



Meet Wellcare By Meridian

2026 Provider Orientation

Agenda

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

Plan Overview



Meet Wellcare By Meridian

Dual Eligibility Product

- **Welcome to the Wellcare By Meridian Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)**, administrated by Centene Corporation. Our FIDE-SNP product is designed to deliver seamless, coordinated care to individuals eligible for both Medicare and Medicaid, ensuring access to the full spectrum of covered services.
- **Our Meridian Medicare-Medicaid Plan (MMP) will sunset on December 31, 2025.**
- **Wellcare By Meridian will offer coordinated delivery of Medicare and Medicaid benefits**—including long-term services and supports (LTSS) and behavioral health services—through a single managed care organization, like the Meridian Medicare-Medicaid Plan (MMP).
- We believe this change makes things easier for members, brokers, and providers.
- Our goal is to ensure your patients receive the best care.

The Strength of Wellcare

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

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

1.1M

Medicare members across **32 STATES**

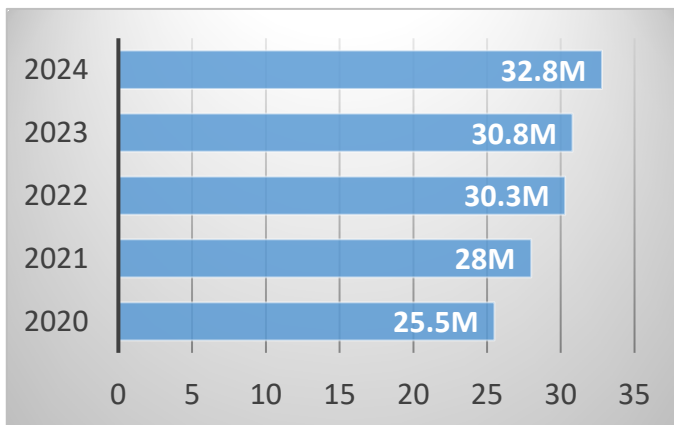
358K

Special Needs Plan members across **30 STATES**

4.1M

Prescription Drug Plan members across **50 STATES**

Total Medicare Advantage Members Nationwide



7.1%

Avg. YoY Growth Medicare Advantage Enrolled

32.8M

Medicare Advantage enrolled members nationwide

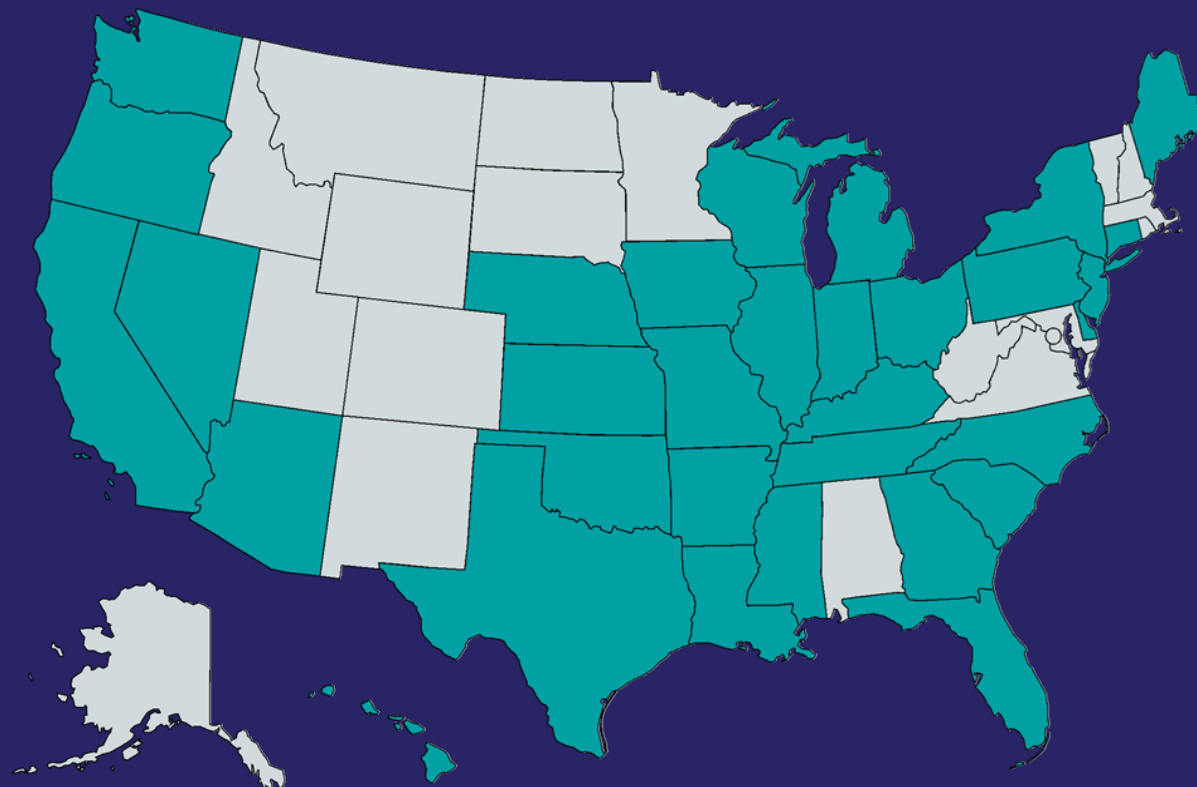
50.2%

Medicare Advantage Penetration Rate nationwide

1.1 Million Medicare Members






#6

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 in-network prescription drugs
-  **Extra benefits that aren't covered by Medicare Part A or Part B (Original Medicare)**

Confidential and Proprietary Information

Additional Services

-  **Telehealth** – Doctors are available by teleconference, day and night and on weekends and holidays.
-  **Free In-Home Support & Chore Services** – Available services to keep members' homes safe and clean, including help with light cleaning, household chores, and meal prep.
-  **Free Transportation** – Free trips to doctor's offices and pharmacies with some plans eligible for non-medical transportation.
-  **OTC Allowances** – Members receive annual over-the-counter (OTC) allowances and pay \$0 for certain OTC products, depending on the plan.
-  **24-Hour Nurse Advice Line** – Speak with a live nurse, 24 hours a day, any day of the year.
-  **Digital Social Support Platform** – Focuses on members behavioral health and social support.



Our Whole Health Approach

Wellcare provides complete continuity of care to Medicare members.

This includes:

- Integrated coordination care
- Care management
- Co-location of behavioral health expertise
- Integration of pharmaceutical services with the PBM
- Additional services specific to the beneficiary needs

