New Hampshire WellSense Medicare Advantage HMO

Orientation and General Overview

January 1, 2023

WellSense HEALTH PLAN

WellSense overview

Working with WellSense Medicare Advantage (HMO)

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Working With WellSense

WellSense HEALTH PLAN

About WellSense

Exceptional care without exception

- WellSense Health Plan is a non-profit Managed Care Organization founded by Boston Medical Center in 1997
- WellSense Health Plan is the trade name rebranded by Boston Medical Center Health Plan (BMCHP) across all products in New Hampshire and Massachusetts
- Learn more about WellSense at **wellsense.org**

Eligibility

One program – three plans

- WellSense Medicare Advantage HMO is a one-stop shop that includes all Original Medicare Part A and Part B benefits, plus Part D prescription drug coverage
  - WellSense Signature (HMO)
  - WellSense Choice (HMO)
  - WellSense Added Value (HMO)

Eligibility

- Phone
  - Medicare Service Center at 888-633-4227
  - Provider Service Center at 866-808-3833
- Secure provider portal HealthTrio at wellsense.org

Check Member Eligibility

To join WellSense Medicare Advantage HMO members must have both Medicare Part A and Part B, and live in our service area. Members must continue to pay their Part B premium as well as any late enrollment penalties.

Before providing services, verify eligibility

WellSense tools to check member eligibility online or by phone:

- Secure provider portal Health Trio at wellsense.org
- Provider Service Center at 866-808-3833, IVR (interactive voice recognition) system
- Medicare eligibility at 877-486-20048 (TTY: 800-633-4227)

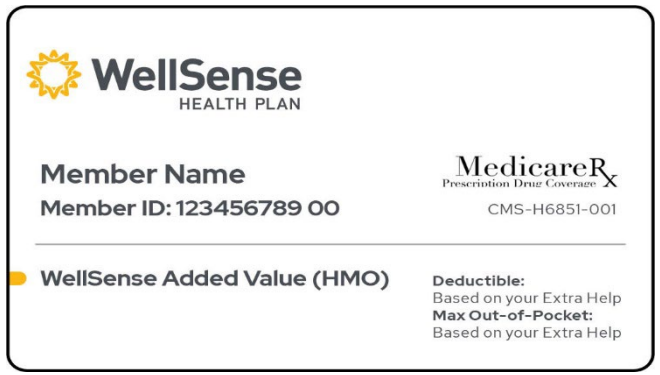
New Member Outreach

Members receive a welcome call within the first month of enrollment from our member services team to ensure the following:

- Verify Primary Care Provider (PCP) or assist in selection of PCP*
- Review benefits
- Verify spoken/written language
- Offer to complete a Health Risk Assessment
- Inform member of care management programs
- TDD/TTY and language options reviewed

*Members are required to have a PCP. If they do not elect one, they will be assigned one.

WellSense Medicare Advantage HMO Member ID Cards



Medicare Advantage HMO Benefits at a Glance

WellSense HEALTH PLAN

$0 premium – WellSense Signature (HMO)

	Plan Number	H6851-002
	Maximum out of pocket	$4,900
	Primary care provider (PCP)	$0 copay
	Specialist	$30 copay
	ER / Urgent Care	$110 / $40 copay
	Inpatient hospital	$375 copay days 1-6, $0 copay days 7-90
	Skilled Nursing Facility (SNF)	$0 copay days 1-20, $196 copay days 21-100
	Prescription drug deductible	$95 Does not apply to Tiers 1 and 2
	Prescription drugs	$0 copay (Tier 1 – preferred generic)
Extras	Over-the-counter card	$50 per quarter, up to $200 per year
Extras	Dental coverage	$0 preventive copay, **$1,250** comprehensive coverage
Extras	Supplemental benefits	**SilverSneakers® fitness benefit**, Vision exams, Eyewear allowance, Hearing aid benefit, Mom's Meals

$19 premium – WellSense Choice (HMO)

