



ILLINOIS | 2010 | ISSUE II



# PROVIDER

## Newsletter

### THE IMPORTANCE OF “HEDIS SEASON”

Every year, Harmony Health Plan of Illinois, Inc. (Harmony) and WellCare Health Plans, Inc. (WellCare) are required to report clinical quality measures to the Centers for Medicare & Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS). These measures, based on the Healthcare Effectiveness Data and Information Set (HEDIS®) developed by the National Committee for Quality Assurance (NCQA), are part of an integrated system to establish accountability in managed care.

Harmony/WellCare contracted with Outcomes Health Information Solutions (OHIS) to assist us in reviewing medical records required for HEDIS data collection.

**A representative from OHIS may have contacted your office to schedule appointments for necessary medical record reviews.**

The time frame for the Medicaid reviews is March 1 to May 30.

The time frame for the Medicare reviews is March 1 to June 30.

Your assistance and cooperation are greatly appreciated.

If you have questions, please call Harmony/WellCare at 1-312-630-2025 and ask for the Quality Improvement Department.

### PROVIDER MATERIALS UPDATE

Since our last newsletter was published, the following communications were sent to providers via fax or were posted on the secure sections of the WellCare Web site or the Harmony Health Plan Web site:

- Illinois Winter 2009 Newsletter
- Changes to Preferred Brands of Insulin—Medicare
- Changes to Medication Benefit Process—Medicare
- LabCorp Laboratory Services—Medicare

You can find copies of these materials when you log in to the secure area of [www.wellcare.com](http://www.wellcare.com) (Medicare) or [www.harmonyhpi.com](http://www.harmonyhpi.com) (Medicaid). Use the white box on the right labeled “Member/Provider Secure Sign-In,” then click on the *Provider* tab. You will see *Messages from WellCare* located in the right-hand column. Remember to check the messages regularly to receive new and updated information.

## SUCCESSFUL STRATEGIES TO HELP GET MEMBERS TO VISIT PROVIDERS' OFFICES FOR PREVENTIVE SERVICES

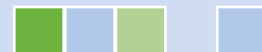
Several Harmony providers shared with us strategies on how they have successfully increased preventive services utilization among members. These strategies include:

- Conduct a well-child visit every time a pediatric member comes into the office, even when the scheduled visit is a sick visit. Documentation in the chart will contain information about the well visit along with the sick visit. When billing for the visit, the preventive medicine services CPT codes (i.e.: 99381–99385) should be utilized. The first ICD-9 code should reflect the well visit (V20.2 and V70.0), and the second ICD-9 code should reflect the reason for the sick visit.
- Collect updated patient demographics at every visit, which will increase contact rates when outreaching to members.
- Use the non-complaint member reports to schedule visits.
  - Call to remind them of their visits 24–48 hours prior to the visit.
  - Confirm that the member came for the visit. If not, call to reschedule and then call to remind them of the new appointment.
  - If the member is a no-show for the second scheduled appointment, send a letter signed by the primary care physician (PCP) to encourage the member to come in. Harmony sends letters encouraging members to get their preventive services; however, a letter from their PCP is more personal and effective.
- Use your member eligibility lists for member outreach.
  - For example, one of Harmony's provider offices assigned one staff member the task of making member outreach phone calls. The staff member utilized the member eligibility list to make the outreach phone calls to their Harmony patients.
  - The non-compliant lists that are sent from Harmony can be used to determine who still has not been in for their services. Office staff can call members every month until they come in for the needed services.
- Update your super-bills, your internal way of coding office visits, to include the correct HEDIS® codes for each targeted measure.

On the next page are scorecards of two physicians in the Harmony Health Plan Medicaid Pay for Quality (PFQ) Program who utilized these strategies to encourage their patients to visit for preventive services.

The PFQ bonus program was implemented to encourage primary care physicians, medical groups and independent practice associations to improve access to, monitoring and/or the provision of certain preventive, screening and disease-specific services (performance indicators) for individuals eligible for and enrolled in Harmony.