Our approach to care management facilitates the integration of community resources, health education, and disease management.

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

Dual Eligibility Products

In 2026, Wellcare By Meridian will implement new Aligned Integrated Plans (AIP) for members that are enrolled in both Medicare and Medicaid. This is an exciting evolution of our product offerings for these members, and we want to ensure that our provider partners are aware of the key details of this change.

What is AIP?

- An Applicable Integrated Plan (AIP) delivers Medicare and Medicaid coverage through a single health insurance product.
AIPs streamline the insurance experience for both members and providers.

About Dual-Eligible Members



Dual-eligible members may be more vulnerable and have more complex care needs than members who are enrolled in only Medicare or Medicaid.



Factors that can lead to dual-eligibility include:

Demographic data including age

Income level

Disability status

Diagnosed clinical conditions

Social determinants of health



Awareness of which factors apply to your dual-eligible patients is critical to understanding their care needs.

Clinical Best Practices

Engage the patient

- Outreach to members without visit, or in need of follow-up care
- Encourage regular preventive care
- Initiate needed screenings and routine monitoring
- Keep track of medication adherence

Take advantage of value-added services such as:

- Dental and vision coverage
- Hearing exams/hearing aids
- Transportation benefits
- Telehealth
- Fitness programs
- If the member is eligible:
- Meal programs
- In-home support

Operational Best Practices

Eligibility Verification

AIP

Single, integrated ID card. Primary ID will be the Medicare ID. Providers will not need the Medicaid ID number.

Authorizations

AIP

Authorization Submission

Providers will submit a single authorization with a unified process, single review and decision.

Authorization Inquiry

Auth status inquiries will be combined into a single view using the single auth number.

Authorization Appeal

Providers will submit a single appeal with a unified process, single review and decision.

Claims

AIP

Claims Submissions

Providers will submit one claim for both Medicare and Medicaid and will get one claim number for reference.

Claims Inquiry

Claim status inquiries will be combined into a single view using the single claim number.

Claims Appeal

Provider will submit a single appeal and will have a single claim number for status inquiries.

Payments and EOPs

AIP

Providers will receive a single EOP with the detail for both Medicare and Medicaid payment amounts.



Key Provider Resources

Wellcare By Meridian Information Highlights

[Wellcare.ILmeridian.com/for-providers](https://wellcare.ilmeridian.com/for-providers) is the provider section home page with links to key resources, provider updates, communications, and resources.

