



PROVIDER

Newsletter

FREE UP YOUR FAX MACHINE!

WELLCARE HAS LAUNCHED PROVIDER E-MAIL COMMUNICATIONS

WellCare Health Plans, Inc. (WellCare) has launched the use of outbound e-mail communications for our Connecticut provider community!

If you have already registered for the secured Web site, thank you for your participation. If you have not yet registered for the Web site, we encourage you to participate by following the simple process outlined below.

HOW TO OPT IN TO E-MAIL COMMUNICATIONS

1. Visit www.wellcare.com and click on the "Provider Sign Up" link on the right side of the page underneath the "Member/Provider Secure Sign-In" section. You will reach the www.wellcare.com/registration/provider page where you can begin the simple, three-step Web registration process.
2. During the Web registration process, you will be asked to supply an e-mail address. The Web site allows you to have as many administrative users as needed.
 - For security purposes, we encourage the use of business e-mail accounts and recommend you provide the main e-mail account for your practice in addition to any other e-mail addresses you wish to provide.
3. Within 24 hours of registration, you will receive an e-mail with a temporary password. Use this password to log in to the WellCare site and create a password of your preference. Please make note of your login and password information for future use.

Please note that contractual and regulatory-based communications will continue to be delivered via other methods, including mailings and faxes.

If you have any questions, please call Provider Services at 1-866-579-8006.

Fast, Secure, at Your Fingertips—Register for the secured Web site and e-mail communications today!

PROVIDER UPDATE

Since our last newsletter published, the following correspondence was sent to providers via fax or was posted on the secure section of the WellCare Web site:

- Connecticut's 2010 Issue IV Provider Newsletter
- Lab Code Unit Limits
- Medicare STAR Rating System
- Launch of E-mail Communication
- Access Health Concerns for Older Patients (e-mail)

You can find copies of some of these correspondences when you log in to the secure area of www.wellcare.com (via the sign-in on the right that says "Member/Provider Secure Sign-In"). Then click on the *Provider* tab and you will see *Messages from WellCare* located in the right-hand side. Remember to check the messages regularly to receive new and updated information.

BREAKING DOWN WALLS

EFFECTIVE COMMUNICATION WITH PATIENTS

It can be very stressful when patients do not understand what their doctors are telling them about their condition. Good communication can help alleviate fear or anxiety they might experience.

Here are some things providers can do to communicate more effectively with their patients:

- Keep the patient's culture in mind; it may differ from yours. The way you communicate both verbally and nonverbally may mean something different to them.
- Assess what the patient already knows by asking questions; encourage patients to keep you informed.
- Assess what the patient wants to know.
- Be empathetic.
- Take the time to explain all treatment options and ensure the patient understands the benefits and risks of each option.
- Keep it simple; explain medical information in easily understood language.
- Be sure to answer all of the patient's questions.



CLAIMS CORNER

CODING FOR WELL AND SICK VISITS

The American Medical Association (AMA) CPT coding manual defines preventive medicine services as *age and gender appropriate history and exam with anticipatory guidance and counseling*. Included in preventive care services are:

- History and exam appropriate for age and gender
- Anticipatory guidance and risk factor reduction
- Ordering of appropriate immunizations, lab/diagnostic procedures
- Treatment and management of insignificant problems

The AMA CPT coding guidelines allow a provider to bill for both a preventive medicine code and a medically necessary evaluation & management (E/M) code when there is “**significant**” extra work required in the diagnosis or treatment of a problem during a routine (annual) examination. **Correct coding guidelines require the addition of modifier -25 to the medically necessary E/M service (99201–99215).**

A provider should bill ONLY the PREVENTIVE MEDICINE code when:

- The patient's status/history shows the patient in good health
- The patient has a minor “stable” problem
- The history of present illness (HPI) is “Doing well, no complaints”
- When the assessment & plan (A/P) addresses only preventive medicine issues

A provider should bill BOTH the PREVENTIVE MEDICINE code and the MEDICALLY NECESSARY E/M service when:

- Patient has chronic medical problems, one or two in poor control
- Patient with three serious chronic problems, all in good control, if they are addressed
- HPI documents poor control of chronic disease or status of stable diseases
- Exam shows unexpected, abnormal findings
- Acute problem treated
- A/P shows treatment of diseases

MIGRATING TO 5010 FOR ELECTRONIC TRANSACTIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that the health care industry use standard formats for electronic claims and related transactions. The current format, 4010A1, is in the process of being replaced by 5010, a new standard format.