The potential bonus is based on the physician's results against the performance indicators and the potential bonus payout targets. The potential bonus payout increases as each compliance target is met. Target 3 provides physicians with the maximum payout that can be achieved for each performance indicator.



### PHYSICIAN 1 SCORECARD

Performance Indicators	Physician's Member Compliance Rate	Target 1	Target 2	Target 3
Appropriate Medications for Asthma - Ages 5–56	100%	90%	93%	96%
Breast Cancer Screening	60%	49%	55%	60%
Cervical Cancer Screening	75%	62%	67%	72%
Childhood Immunization Status (Combo 3)*	0%	58%	66%	70%
Comprehensive Diabetes/HbA1c Test	100%	74%	79%	84%
Lead Screening in Children	23.5%	55%	65%	75%
Pre/Postpartum Care - Postpartum	0%	54%	61%	66%
Pre/Postpartum Care - Prenatal	0%	79%	84%	87%
Well-Child Visit 15 Months (6 visits or more)	25%	52%	59%	70%
Well-Child Visit 3–6 Years	75%	63%	70%	75%

\* Combo 3 = 4 DTaPs, 3 IPV's, 1 MMR, 2 HIB, 3 Hepatitis B, 1 VZV, and 4 Pneumococcal Conjugate

This physician received Pay-for-Quality (physician incentive) in five of the 10 measures. All measures met the Target 3 benchmark.

### PHYSICIAN 2 SCORECARD

Performance Indicators	Physician's Member Compliance Rate	Target 1	Target 2	Target 3
Appropriate Medications for Asthma - Ages 5–56	83%	90%	93%	96%
Breast Cancer Screening	50%	49%	55%	60%
Cervical Cancer Screening	83.1%	62%	67%	72%
Childhood Immunization Status (Combo 3)*	42.6%	58%	66%	70%
Comprehensive Diabetes/HbA1c Test	66.7%	74%	79%	84%
Lead Screening in Children	57.4%	55%	65%	75%
Pre/Postpartum Care - Postpartum	54.5%	54%	61%	66%
Pre/Postpartum Care - Prenatal	54.5%	79%	84%	87%
Well-Child Visit 15 Months (6 visits or more)	50%	52%	59%	70%
Well-Child Visit 3–6 Years	88.6%	63%	70%	75%

\* Combo 3 = 4 DTaPs, 3 IPV's, 1 MMR, 2 HIB, 3 Hepatitis B, 1 VZV, and 4 Pneumococcal Conjugate

This physician received Pay-for-Quality (physician incentive) in five of the 10 measures. Three measures met the Target 1 benchmark, and two measures met the Target 3 benchmark.

## PROVIDER FORMULARY UPDATE

### GENERIC NEWS

The generic drugs listed below are now available to WellCare's **Medicare** members at the lowest cost-sharing benefit:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Acular® 0.5% ophthalmic drops	Ketorolac Tromethamine 0.5% ophthalmic drops	Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
Acular LS® 0.4% ophthalmic drops	Ketorolac Tromethamine 0.4% ophthalmic drops	Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
Alphagan® P 0.15% ophthalmic drops	Brimonidine Tartrate 0.15% ophthalmic drops	Antiglaucoma Agents
Phenytek® 200mg, 300mg extended-release capsules	Phenytoin Sodium 200mg, 300mg extended-release capsules	Anticonvulsants–Hydantoins
Razadyne® 4mg/mL solution	Galantamine Hydrobromide 4mg/mL solution	Alzheimer's Agent– Cholinesterase Inhibitors
Starlix® 60mg, 120mg tablets	Nateglinide 60mg, 120mg tablets	Antidiabetic Agents– Meglitinides
Valtrex® 500mg, 1gm caplets	Valacyclovir Hydrochloride 500mg, 1gm caplets (QL: 62 caplets/31 days)	Anti-infective Agents–Antivirals

