



FLORIDA | SUMMER 2009

PROVIDER

Newsletter

PAYSPAN OFFERS ELECTRONIC MAILBOXES

Electronic mailboxes are now available on PaySpan Health, WellCare's partner for electronic funds transfer and electronic remittance advice (EFT/ERA).

Electronic mailboxes are used to automatically create an 835 and/or PDF files and send them to a secure file transfer protocol (SFTP) site. You or your third-party billing agency can then establish automated data retrieval and storage.

Q: Is it mandatory that I use electronic mailboxes?

A: No, using the electronic mailboxes is strictly voluntary.

Q: If I use an electronic mailbox, can I still download or print directly from PaySpan Health?

A: Yes, using an electronic mailbox only offers another solution to receive payment information. The current processes remain in place.

Q: How long are the payment files available in the electronic mailbox?

A: Payment files are available in the electronic mailbox for 15 days. After that, the files will be deleted from the electronic mailbox but will still be available on PaySpan Health.

Q: Can I receive my capitation payments through the electronic mailbox?

A: No, currently only claims payments are supported by an 835 file.

For more information, select the option to learn about electronic mailboxes from your PaySpan Health home page.

PROVIDER UPDATE

The following correspondence was sent to providers via fax or the WellCare Web site's *Messages* since our last newsletter. When you have logged in to www.wellcare.com, click on the Provider tab, and you will see *Messages from WellCare* located in the right-hand column. Remember to check the messages regularly to receive such new and updated information as:

- A toolkit for treating depression
- A well-child provider toolkit
- Tips for handling the swine flu virus

WEB RESOURCES

WellCare's Preventive and Clinical Practice Guidelines, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) documents, Pharmacy guidelines, Cultural Competency Plan and other helpful resources are available at www.wellcare.com.

WELLCARE PARTNERS WITH CARECENTRIX

Effective July 1, 2009, CareCentrix began providing home health care and durable medical equipment to WellCare's Medicare, and HealthEase and Staywell's Medicaid and Healthy Kids populations in Florida, currently serviced by Atenda. CareCentrix may be reached by phone at 1-888-999-2422, and by fax at 1-800-218-4219.



WEIGHT IS A SERIOUS CONCERN

ADOLESCENTS AND CHILDREN ARE AT RISK FOR OBESITY

The problem of overweight children and adolescents is on the rise. WellCare encourages providers to work with members to alleviate the problem.

Obesity is a serious health concern for children and adolescents. Data from National Health and Nutrition Examination Survey (NHANES) surveys (1976–1980 and 2003–2006) show that the prevalence of obesity has increased.

- In children 2–5 years old, the prevalence increased from 5 percent to 12.4 percent.
- From 6–11 years old, the prevalence increased from 6.5 percent to 17.0 percent.
- From 12–19 years old, the prevalence increased from 5.0 percent to 17.6 percent.

Data indicate that overweight children and adolescents are more likely to have risk factors associated with cardiovascular disease like high blood pressure, high cholesterol and type-2 diabetes than other children and adolescents and are more likely to become obese as adults.

USE OF BMI TO SCREEN FOR WEIGHT PROBLEMS IN CHILDREN

The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) recommend the use of BMI to screen for overweight in children beginning at two years old. For children, BMI is used to screen for overweight, at risk of overweight or underweight.

However, BMI is not a diagnostic tool. For example, a child may have a high BMI for age and sex, but to determine if excess fat is a problem, a health care provider should perform further assessments. These assessments might include skin-fold thickness

measurements, evaluations of diet, physical activity, family history and other appropriate health screenings.

Although the BMI number is calculated the same way for children and adults, the criteria used to interpret the meaning of the BMI number for children and teens are different from those used for adults. For children and teens, BMI age- and sex-specific percentiles are used for two reasons:

- The amount of body fat changes with age.
- The amount of body fat differs between girls and boys.

The CDC BMI-for-age growth charts take into account these differences and allow translation of a BMI number into a percentile for a child's sex and age.

See the accompanying chart for an example of how some sample BMI numbers would be interpreted for a 10-year-old boy.

