Meet Wellcare.

2025 Provider Orientation

SHP_202411436

Agenda

- Plan Overview
- Key Resources for Providers
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (SNP plans 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 makes 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: Superior's Secure Provider Portal
  - Wellcare: Wellcare Provider Portal

The Strength of Wellcare

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

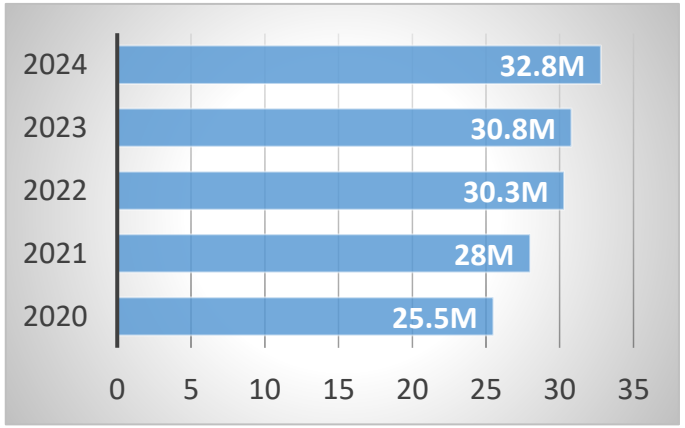
- **Local management with national expertise**
- **Full continuum of Medicare products including:**
  - **HMO**
  - **PPO**
  - **DSNP**
  - **CSNP**
  - **MMP**
  - **PSP**
  - **EGWP**
  - **PDP**

1.1M
Medicare members across **32 STATES**

358K
Special Needs Plan members across **30 STATES**

6.7M
Prescription Drug Plan members across **50 STATES**

Total Medicare Advantage Members Nationwide



7.1%
Avg. YoY Growth Medicare Advantage Enrolled

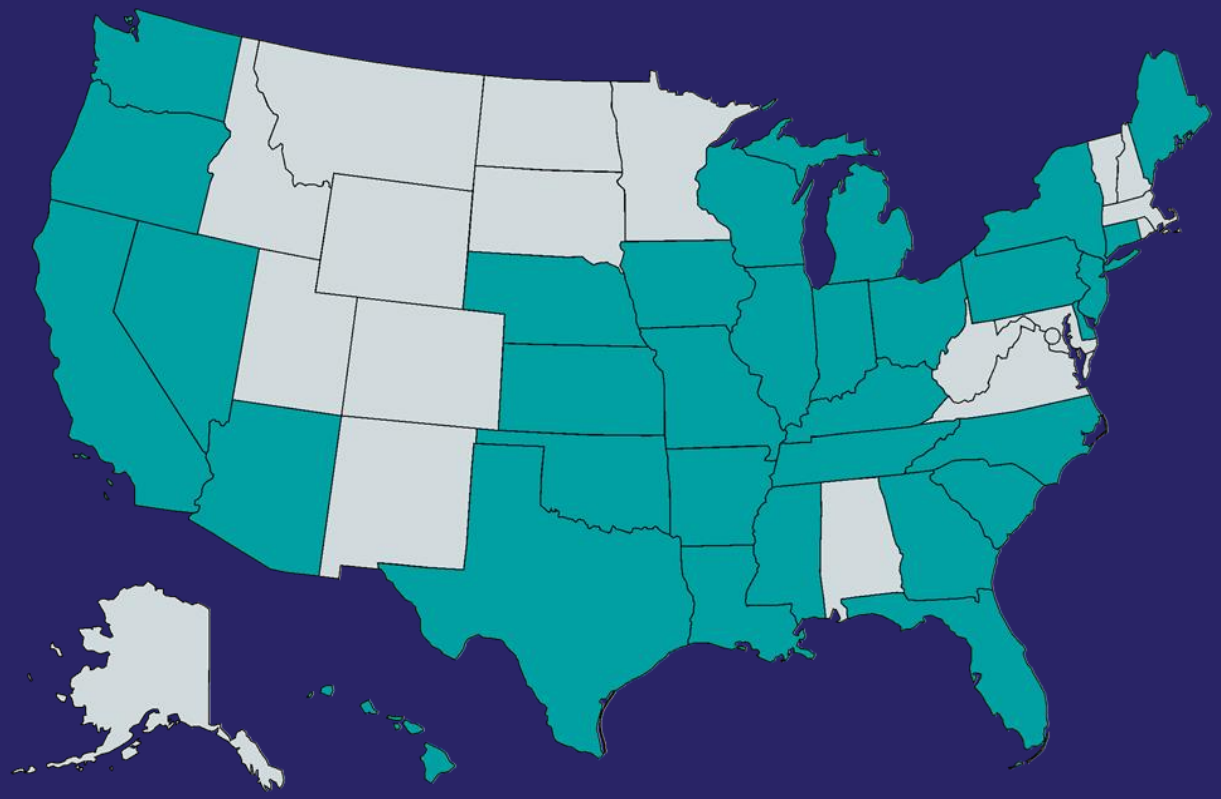
32.8M
Medicare Advantage enrolled members nationwide

50.2%
Medicare Advantage Penetration Rate nationwide

1.1 Million Medicare Members

#6
largest MA plan

#1
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)**

Additional Services

- **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 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.
- **Digital Social Support Platform** – Focuses on members behavioral health and social support.