	Plan Number	H6851-003
	Maximum out of pocket	$5,500
	Primary care provider (PCP)	$0 copay
	Specialist	$25 copay
	ER / Urgent Care	$110 / $40 copay
	Inpatient hospital	$375 copay days 1-6, $0 copay days 7-90
	Skilled Nursing Facility (SNF)	$0 copay days 1-20, $196 copay days 21-100
	Prescription drug deductible	$0
	Prescription drugs	$0 copay (Tier 1 – preferred generic)
Extras	Over-the-counter card	$70 per quarter, up to $280 per year
Extras	Dental coverage	$0 preventive copay, **$1,750** comprehensive coverage
Extras	Supplemental benefits	**SilverSneakers® fitness benefit**, Vision exams, Eyewear allowance, Hearing aid benefit, Mom's Meals

$31.10 premium – WellSense Added Value (HMO)

	Plan Number	H6851-001
	Maximum out of pocket	$8,300
	Primary care provider (PCP)	20% coinsurance
	Specialist	20% coinsurance
	Inpatient hospital	$560 copay days 1-4, $0 copay days 5-90
	Skilled Nursing Facility (SNF)	$0 copay days 1-20, $196 copay days 21-100
	Prescription drug deductible	$505
	Prescription drugs (Tier 1 – preferred generic)	25% coinsurance
Extras	Over-the-counter card	**$150 per quarter**
Extras	Dental coverage	$0 preventive copay **$1,500 comprehensive coverage at 0% coinsurance**
Extras	Vision coverage	$0 preventive copay $200 eyewear allowance
Extras	Supplemental benefits	**SilverSneakers®** and Mom's Meals

Chiropractic Services

- Chiropractic services are covered under WellSense Medicare Advantage HMO
- Services will be subject to Part B Deductible and 80/20 coinsurance. The benefit is limited to the Medicare chiropractic benefit which limits services to the manual manipulation of subluxation of the spine. No reimbursement for any other services, including the evaluation & x-rays
- No visit max for chiropractic visits
- Only codes covered are 98940,98941 & 98942

Acupuncture Services

- Acupuncture Services, although not covered by NH Medicaid, are a covered benefit under WellSense Medicare Advantage HMO
- Covered for chronic low back pain only. Limited to 12 visits in 90 days if the member meets Medicare's definition of chronic low back pain
- An additional eight sessions will be covered for those patients demonstrating improvement. No more than 20 acupuncture treatments may be administered annually
- Member is responsible for Part B deductible and 20% coinsurance
- Code range: HCPCS 97810, 97811, 97813, and 97814

Medicare Supplemental Benefits

WellSense HEALTH PLAN

SilverSneakers and Mom's Meals

SilverSneakers

- SilverSneakers gym membership is available for all plans
- Members get access to thousands of location across the United States
- From, national gyms to local community centers, there are more participating fitness locations available in the U.S. to SilverSneakers members than there are Starbuck

Mom's Meals

- Members get 14 meals after a hospital discharge
- New benefit after every discharge
- Meals are sent to the member's home at no cost
- Meals are nutritionally-tailored and include menus designed by dietitians and professional chefs
- Intended to help our member's achieve a healthier lifestyle with programs that allow them to choose what they want to eat

Dental Benefits

WellSense Added Value (HMO)	WellSense Choice (HMO)	WellSense Signature (HMO)
• 2 exams per year • 2 cleanings per year • X-rays • Comprehensive coverage up to $1,500[1] per year	• 2 exams per year • 2 cleanings per year • X-rays • Comprehensive coverage up to $1,750[1] per year	• 2 exams per year • 2 cleanings per year • X-rays • Comprehensive coverage up to $1,250[1] per year

[1] Comprehensive Dental Care includes extractions, restorative care, endodontic care, periodontic care, crowns (limitations apply), dentures, surgical procedures related to full and partial dentures, and diagnostic care. Review the Evidence of Coverage for additional benefit information.

