

FLORIDA | 2011 | ISSUE III

# PROVIDER

## Newsletter



## 5010 COMPLIANCE IS REQUIRED BY JANUARY 1, 2012. ARE YOU READY?

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, including: claims (professional, institutional and dental), claims status requests and responses, payment to providers, eligibility requests and responses, referral requests and responses, enrollment and disenrollment in a health plan, coordination of benefits and premium payments.

Are you a health care provider:

- Who submits claims (837) electronically?
- Who receives remittances (835) electronically?
- Who electronically sends and receives eligibility statuses (270/271) or claim statuses (276/277)?

If so, your trading partners (clearinghouse, vendor, vendor websites, vendor software, billing service, etc.) involved with processing your transactions (inbound and outbound) have likely been in contact to ensure 5010 changes have been tested and are ready for implementation on or before January 1, 2012.

If your trading partners have not been in contact regarding 5010, WellCare/HealthEase/Staywell (the plan) recommends that you make contact now. By 3rd quarter of 2011, your clearinghouse, software vendors and billing service should be able to confirm their 5010 implementation plans. The plan also recommends that you discuss the specific changes for your organization, as your particular business needs may differ from your vendor's standard implementation plan (see CMS documentation below for helpful hints).

Remember, 5010 adoption is mandated per HIPAA legislation. As of January 1, 2012, use of 4010A1 transactions will be discontinued and only version 5010 will be accepted for electronic claims and related transactions.

For additional information and assistance, please contact:

- E-mail: [5010\\_Questions@wellcare.com](mailto:5010_Questions@wellcare.com)
- CMS assistance: Provider Guide to a Smooth 5010 Transition ([www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf](http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf))

## PROVIDER UPDATE

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

- WellCare Specialty Pharmacy Can Help Fight HCV
- The plan to Launch Provider E-mail Communications
- March Medicaid Preferred Drug List Updates

You can find copies of all of these correspondences when you log in to the secure area of [www.wellcare.com](http://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 on the right-hand side. Remember to check the messages regularly to receive new and updated information.



## WAYS TO REDUCE YOUR PATIENTS' RISK OF COMPLICATIONS FROM DIABETES MELLITUS

The following national statistics and other general information on diabetes were adapted from the Centers for Disease Control and Prevention (CDC) National Diabetes Fact Sheet: National estimates and general information on diabetes in the United States.

- 25.8 million Americans have diabetes — 8.3 percent of the U.S. population. Of these, 7 million do not know they have the disease.
- In 2010, about 1.9 million people ages 20 or older were diagnosed with diabetes.
- The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 18.8 million in 2010, an increase of epidemic proportions.
- Diabetes is the seventh leading cause of death listed on U.S. death certificates.
- Cardiovascular disease is the leading cause of death among people with diabetes — about 68 percent die of heart disease or stroke.
- The overall risk for death among people with diabetes is about double that of people without diabetes.
- Total health care and related costs for the treatment of diabetes run about \$174 billion annually.
- Of this total, direct medical costs (e.g., hospitalizations, medical care and treatment supplies) account for about \$116 billion.
- The other \$58 billion covers indirect costs such as disability payments, time lost from work and premature death.

As you can see from the facts listed above, diabetes is becoming more prevalent. Please educate your patients on a self-care plan so they can take control of their disease and lower their risk of complications.

**Encourage diabetics to use the following as a guide to self-care:**

1. Know their diabetes **ABCs**.
  - **A** is for the **A1C** (blood glucose) test. Results should be < 7.
  - **B** is for **Blood pressure**. It should be below 120/80.
  - **C** is for **Cholesterol**. LDL should be less than 100 and HDL above 40 to lower the patient's chances of having a heart attack, stroke or other associated diabetic problems.
  - **S** is for **Smoking**. Encourage patients to be nicotine free and provide them with the Quit Smoking website [www.smokefree.gov](http://www.smokefree.gov).

(continued from previous page)

2. Stay at a healthy weight by staying on a diet that achieves a BMI in the normal range.
3. Check their blood glucose during the day; know their blood glucose targets and how to use the results to manage their diabetes.
4. Participate in 30 minutes of physical activity 2–4 days per week.
5. Abstain from alcohol or consume it in moderation.
6. Schedule periodic medical checkups to include an annual retinal eye exam by either an ophthalmologist or optometrist, and an annual dental examination to find and treat any problems early.
7. Be mindful of their foot care, being sure to check their feet every day for cuts, blisters, red spots and swelling, and call you right away about any sores that don't go away.
8. Report any changes in their eyesight.
9. Stay up to date with their age-appropriate vaccinations.
10. Use stress management techniques that reinforce positive health care behaviors.

Refer diabetic members to the plan's Disease Management program by calling 1-866-635-7045. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

Sources: Centers for Disease Control and Prevention (CDC) National Diabetes Fact Sheet: National estimates and general information on diabetes in the United States, Updated January 2011. National Diabetes Education Program (NDEP) at <http://www.ndep.nih.gov/publications>

## CANCER SCREENING AWARENESS

October is Breast Cancer Awareness Month. Encourage your female patients to get all their preventive health exams completed during October if they have not already done so this year.

According to the Centers for Disease Control and Prevention (CDC), many deaths from breast and cervical cancer could be avoided by increasing cancer screening rates among women. The CDC reports that deaths from these diseases occur disproportionately among women who rely on public health programs like Medicaid or are uninsured.

