

ILLINOIS | SPRING 2008

PROVIDER

Newsletter

EMERGENCY ROOM OUTREACH PROGRAM

Throughout the years, Harmony Health Plan of Illinois/WellCare has launched a variety of outreach programs to help members get the most out of their relationships with their health care providers. Members have been encouraged to obtain all medical services from their medical home with their Primary Care Physician (PCP) and to use emergency services in true medical emergencies.

To support ongoing educational processes, a formal ER Outreach Program has been implemented. The ER Outreach Program is designed to enhance our members' and their families' overall health and quality of life by helping them identify appropriate providers and facilities, and by coordinating affordable health care services throughout the continuum of service. The program also strives to ensure that the available resources are being used in a timely manner with optimum value for the member and the Plan.

The goal of the ER Outreach Program is to promptly:

- Assess ER encounters
- Complete health risk assessment and care plan with the member
- Educate/redirect and coordinate services for members
- Assist in follow-up appointment with PCP and or reassignment of PCP
- Contact PCP to advise of ER utilization
- Refer member to Case and Disease Management
- Increase utilization of 24-hour nurse line

A new ER brochure is being used to assist in reaching out and educating the membership on what is and what is not an emergency. The brochure encourages members to call their primary care provider first if it is not an emergency. If members can not reach their primary care provider, but they do not think it is an emergency, they are encouraged to call the 24-hour nurse line at 1-800-608-8158 (Medicaid) or 1-800-919-8807 (Medicare).

NEW WEB SITES AVAILABLE

If you haven't visited our Web sites recently, you're in for a pleasant surprise. They have been redesigned to give you immediate access to what you need most.

Our goal is to help you perform daily administrative tasks quickly and easily. With the Web sites' new features and enhanced layout, you will have the ability to:

- Instantly access daily tasks such as eligibility verification
- Check the status of your claims and tailor the view, downloading options, and e-mail details
- Use your Web inbox to receive authorization status, key reports, and more!

Visit our NEW Web sites at www.wellcare.com and www.harmonyhpi.com, and give your fax machine a much needed vacation.



WHAT DOES WELLCARE/HARMONY LOOK FOR DURING A MEDICAL RECORD REVIEW?

Consistent and complete documentation in the medical record is an essential component of quality patient care.

WellCare/Harmony is required to periodically assess the medical records of our members to demonstrate parameters as outlined in the Provider Manual.

An average score of 80% or greater is considered to meet documentation standards. Physicians who score 80% or greater are reviewed every two years. If any physician scores less than 80% on a re-audit, a corrective action plan will be requested. A re-audit will be conducted within three months after the corrective action plan is received by WellCare/Harmony. If the physician fails to improve the score to 80% during this re-audit, the information will be forwarded to the Medical Advisory Committee for review.

For all medical records, it must be legible and include provider and member identification as well as the following:

- Date the service was rendered
- Documentation of allergies
- List of medications
- Problem list with significant illnesses listed
- List of smoking, alcohol, and chemical dependencies
- Notation of advanced directive
- Notation of screening for domestic violence
- Copy of referral request
- Notation that there was patient input into treatment plan
- Record of outpatient and/or emergency care
- Inpatient discharge summary
- Laboratory and X-rays results with signature or initials of provider who ordered them to signify review
- Note from consultant with signature or initials of provider who ordered them to signify review
- History and physical with subjective and objective information, as well as diagnosis, plan of treatment and patient education

For children ages newborn through age 20, the medical record must include documentation of all EPSDT criteria, which include:

- Health and developmental history
- Unclothed physical exam with a notation of height, weight, and growth
- Complete developmental assessment
- Subjective and objective vision assessment, hearing assessment, nutritional assessment, and risk assessment

- Subjective and objective hearing assessment
- Laboratory tests, i.e.: lead screening and anemia screening
- Health education
- Family planning counseling, if appropriate
- WIC referral

For adults the medical record must include documentation of:

- Health History
- Physical exam including height, weight, and blood pressure
- Nutritional assessment
- Tetanus immunization (every 10 years)
- Clinical breast examination
- Pap test and mammogram results
- Documentation of lifestyle and risk counseling
- Laboratory tests, i.e.: cholesterol and hemoglobin and hematocrit
- Colorectal cancer screening and prostate screening

If you have any questions or would like a copy of the medical record audit tool, please contact our Quality Improvement Department at **(312) 630-2025 ext. 1800** or **ext. 1135** (Chicago/Cook County) or **ext. 2419** (Southern Illinois).