WEIGHT STATUS CATEGORY	PERCENTILE RATE
Underweight	Less than the fifth percentile
Healthy weight	Fifth percentile to less than the 85 th percentile
At risk of overweight	85 th to less than the 95 th percentile
Overweight	Equal to or greater than the 95 th percentile

Online resources include the Child-Teen BMI Calculator at apps.nccd.cdc.gov/dnpabmi/Calculator.aspx.

Source: www.cdc.gov/nccdphp/dnpa/obesity/childhood/index.htm

BALANCE BILLING OF “ZERO COST-SHARE” DUAL-ELIGIBLES IS PROHIBITED

There are two classes of zero cost-share beneficiaries: Qualified Medicare Beneficiaries without Medicaid benefits (QMB) and QMB with full Medicaid benefits (QMB+). Individuals who are categorized as QMB or QMB+ have a zero-cost liability and should never receive a bill. In fact, CMS can impose sanctions for the practice.

If you are a provider that offers services, professional or otherwise, to the QMB and/or QMB+ population, it is highly recommended that you participate in the state's Medicaid program and gain access to any billing system from the state in which you operate. This will allow you to easily balance bill the state for your fees.¹

WellCare's Access plan is composed entirely of QMB or QMB+ individuals who are not responsible for co-payments, coinsurance and/or deductibles and should never be directly billed. While the EOP you receive from WellCare may indicate that the member has a payment responsibility, this is only intended as a means for you to submit documentation to the state's Medicaid agency and should not be taken as an instruction to bill the member.

For more information, please contact your local Provider Relations representative.

¹ *In states that have capitation agreements with WellCare, the plan will process the Medicaid payment responsibility on behalf of the state.*

EXPEDITED REQUESTS FOR MEDICARE PROVIDERS

WellCare Health Plans has a process that allows Medicare providers to request an expedited decision on a service authorization request.

- **Expedited Definition:** The physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health or ability to regain maximum function in serious jeopardy.

Once it has been determined that the request meets the expedited definition criteria, your office personnel can assist in the timely processing of your expedited request by ensuring the following:

- **Call** in your expedited request to the state's Medicare-designated telephone line: 1-888-888-9355.
- Have the correct **MEDICARE fax number: 1-877-892-8216 (outpatient) or 1-877-431-8859 (DME/therapy)**
- Have updated Authorization Request forms. The forms with the correct Medicare fax numbers can be found in the *Provider* area of www.wellcare.com or may be obtained from your WellCare Provider Relations representative. Please discard all old forms so the request goes directly to the designated Medicare area.

WELLCARE CLAIMS INFORMATION

From time to time WellCare Health Plans, Inc. (the Plan) reviews its reimbursement policies to maintain close alignment with industry standards and coding updates released by health care industry sources like the Centers for Medicare and Medicaid Services (CMS) and nationally recognized health and medical societies.

Please note that the Plan publishes periodic reimbursement policy updates. To obtain a copy of our current policies, please visit the Provider Resources area of our Web site at www.wellcare.com, and select the “Claims Updates” link.

Thank you for your participation with WellCare. We appreciate the high quality of care you provide to our members.

GENERIC UTILIZATION OF BEHAVIORAL HEALTH MEDICATIONS

Often appreciated for their cost-effectiveness, generic drugs are reviewed by the Food and Drug Administration (FDA) to ensure that they provide the same level of benefit to patients as their trade-name counterparts.¹ Utilization of generic entities whenever possible is particularly important for Medicare beneficiaries because they can bear a significant burden in cost-sharing for prescription medications.

This is particularly true when beneficiaries reach \$2,700 in total drug costs per year and fall into the coverage gap. Significant out-of-pocket expenses can occur during this time until the beneficiary reaches the next threshold of \$4,350 and qualifies for catastrophic coverage.

