# Meet Wellcare.

2026 Provider Orientation

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# Agenda

- Plan Overview
- Key Resources for Providers
- Membership, Benefits, & 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, & Abuse
- CMS Mandatory Trainings

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# Plan Overview

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# Meet Wellcare

- Welcome to Wellcare!
- Wellcare is the Medicare brand for Centene Corporation, a leading healthcare enterprise committed to helping people live healthier lives. Today, Wellcare is proud to offer access to quality, affordable, and culturally sensitive healthcare to more than 1 million Medicare Advantage Members and 4.1 million PDP Members across all 50 states.
- 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.

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# The Strength of Wellcare

***WellCare's experience and exclusive commitment to these programs enable the company to serve its Members and Providers as well as manage its operations effectively and efficiently.***

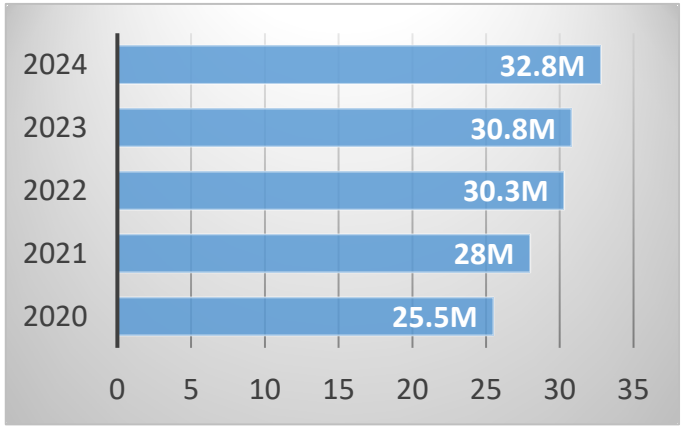
- **Local management with national expertise**
- **Full continuum of Medicare products including:**
  - **HMO**
  - **PPO**
  - **DSNP**
  - **CSNP**
  - **MMP**
  - **PSP**
  - **EGWP**
  - **PDP**

**1.1M**
Medicare members across **32 STATES**

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

**4.1M**
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

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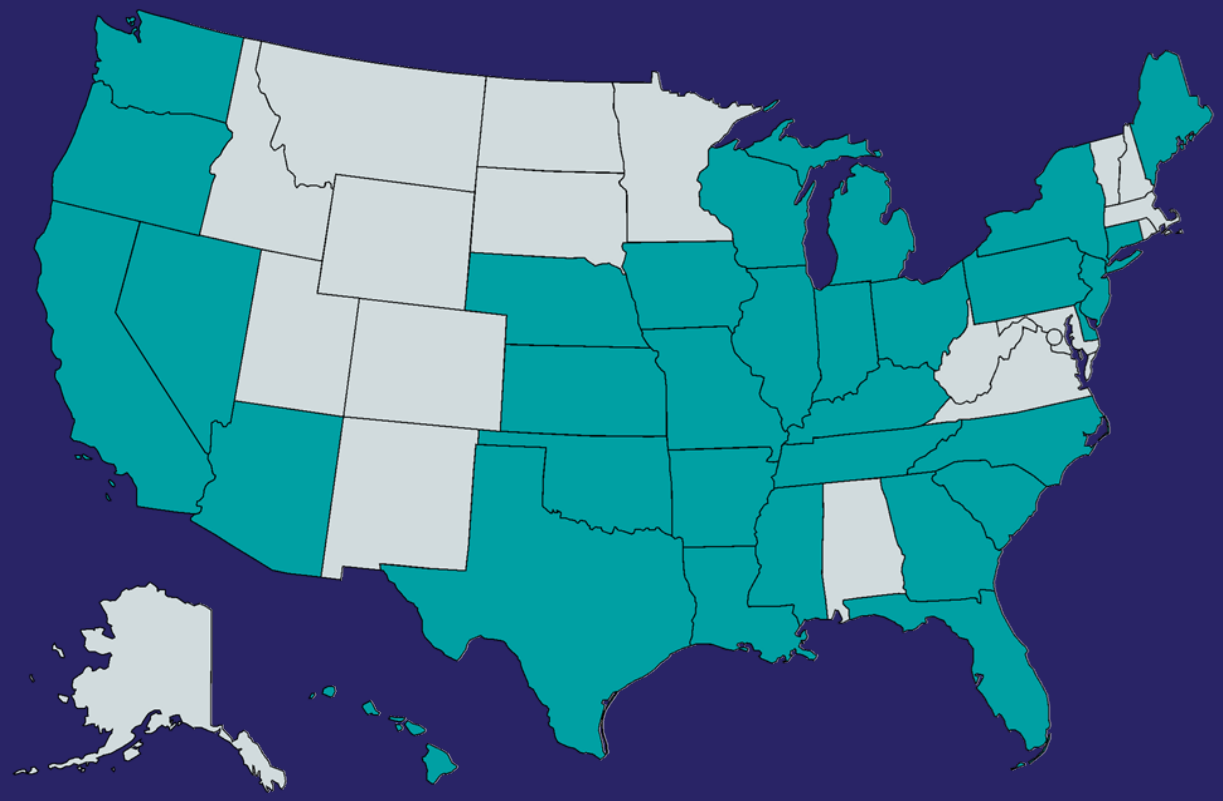
## 1.1 Million Medicare Members

**#6**
largest MA plan

**#1**
largest PDP 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)**

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# 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.