ILLINOIS PHARMACY UPDATE

ASTHMA MEDICATION MANAGEMENT

In 2007, the National Asthma Education and Prevention Program (NAEPP) in coordination with the National Heart, Lung, and Blood Institute (NHLBI) updated the asthma guidelines in *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma—Full Report 2007*. New evidence on medication effects shows children don't respond in the same way as adults.

The new guide restated that patients with persistent asthma (symptoms more than twice a week during the day or more than twice a month at night) need both long-term and quick relief medications. It reaffirmed that inhaled corticosteroids (ICS) continue to be the most effective long-term control medicine for asthma patients. The guideline focuses on a stepwise approach to managing asthma, and in terms of medication, doses should be stepped up or down as needed. Included in the guide is the creation of a new age group for treatment, children ages 5 to 11, who were previously included in the adult group.

Long-acting beta2 agonists (LABAs) are to be used as an adjunct to ICS therapy for providing long-term control of symptoms. According to the panel, the most significant difference today is that LABAs are the preferred treatment in combination with ICS in patients 12 years of age or older and in adults who have persistent asthma or inadequately controlled asthma on low-dose ICS. Short-acting beta agonist (SABA) is the drug of choice for providing quick relief of bronchoconstriction.

The guide is available online at www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm.

Reference: (2007). Expert Panel Report 3(EPR3): Guidelines for the Diagnosis and Management of Asthma. Retrieved January 11, 2008, from <http://www.nhlbi.nih.gov/guidelines/asthma/asthgdln.htm>.



MEDICARE ▼

NEW MEDICARE PHARMACY SERVICES PHONE NUMBER

Effective January 1, 2008, there is a new Medicare Pharmacy Services toll-free telephone number for providers to use when contacting WellCare. Please call **1-866-653-0976** for any Pharmacy-related questions or issues, including after-hours and weekend needs.

MEDICARE ▼

FORMULARY UPDATES

Effective January 1, 2008, Novolin and Novolog products will be Non-Formulary for Illinois Medicare.

NON-FORMULARY

Novolin
Novolog

PREFERRED ALTERNATIVE

Humulin
Humalog

ACCESS AND AVAILABILITY REQUIREMENTS FOR PRIMARY CARE PROVIDERS

It is the Plan's policy to follow access and availability standards set by federal and state requirements. To ensure our members have adequate access to their physicians, the following criteria have been adopted for our Medicaid and Medicare Primary Care Physicians:

- Provide medical coverage 24-hours a day, seven days a week
- See scheduled appointments within 30 minutes of the appointment time
- Schedule and see emergent referral appointments immediately
- Schedule and see urgent referral appointments within 24 hours
- Schedule and see routine "sick" care appointments within one week or five business days, whichever is earlier
- Schedule and see "well" care appointments within 30 days of a member's request

And for our specialty care providers:

- Schedule and see emergent referral appointments immediately
- Schedule and see urgent referral appointments within 24 hours
- Schedule and see routine "sick" care appointments within one week or five business days, whichever is earlier
- Schedule and see "well" care appointments within 30 days of a member's request

Remember that it is a requirement for providers to be available to patients 24 hours a day, seven days a week. The Plan will monitor appointment and after-hours availability of network providers on a routine basis to ensure that access and availability standards are met. The PCP must be available after regular office hours to offer advice and to assess any condition which may require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To ensure accessibility and availability, PCPs must provide one of the following:

- A 24-hour answering service
- Answering system with option to page the physician
- An advice nurse with access to the PCP or on-call physician



REFERRING INTERESTED PROVIDERS

If you know colleagues who are interested in joining the Harmony or WellCare networks, they can call **1-800-608-8158**, press **7** at the prompt, and then ext. **2003**.

