wellcare By allwell™

Meet Wellcare.

2025 Provider Orientation

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

The Strength of Wellcare

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

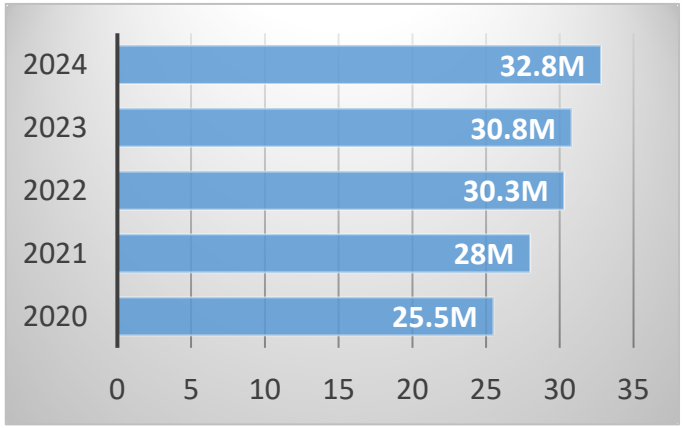
- **Local management with national expertise**
- **Full continuum of Medicare products including:**
  - **HMO**
  - **PPO**
  - **DSNP**
  - **CSNP**
  - **MMP (not in KS)**
  - **PSP (not in KS)**
  - **EGWP (not in KS)**
  - **PDP**

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

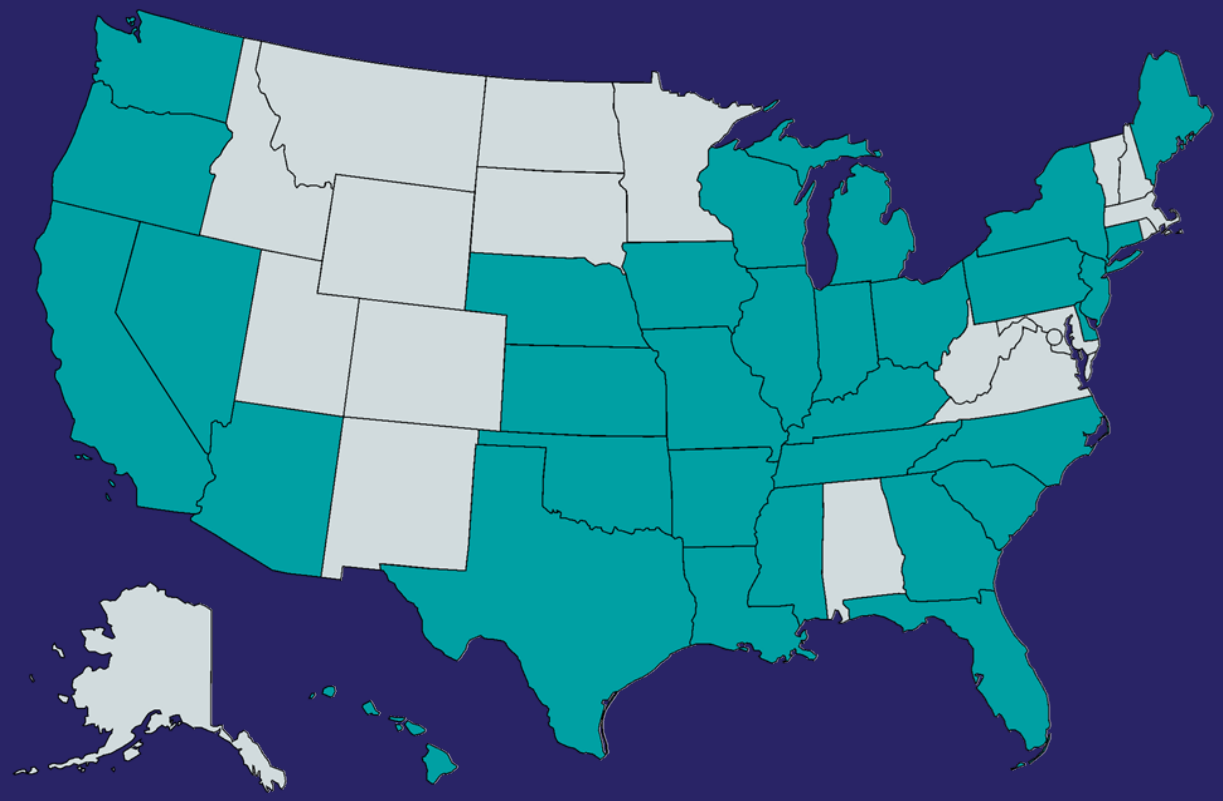
32.8M
Medicare Advantage enrolled members nationwide

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 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.

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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 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

Key Contact Information

PHONE

All Plans 1-800-977-7522

DSNP 1-844-796-6811

Wellcare Complete 1-800-977-7522

TTY

711

WEB

wellcare.sunflowerhealthplan.com
wellcarecomplete.com

PORTAL

provider.sunflowerhealthplan.com
provider.wellcarecomplete.com

Provider Manual

- The Provider Manual is your comprehensive guide to doing business with Wellcare
- The manual includes a wide-array of important information relevant to providers that includes:
    - Network information
    - Billing guidelines
    - Claims information
    - Regulatory information
    - Key contact list
    - Quality initiatives
- The Wellcare by Allwell Provider Manual can be found in the Medicare Provider Resources section at **www.sunflowerhealthplan.com**. The Wellcare Complete Provider Manual can be found under Provider Resources at **www.wellcarecomplete.com**.

Appointment Availability

Primary Care Providers

Emergency: Same day or within 24 hours of the member's call

Urgent Care: Member should be seen within 24 hours of the member's call

Sick Care: Member should be seen within 7 days of the member's call

Routine: Member should be seen within 30 days of the member's call

Specialist Providers

Emergency: Same day or within 24 hours of the member's call

Urgent Care: Member should be seen within 24 hours of the member's call

Routine Care: Member should be seen within 30 days of the member's call

Behavioral Health Providers

Non-Life-Threatening Psychiatric Emergency: Member should be seen within 6 hours of the member's call

Urgent: Member should be seen within 48 hours of the member's call

Routine Initial Assessment: Member should be seen within 10 business days of the member's call

Routine Follow Up Care: Member should be seen within 10 business days of the member's call

Sick Care: Member should be seen within 7 business days of the member's call

24-Hour Access to Providers

Members must be able to access their providers 24-hours a day, 365 days a year

- Provider's office phones must be answered during normal business hours
- Message left during normal business hours should be returned the same day

Members must be able to access their provider after normal business hours and on weekends by either

- Answering service or system that will page physician
- Answering system with option to page physician
- Advice nurse with access to physician
- Answering service that will page the provider after a message is left

Unacceptable after-hours coverage include, but not limited to:

- A recording telling callers to leave a message
- A recording telling callers to go to an emergency department
- Calls not returned within 30 minutes

Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits. It is recommended to record the message banner in English & Spanish.

Health Plan Notification

Providers are required to notify Wellcare when Members receive care in any of the following settings:

- Acute Care Hospitals, including Critical Access Hospitals and Behavioral Health Hospitals
- Inpatient Rehabilitation Facilities
- Long-Term Acute Care Hospitals
- Skilled Nursing Facilities

A notification enables Wellcare to log the admission and follow up with the facility to receive clinical information. Notification can be submitted by fax or phone, or via the secure portal at provider.sunflowerhealthplan.com for registered Providers. The notification information should include Member's name, date of birth, and Member ID; the facility name; and the admitting diagnosis. The Wellcare Complete provider portal can be found at **provider.wellcarecomplete.com.**

Wellcare requires Providers to notify Wellcare by the next business day of a Member's observation or inpatient admission to a hospital. Failure to notify Wellcare of admission by the next business day may result in a denial of the inpatient authorization and/or claim.

