California Medicare Quick Reference Guide

July 2022

www.wellcare.com/California/Providers/Medicare

IMPORTANT NOTE

Please refer to the member ID card to determine appropriate authorization and claims submission process.
Please see below for additional information.

IMPORTANT PHONE NUMBERS

NURSE ADVICE LINE: 800-581-9952
Members may call this number to speak to a nurse **24 hours** a day, **7 days** a week.

CONVENIENT SELF-SERVICE

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

	Portal	Chat	(IVR) Interactive Voice Response
Benefit Information	**Fastest Result**	**Available**	Available
Claims Status	**Fastest Result**	**Available**	Available
Eligibility Verification	**Fastest Result**	**Available**	Available

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

ⓘNote: Includes Pharmacy Medical Requests supplied by physician.
For Pharmacy Benefit related questions please see the Pharmacy Services section.

Provider Services: Interactive Voice Response System Phone: 866-999-3945 TTY: 711

WELLCARE PHONE NUMBERS

RISK MANAGEMENT
FRAUD, WASTE & ABUSE HOTLINE
866-685-8664

COMMUNITY CONNECTIONS HELP LINE
866-775-2192

UTILIZATION MANAGEMENT

PROVIDER SERVICES
Phone: 866-999-3945
Fax: 855-547-9764
Email: ECFaxMedicalManagement@wellcare.com

CASE MANAGEMENT

PROVIDER SERVICES
Phone: 866-999-3945 TTY: 711
Fax: 855-538-0455
Hours: M–F 8 a.m.–4 p.m. Pacific
Email: ECCaseManagement@wellcare.com

QUALITY IMPROVEMENT

QUALITY OF CARE
Phone: 866-999-3945
Fax: 855-671-0254
Email: ECQualityImprovement@wellcare.com

For your convenience, when viewing online, items on this QRG in bold, underlined fonts are hyperlinks to supporting Provider Job Aids, resource guides and forms. NOTE: This guide is not intended to be an all-inclusive list of covered services under Wellcare, a plan offered by WellCare Health Plans, Inc., but it substantially provides current referral and prior authorization instructions All services/procedures are subject to benefit coverage, limitations and exclusions as described in the applicable plan coverage guidelines.

22-449/FLY671799EH01w (7/22)

QUALITY IMPROVEMENT CONTINUED

HEDIS®
Phone: 866-999-3945
Fax: 855-696-7549

CLAIM SUBMISSION INFORMATION

SUBMISSION INQUIRIES:

Support from Provider Services: 866-999-3945
For inquiries related to your electronic or paper submissions to Wellcare, please contact our EDI team at **EDI-Master@wellcare.com**.

ELECTRONIC FUNDS TRANSFER AND ELECTRONIC REMITTANCE ADVICE:

Register online using the simplified, enhanced provider registration process at **PaySpan.com** or call **877-331-7154**. For more details on PaySpan, please refer to your **Provider Manual**.

CLEARINGHOUSE CONNECTIVITY:

Wellcare encourages EDI submissions as they are free to the Provider Community, providing improved accuracy and the fastest turnaround time and enhanced claim status information.

CHANGE HEALTHCARE CLEARINGHOUSE PAYER IDS (CPIDS)

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

PAYER IDs – If your clearinghouse or billing system is not connected to Change Healthcare and requires a 5-digit Payer ID, please use the following according to the file type (Fee-for-Service or Encounters):

Claim Type	FFS (CH – Chargeable) Submissions	Encounter (RF – Reporting only) Submissions
Professional or Institutional	14163	59354

PAPER SUBMISSION GUIDELINES:

We follow the Centers for Medicare & Medicaid Services (CMS) guidelines for paper claim submissions. Since October 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.

Click here to locate claim forms and guidelines.

MAIL PAPER CLAIM SUBMISSIONS TO:

Wellcare
Attn: Claims Department
P.O. Box 260519
Plano, TX 75026-0519

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CLAIM PAYMENT DISPUTES

The Claim Payment Dispute Process is designed to address claim denials for issues related to untimely filing, incidental procedures, unlisted procedure codes, non-covered codes etc. Claim payment disputes must be submitted in writing to Wellcare **within 90 calendar days** of the date on the EOP for contracted providers. Non-participating provider must submit payment disputes in writing within 120 days of the date on the EOP. Submit all claims payment disputes with supporting documentation at **https://provider.wellcare.com/**

MAIL ALL CLAIM PAYMENT DISPUTES WITH SUPPORTING DOCUMENTATION TO:

Wellcare
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, DN038, 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. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

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 us in writing within **90 calendar days** of the date on the EOP for contracted providers. Non-participating providers must submit payment policy-related issues in writing within 120 days of the date on the EOP. Please provide all relevant documentation (please do not include image of claim), 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 IH###, CE###, CCV### (Medical records required) or PD### at: **https://provider.wellcare.com/California**.