# 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.

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# 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

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# Key Resources for Providers

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# Key Contact Information

**PHONE**

**1-855-538-0454**

**TTY/TDD**

**711**

**WEB**

www.wellcare.com

**PORTAL**

www.wellcare.com

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# 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 www.wellcare.com

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# Provider Engagement

- Our Provider Engagement 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 1-855-538-0454, providers are able to access real time assistance for all their service needs

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# Provider Engagement

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

- ✓ Inquiries related to administrative policies, procedures, and operational issues
- ✓ Performance pattern monitoring
- ✓ Contract clarification
- ✓ Membership/provider roster questions
- ✓ Secure Portal registration and PaySpan Health
- ✓ Provider education
- ✓ HEDIS/Care gap reviews
- ✓ Financial analysis
- ✓ EHR Utilization
- ✓ Demographic information updates
- ✓ Initiate credentialing of a new practitioner

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# Membership, Benefits, & Additional Services

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# Membership

- Medicare beneficiaries have the option to stay in the fee-for-service Original Medicare or choose a Medicare Advantage Plan.
- Advantage 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: www.wellcare.com
  - 24/7 Interactive Voice Response Line  - 1-855-538-0454
  - Provider Services - 1-855-538-0454
  - TTY - 711

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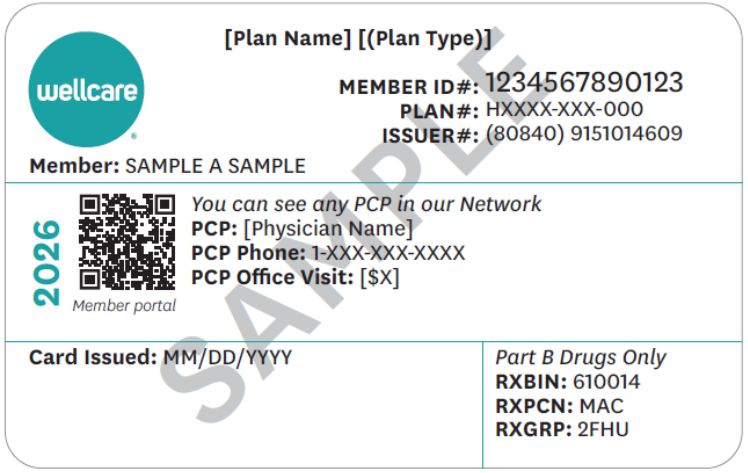
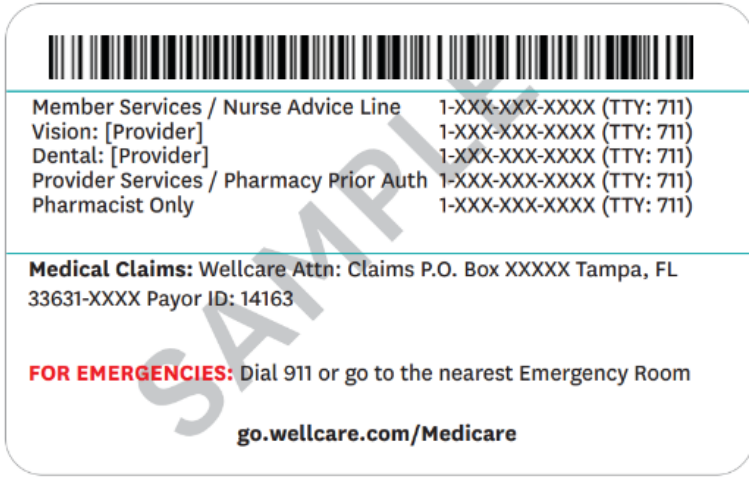
# Member ID Cards



# Plan Coverage

- Medicare Advantage covers:
  - All Part A and Part B benefits by Medicare
  - Part B drugs – such as chemotherapy drugs
  - Part D drugs –deductible may apply at network retail pharmacies or mail order*
  - Additional benefits and services such as dental, vision, $0 PCP copay, $0 generics, etc.

**DSNP plans may have a deductible.*

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# Pharmacy Formulary

- The Advantage formulary is available at:

  http://www.wellcare.com/

- 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 the health plan web address provided above.
- The completed form can be faxed to the Pharmacy Prior Authorization department using the fax number on the form.

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# 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

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# Additional Benefits

## Hearing Services

- $0 co-pay for one routine hearing test every year
- $0 co-pay for one hearing aid fitting evaluation
- Up to $3,000 coverage limit per year for hearing aids (dollar coverage dependent upon service area*); 1 hearing aid per ear

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

## 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
- No dollar limit on HMO-POS plans for preventive services (services deemed reasonable and customery)
- Comprehensive dental benefits range from $1,000 to No Max per year (services deemed reasonable and customery)

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# Additional Benefits *(continued)*

## 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: http://www.wellcare.com/
- Conveniently shipped to member's home within 5 – 12 business days
- Members should use the App, Website, or call the vendor number at 1-866-892-8340 to order items up to $199 per month per plan.