Vision Benefits

WellSense Added Value (HMO)

- Routine vision exam: $0 copay
- Medicare-covered eyewear: $0 copay
- $200 allowance toward eyeglasses, contact lenses or hardware upgrades

WellSense Choice (HMO)

- Routine vision exam: $0 copay
- Medicare-covered eyewear: $0 copay
- $150 allowance toward eyeglasses, contact lenses or hardware upgrades

WellSense Signature (HMO)

- Routine vision exam: $0 copay
- Medicare-covered eyewear: $0 copay
- $150 allowance toward eyeglasses, contact lenses or hardware upgrades

Hearing Benefits

WellSense Added Value (HMO)

Routine hearing exam: $0 copay

WellSense Choice (HMO)

- 2 hearing aids per year
  - $699 copay per Advanced TruHearing aid
  - $999 copay per Premium TruHearing aid
- Routine hearing exam: $0 copay

WellSense Signature (HMO)

- 2 hearing aids per year
  - $699 copay per Advanced TruHearing aid
  - $999 copay per Premium TruHearing aid
- Routine hearing exam: $0 copay

Over-The-Counter (OTC) Benefits

- The over-the-counter allowance is **awarded each calendar quarter** and allows the member access to items and supplies typically found at a pharmacy with their OTC card
- OTC[1] allowance gets loaded at the beginning of each quarter (January, April, July and October, or upon enrollment), and **it's not prorated**
- Can be used at participating retail locations nationwide

Participating locations

OTC Quarterly Allowance

Signature (HMO)	Choice (HMO)	Added Value (HMO)
$50	$70	$150

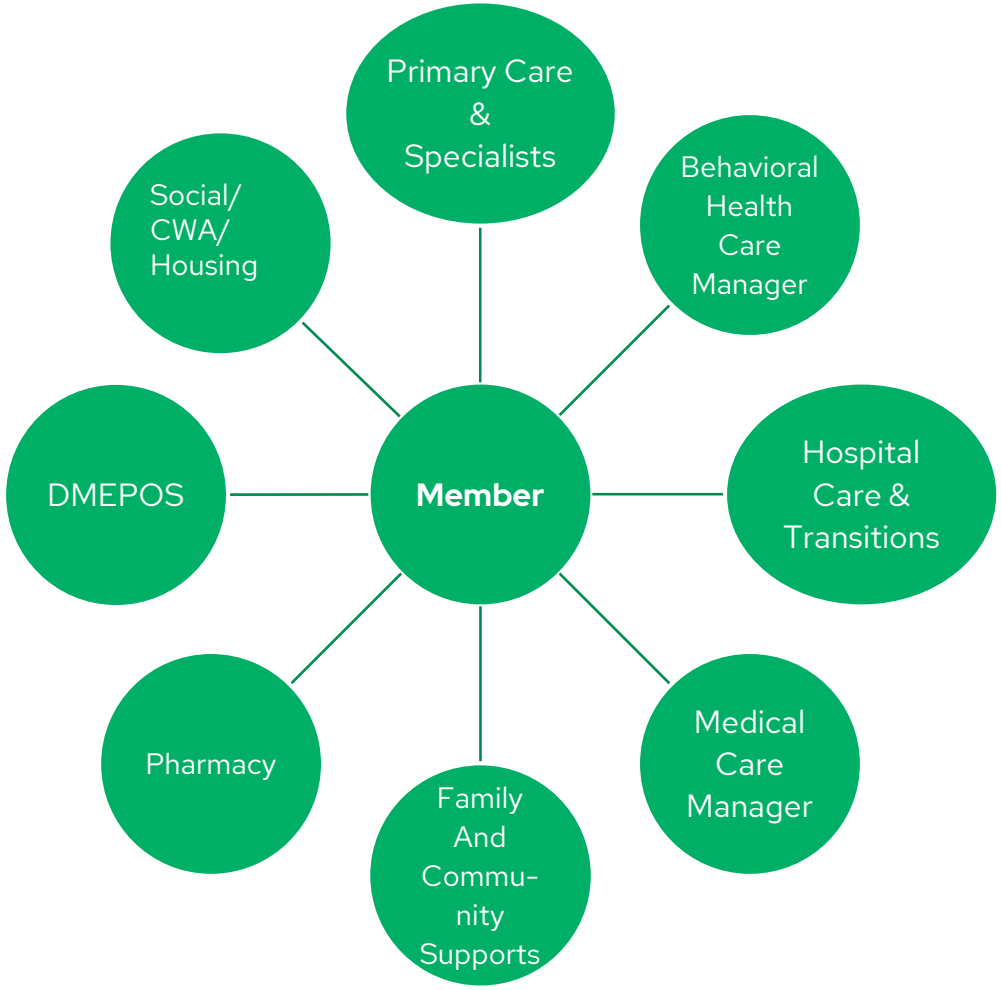
[1] OTC allowance must be used before the end of the calendar quarter. It will not roll over to the next quarter.