WellCare/HealthEase/Staywell covers all regular preventive tests and screenings for women without requiring a referral or prior approval. Help us ensure that our members stay healthy by recommending appropriate preventive tests and screening.

Please continue to encourage women to obtain an annual mammography for breast cancer screening and a Pap smear for cervical cancer screening.





## IMPORTANT CHANGES IN ELECTRONIC DATA INTERCHANGE (EDI) PROCESS

As of **July 24, 2011**, WellCare of Florida/HealthEase of Florida (the Plan) will begin accepting electronic claims only through RelayHealth's pre-adjudication platform. The Plan has selected RelayHealth, a division of McKesson, to manage EDI connectivity between the Plan and our providers. We believe this choice will expand electronic-based real-time services for our providers, increase EDI volume and simplify EDI administration. We also believe this kind of arrangement drives efficiencies and leads to lower overall costs for health care, and that it is becoming commonplace in the health benefits market.

We have requested that our previous partners transfer — at no charge — their EDI connection for Plan claims to RelayHealth's pre-adjudication platform. Although most have agreed, some will no longer accept or send transactions to the Plan upon our switch to RelayHealth on July 24; so you may experience issues with adjudication or payment of those claims.

In most cases the transition will be seamless; however we strongly encourage you to contact your practice management vendor, billing service or clearinghouse immediately and obtain their assurance for continued electronic claims submission to the Plan via RelayHealth on and after July 24 to ensure your practice is prepared for this transition. Upon confirmation from your vendor, billing service or clearinghouse of continuous electronic claims submission to the Plan via RelayHealth, no further action is necessary.

If you have any questions regarding submission of EDI transactions through RelayHealth, you may call **1-888-743-8735** and they will provide you assistance and recommendations regarding the transition. For further details, you may contact us via email at **EDI-MASTER@wellcare.com**. The Plan will respond to those emails in a timely fashion.

We feel strongly that our relationship with RelayHealth will expand our EDI service levels for you and improve your experience with the Plan and our members.

# SPIROMETRY TESTING

## A SIMPLE BREATHING TEST TO ASSESS AND DIAGNOSE COPD

While there is no cure for Chronic Obstructive Pulmonary Disease (COPD), early detection of the disease might help change its course and disease progress. That's why we encourage you to take steps in early detection to help you and your patients manage their disease by carefully monitoring medical and family health history, the presence of symptoms, and airway obstruction (also called airflow limitation).

The Global Initiative for Chronic Lung Disease (GOLD) international COPD guidelines<sup>1</sup>, as well as national guidelines<sup>2</sup>, advise spirometry as the gold standard for accurate and repeatable measurement of lung function. Evidence-based practice guidelines indicate that when spirometry confirms a COPD diagnosis, doctors initiate more appropriate treatment. Spirometry is also helpful in making a diagnosis in patients with shortness of breath and other respiratory symptoms and for screening in high-risk environments.

Consider utilizing spirometry as a diagnostic tool if you have patients that are experiencing some of the more common symptoms:

- A cough that doesn't go away
- Coughing up lots of mucus
- Shortness of breath, especially with activity upon exertion
- Wheezing
- Tightness in the chest
- Limitations in activity

If a diagnosis is confirmed, please educate your patients about avoiding the most common causes of COPD, such as cigarette smoking, being around second-hand smoke, long-term exposure to other home and workplace air pollutants, and chronic respiratory infections.

The goal of COPD treatment is to ease the symptoms, slow the progress, prevent and treat any complications, and improve the patient's overall quality of life.

Refer COPD members to the plan's Disease Management program by calling **1-866-635-7045**. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

## REFERENCES

<sup>1</sup>Global Initiative for Chronic Obstructive Lung Disease. *Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. (Updated 2007)*.<http://www.goldcopd.org>.

<sup>2</sup>National Collaborating Centre for Chronic Conditions. *Chronic obstructive pulmonary disease: national clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care. Thorax 2003, 59 (Suppl 1); 1-232.*

## OTHER SOURCES:

American Lung Association: "Chronic Obstructive Pulmonary Disease (COPD) Fact Sheet." National Heart Lung and Blood Institute: "COPD" and "COPD: Learn More, Breathe Better." American Academy of Family Physicians: "Chronic Obstructive Pulmonary Disease (COPD)." *Journal of the American Medical Association*: "Chronic Obstructive Pulmonary Disease.

## CLAIMS CORNER

### ADD-ON CODES

When primary procedures are conducted, oftentimes there are certain additional procedures that must also be conducted. When this happens, these procedures are categorized as “add-on” codes. Add-on codes are always performed in conjunction with a primary procedure and should never be reported as a stand-alone service(s). The additional procedures are designated as an add-on code by the + symbol located next to the code in the AMA CPT Manual.

WellCare/HealthEase/Staywell (the plan) will not reimburse add-on code(s) if the primary procedure code has not been submitted on the same claim. If the primary procedure code is not allowed or is denied for any reason, then the add-on code associated with that base code will also not be allowed. This concept applies only to procedures performed by the same physician.

Please reference the AMA CPT Manual for additional information on appropriate billing of add-on codes.



