

 PROVIDER
Newsletter

CASE MANAGEMENT AND DISEASE MANAGEMENT

MAINTAINING THE MEMBER'S WHOLE HEALTH

WellCare encourages providers to advise members to take advantage of our Case Management and Disease Management programs to help enhance quality of life, while managing overall health costs.

CASE MANAGEMENT

The WellCare Case Management team facilitates collaborative relationships among members, providers, members' support systems and the Plan, ensuring continuity of care and a smooth transition for the member throughout the care process. The Case Management team advocates for member preferences and members' unique health service needs through assessment, planning and anticipating future health care requirements to promote positive outcomes, prevent complications, and aid eventual recovery.

Through coordination of services, member education, improving access to quality services and maximizing the time members spend in productive, rewarding activities, Case Management ultimately helps lower overall health-related costs.

The case management process consists of four phases:

EVALUATION—Upon entry into the program, a nurse will determine what the member's needs are and whether they are being met. The nurse case manager looks for available resources and family support. At this stage, the nurse case manager identifies possible gaps in care. This leads to the next phase of the case management process: planning.

PLANNING—The nurse case manager constructs and implements a member care plan and shares it with primary care physicians and specialists.

PROVIDER SURVEYS

WE WANT TO HEAR FROM YOU!

Participate in a Customer Service survey today and tell us how we are doing.

WellCare's goal is to provide excellent service to all physicians, providers and facilities.

When you call us, you may be asked if you would agree to participate in a very brief customer satisfaction survey when your call has been completed. We encourage and appreciate your participation.

Simply follow these steps:

1. Press 1 on your telephone keypad when asked if you would like to participate.
2. Enter a 10-digit phone number where you can be reached.
3. You will then be connected to a Customer Service representative who is unaware if you chose to take the survey.
4. Once your call ends, you will be contacted shortly and asked the survey questions.
 - ✓ Your feedback is valuable
 - ✓ Your responses are critical to the enhancement of our service delivery
 - ✓ Your input drives performance improvement through training and agent development



ICD-9-CM DIAGNOSIS CODE CHANGES FOR 2008 AND OFFICIAL GUIDELINES FOR CODING AND REPORTING

In 2008, there are 144 new diagnosis codes, 16 deleted diagnosis codes, and five revised diagnosis codes. The 2008 ICD-9 Diagnosis code changes are available free of charge at: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.

A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

These guidelines have been developed to assist both the health care provider and the claims coder in identifying those diagnoses and procedures that are to be reported.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The ICD-9-CM Official Guidelines for Coding and Reporting guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II, and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

The ICD-9-CM Official Guidelines for Coding and Reporting are available for free at: www.cdc.gov/NCHS/datawh/ftpserv/ftp/cd9/icdguide07.pdf

New code assignments are the result of year-long efforts of the ICD-9-CM Coordination and Maintenance Committee, which is sponsored jointly by NCHS and CMS. The effective date for new codes is the same every year, October 1.

“CASE MANAGEMENT AND DISEASE MANAGEMENT”

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FACILITATION—The nurse case manager works to ensure a member follows the established plan of care. This may include coordination of care, assistance in obtaining PCPs and/or specialists, and any other services a member may need for follow-up care.

ADVOCACY—Understanding health care can be confusing for our medically and behaviorally challenged members. The nurse case manager can have a positive effect and guide the member throughout the case management process.

PCPs and specialty care providers are vital members of the Case Management team. Nurse case managers work with the PCP’s and specialist’s office staffs to ensure that all the member’s needs are addressed and met. WellCare’s Case Management team can save valuable time by guiding members to the right level of care, at the right time.

DISEASE MANAGEMENT

The Disease Management (DM) program provides superior education and support systems to eligible members with certain chronic diseases. The disease manager empowers members to make behavioral changes that will improve health, reduce complications and decrease severity of illness, striving to prevent unnecessary medical complications whenever possible.

The disease manager educates the member on appropriate action plans, preventing reoccurrences, and takes all measures that will decrease the likelihood of adverse outcomes. Disease managers assist members in dealing with the stress of chronic illness, helping them understand how to manage the health care experience and working with their PCPs and specialists in the most effective ways.

Disease managers are sensitive to the emotional and psychological needs of members and their support systems to maximize their adherence to the treatment plan mutually agreed upon with their PCP and/or specialist.

