



PROVIDER

Newsletter

CLAIMS CORNER

According to the American Medical Association (AMA) CPT coding manual, preventive medicine services include:

- History and exam appropriate for age and gender
- Anticipatory guidance and risk factor reduction
- Ordering of appropriate immunizations, lab/diagnostic procedures
- Treatment and management of insignificant problems

AMA CPT coding allows billing for both a preventive medicine code and a medically necessary evaluation & management (E/M) code when there is “**significant**” extra work during a routine examination. For significant, separately identifiable E/M services by the same physician on the same day of the procedure, use both modifiers -25 and -EP on the medically necessary E/M service for Medicaid patients, but only modifier -25 for Medicare patients.

Bill only the preventive medicine code when:

- The patient’s status/history shows the patient in good health
- The patient has a minor “stable” problem
- The history of present illness (HPI) is “Doing well, no complaints”
- When the assessment & plan (A/P) addresses only preventive medicine issues

Bill both the preventive medicine code & the medically necessary E/M service when:

- The patient has chronic medical problems, one or two in poor control
- The patient has three serious chronic problems, all in good control, if they are addressed
- HPI documents poor control of chronic disease or status of stable diseases
- Exam shows unexpected, abnormal findings
- Acute problem treated
- A/P shows treatment of diseases

PROVIDER MATERIALS UPDATE

The following correspondence was placed on Banner Messages or faxed to providers since our last newsletter and can be found at www.wellcare.com (Medicare) or georgia.wellcare.com (Medicaid). Click on the Provider tab, and *Messages From WellCare* is located in the right column. Remember to check the messages regularly to receive new and updated information such as:

- Changes in Web Portal Claim Submission Requirements
- Synagis Administration for the 2010–2011 Season
- 2010–2011 Flu Season Notice
- NDC Billing Requirements
- Concerta Status Change on Medicaid Preferred Drug List
- Paper Claim Format Submission Change
- Process for Corrected or Voided Claims
- Member Rights & Responsibilities
- 2010 Patient Safety Sheet

WEB RESOURCES

Visit www.wellcare.com (Medicare) or georgia.wellcare.com (Medicaid) to access our Preventive Health Guidelines, Clinical Practice Guidelines, EPSDT documents, Pharmacy Guidelines, Cultural Competency Plan and other helpful resources. If you would like to receive a hard copy of the documents above, please contact your Provider Relations representative. For additional information, please contact the Provider Hotline at 1-866-231-1821 (Medicaid) or 1-866-334-7730 (Medicare).

HOW TO IMPROVE COMMUNICATION WITH SPANISH-SPEAKING PATIENTS

“No hablo inglés” is Spanish for “I do not speak any English.” However, this obstacle should not put you into a state of panic or be a barrier to providing your patient with competent care. So, just how can you improve communication with Spanish-speaking patients? The following are some suggestions that may help:

- Use an interpreter.
- Use hand gestures.
- Learn some Spanish phrases.
- Keep a Spanish medical dictionary on hand.
- Use visual aids such as posters or sculptures.
- Speak slowly and use simple words.

Besides being fluent in Spanish, there are other ways you can communicate effectively with your Spanish-speaking patients. Culturally sensitive communication will help to improve patient satisfaction, increase patient retention and improve patient health.



BREAKING DOWN WALLS

EFFECTIVE COMMUNICATION WITH PATIENTS

It can be very stressful when patients do not understand what their doctors are telling them about their condition. Good communication can help alleviate fear or anxiety they might experience.

Here are some things providers can do to communicate more effectively with their patients:

- Keep the patient’s culture in mind; it may differ from yours. The way you communicate both verbally and nonverbally may mean something different to them.
- Assess what the patient already knows by asking questions; encourage patients to keep you informed.
- Assess what the patient wants to know.
- Be empathetic.
- Take the time to explain all treatment options and ensure the patient understands the benefits and risks of each option.
- Keep it simple; explain medical information in easily understood language.
- Be sure to answer all of the patient’s questions.



REFERRING PATIENTS TO A BEHAVIORAL HEALTH SPECIALIST

The Surgeon General estimates that 15 percent of the U.S. population may need the help of a mental health professional in any one year. And because many patients identify their primary care physician (PCP) as the provider they are most likely to consult for a mental health problem, the responsibility for the initial assessment of that behavioral health condition will often lay squarely on your shoulders. That's why you must carefully examine each patient you see, not only for physical ailments but for underlying mental health concerns. The Surgeon General's report indicates that a large percentage of patients will go undiagnosed or under treated. Don't let that happen to your patients! While many mental health problems, including depression, anxiety, and attention deficit hyperactivity disorder, can be effectively managed and treated by the PCP, more complicated problems may indeed require the involvement of specialists in psychiatry. It's important for you to refer patients who exhibit some signs of psychiatric disorder to a licensed mental health behavioral specialist for immediate attention.