ICD-9-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING AND DIAGNOSIS CHANGES FOR 2008

In 2008, there are 144 new diagnosis codes, 16 deleted diagnosis codes, and five revised diagnosis codes. The 2008 ICD-9 Diagnosis code changes are available free of charge at: www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp.

A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the health care provider and the claims coder in identifying those diagnoses and procedures that are to be reported.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

The ICD-9-CM Official Guidelines for Coding and Reporting guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II, and III of ICD-9-CM, but provide

additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

The ICD-9-CM Official Guidelines for Coding and Reporting are available for free at: <http://www.cdc.gov/NCHS/datawh/ftpserv/ftpicd9/icdguide07.pdf>.

New code assignments are the result of year-long efforts of the ICD-9-CM Coordination and Maintenance Committee, which is sponsored jointly by NCHS and CMS. The effective date for new codes is the same every year, October 1.

POINT-OF-SERVICE OPTION AVAILABLE TO MEDICARE MEMBERS

Beginning January 1, 2008, many of our core Medicare Advantage + Prescription Drug (MAPD) plans include a new Point-of-Service (POS) option allowing members out-of-network access for select covered services. Every member of an eligible MAPD plan can choose to exercise the POS option, with your approval.

There is no rider to choose or extra premium for the member to pay. **However, the member's out-of-pocket costs will be higher when they use the POS option for out-of-network services.**

WHAT THE POS OPTION MEANS TO PRIMARY CARE PROVIDERS (PCPS):

- You are the “medical home” for our members. You coordinate care by requesting authorization from the Plan for out-of-network services when requested by the patient.
- Authorization is required for any service obtained out of the Plan's network. The authorization process informs us of your consent for the member to access out-of-network services and to know who will reach out to us for claim payment. We review all authorizations for medical necessity and would only deny a request if the service is not a covered benefit.
- In-network services are managed using existing guidelines as per the Quick Reference Guide and Provider Manual.

For more information regarding the POS option, please contact your Provider Relations representative.



IT'S TIME FOR HEDIS 2008

It's that time of year again...HEDIS! We want to remind all of our providers that over the next several months, you may be contacted to have your medical records reviewed for HEDIS (Health Plan Employer Data Information Set). HEDIS is a mandatory process that occurs annually. It is our and your opportunity to demonstrate the quality and consistency of care that you provided in 2007. The process has changed a little this year; here are the details...

- We are beginning our HEDIS season early this year. We began in January and continue until May 2008. It is important to us to capture all of the services that were provided in 2007, and beginning the process early will allow us to more accurately do so. Furthermore, conducting reviews early in the year allows us an opportunity to intervene with any potential problems or issues the offices may be having in a more timely fashion.
- You or your office staff will be contacted to set up appointments for us to come to your offices and collect the HEDIS data we need from your medical records. You need only schedule an agreed upon time and provide the quality analysts and/or nurses with any requested documentation. It is very important that physicians and offices allow the nurses access to the charts they request. Medical record reviews are our last opportunity to capture the services that physicians provided in 2007. The information gathered from the medical records will be a reflection of each physician's performance in 2007.
- HEDIS addresses several very important areas of preventive medicine. During our reviews, we will assess for services provided in the areas of: well-child/adolescent visits, immunizations, diabetes care, cervical cancer screenings, mammograms, prenatal and postpartum care, asthma care, and other services.

We hope that this year's chart reviews will run smoothly and easily. We know, however, that this can be a busy and stressful time. In an effort to make this as smooth a process as possible, we look forward to your cooperation in scheduling and honoring appointments as well as providing all requested charts. We will do our best to be flexible with your busy clinic schedules and allow you your necessary space and time to continue to run your affairs efficiently. If you have any questions or concerns or should a problem arise, however, please contact our Quality Improvement Department at (312) 630-2025, ext. 1800 or 1135 (Chicago/Cook County) or ext. 2419 (Southern Illinois).

We want to thank you, as always, for your continued efforts toward collaboration with us as well as your success in providing consistent, quality patient care!

