



Meet Wellcare.

2024 Provider Orientation

Agenda



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

Plan Overview

Meet Wellcare



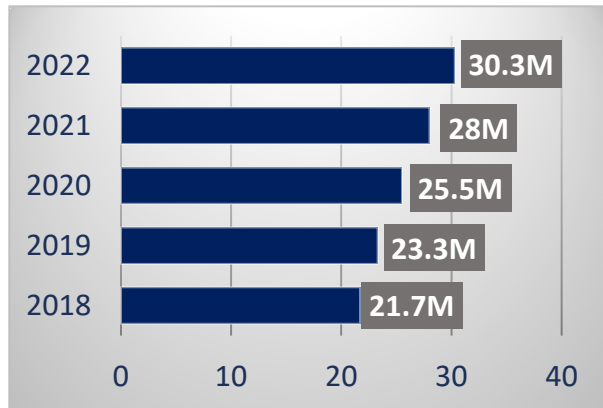
- Welcome to Wellcare!
- We have combined multiple national Medicare brands under the Wellcare name to offer a better range of plans that provide members with affordable access to doctors, nurses, and specialists
- We believe this change will make things easier for members, brokers, and providers like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

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 (not offered in KS)
 - MMP (not in KS)
 - PSP (not in KS)
 - EGWP
 - PDP

Total Medicare Advantage Members Nationwide



1.3M

Medicare members across **37 STATES**

377K

Special Needs Plan members across **33 STATES**

4.4M

Prescription Drug Plan members across **50 STATES**

8.7%

Avg. YoY Growth Medicare Advantage Enrolled

30M

Medicare Advantage enrolled members nationwide

47%

Medicare Advantage Penetration Rate nationwide



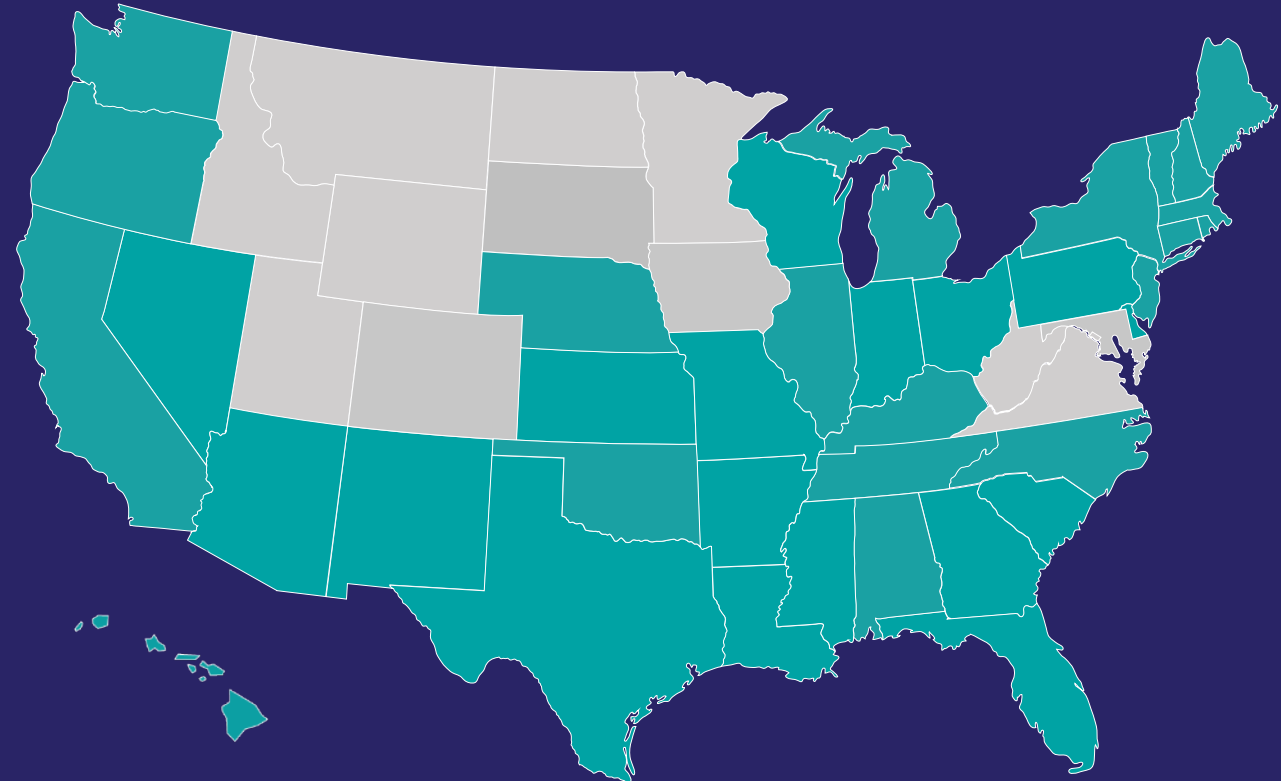
1.3 Million Medicare Members

#6

largest MA plan






#2

largest MAPD plan



Who We Are

Wellcare is designed to give members

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

Confidential and Proprietary Information

Exceptional Benefits



-  **Telehealth** – Doctors are available by teleconference, day and night and on weekends and holidays.
-  **Free Transportation** – Certain plans offer a limited number of trips to doctor's offices and pharmacies with some plans eligible for non-medical transportation.
-  **Wellcare Spendables™** Certain plans have a Spendables Card with benefits that includes Gas pay-at-the-pump; Utilities Assistance; Rent Assistance; Additional Dental, Vision, and Hearing Services; OTC; and Healthy Food in one monthly allowance
-  **OTC Allowances** – Members receive annual over-the-counter (OTC) allowances and pay \$0 for certain OTC products, depending on the plan.
-  **24-Hour Nurse Advice Line** – Speak with a live nurse, 24 hours a day, any day of the year.

