Wellmark Advantage Health Plan

Provider Manual

Wellmark Advantage Health Plan

Update: December 2025

Replaces: August 2025

Y-7821712

Summary of Changes

June, August, and December 2025

Summaries below link to the actual changes in the text. The most recent changes appear in red.

December

- **Page 20:** Updated Services Requiring Medical Necessity and Concurrent Review or Prior Authorization subsection.
- **Pages 20 – 21:** Updated Concurrent Review subsection.
- **Page 21:** Updated Obtain Medical Necessity for Inpatient Admissions, Concurrent Review or Prior Authorization subsection.
- **Page 21:** Renamed Decision Timeframes and Decision Notifications for Services Requiring Medical Necessity and Concurrent Review or Prior Authorization subsection.
- **Page 22:** Updated Advance Coverage Determinations subsection.
- **Page 28:** Updated phone number in Medicare Advantage Case Management Program subsection.
- **Page 31:** Removed bullet.

August

- **Page 15:** Updated Submitting supporting documentation.

June

- **Pages 14 – 15:** Updated Claims Submission subsection.
- **Page 16:** Added Billing for Home Health Services subsection.
- **Page 21:** Updated fax in bullet.
- **Page 26:** Updated fax in bullet.

Table of Contents

1. Plan Overview

Wellmark Advantage Health Plan, Inc. is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare & Medicaid Services to offer Medicare Advantage plans in the market. Wellmark Advantage Health Plan offers Medicare Advantage coverage to Medicare-eligible Iowa and South Dakota residents within the service area.

Wellmark Advantage Health Plan provides, at least, the same level of benefit coverage as Original Medicare (Part A and Part B) and provides enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Wellmark Advantage Health Plan to offer enriched plans by using Original Medicare as the base program and then adding desired benefit options, including a Part D prescription drug benefit. You can find the Evidence of Coverage documents on our website at Wellmark.com/Provider/Medicare-Advantage.

When "Wellmark" is used throughout this Provider Manual, it refers to Wellmark Advantage Health Plan and other entities providing services on behalf of Wellmark Advantage Health Plan, including Wellmark, Inc., CVS Caremark® and UST HealthProof™.

Quick Reference

Wellmark.com/Provider/Medicare-Advantage	• Review benefits (Evidence of Coverage) • Review medical policies • Review part B drug formularies • STARS, Risk Adjustment and Quality • Access forms
Wellmark Secure Provider Portal – Log in and find the Wellmark Advantage Health Plan section	• Check member eligibility • Check a claim • Submit prior authorizations (medical and Part B Drugs)
info.caremark.com/epa	• Submit Part D prior authorizations (CVS)

For additional assistance, contact these resources.

Department	Contact Information	
Provider Services/Inquiries	T: 1 855 716 2556 F: 1 866 530 0102	WMAHP Provider Correspondence P.O. Box 211285 Eagan, MN 55121
Care Management	T: 1 866 866 8964 E: Care Management[1]	
Part B Drug Authorization Requests	T: 1 855 673 4225 F: 1 877 218 0941	
Part D Drug Authorization Requests	T: 1 855 344 0930 F: 1 855 633 7673	
Medical Authorization Requests	T: 1 855 673 4225 F: 1 866 313 8595	
Carenet (24/7 Nurse Line for members)	T: 1 833 968 1747	
Appeals and Grievances	F: 1 866 533 6950	Wellmark Advantage Appeals & Grievances P.O. Box 211483 Eagan, MN 55121
Credentialing	Provider Credentialing	

[1]Blue Cross and Blue Shield of Michigan manages Care Management for Wellmark Advantage Health Plan.

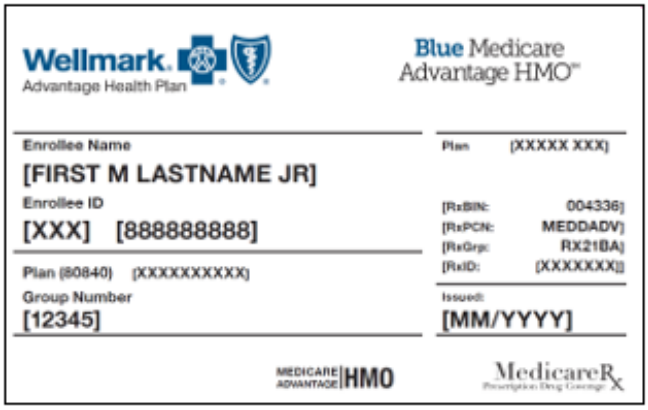
2. Member Information and Eligibility

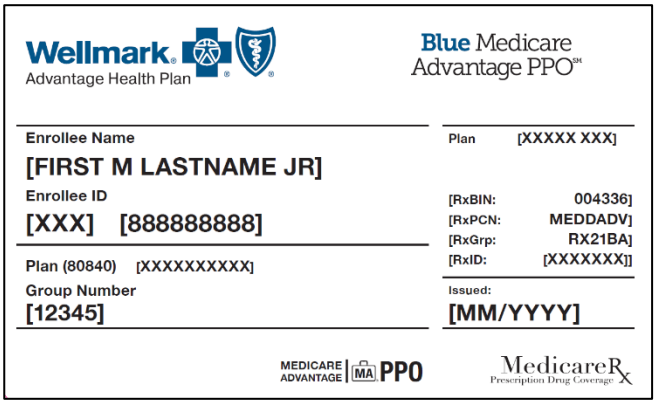
MEMBER IDENTIFICATION CARDS

Our member identification cards contain basic information you will need when providing covered services to our members. The Wellmark Medicare Advantage ID card indicates the member is enrolled in a Wellmark Medicare Advantage plan. Our Wellmark Medicare Advantage members only need to show their ID card to receive services. A member doesn't need to show their Original Medicare ID card to obtain services.

All Blue Cross and Blue Shield Association (the national organization for all Blue plans) cards have a similar look and feel, which promotes nationwide ease of use. The cards include a magnetic strip on the back to provide easier access to eligibility and benefit information.

Providers must include the three-character prefix found on the member's ID card when submitting electronic and paper claims. The prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm member coverage. It is critical for the electronic routing of specific transactions to the appropriate Medicare Advantage plan. Below is a sample of the members' ID card.





The BlueCard® Program links participating providers and the independent Blue Cross and Blue Shield plans across the country and around the world through an electronic network for claims processing and payment. To help identify members who participate in the BlueCard Program, a suitcase logo with "MA" will be on their ID card. This logo indicates that members have health coverage outside of their Blue Cross and Blue Shield Plan's service area.

Medicare Advantage members from other Blue Cross and Blue Shield plans who are covered by an HMO product and whose ID cards do not have the suitcase logo with "MA" on it typically do not have benefits for services received from providers in Iowa and South Dakota, unless the services are a medical emergency. Instructions for verifying eligibility and coverage of these out-of-state Blue Cross and Blue Shield plan members can be found in the Verifying Eligibility, Coverage and Benefits for Out-of-State Blue Cross and Blue Shield Members Section.

Members should provide their ID cards when requesting services from you. Information on the member's ID card may include:

- The Enrollee name, also called the member or subscriber, is the holder of the policy.
- 3-character prefix and Enrollee ID, also called the member or contract number is made up of randomly chosen characters, either alpha-numeric or all numeric.
- Plan number, located just below the member information. This number identifies which Blue plan issued the card.
- Group number.
- A logo in the lower right corner of many cards that identifies the member's prescription drug claims processor (for use by pharmacists).
- Medicare Advantage Plan contact information including phone number(s) and/or website address.
- An address showing where to send claims.

IDENTIFICATION OF WELLMARK MEDICARE ADVANTAGE MEMBERS; ELIGIBILITY AND COVERAGE

Providers are responsible for verifying the eligibility and coverage of each Wellmark Medicare Advantage member before rendering non-emergency services or treatment.

Each time your patient receives care, check to see if there have been any coverage changes.

- Ask to see the patient's Wellmark Medicare Advantage ID card or acknowledgement letter at every encounter.
- Verify eligibility and coverage
  - Online: eligibility information is available on the provider portal and the member's Evidence of Coverage is available at Wellmark.com/Provider/Medicare-Advantage
  - By phone: 1-855-716-2556
  - Electronically through Availity® (270/271 transaction)

VERIFYING ELIGIBILITY, COVERAGE AND BENEFITS FOR OUT-OF-STATE BLUE CROSS AND BLUE SHIELD MEMBERS

To determine eligibility and cost-sharing amounts for Medicare Advantage members from Blue Cross and Blue Shield plans in other states who use Wellmark Medicare Advantage network providers, call 1-800-810-2583 or visit www.BCBS.com and provide the member's three-digit prefix located on the ID card.

BENEFITS AND SERVICES

Members with coverage by Wellmark Medicare Advantage HMO products have no benefits for items, services, or treatments received from providers outside the Wellmark Medicare Advantage HMO Network, except in instances such as medical emergency, urgently needed services when the network is not available, and out-of-area dialysis services.

Participating providers have the option of requesting a network exception for specialized services when there is limited or no access to Wellmark Medicare Advantage HMO network providers.

To request a network exception, Iowa and South Dakota providers can call 1-855-673-4225 or fax 1-866-313-8595.

Wellmark Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) but also offer enhanced benefits to members above and beyond Original Medicare benefits.

For Original Medicare benefits, refer to www.cms.gov.

Information related to the enhanced benefits offered by a Wellmark Medicare Advantage plan can be found in the member's Evidence of Coverage, which is available online at Wellmark.com/Provider/Medicare-Advantage.