PHONE

[1-844-536-2175](tel:1-844-536-2175) (TTY 711)

TTY/TDD

[1-855-538-0454](tel:1-855-538-0454) (TTY 711)

WEB

wellcare.ilmeridian.com

Provider Manual

- The Provider Manual is your comprehensive guide to doing business with Wellcare By Meridian
- 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 Meridian Provider Manual is a digital resource designed to provide comprehensive, easy-to-navigate guidance for participating providers
 - Access the manual at go.wellcare.com/ILMeridian



Provider Engagement

- Our Provider Engagement team includes trained staff available to respond quickly and efficiently to all provider inquiries or requests including, but not limited to:
 - Credentialing/Network status
 - Claims
 - Request for adding/deleting physicians to an existing group
- By calling Provider Services at 1-844-536-2175 (TTY: 711).
- Providers can access real-time assistance for all their service needs

Provider Engagement

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

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



Availity Essentials

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. For providers new to Availity Essentials, getting their Essentials account is the first step toward working in 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 on behalf of their organization.
- Administrators can register with Availity Essentials here:
 - [Availity.com/documents/learning/LP_AP_GetStarted](https://www.availity.com/documents/learning/LP_AP_GetStarted)
 - Providers that need assistance with registration can call Availity Client Services at **1-800-AVAILITY (282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. ET.
- For general questions, providers can reach out to their Provider Engagement representative.

Membership, Benefits, & Additional Services



Membership in Wellcare By Meridian

Wellcare By Meridian offers a comprehensive benefit package to members who are eligible for Medicare and full Medicaid benefits. Covered services are based on medical necessity and must meet professionally accepted standards of care. The plan integrates Medicare and Medicaid benefits, including LTSS, behavioral health, and preventive care.

Wellcare By Meridian Member ID Cards



Wellcare Meridian Dual Align (HMO D-SNP)

Wellcare Meridian Dual Align is a plan that contracts with both Medicare and Illinois Medicaid.



Member Name: Jamie Sample

Member ID: C12345678-01

Effective Date: 01/01/2026

MEMBER CANNOT BE CHARGED

Copays: PCP/Specialist: \$0 ER: \$0

H6971 001

Medicare_{Rx}
Prescription Drug Coverage

RXBIN: 610014

RXPCN: MEDDPRIME

RXGRP: 2FFA



Member Services / Nurse Advice Line 1-844-536-2180 (TTY: 711)

CARES Hotline for Behavioral Health Crisis 1-800-345-9049 (TTY: 711)

Vision: Premier Eye Care 1-855 865-9724 (TTY: 711)

Dental: Centene Dental Services 1-855-586-1415 (TTY: 711)

Provider Services / Pharmacy Prior Auth 1-844-536-2175 (TTY: 711)

Pharmacist Only 1-833-750-4200 (TTY: 711)

Send Claims To: Wellcare By Meridian Attn: Claims P.O. Box 9700
Farmington, MO 63640-0700 Payor ID: 68069

Part D Claims: Wellcare By Meridian Attn: Medicare Part D Member
Reimbursement Dept. P.O. Box 31577 Tampa, FL 33631-3577

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

Website: go.wellcare.com/MeridianIL

Pharmacy Formulary

- The formulary is available at [List of Drugs \(Formulary\)](#).

Please refer to the formulary for specific types of exceptions.

- When requesting a formulary exception, a *Request for Medicare Prescription Drug Coverage Determination* form must be submitted. The form can be found on 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
- 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 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 1-877-374-4056 (TTY: 711)

Non-Emergency Transportation

- Covered for a specified number of one-way trips per year, to approved locations (dependent upon the member's service area)
- Schedule trips 72 hours in advance using the plan's contracted providers
- Contact us at [1-866-892-8340](tel:1-866-892-8340) to schedule non-emergency transportation

Medical Home & Prior Authorization

Primary Care Physicians (PCP)

- **PCPs serve as a “medical home” and provide:**
 - 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 Portal Login](#)

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

Prior Authorization Requirements

Prior authorization is required for:

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

The authorization look-up tool can be found here:
[wellcare.com/illinois/providers/authorization-lookup](https://www.wellcare.com/illinois/providers/authorization-lookup)