Our Whole Health Approach



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

We Are Proud to be Your Medicare Advantage Partner

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





Key Resources for Providers

Key Contact Information

PHONE

1-800-977-7522

DSNP 1-844-796-6811

TTY

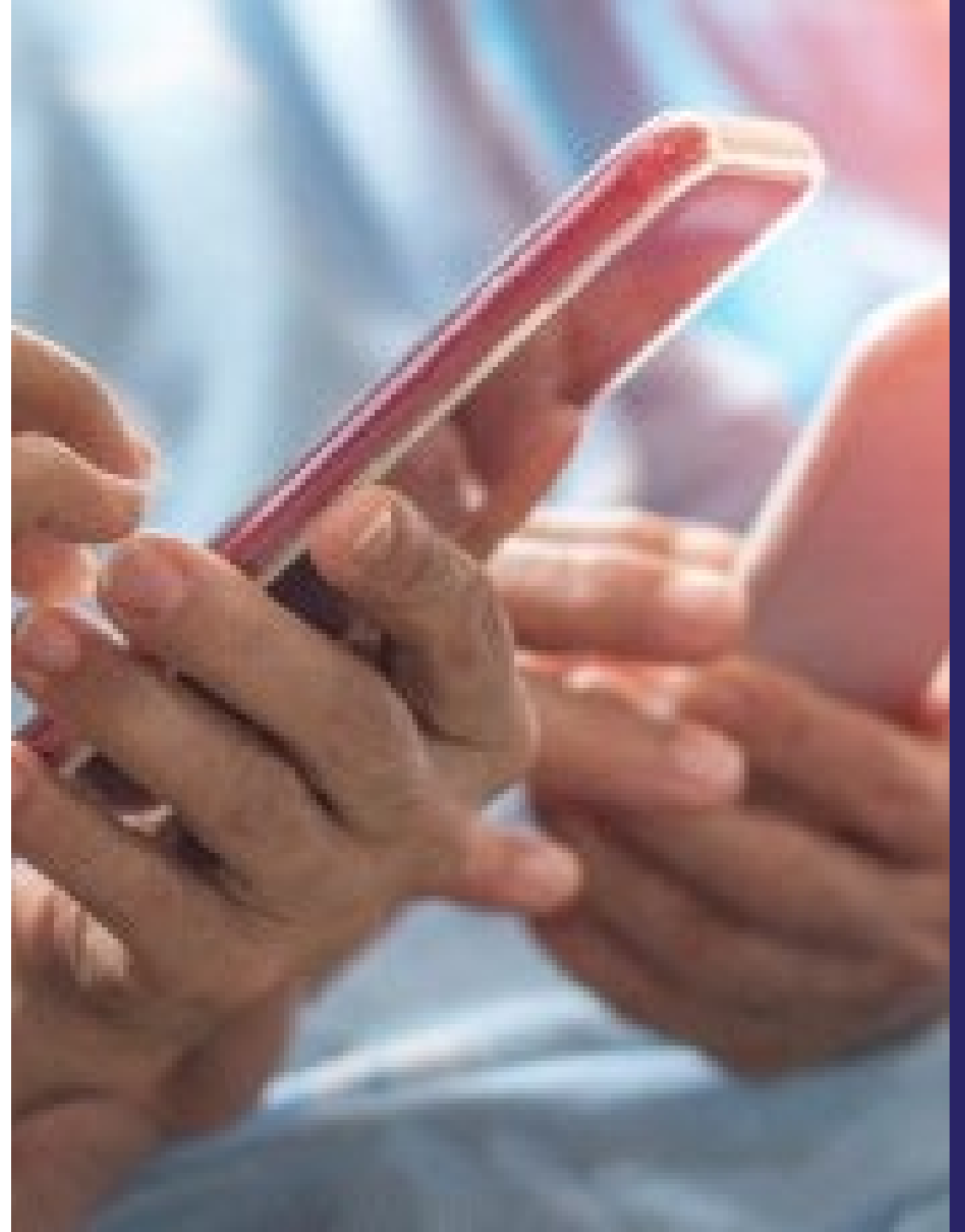
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WEB

<http://www.wellcare.sunflowerhealthplan.com>

PORTAL

<http://www.provider.sunflowerhealthplan.com>



Provider Manual



- The Provider Manual is your comprehensive guide to doing business with Wellcare By Allwell
- 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.sunflowerhealthplan.com.



Provider Services

- Our Provider Service 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 **1-800-977-7522**, **DSNP 1-844-796-6811**, providers are able to access real time assistance for all their service needs



Provider Data Updates

- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 - Download the [Preferred Sunflower Roster Format \(Excel\)](#)
 - Complete the worksheet as indicated on the Instructions & Narratives tab at least quarterly or whenever practitioner changes occur
 - Save and send the spreadsheet to [Provider Network Operations](#) quarterly even if there are no changes
 - Alternative to the Sunflower Roster Form. For practitioners who are already registered on CAQH, additions may be submitted on a CAQH provider data form. Only provide information for one practitioner per [CAQH Provider Data Form](#).

