

A collage of medical professionals in white coats, including doctors and nurses, in various clinical settings. The background is a mix of teal and light green squares.

PROVIDER

Newsletter

DID YOU KNOW?

These tips can help you stay informed with your claims submission and more!

- Make sure you include your current **interim rate letter** with your claim submission if the interim rate has changed since your previous submission.
- Based on CMS guidelines, make sure to add a **certificate of medical necessity (CMN)** when applicable.

WAYS TO SUBMIT PFFS CLAIMS:

- WellCare PFFS accepts **EDI claims**, which can process faster, reduce errors, simplify billing, ensure receipt of claim data and more. The WellCare PFFS EDI Payer ID number is 77072. (In some markets, WellCare has multiple product lines and it is important to use this number for PFFS claims.)

- If you are not registered for electronic claim submission or have technical difficulties, contact Emdeon Business Services between 8am and 8pm Eastern at **1-800-845-6592**, or register online at **emdeon.com**.

- To avoid delays send paper claims to:

Medicare-Covered Claims:

WellCare Health Plans, Inc.
P.O. Box 4438
Scranton, PA 18505

Non-Medicare-Covered Claims:

Dental

Doral National Medicare Plan
P.O. Box 45
Grafton, WI 53024

Vision

Advantica EyeCare
P.O. Box 6546
Ellicott City, MD 21042

Hearing

HearUSA Hearing Care Network
P.O. Box 220807
West Palm Beach, FL 33422

PFFS MEMBER ID NUMBERS START WITH F

You can tell if a patient is a WellCare PFFS member by looking at their member ID number. If it starts with an "F," then it is a PFFS member. If it is all a numeric number then it is most likely a member of another WellCare line of business.

WELLCARE HAS MULTIPLE LINES OF BUSINESS IN SOME STATES

At this time, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas have multiple lines of WellCare business. Each business may have its own member and provider contact phone numbers. For lines of business other than PFFS visit **www.wellcare.com** for contact information.

WHAT TO DO IF YOU SUSPECT FRAUD AND ABUSE

You may report suspected health care fraud and abuse by telephone through the toll-free confidential Compliance Program Hotline at **1-866-678-8355**, 24 hours a day, 7 days a week.

You may also report suspected health care fraud and abuse in writing to the corporate Special Investigations Unit at:

WellCare Health Plans, Inc.
Attn: Director, Special Investigations Unit
P.O. Box 31407
Tampa, FL 33631-3407

If you have problems submitting claims, contact our Provider Service Center at **1-866-235-2770** (TTY/TDD: **1-866-239-6265**) Monday–Sunday, 7am to 2am Eastern.

Coming Soon! The 2009 Provider Resource Guide will be posted to our Web site shortly (**www.wellcarepffs.com/provider/resources**). It includes helpful and important information to help you and your staff stay informed and provide a positive patient experience.

GET TO KNOW WELLCARE'S PRODUCT LINES

WellCare, through its subsidiaries, is a leading provider of managed care services dedicated to government-sponsored health care programs, focusing on Medicaid and Medicare. We operate a variety of health plans for families, children, the aged, blind or disabled, as well as prescription drug plans and private fee-for-service plans.

Our products are designed to offer enhanced benefits to our members as well as cost-sharing alternatives. These products allow flexibility and offer a distinct set of benefits to fit member needs. Below is a list of our products:

MEDICAID

We provide health plans to participants in the federal Supplemental Security Income (SSI) program for the aged, blind and disabled and the Temporary Assistance to Needy Families (TANF) program for low-income families with children. We provide members with access to the entire continuum of care, resulting in healthier members and cost savings for government payers.

STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Under Medicaid, we participate in State Children's Health Insurance Programs (SCHIPs), providing health plans for infants, children and teens. These programs focus on preventive care such as vaccinations, "well-child" checkups and prescription drug coverage.

