



ILLINOIS | 2011 | ISSUE II

PROVIDER

Newsletter

MEDICAID

WELL-CHILD VISIT COMPONENT: ANTICIPATORY GUIDANCE

Health Education/Anticipatory Guidance is a component of Well-Child and EPSDT (Early and Periodic Screening, Diagnostic and Treatment) visits. This component is intended to assist families in understanding what to expect in regard to the child's development, to present information on healthy lifestyles, and to provide advice on accident and disease prevention.

Anticipatory Guidance provides age-appropriate information, and based on the provider's observation and assessment of needs, can be personalized to address individual concerns. Anticipatory Guidance discussions may be supplemented with educational handouts.

Topics may include safety, injury prevention, parenting practices or peer pressure. Safety issues addressed at a newborn Well-Child Visit may include bath temperature or crib safety. While safety issues addressed at an adolescent Well-Child Visit may discuss sport safety or safe-driving practices.

Medical record reviews of EPSDT visits and HEDIS® Well-Child Visit measures require evidence of provided Health Education/Anticipatory Guidance. Compliance with these medical record reviews requires documentation of Health Education/Anticipatory Guidance discussed at the Well-Child Visit. The use of preprinted Well-Child/EPSDT Visit documentation forms may assist in fulfilling this requirement.

Harmony Health Plan has preprinted Well-Child Visit/EPSDT forms available. If you would like to obtain a copy, please call the Quality Improvement Department at 1-312-777-5104.

A list of Anticipatory Guidance topics designated by child's age can be found in the appendix of The Illinois Department of Healthcare and Family Services Handbook for Providers of Healthy Kids Services.

Source: Handbook for Providers of Healthy Kid Services IL Department of Healthcare and Family Services: March 2008

PROVIDER UPDATE

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

- HEDIS® "Measures of the Month" (e-mails)
- WellCare/Harmony to Launch Provider E-mail Communications
- Illinois 2011 Issue I Provider Newsletter
- 2011 Model of Care Self-Study Program

You can find copies of some of these correspondences, when you log in to the secure area of www.wellcare.com (Medicare) or www.harmonyhpi.com (Medicaid) via the sign-in on the right that says "Member / Provider Secure Sign-In." Once logged in, click on the Provider tab and you will see *Messages from WellCare* located in the right-hand column. Remember to check the messages regularly to receive new and updated information.



MEDICAID

MEMBER RIGHTS AND RESPONSIBILITIES

Illinois law requires that health care providers or health care facilities recognize members' rights while they are receiving medical care and that the member respect the health care provider's or facility's right to expect certain behavior on the part of patients. Members may request a copy of the full text of this law from their health care provider or health care facility. A summary of their rights and responsibilities is as follows:

- To be treated with respect and courtesy by their PCP and all office staff members and staff members of Harmony Health Plan.
- To get information about the plan, its services, its Primary Care Providers (PCPs) and health care providers and member rights and responsibilities.
- To choose their own doctor within the Harmony Health Plan network.
- To be told about their treatment plan, before treatment begins.
- To decide with their PCP on the type care they should receive.
- To get information about the plan, its services, its Primary Care Providers (PCPs) and health care providers.
- To receive care consistent with sound nursing and medical practices.
- To talk openly about care they need for their health, regardless of cost or benefit coverage, as well as choices and risks involved. The information must be given in a way they can understand.
- To refuse treatment to the extent of the law and to be told of the outcome.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To voice concerns or complaints about the program and receive prompt answers.
- To have input in the Plan's member rights and responsibilities.
- To request information relating to Harmony's Physician Incentive Plan.
- To request a description of the financial relationships between Harmony and any health care provider. They can also ask for the percentage of total premiums spent on health care-related expenses and the percentage of total premiums spent on other expenses, including administrative expenses.

- They have the right to request the following information from Harmony’s participating health care providers:
 - Copy of the total bill for services they received from their health care provider.
 - Educational background, experience, training, specialty and board certification.
 - The names of the licensed facilities in Harmony’s network where the health care provider presently has privileges for the treatment, illness or procedure they are inquiring about.
 - Information about the health care provider’s participation in continuing education programs.
 - Compliance with licensure, certification or registration requirements.

