



Meet Wellcare.

2023 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



The Wellcare logo is a white circle containing the word "wellcare" in a teal, lowercase, sans-serif font. A small "TM" trademark symbol is located to the right of the circle.

wellcareTM



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)

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
 - MMP
 - PSP
 - EGWP
 - PDP

1.4M

Medicare members across **36 STATES**

340K

Special Needs Plan members across **32 STATES**

4.1M

Prescription Drug Plan members across **50 STATES**

3.6%

YoY Growth Medicare Advantage Enrolled

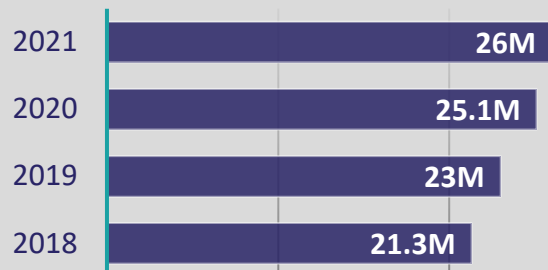
26M

Medicare Advantage enrolled members nationwide

42%

Medicare Advantage Penetration Rate nationwide

Medicare Advantage Enrollees



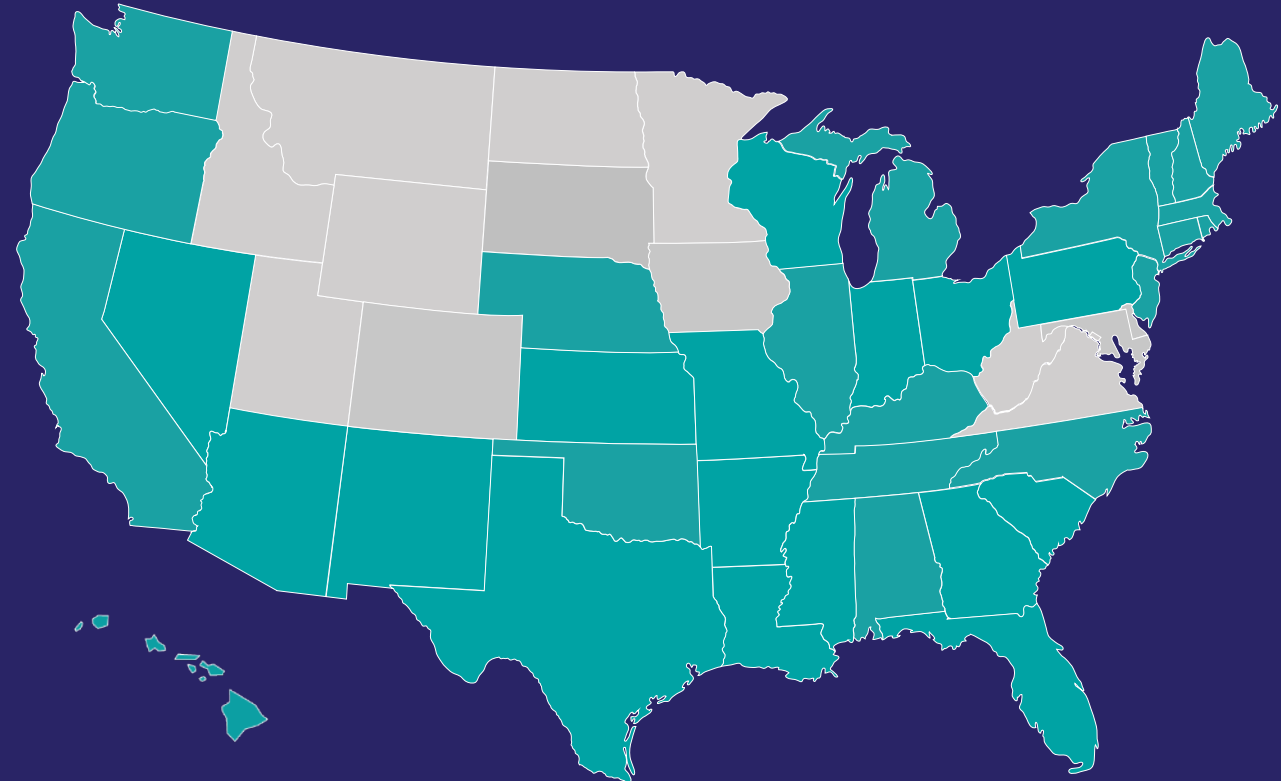
1.4 Million Medicare Members

#6

largest MA plan






#2

largest MAPDP plan



Exceptional Benefits

Wellcare is designed to give members

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



Telehealth – Doctors are available by teleconference, day and night and on weekends and holidays.



Free In-Home Support & Chore Services – Available services to keep members' homes safe and clean, including help with light cleaning, household chores, and meal prep.



Free Transportation – Free unlimited trips to doctor's offices and pharmacies with some plans eligible for non-medical transportation.



OTC Allowances – Members receive annual over-the-counter (OTC) allowances and pay \$0 for certain OTC products, depending on the plan.



