Meet Wellcare

2023 Provider Orientation

Agenda

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- Questions and Answers

Plan Overview

Meet Wellcare by Allwell

- Welcome to the new Wellcare by Allwell!
- While you may have known us as Allwell from Superior HealthPlan before, we are now Wellcare By Allwell. This is a part of Wellcare, which combines multiple national Medicare brands under the 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 remains the same: ensuring 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

Who We Are

- 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
  - MMP

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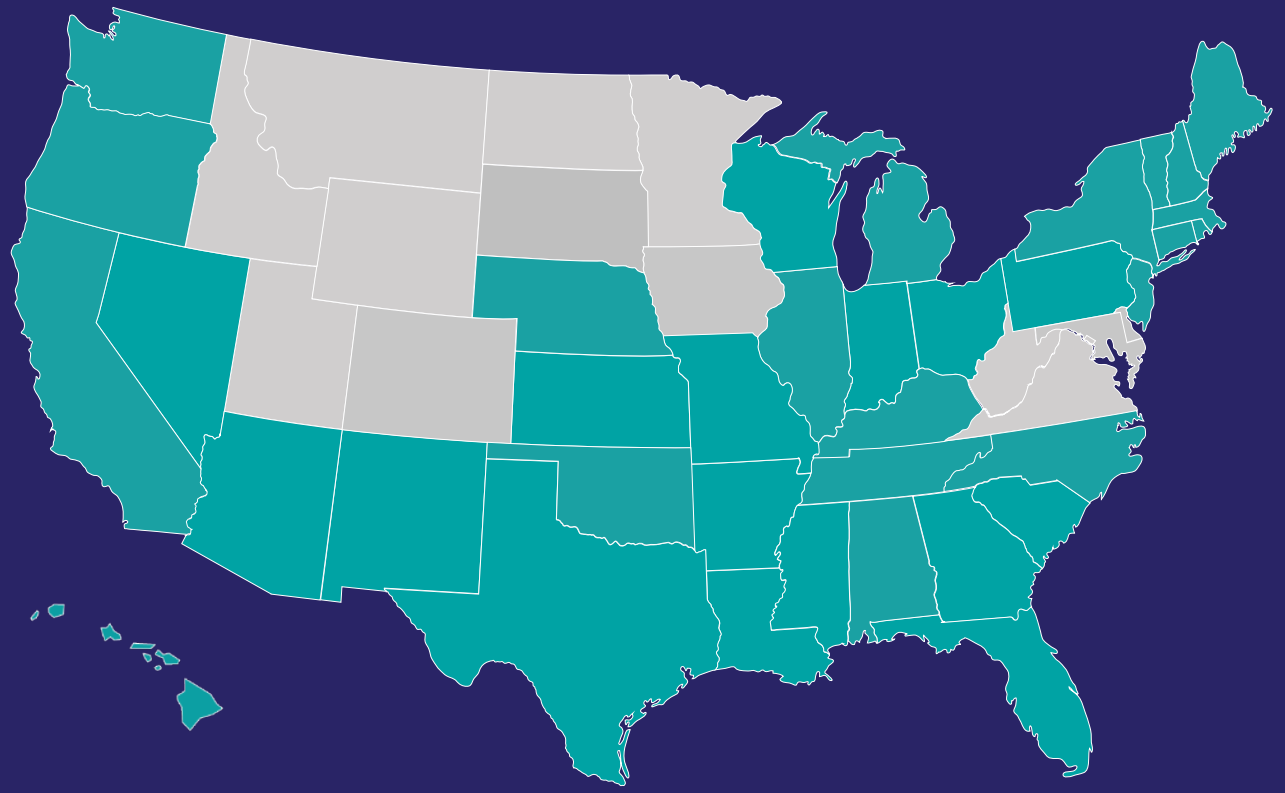
1.4 Million Medicare Members across 36 states



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

- 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)

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.

Flex Card – Prepaid debit card to help cover out-of-pocket expenses for ancillary services such as dental, vision, and hearing.

