



MISSOURI | 2010 | ISSUE IV

PROVIDER

Newsletter

CULTURE OF COMPLIANCE

The WellCare/Harmony Code of Conduct and Business Ethics (the Code) enunciates the basic principles governing our business activities and relationships, and includes principles of fraud, waste and abuse. Values that guide activities, good judgment, personal honesty and sound business ethics are described in the Code. As an extension of WellCare/Harmony, all delegated vendors must adhere to, and comply with, the principles in the Code. Delegated vendors must attest to training and compliance with the Code. The Code may be accessed at the following link: www.wellcare.com/AboutUs/default.

All delegated and contracted providers who render benefits or services for Medicare Part C and Part D programs must complete Fraud, Waste and Abuse training, affirming a commitment of compliance with all applicable federal and state standards to include the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), False Claims Act and the Anti-Kickback Statute. As a WellCare/Harmony delegated and/or contracted provider, this training requirement applies to you and your staff.

Topics addressed in the training include:

- Laws and regulations related to Medicare Advantage (MA) and Medicare Part D fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute HIPAA, etc.).
- Obligations of the first-tier, downstream and related entities, to have appropriate policies and procedures to address fraud, waste and abuse.
- Process for reporting suspected fraud, waste and abuse of first-tier, downstream and related entities to the organization or prescription drug plan (PDP) sponsor.
- Protections for employees of first-tier, downstream and related entities who report suspected fraud, waste and abuse.
- Types of fraud, waste and abuse that can occur in first-tier, downstream and related entities.

FWA training requirements are detailed in federal regulations at 42 C.F.R. § 422.503 and 42 C.F.R. § 423.504.

The link to the training may be accessed at www.wellcare.learnsomething.com, the WellCare Web site at www.wellcare.com and the WellCare Provider Portal at www.wellcare.com/provider.

FWA and HIPAA trainings are an annual requirement. It is important that you maintain documentation of the training to evidence compliance if requested.

PROVIDER UPDATE

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

- Paper Claim Format and SNIP Edits Claims Changes
- Flu Vaccination Notice
- MO 2010 Issue III Provider Newsletter

You can find copies of some of these correspondences when you log in to the secure area of www.wellcare.com (Medicare) or www.harmonyhpm.com (Medicaid) via the sign-in on the right that says "Member/Provider Secure Sign-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.

CLAIMS CORNER—PAPER CLAIM SUBMISSION GUIDELINES AND SNIP EDITS

Harmony Health Plan of Missouri (Harmony) and WellCare Health Plans, Inc. (WellCare) are updating our Provider Manuals to reflect further details on regulatory requirements and industry standards for submissions of health care claims and encounters. The purpose of this additional information is to promote compliance with standards for claims and encounters submission.

PAPER CLAIMS GUIDELINES – EFFECTIVE OCTOBER 28, 2010

- Submit “clean claims” pursuant to your Provider Agreement using the UB-04 and CMS-1500 claim forms. For complete, detailed information about paper claim submissions, refer to the National Uniform Claim Committee (NUCC) – CMS-1500 forms and the National Uniform Billing Committee (NUBC) – UB-04 forms. Refer to the 837 Institutional Implementation Guide by Washington Publishing Company (March 2003) for any EDI-related issues. Please visit our Web site at www.wellcare.com (Medicare) or www.harmonyhpm.com (Medicaid) to find sample CMS-1500 and UB-04 forms and other helpful guidelines.
- Paper claim forms must not be handwritten or have any extraneous data printed or stamped on them.
- Medicare/Medicaid resubmission refers to the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
- “Corrected Claim” in the instance of a re-submission must have the appropriate bill frequency code in the left-hand side of Box 22 and the original reference number in the right-hand side on the CMS-1500. The frequency code is located in the bill type at the top of the UB-04 form.
 - CMS-1500 allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area in Box 22. Please see example below:
 - 7 – Replacement of Prior Claim
 - 8 – Void/Cancel of Prior Claim

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7 OR 8	123456789012A33456

- UB-04 allows for the frequency code to be entered as the third digit of the bill type. An example of this is 127, with the 7 being the frequency code for the Replacement of Prior Claim.

7–Replacement of Prior Claim
8–Void/Cancel of Prior Claim

The codes listed above for the CMS-1500 and UB-04 are not intended for use for original claim submission.