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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 Account Managers 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

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Key Resources for Providers

Key Contact Information

PHONE

1-800-977-7522 (HMO)

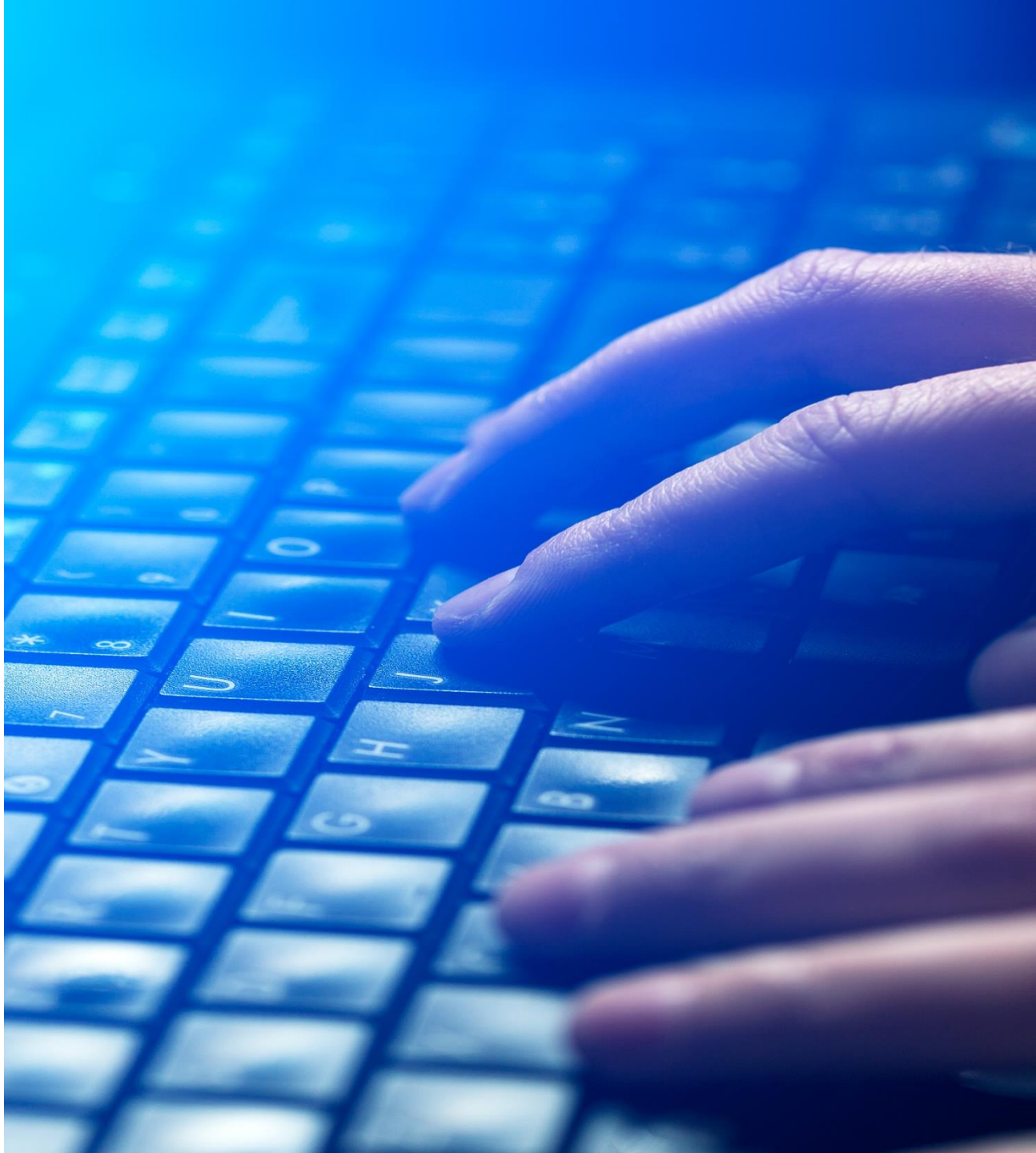
1-877-935-8023 (HMO SNP)

WEB

Superior HealthPlan website

PORTAL

Superior's Secure Provider Portal



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 **Superior's Training and Manuals webpage**.

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
- Providers can access real time assistance for all their service needs by calling Provider Services at:
  - 1-800-977-7522 (HMO)
  - 1-877-935-8023 (HMO SNP)

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:

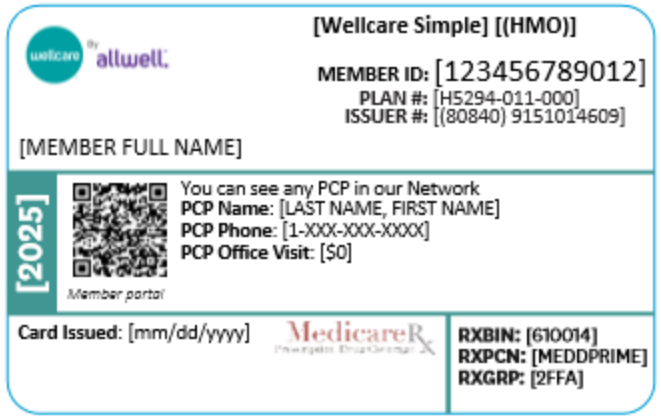
- ✓Inquiries related to administrative policies, procedures, and operational issues
- ✓Contract clarification
- ✓Membership/provider roster questions
- ✓Secure Portal registration
- ✓PaySpan/Zelis
- ✓Provider education
- ✓Demographic information updates
- ✓Initiate credentialing of a new practitioner

