Meet Wellcare.

2024 Provider Orientation

SHP_202310426

Agenda

- Plan Overview
- Key Resources for Providers
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (DSNP only)
- Medicare Star Ratings
- Web Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer & Electronic Medical Records
- Advance Directives
- Fraud, Waste, and Abuse
- CMS Mandatory Trainings

Plan Overview

Meet Wellcare

- Welcome to Wellcare!
- We have combined multiple national Medicare brands under the Wellcare name to offer a better range of plans that provide members with affordable access to doctors, nurses, and specialists.
- We believe this change will make things easier for members, brokers, and providers like you.
- Our goal is to ensure your patients receive the best care.

Wellcare By Allwell vs. Wellcare

- It is important to note that we have two plans: Wellcare By Allwell, which this presentation is specific to, and Wellcare (legacy).
- Pay attention to the member's ID card when verifying eligibility. The plan name will be indicated in the top left corner.
- The plan will also dictate which portal will be used for requesting authorizations, submitting claims, etc.
  - Wellcare By Allwell: Provider.SuperiorHealthPlan.com
  - Wellcare: Provider.Wellcare.com

The Strength of Wellcare

For more than 20 years, Wellcare has offered comprehensive plans featuring affordable coverage and innovative benefits beyond original Medicare.

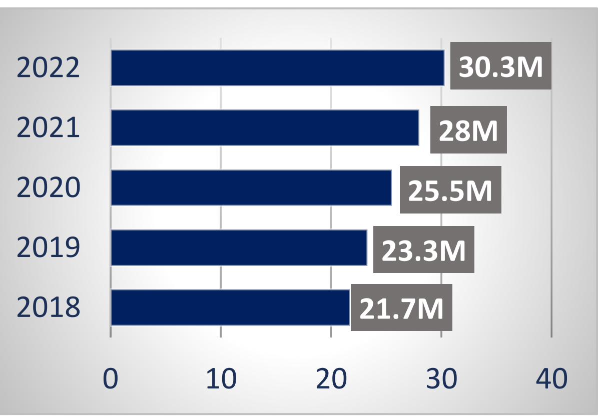
- **Local management with national expertise**
- **Full continuum of Medicare products including:**
  - **HMO**
  - **PPO**
  - **DSNP**
  - **CSNP**
  - **MMP**
  - **PSP**
  - **EGWP**
  - **PDP**

1.3M
Medicare members across **37 STATES**

377K
Special Needs Plan members across **33 STATES**

4.4M
Prescription Drug Plan members across **50 STATES**

Total Medicare Advantage Members Nationwide



8.7%
Avg. YoY Growth Medicare Advantage Enrolled

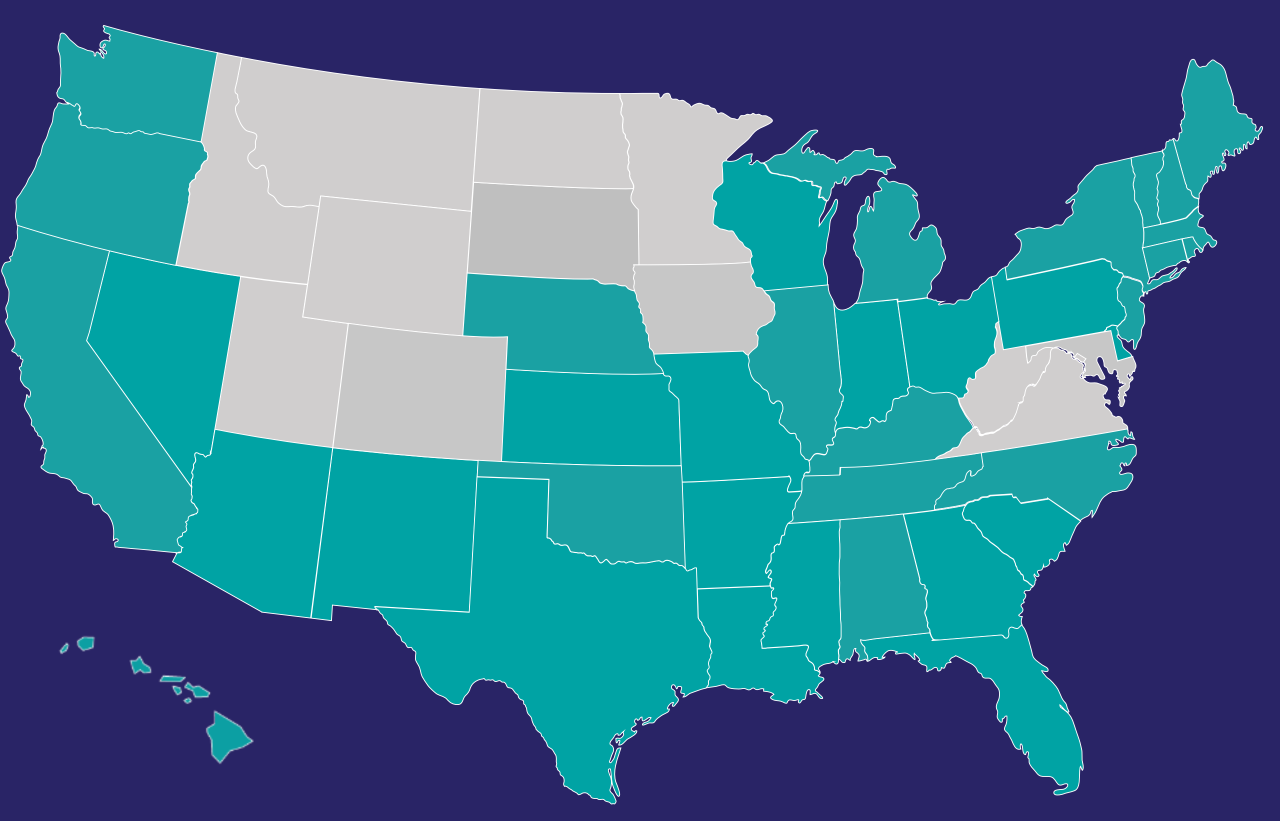
30M
Medicare Advantage enrolled members nationwide

47%
Medicare Advantage Penetration Rate nationwide

1.3 Million Medicare Members

#6
largest MA plan

#2
largest MAPD plan



Who We Are

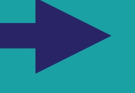
Wellcare is designed to give members

- Affordable healthcare coverage
- Benefits they need to take good care of themselves
- Access to doctors, nurses and specialists who work together to help them feel their best
- Coverage for prescription drugs
- **Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare)**

Exceptional Benefits

Telehealth – Doctors are available by teleconference, day and night and on weekends and holidays.

Free In-Home Support & Chore Services – Available services to keep members' homes safe and clean, including help with light cleaning, household chores, and meal prep.



Free Transportation – Free unlimited trips to doctor's offices and pharmacies with some plans eligible for non-medical transportation.

OTC Allowances – Members receive annual over-the-counter (OTC) allowances and pay $0 for certain OTC products, depending on the plan.

24-Hour Nurse Advice Line – Speak with a live nurse, 24 hours a day, any day of the year.

Our Whole Health Approach

Wellcare provides complete continuity of care to Medicare members.

This includes:

- Integrated coordination care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

Our approach to care management facilitates the integration of community resources, health education, and disease management.

Wellcare promotes members' access to care through a multidisciplinary team – Including registered nurses, social workers, pharmacy technicians and behavioral health case managers – all co-located in a single, locally based unit.

We Are Proud to be Your Medicare Advantage Partner

- As our partner, you can count on Wellcare to provide:
  - Fast and accurate claims payments.
  - Efficient and convenient processes for providing care to our members.
  - Responsive Provider Engagement representatives to assist with all of your needs.
- We are committed to working with you to ensure your patients receive the quality, affordable healthcare they deserve.