- Encounter submission—“Encounter” stamped in red on the paper claim is allowed only if it does not obscure any of the claim’s information.
- Any missing, incomplete or invalid information in any field will cause the claim to be rejected.
- The font should be legible, typed in black ink, and in large, dark font in capital letters. The font should not have broken characters, script, italics or stylized font, red ink, mini font, or dot matrix font.

STANDARDS FOR CLAIMS AND ENCOUNTERS AND SNIP – EFFECTIVE DECEMBER 1, 2010

- Electronic Claims and Encounters—Submit with updated HIPAA Electronic Transaction and Code Sets, included in the Provider Manual(s). Additional guidance can be found at www.cms.hhs.gov/TransactionCodeSetsStands/.
- Strategic National Implementation Process (SNIP)—All claims and encounters will require validation of transaction integrity/syntax at levels 4 and 5.

The Plan will start enforcing additional SNIP 4 and 5 edits to comply with federal and state mandates. This applies to all submission types: paper, electronic claims (EDI) and direct data entry (DDE).

Below are general descriptions of each level:

- **SNIP Type 4**—Situational Requirements. Refer to the frequent examples below:
 1. Physical address of service location is required for all places of service billed.
 2. Additional present on admission (POA) indicator qualifier edits on the 2300 K3 segment.
 3. Total purchased service amount in the 2300 loop.
 4. Purchased service provider name when a purchased service is rendered in the 2300 loop (see #3 above).
 5. Service location address may not contain a P.O. Box.
 6. Taxonomy information is required for rendering and/or bill-to provider.
 7. Patient's date of birth cannot be greater than the date of service.
- **SNIP Type 5**—External Code Set Validation (e.g., Procedure codes, ICD-9 codes, state and ZIP codes, Taxonomy codes)

WHAT DO THESE CHANGES MEAN TO YOU?

It is important that you/your organization comply with these submission requirements in order for your claims/encounters to be processed in a timely manner and to avoid rejections. The Plan is aware that it will take you some time to update your systems accordingly.

- Claims received after the effective date of **October 28, 2010** that do not adhere to the **paper claim guidelines** outlined above will be rejected.
- Full compliance with the **SNIP edits** described above are now required, as of **December 1, 2010**.

Please note that all other WellCare/Harmony claim submission requirements, such as timely filing, are not affected by these additional standards.

Updated copies of the Provider Manuals will be available via the Plan's Web sites at www.wellcare.com (Medicare) or www.harmonyhpm.com (Medicaid). For questions, please contact your Provider Relations representative or call Provider Services at **1-866-822-1340** (Medicaid) or **1-866-687-8994** (Medicare). We appreciate your attention and preparation for these changes.

FIVE REASONS TO SIGN UP FOR EFT

Five reasons to sign up today for Electronic Funds Transfer (EFT):

1. No interrupting your busy schedule to deposit a check.
2. No waiting in line at the bank.
3. No lost, stolen or stale-dated checks.
4. YOU control your banking information.
5. Immediate availability of funds—NO bank holds!

Five reasons to use Electronic Remittance Advice (ERA):

1. Quick posting of claims that we pay.
2. Accurate posting of claims that we pay.
3. HIPAA-compliant file format (835) imports into most practice management systems.
4. Multiple Data Exchange Partners (DEPs) are registered users of PaySpan Health (Avisena, Gateway EDI, GHN Online, Quadax, Relay Health, and SSI Group; RealMed and ZirMed are coming soon).
5. Register for multiple payers.

To view a list of payers that use PaySpan Health, please visit www.payformance.com/for-providers/participating-health-plans.



AFTER-HOURS COVERAGE AND APPOINTMENT TIMELINESS STANDARDS

There are established appointment timeliness standards for members to receive clinical services by network providers. To evaluate compliance with the applicable appointment standards, telephone audits are conducted each year for a random selection of network providers. Providers that do not meet the standards are placed on a Corrective Action Plan (CAP) and are contacted by our staff.

Time between request for appointment and scheduled appointment is not to exceed:

APPOINTMENT TYPE	APPOINTMENT TIMELINESS STANDARD
Average wait time for appointments	Should not exceed one hour from the scheduled appointment time
Time between request for appointment and scheduled appointment is not to exceed:	
Urgent care appointments	Within 24 hours
Routine care, without symptoms	30 calendar days (e.g., well-child exams, routine physical exams)
Routine care, with symptoms	One week or five business days, whichever is earlier
Mental health and substance services, after care	Within one week or five business days after hospital discharge, whichever is earlier
Initial prenatal (member in first or second trimester)	Seven calendar days
Initial prenatal (member in third trimester)	Three calendar days
High-risk pregnancy	Three calendar days or immediately if an emergency exists
Emergency services (by emergency providers)	Immediate service 24 hours a day, seven days per week. Prior authorization is not needed.