TACKLING DIABETES

PARTNERSHIP, EDUCATION, AND PREVENTIVE CARE CAN PAY OFF

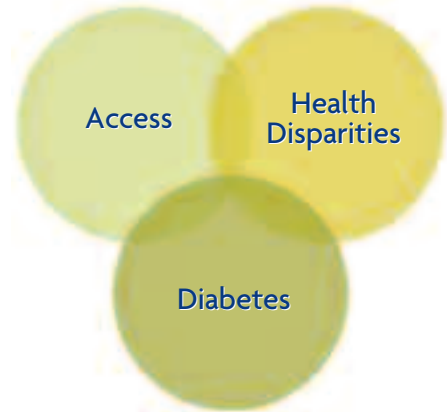
THE PLAN'S ROLE

Harmony/WellCare recognizes the importance of preventive care and the effect it can have on chronic conditions like diabetes. The Plan is committed to working with its partners to increase diabetes awareness and is confident that educational efforts and a focus on early screening and treatment will benefit the communities we serve.

The American Diabetes Association estimates that more than 20 million Americans have diabetes, but that 6.2 million of them have not been diagnosed.¹ In addition, 10.3 million or 20.9 percent of all people 60 or older have diabetes. In addition, ADA data show that one in six overweight adolescents ages 12 through 19 has diabetes and one in every 400 to 600 of them has Type 1 diabetes.

CHALLENGES: DISPARITIES AND ACCESS

Harmony/WellCare concentrates on health care disparity and access challenges associated with diabetes. Diabetes is a major clinical condition that affects many people in our communities. Significant resources in diabetes are increasing to address the chronic condition. According to Mathematica Policy Research analysis, federal spending for diabetes prevention and health promotion in 2005 topped \$3.9 billion, and treatment costs soared past \$79 billion.²



Harmony/WellCare is currently enhancing grassroots efforts to better share information with and among providers, to educate members about healthy living and to share stories with other community leaders. If you would like to share your story about outreach and education concerning diabetes or other health initiatives, or if you are interested in the Plan's grassroots programs, please e-mail Ambassador@wellcare.com.

HEALTH CARE DISPARITIES

Disparities in health care are found in the populations Harmony/WellCare serves—minorities, children, women, low-income individuals, seniors, and people with special health care needs. Health disparities for these populations are observed in almost all aspects of health care, including quality of care, access to care, types of care, and clinical conditions such as diabetes.

In addition to the millions of people among the general population with diabetes, according to a 2006 Institute of Medicine publication, diabetes affects minority populations disproportionately. Research has shown that:

- Diabetes rates are more than 30 percent higher among Hispanics than whites.³
- 2.5 million, or 9.5 percent of Hispanics 20 or older, were diagnosed with diabetes in 2002.⁴
- In 1999, 11,927 African Americans died from diabetes—more than twice the number of whites.⁵

ACCESS TO HEALTH CARE

Many vulnerable populations are left out of the efforts to provide preventive care because they do not access to the health care system.

The Plan excels in improving access to the populations we serve. The Agency for Healthcare Research and Quality defines access to health care as having “the timely use of personal health services to achieve the best health outcomes.” Racial and ethnic minorities and individuals of lower socioeconomic status are “less likely to enter the health care system, establish a regular source of care, or receive care of similar quality to their more advantaged and non-minority peers.”⁶

In addition to general access challenges for the Medicaid populations, health disparities are a specific problem for diabetics. For example, in 2003 only about 42% of diabetes patients got the three recommended tests: Hemoglobin A1c, Dilated Eye Exam and foot exam; and people who got all three tests were more likely to be white, to have medical insurance, and to be 65 or older.⁷ Also, a 2005 Commonwealth Fund study of public hospital-based diabetes care showed that uninsured patients had the worst diabetes control, with 33 percent showing they did not have their condition under control, almost double the rate for Medicare patients.⁸

THE PLAN'S RESPONSE

Harmony/WellCare is uniquely positioned to address disparities in access to health care for vulnerable populations because of our core operational competencies, such as experience with offering:

- Outreach and education to populations most affected by health disparities
- Assignment of PCPs to encourage preventive care
- Coordination of care for members with chronic conditions
- Increased access to specialists through case management and customer service
- Disease-management programs to members with chronic conditions
- Measurement of geographic accessibility through analysis and reporting
- Measurement of timely availability through provider audits
- Measurement of perception of access through Consumer Assessment of Healthcare Providers and Systems® (CAHPS) satisfaction surveys

References:

1. American Diabetes Association Fact Sheet, 2005. <http://www.diabetes.org/uedocuments/NationalDiabetesFactSheetRev.pdf>. Accessed October 2007.
2. Gold, M., Briefel, R. (2007) Study of Federal Spending on Diabetes: An Opportunity for Change. Mathematica Policy Research.
3. Institute of Medicine of the National Academies (2006). Addressing Racial and Ethnic Health Care Disparities brochure. http://www.iom.edu/Object.File/Master/33/249/BROCHURE_disparities.pdf.
4. Health and Human Services Office of Minority Health Diabetes Data/Statistics. <http://www.omhrc.gov>. Accessed October 2007.
5. HHS Office of Minority Health Fact Sheet, "Closing the Health Gap": Reducing Health Disparities Affecting African-Americans, November 19, 2001.
6. Lurie and Dubowitz. (2007) JAMA. Health Disparities and Access to Health. 297: 1118-1121.
7. National Healthcare Disparities Report, 2005. Agency for Healthcare Research and Quality.
8. Regenstejn, M., Huang, J., Cummings, L., Lessler, D., Reilly, B. and Schillinger, D. (2005) Caring For Patients with Diabetes in Safety Net Hospitals And Health Systems. Commonwealth Fund, No. 826.



THE TRUST PROGRAM IS HERE FOR YOU

A culture of compliance and integrity is essential to the Plan. Through our Corporate Ethics and Compliance Program, the *Trust* Program, we promote the prevention, detection and the resolution of conduct that violates federal or state laws or our high standards of business ethics. The *Trust* program applies to Harmony/WellCare's associates, providers, and members.

As a provider partner, you agree to comply with and adhere to the principles of our *Trust* Program, including compliance with HIPAA (Health Insurance Portability and Accountability Act of 1996) and all state and federal laws, rules, and regulations. Specifically, we endeavor to prevent fraud, waste, and abuse. As a provider, you may not participate in any scheme or plan constituting fraud or abuse, and must report all suspected fraud or abuse, including deception or misrepresentation for financial gain, or conduct inconsistent with accepted business or medical standards that results in unnecessary cost.

To learn more about the *Trust* program, or to report a possible violation, please contact the *Trust* Hotline at 1-866-678-8355.

ELECTRONIC FUNDS TRANSFER AVAILABLE TO PROVIDERS

The Plan is pleased to offer EFT/ERA services to its Illinois providers. This free service is available through PaySpan Health and is managed by our partners, Payformance and Chase.

By signing up for Electronic Funds Transfer, you will enjoy many benefits, including:

- Absolutely no cost to you for participating
- A secure, self-service Web site
- Convenient access to view remittance records online, at any time.
- Improves cash flow—Electronic payments can mean faster payments, leading to improvements in cash flow.
- Manages multiple payers—Reuse enrollment information to connect with multiple payers. Assign different payers to different bank accounts, as desired.
- No more waiting for paper checks or paper vouchers
- Reporting mechanisms to access adjudicated claims information
- Reduction in accounting expenses—Electronic remittance advices can be imported directly into Practice Management or Patient Accounting Systems, eliminating the need for manual re-keying.

Enrolling is quick and simple. Using the registration code sent to you in your enrollment letter, go to the PaySpan Health Web site dedicated to WellCare/Harmony providers.

Please call the Provider Hotline at **1-800-504-2766** (Harmony) or **1-866-334-6876** (WellCare) or your Provider Relations representative with any questions.

Should you elect not to receive your payments or vouchers electronically, you will continue to receive paper copies generated from the Payformance payment processing center.



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