the request for the emergency care by telephone or fax.
- Authorization is created for approval for treatment and logged into database.
- Written documentation of the necessity for emergency services must accompany the request for reimbursement.
- Claims received for reimbursement are date stamped on arrival.
- Matched with authorizations, logged into system.

Summary of procedures regarding approval and/or claims payment for out of state and out of network providers

In order for a claim to be accepted and adjudicated, the claim must be received by LIBERTY within **90 days** after the date of service for contracted providers and within **180 days** after the date of service for non-contracted providers. In order for a claim to be considered a "complete claim," it must contain, at a minimum, all the attachments and supplemental information or documentation needed to provide "reasonably relevant information" and "information necessary to determine payer liability" and the following information:

- provider name and license number
- provider facility address
- member name, date of birth, and social security number
- date(s) of service
- ADA / CDT 9 codes
- billed charges for each services
- provider tax ID number or social security number

The "complete claim" may be submitted electronically, via paper, or other agreed upon method. The attachments or supplemental information/documentation needed varies by provider type and service but must provide the minimum information to properly adjudicate the claim and determine payer liability. Although emergency services or out-of-area urgently needed services do not require authorization in order to be considered a "complete claim," the claim must include documentation, including X-rays, that is immediately identifiable as emergent or out-of-area urgent.

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Pharmacy Services

Pharmacy Services **1-888-453-2534**
Including after-hours and weekends **(CVS/Caremark™)**

Rx BIN	**Rx PCN**	**Rx GRP**
004336	MCAIDADV	RX8895

Exactus™ Pharmacy Solutions **1-866-458-9246**
exactus@wellcare.com **TTY 1-855-516-5636**
Fax 1-866-458-9245

Mail Service Pharmacy:
CVS/Caremark Mail Service **1-866-808-7471**
TTY 1-866-236-1069
Fax 1-866-892-8194

Medication Appeals **Fax 1-888-865-6531**
Mail **medication appeals forms** with supporting documentation to:

WellCare Health Plans, Inc.
Attn: Pharmacy Appeals Department
P.O. Box 31398
Tampa, FL 33631-3398

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

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

WellCare Health Plans, Clinical Pharmacy Department
Director of Formulary Services
Pharmacy and Therapeutics Committee
P.O. Box 31577
Tampa, FL 33631-3577

Coverage Determination Requests **FAX: 1-888-340-9512**

Submit a **Coverage Determination Request Form** for:

- Drugs not listed on the Preferred Drug List (PDL)
- Drugs listed on the PDL with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limits (QL)
- Most self-injectable and infusion drugs (including chemotherapy) administered in a physician's office
- Brand-name drugs when an equivalent generic exists
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate
- Drugs that have an age limit (AL)
- Multi-ingredient compounds exceeding $300.00 cost (PA)

HealthHelp® manages Medical Oncology.
Please see below for HealthHelp Contact Information.

Web-based information:
www.wellcare.com/New-Jersey/Providers/Medicaid/Pharmacy

- **Pharmacy Services overview**
- **WellCare of New Jersey Preferred Drug List**
- **Authorization Lookup Tool**
- **Participating Pharmacies**
- **Pharmacy Services forms**

For NJ Liberty (SNP) web-based information:
www.wellcare.com/en/new-jersey/members/medicare-plans-2017/wellcare-liberty-hmo-snp

For Home Infusion/Enteral services:
Once Authorization Approval is obtained through WellCare, please contact our preferred provider **Coram** to initiate services:
Phone: 1-800-423-1411 or **Fax: 1-866-462-6726**

WELLCARE'S PRIOR AUTHORIZATION (PA) LIST:
For full list of Prior Authorizations requirements access www.wellcare.com/en/New-Jersey/Providers/Authorization-Lookup

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. Authorization changes are denoted by a ⚐ symbol for easy identification. Requirements that have been edited for clarification only are denoted with a ⓘ symbol.

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 at an office, clinic or free-standing facility. **A written or faxed script to the specialist is required.** The reason for the referral and the name of the specialist must be documented in the medical record. **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. Specialists may not refer members directly to other specialists.

To check the status of a prior authorization (medical, behavioral, pharmacy, dental) or changes to a prior authorization, please call Provider Services at **1-888-453-2534** or visit **provider.wellcare.com**
For information regarding the status of a prior authorization for LTC (PCA, Medical Day Care, PDN, or HCBS) Please call **1-855-642-6185.**

***Urgent* Authorization Requests and Admission Notifications – Call 1-888-453-2534 for Medical, Behavioral, SUD, PCS, MLTSS, Pharmacy**

- **Web submissions** are faster, and if the procedure requested meets the clinical criteria, the Web provides an approval that can be printed for easy reference
- Notify the plan of unplanned inpatient hospital admissions within **24 hours** of admission (except normal maternity delivery admissions). Telephone authorizations must be followed by a fax submission of clinical information to 1-855-776-9464 – by the next business day.
- Outpatient authorizations for urgent and time sensitive services may be requested by phone when warranted by the member's condition. Please include **CPT and ICD-10 codes** with your authorization request. Standard authorization requests may be submitted online or via fax using the numbers listed below if you are unable to access the portal with your secure login at **https://provider.wellcare.com**.
- Obtaining authorization does not guarantee payment, but rather only confirms whether a service meets WellCare's determination criteria at the time of the request. WellCare retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, the medical necessity of services, and correct coding and billing practices.