Quality Provider Consultant

- HEDIS/Care gap reviews
- EHR utilization
- Financial analysis
- Performance pattern monitoring
- Provider education on quality measures

Contact Quality Provider Support at
providerengagement@sunflowerhealthplan.com

Confidential and Proprietary Information

Provider Engagement

- Inquiries related to administrative policies, procedures, and operational issues
- Contract clarification
- Membership/provider roster questions
- Secure Portal registration and PaySpan
- Provider education

Contact Provider Engagement at:
<https://www.sunflowerhealthplan.com/providers/allwell-provider/provider-service.html>



Membership, Benefits, and Additional Services

Membership




- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare Plan or choose a Medicare Advantage Health Plan
- Advantage members may change PCPs at any time. Changes take effect on the first day of the month. [wellcare.sunflowerhealthplan.com](https://www.wellcare.sunflowerhealthplan.com)
- Providers should verify eligibility before every visit by using one of the below options:
 - Provider Portal: provider.sunflowerhealthplan.com
 - 24/7 Interactive Voice Response Line - 1-800-977-7522, DSNP 1-844-796-6811
 - Provider Services - 1-800-977-7522, DSNP 1-844-796-6811
 - TTY - 711

DSNP Member ID Cards



FRONT PANEL



Wellcare By Allwell
<Wellcare Dual Access
(HMO D-SNP)>
CMS#: <H6550-004>
Effective Date: <MM/DD/YYYY>

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

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

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage Rx

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

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


BACK PANEL

www.wellcare.com/allwellKS


FOR MEMBERS

Member Services:	4 <1-844-796-6811 (TTY: 711)>
Nurse Advice Line:	5 <1-844-796-6811 (TTY: 711)>
1 ModivCare Transportation:	6 <1-877-718-4201 (TTY: 711)>
2 DentaQuest Dental:	7 <1-833-206-6291 (TTY: 711)>
3 Premier Eye Care Vision:	8 <1-866-419-0861 (TTY: 711)>

FOR PROVIDERS

 **For Member eligibility and Medical prior auth/referrals:** <1-844-796-6811> **9**

Medical Claims: <Wellcare By Allwell> <Attn: Claims>
Payor ID: <68069> <P.O. Box 3060 Farmington, MO 63640-3822>

 **Pharmacy prior auth:** <1-800-867-6564>
For help: (PHARMACY USE ONLY) <1-833-750-0202> **10**

Submit Part D Drug Claims to: <Wellcare By Allwell> <Attn: Member Reimbursement Dept> <P.O. Box 31577> <Tampa, FL> <33631-3577>

Medicare Complete Member ID Card



FRONT PANEL

BACK PANEL

The logo for Wellcare By Allwell, featuring a teal circle with the word "wellcare" in white lowercase letters, followed by "By" in a smaller font and "allwell." in a larger, purple, lowercase font.

Wellcare By Allwell
<Wellcare Complete No
Premium (HMO)>
CMS#: <H5398-002>
Effective Date: <MM/DD/YYYY>

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


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


PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage Rx
Rx Processor Part D:
<Express Scripts®>
RXBIN: <610014>
RXPCN: <MEDDPRIME>
RXGRP: <2FFA>

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

www.wellcarecomplete.com

FOR MEMBERS
Member Services: <1-800-977-7522 (TTY: 711)>
Nurse Advice Line: <1-877-236-0230 (TTY: 711)>
ModivCare Transportation: <1-877-718-4201 (TTY: 711)>
DentaQuest Dental: <1-833-206-6291 (TTY: 711)>
Premier Vision: <1-866-419-0861 (TTY: 711)>

FOR PROVIDERS
 For Member eligibility and Medical prior auth/referrals: <1-800-977-7522>
Medical Claims: <Wellcare By Allwell><Attn: Claims>
Payor ID: <68069><P.O. Box 8050 Farmington, MO 63640-8050>

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



Plan Coverage

- Medicare Advantage covers:
 - All Part A and Part B benefits by Medicare
 - Part B drugs – such as chemotherapy drugs
 - Part D drugs – no deductible at network retail pharmacies or mail order*
 - Additional benefits and services such as dental, vision, \$0 PCP copay, \$0 generics, etc.

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

Pharmacy Formulary



- The Advantage formulary is available at:
<https://wellcare.sunflowerhealthplan.com/drug-pharmacy/formulary.html>
- Please refer to the formulary for specific types of exceptions
- When requesting a formulary exception, a *Request for Medicare Prescription Drug Coverage Determination* form must be submitted. 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.



Covered Services

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines – Express Scripts
- Lab and X-Ray - Evolent
- Transportation - ModivCare
- Home Health Services
- Screening Services
- Dental - DentaQuest
- Vision Services – Envolve Vision (medical & surgical) & Premier Eye Care
- Hearing Services – Hearing Care Solutions
- 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 - Evolent
- Chiropractic Services
- Podiatric Services



Additional Benefits

Hearing Services

- \$0 copay for one routine hearing test every year
- \$0 copay for one hearing aid fitting evaluation
- \$1500 to \$5,000 coverage limit per year for hearing aids (dollar coverage dependent upon service area); 1 hearing aid every year

Dental Services

- Two Oral exams per year with no copay
- Two Cleanings per year with no copay
- One Dental X-Ray per year with no copays
- Up to \$3,000 to no annual maximum allowance in comprehensive dental benefits per year (dollar coverage dependent upon plan)

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 plan); for eyewear each year

