New Hampshire WellSense Medicare Advantage HMO and PPO

Orientation and General Overview

November 1, 2024

WellSense HEALTH PLAN

WellSense overview

Working with WellSense Medicare Advantage HMO and PPO Plans

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Benefits at a glance

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Care Management

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Fraud, waste and abuse

Provider resources/training opportunities

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 – five plans

- WellSense Medicare Advantage HMO and PPO 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)
  - WellSense Premium Savings (HMO)
  - WellSense Signature Access (PPO)

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 and PPO, 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 HealthTrio 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)

WellSense HEALTH PLAN

New Member Outreach

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

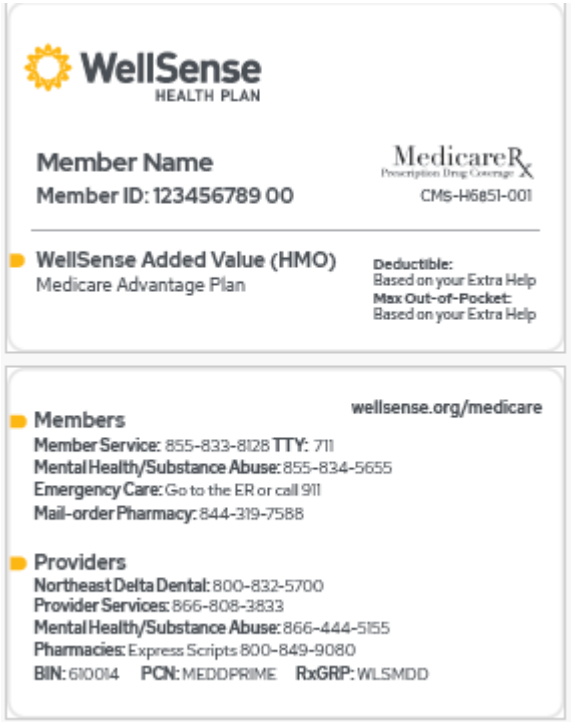
- Verify Primary Care Provider (PCP) or assist in selection of PCP*
- Review benefits
- Verify spoken/written language
- Offer to complete a Health Risk Assessment
- Inform member of care management programs
- TDD/TTY and language options reviewed

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

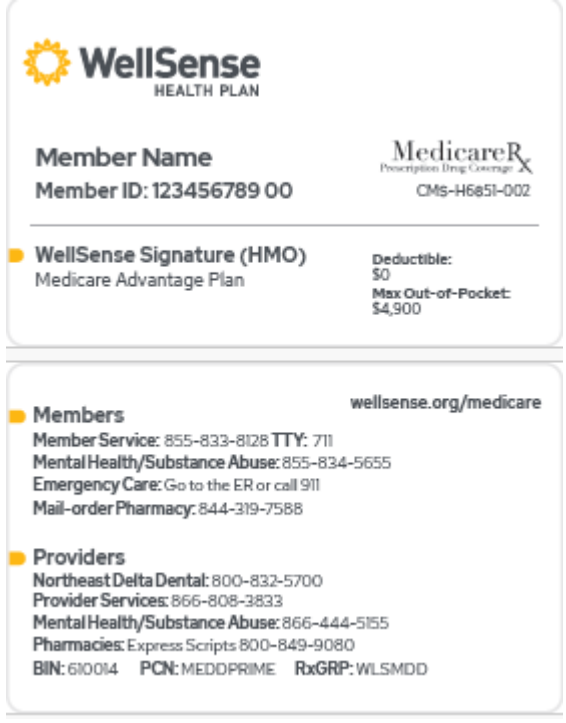
* PPO plan - Members do not need to select a PCP but are encouraged to have one.