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Behavioral Health Services

WellCare Web Submission Portal

For Urgent and Inpatient Hospitalization Authorizations and Provider Services Phone: 1 888 453 2534

Please log in to submit your Outpatient Authorization Requests & Inpatient Clinical only (not Authorization) Submissions.

To fax a request, please access our forms here

Web-based information: **www.wellcare.com/New-Jersey/Providers/Medicaid/Behavioral-Health**

- Emergency behavioral services do not require prior authorization. **In order to obtain authorization, notification of an Inpatient admission is required on the next business day following admission.**
- Inpatient concurrent review is generally done by telephone, but a fax option is available and the forms and fax numbers can be found here. Psychological testing is done telephonically or via fax. All other levels of care requiring authorization including outpatient services can be submitted online.
- For Behavioral Health Crisis call **1-800-411-6485**
- For more information on Authorization Requirements click here and select the "Prior Authorization Grid" PDF under **Helpful Documents**
- Please submit your request for more sessions at least two weeks prior to the completion of the current authorized session(s). Behavioral Health Services are performed by WellCare network providers.

PROCEDURES and SERVICES	Authorization Required	Comments
Emergency Behavioral Health Services	**No**	
Non-contracted (nonparticipating) Provider Services	**Yes**	All services from nonparticipating providers require authorization.
Behavioral Services	**See Comments**	The list of authorizations on the Quick Reference Guide is not the complete list. Please refer to the Prior Authorization Grid under **Helpful Documents** for a complete list of authorization requirements. WellCare Web Submission Portal

Emergency Services

PROCEDURES and SERVICES	Authorization Required	Comments
Emergency Behavioral Health Services	**No**	
Emergent Care Services	**No**	
Emergency Transportation Services	**No**	
Urgent Care Services	**No**	

Inpatient Services

WellCare Web Submission Portal

Please log in to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions.

For non participating providers please use our form here

PROCEDURES and SERVICES	Authorization Required	Comments
Elective Inpatient Procedures	**Yes**	Clinical updates required for continued length of stay.
Inpatient Admissions	**Yes**	Clinical updates required for continued length of stay. *Excludes Normal Newborn Deliveries
Long Term Acute Care Hospital (LTACH) Admissions	**Yes**	Clinical updates required for continued length of stay.
NICU/Sick Baby Admissions	**Yes**	Notification to the plan is required within **24 hours** following admission. Contact Progeny Health at fax **1-844-395-0842** to submit clinical updates for initial and continued length of stay.
Normal Newborn Deliveries	**No**	
Observations (22)*	**See Comments**	ⓘ Elective procedures that convert to an Observation stay are subject to Outpatient authorization requirements. **Authorization Lookup Tool** Services performed during a non-elective Observation stay, such as Advanced Radiology or Cardiology, do not require authorization. Clinical updates required for continued length of stay.
Rehabilitation Facility Admissions	**Yes**	Clinical updates required for continued length of stay.
Skilled Nursing Facility Admissions	**Yes**	Clinical updates required for continued length of stay.

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Outpatient Services

WellCare Web Submission Portal

MLTSS members:

All Outpatient services Fax **1 855 573 2346**

Non MLTSS members:

Please log in to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions.
For non participating providers please use our form here