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

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# Additional Benefits

*(continued)*

- 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 (availability may vary by plan)

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# 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 1-855-538-0454

## 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 1-855-538-0454 to schedule non-emergency transportation

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# Medical Home & Prior Authorization

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# 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

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# 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: https://provider.wellcare.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 |

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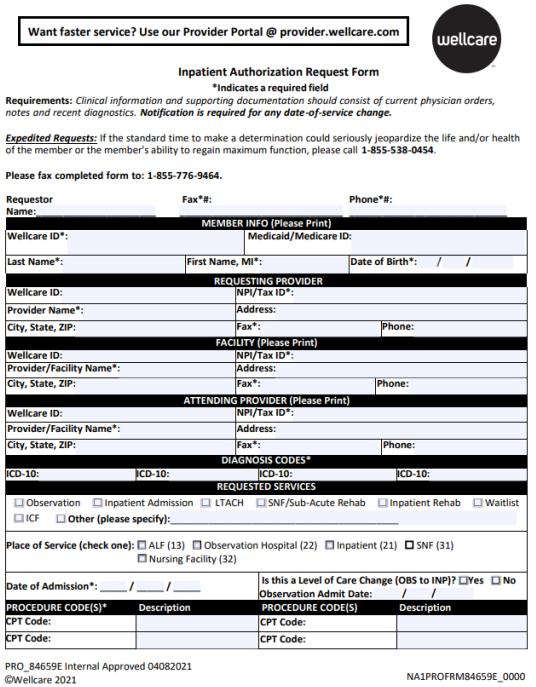
# Prior Authorization Requirements

- 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



Want faster service? Use our Provider Portal @ provider.wellcare.com

**Inpatient Authorization Request Form**

*Indicates a required field

**Requirements:** *Clinical information and supporting documentation should consist of current physician orders, notes and recent diagnostics.* ***Notification is required for any date-of-service change.***

***Expedited Requests:*** If the standard time to make a determination could seriously jeopardize the life and/or health of the member or the member's ability to regain maximum function, please call **1-855-538-0454**.

**Please fax completed form to: 1-855-776-9464.**

| Requestor Name: | Fax*#: | Phone*#: |
|---|---|---|

| MEMBER INFO (Please Print) | | |
|---|---|---|
| Wellcare ID*: | Medicaid/Medicare ID: | |
| Last Name*: | First Name, MI*: | Date of Birth*: / / |

| REQUESTING PROVIDER | | |
|---|---|---|
| Wellcare ID: | NPI/Tax ID*: | |
| Provider Name*: | Address: | |
| City, State, ZIP: | Fax*: | Phone: |

| FACILITY (Please Print) | | |
|---|---|---|
| Wellcare ID: | NPI/Tax ID*: | |
| Provider/Facility Name*: | Address: | |
| City, State, ZIP: | Fax*: | Phone: |

| ATTENDING PROVIDER (Please Print) | | |
|---|---|---|
| Wellcare ID: | NPI/Tax ID*: | |
| Provider/Facility Name*: | Address: | |
| City, State, ZIP: | Fax*: | Phone: |

| DIAGNOSIS CODES* | | | |
|---|---|---|---|
| ICD-10: | ICD-10: | ICD-10: | ICD-10: |

**REQUESTED SERVICES**

☐ Observation ☐ Inpatient Admission ☐ LTACH ☐ SNF/Sub-Acute Rehab ☐ Inpatient Rehab ☐ Waitlist ☐ ICF ☐ Other (please specify):_____

**Place of Service (check one):** ☐ ALF (13) ☐ Observation Hospital (22) ☐ Inpatient (21) ☐ SNF (31) ☐ Nursing Facility (32)

| Date of Admission*: ____ / ____ / ____ | Is this a Level of Care Change (OBS to INP)? ☐Yes ☐ No Observation Admit Date: / / |
|---|---|

| PROCEDURE CODE(S)* | Description | PROCEDURE CODE(S) | Description |
|---|---|---|---|
| CPT Code: | | CPT Code: | |
| CPT Code: | | CPT Code: | |

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**The authorization look-up tool can be found here:**
[http://www.wellcare.com/](http://www.wellcare.com/)

# 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

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# 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

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# 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).

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# Preventive Care *(continued)*

| | | |
|---|---|---|
| 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 |

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# Model of Care

## Special Needs Plans (SNP)

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# Model of Care

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs
- Applies to Dual Special Needs Plan (D-SNP) and Chronic Condition Specials Needs Plan (C-SNP) members
- The goals of our Model of Care are:
  - Improve access to medical, behavioral 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

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# Model of Care Elements

- ✓ Description of the SNP population (D-SNP and C-SNP)
- ✓ Care coordination, transitions of care, and interdisciplinary care team protocol
- ✓ Provider network
- ✓ Quality measurement

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# Model of Care Process

- We contact every SNP member to complete a Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter, or more frequently if there is a significant change in health status.
- 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 Wellcare care coordination staff to support care management and coordination.

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# Model of Care Process *(continued)*

- 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, Providers, and Wellcare care management staff.
  - Interdisciplinary Care Team (ICT) approach tailored to the Member’s medical, behavioral, and social needs.
  - Comprehensive coordination with all care partners including PCPs, specialists, and community supports.
  - Support for the Member's preferences and goals as in documented in the Individualized Care Plan (ICP).
  - Reinforcement of the Member’s connection with their PCP and medical home.

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# Medicare Star Ratings

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# Medicare Star Ratings

## What Are CMS Star Ratings?

- CMS uses a five-star rating system to evaluate Medicare Advantage plans based on quality of care, Member satisfaction, and performance metrics.
- Star Ratings are published annually on www.medicare.gov to help beneficiaries compare Medicare Advantage and Part D plans. The Star Rating program promotes continuous quality improvement and recognizes Providers for improving Member outcomes and adherence to preventive care guidelines.