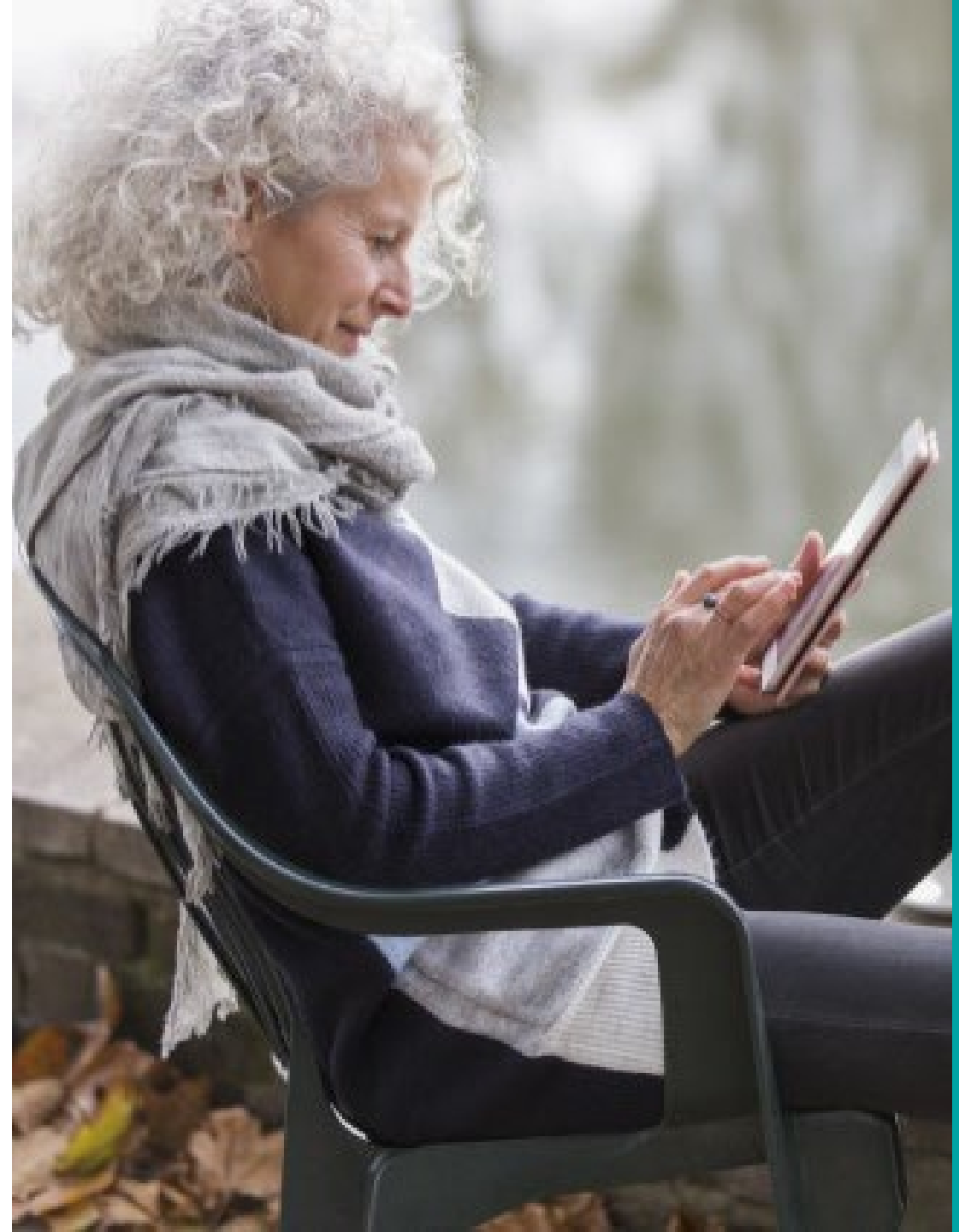
Over-the-Counter Items

- Commonly used over-the-counter items – listing available at: <https://wellcare.sunflowerhealthplan.com/member-resources/member-perks/otc-benefit.html>
- Conveniently shipped to member's home within 5 – 12 business days
- Call Member Services at **1-800-977-7522**, **DSNP 1-844-796-6811 (TTYL: 711)** to order items up to \$45 to \$395 per calendar quarter

Additional Benefits

(continued)

- Nurse Advice Line
 - Free health information line staffed with registered nurses 24/7 to answer health questions 866-822-1339, (TTY: 711)
- 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 1-800-977-7522, DSNP 1-844-796-6811 (TTY: 711)

Non-Emergency Transportation

- For DSNP members
- 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 **DSNP 1-844-796-6811 (TTY: 711)** 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



Prior Authorizations



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



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

Prior Authorization Requirements



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

The authorization look-up tool can be found here:
www.sunflowerhealthplan.com/providers/preauth-check/medicare-pre-auth.html

MEDICARE INPATIENT AUTHORIZATION
KANSAS

For Standard (Elective Admission) requests, complete this form and FAX to 1-844-885-3724. Determination made as expeditiously as the enrollee's health condition requires.

For Expedited requests (admission under the standard time frame), complete this form and FAX to 1-855-565-9519. 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.

For Concurrent request orders and direct admits) (Indicates Required Field)

MEMBER INFORMATION

Request for additional units, Existing Authorization _____ Units _____

Member ID * _____

REQUESTING PROVIDER

Requesting NPI * _____

Requesting Provider Name _____

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI * _____

Servicing Provider/Facility Name _____

AUTHORIZATION REQUEST

Primary Procedure Code (CPT/HCPCS) (Month) _____

Additional Procedure Code (CPT/HCPCS) (Month) _____

INPATIENT SERVICE TYPE

774 C-Section Delivery
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
427 Rehab
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical
992 Transplant
720 Vaginal Delivery

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED.

DISCLAIMER: An authorization is not a guarantee of coverage. It is subject to the terms, conditions, exclusions, and limitations of the plan's policy and procedures.

CONFIDENTIALITY: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient, you are notified that disclosing, copying, distributing, or taking any action in reliance on the contents of this information is strictly prohibited. If you have received this fax in error, please notify us immediately and destroy this document.

MEDICARE OUTPATIENT AUTHORIZATION
KANSAS

Expedited Requests Call: 1-855-565-9519
Standard Requests Fax: 1-844-885-3724
Concurrent Requests Fax: 1-844-226-6443

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 the request.

For Expedited requests, please call 1-855-565-9519. 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.