THEIR RESPONSIBILITIES

As a member of Harmony Health Plan they have the following responsibilities:

- To treat their PCP and office staff with courtesy and respect.
- To fully inform their doctor about their medical problems.
- To decide about having a medical treatment or procedure before it begins.
- To help their PCP obtain their medical records.
- To give information that the plan and its PCPs and health care providers need to provide care.
- To follow plans and instructions for care that they have agreed on with their health care provider.
- To understand their health problems.
- To help set treatment goals that they and their Health Care Provider agree to.
- To not seek care from a specialist, unless referred by their PCP.
- To not seek care in an emergency room for conditions that are not life threatening without contacting their PCP.
- To keep all scheduled appointments and be on time.
- To follow the rules and regulations of Harmony Health Plan.

APPEALING AN ADVERSE DETERMINATION

When an adverse determination has been rendered, a provider may request an appeal of the decision within the time frame specified on the provider evidence of payment (EOP)/provider remittance advice.

The request must be submitted to the following address:

**WellCare Health Plans/Harmony Health Plan
P.O. Box 31368
Tampa, FL 33631-3368**

The request should include information as to why the denial should be reversed. Pertinent documentation that supports the service provided should be included with the appeal request.

Once the case is received, the file will be reviewed by someone who was not previously involved in the initial determination. The Plan will conduct a review of the request that does not give deference to the denial decision. The Plan will also fully investigate the content of the appeal, including all aspects of clinical care involved.

A decision will be rendered to the provider within **15 business days**. Information regarding additional appeal rights, if applicable, will also be included in the appeal outcome letter.

Upon request, a copy of the clinical rationale used in making the appeal decision will be provided.

TAKE POSITIVE ACTION IN MANAGING MEDICATIONS

SIMPLE INTERVENTIONS PROMOTE PROPER DRUG USE, PATIENT SAFETY

WellCare/Harmony encourages providers to make sure your patients are using the medications they need in the way they should be used. Some proactive steps you can take in this area can drive beneficial outcomes for patients.

Providers can almost instantaneously improve their patients' health care status by systematically re-assessing the indications for and dosages of all of the medications (including herbal, over-the-counter and topical preparations) used by their patients. It's also the perfect time to uncover the use of illicit drugs and improper consumption of alcoholic beverages.

For patients on a daily medication regimen, the use of a pill carrier, or even two if a patient is on an AM-PM dosing schedule, will help with compliance. Encouraging the use of this user-friendly tool can keep your patients on track with what medications they need to take and when.

Do you ask your patients if they keep an up-to-date list of all their medications in their wallet or purse? Does the list also include their known allergies? If not, you may want to encourage them to do so.

When a patient goes to an emergency room or sees a specialist, a list of his/her current medications can keep his/her care on track, highlighting the need to treat the complete patient and potentially avoiding harmful drug-drug interactions.

For Medicare patients discharged from an acute or non-acute facility, remember that the prescribing practitioner or clinical pharmacist should reconcile the discharged medications with the most recent medication list in the patient's medical record. This should be completed within 30 calendar days of discharge. An outpatient visit isn't required, just documentation in the patient's medical record that the reconciliation was conducted. Medical record documentation should include:

- Notation that medications prescribed upon discharge were reconciled with current medications by the appropriate practitioner, or
- Medications listed in the discharge summary present on the outpatient medical record and evidenced by reconciliation with current medications by the appropriate practitioner, or
- Notation that no medications were prescribed upon discharge.

S*T*A*R*T CAN STOP THE CYCLE

ENCOURAGE PATIENTS TO QUIT SMOKING

Quitting smoking works best when the person is prepared. Help your patients start by communicating a new acronym, **START**, which stands for these five important steps:

S = **Set** a quit date.

T = **Tell** family, friends and coworkers that you plan to quit.

A = **Anticipate** and plan for the challenges you'll face while quitting.

R = **Remove** cigarettes and other tobacco products from your home, car and work.

T = **Talk** to your doctor about getting help to quit.

For more information, visit www.smokefree.gov.

Source: <http://www.smokefree.gov/qg-preparing-steps.aspx>, January 2011.

WELLCARE'S MAIL-ORDER PHARMACY SERVICE

AN EASY WAY FOR YOUR PATIENTS TO SAVE

With WellCare's new mail-order pharmacy service, your patients can now have the medications they take every month mailed directly to their home. It's easy, convenient (no more waiting in lines at the retail pharmacy) and accurate. They will also save money! By using WellCare's mail-order service, they will receive a three-month supply of medication for only two-and-a-half monthly co-pays.