WellSense Medicare Advantage HMO Member ID Cards

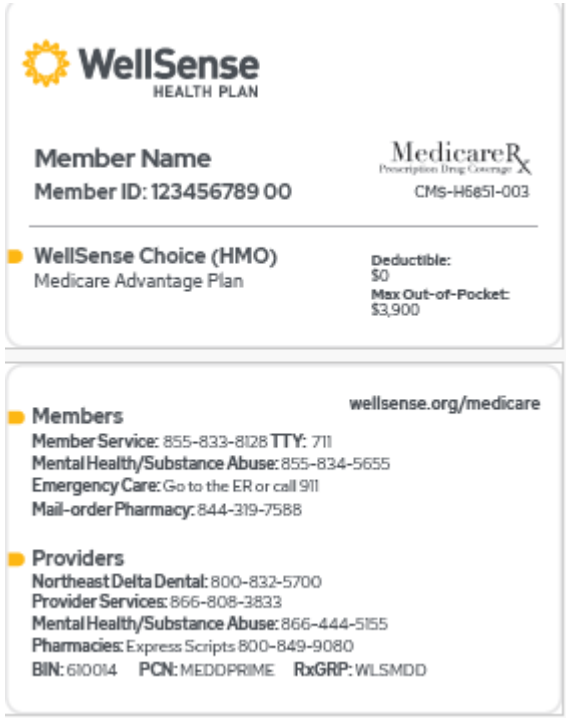
WellSense Added Value (HMO)



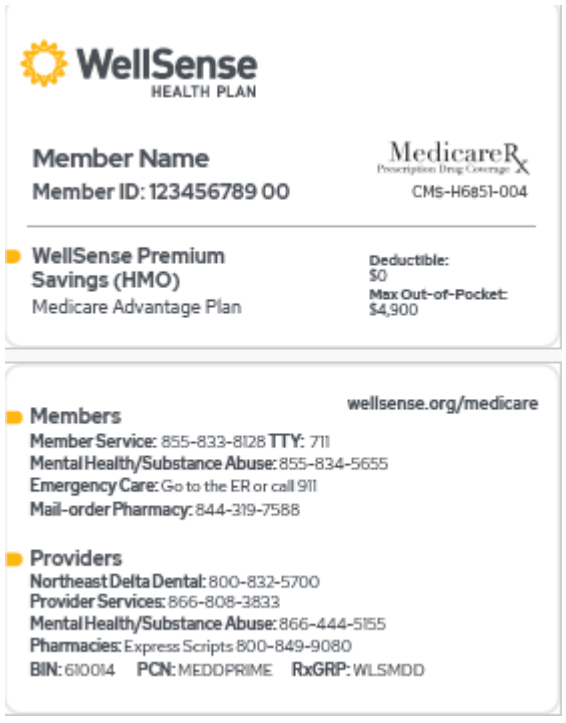
WellSense Signature (HMO)



WellSense Choice (HMO)



WellSense Premium Savings (HMO)



WellSense Medicare Advantage PPO Member ID Card

Medicare Advantage HMO and PPO Plans at a Glance

WellSense HEALTH PLAN

Medicare Advantage HMO Plan Overview

Health Maintenance Organization (HMO)

- HMOs often have a limited network of healthcare providers and require the selection of a primary care physician (PCP).

- The PCP manages and coordinates all of the patient's healthcare needs. If a specialist is needed, the PCP usually provides a referral.

  - **Note:** Referrals for specialists are not required with the *WellSense NH Medicare Advantage HMO,* unlike the industry standard.

- HMO plans usually have lower out-of-pocket costs than PPO plans to offset network restrictions.

- HMO members typically have limited or no coverage for out-of-network services, unless it is an emergency or preauthorized in advance by WellSense.

- Prior authorization is required for certain medical services, procedures, and all out-of-network services.

Medicare Advantage PPO Plan Overview

Preferred Provider Organization (PPO)

- PPO plans offer more flexibility in choosing healthcare providers. Members can usually see any doctor or specialist without a referral, both in and out of the plan's network.

- PPO members have the option to see out-of-network providers who are outside of the organization’s contracted network of providers (in-network) at a higher cost.

- PPO plans may have higher premiums and out-of-pocket costs compared to HMOs, but they offer more freedom in choosing healthcare providers and accessing care.

- Prior authorization requirements will still exist for some services, but the PPO plan may have fewer services requiring PA, and those that do may have less restrictive criteria.

    - As a general rule, secondary plans will follow the prior authorization (PA) requirements of the primary plan. So, if a member’s plan does not require PA for a service and the service pays, then the secondary plan would cover the service without applying any PA rules (e.g., PPO plan members with Medicaid as secondary sees an out-of-network provider).

- **Note:** Some out-of-network services may not require preauthorization but will cost more than if services were provided in-network.