QL = Quantity Limit

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

ADDITIONS	
Adcirca® 20mg tablets (PA)	Morphine Sulfate 1mg/mL syringe
Buprenorphine 2mg, 8mg SL tablets	Piperacillin-Tazobactam 2.25gm, 3.375gm, 4.5gm, 40.5gm vial
Capastat® Sulfate 1gm vial	Sabril® 500mg tablets (PA)
Cervarix® Vaccine (PA)	Saphris® 5mg, 10mg SL tablets (PA)
Codeine Sulfate 15mg, 30mg, 60mg tablets (QL: 248 tablets/31 days)	Seromycin® 250mg capsules
Hiberix® Vaccine	Trecator® 250mg tablets
Lamotrigine Tablet Starter Kit	Venlafaxine ER 37.5mg, 75mg, 150mg, 225mg tablets (QL: 31 tablets/31 days)
Metadate® ER 20mg tablets	Votrient™ 200mg tablets (PA)

PA = Prior Authorization    QL = Quantity Limit

### PLANNED DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Roche	Vesanoid® capsules	Dec. 14, 2009	Vesanoid® capsules are a non-formulary medication that was removed from the market on Dec. 14, 2009.
Eli Lilly	Humulin® 50/50 Insulin	Dec. 31, 2009	Humulin® 50/50 Insulin is no longer available from Eli Lilly. Beginning Jan. 1, 2010, Humulin® 50/50 was no longer a covered benefit on WellCare plans.

## CMS FURNISHES SCREENING FOR HIV IN HIGH-RISK MEDICARE POPULATIONS

The Centers for Medicare & Medicaid Services (CMS) clarified its obligation to furnish human immunodeficiency virus (HIV) screening to members with high-risk profiles, given the recent national coverage decision (NCD) on this particular screening.

Effective Jan. 1, 2010, WellCare covers both standard and U.S. Food and Drug Administration (FDA)-approved HIV rapid screen tests for people at risk. These tests are covered under basic lab services.

The CMS guidelines state these tests must be covered for:

- Annual voluntary HIV screening of Medicare members at increased risk for HIV infection per U.S. Preventive Services Task Force (USPSTF) guidelines, including:
  - Men who have had sex with men after 1975;
  - Men and women having unprotected sex with multiple partners;
  - Past or present injection drug users;
  - Men and women who exchange sex for money or drugs, or have sex with partners who do;
  - Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users;
  - Persons being treated for sexually transmitted diseases;
  - Persons with a history of blood transfusion between 1978 and 1985;
  - Persons who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.
- Voluntary HIV screening of pregnant Medicare members when the diagnosis of pregnancy is known, during the third trimester and at labor.

If you have any questions about these covered tests or this benefit, please call Customer Service at **1-866-334-6876**.

*Source: Centers for Medicare & Medicaid Services. Decision Memo for Screening the Human Immunodeficiency Virus (HIV) Infection (CAG-00409N). Available at <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?from2=viewdecisionmemo.asp&id=229&>.*

## WEB REGISTRATION IS FAST AND EASY

To take advantage of WellCare and Harmony's Web sites, go to [www.harmonyhpi.com](http://www.harmonyhpi.com) for Medicaid and [www.wellcare.com](http://www.wellcare.com) for Medicare and follow these simple steps:

1. Create a new account using the *Sign up Here* link that appears on the home page. The *Register Here* link on the top right side of the following page will direct you to the Provider Registration form.
2. Complete the registration form. Your WellCare/Harmony-issued Provider ID appears in your welcome packet and on your Explanation of Payment copies.
3. Create a user name. A confirmation page will be displayed. You should print this page for your records.
4. Receive a registration e-mail. Within 24 hours of registration, you will receive an e-mail with a temporary password that will expire in 30 days. Use this password to log on to the WellCare/Harmony Web site and create a password of your preference.

Be sure to keep your user name and password information somewhere safe for future reference.