When considering psychiatric consultation and referral, please keep the following in mind as you work with your patients:

- The patient has a chronic medical condition and appears to have a significant behavioral health condition that is untreated or undiagnosed.
- The patient's behavioral health condition appears to be exacerbating the medical condition or vice versa.
- The patient is having suicidal or homicidal thoughts.
- The patient is displaying psychotic symptoms.
- The patient is reporting a history of violence, self-injury or mutilation.
- The patient has a history of frequent inpatient admissions and is prone to relapse.
- The patient has received multiple diagnoses or has complicating factors, including substance abuse and/or personality disorders.
- The patient has no organic etiology for his or her medical complaints.
- The patient is experiencing complex marital or family issues where prolonged or frequent sessions will be required.
- The patient is unresponsive to first-line therapeutic interventions.
- Patients seen in the emergency room or hospitalized on a medical floor where behavioral health issues may have contributed to their admission to a medical service.

Once you've identified that your patient needs a mental health behavioral specialist or psychiatric consultation and management, please contact Magellan Behavioral Health, Inc., for further attention to this matter. Magellan can be reached at **1-877-712-5340**. You may also contact Magellan's Aftercare Team at **1-800-424-5412** Monday through Friday from 8am to 7pm Eastern. Finally, your patient may contact Magellan directly by calling **1-877-712-5340**, which is available 24 hours a day, seven days a week.



CHANGES TO THE EPSDT MEDICAL RECORD REVIEW

The Department of Community Health (DCH) has recently revised its Early Periodic Screening, Diagnosis and Treatment (EPSDT) medical record review tool and definitions. The revised and additional measures came from *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition (2008)*. DCH has recommended that practitioners refer to the BHG to answer any questions they may have on the new or revised requirements.

Here is a list of the changes that went into effect in January 2011:

REVISED OR ADDED MEASURES	DEFINITION AND WHAT IS REQUIRED	RECOMMENDED AGES
Initial and Interval History are Presented – (R)	Initial history – Must be obtained at the time of the visit from the parent or guardian. Interval history – Must include events in the medical history of the child since the last visit.	All ages.
Blood Pressure Assessment – (A)	All measurements in numerical values are to be recorded. All measurements outside of the normal range must have an intervention.	Children under 3 years if at risk. All children 3 years old and older.
Vision – (R)	Children from birth to 3 years – A vision risk assessment at every visit. Children 3 years and older – Use the vision risk assessment or screen for visual acuity.	All ages – see requirements at each age listed to the left.
Hearing – (R)	<ol style="list-style-type: none"> Children from birth to 4 months of age – newborn hearing screening. Infants and toddlers under age 2 years – Monitor for auditory skills, middle ear status and developmental milestones. Children 2 years through 20 years – A risk assessment administered at the 24 month, 30 month, 3 year and 9 year visits and at each visit from 11-20 years. 	<p>All ages – see requirements at each age listed to the left.</p> <p>At the 4, 5, 6, 8 and 10 year visits – appropriate universal hearing screening is required.</p>
Developmental / Behavioral Assessments / Surveillance – (R)	Psychosocial/Behavioral Assessment and Developmental Surveillance at each clinical encounter and should document social, emotional, communication, cognitive and physical development concerns.	All ages.
Standardized Developmental Screen / Autism / Alcohol and Drug Assessment as age appropriate – (A)	This measure includes the following: <ol style="list-style-type: none"> Developmental Screening – This screening must be accomplished using standardized tools with sensitivity and specificity levels of 70 percent to 80 percent. Please see the DCH Health Check Manual for a listing of approved tools. Autism Screening – Performed with an autism-specific screening tool. The Modified Checklist for Autism in Toddlers (M-CHAT) is one of the tools that may be used that is free for download. See www.dbpeds.org or www.firstsigns.org. Alcohol and Drug Use Assessment – At all adolescent (11–20 years) visits, pre-teens and teens should be asked about substance use. 	<ol style="list-style-type: none"> Developmental Screening is required at ages 9 months, 18 months and 30 months. Autism Screening is required at ages 18 months and 24 months or any time parents raise a concern. Alcohol and Drug Use Assessment is required at 11 years through 20 years of age.
Newborn Metabolic / Hemoglobin Screening – (A)	All infants under 4 months should have the metabolic screening performed. If results are outside the normal limits for a newborn screening disorder, the practitioner should ensure that the child receives prompt appropriate retesting and/or a referral to an appropriate specialist.	All infants under 4 months.

