

# PROVIDER

## Newsletter

### MEDICAID

## ADOLESCENT PREVENTIVE CARE SCREENING AND COUNSELING

Quality Assurance Reporting Requirements (QARR) include the following seven components of care for adolescents ages 14–8. These components should be assessed during a member's comprehensive well-care visit with a primary care physician (PCP) or an OB/GYN practitioner:

1. Body Mass Index (BMI) screening
2. Assessment or counseling or education on nutrition
3. Assessment or counseling or education on physical activity
4. Assessment or counseling or education on risk behaviors and preventive actions associated with sexual activity
5. Assessment or counseling or education on depression
6. Assessment or counseling or education about the risks of tobacco usage
7. Assessment or counseling or education about the risks of substance use (including alcohol and excluding tobacco)

### NEW PACKAGE HELPS DOCTORS COUNSEL PARENTS

The American Medical Association has produced a "Parent Package" that is designed to help physicians counsel parents on 15 topics related to adolescent health. The topics include information for screening and counseling on smoking, substance abuse and sexual activity.

Harmony Health Plan of Missouri encourages providers to make parents and caregivers aware of this useful tool.

The package is available at [www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf](http://www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf).

Source:

*The Parent Package. American Medical Association, 2001 available at [www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf](http://www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf).*

## PROVIDER MATERIALS UPDATE

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

- Missouri Winter 2009 Newsletter
- Changes to Preferred Brands of Insulin—Medicare
- Changes to Medication Benefit Process—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.harmonyhpm.com](http://www.harmonyhpm.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.



## MEDICAID

### PERINATAL DEPRESSION SCREENING

*Harmony Health Plan (Harmony) ran this article in the Missouri Fall 2009 Provider Newsletter with an incorrect billing code. We are providing this article again with the correct code. We apologize for any confusion. Please refer to this edition in the future.*

Harmony encourages women's health professionals and pediatricians to screen women for prenatal and postpartum depression. Harmony supports utilization of the Edinburgh Depression Screening Tool and encourages providers to comply with the screening instructions. We recommend you provide the member with the tool just prior to the actual visit and review their responses with them during the actual visit.

#### BILLING, CODING AND DOCUMENTATION

- Billing for reimbursement is available for both prenatal and postpartum depression screening, as a "risk assessment." When billing for perinatal depression screening, use code H1000 (Prenatal care, at-risk assessment).
- Keep a copy of the Edinburgh Depression Scale results in the member's file, along with notes supporting review, appropriate discussion of responses and subsequent referrals.
- If the postpartum depression screening occurs during a well-child visit or episodic visit for an infant (under age 1), the screening may be billed as a "risk assessment" using procedure code H1000 (Prenatal care, at-risk assessment). Document this screening as a "risk assessment" in the infant's record and maintain the Edinburgh Depression Screening Tool results and supporting notes in a separate file (under the mother's name) and not in the infant's file.

#### POSITIVE DEPRESSION SCREENING RESULTS

- If any member screens positive for depression, please refer them to a Harmony Behavioral Health provider as appropriate. Harmony Behavioral Health can be reached at **1-888-684-2026**.
- Harmony's Member Services may also provide assistance. Member Services can be reached at **1-866-822-1340**.
- For more information on screening tools, risk factors and treatment, contact the Hugs Social Service specialist in your area at **1-866-776-9876**.

## DENTAL SERVICES ARE VITAL FOR TOTAL HEALTH

Harmony Health Plan of Missouri encourages providers to reinforce the importance of dental services to our members.

A dental screen is available to the Healthy Children and Youth (HCY)/Early Periodic Screening, Diagnostic and Treatment (EPSDT) population on a periodicity schedule that is different from that of the full HCY/ EPSDT screen.

Children may receive age-appropriate dental screens and treatment services until they reach 21 years old.

A child's first visit to the dentist should occur no later than 12 months of age so the dentist can evaluate the child's oral health, intercept potential problems (such as nursing caries) and educate parents on the prevention of dental disease.

It is recommended that preventive dental services and oral treatments for children begin between the age of 6 to 12 months and be repeated every six months or as indicated.

Please remind patients to make annual dental visits.

Sources:

*American Academy of Pediatrics*

*MO HealthNet Healthy Children and Youth*

## THE "HEDIS SEASON" IS COMING!

Every year, Harmony Health Plan of Missouri (Harmony) and WellCare Health Plans, Inc. (WellCare) are required to report clinical quality measures to the Centers for Medicare & Medicaid Services (CMS) and the Missouri 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 has contracted with Outcomes Health Information Solutions (OHIS) to assist us in reviewing medical records required for HEDIS data collection.