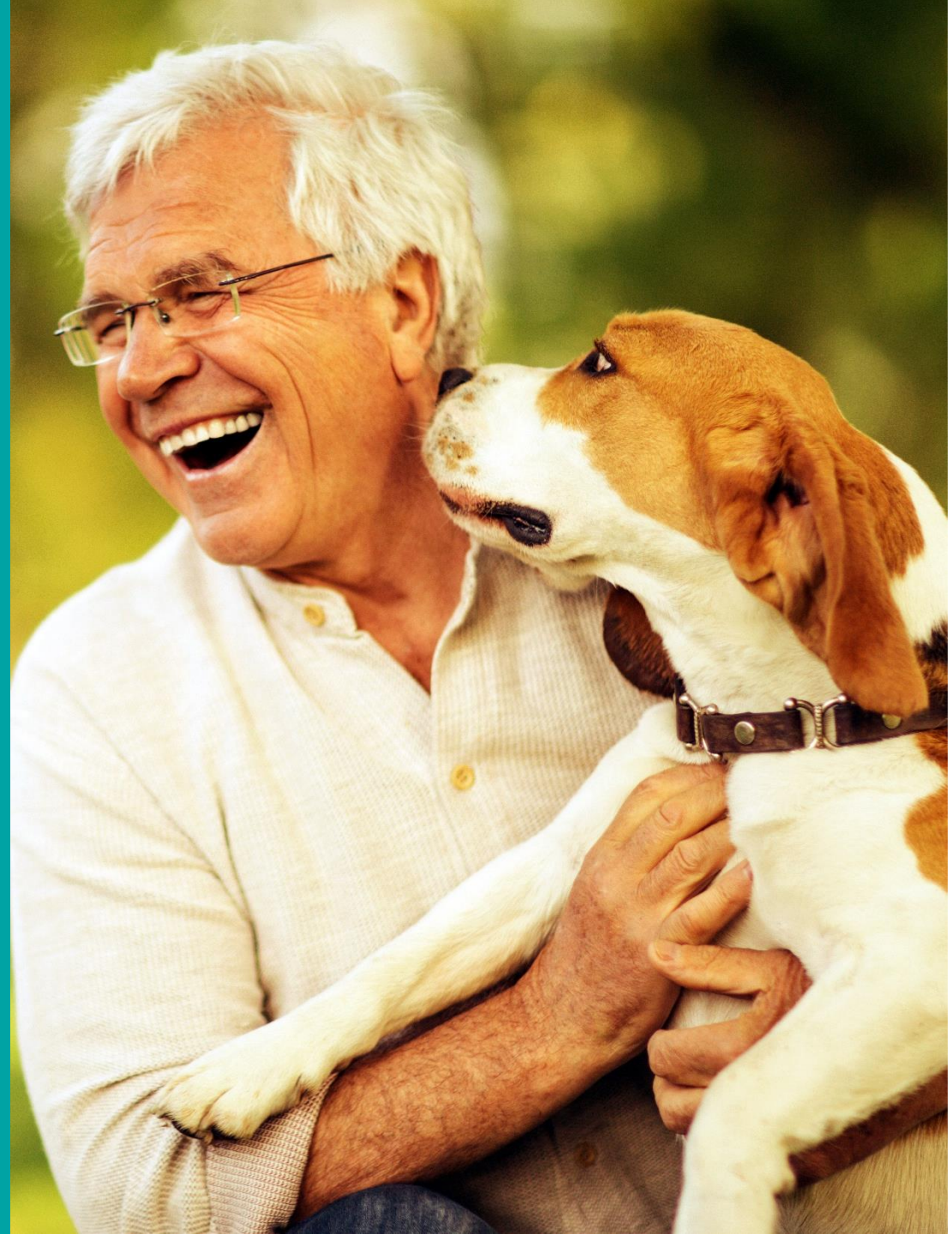
Membership, Benefits, and Additional Services

Membership

- Medicare beneficiaries have the option to stay in the fee-for-service Original Medicare 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:
  - Website: Superior's Secure Provider Portal
  - 24/7 Interactive Voice Response Line:
    - 1-855-766-1572 (TTY:711) (HMO)
    - 1-833-541-0767 (TTY: 711) (HMO SNP)
  - Provider Services:
    - 1-800-977-7522 (HMO)
    - 1-877-935-8023 (HMO SNP)

Member ID Cards





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***
  - **For a summary of plan benefits, visit Wellcare By Allwell's Plan Benefit Materials**

**DSNP plans may have a deductible.*

Pharmacy Formulary

- The Advantage formulary is available on Wellcare's List of Drugs (Formulary)
- 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. The form can be found on Wellcare's Coverage Determinations and Redeterminations for Drugs
- 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
- Appropriate Cancer Screening Exams
- Appropriate Clinical Screening Exams
- 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
- $350 to $1,500 coverage limit per year for hearing aids (dollar coverage dependent upon service area*); 1 hearing aid per ear

Dental Services

- Two Oral exams per year with no co-pay
- Two Cleanings per year with no co-pay
- Every date of service to 36 months depending on the type of service
- $1000 to $5,000 in comprehensive dental benefits per year (dollar coverage dependent upon service area*)

**Dental, vision, and hearing benefits vary by plan. Plans can have the same service area but different benefits.*

Additional Benefits

Vision Services

- One routine eye exam every year>
- One pair of glasses or contacts lenses every year
- $100 to $500 limit (dollar coverage dependent upon service area*); for eyewear each year