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



24-Hour Nurse Advice Line – Speak with a live nurse, 24 hours a day, any day of the year.



Our Whole Health Approach

Wellcare provides complete continuity of care to Medicare members.

This includes:

- Integrated coordination care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the 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're 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 Relations 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

1-855-538-0454

TTY/TDD

711

WEB

www.wellcare.com

PORTAL

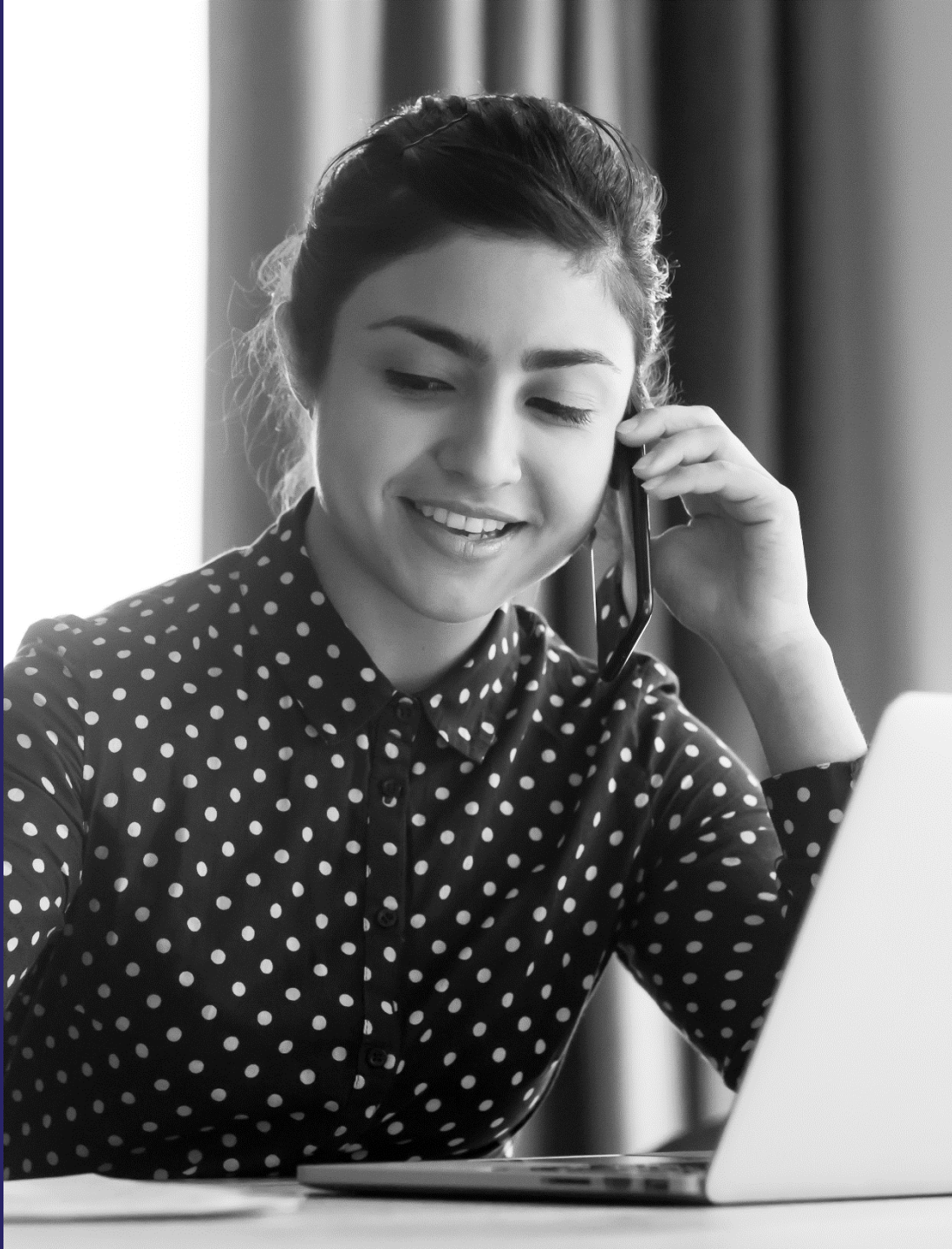
[HTTPS://PROVIDER.WELLCARE.COM/](https://provider.wellcare.com/)





The Provider Manual

- The Provider Manual is your comprehensive guide to doing business with Wellcare
- The Manual includes a wide array of important information relevant to providers including, but not limited to:
 - Network information
 - Billing guidelines
 - Claims information
 - Regulatory information
 - Key contact list
 - Quality initiatives
 - And much more!
- The Provider Manual can be found in the Provider section of the Wellcare website at www.wellcare.com/en/Georgia/Providers/Medicare



Provider Relations

- Our Provider Services department includes trained Provider Relations staff who are available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
 - Credentialing/Network status
 - Claims
 - Request for adding/deleting physicians to an existing group
- By calling Provider Services at 1-855-538-0454, providers will be able to access real time assistance for all their service needs