Pharmacy Medical Requests Fax **1 888 481 7703**

PROCEDURES and SERVICES	Authorization Required	Comments
Select Outpatient Procedures	**Yes - See Comments**	Please refer to the **Authorization Lookup Tool** for prior authorization requirements **WellCare Web Submission Portal**
Advanced Radiology Services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, OB Ultrasounds, PET & SPECT Scans	**Yes - See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **No authorization is required for the initial three OB ultrasounds.** **Advanced Radiology Program Criteria** **Radiology Request Forms**
Cardiology Services: Cardiac Imaging, Cardiac Catheterization, Diagnostic Cardiac Procedures and Echo Stress Tests	**Yes - See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Cardiology Program Criteria** **Cardiology Worksheets**
Dialysis and End Stage Renal Disease Services	**No**	
Durable Medical Equipment purchases and rentals	**Yes – See Comments**	All DME rentals require authorization. DME purchase items reimbursed at OR below **$500** per line item do NOT require authorization.
Home Infusion/Enteral Services	**Yes**	Once Authorization Approval is obtained through WellCare, please contact our preferred provider, **Coram**, to initiate Services: **Phone: 1-800-423-1411 or Fax 1-866-462-6726**
Home and Community Based Services – Benefit for MLTSS Members Only	**Yes**	
Hospice Care Services	**No**	
Investigational & Experimental Procedures and Treatment	**Yes – See Comments**	Refer to **Clinical Coverage Guidelines** **WellCare Web Submission Portal**
Laboratory Management (Certain Molecular and Genetic Tests)	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **WellCare Lab Management Criteria** **Molecular and Genetic Testing Quick ReferenceGuide**
Medical Oncology Services	**Yes – See Comments**	Contact HealthHelp for authorization: **HealthHelp Portal** Phone Number **1-888-210-3736** **Medical Oncology Program Services**
Non-contracted (nonparticipating) Provider Services	**Yes**	All services from nonparticipating providers require authorization.
Orthotics and Prosthetics	**Yes – See Comments**	Purchase items reimbursed at OR below $500 per line item do NOT require authorization.
Pain Management Treatment	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Pain Management Program Criteria** **Musculoskeletal Management Request Forms**

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PROCEDURES and SERVICES	Authorization Required	Comments
Physical and Occupational Therapy (including home-based therapy)	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Physical and Occupational Therapy Criteria** **PT/OT Worksheets**
Radiation Therapy Management	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Radiation Therapy Management Program Criteria** **Radiation Therapy Worksheets**
Radiation Therapy Management	**Yes – See Comments**	Contact HealthHelp for authorization: **HealthHelp Portal** Phone Number **1-888-210-3736** **Radiation Therapy Management Program Resources**
Sleep Diagnostics (11, 12, 22 & 49)*	**Yes – See Comments**	Contact eviCore for authorization: **eviCore Provider Web Portal** Phone Number **1-888-333-8641** **Sleep Diagnostics Program Criteria** **Sleep Management Worksheets**
Speech Therapy	**Yes**	
Transportation (Nonmedical) – Benefit for MLTSS Members Only	**Yes**	

Personal Care Services

WellCare Web Submission Portal

Personal Care Service Requests Fax **1 888 342 6548**

PROCEDURES and SERVICES	Authorization Required	Comments
Personal Care Assistants	**Yes**	
Medical Day Care	**Yes**	

Transplant Services

WellCare Web Submission Portal

Please **log in** to submit your Outpatient Authorization Requests & Inpatient Hospitalization Clinical only (not Authorization) Submissions.
For non participating providers please use our form **here**

PROCEDURES and SERVICES	Authorization Required	Comments
Transplant Services	**Yes**	Please submit clinical records for prior authorization for all transplant phases

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Coordination of Benefits (COB) Frequently Asked Questions

1. **Q:** What is the contact number and /or email address for questions related to COB?
   A: Providers can call **1-888-453-2534** or visit **www.wellcare.com/New-Jersey/Contact-Us**

2. **Q:** If a member is dually eligible or has a TPL policy how often does the provider have to submit a denial from Medicare and/or the TPL insurer?
   A: The Provider will have to submit a denial from Medicare and/or the TPL, annually as long as the Member is covered under the plan or until the coverage is termed.

3. **Q:** Does the Provider submit the denial from the Medicare and/or Commercial Insurance provider electronically or hard copy?
   A: The submission can be submitted both paper and electronic.

4. **Q:** If the EOB denial can be submitted in hard copy what is the address for submission?
   A: WellCare Health Plans, Inc.
   Attn: Claim Payment Department
   P.O. Box 31224
   Tampa, FL 33631-3224

5. **Q:** How do providers track progress of paper copies of the EOB for individual members?
   A: Provider will have to register to PaySpanHealth.com. PaySpan Health offers providers a complete solution for claims payment management. Providers can manage multiple payers, choose from among common and proprietary formats for ERAs, easily reconcile payments with claims, and take advantage of claim and remittance retrieval and reporting. Providers can contact PaySpan Health by calling **1-877-331-7154** or emailing **providersupport@payspanhealth.com**.

6. **Q:** What is required for Providers to submit to WellCare if Member has Medicare and/or Commercial Insurance and the Provider does not participate in the Medicare and/or Commercial Network?
   A: The Provider will have to submit to the Primary Insurance Carrier first even if the Provider does not participate in the Medicare and/or Commercial Network. If the Member has a primary insurance carrier, WellCare requires a copy of the explanation of payment from the other carrier before paying as primary.

7. **Q:** Who do providers contact for technical assistance regarding claims submission and coordination of benefits for dually eligible members and members with Commercial Insurance?
   A: Providers can contact Provider Services at **1-888-453-2534** for questions related to claim submissions. For inquires related to your electronic submissions to WellCare, please contact our EDI team at **EDI-Master@wellcare.com**. Claim forms and guidelines can be found online at **www.wellcare.com/New-Jersey/Providers/Medicaid/Claims**.

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