



WellCare of Nebraska

June 2016 Provider Webinar



- **Contracting and Credentialing**
- **Claims Submission**
- **Appeals and Grievances**
- **Authorizations**
- **Care Management**

CONTRACTING AND CREDENTIALING

Provider Contracting Process



- Provider contract packets have been mailed to Medicaid providers across the state.
- Packets include:
 - *Informational Cover Letter*
 - *Participating Provider Agreement (the contract)*
 - *WellCare Fact Sheet*
 - *Provider Profile sheet*
 - *IRS Form W-9 (“Request for Taxpayer Identification”)*
 - *Nebraska Ownership/Controlling Interest and Conviction Disclosure Form*
- Instructions for help with completing any of the requested information is also included.

Credentialing Requirements



Provider Credentialing is required by law, and WellCare makes every effort to simplify the process while still meeting federal and state regulatory requirements.

CAQH (www.caqh.org) is a national non-profit organization dedicated to reducing the administrative burden of provider credentialing. For more information about enrolling with CAQH, please visit their website.

While WellCare gladly accepts CAQH in lieu of a credentialing application, it is **VERY IMPORTANT** that providers have attested to their CAQH profile within the last six months, and that WellCare has been selected by the provider as an approved payer in order for us to access the provider's CAQH profile. Expiration of CAQH attestation is one of the most frequent reasons for delay in provider credentialing.

For providers who do not participate in CAQH, WellCare's provider credentialing application can be found here:

<https://www.wellcare.com/Nebraska/Providers/Medicaid>

The Credentialing Process



- WellCare follows the specific credentialing process and corresponding criteria set forth by NCQA.
- Whether you provide a completed credentialing application or a recently-attested CAQH number, WellCare's credentialing team will conduct primary source verification as appropriate and prepare the provider's file for review by the Credentials Committee.
- "Clean" credentialing files are reviewed weekly by our Medical Directors and approved accordingly.
- Chaired by our Medical Director, the Credentials Committee meets monthly and makes the final recommendation to accept providers as fully-approved participants in WellCare's provider network.

Contract Effective Date



Providers properly credentialed in 2016 will have a contract effective date of January 1, 2017 to coincide with the launch of Heritage Health.

For providers who submit their contracts and are credentialed after January 1, 2017, contracts will be effective the first day of the following month.

The provider will receive a letter advising them of their contract's effective date, along with an executed copy of the contract. The letter will also include their new WellCare provider identification number and instructions on how to register as a participating provider on our website.

To Avoid Delays...



There are several things a provider can do to avoid delays in the contracting and credentialing process.

- Ensure that the group name (or individual provider's name) *EXACTLY* matches the name reflected on IRS Form W-9.
- If submitting a CAQH number in lieu of a credentialing application, please ensure that the CAQH profile has been attested to in the last six months.
- The CAQH profile or curriculum vitae must reflect work experience for the last five years; if there are gaps, please provide explanation.
- If the answer is “yes” to any of the disclosure questions on the Nebraska Ownership/Controlling Interest and Conviction Disclosure form, please include explanation.

CLAIMS

Claims Submission Timeframes



1. Claims must be submitted within **180 days** of the date of service.
2. Claims will be processed and paid or denied within **15 business days** of receipt.
3. Daily check runs for both paper checks and electronic funds transfer (EFT) payments, except for Sundays and the last day of each month.

You may submit claims to WellCare three ways:

1. Electronic Submission via Electronic Data Interchange
 - a) WellCare's preferred clearinghouse is RelayHealth
2. Direct Data Entry through secure web portal
3. Paper Claims may be mailed to:

**WellCare of Nebraska
Claims Department
PO Box 31372
Tampa, FL 33631**

Appeals and Grievances



•Provider Appeals

- ❑ A Provider may request an Appeal regarding Provider payment or contractual issues, on his or her own behalf within **90 calendar days** from the original utilization management notice of action or claim denial.
- ❑ Cases filed after **90 calendar days** will be denied for untimely filing. If the Provider feels they have filed their case within the appropriate time frame, the Provider may submit documentation showing proof of timely filing.
- ❑ The plan will review the authorization denial, claim or claim-related issue for resolution and respond to the provider within **45 calendar days** of the day after the date of submission to the Plan.
- ❑ When submitting an appeal, the provider must:
 - Supply specific, pertinent documentation that supports the appeal.
 - Include all medical records that apply to the service.
 - Submit the appeal and accompanying documentation to the address below:

WellCare Appeals
P.O. Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657
Telephone: 1-866-334-7927

Hours of Operation: Monday–Friday, from 8 a.m. to 7 p.m.

