West Virginia – Provider Orientation

Wellpoint Medicare Advantage (HMO-POS)

Wellpoint Medicare Full Dual Advantage (HMO D-SNP)

Wellpoint

What is Wellpoint?

Wellpoint is the name for our health insurance plans, which deliver whole-health insurance solutions. Wellpoint is an affiliate of Elevance Health.

We believe focusing on the whole person is the foundation to living well because health is beyond physical — it's recognizing the behavioral and social drivers that impact it, too.

For decades, we've proven that serving the most vulnerable enables us to better serve everyone. Healthcare is more than coverage alone. It's being there when people need you the most and helping in ways they never imagined

For more information on Wellpoint, visit the About Us Wellpoint page, About Us | Wellpoint

What is a Health Maintenance Organization (HMO)?

An HMO is a type of Medicare Advantage Plan (Part C) that combines the benefits of Medicare Part A and Part B, often including additional benefits like prescription drug coverage (Part D) and services such as vision and hearing care.

Members must use healthcare providers and facilities within the HMO's network. The PCP will coordinate all its members' needs.

HMO plans do not cover out-of-network care except in emergency or specific situations, such as urgent care while traveling outside the service area.

More information can be found at Health Maintenance Organizations (HMOs) | Medicare

What is a Dual Special Needs Program (D-SNP)?

D-SNP stands for *Dual Special Needs Plan.* A D-SNP is a Medicare Advantage prescription drug (MAPD) plan for consumers who are entitled to both Medicare (Title XVIII) and Medical Assistance from a state plan under Title XIX (Medicaid).

D-SNPs are specialized Medicare plans for people who have both Medicare and Medicaid, also known as dually eligible consumers. Individuals qualify for Medicaid and Medicare separately.

D-SNP eligible consumers can include low-income seniors ages 65 and older and people with disabilities who are younger than 65. D-SNP types include data coordination, highly integrated dual eligible (HIDE), and fully integrated dual eligible (FIDE).

A D-SNP provides the same coverage consumers would normally receive under original Medicare but comes with a prescription drug plan (PDP) and extra benefits, such as dental, vision, and hearing. Those extra benefits are services not covered under original Medicare.

More information can be found at https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/dual-eligible

What is a Dual Special Needs Program (D-SNP)?

For plan year 2026, Wellpoint's Full Dual Advantage (HMO D-SNP) is a Data Coordination D-SNP.

A Data Coordination DSNP ensures beneficiaries receive the necessary care and services. This includes coordinating services between Medicare and Medicaid benefits.

Beneficiaries will have Medicaid and can choose Wellpoint for Medicare Advantage/DSNP. Wellpoint will coordinate care for members regardless of how they receive their Medicaid.

- Two ID cards: One for Medicaid, One for Medicare
- Claims: File Medicare claim to Wellpoint for primary payment. Once EOP is received, providers must submit a secondary claim to Medicaid.

In some instances, members may change DSNP plans monthly.

Wellpoint is responsible for coordinating care for DSNP members.

Coordination means assisting the members with obtaining the care they need, even if it is not a benefit covered under the DSNP. It is everyone's responsibility to help and find care. This includes assisting with billing and service.

Referrals

Specialty Referrals:

- All Wellpoint Medicare Advantage Plans (HMO and POS) are open access, meaning members do not require referrals to see a specialist.
- Members still require a PCP selection.