MEDICARE ADVANTAGE PLANS

COORDINATED CARE

Our coordinated care plans ensure members' access to comprehensive care with additional benefits that go beyond traditional Medicare. These additional benefits include lower co-payments as well as hearing, vision and dental care. Members are also given more options with prescription drug coverage and may choose a WellCare health plan with a built-in drug benefit.

PRESCRIPTION DRUG PLANS

WellCare offers stand-alone Part D prescription drug plans (PDPs) with low premiums and low co-pays. The plans are available nationwide. Our current suite of products includes plans with zero deductible as well as plans offering generic drug coverage in the "doughnut hole."

PRIVATE FEE-FOR-SERVICE

WellCare offers Private Fee-for-Service (PFFS) plans that allow members to see any Medicare-eligible physician or facility that agrees to accept WellCare PFFS Terms and Conditions of Payment. PFFS plans are in place of Original Medicare and may include enhanced dental, vision and hearing coverage and Part D prescription drug coverage.



Please note that WellCare may have PFFS and coordinated care plans in the same counties in some states. In an effort to streamline provider payment and service, please note these plans may have different billing addresses, member ID numbers and support service numbers.



IN A NUTSHELL: CLAIM DISPUTES AND BENEFIT APPEALS

Providers have the right to address situations when they feel they haven't been paid fairly or when they disagree with a plan decision about services. There are two separate processes for trying to resolve these issues. Knowing what steps to take and when can help you save time and avoid frustration.

PROVIDER CLAIM PAYMENT DISPUTES

This happens when you believe that the payment amount you received for a service is less than the amount indicated in our *Terms and Conditions of Payment*. If so, follow the Provider Claims Payment Dispute Resolution Process.

A provider has 120 days from the date of the initial determination notice to submit a dispute. To submit a dispute, mail or fax the *Provider Claim Payment Resolution Process Form*, a copy of the claim being disputed and all supporting documentation to:

Mail: WellCare Health Plans, Inc.
Attn: PFFS Provider Claims Dispute
P.O. Box 4438
Scranton, PA 18505

Fax: 1-866-473-9122

WellCare will resolve provider claim disputes within 30 days of receipt of the documentation.

After completing the WellCare PFFS dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by CMS. To file a request for review of a payment dispute with the independent entity, you may contact the entity directly. Contact information is available via our Web site at www.wellcarepffs.com/provider/claiminformation.

PROVIDER APPEAL FOR MEDICAL NECESSITY AND/OR BENEFITS PROCESS

You would follow this process if you disagree with a decision the plan made about coverage. This type of decision might include the following:

- Denial or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or in part, of payment for a service that the enrollee believes is medically necessary.

- The failure to provide services in a timely manner or to provide the enrollee with timely notice of an adverse determination, when such a delay would adversely affect the health of the enrollee.

A provider has 60 days from the date of the initial determination to submit a medical necessity and/or benefit appeal. To submit an appeal, mail or fax the *Provider PFFS Appeal Form*, all other appropriate appeal forms and medical records to:

Mail: WellCare Health Plans, Inc.
Attn: PFFS Provider Appeals
P.O. Box 31368
Tampa, FL 33631

