

OHIO MEDICAID QUICK REFERENCE GUIDE

October 2011

Web Address: <http://ohio.wellcare.com>

Important Telephone Numbers		
Provider Services (800) 951-7719 Eligibility verification, Claims, Utilization Mgmt., Translation Services, Transportation and Provider Complaints	Nurse Advice Line (800) 951-7719 Members may call this number to speak to a nurse 24 hours a day, 7 days a week.	
TTY/TDD (877) 247-6272	Risk Management (866) 678-8355 Fraud, Waste and Abuse Hotline	
How to Become a Registered Web User		
How to Verify Eligibility		
Claim Submissions	Claim Payment Disputes	
Claims Department (800) 951-7719 Including EDI questions and assistance Preferred EDI Partner EDI Payor ID RelayHealth (McKesson) 14163 (877) 411-7271 Encounter Data Submissions 59354 WellCare follows the Centers for Medicare and 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. Claim forms and guidelines may be found on our website at: http://ohio.wellcare.com/provider/resources Mail paper claim submissions to: WellCare Health Plans, Inc. Claims Department PO Box 31224 Tampa, FL 33631-3224	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 days of the date on the EOP. Mail or fax all claim payment disputes with supporting documentation to: WellCare Health Plans, Inc. Fax (877) 277-1808 Attn: Claim Payment Disputes PO Box 31370 Tampa, FL 33631-3370 <th style="background-color: #0056b3; color: white;">Claim Payment Policy Disputes</th> 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 (Explanation of Payment Codes beginning with IHXXX, MKXXX or PDXXX) must be submitted to WellCare in writing within 90 days of the date of denial on the EOP. Mail all disputes related to payment policy issues to: WellCare Health Plans, Inc. Fax (877) 277-1808 Payment Policy Disputes Department PO Box 31426 Tampa, FL 33631-3426	Claim Payment Policy Disputes
Appeals (Medical)		
Providers may seek an appeal through the Appeals department within ninety calendar days of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient documentation or late notification. Mail or fax medical appeals with supporting documentation to: WellCare Health Plans, Inc. Fax (866) 201-0657 Attn: Appeals Department PO Box 31368 Tampa, FL 33631-3368		
Non-Medicare Member Appointment of Representative Form		
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 (866) 388-1769 Attn: Grievance Department PO Box 31384 Tampa, FL 33631-3384 Non-Medicare Member Grievance Form		

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Pharmacy Services

Pharmacy Services (800) 951-7719
Including after-hours and weekends (CatalystRx)
Group number 716257
BIN 603286
PCN 01410000

Medication Appeals Fax (888) 865-6531

Medication appeals may also be initiated by calling Provider Services.

Mail medication appeals with supporting documentation to:

WellCare Health Plan, Inc.
Attn: Pharmacy Appeals Department
PO Box 31398
Tampa, FL 33631-3398

To request consideration for inclusion of a drug to WellCare's PDL, providers may write WellCare explaining the medical justification.

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

Drug Evaluation Review (DER) Fax (877) 277-6892

DER requests are required for:

- Brand name drugs when a generic exists
- Drugs not listed on the Preferred Drug List (PDL)
- Drugs listed on the PDL with a Prior Authorization (PA)
- Drugs that have a step edit (ST) and the first line therapy is inappropriate
- Prescriptions that exceed the FDA daily or monthly quantity limit (QL)
- Duplication of therapy
- Most self-injectable and infusion drugs

Web-based information: www.ohio.wellcare.com

- Pharmacy services overview
- Preferred Drug List (PDL)
- Participating pharmacies

[Injectable Infusion Request Form](#)

[Enteral Nutrition Request Form](#)

[Medical Injectables – No Authorization Required List](#)

Behavioral Health

Magellan Behavioral Health (800) 951-7719

- Contact Magellan for **all** Mental Health and Substance Abuse services including Inpatient hospitalization **and** Outpatient counseling.
- Inpatient admission notification is required within 24 hours.
- Authorization is not required for the first outpatient visit. **Prior approval is required for continued services.**

For real-time authorization responses, submit your secure request online at www.MagellanHealth.com/provider (select "Request Outpatient Authorization"). Complete your request for more sessions at least two weeks prior to the completion of the current authorized session(s).

Radiology Prior Authorization

CareCore National is our in-network radiology services vendor for places of service (POS): 11, 22 & 24. Contact CareCore for all *authorization* related submissions for services rendered in places of service listed above.

Urgent Authorizations and Provider Services (888) 333-8641
Authorization Request Submissions Fax (866) 896-2152

Web submissions may also be submitted via the [CareCore Provider Web Portal](#) or www.carecorenational.com.

[CareCore National Frequently Asked Questions \(FAQs\)](#)

Contracted Networks

Dental (800) 341-8478
[DentaQuest](#)

**Routine dental services do not require an authorization.*

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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. There were no changes to authorization requirements on this list. Requirements that have been edited for *clarification only* are denoted with a ① symbol.

All services rendered by non-participating providers and facilities require authorization. Primary Care Specialists must refer members to participating specialists. It is the responsibility of the provider rendering care to verify that the authorization request was approved before services are rendered.

A referral is a request by a PCP for a member to be evaluated and/or treated by a participating specialty physician. No communication to WellCare is required.