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 (all plans), DSNP 1-844-796-6811 (D-SNP only),** 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 Practice Advisory

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

Contact Quality Provider Support at providerengagement@sunflowerhealthplan.com

Provider Engagement

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

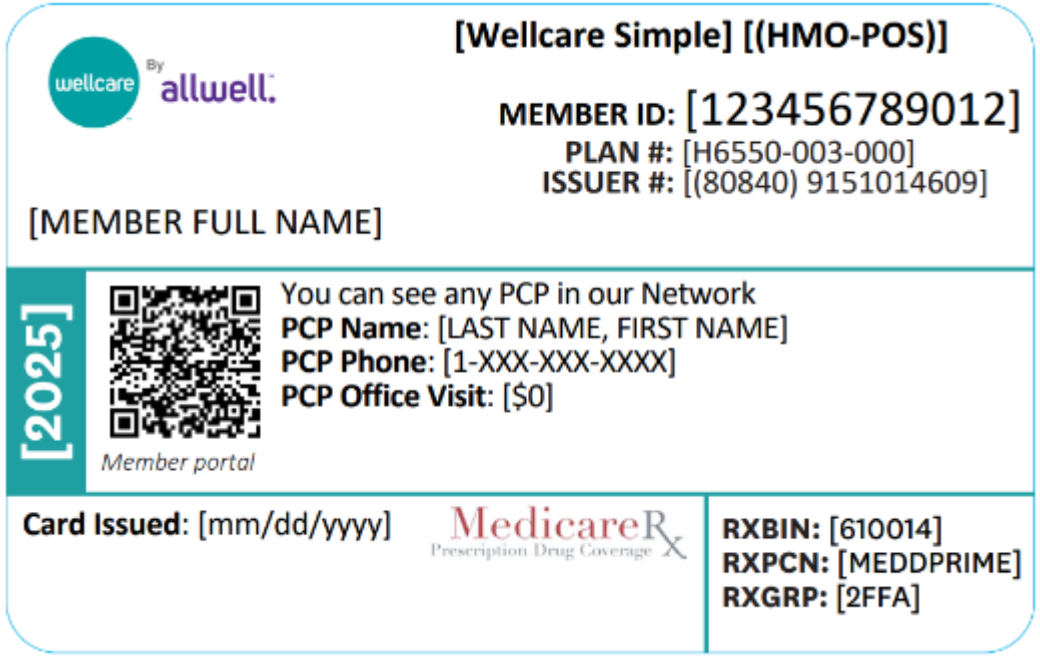
Contact Provider Engagement at:
Wellcare_KS_PR@sunflowerhealthplan.com or
WellcareComplete_KS_PR@centene.com

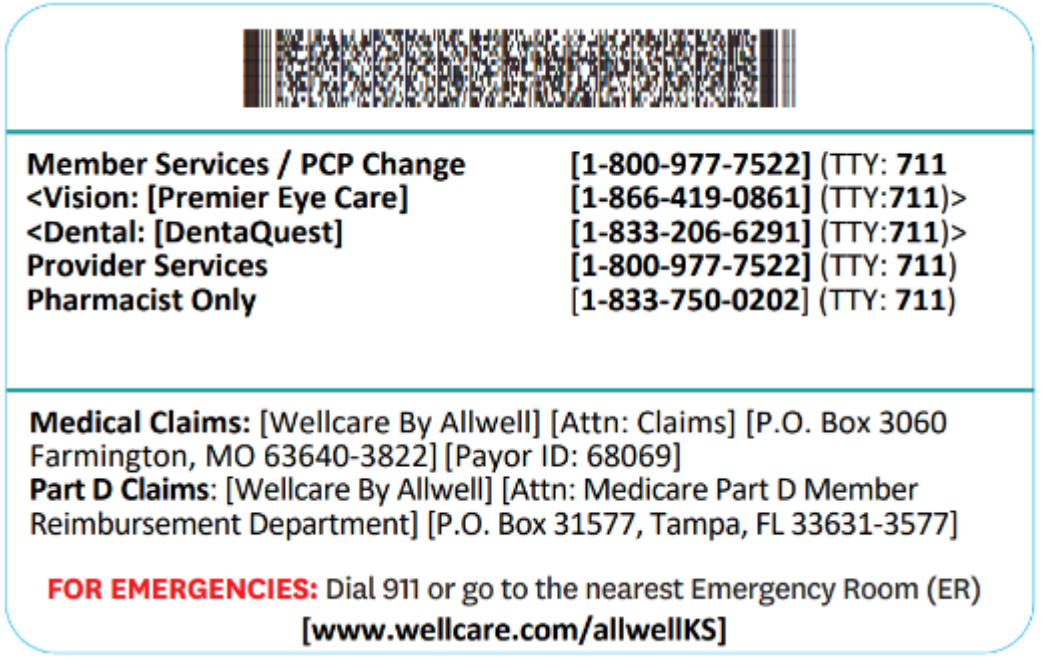
Membership, Benefits, and Additional Services

Membership

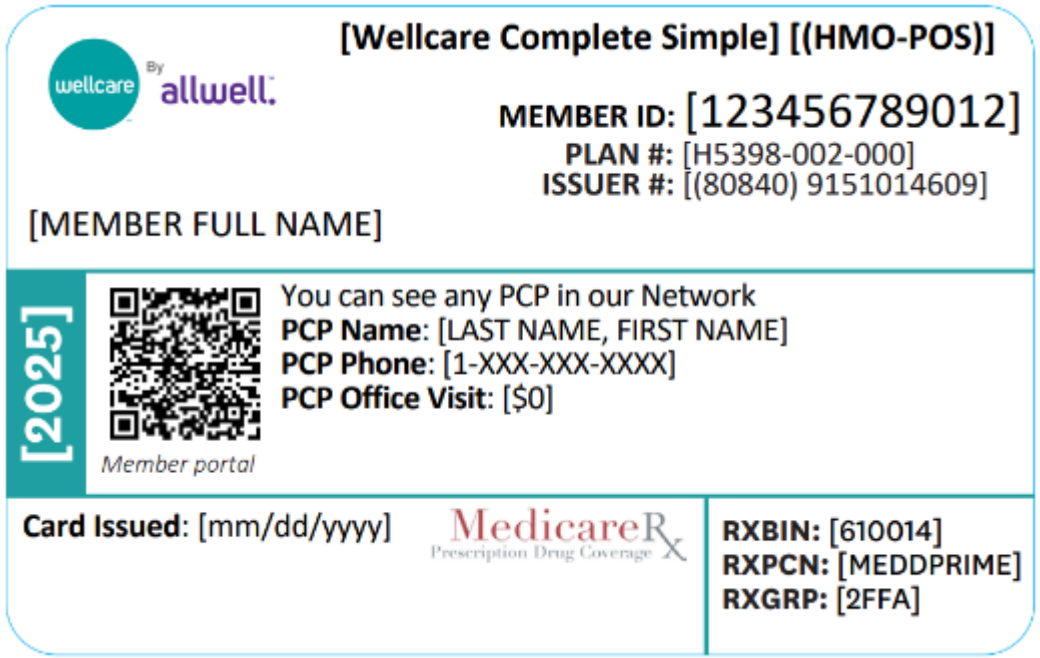
- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare Plan or choose a Medicare Advantage Health Plan
- Advantage members may change PCPs at any time. Changes take effect on the first day of the month. wellcare.sunflowerhealthplan.com
- Providers should verify eligibility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