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 Pharmacy Benefits Manager (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 all co-located in a single, locally-based unit. The multidisciplinary team includes:
  - Registered nurses
  - Social workers
  - Pharmacy technicians
  - Behavioral health case managers

Wellcare Medicare (HMO)

- Superior offers non-dual HMO plans. These HMO plans cover all Medicare-required services, along with a prescription drug benefit. HMO plans (unlike HMO DSNP and MMP) do not require Medicaid to enroll.
  - Most Medicare plans (sometimes referred to as "Part C") include the Part D prescription drug benefit plan. This is Superior's Wellcare Medicare (HMO) plan.
  - HMO plans cover the most commonly prescribed drugs. However, each specific Part D plan may determine which drugs are covered. The covered drugs are included in the plan's formulary, or list of drugs: Wellcare.SuperiorHealthPlan.com/Drug-Pharmacy/Formulary.html

Wellcare Dual Medicare (HMO DSNP)

- Wellcare Dual Medicare (HMO DSNP) is a plan for individuals with specific conditions or financial needs who are eligible for both Medicare and medical assistance from Texas Medicaid.
- For HMO DSNP members, Medicare is always the primary payor and Medicaid is secondary payor.
- HMO DSNP members may have both Superior Medicare and Superior Medicaid but not always, so it is important to verify coverage prior to servicing the member.

Please note: You may see members with Superior Medicare where their Medicaid is under another health plan or traditional Fee-For-Service (FFS) Medicaid or vice versa.

Key Resources for Providers

Key Contact Information

Phone

1-877-391-5921

Web

SuperiorHealthPlan.com

Portal

Provider.SuperiorHealthPlan.com

The 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 including, but not limited to:
    - Network information.
    - Billing guidelines.
    - Claims information.
    - Regulatory information.
    - Key contact list.
    - Quality initiatives.
    - And much more!
- The Provider Manual can be found in under the Provider Manuals section at SuperiorHealthPlan.com/ProviderManuals.

Provider Services

- Our Provider Services Department includes trained staff who are 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 will be 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 with things like:

- ✓Inquiries related to administrative policies, procedures, and operational issues
- ✓Contract clarification
- ✓Membership/provider roster questions
- ✓Secure Provider Portal registration and PaySpan
- ✓Provider education
- ✓Demographic information updates
- ✓Initiate credentialing of a new practitioner

Membership

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.
- Wellcare members may change Primary Care Providers (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 options below:
  - Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - 24/7 Interactive Voice Response Line: 1-800-218-7453
  - Provider Services: HMO and HMO DSNP – 1-877-391-5921

Member ID Card

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: $X

PHARMACY INFORMATION
Medicare Rx Prescription Drug Coverage
Rx Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: <RX8124>

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

BACK PANEL

www.wellcare.com/allwellTX

FOR MEMBERS

Member Services:	<1-877-935-8023 (**TTY:** 711)>
Nurse Advice Line:	<1-877-935-8023 (**TTY:** 711)>
Transportation:	<1-877-718-4201 (**TTY:** 711)>
Envolve Dental (For Members and Providers):	<1-855-586-1417 (**TTY:** 711)>
Envolve Vision (For Members and Providers):	<1-866-897-4785 (**TTY:** 711)>

FOR PROVIDERS

For Member eligibility and Medical prior auth/referrals: <1-877-935-8023>
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) <1-888-865-6567>
Submit Part D Drug Claims to: <Wellcare By Allwell> <Attn: Member Reimbursement Dept> <P.O. Box 31577><Tampa, FL> <33631-3577>

Benefits and Additional Services

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Plan Coverage

Wellcare 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
  - No Cost/Low Cost PCP copay*
  - $0 generic prescription drugs
- For a summary of plan benefits, visit: Wellcare.SuperiorHealthPlan.com/Plan-Benefit-Materials.html

**Dependent on plan*

Pharmacy Formulary

- The Wellcare 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 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:
  - Wellcare.SuperiorHealthPlan.com/Drug-Pharmacy/Coverage-Determinations-Redeterminations.htm
  - The completed form can submitted by mail, fax or through electronic prior authorization (ePA).