A representative from OHIS may contact 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 any questions, please call Ramona Kaplenk, Accreditation and HEDIS Manager, at **1-618-641-4647**.



# HARMONY HEALTH PLAN OF MISSOURI

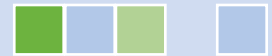
## HEDIS® MEASURES THROUGH CLOSE OF YEAR 2010 THROUGH 2011

The chart below includes descriptions of the components of targeted Healthcare Effectiveness Data and Information Set (HEDIS®) measures for the Harmony Health Plan of Missouri, 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.

### 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          or  <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>

## 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.

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### 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%	<b>96%</b>
Breast Cancer Screening	60%	49%	55%	<b>60%</b>
Cervical Cancer Screening	75%	62%	67%	<b>72%</b>
Childhood Immunization Status (Combo 3)*	0%	58%	66%	70%
Comprehensive Diabetes/HbA1c Test	100%	74%	79%	<b>84%</b>
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%	<b>75%</b>

\* Combo 3 = 4 DTaPs, 3 IPV, 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, 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.

## 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.

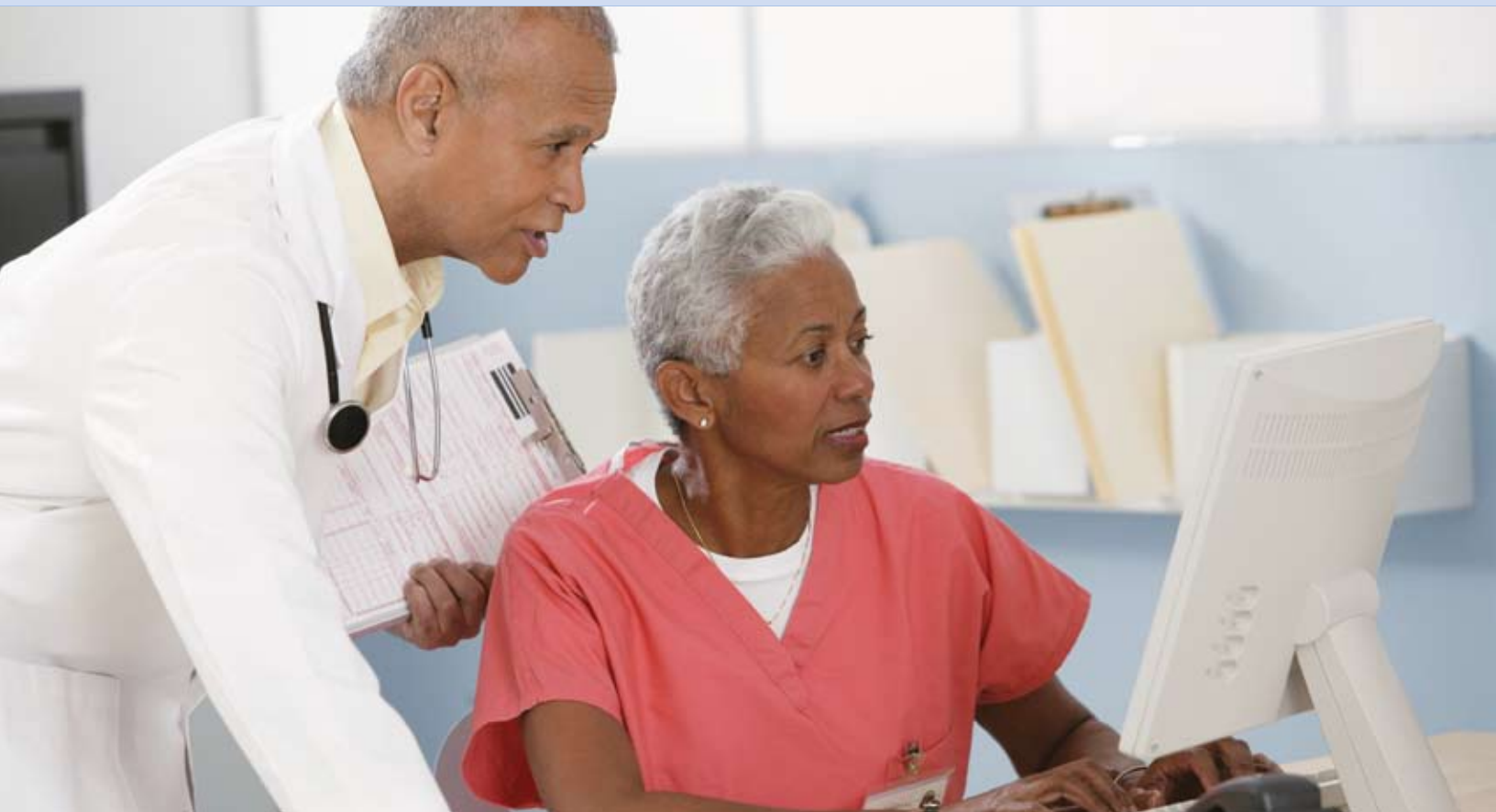
Effective Jan. 1, 2010, WellCare covers both standard and U.S. Food and Drug Administration (FDA)-approved HIV rapid screen tests for people at risk. These tests are covered under basic lab services.