Quick Reference Guide

Question	HMO	PPO
Are members required to have a primary care physician (PCP) on file?	**Yes**	**No**
Can members see out-of-network providers and still be covered? *It may be possible to have out-of-network services preauthorized for *WellSense NH Medicare Advantage HMO* plan members (**Exception:** Emergency services do not require preauth.)	**No***	**Yes**
Do members receive coverage for a range of preventive services at no cost to them when received from **in-network** providers?	**Yes**	**Yes**
Will the member have the right to appeal decisions made by WellSense regarding coverage, claim denials, and other issues related to healthcare benefits?	**Yes**	**Yes**
Are members covered by WellSense for emergency medical services, regardless of whether the provider is in-network or out-of-network?	**Yes**	**Yes**
Plan Comparison: HMO and PPO plans offer similar benefits; however, PPO plans offer more flexibility in choosing healthcare providers.		

Medicare Advantage HMO and PPO 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	$25 copay
	ER/Urgent Care	$125/$40 copay (ER copay waived if admitted within 24 hours)
	Prescription drug deductible	$0
	Prescription drugs	Tier 1 preferred generic: $0 copay Tier 2 generic mail order (30- and 90-day): $0 copay
Extras	Over-the-counter card	$100 per quarter, up to $400 per year
Extras	Dental coverage	$0 for preventive dental services; $3,500 comprehensive coverage at 0% coinsurance
Extras	Vision coverage	$0 for routine vision exam; $150 eyewear allowance
Extras	Additional Supplemental Benefits	SilverSneakers® fitness benefit, Hearing aid benefit, Meals, 24/7 Nurseline

$0 Premium – WellSense Premium Savings (HMO)

	Plan Number	H6851-004
	Part B Reduction	$50
	Maximum out of pocket	$4,900
	Primary care provider (PCP)	$0 copay
	Specialist	$50 copay
	ER/Urgent Care	$125/$55 copay (ER copay waived if admitted within 24 hours)
	Prescription drug deductible	$295 Does not apply to Tiers 1, 2 and 3
	Prescription drugs	Tier 1 preferred generic: $0 copay Tier 2 generic mail order (30- and 90-day) : $0 copay
Extras	Dental coverage	$0 for preventive dental services; $1,500 comprehensive dental at 50% coinsurance
Extras	Vision coverage	$0 for routine vision exam; $150 eyewear allowance
Extras	Additional Supplemental Benefits	SilverSneakers® fitness benefit, Hearing aid benefit, Meals, 24/7 Nurseline

$29 premium – WellSense Choice (HMO)

	Plan Number	H6851-003
	Maximum out of pocket	$3,900
	Primary care provider (PCP)	$0 copay
	Specialist	$20 copay
	ER/Urgent Care	$140/$40 copay (ER copay waived if admitted within 24 hours)
	Prescription drug deductible	$0
	Prescription drugs	Tier 1 preferred generic: $0 copay Tier 2 generic mail order (30- and 90-day): $0 copay
Extras	Over-the-counter card	$125 per quarter, up to $500 per year
Extras	Dental coverage	$0 for preventive dental services; $5,000 comprehensive coverage at 10% coinsurance
Extras	Vision coverage	$200 debit card for vision exams and eyewear
Extras	Additional Supplemental Benefits	SilverSneakers® fitness benefit, Hearing aid benefit, Meals, 24/7 Nurseline

$33.80 premium – WellSense Added Value (HMO)

This plan works well with those who are eligible for Medicaid/Extra Help

	Plan Number	H6851-001 With Medicaid Cost Share Assistance	H6851-001 Without Medicaid Cost Share Assistance
	Maximum out of pocket	$8,850	$8,850
	Primary care provider (PCP)	$0 copay	20% coinsurance
	Specialist	$0 copay	20% coinsurance
	ER/Urgent Care	$0/$0 copay	$110/$45 copay (ER copay waived if admitted within 24 hours)
	Prescription drug deductible	$0	$590
	Prescription drugs – generic	$0, $1.60 or $4.90 copay	25% coinsurance
Extras	Over-the-counter card	$275 per quarter, up to $1,100 per year	
Extras	Dental coverage	$0 for preventive dental services; $1,500 comprehensive coverage	
Extras	Vision coverage	$400 debit card for vision exams and eyewear	
Extras	Additional Supplemental Benefits	SilverSneakers® fitness benefit, Meals, 24/7 Nurseline	