Key Resources for Providers

Key Contact Information

PHONE

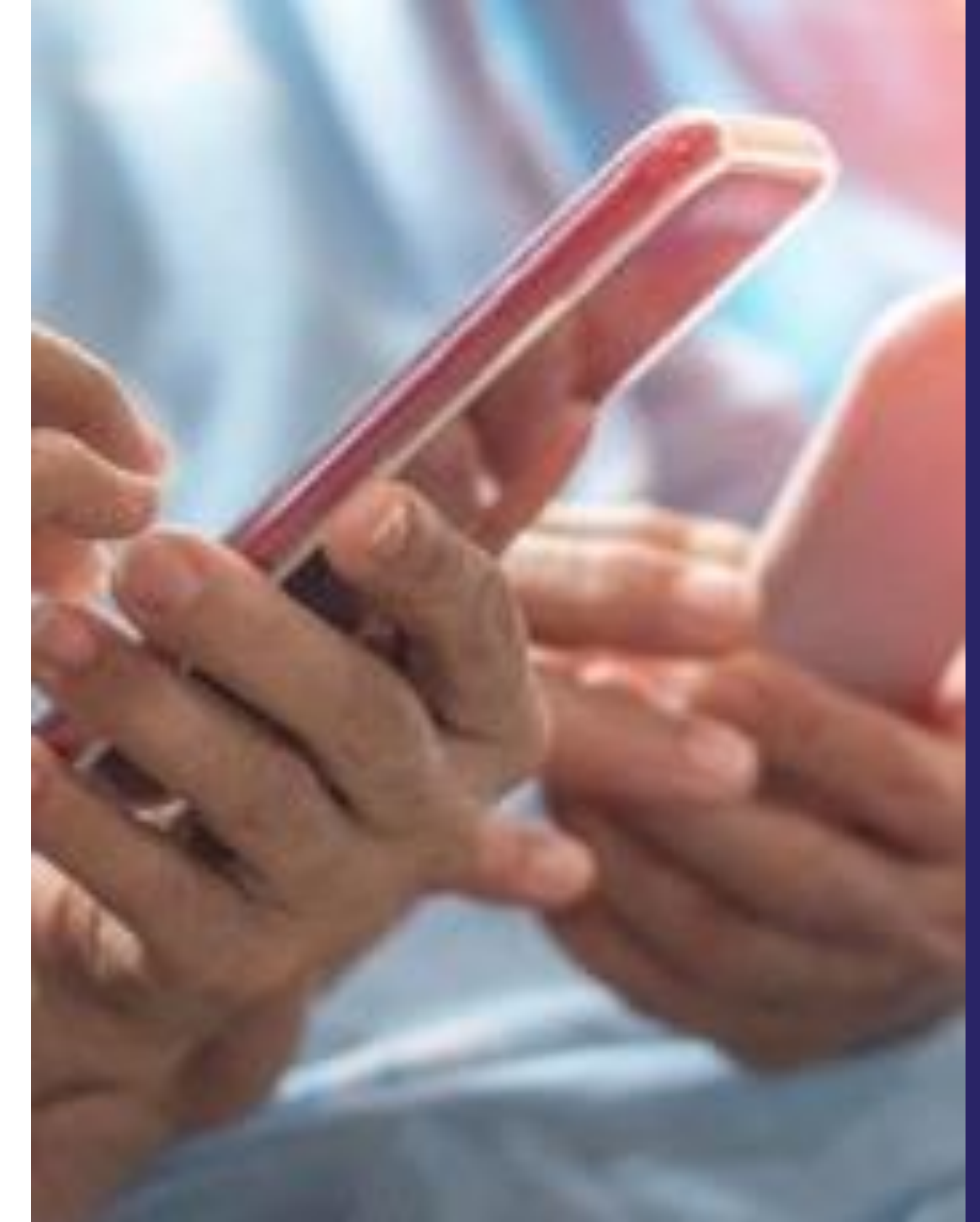
1-877-391-5921

WEB

SuperiorHealthPlan.com

PORTAL

Provider.SuperiorHealthPlan.com



Provider Manual

- The Provider Manual is your comprehensive guide to doing business with Wellcare.
- The manual includes a wide-array of important information relevant to providers that includes:
  - Network information
  - Billing guidelines
  - Claims information
  - Regulatory information
  - Key contact list
  - Quality initiatives
- The Provider Manual can be found in the Provider section of the Wellcare website at SuperiorHealthPlan.com/ProviderManuals.

Provider Services

- Our Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
  - Credentialing/Network status
  - Claims
  - Request for adding/deleting physicians to an existing group
- By calling Provider Services at 1-877-391-5921, providers are able to access real time assistance for all their service needs.

Account Management

- As a Wellcare provider, you will have a dedicated Account Manager available to assist you.
- Our Account Managers serve as the primary liaisons between our health plan and provider network.
- Your Account Manager is here to help you operate your practice and address needs:

✓ Inquiries related to administrative policies, procedures, and operational issues

✓ Contract clarification

✓ Membership/provider roster questions

✓ Secure Portal registration

✓ Pay Span

✓ Provider education

✓ Demographic information updates

✓ Initiate credentialing of a new practitioner

Membership, Benefits, and Additional Services

Membership

- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare Plan or choose a Medicare Advantage Plan, such as Wellcare By Allwell
- Wellcare By Allwell members may change PCPs at any time. Changes take effect on the first day of the month
- Providers should verify eligibility before every visit by using one of the below options:
  - Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - 24/7 Interactive Voice Response Line:
    - HMO: 1-855-766-1572 (TTY: 711)
    - HMO DSNP: 1-833-541-0767 (TTY: 711)
  - Provider Services – 1-877-391-5921

Member ID Cards

FRONT PANEL

<Wellcare By Allwell>
<Wellcare Dual Liberty Nurture (HMO D-SNP)>
CMS#: <H5294-010>
Effective Date: <MM/DD/YYYY>

MEMBER INFORMATION
Name: <First MI Last>
Member ID#: <XXXXXXXXX-XXX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >
PCP Office Visit: $0

PHARMACY INFORMATION

Rx Processor Part D:
<Express Scripts ®>
RXBIN: <610014>
RXPCN: <MEDDPRIME>
RXGRP: <2FFA>

FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).

BACK PANEL

www.wellcare.com/allwellTX

FOR MEMBERS

Member Services:	<1-844-796-6811 (TTY: 711)>
Nurse Advice Line:	<1-844-796-6811 (TTY: 711)>
ModivCare Transportaton:	<1-877-718-4201 (TTY: 711)>
Liberty Dental:	<1-866-544-4669 (TTY: 711)>
Premier Vision:	<1-855-879-1456 (TTY: 711)>

FOR PROVIDERS

For Member eligibility and Medical prior auth/referrals: <1-844-796-6811>
Medical Claims: <Wellcare By Allwell> <Attn: Claims>
Payor ID: <68069><P.O. Box 3060 Farmington, MO 63640-3822>

Pharmacy prior auth: <1-800-867-6564>
For help: (PHARMACY USE ONLY) <1-833-750-0202>
Submit Part D Drug Claims to: <Wellcare By Allwell> <Attn: Member Reimbursement Dept> <P.O. Box 31577><Tampa, FL> <33631-3577>

APRON

Enclosed is your new Wellcare By Allwell member identification card. Please continue using your current ID card through the end of the current year, then use this card beginning the first of the year.