Simply call 1-866-892-9006, Monday–Friday, from 8 a.m. to 6:30 p.m. Eastern, to get your patients started. Or fax their maintenance medication prescriptions to 1-866-892-8194. Remember to prescribe the maximum days' supply (93 days) plus refills for up to one year.

Because the pharmacy team at WellCare's mail-order service has a deep understanding of the insurance process, they will work with your office to obtain all necessary information, allowing your patients to receive their medications promptly.



CLAIMS CORNER

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 a lack of, or in excess of, authorization.

Appeals should be sent to:

WellCare Health Plans/Harmony Health Plan
P.O. Box 31368
Tampa, FL 33631

If you believe 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

Please be advised that the P.O. Box for claim disputes has changed since this article was last published in Issue II 2010. The updated P.O. Box is included below.

Claim disputes should be sent to:

WellCare Health Plans/Harmony Health Plan
P.O. Box 31370
Tampa, FL 33631-3370

Payment policy disputes (i.e., denials starting with IHXXX, MKXXX, or PDXXX) should be sent to:

WellCare Health Plans/Harmony Health Plan
P.O. Box 31426
Tampa, FL 33631-3426

For more information about appeals or claim disputes, please refer to the telephone numbers on the Quick Reference Guides, available on the provider website at www.wellcare.com (Medicare) or www.harmonyhpi.com (Medicaid).



EMPOWER PATIENTS TO MANAGE THEIR ASTHMA

As a provider, you can help your patients manage their asthma by continuously educating them in these areas, as outlined in the *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma — Full Report, 2007*:

1. **Self-assessment and monitoring:** Encourage patients to keep a daily log of their peak flow volume upon waking and going to bed to detect subtle changes in their lung function. Spirometry testing is advised at least yearly.
2. **Patient education:** You play a crucial role in teaching a patient the skills he or she needs to self-monitor asthma and when to seek medical care. According to a report, only 34 percent reported receiving an asthma management plan with specific instructions on how to change the amount or type of medicine taken, when to call a doctor for advice, and when to go to the emergency department.¹ Reinforce how to handle exacerbations using a written asthma action plan. The templates for asthma action plans may be accessed at www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf.
 - Refer WellCare/Harmony members to our Disease Management program by calling 1-866-635-7045. This program provides telephonic education from an RN, at no cost to the member, to reinforce their understanding of asthma and adherence to their asthma action plan.
3. **Medications:** Help patients understand the importance of compliance with maintenance medications and the rationale for following the National Heart, Lung, and Blood Institute's Stepwise treatment guidelines. Consider referral to an asthma specialist for Step 3 and above or if difficulties persist in controlling asthma.²

National Heart, Lung, and Blood Institute's Stepwise treatment guidelines:

- **Step 1: Mild intermittent:** No daily medications needed. Rescue inhalers known as Short-acting Beta₂ Adrenergic Agonist Bronchodilators (SABA), i.e., albuterol.
- **Step 2: Mild persistent:** Low-dose inhaled corticosteroids. To be added for all persistent diseases, i.e., beclomethasone, mometasone. Alternative tx: leukotriene modifier, i.e., montelukast.
- **Step 3: Moderate persistent:** Daily symptoms. Low- to medium-dose inhaled corticosteroids *and* Long-acting Beta₂ Adrenergic Agonist Bronchodilators (LABA), i.e., salmeterol or formoterol, to be added for asthmatics inadequately controlled on steroids. Per the FDA, LABAs are never to be used alone in the treatment of asthma.³
- **Step 4: Severe persistent:** High-dose inhaled corticosteroids *and* LABAs, *and* as needed, oral corticosteroids.

And finally, be sure to follow up with your asthma patients seasonally or no less than every six months if stable. Discuss their concerns and adjust step-up or step-down treatment as necessary.

SOURCES

¹Centers for Disease Control & Prevention; National Center for Health Statistics, *National Health Statistics Reports, Number 32, January 12, 2011* pg.5; www.cdc.gov/nchs.

²National Heart, Lung, and Blood Institute; *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma — Full Report, 2007*; www.nhlbi.nih.gov/guidelines/asthma/index.htm.

³U.S. Food and Drug Administration press release, "FDA Announces New Safety Controls for Long-Lasting Beta Agonists, Medications Used to Treat Asthma," Feb. 18, 2010; www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm200931.htm.