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# Star Rating Program Measures

## Part C

1. Staying healthy through preventive screenings, tests, and vaccinations
2. Managing chronic conditions such as diabetes, hypertension, and cardiovascular disease
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 health plan including access to care and satisfaction
4. Drug safety, adherence, and accuracy of drug pricing

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# 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).

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# Web-Based Tools

http://www.wellcare.com/

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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:**
**HTTP://WWW.WELLCARE.COM/EN/GEORGIA/PROVIDERS/MEDICARE**

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- 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 https://provider.wellcare.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”

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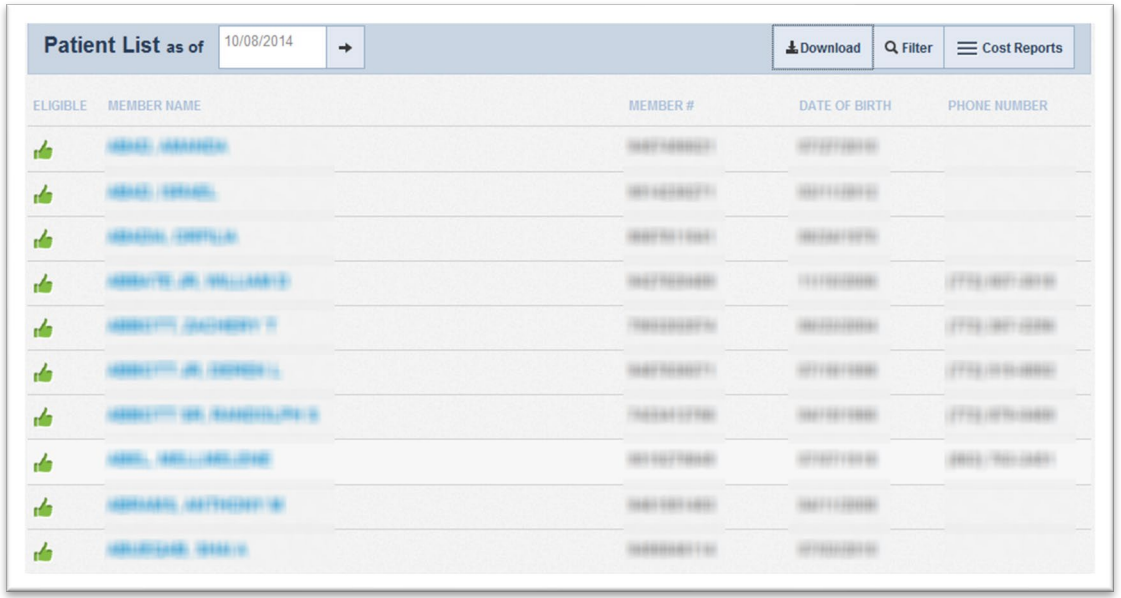
# Primary Care Provider Reports

## Patient List

- Located on the Secure Provider Portal at https://provider.wellcare.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

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# Members With Frequent ER Visits

- Located on the Secure Provider Portal at https://provider.wellcare.com/
- 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

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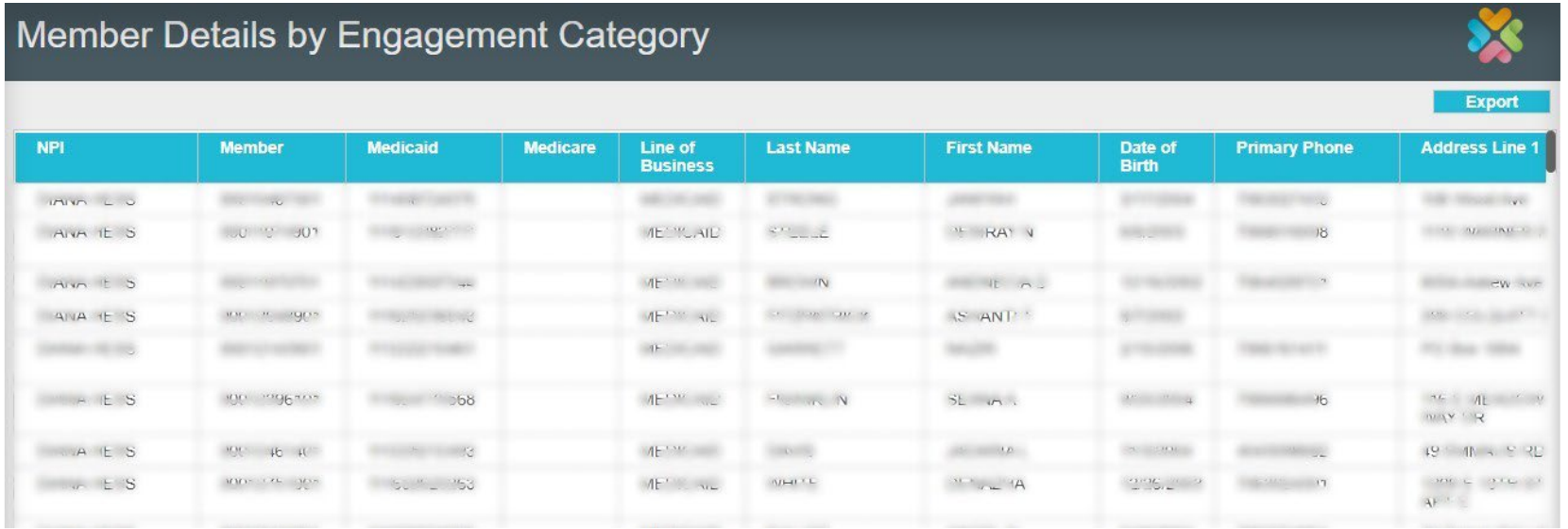
# PCP Cost Reports *(Continued)*