West Virginia Medicare Provider Participation

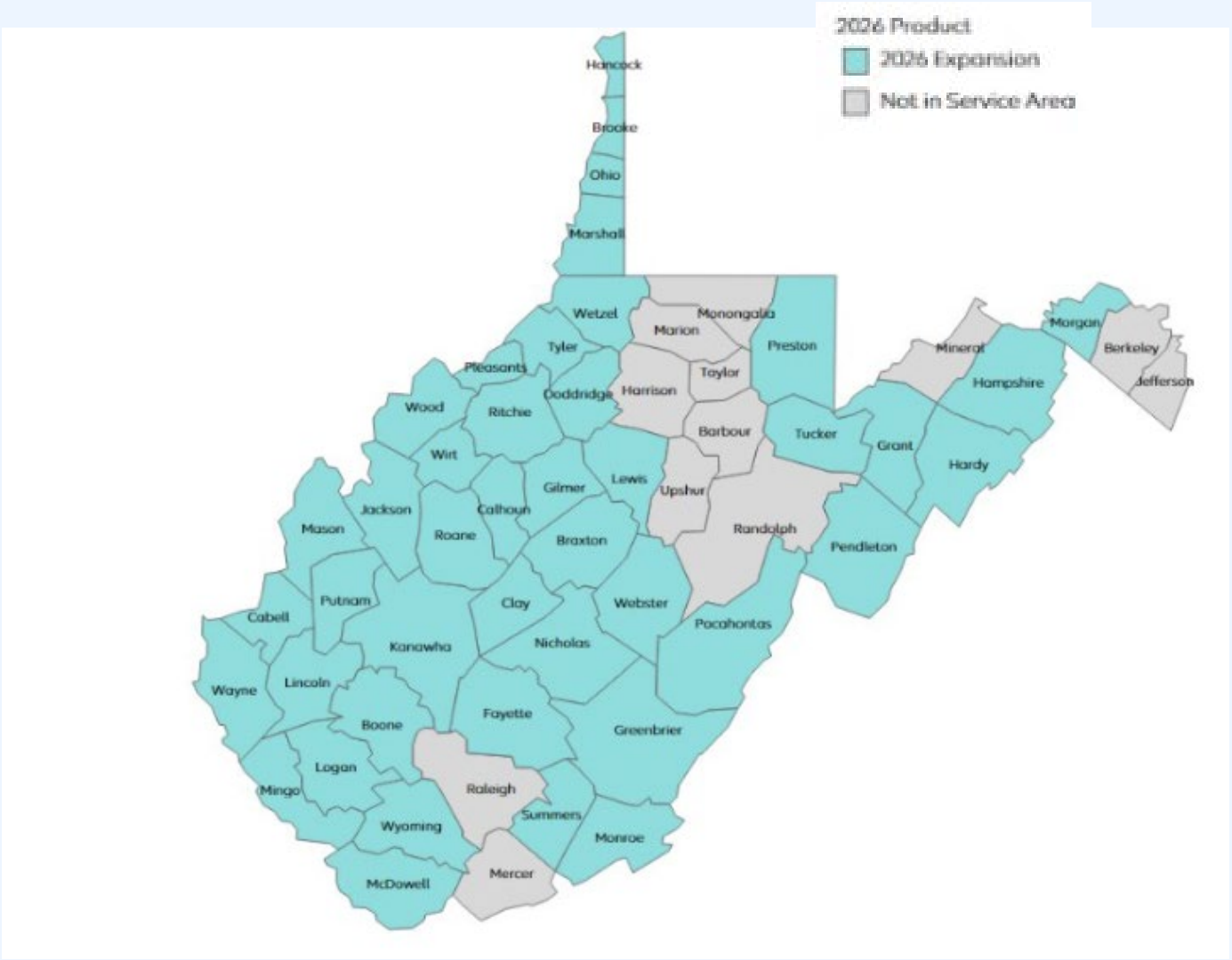
- Wellpoint has been developing the Medicare Advantage network since 2017.
- Amendment by Notice (ABNs) were sent to Wellpoint West Virginia Medicaid network providers in 2017, 2018, and 2024, bringing them into the Medicare network.
- Additionally, some providers signed contracts outside of the ABNs.
- Wellpoint has taken time to thoughtfully launch a Medicare Advantage program in West Virginia.
- West Virginia Medicare beneficiaries' health is a Wellpoint priority as we focus on whole health.

Service Area:

Wellpoint Medicare Advantage (HMO-POS) and Wellpoint Medicare Full Dual Advantage (HMO D-SNP)