To refer a member to Case Management or Disease Management, please call:

Toll-free: 1-866-635-7045

TTY/TDD: 1-888-505-1194.

EDUCATE PATIENTS ON UNNECESSARY EMERGENCY DEPARTMENT UTILIZATION

The rising use of emergency departments for non-urgent care results in the inefficient use of hospital resources and disruption to the continuity of care for patients. Physicians play a key role in educating patients about appropriate emergency department utilization.

Please:

1. Talk with your patients about what constitutes emergency care and what can be handled during a primary office visit.
2. Let your patients know how to access you after hours if they have questions about the care they need to receive.
3. Advise your patients to follow-up with you when they do seek care in an emergency department.
4. Identify at-risk patients and refer them to our Case and Disease Management program by calling 1-866-635-7045.

FRAUD AND ABUSE

MAINTAIN PROPER MEDICAL DOCUMENTATION

Health plans and other payers often presume that if something is not documented, it did not happen. Well-intentioned practitioners can be required to repay monies, may lose their license or even go to jail because insufficient medical records do not support claims.

In recent years, government agencies and health plans have continued to emphasize the importance of proper medical documentation and have shown little empathy for those who take shortcuts and lack adequate medical documentation.

COMMON MEDICAL RECORD ISSUES

Thousands of medical records and other supporting documents have come under close scrutiny in recent years and continue to be an area of interest for Special Investigation Units, Medicaid Fraud Control Units, and the Health and Human Services Office of the Inspector General.

Some of the most common issues include, but are not limited to:

- Failure to adequately document the medical necessity of services provided or falsifying records to misrepresent the level of services provided.
- Billing all or most evaluation and management services as “complex” without adequate medical documentation.
- Failure of the physician to document his/her presence during all critical portions of a complex surgery or other complex procedure.
- Failure of the physician, nurse or other practitioner to document the physician’s presence during the portion of evaluation and management services that determine the level of payment.
- Failure to adequately document subjective, objective, assessment and plan entries in the medical records to clearly describe why a procedure was complex.
- Other lack of supporting documentation (such as lab results, prescriptions, diagnostic test results, etc.) in medical records that justify payment of claims.
- Failure to document the date of service and the amount of time actually spent with a patient for procedures measured by time.
- Failure to document the request for a consult and the medical necessity of the consult.

WHAT YOU SHOULD DO

You should sufficiently document the encounter so that another physician or health care provider can easily read and understand the nature of the problem, learn what treatment has been rendered and determine the best course of action. You should also review and compare your medical records against industry standards and recommendations for proper documentation.

The American Medical Association, through the most current Common Procedural Terminology (CPT) manual, and the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services, provide widely recognized and accepted documentation standards.

Sources:

Implementing Practice Parameters on the Local/State/Regional Level. Chicago: Office of Quality Assurance and Medical Review of the American Medical Association, 1994:21–22.

National Utilization Review Standards. Utilization Review Accreditation Commission, now the American Accreditation Health Care Commission. April, 1994:11, 16.

Manual of Psychiatric Quality Assurance. Washington, DC: American Psychiatric Association, 1992:72, 76.

Policy Summaries. Dallas: American College of Emergency Medicine, 1995:39, 63.

Admission Criteria to Comprehensive Medical Rehabilitation Hospitals/Units. Chicago. American Academy of Physical Medicine and Rehabilitation: 2.

PHARMACY UPDATE

GENERIC DRUG UTILIZATION

According to the Food and Drug Administration (FDA), generic drugs account for about half of all prescription drug purchases in the United States. This provides a huge cost-savings for not only the patient, but also for the Medicare program and taxpayers. In fact, in many states, generics are to be dispensed by the pharmacy unless the patient asks for brand or the prescriber indicates that the brand is medically necessary.

Most Medicare plans (and private prescription plans such as WellCare) offer very low co-payment amounts for generic drugs. Many Medicare plans (including some of WellCare's) even offer generics at no cost to the patient.

Physicians play a major role in educating patients on the safe and effective usage of generics. You can assure patients that the FDA requires generics to have the "same high quality, strength, purity and stability as brand name drugs." And while differences may exist between brand and generic drugs in terms of inactive ingredients, the chances of having a reaction to an inactive ingredient are very low.

