Provider Orientation
Medicare Advantage

1/2/2018

Agenda

- Plan Overview
- Membership, Benefits, and Additional Services
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (D-SNP only)
- Medicare STAR Ratings
- Web Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer and Electronic Medical Records
- Advance Directives
- Fraud, Waste, and Abuse
- CMS Mandatory Trainings

Plan Overview

Overview: Medicare Advantage Plans

- Allwell from Absolute Total Care (Allwell) provides complete continuity of care to members. This includes:
  - Integrated coordination of care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the PBM
  - Additional services specific to the beneficiary needs

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

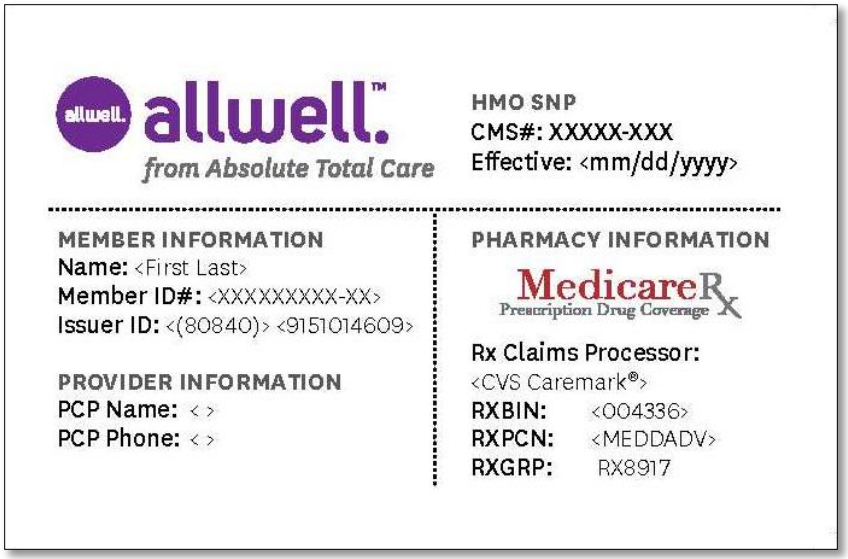
- It promotes access to care as the beneficiaries are served through a multidisciplinary team including RNs, Social Workers, Pharmacy Technicians, and Behavioral Health Case Managers, all co-located in a single, locally based unit.

Membership, Benefits, and Additional Services

Membership

- Medicare beneficiaries have the option to stay in the original fee-for-service Medicare or choose a Medicare Health Plan.
- Allwell members may change Primary Care Providers (PCPs) at any time. Changes take effect on the first day of the month.
- Providers should verify eligibility before every visit by using one of the below options:
  - Website - allwell.absolutetotalcare.com
  - 24/7 Interactive Voice Response Line - 1-855-766-1497
  - Provider Services - 1-855-766-1497
  - TTY - 711

Membership *(continued)*


allwell™
from Absolute Total Care

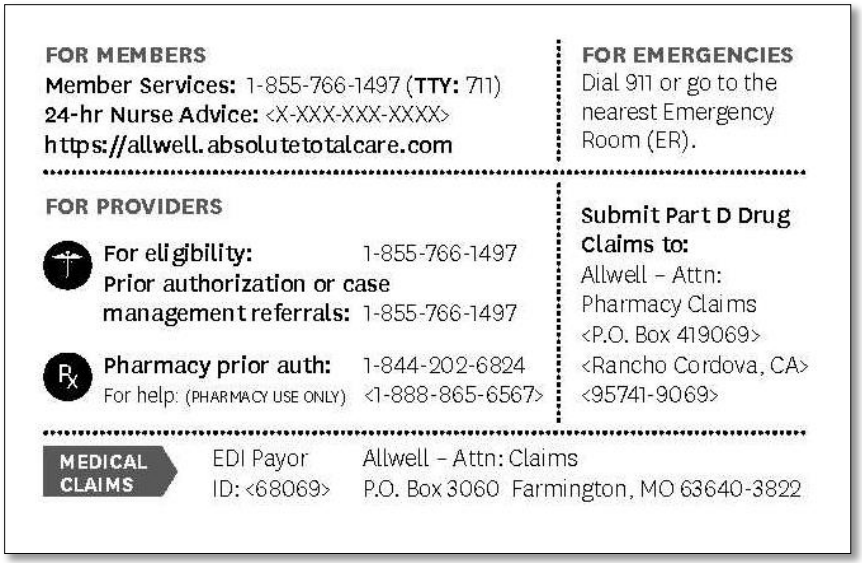
HMO SNP
CMS#: XXXXX-XXX
Effective: <mm/dd/yyyy>

