



PROVIDER

Newsletter

CHANGES IN PRESCRIPTION COVERAGE FOR WELLCARE OF OHIO MEDICAID MEMBERS

Effective Feb. 1, 2010, the coverage of prescription drugs and certain medical supplies changed for members of Ohio Medicaid Managed Care Plans (MCPs), including WellCare of Ohio Medicaid members. Beginning Feb. 1, prescription coverage for members of Medicaid MCPs will be transferred to the state Medicaid fee-for-service (FFS) program.

The following summarizes some of the changes and how this impacts providers and members:

- WellCare of Ohio is no longer responsible for prescription drug coverage for its Ohio Medicaid members.
 - This change **does** impact:
 - ◇ Prescription drugs that are administered in the patient's home, home health settings or a nursing facility
 - ◇ Some medical supplies, such as diabetic testing supplies, supplies for injection of insulin and other drugs, inhaler spacers and peak flow meters
 - ◇ Retail pharmacy orders

These prescription drugs need to be billed through the Ohio Medicaid FFS program. (Please note that prescriptions billed through the FFS program may be subject to co-payments.)

- This change **does not** impact:
 - ◇ Covered drugs administered to members in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center. **These covered drugs continue to be WellCare's responsibility and are subject to existing WellCare coverage, authorization and billing requirements.**

WellCare Medicaid members received new ID cards. The backs of these new ID cards contain the billing information related to retail pharmacy as well as contact information for ACS—the Ohio Medicaid FFS pharmacy vendor. More information on state pharmacy policies is available on ODJFS' Web site at <http://jfs.ohio.gov/Ohp/bhpp/meddrug.stm>.

If you have any questions specific to WellCare coverage, please call WellCare of Ohio Provider Services at 1-800-951-7719.

PROVIDER MATERIALS UPDATE

Since our last newsletter was published, the following correspondence was sent to providers via fax or posted in the secure sections of the WellCare Web sites:

- Changes in Prescription Coverage for WellCare of Ohio Medicaid Members
- LabCorp Laboratory Services Available—Medicare
- Ohio Winter 2009 Newsletter
- Changes to Medication Benefit Process
- Changes to Preferred Brands of Insulin

You can find copies of these materials when you log in to the secure area of www.wellcare.com (Medicare) or ohio.wellcare.com (Medicaid). Use the white box on the right labeled "Member/Provider Secure Sign-In," then click on the *Provider* tab. You will see *Messages from WellCare* located in the right-hand column. Remember to check the messages regularly to receive new and updated information.

SUNCAP

WellCare offers an electronic version of cap payments called SUNCAP. The reports are usually available the 20th of each month and include member-level detail, which allows larger provider groups and ancillary providers an electronic means to reconcile payments to their assigned membership.

The files are sent in a standard text format to a secure site that allows you to import the data into any software system that you choose.

For more information on signing up to receive SUNCAP reports, please contact your Provider Relations representative.



EFT HELPS YOU RECEIVE PAYMENTS FASTER

You can receive your WellCare payments faster by signing up to receive electronic funds transfer (EFT) through our payment partner, Payformance.

Registration is quick and simple.

1. Obtain your registration letter or contact your Provider Relations representative for your registration code.
2. Once you have your registration code, go to the PaySpan Health Web site at www.payspanhealth.com. The Web site will walk you through the 5- to 10-minute registration process. The article to the right outlines these steps. You will receive a deposit from Payformance, which you'll need to confirm. EFT payments are typically received 2 to 5 days sooner than paper checks.

If you have questions, please contact your Provider Relations representative, or call the Provider Hotline at **1-866-687-8815** (Medicare) or **1-800-951-7719** (Medicaid). You can also contact Payformance at **1-877-331-7154** Monday through Friday, 7am to 9pm Eastern.

HOW TO REGISTER AS A PROVIDER ON PAYSPAN HEALTH'S WEB SITE

If you'd like to receive your WellCare payments faster, simply sign up for EFT payments at PaySpan Health's Web site. The registration process is outlined below.

TO BEGIN REGISTRATION:

1. Navigate to www.payspanhealth.com.
2. Click on the orange *Secure Registration* button.
3. A screen will appear for you to enter your registration code.
4. Type in the registration code from the registration letter, or use the code given to you by your Provider Relations representative.
5. Click the *OK* button.
6. The *Welcome Page* screen will appear.
7. Type in your Payee Identification Number (PIN) and Tax Identification Number (TIN). The PIN/Vendor is the payee ID assigned by the payer.
8. Click the *Begin* button to start the registration process.