Provider Relations

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

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



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 Health Plan
- Advantage members may change PCPs at any time. Changes take effect on the first day of the month
- Providers should verify eligibility before every visit by using one of the below options:
 - Website: www.wellcare.com
 - 24/7 Interactive Voice Response Line - 1-855-538-0454
 - Provider Services - 1-855-538-0454
 - TTY - 711



Member ID Cards

wellcare Wellcare No Premium Essential (HMO-POS)
(H9730-005-000)
Card Effective Date: 01/01/2023

Member: **LAUREN J IPSOM**
Member ID: **22334455** Issuer: **80840** Policy #: KY159

You can see any PCP on our Network
PCP Name: ALLISON SMITH
PCP Phone: 1-606-123-4567

PCP Office Visit: \$x

MedicareRx
Prescription Drug Coverage

RXBIN: 004336
RXPCN: MEDDADV
RXGRP: 788257
Card Issued: 10/15/2022

000001



FOR MEMBERS
For questions or to change your PCP: 1-833-444-9088
Member Services: 1-833-444-9088 TTY: 711
Nurse Advice Line: 1-800-581-9952

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

FOR PROVIDERS
Provider Service: 1-855-538-0454
Avisis Vision (For Providers and Members): 1-855-469-3368
Avisis Dental (For Providers and Members): 1-888-211-9986

SUBMIT MEDICAL CLAIMS TO
Wellcare Health Plans Attn: Claims Department PO Box 31372
Tampa, FL 33631-3372
Payor ID: 14163

Your current co-pay, PCP and benefit details can be found online/mobile app:
www.wellcare.com/medicare

HMO Card Sample

PPO Card Sample

wellcare Wellcare No Premium Rx Plus Open (PPO)
(H7323-006-000)
Card Effective Date: 01/01/2023


Member: **LAUREN J IPSOM**
Member ID: **22334455** Issuer: **80840** Policy #: NC081

In Network PCP Office Visit: [\$x]
Out Of Network PCP Office Visit: [\$x]

MedicareRx
Prescription Drug Coverage

RXBIN: 004336
RXPCN: MEDDADV
RXGRP: 788257
Card Issued: 10/15/2022

000001



Medicare limiting charges apply.

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

FOR PROVIDERS
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Envolve Vision (For Providers and Members): 1-833-813-0532
Envolve Dental (For Providers and Members): 1-833-813-0532

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Your current co-pay, PCP and benefit details can be found online/mobile app:
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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:
www.wellcare.com
- Please refer to the formulary for specific types of exceptions
- When requesting a formulary exception, a Request For Medicare Prescription Drug Coverage Determination form must be submitted
- The completed form can be faxed to Envolve Pharmacy Solutions at:
1-800-977-8226



Covered Services

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines
- Lab and X-Ray
- Transportation
- Home Health Services
- Screening Services
- Dental
- Vision Services
- Hearing Services
- Behavioral Health
- Medical Equipment & Supplies
- Appropriate Cancer Screening Exams
- Appropriate Clinical Screening Exams
- Initial Preventative Physical Exam – Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatric Services

Additional Benefits

Hearing Services

- \$0 co-pay for one routine hearing test every year
- \$0 co-pay for one hearing aid fitting evaluation
- Annual amount for hearing aids (dollar coverage dependent upon plan and service area)

Dental Services

- Two Oral exams per year with no co-pay
- Two Cleanings per year with no co-pay
- One Dental X-Ray per year with no co-pays
- Annual amount for comprehensive dental benefits (dollar coverage dependent upon plan and service area)

Additional Benefits *(continued)*

Vision Services

- One routine eye exam every year
- One pair of glasses or contacts lenses every year
- \$200 to \$300 limit (dollar coverage dependent upon service area); for eyewear each year