**Dental, vision, and hearing benefits vary by plan. Plans can have the same service area but different benefits.*

Over-the-Counter Items

- Commonly used over-the-counter items – listing available on **Superior's Secure Member Portal**
- Conveniently shipped to member's home within 3-7 Business Days
  - Members can order OTC items by:
    - In-store by visiting a participating retailer
    - Downloading the Healthy Benefits+ mobile app
    - Online by logging into Superior's Secure Member Portal, click Wellcare Spendables to link to Healthy Benefits+ website
    - Phone: 1-855-256-4620, TTY 711

Additional Benefits

- NurseWise
  - Free health information line staffed with registered nurses 24/7 to answer health questions
- Certified fitness program at specified gyms at no extra cost

Additional Services

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 us at 1-866-393-2166 (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)
- 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 (PCP)

- 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 an/or authorized representative
  - PCP
  - Family and/or caregiver, if approved by the member
  - Care coordinator(s) (Service Coordinator, 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

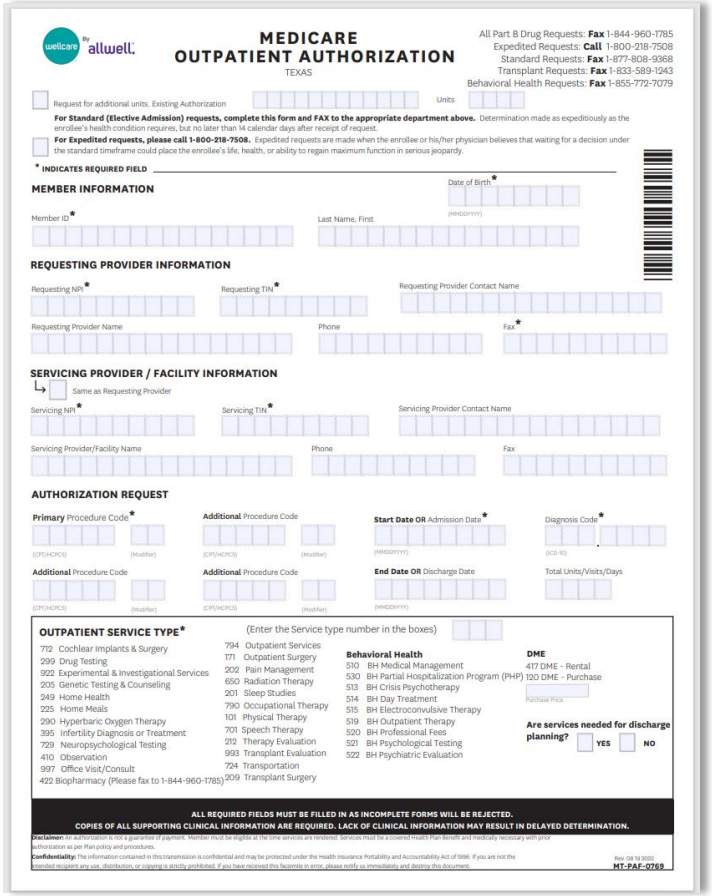
- Authorization must be obtained prior to the delivery of certain elective and scheduled services
- The preferred method for submitting authorization requests is through Superior's Secure Provider Portal

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
  - 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 on
[Superior's Medicare Prior Authorization webpage]



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
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

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.

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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

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Preventive Care

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventative 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 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

(SNP only)

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Model of Care

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs
- Only applies to Dual Special Needs Plan 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

- We contact every DSNP and CSNP member to evaluate their health status with a comprehensive Health Risk Assessment (HRA) within 90 Calendar Days of enrollment, and at a minimum annually, or more frequently with any significant change in condition or health risk level.
- The HRA collects information about the member's medical, psychosocial, cognitive, functional and social determinate needs, and medical and behavioral health history. The HRA is scored for risks to assist with triage.
- Members HRA risk level helps to determine the appropriate level of care management and composition of an Interdisciplinary Care Team (ICT).
- At a minimum, every member is provided an annual Individualized Care Plan (ICP) outlining health goals and interventions.
- Each member receives an annual in-person or virtual face-to-face encounter with a provider or with care coordination staff for the purpose of delivering health care, care management, or care coordination services.

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, 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.

Star Rating Program Measures

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

SUPERIOR HEALTHPLAN WEBSITE

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Public Provider Website

Through the provider page on the Wellcare website, providers can access:

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

EXPLORE NOW:

Superior HealthPlan

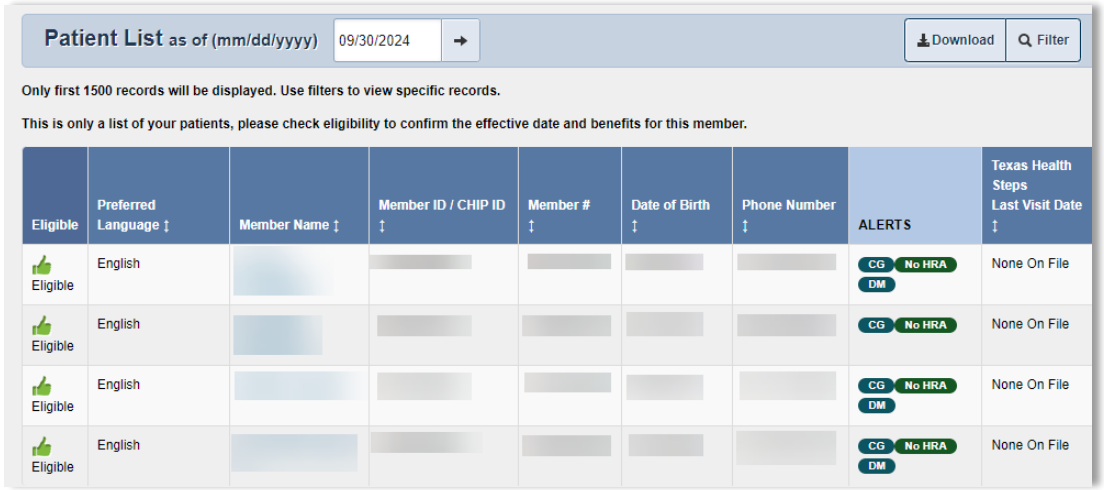
Provider Directory Updates

- 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 **Superior's Secure Provider Portal**
  - 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 **Superior's Secure Provider Portal**
- 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 information.
- **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 information.
- **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 information

Availity Essentials

Effective November 18, 2024, Wellcare has chosen Availity Essentials as its new, secure provider portal. Providers can validate eligibility and benefits, submit claims, check claim status, submit authorizations, and access payer resources, via Availity Essentials. Our current secure portal is still available for other functions that providers use today. For providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.

- The provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
  - **Availity Learning website**
  - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548),** Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their Account Manager.

Network Partners

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	Evolent (NIA)	1-866-214-2569 Evolent website
Vision Services	Premier Eye Care	1-855-879-1456 Premier Eye Care website
Dental Services	Liberty Dental	1-866-544-4669 Liberty Dental Plan website
Pharmacy Services	Express Scripts	1-866-768-7147 (Phone) 1-833-423-2523 (Fax)

DME and Lab Partners

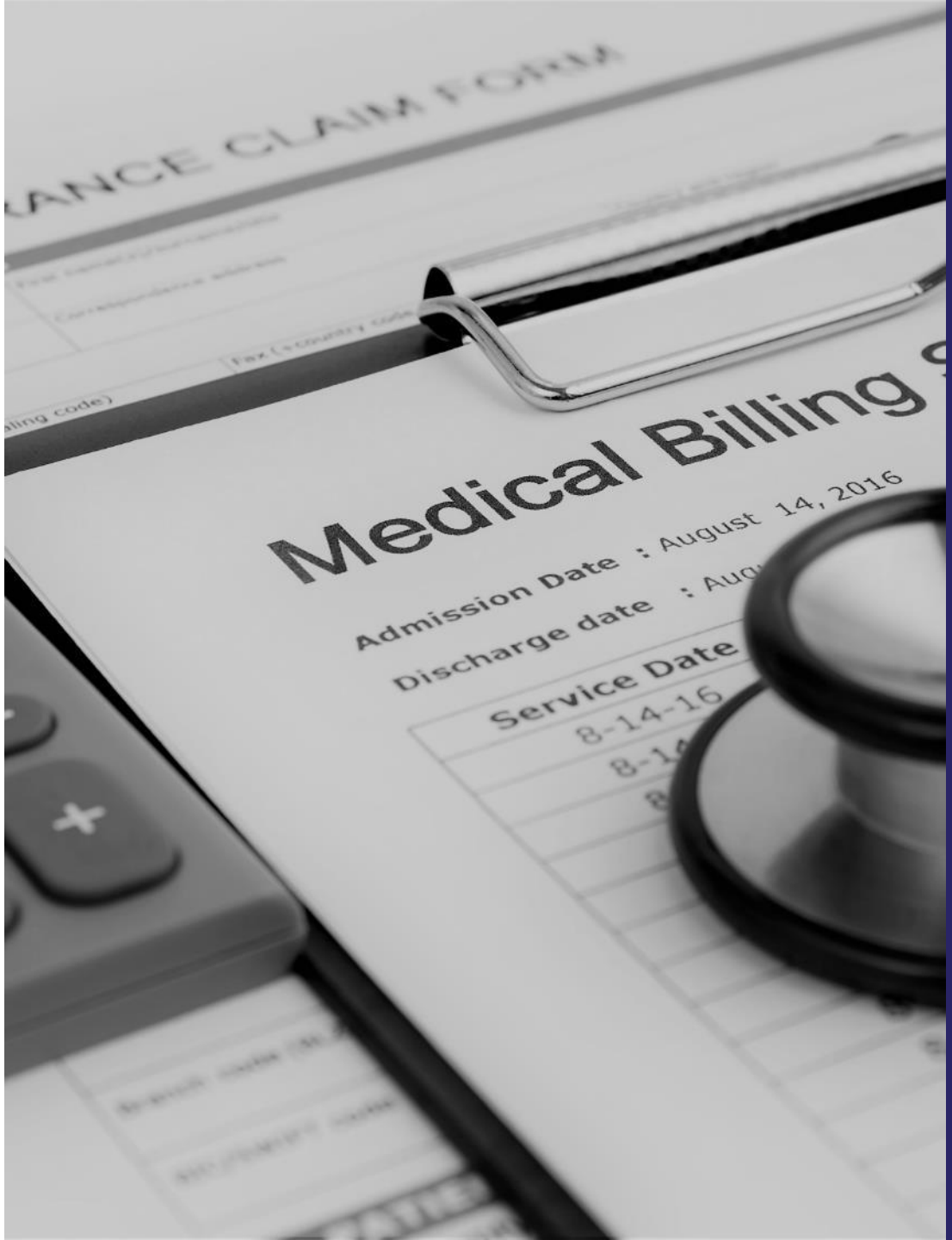
DME	
180 Medical	J&B Medical
ABC Medical	KCI
American Home Patient	Lincare
Apria	Hanger Prosthetics and Orthotics
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical
EBI	Tactile Medical
Edge Park	Zoll

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
- Wellcare partners with six clearinghouses for submission:
  - Emdeon – Payer ID 68069
  - Gateway
  - Availity/THIN
  - SSI
  - Medavant
  - Smart Data Solution



Need EDI Support?