## MEDICAID

### MEDICAID COVERAGE CRITERIA FOR THERAPY SERVICES

All therapy providers, Florida Medicaid provider handbooks are available that provide the Florida Medicaid coverage criteria for therapy services. Please access their website at: [http://portal.flmmis.com/FLPublic/Provider\\_Home/tabId/36/Default.aspx](http://portal.flmmis.com/FLPublic/Provider_Home/tabId/36/Default.aspx) for manuals that provide specific guidance for therapy services. The definition of medical necessity is also defined, and Medicaid recipients need to meet the medical necessity requirements for coverage of requested therapy services. WellCare also has posted Clinical Coverage for Florida therapy services and developmental delay. You can access clinical coverage guidelines on the WellCare provider portal. Additionally, please include the following information with your request:

1. A signed physician order for therapy
2. A written Plan of Care with measurable goals that is signed by the ordering physician
3. An evaluation that includes a standardized, functional assessment for developmental delays or measurable objectives for acute therapy requests
4. Documentation of specific progress toward previous goals for continuation of services including the last 30 days of progress/treatment notes
5. A copy of the member's IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan) or specific documentation on the reason the member does not have one
6. If the member has an IEP, then specific documentation on the medical necessity for services above the services being provided under the IEP is required

HealthEase/Staywell will review the request and render a decision based on coverage rules as outlined in the Florida Medicaid Provider Handbooks.

## SEPTEMBER IS NATIONAL CHOLESTEROL EDUCATION MONTH

Cardiovascular disease (CVD) is a leading cause of preventable illness, disability and death in adults. There are social, environmental and genetic components that all contribute to the onset of CVD. Some of these factors can be modified, treated and controlled, while others cannot.

### Non-modifiable Risk Factors:

- Age (men > age 55 & women > age 65)
- Familial history and genetics
- Gender

### Modifiable Risk Factors:

- Smoking
- Uncontrolled hypertension
- Uncontrolled dyslipidemia
- Physical inactivity
- Obesity and excessive weight
- Poor diet
- Uncontrolled diabetes mellitus
- Stress
- Excessive alcohol consumption

As a health care provider, it is essential to properly screen and identify those patients who are at an increased risk of having CVD. This includes comprehensive health risk assessments, positive health-related behavior changes, management of lipid levels, evidence-based treatment interventions and patient education. To help patients control their cholesterol and decrease their risk of having a CV-related event, the Centers for Disease Control (CDC) – Division of Heart Disease and Stroke Prevention (DHDSPP) encourages all health care providers to participate in the overall management of cardiovascular disease. A comprehensive approach includes a cardiovascular risk assessment, patient monitoring and treatment protocols.

Patient-specific treatment plans should include the following components:

- Patient education on lifestyle modifications — the cornerstone of CVD prevention;
- Implementation of evidence-based treatment interventions for patients with a clinical diagnosis of coronary artery disease, other atherosclerotic diseases and diabetes;

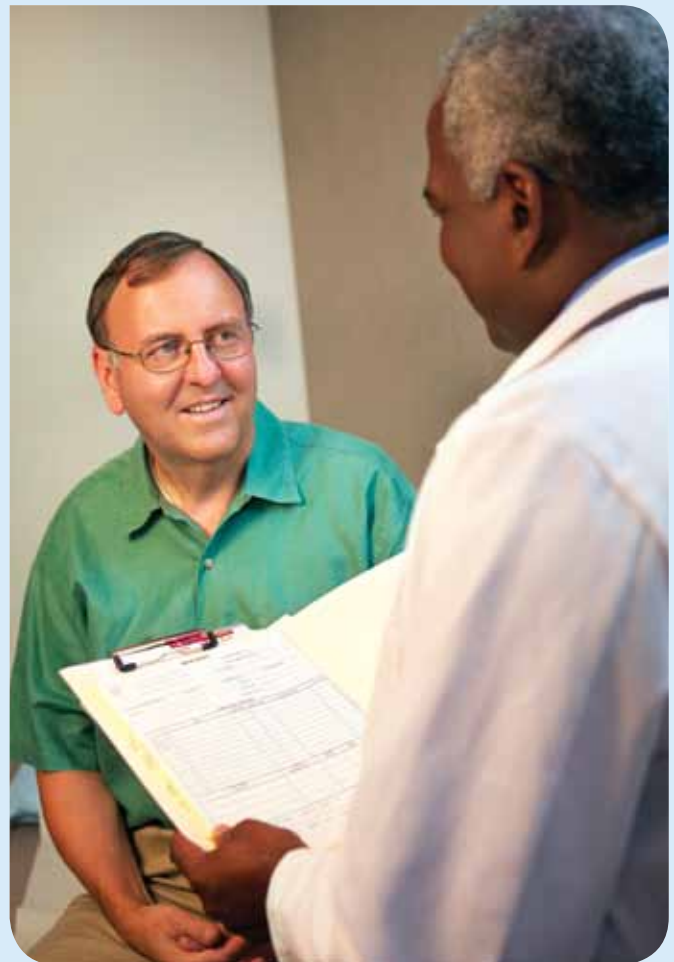
- Pharmacological treatment options for patients with elevated risk factors, including the prescription of statin drugs to lower LDLs.

For individuals with a clinical diagnosis of diabetes, the CDC recommends the following cholesterol levels:

- Total cholesterol under 200
- LDL (“bad” cholesterol) under 100
- HDL (“good” cholesterol) above 40 in men and above 50 in women
- Triglycerides under 150

As a health plan, we appreciate your actions to help patients maintain a healthy lifestyle and reduce the incidence of cardiovascular-related diseases to improve their overall quality of life.