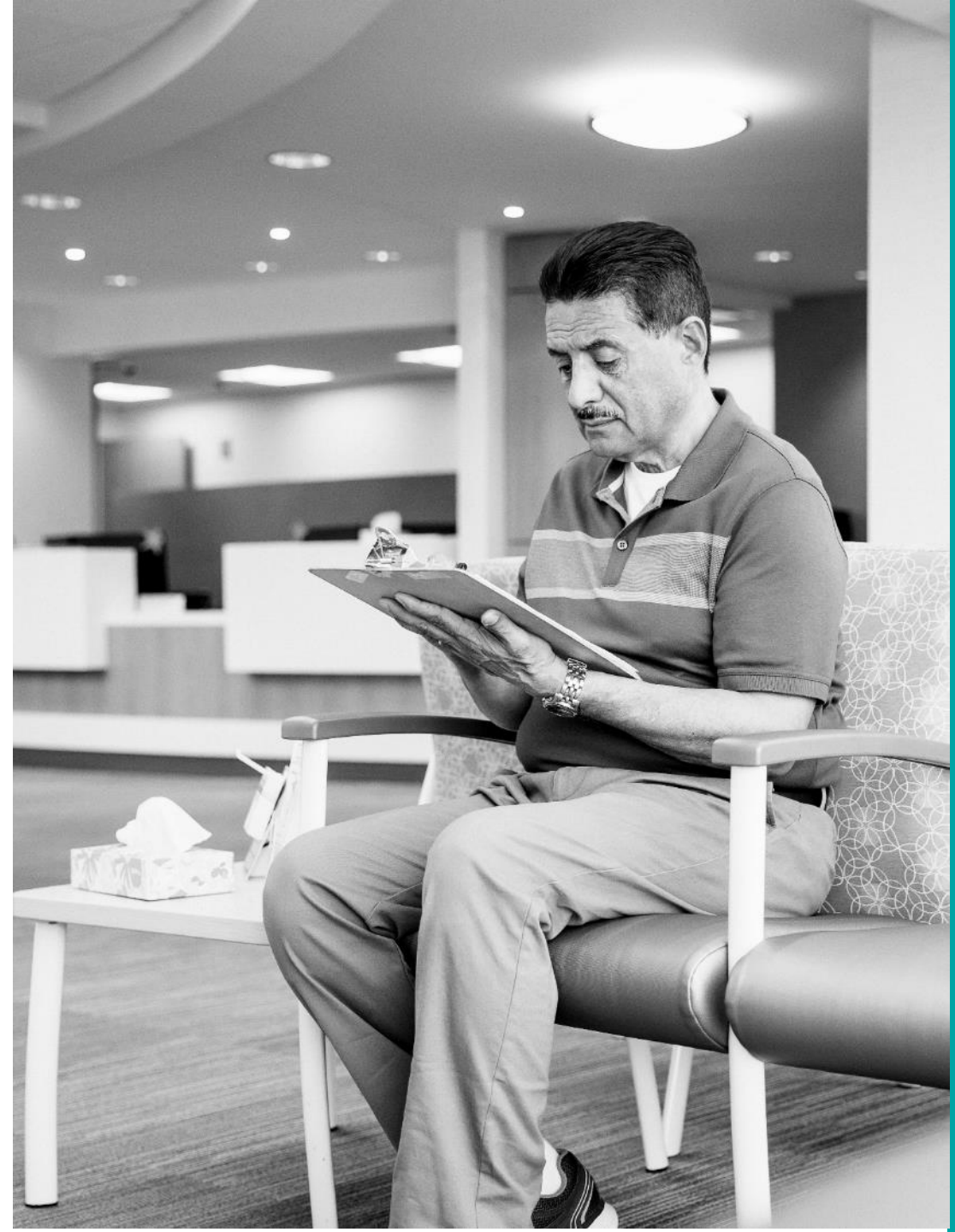
Over-the-Counter Items

- Commonly used over-the-counter items – listing available at: www.wellcare.com
- Conveniently shipped to member's home within 5 – 12 business days
- Call Member Services at 1-866-892-8340 to order items up to \$10 - \$490 per calendar quarter (dollar coverage dependent upon service area)

Additional Benefits

(continued)

- NurseWise
 - Free health information line staffed with registered nurses 24/7 to answer health questions
- Certified fitness program at specified gyms at no extra cost (coverage dependent upon service area)



Additional Services

Multi-language Interpreter Services

- Interpreter services are available at no cost to Wellcare members and providers without unreasonable delay at all medical points of contact.
- To get an interpreter, call us at 1-855-538-0454

Non-Emergency Transportation

- Covered for a specified number (dependent upon the member's service area) of one-way trips per year, to approved locations
- Schedule trips 48 hours in advance using the plan's contracted providers
- Contact us at 1-888-822-6135 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: <https://provider.wellcare.com/>

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

Prior 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

Prior Authorization for COVID-19

COVID-19 Testing, Screening and Vaccinations

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

Prior Authorization for COVID-19

COVID-19 Treatment Related Services

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

Prior Authorization for COVID-19

Telehealth Services

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



Out-of-Network Coverage

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

Medical Necessity Determination

- When medical necessity cannot be established, a peer-to-peer conversation is offered
- Denial letters will be sent to the member and provider
- The clinical basis for the denial will be indicated
- Member appeal rights will be fully explained