- Companion guides for EDI billing requirements plus loop segments can be found on Superior's Billing and Coding webpage
- For more information about EDI, contact:

Wellcare By Allwell
c/o Centene EDI Department

1-800-225-2573 ext. 6075525

E-mail: EDIBA@centene.com

Claims Submission Timelines

- Medicare Advantage claims need to be mailed to the following billing address:

  Wellcare By Allwell

  Attn: Claims

  P.O. Box 3060 Farmington, MO 63640-3822

- Participating providers have 95 Calendar Days from the date of service to submit a timely claim

- All requests for reconsideration or claim disputes must be received within 120 Calendar Days from the original date of notification of payment or denial.

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

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 on the **Payspan website**

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

Claims Reconsideration & Disputes

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Contracted providers can submit claims payment disputes by submitting a reconsideration form within 120 Calendar Days from the claim determination notice.
- Submit reconsiderations or disputes to:

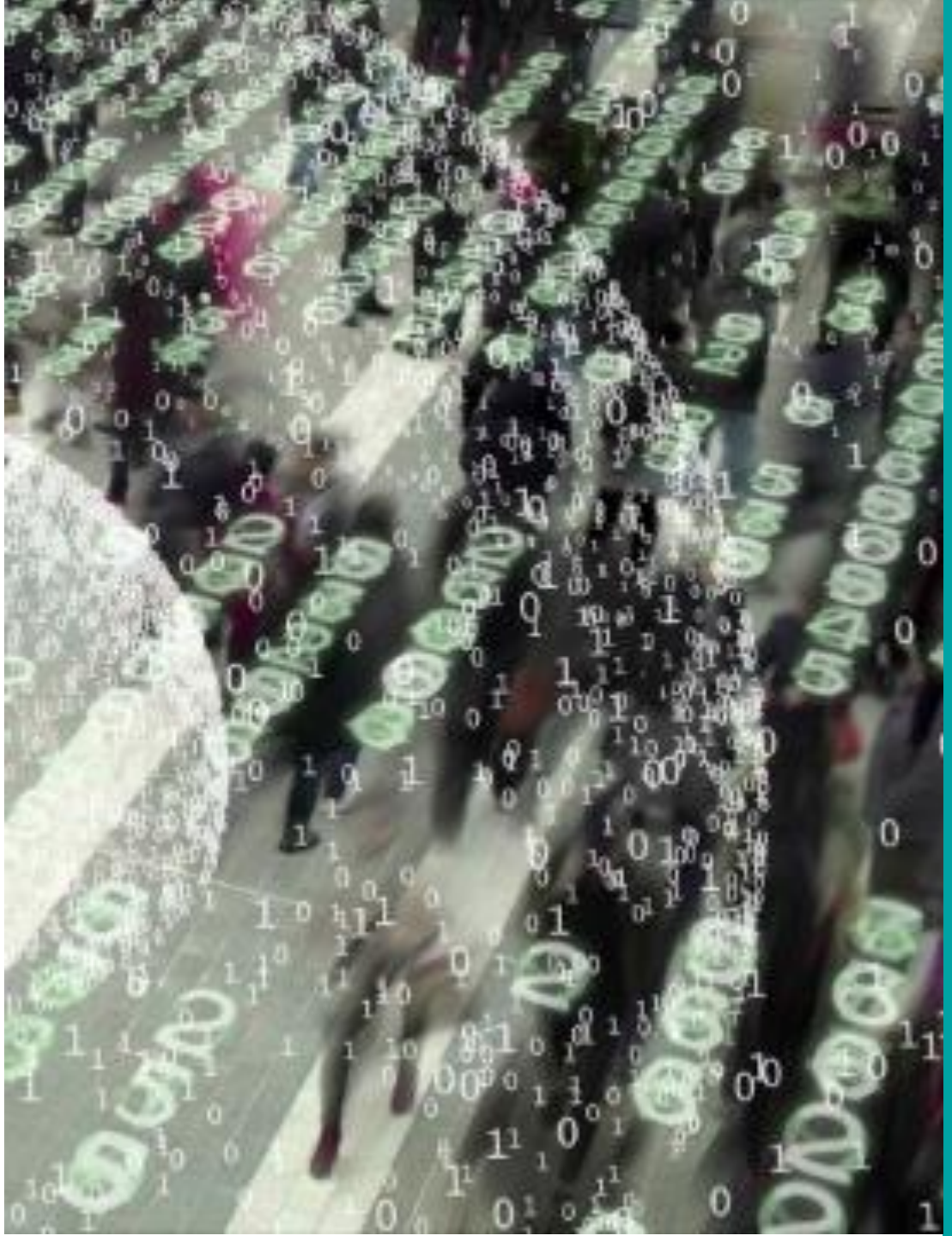
Wellcare By Allwell
Attn: Reconsiderations
P. O. Box 3060
Farmington, MO 63640-3822

Meaningful Use:
Electronic Medical Records

Meaningful Use

- 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.
  - Providers shall not, as a condition of treatment, require a Member to execute or waive an Advance Directive.