You'll want to take a few minutes to carefully review all of the information on the card, including the spelling of your name. Also, be sure the PCP you selected matches what is on your ID card. If it doesn't, please call Member Services at 1-844-796-6811 (TTY: 711) so we can fix that for you. If you didn't select a PCP, we selected one for you; but don't worry, you can choose a new PCP by calling Member Services at the number noted above. We can help you Monday-Friday, 8 a.m. to 8 p.m. Between October 1 and March 31, we're available Monday-Sunday, 8 a.m. to 8 p.m.

Your ID card is very important so be sure to have it with you and show it at all of your healthcare appointments.
You must present both your Wellcare By Allwell Medicare identification card and your Medicaid identification card from the State of Texas to providers when you receive medical care.

Thank you for choosing Wellcare By Allwell. We appreciate the trust you put in us and look forward to serving you.

Plan Coverage

- Medicare Advantage covers:
  - **All Part A and Part B benefits by Medicare**
  - **Part B drugs – such as chemotherapy drugs**
  - **Part D drugs – no deductible at network retail pharmacies or mail order***
  - **Additional benefits and services such as**
    - **Dental, Vision, and Hearing Coverage**
    - **Low out-of-pocket maximum costs**
    - **Low to no monthly premiums**
    - **Healthy Foods Card for use at participating retailers**
    - **Fitness membership available at no cost**
    - **No/Low Cost PCP copay**
    - **Prescription drugs coverage/ mail-order service**
  - For a summary of plan benefits, visit: Wellcare.SuperiorHealthPlan.com/Plan-Benefit-Materials.html

**DSNP and ISNP plans may have a deductible.*

Pharmacy Formulary

- The formulary is available at:

  Wellcare.SuperiorHealthPlan.com/Drug-Pharmacy/Formulary.html

- Please refer to the formulary for specific types of exceptions.
- When requesting a formulary exception, a *Request for Medicare Prescription Drug Coverage Determination* form must be submitted. These forms can be found under the *Drug Coverage Determination Forms* section of the *Coverage Determinations and Redeterminations for Drugs* webpage:
  - Coverage Determinations and Redeterminations | Wellcare By Allwell from Superior HealthPlan
  - The completed form can be faxed to the Pharmacy Prior Authorization department using the fax number on the form.

Covered Services

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines
- Lab and X-Ray
- Transportation
- Home Health Services
- Screening Services
- Dental
- Vision Services
- Hearing Services
- Behavioral Health
- Medical Equipment & Supplies
- Initial Preventative Physical Exam – Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatric Services

Additional Benefits

Hearing Services

- $0 co-pay for one routine hearing test every year
- $0 co-pay for one hearing aid fitting evaluation
- $700 to $3,000 coverage limit per year for hearing aids (dollar coverage dependent upon service area); limited to 2 hearing aids per year

Dental Services

- Two Oral exams per year with no co-pay
- Two Cleanings per year with no co-pay
- One Dental X-Ray per year with no co-pays
- $1,000 to $4,000 in comprehensive dental benefits per year (dollar coverage dependent upon service area)

Additional Benefits

Vision Services

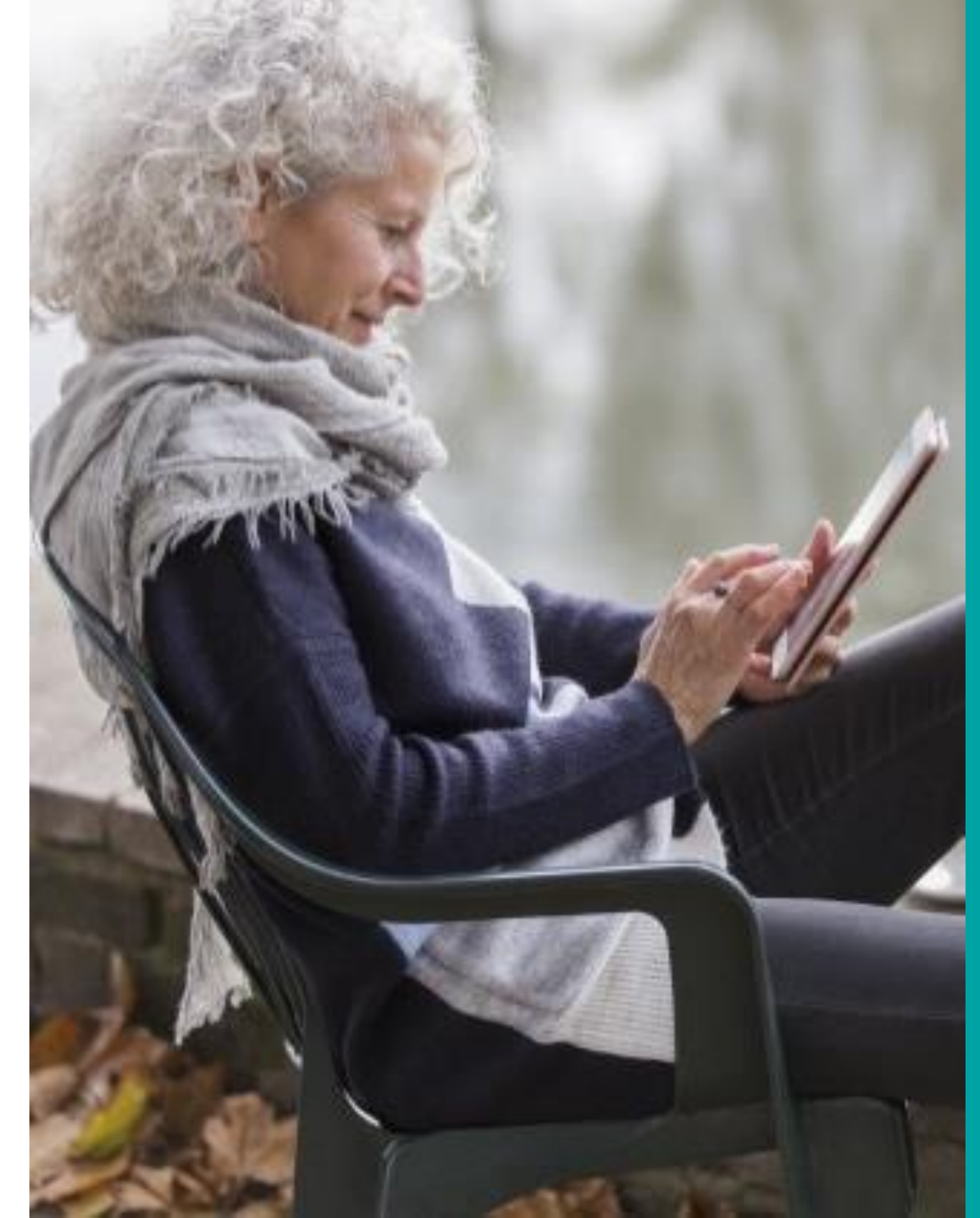
- One routine eye exam every year
- One pair of glasses or contacts lenses every year
- $100 to $600 limit (dollar coverage dependent upon service area); for eyewear each year

Over-the-Counter Items

- Commonly used over-the-counter items – listing available at: wellcare.superiorhealthplan.com/plan-benefit-materials
- Call Member Services printed on OTC card to order items per calendar quarter

Additional Benefits

- Nurse Advice Line
  - Free health information line staffed with registered nurses 24/7 to answer health questions.