DIABETES MANAGEMENT: 2011 GUIDELINES

The American Diabetes Association has published its 2011 standards of medical care for diabetes in the January edition of *Diabetes Care*.

The following is a partial listing of the guidelines found in *Diabetes Care*:

GLYCEMIC, BLOOD PRESSURE AND LIPID CONTROL

Recommended monitoring schedule:

- A1C: perform testing at least two times per year in patients who are meeting goals and who have stable glycemic control. Perform A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals.
- Lipids: in most adult patients, measure fasting lipid profile at least annually.
- In adults with low-risk lipid values (LDL <100 mg/dl, HDL >50 mg/dl, triglycerides 150 mg/dl), lipid assessments may be repeated every two years.
- Blood pressure should be measured at every routine diabetes visit.

Summary of recommendations for glycemic blood pressure and lipid control for most adults with diabetes:

A1C: LESS THAN 7.0%

- More or less stringent glycemic goals may be appropriate for individual patients. Goals should be individualized based on duration of diabetes, age/life expectancy, comorbid conditions, known CVD or advanced microvascular complications, hypoglycemia unawareness and individual patient considerations.

LDL CHOLESTEROL: LESS THAN 100 MG/DL (LESS THAN 2.6 MMOL/L)

- In individuals with overt CVD, a lower LDL cholesterol goal of less than 70 mg/dl (1.8 mmol/l), using a high dose of a statin, is an option.

BLOOD PRESSURE: LESS THAN 130/80 MMHG

- Based on patient characteristics and response to therapy, higher or lower systolic blood pressure targets may be appropriate.

NEPHROPATHY SCREENING

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of more than or equal to five years and in all type 2 diabetic patients starting at diagnosis.
- Screening for microalbuminuria can be performed by measurement of the albumin-to-creatinine ratio in a random spot collection.



RETINOPATHY SCREENING

- Annual dilated eye examinations are recommended for type 1 and type 2 diabetic patients.

NEUROPATHY SCREENING

- All patients should be screened for distal symmetric polyneuropathy (DPN) at least annually, using simple clinical tests.

FOOT CARE

- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations.
- Provide general foot self-care education to all patients with diabetes.

SMOKING CESSATION

- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care.

The full text of the Executive Summary, “Standards of Medical Care in Diabetes-2011,” may be found at the American Diabetes Association’s Diabetes Care website at care.diabetesjournals.org.

Source: *Diabetes Care*, Volume 34, Supplement 1, January 2011.

TIPS FOR SUCCESSFUL PAY FOR PERFORMANCE

PART 1: APPROPRIATE MEDICATIONS FOR ASTHMA, CERVICAL CANCER SCREENING AND COMPREHENSIVE DIABETES HBA1C

During the months of September, October, November and December 2010, the Illinois Quality Improvement department performed chart reviews, at selected physicians' offices identified as having non-compliant members in one of the six HEDIS® Pay For Performance (P4P) measures:

- Appropriate Medications for Asthma 5–50
- Cervical Cancer Screening
- Comprehensive Diabetes HbA1C Testing

The focus was to identify potential areas for improvement and provide education regarding the criteria to increase the compliance rates. Presented below are the global issues identified and strategies for improvement:

Across the Board for All Measures:

- Ensure that encounters or claims are submitted for all services rendered.
- Track your encounters or claims to make sure they are processed.
- Provide at least a 90-day lag time between the time the encounter or claim is submitted and when it appears in the Plan's system.

APPROPRIATE MEDICATIONS FOR ASTHMA 5–50

Issues Identified:

- Members who are identified as persistent asthmatic are not routinely filling prescriptions for long-term controller medications.
- Physicians are unaware of members obtaining asthma treatment at other points of service.

Strategy:

- Ensure that all Harmony members understand there is no co-pay for pharmaceuticals when they present both their Medicaid Card and their Harmony ID Card at the pharmacy.
- Standardized questions regarding services received at other points of services since the last visit to the PCP should be incorporated into the intake process.

CERVICAL CANCER SCREENING

Issues Identified:

- Inappropriate ICD-9 Diagnosis Codes are utilized when obtaining the sample.
- Documentation of cervical cancer screening/tests performed at other points of service is not complete.

Strategy:

- Use appropriate ICD-9 Diagnosis Code for cervical cancer screening.
- Documentation must include date of service and results of test.