Numerous behavioral health medications are available generically and treat a variety of indications. The Plan requests that providers take into account the following points when prescribing behavioral health medications:

- Risperidone is a viable option when an atypical antipsychotic agent is warranted. Invega® (paliperidone) is the active metabolite of risperidone.
- Numerous generic antidepressants (citalopram, fluoxetine, paroxetine, sertraline, venlafaxine, bupropion) are available and provide cost-effective treatment options for multiple indications, including major depressive disorder, generalized anxiety disorder, obsessive compulsive disorder and premenstrual dysphoric disorder, to name a few. Lexapro® (escitalopram) is the S-enantiomer of racemic citalopram, and Pristiq® (desvenlafaxine) is the active metabolite of venlafaxine.

- Various generic stimulant medications for ADHD are available in short- and longer-acting amphetamine and methylphenidate products. Vyvanse® (lisdexamfetamine) is a prodrug that is rapidly absorbed from the gastrointestinal tract and converted to dextroamphetamine, which is available generically in an extended-release formulation (dextroamphetamine ER).

Beneficial clinical outcomes and cost savings to Medicare beneficiaries can be achieved through the utilization of generic behavioral health medications. Please consider these medications in an effort to add value to the health care dollar and minimize out-of-pocket expenses for the members we serve.

¹ Food and Drug Administration Web site. Available at www.fda.gov/Drugs/EmergencyPreparedness/BioterrorismandDrugPreparedness/ucm134212.htm. Accessed June 26, 2009.

FARS AND CFARS ARE A BEHAVIORAL HEALTH NECESSITY

Community behavioral health service providers are required to administer functional assessments using the Functional Assessment Rating Scales (FARS) for enrollees older than 18 and the Child Functional Assessment Rating Scale (CFARS) for enrollees 18 and younger on admission, at six month intervals and at discharge.

Providers must submit a report with assessments conducted each month by the 10th of the following month in the specified format. The reports should only

include data for the assessments conducted the previous month. For those providers having difficulty formatting or compiling the report per specifications, Harmony Behavioral Health now has a step-by-step training manual that is posted on the provider Web site at www.harmonybehavioralhealth.com.

If you have additional questions regarding report submission or content, please contact Jonathan Milliner at 1-813-420-5527.

PROVIDER FORMULARY UPDATE

Generic News: The generic drugs listed below are now available to WellCare’s Medicaid and Medicare members at the lowest co-payment (if applicable):

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Depakote® Sprinkle Capsule*	<i>divalproex sodium</i> sprinkle delayed-release capsule	Anticonvulsant agent
Depakote® ER Tablet*	<i>divalproex sodium</i> extended-release tablet	Anticonvulsant agent
Imitrex® Nasal Spray*	<i>sumatriptan</i> nasal spray	Antimigraine agent
Imitrex® Tablet*	<i>sumatriptan succinate</i> tablet	Antimigraine agent
Risperdal M-TAB™*	<i>risperidone</i> orally disintegrating tablet	Antipsychotic agent
Zerit® Capsule*	<i>stavudine</i> capsule	Antiviral agent

*These brand-name drugs have been removed from WellCare’s Medicaid Preferred Drug Lists.

The following changes have been made to WellCare’s Medicaid Preferred Drug List:

ADDITIONS	REMOVALS
Kionex® Powder	Androgel® 1%
Ribavarin Tablets	Androgel® 1% Pump
Namenda® Tablet (with Step Therapy)	Maxalt® Tablet
Neupogen® (with a Prior Authorization)	Maxalt-MLT® Orally Disintegrating Tablet
Suboxone® Tablet (with a Prior Authorization)	Relpax® Tablet
Testim® 1% Topical Gel (with a Prior Authorization)	Ribavirin Capsules
	Seroquel® Tablet

The following additions have been made to WellCare’s Medicare Formulary:

ADDITIONS
Hyoscyamine Sulfate 0.125–0.25mg IR/SR Biphasic Tablet
Kionex® Powder
Klor-Con® 20mEq Powder
Methitest™ Tablet
Nimodipine 30mg Capsule
Pancrease® MT Capsule
PrandiMet™ Tablet
Prezista® 75mg Tablet
Ramipril Capsule
Tindazole 500mg Tablet
Xibrom™ 0.09% Ophthalmic Solution

Also note we have increased the quantity limit per month for the following medication on WellCare’s Medicaid Preferred Drug List and WellCare’s Medicare Formulary:

QUANTITY LIMIT INCREASE
Ondansetron HCl Tablets QL has been increased to 62 tablets per 31 days

SERVICE REQUEST DENIAL RECONSIDERATION

WellCare reviews all requests for outpatient and inpatient services for medical necessity, appropriateness of care and place of service. The review determinations are made in accordance with nationally recognized criteria, which are objective and based on medical evidence. The review also takes into consideration the individual needs of the patient and the capabilities of the local health care delivery system.