Although some patients may only have small differences between the co-payment amounts for brand and generic, using a brand medication will put the patient at a higher risk for going into the coverage gap (commonly called the "doughnut-hole"). Once a patient reaches the coverage gap, he or she is responsible for paying 100 percent of his or her drug costs (some plans may cover generics during this time). According to a study done by Walgreens Health Services, the coverage gap was estimated to have reduced medication utilization by approximately 188 days, while increasing costs by approximately \$796.

We encourage you to speak with your patients about generic drugs and prescribe them when appropriate.

Sources

McClellan MB. *Generic Drug Utilization in the Medicare Prescription Drug Benefit [testimony before US Senate]*. Available at www.hhs.gov/asl/testify/t060921.html. 2006.

Sun SX, Lee KY. *The Medicare Part D doughnut hole: effect on pharmacy utilization*. *Manag Care Interface*. 2007; 20: 51-55, 59.

FDA UPDATE ON SINGULAIR

The FDA is investigating the possible association between the use of Singulair and behavior/mood changes, suicidal behavior and suicide. Singulair is a leukotriene receptor antagonist used to treat asthma and the symptoms of allergic rhinitis and to prevent exercise-induced asthma. Patients should not stop taking Singulair before talking to their doctor, if they have questions about the new information. Patients taking Singulair should be monitored for changes in behavior and mood, and thoughts of suicide. The FDA's investigation may take up to nine months to conclude and will be communicated to the public.

Source FDA Web site. Available at www.fda.gov/cder/drug/early_comm/montelukast.htm



2008 STANDARDS OF MEDICAL CARE FOR DIABETES

For your reference, below are the 2008 standards of medical care for diabetes, according to the American Diabetes Association.

- A1C testing twice a year for those who meet treatment goals and quarterly for those not meeting glycemic goals or who have changed therapies. Lowering A1C to an average of seven percent has been shown to reduce microvascular and neuropathic conditions of diabetes.
- Modest weight loss in overweight and obese insulin-resistant individuals has been shown to decrease insulin resistance.
- People with diabetes should receive diabetes self-management education when their diabetes is diagnosed and as needed thereafter.
- Blood pressure should be monitored at every routine diabetes visit and be maintained at < 130mmHg/80mmHg.
- Measure fasting lipids at least annually with LDL <100 mg/dl, HDL >50 mg/dl and triglycerides <150 mg/dl.
- Perform an annual test to assess urine albumin excretion.
- Adult diabetics should have a dilated and comprehensive eye exam annually. Diabetic retinopathy is the leading cause of blindness in diabetics.
- For all patients with diabetes, perform an annual comprehensive foot exam to identify risk factors predictive of ulcers and amputations. Check feet on every diabetic visit to assess any issues.
- People with diabetes should be advised to perform at least 150 minutes per week of moderate-intensity aerobic physical activity at 50 to 70 percent of maximum heart rate.

Source: *Diabetes Care 2008 American Diabetes Association*

FDA PATIENT SAFETY NOTICES

SIGN UP FOR HEALTH CARE NOTIFICATION NETWORK ALERTS

We encourage you to sign up for a new electronic service that furnishes clinicians with instantaneous FDA (Food and Drug Administration) patient safety alerts. The Health Care Notification Network (HCNN) service provides a quick and systematic way for your practice to improve patient safety by getting important alerts, including product recalls and warnings.

To register for the free service, please go to www.hcnn.net/Registration/registration.aspx. You can designate other staff members to receive the online alerts and you can opt out at any time.

The HCNN initiative is being launched by the iHealth Alliance and managed by Medem, a health information technology firm founded by the AMA and state medical societies. For more information, visit www.hcnn.net.



NPI STANDS ALONE

The May 23, 2008 federal deadline for National Provider Identifier (NPI) compliance has passed. If you are not yet in compliance, you must become compliant immediately to avoid rejection of claims.

WellCare's new claims submission policy took effect as of the federal deadline to comply with the Health Insurance Portability and Accountability Act (HIPAA) requirement to use only the NPI and taxonomy codes to identify providers on standard transactions like health care claims. This policy serves as a modification to your provider manual's specifications on claims submissions.