MEMBER INFORMATION
Name: <First Last>
Member ID#: <XXXXXXXXX-XX>
Issuer ID: <(80840)> <9151014609>

PROVIDER INFORMATION
PCP Name: < >
PCP Phone: < >

PHARMACY INFORMATION
MedicareRx
Prescription Drug Coverage

Rx Claims Processor:
<CVS Caremark®>
RXBIN: <004336>
RXPCN: <MEDDADV>
RXGRP: RX8917


FOR MEMBERS
Member Services: 1-855-766-1497 (TTY: 711)
24-hr Nurse Advice: <X-XXX-XXX-XXXX>
https://allwell.absolutetotalcare.com

FOR EMERGENCIES
Dial 911 or go to the nearest Emergency Room (ER).

FOR PROVIDERS
For eligibility: 1-855-766-1497
Prior authorization or case management referrals: 1-855-766-1497
Pharmacy prior auth: 1-844-202-6824
For help: (PHARMACY USE ONLY) <1-888-865-6567>

Submit Part D Drug Claims to:
Allwell – Attn: Pharmacy Claims
<P.O. Box 419069>
<Rancho Cordova, CA>
<95741-9069>

MEDICAL CLAIMS
EDI Payor ID: <68069>
Allwell – Attn: Claims
P.O. Box 3060 Farmington, MO 63640-3822

Plan Coverage

Medicare Advantage covers:

- All Part A and Part B benefits by Medicare
- Part B drugs – such as chemotherapy drugs
- Part D drugs – no deductible at network retail pharmacies or mail order*
- Additional benefits and services such as dental, vision, $0 PCP copay, $0 generics, etc.

*D-SNP plans may have a deductible.

Pharmacy Formulary

- The formulary is available at allwell.absolutetotalcare.com
- Please refer to the formulary for specific types of exceptions
- When requesting a formulary exception, a Request For Medicare Prescription Drug Coverage Determination form must be submitted
- The completed form can be faxed to Envolve Pharmacy Solutions at: 1-866-226-1093

Covered Services

- Hospital Inpatient
- Hospital Outpatient
- Physician Services
- Prescribed Medicines
- Lab and X-Ray
- Home Health Services
- Screening Services
- Dental Services*
- Vision Services*
- Hearing Services*
- Behavioral Health
- Medical Equipment & Supplies
- Appropriate Cancer Screening Exams
- Appropriate Clinical Screening Exams
- Initial Preventative Physical Exam – Welcome to Medicare
- Annual Wellness Visit
- Therapy Services
- Chiropractic Services
- Podiatric Services

Note: Services may vary according to plan

Additional Benefits

Hearing Services

- $1,500 allowance/one hearing aid per year for either the right or left ear or $2,000 allowance/one hearing aid every three years for either the right or left ear

Dental Services

- $250 preventive/comprehensive dental benefit allowance per year

Vision Services

- One routine eye exam every year
- One pair of glasses or contact lenses every year; $225 to $250 limit

Over-The-Counter Items

- $85 to $100 allowance every 3 months
- Commonly used over-the-counter items – listing available at allwell.absolutetotalcare.com

Note: Services may vary according to plan

Additional Benefits

Nurse Advice Line

- Free health information line staffed with registered nurses 24/7 to answer health questions

Fitness Benefit

- Certified fitness program at specified gyms at no extra cost

Note: Services may vary according to plan

Additional Services

Multi-language Interpreter Services

- Free interpreter services to answer questions about the medical or drug plan. To get an interpreter, call us at 1-855-766-1497

Providers and Authorization

Primary Care Physicians

PCPs serve as a “medical home” and provide the following:

- Sufficient facilities and personnel
- Covered services as needed
  - 24-hours a day, 365 days a year
- Coordination of medical services and specialist referrals
- After-hours accessibility for members using one of the following methods:
  - Answering service
  - Call center system connecting to a live person
  - Recording directing member to a covering practitioner
  - Live individual who will contact a PCP