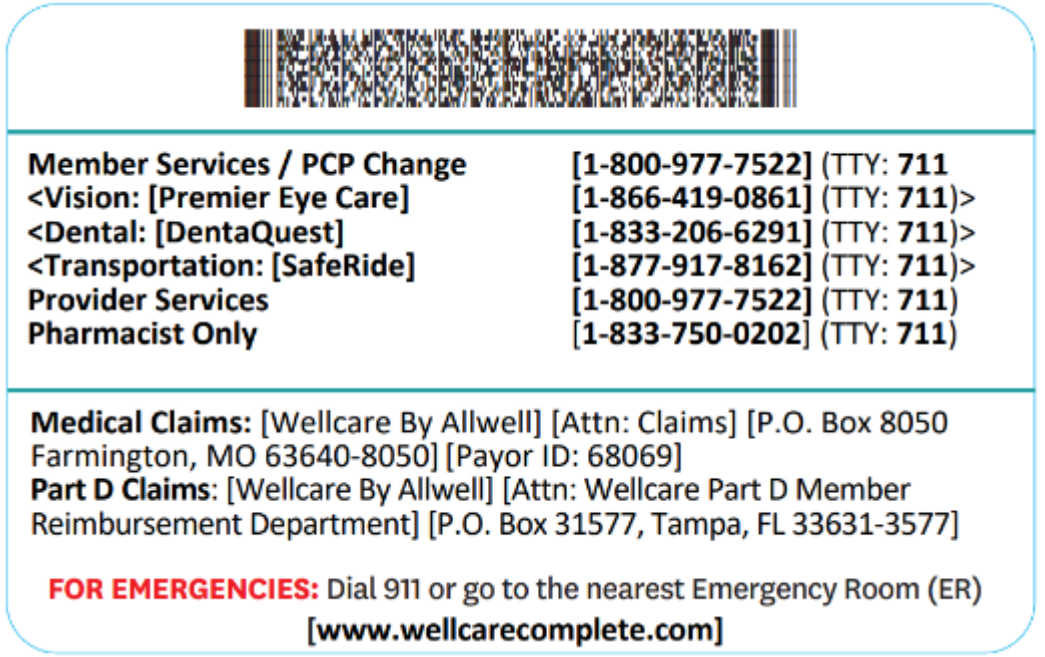
Member ID Cards





Wellcare Complete 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*
  - Additional benefits and services such as dental, vision, $0 PCP copay, $0 generics, etc.

**DSNP plans may have a deductible.*

Pharmacy Formulary

- The Advantage formulary is available at:

Wellcare by Allwell Drug Formulary or Wellcare Complete Drug 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 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 - *SafeRide*
- Home Health Services
- Screening Services
- Dental - *DentaQuest*
- Vision Services - *Centene 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
- $700 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)

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

Additional Benefits *(continued)*

Vision Services

- One routine eye exam every year
- One pair of glasses or contacts lenses every year
- $40 to $208 limit (frequency and dollar coverage dependent upon plan); 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 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 (all plans), DSNP 1-844-796-6811 (D-SNP only) (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 (all plans), DSNP 1-844-796-6811 (D-SNP only) (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 (D-SNP only) (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 or provider.wellcarecomplete.com

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

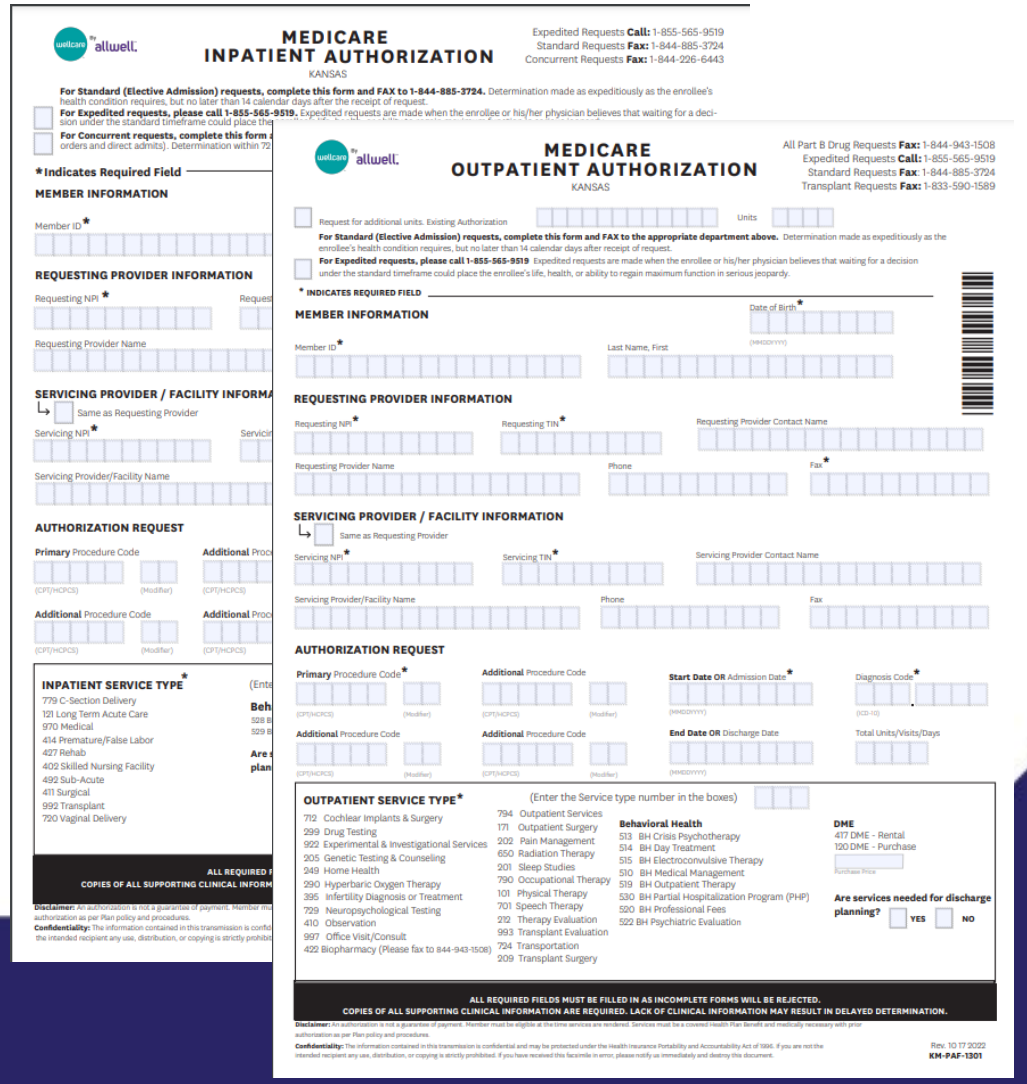
Prior Authorization Requirements

- Prior authorization is required for:
  - Inpatient admissions
  - 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

Use the Pre-Auth Check tool to determine if the service being provided requires authorization.