AFTER-HOURS COVERAGE

In addition, the primary care physician (PCP) must be available after regular office hours to offer advice and to assess any condition that may require immediate care. This includes referral to the nearest hospital emergency room in the event of a serious illness.

To assure after-hours accessibility and availability, PCPs must provide one of the following:

- Answering service with option to page or contact physician;
- Advice nurse with access to the physician or on-call physician;
- Answering system that provides an option to page the physician; or
- Answering system that pages the physician once the message is left.

Please note, recorded messages are not acceptable.

If you have any questions regarding Harmony’s Medicaid appointment timeliness or after-hours coverage standards, please contact our Customer Service department at **1-866-822-1340**. Additional information can be found in the Provider Manual posted on the Web site: www.harmonyhpm.com/Provider/ProviderManual.

PROVIDER DIRECTORY CHANGE

In 2011, Dual Special Needs Plans (D-SNPs) will be required to display the Medicaid indicator in the provider directory when they have contracts with state Medicaid agencies. WellCare will be populating the flag on network providers in all states where we have D-SNPs to provide the most comprehensive information to members, even if we are currently still not contracted with the state. We will direct members to contact your office first to ensure you are still accepting Medicaid patients prior to making appointments.

Source: 42 CFR 422.111(b)(3)(i), 422.111(e)



HELPFUL TIPS FOR CONTACTING OUR CUSTOMER SERVICE DEPARTMENT

WellCare/Harmony wants you to know where to turn for the answers you need to effectively service your patients: Customer Service.

Our award-winning Customer Service department is here to help you. Please utilize the means below to locate the tools and resources you need to properly service our members.

1. **Visit our Web sites at www.wellcare.com (Medicare) or www.harmonyhpm.com (Medicaid).** By far our most convenient and quick form of customer service information, our Web sites are invaluable resources for those in need. Once you become a registered
2. **Utilize our automated phone system (IVR) available 24 hours a day, seven days a week.** Through the automated system, you can check member eligibility, claims status and authorization status.
3. **Contact a Customer Service representative at the number designated for your line of business.**
 - Medicare: 1-866-687-8994
 - Medicaid: 1-866-822-1340

user on our Web sites, you can verify eligibility, check claims status and receive updates on authorization requests. And if you still have questions, you can submit an e-mail form under the “*Contact Us*” option.

ACCESS AND AVAILABILITY PROVIDER AUDITS

To ensure that WellCare/Harmony members have timely access to their physicians, WellCare/Harmony conducts random, annual telephone audits of its provider network. This audit is required by our regulatory partners in Medicare and Medicaid. WellCare/Harmony must be able to report the annual results of these audits to these regulatory partners upon request.

The access audit consists of several questions to determine the next available appointment times for our members, and the average wait time in the provider’s office once the member arrives for his/her appointment. The availability audit verifies whether members have access to their provider, an on-call physician or an advice nurse after office hours.

Audit calls take only a few minutes to complete and participation in these audits is a condition of your contract with WellCare/Harmony. Additional information regarding your responsibilities as a WellCare/Harmony provider can be found in the WellCare/Harmony Provider Manuals.

We appreciate you and your staff participating in this effort. If you have any questions regarding these audits, please contact your Provider Relations representative.

ACETAMINOPHEN

A FEW POINTS TO CONSIDER

A growing number of serious liver injury cases are caused by unintentional acetaminophen (APAP) overdoses each year. Recently, the Food and Drug Administration (FDA) has been enhancing awareness that the maximum recommended daily dose of APAP should not exceed four grams in healthy adults. Unfortunately, many people are overusing the drug. Here are some factors that may contribute to APAP over-utilization:

- The availability of APAP in many prescription combination medications, and in single-agent and combination over-the-counter (OTC) products
- The lack of patient knowledge and/or awareness
- Patients seeing multiple prescribers who are unaware of what is in the medications the other practitioners have prescribed for the patient
- The possibility of prescriber or pharmacist oversight
- The use of multiple pharmacies

Beginning in the 1990s, APAP over-utilization emerged as a leading factor in cases of unintentional acute liver failure in the United States. One chief cause can be attributed to the fact that the majority of consumers are unaware they are exceeding the maximum recommended dosages. As mentioned above, APAP is available in numerous combination products with varying indications. As a result, much of this problem is flying “under the radar.” While some patient populations are already at a higher risk for liver damage, including those who consume greater than or equal to three alcoholic beverages daily, or already have some degree of liver dysfunction, this amount of liver failure is certainly cause for concern.