## High Cost Claims

- Located on the Secure Provider Portal at https://provider.wellcare.com/
- 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

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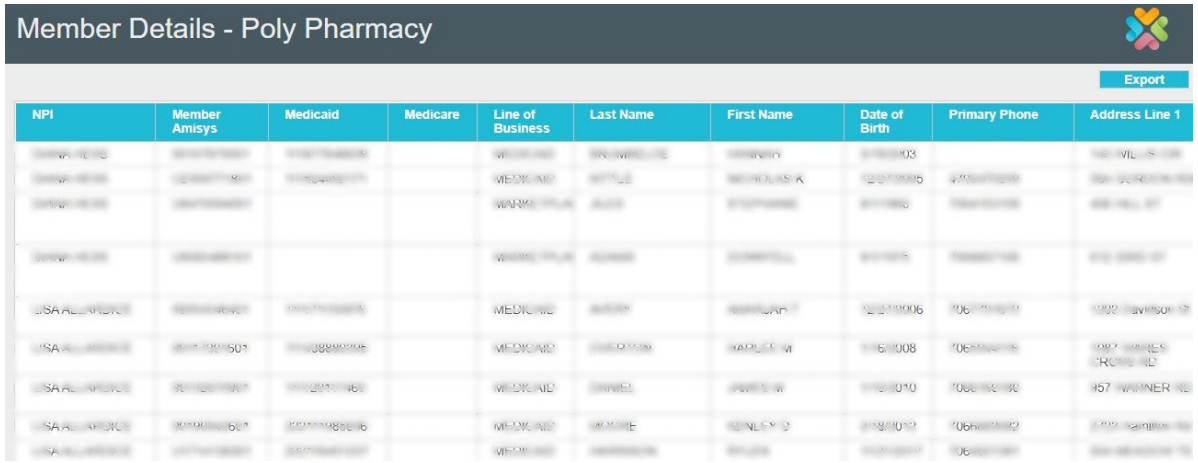
# PCP Cost Reports *(Continued)*

## Rx Claims Report

- Located on the Secure Provider Portal at https://provider.wellcare.com/
- 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

Centene 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. A phased rollout schedule by state goes through Q1 2025.

- 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:
  - **www.Availity.com/documents/learning/LP_AP_GetStarted**
  - 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 health plan Provider Engagement representative.

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# Network Partners

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# Partners and Vendors

| Service | Specialty Company/Vendor | Contact Information |
|---|---|---|
| Physical Therapy Services | Therapy Network of Georgia | 1-855-825-7818 (phone)<br>1-855-597-2697 (fax) |
| High Tech Imaging Services | Evolent | 1-866-214-2569<br>http://www.radmd.com/ |
| Vision Services | Premier | 1-866-419-0816 |
| Dental Services | DentaQuest | 1-833-206-6289 |
| Pharmacy Services | Express Scripts | 1-833-750-0201 |

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# DME & 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 | |

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# Billing Overview

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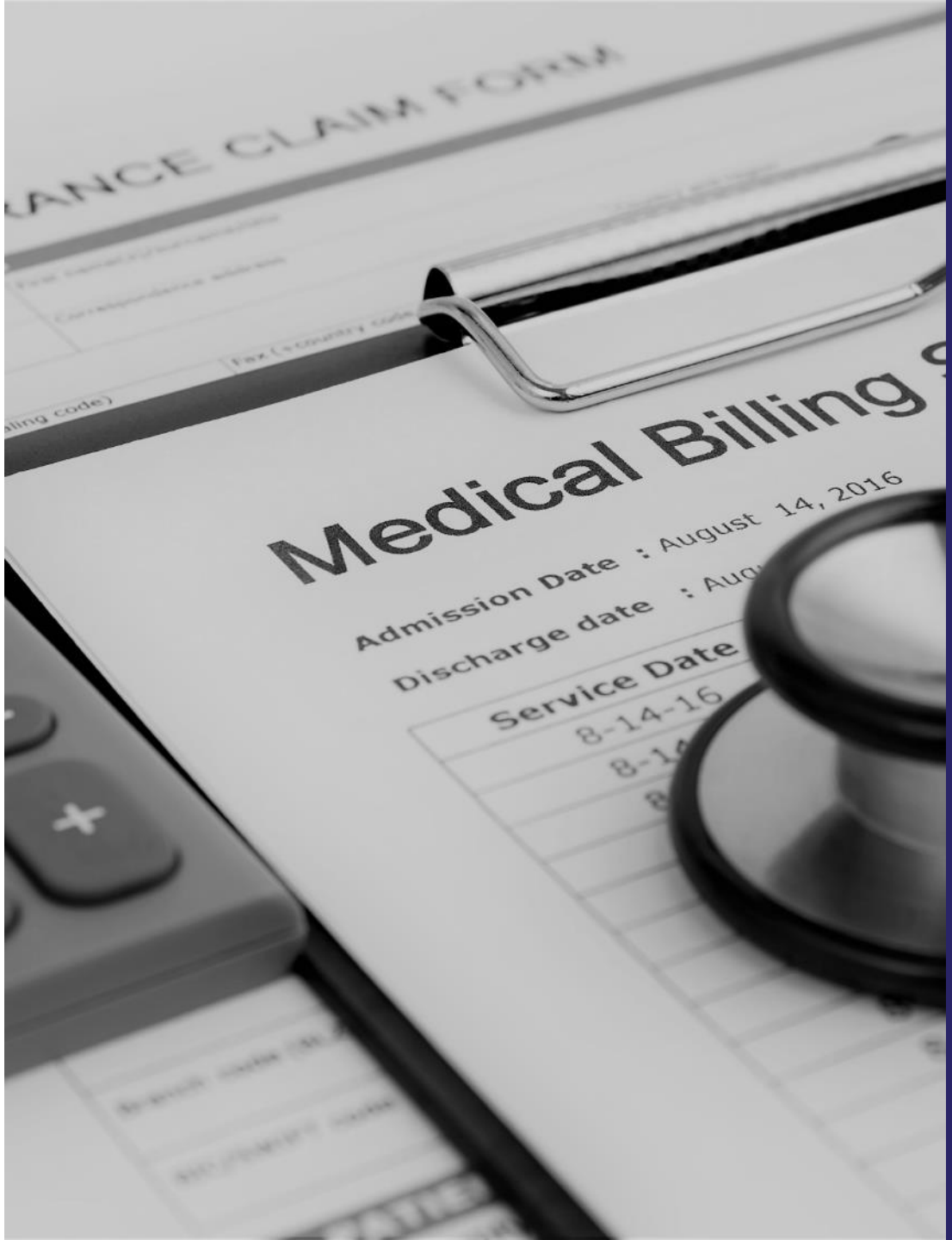
# Electronic Claims Transmission