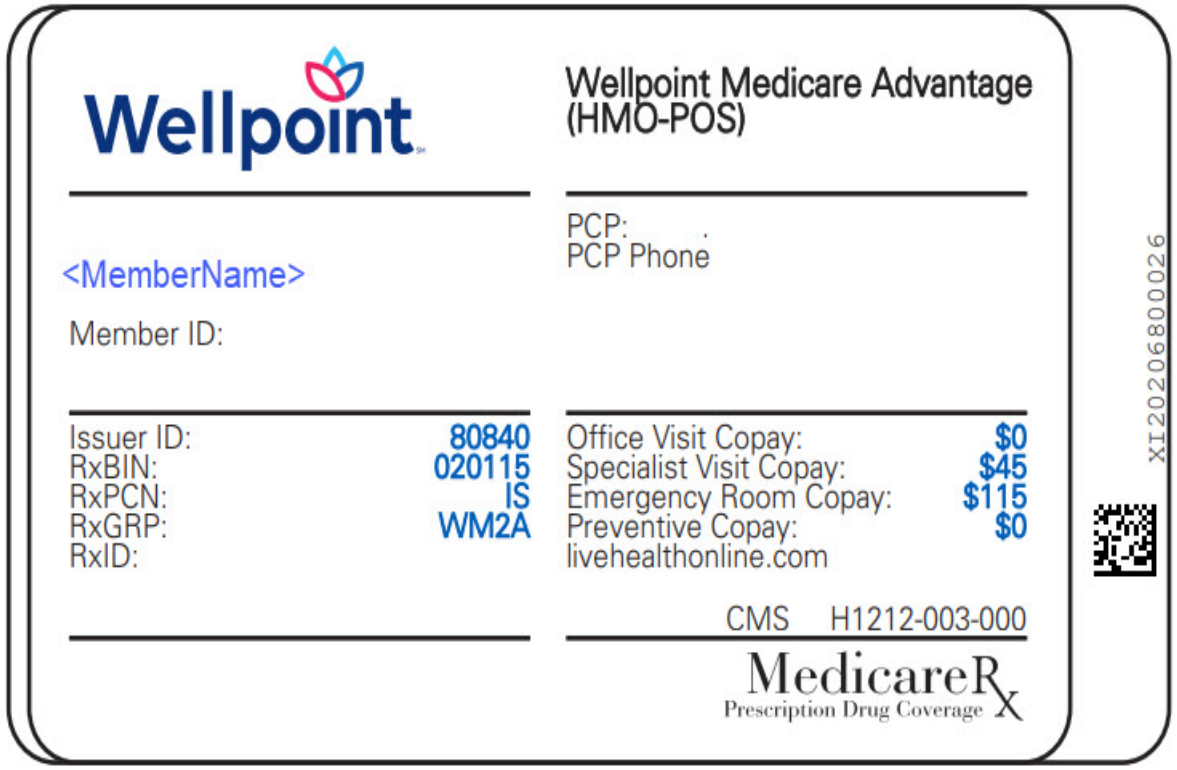
<u>The plans will be available in the following 43 Counties as of January 1, 2026:</u>

Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Jackson, Kanawha, Lewis, Lincoln, Logan, Marshall, Mason, McDowell, Mingo, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Ritchie, Roane, Summers, Tucker, Tyler, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming



Sample ID Card – Wellpoint Medicare Advantage (HMO-POS)