Some of the enhanced benefits available through Wellmark Medicare Advantage include:

- **Vision**
  - Vision coverage services are administered by **Vision Service Plan (VSP®)**. When members obtain covered services from a VSP network provider, they receive the maximum level of coverage available under their plan. Information about VSP is available at 1-855-492-9028 and on their website at www.vsp.com.
- **Dental**
  - Wellmark Medicare Advantage plans include coverage for preventive and comprehensive dental services beyond Original Medicare. For more information about covered dental services, see the Wellmark Medicare Advantage member's Evidence of Coverage available on Wellmark.com/Provider/Medicare-Advantage.
  - **Iowa members**: Dental services are administered by **Delta Dental of Iowa®**. Information about Delta Dental of Iowa is available at 800-544-0718 and on their website at IowaDentalMA.com.
    - To check patient benefit and eligibility information, submit claims, review claim and payment status and recent communications, visit the Delta Dental website at deltadentalia.com/dentists.
    - To verify eligibility by phone, you may call the Interactive Voice Response system at: 800-544-0718.
    - To register for the provider portal, visit deltadentalia.com, select "New User? Sign up" and follow the instructions. A Business Key can be obtained by calling provider customer service at 800-544-0718.
    - To submit a claim:
      - Electronic claims:

- Provider web portal: https://secure.deltadentalia.com/portal/dentist/patient-info/patient-search
- Clearinghouse: use CDIA1

- Paper claims can be submitted using the following address:
  - Delta Dental of Iowa
    Medicare Advantage
    PO BOX 9040
    Johnston, IA 50131-9000

– Contact Delta Dental of Iowa at 800-544-0718 should you have any questions regarding your network participation.

– **South Dakota members**: Dental services are administered by **Delta Dental of South Dakota®**. Information about Delta Dental of South Dakota is available at 800-881-9928 and on their website at deltadentalsd.com/medicare-advantage.

- To check patient benefit and eligibility information, submit claims, review claim and payment status and recent communications, visit the Delta Dental website at dentalofficetoolkit.com.
- To register for the provider portal, visit dentalofficetoolkit.com. Once on the website, select the Register button to register for the first time.
- To submit a claim: Use Payer ID SDCMS
  - Electronic claims:
    - Provider web portal: dentalofficetoolkit.com
    - Clearinghouse: Change Health Care (CHC), DentalXchange (DXC), and Tesia
  - Paper claims can be submitted using the following address:
    - PO Box 9215
      Farmington Hills, MI 48333

- **Supplemental Hearing**

  – Wellmark Medicare Advantage plans (except Blue Medicare Advantage Valor PPO) include a routine hearing exam and offer hearing aid coverage. More information about this benefit is available from NationsHearing® at 800-921-4559 or in the member's Evidence of Coverage, available at Wellmark.com/Provider/Medicare-Advantage.

- **Telehealth (Online Visits)**

  – Wellmark Medicare Advantage members have a Telehealth (Online) Visit benefit. Members may utilize a network provider or Doctor on Demand® for non-urgent medical and behavioral health concerns. To access this benefit through Doctor on Demand, members can visit their website at doctorondemand.com.

- **Fitness Program**

  – Wellmark Medicare Advantage plans offer a fitness benefit through the SilverSneakers® Fitness Program. Our health plan supports physical fitness at any age and hope that you will encourage your Wellmark Medicare Advantage patients to enroll in the program, which offers complimentary membership to any participating location. SilverSneakers also includes a self-directed program for members who are unable to leave the home. More information about this fitness benefit is available online at silversneakers.com.

- **Meal Benefit**

  – Wellmark Medicare Advantage plans offer a meal benefit for eligible members who have been discharged from an inpatient hospital or skilled nursing facility. An assessment with the member's case manager is required to determine eligibility for the meal benefit. If a member qualifies for this benefit, a case manager will contact the member shortly after discharge to arrange meal delivery.

- **Live Healthy Blue Program**

  – Wellmark Medicare Advantage plans offer rewards and incentives for members registered in the Live Healthy Blue Program. Our Live Healthy Blue Program is an interactive program that rewards members for completing health actions such as completing their annual physician check-ups and other necessary screenings. Members must register to participate in the program and to redeem their rewards. Rewards include gift cards to select retailers.

COORDINATION OF BENEFITS (COB)

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we will pay depends on the amount paid by the primary plan. We follow all Medicare secondary-payer laws.

SUBROGATION

In the event there is a third party responsible for the cause of a Wellmark Medicare Advantage member's injury or illness, Wellmark reserves the right to recover benefits previously paid to a provider for related healthcare services. Recoveries can be pursued by Wellmark or its contracted vendors to the extent permitted under applicable law.

MEMBERS' RIGHTS AND RESPONSIBILITIES

Wellmark Medicare Advantage members have certain rights and responsibilities when it comes to their care, and providers are required to provide services in accordance with these rights and responsibilities. Wellmark Medicare Advantage member rights and responsibilities are outlined in the member's Evidence of Coverage (Wellmark.com/Provider/Medicare-Advantage) and generally align with the rights and responsibilities of Original Medicare members.

Among these member rights are special appeal rights if a Wellmark Medicare Advantage member is being discharged from a hospital and is dissatisfied with the discharge plan or believes that coverage of their hospital stay is ending too soon. Wellmark Medicare Advantage members also have special appeal rights when they receive notice that a stay at a skilled nursing facility or comprehensive outpatient rehab facility or services from a home health agency are ending, if they disagree with the decision to end covered services. These special appeal rights afford Wellmark Medicare Advantage members expedited review of the discharge plan or decision to end covered services by a Quality Improvement Organization (QIO). The provider, the member and Wellmark are notified of the decision by the QIO, and providers must abide by the QIO's decision. For more information about these special appeal rights, visit Wellmark.com/Provider/Medicare-Advantage for the member's Evidence of Coverage.

CULTURAL COMPETENCY

Wellmark Medicare Advantage network providers must ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those members with limited English proficiency, or reading skills and those with diverse cultural and ethnic backgrounds. Providers and their office staff are not allowed to discriminate against members in the delivery of health care services consistent with benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as end stage renal disease, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment. Providers must be able to treat any member in need of health care services and demonstrate that they have implemented effective policies of non-discrimination.

ADVANCE DIRECTIVES

Wellmark Medicare Advantage plans provide members information on their right to complete an advance directive. Advance directive means a written instruction, recognized under state law, relating to how to provide health care when an individual is incapacitated. As part of Wellmark's medical record content requirements, physicians must document in the medical record whether a member has or does not have an advance directive. If a member has completed and presents an advance directive, then the provider must include it in the member's medical record.

3. Provider Responsibility

NETWORK PARTICIPATION AND PARTICIPATION STANDARDS

Providers have an opportunity to apply for participation in Wellmark's Medicare Advantage networks. Network providers provide care to Wellmark Medicare Advantage members, and we reimburse them for covered services at the agreed upon payment rate. Network providers must sign formal agreements with Wellmark to participate in Wellmark's Medicare Advantage networks. By signing the agreement, the provider agrees to bill us for covered services provided to Wellmark Medicare Advantage members, accept our reimbursement as full payment minus any member required cost sharing, and receive payment directly from Wellmark.

To be included in Wellmark's Medicare Advantage networks, providers must meet certain criteria as outlined in the "Credentialing and Network Participation" section of the Provider Guide (For more information about provider eligibility and the application and credentialing process, view this online resource.)

APPOINTMENTS AND ACCESS STANDARDS

a. After-hours access

CMS requires that the hours of operation of its practitioners are convenient for and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, 7 days a week with a published after-hours telephone number (to a practitioner's home or other relevant location), pager or answering service, or a recorded message directing members to a practitioner for after-hours care instruction.

Note: Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening are not acceptable. In addition, primary care providers must provide appropriate backup for absences.

b. Appointment standards

Each practitioner must, at a minimum, meet the following appointment standards for all Wellmark Medicare Advantage members, including but not limited to primary care and behavioral health services. Appointment accessibility will be measured and monitored using the following standards:

- Routine and preventive care appointment (routine primary and specialty care) – service is provided within 30 business days.
- Services that are not emergency or urgently needed, but the enrollee requires medical attention (follow-up, non-urgent, symptomatic) – service is provided within 7 business days.
- Urgently needed services or emergency – service is provided immediately.

c. Failure to meet Access and Appointment Standards

If it is determined that a practitioner does not meet access and/or appointment standards, the non-compliant practitioner must submit a corrective action plan within 30 days of notification.

If…	Then…
The practitioner's corrective action plan is approved	The practitioner is notified, and the provider's office will be called approximately 14 days after receipt of the corrective action plan to reassess compliance with the corrective action plan.
The corrective action plan is not approved	A request will be made that the practitioner submit an acceptable corrective action plan within 14 days.
A reply is not received within 14 days	The practitioner will be sent a second letter, signed by the appropriate medical director. Copies of the letter will be forwarded to the Wellmark Medicare Advantage Quality Improvement Department.
A reply to the second letter is not received within 14 days	A third letter, signed by an appropriate medical director, will be sent to inform the practitioner that termination will occur within 60 days.

Wellmark encourages practitioners (or their office staff) to assist Wellmark Medicare Advantage members whenever possible in finding an in-network practitioner who can provide necessary services. If assistance is needed arranging for specialty care (in- or out-of- network), call our Provider Inquiry department at 1-855-716-2556.

ACCESS TO MEDICAL RECORDS

a. Responsibility to Provide Medical Records

Medical records may be requested for several reasons, including, but not limited to, rendering a decision, investigating potential quality concerns, and reviewing HEDIS and risk adjustment data. The provider agreement and the members' contract allow Wellmark to review all medical records. Neither Wellmark nor the member is responsible for any cost associated with the production or retrieval of medical records, and therefore, it is the financial responsibility of the provider and/or third-party vendor contracted with the provider to provide the requested records. Wellmark must receive all records within 10 days of the request unless a longer time is specified in the medical records request.

b. HEDIS Medical Record Reviews

Wellmark records medical data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records/data may be required to complete data collection.

For HEDIS reviews, we collect details that may not have been captured in claims data such as blood pressure readings, lab services, breast cancer and colorectal cancer screenings, diabetic eye exam screenings, admission and discharge documentation and body mass index. This information helps us enhance our member quality improvement initiatives.

A Wellmark employee or designated vendor(s) collects the requested HEDIS documentation. Provider offices are responsible for returning the documentation requested in a timely manner, if possible, within 7 days of the request. Wellmark or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data requested or provide remote EMR access. A patient list will be sent including the name and information being requested. If your office prefers an onsite visit, have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the Wellmark employee or the designated vendor immediately.

We request that providers allow Wellmark employees or its designated vendor(s) to scan medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record. Wellmark will not reimburse for copy house services. If a provider or an accountable care organization contracts with a copy house vendor, they will be responsible for reimbursing that vendor.