Utilization Management

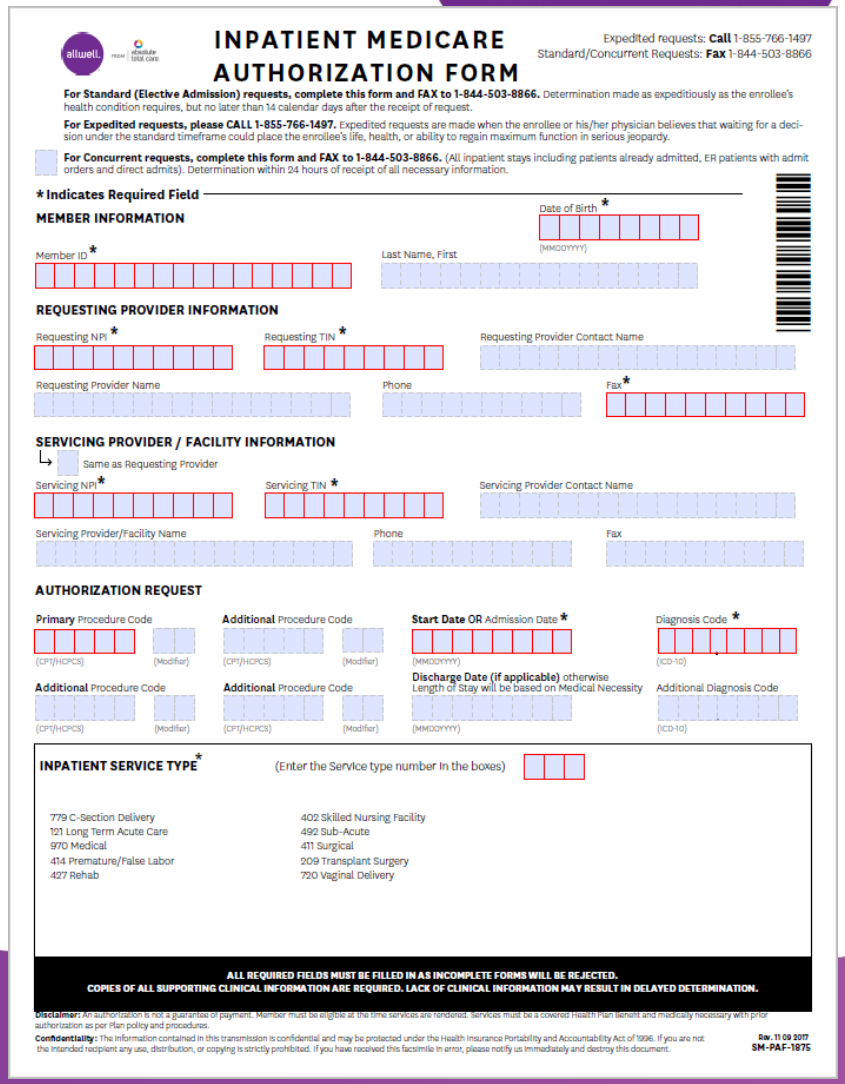
Authorization must be obtained prior to the delivery of certain elective and scheduled services. The preferred method for submitting authorization requests is through the Secure Provider Portal at allwell.absolutetotalcare.com

Service Type	Time Frame
Elective/scheduled admissions	Required five (5) business days prior to the scheduled admission date
Emergent inpatient admissions	Notification required within one (1) business day
Emergency room and post stabilization, urgent care and crisis intervention	Notification requested within one (1) business day

Prior Authorizations

Prior authorization is required for:

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



INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call** 1-855-766-1497
Standard/Concurrent Requests: **Fax** 1-844-503-8866

For Standard (Elective Admission) requests, complete this form and FAX to 1-844-503-8866. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.

For Expedited requests, please CALL 1-855-766-1497. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

For Concurrent requests, complete this form and FAX to 1-844-503-8866. (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

* Indicates Required Field

MEMBER INFORMATION

Member ID *
Last Name, First
Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *
Requesting TIN *
Requesting Provider Contact Name
Requesting Provider Name
Phone
Fax *

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider
Servicing NPI *
Servicing TIN *
Servicing Provider Contact Name
Servicing Provider/Facility Name
Phone
Fax

AUTHORIZATION REQUEST

Primary Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Start Date OR Admission Date * (MMDDYYYY)
Diagnosis Code * (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity (MMDDYYYY)
Additional Diagnosis Code (ICD-10)

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

779 C-Section Delivery
121 Long Term Acute Care
970 Medical
414 Premature/False Labor
427 Rehab
402 Skilled Nursing Facility
492 Sub-Acute
411 Surgical
209 Transplant Surgery
720 Vaginal Delivery