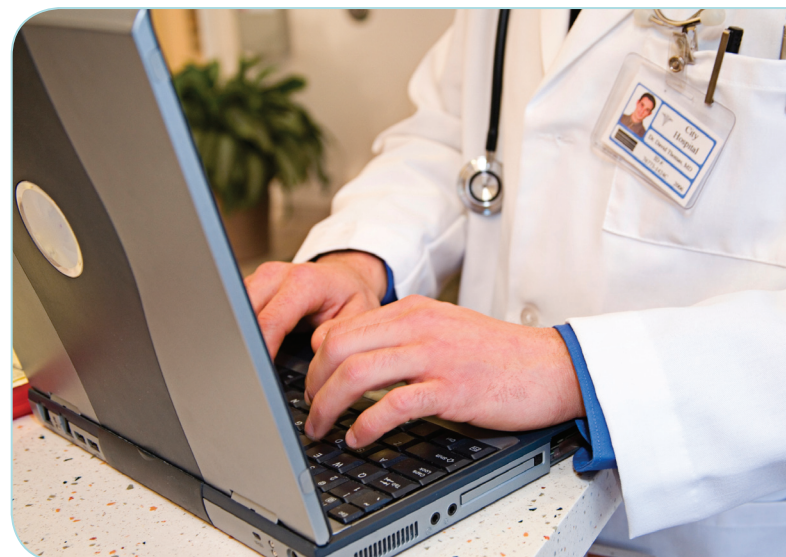
Fax: 1-866-201-0657

WellCare will resolve provider appeals in writing within 60 days of receiving the appeal.

A provider may also appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability in order for a provider to appeal utilizing the member's appeal process.

QUESTIONS? NEED FORMS?

You can find WellCare PFFS plans' claim dispute and appeals procedures and appropriate forms online at www.wellcarepffs.com/provider. Contact our Provider Service Center at 1-866-235-2770 (TTY/TDD: 1-866-239-6265) Monday–Sunday, 7am to 2am Eastern for questions related to claim disputes or appeals.



WELLCARE PFFS PROVIDER FORMS ON OUR WEB SITE

Need forms in a hurry? Just visit www.wellcarepffs.com/provider/forms for these and more:

Appointment of Representation Form	To be used when acting on behalf of a member in connection with a claim or an asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act.
Provider Claim Payment Resolution Process Form	To be used if you believe that the payment amount you received for a service is less than the amount indicated in our <i>Terms and Conditions of Payment</i> . Submit this form along with a copy of the claim being disputed and all supporting documentation.
Provider PFFS Appeal Form	To be used when submitting a provider appeal for medical necessity and/or benefits. Submit this form along with all additional, appropriate appeal forms and medical records.
Waiver of Liability Form	To be used when using the member's appeal process. It promises you will hold the member harmless regardless of the outcome.
W-9 Form—Request for Taxpayer Identification Number and Certification	To be used to submit your tax identification number and certification either for the first time or anytime your tax information changes.

PHARMACY/PRESCRIPTION DRUG FORMS

Injectable/Infusion Prescription Order Form	To be used for an injectable infusion prior authorization request.
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DRUG EVALUATION PROCESS FORMS

Drug Evaluation Review (DER) Form	To be used to determine coverage for medication prior authorizations, non-formulary medications and medications with utilization management rules.
Redetermination Form	To be used when you want us to reconsider and change a decision we have made about what prescription drug benefits are covered or what we will pay for a prescription drug. In order to file an appeal, you must first go through the Drug Evaluation Review (DER) process.
IRE Reconsideration Form	If the decision of the prescription drug appeal (redetermination) is to continue the denial of coverage or payment, then the member or the member's appointed representative has the right to file a request for reconsideration with Maximus, a company contracted by Medicare to review managed care organization denials. This is the form that should be used for that process.

COORDINATION OF BENEFITS—PFFS

A FRIENDLY REMINDER ABOUT DUAL-ELIGIBLE MEMBERS

Coordinating benefits for Medicare/Medicaid dual-eligible members can be difficult. As such, we want to share some information regarding cost-sharing coverage for dual-eligible members in WellCare PFFS plans.

When you bill WellCare PFFS as the primary payer for services to a dual-eligible member, you must look to the state Medicaid agency to collect the Medicaid-allowable cost-sharing amount for PFFS members. WellCare PFFS *Terms and Conditions of Payment* prohibits you from balance-billing the member.

PREVENTIVE SCREENINGS, DIABETIC ANNUAL EYE EXAMS AND GLAUCOMA SCREENING

HEDIS®—the Healthcare Effectiveness Data and Information Set—is a widely used scorecard of plan performance. It gives a plan and its members an idea of how well the plan measures up in crucial areas like quality of care, access to care, and member satisfaction with the health plan and doctors.