*References: Centers for Disease Control & Prevention (CDC)-Division for Heart Disease and Stroke Prevention-cholesterol. Page last reviewed March 24, 2011, page last updated: March 24, 2011.*



## COORDINATION OF BEHAVIORAL CARE MAXIMIZES OUTCOMES

A recent Google™ search identified more than 34 million documents related to coordination of care and more than 4 million documents related to continuity of care. With so much information available regarding these topics, one might think that they are commonly used phrases and practice. In reality, however, they are not practices routinely utilized by all health care professionals.

WellCare/HealthEase/Staywell (the plan) reminds providers that continuity and coordination of care are appropriate for all disciplines at all levels of care, including inpatient-outpatient, medical-behavioral, PCP-specialty and intra-disciplinary. Communication and coordination/integration of care among health care providers is a best practice principle essential to optimizing consumer safety and clinical outcomes. Patients with co-morbid medical and behavioral health conditions can be particularly vulnerable to complications that may result from inadequate coordination of care between treating providers. All providers, all disciplines, are expected to initiate communication that facilitates and enhances continuity of care, relapse prevention, patient safety and satisfaction. It must be noted, though, that health care providers can only coordinate care to the extent permitted by confidentiality requirements. There may be occasions when the patient refuses to sign consent for release of information.

Keeping in mind the ultimate goal of enhanced patient well-being, it behooves all parties to take the necessary steps for continuity and coordination of care.

## TIMELY FOLLOW-UP CARE AFTER BEING HOSPITALIZED FOR MENTAL ILLNESS

The National Committee for Quality Assurance (NCQA) developed several HEDIS® measures of mental health quality that are used by health care consumers and regulatory agencies to monitor the performance of managed care organizations.

Outpatient follow-up care post-discharge is an important component of the continuum of care to assist an individual with their transition from hospital back into their family, work and community environment. Follow-up care may also reduce re-hospitalizations or help facilitate a necessary readmission before an individual reaches the crisis stage. Follow-up care may be even more important, and perhaps more problematic, for patients who have been hospitalized for a serious mental illness.

Primary care physicians (PCPs) should recommend early post-discharge follow-up visits 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 help reduce readmissions and improve the continuity of care for your patients.

If your patient misses his/her early follow-up appointment, reschedule the outpatient visit and complete it no later than 30 days after the recent hospital discharge. Confirmation that the patient understands his/her medicines, management of co-morbidities, step-action treatment plans and co-management of mixed illness diseases to discuss how the patient can get help, especially after normal office hours, are all important topics to discuss at the post-discharge follow-up visit.

Together, you can help your patient to continue to live at home and/or work while being in treatment.

## COMMUNICATING EFFECTIVELY FOR CONTINUITY OF CARE

WellCare/HealthEase/Staywell (the plan) encourages all providers—medical and behavioral—to initiate communication that facilitates and enhances continuity of care, relapse prevention, member safety and member satisfaction. Few would challenge the hypothesis that effective integration and collaboration between primary care physicians (PCPs) and mental health specialists (to include psychiatrists, social workers and ARNPs) is essential for consumer well-being. Yet it is not uncommon to hear medical providers and behavioral health providers complaining they do not receive information from the opposite discipline. Barriers often cited for the dearth of provider communication are time and resource limitations. However, when one considers the potential impact on optimal member care, communication is clearly a critical necessity.

### WHAT YOU CAN DO AS THE INDIVIDUAL PRACTITIONER

- Get to know your fellow physicians, PCPs and psychiatrists. Go to meetings whenever possible where you can get to know one another.
- Pick up the phone. Colleagues will appreciate the time and effort taken for communication.
- Request copies of records from physicians who have cared for the patient before your involvement.
- Set up systems in your office and hospital units that enhance and automate patient communication and permit transition of care in a safe and effective way.
- Include the PCP on admission and discharge reports, letting your colleague know about discharge appointments, medications and any specialty consultations required post-hospitalization.
- Utilize health plan Care Manager resources to assist you in making appointments and arranging follow-up care. Our staff can also work with the member to make sure he/she makes his/her appointments.

If you have questions or feedback about physician communication or quality-related topics, please contact the health plan or your local Provider Relations representative.



## INCREASE YOUR PATIENTS' ADHERENCE TO PRESCRIBED TREATMENT AFTER A HEART ATTACK

One quality measure for patients' myocardial infarction (MI) is the persistent use of beta-blockers. Evidence-based practice shows a decrease in re-infarction and mortality in heart attack sufferers when they are prescribed beta-blockers. The American Heart Association/College of Cardiology 2006 Update of Guidelines for Secondary Prevention for patients with coronary vascular disease recommends the indefinite use of beta-blockers after heart attack unless contraindicated.<sup>1</sup>

The WellCare Formulary includes the following beta-blocker drugs: acebutolol, atenolol, betaxolol, bisoprolol/hydrochlorothiazide, metoprolol, nadolol, sotalol and timolol. For a complete list, please refer to the formulary at [www.wellcare.com](http://www.wellcare.com).