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;
- 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 **1-866-687-8994**.

*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=2296>.*

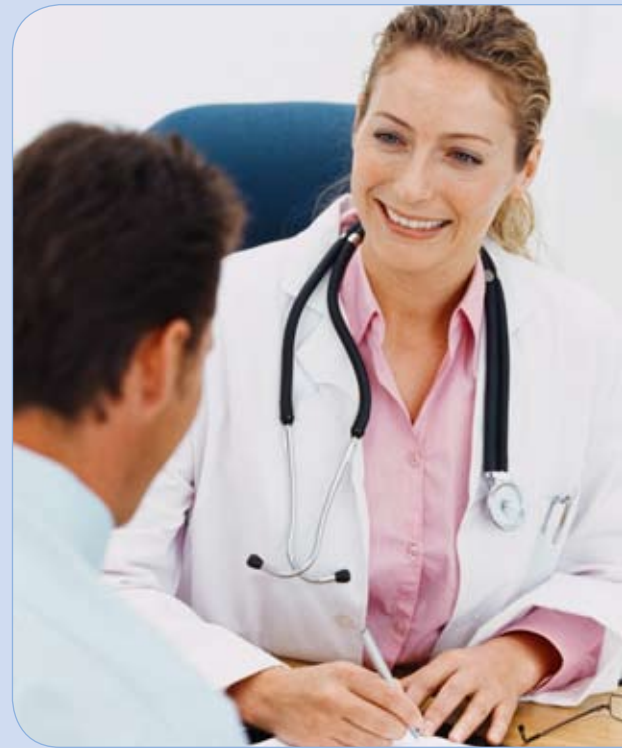


## EFFECTIVE COMMUNICATION WITH PATIENTS

Patients often face a frightening time when they seek treatment, especially when they do not understand what a physician is telling them about their condition.

Good communication can help alleviate the fear or anxiety they might experience. As a partner in rendering health care services, providers have an obligation to inform patients of their medical conditions, and are responsible for effectively communicating medical terms in a manner that can be understood by the patient. Here are some thoughts to consider when attempting to break through communication barriers:

- Assess what the patient wants to know.
- Assess what the patient already knows by encouraging the sharing of information.
- Be empathetic.
- Take the time to explain all treatment options.
- Keep it simple: Explain medical information in easily understood language.
- Be sure to answer all the patient's questions.



## 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 exceeding 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 sites at [www.wellcare.com](http://www.wellcare.com) or [www.harmonyhpm.com](http://www.harmonyhpm.com).

## SUNCAP

WellCare/Harmony offers an electronic version of cap payments, called SUNCAP. The reports are usually available the 20th of each month and include member-level detail, which allows larger provider groups and ancillary providers an electronic means to reconcile payments to their assigned membership.

The files are sent in a standard text format to a secure site that allows you to import the data into any software system that you choose.

For more information on signing up to receive SUNCAP reports, please contact your Provider Relations representative.



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## 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 **1-866-687-8994** (Medicare) or **1-866-822-1340** (Medicaid). You can also contact Payformance at **1-877-331-7154** Monday through Friday, 7am to 9pm Eastern.

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

If you'd like to receive your WellCare 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 on 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 on 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 on 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.





Harmony Health Plan  
13 Wolf Creek Drive, Suite 4  
Swansea, IL 62226

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## 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 on [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 on [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).

## PROVIDER FORMULARY UPDATE

### GENERICS 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.

## 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, 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 Customer Service at 1-866-687-8994.