Wellcare by Allwell Auth forms

Wellcare Complete Auth forms



MEDICARE INPATIENT 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 1-844-885-3724. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of 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
For Concurrent requests, complete this form orders and direct admits). Determination within 72

***Indicates Required Field**

MEMBER INFORMATION

Member ID*

REQUESTING PROVIDER INFORMATION

Requesting NPI*

Requesting Provider Name

SERVICING PROVIDER / FACILITY INFORMA

Same as Requesting Provider

Servicing NPI*

Servicing Provider/Facility Name

AUTHORIZATION REQUEST

Primary Procedure Code

Additional Procedure Code

INPATIENT SERVICE TYPE*

779 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

ALL REQUIRED
COPIES OF ALL SUPPORTING CLINICAL INFORM

Disclaimer: An authorization is not a guarantee of payment. Member
authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission is confi
the intended recipient any use, distribution, or copying is strictly prohibi

MEDICARE OUTPATIENT AUTHORIZATION
KANSAS

All Part B Drug Requests **Fax:** 1-844-943-1508
Expedited Requests **Call:** 1-855-565-9519
Standard Requests **Fax**: 1-844-885-3724
Transplant Requests **Fax:** 1-833-590-1589

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 1-855-565-9519 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.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID*

Date of Birth*

Last Name, First

REQUESTING PROVIDER INFORMATION

Requesting NPI*

Requesting TIN*

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax*

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI*

Servicing TIN*

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code*

Additional Procedure Code

Start Date OR Admission Date*

Diagnosis Code*

Additional Procedure Code

Additional Procedure Code

End Date OR Discharge Date

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
290 Hyperbaric Oxygen Therapy
395 Infertility Diagnosis or Treatment
729 Neuropsychological Testing
410 Observation
997 Office Visit/Consult
422 Biopharmacy (Please fax to 844-943-1508)
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
513 BH Crisis Psychotherapy
514 BH Day Treatment
515 BH Electroconvulsive Therapy
510 BH Medical Management
519 BH Outpatient Therapy
530 BH Partial Hospitalization Program (PHP)
520 BH Professional Fees
522 BH Psychiatric Evaluation

DME
417 DME - Rental
120 DME - Purchase

Purchase Price

Are services needed for discharge planning? YES NO

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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 10 17 2022
KM-PAF-1301

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, see the Provider and Billing Manual for details, www.sunflowerhealthplan.com/providers/allwell-provider.html or 2025 Wellcare Complete Provider Manual
- 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 CSNP only)

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 (DSNP) and Chronic Condition Specials Needs Plan (CSNP) 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 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 *(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:

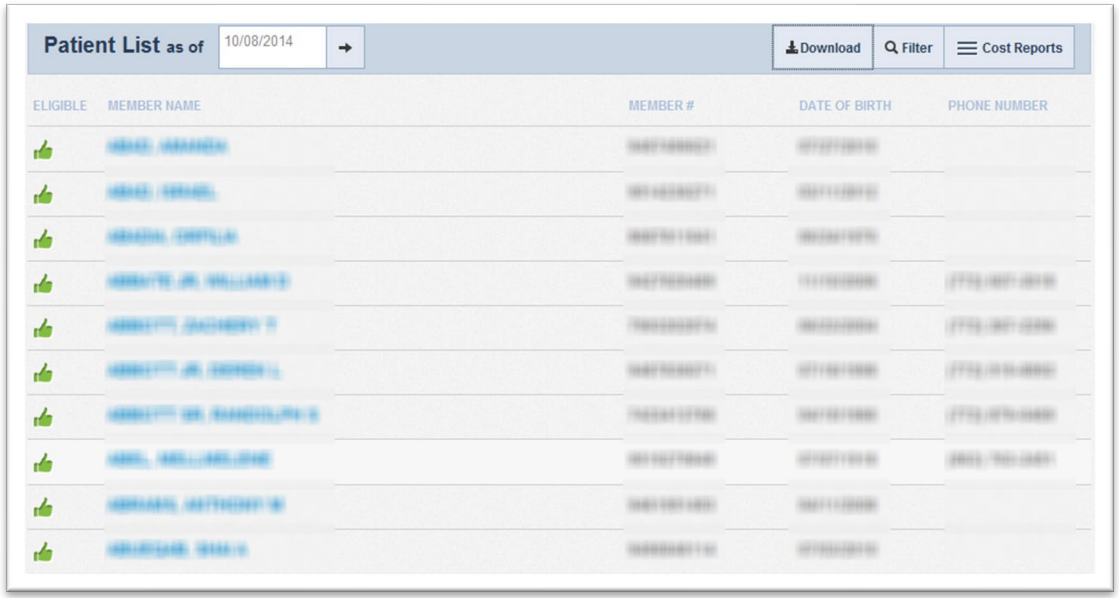
www.sunflowerhealthplan.com/providers/allwell-provider.html

Primary Care Provider Reports

Patient List

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.com or provider.wellcarecomplete.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.

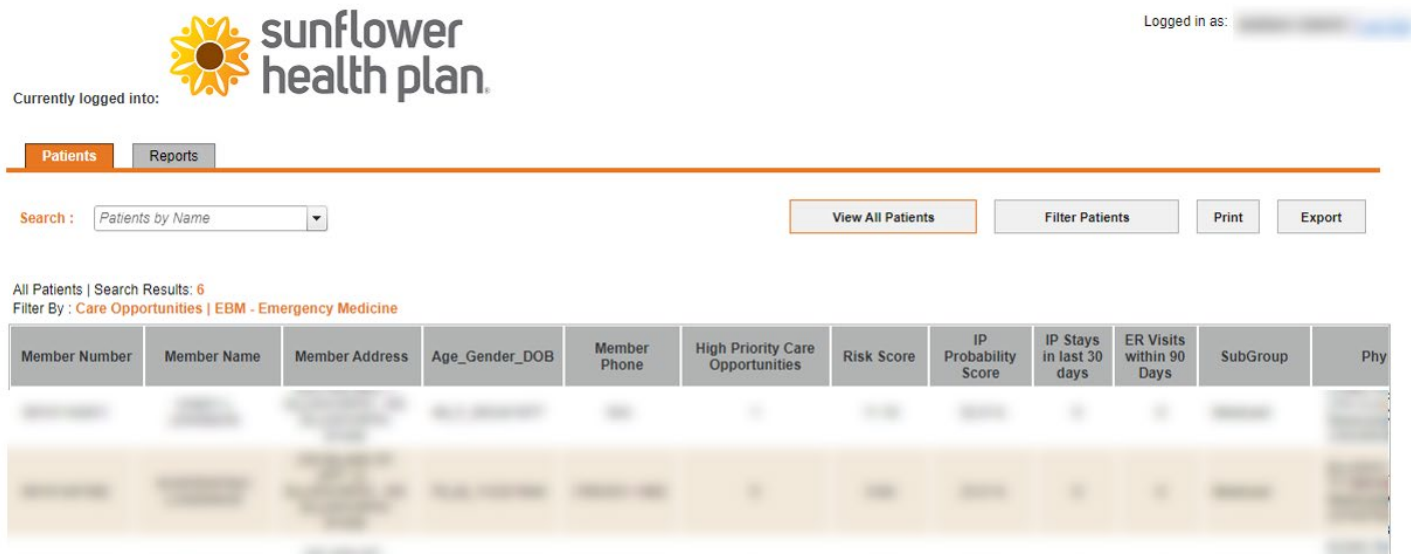


Primary Care Provider Reports

Members With Frequent ER Visits

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.com or provider.wellcarecomplete.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, [illegible]ation