REVISED OR ADDED MEASURES	DEFINITION AND WHAT IS REQUIRED	RECOMMENDED AGES
Immunizations completed for age	An immunization assessment is required for all children. All immunizations (historic and current) must be documented in the medical record and recorded in the Georgia Registry of Immunization Transactions and Services (GRITS). All refusals of immunizations made by the parent or guardian must have a signed document.	All ages.
Blood Lead Risk Assessment – (A)	Change: Assessment questions are not needed if the Blood Lead Level (BLL) Screening is given at the visit instead. If positive on the initial risk assessment questions, there should be a Blood Lead Level test recorded.	Ages 6, 9, and 18 months.
Tuberculin Risk Assessment – (R)	An assessment is given using validated questions. See page 234 in the 2008 BFG. Other validated questions may come from the Georgia TB program, the Centers for Disease Control and Prevention (CDC), or the American Academy of Pediatrics (AAP). If positive on the initial risk assessment questions, there should be a TB test recorded.	Ages 1, 6, 12 and 18 months and then annually beginning with the 24-month visit.
Dyslipidemia Assessment / Screening – (A)	An assessment to determine a child’s risk should be performed at ages 2, 4, 6, 8, 10 year and adolescence. The results of the risk assessment and any screenings are needed. Abnormal findings during assessment or screening require further evaluation, follow-up or parental counseling.	Ages 2, 4, 6, 8, 10 year and adolescence (11 through 20 year) visits. At age 20 years, a universal screening is needed if not done previously in late adolescence.
Sexually Transmitted Infection (STI) Screening – (A)	If the member is sexually active, an annual screening is required to detect sexually transmitted infections. Documentation of the screening and results or referrals is required.	All sexually active members.
Cervical Dysplasia / Pap Screening – (A)	Screening should be performed to detect cervical dysplasia using a Pap smear as part of a pelvic exam. Evidence of pelvic exam and Pap smear, conventional slide or liquid base sent to laboratory or referral. Abnormal findings require further evaluation or follow-up and counseling.	All sexually active girls within 3 years of onset of sexual activity.
Oral Health – (A)	Document a referral or the inability to refer a patient to a dental home. If no dental home is available, conduct an oral health risk assessment. At age 3 years, determine if the patient has a dental home. If not, referral should be made. Document dental appointments for older children and care per AAPD periodicity schedule.	Ages 4 months to 3 years.
Anticipatory Guidance – (R)	This measure was formerly called “Health Education.” Anticipatory guidance and health education must be offered. Documentation of the topics or the name of the handout given to the parent or guardian is required.	All ages.
Referral / Treatment or Follow-Up Noted – (R)	Formerly, this measure was split into two – Referral / Treatment and Follow-Up for Abnormal Values. The requirement is that all suspicious or abnormal findings identified during a Health Check (EPSDT) visit must be treated or be further evaluated. The practitioner must either treat (if qualified) or refer all members with abnormal findings to specialists. There must be evidence of an appropriate plan of care, treatment, or referral for all components, results, and overriding concerns.	All ages.



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 who serves the QMB and/or QMB+ population, it is highly recommended that you participate in your state's Medicaid program and gain access to any billing system the state uses. This will allow you to easily balance bill the state for your fees.¹

WellCare's Access plan is composed entirely of QMB and/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.

FINANCIAL ASSISTANCE TO IMPLEMENT ELECTRONIC HEALTH RECORDS

Physicians can receive up to \$64,000 to help transition from paper-based medical records to Electronic Health Records (EHR). To qualify, physicians must not only adopt but demonstrate meaningful use of certified EHR systems. Beginning in 2011, the program is designed to support physicians in this period of Health IT transition and instill the use of EHRs in meaningful ways. Help improve the quality, safety and efficiency of patient health care by investing in EHR.

For more information, visit <http://www.cms.gov/EHRIncentivePrograms/>.

MIGRATING TO 5010 FOR ELECTRONIC TRANSACTIONS

The Health Insurance Portability and Accountability Act of 1996 (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. These include:

- Claims (professional, institutional and dental)
- Claims status requests and responses
- Payments to providers
- Eligibility requests and responses
- Referral requests and responses
- Enrollment and disenrollment in a health plan
- Coordination of benefits
- Premium payments

For the majority of the year 2010, the 5010 project focus was achieving Level I compliance. The Centers for Medicare and Medicaid Services (CMS) defines Level I compliance as follows: *a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.*

For the year 2011, focus is shifting to testing and becoming Level II compliant. CMS defines Level II compliance as follows: *a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.*

TESTING SCHEDULE: WHO AND WHEN

A testing schedule was developed for providers who submit electronic transactions directly to, or receive electronic transactions directly from WellCare. Testing began in January 2011 and will proceed through quarter two of 2011, depending on the provider and their transaction utilization.