Additional Services

Multi-language Interpreter Services

- Interpreter services are available at no cost to Wellcare By Allwell members and providers without unreasonable delay at all medical points of contact
- To get an interpreter, call us at
  - HMO: 1-800-977-7522 (TTY: 711)
  - HMO DSNP: 1-844-796-6811 (TTY: 711)

Non-Emergency Transportation

- Covered for a specified number of one-way trips per year, to approved locations (dependent upon the member's service area)
- The Medical Transportation Program (MTP) provides non-emergency transportation, if it is not covered by Medicare
- $0 co-pay for covered services
- Schedule trips 48 hours in advance using the plan's contracted providers
- Contact us at 1-877-718-4201 to schedule non-emergency transportation

Medical Home & Prior Authorization

Primary Care Physicians

- Primary Care Physicians (PCPs) serve as a “medical home” and provide the following:
  - Sufficient facilities and personnel
  - Covered services as needed
    - 24-hours a day, 365 days a year
- Coordination of medical services and specialist referrals
- Members with after-hours accessibility using one of the following methods:
  - Answering service
  - Call center system connecting to a live person
  - Recording directing member to a covering practitioner
  - Live individual who will contact a PCP

Interdisciplinary Care Team

- The purpose of the Interdisciplinary Care Team (ICT) is to collaborate with the member, their providers/specialists and other health-care professionals to ensure appropriate services are in place, and to identify alternative solutions to barriers identified in a member's care plan.

- Superior's program is member-centric with the PCP being the primary ICT point of contact. Superior staff works with all members of the ICT in coordinating the plan of care for the member.

Interdisciplinary Care Team

- As part of the ICT process, providers are responsible for:
  - Accepting invitations to attend member’s ICT.
  - Maintaining copies of the Individualized Care Plan (ICP), ICT worksheets and transition of care notifications in the member’s medical record.
  - Collaborating and actively communicating with care managers the ICT, members and caregivers.
- Superior Care Managers (CMs) work with the member to encourage self-management of their condition, as well as communicate the member’s progress toward these goals to the other members of the ICT.

Interdisciplinary Care Team

- The ICT will be led by a Care Coordinator, and at a minimum is comprised of the following core members:
  - Member and/or authorized representative
  - PCP
  - Family and/or caregiver, if approved by the member
  - Care coordinator(s) (Service Coordinator [SC], Behavioral Health CM)
  - Specialist if serving as member's PCP

Responsibility of the Interdisciplinary Care Team

- Analyze and incorporate the results of the initial and annual health risk assessment into the individualized care plan.
- Coordinate the medical, cognitive, psychosocial and functional needs of members.
- The development and implementation of ICP with the member's participation, as feasible.
- Conduct ICT meetings according to the member's condition; these meetings may be held face to face, via conference call, or web- based interface.

Prior Authorizations

- Authorization must be obtained prior to the delivery of certain elective and scheduled services
- The preferred method for submitting authorization requests is through the Secure Web Portal at: Provider.SuperiorHealthPlan.com

Service Type	Time Frame
Elective/scheduled admissions	Required five calendar days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorization Requirements

- Prior authorization is required for:
  - Inpatient admissions, including observation
  - Home health services
  - Ancillary services
  - Radiology – MRI, MRA, PET, CT
  - Pain management programs
  - Outpatient therapy and rehab (OT/PT/ST)
  - Transplants
  - Surgeries
  - Durable Medical Equipment (DME)
  - Part B drugs

The authorization look-up tool can be found here:

[Texas Medicare Pre-Auth | Superior HealthPlan]

wellcare By allwell

MEDICARE
OUTPATIENT AUTHORIZATION
TEXAS

All Part B Drug Requests: **Fax** 1-844-960-1785
Expedited Requests: **Call** 1-800-218-7508
Standard Requests: **Fax** 1-877-808-9368
Transplant Requests: **Fax** 1-833-589-1243
Behavioral Health Requests: **Fax** 1-855-772-7079

☐ Request for additional units. Existing Authorization ____ Units ____

For Standard (Elective Admission) requests, complete this form and FAX to the appropriate department above. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after receipt of request.

☐ **For Expedited requests, please call 1-800-218-7508.** Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

* **INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Date of Birth* (MMDDYYYY)
Member ID*
Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI*
Requesting TIN*
Requesting Provider Contact Name
Requesting Provider Name
Phone
Fax*

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider
Servicing NPI*
Servicing TIN*
Servicing Provider Contact Name
Servicing Provider/Facility Name
Phone
Fax

AUTHORIZATION REQUEST

Primary Procedure Code* (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Start Date OR Admission Date* (MMDDYYYY)
Diagnosis Code* (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
End Date OR Discharge Date (MMDDYYYY)
Total Units/Visits/Days

OUTPATIENT SERVICE TYPE* (Enter the Service type number in the boxes)

712 Cochlear Implants & Surgery
299 Drug Testing
922 Experimental & Investigational Services
205 Genetic Testing & Counseling
249 Home Health
225 Home Meals
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
422 Biopharmacy (Please fax to 1-844-960-1785)

794 Outpatient Services
171 Outpatient Surgery
202 Pain Management
650 Radiation Therapy
201 Sleep Studies
790 Occupational Therapy
101 Physical Therapy
701 Speech Therapy
212 Therapy Evaluation
993 Transplant Evaluation
724 Transportation
209 Transplant Surgery

Behavioral Health
510 BH Medical Management
530 BH Partial Hospitalization Program (PHP)
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
519 BH Outpatient Therapy
520 BH Professional Fees
521 BH Psychological Testing
522 BH Psychiatric Evaluation

DME
417 DME - Rental
120 DME - Purchase
Purchase Price

Are services needed for discharge planning? ☐ **YES** ☐ **NO**

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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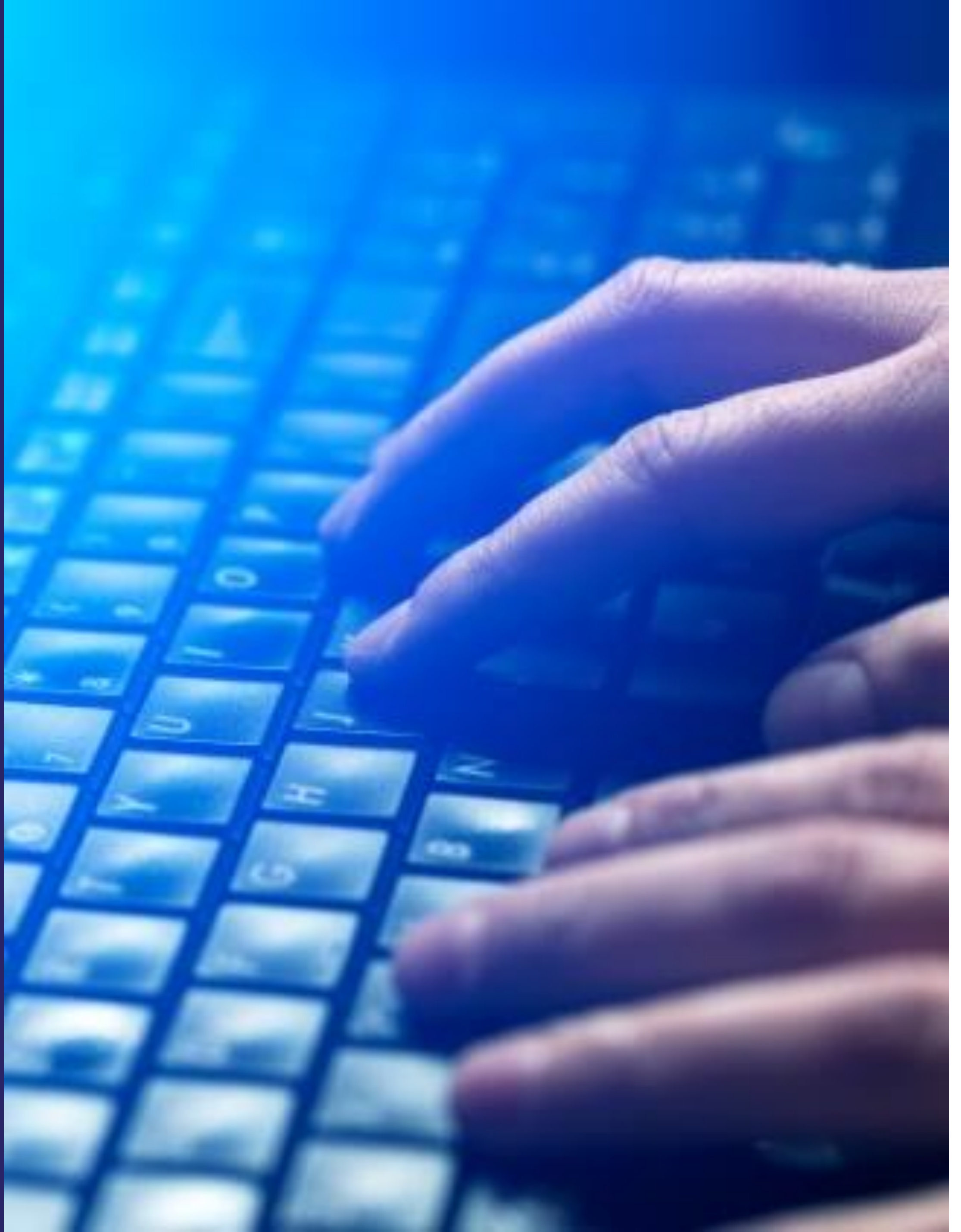
MT-PAF-0769