MEMBER INFORMATION

Member ID * _____ Date of Birth * (MM/DD/YYYY) _____

Last Name, First (Last Name) _____

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) (Month) _____ Additional Procedure Code (CPT/HCPCS) (Month) _____ Start Date OR Admission Date * (MM/DD/YYYY) _____ Diagnosis Code * (ICD-10) _____

Additional Procedure Code (CPT/HCPCS) (Month) _____ Additional Procedure Code (CPT/HCPCS) (Month) _____ End Date OR Discharge Date (MM/DD/YYYY) _____ Total Units/Visits/Days _____

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

712 Cochlear Implants & Surgery	794 Outpatient Services	Behavioral Health	DME
299 Drug Testing	171 Outpatient Surgery	513 BH Crisis Psychotherapy	477 DME - Rental
992 Experimental & Investigational Services	202 Pain Management	514 BH Day Treatment	100 DME - Purchase
205 Genetic Testing & Counseling	650 Radiation Therapy	515 BH Electroconvulsive Therapy	
249 Home Health	201 Sleep Studies	518 BH Medical Management	
290 Hyperbaric Oxygen Therapy	790 Occupational Therapy	519 BH Outpatient Therapy	
395 Infertility Diagnosis or Treatment	101 Physical Therapy	530 BH Partial Hospitalization Program (PHP)	
729 Neuropsychological Testing	101 Speech Therapy	500 BH Professional Fees	
410 Observation	292 Therapy Evaluation	522 BH Psychiatric Evaluation	
997 Office Visit/Consult	993 Transplant Evaluation		
422 Biopharmacy (Please fax to 844-943-1508)	724 Transportation		
	209 Transplant Surgery		

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.

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Rev. 10/17/2022
KIP-PAF-1301

Medical Necessity Determination



- When medical necessity cannot be established, a peer-to-peer conversation is offered, see the Provider and Billing Manual for details, www.sunflowerhealthplan.com/providers/allwell-provider.html
- 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. Provider appeal rights can be found in the Provider and Billing Manual (link above).

Preventive Care & Screening Tests

Preventive Care



- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventative Physical Exam –Welcome to Medicare:
 - 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 *(continued)*



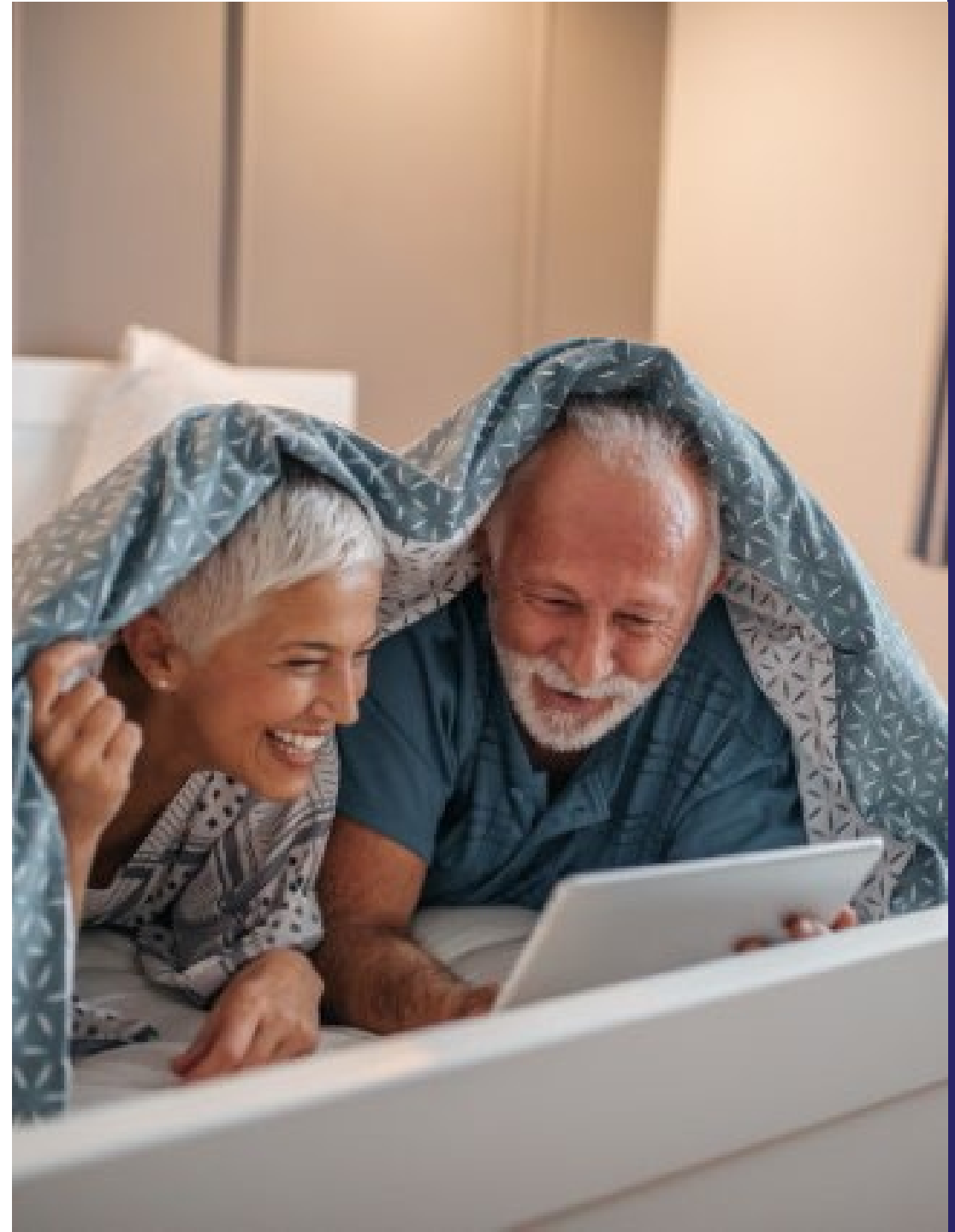
Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain 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

Model of Care

(DSNP and MMP only)

Model of Care

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





Model of Care Elements

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

Model of Care Process



- Every dual/SNP member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at a minimum annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Wellcare Case Management Program for follow up.



Model of Care Process *(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, 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.

[Model of Care Training site](#)

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, www.medicare.gov, to give beneficiaries help in choosing an MA and MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.