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



Inpatient Authorization Request Form

*Indicates a required field

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

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

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

Requestor Name:		Fax*#:	Phone*#:
MEMBER INFO (Please Print)			
Wellcare ID*:		Medicaid/Medicare ID:	
Last Name*:	First Name, MI*:	Date of Birth*: / /	
REQUESTING PROVIDER			
Wellcare ID:		NPI/Tax ID*:	
Provider Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
FACILITY (Please Print)			
Wellcare ID:		NPI/Tax ID*:	
Provider/Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
ATTENDING PROVIDER (Please Print)			
Wellcare ID:		NPI/Tax ID*:	
Provider/Facility Name*:		Address:	
City, State, ZIP:		Fax*:	Phone:
DIAGNOSIS CODES*			
ICD-10:	ICD-10:	ICD-10:	ICD-10:
REQUESTED SERVICES			
<input type="checkbox"/> Observation <input type="checkbox"/> Inpatient Admission <input type="checkbox"/> LTACH <input type="checkbox"/> SNF/Sub-Acute Rehab <input type="checkbox"/> Inpatient Rehab <input type="checkbox"/> Waitlist <input type="checkbox"/> ICF <input type="checkbox"/> Other (please specify): _____			
Place of Service (check one): <input type="checkbox"/> ALF (13) <input type="checkbox"/> Observation Hospital (22) <input type="checkbox"/> Inpatient (21) <input type="checkbox"/> SNF (31) <input type="checkbox"/> Nursing Facility (32)			
Date of Admission*: ___ / ___ / ___		Is this a Level of Care Change (OBS to INP)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PROCEDURE CODE(S)*		PROCEDURE CODE(S)	
Description		Description	
CPT Code:		CPT Code:	
CPT Code:		CPT Code:	

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Out-of-Network Coverage

Prior authorization is required for out-of-network services, except:

- Emergency care
- Urgently needed care when the network provider is unavailable (usually due to out-of-area)
- Kidney dialysis at Medicare-certified dialysis centers, when the member is temporarily out of the service area

Medical Necessity Determination

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

Preventive Care & Screening Tests

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

Dual-Eligible Special Needs Plans (DSNP)

Model of Care

- Wellcare's Model of Care plan delivers our integrated care management program for members with special needs
- Applies to Dual Special Needs Plan (D-SNP) and Chronic Condition Specials Needs Plan (C-SNP) members
- The goals of our Model of Care are:
 - Improve access to medical, behavioral health, and social services
 - Improve access to affordable care
 - Improve coordination of care through an identified point of contact
 - Improve transitions of care across healthcare settings and providers
 - Improve access to preventive health services
 - Assure appropriate utilization of services
 - Assure cost-effective service delivery
 - Improve beneficiary health outcomes

Model of Care Elements

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

Model of Care Process

- We contact every SNP member to complete a Health Risk Assessment (HRA) within 90 days of enrollment and annually thereafter, or more frequently if there is a significant change in health status.
- The HRA collects information about the member's medical, psychosocial, cognitive, functional and social determinant needs, and medical and behavioral health history. The HRA is scored for risks to assist with triage.
- Member's HRA risk level helps to determine the appropriate level of care management and composition of an Interdisciplinary Care Team (ICT).
- At a minimum, every member is provided an annual Individualized Care Plan (ICP) outlining health goals and interventions.
- Each member receives an annual in-person or virtual face-to-face encounter with a provider or Wellcare care coordination staff to support care management and coordination.

Model of Care Process *(continued)*

- Wellcare values our partnership with our physicians and providers.
- The Model of Care requires all of us to work together to benefit our members by:
 - Enhanced communication between members, providers, and Wellcare care management staff.
 - Interdisciplinary Care Team (ICT) approach tailored to the member's medical, behavioral, and social needs.
 - Comprehensive coordination with all care partners including PCPs, specialists, and community supports.
 - Support for the member's preferences and goals as is documented in the Individualized Care Plan (ICP).
 - Reinforcement of the member's connection with their PCP and medical home.

Medicare Star Ratings

Medicare Star Ratings

What Are CMS Star Ratings?

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

Star Rating Program Measures

Part C

1. Staying healthy through preventive screenings, tests, and vaccinations
2. Managing chronic conditions such as diabetes, hypertension, and cardiovascular disease
3. Member experience with the health plan
4. Member complaints, problems getting services, and improvement in the health plan's performance
5. Health plan customer service

Part D

1. Drug plan customer service
2. Member complaints and changes in the drug plan's performance
3. Member experience with the health plan including access to care and satisfaction
4. Drug safety, adherence, and accuracy of drug pricing

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 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

wellcare.com/illinois/providers

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:
go.wellcare.com/MeridianIL