*Skilled Nursing Facility providers must electronically submit to the HHSC Medicaid Claims administrator a resident transaction notice (form 3618/3619) within seventy-two (72) hours after a Dual Eligible Member's admission or discharge form the nursing facility per TX Code § 554.2615.



Out-of-Network Coverage

- Prior authorization is required for out-of-network services, except:
  - Emergency care
  - Urgently needed care when the network provider is unavailable (usually due to out-of-area)
  - Kidney dialysis at Medicare-certified dialysis centers, when the member is temporarily out of the service area

Medical Necessity Determination

- When medical necessity cannot be established, a peer-to-peer conversation is offered
- Denial letters will be sent to the member and provider
- The clinical basis for the denial will be indicated
- Member appeal rights will be fully explained

Preventive Care & Screening Tests

Preventive Care

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventative Physical Exam –Welcome to Medicare:
  - The exam includes a detailed medical/family history, performance of a detailed head-to-toe assessment with a hands-on examination of all the body systems, recommendations for preventive screenings/care, and counseling about healthy behaviors, and is beyond the Annual Wellness Visit services.
- Annual Wellness Visit:
  - Available to members after the member has the one-time initial preventative physical exam (Welcome to Medicare Physical).

Preventive Care

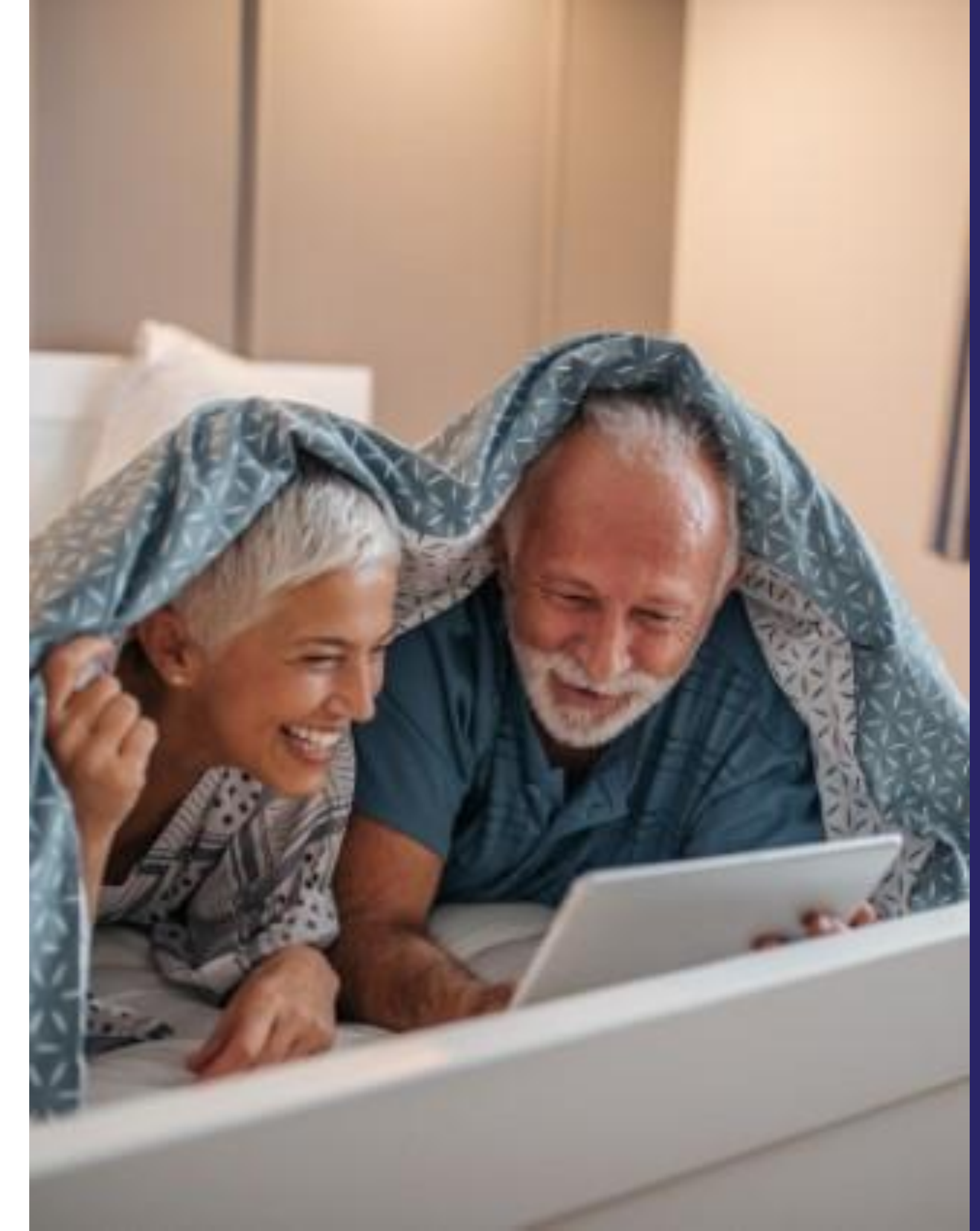
Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain Assessment
Bone mass measurement	Diabetes Screenings	Prostate Cancer Screenings (PSA)
Breast Cancer Screening (mammogram)	Fecal Occult Blood Test	Sexually Transmitted Infections Screening and Counseling
Cardiovascular Disease (behavioral therapy)	Flexible Sigmoidoscopy	Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
Cardiovascular Screenings	HIV screening	Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

Model of Care

(DSNP only)

Model of Care

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs.
- Only applies to DSNP members.
- The goals of our Model of Care are:
  - Improve access to medical, mental health, and social services.
  - Improve access to affordable care.
  - Improve coordination of care through an identified point of contact.
  - Improve transitions of care across healthcare settings and providers.
  - Improve access to preventive health services.
  - Assure appropriate utilization of services.
  - Assure cost-effective service delivery.
  - Improve beneficiary health outcomes.



Model of Care Elements

- ✓ Description of the SNP population
- ✓ Care coordination and care transitions protocol
- ✓ Provider network
- ✓ Quality measurement

Model of Care Process

- Every dual/SNP member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at a minimum annually, or more frequently with any significant change in condition or transition of care.

- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.

- Members are then triaged to the appropriate Wellcare Case Management Program for follow up.

Model of Care Process

- Wellcare values our partnership with our physicians and providers.
- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers, and Wellcare.
  - Interdisciplinary approach to the member's special needs.
  - Comprehensive coordination with all care partners.
  - Support for the member's preferences in the Model of Care.
  - Reinforcement of the member's connection with their medical home.

Medicare Star Ratings

Medicare Star Ratings

What Are CMS Star Ratings?

- The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the healthcare system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

- The ratings are posted on the CMS consumer website, Medicare.gov, to give beneficiaries help in choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.

Part C

1. Staying healthy: screenings, tests and vaccines.
2. Managing chronic (long-term) conditions.
3. Member experience with the health plan.
4. Member complaints, problems getting services and improvement in the health plan’s performance.
5. Health plan customer service.

Part D

1. Drug plan customer service.
2. Member complaints and changes in the drug plan’s performance.
3. Member experience with the drug plan.
4. Drug safety and accuracy of drug pricing.

How Can Providers Improve Star Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Management of chronic conditions such as hypertension and diabetes including medication adherence.
- Continue to talk to your patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity and emotional health and well-being (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).

Web-Based Tools

SUPERIORHEALTHPLAN.COM

Public Provider Website

Wellcare's provider information and resources are available on Superior's website. Providers can access:

- Provider Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider news
- Pre-Auth Needed tool
- Provider resources

EXPLORE NOW:

SuperiorHealthPlan.com

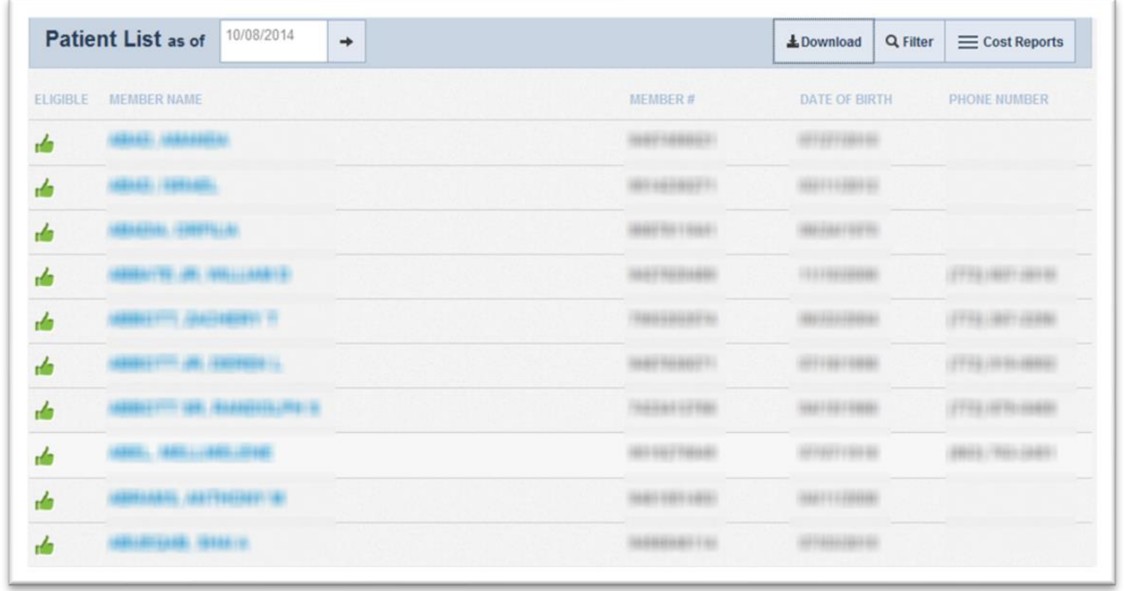
Provider Directory Updates

- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
  - Login to the Secure Provider Portal at Provider.SuperiorHealthPlan.com
  - From the main tool bar, select "Account Details"
  - Select the provider whose data you want to update
  - Choose the appropriate service location
  - Make appropriate edits and click "Save"

Primary Care Provider Reports

Patient List

- Located on the Secure Provider Portal at Provider.SuperiorHealthPlan.com
- Includes member's name, ID number, date of birth, and telephone number
- Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address



PCP Cost Reports

- **Members with Frequent ER visits:** This report includes members who frequently visit the ER on a monthly basis. The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis and cost.

- **High-Cost Claims:** This report includes members with high-cost claims. The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis and cost.

- **Rx Claims Report:** This report includes members with pharmacy claims on a monthly basis. The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.) and cost.

Network Partners

Partner and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent (NIA)	1-866-214-2569 radmd.com
Vision Services	Premier Eye Care	1-855-879-1456 premiereyecare.net
Dental Services	Liberty Dental	1-866-544-4669
Pharmacy Services	Express Scripts	1-833-750-4508

DME and Lab Partners

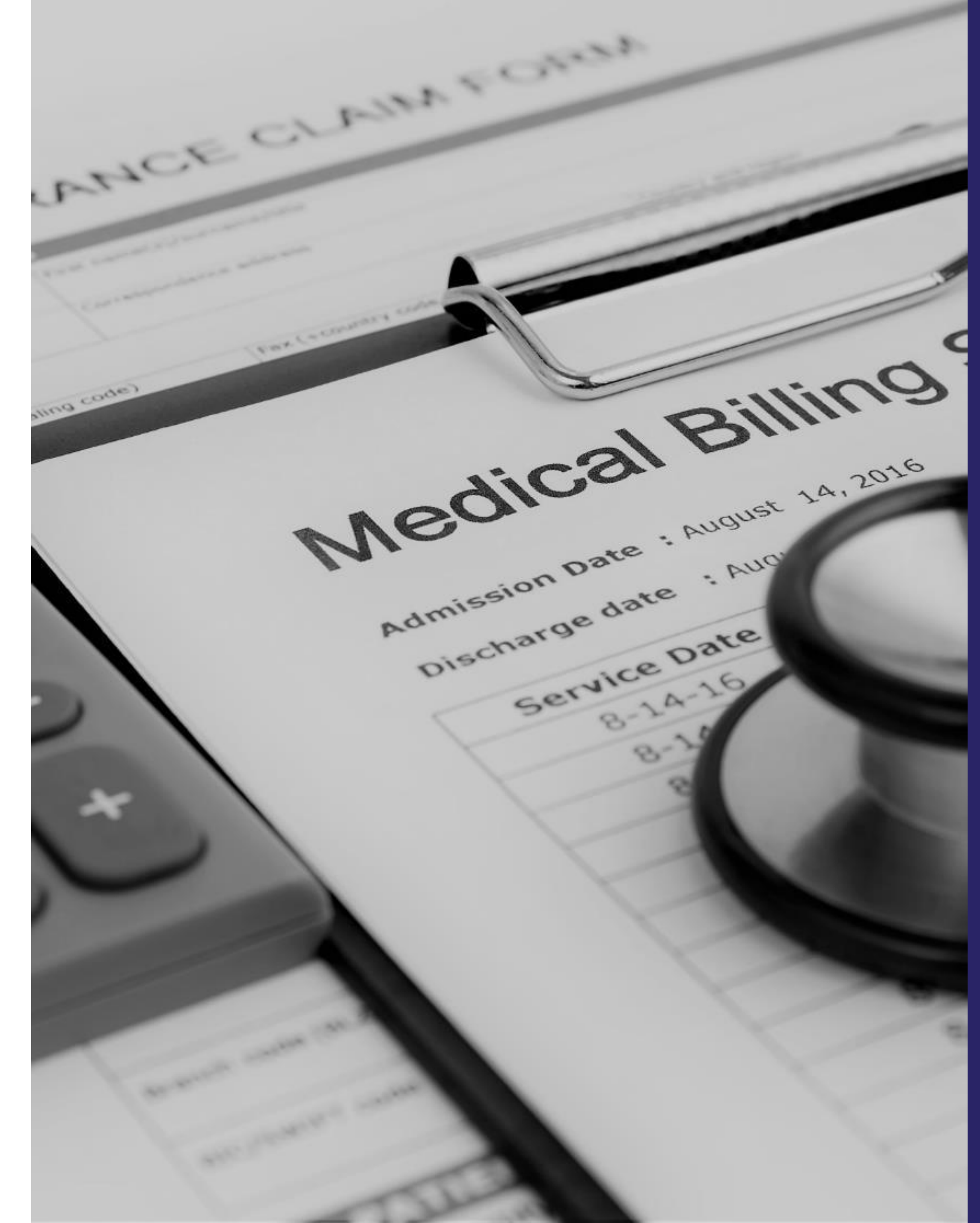
DME	
180 Medical	J&B Medical
ABC Medical	KCI
American Home Patient	Lincare
Apria	Hanger Prosthetics and Orthotics
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical
EBI	Tactile Medical
Edge Park	Zoll

Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	

Billing Overview

Electronic Claims Transmission

- When possible, we recommend utilizing Electronic Data Interchange (EDI) to submit claims and attachments for payment.
- EDI allows for a faster processing turn around time than paper submission.
- The Wellcare By Allwell Payer ID is 68069.
- For a list of the clearinghouses that we currently work with, please visit our website at: https://www.superiorhealthplan.com/providers/resources/electronic-transactions.html



Electronic Claims Transmission and Support

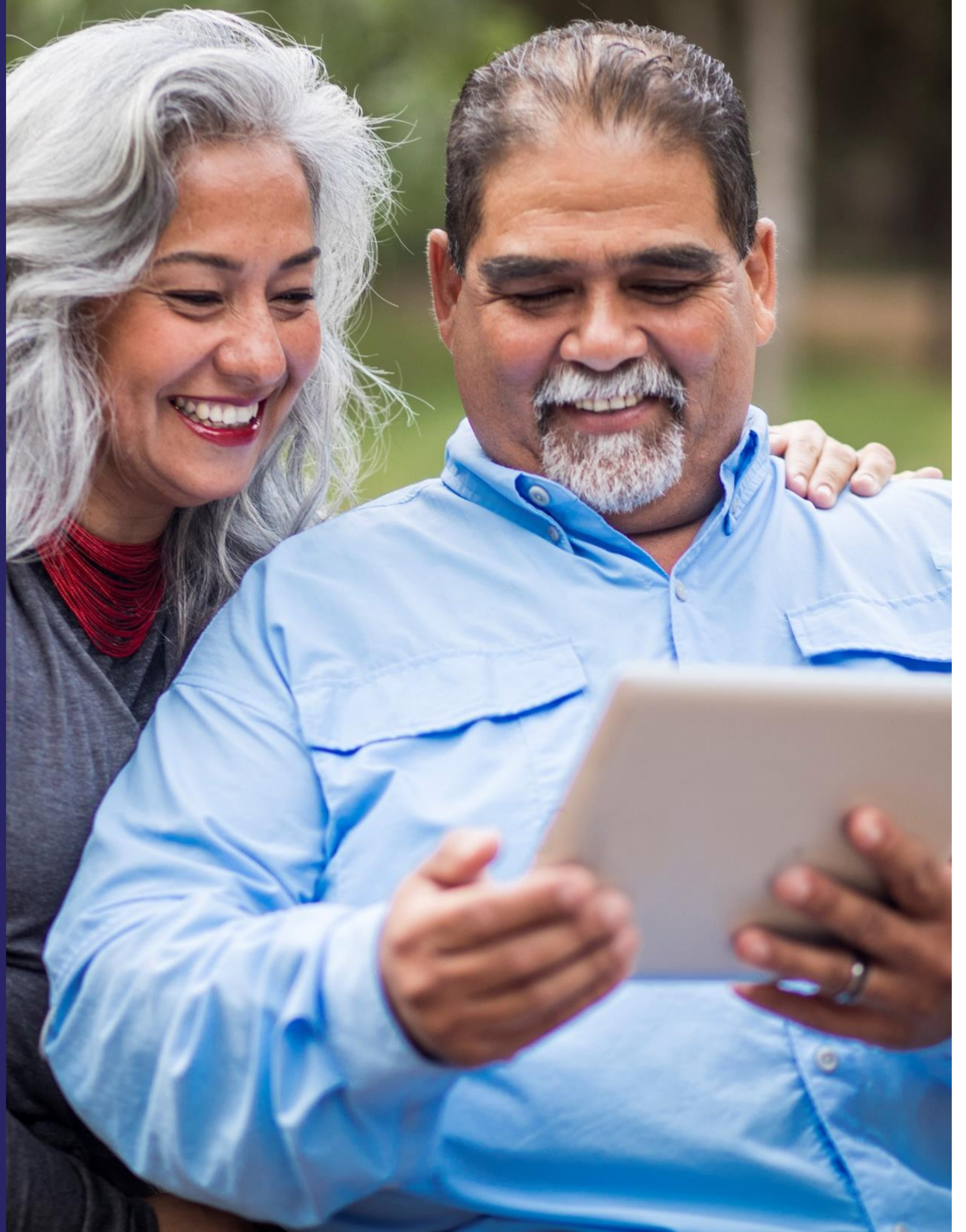
- When possible, we recommend utilizing Electronic Data Interchange (EDI) to submit claims and attachments for payment.
- EDI allows for faster processing turn around time than paper submission.
- Wellcare partners with Availity for EDI submissions
  - Providers may continue to use the trading partner they are contracted with, and these submissions will be routed through our designated direct submitter provider.
- Companion guides for EDI billing requirements and loop segments can be found at SuperiorHealthPlan.com/Billing.
- For more information, email EDIBA@centene.com.

Claims Submission Timelines

- Wellcare claims should be mailed to the following billing address:
  - Wellcare By Allwell
    Attn: Claims
    P.O. Box 3060
    Farmington, MO 63640-3822
- Participating providers have 95 Days from the date of service to submit a timely claim.
- All requests for reconsideration or claim disputes must be received within 120 Days from last timely processed claim.

Claims Payment

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may **not** bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Providers may **not** balance bill members for any differential.



Coding Auditing & Editing

Wellcare uses code editing software based on a variety of edits:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)
- Software audits for coding inaccuracies such as:
  - Unbundling
  - Upcoding
  - Invalid codes

Corrected Claims and Requests for Reconsideration

- A corrected claim is submitted when information requires a change from the original claim submission.
- A request for reconsideration is submitted when there is a disagreement with the manner in which a claim was processed. Reconsideration request may require medical records if related to code audit, code edit or auth denial.
- Submit corrected claims or reconsiderations to:
  - Wellcare By Allwell
    Attn: Corrections/Reconsiderations
    PO Box 3060
    Farmington, MO 63640-3822

Claim Disputes

- A claim dispute should be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- The claims payment dispute process addresses claim denials for issues related to untimely filing, incidental procedures, bundling, unlisted procedure codes, non-covered codes, etc.
- Claim payment disputes must be submitted to Wellcare in writing within 120 calendar days of the date of denial in the EOP.
- Mail claim disputes to:

  Wellcare By Allwell

  Attn: Claim Dispute

  PO BOX 4000

  Farmington, MO 63640-4400

Electronic Funds Transfer (EFT) Electronic Remittance Advice (ERA)

- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly.
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Free service for network providers: www.payspanhealth.com

Meaningful Use:
Electronic Medical Records

Electronic Medical Records

- The exchange of patient data between healthcare providers, insurers, and patients themselves is critical to advancing patient care, data security, and the healthcare industry as a whole.
- Electronic Health Records/Electronic Medical Records (EHR/EMR) allow healthcare professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
    - Complete and accurate information
    - Better access to information
    - Patient empowerment

(Incentive programs may be available)

Advance Directives

Advance Medical Directives

- An advance directive will help the PCP understand the member's wishes about their healthcare in the event they become unable to make decisions on their own behalf. Examples include:
  - Living will
  - Healthcare power of attorney
  - "Do Not Resuscitate" orders
- Execution of an advance directive must be documented on the member's medical records.
- Providers must educate staff on issues concerning advance directives and maintain written policies that address a member's right to make decisions about their own medical care.