# HARMONY HEALTH PLAN OF ILLINOIS

## HEDIS® MEASURES THROUGH CLOSE OF YEAR 2010 THROUGH 2011

The chart below includes descriptions of the components of targeted Healthcare Effectiveness Data and Information Set (HEDIS®) measures for the Harmony Health Plan of Illinois, Inc. Medicaid population. The primary CPT codes and diagnosis codes, which will appropriately identify the services rendered as meeting the HEDIS specifications, are also included. These are the codes that will be accepted by the state of Illinois.

DESCRIPTIONS OF MEASUREMENTS AND PRIMARY CODES		
<p><b>1. Well-Child Visits in the First 15 Months of Life</b>                      Children who turned 15 months old during 2010 and <u>had six or more</u> well-child visits (EPSDT) with a PCP.</p> <ul style="list-style-type: none"> <li>• A comprehensive health and developmental history—physical health, mental health (including social, emotional and behavioral issues), development and nutrition</li> <li>• A comprehensive unclothed physical exam—measurements, height, weight, head circumference, general appearance, head, neck, eyes, ears, cardiovascular, respiratory, gastrointestinal, neurological evaluation, reproductive systems and breast, musculoskeletal, lymphatic system, integument, speech patterns, orientation and mental alertness, parent and child interaction and behavior</li> <li>• Health education/anticipatory guidance—oral health, infant care, parent interaction, injury/illness prevention and community resources</li> <li>• Immunizations and lead testing—up to date</li> </ul>	<p><b>Primary CPT Codes</b></p> <ul style="list-style-type: none"> <li>• 99381 (new patient; younger than 1 year)</li> <li>• 99382 (new patient; age 1–4 years)</li> <li>• 99391 (established; younger than 1 year)</li> <li>• 99392 (established; age 1–4 years)</li> <li>• 99461 (initial care; Evaluation &amp; Management of newborn)</li> </ul>	<p><b>Primary ICD-9 Diagnosis Codes</b></p> <ul style="list-style-type: none"> <li>• V20.2</li> <li>• V70.0</li> <li>• V70.3</li> <li>• V70.5</li> <li>• V70.6</li> <li>• V70.8</li> <li>• V70.9</li> </ul>
<p><b>2. Well-Child Visit 3–6 Years of Life</b>                      Children who were 3, 4, 5 or 6 years of age during 2010 and had one or more well-child visits (EPSDT) with a PCP.</p> <p>Documentation from the medical record must include a note indicating a visit with a primary care physician (PCP), the date the well-child visit occurred and evidence of ALL of the following:</p> <ul style="list-style-type: none"> <li>• A comprehensive health and developmental history—physical health, mental health (including social, emotional and behavioral issues), development and nutrition</li> <li>• A comprehensive unclothed physical exam—measurements, height, weight, head circumference, general appearance, head, neck, eyes, ears, cardiovascular, respiratory, gastrointestinal, neurological evaluation, reproductive systems and breast, musculoskeletal, lymphatic system, integument, speech patterns, orientation and mental alertness, parent and child interaction and behavior</li> <li>• Health education/anticipatory guidance—oral health, health/safe habits, social competence, injury/illness prevention and community resources</li> <li>• Immunizations and lead testing—up to date</li> </ul>	<p><b>Primary CPT Codes</b></p> <ul style="list-style-type: none"> <li>• 99382 (new patient; age 1–4 years)</li> <li>• 99383 (new patient; age 5–11 years)</li> <li>• 99392 (established; age 1–4 years)</li> <li>• 99393 established; age 5–11 years)</li> </ul>	<p><b>Primary ICD-9 Diagnosis Codes</b></p> <ul style="list-style-type: none"> <li>• V20.2</li> <li>• V70.0</li> <li>• V70.3</li> <li>• V70.5</li> <li>• V70.6</li> <li>• V70.8</li> <li>• V70.9</li> </ul>
<p><b>3. Lead Screening</b>                      Children who received at least two capillary or venous lead tests:</p> <ul style="list-style-type: none"> <li>• First test by first birthday; and the</li> <li>• Second test by second birthday</li> </ul>	<p><b>Primary CPT Code</b></p> <ul style="list-style-type: none"> <li>• 83655</li> </ul>	