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

<https://provider.sunflowerhealthplan.com>

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:

www.sunflowerhealthplan.com/providers/allwell-provider.html



Primary Care Provider Reports

Patient List

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.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

Be sure the Plan Type is set to Wellcare on the portal landing page.

ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(770) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(770) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(770) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(770) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(866) 760-0001
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	

PCP Cost Reports *(Continued)*



Members With Frequent ER Visits

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.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

Be sure the Plan Type is set to Wellcare on the portal landing page.

sunflower health plan

Logged in as: [blurred]

Currently logged into:

Patients Reports

Search: Patients by Name [dropdown]

View All Patients Filter Patients Print Export

All Patients | Search Results: 6
Filter By: Care Opportunities | EBM - Emergency Medicine

Member Number	Member Name	Member Address	Age_Gender_DOB	Member Phone	High Priority Care Opportunities	Risk Score	IP Probability Score	IP Stays in last 30 days	ER Visits within 90 Days	SubGroup	Phy
[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]
[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]	[blurred]

PCP Cost Reports *(Continued)*



High Cost Claims

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.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

Be sure the Plan Type is set to Wellcare on the portal landing page.

sunflower health plan. Logged in as: [redacted]

Currently logged into:

Patients Reports

Search: Patients by Name [dropdown]

View All Patients Filter Patients Print Export

All Patients | Search Results: 5
Filter By: Disease and Conditions | High Cost Chronic Conditions

Member Number	Member Name	Member Address	Age_Gender_DOB	Member Phone	High Priority Care Opportunities	Risk Score	IP Probability Score	IP Stays in last 30 days	ER Visits within 90 Days	SubGroup
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

PCP Cost Reports *(Continued)*



Rx Claims Report

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.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

Be sure the Plan Type is set to Wellcare on the portal landing page.

Currently logged into: sunflower health plan. Logged in as:

Patients Reports

Search: Patients by Name

All Patients | Search Results: 4
Filter By: Disease Registry | *g: Polypharmacy, 10 or more distinct drug classes in last 120 days

Member Number	Member Name	Member Address	Age_Gender_DOB	Member Phone	High Priority Care Opportunities	Risk Score	IP Probability Score	IP Stays in last 30 days	ER Visits within 90 Days	SubGroup	Phy
12345	J. Doe	123 Main St	45 M 1/1/1980	555-123-4567	1	100	800	2	1	1000	1000
12346	J. Doe	123 Main St	45 M 1/1/1980	555-123-4567	1	100	800	2	1	1000	1000
12347	J. Doe	123 Main St	45 M 1/1/1980	555-123-4567	1	100	800	2	1	1000	1000
12348	J. Doe	123 Main St	45 M 1/1/1980	555-123-4567	1	100	800	2	1	1000	1000

Network Partners

Partner and Vendors



Service	Specialty Company/Vendor	Contact Information
Physical Therapy Services	Evolent (formally NIA)	1-877-644-4623
High Tech Imaging Services	Evolent (formally NIA)	1-877-644-4623 www.radmd.com
Vision Services – Medical or Surgical	Envolve Vision	1-800-334-3937
Vision Services	Premier Eye Care (routine care)	1-866-419-0861
Dental Services	DentaQuest	1-833-206-6291 https://www.dentaquest.com
Pharmacy Services	Express Scripts	1-800-717-6630

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

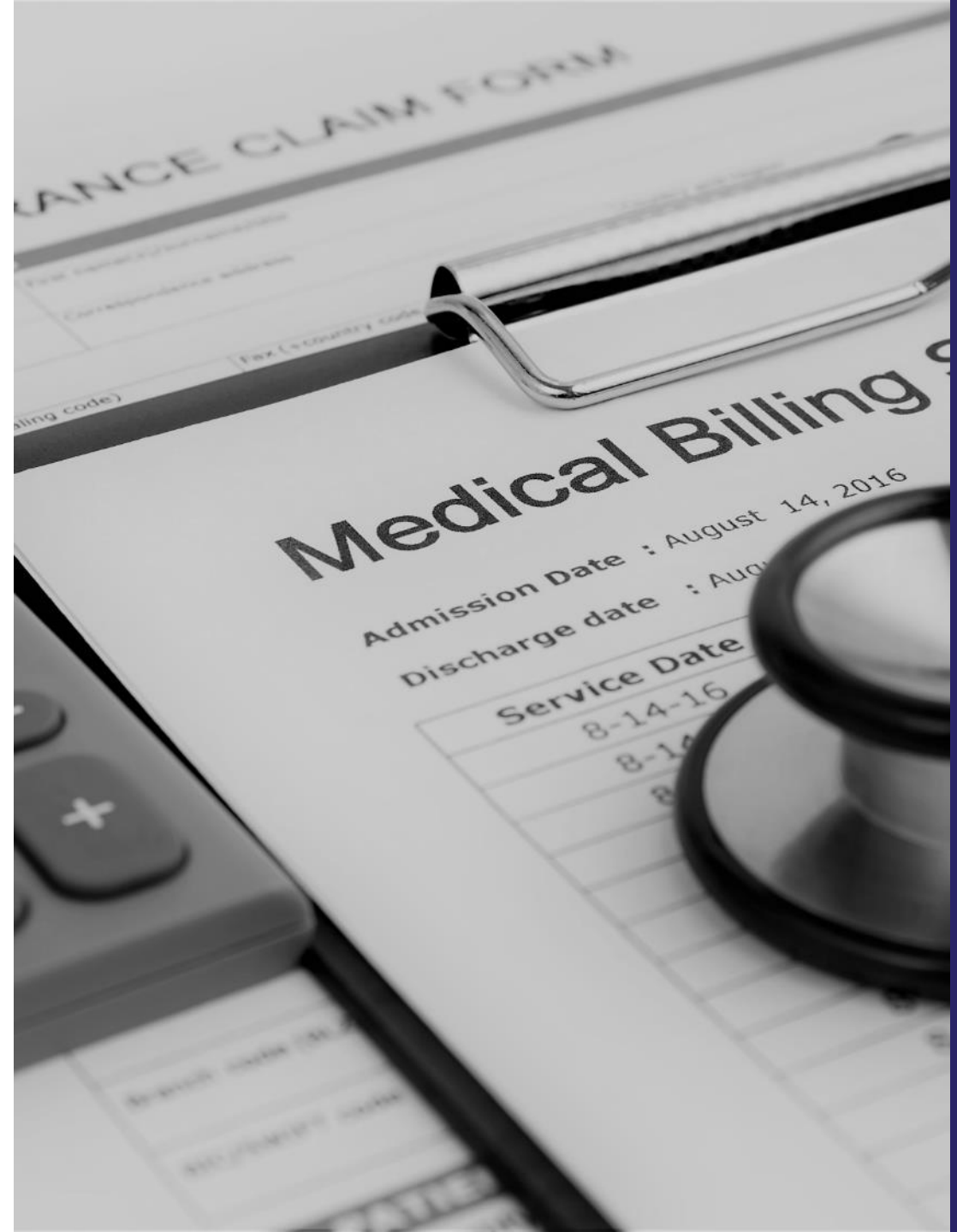
Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	