All covered entities (health plans, health care clearinghouses and certain health care providers) will be required to use the 5010 standard when conducting electronic transactions. These include:

- Claims (professional, institutional and dental)
- Claims status requests and responses
- Payments to providers
- Eligibility requests and responses
- Referral requests and responses
- Enrollment and disenrollment in a health plan
- Coordination of benefits
- Premium payments

For the majority of the year 2010, the 5010 project focus was achieving Level I compliance. The Centers for Medicare & Medicaid Services (CMS) defines Level I compliance as follows: *a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.*

For the year 2011, focus is shifting to testing and becoming Level II compliant. CMS defines Level II compliance as follows: *a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.*

TESTING SCHEDULE: WHO AND WHEN

A testing schedule was developed for providers who submit electronic transactions directly to or receive electronic transactions directly from WellCare/Harmony. Testing began in January 2011 and will proceed through quarter two of 2011, depending on the provider and their transaction utilization.

For providers who submit electronic transactions through a third-party vendor, please note that WellCare/Harmony is also testing with vendors during the same time frame. The specific types of vendor testing are listed below.

- 837I, 837P, 837D (Claims)—WellCare/Harmony will test with clearinghouses
- 276/277 (Claim Status)—WellCare/Harmony will test with clearinghouses and providers
- TAI, 999, 277CA (Response Files)—WellCare/Harmony will test with clearinghouses
- Outbound 834 (Eligibility)—WellCare/Harmony will test with providers
- 835 (Payments)—WellCare/Harmony will test with payment vendor and providers
- NCPDP D.0 (Pharmacy)—WellCare/Harmony will test with pharmacy claims vendors
- Encounters—WellCare/Harmony will test with vendors and providers

KEEP COMMUNICATION LINES OPEN

- Notify WellCare/Harmony regarding any software and/or vendors that are not 5010 test-ready for external partners through our EDI department: **EDI-Master@WellCare.com**.
- Designate a primary contact (i.e., office manager, billing manager) who is familiar with 5010 and its implications for your office. A single point of contact will ensure communications to and from WellCare/Harmony are received timely.

RESOURCES

- CMS checklist for a smooth 5010 transition: www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
- CMS presentations from the National Provider calls: www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage

For inquiries related to your electronic claim submissions to WellCare/Harmony and related transactions, please contact our EDI team via e-mail at **EDI-Master@WellCare.com**.



DIABETES AND THE A1C TEST

The A1c test (a.k.a., HbA1c, glycated hemoglobin or glycosylated hemoglobin) is an essential measure for guiding your diabetic care management decisions. While conventional home glucose monitoring measures a patient's blood glucose at a given moment-in-time, the A1c test indicates a patient's average blood glucose concentration over the past few months.

UNDERSTANDING A1C NUMBERS

For healthy, non-diabetic patients the A1c measurement is in the range of 5 percent. For patients with diabetes mellitus, the American Diabetes Association (ADA) recommends an A1c target of less than 7 percent while the American Association of Clinical Endocrinologists recommends a modestly lower level of less than 6.5 percent.

Importantly, the ADA emphasizes that each patient's A1c goal should be individualized to best meet their health needs. The National Institutes of Health (NIH) points out that a percentage point drop in an A1c result (e.g., from 8 to 7 percent) reduces the risk of eye, kidney and nerve disease by 40 percent. A mean blood glucose of 150 mg/dL translates into an A1c of approximately 7 percent.

HOW THE A1C TEST WORKS

Hemoglobin A, a protein found inside red blood cells (RBC), carries oxygen throughout the body. Glucose in the bloodstream bonds (glycates) to the hemoglobin A-protein. More glucose in the blood results in a higher percent of hemoglobin proteins becoming glycated. Once glucose sticks to a hemoglobin A-protein, it typically remains as long as 120 days, the lifespan of a red blood cell. Therefore, at any moment, the glucose attached to the hemoglobin A protein reflects the level of the blood sugar over the last two to three months. A patient's A1c level will not change significantly over the course of a few days, but it will shift in response to

a change in overall glucose control. It is estimated that the 30-day period prior to the date of the sample will account for about 50 percent of an A1c value.

