

## Frequently Asked Questions for Wellcare/Triad

### New York & New Jersey

**Summary:** Triad will assist WellCare in delivering a chiropractic benefit to their Medicare Advantage members in New York and New Jersey. Chiropractic Benefit Management includes clinical data collection, care planning, healthcare coaching, provider network management, and claims administration.

**EFFECTIVE DATE:** New York effective 5/27/2007. New Jersey effective 1/1/2008

**How do I verify patient eligibility?** Office staff may contact Triad at 1-800-409-9081 to verify member eligibility and inclusion in this program.

**Does Triad's program require a PCP referral?** This program does not require a PCP referral.

**Does the program require an authorization?** Yes. All chiropractic services must be reported utilizing the appropriate Triad pre-service care plan (Initial Care Plan [ICP] or Extension of Care Plan [EOC]) form. As a traditional Medicare-based program, Triad can only approve medically necessary chiropractic manipulative therapy (CMT) of the spine for eligible members and providers.

**When do I need to submit a care plan?** As with Triad's other programs, ICPs must be submitted before the patient's second visit, or within fourteen (14) days of the initial visit, whichever occurs first. The ICP should include services provided during the initial visit, in addition to the services you are planning to render. You may elect to provide additional information (i.e., SOAP notes) to Triad Healthcare for review.

**Why do I have to complete the entire Care Plan when only spinal CMT is covered?** This process is consistent across all of Triad's contracts. Consistent processes tend to be easier for providers to administer. This process also allows Triad to communicate to both the provider and the insured that non-covered services may be billed to the patient (following appropriate Medicare protocol), enforcing your advance notice to your patient of their financial responsibility for non-covered services. As previously noted, reporting this information to Triad enables us to recommend future enhancements to the fee schedule to benefit both the health plan's membership and the providers who treat them.

**Are my services going to be limited?** In general, the definition and limitation of covered services are embedded in your patient's summary of benefits and evidence of coverage (also referred to as the certificate of coverage). Although each health plan has their unique coverage limitations, many share common language that defines the parameters of covered and non-covered services. Most, if not all, have provisions which exclude coverage for services which are not found to be medically necessary. Triad is responsible for determining the medical necessity of services rendered, and provides the assistance of clinical coaches to assist and discuss determinations with our network providers. There is no maximum limit of medically necessary spinal CMT which can be rendered per year.



**Where do I submit medical records and care plans?** Fax your completed care plan and/or medical records to 1-866-225-1033. You may also mail completed care plans and/or medical records to Triad Healthcare, 80 Spring Lane, Plainville, CT 06062.

**Can a WellCare Medicare Advantage Member seek chiropractic care from any chiropractor?** Covered chiropractic services for WellCare's Medicare Advantage members are only available through Triad's network of participating providers who also participate with Medicare. If you currently participate with both Triad and Medicare and have not received a packet, please update your Medicare status with Triad's network management department and a packet will be sent to you accordingly.

**Who do I contact to obtain reimbursement for non-covered services?** In the event that a member requires or requests a service that is not a covered chiropractic service, the IPA provider must inform the member that the member will be personally responsible for all fees related to the service and the estimated fee for the service, and obtain an executed acknowledgement of financial responsibility from the member or the member's legal representative. Only if these steps have been taken shall the IPA provider be entitled to bill the member and collect for such services. Reimbursement for non-covered services are payable by the member once you follow appropriate Medicare guidelines. Since this is a Medicare Advantage Program which limits chiropractic coverage to spinal CMT, your patient may have coverage for other services provided by other health care providers. The member may contact WellCare's member services department at the number on the back of their identification card to obtain other coverage information.

**What are determinations of medical necessity?** Coverage is limited to medically necessary healthcare services not otherwise excluded from its benefit plans. Triad has been delegated the responsibility to review chiropractic services to determine medical necessity. In general, chiropractic care is considered medically necessary for the treatment of a wide scope of neuromusculoskeletal (NMS) conditions, the most common being spinal subluxation. After an initial trial, ongoing chiropractic care for these conditions is considered medically necessary during a period of time in which measurable clinical improvement of the patient is documented.

**How can I access Triad's Medical Policies?** All of Triad's medical policies are accessible on Triad's website ([www.triadhealthcareinc.com/providers/policies.aspx](http://www.triadhealthcareinc.com/providers/policies.aspx)). Changes to medical policy occur from time to time as new information and/or evidence becomes available. These changes are noted on the website and published thirty (30) days prior to implementation.

**Who performs determinations of medical necessity?** Determinations of medical necessity are performed by licensed chiropractors.

**How does the Pre-service process work?** The Pre-service process requires the use of a standardized data collection form – Triad Initial Care Plan and Triad Extension of Care Plan. The forms include provider and patient demographics, patient-centered clinical information and the proposed treatment plan.

1. **Initial Care Plan (ICP)** - After the patient's initial visit and before that patient returns for a second visit an ICP can be submitted. The ICP should include the services provided during the initial visit, in addition to the services you are planning to render. You may elect to submit additional information (i.e., SOAP notes) to Triad for review. Additional information can be written in the comment section at the end of the care plan, attached to the care plan, or faxed separately to 1-866-225-1033.
  - a. An ICP should be submitted before the second visit or within fourteen (14) business days of a patient's initial date of entry, whichever occurs first.
  - b. An ICP should be submitted for patients returning to care after an interruption of greater than ninety (90) days or for patients in a current course of care who develop a new condition that requires a change in their existing treatment plan.
2. **Extension of Care (EOC)**- If you determine that ongoing care is necessary after you have completed the ICP, you may submit an EOC. The purpose of the EOC is to document measurable clinical improvement of the patient during the initial plan of care.
  - a. The EOC form should be submitted as soon as possible following the end of initial care or as close to the first day, your patient returns to care after an interruption.