MEDICAL RECORD STANDARDS

Patient medical records and health information shall be maintained in accordance with current federal and state regulations (including prior consent when releasing any information contained in the medical record).

Wellmark providers must maintain timely and accurate medical, financial, and administrative records related to services they render to Wellmark members, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts as required by applicable federal, state and local laws and the provider agreement.

Medical record content and requirements for all practitioners (for behavioral health practitioners, see below) include, but may not be limited to:

- **Clinical record**
  - Patient name, identification number (name and ID number must be on each page), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.
- **Medical documentation**
  - History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services, and other risk screening.

- Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
    - Past medical, surgical, and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
    - Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.
- Clinical record — progress notes
    - Identification of all providers participating in the member's care and information on services furnished by these providers.
    - Reason for visit, or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed and follow-up report to referring practitioner (if applicable).
- Clinical record — reports content (all reviewed, signed, and dated within 30 days of service or event)
    - Lab, X-ray, referrals, consultations, discharge summaries, and summary reports from health care delivery organizations, such as skilled nursing facilities, home health care, free- standing surgical centers, and urgent care centers.

- **For behavioral health practitioners:**
    - Chief complaint, review of systems and complete historyof present illness
    - Past psychiatric history
    - Social history
    - Substance use history
    - Family psychiatric history
    - Past medical history
    - A medication list including dosages of each prescription,the dates of the initial prescription and refills
    - At least one complete mental status examination,usually done at the time of initial evaluation and containing each of the items below:
        - Description of speech
        - Description of thought processes
        - Description of associations (such as loose,tangential, circumstantial, or intact)
        - Description of abnormal or psychotic thoughts
        - Description of the patient's judgment
    - Complete mental status examination
    - Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content(including any thoughts of harm), mood, affect and other information relevant to the case.
    - A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination and otherassessment data

NON-COVERED SERVICES AND REFERRALS FOR NON-COVERED SERVICES — PROVIDER RESPONSIBILITIES

Sometimes you and your patient may decide that an item, service, or treatment is the best course of care, even though it isn't covered by Wellmark Medicare Advantage plans or it may be supplied by another provider or practitioner outside the Wellmark Advantage Health Plan Networks. Wellmark Advantage Health Plan follows CMS as it relates to the Advance Beneficiary Notice of Non-coverage (ABN). Do not submit ABNs for items, services, or treatments provided or denied under Medicare Parts C or D.

You are responsible for determining which items, services or treatments are covered by reviewing Original Medicare benefits and Wellmark Medicare Advantage enhanced plan benefits. Providers may choose to obtain a written advance coverage determination from Wellmark before providing an item, service, or treatment to determine if it would be covered under the member's health plan benefits. Once a determination has been made, if a denial is warranted, an Integrated Denial Notice (IDN) will be sent to the member and provider and will include important appeal rights guaranteed to the member and provider. For additional information about advance coverage determinations, refer to Section 6 of this Provider Manual.

If you believe that an item, service, or treatment won't be covered, you must tell the member and document that the member was told before the service or treatment is performed or item obtained. If the member acknowledges the documentation that the item, service, or treatment won't be covered by Wellmark and agrees that they will be solely responsible for paying you, you may perform and bill the member for the non-covered item, service, or treatment.

Providers are responsible for managing agreements related to non-covered services and can bill liability modifiers (e.g., GA, GX, GY, GZ) that denote there is a liability agreement in place. The claim will be processed based on the medical criteria and benefit of the service rendered. When the member decides to cover an expense for an item, service or treatment not covered by their plan, the rendering provider will submit a claim to the member's plan for a post-service organization determination.

If you believe that an item, service, or treatment won't be covered by the non-contracted provider supplying it, you must tell the member and document that the member was told before you refer them and before they seek the item, service, or treatment from the provider. If the member acknowledges that the item, service, or treatment won't be covered and understands that you're referring them to a non-contracted provider and agrees that they will be solely responsible for paying for the item, service, or treatment, then you or the rendering provider must obtain an advance coverage determination before the item, service, or treatment is provided.

If you provide an item, service, or treatment that is not covered or refer the member to a non-contracted provider for services and have not provided the patient with prior notice that the item, service, or treatment is not (or may not be) covered by the plan, you cannot bill the patient for such non-covered items, services, or treatments.

OTHER PROVIDER RESPONSIBILITIES

In addition to the rights and responsibilities outlined in the provider agreement, providers have the following rights and responsibilities:

- Providers must cooperate with Wellmark to resolve any Wellmark Medicare Advantage member grievance involving the provider within the time frame required under federal law.
- Providers who are hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities, must provide applicable CMS member appeal notices.
- Providers cannot charge the member in excess of cost-sharing under any condition, including in the event of plan bankruptcy.
- Providers may only provide certain special services to members if the provider is approved by Medicare to provide such services (e.g., transplants, VAD distribution therapy, carotid stinting, bariatric surgery, PET scans for oncology, or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Providers agree to accept all Wellmark Medicare Advantage members unless the practice is closed to all new patients (commercial or Medicare).
- Providers can only bill for professional services personally provided by the Wellmark Medicare Advantage provider. (This specifically prohibits billing for services provided by any subcontractor, or other provider, including a partner in a group practice.)
  - **Note:** The only exception is when a physician personally supervises a provider who cannot bill Wellmark directly. Providers must provide complete care within the Wellmark Medicare Advantage provider's specialty and do not systematically refer or "share" the care of patients.
- Providers (including facilities) must provide safe, medically necessary, and cost-effective care.
- Practitioners must maintain a current and accurate Council for Affordable Quality Health Care (CAQH) ProView Datasource ProView record Practitioners must update the CAQH ProView minimally once every 120 days and re-attest to the completeness and accuracy of the information.

COMPLIANCE WITH FEDERAL LAWS

Federal regulations require Medicare Advantage Organizations like Wellmark to have oversight of providers and to ensure that all services are provided in compliance with applicable laws, regulations, CMS instructions, and the contract Wellmark holds with CMS. As part of those compliance obligations, providers are required to comply with applicable laws protecting patient privacy rights, including the Health Information Portability and Accountability Act of 1996 and its corresponding regulations, that apply to covered services furnished to Wellmark Medicare Advantage members.

Additionally, providers participating in Wellmark's Medicare Advantage networks are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-kickback Statute (section 128B(b) of the Social Security Act).

Consistent with Section 130 of the Medicare Benefit Policy Manual, Wellmark will not reimburse practitioners for professional services provided to a practitioner's immediate family member(s) or that the practitioner provides to themself. Family members include the practitioner's spouse; natural or adopted parents, children, and siblings; stepparents, stepchildren, and stepsiblings; in-laws; grandparents and grandchildren and their spouses. Wellmark will also not reimburse practitioners for professional services provided to individuals sharing the same household with the practitioner as part of a single-family unit.

Because of the relationship between the practitioner and the patient, Medicare expects these services would ordinarily be furnished free of charge.

4. Reimbursement, Claims and Billing

REIMBURSEMENT

Wellmark reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage agreement minus any member required cost-sharing; for all medically necessary services covered by the Wellmark Medicare Advantage plan. Payment from Wellmark and collection of applicable member cost-share together represent payment in full.

We will process and pay clean claims within 30 calendar days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest in accordance with the applicable CMS guidelines.

All remittances for Wellmark Medicare Advantage members (Explanations of Payment or "EOPs") will be available on the Wellmark Advantage Health Plan provider portal.

Wellmark provides Evidence of Coverage (EOC) to all members following enrollment, which a provider can view online at Wellmark.com/Provider/Medicare-Advantage. This document provides general benefit information for members by plan option. It also describes member cost-sharing requirements that can be used by the provider to collect payment at the time the service is provided, rather than waiting for the claim to be processed and the member billed.

Original Medicare benefit coverage rules apply, except where noted. Wellmark will not reimburse providers for services that are not covered under Original Medicare unless such services are specifically listed as covered services under the member's Wellmark Medicare Advantage plan.

Wellmark and providers must also comply with CMS' National Coverage Determinations (NCDs), general coverage guidelines included in Original Medicare manuals and instructions, and written coverage decisions of the local Medicare Administrative Contractor (LCDs). Applicable NCDs and LCDs can be found on CMS's Medicare Coverage Database at cms.gov.

Follow all Original Medicare billing guidelines and be sure to include the following on all claims:

- Diagnosis code to the highest level of specificity. When a sixth or seventh digit exists for a code, you must supply all applicable digits.
- National coding guidelines are accessible at https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines-updated-01/11/2023.pdf
- Medicare Part B supplier number, National Provider Identifier (NPI) and federal tax identification number
- The member's Wellmark Medicare Advantage numbers, including the prefix, found on the member's ID card
- For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 (02-12) claim form.

Wellmark Medicare Advantage network providers agree to Wellmark reimbursement policies outlined in the provider's Medicare Advantage agreement. These include but are not limited to:

- Accepting the applicable reimbursement level stated in the provider's Medicare Advantage agreement as payment in full for covered services, except for cost sharing, which is the member's responsibility
- Billing Wellmark, not the patient, for covered services
- Not billing patients for covered services that:
  - Required but did not receive prior authorization or pre-service approval.
  - Were denied for timely filing reasons.
  - Were not eligible for payments as determined by Wellmark based upon our credentialing or privileging policy for the service rendered.
  - Were denied for any other reason, unless the provider provided the member with an appropriate Notice of Medicare Non-Coverage before the covered services were performed.

CLAIMS SUBMISSION

Claims that are not filed by a provider prior to the claim filing limit of 180 days from date of service or discharge will be the provider's liability.

Where to submit a claim:

The preferred method for submitting professional or facility claims is electronically (ANSI X12 837). However, paper claims can be sent to the address listed below. Providers submitting paper claims must use the appropriate claim form (Professional: National Uniform Claim Committee's CMS-1500 Health Insurance Claim Form (version 02/12); Facility: CMS-1450 (UB-04). Information regarding the National Uniform Billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their website at https://www.nubc.org/. Paper claims received by mail will be converted to electronic format for adjudication.