HOW OFTEN IS AN A1C TEST NECESSARY?

Patients with diabetes should initially have their A1c tested every three months. If blood glucose levels are fairly stable and are at near-normal levels, testing twice a year may be sufficient. More frequent A1c testing may be appropriate under changing clinical situations.

WHAT ARE THE LIMITATIONS OF THE A1C TEST?

While the A1c testing is a good measure of overall glucose control, it cannot and should not replace patient self-testing and lab-based spot checks of fasting serum glucose levels. Like other tests, results may vary from lab to lab. An international effort is underway to standardize the A1c testing to follow a new International Federation of Clinical Chemistry and Laboratory Medicine standard.

A1c results can become inaccurate when red blood cell survival times are prolonged or reduced. Conveniently, A1c testing does not require a fasting sample.

References:

"A1c Test." *Diabetes.org*. American Diabetes Association. 10 Sep 2007. www.diabetes.org/type-1-diabetes/a1c-test.jsp

"A1c: The Test." *Lab Tests Online*. 29 Aug. 2005. American Association for Clinical Chemistry. 10 Sep 2007.

www.labtestsonline.org/understanding/analytes/a1c/test.html

"If You Have Diabetes, Know Your Blood Sugar Numbers!" *National Diabetes Education Program*. July 2005. National Institute of Diabetes and Digestive and Kidney Diseases. 10 Sep 2007.

www.ndep.nih.gov/diabetes/pubs/KnowNumbers_Eng.pdf.

"IFCC Standardization of HbA1c." *National Glycohemoglobin Standardization Program*. Aug. 2007. National Glycohemoglobin Standardization Program. 10 Sep 2007.

www.ngsp.org/prog/IFCCstd.pdf

diabetes.about.com/od/symptomsdiagnosis/a/HbA1c.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 who serves the QMB and/or QMB+ population, it is highly recommended that you participate in your state’s Medicaid program and gain access to any billing system the state uses. This will allow you to easily balance bill the state for your fees.¹

WellCare’s Access plan is composed entirely of QMB and/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.

WHAT IS HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS®) consists of a set of health care performance measures utilized by health plans to define and report the quality of care their members receive. This information is used to compare how well a plan performs in several areas:

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

WHY HEDIS® IS IMPORTANT

HEDIS statistics are used to ensure that health plans are offering quality preventive care and service to their members. These reports offer informative comparisons of health plan-specific results for important stakeholders such as: individual health plan enrollees, state and federal regulatory agencies and businesses that purchase health care coverage for their employees.

VALUE OF HEDIS® TO PROVIDERS

Our HEDIS patient-specific reports—members who do not appear (from claims and encounter data processed by the Plan) to have had an important health care service—may help with the effective and efficient care management of your panel of patients. By proactively managing patients’ care, you are able to monitor their health, prevent further complications and identify issues that may arise from presumptive gaps in their care.

Your HEDIS scores may also help you:

- Identify at-risk members to ensure they receive preventive screenings
- Appreciate how your practice’s compliance with these national standards compares with other WellCare providers and with national practice patterns



MEDICAL INJECTABLES

WellCare continuously strives to reduce barriers to care and therapies. In reviewing our medical injectable (J-code) prior authorization requirements, WellCare identified an opportunity to consolidate and align the list of required codes. To that end, we combined our Medical and Pharmacy injectable prior authorization code lists into one consistent list, and aligned that list with current industry practice. The modified list of medical injectables that require prior authorization went into effect **December 7, 2010**.

Please note that some drugs continue to require prior authorization. Traditionally, J-code medications that were administered in the office setting required prior authorization. Under this new program, the list of drugs is reduced, but for those drugs still requiring prior authorization, the authorization is needed in all outpatient treatment settings, with the exception of emergent and urgent care. This allows WellCare greater review for medical necessity and fraud and abuse prevention.

WHAT DOES THIS MEAN TO YOU?

By removing the prior authorization requirement on a number of medical injectables, this enables you to treat your patients who are WellCare members without obtaining a prior authorization or completing a drug evaluation review (DER) for certain drug products. All other drug products, and home infusion therapy, still require a DER.

You are responsible for adhering to utilization management principles such as prior authorization. The Plan's Utilization Management (UM) program is designed to meet contractual requirements and comply with federal and/or state regulations while providing members access to high-quality, cost-effective, medically necessary care and ensuring prompt and accurate payment to our providers.

