



SUMMER 2007

# PROVIDER

## Newsletter

## HPV VACCINE AVAILABLE THROUGH VFC

HUMAN PAPILLOMAVIRUS (HPV) IS MOST COMMON IN YOUNG MEN AND WOMEN IN THEIR TEENS AND EARLY 20'S.

In June 2006, the Advisory Committee on Immunization Practices (ACIP) recommended that the first licensed HPV vaccine be routinely administered to females ages 11–12 years. The ACIP also recommends administering the vaccine to girls as young as nine years old and giving catch-up vaccinations for females ages 13–26 years.<sup>1</sup>

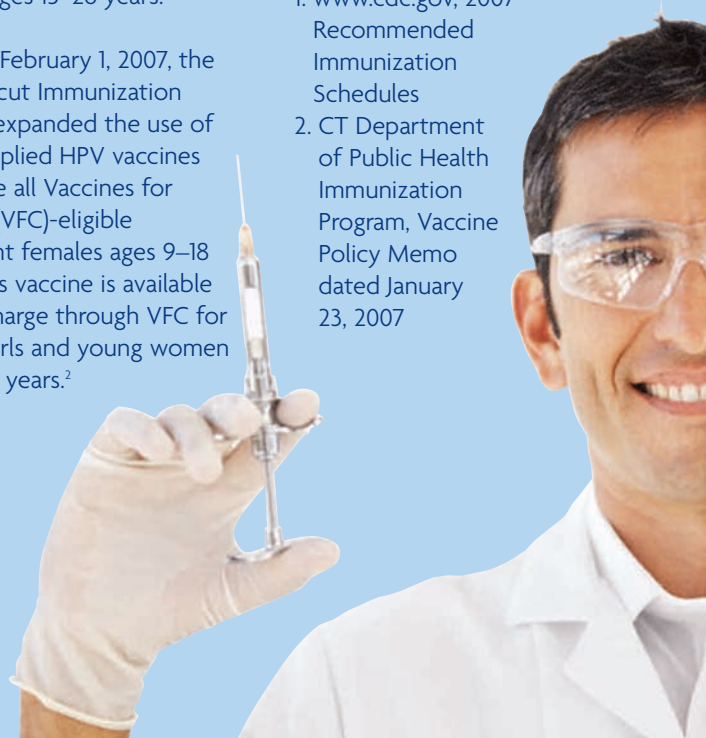
Effective February 1, 2007, the Connecticut Immunization Program expanded the use of State-supplied HPV vaccines to include all Vaccines for Children (VFC)-eligible adolescent females ages 9–18 years. This vaccine is available free of charge through VFC for HUSKY girls and young women ages 9–18 years.<sup>2</sup>

*PreferredOne* will no longer reimburse vaccine purchase prices for clients in this age range.

For more information, contact the Connecticut Immunization Program at (860) 509-7929.

#### Sources:

1. [www.cdc.gov](http://www.cdc.gov), 2007 Recommended Immunization Schedules
2. CT Department of Public Health Immunization Program, Vaccine Policy Memo dated January 23, 2007



## PROVIDE UPDATED INFORMATION TO WELLCARE

As a reminder, please provide any updated information or changes to WellCare which 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 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.

# NEW CLAIMS FORMS AND GUIDELINES

As you may already be aware, the Centers for Medicare & Medicaid Services (CMS) has changed its standard claims submission forms. Please familiarize yourself with the changes to ensure a seamless transition for your practice and our systems so that there are no delays in processing your claims going forward.

To allow for the inclusion of HIPAA-mandated unique National Provider Identifiers (NPIs), the CMS 1500 (formerly HCFA 1500) is being updated to a new version, and the UB-92 is being replaced by the UB-04. WellCare is ready to accept both of these new forms from providers.

## CMS 1500

On the new CMS 1500, several fields have been added to accommodate the NPIs for referring, rendering, facility and billing providers. While CMS has not yet said when it will begin rejecting the old version of the form, it is best to begin using the new version as soon as possible to ease the transition to the use of NPI in claims submissions.

## CAUTION

CMS has published two iterations of the new CMS 1500 form. The most effective way to know that you have a current CMS 1500 form is to refer to the footer and locate the form control number. The proper control number is: **OMB-0938-0999**.

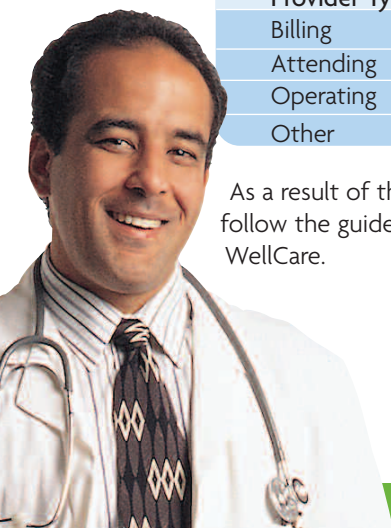
CMS 1500	
Provider Type	NPI Field
Referring Provider	17B
Rendering Provider	24J, Lines 1–6
Facility	32A
Billing Provider	33A

## UB-04

The new UB-04 contains several new fields for the submission of NPIs for billing, attending, operating and other providers. The UB-92 is no longer being accepted as of May 23, 2007, so please always use the UB-04 going forward.