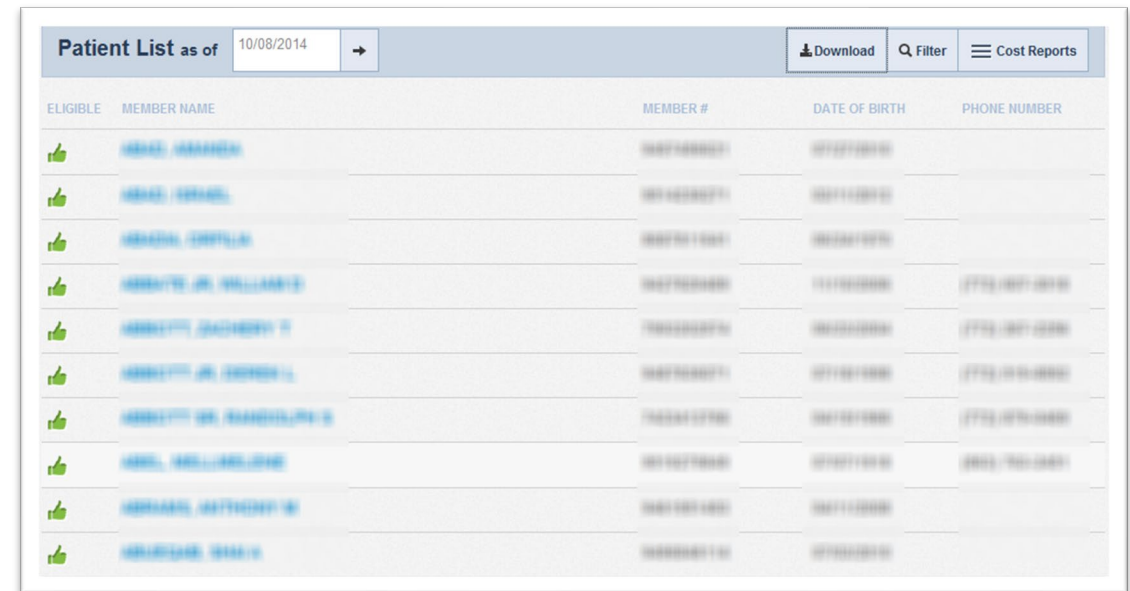


- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 - Login to the Secure Provider Portal at ilmeridian.com/providers/login.html
 - From the main tool bar, select “Account Details”
 - Select the provider whose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

Primary Care Provider Reports

Patient List

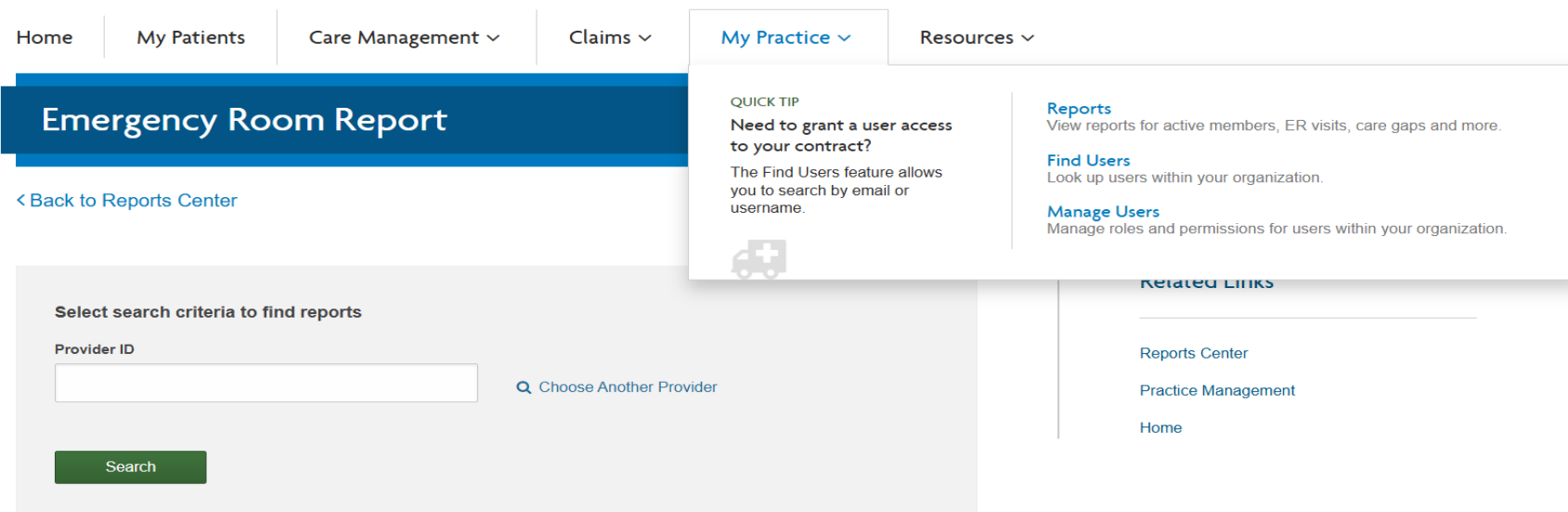
- Located on the Secure Provider Portal at ilmeridian.com/providers/login.html
- Includes member's name, ID number, date of birth, and telephone number
- Available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, 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) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(772) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(772) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(772) 497-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	(888) 760-0000
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	
👍	MEMBER NAME	MEMBER #	DATE OF BIRTH	