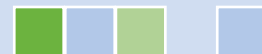
COMPREHENSIVE DIABETES HBA1C

Issues Identified:

- Members that have been identified as having diabetes are declining the blood draw required for the HbA1C test, or they do not return to have it performed.
- HbA1C tests performed in physician's offices are not always properly coded.
- Members with gestational diabetes only are inappropriately coded with ICD-9 250.00 Diabetes Mellitus instead of the appropriate ICD-9 648.83 Abnormal Glucose-Antepartum.

Strategy:

- Educate members on the importance of and difference between the HbA1C test and standard glucose testing.
- If the HbA1C is performed in the office use the appropriate CPT II code.
- When coding services for a member with "Gestational Diabetes" please code only the most appropriate ICD-9.



PART II: CHILDHOOD IMMUNIZATION (COMBO 3) AND WELL-CHILD VISITS

CHILDHOOD IMMUNIZATION (COMBO 3)

Issues Identified:

- Members are not receiving all Combo 3 Immunizations on or before age 2.
- Record of Hepatitis B given at birth is not present in patient chart.
- I-Care is not being effectively utilized to track immunization history.

Strategy:

- Review immunization history and provide vaccines based on Combo 3 Immunizations schedule.
- The patient chart should include information about immunizations provided at other points of service.
- Utilize I-Care to report and track immunizations administered.

WELL-CHILD VISITS DURING THE FIRST 15 MONTHS OF LIFE AND FOR CHILDREN AGES 3–6 YEARS

Issues Identified:

- Wrong CPT codes used: Evaluation and Management codes have been used instead of Preventive Services Codes.
- Missed opportunity to perform a Well-Child Visit in conjunction with a sick visit.
- Members are seen for sick visits or school physicals, but all components of a Well-Child Visit are not performed/documented.

The criteria for a Well-Child Visit are:

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance
- Six or more Well-Child Visits were not performed during the first 15 months of life. (Fifteen months of life is calculated by the adding 90 days to the 1st birthday).
- One Well-Child Visit was not performed in each of the 3rd, 4th, 5th and 6th years of life.

Strategy:

- Utilize the appropriate Preventative Service Code. (Note that these codes are age-specific.)
- Refer to the “**How to Code for a Well-Child Visit With a Sick Visit**” article from the IL 2010 Issue III Provider Newsletter (pgs. 6-7) available on the Plan’s website at www.harmonyhpi.com/provider/resources.
- Perform all components of a Well-Child Visit.
- Perform at least six Well-Child Visits on or before 15 months of life.
- Perform a Well-Child Visit in each year of the 3rd, 4th, 5th and 6th years of life.





HELPING PATIENTS WITH RHEUMATOID ARTHRITIS (RA)

According to a U.S. government survey on arthritis statistics, one out of every four adults in America will have arthritis by 2030. There are over 50 million people who suffer from arthritis and, according to the Centers for Disease Control and Prevention, people with rheumatoid arthritis die up to 10 years earlier than those who do not have this disease.

Together, we can help your patients become more educated about the disease process, maximize current treatment methods and avoid common mistakes associated with their RA. Consider the following strategies:

Prescriptions: Emphasize the importance of taking a disease-modifying anti-rheumatic drug (DMARD) or a biologic early on, since these classes of drugs address the root cause of the immune system malfunction, often at the cellular level. The American College of Rheumatology (ACR) recommends that all RA patients be given a DMARD, regardless of how active or severe their RA is. Studies show that starting powerful drugs earlier may be more effective in reducing or preventing joint damage.

Medication Regimen: Patients may stop taking their medications or skip doses as they feel better. Therefore, it is critical to help them understand that failing to take their medication may cause pain or the arthritis to get worse. Patient education in this area is a key to a successful treatment outcome.

Depression: Watch for depression in RA patients, since this chronic condition can negatively affect their psychosocial well-being. Some people with RA benefit from antidepressants in concert with help from a mental health professional. As you deem beneficial, advise patients to utilize their mental health benefits by calling the number on the back of their Plan member ID card. In addition, encourage them to attend local support groups such as those offered by The Arthritis Foundation or local hospitals.

Exercise: It is recommended that RA patients take short rest breaks throughout the day, especially when the disease is active or exacerbated. This can help reduce joint inflammation, pain and fatigue. However, it is prudent to advise RA patients that too much resting will increase stiffness and decrease joint mobility. Teach gentle range-of-motion exercises and encourage exercising in the water during flare-ups. When patients are feeling better, promote increased activity and resistance exercise to build muscle strength.