Whether you are a Wellmark Medicare Advantage network provider or an Iowa or South Dakota non-contracted Medicare Advantage provider filing a claim for a Wellmark Medicare Advantage member or out-of-state Blue Cross Blue Shield Medicare Advantage member, file the claims to Wellmark. Wellmark uses a third-party clearinghouse to receive electronic claims and claim corrections. Refer to https://www.wellmark.com/provider/claims-payment for more information.

Contact Availity to enroll in electronic claim submissions or for questions related to electronic claim submissions.

Submit claims:

- Electronically (preferred) using Payor ID **88848**.
- By mail to:

  Wellmark Advantage Health Plan
  Station 1E238
  PO Box 9291
  Des Moines, IA 50306

All claims received, regardless of submission method, that do not meet clean claim criteria will not be rejected electronically. These claims will be returned via mail to the billing address submitted on the claim record along with a letter of explanation for the rejection.

Note: Providers located in contiguous counties may directly contract with a Blue Cross Blue Shield plan in an adjacent state for HMO members. If you are directly contracted with the HMO member's home plan, the claim should be filed directly to the HMO member's home plan.

When submitting claims:

- Follow HIPAA standard implementation guides and CMS requirements for all claims submissions unless specific instructions are otherwise stated within this Provider Manual.
- Submit CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
- Include NPI numbers on all claims.
- Send claims to your local Blue Cross and Blue Shield Medicare Advantage plan. Ancillary claims filing rules apply to Medicare Advantage.
- For independent clinical laboratories, the local plan is the Blue Cross and Blue Shield Medicare Advantage plan in whose service area the specimen was drawn, which is determined by the state in which the referring physician is located.
- For DME suppliers and orthotic & prosthetic suppliers, the local plan is the Blue Cross and Blue Shield Medicare Advantage plan whose service area the equipment was shipped, or in which it was purchased at a retail store.

Physical Medicine Providers

Wellmark Physical Medicine providers who are contracted as individual practitioners for participation in Wellmark's provider networks including Medicare Advantage, but have enrolled as a Rehabilitation Agency with Medicare**,** should file claims for services rendered to Medicare Advantage members to Wellmark on an 837P or CMS-1500. Submit claims with appropriate billing and rendering NPI per your Wellmark provider enrollment as an individual practitioner and current taxonomy code registered with National Plan & Provider Enumeration System (NPPES) based on services billed to ensure proper adjudication.

Submitting supporting documentation:
Supporting documentation for claims may be required to review description of services or to determine medical necessity. Claims may deny indicating information required was not submitted. To submit required information, complete a Claim Supporting Documentation Submission Form, include the required supporting documentation, and submit by fax or mail. Note: Do not use this form for disputes or appeals.

Fax: 1 866 530 0102 (preferred)

Mail: WMAHP Provider Correspondence
P.O. Box 211285
Eagan, MN 55121

Claim corrections and void/cancels:

Claim corrections should be submitted electronically. The provider must enter 7 for Replacement of a prior claim or 8 for Void/Cancel of a prior claim in the Resubmission portion of the field. The original claim number must be supplied in the Original Reference Number portion of the field. Claim adjustments must also include the appropriate claim change reason code. Remarks to explain the reason for the adjustment are optional, except that remarks are required when the default condition code D9 and adjustment reason code OT are used.

The claim void/cancel process is only used if a processed claim should never have been submitted.

If changes need to be made to the first two digits of the type of bill (TOB) (e.g., changing TOB 111 inpatient to TOB 131 outpatient), the original claim must be voided by submitting TOB XX8. Submit a **new** claim with the correct TOB for processing.

Claims, including revisions or adjustments, that are not filed by a provider prior to the claim filing limit of 180 days from date of service or discharge, will be the provider's liability.

Taxonomy codes:

Providers must register taxonomy codes under their NPI and make timely changes or additions to their NPI through National Plan & Provider Enumeration System (NPPES). Providers that have more than one taxonomy code must register all applicable taxonomy codes based on their specialty and the services provided, and this must be done prior to providing services. Inaccurate taxonomy codes registered in NPPES for the services billed at the time claims are received may result in claim denials.

Subparts, defined by CMS and registered in NPPES as such, are required to submit taxonomy codes on all claim submissions for processing.

Billing Not Otherwise Classified (NOC) or Not Otherwise Specified (NOS) codes:

Providers should always bill a defined code for medical services when one is available. If one is not available, use an unlisted service (NOC or NOS code), and provide a concise description of the service on the claim submission. For drugs and biological products, submit NOC (J-codes) with the National Drug Code (NDC) number and total quantity of the drug that was administered, expressed in the unit of measure applicable to the drug or biological submitted on the claim submission.

See "Submitting supporting documentation" section above for information about if the claim denies for requiring additional information.

Submitting modifier -22 (Increased procedural services):

Modifier -22 (Increased procedural services): Provider should only use this modifier when additional work requiring the practitioner's technical skill involve significantly increased work, time, and complexity than when the procedure is normally performed. The procedure and/or service may be surgical or non-surgical. Reimbursement already accounts for the possibility that sometimes the procedure will be simpler and other times more difficult than normal. However, there are times when a procedure can be significantly more difficult. Medical documentation cannot be submitted electronically with the claim submission. Following finalization of the claim, submit medical documentation by following the level 1 appeal process.

INTERIM RATE LETTERS

Reimbursement for Medicare certified provider types, such as Critical Access Hospitals with or without Swing Beds and Rural Health Clinics, is based on the provider's Interim Rate Letters (IRLs). Those providers must submit all copies of their annual IRLs and periodic rate change letters to Wellmark upon receipt in accordance with the provider agreement.

New providers with these provider types applying to join Wellmark's Medicare Advantage networks must include all applicable IRLs back to the requested effective date of the networks.

Submit the IRLs by email.

OFFSETS AND OVERPAYMENTS

Wellmark will withhold funds from future claim payment(s) to providers up to the amount of any identified overpayment. For more information about overpayment identification, see the Repayment Rule Section. If you have questions about an offset or overpayment, contact Provider Inquiries at 1-855-716-2556.

EXCLUDED PROVIDERS

Wellmark is prohibited from issuing payment to a provider or entity that appears on the List of Excluded Individuals/Entities as published by the U.S. Department of Health and Human Service Office of Inspector General or on the list of debarred contractors as published by the U.S. General Services Administration (with the possible exception of payment for emergency services under certain circumstances). Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals/Entities can be found at oig.hhs.gov > Exclusions > Online Searchable Database.
- The General Services Administration list of debarred contractors can be found in the System for Award Management (SAM) website at sam.gov.

BILLING WELLMARK MEDICARE ADVANTAGE MEMBERS

Providers should collect any applicable cost-share from Wellmark Medicare Advantage members at the time of service or when possible. Providers are not allowed to balance bill members for differences between the allowed amount and charges. If a provider determines that a Wellmark Medicare Advantage member has paid more than the member's applicable cost-share, the provider must refund the overpayment to the member within 30 days of identification.

Providers are generally prohibited from billing Wellmark Medicare Advantage members for health care services for which Wellmark denies payment, unless the member is informed in advance regarding their payment responsibility in accordance with the applicable provider agreement. In limited circumstances, Wellmark Medicare Advantage members are held at financial risk for denied services.

If you have questions about a Wellmark Medicare Advantage member's financial liability for health care services, call Provider Inquiry Services at 1-855-716-2556 for assistance.

BILLING FOR HOME HEALTH SERVICES

Notice of Admissions (NOAs) are required to be submitted by home health agencies according to CMS guidelines. NOAs must be submitted within 5 calendar days from the start of care.

BILLING FOR HOSPICE SERVICES

Federal regulations require that Medicare fee-for-service contractors (Medical fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan or other carrier) maintain payment responsibility for Wellmark Medicare Advantage patients who elect hospice care. Claims for services provided to a Wellmark Medicare Advantage patient who has elected hospice care should be billed to the appropriate Medicare contractor.

- If the patient elects hospice care and the service is related to the patient's terminal condition, submit the claim to the regional home health intermediary.
- If the patient elects hospice care and the service is not related to the patient's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.
- If the service is provided during a lapse in hospice coverage, submit the claim to the appropriate Blue plan as described in the Claims Submission Section, above.
- If the service is not covered under Original Medicare but is offered as an enhanced benefit under the patient's Medicare Advantage plan (for example, vision), submit the claim to the appropriate Blue plan as described in the Claims Submission Section, above.

A Wellmark Medicare Advantage member who elects hospice care but chooses not to disenroll from the plan is entitled to receive (through Wellmark) any Medicare Advantage benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the member and Wellmark will continue to pay providers and suppliers for other Medicare-covered services furnished to the Wellmark Medicare Advantage member. The table below summarizes the cost-sharing and provider payments for services furnished to a Wellmark Medicare Advantage member who elects hospice.

Type of Services	Wellmark Medicare Advantage Member Coverage Choice	Member Cost-Sharing	Payments to Provider
Hospice program	Hospice program	Original Medicare cost-sharing	Original Medicare
Non-hospice care*, Parts A & B	Wellmark or Original Medicare	Wellmark cost-sharing, if member follows Wellmark's plan rules**	Original Medicare**
		Original Medicare cost-sharing, if member does not follow Wellmark's plan rules**	Original Medicare
Non-hospice care*, Part D	Wellmark	Wellmark cost-sharing	Wellmark
Enhanced services	Wellmark	Wellmark cost-sharing	Wellmark

* Original Medicare covers items and services related to the terminal illness for which the Wellmark Medicare Advantage member entered the hospice. The term "non-hospice care" refers either to services not covered by Original Care or to services not related to the terminal condition for which the member entered the hospice.

** A Wellmark Medicare Advantage member who receives out-of-network services and has followed plan rules is only responsible for Wellmark cost-sharing amounts. The Wellmark Medicare Advantage member is not required to communicate to Wellmark in advance regarding the member's choice of where services are obtained.

CLINICAL RESEARCH STUDIES

If a patient with Wellmark Medicare Advantage coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay you on behalf of the Wellmark Medicare Advantage plan. Wellmark will pay for Medicare-covered services that are not affiliated with the clinical trial. Therefore, you must submit claims for Medicare-covered services related to the clinical trial to carriers and fiscal intermediaries, not to Wellmark, using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to Wellmark, and Wellmark will reimburse you accordingly.