Front



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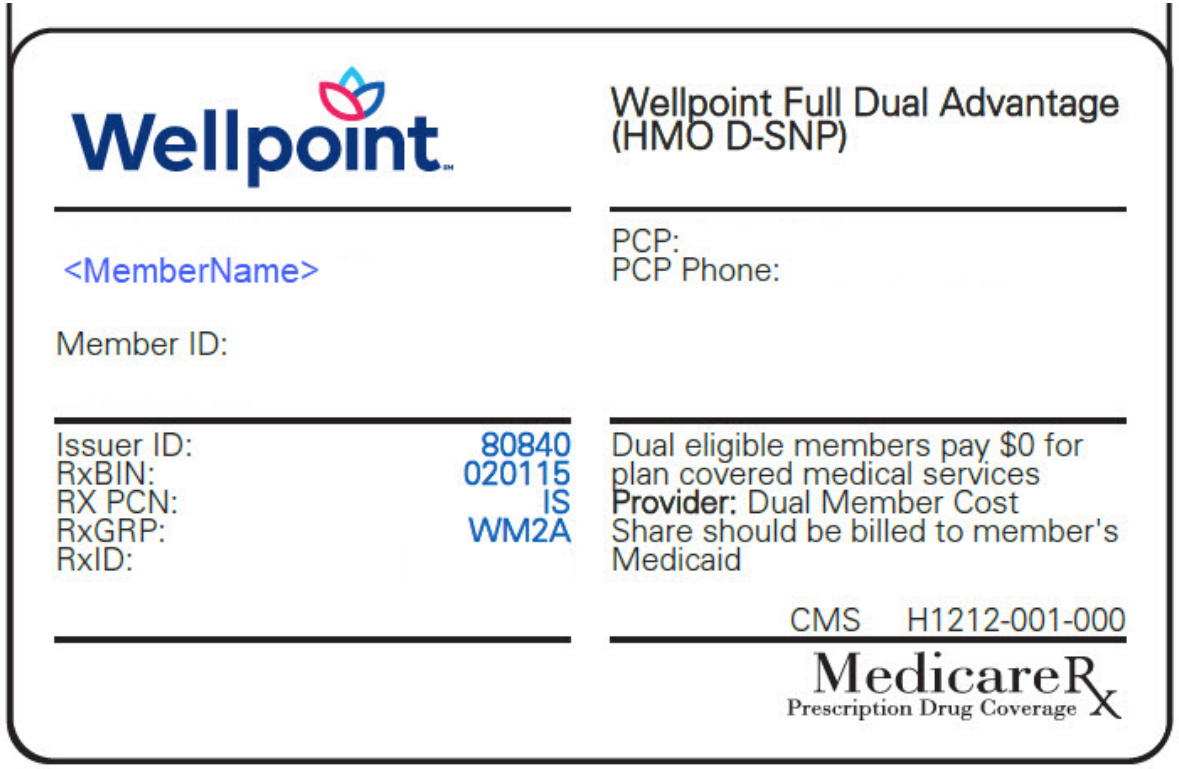
Sample ID Card – Wellpoint Full Dual Advantage (HMO-DSNP)

Front



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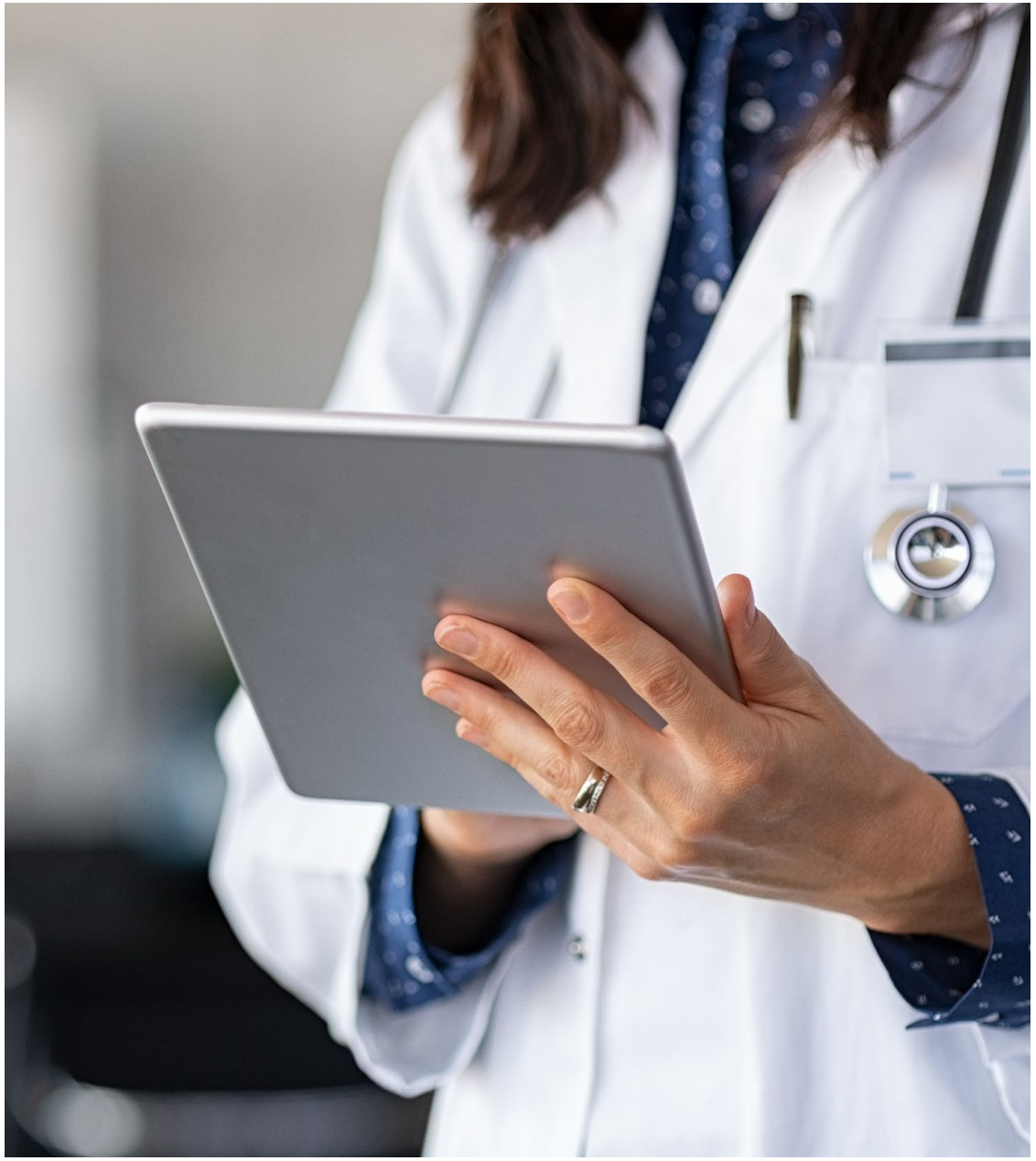
Provider Manual