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH IH###, CE###, CV### (MEDICAL RECORDS REQUIRED) OR PD### TO:

Wellcare
Attn: Payment Policy Disputes Department
P.O. Box 31426
Tampa, FL 33631-3426

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CLAIM PAYMENT POLICY DISPUTES CONTINUED

MAIL ALL MEDICAL RECORDS AND INITIAL REVIEWS AND 1ST LEVEL APPEALS RELATED TO EXPLANATION OF PAYMENT CODES BEGINNING WITH CPI##:

BY MAIL (U.S. POSTAL SERVICE)
Phone: 844-458-6739
Fax: 267-687-0994
Optum
P.O. Box 52846
Philadelphia, PA 19115

BY DELIVERY SERVICES (FEDEX, UPS)
Optum
458 Pike Road
Huntingdon Valley, PA 19006

BY SECURE INTERNET UPLOAD
Refer to Optum's Medical Record Request letter for further instructions

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES LT###, RVLT# AND CPI## 2ND LEVEL APPEALS TO:

Wellcare
Attn: CCR
P.O. Box 31394
Tampa, FL 33631-3394

MAIL ALL DISPUTES RELATED TO EXPLANATION OF PAYMENT CODES RVPI# TO:

PICRA
P.O. Box 31416
Tampa, FL 33631-3416

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 the attachment(s) and sent to:

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
PO Box 947945
Atlanta, GA 30394-7945

If you do not agree with this proposed Wellcare overpayment notification related to adjustments **RVXX (Except RV059**, which should refer to the **Claim Payment Disputes** section above), you may request an Administrative Review by submitting a dispute in writing within **45 days** of the recovery letter date. 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:

Fax: 813-283-3284
Wellcare
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 submit a dispute or render payment within the time period referenced above, we will take action to recover the amount owed as allowed by law, or as outlined within the contract between you and Wellcare.

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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(s) of service, reason(s) why the denial should be reversed, copies of related documentation and all applicable medical records related to support appropriateness of the services rendered.

YOUR DISPUTE SHOULD BE SENT TO:
Fax: 203-202-6607
Cotiviti
Attn: Wellcare Clinical Chart Validation
HillCrest III Building
731 Arbor Way, Suite 150
Blue Bell, PA 19422

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.

Wellcare – Comprehensive Health Management
Attn: Recovery/Cost Containment Unit (CCU)
PO Box 947945
Atlanta, GA 30394-7945

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.

APPEALS (MEDICAL)

All non-participating Medicare provider appeals must be submitted within **60 calendar days** and they must also submit a signed waiver of liability (WOL) with their request for processing. Participating providers also can seek an appeal through the Appeals Department within **90 calendar days** of a claim denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Examples include Explanation of Payment codes DN001, DN004, DN038, 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. Include all substantiating information (please do not include image of claim) like a summary of the appeal, relevant medical records and member-specific information.

MAIL OR FAX ALL MEDICAL APPEALS WITH SUPPORTING DOCUMENTATION TO:
Fax: 866-201-0657
Wellcare
Attn: Appeals Department
P.O. Box 31368
Tampa, FL 33631-3368

GRIEVANCES

Member grievances may be filed verbally by contacting Customer Service or submitted in writing via mail, email or fax. Providers may also file a grievance on behalf of the member with the member's written consent. Provider complaints related to any administrative issue, such as Wellcare's policies and procedures or authorization/referral process, must be submitted within **60 calendar days** of the event that gave rise to the complaint.

Medicare Appointment of Representative Form

MAIL, EMAIL, PHONE OR FAX ALL MEMBER GRIEVANCES TO:
Phone: 877-902-6784
Fax: 866-388-1769
Wellcare
Attn: Grievance Department
P.O. Box 31384
Tampa, FL 33631-3384
Email: Operationalgrievance@wellcare.com or pdpgrievance@wellcare.com

BEHAVIORAL HEALTH

Please refer to your primary care provider for a list of options.