Covered Services

- Covered Services include, but are not limited to:
  - Ambulance
  - Behavioral Health
  - Hospital Inpatient/Outpatient
  - Lab and X-Ray
  - Medical Equipment and Supplies
  - Physician Services
  - Podiatry
  - Prescribed Medicines
  - Therapy
  - Wellness Programs
  - 24-Hour Nurse Advice Line

Additional

- ✓ Transportation
- ✓ Dental
- ✓ Vision
- ✓ Hearing
- ✓ Fitness
- ✓ Meals
- ✓ OTC
- ✓ PERS
- ✓ Utilities Flex Card
- ✓ Helper Bee’s Care Concierge
- ✓ Grocery Card by Shipt
- ✓ Telemedicine

**Benefit levels vary by plan/service area*

Additional Benefits

- Multi-language Interpreter Services
  - Interpreter services are available at no cost to Wellcare members and providers without unreasonable delay at all medical points of contact. To get an interpreter, call member services at:
    - HMO: 1-844-796-6811 (TTY: 711)
    - HMO DSNP: 1-877-935-8023 (TTY: 711)
- Non-Emergency Transportation
  - Covered for a specified number (dependent upon the member's service area) of one-way trips per year, to approved locations.
  - Schedule trips 48 hours in advance using the plan's contracted providers.
  - Contact us at 1-877-718-4201 to schedule non-emergency transportation.

Network

- HCA/Methodist
- Texas Tech
- University Hospital –Bexar, El Paso
- El Paso Medical Network
- Christus Santa Rosa Health
- Doctors Hospital at Renaissance (DHR)
- Mission Health
- Baptist health System
- Southwest General Hospital
- Texas Health Resources (THR)

Medical Home & Prior Authorization

Primary Care Providers (PCPs)

- 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
  - 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.

