

WELLMARK ADVANTAGE CLAIMS FILING GUIDE

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Chapter 1: Prior to Delivering Services to Members

Before providing services, providers should review member benefits, prior authorization requirements, applicable medical policies, and any medical necessity considerations.

Member Verification and Benefit Review

Wellmark Advantage Health Plan Members:

- **Verify eligibility**
 - Online through the Wellmark Provider Portal
 - Electronically via Availity (270/271 transactions)
 - By phone at 1-855-716-2556
- **Confirm member benefits**
 - Online through the Wellmark Provider Portal
 - By reviewing the member's Evidence of Coverage (EOC)
 - By phone at 1-855-716-2556
- **Review utilization management requirements, including prior authorization needs**
 - Available on Wellmark.com
 - Refer to the Wellmark Advantage Health Plan Provider Manual (Provider Manual) for details

Out-of-State BCBS Medicare Advantage Members

Providers are encouraged to learn about the BlueCard® Program, which allows providers to serve members from all Blue Cross and Blue Shield (BCBS) plans through a nationwide claims processing network. For members covered by other BCBS plans, providers should:

- **Verify eligibility, benefits, and utilization management requirements**
 - Online at www.BCBS.com
 - By phone at 800-810-2583, using the member's three digit prefix

Chapter 2: Claim Resources

Use the resources outlined in this chapter to support proper claim submission, understand claims editing and payment policies, and determine the correct plan to file claims.

Tools and Resources

Wellmark Advantage offers a variety of tools and resources to support providers in managing Medicare Advantage members efficiently.

- [Provider Manual - Wellmark Advantage Health Plan](#) - Access the comprehensive Provider Manual for detailed program requirements, policy, and operational guidance.
- [Wellmark Advantage Health Plan Provider Portal](#) – Access essential tools for managing Wellmark Advantage members including claim status and prior authorization tools. Important: Registration for the Wellmark Provider Portal is required to access provider tools and resources for Wellmark BCBS IA/SD

and Wellmark Advantage. After logging in to Wellmark.com, navigate to the Wellmark Advantage Health Plan section and select Provider Portal to:

- Check member eligibility
- Check claim status
 - *Note: BlueCard® out-of-state Medicare Advantage claims are not available in the Wellmark Advantage Provider Portal*
- Manage authorizations and other member-related functions
- **Symphony** User Guide – Symphony is Wellmark Advantage's electronic authorization tool for medical and Medicare Part B services. User guides and reference materials are available on our [Utilization Management](#) page on Wellmark.com to support authorization workflows and care management activities.
- **[Forms and Resources](#)** - Access commonly used forms and reference materials to support your daily workflow.

Stay informed

- **Subscribe to Blue InkSM** Wellmark's bi-monthly newsletter for providers offers in-depth information on working with Wellmark and Wellmark Advantage. Subscribe today: [Blue Ink provider newsletter | Wellmark](#)
- **Register for the Wellmark Information Notification System (WINS)** Receive real-time provider updates directly in your inbox whenever important news, policy changes, or resource updates become available. Be sure you are registered for the Medicare Advantage category at [Wellmark.com/Provider/WINS](#).

Claims Editing and Payment Policies

NCCI Editing

Medicare National Correct Coding Initiative (NCCI) edits are designed to promote proper coding and prevent unbundling or inappropriate code pair submissions. Providers should refer to CMS NCCI guidance to stay current with edit rules and reduce the likelihood of claim denials. Please refer to [CMS Guidelines](#) related to NCCI editing.

Payment Integrity

Wellmark is committed to supporting health care affordability and managing the total cost of care for all members through both pre and post-payment claim review activities. A key component of this effort is our payment integrity program, which helps ensure claims are paid accurately, appropriately, and to the correct provider for the services rendered.

Pre-payment claim editing helps verify that claims are coded correctly and in accordance with industry standards. Post-payment reviews may focus on areas such as home health services, duplicate billing, or other billing patterns.

The following resources are available on Wellmark.com through the secure provider portal: Payment Integrity Resources (login required)

- Payment Policies and Reports section of the Wellmark Provider Guide (login required)
- MA Payment Policies for Wellmark Advantage (login required)

Determining the Correct Plan for Claim Filing

Contiguous County

Providers that are located in a contiguous county to Wellmark's service area and are Wellmark Advantage HMO providers with Wellmark must submit HMO claims for Wellmark members directly to Wellmark. Providers that are **not** in the HMO network with Wellmark must file their claims with their Home (local) Blue Cross Blue Shield Plan. Additional information can be found in our [BlueCard Program](#) provider guide.