For providers who submit electronic transactions through a third party vendor, please note that WellCare is also testing with vendors during the same time frame. The specific types of vendor testing are listed below.

- 837I, 837P, 837D (Claims) – WellCare will test with clearinghouses
- 276/277 (Claim Status) – WellCare will test with clearinghouses and providers
- TA1, 999, 277CA (Response Files) – WellCare will test with clearinghouses
- Outbound 834 (Eligibility) – WellCare will test with providers
- 835 (Payments) – WellCare will test with payment vendor and providers
- NCPDP D.0 (Pharmacy) – WellCare will test with pharmacy claims vendors
- Encounters – WellCare will test with vendors and providers

KEEP COMMUNICATION LINES OPEN

- Notify WellCare regarding any software and/or vendors that are not 5010 test-ready for external partners through our EDI department: **EDI-Master@WellCare.com.**
- Designate a primary contact (i.e., office manager, billing manager) who is familiar with 5010 and its implications for your office. A single point of contact will ensure communications to and from WellCare are received timely.

RESOURCES

- CMS checklist for a smooth 5010 transition: www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage.
- CMS presentations from the National Provider calls: www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage.

For inquiries related to your electronic claim submissions to WellCare/Harmony and related transactions, please contact our EDI team via e-mail at **EDI-Master@WellCare.com.**

ASSESS POTENTIAL HEALTH CONCERNS FOR YOUR OLDER PATIENTS

WellCare encourages you to dedicate a few minutes during a patient visit to discuss the following health concerns with your older patients:

FALL RISK MANAGEMENT

- **Ask your patients if they have fallen or almost fell, but were caught by someone or managed to grab hold of something just in time.**

Fall prevention is one of the biggest safety concerns for older patients, especially those that live alone. Slip and fall accidents are one of the leading causes for seniors having to go to the hospital. An important aspect of patient education and injury prevention is to alert your patients of ways to prevent falling, including wearing sensible shoes and using an assisted device—which is especially important for seniors—because their balance may be impaired, leading to increased falls.

ASSESS PHYSICAL ACTIVITY – KEEP YOUR PATIENTS MOVING

- **Talk to your patients about their physical activity. For example, do they exercise regularly or take part in physical exercise?**

You may want to advise them to start, increase or maintain their level of exercise or physical activity to maintain and/or improve their health. Physical activity can improve strength, balance, coordination and flexibility, and can go a long way toward fall prevention.

URINARY INCONTINENCE (UI)

- **In addressing a topic as sensitive as this, it is important to put the patient at ease so they will feel comfortable discussing such a private issue with you.**

Loss of bladder control is common among older patients. Urinary incontinence may be underreported because patients do not believe that anything can be done about it.

Underlying health problems may contribute to incontinence, such as menopause for women and enlarged prostate for men.

If the patient is experiencing symptoms of urinary incontinence, discuss treatment options that may include bladder training, physical therapy or sometimes, just a simple change in toileting habits may bring relief.

CHECK FOR OSTEOPOROSIS

- **Assess your patients' bone health. Because osteoporosis can be asymptomatic for a prolonged period of time, do bone mineral density (BMD) testing if applicable.**

With age, bones tend to shrink in size and density, which weakens them and makes them more susceptible to fracture. The U.S. Preventive Services Task Force (USPSTF) recommends BMD testing on all women age 65 and older, all men age 70 and older, and other patients based on their clinical profile.

You may want to give them tips on what they can do to prevent bone loss or the progression of osteoporotic bones. For example, tell them to include plenty of calcium and vitamin D in their diets, and to consider strength training to increase bone density and reduce the risks of osteoporosis. Medication management is a treatment option to slow bone loss and maintain bone mass, when applicable.

Always remind your patients that it's never too late to adopt a healthy lifestyle. As their physician, you can not stop the aging process, but your patients can minimize the impact by making healthy lifestyle choices with your guidance.

MEASURE BONE LOSS

In agreement with the U.S. Preventive Services Task Force (USPSTF) recommendations for postmenopausal women, The National Osteoporosis Foundation (NOF) recommends bone density imaging on:

- All women age 65 and older
- All men age 70 and older
- Younger postmenopausal women and men ages 50 to 69 about whom you may have concern based on their clinical risk factor profile
- Women in the menopausal transition if there is a specific risk factor associated with increased fracture risk, such as low body weight, prior low-trauma fracture or high-risk medication
- Adults who have had a fracture after age 50
- Adults with a condition (e.g., rheumatoid arthritis) or taking a medication (e.g., glucocorticoids in a daily dose more than or equal to 5mg prednisone or equivalent for more than or equal to three months) associated with low bone mass or bone loss
- Anyone being considered for pharmacologic therapy for osteoporosis
- Anyone being treated for osteoporosis, to monitor treatment effect
- Anyone not receiving therapy in whom evidence of bone loss would lead to treatment

People with osteoporosis are frequently asymptomatic—sometimes for a prolonged period of time—until they suffer a fracture, which can lead to even more complications. Not uncommonly, the fracture occurs following minimal trauma. Although a fracture may be followed by a full recovery, chronic morbidity, disability and even death are all too common. Osteoporotic fractures may lead to psychological symptoms, most notably depression and loss of self-esteem, as patients grapple with pain, physical limitations and the need for lifestyle changes.