UB-04	
Provider Type	NPI Field
Billing	56
Attending	76
Operating	77
Other	78, 79

As a result of these HIPAA-mandated changes, please follow the guidelines at right when submitting claims to WellCare.



## Required Information on the New CMS 1500 and UB-04 Claims Forms

1. **NPI** – The new form has fields to include NPI numbers for the attending, operating and billing providers.
2. **Federal Tax ID** – WellCare requires the inclusion of the tax ID for validation purposes. Claims without a tax ID cannot be processed and will be returned.
3. **WellCare Provider ID** – The WellCare ID is still very useful to us. Please include it on all claim submissions. Non-participating providers should include their federal tax ID, NPI, state license number or taxonomy.
4. **Encounter Claims Submissions** – Must include the Medicaid ID for proper adjudication.
5. **Less is NOT more.** As we transition, please include as many identifiers, along with their qualifiers, as you may have available to ensure your claim is adjudicated properly.

## QUALIFIERS

So that identifier types may be differentiated in the processing of claims forms, distinct qualifiers must be attached to the IDs provided on the UB-04 and CMS 1500 forms. Please refer to the list below and make sure to attach the proper qualifier to the provider identifier so that the claims process can go as smoothly as possible.

Identifier	Qualifier
Tax ID	24 (if used as an identifier in fields other than those specified for the TIN)
WellCare ID	G2
Medicaid ID	ID
Medicare ID	1C
Taxonomy	ZZ
State License	0B

WellCare has issued guidance directly to providers on the use of the new claims forms. Please refer to this guidance in the completion and submission of these forms to ensure a seamless transition to the new standards for your practice and our systems and to ensure that there are no delays in the payment of claims.

More information on the new claims forms standards may be found on WellCare's Web site at [www.wellcare.com](http://www.wellcare.com) and on the CMS Web site at [www.cms.gov](http://www.cms.gov).



# ACCESS AND AVAILABILITY REQUIREMENTS FOR PREFERRED ONE PRIMARY CARE PROVIDERS



It is WellCare's policy to follow access and availability standards set by federal and state requirements. Participating PreferredOne Primary Care Providers (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 six weeks of PCP notification.
  - Specialist visits should be scheduled within professionally accepted promptness standards.
  - 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 patients 24 hours a day, seven days per week by making arrangements for an answering service with options to page the provider, an advice nurse with access to the PCP or an on-call provider.
  - On a routine basis, WellCare will monitor appointment availability as well as after-hours availability of the network of participating providers to ensure that access standards are met.

## CHANGE TO THE SITE VISIT PROCESS

Based on a recommendation from the 2006 external quality review audit, Provider Relations representatives will be verifying appointment access when a site visit is conducted. The PCP scheduling practices that will be verified are:

- Emergent care
- Urgent care
- Routine care
- Well-care visits
- Office wait times



## GROVE HILL MEDICAL CENTER JOINS WELLCARE NETWORK

Grove Hill Medical Center, PC is now a participating provider in the WellCare Medicare Coordinated Care Plan networks. The addition of this group with locations in New Britain, Southington, Plainville and Bristol will provide both members and providers greater flexibility and choice in accessing services. You can learn more about Grove Hill Medical Center by visiting [www.grovehill.com](http://www.grovehill.com). Please visit [www.wellcare.com](http://www.wellcare.com) for a complete listing of participating providers and facilities.

## CHANGES TO NOTIFICATION AND AUTHORIZATIONS REQUIREMENTS

WellCare of Connecticut is eliminating the requirements around notifications. WellCare is also currently reviewing the Prior Authorization list and eliminating many services. The updated list will be distributed to our participating providers in the coming weeks.

The Quick Reference Guide is your best resource for the most up-to-date authorization rules and guidelines. You may access copies of the Quick Reference Guides at [www.wellcare.com](http://www.wellcare.com). Please always refer to the online versions to ensure you are using the most recent versions.



# NPI REMINDER

WellCare providers should be aware that the federal deadline for National Provider Identifier (NPI) compliance was May 23, 2007. All providers must now have and use their 10-digit NPI numbers. With that in mind, please take note of the following:

## Submitting Your NPI to WellCare

- There are NPI submission forms available on the Provider area of our Web site: <http://www.wellcare.com/>. The forms will allow providers to enter their NPIs directly into our database. In addition, you will find a wealth of NPI information on that Web page.
- WellCare has sent communications soliciting NPI numbers by fax and mail. If you have not submitted your NPI to WellCare and have received this correspondence, please fill out the submission form and return it as soon as possible or download a copy of the Web form from our Web site as mentioned above.
- Continue to use your WellCare ID. The NPI will only replace your WellCare ID in HIPAA transactions such as claims

processing and will not replace your WellCare ID for daily business transactions with our plan. You should continue to identify yourself using your WellCare ID when calling WellCare Customer Service or your Provider Relations representative.