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

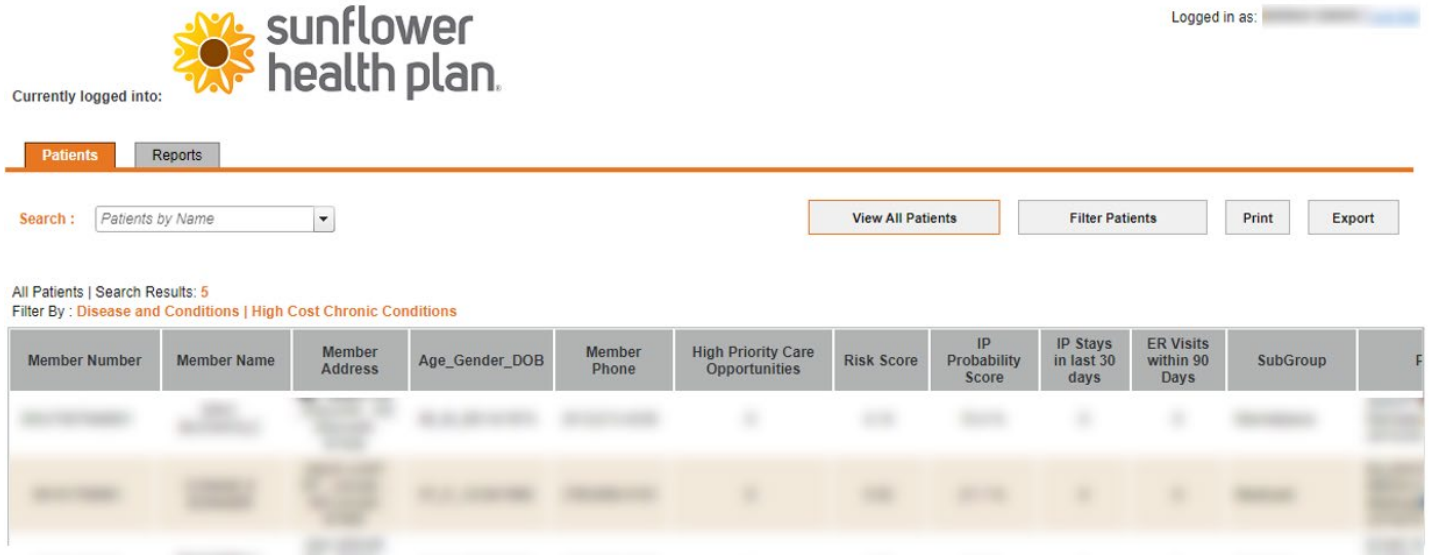


PCP Cost Reports *(Continued)*

High Cost Claims

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.com or provider.wellcarecomplete.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.

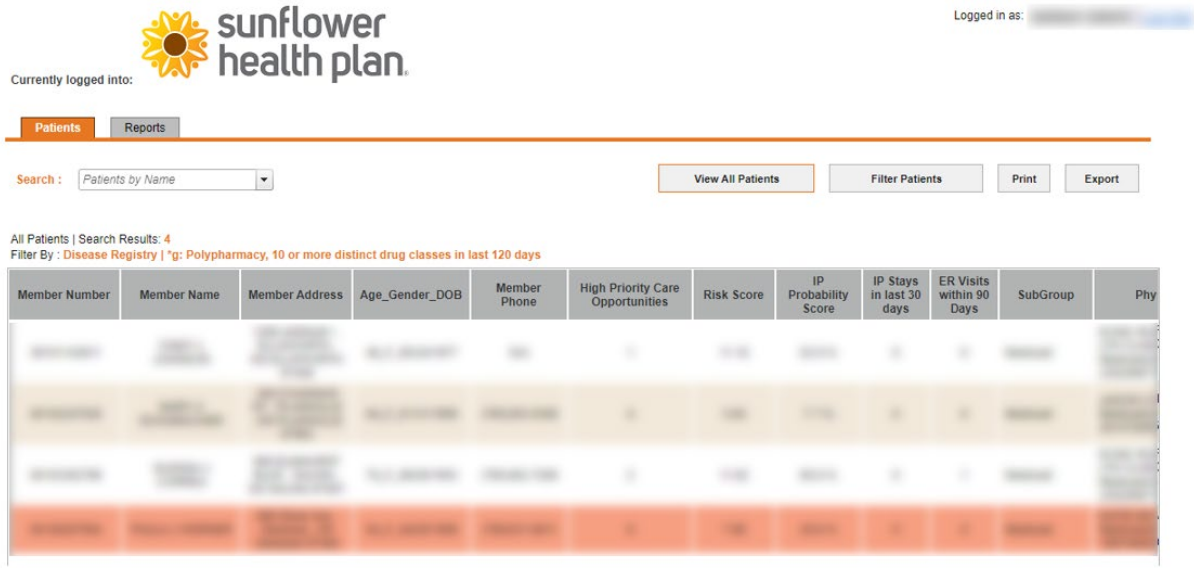


PCP Cost Reports *(Continued)*

Rx Claims Report

- Located on the Secure Provider Portal at provider.sunflowerhealthplan.com or provider.wellcarecomplete.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.



Availity Essentials

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:
  - **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, 7 a.m. – 7 p.m. CT.
- For general questions, providers can reach out to their health plan Provider Engagement representative.

Network Partners

Partners and Vendors

Service	Specialty Company/Vendor	Contact Information
Physical Therapy Services	Evolent	1-877-644-4623
High Tech Imaging Services	Evolent	1-877-644-4623 www.radmd.com
Vision Services – Medical or Surgical	Centene Vision Services	1-877-865-1834
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
Hearing Services	Hearing Care Solutions	1-866-344-7756

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

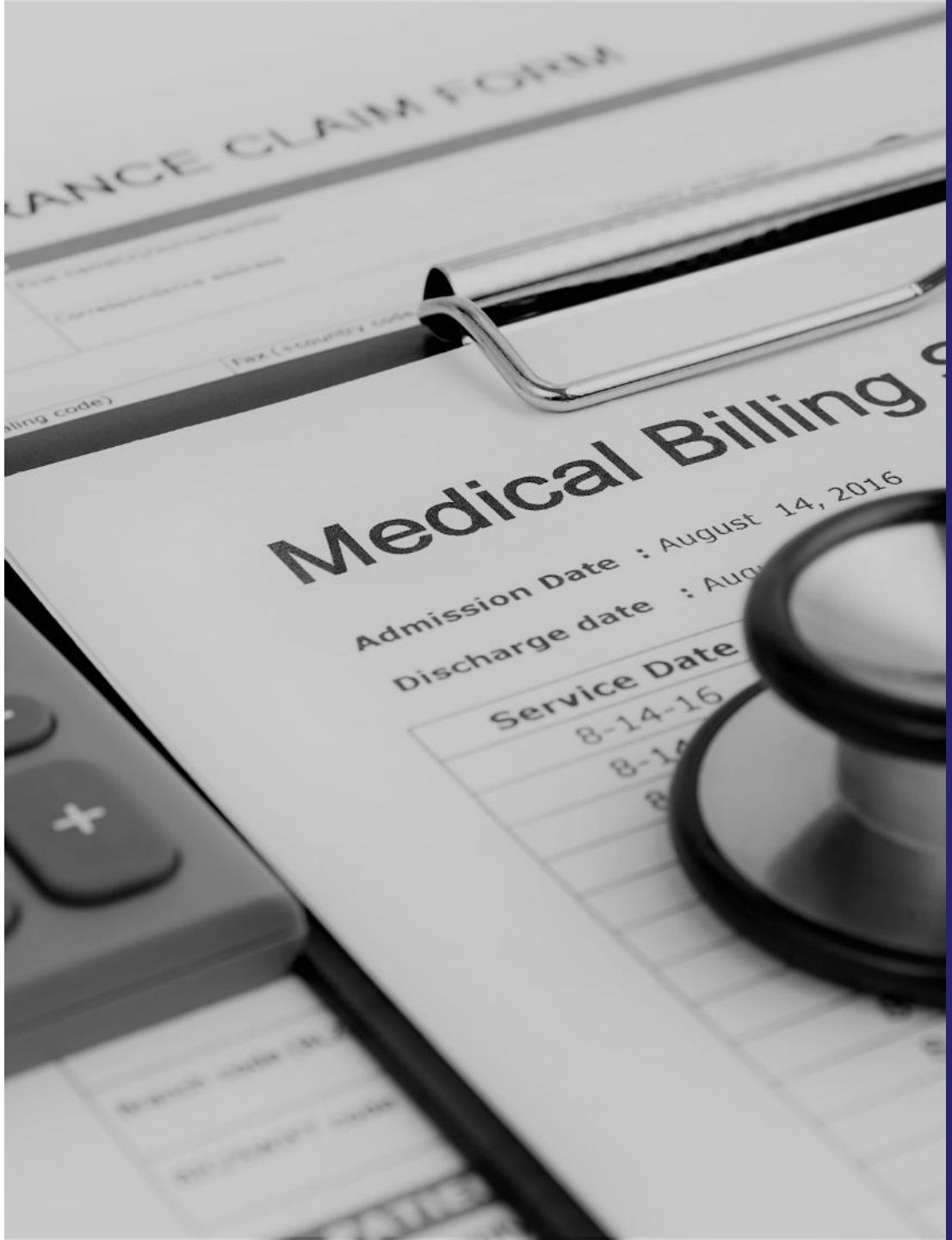
Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	