The following tables detail select analgesics, both with and without acetaminophen, that are indicated for moderate to severe pain. For your reference, there is also a table indicating the maximum acetaminophen use for common strengths of analgesics that contain acetaminophen.

Analgesics Without Acetaminophen

Tramadol	Oxycodone (Immediate Release)	Methadone/ Methadose	Hydromorphone	Morphine (Immediate Release or Extended Release)
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Analgesics With Acetaminophen

Codeine/Acetaminophen	Oxycodone/Acetaminophen	Hydrocodone/Acetaminophen
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Maximum Acetaminophen Usage

Acetaminophen Strength (mg)	Maximum Tablets/Day	Maximum Tablets/Month
300	13	390
325	12	360
500	8	240
650	6	180
750	5	150

Acetaminophen-induced liver toxicity is an easily avoidable injury that has gained escalating attention in the health care industry. Increased awareness in both health care professionals and patients will facilitate prevention of this undesirable outcome.

Reference: <http://www.fda.gov/advisorycommittees/calendar/ucm143083.htm>

MEMBER RIGHTS AND RESPONSIBILITIES

Harmony members have the following rights:

- To be treated with respect and courtesy by their health care providers and their office staff, and all Harmony staff;
- To select their own PCP;
- To refuse treatment;
- To be treated with due consideration for his/her dignity, privacy and confidentiality;
- To receive care consistent with sound nursing and medical practices;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand, before treatment begins;
- To participate in decisions regarding his/her health care, including the right 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 request and receive a copy of his/her medical records (one copy per year at no cost to the member), and to request that they be amended or corrected;
- To voice concerns or complaints about the program and receive prompt answers;
- To be free to exercise his/her rights and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member;
- 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 by contacting Member Services.

Harmony members have the right to request the following information from Harmony's participating health care providers:

- Copy of the total bill for services received from the member's 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 for which the member is inquiring;
- Information about the health care provider's participation in continuing education programs;
- Compliance with licensure, certification or registration requirements.

RISK APPRAISAL

The Missouri Department of Social Service, MO HealthNet Division (MHD), is requiring that the **Risk Appraisal Form for Pregnant Women** be included in all pregnant MO HealthNet participants' medical records.

In an effort to reduce the amount of paperwork, WellCare and Harmony Health Plan of Missouri will be accepting this form as an OB Notification and a request for an OB Global Authorization. The Risk Appraisal Form for Pregnant Women can be located on the Web at: http://manuals.momed.com/forms/Risk_Appraisal_for_Pregnant_Women.pdf.

Please continue using the WellCare OB Authorization Line at 1-800-351-8777, ext. 4038 and the Global OB Fax at 1-877-647-7475.

Finally, we would appreciate your help in getting the word out to our members about the Harmony Hugs program. Harmony Hugs is a perinatal outreach and support program that assists members in having a healthy pregnancy.

Please feel free to contact your Harmony Provider Relations representative with any questions you may have.

LET'S GET THE LEAD OUT

Missouri is known to be the number one lead-producing state in the United States. Approximately 1.2 percent of Missouri's children under the age of 6 who were tested are known to have an elevated blood lead level of greater than or equal to 10 µg/dl.

The Centers for Medicare & Medicaid Services (CMS) as well as the Missouri Department of Social Services, Division of Medical Services, requires a blood lead test at 12 and 24 months for all children receiving benefits under MO HealthNet Managed Care.

The sampling collection method (venous or capillary) can be determined by the provider. If the fingers, heels and earlobes are cleaned carefully, the capillary method can be an effective testing method. According to the guidelines, results that are questionable and are greater than or equal to 10 µg/dl should be confirmed by a venous blood draw.

Blood level testing should be performed on any child 12 to 72 months old who is receiving benefits under MO HealthNet Managed Care, and does not already have a documented blood lead test.