Preventive Care & Screening Tests



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

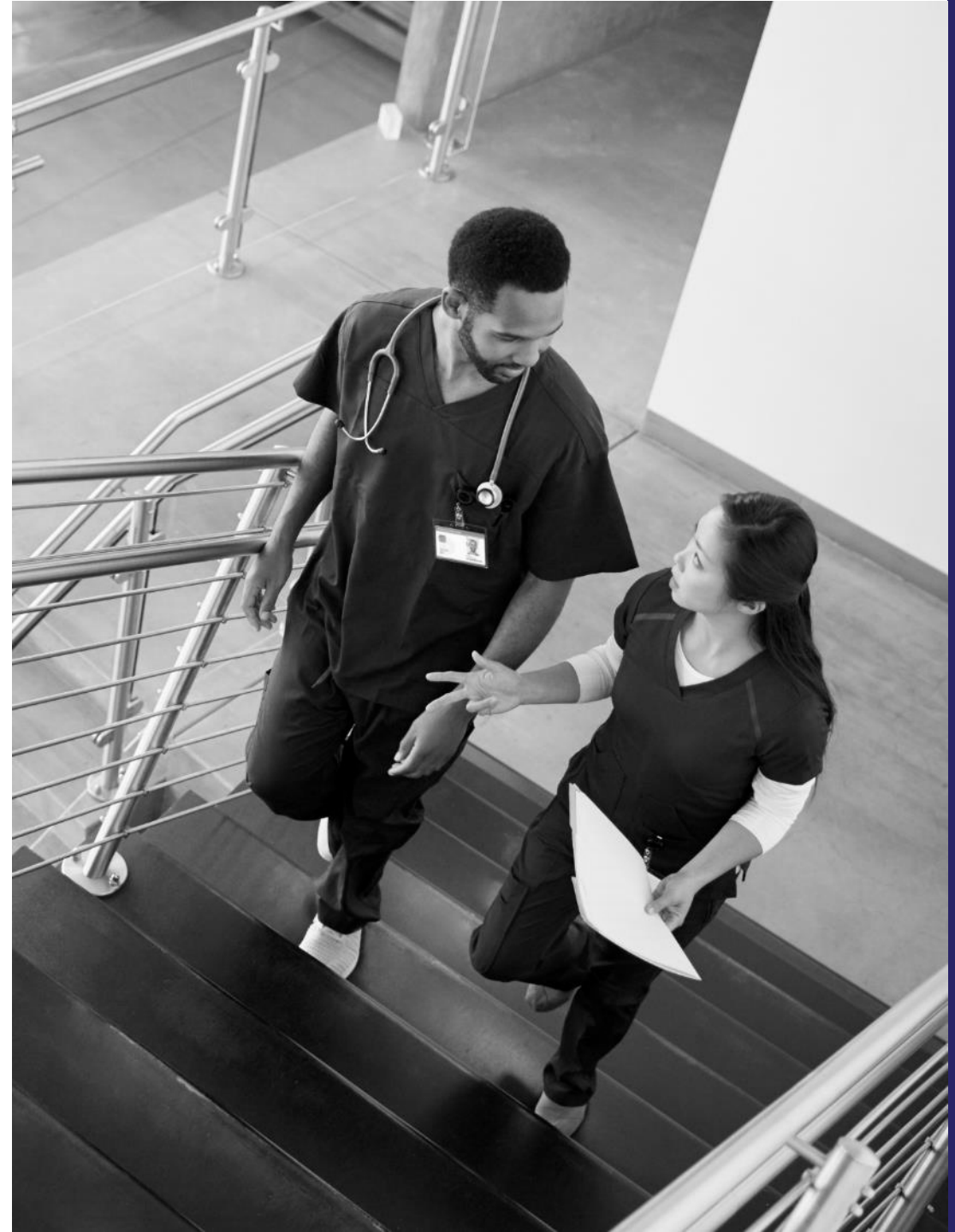
Model of Care

(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 member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at 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.

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 health care 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 wellbeing (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