5. Fraud, Waste and Abuse

DETECTING AND PREVENTING FRAUD, WASTE AND ABUSE

Wellmark Advantage Health Plan is committed to detecting, mitigating and preventing fraud, waste, and abuse. Providers are also responsible for exercising due diligence in the detection and prevention of fraud, waste, and abuse, in accordance with the Wellmark Advantage Health Plan Detection of Fraud, Waste and Abuse policy.

Wellmark Advantage Health Plan encourages providers to report any suspected fraud, waste, and/or abuse to the Wellmark Advantage Health Plan Corporate and Financial Investigations department, the Corporate Compliance Officer, the Medicare Compliance Officer, or through the fraud hotline, 877-411-6950. The reports may be made anonymously.

WHAT IS HEALTHCARE FRAUD, WASTE AND ABUSE?

What is fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information to the government or a government contractor (such as Wellmark Advantage Health Plan) in order to get money or a benefit.

Examples of fraud

Examples of fraud include:

- Billing for services not rendered
- Billing for services provided to a member at no cost
- Upcoding services – billing for a more costly service than the one actually performed
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

What is waste?

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of waste

Example of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling orclaims
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed
- Overuse, underuse, and ineffective use of services

What is abuse?

Abuse includes practices that result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of abuse

Examples of abuse include:

- Providing and billing for excessive orunnecessary services
- Routinely waiving member coinsurance,copayments, or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

MEDICARE PART D PROGRAM – PRESCRIBER PRESCRIPTION VERIFICATIONS

As part of an ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, CMS' program integrity contractor, the NBI MEDIC (Health Integrity, LLC), requests prescriber prescription verifications. The NBI MEDIC routinely mails prescriber prescription verification forms containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks the prescriber to check yes or no to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

A timely and complete response to prescription verification is important as it is likely to result in the elimination of an allegation of wrongdoing and/or prevent the payment of fraudulent prescriptions without need for further investigation. Providers who are involved in the administration or delivery of the Medicare Part D prescription drug benefit are strongly encouraged to respond in a timely manner to prescription verifications when contacted by the NBI MEDIC.

Additionally, beginning January 1, 2016, if a prescriber wants Part D to cover a prescription, not only must the prescriber have a valid NPI number, but the prescriber must also be either: (1) enrolled in Medicare or (2) validly opted-out of the program. Wellmark Advantage Health Plan will reject an otherwise valid prescription, if it was written by a prescriber who is neither enrolled in Medicare nor validly opted-out of the program.

REPAYMENT RULE

Under the Patient Protection and Affordable Care Act, providers are required to report and repay overpayments to the appropriate Medicare Administrative or other contractor (Fiscal Intermediary or Carrier) within the later of (a) 60 days after the overpayment is identified, or (b) the date of the corresponding cost report is due, if applicable.

Under the Affordable Care Act, a provider is obligated to report and return an overpayment by the later of (1) 60 days after the date on which the overpayment was identified; or (2) the date any corresponding cost report is due (if applicable). Failure to do so may render the provider subject to liability and penalties under the False Claims Act, 31 U.S.C. 3729, et seq.

Mail overpayments for Medicare Advantage claims for Wellmark Advantage and Medicare Advantage out-of-state members to the following address:

Wellmark Advantage Health Plan
PO Box 675367
Detroit, MI 48267-5367

Please include with the refund to ensure it is applied appropriately:

- Member Name or Member ID number
- Claim Number and Date of Service
- Copy of the Explanation of Payment (EOP)
- Copy of the letter for overpayment, if overpayment was requested

6. Health Services and Utilization Management

SERVICES REQUIRING MEDICAL NECESSITY AND CONCURRENT REVIEW OR PRIOR AUTHORIZATION

Certain benefits require that providers obtain medical necessity review or prior authorization before providing or scheduling the service. For information on how to access Wellmark Advantage member eligibility and benefit information, refer to Section 2 of this Provider Manual. For information on current utilization management requirements and policies, refer to the Medicare Advantage page under the Utilization Management section.

Inpatient Review				
Type of Admission		**Review Type**	**Pre-service Submission Timing**	**Concurrent Review Required**
Acute Inpatient	Urgent/Emergent	Medical Necessity	Submit within 1 business day of admission	N/A
	Elective/Planned	Medical Necessity & Pre-service	Submit before the scheduled admission (Pre-Service)	N/A
Inpatient Behavioral Health		N/A	N/A	N/A
SNF and LTACH (Post-Acute)		Medical Necessity & Pre-service	Submit before the scheduled admission (Pre-Service)	Initial review is done within 14 days of admission, then every 14 days or sooner based on medical necessity
Inpatient Rehabilitation (Post-Acute)		Medical Necessity & Pre-service	Submit before the scheduled admission (Pre-Service)	Initial review is done within 7 days of admission, then every 7 days or sooner based on medical necessity

Other Services	
Type	**Prior Authorization Required**
Medical Services	Suspended until further notice
Certain Part B Medications including Home Infusion Therapy Drugs (see prior authorization list on the Medicare Advantage page under Utilization Management)	X

PRIOR AUTHORIZATIONS

Prior authorization is required for all designated services listed above.[1] If the prior authorization is not approved or not completed prior to the service being provided, the claim will be denied. The provider will receive an authorization number through the prior authorization process that must be submitted on all claims associated with the procedure. If the procedure is the primary reason for the hospital stay and the prior authorization is not completed or is not approved, the inpatient admission will not be covered.

For approved acute inpatient stays, submit the discharge date and summary through Symphony within 24 hours of discharge. If the patient is discharged beyond the approved inpatient dates, an updated approval letter will be sent, and prior authorization will be updated in Symphony within 48 hours.

In some instances where a prior authorization was not able to be obtained prior to the service being provided (e.g., a member did not provide current ID card at the time of service), providers can submit a retrospective review (online preferred) up to 180 days from the date of service. If the retrospective review is approved, the provider will need to submit a new claim with the authorization number within 180 days from the date of service.

[1]No prior authorization is needed for ambulatory or inpatient behavioral health services.

CONCURRENT REVIEW

Concurrent review includes utilization management activities that take place during inpatient level of care, for post-acute care services, or an ongoing outpatient course of treatment. The concurrent review process includes obtaining necessary clinical information from facility staff, practitioners, and providers to determine medical necessity and the appropriate ongoing level of care.

If a member's discharge is expected to be greater than the length of stay as determined in the preceding decision, clinical documentation must be provided to support the continued stay. Refer to the Inpatient Review table above and the determination letter for additional information.

OBTAIN MEDICAL NECESSITY FOR INPATIENT ADMISSIONS, CONCURRENT REVIEW OR PRIOR AUTHORIZATION

Prior authorization requests and requests for concurrent review for Wellmark Medicare Advantage members can be submitted as follows:

1. *Preferred:* Online through Symphony in the Wellmark Secure Provider Portal (Wellmark Advantage Health Plan section)

2. Via Fax 24/7- *Note, Faxed requests will only be processed during normal business hours (8 a.m. – 5 p.m. Central Time)
   - Acute Hospital Admissions, Post-Acute Admissions (SNF, LTACH, and Inpatient Rehabilitation), and DME
     Fax: 1 866 313 8595
   - Concurrent Review for Acute Hospital Admissions, Post-Acute Admissions (SNF, LTACH, and Inpatient Rehabilitation), and DME
     Fax: 1 866 313 8595

3. Via toll-free telephone during normal business hours (8 a.m. – 5 p.m. Central Time)
   Phone: 1-855-673-4225

4. Part B Medications
   Fax: 1 877 218 0941

Providers will have access to form templates, which identify the specific information required for a prior authorization request. Forms are available on Wellmark's website at Wellmark.com/Provider/Medicare-Advantage.

DECISION TIMEFRAMES AND DECISION NOTIFICATIONS FOR SERVICES REQUIRING MEDICAL NECESSITY AND CONCURRENT REVIEW OR PRIOR AUTHORIZATION

Wellmark conducts timely reviews of all requests for service, according to the type of service requested. Decisions are made:

Type of Request		Decision	Initial Notification	Written Notification
Inpatient Admissions/ Concurrent Review	Pre-service (urgent)*/ concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification
	Pre-service standard	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request
	Post-service	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request
Part B Drugs	Pre-service (urgent)*/ concurrent	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 3 days of initial notification
	Pre-service standard	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of initial notification
	Post-service	Within 7 days from receipt of request	Within 7 days from receipt of request	Within 7 days of initial notification

*Urgent pre-service means that the provider believes waiting for a decision under the standard timeframe could place a Wellmark Medicare Advantage member's life, health or ability to regain maximum function in serious jeopardy.

The timelines described above for Inpatient Admissions/Concurrent Review may be extended by up to 14 days either due to the member's request or if Wellmark believes that the delay is in the member's best interest.

When Wellmark makes a decision, members and providers receive notice of that decision.

If...	Then...
The service is approved	For all service requests, the members and providers receive written notification. Providers will also receive verbal notification for inpatient and post-acute services.
The service is denied	Wellmark sends the member, practitioner and facility a letter within the time frames stated above. The denial notification includes: • Description of the criteria utilized to render the determination • Reason for the denial • Right to request the criteria used to render the decision • Right to request the diagnosis and procedure codes related to the request • Description of how to file an appeal • The specific location in the Evidence of Coverage that describes the exclusion, as well as the member appeal rights (if denial is based on a benefit determination)

ADVANCE COVERAGE DETERMINATIONS

For services not requiring pre-service review or prior authorizations, providers may choose to obtain a written advance coverage determination (also known as an organization determination) from Wellmark before providing a service or item.

All Wellmark Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets the criteria outlined in the Decision-Making Process and Notifications Section, it will be covered by the Wellmark Medicare Advantage plan.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To request an advance coverage determination, Iowa and South Dakota providers can call 1-855-673-4225 or fax 1-866-313-8595.

In cases where the provider believes that waiting for a decision under the standard time frames listed below could place the member's life, health or ability to regain maximum function in serious jeopardy, the provider can request an expedited determination. To obtain an expedited determination, fax your request indicating "Urgent" or "Expedite" on the first page of the request.