**Which form do I submit for existing patients, an ICP or EOC?** If you elect to submit a request for pre service review, an ICP should be submitted for new patients as well as existing patients being treated for the first time under the new program.

**Where can I obtain an ICP or EOC form?** Forms and instructions can be found on our website ([www.triadhealthcareinc.com/providers/forms.aspx](http://www.triadhealthcareinc.com/providers/forms.aspx)). Forms can also be emailed or mailed directly to your office by calling 1-800-409-9081.

**How will I receive notification of a medical necessity determination?** Triad will return all medical necessity determinations by fax or mail depending on the method of submission by the provider. Triad makes every effort to provide determinations within two (2) business days.

**Where do I submit claims?** Participating providers will need to submit all claims for WellCare Medicare Advantage members in New York and New Jersey directly to Triad. Participating provider claims submitted directly to WellCare will be denied and will have to be resubmitted to Triad.

1. Paper claims can be submitted directly to Triad at: Triad Healthcare, Inc. Attn: Claims, 80 Spring Lane, Plainville, CT 06062.
2. Electronic Submission – Triad Healthcare, Inc. has partnered with MD On-Line for electronic claim submission. Claims can be individually entered free of charge. To access this benefit, log on to [www.triadhealthcareinc.com/providers/onsolution.aspx](http://www.triadhealthcareinc.com/providers/onsolution.aspx) and click the “Submit” button under *Online Solutions*. This will route you to MD On-Line's portal for Triad Providers. Please include Triad's address (see above) and electronic payer ID #39181.To



learn more about MD On-Line's products for submitting Triad claims electronically FREE OF CHARGE, please call: 1-888-499-5465.

**I am already contracted with an EDI vendor for claims submission. Can I continue to submit claims through my current vendor?** You will need to contact your current vendor to determine if they will continue to accept electronic claims and convert them to paper in order to submit to Triad Healthcare. Triad's only electronic connection is MD On-line.

**How long do I have to submit a claim?** All claims should be submitted within 180 days from the date of rendered services to be considered for payment.

**How do I contract with Triad?** If you have not contracted with Triad, you may do so now by calling Triad Provider Service at 1-888-584-8742. All the necessary information will be provided to you at that time.

**Where can I get a copy of the provider manual?** Participating providers can obtain a copy of the provider manual at Triad's website ([www.triadhealthcareinc.com/providers/manual.aspx](http://www.triadhealthcareinc.com/providers/manual.aspx)). You can view the manual or print a copy for your records.

**If I have a change in business information (business name, address or Tax Identification Number) what do I need to do to get it updated with Triad?** If you have a business name change or address change, you will need to submit the changes in writing including the effective date of the change. Please fax all changes to 888-844-6645. If you have a Tax Identification Number (TIN) change, you will need to contact Triad's customer service to obtain the appropriate documentation for your TIN change.

**Who do I notify if I add a provider to my practice?** All providers that will be billing under your Tax Identification Number will need to become participating in the Triad network. Please contact Triad's customer service department to obtain an enrollment packet.

**Am I participating under all locations and Tax Identification Numbers?** Yes, under your contract with Triad Healthcare you are considered participating under all practice locations and Tax Identification Numbers that you submit on a claim.

**Can I appeal a clinical decision made by Triad?** Yes. If you find that you are in disagreement with a determination of medical necessity that cannot be resolved verbally with Triad, you can appeal this decision. Please refer to the appeal rights attached to your determination letter in order to determine where your appeal should be submitted.

**Can I appeal a claim determination made by Triad?** Yes. Triad shall include an attached explanation of the relevant appeals process with all claim denials sent both to the member and provider. All written comments, documents, records and other information submitted with the appeal will be reviewed and considered without regard to whether those documents or materials were considered in making the initial denial. Appeals must be submitted in writing and must be received by Triad within ninety (90) days of receipt of the adverse determination. Providers must use the New



Jersey Department of Banking & Insurance “Health Care Provider Application to Appeal a Claim Determination” form, which is available on Triad’s website.

([www.com.triadhealthcareinc.com/providers/forms.aspx](http://www.com.triadhealthcareinc.com/providers/forms.aspx)).

**Appeals and Grievances** - *the following process pertains to the WellCare / Triad contract only.*

For additional information about the appeal process, please refer to the denial letter.

You may request another copy of the denial letter by calling Triad’s Network Services Department 1-800-409-9081.

**All Member Appeals and Prospective (UM) denial of treatment mail to:**

WellCare  
Attn: New York Appeals Department  
PO Box 31368  
Tampa, FL 33631-3368

**All Participating Provider Claims, Administrative, and Retrospective (UM) denial of treatment mail to:**

Triad Healthcare  
Appeals Department  
80 Spring Lane  
Plainville, CT 06062  
Fax to 860-793-3317

**How can I provide feedback to Triad?** Complete a survey. To provide the highest quality of service and measure our effectiveness, we have made surveys available to our provider community. Periodically we will notify you of survey opportunities. Please take the time to complete these surveys as this is one of the ways Triad enhances its service to the provider community.

**How can I contact Triad:** If you would like to speak with someone at Triad, contact Triad’s Call Center at 1-800-409-9081. A representative will answer your questions or schedule a call with a clinical coach. All providers are encouraged to speak directly to a clinical coach regarding clinical determinations for which there is a question or concern.