*Continued on next page*

## DESCRIPTIONS OF MEASUREMENTS AND PRIMARY CODES *continued*

<p><b>4. Childhood Immunization Status</b> Children who turn 2 years of age during 2010 and have had the vaccinations listed below on or before their second birthday. Documentation from the medical record must include ALL of the following:</p> <ul style="list-style-type: none"> <li>• 4 DTaP (do not count any before 42 days of age)</li> <li>• 3 IPV (do not count any before 42 days of age)</li> <li>• 1 MMR</li> <li>• 2 HiB (do not count any before 42 days of age)</li> <li>• 3 Hepatitis B</li> <li>• 1 VZV, positive serology or documented chicken pox disease on or before second birthday</li> <li>• 4 pneumococcal conjugate (do not count any before 42 days of age)</li> <li>• 2 Hepatitis A</li> <li>• 2 or 3 Rotavirus (depending on which vaccination is administered, do not count any before 42 days of age)</li> <li>• 2 Influenza (do not count any before 6 months of age)</li> </ul>	<p><b>Primary CPT Codes:</b>  <b>DTaP:</b> 90698 (Combo DTaP+ Hib+ IPV), 90700, 90721 (combo DTaP+Hib), 90723 (combo DtaP+Hep B+ IPV)  <b>IPV:</b> 90698 (Combo DTaP+ Hib+ IPV), 90713, 90723 (combo DtaP+Hep B+ IPV)  <b>MMR:</b> 90707, 90710 (MMRV - measles, mumps, rubella and varicella)  <b>Hib:</b> 90645-90648, 90698 (Combo DTaP+ Hib+ IPV), 90721 (combo DTaP+Hib), 90748 (combo Hep B+Hib)  <b>Hepatitis B:</b> 90723 (combo DtaP+Hep B+ IPV), 90740 (3-dose schedule), 90744 (3-dose schedule), 90747 (4-dose schedule), 90748 (combo Hep B+Hib)  <b>VZV:</b> 90710 (MMRV - measles, mumps, rubella and varicella), 90716  <b>Pneumococcal conjugate:</b> 90669  <b>Hepatitis A:</b> 90633  <b>Rotavirus (2-dose schedule):</b> 90681  <b>Rotavirus (3-dose schedule):</b> 90680  <b>Influenza:</b> 90655, 90657</p>	
<p><b>5. Use of Appropriate Medications for People With Asthma</b> Patients 5–50 years of age during 2010 who were identified as having at least one filled prescription for the appropriate therapy.</p>	<p><b>Primary Appropriate Medications:</b> Anti-asthmatic combinations; antibody inhibitors; inhaled steroid combinations; inhaled corticosteroids; leukotriene modifiers; mast cell stabilizers; methylxanthines.</p>	
<p><b>6. Timeliness of Prenatal Care</b> Deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment with Harmony.</p>	<p><b>FOR OB/GYNs ONLY:</b>  <b>Primary CPT Codes with an ICD-9 Diagnosis Code:</b>            99201-99205, 99211-99215, 99241-99245; V22.x-V23.x, v28.x  <b>or</b>  <b>FOR OB/GYNs, PCPs, FAMILY PRACTICE PHYSICIANS:</b>  <b>Primary CPT II Codes:</b>            0500F (initial prenatal visit) or 0502F (subsequent prenatal visits)</p>	
<p><b>7. Timeliness of Postpartum Care</b> Deliveries that received a postpartum visit <i>on or between</i> 21 to 56 days after delivery.</p>	<p><b>Primary CPT Codes:</b> 57170, 59430</p>	<p><b>ICD-9 Diagnosis Codes:</b> V24.1, V24.2, V25.1</p>
<p><b>8. Cervical Cancer Screening</b> Women 24 to 64 years old with one or more Pap tests during 2010, 2009 or 2008.</p>	<p><b>Primary CPT Codes:</b> 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174-88175</p>	<p><b>ICD-9 Diagnosis Codes:</b> V72.32, V76.2</p>
<p><b>9. Breast Cancer Screening</b> Women 42 to 69 years old who had one or more mammogram(s) during 2010 or 2009.</p>	<p><b>Primary CPT Codes:</b> 77055 (unilateral), 77056-77057 (bilateral)</p>	<p><b>ICD-9 Diagnosis Codes:</b> V76.11, V76.12</p>
<p><b>10. HbA1C Testing/Comprehensive Diabetes Care</b> Members 18–75 years of age with diabetes (Type 1 and Type 2) who had at least one HbA1C test during 2010.</p>	<p><b>Primary CPT Codes:</b> 83036, 83037</p>	<p><b>Primary CPT II Codes:</b> 3044F, 3045F, 3046F</p>