Referrals: Refer RA patients to follow up with a rheumatologist for ongoing monitoring, labs and medical treatment. Advise them to find a local rheumatologist through the Plan's website at www.wellcare.com/www.harmonyhpi.com or by calling Customer Service.

WellCare/Harmony also has specialized Disease Management nurses who speak to members with RA via telephone to provide education in conjunction with educational mailings. To refer a member to Disease Management, please call 1-866-635-7045. This program is at no charge to the member.

*Sources: Arthritis Foundation, The American College of Rheumatology (ACR), <http://www.arthritis.org/facts.php>
The Centers for Disease Control (CDC), <http://www.cdc.gov/arthritis/media/quickstats.htm>*



SERVICE AUTHORIZATION REQUESTS

For some treatments and services, WellCare Health Plans/Harmony Health Plan requires a service authorization request, as listed in the Quick Reference Guide (QRG). The QRG, which is updated on an annual basis and can be found on the provider website, lists all of the services that require prior authorization, as well as the appropriate steps to follow when requesting a service authorization.

WellCare/Harmony has a review team of nurses and physicians that ensures members receive appropriate health care services, with a focus on meeting the clinical coverage guidelines and standards of practice.

Currently, reviews are conducted within the state-mandated time frames for Medicaid members and federally mandated time frames for Medicare members. However, with WellCare/Harmony seeking NCQA accreditation, going forward we will conduct reviews using the more stringent review time frame, whether that is the state/federal requirement or the NCQA requirement. Any decision to deny a service authorization request, or to approve it for an amount that is less than asked for, is called an adverse organization determination. This determination will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a physician reviewer.

After we receive your request, we will review it under a standard or an expedited review process. Physicians who determine that a review under the standard time frame would jeopardize the member's life or health, or the member's ability to regain maximum function, can request an expedited review. Any physician request for an expedited review will be honored by WellCare/Harmony. If a request for an expedited review is made by a member, we will look at the request and determine if it meets the standard above. If it does not, we will notify the member and handle the request within the standard time frame.

WellCare/Harmony will provide you our decision through a fax or phone notification. If we deny your request, the attending or treating physician has the right to discuss the denial with the physician who made the decision. When we notify you of the decision, we will provide instructions on how you would request a peer-to-peer review, so that you may present your reasons as to why you think we should overturn the denial decision. Physicians may contact WellCare/Harmony during working hours and after hours by calling 1-866-334-6876 (Medicare) or 1-800-504-2766 (Medicaid) regarding UM issues or decisions.



THE SURGEON GENERAL'S CALL TO ACTION TO SUPPORT BREASTFEEDING

In January 2011, Dr. Regina M. Benjamin, Surgeon General of the United States, released a “Call to Action to Support Breastfeeding.”

According to the report, in addition to reducing the risk of Sudden Infant Death Syndrome (SIDS), breastfeeding may protect babies from infections and illnesses such as diarrhea, ear infections and pneumonia. Breastfed babies are less likely to develop asthma, and, if breastfed for at least six months, less likely to become obese. Mothers who breastfeed have a decreased risk of breast and ovarian cancers.

The report also cites a study published last year in the journal *Pediatrics*, which estimated that the nation would save \$13 billion per year in health care and other costs if 90 percent of U.S. babies were exclusively breastfed for six months.

The Centers for Disease Control and Prevention (CDC) has reported that, despite the potentially significant health and financial benefits derived from breastfeeding for at least six months, only 75 percent of all U.S. babies start out breastfeeding. For African-American babies, this percentage declines to 58 percent. After six months, between 8 to 13 percent of babies, respectively, continue to be breastfed exclusively.

A review by the U.S. Preventive Services Task Force (USPSTF) in July 2003 determined education on breastfeeding to be the most effective single intervention for increasing breastfeeding initiation. Mothers who are knowledgeable about the numerous health benefits of breastfeeding are more likely to breastfeed. And, while having information about the health advantages of breastfeeding is important, knowing how to breastfeed is crucial.

Sources:

“The Surgeon General’s Call to Action to Support Breastfeeding” (full text available at [HYPERLINK “http://www.surgeongeneral.gov”](http://www.surgeongeneral.gov) <http://www.surgeongeneral.gov>)

National Women’s Health Information Center. Website: [HYPERLINK “http://www.womenshealth.gov”](http://www.womenshealth.gov) <http://www.womenshealth.gov>.