The National Committee for Quality Assurance (NCQA) recommends the use of beta-blockers post myocardial infarction as one way to measure how well physicians are providing quality care to their patients with heart disease. However, despite provider education and prescriptions for the indefinite use of beta-blockers when indicated, data still shows our members have a low adherence to their treatment plan. We'd like to work with you to increase our members' persistent use of their medications, break down barriers, and improve our patients' outcomes.

A 2002 Vanderbilt University study determined that patients younger than 75 with a discharge order for beta-blocker therapy were more likely to fill their prescription within the first 30 days post discharge than people older than 75. Of the 85 percent that would fill their prescription within 30 days of discharge, the refill compliance would drop down to 61 percent after the first year. In contrast, of those patients discharged from the hospital without a beta-blocker, only 8 percent would fill a new prescription within the first 30 days after an acute MI<sup>2</sup>, indicating that patients who receive a prescription for beta-blockers while they are still in the acute facility have the greatest probability of continued use post discharge.

### WHAT CAN YOU DO?

Start with something as simple as listening to your patients' concerns, answering their questions and empowering them to take appropriate action. The following can serve as a guide:

- Be involved with your patients' plan of care while they are in the hospital. Stay involved with the attending doctors to help bridge the gap in care post discharge.
- Identify the member or caretaker that may need additional educational reinforcement about the increased risk for another heart attack or stroke if they discontinue taking their medication.
- If financial constraints are an issue to their adherence, consider prescribing a generic or utilize ½ tablet prescription also known as pill splitting when appropriate.
- Send the member a prescription refill reminder by mail or place a courtesy call.
- Address adverse effects that may be the cause for their discontinuation of the medication.

Quality improvement efforts will need to continue to be a focus so that our post-acute MI patients stay on their beta-blockers for no less than six months if indefinite therapy is not planned.

#### Sources:

1. *Gottlieb SS, McCarter RJ, Vogel RA. Effect of beta-blockade on mortality among high-risk and low-risk patients after myocardial infarction N Engl J Med 1998; 339:489-497. [CrossRef][Web of Science][Medline].*
2. *Journal of American College of Cardiology – Vol. 40 # 9 2002 by Javed Butler MD, MHP, FAAC et al. Downloaded online jaac.org March 17, 2011.*

## CASE AND DISEASE MANAGEMENT PROGRAMS

WellCare's Case Managers support you and your hectic schedules, freeing you to spend more time with your patients by:

- Collaborating with providers and physicians to create a targeted assessment and treatment plan for the patient's condition
- Maintaining communication between the patients and their families, and the team of physicians
- Identifying opportunities for interventions such as ineffective treatment plans or lack of financial resources to meet the needs
- Assisting with patient transition when discharged from the program

The types of cases targeted by our Case Management program include, but are not limited to, the following types of patients:

- Complex case needs requiring coordination of multiple outpatient services
- Transplants
- Frequent inpatient admissions and readmissions
- Prolonged or debilitating illness or injuries

WellCare's Disease Managers support you and your hectic schedules too, freeing you to spend more time with your patients by:

- Educating them on how to deal with challenges of their disease
- Documenting progress in clinical notes and alerting their patients of significant changes or findings

Our Disease Management program targets the following conditions:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV
- Hypertension

Our Case and Disease Management programs identify potential candidates based on available data and referrals from multiple sources:

- Claims or encounter data
- Pharmacy
- Laboratory data
- Utilization Management, Case Management, Disease Management and Discharge Planner referrals
- Practitioner and member referrals
- Behavioral health vendors

If you would like to refer your WellCare patients to either or both of these programs, please call the Case and Disease Management Referral Line at **1-866-635-7045** Monday through Friday, from 8 a.m. to 5 p.m. Eastern.

## Q3 PROVIDER FORMULARY UPDATE 2011

### GENERIC NEWS

The generic drug listed below is now available to **HealthEase/Staywell Medicaid and Healthy Kids members ONLY** at the lowest co-payment (if applicable), and the brand name drug has been removed from the HealthEase/Staywell Medicaid and Healthy Kids Preferred Drug List:

| BRAND NAME                                   | GENERIC NAME  | THERAPEUTIC CLASS |
|--|---|-------------------|
| Gemzar® 200mg, 1gm, 2gm powder for injection | Gemcitabine HCl 200mg, 1gm, 2gm powder for injection (PA) | Antimetabolite    |

The generic drug listed below is now available to **HealthEase/Staywell Medicaid and Healthy Kids and Medicare members** at the lowest co-payment (if applicable), and the brand name drug has been removed from the HealthEase/Staywell Medicaid and Healthy Kids Preferred Drug List:

| BRAND NAME          | GENERIC NAME                   | THERAPEUTIC CLASS            |
|---------------------|--------------------------------|------------------------------|
| Nardil® 15mg tablet | Phenelzine Sulfate 15mg tablet | Non-selective MAO Inhibitors |

The following changes have been made to the **HealthEase/Staywell Medicaid and Healthy Kids Preferred Drug List**:

| ADDITIONS                       |   |
|---------------------------------|---|
| Denavir® 1% cream               | Simponi™ 50mg/0.5mL pre-filled syringe (PA) |
| Fortical® nasal spray           | Sprycel® 80mg, 140mg tablet (PA)            |
| Intelence® 200mg tablet         | tamsulosin 0.4mg capsule                    |
| Pantoprazole 20mg, 40mg tablets |   |