Care Management

WellSense HEALTH PLAN

Care Management Care Model

Our collaborative approach assesses the member's overall health status, facilitates coverage for medically necessary services, works with social and community-based services, and advocates for the member as they navigate the healthcare system



Care Management

- With a focus on members with high risk/high needs, WellSense's Care Management program integrates physical, social, and behavioral health supports services. WellSense Care Management collaborates with local community-based agencies, Area Agencies, Community Mental Health Centers, Local Care Management entities, and all our Providers. This collaborative approach assesses the member's overall health status, facilitating coverage for medically necessary services, social and community-based services, and advocating for the Member as he or she navigates the healthcare system

- Our interdisciplinary team of Registered Nurses, Social Workers, Behavioral Health clinicians, Community Wellness Advocates, Housing Coordinator, and Care Navigators work closely with our Pharmacy, Utilization Management, and Vendors (nonemergency transportation, durable medical equipment, etc.) to ensure support services are wrapped around the member as needed

- Our Goal is always for members to maintain optimum health and achieve wellness and self-management in their community setting

Care Management Referrals

Submit member referrals to Care Management

- Call 855-833-8119
- Monday through Friday from 8:30 a.m. – 5:00 p.m.
- Email NH Medicare Advantage Care Management: NHCM.MedAdv@wellsense.org

Claims and Appeals
Member & Provider

WellSense
HEALTH PLAN

Claim Submission

To expedite payments, we recommend submitting claims electronically

Electronic claims

- WellSense Payor IR: 13337
- Submit an 837 transaction

Submit through direct submission (WellSense payor ID is 0515)

- Examples: XACTIMED, Emdeon/Web MD, McKesson, SSI

HealthTrio – WellSense secure provider portal

Paper claim submissions

WellSense Health Plan
Claims Department
P.O. Box 55049
Boston, MA 02205-5049

Prior Authorization

Prior Authorization is required for:

- Outpatient medical/surgical services
- Home health services
- Inpatient admission

Notification is required for:

- Emergency services pending inpatient admission
- Observation
- Urgent care services

Prior Authorization (cont.)

- The Prior Authorization Matrix reference guide identifies services that require authorization/notification or you can consult the look up tool by service code. Look Up Tool: https://www.wellsense.org/providers/prior-authorization
- Specialist office visits do NOT require referrals for in network providers
- Authorization requests and notifications may be submitted online using HealthTrio or via fax at 603-218-6634. Authorization decisions are communicated to providers via online or by telephone/letter
- Members receive a letter for all denials which include member appeal rights, including the right of a provider to file a member appeal on behalf of the member.
- For denials, requesting providers may seek a telephonic peer-to-peer review with a Medical Director

Claims and Provider Administrative Appeals

WellSense Health Plan

- Claims must be received within 120 calendar days from the date of service. Coordination of Benefits and Other Party Liability rules apply