NOTICE OF PROPOSED ACTION/ADVERSE DETERMINATION

When the review determination results in an adverse determination (denial), a Notice of Proposed Action letter is mailed to the member and the requesting provider.

PEER-TO-PEER RECONSIDERATION AVAILABLE

The attending physician or the ordering provider has the option to request a peer-to-peer reconsideration of an adverse review determination based on medical necessity review. The option of peer-to-peer reconsideration and how to request it are included in the courtesy notification delivered by fax or verbally to the provider at the time of the decision. The provider may contact the medical director who made the adverse review determination at **1-866-425-3508** to provide additional clinical information.

Reconsideration is available to providers within three business days of the denial decision date. Please use the number on the fax for physician/provider communications only. WellCare believes these changes will give providers the opportunity to present additional information supporting the request for services, as well as facilitate timely authorization.

PROVIDE UPDATED INFORMATION TO WELLCARE

As a reminder, please provide to WellCare any updated information or changes that would affect your status with the plan.

Inform the plan in writing within 24 hours of:

- Any revocation or suspension of your DEA number, and/or
- Suspension, limitation, or revocation of your license, certification or other legal credential authorizing you to practice in the state of Florida.

Inform the plan in writing immediately of changes to:

- Licensure status
- Tax identification numbers
- Telephone numbers
- Addresses
- Status at participating hospitals
- Loss of liability insurance

By keeping your information up-to-date, you are helping to improve member accessibility.

MEDICAL CARE AND RECORD KEEPING FOR DIABETES

WellCare encourages all of our partner providers to conduct routine assessments for members with diabetes. All laboratory values, physical assessment and evaluation details, and vaccination history associated with the assessments should be noted in the medical record.

Patients with diabetes should receive at least one periodic assessment annually. The assessment should check blood pressure, body mass index (BMI), psychosocial assessment for depressed mood, anxiety, substance abuse or cognitive impairment, cardiovascular risk assessment, comprehensive foot exam, observation for signs of organ disease and hypoglycemia, dilated eye examination and retinopathy screening by an optometrist or ophthalmologist, and a neuropathy screening.