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. 11 09 2017
SM-PAF-1875

Out-of-Network Coverage

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

- Emergency care
- Urgently needed care when the network provider is not available (usually due to out-of-area)
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area

Medical Necessity Determination

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

Preventive Care & Screening Tests

Preventive Care

- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam – Welcome to Medicare: Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other routine measurements. Also includes an electrocardiogram, education, and counseling. Does not include lab tests. Limited to one per lifetime.
- Annual Wellness Visit – Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care

Abdominal Aortic Aneurysm Screening	Cervical and Vaginal Cancer Screenings	Medical Nutrition Therapy Services
Alcohol Misuse Counseling	Colonoscopy	Medication Review
Blood Pressure Screening	Colorectal Cancer Screenings	Obesity Screening and Counseling
BMI, Functional Status	Depression Screening	Pain Assessment
Bone mass measurement	Diabetes Screenings	Prostate Cancer Screenings (PSA)
Breast Cancer Screening (mammogram)	Fecal Occult Blood Test	Sexually Transmitted Infections Screening and Counseling
Cardiovascular Disease (behavioral therapy)	Flexible Sigmoidoscopy	Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
Cardiovascular Screenings	HIV screening	Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots

Model of Care

(D-SNP Only)

Model of Care (D-SNP Only)

The Model of Care is Allwell's plan for delivering our integrated care management program for members with special needs. The goals of the Model of Care are:

- Improve access to medical, mental health, and social services
- Improve access to affordable care
- Improve coordination of care through an identified point of contact
- Improve transitions of care across healthcare settings and providers
- Improve access to preventive health services
- Assure appropriate utilization of services
- Assure cost-effective service delivery
- Improve beneficiary health outcomes

Model of Care (D-SNP Only)

- Model of Care elements are:
  - Description of the SNP Population
  - Care Coordination and Care Transitions Protocol
  - Provider Network
  - Quality Measurement

Model of Care Process (D-SNP Only)

- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment, and at minimum annually, or more frequently with any significant change in condition or transition of care.

- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.

- Members are then triaged to the appropriate Allwell Case Management Program for follow up.

Model of Care Process (D-SNP Only)

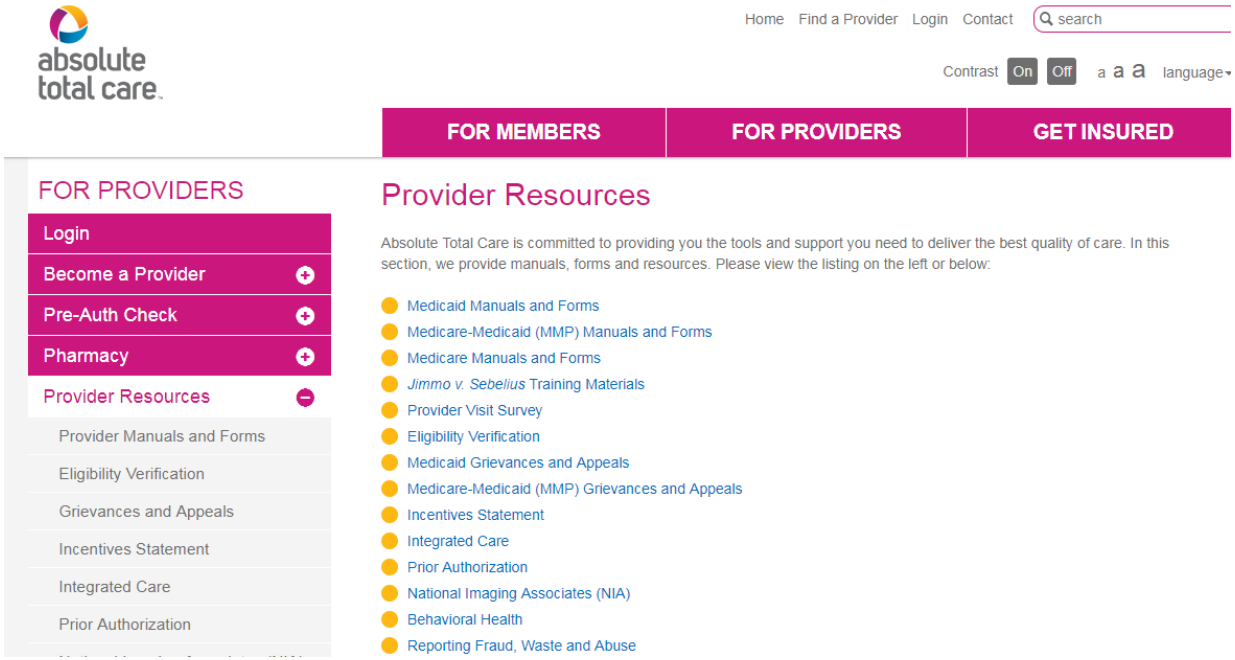
- Allwell values our partnership with our physicians and providers.