Provider Administrative Appeals

- Provider administrative appeals include requests for reviews of denied claims (including but not limited to untimely claims filing, level of compensation/reimbursement, no prior authorization/inpatient notification, member eligibility issues, clinical editing, COB denials) credentialing/re-credentialing denials, program integrity issues
- Provider administrative appeals must be received within 30 calendar days from the date of the original claim denial

Health Trio

- Please submit claim reviews/appeals using Health Trio

Member Appeals And Grievances

Member Appeals

WellSense has an efficient process in place to resolve member appeals. A member or authorized representative, which includes a provider acting on behalf of a member, may request three types of member appeals. Member internal appeals must be received by WellSense within 60 calendar days of the date listed on the notice of the initial coverage decision.

- **Standard Internal Appeal** resolved within 30 calendar days, unless extended. A signed Authorized Representative Form is required from the member for a provider or any other Authorized Representative to file the appeal on the member's behalf. The appeal is dismissed if this form is not received by the 30th calendar day
- **Expedited Internal Appeal** resolved within 72 hours unless extended. For the Plan's records, a provider must formally assert that a member's health and/or life is in serious jeopardy awaiting the Standard Internal Appeal timeframe. If this is the case, a signed Authorized Representative Form from the member is not required for a provider to file the appeal on the member's behalf.

Member Appeals And Grievances (cont.)

Information on the Member Appeals process is included in all initial denial letters sent to members and requesting/servicing providers and is located after the denial or partial approval rationale. The detailed information in the letter from the Plan includes but is not limited to:

- timeframes for filing member appeals
- methods and contact information for filing member appeals
- timeframes for processing of member appeals
- rights of the member throughout the appeal
- information on Authorized Representatives
- an informative member appeals insert
- an Authorized Representative Form

It is essential that providers/office staff review the denial or partial approval letter in its entirety to ensure any Member Appeals for prospective services are sent to the appropriate department at the Plan. This will allow the Plan to process the member appeal as quickly as possible for the member.

Member Appeals And Grievances (cont.)

Member Grievances

Process where members or their Authorized Representative, including providers on a member's behalf, express dissatisfaction about the services they receive from the Plan and/or providers. Types of grievances include but are not limited to:

- Plan processes
- Plan staff
- Provider and/or provider staff attitude/service
- Quality of care
- Quality of practitioner office site
- Billing/financial issues
- Access and availability

Member Appeals and Grievances (cont.)

Providers may assist members or their Authorized Representatives in bringing forth grievances. Grievances may be filed with the Plan verbally through the Plan's Member and Provider Services department, via fax to the Member Appeals and Grievances department to 617-897-0805 or in writing to:

WellSense Medicare Advantage
Attn: Member Appeals
529 Main Street 5th Floor
Charlestown, MA 02129

If a member or their Authorized Representative files a grievance against a facility, provider and/or provider staff member, providers are expected to work with Plan staff by reviewing the expression of dissatisfaction and responding timely to the Plan's requests for administrative and/or clinical information.

WellSense Medicare Advantage HMO
Member Grievances Department
529 Main Street, Suite 500
Charlestown, MA 02129

The member can also submit their complaint directly to Medicare. You can use their online form or you can call, 1-800-MEDICARE (1-800-633-4227) to speak with a representative. TTY/TDD users can call 1-877-486-2048. These lines are open 24 hours per day, seven days a week.

*Members, or their Authorized Representatives, may also file a Grievance at any time with CMS.

Partnerships and Strategic Relations

WellSense HEALTH PLAN

Partnerships And Strategic Relations

WellSense collaborates with vendors to build our New Hampshire network of behavioral health care, pharmacy, radiology, durable medical equipment, and vision care providers.