RESOURCES

To determine if a prior authorization is required, a No Authorization Required Medical Injectable List may be accessed at <http://www.wellcare.com/provider/pharmacyservices>.

If you should have any questions, please contact Provider Services at 1-866-579-8006.

Q1 2011 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
ASTELIN Nasal Spray [†]	Azelastine HCl 137mcg Spray	Antihistamine
Exelon [®] 1.5mg, 3mg, 4.5mg and 6mg Capsules	Rivastigmine 1.5mg, 3mg, 4.5mg and 6mg Capsules	Cholinesterase Inhibitor
Zegerid [®] 20mg Capsule [†]	Omeprazole/Sodium Bicarbonate 20mg Capsule	Proton Pump Inhibitor
Zegerid [®] 40mg Capsule	Omeprazole/Sodium Bicarbonate 40mg Capsule	Proton Pump Inhibitor

[†] Not covered on the 2011 Medicare formulary

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

ADDITIONS
Afinitor [®] 2.5mg Tablet (PA)
Amikacin Sulfate 100mg/2mL, 500mg/2mL and 1,000mg/4mL Vials
Ceftazidime 500mg Vial
Epinephrine 0.15mg and 0.3mg Auto-Injectors
Gianvi [™] 3mg–0.02mg Tablet
HalfLytely [®] & Bisacodyl Tablets Bowel Prep Kit
Methylphenidate 5mg/5mL and 10mg/5mL Oral Solutions
Suboxone [®] 2mg–0.5mg and 8mg–2mg SL Films (PA)
Tasigna [®] 150mg Capsule (PA)

PA = Prior Authorization

Please visit www.wellcare.com to view the current formulary and pharmacy updates.



ASSESS POTENTIAL HEALTH CONCERNS FOR YOUR OLDER PATIENTS

WellCare encourages you to dedicate a few minutes during a patient visit to discuss the following health concerns with your older patients:

FALL RISK MANAGEMENT

- **Ask your patients if they have fallen or almost fell, but were caught by someone or managed to grab hold of something just in time.**

Fall prevention is one of the biggest safety concerns for older patients, especially those that live alone. Slip and fall accidents are one of the leading causes for seniors having to go to the hospital. An important aspect of patient education and injury prevention is to alert your patients of ways to prevent falling, including wearing sensible shoes and using an assisted device—which is especially important for seniors—because their balance may be impaired, leading to increased falls.

ASSESS PHYSICAL ACTIVITY—KEEP YOUR PATIENTS MOVING

- **Talk to your patients about their physical activity. For example, do they exercise regularly or take part in physical exercise?**

You may want to advise them to start, increase or maintain their level of exercise or physical activity to maintain and/or improve their health. Physical activity can improve strength, balance, coordination and flexibility, and can go a long way toward fall prevention.

URINARY INCONTINENCE (UI)

- In addressing a topic as sensitive as this, it is important to put the patient at ease so they will feel comfortable discussing such a private issue with you.

Loss of bladder control is common among older patients. Urinary incontinence may be underreported because patients do not believe that anything can be done about it.

Underlying health problems may contribute to incontinence, such as menopause for women and enlarged prostate for men.

If the patient is experiencing symptoms of urinary incontinence, discuss treatment options that may include bladder training, physical therapy or sometimes, just a simple change in toileting habits may bring relief.

CHECK FOR OSTEOPOROSIS

- **Assess your patients' bone health.** Because osteoporosis can be asymptomatic for a prolonged period of time, do bone mineral density (BMD) testing if applicable.

With age, bones tend to shrink in size and density, which weakens them and makes them more susceptible to fracture. The U.S. Preventive Services Task Force (USPSTF) recommends BMD testing on all women age 65 and older, all men age 70 and older, and other patients based on their clinical profile.