* See our [Find A Doctor](#) tool for contracted providers in your area

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 Availity clearinghouse for submission, Payer ID 68069



Need EDI Support?



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

www.sunflowerhealthplan.com/providers/resources/electronic-transactions.html

For more information about EDI, contact:

Wellcare

c/o Centene EDI Department

1-800-225-2573, ext. 6075525

E-mail: EDIBA@centene.com

Clinical and Payment Policies



WELLCARE BY ALLWELL PAYMENT POLICIES

- Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules.
- Health care claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding.

www.sunflowerhealthplan.com/providers/resources/clinical-payment-policies.html

POLICY #	TITLE
CC.PP.007	Maximum Units (PDF)
CC.PP.008	Cerumen Removal (PDF)
CC.PP.009	Unlisted Procedure Codes (PDF)
CC.PP.010	EM Bundling Edits (PDF)
CC.PP.011	Coding Overview (PDF)
CC.PP.012	IV Hydration (PDF)
CC.PP.013	Modifier -25 clinical validation (PDF)
CC.PP.014	Modifier -59 clinical validation (PDF)

Claims Submission Timelines



- Medicare Advantage claims need to be mailed to the following billing address:
Wellcare
Attn. Claims
P.O. Box 3060
Farmington, MO 63640-3822
- Participating providers have **180 DAYS** from the date of service to submit a timely claim
- All requests for reconsideration or claim disputes must be received within **365 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:
www.payspanhealth.com





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 365 days from the claim determination notice.

Submit reconsiderations or disputes to:

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

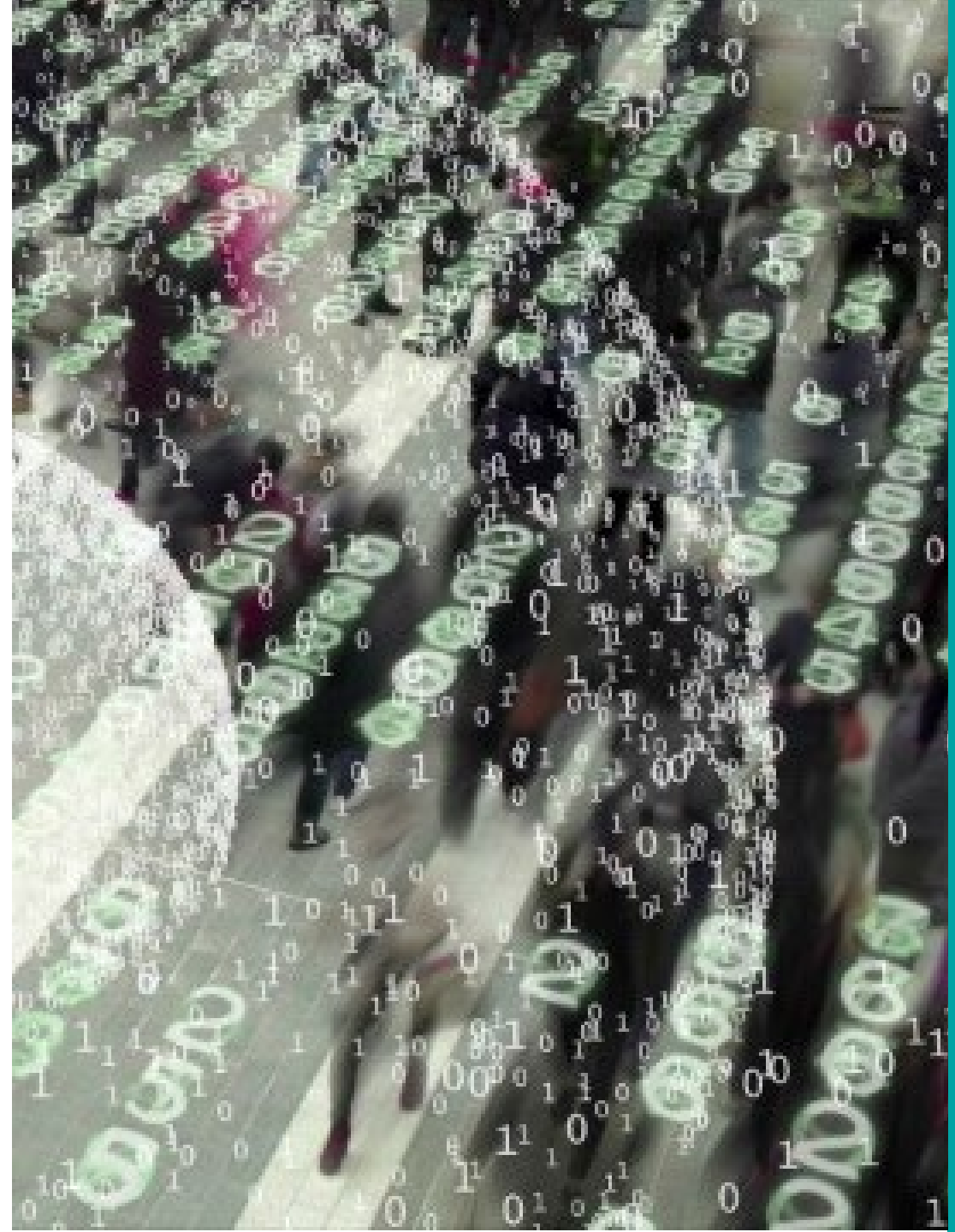
Wellcare By Allwell
Attn: Claim Dispute
PO Box 4000
Farmington, MO 63640-4400