One of several obstacles faced by women who want to breastfeed, as identified in Dr. Benjamin’s report, is lack of up-to-date instruction and information from health care professionals. Although pregnant women and mothers consider the advice of clinicians to be very important with regard to their decisions about breastfeeding, clinicians often underestimate their influence. Obstetrician-gynecologists, pediatricians and other providers of maternal and child care have unique opportunities to promote and support breastfeeding among their patients.

In addition to educating their pregnant patients about the benefits of breastfeeding, physicians and other health care practitioners are encouraged to provide mothers with educational resources, including access to classes and support groups.

RESOURCES

- The National Women’s Health Information Center: www.womenshealth.gov.
- “Your Guide to Breastfeeding” is available for free on this website at www.womenshealth.gov/pub/bf.cfm in three languages (English, Spanish and Chinese) and in multiple versions targeting various demographic groups of women.
- Telephone support line: **1-800-994-9662**

The Illinois WIC (Women, Infants, and Children) program, via the Illinois Department of Human Services (DHS), provides support and education related to breastfeeding:

- Website: www.dhs.state.il.us/page.aspx?item=30513
- DHS Helpline: **1-800-843-6154**

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
Accolate® 10mg, 20mg tablets	Zafirlukast 10mg, 20mg tablets	Antileukotrienes
Aricept® 5mg, 10mg tablets	Donepezil HCl 5mg, 10mg tablets	Cholinesterase Inhibitors
Aricept® ODT 5mg, 10mg tablets	Donepezil HCl 5mg, 10mg orally disintegrating tablets	Cholinesterase Inhibitors
Dovonex® 0.005% topical ointment†	Calcipotriene 0.005% topical ointment	Dermatological Agents
Mirapex® 0.75mg tablet†	Pramipexole Dihydrochloride 0.75mg tablet	Antiparkinson Agents

†Not covered on the 2011 Medicare Formulary

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

ADDITIONS	
Bromday™ 0.09% Ophthalmic Solution (QL: 2.5mL/31 days)	Lumigan® 0.01% Ophthalmic Solution (QL: 5mL/31 days)
Calcitriol 1mcg/mL Solution (PA)	Jalyn™ 0.5mg/0.4mg Capsule
Carisoprodol 250mg Tablet (QL: 124 tablets/31 days)	Latuda® 40mg, 80mg Tablets (PA)
Cimetidine HCl 300mg/5mL Solution	Pantoprazole Sodium 20mg, 40mg Delayed-Release Tablets
Doxepin HCl 150mg Capsule	Renvela® 800mg Tablet, 0.8g and 2.4g Packets
Dulera® 100mcg/5mcg, 200mcg/5mcg Inhalation Solutions	

PA = Prior Authorization QL = Quantity Limit

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

DRUG NAME	CHANGE
Byetta® 5mcg, 10mcg injections	PA removed
Eliphos™ 667mg tablet	PA removed

PA = Prior Authorization

Please visit www.wellcare.com/medicare/medication_guide to view the complete formulary as well as formulary updates.

IMPROVE YOUR PATIENTS' CARE WITH THE GUIDANCE OF THE MEDICARE STAR RATING SYSTEM

In order to arm members with the knowledge needed to make sound decisions about their health care, the Centers for Medicare & Medicaid Services (CMS) implemented a rating system that evaluates the relative quality of the private plans being offered to Medicare beneficiaries. Scored on a one- to five-star scale, with five stars representing the highest quality, members can use these ratings as a collective gauge of the quality of care, ease of access to care, provider responsiveness, and beneficiary approval of the plan.

Currently, the rating system exists for both Part C and Part D, focusing on a variety of quality and service metrics that result from the following sources:

- Healthcare Effectiveness Data and Information Set (HEDIS®): These scores are derived from the combination of the administratively compliant members and the medical record review compliant members.
- Key HEDIS Measures:
 - Breast Cancer Screening
 - Colorectal Cancer Screening
 - Cardiovascular Care
 - Diabetes Care
 - Glaucoma Testing
- Consumer Assessment of Healthcare Providers and Systems (CAHPS): This program uses standardized surveys that ask patients to report on and evaluate their experiences with health care, including

accessibility of services and their provider's communication skills.