- 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

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# Need EDI Support?

Companion guides for EDI billing requirements plus loop segments can be found on the Wellcare website:

**http://www.wellcare.com/**

For more information about EDI, contact:

Wellcare
c/o Centene EDI Department

E-mail: **EDIBA@centene.com**

# Claims Submission Timelines

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

Wellcare
Attn: Claims Department
P.O. Box 31224
Tampa, FL 33631-3224

- Participating providers have 180 from the date of service to submit a timely claim

- All requests for reconsideration or claim disputes must be received within 90 from the original date of notification of payment or denial

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# 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 Covered Services denied due to lack of authorization unless the Member was informed in writing beforehand and agreed to pay
- Dual-eligible Members with QMB/QMB+ status must not be balance billed for Medicare Parts A and B cost-share amounts. Providers must accept Wellcare's payment as payment in full.
- Providers may **not** balance bill members for any differential

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# 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.
- Providers can register using PaySpan's enhanced Provider registration process at **www.payspanhealth.com**. For support, contact Providersupport@payspanhealth.com or call 1-877-331-7154.

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# Coding Auditing & Editing

Wellcare uses claims editing software programs that incorporate CMS guidelines, AMA guidance, and specialty society recommendations to ensure proper coding and prevent improper billing practices:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)
- Software audits identify improper billing practices including :
  - Unbundling
  - Upcoding
  - Excessive units
  - Invalid codes

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# 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 180 from the claim determination notice.

Submit reconsiderations or disputes to:

Wellcare
Attn: Reconsiderations
P. O. Box 4000
Farmington, MO  63640-4000

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# Meaningful Use:
# Electronic Medical Records

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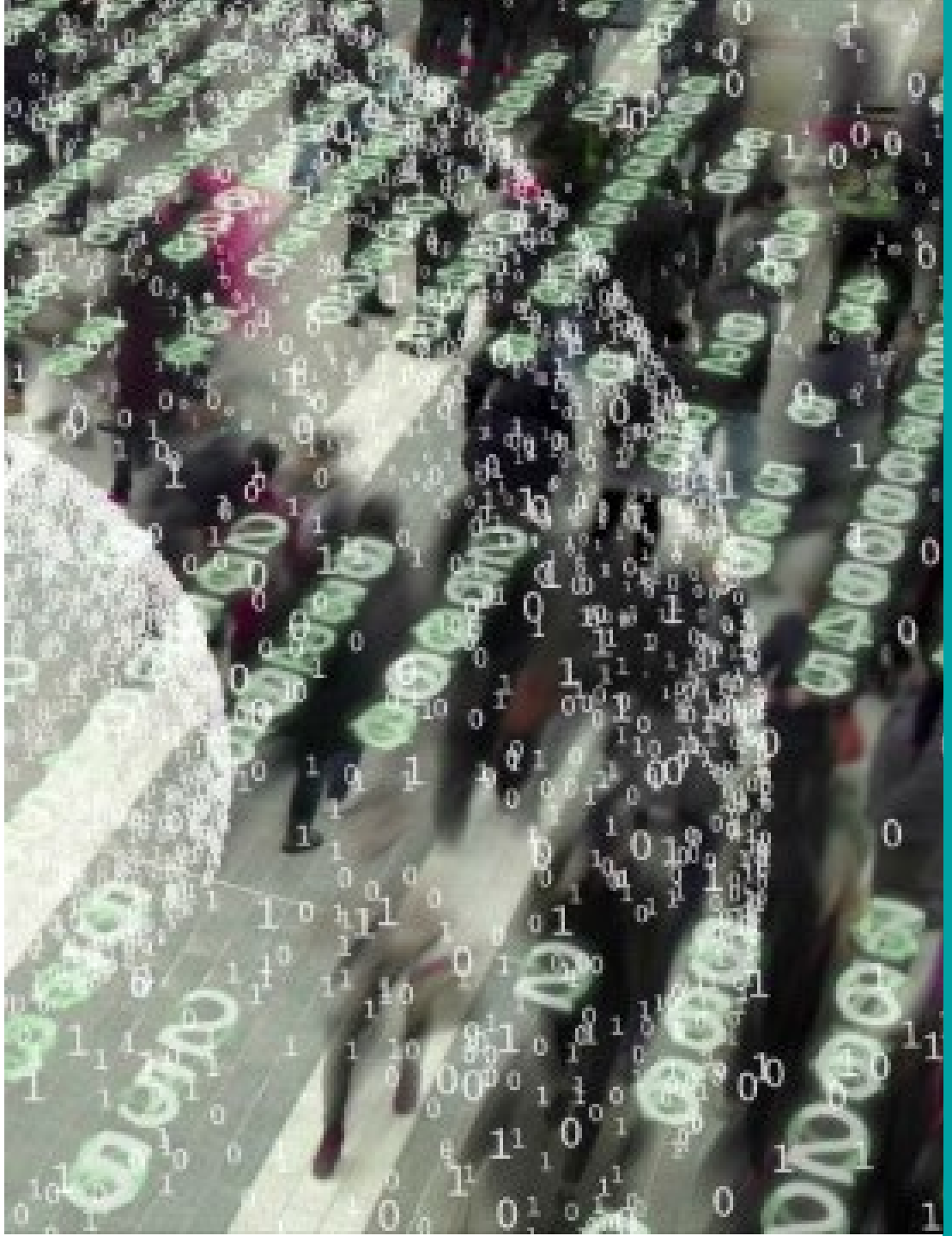
# Meaningful Use