STEP 1: THE REGISTRATION INFORMATION SCREEN WILL APPEAR.

1. Complete the required registration information questions.
2. The e-mail address will become your user name when logging in to the PaySpan Health Web site.
3. Click on the *Next* button to continue to Step 2.

STEP 2: THE ACCOUNTING INFORMATION SCREEN WILL APPEAR.

1. Type in an account name to identify the receiving account.
Note: Providers typically use the account name to specify the payee designation (i.e., General Hospital may be paid by Community Health Plan to separate payee accounts such as General Hospital ER and General Hospital Labs). Each payee will have a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.
2. Enter the routing number and account number in the specified fields.
3. Click on the *Next* button to continue to Step 3.

STEP 3: THE TERMS AND CONDITIONS SCREEN WILL APPEAR.

1. Review the registration information.
2. Click the *Edit* button to make any corrections.
3. Read the service agreement then check the terms and conditions box if in agreement.
4. Click the *Submit* button.

This will complete the registration process.

You will receive an e-mail confirmation of your completed registration. In a few days, you will need to verify with your bank that a minimal deposit has been made by Payformance. This deposit amount will be used to confirm that your electronic payments are set up appropriately through PaySpan Health and your bank. You will see this confirmation page the next time you log in to www.payspanhealth.com using your user name (your e-mail address) and your password.

If you have any questions about the registration process or the PaySpan Health Web site, please contact Payformance's Provider Support Team at 1-877-331-7154 Monday through Friday, 7am to 9pm Eastern.



UNDERSTANDING MEMBER COST-SHARING

WELLCARE COORDINATED CARE PLANS

What is cost-sharing?

Cost-sharing is the amount a member pays for health care and/or prescriptions. This amount can include co-payments, coinsurance and/or deductibles.

Providers should collect the applicable cost-share from the member at the time of the service when possible. Some members qualify for state programs to help them pay their out-of-pocket costs for Medicare. Members enrolled in these programs may still have to pay a Medicaid co-payment, depending on the rules in their state.

Would there ever be more than one co-payment due from a member in a single day?

Yes, there are certain situations when a member would be responsible for more than one co-payment in a single day.

1. If a member sees more than one provider on a given day, he or she would be responsible for the appropriate co-payment for each provider. For example, if a member has office visits with a PCP and a specialist on the same day, even if they are in the same office, he or she would be responsible for both the PCP and the specialist co-payments.
2. If a member has more than one diagnostic test or procedure in an outpatient or office setting on a single day, he or she would be responsible for the appropriate outpatient or office co-payment, plus the co-payment for each category of diagnostic services.

As an example, please refer to the chart below:

CATEGORY OF SERVICES	2010 AMOUNT
Lab services (i.e., urinalysis)	\$0 co-payment
Basic diagnostic radiological services (i.e., flat film X-ray)	\$0 co-payment
Basic diagnostic tests (i.e., allergy test)	\$20 co-payment
Advanced diagnostic tests (i.e., cardiac stress test)	\$50 co-payment
Advanced diagnostic radiological services (i.e., MRI)	\$50 co-payment

Let's say a member has an allergy test and a cardiac stress test performed by a single provider on the same day. By referring to the chart above, we can see that the member would be responsible for a \$20 co-payment for the allergy test, plus a \$50 co-payment for the cardiac stress test. If a member has these services performed in an outpatient facility, then he or she would be responsible for the appropriate outpatient facility co-payment amount, plus the allergy and cardiac stress test co-payments.

For additional information, visit www.wellcare.com or call the Provider Hotline at 1-866-687-8815.

CHANGES TO MEDICARE REDETERMINATION PROCESS FOR MEDICATION BENEFITS

EFFECTIVE JAN. 1, 2010

WellCare has changed how Medicare redeterminations (appeals) are being processed.

In order to facilitate redetermination requests and to offer better service to our providers and members, WellCare made the decision to have medical benefit claim redeterminations and medication benefit redeterminations processed separately.

Continued on next page



Beginning Jan. 1, 2010, if you would like to request an appeal for a medication benefit, please utilize the following contact information:

To request a **medication appeal** for a Medicare member, mail or fax a completed Medication Appeal Request form to:

WellCare Health Plans, Inc.
Attn: Pharmacy Appeals
P.O. Box 31383
Tampa, FL 33631-3383
Fax: 1-866-388-1766

The Medicare Medication Appeal Request form is available on www.wellcare.com under your state's *Provider Manual Forms*. You may also contact us regarding any questions or concerns you have regarding medication appeals by using the Customer Service telephone number on the *Quick Reference Guide* (QRG) found on www.wellcare.com.