All children who are less than 6 years of age and are believed to be at risk of lead poisoning should be evaluated at least annually during their health care visits. Utilization of the Healthy Children and Youth (HCY) Lead Risk Assessment Guide and a blood draw are both recommended for all children who may have been exposed to lead, in any form.

Source: <http://www.dhss.mo.gov/ChildhoodLead/Guidelines.html>.

CAPTURE A WELL VISIT EVERY TIME!

We encourage practitioners to provide a well visit at every encounter with a patient, and at least annually with every child up to age 21. It is part of the Healthcare Effectiveness Data and Information Set (HEDIS®) requirements that all children ages 2 to 21 years receive one well visit annually, and infants from birth to 15 months receive at least six well-child visits.

What constitutes a well visit?

- A physical exam
- A patient history exam
- Anticipatory guidance
(wellness education appropriate to the age of the patient)

How do I code?

- Harmony encourages all practitioners to code for both a sick and well visit if the patient came in because he/she was sick and if the practitioner provided all components of a well visit.
- Practitioners generally provide all three well-visit components regardless of the initial purpose of the visit; be sure to receive credit for this and code as such.
- If only a sick visit was completed (all three well-visit components were not addressed) or only a well visit was completed, code with the one appropriate code.
- Do not overlook the opportunity to do a well visit and code as such at every encounter with the patient. This may be the only time you see that patient this year.

Reference: 2011 HEDIS technical specifications



WINTER 2010 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
Arimidex® 1mg Tablet	Anastrozole 1mg Tablet	Aromatase Inhibitor
Cardizem® LA 180mg, 240mg, 300mg, 360mg, 420mg Extended-Release Tablets	Diltiazem HCl 24HR 180mg, 240mg, 300mg, 360mg, 420mg Extended-Release Tablets	Calcium-Channel Blocker
Effexor XR® 37.5mg, 75mg, 150mg Extended-Release Capsules	Venlafaxine HCl 37.5mg, 75mg, 150mg Extended-Release Capsules	Serotonin-Norepinephrine Reuptake Inhibitor
EpiPen® Auto-Injector 0.3mg/0.3mL Solution for Injection	Epinephrine 0.3mg/0.3mL Auto-Injector Solution for Injection	Anaphylaxis Agent
Keppra® 500mg/5mL Solution for Injection	Levetiracetam 500mg/5mL Solution for Injection	Anticonvulsant

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

ADDITIONS	
Ampicillin Sodium 125mg, 250mg, 500mg, 2gm Powder for Injection	Pfizerpen® 5,000,000 units, 20,000,000 units for Injection
Ciclopirox 1% Shampoo	Rapamune® 0.5mg Tablet (PA)
Clindamycin Phosphate 1% Foam	Ribasphere® 200mg Tablet (PA)
Creon® 6,000 USP units of lipase, 12,000 USP units of lipase, 24,000 USP units of lipase Delayed-Release Capsules	Sumatriptan 4mg/0.5mL, 6mg/0.5mL Syringes (QL: 8mL (16 syringes)/31 days)
Hydromorphone 2mg/mL Vial	Vimpat® 10mg/mL Oral Solution (PA)
NovoPen® 3 Insulin Device	Zortress® 0.25mg (PA; QL: 62 tablets/31 days), 0.5mg (PA), 0.75mg (PA) Tablets
Ondansetron 32mg/50mL Bag (PA)	

PA = Prior Authorization QL = Quantity Limit

The prior authorization associated with the following medication has been removed for the WellCare Medicare Formulary:

DRUG NAME
Lovaza® 1gm Capsule

PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Novo Nordisk	Vagifem® 25mcg vaginal tablets	July 30, 2010	Novo Nordisk decided to discontinue Vagifem® 25mcg because medical societies have recommended that the lowest effective dose of estrogen consistent with treatment goals, benefits and risks for the individual woman should be the therapeutic goal. Novo Nordisk has recently launched low-dose Vagifem 10mcg. The Vagifem 25mcg vaginal tablets that Novo Nordisk is going to be withdrawing and the recently launched Vagifem 10mcg vaginal tablets are not a covered benefit for members of WellCare Medicare.
Pfizer	Mylotarg® 5mg Powder for Injection	October 15, 2010	Pfizer has announced it will be discontinuing commercial availability of Mylotarg® in the U.S. Patients who are currently taking Mylotarg and those patients who have been prescribed Mylotarg may continue their course of therapy in consultation with their physicians. However, Pfizer recommends no new patients in the U.S. be prescribed Mylotarg. Future use of Mylotarg for new patients in the U.S. will require physician submission of an Investigational New Drug (IND) application to the U.S. Food and Drug Administration (FDA).