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 on CMS Beneficiary Notices Initiative (BNI)

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:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
- Detection through data analytics and medical records review.
- 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).
- 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

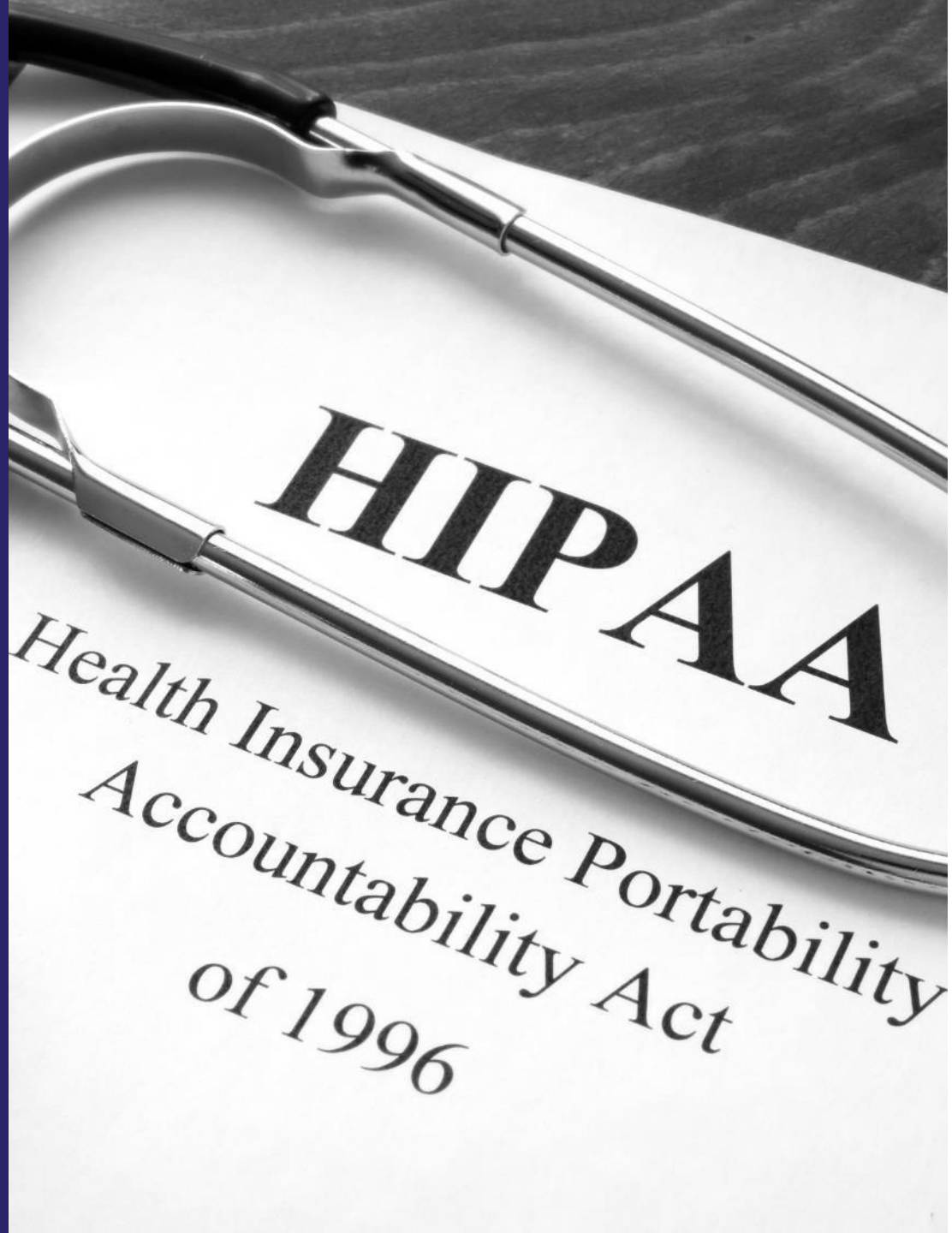
Wellcare performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:

- 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: 1-866-685-8664
  - The Compliance Officer: 1-866-685-8664
- 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: **HHS OIG website**
  - Medicare's Texas Fraud Hotline: 1-800-436-6184
  - Email: **HHSTips@oig.hhs.gov**