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HEALTH PLAN PARTNERS

Contracted Networks

HEARING

HCS
Phone: **866-344-7756**

VISION

Envolve
Phone: **866-392-6058**

DENTAL

Delta Dental
Phone: **855-643-8515**

TRANSPORTATION

Access2Care
Phone: **844-809-9034**

- Members must call **48 business hours** in advance for routine trips and may call same day for urgent care. Benefit limitations may apply.
- Please contact Provider Services for additional information.

OTC

United Medco
Phone: **888-979-4319**

PHARMACY SERVICES

PHARMACY SERVICES: **866-999-3945**

Including after-hours and weekends – CVS Caremark®

Rx BIN	Rx PCN	Rx GRP
004336	MEDDADV	788257

Click here to locate CVS Caremark®
Mail Order Info: **844-635-3406**
TTY: **866-507-6135**
Fax: **866-892-8194**

ACARIAHEALTH™

AcariaHealth is a national comprehensive specialty pharmacy focused on improving care and outcomes for patients living with complex and chronic conditions. AcariaHealth comprises dedicated healthcare professionals who work closely with physician offices, including support with referral and prior authorization processes. This collaboration allows our patients to receive the medicine they need as fast as possible.

Representatives are available from Monday–Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 6 p.m. ET.

AcariaHealth™ Pharmacy #26, Inc.
8715 Henderson Rd., Tampa, FL 33634
Phone: 866-458-9246 (TTY 855-516-5636)
Fax: 866-458-9245
Website: www.acariahealth.com

MEDICATION APPEALS: **Phone: 866-999-3945**

Fax: 866-388-1766

Click here to locate Medication Appeal Request (form) and mail with supporting documentation to:

Wellcare
Attn: Pharmacy Appeals Department
P.O. Box 31383
Tampa, FL 33631-3383

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

FORMULARY INCLUSIONS:

To request consideration for inclusion of a drug to the formulary, providers may submit a medical justification to us in writing to:

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

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PHARMACY SERVICES CONTINUED

COVERAGE DETERMINATION REQUESTS:

Phone: 866-999-3945
Fax: 866-388-1767

Click here to locate Coverage Determination Request (form) to be submitted for the exceptions listed below:

- Medications not listed on the formulary
- Drugs listed on the formulary with a prior authorization (PA)
- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity limit (QL)
- Most self-injectable and infusion medications (including chemotherapy administered in a physician's office)
- Drugs that have a step edit (ST) and the first-line therapy is inappropriate
- Drugs that have an age limit (AL)
- Drugs listed on the formulary with a quantity limit (QL)

Click here to locate **the Medication Guide/Formulary**

Click here to locate **Pharmacy Request forms** such as Injectable Infusion, CVS Caremark Mail Order Service, etc.

Click here to locate **AcariaHealth™ Pharmacy Solutions – Specialty**

HealthHelp will manage Medical Oncology Services. Please see below for HealthHelp Contact Information.
For Home Infusion/Enteral services:
Once authorization approval is obtained through Wellcare, if required, please contact our providers below to initiate services:

Coram®: Phone: 800-423-1411 or Fax: 866-462-6726

Option Care Health™ aka Option Care and BioScrip Infusion Services® and Crescent Healthcare: Phone: 833-466-0358

KabaFusion: Phone: 562-863-0555 or Fax: 877-445-8821

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REQUIREMENTS

Wellcare delegates prior authorization to the contracted MSO, IPA or medical group that then determines prior authorization requirements for their assigned members.

IPAs must make every attempt to authorize services that are the financial responsibility of Wellcare to a provider within Wellcare's contracted network. If a member requires out-of-network services because Wellcare is not contracted with a provider of like specialty, the IPA is required to notify Wellcare's Utilization Management Department prior to issuing an authorization.

The Utilization Management Department will discuss the case with the Wellcare Contracting Department and notify the IPA accordingly such that an authorization may be issued. For services that are the financial responsibility of the IPA, the IPA is required to follow its organization's policy in reference to authorization of out-of-network providers.

Emergency admissions that are outside the IPA/medical group's service area are monitored by the Wellcare Utilization Management Department. Wellcare's Medical Management Department will be responsible for issuing an authorization, performing concurrent review, and working with the IPA to coordinate transfer of the member to an in-network facility once the member has been stabilized.

For specific authorization requirements, please follow your group's direction.

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