CareCore National Frequently Asked Questions (FAQ)

1. What is changing?
   Based on the implementation date of your provider notification letter, a limited range of
   Musculoskeletal Pain, Sleep and Cardiology services will require prior authorization for correct
   claims payment. A list of criteria can be found at

2. Who is CareCore National?
   CareCore National is a company that provides Utilization Management services for Health Plans.
   As a specialty benefit management company, CareCore manages the quality and use of
   outpatient diagnostic and cardiac imaging, cardiac implantable devices, oncology drugs and
   therapeutic agents, radiation therapy, sleep, pain and lab services.

3. What is the relationship between the Plan and CareCore National?
   WellCare has contracted with CareCore National to manage select outpatient radiology,
   cardiology, musculoskeletal pain management, and sleep services.

4. How can I request a Prior Authorization?
   ▪ On the web at www.carecorenational.com. First time users will be required to register.
   ▪ By phone at 1-888-333-8641

5. What Plans are covered under this agreement and what are the Plan’s important telephone
   numbers?

<table>
<thead>
<tr>
<th>State / LOB</th>
<th>Phone Number</th>
<th>State / LOB</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT / Medicare</td>
<td>866-579-8006</td>
<td>LA/Medicare</td>
<td>866-804-5926</td>
</tr>
<tr>
<td>FL / Healthease</td>
<td>800-278-0656</td>
<td>MO / Medicare</td>
<td>866-687-8994</td>
</tr>
<tr>
<td>FL / Healthease-Kids</td>
<td>800-278-8178</td>
<td>NJ/ Medicare</td>
<td>866-687-8570</td>
</tr>
<tr>
<td>FL / Medicare</td>
<td>888-888-9355</td>
<td>NY / Medicaid</td>
<td>800-288-5441</td>
</tr>
<tr>
<td>FL / Staywell</td>
<td>866-334-7927</td>
<td>NY / Medicare</td>
<td>800-278-5155</td>
</tr>
<tr>
<td>FL / Staywell-Kids</td>
<td>866-698-5437</td>
<td>OH / Medicaid</td>
<td>800-951-7719</td>
</tr>
<tr>
<td>GA / Medicaid</td>
<td>866-231-1821</td>
<td>OH / Medicare</td>
<td>866-687-8815</td>
</tr>
<tr>
<td>GA / Medicare</td>
<td>866-334-7730</td>
<td>TX / Medicare</td>
<td>866-687-8878</td>
</tr>
<tr>
<td>IL / Medicaid</td>
<td>800-608-8158</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL / Medicare</td>
<td>866-334-6876</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. What are CareCore National’s hours and days of operation?
   CareCore National is available from 7:00 a.m. to 7:00 p.m. Monday through Friday. Web based
   services are available 24 hours a day, 7 days a week.
7. What holidays does CareCore National observe?

8. What is CareCore National’s Web site address?
   www.carecorenational.com

9. What is the Plan’s Web site address?
   www.wellcare.com

10. Will CareCore National be processing claims for the Plan?
    CareCore National will continue to process claims in New York only (all counties EXCEPT Erie, Monroe, Wayne, Onondaga, and Niagara) for diagnostic imaging outpatient services (POS 11).

11. Will new ID cards be issued to Plan members?
    No.

12. What procedures will require prior authorizations?
    **Radiology Procedures:** Magnetic Resonance Image (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CT), OB Ultrasounds (Medicaid ONLY), Positron-Emission Tomography (PET), and Nuclear Medicine.
    **Cardiology Procedures:** Nuclear Stress, Echocardiography, Echocardiography Stress, Cardiac MR, Cardiac PET, Cardiac CT/CCT, and Diagnostic Cardiac Heart Catheterizations.
    **Musculoskeletal Pain Management Services:** Including Percutaneous Injection Procedures for Epidural Nerve Blocks, Facet Joint Injections, Nerve Ablation, Pain Anesthesia MAC, Sacroiliac Joint Injections, Vertebroplasty/Kyphoplasty, and Trigger Point Injection Procedures amongst others as listed on the CareCore National Website
    **Sleep Procedures:** Attended Polysomnography (baseline and PAP titration), Home Sleep Tests, Multiple Sleep Latency Tests and Maintenance of Wakefulness Tests.
    A complete list of CPT codes that require prior authorization can be found on the CareCore National website at www.carecorenational.com.

13. What medical providers will be affected by this agreement?
    **Radiology Program:** All freestanding diagnostic facilities, outpatient hospital settings, and ambulatory surgery centers as well as any physician’s office that administers the procedures listed in question #13 above.
    **Sleep Program:** All Physicians who order sleep tests are required to obtain a prior authorization for services being rendered. The servicing provider must ensure that there is an authorization in order to ensure payment.
    **Cardiology Program:** All freestanding diagnostic facilities, outpatient hospital settings, and ambulatory surgery centers as well as any physician’s office that administers the procedures listed in question #13 above.
**Musculoskeletal Pain Program**: All freestanding diagnostic facilities, outpatient hospital settings, and ambulatory surgery centers as well as any physician’s office that provide pain management services.

14. If a Primary Care Physician refers a patient to a specialist, who determines that the patient needs a study that requires prior authorization, who needs to request the prior authorization? The physician who orders the study should request the prior authorization. In this case, it would be the specialist.