* 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 electronic submissions, 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

- 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

WELLCARE BY ALLWELL PAYMENT POLICIES

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
  PO 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 **180 DAYS** from the original date of notification of payment or denial

Timely Filing Provider Bulletin - January 2024

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

Level 1 Dispute (Claim Reconsideration)

A Claim Level 1 Dispute (reconsideration) is to be used only when a provider has received an unsatisfactory response to a claim adjudication.
Contracted providers can submit claims payment disputes by submitting a reconsideration form within **180 DAYS** from the Explanation of Payment.

Wellcare Complete Reconsideration must be submitted within **90 DAYS** for participating providers and **60 DAYS** for non-participating providers.

Submit Level 1 disputes to:

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

Timely Filing Provider Bulletin - January 2024

Level II Dispute (Claim Dispute)

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 DAYS** from the claim determination notice.

Submit Level II Disputes to:

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

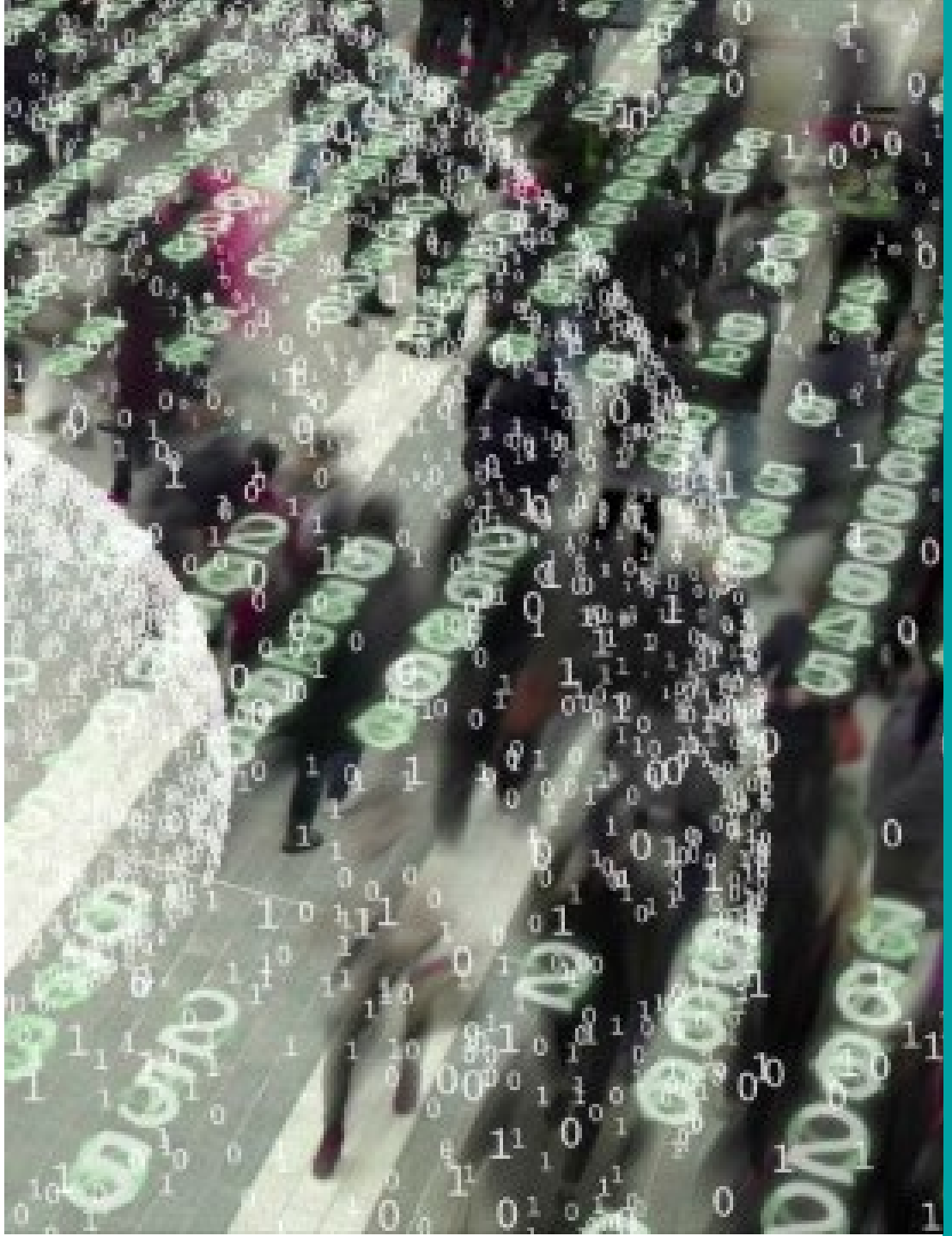
Timely Filing Provider Bulletin - January 2024

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 at: **www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html**