Osteoporosis-related fractures create both a personal and communal economic burden, necessitating more than 432,000 hospital admissions, almost 2.5 million medical office visits, and about 180,000 nursing home admissions annually in the U.S. Interventions that focus on early detection (radiologist supervised bone density imaging) and treatment of osteoporosis, and prevention of falls, should be a routine focus of primary care office visits for at-risk patients.

Source: National Osteoporosis Foundation Clinician's Guide to Prevention and Treatment of Osteoporosis. Washington, DC: National Osteoporosis Foundation; 2010.

http://www.nof.org/sites/default/files/pdfs/NOF_ClinicianGuide2009_v7.pdf



ANTIBIOTIC AND THE UPPER RESPIRATORY TRACT INFECTION

The inappropriate use of antibiotics in treating mild upper respiratory tract infections (URI) is an ongoing problem in the health care community. Although studies have shown that the majority of URIs are caused by viruses, an overwhelming 75 percent of adults diagnosed with a URI are prescribed an antibiotic by their physician. These practices are contributing to the spread of antibiotic resistance, as well as presenting a financial burden on the health care system through the tremendous cost associated with treating antibiotic-resistant infections once they develop.

PRESCRIBING OF ANTIBIOTICS WITH COMMON URIs

NONSPECIFIC URI

Antibiotics are **NOT** recommended. These infections are, in most cases, self-limiting and resolve on their own within 3–10 days.

ACUTE SINUSITIS

Narrow spectrum antibiotics should only be prescribed if symptoms do not resolve within 7 days or severe acute sinusitis is present.

ACUTE PHARYNGITIS

Antibiotics use is only effective in acute pharyngitis caused by Group A β -hemolytic streptococcus (GABS). The patient who presents with clinical symptoms should have a Rapid Strep Test or Molecular Probe for GABS assay performed to confirm the presence of GABS before antibiotics are prescribed.

ACUTE BRONCHITIS

In uncomplicated cases, antibiotics are **NOT** recommended.

SUMMARY

Most URIs resolve spontaneously within 3–10 days of symptom onset. With the exception of GABS-confirmed acute pharyngitis and severe acute sinusitis, symptomatic relief is first-line in treating patients diagnosed with URI. Recommendations for appropriate treatment of URI in the presence and absence of a positive MPGABS or RST result is available in the WellCare of Georgia Clinical Practice Guidelines at <http://georgia.wellcare.com/provider/pem> (Medicaid) or www.wellcare.com/provider (Medicare).

Finally, patient education is paramount in dealing with the common patient expectation of receiving an antibiotic when presenting with URI symptoms that clinically do not require antibiotic treatment. Communication with the patient explaining the hazards and cost of taking unnecessary antibiotics is vital, as well as ensuring the patient is advised on how to reduce symptoms either with home remedies or medications that provide symptomatic relief. This approach should aid in bridging a trust between you and the patient in taking the “watch and wait” course of action before prescribing an antibiotic.

Sources:

Sherif.B. Mossad. Cleveland Clinic Center for Continuing Education. Upper Respiratory Tract Infections. <http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/infectious-disease/upper-respiratory-tract-infection/>

Timothy Begany. Avoid Treating Most URIs with Antibiotics. Pulmonary Reviews.com. Vol6. No.7. July 2001. http://www.pulmonaryreviews.com/jul01/pr_jul01_URI.html

CHILD PREVENTIVE HEALTH GUIDELINES

The 2008 Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) can be viewed by accessing the AAP Web site at <http://practice.aap.org/content.aspx?aid=1599>, on the georgia.wellcare.com portal, or by contacting your Provider Relations representative. It is very important to use the 2008 Bright Futures/American Academy of Pediatrics guideline for the appropriate health check and risk assessment during the member’s well-child checkup.

KEEPING PREGNANT MEMBERS AND THEIR UNBORN BABIES HEALTHY

As a health plan, we have an obligation to help pregnant members' and their unborn babies stay healthy. One of the ways we will accomplish this is through our Maternity Education and Member Incentive Program, a component of our Quality Improvement Program.

The Program goals:

- Engage pregnant members in managing and maintaining and/or improving their current state of health.
- Improve compliance with timely scheduling and attendance of their prenatal care visits and postpartum care visit.
- Decrease the likelihood of negative consequence associated with not achieving a healthy outcome.