WELLCARE NPI CLAIM/ENCOUNTER SUBMISSION POLICY

The NPI is required in the primary and secondary provider fields for all electronic, direct data entry (DDE) and paper health care claims, and encounters submissions. Claims and encounter submissions will not be processed and will be rejected if they:

- Lack NPI when required per Implementation Guides and CMS requirements
- Contain an invalid NPI
- Contain only legacy identifiers (i.e. UPIN, Medicaid ID or WellCare ID)
- Contain both legacy identifiers and NPIs

STEPS PROVIDERS MUST TAKE TO ENSURE NPI COMPLIANCE

1. If you have not already done so, you **MUST** supply your NPI and taxonomy information to the Plan immediately.
2. Provide NPI information to your clearinghouse and/or software vendor and ensure problems evident in your billing systems and processes are quickly resolved.
3. For electronic claims, comply with electronic loop and data segment instructions. For paper claim submissions, utilize the new paper claims forms. You may download this information from WellCare's Web site, www.wellcare.com.
4. Consult the Electronic Data Interchange Transaction Set Implementation Guides for electronic claim transactions.

You may download instructions for submitting your NPI as well as information on claim submissions from the WellCare Web site at www.wellcare.com.

For questions regarding NPI, please access www.cms.hhs.gov/.

NPI FAQs

Q: Which transactions require NPI?

A: Your NPI is required in all HIPAA transactions, including claim submissions, claim payment, coordination of benefits, eligibility, referrals and claim status.

Q: Does the NPI mean I need to change the way I bill WellCare?

A: Yes, the NPI should now be included for primary and secondary provider types on your claims and encounters submissions. Legacy identifiers should no longer be included on the claim or encounter submission.

Q: What legacy identifiers will NPI replace?

A: The NPI will replace all legacy identifiers that identify health care providers. This includes WellCare IDs, Medicaid and Medicare IDs and UPINs. It does not replace Tax IDs (TIN), which will continue to be required on all claims.

Q: What are the primary and secondary providers?

A: Providers are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, rendering or attending. Secondary providers include supervising and operating physicians, referring providers, facility, care plan oversight, purchase services and others.

Q: Can a provider or organization have more than one NPI?

A: Yes. Some health care provider organizations are made up of components or business units that function somewhat independently of the "parent" health care organization of which they are a part of. These are referred to as "subparts" in the regulation and might be at the same or at a different address than the organization provider "parent," might conduct their own standard transactions and might furnish a type of service different than the organization provider "parent." These subparts might be required by federal regulations to have unique identifiers for billing purposes. Each organization must make a determination regarding the status of its subparts, and apply for NPIs as appropriate.

Q: My organization or group obtained its NPI. As a physician with this organization, do I have to also obtain an NPI?

A: Yes. Even though the organization that you are working with has enumerated, you need to obtain an NPI as an individual provider.

Q: How can I be sure I am providing the NPI in the correct format for electronic billing?

A: For electronic claim submissions, consult the Electronic Data Interchange Transaction Set Implementation Guides adopted as HIPAA standard requirements for compliant completion of transactions. Provide NPI information to your clearinghouse and/or software vendor. Additionally, you may access any published companion guides and related instructions on www.wellcare.com.

TIMELY CLAIMS FILING

As a reminder, Medicare timely claims filing is **180 days** from the date of service to the primary payers. You may submit claims electronically or via paper.

EDI Questions and Assistance: 1-800-960-2530, ext. 4096

Electronic Funds Transfers & Electronic Remittance Advice (EFT/ERA):

Customer Service: 1-866-579-8006

Web site: www.payspanhealth.com

Mail medical paper claim submissions to:

WellCare Health Plans, Inc.

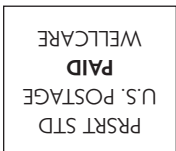
Claims Department

P.O. Box 31372

Tampa, FL 33631-3372

EDI Partner	EDI Payer ID	Contact
ACS EDI Gateway, Inc.	77004	1-800-987-6720
Availity	14163	1-800-282-4548
Emdeon (former WebMD®)	14163	1-800-845-6592
RelayHealth (McKesson)	14163	1-800-522-6562
SSI Group	14163	1-800-880-3032
ZirMed	14163	1-877-494-7633
Encounter Data Submissions	59354	

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