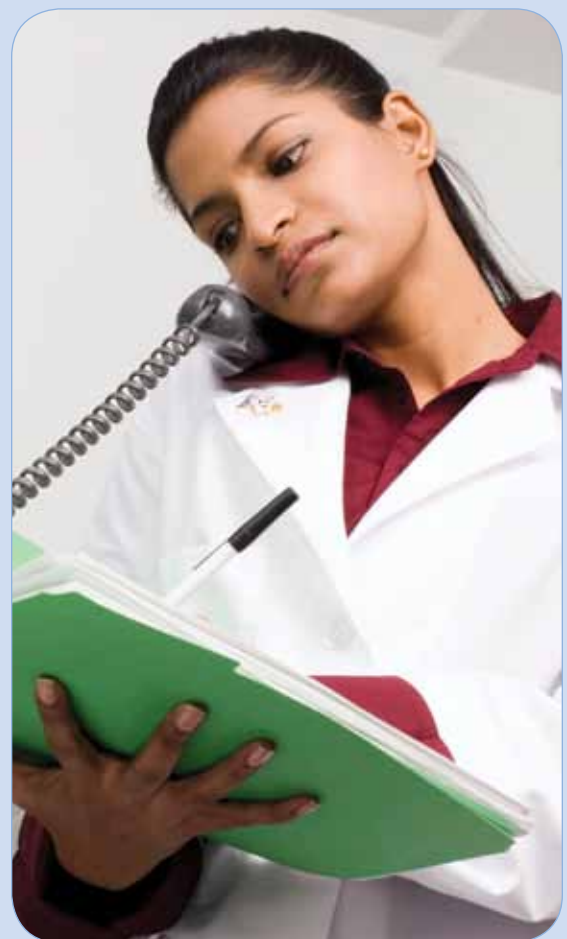
You may want to give them tips on what they can do to prevent bone loss or the progression of osteoporotic bones. For example, tell them to include plenty of calcium and vitamin D in their diets, and to consider strength training to increase bone density and reduce the risks of osteoporosis. Medication management is a treatment option to slow bone loss and maintain bone mass, when applicable.

Always remind your patients that it's never too late to adopt a healthy lifestyle. As their physician, you can not stop the aging process, but your patients can minimize the impact by making healthy lifestyle choices with your guidance.

ACCESS AND AVAILABILITY FOR PRIMARY CARE PROVIDERS

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

- A 24-hour answering service that connects the member to someone who can render a clinical decision or reach the PCP;
- An answering system with an option to page the physician; or
- An advice nurse with access to the PCP or on-call physician.



DIABETES AND EYE DISEASE: EIGHT FACTS YOUR PATIENTS NEED TO KNOW

Discussing the following facts about diabetic eye complications, and motivating your patients to engage in improved self-directed care, may lower a patient's risk of developing loss of vision.

1. DIABETES MAY LEAD TO EYE DISEASE

Several factors influence whether patients suffer from diabetic eye disease (diabetic retinopathy and premature development of cataracts) including their blood glucose control, systemic blood pressure levels and genetic influences. Keeping blood glucose and A1c levels close to normal may reduce their chance of developing diabetic eye disease.

2. THERE MAY BE NO WARNING

While a few diabetic patients receive no warning sign of an impending catastrophic vision loss, it's important to know the early warning symptoms that significant eye disease may be developing:

- Blurry vision
- Double vision
- Rings, flashing lights or blank spots
- Dark spots or floaters
- Pain or pressure in the eyes
- Trouble seeing out of the corners of your eyes

3. DIABETIC PATIENTS NEED ANNUAL DILATED EYE EXAMS

Regular eye exams, by an eye-care professional, are important for early detection of eye disease. If identified at an early stage, diabetic eye disease can often be successfully treated before severe vision loss occurs.

4. CONTROLLING DIABETES WON'T PREVENT DIABETIC EYE DISEASE

Unfortunately, even if your patient's blood glucose levels are steady, diabetic eye disease can still develop. However, successful management of a patient's blood glucose levels may slow the onset and progression of diabetic retinopathy.

5. PATIENTS WITH DIABETES MAY DEVELOP GLAUCOMA

Patients with diabetes are 40 percent more likely to suffer from glaucoma than people without this illness. The longer a patient has diabetes, the more common it is for glaucoma to develop. Even for patients who develop diabetes later in their life, advancing age is an independent risk factor for developing glaucoma.

6. PATIENTS WITH DIABETES MAY DEVELOP CATARACTS

Diabetes increases the chances of developing cataracts. Patients with diabetes tend to get cataracts at a younger age and have them progress faster.