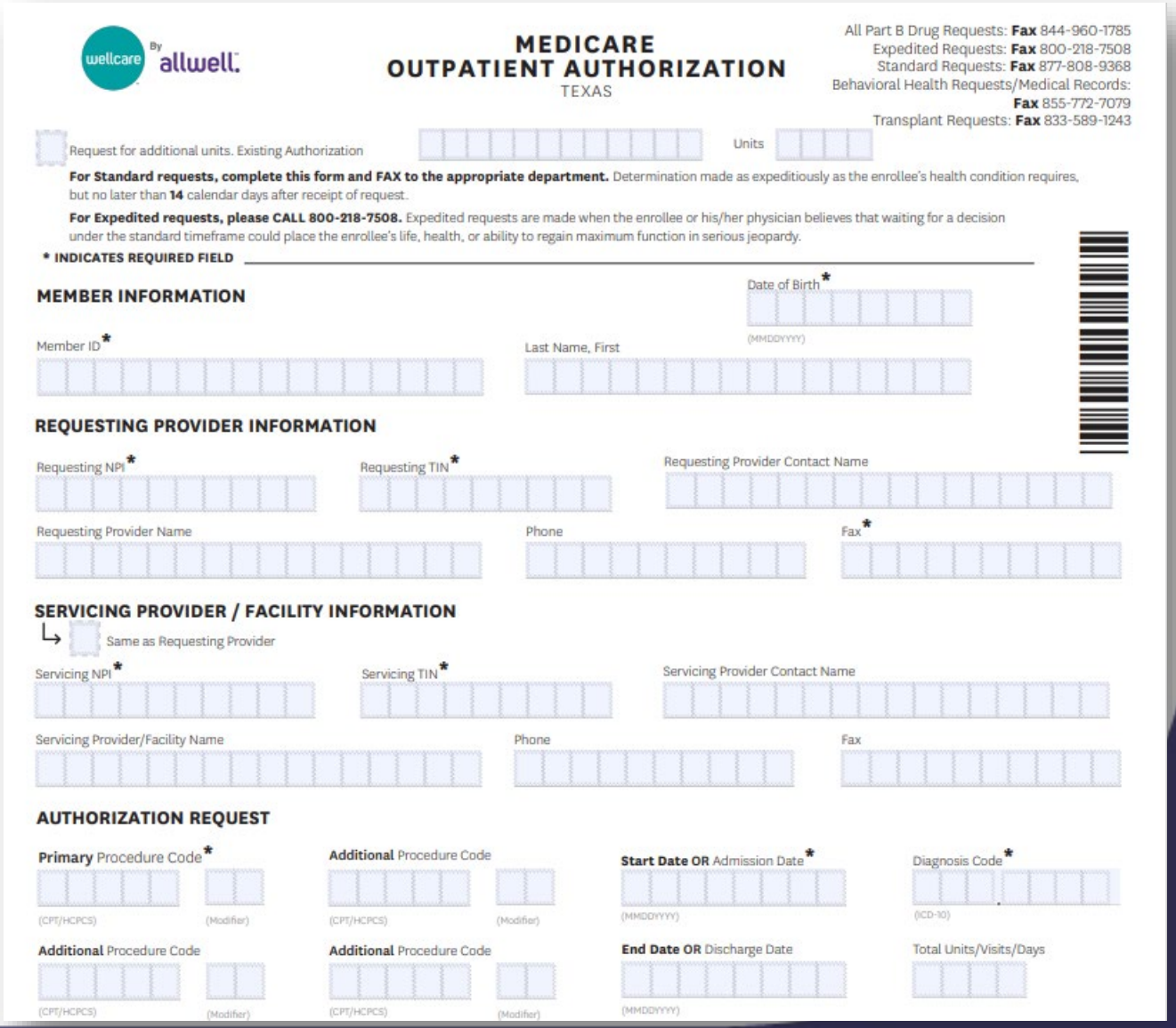
Utilization Management

- 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 Provider Portal at Provider.SuperiorHealthPlan.com.

Service Type	Time Frame
Elective/scheduled admissions	Required five Business 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 Authorizations

- 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



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MEDICARE OUTPATIENT AUTHORIZATION
TEXAS

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

Request for additional units. Existing Authorization Units

For Standard requests, complete this form and FAX to the appropriate department. 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 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

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

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

Prior Authorization for Covid-19

COVID-19 Testing, Screening and Vaccinations

- Prior authorization requirements will be waived for COVID-19 testing, screening and vaccination services at this time
- Member cost share liability (copayments, coinsurance and/or deductible cost share amounts) will also be waived for these services

Prior Authorization for Covid-19

COVID-19 Treatment Related Services

- COVID-19 treatment related services (those billed with a confirmed ICD-10 diagnosis code) will continue to be eligible for coverage at this time, in accordance with the member's plan benefits
- Prior authorization is required for COVID-19 treatment related services in accordance with CMS guidance and plan benefits
- Providers should also collect Medicare member liability at the point of service for applicable treatment related services

Prior Authorization for Covid-19

Telehealth Services

- Any services that can be delivered virtually will continue to be eligible for telehealth coverage at this time
- Any prior authorization requirements that apply to in-office services will also apply to those services when delivered via telehealth
- Providers should collect Medicare member liability at the point of service for applicable telehealth services, in accordance with the member's plan benefits
- Providers should reflect telehealth care on their claim form by following standard telehealth billing protocols in their state.

Out-of-Network Coverage

- Plan authorization is required for out-of-network services, except:
  - Emergency care
  - Urgently needed care when the network provider is not available (usually due to out-of-area)
  - Kidney dialysis at Medicare-certified dialysis centers when temporarily out of the service area

Medical Necessity Determination

- When medical necessity cannot be established, a peer-to-peer review 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 and Screening Test

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Preventive Care

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam – Welcome to Medicare:
  - Measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements. Also includes an electrocardiogram, education and counseling. Does not include lab tests. Limited to one per lifetime.
- Annual Wellness Visit
  - Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care

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

Medicare
Star Ratings

Medicare Star Ratings

- What are Centers for Medicare and Medicaid Services (CMS) Star Ratings?
  - CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health-care system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MAPD).
  - The ratings are posted on the CMS consumer website, www.Medicare.gov, to give beneficiaries help in choosing a plan offered in their area. The Star Rating System 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.

Medicare Star Ratings

- CMS' Star Rating Program is based on measures in 9 different areas:

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 and Changes 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.
- Manage chronic conditions, such as cholesterol, hypertension and diabetes, including improvement to medication adherence.
- Continue to talk to 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

Superior Website

- Through SuperiorHealthPlan.com, providers can access:
  - Provider Manuals
  - Forms
  - HEDIS Quick Reference Guides
  - Provider News
  - Pre-Auth Needed Tool
  - Provider Resources