The table below outlines the processing time frames for Advance Coverage Determinations:

Type of Request		Decision
Inpatient Admissions/Medical Services	Pre-service (urgent)*	72 hours from receipt of request
	Pre-service standard	14 calendar days from receipt of request
Part B Drugs	Pre-service (urgent)*	24 hours from receipt of request
	Pre-service standard	72 hours from receipt of request

*Urgent pre-service means that the provider believes waiting for a decision under the standard timeframe could place a Wellmark Medicare Advantage member's life, health or ability to regain maximum function in serious jeopardy.

Wellmark will make a decision within the specified timeframes and notify you as described in the Decision Timeframes and Decision Notifications Section.

Be sure to include the following information with your request for an advance coverage determination:

- Provider or supplier contact information, including name and address
- Anticipated date of service, if applicable
- Procedure/HCPCS and Diagnosis codes
- Pricing information, including NPI number (and CMS Certification Number (CCN) for institutional providers), ZIP code where services were rendered, and physician specialty
- Documentation and any correspondence that supports your position that the plan should cover the service or item (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)

MEDICAL NECESSITY; DECISION-MAKING PROCESS, CRITERIA AND GUIDELINES

1. Medical Necessity Considerations Generally

As required by your provider agreement and the Wellmark Medicare Advantage member's Plan Benefit Packet, all covered services provided by a provider to the member must be medically necessary. As a Medicare Advantage plan, Wellmark is required by CMS to provide coverage to its members for all Part A and Part B Original Medicare covered services. However, CMS does not require that Medicare Advantage plans follow the same payment determination rules or processes for providers as Original Medicare does.

While Wellmark does apply medical necessity criteria to determine coverage, the criteria does not have to be applied in the same manner as required under Original Medicare. Specifically:

- Benefits: Medicare Advantage plans must provide or pay for medically necessary covered items and services under for beneficiaries enrolled in Part A and Part B.
- Access: Medicare Advantage members must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage members the same access to providers that is provided under Original Medicare.
- Billing and payment: Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures if both contracted and non-contracted providers are paid accurately, in a timely manner and with an audit trail.

2. Decision-Making Process and Notifications

Clinical information is necessary for all services that require clinical review to determine medical necessity. In addition to reviewing clinical information, Wellmark's Care Management team evaluates:

- The member's eligibility coverage and benefits
- The medical need for the service
- The appropriateness of the service and setting

If additional clinical information is required to approve the service, a Wellmark Care Management representative will contact the provider to ensure that all needed information is received in a timely manner. A written request may also be sent to the member or provider requesting the authorization.

If Wellmark's nursing clinical review staff is unable to approve the request for services, the request is referred to a plan medical director for review.

When the plan medical director is unable to approve the service, a denial notification is sent to the member and applicable provider(s).

Pharmacists review and make final determinations on all requests for Part B Medications that require prior authorization.

Wellmark's clinical staff also reviews requests that require a benefit determination. If the service is not a covered benefit, Wellmark's clinical staff denies the request.

All decisions are made, and notifications are provided in compliance with state and federal laws, regulations and accreditation standards. A plan medical director makes all denial determinations based on medical necessity.

Both Wellmark and Original Medicare coverage and payment are contingent upon all the following conditions being met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury, to improve functioning of a malformed body patient, or is a covered preventative service.

3. Criteria and guidelines for decisions

In addition to Original Medicare medical necessity criteria, Wellmark utilizes InterQual criteria (updated annually) and other criteria to make decisions, as outlined below:

Criteria	Application
InterQual® Acute – Adult	Inpatient admissions Continued stay and discharge readiness
InterQual Level of Care – Subacute and Skilled Nursing Facility	Subacute and skilled nursing facility admissions
InterQual Rehabilitation – Adult (Inpatient)	Inpatient admissions Continued stay and discharge readiness
InterQual Level of Care – Long Term Acute Care	Long-term acute care facility admissions
CMS Inpatient Procedure List	CMS list of procedures that can be performed in the inpatient setting

OBSERVATION SERVICES AND THE MEDICARE OUTPATIENT OBSERVATION NOTICE

Observation services are outpatient, short-term services provided to a patient for monitoring purposes and/or while a decision is being made whether to admit the patient as a hospital inpatient. Observation stays of up to 48 hours for patients may be eligible for reimbursement when you need more time to evaluate and assess a patient's needs to determine the appropriate level of care.

1. Providing Medicare Outpatient Observation Notice (MOON)

Wellmark follows CMS guidance for the Medicare Outpatient Observation Notice (MOON). Hospitals and Critical Access Hospitals (CAHs) are required to furnish the MOON to any Medicare beneficiary who has been receiving observation services as an outpatient for more than 24 hours. The MOON is a standardized notice developed to inform beneficiaries (including Medicare health plan enrollees) that they are an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH). The notice must be provided no later than 36 hours after observation services are initiated or, if sooner, upon release.

The MOON notice informs beneficiaries of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services.

Provider compliance with this notification requirement is mandatory.

The standard language for the MOON notice and instructions can be accessed at the following link:
cms.gov/Medicare/Medicare-General-Information/BNI/

2. Options available beyond the observation period

For members who require care beyond the observation period, the following options are available:

- Contact Wellmark clinical staff at **800-662-5685** to discuss alternate treatment options such as home care or home infusion therapy
- Request an inpatient admission

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

3. Medical necessity considerations: inpatient vs. observation stays

When Medicare Advantage members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses.

Here are some guidelines that clarify how Wellmark determines medical necessity:

- Wellmark uses InterQual criteria to make determinations of medical necessity for all Medicare Advantage members.

- When the application of InterQual criteria results in a Medicare Advantage member's inpatient admission being changed to observation status, all services should be billed as observation.
- Wellmark's clinical review process takes precedence over the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures.

STEP THERAPY FOR PART B DRUGS

Wellmark may require that a Medicare Advantage member try a Part B preferred drug to treat a medical condition before Wellmark covers a different non-preferred Part B drug.

QUALITY IMPROVEMENT AND THE MEDICARE STAR RATING SYSTEM

Wellmark is committed to improving the quality of health care for its Medicare Advantage members. Wellmark maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services patients receive and routinely measure the results to ensure patients are satisfied and expectations are met. Providers are required to cooperate with Wellmark's quality improvement activities. By working together, Wellmark and providers can ensure that Wellmark Medicare Advantage members receive high-quality health care services and are connected with resources and opportunities that can improve the health status of our members.

In addition to improving health care quality and outcomes for Wellmark Medicare Advantage members, Wellmark's quality improvement initiatives contribute to Wellmark's CMS Star ratings. The CMS plan rating uses quality measurements widely recognized within the health care and health insurance industries to provide an objective method for evaluating health plan quality. CMS issues Star ratings to Medicare Advantage health insurance plans annually to help beneficiaries choose a Medicare Advantage plan offered in their area. CMS's methodology and guidelines may change from year to year. Wellmark periodically reviews and updates its quality improvement programs and initiatives to incorporate quality measurements utilized by CMS and quality measurements that Wellmark believes can make the most impact on the health of Wellmark Medicare Advantage members.

7. Care Management and Care Transitions

DISCHARGE PLANNING

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care physician
- Specialists and other practitioners
- Hospital discharge planning staff
- Ancillary providers, as necessary

Wellmark monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements tocontinue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. Wellmark nurses work in conjunction with members' healthcare providers to authorize and coordinate post-hospital needs, such as home health care, durable medical equipment and skilled nursing placement. For these members, providers should follow the processes described below.

MEDICARE ADVANTAGE CARE TRANSITION

The Medicare Advantage Care Transition Program is the coordination of care after a member is discharged from an inpatient acute care facility. Proactive interventions begin when the member is directly contacted by telephone prior to discharge and continues post discharge during a 34-day period. Wellmark annually reviews and updates the Medicare Advantage Care Transition Program.

The primary goals of the Medicare Advantage Care Transition Program are:

- Increase member adherence to treatment plan through education
- Affect healthy outcomes and memberexperience
- Encourage member communication with their practitioner about their health conditions and treatment
- Assist in coordinating care after discharge including follow up visitsfollowing discharge
- Provide information about communityresources that may be helpful
- Decrease inappropriate inpatient admissions and emergency room visits

Providers play an important role in the transition of Wellmark Medicare Advantage members to their home after an inpatient stay. Wellmark Care Transition nurses coordinate with the member and discharge planners to provide education, address gaps in care and medication adherence issues, and coordinate services as needed. To facilitate a smooth member transition to home, inpatient acute care facilities are expected to engage with Wellmark's Care Transition nurses related to a Wellmark Medicare Advantage member's discharge plan and should use their best efforts to provide Wellmark with a copy of the discharge plan before the member's discharge by fax to 866-313-8595. Other providers, including physicians, may also be asked to assist Wellmark Care Transition nurses and discharge planners in ensuring a safe and effective discharge for Wellmark Medicare Advantage members.

MEDICARE ADVANTAGE CASE MANAGEMENT PROGRAM

The Medicare Advantage Case Management Program is a collaborative process in which a Wellmark Case Manager works with members, their families, their treating practitioner(s) and other health professionals to facilitate appropriate utilization of health care services, to promote quality and cost-effective interventions and outcomes across the continuum of care, and to help members reach their optimum level of wellness through education, support and coordination of care. The primary goals of the Medicare Advantage Case Management Program are to:

- Reduce costs related to unplanned readmissions, optimize resource utilization, affect healthy outcomes and member experience, and support efforts for measures and STARS rating.
- Help members manage complex and chronic health conditions.
- Decrease the burden of disease complications through referrals to improve member self- management, increase member compliance with treatment plans to maximize quality of life and reduce risk of unnecessary utilization.

Wellmark annually reviews and updates its Medicare Advantage Case Management program.

A Case Manager facilitates a practitioner's plan of treatment and the provision of health care services as outlined in evidence-based clinical practice guidelines. The Case Manager contacts members by phone to perform an assessment of the member's health care status. Goals are identified and interventions are implemented to support the practitioner's treatment plan. The Case Manager provides personalized support and education on disease, nutrition, medication and managed care processes and also identifies and facilitates access to benefits and resources available to prevent complications and progression of disease. The Case Manager coordinates care with the treating practitioners and offers suggestions to practitioners for member management. Ongoing communication occurs based on changes in the member's condition or identified needs.