Members With Frequent ER Visits

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



The screenshot shows the 'Emergency Room Report' page in a provider portal. The navigation bar includes 'Home', 'My Patients', 'Care Management', 'Claims', 'My Practice', and 'Resources'. The main heading is 'Emergency Room Report' with a blue background. Below the heading is a link to '< Back to Reports Center'. A search section titled 'Select search criteria to find reports' contains a 'Provider ID' input field, a 'Search' button, and a 'Choose Another Provider' link. A 'QUICK TIP' box is overlaid on the page, stating: 'Need to grant a user access to your contract? The Find Users feature allows you to search by email or username.' To the right of the tip is a 'Reports' section with links for 'Find Users' and 'Manage Users'. A 'Related Links' section at the bottom right lists 'Reports Center', 'Practice Management', and 'Home'.

PCP Cost Reports *(Continued)*

High Cost Claims

- Located on the Secure Provider Portal at ilmeridian.com/providers/login.html
- 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

PCP Cost Reports *(Continued)*

Rx Claims Report

- Located on the Secure Provider Portal at ilmeridian.com/providers/login.html
- 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

Network Partners

Partners & Vendors



Service	Specialty Company/Vendor	Contact Information
Physical Therapy Services	WellCare	wellcare.com/illinois
High Tech Imaging Services	Evolvant	1-800-424-5388 my.newcenturyhealth.com
Vision Services	Premier Eyecare	1-855-865-9724 premiereyecare.net
Dental Services	DentaQuest	1-844-822-8111
Pharmacy Services	Express Scripts	express-scripts.com/rx <u>1-833-750-0201</u>

DME & Lab Partners

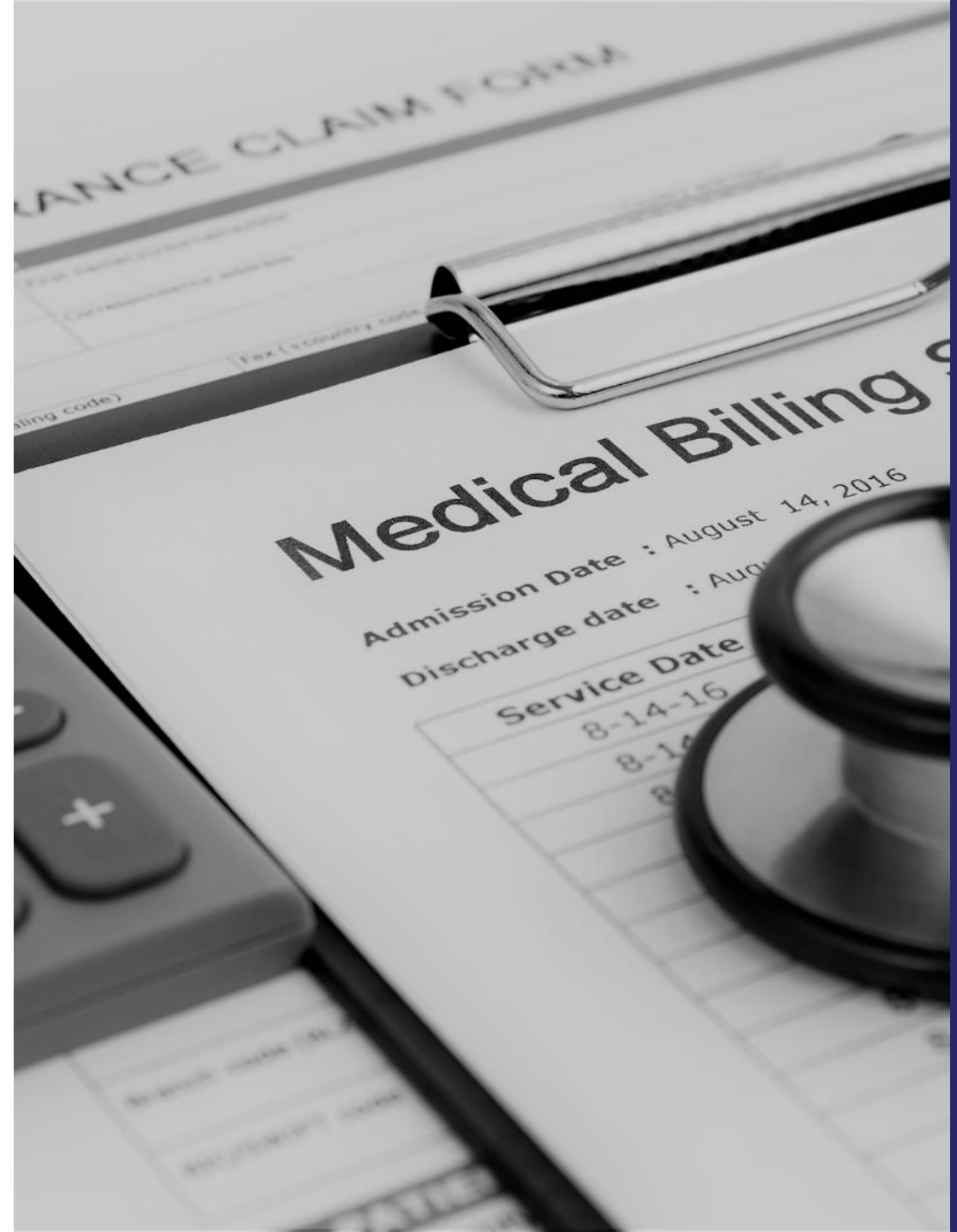
DME	
180 Medical	J&B Medical
ABC Medical	KCI
American Home Patient	Lincare
Apria	Hanger Prosthetics and Orthotics
Breg	National Seating & Mobility
CCS Medical	Numotion
Critical Signal Technologies	Shield Healthcare
DJO	St. Louis Medical
EBI	Tactile Medical
Edge Park	Zoll

