

KEEP KIDS

ON TRACK TO WELLNESS

Providers are encouraged to schedule child health checkup visits for members who have not completed the recommended schedule; to perform and document the required age appropriate components; and to use appropriate CPT codes and modifiers to receive proper credit for the visit.

Please note: Although the AAP Periodicity Schedule recommended guidelines state one screening every two years per child at seven to eight years of age and nine to ten years of age, per provider, WellCare approves one screening **annually** per child at seven to ten years of age. Screenings should be spaced as close to an annual interval as possible.

CHILD HEALTH CHECKUP PERIODICITY SCHEDULE

- Birth or Neonatal examination
- 2-4 days for newborns discharged in less than 48 hours
- By 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- Once per year for 2- to 20-year-olds

PEDIATRIC

LEAD TESTING IS NOT A THING OF THE PAST

Screening for lead poisoning remains a federal mandate for Medicaid children. It is a required component of the Early and Periodic Screening, Diagnosis and Treatment guidelines.

A blood test should be completed at both 12 months and 24 months of age. Children between the ages of 36 and 72 months should be tested if they have not been previously screened.

Children with elevated blood lead levels (BLLs) in the 10-25 micrograms per deciliter (mcg/dL) range do not develop clinical symptoms. Screening is necessary to identify children who need environmental or medical interventions to reduce their blood lead levels.



INTRODUCING MANDATORY DRUG FORMULARY

PreferredOne is pleased to announce the Department of Social Services (DSS) approval of a Drug Formulary applicable for use with HUSKY A and HUSKY B Members enrolled with our Plan. The formulary is a prescribing reference and clinical guide of prescription drug products developed by physicians, pharmacists and nurses on our Pharmacy and Therapeutics Committee (P&T Committee). The formulary implementation date was March 1, 2006.

Please note that PreferredOne Members who have active prescriptions will have their prescriptions “grandfathered” and will not be impacted by the changes. The changes will only affect new prescriptions. For example, if you have a patient currently on medications for an ongoing condition such as diabetes or asthma, there will be no changes to the medications they are taking unless they have stopped taking those medications for 90 days or more. If the member stops taking the medication for 90 days or more, the new formulary should be followed. If the medication you are prescribing is not on the formulary, prior authorization should be submitted for the medication.

We have encouraged providers to increase appropriate first line use of generic medications such as Lovastatin (generic of Mevacor). It is important to remember that we have worked diligently over the past 15 months to remind prescribing providers that PreferredOne covers over-the-counter (OTC) medications such as Prilosec OTC and Claritin OTC. Prescriptions written for these OTC medications are encouraged and will continue to be a covered benefit for PreferredOne Members **even after the implementation of the mandatory drug formulary. As part of this benefit, all OTC medications require a written prescription for coverage.**

You can contact the Pharmacy Services department by dialing **1-877-647-7473**, option 3. Business hours are 8am – 9pm EST. After normal business hours, callers will be automatically connected to our after-hours service: Walgreens Health Initiative (WHI).



HELP

WELLCARE PREVENT FRAUD

Fraud can be defined as an intentional misrepresentation in order to gain benefit or value. Billions of dollars are lost to fraudulent activity each year in the form of false claims, improper coding, services not rendered, overutilization and misuse of modifiers.

You can make a difference by reporting any suspicious activity. Medicare Part D will be no exception, and we need everybody's help to prevent our tax dollars from being lost.

WellCare is committed to the prevention, identification and resolution of any fraudulent health care activity and is an active member of, as well as supports, the National Health Care Anti-Fraud Association (NHCAA).

To report Fraud Waste and Abuse (FWA) please contact our TRUST Hotline number, toll free **1-866-678-8355**.

ACCESS

AND AVAILABILITY REQUIREMENTS

It is the policy of WellCare to follow access and availability standards set by federal and state requirements. Participating PreferredOne PCPs are to adhere to the following scheduling practices:

- Emergency cases shall be seen immediately or referred to an emergency facility;
- Urgent cases shall be seen within 48 hours of PCP notification;
- Routine cases shall be seen within 10 days of PCP notification;
- Well-care visits shall be scheduled within 4 weeks of PCP notification;
- Members should be seen within 30 minutes from the time of their scheduled appointment.

Additionally, after normal business hours, PCPs should provide patients with one of the following:

- Provider will be available to the patients 24 hours per day, 7 days per week.
- Providers should have an answering service with an option to page the provider or an advice nurse with access to the PCP or on-call provider.