Members who are eligible for the Wellmark Medicare Advantage Case Management program are those that:

- Are dealing with chronic or complex disease process
- Are at high risk for health complications
- Demonstrate high use of health care resources
- Experience admissions and readmissions to an inpatient care setting
- Have gaps in medical care
- Have medication compliance issues

These members are identified by Wellmark through various means, including through practitioner referrals. To refer a Wellmark Medicare Advantage member to the Wellmark Medicare Advantage Case Management program, call 866-866-8964.

Successful member interventions for the Wellmark Medicare Advantage Case Management program are made possible through collaboration and coordination between practitioners and Wellmark's Case Managers. Timely communication between a treating practitioner and Wellmark's Case Managers is essential for case management activities. Treating practitioner(s) may receive requests for information from Wellmark's Case Managers, and Wellmark expects treating practitioner(s) and other health care professionals to engage with Wellmark's Case Managers as requested.

Similarly, Wellmark's Case Managers can help practitioners provide better and more efficient care for Wellmark Medicare Advantage members that are enrolled in the Wellmark Medicare Advantage Case Management program. Upon request by a treating practitioner, Wellmark's Case Managers can:

- Provide information about case management programs and case management staff members involved in particular Wellmark Medicare Advantage members' case management.
- Update the practitioner regarding Wellmark's case management activities, interventions, and treatment plans; and,
- Work with the practitioner to incorporate the practitioner's feedback into the collaborative decision-making process with the case management team and members.

For more information or to engage with Wellmark's case management process, practitioners should call 866-866-8964.

8. Disputes, Appeals and Resolutions

BEFORE SERVICES ARE PROVIDED

a. Appealing Pre-Service Organization Determinations

Providers who provide services for Wellmark Medicare Advantage members have the right to appeal on behalf of a Medicare Advantage member any adverse pre-service organization determination, such as a prior authorization denial or an advance coverage determination, made by Wellmark's Health Management team that resulted in a pre-service denial or other limitation of covered healthcare services. The provider appeals process for Medicare Advantage members is governed by Medicare regulations.

A contracted or non-contracted provider who is providing treatment to a Wellmark Medicare Advantage member may appeal pre-service organization determination decisions to Wellmark on behalf of the member. Resolve pre-service denials by appeal before services are rendered, or prior to submitting a claim for services already rendered. In any case, the member can choose to appeal a decision as well.

Standard (non-urgent) pre-service organization determination appeal requests should be submitted in writing to:
Wellmark Advantage Health
PlanAppeals & Grievances
P.O. Box 211483
Eagan, MN 55121

Or faxed to: 866-533-6950

The table below outlines level one appeal processing timeframes for pre-service organization determination appeal requests.

Type of Request		Decision
Inpatient Admissions/ Concurrent Review	Pre-service (urgent)*/ concurrent	Within 72 hours from receipt of request
	Pre-service standard	Within 30 days of receipt of request
Part B Drugs	Pre-service (urgent)*/ concurrent	Within 72 hours from receipt of request
	Pre-service standard	Within 7 calendar days from receipt of request

*Urgent pre-service means that the provider believes waiting for a decision under the standard timeframe could place a Wellmark Medicare Advantage member's life, health or ability to regain maximum function in serious jeopardy.

Note: A request for a peer-to-peer call is available as part of the pre-service appeal process. Submit the Appeal Form or same information in similar format and supporting documentation, preferably via fax, and include some available dates and times for the peer-to-peer call. Wellmark Advantage Health Plan will review and, at the discretion of the Medical Director, will then reach out to the provider to set up a time for the peer-to-peer call.

If contracted providers disagree with the level one appeal decision, they should follow the steps outlined in the decision letter to submit a level two appeal request.

All non-contracted providers who receive a level one partially favorable or an adverse decision are forwarded to the Independent Review Entity (IRE) for a level two appeal. A party does not have to make a separate request for a level two appeal. The IRE sends written notification to all parties that the level two appeal request has been received. The IRE must adhere to the following timeframes for notifying all parties in writing of their decision on the respective pre-service case type:

Type of Request:	Processing Timeframe:
Standard	Items and Services: 30 days Part B Drugs: 7 days
Expedited	72 hours

AFTER SERVICES ARE PROVIDED

a. Appealing Post-Service Claim Decisions

Contracted and non-contracted providers have appeal rights for Wellmark claim decisions.

Calling Provider Inquiry Services at 1-855-716-2556 is the first step in addressing questions or concerns (e.g., asking questions to better understand processing of a claim). If the provider did not receive resolution to the issue or if further review is needed on the claim after speaking with a representative, a two-level written appeals process is available to all providers, as described in the table below.

For a non-contracted provider to appeal a post-service decision on behalf of a Wellmark Medicare Advantage member, the non-contracted provider must sign and submit a Waiver of Liability. The Waiver of Liability indicates that the non-contracted provider formally agrees to waive any right to payment from the member for the service in question regardless of the outcome of the provider's appeal. The Waiver of Liability can be found at cms.gov/Medicare/Appeals-and- Grievances/MMCAG.

Two Level Appeal Process Applicable to Post-Service Health Management and Care Management Claim Decisions		
Level One appeals	Provider Request Filing and Deadline	Level One appeal requests must be submitted to Wellmark in writing within 65 calendar days of the date noted on the written denial notification. Level One appeal requests may be in writing and must include appropriate documentation to support the request or may be done verbally.
	Submission Information	Write to: Wellmark Advantage Health Plan Attn: Provider Appeals P.O. Box 211483 Eagan, MN 55121 Fax: 866-533-6950 Call: 855-716-2556
	Wellmark Response Time	Wellmark notifies the provider of the decision within 60 calendar days of receiving all necessary information.
Level Two appeals	Provider Request Filing and Deadline	Contracted provider Level Two appeal requests must be submitted to Wellmark in writing within 65 calendar days of the date noted on the Level One appeal decision notification. A copy of the Level One decision letter and appropriate documentation to support the provider's Level Two appeal request must be submitted. Additional information about appropriate documentation for this appeal request is included below the table.
	Note: Adverse Level One appeal decisions for non-contracted providers are automatically forwarded to the IRE for a Level Two review.	
	Submission Information	Write to: Wellmark Advantage Health Plan Attn: Provider Appeals P.O. Box 211483 Eagan, MN 55121 Fax: 866-533-6950
	Wellmark Response Time	Wellmark notifies the contracted provider of the decision within 60 calendar days of receiving all necessary information. For non-contracted providers, the IRE will provide their decision in writing to all applicable parties within 60 calendar days of receipt of the case.
	Note: Wellmark's Level Two appeal decisions are always final and binding on the provider.	

Follow the level one appeal process to submit the required medical documentation for review for the below scenario:

- Modifier -22 (Increased procedural services): When modifier 22 is billed on the claim, it indicates that additional work requiring the practitioner's technical skill involve significantly increased work, time, and complexity than when the procedure is normally performed. The procedure and/or service may be surgical or non-surgical. Reimbursement already accounts for the possibility that sometimes the procedure will be simpler and other times more difficult than normal. However, there are times when a procedure can be significantly more difficult.

As noted above, the provider must submit appropriate documentation for Level One appeal requests when appealing post-service claim decisions regarding medical necessity, medical appropriateness and other health management/care management claim denials. Appropriate documentation for those appeal requests includes:

- Completed Appeal Form or the same information in a similar format that includes:
    - Urgency
    - Provider or supplier contact information including name and address
    - Member information
    - Type of appeal
    - Claim information
    - Reason for dispute - a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Documentation and any correspondence that supports the provider's position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation)

b. Payment Disputes

Provider payment disputes are disputes in which the provider believes that the payment amount made by the Wellmark Medicare Advantage plan to providers differs from the payment amount specified in a participating provider's agreement with Wellmark.

If a provider believes that the payment amount the provider received for a service differs from the amount set forth in the applicable provider agreement or paid by Medicare, as applicable, the provider has the right to dispute the payment amount by following Wellmark's two-level payment dispute process described below.

Two-Level Payment Dispute Process (Available to Contracted Providers)			
First Level Payment Disputes	Provider Request Filing and Deadline	Payment amounts must be disputed within 120 calendar days from the date payment is initially received. Appropriate documentation must be submitted to support the provider's first-level payment dispute request. Additional information about appropriate documentation for this request is included below the table.	
	Submission Information for IA/SD providers*	Write to: Wellmark Advantage Health Plan Appeals & Grievances P.O. Box 211483 Eagan, MN 55121	Fax: 1-866-533-6950
	Submission Information for providers outside IA/SD*	Provider's local BCBS plan	
	*Independent clinical laboratories and DME/orthotic/prosthetic suppliers should review Section 4, Claims Submission, to determine the appropriate plan.		
	Wellmark Response Information	Wellmark will review the payment dispute and respond to the provider within 60 calendar days from the time Wellmark receives notice of the first-level payment dispute request. If we agree with the provider's position, then Wellmark will pay the provider the correct amount. Wellmark will inform the provider in writing if the first-level payment dispute is denied.	

Two-Level Claim Payment Dispute Process (Available to Contracted Providers)		
Second Level Payment Disputes	Provider Request Filing and Deadline	After completing the first level payment dispute process as described above, if a provider still believes that Wellmark has reached an incorrect decision regarding a payment dispute, the provider may file a request for a second-level review of this determination within 60 calendar days of receiving written notice of Wellmark's first level decision. Appropriate documentation must be submitted to support the provider's second-level payment dispute request, along with a copy of the first-level decision letter. Additional information about appropriate documentation for this request is included below the table.

	Submission Information for IA/SD providers*	Write to: Wellmark Advantage Health Plan Appeals & Grievances P.O. Box 211483 Eagan, MN 55121	Fax: 1-866-533-6950
	Submission Information for providers outside IA/SD*	Provider's local BCBS plan	
	*Independent clinical laboratories and DME/orthotic/prosthetic supplies should review Section 4, Claims Submission, to determine the appropriate plan.		
	Wellmark Response Information	Wellmark will review the payment dispute and respond to the provider within 60 calendar days from the time Wellmark receives notice of the provider's second-level payment dispute request. Again, if Wellmark agrees with the provider's position during this second-level review, then Wellmark will pay the provider the correct amount. Wellmark will inform the provider in writing if the provider's second-level payment dispute is denied.	
	Note: Wellmark's second-level payment dispute decisions are always final and binding on the provider.		