Redetermination (appeal) requests for **medical benefits** and **claims** will be handled in the same manner as in the past. This information can be found in the *Quick Reference Guide* available on the provider Web site at www.wellcare.com.

CMS FURNISHES SCREENING FOR HIV IN HIGH-RISK MEDICARE POPULATIONS

The Centers for Medicare & Medicaid Services (CMS) clarified its obligation to furnish human immunodeficiency virus (HIV) screening to members with high-risk profiles, given the recent national coverage decision (NCD) on this particular screening.

Effective Jan. 1, 2010, WellCare covers both standard and U.S. Food and Drug Administration (FDA)-approved HIV rapid screen tests for people at risk. These tests are covered under basic lab services.

The CMS guidelines state these tests must be covered for:

- Annual voluntary HIV screening of Medicare members at increased risk for HIV infection per U.S. Preventive Services Task Force (USPSTF) guidelines, including:
 - Men who have had sex with men after 1975;
 - Men and women having unprotected sex with multiple partners;
 - Past or present injection drug users;
 - Men and women who exchange sex for money or drugs, or have sex with partners who do;
 - Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users;
 - Persons being treated for sexually transmitted diseases;
 - Persons with a history of blood transfusion between 1978 and 1985;
 - Persons who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.
- Voluntary HIV screening of pregnant Medicare members when the diagnosis of pregnancy is known, during the third trimester and at labor.

If you have any questions about these covered tests or this benefit, please call WellCare Customer Service at **1-866-687-8815**.

Source: Centers for Medicare and Medicaid Services. Decision Memo for Screening the Human Immunodeficiency Virus (HIV) Infection (CAG-00409N). Available at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=229&>

PROVIDER FORMULARY UPDATE

GENERIC NEWS

The generic drugs listed below are now available to WellCare's **Medicare** members at the lowest cost-sharing benefit:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Acular® 0.5% ophthalmic drops	Ketorolac Tromethamine 0.5% ophthalmic drops	Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
Acular LS® 0.4% ophthalmic drops	Ketorolac Tromethamine 0.4% ophthalmic drops	Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
Alphagan® P 0.15% ophthalmic drops	Brimonidine Tartrate 0.15% ophthalmic drops	Antiglaucoma Agents
Phenytek® 200mg, 300mg extended-release capsules	Phenytoin Sodium 200mg, 300mg extended-release capsules	Anticonvulsants—Hydantoins
Razadyne® 4mg/mL solution	Galantamine Hydrobromide 4mg/mL solution	Alzheimers Agent—Cholinesterase Inhibitors
Starlix® 60mg, 120mg tablets	Nateglinide 60mg, 120mg tablets	Antidiabetic Agents—Meglitinides
Valtrex® 500mg, 1gm caplets	Valacyclovir Hydrochloride 500mg, 1gm caplets (QL: 62 caplets/31 days)	Anti-infective Agents—Antivirals

QL = Quantity Limit

The following additions have been made to the WellCare **Medicare Formulary**:

ADDITIONS	
Adcirca® 20mg tablets (PA)	Morphine Sulfate 1mg/mL syringe
Buprenorphine 2mg, 8mg SL tablets	Piperacillin-Tazobactam 2.25gm, 3.375gm, 4.5gm, 40.5gm vial
Capastat® Sulfate 1gm vial	Sabril® 500mg tablets (PA)
Cervarix® vaccine (PA)	Saphris® 5mg, 10mg SL tablets (PA)
Codeine Sulfate 15mg, 30mg, 60mg tablets (QL: 248 tablets/31 days)	Seromycin® 250mg capsules
Hiberix® vaccine	Trecator® 250mg tablets
Lamotrigine starter kit tablets	Venlafaxine ER 37.5mg, 75mg, 150mg, 225mg tablets (QL: 31 tablets/31 days)
Metadate® ER 20mg tablets	Votrient™ 200mg tablets (PA)

PA = Prior Authorization QL = Quantity Limit

PLANNED DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Roche	Vesanoid® capsules	Dec. 14, 2009	Vesanoid® capsules are a non-formulary medication that was removed from the market on Dec. 14, 2009.
Eli Lilly	Humulin® 50/50 Insulin	Dec. 31, 2009	Humulin® 50/50 Insulin is no longer available from Eli Lilly. Beginning Jan. 1, 2010, Humulin® 50/50 was no longer a covered benefit on WellCare plans.