AUTHORIZATIONS

Utilization Management



WellCare of Nebraska's Utilization Management (UM) program includes review processes such as notifications, referrals, prior authorization, concurrent review and/or retrospective review.

Prior Authorization

- WellCare of Nebraska requires prior authorization for elective or non-emergency services, as designated by WellCare of Nebraska.
- **Reasons for requiring authorization may include:**
 - Review for medical necessity
 - Appropriateness of rendering provider and/or place of service
 - Appropriateness of setting
 - Care and Disease management considerations
- **Decision Timeframes:**
 - Notice will be given as expeditiously as a member's condition requires, but will not exceed 14 calendar days from receipt of request. Certain requests have specific contractual timeframes (ex., pharmacy requests must be turned around within 24 hours)
 - Expedited requests will not exceed 72 hours from receipt of request
- **Prior authorizations may be requested three ways:**
 - Online via the secure Provider Portal
 - Fax
 - Phone for urgent requests

Retrospective Review

- WellCare of Nebraska reviews post-service requests for authorizations of inpatient admissions or outpatient services when there are retro-eligibility instances (please submit proof of retro eligibility when submitting a retro review request).
- Retrospective review includes making coverage determinations for the appropriate level of services, quality issues, utilization issues and the rationale behind failure to follow WellCare of Nebraska's prior authorization guidelines.
- A retrospective review can be initiated by WellCare of Nebraska or the provider.
- Retrospective reviews may take up to 30 days to make a determination.

Resources Available On Web Portal:

Clinical Coverage Guidelines (CCGs)

We offer a helpful search tool that allows providers to search evidence-based guidelines detailing the medical necessity of procedures or technologies.

Clinical Practice Guidelines (CPGs)

Best-practice recommendations based on available clinical outcome trend and scientific evidence.

Authorization Look-up Tool

An easy way to verify authorization requirements by CPT code and place of service.

Utilization Management



Authorization Lookup Tool

WellCare Health Plans [Login / Register](#) [Contact Us](#) [Help](#) [Illinois](#)

[Need a Plan](#) [Members](#) [Providers](#) [Corporate](#) [Find a Provider/Pharmacy](#)

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Providers

[Providers](#) / [Authorization Lookup](#)

Related Information

[CareCore National](#)

Authorization Lookup

Please select your line of business and enter a CPT to look up authorization for services.

Select Line of Business

Enter CPT Code

[Reset](#)

[Lookup](#)

Resources:

- [CPT Code Additions to Authorization Required List – Effective 4/1/16](#)
- [Medicaid Quick Reference Guide](#)
- [Medicare Quick Reference Guide](#)

Utilization Management



WellCare Health Plans Search WellCare Login / Register Contact Us Help Illinois

Need a Plan Members Providers Corporate Find a Provider/Pharmacy PDF Print Page Help

Providers

Providers / Authorization Lookup

Authorization Lookup

Please select your line of business and enter a CPT to look up authorization for services.

Select Line of Business
IMD - Harmony Illinois (Medicaid)

Enter CPT Code
99363

Reset Lookup

Results as of : 6/8/2016 11:57:28 AM

CPT Code :
99363

Description :
ANTICOAGULANT MANAGEMENT FOR AN OUTPATIENT TAKING WARFARIN,
PHYSICIAN REVIEW AND INTERPRETATION OF INTERNATIONAL NORMALIZED RATIO

11 Office :
No Authorization Required

22 Outpatient Hospital :
No Authorization Required

24 Ambulatory Surgery :
No Authorization Required

Resources:

- CPT Code Additions to Authorization Required List – Effective 4/1/16
- Medicaid Quick Reference Guide
- Medicare Quick Reference Guide

Related Information

[CareCore National](#)

Important Contacts



For questions/support or to request a contract packet:

NetworkExpansion@wellcare.com

Phone: 1-855-599-3814

Fax: 1-877-277-1815

Local Contact:

Tracy Smith, Senior Director of Network Management

tracy.smith@wellcare.com

402-802-6936