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)*

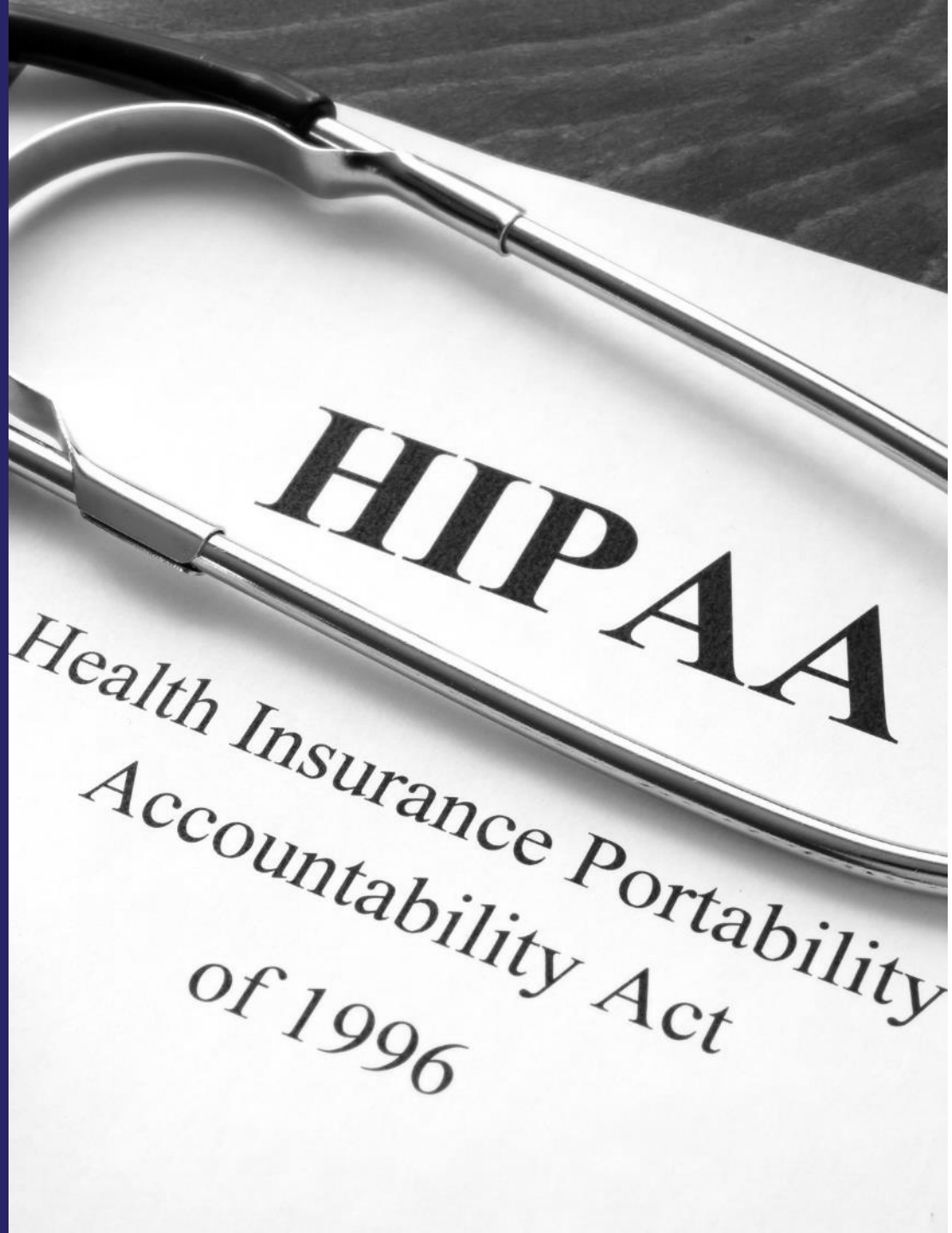
Wellcare performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:

- 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



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

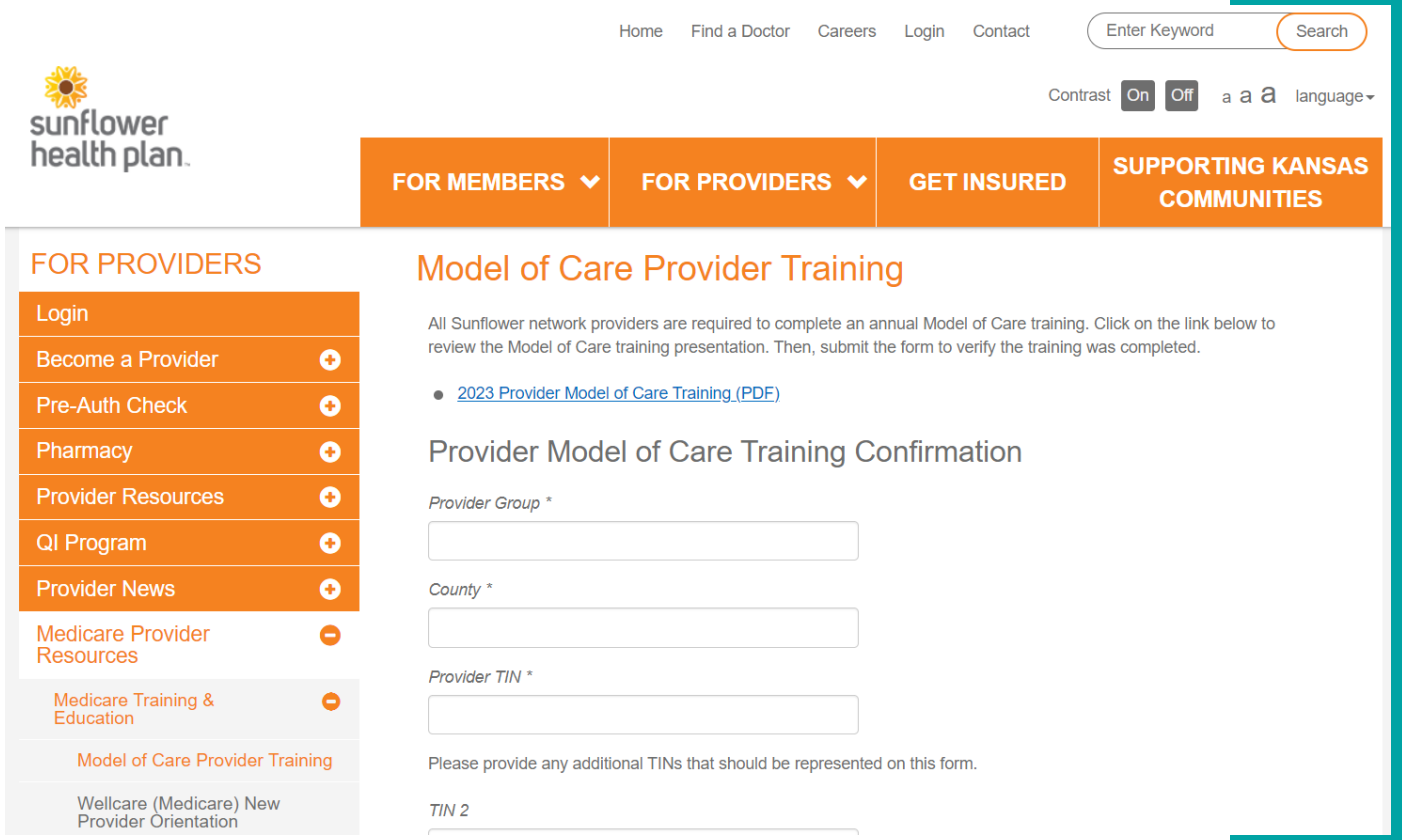
All Wellcare contracted providers, contractors, and subcontractors are required to complete three required trainings:

- Model of Care (MOC): For DSNP 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