- Carelon Behavioral Health (CBH) formally Beacon Health Strategies
- Express Scripts (pharmacy)
- Cornerstone Health Solutions (Specialty Pharmacy Program)
- eviCore (high-end radiology)
- Northwood Inc. (DME)
- Vision Service Plan (VSP) (vision services)

Carelon Behavioral Health (BH)

Providers interested in participating in the Carelon BH network should follow these steps:

- Request participation through their website at: https://www.carelonbehavioralhealth.com/providers/join-our-network
- Complete a Letter of Interest (LOI)
- Credentialing Application/Provider Service Agreements

**There is a 45 day turnaround for all complete submissions

Carelon Online Resources

- Provider Manual – provides a variety of information including, performance measures and standards
- Notifications and FAQ's
- eServices provides clinical, administrative, claims transactions and access to:
    - Submit claims and authorization requests
    - Verify member eligibility
    - Confirm authorization status
    - Check claim status
    - View claims performance information
    - Access to forms, bulletins and mailings
    - View or print frequently asked questions (FAQs)
    - Toolkit to assist PCP in the diagnosis and treatment of mental health and substance use disorders

Carelon Behavioral Health Provider Reference Guide

Description	Contact information
Main Phone Number (claims, web, benefits/eligibility, authorizations, credentialing/contracting)	855-834-5655 Monday–Friday, 8 a.m.–6 p.m. ET
National Provider Services Line	800-397-1630 Monday–Friday, 8 a.m.–8 p.m. ET
TTY Number	711
Website	https//www.carelon.com/
Provider Portal	providerportal.carelonbehavioral.com/index.html#/login
EDI Helpdesk	888-247-9311 Monday–Friday, 8 a.m.-6 p.m. ET
EDI Helpdesk Email	e-supportservices@Carelon.com
EDI Operations (technical questions about electronic transactions)	EDI.Operations@carelon.com
Provider Relations Department Email	BH_Provider.Relations@Carelon.com Indicate NH in addition to name, NPI, Tax ID, and inquiry details
Appeals, Complaints, and Grievances	844-231-7949 or email Woburn.appeals@Carelon.com Include detailed description, records, and claims as applicable

Express Scripts – Pharmacy Benefit

WellSense Health Plan is contracted with Express Scripts

- Please visit wellsense.org for helpful information on
  - Formulary
  - Pharmacy benefits
  - Prior authorization requirements and process

CORNERSTONE Health Solutions

The Specialty Pharmacy Program requires that certain drugs be supplied by a specialty pharmacy. These drugs include injectable, intravenous and oral drugs that are often used to treat chronic conditions, like Hepatitis or Crohn's disease. Storing and dispensing these drugs generally requires special expertise and facilities. In addition, specialty pharmacies have extensive training and detailed knowledge to provide personalized support to members and providers.

Cornerstone Health Solutions:

- Phone: 844-319-7588
- Fax: 781-805-8221
- Mail: 41 Teed Dr., Randolph, MA 02368

eviCore healthcare

Outpatient High-End Radiology

- Services
- CT scans
- MRI/MRA
- PET scans
- Nuclear Cardiology
- Genetic Testing
- Musculoskeletal and Rehabilitation Radiology

Authorization requests can be made via phone, fax or web

- Phone: 888-693-3211
- Fax: 888-693-3210
- Website: www.evicore.com

Northwood, Inc.

Administrator of a national network of home care providers with over 5,800 retail centers throughout the US

- Manages our DME, prosthetics & orthotics, and medical supplies network
- Prior authorization is required for all DMEPOS dispensed and billed items by a DMEPOS supplier and oral enteral dispensed to any provider
- Dedicated provider line: 866-802-6471
- Website: northwoodinc.com

Vision Service Plan (VSP)

VSP manages the vision benefits offered to WellSense Health Plan members, including routine and non-routine eye care and vision hardware

- Phone: 855-492-9028
- Website: vsp.com

Provider Responsibilities

Provider Changes/Credentialing

Demographic Changes must be reported to the Plan using our Change Form available on our website at: www.wellsense.org

Adding new providers?