PRIOR

AUTHORIZATION REQUIREMENT REMOVED

To streamline administrative policies and provide easier access to health care services, WellCare has removed the Prior Authorization requirement for outpatient hospital lab services on its Medicare Advantage plans. This change became effective February 1, 2006.

We believe that reducing this administrative burden is a way to create a true partnership between WellCare and our network of participating providers.

ASTHMA

FAX ALERT PROGRAM FOR PATIENT FOLLOW-UP VISITS

The Utilization Management and Quality Improvement Departments have instituted a fax alert program for members who received treatment in the Emergency Department (ED) for an asthmatic condition. If one of your patients visits the ED for treatment of asthma, your office will receive a fax alert providing the name of the patient, hospital and the date of the ED visit with a request to make a follow-up ambulatory visit with that patient within two weeks, as recommended by the Department of Social Services. PreferredOne hopes that you will find this program useful in tracking those patients that visit the ED for asthma and need follow-up.



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CTT031_02_06

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PROVIDER

Newsletter

WELLCARE

MEDICARE ADVANTAGE ROLL OUT '06

On January 1, 2006, WellCare rolled out several major expansions in Connecticut to include the opening of Hartford County and WellCare becoming a national PDP Rx plan for Medicare recipients in all 50 states. The growth of our "\$0" Premium Medicare plans in New Haven, Fairfield and Hartford counties is based on the partnerships with providers and community programs. We have assessed the needs in Connecticut and added several plan options for 2006. We believe we are positioned to offer Connecticut the best product mix in the state.

CORE PROGRAMS

WellCare Choice (MA + PD): WellCare's most popular health plan, the Choice plan provides preventive health care, low co-pays for many services and Part D prescription drug coverage, all for no monthly plan premium.

WellCare Advance (MA only): The Advance benefit plan offers low co-payments for provider services. This plan was designed for individuals who receive prescription drug coverage from other sources.

SPECIAL NEEDS PROGRAMS

WellCare Access (Full dual eligible): WellCare Access gives members all of the Medicaid and Medicare benefits plus Part D prescription drug coverage in one easy package. To qualify, members must receive full Medicaid and Medicare benefits.

WellCare Select (Partial dual eligible): This is an especially attractive benefit offering available to those who receive help from Medicaid paying for Medicare premiums. In general, if the annual income is between 100 percent (or below) to 150 percent of the federal poverty level (FPL), members may be able to qualify.

With a grassroots marketing effort in the community underway, we have partnered with providers, senior centers and community organizations to grow our membership. One of the most innovative approaches to having a presence in the community is the establishment of the WellCare RV (mobile office) program. This program has an RV designated for each county that supports field activities at senior centers and provider offices and community activities, providing consistent access to our members with onsite presence for WellCare. Innovative community programs such as this will position WellCare as the plan of choice in Connecticut.

BEHAVIORAL HEALTH SERVICES UPDATE

Effective January 1, 2006, the Department of Social Services (DSS) and the Department of Children and Families (DCF) implemented a new initiative called the Connecticut Behavioral Health Partnership (CT BHP). Under this initiative, DSS and DCF contracted with an Administrative Services Organization (ASO) to authorize and manage behavioral health services for all HUSKY A and HUSKY B Members. CompCare will no longer be responsible for managing behavioral health services for PreferredOne Members after this date.

The CT BHP provides member services, provider services, utilization management, quality management and intensive care management services for behavioral health conditions.

PreferredOne retains responsibility for all primary care services, ancillary services (laboratory, radiology and medical equipment devices and supplies), hospital emergency department services and pharmacy services regardless of diagnosis. For HUSKY A clients, PreferredOne retains responsibility for transportation services regardless of diagnosis.

PreferredOne will continue to be responsible for primary care and other medical services provided by freestanding clinics regardless of diagnosis, except for behavioral health evaluation and treatment services provided for a primary behavioral health diagnosis and when provided by a licensed behavioral health professional.

ED MEDICATION

COVERAGE DISCONTINUED IN MEDICAID FEE FOR SERVICE PROGRAM

Effective January 1, 2006, drugs used for the treatment of Erectile Dysfunction (ED) are no longer covered for Medicaid fee for service clients. This change in coverage is a result of a federal measure that bans Medicare and Medicaid coverage for ED medications. Under the bill, which was passed in June 2005, federally funded programs may still cover these drugs if they are used to treat conditions other than ED.

All claims submitted for ED drugs dispensed on or after January 1, 2006, will be denied due to policy restriction unless they are prescribed for a condition other than Erectile Dysfunction.