Refer to the Wellpoint Provider Manual for any questions about operations and procedures related to our Anthem Full Dual Advantage (HMO D-SNP) members. The guidebook provides information on:

- Medicare overview.
- Expectations and responsibilities as a participating provider.
- Provider credentialing.
- Payment disputes, appeals, and grievances.
- Fraud, waste, and abuse.
- Additional topics important to our plan.



Claims filing procedures

Wellpoint Medicare Advantage (HMO-POS)

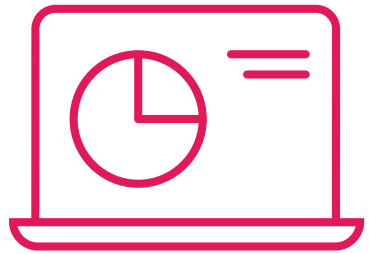
- File claims directly to Wellpoint, which will process and provide payment information via remittance.

Wellpoint Medicare Full Dual Advantage (HMO D-DSNP)

- Since the D-SNP is the primary plan, providers should submit the claims to the address on the back of the member's ID card or through Availity Essentials.
- Once the claim has been processed through the DSNP carrier and an EOP is received, providers must submit a secondary claim to Medicaid.
- If there is still a balance after claims payment, the provider may not bill those to the member. D-SNP members may not be balance-billed per the provider contract.
- Medicare cost sharing is paid according to each state's Medicaid reimbursement policy. Some states do not reimburse for Medicare cost-sharing if the payment has already met or exceeded Medicaid reimbursement.

Claims payment

- Electronic Data Interchange (EDI)
- Availity
- Paper
- Timely filing is within 90 days of the service date.



Paper submissions	Electronic submission payers	EDI hotline
Wellpoint **P.O. Box 61010** **Virginia Beach, VA 23466-1010**	Availity Essentials: **800-282-4548** Website: Availity.com Payer ID: WLPNT	Phone: **800-590-5745**

Electronic remittance advice and electronic funds transfer enrollment

Electronic remittance advice (ERA):

- The ERA eliminates the need for paper remittance reconciliation.
- Use Availity Essentials to register and manage ERA account changes with these easy steps:
    1. Log in to Availity.com >
    2. Select My Providers >
    3. Then Enrollment Center >
    4. Then ERA Enrollment

Note: If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERAs.

Electronic funds transfer (EFT):

- EFT is a secure and fast way to receive payment, reducing administrative processes.
- EFT deposits are assigned a trace number matched to the ERA for simple payment reconciliation.
- Use enrollsafe.payeehub.org to register and manage EFT account changes.

Rejected versus denied claims

Rejected

- Does not enter the adjudication system due to missing or incorrect information.
- Resubmission is subject to a 90-day timely filing deadline.

Denied

- Completes the adjudication process but is denied for payment.
- An appeal deadline of XXX days from the Explanation of Payment (EOP) date applies.