www.wellcare.com



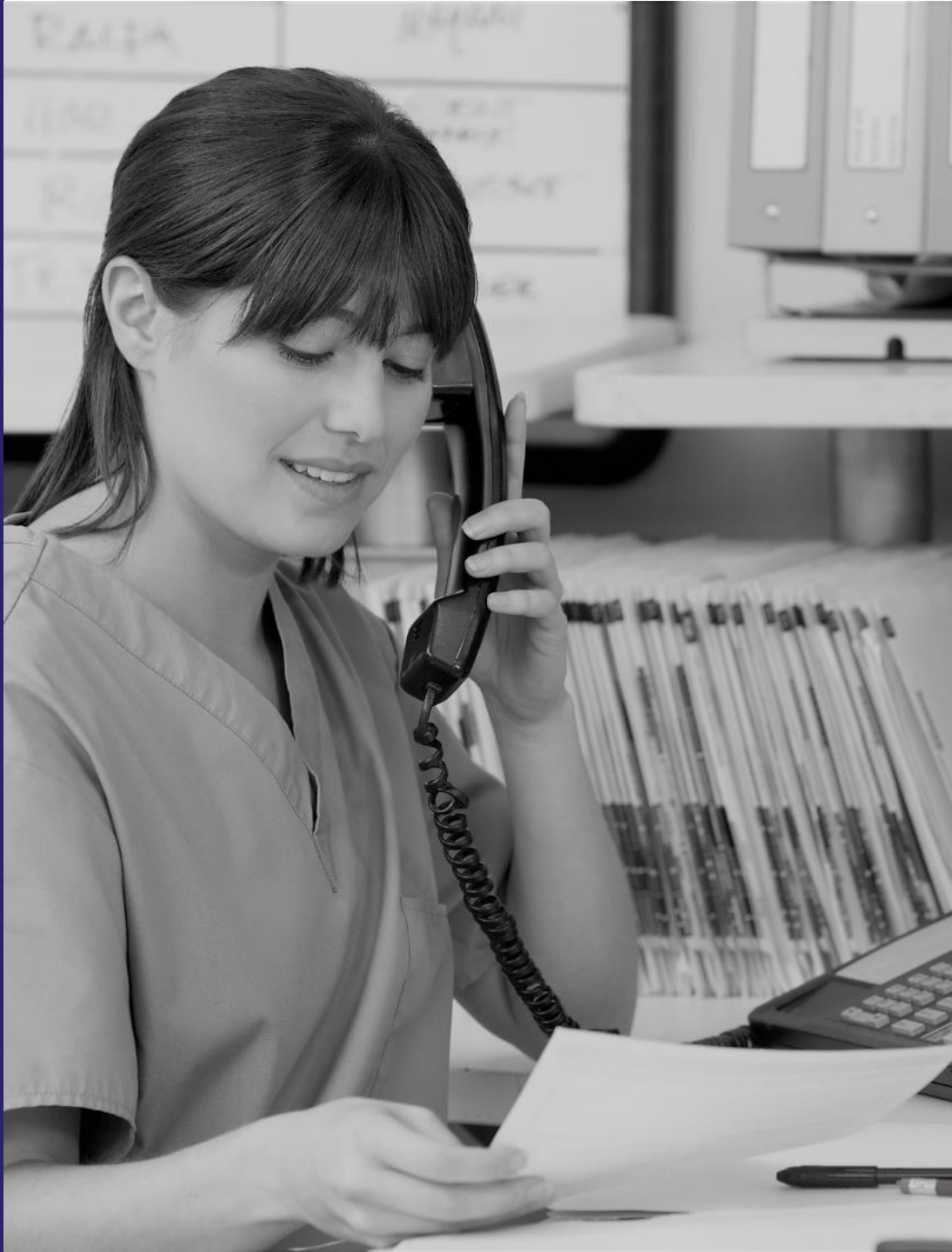
Public Provider Website

Through 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.wellcare.com/en/Georgia/Providers/Medicare



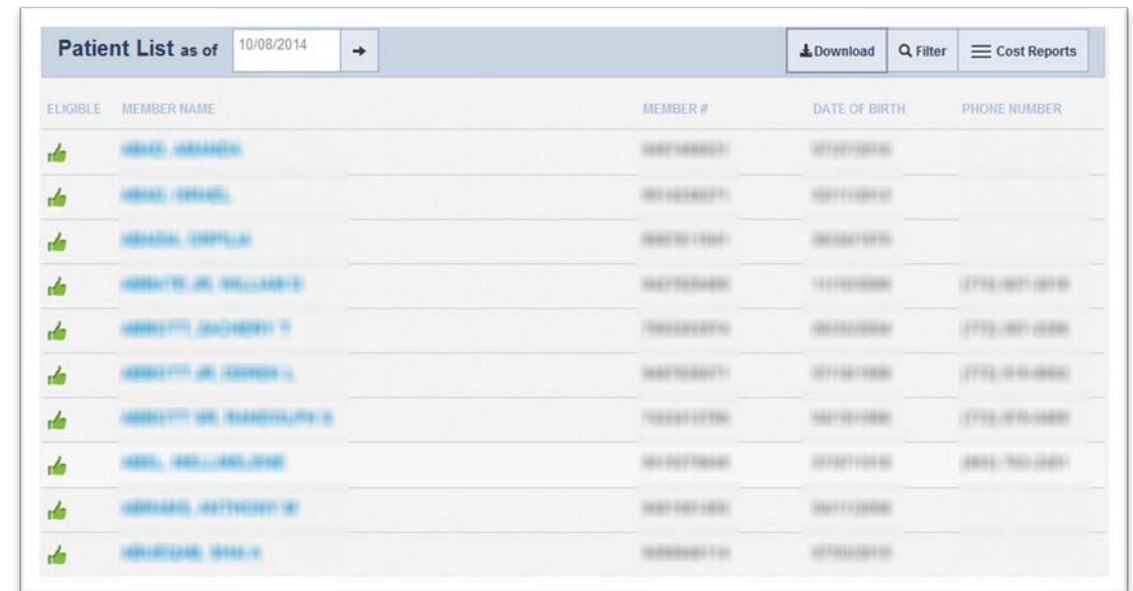
Updating Your Data

- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 - Login to the Secure Provider Portal at <https://provider.wellcare.com/>
 - From the main tool bar, select “Account Details”
 - Select the provider whose data you want to update
 - Choose the appropriate service location
 - Make appropriate edits and click “Save”

Primary Care Provider Reports

Patient List

- Located on the Secure Provider Portal at <https://provider.wellcare.com/>
- Includes member's name, ID number, date of birth, and telephone number
- Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address



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	(772) 972-2222
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PCP Cost Reports

Members With Frequent ER Visits

- Located on the Secure Provider Portal at <https://provider.wellcare.com/> This report includes members who frequently visit the ER on a monthly basis
- The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis, and cost