15. What information will be required to obtain a prior authorization?

- Members Plan Name
- Patient’s Name, Date of Birth, and Member ID Number
- Ordering Physician’s Name, Provider ID Number, Address, Telephone and Fax Numbers
- Facility’s Name, Telephone and Fax Number (For Radiology imaging and members in NY, NJ and CT only).
- Requested Test(s) (CPT Code or Description)
- Working Diagnosis
  - Signs and Symptoms
  - Results of Relevant Tests
  - Relevant Medications

If initiating the prior authorization by telephone, the caller should have the medical record available. Please note that some procedures may require clinical notes to be submitted to CareCore National prior to an authorization being issued.

16. Do the services provided in an inpatient setting at a hospital or emergency room setting require a prior authorization?

Studies ordered through an emergency room treatment visit or during an inpatient stay, **do not** require a prior authorization. However, pre-planned surgical procedures performed in an observation setting will require an authorization from CareCore.

17. What will happen if the referring provider’s office does not know the specific test code (CPT) that needs to be ordered?

CareCore National will assist the physician’s office in identifying the appropriate test based on presented clinical information and the Physicians’ Current Procedural Terminology (CPT) code.

18. If the referring provider orders a study, but the rendering provider (ex: radiologist or cardiologist) thinks it would be more appropriate to do a different study, will that require a correction to the prior authorization on file?

Yes. The rendering provider may call CareCore National and update the prior authorization up to three (3) days after the service has been rendered. A demonstration of medical necessity may be required with the modification request.

19. What is the process that providers will follow if CareCore National is not available when they need to obtain a prior authorization?
Providers may submit a request up to three (3) days after the service has been rendered via the web and CareCore National will process on the next business day. The clinical indication for the test must be included.

20. How can a referring provider indicate that the procedure is clinically urgent?

Notify the CareCore National Clinical Reviewer that the test is “URGENT” and demonstrate medical necessity by providing the appropriate clinical documentation. Urgent care decisions will be made when following the standard timeframe could result in seriously jeopardizing the member’s life, health or ability to regain maximum function.

21. How long will the prior authorization process take?

70% of all requests are resolved on first contact. If a prior authorization is initiated online and the request meets criteria, the test will be approved immediately, a time stamped approval will be available for printing.

22. What types of physicians does CareCore National employ to review prior authorization requests?

CareCore National employs physicians of various specialties to respond to network needs. The physicians employed have expertise in those procedures covered by the program to review clinical cases and to be available for physician to physician calls as necessary.

23. How will the referring provider or rendering provider know that a prior authorization has been completed?

The referring provider or rendering provider will be able to verify if a prior authorization request was approved by checking the status on the CareCore National website.

24. What information about the prior authorization will be visible on the CareCore National Web site?

- The authorization status function on the Web site will provide the following information:
  - Prior Authorization Number/Case Number
  - Status of Request
  - CPT Code
  - Procedure Name
  - Site Name and Location
  - Prior Authorization Date
  - Expiration Date

25. How will all parties be notified if the prior authorization has been approved?

Referring providers will be notified of the prior authorization via fax. Rendering providers can validate a prior authorization by using the CareCore National website. Members will be notified in writing of any adverse determinations. Written notification is provided upon request if the rendering provider contacts CareCore National’s Customer Service.
26. If a prior authorization is not approved, what follow up information will the referring provider receive?
   
   The referring provider will be informed of the reason for denial, as well as how to initiate a reconsideration or appeal. If a provider resubmits an authorization request for a service within the timeframe allowed for an appeal that was previously denied, CareCore National will consider this request an appeal and will forward to WellCare for review. If the timeframe to file an appeal has expired, the request will be treated as a new request for auth. Within seven business days after the denial has been issued, the provider may request reconsideration with a CareCore National Medical Director to review the decision.

27. Can the rendering provider or diagnostic facility initiate the prior authorization for the referring provider?
   
   No. The attending physician who has determined the need for the study must initiate the prior authorization. Therefore, it is the responsibility of the referring provider to obtain prior authorization.

28. Is there an appeals process if the prior authorization is not approved?
   
   Yes. The plan will be handling all levels of appeals. Appeal rights are detailed in communications sent to the providers with each adverse determination. Providers may also request reconsideration from CareCore within three days of the denial decision.

29. What is the format of the CareCore National authorization number?
   
   An authorization number is (1) one Alpha character followed by (9) nine numeric numbers, and then the CPT code of the procedure authorized. For example: A123456789-70553.

30. If a physician, wishes to modify an approved Non-contrast MRI to a Contrast MRI – does the physician need to notify CareCore National to update the authorization?
   
   Yes. The office needs to call within two (2) business days of rendering the procedure with clinical information indicating the necessity for the modification. The clinical information will be reviewed for medical necessity and a new authorization number will be issued if the procedure is determined to be medically necessary.

31. Is a separate authorization needed for each CPT code?
   
   Yes.

32. Does the authorization number need to be included on the claim form when submitting an insurance claim for payment?
   
   Yes, but only the Authorization Number for the Primary Procedure Code needs to be submitted on the claim.

33. How long will the authorization approval be valid?
   
   Prior Authorizations are valid for 45 calendar days from the date of the approval.
34. If a prior authorization number is valid for 45 days and a patient comes back within that time for follow up and needs another procedure, will a new authorization number be required? Yes.

35. If the office does not have web access, how can a provider verify that a study has been prior approved?  
   If the office does not have web access, you can call CareCore National toll free at 1-866-665-8323.

SPECIFIC PROGRAM QUESTIONS FOR SLEEP PROGRAM

1. How do I request a “Split-Night” Study?
   A “Split Night” request is initiated and approved as a 95810 attended sleep study. If the “Split-Night” is successfully completed, 95811 may be billed using the existing authorization number. Only one code (95811 or 95810) can be billed.