The Department of Social Services will continue to cover Viagra and Revatio for clients in the Medicaid fee for service program with a documented diagnosis of 416.0, indicating Primary Pulmonary Hypertension. The diagnosis

must be entered on the prescription either by the authorized prescriber or by the pharmacist after verification with the prescriber. Both drugs are the only ED drugs currently available with an approved indication for Primary Pulmonary Hypertension. Claims received for either Viagra or Revatio with any diagnosis code other than 416.0 will be denied.

Source: Connecticut Department of Social Services

2006

BLACK HISTORY AWARD CELEBRATION

On February 4, 2006, PreferredOne was recognized at the Urban League of Greater Hartford's 2006 Black History Award Celebration for its continued support of the organization as an Urban Sponsor. Damion Fray, Connecticut Medicaid Marketing Manager, and Rosa Rodriguez, Community Relations Manager, were in attendance and accepted the award on behalf of the company. The awards ceremony recognizes African Americans for their contributions to the community of Greater Hartford. Among this year's honorees was Connecticut State Treasurer Denise Nappier. In 1998, Ms. Nappier became the first African-American woman to be elected to a statewide office in Connecticut. She is also the first woman in Connecticut history to be elected Treasurer.

Additionally, in recognition for her three years of involvement with the organization, the Urban League invited Rosa Rodriguez to become a member of their board of directors. Rosa's term is scheduled to begin in April 2006.



SERVICES

UNDER THE WIC PROGRAM FOR PREFERREDONE MEMBERS

WIC participation positively affects children's use of health care services, iron and immunization status, and overall health. Screening examinations and interperiodic screening examinations necessary for WIC certification are covered for PreferredOne Members. Infants are initially certified for the WIC program up to their first birthday and at six-month intervals thereafter.

If you are treating a child that is receiving services under the WIC program, please be advised that a height, weight and anemia screening documented in the medical record is required every six months for continued participation in WIC, even if the child is in the two- to five-year age range.

REMINDERS

FROM THE CLAIMS DEPARTMENT

- Since our fee schedules are a derivative of the State's fee schedule, the new CPT/HCPC codes approved by the State effective January 1, 2006, will not appear on our Fee Schedules until the State updates their fee schedules, and these codes should not be billed until that time.
- PreferredOne maintains a 120-day timely filing limit and a 60-day re-file/appeal limit, and claims submitted for review past the 60-day limit will be denied.
- Immunization CPT Codes **must** be billed along with the Administration Codes 90741 and 90472 or 90465 and 90466. Immunization Codes are required for tracking and reporting purposes. Please note:
 - Providers must bill \$0 for the Immunization CPT Codes.
 - Proof of purchase is required for all vaccines billed to PreferredOne for patients under 21 years of age.



MEMBER

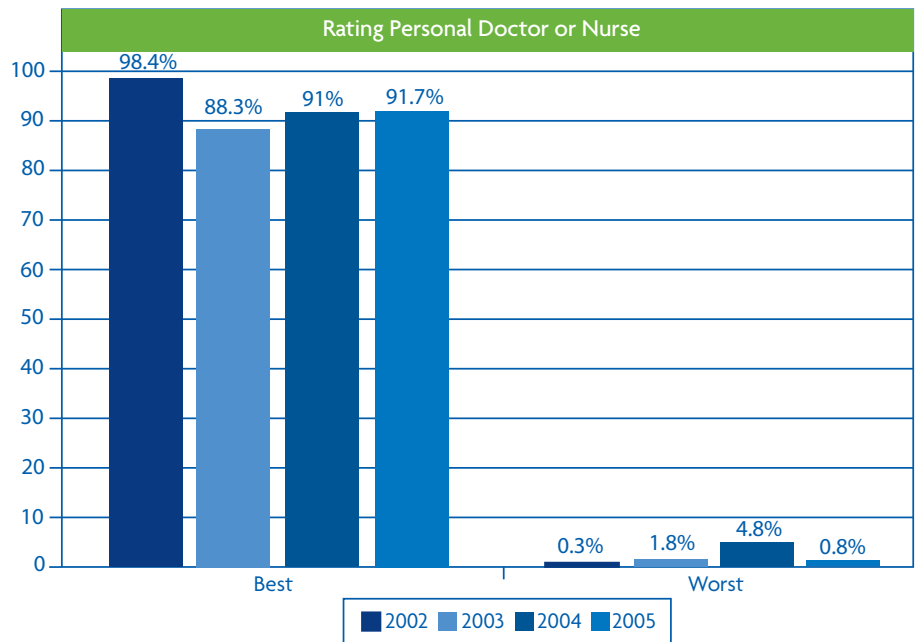
SATISFACTION SURVEY

The Center for Research and Public Policy conducted PreferredOne's annual Member Satisfaction Survey, and we are extremely pleased to share the results with our provider community. We thank you for continuing to deliver this high-quality care to our members.