As a part of the Program, we will provide eligible pregnant Medicaid members with the Program's Educational Booklet, "**Mommy and Baby Matters, Taking Care of Yourself and Your Baby.**" The booklet provides basic prenatal and postpartum tips to enhance pregnant members' awareness about the importance of taking good care of themselves and their unborn baby both during and after pregnancy. To view a copy of the Maternity Education booklet, please visit www.wellcare.com/provider/resources.

As a component of the Maternity Education Program, the health plan is offering a Prenatal Reward Program that will reward pregnant members for receiving timely prenatal care visits and a postpartum care visit. If they choose to participate in this voluntary program, **they must attend at least six prenatal visits and one postpartum visit between the third and seventh week after the baby's birth.** You, as the provider of care, will need to date and sign for each visit to confirm compliance and fax the completed form to the health plan. If they meet their visits and other eligibility criteria, including enrollment in the Georgia Prenatal Program, their reward is a new baby stroller at no cost to them.

Partnering with us as a health plan, we'd like you to emphasize to our pregnant members the importance of taking care of themselves during their pregnancy. More important, new mothers must be reminded to schedule and keep their appointments so you as their health care provider can monitor not only their health, but their baby's development to achieve a healthy outcome.



CDC GUIDELINES

The Centers for Disease Control and Prevention (CDC) has released the 2010 Advisory Committee on Immunization Practices (ACIP) schedule for immunization. It can be viewed by accessing the CDC Web site at www.cdc.gov/vaccines/recs/schedules, on the georgia.wellcare.com portal, or by contacting your Provider Relations representative.

Q1 2011 PROVIDER FORMULARY UPDATE

The generic drugs listed below are now available to WellCare of Georgia Medicaid and Medicare members (unless otherwise noted) at the lowest co-payment (if applicable), and the brand-name drugs have been removed from the WellCare of Georgia Medicaid Preferred Drug List:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
ASTELIN Nasal Spray®†	Azelastine HCl 137mcg spray	Antihistamine
Cleocin Pediatric® 75mg/mL Granules†	Clindamycin 75mg/mL solution (QL: 300mL/31 days) Medicaid only	Anti-Infective Agent
Cosmegen® 0.5mg Powder for Injection††	Dactinomycin 0.5mg Vial (PA) Medicaid only	Antineoplastic Agent
Exelon® 1.5mg, 3mg, 4.5mg and 6mg Capsules††	Rivastigmine 1.5mg, 3mg, 4.5mg and 6mg Capsules	Cholinesterase Inhibitor
Lovenox® 30mg/0.3mL, 40mg/0.4mL, 60mg/0.6mL, 80mg/0.8mL, 100mg/mL, 120mg/0.8mL and 150mg/mL Syringes†	Enoxaparin 30mg/0.3mL, 40mg/0.4mL, 60mg/0.6mL, 80mg/0.8mL, 100mg/mL, 120mg/0.8mL and 150mg/mL Syringes (QL varies per strength) Medicaid only	Anticoagulant
Prenatal-U Capsule†	Triveen-U Capsule Medicaid only	Multivitamin
Zegerid® 20mg Capsule††	Omeprazole/Sodium Bicarbonate 20mg Capsule	Proton Pump Inhibitor
Zegerid® 40mg Capsule	Omeprazole/Sodium Bicarbonate 40mg Capsule	Proton Pump Inhibitor

† Not covered on the 2011 Medicare Formulary

QL = Quantity Limit

PA = Prior Authorization

†† Remains covered on the 2011 Medicare Formulary

The following changes have been made to the **WellCare of Georgia Medicaid Preferred Drug List**:

ADDITIONS	REMOVALS
<ul style="list-style-type: none"> Bromhist-NR Drops (AL = age 20 & younger) 	<ul style="list-style-type: none"> Adderall XR® 5mg, 10mg, 15mg, 20mg, 25mg and 30mg Capsules
<ul style="list-style-type: none"> Cavan-Alpha Kit 	<ul style="list-style-type: none"> Desoximetasone 0.05% Cream
<ul style="list-style-type: none"> Dextroamphetamine-Amphetamine ER 5mg, 10mg, 15mg, 20mg, 25mg and 30mg Capsules (QL = 31/31 days) 	<ul style="list-style-type: none"> Eloxatin® 50mg/10mL, 100mg/20mL and 200mg/40mL Vials
<ul style="list-style-type: none"> Diazepam 2.5mg, 10mg and 20mg Rectal Gel (PA, QL = 3/31 days) 	<ul style="list-style-type: none"> Lamotrigine Tab Start Kits (25mg–100mg) (Green and Orange)
<ul style="list-style-type: none"> Epinephrine 0.15mg and 0.3mg Auto-Injectors (QL = 2 pens/31 days) 	<ul style="list-style-type: none"> Veetids® 125mg/5mL Oral Suspension and 500mg Tablet
<ul style="list-style-type: none"> Gianvi™ 3mg–0.02mg Tablet 	
<ul style="list-style-type: none"> Revlimid® 5mg, 10mg, 15mg and 25mg Capsules (PA) 	
<ul style="list-style-type: none"> Tasigna® 150mg Capsule (PA) 	