BlueCard Ancillary Claims Filing

Ancillary claims filing rules apply to Wellmark Advantage the same way they do for commercial plans. Please send claims to your local Blue Cross and Blue Shield Medicare Advantage plan as outlined below:

- For independent clinical laboratories, the local plan is the Blue Cross and Blue Shield Medicare Advantage Plan in whose service area the specimen was drawn, which is determined by the state in which the referring physician is located.
- For DME suppliers and orthotic & prosthetic suppliers, the local plan is the Blue Cross and Blue Shield Medicare Advantage plan whose service area the equipment was shipped, or in which it was purchased at a retail store.
- Additional information can be found in our BlueCard Program provider guide.

Ambulance

For providers submitting ambulance claims, enter the authorization number in Field 23 of the CMS-1500 form. Also report the ZIP code of the pick-up location in the same field. If both the authorization number and ZIP code need to be included, separate them with a semicolon.

- File the claim to the state associated with the ZIP code of the patient's pick-up location.

Provider Payments and Remittance

- To manage and understand payments, providers should take the following steps: Maintain current Electronic Funds Transfer (EFT) enrollment information to receive timely payment
- Access Explanation of Payments (EOP) and 835 remittance files for payment reconciliation. Remittance information for Wellmark Medicare Advantage members is available on the Wellmark Advantage Health Plan secure provider portal
- Review the [Payment Policies and Reports](#) section of the Wellmark Provider Guide for detailed payment policies and guidance. The Provider Guide is available on Wellmark.com through the secure provider portal.

Chapter 3: Submitting Claims Overview

This chapter outlines the claims submission workflow and highlights the timely filing requirements that must be met to promote successful processing.

Timely Filing

Wellmark Advantage Members

- Claims must be submitted within 180 days of the date of service or discharge. Claims filed after this deadline will be processed towards provider's liability.

Out-of-State (OOS) BCBS Medicare Advantage Members

- BlueCard claims must meet the timely filing requirements of **both** Wellmark Advantage Medicare Advantage **and** the member's **Home Plan** to be eligible for benefit consideration.

Additional Guidance

- Refer to [Wellmark's Claim Filing Guide](#) for detailed information on timely filing standards and submission expectations.

Submission Methods

Method	Details
Electronically (Preferred)	Submit through Availity® using Payor ID 88848
Mail	Wellmark Advantage Health Plan Station 1E238 PO Box 9291 Des Moines, IA 50306

Refer to wellmark.com/provider/claims-payment for more information.

Claim Attachments

Wellmark does not accept attachments or supporting documentation with claims, whether submitted electronically (275 transactions) or by mail. Any attachments received with paper claims are destroyed upon receipt.

Pre-Payment Medical Necessity Review

Certain services may be reviewed on a pre-payment basis. Wellmark will pend claims, placing the claim on hold, for up to 30 days and request medical records by mail. Providers should submit requested documentation promptly. If not received within 30 days, claims are denied until sufficient documentation is provided. Upon denial, follow the appeals process.

Submitting Supporting Documentation

Submit additional required documentation using the [Claim Supporting Documentation Submission Form](#) by fax to 1-866-530-0102 (preferred) or by mail to: WMAHP Provider Correspondence, P.O. Box 211285, Eagan, MN 55121. Do not use this form for disputes or appeals.

Chapter 4: Billing Requirements by Provider Type

Some provider types have unique billing requirements based on how they are credentialed with Wellmark. Additionally, certain CMS billing practices for Traditional Medicare may differ for Wellmark Advantage members. This section is not intended to be a comprehensive list of all billing and claims requirements but rather a callout for specific areas of consideration. You may refer to CMS.gov for further billing guidance and policies.

Ambulatory Surgery Centers

Submit claims for Medicare Advantage Members using 837P or CMS-HCFA 1500 claim format.

Durable Medical Equipment (DME)

Unless otherwise stated in the Provider's MA agreement, all DME must be provided by a CMS Certified DME supplier.

Home Health Services

Submit Notice of Admissions (NOAs) within five calendar days from the start of care, per CMS guidelines. For members who change to Wellmark Advantage during a Home Health Agency (HHA) episode or at the start of a

new plan year, submit a new NOA before submitting claims. For denied HHA claims due to missing NOAs, use the appeals process.

Hospice Services

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for Wellmark Advantage patients who elect hospice care. Bill claims for hospice-related services to the regional home health intermediary or to the appropriate carrier as applicable. For services not covered under Traditional Medicare but offered as enhanced benefits under the Medicare Advantage plan, submit claims to the appropriate Blue plan. Wellmark continues to pay for benefits outside hospice responsibility.

Refer to Chapter 4 of the [Provider Manual](#) for more information related to hospice services.

Long-Term Acute Care Hospitals (LTACH) / Outpatient Rehab Facilities

Submit claims for Medicare Advantage Members using 837I or CMS-UB04 claim format.

Physical Medicine Providers

Wellmark Advantage contracts with Practitioners for physical medicine, unlike CMS, which works with Rehabilitation Agencies. Providers should file claims for Medicare Advantage members to Wellmark using 837P or CMS-HCFA1500, including the appropriate billing and rendering National Provider Identifier (NPI) and taxonomy code as registered with the CMS National Plan and Provider Enumeration System (NPPES).