Among the highlights: 1) Providers are consistently treating our members with a high level of care, courtesy and respect. 2) Members are highly satisfied with the services they receive from specialty providers. 3) Members are ranking PreferredOne positively as a health plan. Specific areas surveyed are outlined below.

ON RATING THEIR PERSONAL DOCTOR OR NURSE

Among those members who currently report having a personal doctor or nurse, 91.7% continue to provide positive ratings when rating their own doctor or nurse.



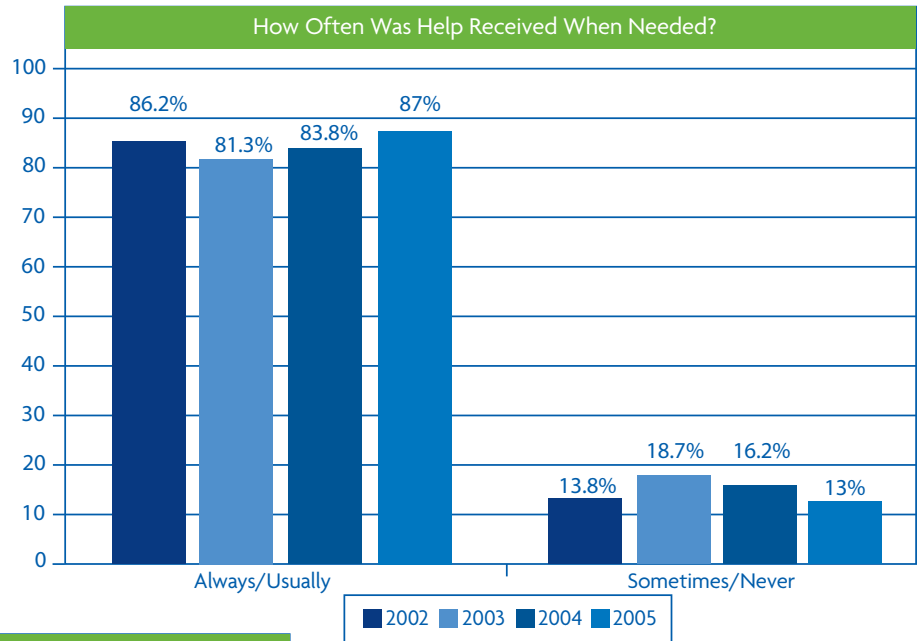
ON SPECIALISTS

Satisfaction with specialists has increased once again among members of PreferredOne in 2005. Among those reporting a visit to a specialist, 85.2% of the respondents offered positive ratings.

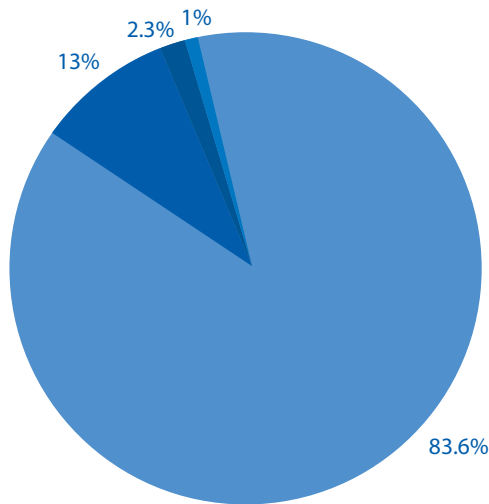


CALLING DOCTORS' OFFICES

87% of the members polled reported receiving the help or advice they needed either "always" or "usually" when calling their doctor's office or clinic during normal business hours.



How Often Did Staff Treat You with Courtesy and Respect?



ON TREATMENT BY THE OFFICE STAFF

Respondents were asked how often office staff at the doctor's office or clinic treated them with courtesy and respect. The majority, 96.7%, said "always" (83.6%) or "usually" (13%), while the remaining 3.3% said only "sometimes" (2.3%) or "never" (1%).

Legend: Always (light blue), Usually (medium blue), Sometimes (dark blue), Never (darkest blue)

RATING THE HEALTH PLAN

Respondents were asked overall to rate their health plan. The cumulative total for those respondents providing a positive rating is 89.4%, while the cumulative total for those respondents providing a negative rating is 2%.