PA = Prior Authorization

| REMOVALS  |  |
|---|--|
| Ceron-DM syrup                                      | Ortho-Evra® Transdermal Patch (Members having utilization within the past 100 days will be grandfathered)  |
| De-Chlor DR syrup                                   | Potassium Chloride 0.15% NACL 0.9%   |
| EpiPen Jr® 0.15mg/0.15mL auto-injector              | Potassium Chloride 0.15%/NACL 0.9%/viaflex   |
| Eurax® 10% cream, lotion                            | Potassium Chloride 0.3%/NACL 0.9%/viaflex  |
| Lansoprazole 15mg, 30mg capsules                    | Potassium Phosphate 3mmole/mL solution   |
| Meperidine 50mg, 100mg tablets & 50mg/5mL solution  | Zegerid® 20mg, 40mg capsules   |
| Micardis® 20mg, 40mg, 80mg tablets                  | Due to FDA action and their mandatory removal of unapproved cough and cold medications in February, several cough and cold medications were removed from the PDL. Please refer to the Medicaid Cough and Cold Alternative List at <a href="http://www.wellcare.com/WCAssets/corporate/assets/MCD_FLORIDA_CoughColdAlternativesDL.pdf">www.wellcare.com/WCAssets/corporate/assets/MCD_FLORIDA_CoughColdAlternativesDL.pdf</a> to view the cough and cold products covered on the Staywell/HealthEase and Healthy Kids Medicaid PDL. |
| Micardis® HCT 40/12.5mg, 80/12.5mg, 80/25mg tablets |  |

(continued from previous page)

The Utilization Management criteria have changed for the following medications as noted below for the Staywell/HealthEase and Healthy Kids Preferred Drug List:

| DRUG NAME  | CHANGE                           |
|--|----------------------------------|
| Amphetamine/Dextroamphetamine salts extended-release caps            | QL updated; #62 capsules/31 days |
| Arixtra® 2.5mg/0.5mL injection                                       | QL updated; #16mL/31 days        |
| Methotrexate Sodium solution   | PA removed                       |
| Ondansetron 4mg, 8mg tablets, 4mg, 8mg ODT tablets, 4mg/5mL solution | QL removed                       |
| Venlafaxine HCl 37.5mg, 75mg, 150mg extended-release tablets         | ST added                         |

PA = Prior Authorization      QL = Quantity limit      ST = Step Edit

Please refer to your provider manual available at [www.wellcare.com/Provider/ProviderManuals](http://www.wellcare.com/Provider/ProviderManuals) to view more information regarding WellCare's pharmacy utilization management policy/procedures and medication copayments and coinsurance requirements that may apply. The most up to date complete preferred drug list can be found at [www.wellcare.com/WCAAssets/corporate/assets/MCD\\_FLORIDA\\_PDL.pdf](http://www.wellcare.com/WCAAssets/corporate/assets/MCD_FLORIDA_PDL.pdf).

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

| ADDITIONS  |   |
|--|---|
| Alphagan® P 0.1% and 0.15% ophthalmic solution   | Moxeza™ 0.5% ophthalmic solution              |
| A-Methapred® 40mg, 125mg solution  | Pataday™ 0.2% ophthalmic solution             |
| Amitiza® 8mcg, 24mcg capsules (ST)   | Patanol® 0.1% ophthalmic solution             |
| Dexilant™ 30mg, 60mg capsules  | Potassium Chloride 10% liquid                 |
| Duetact® 30mg/2mg, 30mg/4mg tablets (QL; 31 tablets/31 days)   | Sprycel® 80mg, 140mg tablets (PA)             |
| Enoxaparin Sodium solution 30mg/0.3mL, 40mg/0.4mL, 60mg/0.6mL, 80mg/0.8mL, 100mg/mL, 120mg/0.8mL, 150mg/mL (QL varies depending on strength) | TobraDex® ST 0.3%-0.05% ophthalmic suspension |
| Fortical® nasal spray  | Zymaxid™ 0.5% ophthalmic solution             |
| Intelence® 200mg tablet (QL; 124 tablets/31 days)  |   |

PA = Prior Authorization      QL = Quantity Limit      ST = Step Edit

The Utilization Management criteria have changed for the following medications as noted below for the WellCare Medicare Formulary:

| DRUG NAME  | CHANGE                                       |
|--|--|
| Calcitriol 0.25mg, 0.5mg capsules                  | PA added                                     |
| Calcitriol 1mcg/mL, 2mcg/mL solution for injection | PA added                                     |
| Calcitriol 1mcg/mL oral solution                   | PA added                                     |
| Hectorol® 0.5mcg, 1mcg, 2.5mcg capsules            | PA added                                     |
| Hectorol® 4mcg/2mL solution                        | PA added                                     |
| Spiriva® HandiHaler®                               | ST removed (QL remains: 30 capsules/30 days) |
| Vancomycin HCl 1000mg, 10gm solution               | PA added                                     |

PA = Prior Authorization      ST = Step Edit

(continued from previous page)

Please refer to your provider manual available at [www.wellcare.com/Provider/ProviderManuals](http://www.wellcare.com/Provider/ProviderManuals) to view more information regarding WellCare's pharmacy utilization management policy/procedures and medication copayments and coinsurance requirements that may apply. The most up to date complete formulary can be found at [www.wellcare.com/medicare/medication\\_guide](http://www.wellcare.com/medicare/medication_guide).