HEDIS® ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

For providers, HEDIS® can help you proactively manage patients' care. It can help you ensure members are getting the preventive screenings they need. It also lets you know how you compare with other WellCare providers as well as with the national average.

A FOCUS ON PREVENTIVE CARE

Preventive screenings, diabetic annual eye exams and glaucoma screenings are a crucial part of the HEDIS® scoring process. Many members know these preventive services are important but may forget to schedule them.

Below is a quick reference to use in billing for several common preventive services. You can find more on the CMS Web site: www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf

HOW YOU CAN HELP

- Encourage your patients to schedule preventive exams.
- Remind your patients to follow up with ordered tests.
- Complete outreach calls to noncompliant members.

OTHER HEDIS® TIPS

- Be sure to code the diabetic diagnosis along with diabetic eye exams.
- When you perform a preventive screening during an annual health exam, be sure to submit bills for the screenings along with the billing for the exam.
- WellCare covers glaucoma screening and diabetic annual eye exams, so please don't hesitate to submit claims data for these services.

MANY WELLCARE PFFS PREVENTIVE SERVICES HAVE \$0 CO-PAYS

- \$0 co-pay for Medicare-covered bone mass measurement.
- \$0 co-pay for Medicare-covered colorectal screenings.
- \$0 co-pay for flu and pneumonia vaccines.
- \$0 co-pay for hepatitis B vaccine.
- \$0 co-pay for Medicare-covered screening mammograms.
- \$0 co-pay for Medicare-covered Pap smears and pelvic exams.
- \$0 co-pay for Medicare-covered prostate cancer screening.

SERVICE	HCCPS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED?
Diabetes Screening Tests	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (includes glucose)	V77.1 <i>Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of pre-diabetes</i>	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes <i>Beneficiaries previously diagnosed with diabetes are not eligible for this benefit</i>
Screening Mammography	77052, 77057, G0202	V76.11 or V76.12	All female Medicare beneficiaries age 40 or older
Bone Mass Measurements	G0130, 77078, 77079, 77080, 77081, 77083, 76977	Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for developing osteoporosis
Glaucoma Screening	G0117 – By an optometrist or ophthalmologist G0118 – Under the direct supervision of an optometrist or ophthalmologist	V80.1	Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and over

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
Source: www.ncqa.org



Private Fee-for-Service (PFFS)
Provider Relations
P.O. Box 31405
Tampa, FL 33631-3405

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WELLCARE PFFS SERVICES FOR PROVIDERS

WellCare Private Fee-for-Service (PFFS) is committed to supporting providers' efforts by offering:

The WellCare PFFS Provider Service Center (PSC)—helps in getting questions answered—**1-866-235-2770** (TTY/TDD: **1-866-239-6265**) Monday–Sunday, 7am to 2am Eastern. The PSC is staffed by knowledgeable, trained associates who

are ready to assist providers in their inquiries about WellCare PFFS plans, member eligibility, claim status and more.

EDI Submission—Submit your claims electronically. Claims submitted electronically process faster, have less chance of error, simplify billing, minimize cash flow disruption, receive fewer claim rejections and streamline administrative tasks. Please use Payer ID #77072 for WellCare PFFS submissions. If you are not already set up for EDI and need assistance or more information, contact Emdeon Business Services at **1-800-845-6592** between 8am and 8pm or visit www.emdeon.com.

Visit www.wellcarepffs.com to find the tools you need.

- Member Summary of Benefits (under “Our Plans”)
- Terms and Conditions of Payment
- Proxy Reimbursement Grid
- Quick Reference Guide
- In addition, after a simple registration process you can access the following with just a few clicks.
 - Claim status
 - Claim payments including line-by-line payment information
 - Member eligibility