## EFT HELPS YOU RECEIVE PAYMENTS FASTER

You can receive your WellCare/Harmony payments faster by signing up to receive electronic funds transfer (EFT) through our payment partner, Payformance.

Registration is quick and simple.

1. Obtain your registration letter or contact your Provider Relations representative for your registration code.
2. Once you have your registration code, go to the PaySpan Health Web site at [www.payspanhealth.com](http://www.payspanhealth.com). The Web site will walk you through the 5- to 10-minute registration process. The article to the right outlines these steps. You will receive a deposit from Payformance that you'll need to confirm. EFT payments are typically received 2 to 5 days sooner than paper checks.

If you have questions, please contact your Provider Relations representative, or call Provider Services at 1-866-334-6876 (Medicare) or 1-800-504-2766 (Medicaid). You can also contact Payformance at 1-877-331-7154 Monday through Friday, 7am to 9pm Eastern.

### MEDICARE

## CHANGES TO MEDICARE REDETERMINATION PROCESS FOR MEDICATION BENEFITS

EFFECTIVE JAN. 1, 2010

WellCare has changed how Medicare redeterminations (appeals) are being processed effective Jan. 1, 2010.

In order to facilitate redetermination requests and to offer better service to our providers and members, WellCare made the decision to have medical benefit claim redeterminations and medication benefit redeterminations processed separately.

Beginning Jan. 1, 2010, if you would like to request an appeal for a medication benefit, please utilize the following contact information:

To request a **medication appeal** for a Medicare member, mail or fax a completed Medication Appeal Request form to:

WellCare Health Plans, Inc.  
Attn: Pharmacy Appeals  
P.O. Box 31383  
Tampa, FL 33631-3383  
Fax: 1-866-388-1766

The Medicare Medication Appeal Request form is available at [www.wellcare.com](http://www.wellcare.com) under your state's *Provider Manual Forms*. You may also contact us regarding any questions or concerns you have about medication appeals by using the Customer Service telephone number on the *Quick Reference Guide* (QRG) found at [www.wellcare.com](http://www.wellcare.com).

Redetermination (appeal) requests for **medical benefits** and **claims** will be handled in the same manner as in the past. This information can be found on the *Quick Reference Guide* available on the provider Web site at [www.wellcare.com](http://www.wellcare.com).

# HOW TO REGISTER AS A PROVIDER ON PAYSPAN HEALTH'S WEB SITE

If you'd like to receive your WellCare/Harmony payments faster, simply sign up for EFT payments at PaySpan Health's Web site. The registration process is outlined below.

## TO BEGIN REGISTRATION:

1. Navigate to [www.payspanhealth.com](http://www.payspanhealth.com).
2. Click the orange *Secure Registration* button.
3. A screen will appear for you to enter your registration code.
4. Type in the registration code from the registration letter, or use the code given to you by your Provider Relations representative.
5. Click the *OK* button.
6. The *Welcome Page* screen will appear:
7. Type in your Payee Identification Number (PIN) and Tax Identification Number (TIN). The PIN/Vendor is the payee ID assigned by the payer.
8. Click the *Begin* button to start the registration process.