- Please send the following documents:
  - HCAS Enrollment Form
  - WellSense Health Plan Provider Data Form
  - W-9
- Submit completed documents:
  - NHProvider.Enrollment@wellsense.org

Cultural Competency

The Plan encourages and expects providers to:

- Be aware of cultural differences and the potential impact of those cultural differences
- Acquire cultural knowledge and skills to understand the needs of the populations they serve.
- Ask questions relevant to how the family and culture values might influence the patient's health care perceptions and needs
- Listen to the patient's opinion in considering treatment options
- Assist members (such as those with disabilities) in maximizing both their involvement in their care as well as their independence and functioning
- Let us know if your providers receive this training which will be published in our provider directory

Visit our website for additional information
www.wellsense.org/providers/resources/training/cultural-competency

Primary Care Provider Responsibilities

- PCPs must provide comprehensive primary care services to members
- Schedule timely appointments in accordance with Access to Care standards
- Refer and assist with scheduling follow-up care with other providers

Fraud, Waste and Abuse

WellSense
HEALTH PLAN

Fraud, Waste and Abuse

- You must report any provider, pharmacy or member who is suspected of committing fraud, waste or abuse
- You do not have to give your name to report an incident
- You can report an incident by calling the Compliance Hotline at 888-411-4959

  Or in writing to:
  WellSense Health Plan
  Compliance Officer
  Schrafft's City Center
  529 Main Street, Suite 500
  Charlestown, MA 02129

Fraid, Waste and Abuse Definitions

- **FRAUD**: Intentionally making, or attempting to make, a false claim, representation or promise in an effort to receive payment or property to which one is not entitled. It can also be a concealment or omission of a material fact

- **WASTE**: Poor or inefficient practices occurring without intent to deceive that result in the provision of unnecessary health care services and subsequent expenditures

- **ABUSE**: Any activity that unjustly allows the perpetrator to obtain money or health care services to which he or she is not entitled but for which there is not the intent to deceive that is necessary for fraud to have occurred

Common Fraud, Waste and Abuse Schemes/Situations To Avoid

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Billing for medically unnecessary services
- Misrepresenting dates of service, locations of service, and/or provider of service
- Billing services performed by one professional under another professionals provider ID
- Waiving of deductibles and/or co-payments
- Incorrect reporting of diagnoses, modifiers or procedures
- Overutilization of services
- False or unnecessary issuance of prescription drugs

Common Fraud, Waste and Abuse Schemes/Situations To Avoid (cont.)

- Up coding services by billing for services at a higher complexity than services actually provided.
- Unbundling-billing for services included in a panel, global reimbursement, or capitation arrangement.
- Paying or receiving "Kickbacks" in Exchange for Referring Business
- Charging members out of pocket for covered services
- Cutting and pasting electronic medical records (cloning)
- Double billing for services

Suspected Member Fraud That Should Be Reported

- Insurance card sharing
- Ineligible members (financial or geographical)
- Identity Theft (look for complaints of member's claiming they did not have a service with you, or that their ID was stolen; photo ID does not match individual seen in your office)
- Prescription fraud:
- Allegations of forged prescriptions
- Doctor shopping
- Theft of prescription pads/paper

Provider Resources

WellSense HEALTH PLAN

Provider Resources

Wellsense.org (our website)

- Provider Manual, including a forms section
- Provider Directory
- Check member eligibility, claims status, remittance history
- Important reports through the provider portal
- Clinical & reimbursement policies
- Quick reference guides
- Benefit summaries
- News and updates
- And much more

*Visit to register for your provider portal secure login

Training Opportunities

Call your Provider Relations Consultant for:

- Requests to join the Plan
- Participation status
- New Provider Orientation
- General Plan questions
- Provider Portal training
- Review of policies & procedures
- Requests for materials
- Re-education

Important Websites

• WellSense Health Plan	wellsense.org
• eviCore	evicore.com
• Carelon Behavioral Health	plan.carelonbehavioralhealth.com
• Express Scripts	express-scripts.com
• Northwood	northwoodinc.com
• VSP	vsp.com
• CMS	cms.gov

Thank you for joining the WellSense network

WellSense
HEALTH PLAN