For claim inquiries, please call Provider Services:

- Wellpoint Medicare Advantage (HMO-POS): 1-844-421-5633
- Wellpoint Medicare Full Dual Advantage (HMO D-SNP): 1-844-765-5160

Claim Payment Reconsiderations

Reconsideration requests in writing, verbally, and through our provider website are due within **120 calendar days** from the date on the *EOP*.

Plan will make every effort to resolve claim payment appeals within 30 **calendar days** of receipt

Refer to the denial letter issued to determine the correct appeals/ dispute process.

For more information, visit our provider manual, Wellpoint Provider Manual

Claims Payment Appeal

If dissatisfied with the outcome of a reconsideration determination, you may submit a claim payment appeal.

Include as much information as you can to help us understand why you think the reconsideration determination was in error.

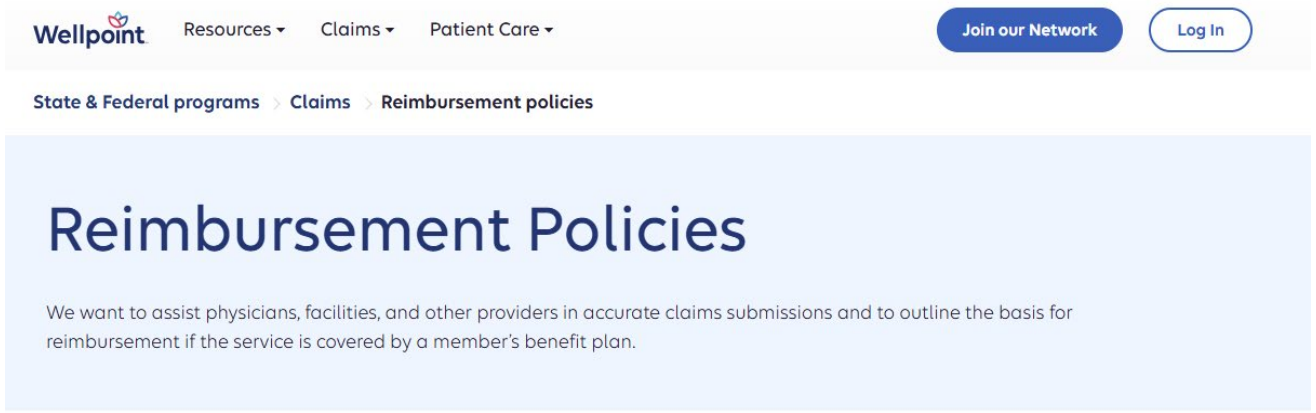
For more information, visit our Provider Manual, Wellpoint Provider Manual

Plan will make every effort to resolve claim payment appeal within **30 calendar days** of receipt.

Reimbursement Policies

Providers and facilities are required to use industry-standard codes for claim submissions and should bill according to Medicare guidelines. Services should be billed with CPT® codes, HCPCS codes, and/or revenue codes. The billed code(s) should be fully supported in the medical record and/or office notes.

[Wellpoint Reimbursement Policies]

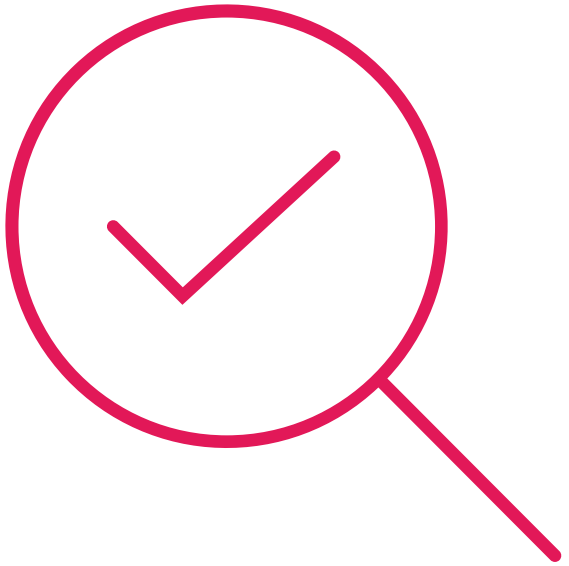


Credentialing

- Credentialing is for a three-year period
- Recredentialing efforts begin six months before the end of the current credentialing period:
  - First notice and second notice letters are faxed/mailed to providers.
  - Third and final notice letters are mailed to providers
- Providers who do not respond or submit a complete recredentialing packet will be de-credentialed/considered out-of-network
  - Providers must begin the contracting and credentialing process from the beginning to rejoin the network.