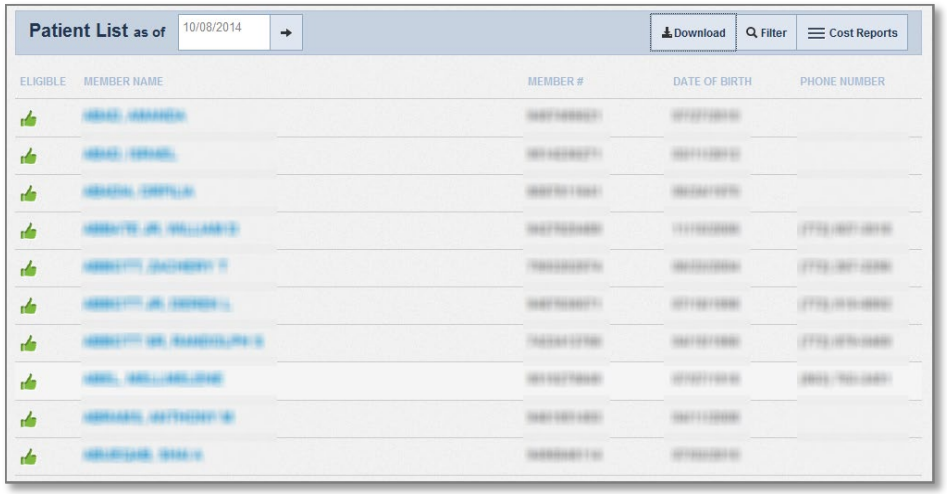
Superior Secure Provider Portal

- On Superior's Secure Provider Portal (Provider.SuperiorHealthPlan.com), providers can access:
  - Authorizations
  - Claims
    - Download Payment History
    - Processing Status
    - Submission / Adjustments
    - Clean Claim Connection – Claim Auditing Software
  - Health Records
    - Care Gaps*
  - Patient Listings* and Member Eligibility

**Available for PCPs only.*

Primary Care Provider Reports

- Patient List – Located on Provider.SuperiorHealthPlan.com.
  - Includes member's name, ID number, date of birth and telephone number.
  - The Patient List is available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender and address.



Updating Your Data

- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
    1. Log in to the Secure Provider Portal
    2. From the main tool bar, select “Account Details”
    3. Select the provider whose data you want to update
    4. Choose the appropriate service location
    5. Make appropriate edits and save

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

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-866-214-2569 www.radmd.com
Interventional Pain Management	National Imaging Associates	1-866-214-2569 www.radmd.com
Vision Services	Envolve Vision Benefits	1-800-334-3937 www.visionbenefits.envolvehealth.com
Dental Services	Envolve Dental Benefits	www.dental.envolvehealth.com
Pharmacy Services	CVS Caremark	1-800-364-6331
Hearing Aids	Hearing Care Solutions	1-303-407-6813 www.hearingcaresolutions.com

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
Fitness Services	ASH	www.silverandfit.com
MealsVendor Services	GA Foods & Mom's Meals	1-877-508-6667 https://www.momsmeals.com/ 1-866-575-2772 www.GAFoods.com
OTC Services	CVS	Wellcare By Allwell: https://www.cvs.com/otchs/allwell Wellcare: https://www.cvs.com/otchs/wellcare
PERS Services	VRI	1-800-750-8694 www.wellcarepers.com
Transportation Services	ModivCare	1-877-718-4201

TurningPoint HealthCare Solutions

- Superior HealthPlan started working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint is responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures, certain Cardiac procedures, Ear, Nose and Throat (ENT) surgeries and sleep study procedures.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under Billing Resources at SuperiorHealthPlan.com/ProviderResources.

TurningPoint HealthCare Solutions

- Prior authorization is required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Knee Arthroplasty and Arthroscopy	Spinal Fusion Surgeries
Uni/Bi-Compartmental Knee Replacement	Cervical
Hip Arthroplasty and Arthroscopy	Lumbar
Acromioplasty and Rotator Cuff Repair	Thoracic
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Osteochondral Defect Repair	Laminectomy/Discectomy

*This is not an all-inclusive list. For a detailed list of impacted CPT codes, visit TurningPoint's Web Portal or SuperiorHealthPlan.com/MedicarePriorAuth

TurningPoint Healthcare Solutions – Cardiac Surgical Procedures

- Prior authorization is required for the following Cardiac surgical procedures in both inpatient and outpatient settings:
  - Arterial Procedures
  - Loop Recorders
  - Coronary Angioplasty/Stenting
  - Non-coronary Angioplasty/Stenting
  - Coronary Artery Bypass Grafting
  - Pacemaker
  - Implantable Cardioverter Defibrillator (ICD)
  - Pacemaker Revision or Removal
  - ICD Revision or Removal
  - Valve Replacement
  - Left Atrial Appendage Occluders
  - Wearable Cardiac Defibrillator

TurningPoint Healthcare Solutions – ENT Surgery and Sleep Study

- Prior authorization is required for the following ENT surgeries and sleep studies performed in the inpatient, outpatient, physician's office and in-home settings.