Hyperlinks for some supporting WellCare forms and documents have been added to this Quick Reference Guide. Additional forms and documents such as Hysterectomy Consent Forms, Claims Encounter Guides and Authorization Request Forms are available online by visiting <http://ohio.wellcare.com/provider/forms>.

Prior Authorization requests for members under age 21 for screening, diagnostic and treatment services available to Medicaid consumers pursuant to 42 U.S.C. 1396d(a) that go beyond the coverage and limitations set forth in Chapters 5101:3-1 to 5101:3-24 to 5101:3-30 and 5101:3-56 of the OAC must be reviewed for medical necessity as defined in OAC 5101:3-1-01.

WELLCARE'S PRIOR AUTHORIZATION (PA) LIST:

- **Inpatient admission notifications:** Submit unplanned Inpatient hospital admission notifications to the Plan by calling (800) 951-7719. Inpatient hospital admission notification is requested by the next business day. Clinical information can be faxed to the Inpatient Services fax number listed below.
- **Urgent and time sensitive outpatient requests:** Requests for urgent and time sensitive outpatient services may be submitted via phone when warranted by the member's condition by calling: (800) 951-7719. Please include **CPT and ICD-9 codes** with your authorization request.
- **Standard authorizations requests:** Submit requests online or via fax using the numbers listed below.
- **OB Notifications:** Please fax notification of the first Obstetric visit to (877) 647-7475. OB Notifications may also be submitted online.

PROCEDURES and SERVICES	Auth Required	No Auth Required	Comments
📄 = New or changed requirement ① = Clarification of current requirement			
DME Services		Fax (877) 431-8859	
All Durable Medical Equipment rentals	X		
Durable Medical Equipment purchases (Including Orthotics and Prosthetics)	X		DME purchases with billed charges less than \$200 per item do not require an authorization.
Hearing Aids	X		Refer to Clinical Coverage Guidelines
Home Health Services		Fax (866) 886-4321	
Home health care services	X		
Inpatient Services		Fax (877) 431-8860	
Ambulance services		X	
Emergency behavioral health services		X	
Emergency room services		X	
Inpatient hospital admissions	X		Clinical updates required for continued length of stay.
Labor checks		X	
Long Term Acute Care Hospital (LTACH) admissions	X		Clinical updates required for continued length of stay.
Newborn (normal) deliveries ①		X	Notification is requested the next business day following the delivery.
NICU/Sick Baby admissions ①	X		Notification is required the next business day following the admission. Clinical updates required for continued length of stay.
Observation stays (up to 48 hours) ①		X	Notification is required regardless of the length of stay.
Rehabilitation facility admissions	X		Clinical updates required for continued length of stay.
Skilled nursing facility admissions	X		Clinical updates required for continued length of stay.




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Outpatient Services		Fax (877) 277-1820	
Abortions (ODJFS certification form required)	X		ODJFS Abortion Certification Form
Advanced Radiology services: CT, CTA, MRA, MRI, Nuclear Cardiology, Nuclear Medicine, OB Ultrasounds, PET & SPECT scans (11, 22 & 24)*	X		Contact CareCore National for authorization. See Radiology Prior Authorization on page 2. <i>No authorization is required for the initial 3 OB ultrasounds: (CPT code ranges 76801 – 76810 & 76815)</i>
Allergy and Clinical Immunology services	X		Includes CPT code ranges: 95010, 95015 – 95075, 95120 - 95199
Arterial Blood Gasses		X	CPT code 36600
Cardiac and Pulmonary Rehabilitation Programs	X		Refer to Clinical Coverage Guidelines
Chiropractic care services		X	15 visits per rolling 12 months for members over age 21. 30 visits per rolling 12 months for members under age 21.
Cytogenetic, Reproductive and Molecular Diagnostic Laboratory testing	X		Refer to Clinical Coverage Guidelines
Dermatology procedures (POS 11 only)	X		Exceptions: No Authorization is required for CPT code ranges: 1400 – 14061, 14350, 15100, 15120 – 15121, 15200, 15240 – 15261, 15576, 15630, 15731, 15740, 15760, 17000 – 17004, 17312, 17315, 21235, 41105
Dialysis		X	
Family planning		X	
Federally Qualified Health Center (FQHC), Public Health Clinic, Qualified Family Planning (QFP) and Rural Health Clinic (RHC) visits		X	
Gynecologist, Obstetrician and Certified Nurse Midwife services		X	
Hearing test evaluations		X	
Hospice care services	X		
New technology and experimental procedures	X		
Pain Management services	X		
Podiatry care		X	
Primary Care Physician (PCP) office visits		X	Includes health checks and annual exams
Radiology Anesthesia		X	Applicable CPT code range: 01916 - 01936
Routine Laboratory testing		X	
Routine Vision care services		X	
Routine X-ray films		X	
Sleep studies	X		
Sterilizations (consent form required for payment)		X	ODJFS Sterilization Consent Form Federal Sterilization Consent Form
Surgical procedures	X		Includes ambulatory surgery, cosmetic and oral surgery
Urgent Care center services		X	
Prenatal Notifications		Fax (877) 647-7475	
Obstetric Global Care		X	Prenatal notification form required
Skilled Therapy Services		Fax (877) 709-1698	
Occupational, Physical and Speech therapy services 	X		Authorization is not required for the initial evaluation. All subsequent treatment requires an authorization

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