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

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



Claims Submission Timelines

Wellcare By Meridian claims should be mailed to: Wellcare By Meridian

P.O. Box 9700

Farmington, MO 63640-0700

- Contracted providers and non-contracted providers: Submitters have 60 calendar days from the Explanation of Payment (EOP) to request reprocessing by submitting a corrected claim.
- Medicaid only services: Submitters have 90 calendar days from the Explanation of Payment (EOP) to request reprocessing by submitting a corrected claim.

Claims Payment

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may **not** bill members for Covered Services denied due to lack of authorization unless the member was informed in writing beforehand and agreed to pay.
- Dual-eligible members with QMB/QMB+ status must not be balance billed for Medicare Parts A and B cost-share amounts. Providers must accept Wellcare's payment as payment in full.
- Providers may **not** balance bill members for any differential.

D-SNP Operational Best Practices

Eligibility Verification

AIP

Single, integrated ID card. Primary ID will be the Medicare ID. Providers will not need the Medicaid ID number.

Authorizations

AIP

Authorization Submission

Providers will submit a single authorization with a unified process, single review, and decision.

Authorization Inquiry

Auth status inquiries will be combined into a single view using the single auth #

Authorization Appeal

Providers will submit a single appeal with a unified process, single review, and decision.

D-SNP Operational Best Practices, cont.

Claims	
	AIP
Claims Submissions	Providers will submit one claim for both Medicare and Medicaid and will get one claim number for reference
Claims Inquiry	Claim status inquiries will be combined into a single view using the single claim number
Claims Appeal	Provider will submit a single appeal and will have a single claim number for status inquiries

Payments and EOPs
AIP
Providers will receive a single EOP with the detail for both Medicare and Medicaid payment amounts

Electronic Funds Transfer (EFT) Electronic Remittance Advice (ERA)

- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly.
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Providers can register using PaySpan's enhanced Provider registration process at payspanhealth.com. For support, contact Providersupport@payspanhealth.com or call 1-877-331-7154.



Coding Auditing & Editing

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

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

Claims Reconsideration & Disputes

Requests for payment disputes must be filed within 90 calendar days of the date of this EOP (or as outlined in your contract).

Payment disputes should be submitted via the secure provider portal or by mail to the following address:

Wellcare By Meridian
Attn: Claim Dispute
P.O. Box 9700
Farmington, MO 63640-0700
Fax: 1-866-201-0657

Meaningful Use: Electronic Medical Records (EMR)

Meaningful Use

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

(Incentive programs may be available)

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

Fraud, Waste & Abuse

Fraud, Waste & Abuse

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

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
- Detection tools have been developed to identify patterns of healthcare service use, including overutilization, unbundling, upcoding, misuse of modifiers, and other common schemes.
- Detection through data analytics and medical records review.
- Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ), and Medicaid Fraud Control Unit (MFCU).
- Correcting fraud, waste, or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan.