CMS Mandatory Trainings

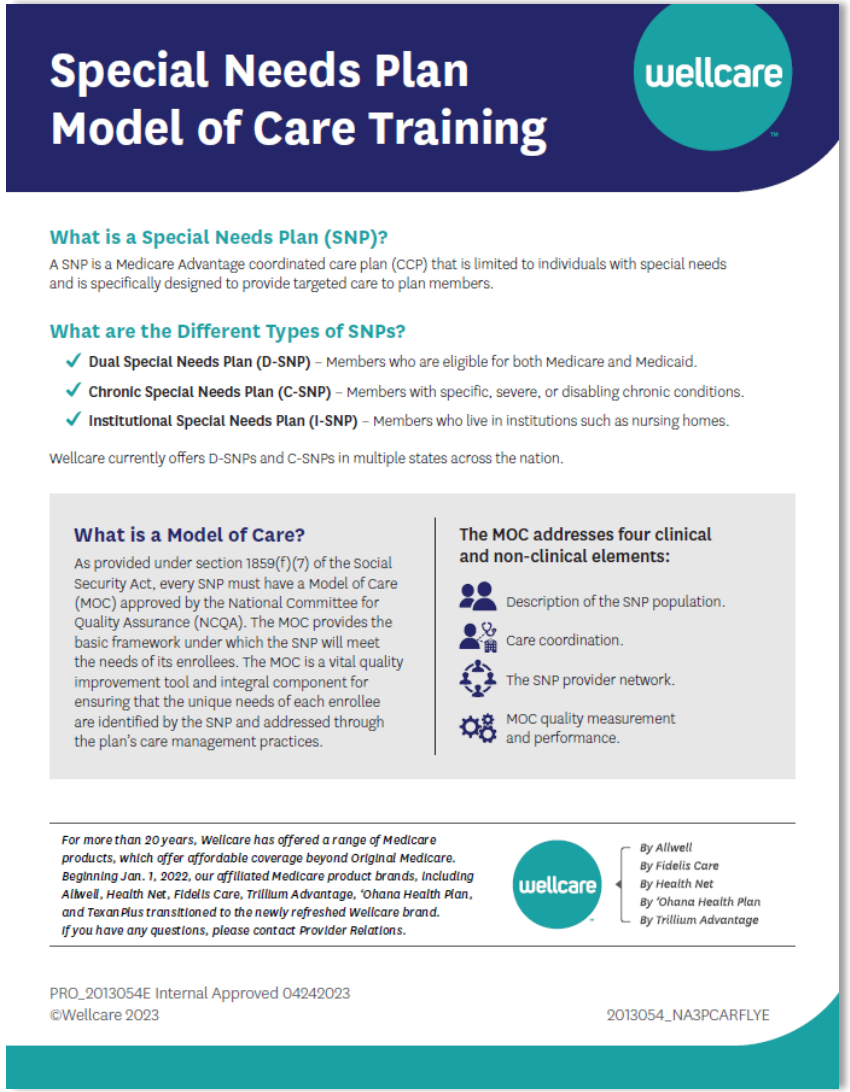
CMS Mandatory Trainings

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

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

Model of Care Training

- Model of Care training is a CMS requirement for any provider that treats SNP members to be completed annually
- Newly contracted Medicare providers should complete within 30 Calendar Days of execution of contract
- Model of Care information is available on Superior's Model of Care Training webpage



Special Needs Plan Model of Care Training

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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.

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

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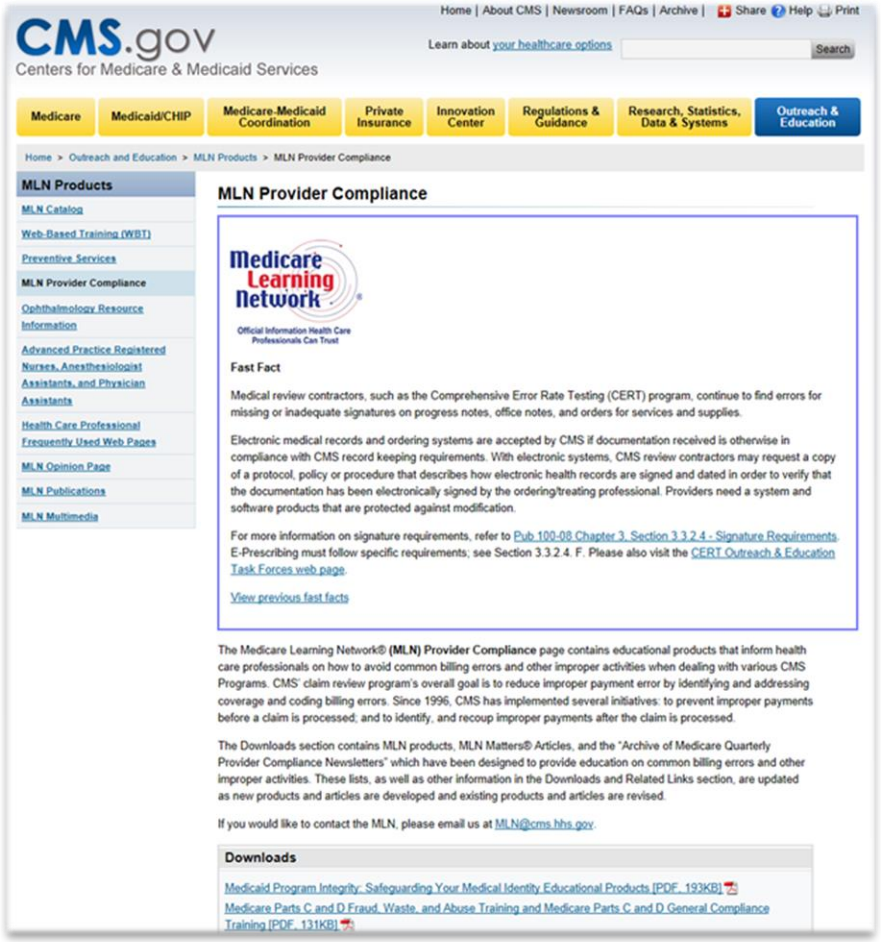
General Compliance & Medicare Fraud, Waste, And Abuse Training

- 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 Calendar 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 Calendar 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