AL = Age Limit

PA = Prior Authorization

QL = Quantity Limit

The Utilization Management criteria have changed for the following medications as noted below for the **WellCare of Georgia Preferred Drug List**:

DRUG NAME	CHANGE
Concerta 18mg, 27mg, 36mg Tablets (QL = 62/31 days)	ST added

QL = Quantity Limit ST = Step Edit

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

ADDITIONS
• Afinitor® 2.5mg Tablet (PA)
• Amikacin Sulfate 100mg/2mL, 500mg/2mL and 1,000mg/4mL Vials
• Ceftazidime 500mg Vial
• Epinephrine 0.15mg and 0.3mg Auto-Injectors
• Gianvi™ 3 mg–0.02mg Tablet
• HalfLyte® & Bisacodyl Tablets Bowel Prep Kit
• Methylphenidate 5mg/5mL and 10mg/5mL Oral Solutions
• Suboxone® 2mg–0.5mg and 8mg–2mg SL Films (PA)
• Tasigna® 150mg Capsule (PA)

PA = Prior Authorization

Please visit georgia.wellcare.com (Medicaid) or www.wellcare.com (Medicare) to view the current Preferred Drug List and Formulary and pharmacy updates.





LIPID AND GLUCOSE TESTING FOR ATYPICAL ANTIPSYCHOTICS

Atypical, or second-generation, antipsychotics (SGAs) are most often utilized in the treatment of schizophrenia and bipolar disorder. Side effects of these agents can include metabolic complications such as weight gain, hyperglycemia, and hyperlipidemia.

The American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity have recommended guidelines for safe prescribing of atypical antipsychotics—which includes assessing health status, recording screening measurements, and monitoring certain diagnostic test levels at regular frequencies.¹

Based on documented health concerns related to these medications, WellCare reviewed 2008's claims history to understand network prescribing habits and the extent of medical follow-up. Medical care providers prescribed 63 percent of the SGAs, while behavioral health providers prescribed 37 percent. It is important to note that nearly half of the prescriptions were written by pediatricians, and approximately 70 percent of the prescriptions were for members younger than 21; 47 percent were prescribed to children younger than 14.

A review of laboratory data in 2007 showed that 6,589 members were on SGAs. Of those, 13 percent were found to have a lipid screening and 6.9 percent had a glucose test. Reassessment of the data at the end of 2009 showed a slight decrease in lipid and glucose testing.

WellCare will continue to monitor and encourage providers to follow nationally recognized guidelines for the appropriate use and monitoring of atypical antipsychotics. If you have members on second-generation antipsychotics, please bolster your assessment of side effects by ordering fasting serum glucose and a fasting lipid profile upon initiation of therapy, again 12 weeks later, and at least annually thereafter. WellCare is committed to ensuring the appropriate utilization of atypical antipsychotics for our members. Please join us in our efforts to ensure appropriate follow-up and monitoring of these agents.

Sources:

¹ American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care* 2004; 27(2):596-601

DRUG INTERACTIONS

A drug interaction can be defined as an interaction between a drug and another substance that prevents the drug from performing as expected. Two out of every three patients who visit a doctor leave with at least one prescription for medication, according to a 2007 report on medication safety issued by the Institute for Safe Medication Practices. Approximately 40 percent of the U.S. population receive prescriptions for four or more medications, and the rate of adverse drug reactions increases dramatically after a patient is on four or more medications.

When a WellCare of Georgia member presents a prescription at a retail pharmacy, the Walgreens Health Initiatives (WHI) system will indicate if there is a Therapeutic Duplication or Drug-to-Drug interaction based on the medications in the member's profile. This duplication will prompt the retail pharmacist to contact the member's physician to discuss the therapy before processing the prescription. A level 1 interaction is considered major or highly clinically significant; level 2 is moderate. WellCare prescription data shows the most common level 1 interactions occurred with Gemfibrozil and Simvastatin, and with Verapamil and Simvastatin. Tramadol and Cyclobenzaprine along with Alprazolam and Fluoxetine were the most common level 2 interactions.