Refer to CMS and the [Provider Manual](#) for additional information.

Rural Health Centers

Submit claims for Medicare Advantage Members using 837I or CMS-UB04 claim format.

Chapter 5: Claim Resolution

Providers should review claim outcomes promptly and take appropriate action to correct, dispute, or appeal in accordance with Wellmark Advantage guidelines.

Rejected Claims

All claims that do not meet clean claim criteria will not be rejected electronically. These claims will be returned via mail to the billing address submitted on the claim record along with a letter of explanation for the rejection.

Providers should review the rejection letter carefully and reference common rejection scenarios to determine the necessary corrections.

A **new claim**, with the appropriate updates or corrections, must be submitted within Wellmark's timely filing guidelines.

Electronic Claim Corrections and Voids

- **Submit claim corrections electronically** by using:
 - “7” in the Resubmission field for a Replacement of a prior claim.
 - “8” in the Resubmission field for a Void/Cancel of a prior claim.
- **Include the original claim number** and the appropriate **claim change reason code** with the correction request.

- **Remarks are optional**, unless you are submitting condition code D9 with adjustment reason code OT, in which case remarks are required.
- **Submit void/cancel claims only when the original claim should never have been processed.**
 - If changes are needed to the type of bill or member information, void the original claim and submit a **new** claim with correct type of bill.
- **Submit corrections and adjustment requests within 180 days** from the paid date of the claim being adjusted; requests submitted after this timeframe will be denied and become the provider's liability.

Claim Processing Related to Provider Eligibility

If a claim is denied or processed incorrectly as a result of provider eligibility or network status, providers should first contact Wellmark Advantage to verify the provider's status. If there is a disagreement with the status determination, Provider Credentialing may be contacted for additional assistance at providercredentialing@wellmark.com.

Payment Disputes

Provider payment disputes are disputes in which the provider believes that the payment amount made by the Wellmark Medicare Advantage plan to providers differs from the payment amount specified in a participating provider's agreement with Wellmark.

If a provider believes that the payment amount the provider received for a service differs from the amount set forth in the applicable provider agreement or paid by Medicare, as applicable, the provider has the right to dispute the payment amount by following Wellmark's two-level payment dispute process described below.

- **Level 1:** Submit a dispute within 120 calendar days from the date the payment was originally received, including all required information as outlined in the Provider Manual.
- **Level 2:** Submit a dispute within 60 days of receiving Wellmark's first-level decision, including all required information as outlined in the Provider Manual.

Claim Appeals

Wellmark Advantage Members

Providers may submit claim appeals for all claims processed by Wellmark, including those for Wellmark Advantage and out-of-state (OOS) BCBS Medicare Advantage members. Turnaround times and submission requirements vary depending on the type of appeal.

- **Level 1:** Submit appeal within 65 calendar days of the date noted on the written denial notification. Ensure all necessary documentation is included as outlined in the [Provider Manual](#).
- **Level 2:** Submit appeal within 65 calendar days of the date noted on the first-level appeal decision notification. Ensure all necessary documentation is included as outlined in the [Provider Manual](#).

Out-of-State (OOS) BCBS Medicare Advantage Members

- All appeals for OOS BCBS Medicare Advantage members must be submitted to the provider's local plan. **Do not** send appeals directly to the member's home plan.

Wellmark Advantage will review an appeal only if the portion of the claim being disputed was processed by Wellmark Advantage. If the provider is appealing claim processing on behalf of the member, the appeal will be forwarded to the member's home plan for review.

- If appealing on behalf of a member, include the required authorization or supporting documentation.
- Do *not* send appeals directly to the members' plan.

Non-Participating (Non-Par) Provider Appeals

Non-contracting, non-participating providers who do not accept Medicare assignments should contact Wellmark with questions regarding claim payments. Appeal rights for non-par providers are available.

To appeal a post-service decision, non-contracted providers must sign and submit a Waiver of Liability, confirming they will not seek payment from the member. The Waiver of Liability is available through CMS at: www.cms.gov/medicare/appeals-grievances/managed-care/notices-forms.

Status of Claim, Dispute or Appeal (In-network Providers)

Claim Status:

- For Wellmark Advantage members, claim status is accessible on the provider portal.
 - Allow 30 days from receipt of claim for processing.
 - If after 30 days you need status on a Wellmark Advantage member or Out-of-State BCBS MA member, call Wellmark Advantage at 1-855-716-2556.

Payment Dispute or Appeal Status:

- Allow 60 calendar days from receipt for processing.
- If after 60 calendar days, you need status on a Wellmark Advantage member or Out-of-State BCBS MA member, call Wellmark Advantage at 1-855-716-2556.

Symphony is a tool that enables authorization services on behalf of Wellmark Advantage Health Plan, Inc.