7. DIABETIC RETINOPATHY DAMAGES THE RETINA

When blood glucose levels become too high, blood vessels in the retina weaken and fluid begins to leak outside the blood vessels. Additionally, new but fragile blood vessels grow (neo-vascularization). The new vessels are even more prone to leak fluid and they overgrow the light-sensing cells of the retina. This causes the retinal tissue to be damaged and results in vision loss and/or blindness.

8. LASER SURGERY SLOWS THE PROGRESSION OF DIABETIC EYE DISEASE

Laser surgery can be used to shrink the abnormal blood vessels or seal leaking blood vessels in the retina. The risk of vision loss from diabetic retinopathy is greatly reduced in some patients after having laser surgery.

Source:

Understanding Diabetes-Related Eye Conditions, Royal National Institute of Blind People (RNIB), 10 Jun 2006.



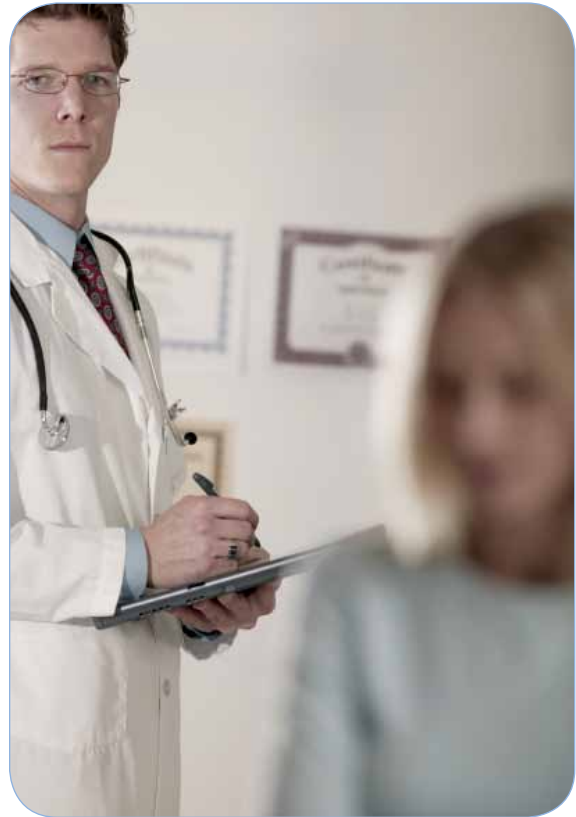
OUTPATIENT FOLLOW-UP AFTER A BEHAVIORAL HEALTH-RELATED INPATIENT ADMISSION

An example of a HEDIS® measure is the rate of outpatient follow-up with a behavioral health provider after a patient is discharged from an acute inpatient facility for a behavioral health illness.

Post-discharge outpatient follow-up is critical to reduce readmissions. This may be even more important, and perhaps more problematic, for patients who have been hospitalized for a behavioral health issue.

Primary care physicians should always recommend early post-discharge follow-up for their hospitalized patients. Directing your staff to facilitate outpatient visits with you and the behavioral health providers within seven days of a hospital discharge will reduce readmissions and improve the continuity of care for your patients.

If your patient misses his/her early follow-up appointment, it is imperative that an outpatient visit is rescheduled and completed as soon as possible and certainly within 30 days of the recent hospital discharge. Medication reconciliation, management of comorbidities, step-action treatment plans and comanagement of mixed illness diseases are important topics that need to be discussed at the time of the post-discharge follow-up visit.



UPDATED INFORMATION? LET US KNOW!

Please provide 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 Connecticut.

Inform the Plan immediately, in writing, of changes to:

- Licensure status
- Tax identification numbers
- Telephone and fax numbers

- Addresses
- Status at participating hospitals
- Loss of liability insurance

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

Any changes to your data should be sent to:

WellCare of Connecticut, Inc.
Attention: Provider Relations
127 Washington Ave.
4th Floor
North Haven, CT 06473

A copy should also be sent to your IPA if you are contracted with us through an IPA relationship.



WellCare of Connecticut, Inc.
 127 Washington Ave., 4th Floor
 North Haven, CT 06473

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WELLCARE EXPANDS HOSPITAL NETWORK

WellCare is pleased to announce that Hartford Hospital and MidState Medical Center are participating hospitals. Providers may admit patients to either facility following the same UM process for in-network hospitals. Members will receive their in-network benefit level for services rendered at either facility.