- The Model of Care requires all of us to work together to benefit our members by:
  - Enhanced communication between members, physicians, providers, and Allwell
  - Interdisciplinary approach to the member's special needs
  - Comprehensive coordination with all care partners
  - Support for the member's preferences in the Model of Care
  - Reinforcement of the member's connection with their medical home

Model of Care Information (D-SNP Only)

Model of Care information is available at

allwell.absolutetotalcare.com



Medicare STAR Ratings

Medicare STAR Ratings

What Are CMS Star Ratings?

- The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).

- The ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing an MA or MA-PD plan offered in their area. The Star Rating program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.

Medicare STAR Ratings

CMS's Star Rating Program is based on measures in five different domains:

1. Staying healthy: screenings, tests, and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services, and improvement in the health plan's performance
5. Health plan customer service

How Can Providers Improve STAR Ratings?

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Management of chronic conditions such as hypertension and diabetes, including medication adherence.
- Continue to talk to your patients and document interventions regarding topics such as fall prevention, bladder control, and the importance of physical activity and emotional health and wellbeing (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).

How Can Providers Improve STAR Ratings? – *cont.*

- Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members, including availability of medical record for chart abstractions.
- Review the gap in care files listing members with open gaps which is available on our secure portal.
- Review medication and follow up with members within 14 days post hospitalization.
- Identify opportunities for you or your office to have an impact on your patient's health and well-being.
- Make appointments available to patients and reduce wait times (CAHPS).

Web-Based Tools

Health Plan Website

On the health plan website, providers can access:

- Billing Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider News
- Pre-Auth Check Tool
- Provider Resources

Secure Provider Portal

Through the secure provider portal on our health plan website providers can access:

- Authorizations
- Claims
  - Download Payments History
  - Processing Status
  - Submission / Adjustments
  - Clear Claim Connection – Claim Auditing Software
- Health Records
  - Care Gaps*
- Monthly PCP Cost Reports*
- Patient Listings* & Member Eligibility

*Available for PCPs only

Updating Your Data

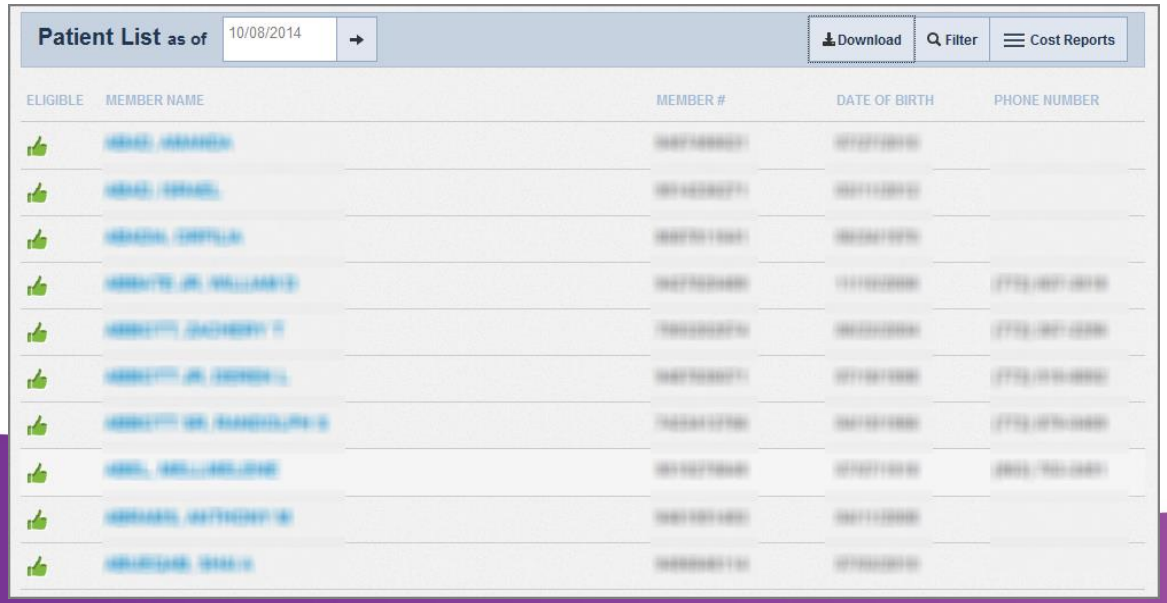
- Providers can improve Member access to care by ensuring that their data is current in our provider directory.