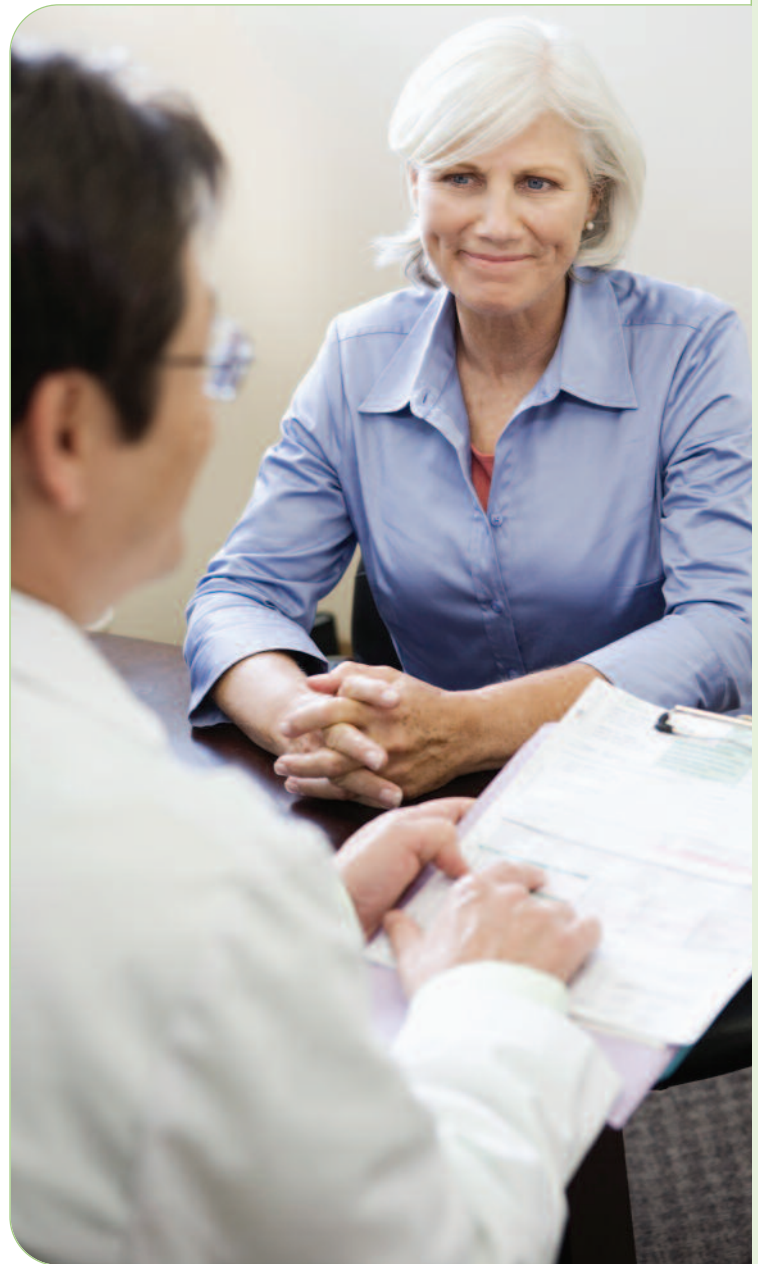
The patient's diabetic management plan should include blood glucose management, nutrition counseling, exercise program, foot care, cardiovascular risk reduction (i.e., smoking cessation, obesity, stress and dyslipidemia) and blood pressure management.

The measurement of hemoglobin A1c is a key test in the management of diabetes. The test should be performed two to four times a year, depending on the glycemic control of the member. A1c < 7 percent has been shown to reduce microvascular and neuropathic complications of diabetes, and thus is the recommended A1c goal for adults. Studies have suggested an incremental benefit to lowering A1c from 7 percent into the normal range. Therefore, the A1c goal for selected individual members is as close to normal (< 6 percent) as possible without significant hypoglycemia.

A fasting lipid profile should be done annually with the following targets: LDL < 100 mg/dl, HDL > 40 mg/dl for men, and HDL > 50 mg/dl for women. Saturated fat intake should be < 7 percent of total calories, and the intake of trans fats should be minimized.

Other vital laboratory tests include a urinalysis for microalbuminuria (screen for nephropathy) and a screening for thyroid-stimulating hormone (TSH).

Source: Standards of Medical Care in Diabetes. V. Diabetes Care, American Diabetes Association. Diabetes Care, 31 (Suppl 1): S16–24, January, 2008.





WellCare of Florida, Inc.
8735 Henderson Road
Renaissance One
Tampa, FL 33634

PRSR STD
U.S. POSTAGE
PAID
WELLCARE

27160

FL010058_WCG_NEW_ENG
©WellCare 2009 FL_04_09

ACCESS AND AVAILABILITY STANDARDS

To ensure that WellCare members have access to their physicians, the following criteria have been adopted for our primary care providers:

- Provide medical coverage 24 hours a day, seven days a week
- See scheduled appointments within 30 minutes of the appointment time
- Schedule and see emergent referral appointments immediately
- Schedule and see urgent referral appointments within one day
- Schedule and see routine sick-care appointments within one week
- Schedule and see well-care appointments within 30 days of a member's request

And for our specialty care providers:

- Schedule and see emergent referral appointments immediately
- Schedule and see urgent referral appointments within one day
- Schedule and see routine sick-care appointments within one week
- Schedule and see well-care appointments within 30 days of a member's request