PCP Cost Reports *(Continued)*

High Cost Claims

- Located on the Secure Provider Portal at <https://provider.wellcare.com/>
- This report includes members with high cost claims
- The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost



PCP Cost Reports *(Continued)*

Rx Claims Report

- Located on the Secure Provider Portal at <https://provider.wellcare.com/> This report includes members with pharmacy claims on a monthly basis
- The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.), and cost

Network Partners





Partner and Vendors

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	866-214-2569 www.radmd.com
Vision Services	Envolve Vision Benefits	1-800-334-3937 www.envolvevision.com
Dental Services	Envolve Dental	www.envolvedental.com
Pharmacy Services	Envolve Pharmacy Solutions	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)



DME and Lab Partners

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

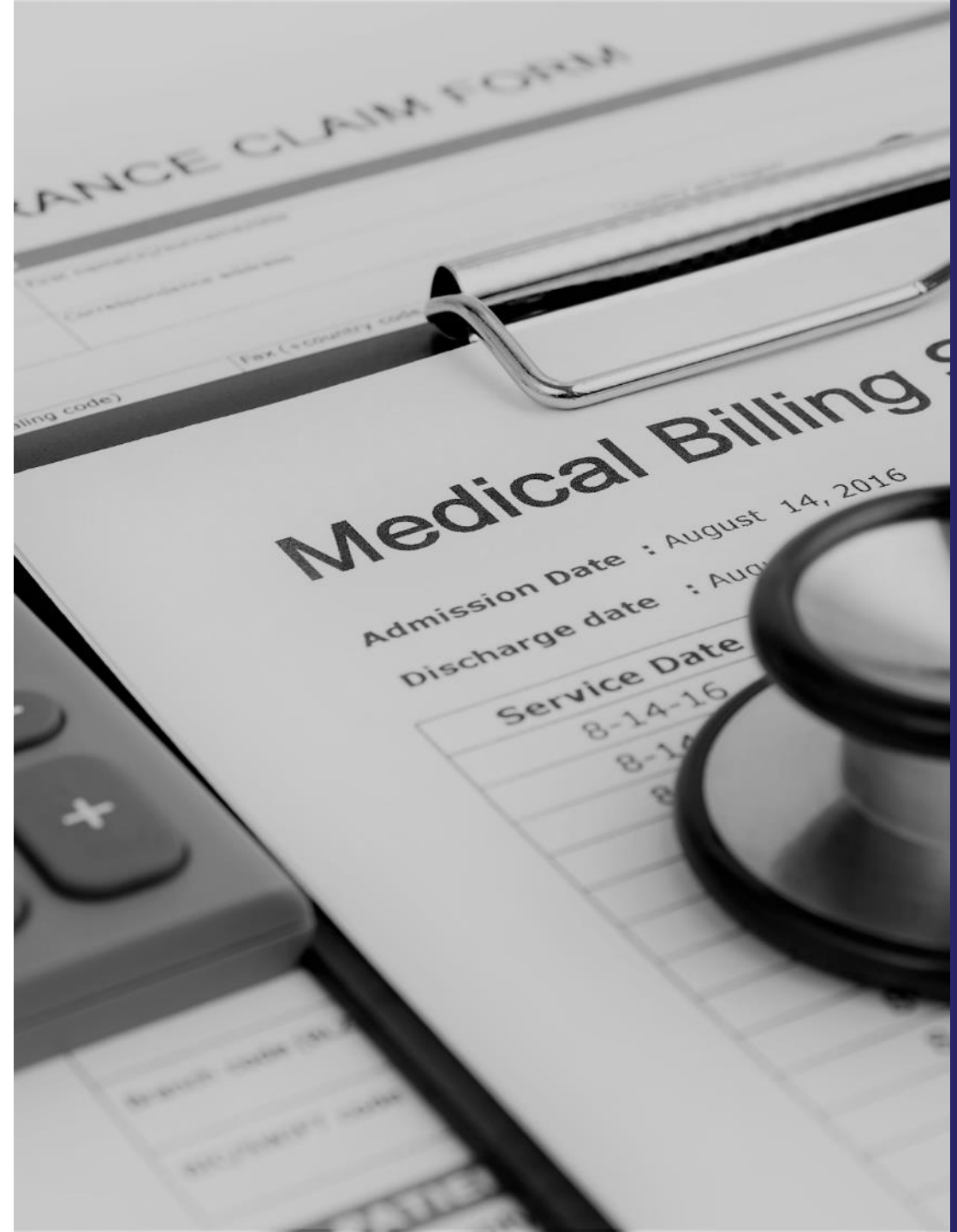
Lab	
Bio Reference	Diatherix Laboratories, LLC
Sequenome Center	Ambry Genetics Corp.
MD Labs	Natera, Inc.
Lab Corp	Myriad Genetic Laboratories
Quest	Eurofins NTD
CPL	

Billing Overview



Electronic Claims Transmission

- When possible, we recommend utilizing Electronic Data Interchange (EDI) to submit claims and attachments for payment
- EDI allows for a faster processing turn around time than paper submission
- Wellcare partners with six clearinghouses for submission:
 - Emdeon – Payer ID 68069
 - Gateway
 - Availity/THIN
 - SSI
 - Medavant
 - Smart Data Solution





Need EDI Support?