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.

Regulatory Information

Medicare Outpatient Observation Notice (MOON)



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



Notice of Admission

Admissions, Census Report or Face Sheets should be faxed to 1-844-283-5813

Hospitals must issue the Important Message within two calendar days of admission, obtain signature of the patient or their authorized representative and provide a signed follow-up copy to the patient in advance of discharge, but not more than two calendar days before discharge.

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 *(continued)*



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 *(continued)*



Benefits of stopping fraud, waste, and abuse:

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

A black and white photograph of a stethoscope resting on a document. The document is titled "HIPAA Health Insurance Portability and Accountability Act of 1996". The stethoscope is positioned diagonally across the top of the page, with its chest piece resting on the text.

Fraud, Waste and Abuse *(continued)*

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 *(continued)*

- Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at **1-866-685-8664** or by contacting the Compliance Officer at:
 - Phone: 1-877-644-4623
 - Email: Sunflower_contract_compliance@sunflowerhealthplan.com
- 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 Kansas Fraud Hotline: 1-866-551-6328
 - Website: <https://ag.ks.gov/fraud-abuse/medicaid-fraud>

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 and MMP only. Within 30 days of joining Wellcare and annually thereafter [Model of Care training page](#)
- General Compliance (Compliance): Within 90 days of joining Wellcare and annually thereafter [Medicare Provider Compliance Tips](#)
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Wellcare and annually thereafter [Medicare & Medicaid FWA e-course](#)

Model of Care Training

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

www.sunflowerhealthplan.com/providers/allwell-provider/allwell-training/moc.html

The screenshot shows the Sunflower Health Plan website. At the top, there is a navigation bar with links for Home, Find a Doctor, Careers, Login, and Contact. A search bar is on the right with the text "Enter Keyword" and a "Search" button. Below the navigation bar is the Sunflower Health Plan logo. A secondary navigation bar contains four orange buttons: "FOR MEMBERS", "FOR PROVIDERS", "GET INSURED", and "SUPPORTING KANSAS COMMUNITIES". The "FOR PROVIDERS" button is selected, and a dropdown menu is visible with the following items: "Login", "Become a Provider", "Pre-Auth Check", "Pharmacy", "Provider Resources", "QI Program", "Provider News", "Medicare Provider Resources", "Medicare Training & Education", "Model of Care Provider Training", and "Wellcare (Medicare) New Provider Orientation". The "Model of Care Provider Training" item is highlighted in orange. The main content area is titled "Model of Care Provider Training" and contains the following text: "All Sunflower network providers are required to complete an annual Model of Care training. Click on the link below to review the Model of Care training presentation. Then, submit the form to verify the training was completed." Below this text is a bullet point with a link: "2023 Provider Model of Care Training (PDF)". The next section is titled "Provider Model of Care Training Confirmation" and contains three text input fields: "Provider Group *", "County *", and "Provider TIN *". Below these fields is a note: "Please provide any additional TINs that should be represented on this form." At the bottom of the form is a label "TIN 2" followed by a text input field.

General Compliance & Medicare Fraud, Waste, And Abuse Training



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

A screenshot of the CMS.gov website. The header includes the CMS.gov logo and "Centers for Medicare & Medicaid Services", along with navigation links for "About CMS", "Newsroom", and "Data & Research". A search icon is also present. Below the header is a navigation menu with categories: "Medicare", "Medicaid/CHIP", "Marketplace & Private Insurance", "Priorities", and "Training & Education". The main content area features a "Fast Facts" box on the left with a green border, containing the text: "Quickly learn about compliance issues and avoid common billing errors." and a link: "» Critical Access Hospitals: Bill Correctly". To the right of the "Fast Facts" box is the "Provider Compliance" section, which includes the heading "Provider Compliance" and the text "Learn how to avoid common coverage, coding, and billing errors with these educational resources:". Below this text are two bullet points: "• [CERT Outreach & Education Task Force](#)" and "• [Medicare Provider Compliance Tips](#) educational tool".

Confidential and Proprietary Information

General Compliance & Medicare Fraud, Waste, And Abuse Training



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



Additional Training Opportunities

- Annual Cultural Competency Training available On Demand

www.sunflowerhealthplan.com/providers/resources/provider-training/cultural-competency-traiing.html

- Project ECHO offers free continuing education credit quarterly

www.sunflowerhealthplan.com/providers/project-echo.html

- Office Hours offers an opportunity to get guidance on navigating the health plan. See our website for session dates

www.sunflowerhealthplan.com/providers/resources/provider-training.html

- Sign up for Email Alerts to be notified of policy changes, check run updates and upcoming training sessions.

- www.sunflowerhealthplan.com/providers/resources.html

Get The Latest News

Click below to sign up for email alerts for all the latest Sunflower bulletins, webinars and more!

Sign Up



Questions?

Training Questions – provider_training@sunflowerhealthplan.com

General Questions - www.sunflowerhealthplan.com/providers/allwell-provider/provider-service.html