Sleep Study Procedures
Actigraphy
Home Sleep Study
Multiple Sleep Latency and Maintenance of Wakefulness Testing
Polysomnography

ENT Surgeries
Balloon Dilation Esophagoscopy
Cochlear Implant Device
Laryngoscopy and Laryngoplasty
Rhinoplasty and Septoplasty
Sinus Surgery
Thyroidectomy and Parathyroidectomy
Tonsillectomy (with or without Adenoidectomy)
Tympanostomy and Tympanoplasty

TurningPoint Healthcare Solutions

- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions regarding this notification, prior authorization requirements, or impacted CPT codes, please contact TurningPoint:
  - Email: providersupport@turningpoint-healthcare.com
  - Phone:
    - TurningPoint Provider Support: 1-866-422-0800.
    - Intake: 1-855-336-4391

Lab and DME Partners

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

AcariaHealth - Specialty Pharmacy

- AcariaHealth is a national, comprehensive specialty pharmacy providing services in all specialty disease states including:
  - Cystic Fibrisis
  - Hemophilia
  - Hepatitis C
  - Multiple Sclerosis
  - Oncology
  - Rheumatoid Arthritis
- Most biopharmaceuticals and injectables require prior authorization at:
  - CustomerCare@acariahealth.com

Billing Overview

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 Filing 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, co-insurance and copayments.
- Providers may **not** balance bill members for any differential.

Coding Auditing and Editing

- Wellcare uses code editing software based on a variety of edits including:
  - American Medical Association (AMA)
  - Specialty society guidance
  - Clinical consultants
  - Centers for Medicare and 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 is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Submit claim disputes to:
  - Wellcare By Allwell
    Attn: Claim Dispute
    PO Box 4000
    Farmington, MO 63640-4400

Ophthalmology for Medical Eye Care Services

- Superior HealthPlan handles medical eye care services delivered by ophthalmologists for all Superior members.
- Envolve Vision continues to manage routine eye care services and full-scope of licensure optometric services for Superior HealthPlan.
- Superior manages all functions for ophthalmologists providing medical eye care services, including but not limited to:
  - Claim Processing and Appeals.
  - Contracting/Credentialing.
  - Prior Authorization.
  - Retrospective Utilization Review.
  - Medical Necessity Appeals.
  - Provider Complaints related to medical eye care services.
  - Provider Relations/Account Management.
  - Provider Services.
  - Secure Provider Portal.
- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool: SuperiorHealthPlan.com/PriorAuth

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

- Electronic payments can mean faster payments, leading to improvements in cash flow
- Elimiate 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
- Access payment services for free: www.PayspanHealth.com.

Meaningful Use – Electronic Medical Records

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Electronic Medical Records

- The exchange of patient data between health-care providers, insurers and members is critical to advancing member care, data security and the health-care industry as a whole.
- Electronic Health Records/Electronic Medical Records (EHR/EMR) allow health-care 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

Please note: Incentive programs may be available.

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 that the member is 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 Office of Management and Budget (OMB) approved MOON and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

- Wellcare follows the 4 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 care manager.
  - Lending of insurance card

- 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 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)
  - US Criminal Codes

Medicare Reporting

- Potential fraud, waste or abuse reports may be called in to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-866-796-0530.
- To report suspected fraud, waste or abuse in the Medicare program, please use one of the following avenues:
  - Office of Inspector General (OIG):
    - Phone: 1-800-447-8477/ TTY: 1-800-377-4950
    - Fax: 1-800-223-6167
    - Email: www.OIG.HHS.gov/fraud or HHSTips@oig.hhs.gov
  - NBI MEDIC: 1-877-772-3379
  - Medicare: 1-800-Medicare (1-800-633-4227)