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. However, while these ratings were designed with members in mind, providers may also reap tremendous benefits from reviewing these scores and learning how to best help their Medicare patients receive improved customer service and quality care.

It's important for our providers to familiarize themselves with the Medicare Star Rating System, as well as the important measures that will help improve our patients' care. 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®):** One of the most widely used sets of health care performance measures in the United States, 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 our patients. Please keep these scores in mind as you work with our members.



WHAT DOES HARMONY LOOK FOR DURING A MEDICAL RECORD REVIEW?

Consistent and complete documentation in the medical record is an essential component of quality patient care. All medical records must be legible and include the following:

- Identity of member to whom service was rendered
- Identity and title of provider rendering service
- Date on which the service was rendered
- Documentation of allergies
- List of medications
- Problem list with significant illnesses listed
- Past medical history
- List of smoking and chemical dependencies
- History and physical with subjective and objective information
- Laboratory and X-ray results with signature or initials of provider who ordered them to signify review
- Documentation of diagnosis with treatment plan
- Copy of referral request
- Note from consultant with signature or initials of provider who ordered them to signify review
- Record of outpatient and/or emergency care
- Inpatient discharge summary
- Notation of advance directive

For children, ages newborn through 20, the medical record must include:

- Health and developmental history
- Physical exam
- Subjective and objective vision assessment
- Subjective and objective hearing assessment
- Documentation of immunizations
- Laboratory tests
- Health education
- Subjective and objective dental assessment
- Documentation of dental referral (starting at 24 months)

For adults, the medical record must include documentation of:

- Cholesterol screening (starting at age 35 for men and age 45 for women)
- Cervical cancer screening (starting at age 18 for women)
- Breast cancer screening (starting at age 40 for women)
- Colon cancer screening (starting at age 50 for both men and women)
- Tetanus immunization (every 10 years)

POLICY RECOMMENDATIONS FOR COMMUNICATING ABNORMAL TEST RESULTS

Health care providers sometimes find it difficult to communicate and act upon critical diagnostic test results in a timely and appropriate manner. In 2001, this topic was addressed as a National Patient Safety Goal by the Joint Commission. For that reason, evidence-based and practical policies have been developed by health care providers to enhance communication of abnormal test results.

Recommendations on establishing policies have been published in the Joint Commission Journal on Quality and Patient Safety. These recommendations include:

- Key terms should be clearly defined in the policies: such as *critical*, *suspicious* and *significantly abnormal*.
- The policies should outline which provider is responsible for follow-up.
- There should be specific procedures for communication of the test results to the ordering providers.

- Policies should define which mechanism should be used for significant abnormal tests (i.e., *verbal* or *electronic*).
- The policies should define *critical tests* and the lag time between the order and reporting of the findings.
- Policies should be established to provide guidance on how and when the information should be disseminated to the patient.
- Key stakeholders (lab personnel, radiologist, QI personnel and residents) should be involved in providing feedback when the policies are being written.
- The procedure should be audited to monitor and evaluate the process.

Source: The Joint Commission Journal on Quality and Patient Safety May 2010 Volume 36 (5), 226-232. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/20480756>.

THE PROVIDER'S ROLE IN DATA GATHERING

Prior to billing Medicare, providers must ensure that they are billing the correct primary payer. A few minutes during each visit can help save time and money later. When collecting this data, the provider must indicate if the health care coverage is due to retirement and a supplemental policy.

Providers should be considering questions similar to the following:

- Does the patient have any group health plan (GHP) coverage based upon his/her current employment? (Medigap coverage should not be indicated.)
- Does the patient have any GHP coverage based upon his/her former employment?
- How many employees, including the patient, work for the employer from whom the patient has health insurance?
- Does the patient have any GHP coverage based upon his/her spouse's or another family member's current employment?
- Does the patient have any GHP coverage based upon his/her spouse's or another family member's former employment?
- How many employees, including the patient's spouse or other family members, work for the employer from whom the patient has health insurance?
- Is the patient receiving Black Lung benefits?
- Is the patient receiving workers' compensation benefits?
- Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

PATIENT SAFETY TIPS

WellCare/Harmony encourages providers to keep these important safety tips in mind when caring for our members, your patients.