Fraud, Waste & Abuse *(continued)*

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

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

Fraud, Waste & Abuse *(continued)*

Benefits of stopping fraud, waste, and abuse:

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

Fraud, Waste & Abuse *(continued)*

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

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



Fraud, Waste & Abuse *(continued)*

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

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- U.S. Criminal Codes

Fraud, Waste & Abuse *(continued)*



- Suspected fraud, waste, and abuse can be reported anonymously
 - via Wellcare's hotline at **1-866-685-8664** or by emailing the Compliance Officer at Special_investigations_Unit@centene.com
 - or directly to the Office of Inspector General (OIG) or NBI MEDIC. Protections are in place for whistleblowers
- 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: [OIG.HHS.gov/fraud](https://oig.hhs.gov/fraud) or HHSTips@oig.hhs.gov
 - Medicare's Illinois Fraud Hotline: 1-800-HHS-TIPS (1-800-447-8477)
 - Email: [OIG.HHS.gov/fraud](https://oig.hhs.gov/fraud) or HHSTips@oig.hhs.gov

CMS Mandatory Trainings

CMS Mandatory Trainings

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

- Model of Care (MOC): For DSNP only. Within 30 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 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 at:

[wellcare.com/Wellcare/Illinois/Providers/Medicare/Training](https://www.wellcare.com/Wellcare/Illinois/Providers/Medicare/Training)

The screenshot displays the Wellcare website interface. At the top, the Wellcare logo is on the left, and navigation links for 'Portal Login and Register', 'Contact Us', 'Help', and 'Illinois' are on the right. Below the logo, there are dropdown menus for 'Explore Plans', 'Members', 'Providers', and 'Brokers'. A search bar labeled 'Find a Provider/Pharmacy' is also present. The main header area is teal and features the text 'Medicare Providers' with a breadcrumb trail: 'Providers > Medicare Overview > Training'. A 'Size' adjustment button is visible in the top right of this header.

The main content area is titled 'Training' and includes the following sections:

- Training**: A sub-header with the text 'Wellcare has created several educational resources for providers.'
- Fraud, Waste and Abuse Training**: A sub-header with the text 'The Centers for Medicare & Medicaid Services (CMS) requires all delegated and contractual Medicare Part C and Part D providers to complete Fraud, Waste and Abuse (FWA) training. Combatting Fraud, Waste and Abuse (FWA) Training is available online for Wellcare providers.'
- SNP Model of Care Training Materials**: A sub-header with the text 'Health plans are required to provide their Special Need Plans (SNP) provider network with information about their basic model of care. Wellcare has created self-study materials that online basic requirements and frequently asked questions.' Below this are two bullet points: 'Model of Care Program Training' and 'SNP Frequently Asked Questions'.

On the right side of the page, there is a vertical navigation menu with the following items: 'Claims', 'Authorizations', 'Forms', 'Pharmacy', 'Quality', 'Behavioral Health', 'Training', and 'Risk Adjustment Programs'. The 'Training' item is currently selected.

Below the main content, there is a section titled 'Additional Training' with a sub-header 'SECURE PORTAL' and a box titled 'Secure Provider Portal'. The text inside the box states: 'Most of our provider training is available via the secure provider portal. Providers can sign up for an account, then log in and view the Training tab to complete required courses and attestations.'

At the bottom of the page, there is a footer area with a phone icon, the text 'Need help? We're here for you.', and a 'Contact Us' button.

General Compliance & Medicare Fraud, Waste, & Abuse Training



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

A screenshot of the CMS.gov website. The page title is "MLN Provider Compliance". The CMS.gov logo is at the top left, and the navigation menu includes links for Home, About CMS, Newsroom, FAQs, Archive, Share, Help, and Print. Below the navigation menu are several tabs: Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area features the Medicare Learning Network logo and a "Fast Fact" section. The "Fast Fact" section discusses the Comprehensive Error Rate Testing (CERT) program and the importance of accurate signatures on progress notes, office notes, and orders for services and supplies. It also mentions that electronic medical records and ordering systems are accepted by CMS if documentation is otherwise in compliance with CMS record keeping requirements. Below the "Fast Fact" section, there is a "Downloads" section with links to "Medicaid Program Integrity, Safeguarding Your Medical Identity Educational Products [PDF, 193KB]" and "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training [PDF, 131KB]".



Questions & Answers

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