## STEP 1: THE REGISTRATION INFORMATION SCREEN WILL APPEAR.

1. Complete the required registration information questions.
2. The e-mail address will become your user name when logging in to the PaySpan Health Web site.
3. Click on the *Next* button to continue to Step 2.

## STEP 2: THE ACCOUNTING INFORMATION SCREEN WILL APPEAR.

1. Type in an account name to identify the receiving account.

**Note:** Providers typically use the account name to specify the payee designation (i.e., General Hospital may be paid by Community Health Plan to separate payee accounts such as General Hospital ER and General Hospital Labs). Each payee will have a separate registration code and can therefore have a separate receiving account established. The same routing and account number can be used for multiple receiving accounts.

2. Enter the routing number and account number in the specified fields.
3. Click the *Next* button to continue to Step 3.

## STEP 3: THE TERMS AND CONDITIONS SCREEN WILL APPEAR.

1. Review the registration information.
2. Click the *Edit* button to make any corrections.
3. Read the service agreement then check the terms and conditions box if in agreement.
4. Click the *Submit* button.

This will complete the registration process.

You will receive an e-mail confirmation of your completed registration. In a few days, you will need to verify with your bank that a minimal deposit has been made by Payformance. This deposit amount will be used to confirm that your electronic payments are set up appropriately through PaySpan Health and your bank. You will see this confirmation page the next time you log in to [www.payspanhealth.com](http://www.payspanhealth.com) using your user name (your e-mail address) and your password.

If you have any questions about the registration process or the PaySpan Health Web site, please contact Payformance's Provider Support Team at **1-877-331-7154** Monday through Friday, 7am to 9pm Eastern.



# WHAT MEDICAID MEMBERS ARE SAYING

## MEMBER SATISFACTION SURVEY RATINGS

Every year, Harmony Health Plan of Illinois, Inc. works with a research firm to survey members or parents/guardians of members to rate their satisfaction with Harmony Health Plan and the providers. The survey used is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS). It aims to capture accurate and complete information related to the members' experiences with health care and the services provided by the plan. The results are shown below for Harmony Health Plan.

CAHPS Measures—Adult	Rate 2009	Quality Compass Mean	Percentage Difference
Getting Needed Care	60.3%	76.4%	-16.1%
Getting Care Quickly	74.6%	80.4%	-5.8%
How Well Doctors Communicate	86.0%	86.8%	-.8%
Shared Decision-Making	58.8%	58.5%	+3.3%
Coordination of Care	69.4%	76.4%	-7.0%
Rating of Doctor	71.0%	76.2%	-5.2%
Rating of Health Care	60.2%	67.4%	-7.2%

CAHPS Measures—Child	Rate 2009	2008 National CAHPS Benchmarking Database	Percentage Difference
Getting Needed Care	46%	50%	-4.0%
Getting Care Quickly	63%	69%	-6.0%
How Well Doctors Communicate	71%	75%	-4.0%
Shared Decision-Making	64.8%	65.3%	-.5%
Coordination of Care	67.3%	77.4%	-10.1%
Rating of Doctor	78.3%	83.9%	-5.6%
Rating of Health Care	66.8%	79.9%	-13.1%

Both the Adult and Child CAHPS survey results indicate there are opportunities to improve member satisfaction. Harmony has identified a number of action steps it will take during the upcoming year targeted at improving member satisfaction.

We encourage you and your staff to join the effort to improve member satisfaction, specifically in the areas of communication and shared decision-making. Listening to patients, spending enough time to ensure patients understand their condition and treatment plan, and including patients in treatment decisions all contribute to improved patient satisfaction.

If you have questions regarding the CAHPS results, please contact the Plan at 1-312-630-2025 and ask for the Quality Improvement Department.