Is Prior Authorization Needed?

- Determine if specific outpatient procedures and/or services require prior authorization through the precertification lookup tool, which allows you to search by market, member's product, and CPT® code.
- Resources such as our provider website and your provider manual will also help you determine if prior authorizations are necessary.
- Prior authorizations can be submitted through the interactive care reviewer (ICR).



Required documentation for prior authorizations

- A completed prior authorization request is required to eliminate delays in processing, which includes all required essential information, documentation, current clinical information, and a signed authorization form by the requesting provider.
- **Note:** Obtaining a prior authorization is not a guarantee of payment.

To prevent delays, we request the following information to be included with the request to allow for timely processing:

Requesting provider's name, NPI, Tax Identification Number, and signature

Diagnosis code, CPT, HCPCS, or current dental terminology (CDT)

Service request start and end date, and quantity of service units requested based on the CPT, HCPCS, or CDT requested

Member name, date of birth, and the Wellpoint subscriber and state-issued identification number

Prior authorization and important contact information

Routine vision: Superior Vision	**1-866-819-4298**
Hearing: TruHearing	**1-866-581-9462**
Dental Member Services: Skygen	**1-877-408-0881**
Member Pharmacy Services	**1-833-485-9137**
Member Services	**1-833-613-3324**
Silver Sneakers	**1-855-741-4985**
24/7 Nurse Helpline	**1-866-805-4589**

D-SNP model of care

All D-SNP plans are **required by CMS to** have a model of care that provides the basic framework under which the D-SNP will meet the needs of each of its members. **What does the model of care do?**

- Identifies and evaluates D-SNP population
- Details care coordination procedures
- Details importance of the provider network and role of the provider
- Identifies quality measurement protocols and expectations

D-SNP model of care (cont.)

The model of care is a vital quality improvement tool and integral component for ensuring that the unique needs of each member are identified by the D-SNP and addressed through the plan's care management practices.

The model of care provides the foundation for promoting D-SNP quality, care management, and care coordination processes.

Our model of care is unique and distinct to our plan. Another payer's model of care cannot be applied Wellpoint Full Dual Advantage (HMO D-SNP).

Participating providers are required to take Wellpoint's model-of-care training annually. The training can be found under training & education on our provider website, <<Insert Link>>

Adherence to our model of care ensures that members have improved quality of care and better health outcomes.

Fraud, waste, and abuse

Help us prevent it and tell us if you suspect it!

How to report:

- You can find healthcare fraud prevention information on our website, which will direct you to the www.fighthealthcarefraud.com education site.
- Select Report It and complete the Report Waste, Fraud, and Abuse form.
- Providers or facilities may also contact customer service using the phone number on the back of the member ID card.

Availity Essentials Resource

Online claims submission

Free online claim submission application at Availity.com. Submit claims, check claim status, dispute claim payment, and use Clear Claim Connection.

Eligibility verification/authorization – you can verify member eligibility and submit authorizations by searching with the Wellpoint subscriber or state-issued identification number. You can also submit prior authorization requests online through Availity.com.