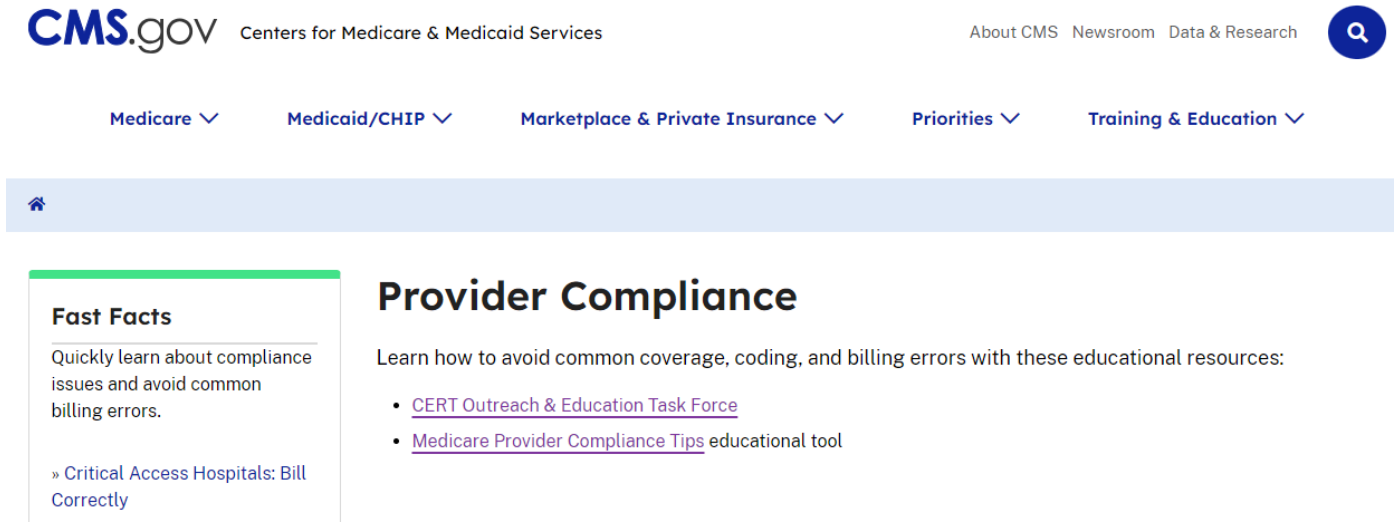
- Model of Care training is a CMS requirement for any provider that treats SNP members to be completed annually
- Newly contracted Medicare providers should complete within 30 days of execution of contract
- Model of Care information is available on:

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



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 provider_training@sunflowerhealthplan.com



General Compliance & Medicare Fraud, Waste And Abuse Training

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

HealthCare Effective Data Information Set (HEDIS)

- **HEDIS** is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across health plans. It gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.
- **HEDIS** Scores – Physician-specific scores are used to measure PCP practice's preventive care efforts.
- How Can Providers Improve Their **HEDIS** Scores?

Knowledge & Understanding of HEDIS Measures	**Submit Claims Including CPT II & Encounter Claims**	**Chart Documentation Reflects Services Provided**	**Provide Medical Records When Requested**

2025 Medicare HEDIS Measures

AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	DMH - Diagnosed Mental Health Disorders	HPC - Hospitalization for Potentially Preventable Complications
AAP - Adults' Access to Preventive/Ambulatory Health Services	DMS-E - Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	IET - Initiation and Engagement of Substance Use Disorder Treatment
ACP - Advance Care Planning	DRR-E - Depression Remission or Response for Adolescents and Adults	KED - Kidney Health Evaluation for Patients with Diabetes
AHU - Acute Hospital Utilization	DSF-E - Depression Screening and Follow-Up for Adolescents and Adults	LBP - Use of Imaging Studies for Low Back Pain
AIS-E - Adult Immunization Status	DSU - Diagnosed Substance Use Disorders	MSC - Medical Assistance With Smoking and Tobacco Use Cessation
ASF-E - Unhealthy Alcohol Use Screening and Follow-Up	EDH - Emergency Department Visits for Hypoglycemia in Older Adults With Diabetes	MUI - Management of Urinary Incontinence in Older Adults
AXR - Antibiotic Utilization for Respiratory Conditions	EDU - Emergency Department Utilization	OSW - Osteoporosis Screening in Older Women
BPC-E - Blood Pressure Control for Patients With Hypertension	EED - Eye Exam for Patients with Diabetes	PAO - Physical Activity in Older Adults
BPD - Blood Pressure Control for Patients with Diabetes	FMA-E - Follow-Up After Abnormal Mammogram Assessment	PBH - Persistence of Beta-Blocker Treatment After a Heart Attack
BSC-E - Breast Cancer Screening	FMC - Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions	PCR - Plan All Cause Readmissions
CBP - Controlling High Blood Pressure	FRM - Fall Risk Management	POD - Pharmacotherapy for Opioid Use Disorder
COA - Care for Older Adults	FUA - Follow Up After Emergency Department Visit for Substance Use	PSA - Non-Recommended PSA-Based Screening in Older Men
COL-E - Colorectal Cancer Screening	FUH - Follow Up After Hospitalization for Mental Illness	SAA - Adherence to Antipsychotic Medications for Individuals with Schizophrenia
COU - Risk of Continued Opioid Use	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder	SNS-E - Social Need Screening and Intervention
CRE - Cardiac Rehabilitation	FUM - Follow Up After Emergency Department Visit for Mental Illness	SPC - Statin Therapy for Patients With Cardiovascular Disease
CWP - Appropriate Testing for Pharyngitis	GSD - Glycemic Status Assessment for Patients With Diabetes	SPD - Statin Therapy for Patients With Diabetes
DAE - Use of High-Risk Medications in Older Adults	HDO - Use of Opioids at High Dosage	TRC - Transitions of Care
DBM-E - Documented Assessment After Mammogram	HFS - Hospitalization Following Discharge From a Skilled Nursing Facility	UOP - Use of Opioids From Multiple Providers
DBO - Deprescribing of Benzodiazepines in Older Adults	HOS - Medicare Health Outcomes Survey	URI - Appropriate Treatment for Upper Respiratory Infection
DDE - Potentially Harmful Drug-Disease Interactions in Older Adults		

For additional HEDIS information www.sunflowerhealthplan.com/providers/quality-improvement/hedis.html

Why Did We Receive a Request for Medical Records?

You may receive a request from Sunflower's Medical Management, Quality, Auditing department, etc. We would like to remind you that Medical Records are required by contract for:

- All covered members (including those dual eligible where Sunflower was not payer of service provided)
- Contractual reasons for record requests
- To conduct utilization or quality review of member care
- Regulatory audits, monitoring, or reviews by the state, federal government or MCO
- To meet document requests required by accrediting organizations
- Public official requests

www.sunflowerhealthplan.com/content/dam/centene/sunflower/pdfs/Sunflower-Chasing-the-Chart-Provider-Info.pdf

Medical Record Requests & Review for Quality

Provider Responsibilities:

- Documentation needs to fully meet request (read request document carefully and include all items in request)
- Timely submission (all requests will include a deadline and a contact number for questions, to discuss delivery, or if an extension is available)
- Submit documents in a secure, useable format (email, fax, upload to portal or mail)
- Specialists are to provide reports back to the member's PCP on a regular basis for coordination of care

Always submit medical records in PDF format

Medical Record Documentation

Provider Responsibilities:

- To maintain clinical and medical records in a manner that is current, detailed and organized.
- Retain medical records for 10 years with additional details explained for extending the record retention timeframe noted in the provider manual.

Maintain the confidentiality of clinical and medical record information and release the information in the following manner:

- All clinical and medical records of members shall be confidential and shall only be released in compliance with HIPAA and other applicable record-protection laws.
- Written consent of the member is only required for the transmission of the clinical and medical record information of a former enrolled member for “sensitive conditions” or as otherwise specified by HIPAA and other applicable protection laws.
- Authorization is not required when the provider is transitioning care to another KanCare provider.
- The extent of clinical or medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or a facility requesting the information.
- All releases of information for SUD specific clinical or medical records must meet federal guidelines at 42 CFR Part 2.

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

Questions & Answers

Provider Training:
Provider_Training@sunflowerhealthplan.com

Provider Engagement Team:
Wellcare_KS_PR@sunflowerhealthplan.com or
WellcareComplete_KS_PR@centene.com