DRUG INTERACTIONS AND DUPLICATE DRUG THERAPIES

- Ask patients to keep an accurate list of all medications, including herbal and nutritional supplements, or put them in a bag and bring them to their next office visit.
- Implement a computerized physician order-entry system, which reduces risk by checking a patient's history, lab results, current medications, allergies and weight before a prescription is ordered.
- Consult with the patient's pharmacist if you have questions about other drugs that may have been prescribed to the patient by another physician.
- Watch for these clinical identifiers that may indicate the occurrence of a medication error:
 - Rash
 - Seizure

MEDICARE ADVANTAGE PLANS 2011

Each year, WellCare must resubmit Medicare Advantage plan bids to the Centers for Medicare & Medicaid Services (CMS). As a result, WellCare's plans may change service area, plan names or both. Members who have been impacted by a change in service area will need to re-enroll during the Annual Enrollment Period (AEP). Members who have had only a plan name change will be rolled-over into a new plan that offers similar benefits.

Members who are currently enrolled in a terminating plan were notified by letter on September 22. There has been some confusion regarding these notifications that some of your patients may have received. **Please note that WellCare is not exiting any counties and has alternative products available for all members that received this communication.**

If a member has questions about the notification, please advise them to contact WellCare Customer Service at 1-866-687-8994. Customer Service has talking points on this communication and will direct them to the appropriate staff that can help them get enrolled in an alternate WellCare plan.

As a provider, please continue to perform the same services to members on your panel as you normally would.

To ensure a successful new plan year transition, please remember these helpful tips:

- Always check the member's ID card and verify eligibility at each office visit.

- You can identify a WellCare Medicare Advantage member by looking at his or her member ID number, which should contain only numerals.
- If a member makes an appointment with you before receiving their cards, you may contact Customer Service for plan-specific information.
- An enrollee's membership is effective the first day of the month following receipt of his or her application.

To validate eligibility of WellCare Medicare Advantage members, please call the Customer Service telephone number listed on the back of the ID card. As a registered user, you can also check on the Plan's Web site at www.wellcare.com. If you are not a registered user, you can easily register by following steps outlined below:

1. Go to www.wellcare.com/provider/default and click on the *Sign Up Here* link next to *Register Today!* You will reach the www.wellcare.com/registration/provider page, where you will begin the simple, three-step process.
2. You will be asked to supply an e-mail address. The WellCare Web site allows you to have as many administrative users as needed, and you can tailor views, downloading options and e-mail details. For security purposes, we encourage the use of business e-mail accounts (instead of personal e-mail addresses).

For more information on WellCare's 2011 Medicare Advantage plans, please visit the Plan's Web site at www.wellcare.com.

- Abnormal heart and/or respiratory rate
- Diarrhea
- Hearing change
- Fever
- Altered mental state

CONTINUITY AND COORDINATION OF CARE

- Remember to schedule follow-up appointments in your discharge-planning process.
- Give patients the opportunity to read their own medical records.
- Encourage patients to see a specialist within 30 days.
- Ask your patient whether he or she has seen a specialist.
- If you are a specialist, please remember that:
 1. The consultant notes should be *entered into the health record following the completion of service.*
 2. Ensure that discharge summaries and lab results are sent to the primary care provider (PCP).



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CHANGES TO YOUR 835 EXPLANATION OF BENEFITS

WellCare/Harmony has enhanced our claims systems to capture claims that have been finalized (F-processing status) and processed in our system but have not been included on an EOP (explanation of payment) due to one of the reasons noted below. You may now see more details on your claims and EOPs that were not there in the past. Processes for submitting claims remain the same.

Claims may be in F-processing status for one of the following reasons:

- If your vendor has a negative balance due to retroactivity with payable or denied claims. A refund request letter was initiated and sent by the Cost Containment department in regard to the claims that were overpaid that created the F-processing status on the payable and denied claims.
- If the claims are capitated.
- In the event the claims have been processed, but have not passed completely through the A/P cycle.
- If the claim has no payables and all of your claims have been denied. In the past you have received a mailed nonpayable EOP which included these claims. With the enhancement, these will be included in your 835.

WellCare/Harmony asks that you contact Customer Service at **1-866-822-1340** (Medicaid) or **1-866-687-8994** (Medicare) with any questions on the EOPs that you receive from this enhancement or any other questions you may have about the claims in the F-processing status.