- **The exchange of patient data between healthcare providers, insurers, and patients themselves is critical to advancing patient care, data security, and the healthcare industry.**
- **Electronic Health Records/Electronic Medical Records (EHR/EMR) allow healthcare professionals to provide patient information electronically instead of using paper records.**
- **Bi-directional EMR data exchange allows payers to share insights directly within the:**
    - *Provider's EMR,*
    - *Supporting Risk Adjustment*
    - *Chronic Care Management*
    - *Care Gaps closure*
- **EHR/EMR can provide many benefits, including:**
    - *Complete and accurate information*
    - *Better access to information*
    - *Patient empowerment*

*(Incentive programs may be available)*



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# Advance Directives

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# 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.

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# Regulatory Information

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# Medicare Outpatient Observation Notice (MOON)

- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON). Contracted hospitals and Critical Access Hospitals must deliver the 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 MOON and instructions are available at: **www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html**

# Fraud, Waste & Abuse

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# Fraud, Waste & Abuse

Wellcare is committed to the prevention, detection and reporting of suspected healthcare fraud, waste, and abuse according to applicable federal and state statutory, regulatory and contractual requirements:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
- Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers and other common schemes.
- 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.

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# Fraud, Waste & Abuse *(continued)*

Federal and state regulatory agencies, law enforcement, and Wellcare vigorously investigate incidents of suspected fraud, waste, and abuse:

- Medical records and other documentation must be legible and support the level of care and service indicated on claims
- Not following the service authorization
- Procedure code not being consistent with provided service
- Providers engaged in fraud, waste, and abuse may be subject to disciplinary and corrective actions, including termination and prosecution.
- ending of insurance card

# Fraud, Waste & Abuse *(continued)*

Benefits of stopping fraud, waste, and abuse:

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

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# Fraud, Waste & Abuse *(continued)*

*Participating Providers must be in compliance with all CMS rules and regulations*:

- All employees who work for or contract with a Medicaid managed care organization must meet annual compliance and educational training requirements with respect to FWA
- Providers must check the OIG/GSA Exclusion and CMS Preclusion List prior to hiring or contracting and monthly thereafter.

# Fraud, Waste & Abuse *(continued)*

Providers must comply with all applicable federal and state laws including the False Claims Act, Anti-Kickback Statute, HIPAA, and CMS regulations. Annual training and policy updates are required to maintain compliance:

- 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

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# Fraud, Waste & Abuse *(continued)*

- Suspected fraud, waste, and abuse can be reported anonymously via Wellcare's hotline or directly to the Office of Inspector General (OIG) or NBI MEDIC. Protections are in place for whistleblowers. Hotline at **1-866-685-8664** or by contacting the Compliance Officer at:
  - Annette Zerbe, GA Vice President of Compliance
- 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**)
  - Email: **www.OIG.HHS.gov/fraud** or **HHSTips@oig.hhs.gov**
  - Medicare's Georgia Fraud Hotline: **1-866-685-8664**

# 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): For DSNP and CSNP 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