As noted above, appropriate documentation for a provider's first-level and second-level payment dispute review requests must be submitted, including:

- Completed Appeal Form or the same information in a similar format that includes:
    - Urgency
    - Provider or supplier contact information including name and address
    - Member information
    - Type of appeal
    - Claim information
    - Reason for dispute - a description of the specific issue
- Pricing information such as interim rate letter or pricer documentation, including NPI number (and CCN for institutional providers), ZIP code whereservices were rendered, and physician specialty
- Copy of the plan's original pricing determination
- Pricer documentation that reflects correct reimbursement
- CMS documentation and/or other correspondence that supports the provider's position that theplan's reimbursement was incorrect (including a remittance advice or other evidence of payment from Original Medicare for the same services, when appropriate)

9. Part D Pharmacy Services

NETWORK PARTICIPATION

Wellmark has partnered with CVS Caremark for pharmacy benefit management services, including pharmacy network management, for Wellmark's Medicare Part D plan benefits. To be included as a participating pharmacy for Wellmark's Medicare Part D plan benefits, pharmacies must meet certain criteria for CVS Caremark Medicare Advantage network participation and sign a formal participation agreement with CVS Caremark. For more information about pharmacy eligibility and the application and credentialing process, contact CVS Caremark via the online Pharmacy Enrollment Self Service tool that can be found on www.caremark. com/pharminfo and follow the links to Pharmacy Enrollment Self Service, Pharmacy Provider Question Form.

FORMULARY OVERVIEW AND EXCLUSIONS

Wellmark contracts with CVS Caremark for formulary management. CVS Caremark's pharmacy and therapeutics (P&T) committee regularly reviews medications and determines which medications to include in the Wellmark Medicare Advantage Formulary. Prior authorization requirements apply to certain medications as described in the Part D Utilization Management Section below. Some medications may also have limitations on supply, dosage, or patient age as listed on the Formulary. Unless as noted in Formulary documents, all applicable dosage forms and strengths of the identified drug generally are included in the Wellmark Medicare Advantage Formulary.

Certain drugs or drug purposes are not covered by Wellmark's Medicare Part D plan benefits. These include, but are not limited to, over-the-counter (OTC drugs), drugs used for weight loss or weight gain, drugs used for cosmetic purposes, and drugs used in the treatment of sexual/erectile dysfunction. A complete list of Wellmark Medicare Advantage Formulary exclusions can be found in the Formulary documents.

Formulary documents are available on the Wellmark website: Wellmark.com/Provider/Medicare-Advantage

PART D STEP THERAPY

In some cases, Wellmark may require that a Medicare Advantage member try a Part D preferred drug to treat a medical condition before Wellmark covers another non-preferred Part D drug. The step therapy requirement will not apply to members who've already received treatment with a non-preferred drug within the past 180 days.

More about Part D step therapy requirements can be found in the Formulary documents on the Wellmark website: https://www.wellmark.com/member/medicare-advantage/drug-policies-and-programs

FORMULARY-LEVEL OPIOID SAFETY EDITS

Because of the risks involved with opioid use, Wellmark has partnered with its pharmacy benefits manager CVS Caremark to implement certain point-of-sale edits to encourage safe and appropriate use of opioid prescription drugs by Wellmark's Medicare Advantage members and to align with CMS Medicare Part D Opioid Overutilization Policy.

Edits implemented for opioid safety include, but are not limited to:

- Supply limits for initial opioid prescriptions, coupled with a look-back period
- Edits to reject concurrent use of certain medications, such as opioids with benzodiazepine
- Duplicate long-acting opioids edits

More information about the specific point-of-sale edits that apply to opioids prescribed for Wellmark Medicare Advantage members is available at https://www.wellmark.com/member/medicare-advantage/drug-policies-and-programs.

Wellmark expects that its providers will respond promptly if Wellmark or a pharmacy requests additional information regarding an opioid prescription or opioid safety alert. Timely prescriber response to requests for information will avoid delays in drug therapy prescribed for your patients. Wellmark may limit coverage for a prescribed opioid therapy and/or report Wellmark's opioid safety findings to CMS in response to the prescriber's failure to respond to requests for information or if Wellmark finds that a prescribed opioid therapy is not clinically appropriate.

Providers and pharmacies having questions about an opioid prescription can call the CVS Caremark Help Desk number on the Wellmark Medicare Advantage member's ID card. For PPO plans, call 888-832-6168. For HMO plans, call 800-323-3098.

PART D UTILIZATION MANAGEMENT

Prior authorization requirements apply to certain medications, which requires approval from Wellmark before the prescription is filled for the prescription to be covered. If approval is required for a particular drug and is not obtained, the drug will not be covered. For more information about how to submit a prior authorization, see the Part D Coverage Determinations Section below. Prescription drugs requiring prior authorization are outlined on the Wellmark website: Wellmark.com/Provider/Medicare-Advantage.

PART D COVERAGE DETERMINATIONS

i. Coverage Determination Requirements

A coverage determination occurs when members ask for coverage or payment of a Part D prescription drug they believe Wellmark should provide and when Wellmark issues an approval or denial decision in connection with that request. A provider, as well as a member, can ask for a coverage determination for a Part D prescription drug. Members can also appoint a representative (such as a relative) to request a coverage determination on their behalf.

A coverage determination request is required for:

- Drugs not listed on the formulary
- Drugs listed on the formulary with a prior authorization
- Prescriptions that exceed the permitted limit noted on the formulary
- Drugs with a step edit, where the first-line therapy is inappropriate
- A request by a member for a lower copay tier for a prescribed drug on a higher copay tier

ii. Part D coverage determination submission

To submit a coverage determination request:

Part D Coverage Determination Process			
Provider Request Filing and Deadline	Part D coverage determination decisions must be disputed within 65 calendar days from the date of CVS Caremark's first decision.		
Preferred submission method	By ePA: Access ePA through a web-based secure online portal: CoverMyMeds: https://www.covermymeds.com/epa/caremark/ Surescripts: https://providerportal.surescripts.net/providerportal/cvs		
Additional submission methods and information	By phone: CVS Caremark Part D Appeals department Prescriber Number: 1-855-344-0930 (TTY 711) Available 24/7	By fax: Complete and send the Request for a Medicare Prescription Drug Coverage Determination Form 1-855-633-7673	By mail: Complete and send the Request for a Medicare Prescription Drug Coverage Determination Form CVS Caremark Attn: Part D Appeals PO Box 52000, MC109 Phoenix, AZ 85072-2000
Wellmark Response Information	CVS Caremark will notify you of the decision by fax.		

*The forms provided are a recommendation. Any type of form that is submitted by a Provider via fax or mail will be worked appropriately.

If a provider is requesting a Formulary exception, the provider must provide medical history and/or other pertinent patient information when submitting the Request for Medicare Prescription Drug Coverage Determination form.

iii. Part D coverage determination decisions

Part D coverage determination decisions are made:

Type of Request		Decision	Prescriber Notification
Part D Drugs	Expedited* pre-service	Within 24 hours from receipt of request	Within 24 hours from receipt of request
	Standard pre-service	Within 72 hours from receipt of request	Within 72 hours from receipt of request
	Expedited pre-service exception request	Within 24 hours from receipt of supporting statement	Within 24 hours from receipt of supporting statement
	Standard pre-service exception request	Within 72 hours from receipt of supporting statement	Within 72 hours from receipt of supporting statement
	Payment request	Within 14 calendar days from receipt of request	Within 14 calendar days from receipt of request

*Expedited pre-service means that the provider believes waiting for a decision under the standard timeframe could place a Wellmark Medicare Advantage member's life, health, or ability to regain maximum function in serious jeopardy.

The Exception Request timelines described above may be extended by up to 14 days when applicable to allow for receipt of the prescribers supporting statement.

If the request is denied, information about the denial will be provided to you.

In the event the requesting provider disagrees with the decision regarding coverage of a Part D medication, the provider can request a free copy of the criteria or guidelines used in making the decision and any other information related to the determination by calling CVS Caremark toll-free at 1-855-344-0930.

PART D APPEALS

If the requesting provider or a member disagrees with the decision regarding coverage of a Part D prescription drug, the provider or member has the right to file an appeal as outlined below.

Part D Coverage Determination Appeals Process			
Provider Request Filing and Deadline	Part D coverage determination decisions must be disputed within 65 calendar days from the date of CVS Caremark's first decision.		
Preferred submission method	By ePA: Access ePA through a web-based secure online portal: CoverMyMeds: https://www.covermymeds.com/epa/caremark/ Surescripts: https://providerportal.surescripts.net/providerportal/cvs		
Additional Submission Information	By phone: CVS Caremark Part D Appeals department Prescriber Number: 1-855-344-0930 (TTY 711) Available 24/7	By fax: Complete and send the Request for Redetermination of Medicare Prescription Drug Denial form 1-855-633-7673	By mail: Complete and send the Request for Redetermination of Medicare Prescription Drug Denial form CVS Caremark Attn: Part D Appeals PO Box 52000, MC109 Phoenix, AZ 85072-2000
Wellmark Response Information	CVS Caremark will notify you of the decision by fax.		

*The forms provided are a recommendation. Any type of form that is submitted by a Provider via fax or mail will be worked appropriately.

Part D coverage determination appeal decisions.

Part D coverage determination appeal decisions are made:

Type of Request		Decision	Prescriber Notification
Part D Drugs	Pre-service – expedited*	Within 72 hours from receipt of request	Within 72 hours from receipt of request
	Pre-service - standard	Within 7 days from receipt of request	Within 7 days from receipt of request

PART D GRIEVANCES

Wellmark Medicare Advantage members have the right to file a grievance against Wellmark, CVS Caremark, or any network provider or pharmacy for issues not relating to coverage for a particular prescription drug. Members can find information about filing grievances in their *Evidence of Coverage*. Network providers and pharmacies must cooperate with Wellmark and CVS Caremark to resolve any Wellmark Medicare Advantage member grievance involving the provider or pharmacy within the time frame required under federal law.