#### PLANNED MARKET DRUG WITHDRAWALS

| COMPANY NAME         | DRUG NAME                                      | DATE OF REMOVAL         | COMMENTS  |
|----------------------|--|-------------------------|---|
| Endo Pharmaceuticals | Opana® ER 7.5mg, 15mg extended-release tablets | On or about May 1, 2011 | Please be advised that Endo Pharmaceuticals will discontinue the sale and distribution of two strengths of Opana® ER (oxymorphone HCl) Extended-Release Tablets CII. Endo estimates these two strengths will no longer be on retail shelves on or about May 01, 2011. Due to increased demand for Opana ER, Endo is streamlining operations to focus on the most commonly prescribed dosages, enabling us to serve the needs of our customers while continuing to supply a wide range of dose strengths. Opana® ER dose strengths of 5mg, 10mg, 20mg, 30mg and 40mg will continue to be available at your local pharmacy. |
| Allergan, Inc.       | ZYMAR®   | February 28, 2011       | The anti-infective activity of fluoroquinolones, such as gatifloxacin, is concentration-dependent. ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5% has a greater concentration of the active agent gatifloxacin when compared with ZYMAR® (gatifloxacin ophthalmic solution) 0.3% formulation. Therefore, effective February 28, 2011, Allergan, Inc. discontinued ZYMAR® (gatifloxacin ophthalmic solution) 0.3%. Allergan will continue to manufacture ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5%.   |



## CHILD HEALTH CHECK-UP TIPS

HealthEase, HealthEase Kids, Staywell and Staywell Kids members are entitled to receive a comprehensive package of preventive health care. Here are some questions and answers to help you conduct, document and bill for the Child Health Check-Up (CHCUP) exams.

### Billing Requirements:

**New Patient:** Initial evaluation and management of a healthy individual requiring a comprehensive history, an examination, identification of risk factors and ordering of appropriate lab/diagnostic procedures

| PROCEDURE CODE | AGE GROUP                                 |
|----------------|---|
| 99381          | Infant (age under 1 year)                 |
| 99382          | Age 1 through 4 years                     |
| 99383          | Age 5 through 11 years                    |
| 99384          | Age 12 through 17 years                   |
| 99385          | Age 18 through 20 years – use EP modifier |

**Established Patient:** Periodic re-evaluation and management of a healthy individual requiring a comprehensive history, examination, identification of risk factors and the ordering of appropriate lab/diagnostic procedures

|       |   |
|-------|---|
| 99391 | Infant (age under 1 year)                 |
| 99392 | Age 1 through 4 years                     |
| 99393 | Age 5 through 11 years                    |
| 99394 | Age 12 through 17 years                   |
| 99395 | Age 18 through 20 years – use EP modifier |

*(continued on next page)*

(continued from previous page)

**Newborn Care:** Services to newborns, including physical examination, initiation of diagnostic and/or treatment, and preparation of medical records for the infant.

**Note:** CPT code changes for newborn screens.

|                    |  |
|--------------------|--|
| 99460 (old: 99431) | Newborn Care - History and Examination (replaces code 99431) |
| 99461 (old: 99432) | Normal Newborn Care (replaces code 99432)                    |
| 99463 (old: 99435) | Newborn Care (history and examination) (replaces code 99435) |

**Referral Codes:** It is a federal requirement that referral codes are billed for CHCUP services. Your claim and/or encounter will be rejected if you do not include a referral code on the claim or encounter.<sup>14</sup>

| REFERRAL CODES |  |
|----------------|--|
| Code           | Referral Description   |
| AV             | Patient Refused Referral (Available, Not Used)   |
| NU             | Patient Not Referred (Not Used)  |
| S2             | Under Treatment (For referred diagnostic or corrective health problem)   |
| ST             | New Services Requested (Patient referred to another provider for diagnostic or corrective treatments or scheduled for another appointment with check-up provider or diagnostic or corrective treatment for at least one health problem identified during a Child Health Check-Up, not including dental referrals.) |

#### CHILD HEALTH CHECK-UP

The Child Health Check-Up (CHCUP) claim is now billed on a physician claim form. CHCUP is referred to as EPSDT (Early and Periodic Screening, Diagnosis and Treatment) in national publications. The CHCUP procedure code is entered on one line and any other services provided can be entered on subsequent lines. CHCUP claims can only be billed in the following formats: CMS-1500, NSF, X12N 837P, or WINASAP 2003, Professional.

| CHCUP INDICATOR  | CHCUP REFERRAL CODE   | SPECIAL PROGRAM INDICATOR |
|--|---|---------------------------|
| <b>CMS-1500 Claim Form</b><br><b>Box 24H</b> (EPSDT/Family Planning) – Enter “Y” if service is a result of a CHCUP referral (Use when service is not a CHCUP procedure code).  | <b>Box 24H</b> (EPSDT/Family Planning) – Enter “V”, “U”, “2”, or “T” (see table) for the referral code most applicable (Use only when service is a CHCUP procedure code). | Not applicable            |
| <b>NSF Format</b><br><b>FB0-22.0</b> (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral, “N” or space if not (Use when service is not a CHCUP procedure code). To bill a CHCUP screening claim as a physician claim, also complete these fields: BA0-03.0 Batch Type = 100 EA0-32.0 Diagnosis Code 1 = required (at least one diagnosis is required) FA0-14.0 Diagnosis Code Pointer 1 = required (at least one is required) | <b>FB0-22.0</b> (EPSDT Indicator) – Enter “V”, “U”, “2”, or “T” (see table) for the referral code most applicable (Use only when service is a CHCUP procedure code).      | Not applicable            |