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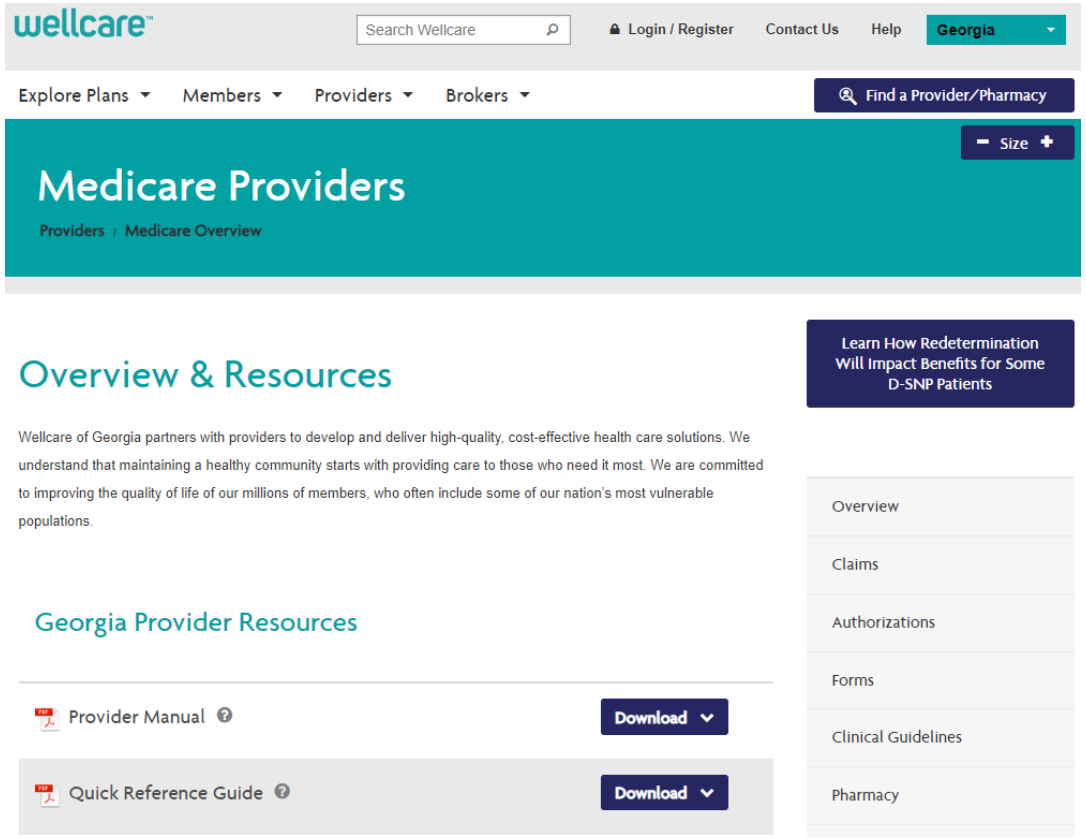
# Model of Care Training

- 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 days of execution of contract
- Model of Care information is available on:

  https://provider.wellcare.com/

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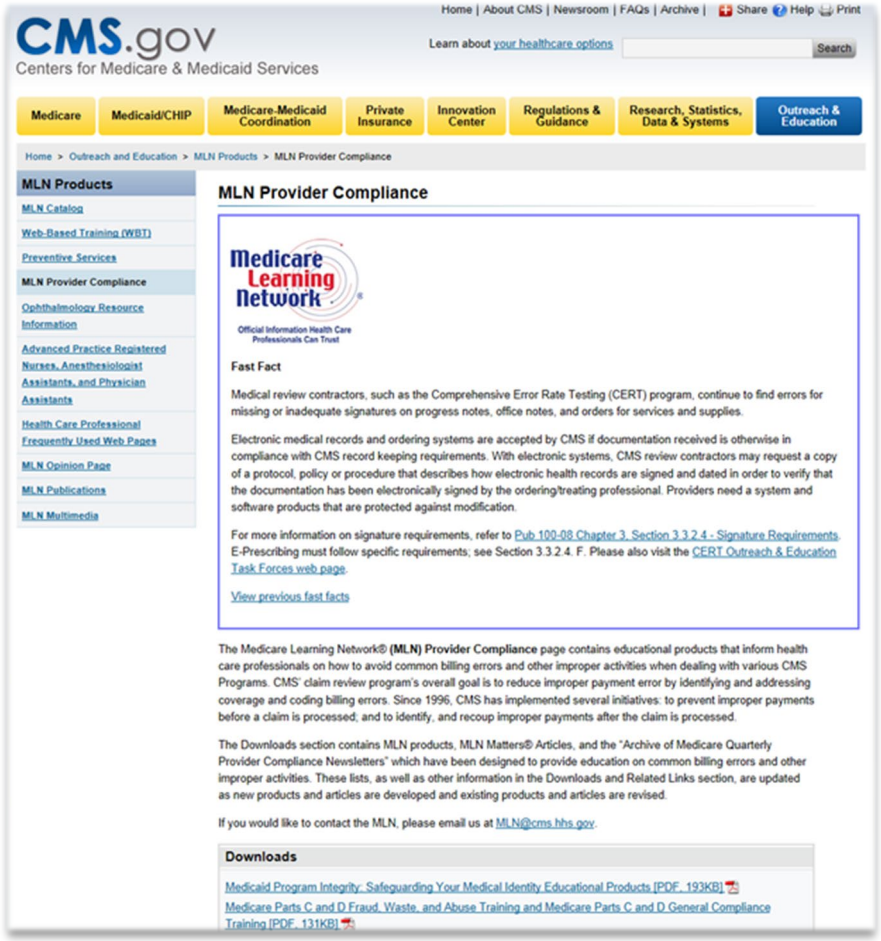
# General Compliance & Medicare Fraud, Waste, & Abuse Training

All providers, practitioners, and delegated entities must complete General Compliance and FWA training via the CMS Medicare Learning Network (MLN) within 90 days of contracting and annually thereafter. Each individual must complete the training and submit a certificate or attestation to Wellcare.



# General Compliance & Medicare Fraud, Waste, & Abuse Training

All First-Tier, Downstream, and Related Entities (FDRs), including delegated entities, must complete General Compliance and FWA training via the CMS MLN website within 90 days of contracting and annually thereafter. Each individual provider, practitioner, administrator, or applicable entity must complete the training and submit a certificate or attestation to Wellcare.

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# Questions & Answers

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