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

www.wellcare.com

For more information about EDI, contact:

Wellcare

c/o Centene EDI Department

E-mail: EDIBA@centene.com

Claims Submission Timelines

- Medicare Advantage claims need to be mailed to the following billing address:
Wellcare
Attn: Claims Department
P.O. Box 31224
Tampa, FL 33631-3224
- Participating providers have 180 days from the date of service to submit a timely claim
- All requests for reconsideration or claim disputes must be received within 90 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.

Submit reconsiderations or disputes to:

Wellcare

Attn: Reconsiderations

P. O. Box 4000

Farmington, MO 63640-4000

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 health care in the event they become unable to make decisions on their own behalf. Examples include:
 - Living will
 - Health care 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

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
- 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

Medicare Reporting

- 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:
 - **Annette Zerbe, GA Vice President of Compliance**
- To report suspected fraud, waste, or abuse in the Medicare program, please use one of the following avenues:
 - Office of Inspector General (HHS-OIG): 1-800-447-8477/ TTY: 1-800-377-4950
 - Fax: 1-800-223-8164
 - NBI MEDIC: 1-877-7SafeRx (1-877-772-3379)
 - Email: www.OIG.HHS.gov/fraud or HHSTips@oig.hhs.gov
 - Medicare's GA Fraud Hotline: 1-866-685-8664

CMS Mandatory Trainings



CMS Mandatory Training

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
- General Compliance (Compliance): Within 90 days of joining Wellcare and annually thereafter
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Wellcare and annually thereafter

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:
<https://provider.wellcare.com/>

The screenshot shows the Wellcare website interface. At the top, there is a navigation bar with the Wellcare logo, a search bar, and links for Login/Register, Contact Us, and Help. A dropdown menu for 'Georgia' is visible. Below the navigation bar, there are links for 'Need a Plan', 'Members', 'Providers', and 'Corporate'. A prominent teal banner reads 'Medicare Providers' with a sub-link 'Providers / Medicare Overview'. Below this banner, there are two informational boxes: one for Peach State Health Plan members transitioning to Wellcare of Georgia in 2023, and another for Special Supplemental Benefits for the Chronically Ill - Attestation process. The main content area is titled 'Overview & Resources' and contains a paragraph about Wellcare of Georgia's commitment to high-quality, cost-effective health care. A 'Resources' section is also visible, with a list of links on the right side: Overview, Claims, Authorizations, Forms, Clinical Guidelines, Pharmacy, and Quality.

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.

The screenshot shows the CMS.gov website with the Medicare Learning Network (MLN) Provider Compliance page. The page features a navigation menu with categories like Medicare, Medicaid/CHIP, and Private Insurance. The main content area is titled "MLN Provider Compliance" and includes a "Fast Fact" section. The fast fact discusses the Comprehensive Error Rate Testing (CERT) program and the importance of electronic medical records and ordering systems. It also provides links to signature requirements and other resources. A "Downloads" section at the bottom lists educational products for PDF download.

MLN Provider Compliance

Fast Fact

Medicare review contractors, such as the Comprehensive Error Rate Testing (CERT) program, continue to find errors for missing or inadequate signatures on progress notes, office notes, and orders for services and supplies.

Electronic medical records and ordering systems are accepted by CMS if documentation received is otherwise in compliance with CMS record keeping requirements. With electronic systems, CMS review contractors may request a copy of a protocol, policy or procedure that describes how electronic health records are signed and dated in order to verify that the documentation has been electronically signed by the ordering/treating professional. Providers need a system and software products that are protected against modification.

For more information on signature requirements, refer to [Pub 100-08 Chapter 3, Section 3.3.2.4 - Signature Requirements](#). E-Prescribing must follow specific requirements; see Section 3.3.2.4.F. Please also visit the [CERT Outreach & Education Task Forces web page](#).

[View previous fast facts](#)

The Medicare Learning Network® (MLN) Provider Compliance page contains educational products that inform health care professionals on how to avoid common billing errors and other improper activities when dealing with various CMS Programs. CMS' claim review program's overall goal is to reduce improper payment error by identifying and addressing coverage and coding billing errors. Since 1996, CMS has implemented several initiatives to prevent improper payments before a claim is processed, and to identify, and recoup improper payments after the claim is processed.

The Downloads section contains MLN products, MLN Matters® Articles, and the "Archive of Medicare Quarterly Provider Compliance Newsletters" which have been designed to provide education on common billing errors and other improper activities. These lists, as well as other information in the Downloads and Related Links section, are updated as new products and articles are developed and existing products and articles are revised.

If you would like to contact the MLN, please email us at MLN@cms.hhs.gov.

Downloads

[Medicaid Program Integrity, Safeguarding Your Medical Identity Educational Products \[PDF, 193KB\]](#)

[Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training \[PDF, 131KB\]](#)

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.



Q + A