CMS Mandatory Trainings

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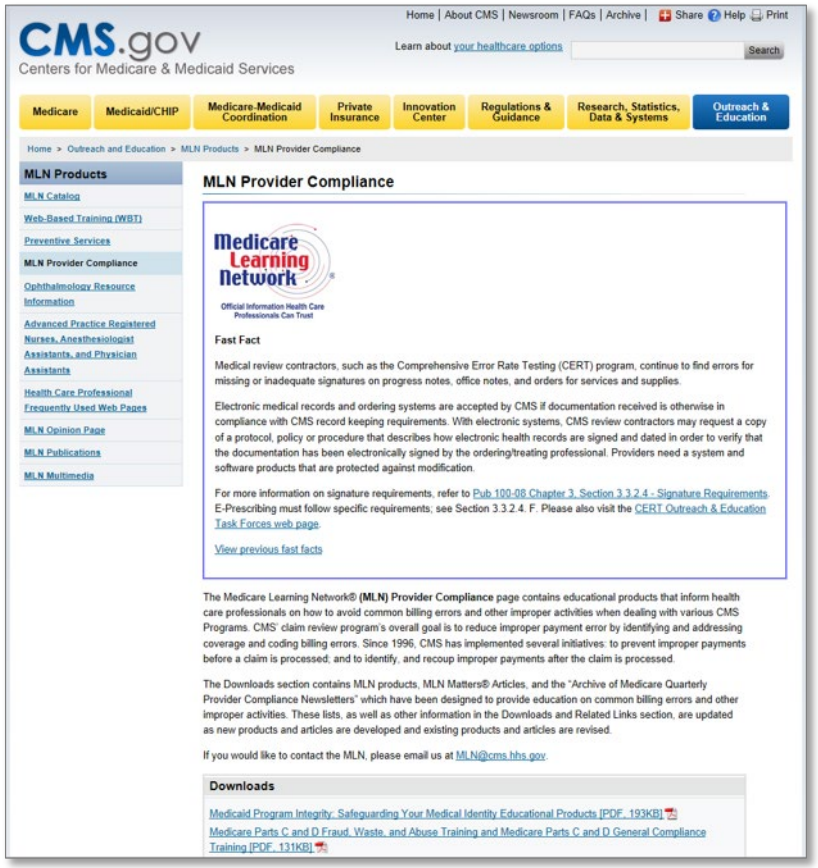
CMS Mandatory Trainings

- All Wellcare contracted providers, contractors, and subcontractors are required to complete three required trainings:
  - Model of Care (MOC): Within 30 Days of joining Wellcare and annually thereafter (DSNP and MMP only).
  - 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.

General Compliance and 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 MLN website.
- The trainings must be completed by each individual provider or 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(s) through the CMS MLN and provide a copy to Wellcare.

Model of Care

Wellcare Dual Medicare (HMO DSNP) Only

Model of Care (HMO DSNP Only)

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs.
- This only applies to DSNP members.
- The goals of the 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 health-care 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 (HMO DSNP Only)

- Model of Care elements:
  - Description of the HMO DSNP population.
  - Care coordination and care transitions protocol
  - Provider network.
  - Quality measurements and performance improvement.

Model of Care Process (HMO DSNP Only)

- Every dual 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 (HMO DSNP Only)

- Wellcare values its partnership with network physicians and providers.
- The Model of Care requires that Superior and providers collaborate to benefit members by:
  - Enhancing communication between members, physicians, providers and Wellcare.
  - Taking an interdisciplinary approach with regard to the member's special needs.
  - Providing comprehensive coordination with all care partners.
  - Supporting the member's preferences in the Model of Care.
  - Reinforcing the member's connection with their medical home.

Model of Care Information (HMO DSNP Only)

- Model of Care information is available at SuperiorHealthPlan.com/ModelOfCare.
- Model of Care training is a CMS requirement for newly contracted Medicare providers within 30 Days of execution of their contract.
- The Model of Care Training must be completed by each participating provider annually, during each calendar year.

Model of Care Training

Superior HealthPlan network providers who serve Allwell from Superior HealthPlan members are required to complete an annual Model of Care training.

Click on either of the links below to review the Model of Care training. Then, submit the form to verify the training was completed.

- Model of Care Training (PDF)*(presentation)*
- Model of Care Training (PDF)*(attestation included)*
- Model of Care Training Self-Study Program (PDF)

Questions and Answers

Thank you for attending!