WHAT IS HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS) consists of a set of performance measures utilized by more than 90 percent of American health plans. This information is used to compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS IS IMPORTANT

HEDIS ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS TO PROVIDERS

By proactively managing your patients' care, you are able to effectively monitor their health, prevent complications and identify issues that may arise with their care. Providing preventive services, which improve HEDIS scores, demonstrates a commitment to quality patient care and is often reflected in your patients' satisfaction with their health care and their relationships with their doctors.

HEDIS can also help you:

- Identify at-risk members to ensure they receive preventive screenings
- Understand how you compare with other WellCare providers as well as with the national average

VALUE OF HEDIS TO PATIENTS

HEDIS works to ensure that members receive preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed health care choices.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Source: www.ncqa.org

WHAT YOU CAN DO:

- Encourage your patients to schedule preventive exams.
- Remind your patients to follow up with ordered tests.
- Conduct outreach calls to members who do not receive their annual screenings.

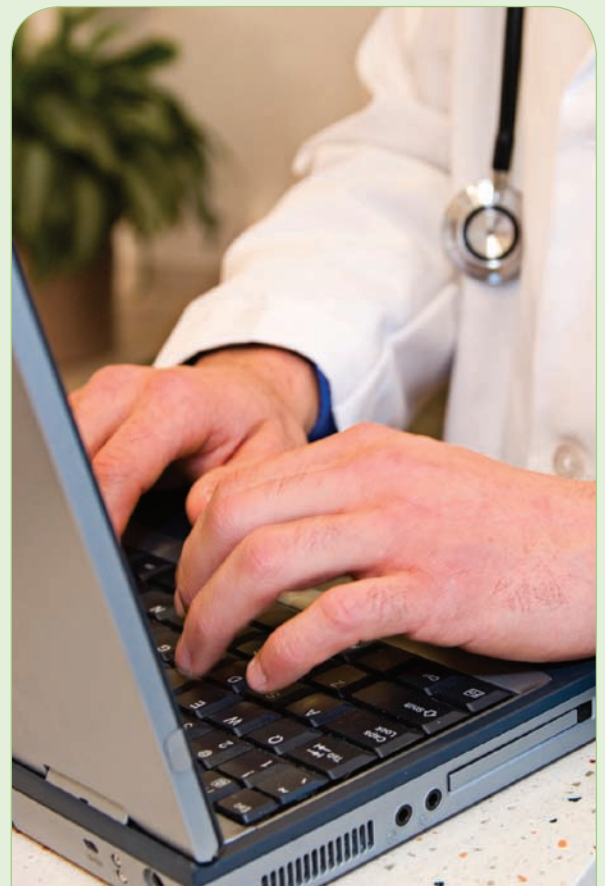
If you have questions about HEDIS or need more information, please contact your Provider Relations representative.

WEB REGISTRATION IS FAST AND EASY

To take advantage of WellCare and WellCare of Ohio's Web sites, go to www.wellcare.com (Medicare) or ohio.wellcare.com (Medicaid) and follow these simple steps:

1. Create a new account using the *Sign up Here* link that appears on the home page. The *Register Here* link on the top right side of the following page will direct you to the Provider Registration form.
2. Complete the registration form. Your WellCare-issued Provider ID appears in your welcome packet and on your Explanation of Payment copies.
3. Create a user name. A confirmation page will be displayed. You should print this page for your records.
4. Receive a registration e-mail. Within 24 hours of registration, you will receive an e-mail with a temporary password that will expire in 30 days. Use this password to log on to the WellCare site and create a password of your preference.

Be sure to keep your user name and password information somewhere safe for future reference.





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WHAT'S THE DIFFERENCE BETWEEN AN APPEAL AND A CLAIMS DISPUTE?

You should file an appeal if you disagree with an adverse organization determination. In most cases, these are related to authorization denials, claims denials or denials for reimbursement (typically related to the member paying out-of-pocket for services and requesting reimbursement from the health care plan).

A contracted provider has the right to appeal authorization denials, or claims denials related to lack of, or in excess of, authorization.

Appeals should be sent to:

WellCare Health Plans, Inc.
P.O. Box 31368
Tampa, FL 33631

If you believe there has been an error in payment, or you believe a claim payment did not follow guidelines, you have the right to dispute the payment amount by submitting a claims dispute. Claims disputes can include:

- A claim denial for timely filing
- Coding- or billing-related issues
- A dispute in the amount paid on a claim

Claims disputes should be sent to:

WellCare Health Plans, Inc.
P.O. Box 31372
Tampa, FL 33631

For more information about appeals or claims disputes, please refer to the telephone numbers on the Quick Reference Guides available on the provider Web sites at www.wellcare.com (Medicare) or ohio.wellcare.com (Medicaid).