## MEDICARE

### SEE THE VALUE OF ANNUAL EYE EXAMS

Please encourage your patients to get an annual eye examination. It is WellCare's goal for every Medicare member to receive a routine eye exam annually. If you have patients who have not yet had an annual eye exam, please remind them to schedule an appointment.

Consult the *Quick Reference Guide* to refer members to the appropriate contracted vision vendor.

## UNDERSTANDING MEMBER COST-SHARING

### WELLCARE COORDINATED CARE PLANS

#### What is cost-sharing?

Cost-sharing is the amount a member pays for health care and/or prescriptions. This amount can include co-payments, coinsurance and/or deductibles.

Providers should collect the applicable cost-share from the member at the time of the service when possible. Some members qualify for state programs to help them pay their out-of-pocket costs for Medicare. Members enrolled in these programs may still have to pay a Medicaid co-payment, depending on the rules in their state.

#### Would there ever be more than one co-payment due from a member in a single day?

Yes, there are certain situations when a member would be responsible for more than one co-payment in a single day.

1. If a member sees more than one provider on a given day, he or she would be responsible for the appropriate co-payment for each provider. For example, if a member has office visits with a PCP and a specialist on the same day, even if they are in the same office, he or she would be responsible for both the PCP and the specialist co-payments.
2. If a member has more than one diagnostic test or procedure in an outpatient or office setting on a single day, he or she would be responsible for the appropriate outpatient or office co-payment, plus the co-payment for each *category* of diagnostic services.

As an example, please refer to the chart below:

CATEGORY OF SERVICES	2010 AMOUNT
Lab services (i.e., urinalysis)	\$0 co-payment
Basic diagnostic radiological services (i.e., flat film X-ray)	\$0 co-payment
Basic diagnostic tests (i.e., allergy test)	\$20 co-payment
Advanced diagnostic tests (i.e., cardiac stress test)	\$50 co-payment
Advanced diagnostic radiological services (i.e., MRI)	\$50 co-payment

Let's say a member has an allergy test and a cardiac stress test performed by a single provider on the same day. By referring to the chart above, we can see that the member would be responsible for a \$20 co-payment for the allergy test, plus a \$50 co-payment for the cardiac stress test. If a member has these services performed in an outpatient facility, then he or she would be responsible for the appropriate outpatient facility co-payment amount, plus the allergy test and cardiac stress test co-payments.

For additional information, visit [www.wellcare.com](http://www.wellcare.com) or call Provider Services at 1-866-334-6876.





Harmony Health Plan  
200 W. Adams Street, Suite 800  
Chicago, IL 60606

IL012327\_WCG\_NEW\_ENG  
©WellCare 2010 IL\_04\_10

31456

## WHAT'S THE DIFFERENCE BETWEEN AN APPEAL AND A CLAIM DISPUTE?

You should file an appeal if you disagree with an adverse organization determination. In most cases, these are related to authorization denials, claim denials or denials for reimbursement (typically related to the member paying out-of-pocket for services and requesting reimbursement from the health care plan).

A contracted provider has the right to appeal authorization denials, or claim denials related to lack of, or in excess of, authorization.

Appeals should be sent to:

WellCare Health Plans, Inc.  
P.O. Box 31368  
Tampa, FL 33631

If you believe that there has been an error in payment, or you believe a claim payment did not follow guidelines,

you have the right to dispute the payment amount by submitting a claim dispute. Claim disputes can include:

- A claim denial for timely filing
- Coding- or billing-related issues
- A dispute in the amount paid on a claim

Claim disputes should be sent to:

WellCare Health Plans, Inc.  
P.O. Box 31372  
Tampa, FL 33631

For more information about appeals or claims disputes, please refer to the telephone numbers on the *Quick Reference Guides* available on the provider Web site at [www.wellcare.com](http://www.wellcare.com) (Medicare) or [www.harmonyhpi.com](http://www.harmonyhpi.com) (Medicaid).