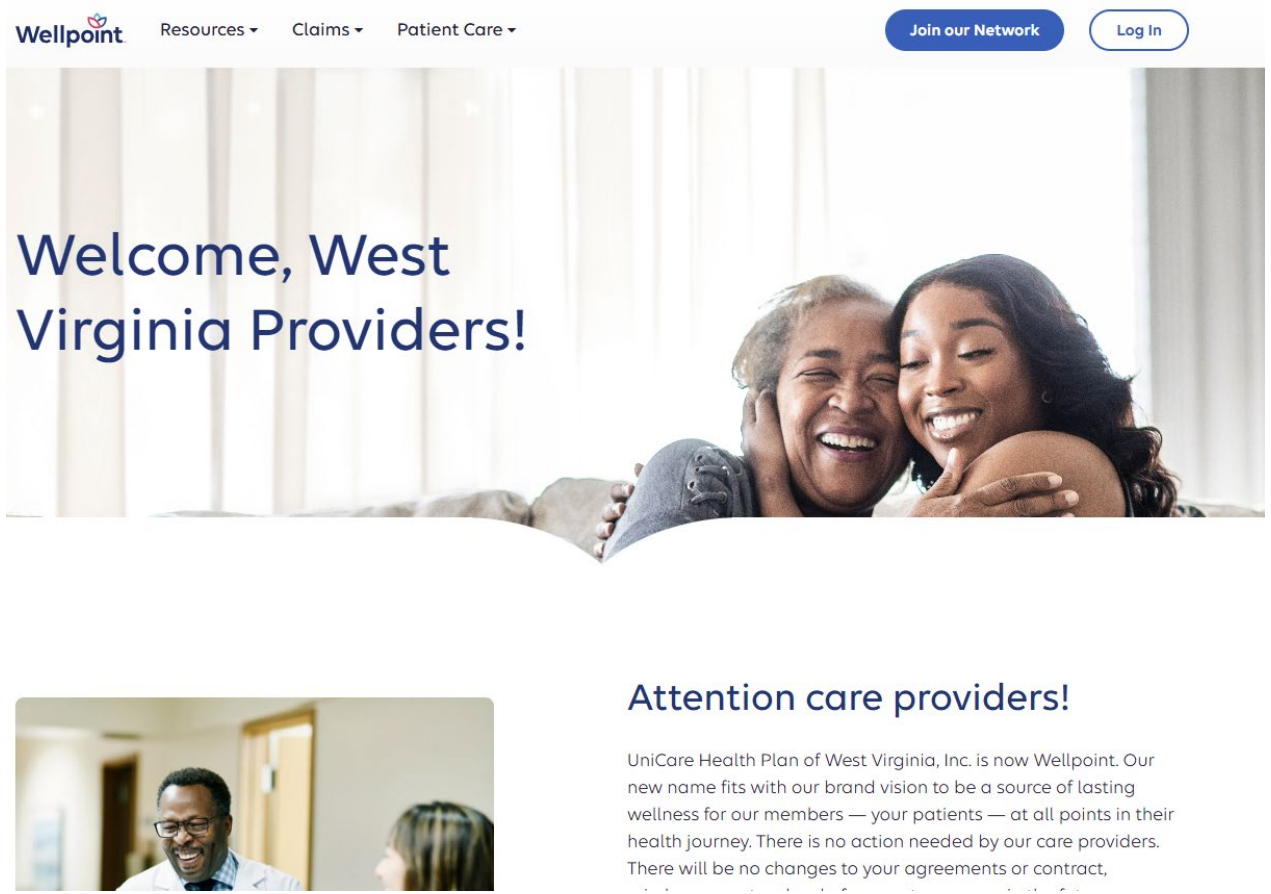
Interactive Care Reviewer (ICR): Any staff member can access ICR at anytime. ICR lets users inquire about prior authorization requests submitted through Availity.com.

Total Member View (TMV):

- TMV is an application in Availity Essentials that provides a picture of a member's health and treatment history, including gaps in care and care reminders.
- Sharing relevant case information in a timely, helpful, and confident manner is a Wellpoint requirement.
- To access TMV, log in to Availity.com and select Wellpoint under *Payer Spaces*. It will appear under the *Applications* tab on the bottom portion of the screen.

Provider website

- Available to all providers regardless of participation status
- Multiple resources available without login
- Accessible 24/7
- [Wellpoint West Virginia]



Provider communications and training resources

We have curated trainings and provider communications to ensure you and your staff are aware of updates, training, and onboarding resources that every provider — new or experienced — can use to further their education. All training resources are accessible through the training academy:

- For more information, visit:
  - Medicare Training
  - Provider News

Provider relationship account management responsibilities

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your assigned provider relationship management associate or Provider Services at **833-476-1458**.

Important Links

- Wellpoint West Virginia
- Wellpoint Provider Manual
- Wellpoint Reimbursement Policies
- Availity
- Model of Care training

Next steps

– Register for Availity Essentials.

– Register for electronic data interchange.

– Register for EFT services.

– Read your Provider Manual.

– Visit our provider website.

Thank you for working with us!


Wellpoint