Regulatory Information

Medicare Outpatient Observation Notice (MOON)

- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any member who receives observation services as an outpatient for more than 24 hours.
- The MOON is a standardized notice to a member informing them they are an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status.
- The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release.
- The OMB approved Medicare Outpatient Observation Notice and accompanying form instructions can be found at: cms.gov/medicare/forms-notices/beneficiary-notices-initiative.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Wellcare follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:

1. Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
2. Detection through data analytics and medical records review.
3. Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
4. Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan.

Fraud, Waste and Abuse

Wellcare performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:

- Use of incorrect billing code.
- Not following the service authorization.
- Procedure code not being consistent with provided service.
- Excessive use of units not authorized by the case manager.
- Lending of insurance card.

Fraud, Waste and Abuse

Benefits of stopping fraud, waste, and abuse:

- Improves patient care.
- Helps save dollars and identify recoupments.
- Decreases wasteful medical expenses.

Fraud, Waste and Abuse

Wellcare expects all of our providers, contractors, and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- U.S. Criminal Codes

Fraud, Waste and Abuse

- Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at:
  - **1-866-685-8664** or by contacting the Compliance Officer at **1-800-218-7453**
- To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:
  - Office of Inspector General (HHS-OIG): **1-800-447-8477**/ TTY: **1-800-377-4950**
  - Fax: **1-800-223-8164**
  - NBI MEDIC: **1-877-7SafeRx** (**1-877-772-3379**)
  - Visit: **OIG.HHS.gov/fraud**
  - Medicare's Fraud Hotline: **1-800-MEDICARE (1-800-633-4227)**
  - Email: **HHSTips@oig.hhs.gov**

CMS Mandatory Trainings

CMS Mandatory Trainings

All Wellcare contracted providers, contractors, and subcontractors are required to complete three required trainings:

- **Model of Care** (**MOC**): For DSNP only. Within 30 days of joining Wellcare and annually thereafter.
- **General Compliance** (**Compliance**): Within 90 days of joining Wellcare and annually thereafter.
- **Fraud, Waste, and Abuse** (**FWA**): Within 90 days of joining Wellcare and annually thereafter.

Model of Care Training

- Model of Care training is a CMS requirement for newly contracted Medicare providers within 30 days of execution of contract.
- Model of Care training must be completed annually by each participating provider.
- Model of Care information is available by visiting:

  SuperiorHealthPlan.com/ModelOfCare

Special Needs Plan Model of Care Training

What is a Special Needs Plan (SNP)?

A SNP is a Medicare Advantage coordinated care plan (CCP) that is limited to individuals with special needs and is specifically designed to provide targeted care to plan members.

What are the Different Types of SNPs?

- ✓ **Dual Special Needs Plan (D-SNP)** – Members who are eligible for both Medicare and Medicaid.
- ✓ **Chronic Special Needs Plan (C-SNP)** – Members with specific, severe, or disabling chronic conditions.
- ✓ **Institutional Special Needs Plan (I-SNP)** – Members who live in institutions such as nursing homes.

Wellcare currently offers D-SNPs and C-SNPs in multiple states across the nation.

What is a Model of Care?

As provided under section 1859(f)(7) of the Social Security Act, every SNP must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA). The MOC provides the basic framework under which the SNP will meet the needs of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.

The MOC addresses four clinical and non-clinical elements:

Description of the SNP population.

Care coordination.

The SNP provider network.

MOC quality measurement and performance.

For more than 20 years, Wellcare has offered a range of Medicare products, which offer affordable coverage beyond Original Medicare. Beginning Jan. 1, 2022, our affiliated Medicare product brands, including Allwell, Health Net, Fidelis Care, Trillium Advantage, 'Ohana Health Plan, and TexanPlus transitioned to the newly refreshed Wellcare brand. If you have any questions, please contact Provider Relations.

By Allwell
By Fidelis Care
By Health Net
By 'Ohana Health Plan
By Trillium Advantage

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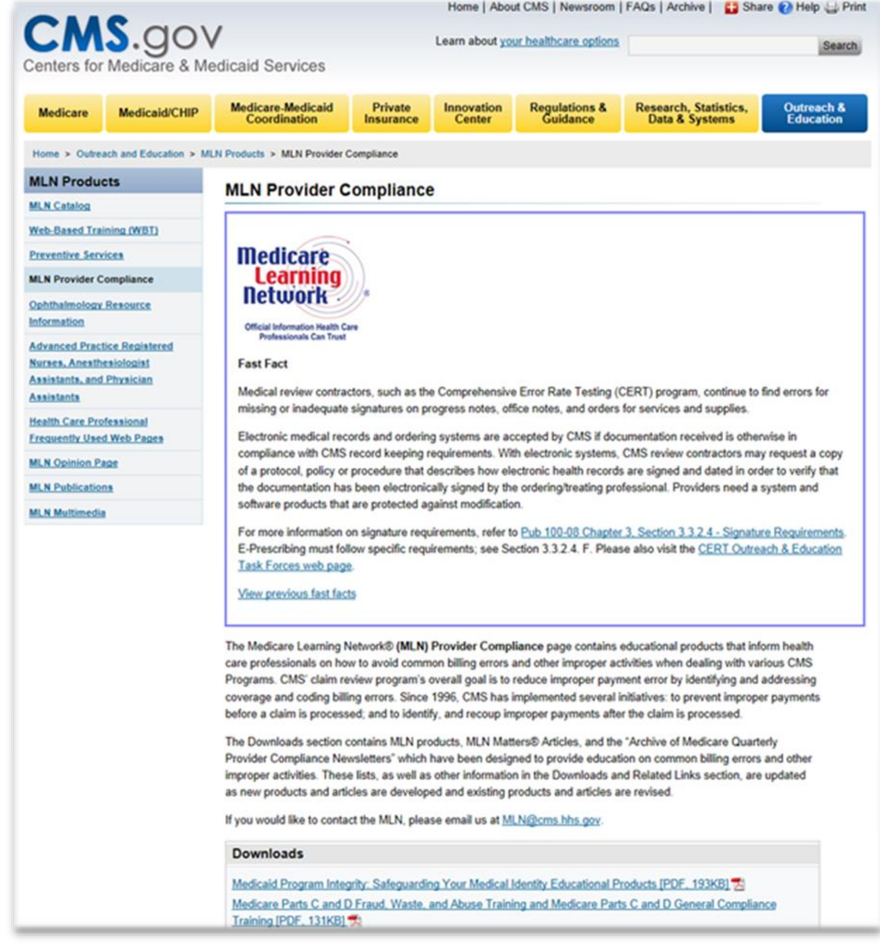
General Compliance & Medicare Fraud, Waste, And Abuse Training

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Wellcare.



General Compliance & Medicare Fraud, Waste, And Abuse Training

- First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, are required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter.
- Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Wellcare.

Questions & Answers