

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 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 MATERIALS UPDATE

The following information was sent to providers via fax or the WellCare Web site's *Messages* since our last newsletter:

- Tips for handling the H1N1 virus
- Enhancement to the provider Explanation of Payment
- Connecticut's Spring Provider Newsletter

When you log on 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 new and updated information.

WEB RESOURCES

WellCare's Preventive and Clinical Practice Guidelines, Quick Reference Guide, Pharmacy Guidelines, Cultural Competency Plan and other helpful resources are available at www.wellcare.com.

MEDICAL CARE AND RECORDKEEPING FOR DIABETES

WellCare encourages our primary care providers to conduct a yearly comprehensive assessment of patients with diabetes mellitus. All of the following should be documented legibly in each patient's chart: an up-to-date problem list, medication reconciliation, detailed H&P examination addressing the patient's acute and chronic care concerns, and laboratory tests and imaging studies ordered and indicating their results. Age-appropriate preventive screening and vaccinations also should be addressed.

The patient's body mass index (BMI) and vital signs should be recorded with each office visit. A psychosocial assessment, useful in identifying depression, anxiety, substance abuse and/or cognitive impairment, is too frequently overlooked during this comprehensive examination. A cardiovascular (heart and peripheral artery disease) risk assessment, comprehensive foot examination, and the focus on identifying signs of end-organ damage—including a dilated eye examination or referral to an eye specialist for this examination—are critically important components of this annual evaluation.

Diabetic patients' care management should include a written management plan, revised at least annually, that incorporates patient self-management information about blood glucose monitoring, nutrition counseling, an exercise program, appropriate foot care and cardiovascular risk-reduction options (i.e., smoking cessation, weight control, stress-management, and cholesterol and blood pressure control).

The measurement of the hemoglobin A1c (HbA1c) is a key test in the management of diabetes. The test should be performed two to four times per year, depending on the patient's glycemic control. An HbA1c of less than 7 percent has been shown to reduce microvascular and neuropathic complications and is the recommended goal for adults. Studies have suggested an incremental benefit of lowering the HbA1c from 7 percent into the normal range (< 6 percent). Therefore, the HbA1c goal for selected individual patients is as close to normal as possible, without encountering significant and frequent hypoglycemic episodes.

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. Daily saturated fat intake should be less than 7 percent of the total calories, and the intake of trans fats should be minimized. Screening studies for nephropathy (microalbuminuria) and hypothyroidism (TSH level) are also appropriate lab tests.

Proper medical record documentation for all patients is obviously important. The submission of claims and encounter data, with the most specific and accurate ICD-9 codes, supported by the record of the patient's current and historical medical conditions, are also key components of a complete and accurate medical record.

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

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, for example, 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.

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.

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

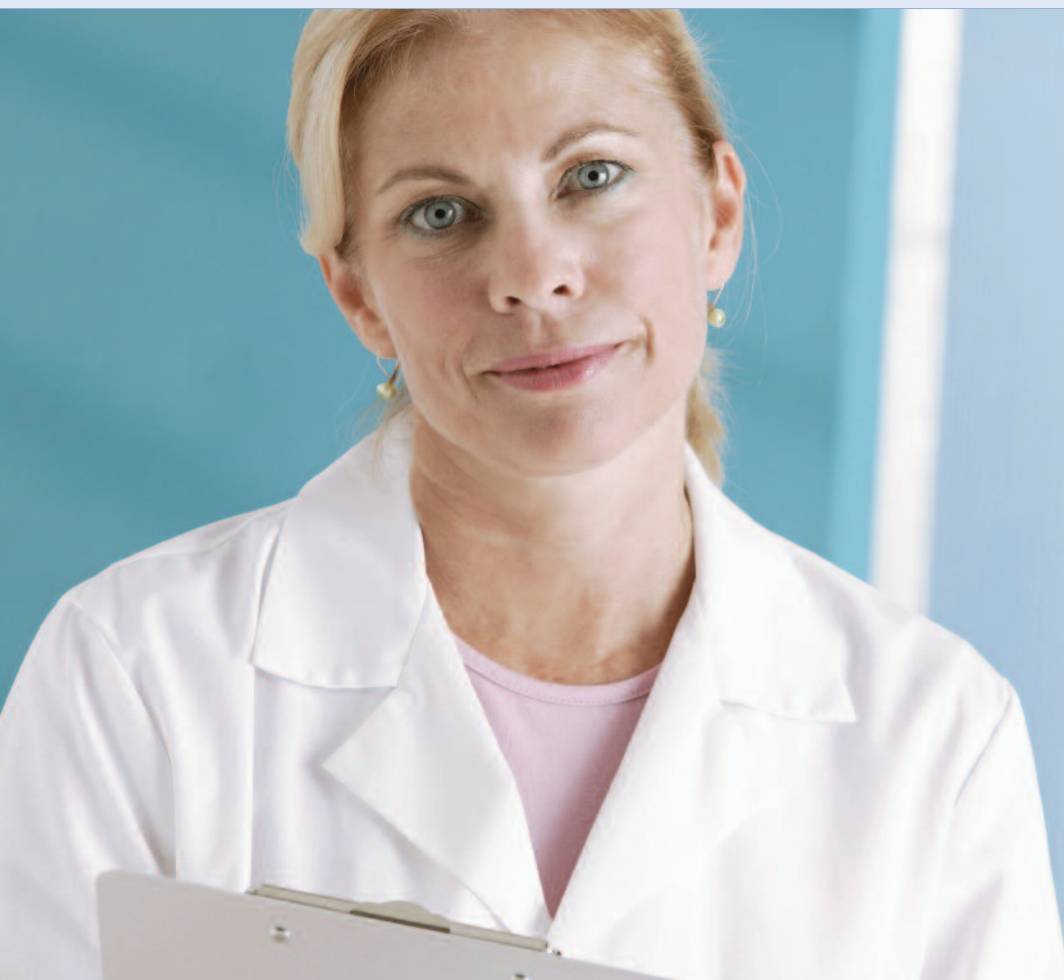
EXPEDITED REQUESTS FOR MEDICARE PROVIDERS