– Key CAHPS Measures:

- ◊ Timely Access to Appointments and Care
- ◊ Effective Communication
- ◊ Annual Flu Vaccine
- ◊ Customer Service
- ◊ Overall Rating of Health Care Quality

- Health Outcomes Survey (HOS): Survey designed to evaluate physical and mental health, as well as quality of life, of Medicare beneficiaries currently enrolled in Medicare Advantage Plans; a follow-up survey is also conducted two years later.

– Key HOS Measures:

- ◊ Testing for Osteoporosis
- ◊ Monitoring of Physical Activity
- ◊ Improving or Maintaining Physical and Mental Health
- ◊ Reducing the Risk of Falling
- ◊ Improving Bladder Control

While the STARS ratings provide a tremendous benefit to members seeking exceptional medical care, it also serves as a reminder for you, as medical professionals, to never forget your primary goal: caring for your patients. Since WellCare's scores are tied to important HEDIS® initiatives such as the ones listed above, we may be able to improve our ratings simply by effectively serving patients.

PROVIDE UPDATED INFORMATION TO WELLCARE/HARMONY

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

Please be sure to inform the Plan in writing within 24 hours of:

- Any revocation or suspension of your DEA number
- Suspension, limitation or revocation of your license, certification or other legal credential authorizing you to practice in Illinois

In addition, please inform the Plan in writing immediately of changes to licensure status, tax identification numbers, telephone numbers, addresses, status at participating hospitals or loss of liability insurance.

By keeping your information up to date, you are helping to improve member accessibility. You will also help to ensure all correspondence, claim payments and notifications the Plan sends will get to your correct location.

WHAT IS HEDIS®?

HEDIS® (Healthcare Effectiveness Data and Information Set) consists of a set of performance measures utilized by more than 90 percent of American health plans that compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS® IS IMPORTANT

HEDIS® ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS® TO YOU, OUR PROVIDERS

HEDIS® can help you save time while also potentially reducing health care costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care. HEDIS® can also help you:

- Identify noncompliant members to ensure they receive preventive screenings.
- Understand how you compare with other WellCare/Harmony providers as well as with the national average.

VALUE OF HEDIS® TO YOUR PATIENTS, OUR MEMBERS

HEDIS® ensures that members will receive optimal preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed health care choices. In the upcoming months, as part of our planned HEDIS® initiatives, we will be making outreach phone calls and/or mailing periodicity letters to members and/or parents or guardians of targeted members. These calls and letters will inform and educate them about the importance of preventive health screenings. We will encourage the scheduling of appointments for breast cancer and cervical cancer screening, child and adolescent well visits, childhood immunizations, lead screening, glaucoma screening, postpartum visits and other preventive screenings.

WHAT YOU CAN DO

- Encourage your patients to schedule their preventive screening exams.
- Remind your patients to follow up with ordered tests.
- Complete outreach calls to noncompliant members.

If you have questions about HEDIS® or need more information, please contact your local Provider Relations representative.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).





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REAP THE BENEFITS OF WELLCARE SPECIALTY PHARMACY

Helping your patients manage their long-term and/or rare conditions is never an easy task, especially considering the unique challenges each patient presents and the vast array of medications available to address those challenges. That's why it's important for you to partner with a pharmacy that will work with you and your patients to manage their health condition and therapy.

When you refer your Medicare patients to WellCare Specialty Pharmacy, you enlist the expertise of a team skilled in the handling of medications for conditions that include anemia, ankylosing spondylitis, cancer, Crohn's disease, hemophilia, hepatitis, HIV, multiple sclerosis, organ transplant, psoriasis and others. However, patients aren't the only ones to reap countless benefits. With just one simple call, both you and your office staff can also benefit from a team that will:

- Help manage medication side effects and symptoms
- Order medication refills and supplies
- Work closely with your office to provide the right information to WellCare in order to obtain the medication promptly
- Provide educational materials
- Research alternative funding when needed
- Assist in teaching how to administer the medication
- Answer any questions regarding medication or condition
- In rare cases, quickly triage the order to another pharmacy while informing the patient and your office staff

For your patients to begin receiving the benefits of WellCare Specialty Pharmacy, call in their specialty medication order to **1-866-458-9246**, Monday–Friday, 8 a.m. to 6:30 p.m. or fax the order to **1-866-458-9245**.