It is important to remind patients of the significance of drug interactions and the impact it could have on their health. Here are some tips you can share with your patients to reduce their risk of drug interactions:

- Encourage patients to consult their doctor or pharmacist before taking any new drugs, including over-the-counter medications and dietary supplements such as medicinal herbs.
- Remind patients to keep medications in their original containers so that they can easily identify them.
- Use one pharmacy for all of their medication needs.
- Keep all of their health care professionals informed about everything that they take.
- Keep a list of all drugs being taken.
- Take drugs as instructed.

References:

www.fda.gov/consumer/consumernews.html

Drug Interactions: Factors Affecting Response to Drugs. Daniel Hussar, PhD. Merck Manual. April 2007





SATISFIED MEMBERS AND PROVIDERS

WellCare of Georgia Inc., continually strives to deliver and improve member and provider satisfaction. The 2010 Medicaid Child, Medicaid Adult, and Provider Satisfaction surveys showed many improvements in the levels of satisfaction among a variety of categories.

Some highlights from the 2010 Medicaid Satisfaction surveys include:

- 92.8 percent of the parents or guardians of child members reported their doctors explaining things in an understandable way.
- 92.1 percent of the parents or guardians of child members agreed their doctors listened carefully to them.
- 94.4 percent agreed that their doctors showed respect for what the parents or guardians of child members had to say.
- 85.8 percent of parents or guardians of child members highly rated their child's personal doctor.
- 89.1 percent of parents or guardians of child members highly rated their child's specialist.
- 90.9 percent of adult members reported their doctors explaining things in an understandable way.
- 90.5 percent of adult members reported their doctors showed respect for what they had to say.
- 91.1 percent of adult members agreed that they were treated with courtesy and respect by customer service staff.

In the 2010 Provider Satisfaction survey results, there were reported improvements over the 2009 results. These include:

- Process of obtaining pre-certifications, referrals and authorizations.
- Timeliness of Utilization Management's pre-certification process.
- Responsiveness and courtesy of the health plan's provider relations staff.
- Timeliness to answer questions and/or resolve problems.
- Degree to which the plan covers and encourages preventive care and health wellness.

However, there is still room for improvement. Identified areas for improvements include:

- Create new opportunities for practitioners to provide input and make recommendations on ways to improve the health plan.
- Make improvements to the provider orientation process.
- Increase member understanding about their benefits and the referral process.

WellCare thanks all of the providers who have participated in the surveys for their feedback and for their partnership in serving members.

Member and Provider satisfaction surveys are conducted by The Myers Group.



NEW AND REVISED CLINICAL PRACTICE GUIDELINES AVAILABLE

WellCare strives to supply our providers with the most up-to-date clinical practice recommendations. We would like to bring your attention to the newly created and recently updated Clinical Practice Guidelines (CPG).

The CPGs provide you with important information regarding guidelines for the management of certain health conditions.

Newly Created Clinical Practice Guideline:

1. Care of Children and Adolescents with Type I Diabetes Mellitus

Recently Updated Clinical Practice Guidelines:

1. Management of Diabetes Mellitus in Adults 18–75 years of age
2. Management of Asthma in Children and Adults

The Clinical Practice Guidelines are available online at georgia.wellcare.com/provider/pem (Medicaid) and www.wellcare.com/Provider/Resources_GAMedicarePEM (Medicare). Providers can also request hard copies of the CPGs by contacting their Provider Relations representative.

If you need assistance or have questions related to this update, please contact your Provider Relations representative or call our Customer Service team at 1-866-231-1821 (Medicaid) or 1-866-334-7730 (Medicare).



SERVICE REQUEST DENIAL RECONSIDERATION

WellCare reviews all 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 determination based on the medical necessity review. The option of peer-to-peer reconsideration and how to request one 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 determination at 1-866-425-3508, to provide additional clinical information.

Reconsiderations are available to providers within 3 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 supporting the request for services and facilitate timely authorization.

MAGELLAN WEB ACCESS

As a participating WellCare of Georgia provider, you have access to a wealth of information regarding behavioral health and substance abuse care. You can obtain the information by visiting Magellan Health Services' Web site: www.magellanhealth.com



1. Go to www.magellanhealth.com and click on the Behavioral Health tab



2. Click on the Learn More link



3. Click on the I'm A PROVIDER button



4. Click on the Clinical Guidelines link



5. Click on the Clinical Practice Guidelines link

You can go directly to the clinical practice guidelines site by entering this URL in your Web browser:

www.magellanprovider.com/MHS/MGL/providing_care/clinical_guidelines/clin_prac_guidelines/index.asp

You can find clinical practice guidelines on topics such as attention deficit hyperactivity disorder, autism, bipolar disorder, depression, eating disorders and substance use disorders. If you have any questions about the care of a specific WellCare member, please call Magellan at 1-800-424-5412.