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 patient'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: 1-866-579-8006.
- Have the correct **MEDICARE fax number: 1-877-892-8215 (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.



UPDATED INFORMATION? LET US KNOW!

Please provide WellCare with any updated information or changes that would affect your status with the Plan.

Inform the Plan in writing immediately of:

- Any revocation or suspension of your DEA number;
- Any adverse determination, including a stayed judgment that results in the suspension, limitation or revocation of your license or certification authorizing you to practice in Connecticut or another state.

Inform the Plan in writing immediately of any changes to:

- Tax identification number
- Telephone and fax numbers
- Address(es)

- Privileges at hospitals
- Liability insurance and/or loss of liability insurance
- Loss of your ability to participate with CMS programs (Medicaid or Medicare)

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

Any changes to your data should be sent to:

WellCare Health Plans, Inc.
Attention: Provider Relations
127 Washington Avenue, 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.



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.

SERVICE REQUEST DENIAL RECONSIDERATION

WellCare reviews 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.

When the review determination results in an adverse determination (denial), a formal denial 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 that is relevant and helpful in making the correct determination during the authorization review process.

ENHANCEMENTS TO THE EXPLANATION OF PAYMENT PROVIDE EASE OF USE AND SIMPLIFIED PAYMENT ALLOCATIONS

Our Explanation of Payment (EOP) document is now easier for you and your staff to review which means allocating the proper payments is simplified!

The enhancements to the EOP include:

Changes:

- *Claim level totals* are populated. In the past only the *billed amount* and *paid* columns were shown.
- Claim totals are broken down for each provider listed on the EOP. This will help you allocate the payments to the provider who performed the service(s).

Additions:

- The grand total labeled as *Vendor total* includes a summary for *billed, allowed, co-pay/co-insurance, other carrier* and *paid* amounts.
- The *co-pay/co-insurance* amount at the claim level total is populated, when *Total PR* (Patient Responsibility) is populated in the header row of a claim. This is more convenient for the provider, Centers for Medicare and Medicaid Services (CMS), and other entities.

Please visit www.wellcare.com and navigate to the *Latest Claims Updates* page at www.wellcare.com/Provider/ClaimsUpdates to download a sample version of the EOP with the enhancements pointed out.

PROVIDER FORMULARY UPDATE

GENERIC NEWS:

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

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Depakote® Sprinkle Capsule	Divalproex Sodium Sprinkle Delayed-Release Capsule	Anticonvulsant Agent
Depakote® ER Tablet	Divalproex Sodium Extended-Release Tablet	Anticonvulsant Agent
Imitrex® Nasal Spray	Sumatriptan Nasal Spray	Antimigraine Agent
Imitrex® Tablet	Sumatriptan Succinate Tablet	Antimigraine Agent
Risperdal M-TAB™	Risperidone Orally Disintegrating Tablet	Antipsychotic Agent
Zerit® Capsule	Stavudine Capsule	Antiviral Agent

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

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

We have increased the quantity limit per month for the following medication on WellCare's Medicare Formulary:

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



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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.