- To update your provider data:
  - Login to the Secure Provider Portal
  - From the main tool bar select “Account Details”
  - Select the provider whose data you want to update
  - Choose the appropriate service location
  - Make appropriate edits and save

Primary Care Provider Reports

Patient List – located on the secure portal at allwell.absolutetotalcare.com

Includes member's name, ID number, date of birth, and telephone number. The Patient List is available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender, and address.



Primary Care Provider Cost Reports

Members with Frequent ER visits: This report includes members who frequently visit the ER on a monthly basis. The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis, and cost.

High Cost Claims: This report includes members with high cost claims. The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis, and cost.

Rx Claims Report: This report includes members with pharmacy claims on a monthly basis. The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.), and cost.

Network Partners

Partners and Vendors

- Pharmacy Benefit Manager: Envolve Pharmacy Solutions

  1-844-202-6824 Phone

  1-866-226-1093 (Fax) PA Requests
- Cenpatico: Behavioral Health

  www.cenpatico.com
- Envolve Vision: Routine Eye Care & Ophthalmology Specialty Care

  1-800-334-3937

  www.visionbenefits.envolvehealth.com
- Envolve Dental: Dental Services

  1-844-617-2618

  www.providerrelations.envolvehealth.com
- National Imaging Associates (NIA) for non-emergent, outpatient high tech imaging

  1-877-807-2363

  www.RadMD.com

Lab and DME Partners

Lab

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

DME

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

AcariaHealth - Specialty Pharmacy

AcariaHealth is a national comprehensive specialty pharmacy providing services in all specialty disease states including:

- Cystic Fibrisis
- Hemophilia
- Hepatitis C
- Multiple Sclerosis
- Oncology
- Rheumatoid Arthritis

Most biopharmaceuticals and injectables require prior authorization at:

customercare@acariahealth.com

Billing Overview

Electronic Claims Transmission

Allwell has selected Availity as its primary gateway connection for Electronic Data Interchange (EDI) submission. This allows Allwell to better service its providers with more advanced engagement and communication strategies. Providers who currently submit claims through other clearinghouses may continue to do so with no interruption to their current business process.

Payer ID - 68069

EDI Support

- Companion guides for EDI billing requirements plus loop segments can be found on the following website:

  allwell.absolutetotalcare.com

- For more information, contact:

  Allwell from Absolute Total Care

  c/o Centene EDI Department

  1-800-225-2573, extension 6075525

  e-mail: **EDIBA@centene.com**

Claims Filing Timelines

- Claims are to be mailed to the following billing address:

Allwell from Absolute Total Care
Attn: Claims
P.O. Box 3060
Farmington, MO 63640-3822

- Participating providers have **365 days** from the date of service to submit a timely claim.

- All requests for corrected claims, reconsideration or claim disputes must be received within **60 days** from the original date of notification of payment or denial.

Claims Payment

- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may NOT bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Providers may not balance bill members for any differential.

Coding Auditing & Editing

Allwell uses code editing software based on a variety of edits:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

Software audits for coding inaccuracies such as:

- Unbundling
- Upcoding
- Invalid codes

Claims Reconsiderations & Disputes

- A request for reconsideration is to be used when a provider disagrees with the original claim outcome (payment amount, denial outcome, etc.)
- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Submit reconsiderations or disputes to:

  Allwell from Absolute Total Care
  Attn: Reconsiderations or Claim Dispute
  P. O. Box 3060
  Farmington, MO 63640-3822

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

EFT/ERA

- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly.
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Free service for network providers - **www.payspanhealth.com**

Meaningful Use – Electronic Medical Records

Meaningful Use

- EHR/EMR allows healthcare professionals to provide patient information electronically instead of using paper records.
- Electronic Health Records/Electronic Medical Records (EHR/EMR) can provide many benefits, including:
  - Complete and accurate information
  - Better access to information
  - Patient empowerment

(Incentive programs may be available)

Advance Directives

Advance Medical Directives

An advance directive will assist the Primary Care Provider to understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:

- Living Will
- Health Care Power of Attorney
- "Do Not Resuscitate" Orders

- Member's medical records must be documented to indicate whether an advance directive has been executed.

- Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions about medical care.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Allwell follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:

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

Fraud, Waste and Abuse

Allwell performs front and back end audits to ensure compliance with billing regulations. Most common errors include:

- Use of incorrect billing code
- Not following the service authorization
- Procedure code not being consistent with provided service
- Excessive use of units not authorized by the case manager
- Lending of insurance card

Benefits of stopping fraud, waste, and abuse:

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

Fraud, Waste and Abuse

Allwell expects all its providers, contractors, and subcontractors to comply with applicable laws and regulations, including, but not limited to the following:

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

Fraud, Waste and Abuse

Training Requirements:

- First-Tier, Downstream, and Related Entities (FDR), as well as delegated entities, will be required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter.
- Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan.

Medicare Fraud, Waste and Abuse Reporting

Potential fraud, waste, or abuse reporting may be called to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-855-766-1497 or by email to ATC.Compliance@centene.com

To report suspected fraud, waste, or abuse in the Medicare program, providers may also use one of the following avenues:

Office of Inspector General (HHS-OIG): 1-800-447-8477

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
P.O. Box 23489
Washington, DC 20026

CMS Mandatory Trainings

CMS Mandatory Trainings

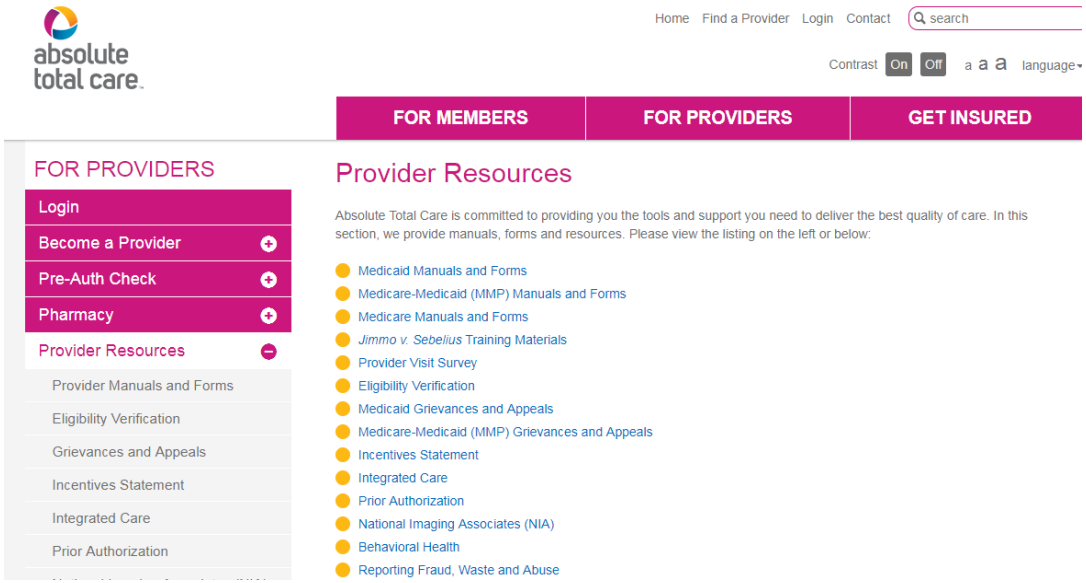
All contracted providers, contractors, and subcontractors must complete three required trainings:

- Model of Care (MOC): Within 30 days of joining Allwell and annually thereafter. (D-SNP only)
- General Compliance (Compliance): Within 90 days of joining Allwell and annually thereafter.
- Fraud, Waste, and Abuse (FWA): Within 90 days of joining Allwell and annually thereafter.

CMS.gov
Centers for Medicare & Medicaid Services

Model of Care Training Requirements*

- Model of Care training is a CMS requirement for newly contracted Medicare Providers within 30 days of execution of contract.
- Model of Care training must be completed annually by each participating Provider.
- Model of Care information is available at allwell.absolutetotalcare.com



*DSNP only

General Compliance & Medicare Fraud, Waste and Abuse Training

- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan.

Questions and Answers