## Getting Your NPI

If you have not yet obtained your NPI, please review the following guidelines.

- Any health care provider or organization defined as a covered entity under HIPAA is required to obtain an NPI. Providers who transmit health care information via HIPAA standard electronic transactions are covered entities under HIPAA, whether they transmit the transactions themselves or use a vendor to transmit them.

- Type 2 (organizational) providers must obtain and submit NPI numbers for the organization as well as all providers subparted within the organization.
- The Centers for Medicare & Medicaid Services (CMS) estimates that once a provider obtains an NPI number, it will take about 120 days to update office systems, coordinate with all of the entities that require the number and begin using it.

## More NPI Information

- Further NPI information can be found on the CMS Web site at <http://www.cms.hhs.gov/NationalProviderStand/>. Periodically check the CMS and WellCare Web sites for updates.



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



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# PHARMACY GUIDE FOR PREFERRED ONE PROVIDERS



The Preferred Drug List (PDL) is a standardized prescribing reference and clinical guide of prescription drug products selected by WellCare's Pharmacy and Therapeutics Committee. The selection of drugs is based on each drug's efficacy, safety, side effects, pharmacokinetics, clinical literature and cost-effectiveness profile.

Most medications on the PDL are covered without prior authorization or Drug Evaluation Review (DER). However, some PDL items are only covered with a DER. Medications that require a Drug Evaluation Review are noted with a DER or ST (step therapy) listed next to the medication. All non-PDL medications require the submission of a Drug Evaluation Review request.

The Preferred Drug List can be viewed at [www.wellcare.com/Providers/Pharmacy/Services/Connecticut.aspx](http://www.wellcare.com/Providers/Pharmacy/Services/Connecticut.aspx).

## Drug Evaluation Review

PreferredOne's Drug Evaluation Review (DER) process is designed to minimize adverse drug events, ensure appropriate utilization and clinical monitoring and maintain the highest level of pharmaceutical care for our members. A Drug Evaluation Review is needed for any of the following:

- Duplication of therapy
- Prescriptions that exceed the FDA daily or monthly quantity maximum
- Most self-injectable and infusion medications
- Medications not listed on the Preferred Drug List (PDL)
- Some PDL medications that require a DER
- Request for a brand-name drug when a generic exists
- Drugs with a step edit and the first line drug is inappropriate

## Obtaining a Drug Evaluation Review

Submit all requests to the Pharmacy Services department following these easy steps:

1. Complete a Drug Evaluation Review form found on the WellCare Web site.
2. Submit the form to the WellCare Pharmacy Department via fax to **(866) 388-1517**.
3. For injectable and specialty medications, complete the Injectable Infusion Order Form on the WellCare Web site and fax it to the Injectables department at **(866) 388-1517**.
4. Include pertinent medical history when submitting a Prior Authorization form for medical exception.

Our standard is to respond to DER requests within 72 hours.

If the DER meets the approved Pharmacy & Therapeutics Committee (P&T) protocols and guidelines, the provider and pharmacy will be contacted with the DER approval.

If the DER is not a candidate for approval based on approved P&T protocols and guidelines, it is initially reviewed by a clinical pharmacist and secondly reviewed by the Medical Director for final determination.

For those requests that are not approved, a follow-up Drug Utilization Review (DUR) form is faxed to the provider stating why the DER was not approved and listing the preferred drugs that are available as alternatives.

To request an appeal of a DER decision, fax your request to the Appeals Department. Refer to the Quick Reference Guide for the fax number. The request will follow the appeals process found in the Provider Manual.

## After-Hours Prescription Requests

If a member is in need of a prescription that requires a Drug Evaluation Review during weekends or after-hours, a 30-day temporary supply will be authorized at a network pharmacy. Pharmacists may call our help desk at **(877) 647-7473** to obtain the authorization.

WellCare's Pharmacy Call Center is available to assist providers Monday through Friday from 8am to 9pm Eastern. During weekends and after normal business hours, Walgreens Health Initiatives (WHI) is accessible to health care providers requiring pharmaceutical services and can provide therapeutic options available on the Preferred Drug List, as well as a 30-day temporary supply for urgent or emergent situations. The after-hours contact number is **(877) 647-7473**.

## Urgent or Emergency Prescription Fills

WellCare will provide up to a 30-day temporary supply of a prescribed non-preferred medication without delay for those prescriptions that the pharmacist determined to be necessary to address an urgent or emergent condition, or if the pharmacy staff has been unable to contact the provider to discuss an effective formulary alternative.

Pharmacists should call our help desk at **(877) 647-7473** to obtain this temporary supply.

Following the provision of the temporary supply, contact is made with the physician to discuss an alternative drug of choice with optimal indication for the disease state.

If the drug is manufactured in a form that is unable to be dispensed in a 30-day supply (external cream, ophthalmic solution, patches, etc.), authorization will be given for the full amount.