(continued from previous page)

| CHCUP INDICATOR  | CHCUP REFERRAL CODE   | SPECIAL PROGRAM INDICATOR  |
|--|---|--|
| <b>X12N 837P</b><br><b>Loop 2400, Segment SV1, Element 11</b> (EPSDT Indicator) – Enter “Y” if service is a result of a CHCUP referral (Use when service is not a CHCUP procedure code). | <b>Loop 2300, Segment CRC, (EPSDT Referral), Element 03</b> (Condition Code) – Enter “AV”, “NU”, “S2”, or “ST” (see table) for the referral code most applicable. If CRC02 is “N,” this value must be “NU” (Use only when service is a CHCUP procedure code). | <b>Loop 2300, Segment CLM, Element 12</b> (Special Program Code) – Enter “01” if any line item in the transaction contains a service that is a CHCUP procedure code. |

### CHILD HEALTH CHECK-UP REQUIREMENTS

Exam consists of the following three components that must be provided:

- A comprehensive health history—including an assessment of physical and mental development
- A comprehensive unclothed physical exam
- Health education, including anticipatory guidance

Frequency of visits:

- 0–4 weeks of age
- 2 months of age
- 4 months of age
- 6 months of age
- 9 months of age
- 12 months of age
- 15–18 months of age
- 2 years of age
- 3 years of age
- 4 years of age
- 5 years of age
- 6 years of age
- Yearly up to age 20

#### Medical Record Documentation Requirements:

Documentation in the medical record must include a note indicating a visit with a primary care practitioner, the date the CHCUP visit occurred, and evidence of all three of the required components listed above.

#### Sample evidence for comprehensive health history and health education/anticipatory guidance:

##### Mental and Physical—Both:

##### 0–2 years

- Separation anxiety

- Walking
- Child acting age appropriate
- Sitting up
- Child bonding well with mother
- Turning over
- Child crawling
- Imitates activities and sounds
- Growth appropriate for age
- Recognizes familiar faces and voices

##### 3–6 Years

- Follows simple directions
- Listens to stories
- Good language skills
- Mature pencil grasp and can copy shapes
- Parent-child interaction
- Balances on one foot, hops and skips
- Names a friend
- Knows name
- Growth appropriate for age
- Converses in 2–3 sentences

##### Adolescents:

- Observe parent & youth interaction
- Behaviors that develop lifestyle
- Establishing relationships
- Engagement in community
- Increasingly independent decision-making
- Discussion regarding sexual activity
- Sexually active
- Discussion regarding smoking, alcohol, substance use, etc.

(continued from previous page)

## Health Education/Anticipatory Guidance

### 0–2 years

- Treating illnesses that are not current (ex. fever information) if physician is discussing a future possibility and possible outcomes.
- Anticipatory guidance done (the wording “Anticipatory Guidance” written in a note will count)
- Teaching done
- Advising parents about seat belt use for their children
- Fire/Carbon Monoxide Detector
- Child-proofing home
- Education on stages of development
- Immunization schedule
- Projecting how to care for things in the future
- Advice on how to care for sick child in future

### 3–6 years

- Treating illness that are not current (ex. fever information) if physician is discussing a future possibility
- Anticipatory guidance done (the wording “Anticipatory Guidance” written in a note will count)
- Advice on how to care for sick child in future possible outcomes.
- Injury prevention: safety seats & belts, protective gear, guns
- Child-proofing home
- Immunization schedule
- Supervision of outside play
- Bedtime ritual
- Fire/Carbon Monoxide Detector
- Curiosity about the body
- Projecting how to care for things in the future
- Education on stages of development

### Adolescents through age 21:

- Discuss tobacco, alcohol and drugs
- Encourage activity/exercise
- Overall, if physician is discussing a future possibility and possible outcomes, the wording “Anticipatory Guidance” or “AG Communicates rules/expectations/responsibilities done”
- Discuss relationships, sex, values, protected sex and STD prevention

- Involved in family decision-making
- Explores interests and new activities
- Discuss physical changes that occur during puberty
- Awareness of community issues and needs
- Injury prevention: safety belts, protective gear, guns, driving safety, riding with impaired drivers
- Encourage regular dental appointments
- Encourage healthy diet

**There are several forms available that can assist you in assuring you have documented correctly. You may find these forms:**

- In your Provider Manual (Forms section)
- Georgetown University’s Bright Futures program at: [www.brightfutures.org/encounter/provider/index.html](http://www.brightfutures.org/encounter/provider/index.html)

For more information on CHCUP and well-child exams, please visit the Florida Well-Child Provider Toolkit at [www.wellcare.com/Provider/QI\\_FL\\_WellChildProviderToolkit](http://www.wellcare.com/Provider/QI_FL_WellChildProviderToolkit).

This toolkit includes helpful resources such as: immunization schedules, CHCUP tracking forms and lead poisoning screening materials. Please refer to this toolkit on a regular basis, as more resources will be added.

*Source: American Academy of Pediatrics*