NEW $0 PPO plan – WellSense Signature Access (PPO)

	Plan Number	H7980-001 In network	H7980-001 Out of network
	Maximum out of pocket	$4,900	$9,900 (combined in and oon maximum)
	Primary care provider (PCP)	$0 copay	$20 copay
	Specialist	$30 copay	$50 copay
	ER/Urgent Care	$125/$40 copay	$125/$40 copay (ER copay waived if admitted within 24 hours)
	Prescription drug deductible	$0	
	Prescription drugs – generic	Tier 1 preferred generic: $0 copay Tier 2 generic mail order (30- and 90-day): $0 copay	
Extras	Over-the-counter card	$75 per quarter, up to $300 per year	
Extras	Dental coverage	$0 preventive copay $3,000 comprehensive coverage at 0% coinsurance	30% cost share amount for preventive copay $3,000 comprehensive at 70% coinsurance
Extras	Vision coverage	$0 cost share for routine vision exam; $150 eyewear allowance	40% coinsurance cost share for routine vision exam; $150 eyewear allowance
Extras	Additional Supplemental benefits	SilverSneakers® fitness benefit, Hearing aid benefit, Meals, 24/7 Nurseline	

WellSense HEALTH PLAN

Medicare Supplemental Benefits

Fitness Benefit

SilverSneakers® gym membership available for all plans

- Members have access to 15,000+ fitness and community locations nationwide
- Access to everything your fitness location offers including pools, saunas, cardio equipment, walking tracks, and much more!
- Specially designed exercise classes and workshops for all fitness levels online
  - SilverSneakers LIVE offers live classes online
  - SilverSneakers On-Demand library contains hundreds of videos with 24/7 access
- SilverSneakers GO app allows members to access fitness programs, track and schedule activities, find locations, and use member ID
- Fitness Kits available to support home workouts
  - Walking kit – pedometer
  - Strength kit – resistance tubing
  - Mobility kit – exercise ball
  - Yoga kit – yoga strap

Home Meals

Mom's Meals available for all plans

- Members get 28 meals after a hospital discharge
  - 2 shipments of 14 meals delivered a week apart
  - New benefit after every discharge
- Meals are never frozen and can be kept refrigerated for 14 days
- Nine condition-specific menus and 60+ meal options
  - Vegetarian, Diabetes Friendly, Gluten Free, Heart Friendly, Low Sodium, Protein+, Pureed, Renal Friendly, and Vegetarian
- 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

	Signature Access (PPO)	Signature (HMO)	Choice (HMO)	Premium Savings (HMO)	Added Value (HMO)
Comprehensive maximum	$3,000	$3,500	$5,000	$1,500	$1,500
Coinsurance	In network: 0% Out of network: 30%	0%	10%	50%	0%

- All plans include $0 preventive dental copays, which include 2 exams, cleanings, fluoride treatments and X-rays per year
- Contracted with more than 875 dentists in New Hampshire, 1,000 in Maine and Vermont and thousands of dentists nationwide
- Comprehensive dental coverage includes:
  - Dentures
  - Restorative
  - Endodontics
  - Periodontics
  - Extractions
  - Surgical procedures
  - Crowns

DELTA DENTAL®

Vision Benefits

vsp vision care

Signature Access (PPO)	Signature (HMO)	Premium Savings (HMO)
• $0 routine exam in network • $150 eyewear allowance (combined in and out of network)	• $0 routine exam in network • $150 eyewear allowance	• $0 routine exam in network • $150 eyewear allowance
• VSP Network	• VSP Network	• VSP Network

Choice (HMO)	Added Value (HMO)
$200/year vision	**$400/year vision**
• **OTC + Vision debit card**	• **OTC + Vision debit card**

- OTC + Vision debit card for Added Value (HMO) and Choice (HMO) members
  - Members receive a separate allowance on their OTC card for any vision related service

Hearing Aids

Hearing aid benefit available on the following plans: Signature Access (PPO), Signature (HMO), Choice (HMO) and Premium Savings (HMO)

Members get:

- One routine exam
- $0 fitting and evaluation
- TruHearing hearing aid options
  - Advanced: $699 copay
  - Premium: $999 copay
- Hearing aid purchase includes:
  - First year of follow-up provider visits
  - 60-day trial period
  - 3-year extended warranty
  - 80 batteries per aid for non-rechargeable models

TruHearing™

Concierge level service provided by TruHearing to assist in scheduling all appointments and follow-ups

Over-The-Counter (OTC) Benefits

- Preloaded debit card with additional funds added each quarter (January, April, July and October, or upon enrollment)
- Can be used at participating retail locations nationwide
- Can access benefit in multiple ways:
  - At participating retail locations nationwide
  - Online at mybenefitscenter.com
  - On the app
  - Over the phone
  - Physical catalog available upon request
- App provides real-time spend and balance tracking

Signature Access (PPO)	Signature (HMO)	Choice (HMO)	Added Value (HMO)
$75/quarter	$100/quarter	$125/quarter	$275/quarter

Some participating retail locations

CVS/pharmacy
shaw's
DOLLAR GENERAL
STAR MARKET
FAMILY DOLLAR
my family, my family dollar.
Walgreens
Hannaford
RITE AID PHARMACY
Walmart

and many more!

Care Management

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

WellSense HEALTH PLAN

Care Management

- With a focus on members with high risk WellSense's Care Management program integrates physical, social, and behavioral health supports services to support our members navigating the health care system. WellSense Care Management collaborates with local community-based agencies and our Providers to assess the member's overall health status and facilitate coverage for medically necessary services.

- 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 (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

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 for in-network providers 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 60 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 65 calendar days of the date listed on the notice of the initial coverage decision.

- **Standard Internal Appeal** A signed Authorized Representative Form is required from the member for an Authorized Representative to file the appeal on the member's behalf. If the appellant is the member's treating or prescribing physician, no AOR is required. The appeal is dismissed if this form is not received by the expiry of the due date of the case + extension where applicable."

- **Expedited Internal Appeal** resolved within 72 hours unless extended when allowed. A signed Authorized Representative Form is required from the member for an Authorized Representative to file the appeal on the member's behalf. If the appellant is the member's treating or prescribing physician, no AOR is required. The appeal is dismissed if this form is not received by the by the expiry of the due date of the case + extension where applicable"

Member Appeals And Grievances, Continued

Part B and Part D Appeal Turnaround Times applicable to NH in 2025

I. Part C (Medical Services or Supplies) TAT Standard Pre-service = 30 calendar days, 14-day extensions when appropriate
II. Part C (Medical Services or Supplies) TAT Expedited = 72 hours calendar days, 14-day extensions when appropriate
III. Part C and B (Medical Services or Supplies) TAT Standard Post-service payment disputes (member liability) = 60 calendar days, no extensions
IV. Part B (Medical Drug) TAT Standard = 7 calendar days, no extensions
V. Part B (Medical Drug) TAT Expedited = 72 hours, no extensions
VI. Part D (Pharmacy Prescription Drug) TAT Standard = 7 calendar days, no extensions
VII. Part D (Pharmacy Prescription Drug) TAT Expedited = 72 hours, no extensions
VIII. Part D (Pharmacy Prescription Drug) TAT Standard post-service payment = 14 calendar days, no extensions

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

NOTE: that grievances must be filed within 60 days of the date of incident, if filed after that timeframe, member must include good cause for missing the deadline. If no good cause provided, Member Appeals and Grievances may dismiss the grievance for being untimely.

Member Appeals and Grievances (cont.)

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 Health Plan
Attn: Member Appeals and Grievances
100 City Square, Suite 200
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 Health Plan
Attn: Member Appeals and Grievances
100 City Square, Suite 200
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 by EverNorth(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 by EverNorth– Pharmacy Benefit

WellSense Health Plan is contracted with Express Scripts by EverNorth

- 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

- Musculoskeletal and Pain Management Procedures
- Genetic Testing
- Outpatient High-End Radiology
    1. Services
    2. CT scans
    3. MRI/MRA
    4. PET scans
    5. Nuclear Cardiology

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:

  Compliance Officer
  WellSense Health Plan
  100 City Square, Suite 200
  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 wellsense.org 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 by EverNorth	express-scripts.com
• Northwood	northwoodinc.com
• VSP	vsp.com
• CMS	cms.gov

Thank you for joining the WellSense network

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