MISSOURI | 2011 | ISSUE III

PROVIDER Newsletter

5010 COMPLIANCE IS REQUIRED BY JANUARY 1, 2012. ARE YOU READY?

HIPAA legislation mandates that the health care industry use standard formats for electronic claims and related transactions. The current format, 4010A1, is in the process of being replaced by 5010, a new standard format. All covered entities (health plans, health care clearinghouses, and certain health care providers) will be required to use the 5010 standard when conducting electronic transactions, including: claims (professional, institutional and dental), claims status requests and responses, payment to providers, eligibility requests and responses, referral requests and responses, enrollment and disenrollment in a health plan, coordination of benefits and premium payments.

Do you:

- Submit claims (837) electronically?
- Receive remittances (835) electronically?
- Electronically send and receive eligibility statuses (270/271) or claim statuses (276/277)?

If so, your trading partners (clearinghouse, vendor, vendor websites, vendor software, billing service, etc.) involved with processing your transactions (inbound and outbound) have likely been in contact to ensure 5010 changes have been tested and are ready for implementation on or before January 1, 2012.

If your trading partners have not been in contact regarding 5010, WellCare/Harmony recommends that you make contact now. By 3rd quarter of 2011, your clearinghouse, software vendors and billing service should be able to confirm their 5010 implementation plans. WellCare/Harmony also recommends that you discuss the changes for your organization, as your particular needs may differ from your vendor's standard implementation plan (see CMS documentation below for helpful hints).

Remember, 5010 adoption is mandated per HIPAA legislation. As of January 1, 2012, use of 4010A1 transactions will be discontinued and only version 5010 will be accepted.

For additional information, please contact:

- E-mail: **5010_Questions@WellCare.com**
- CMS assistance: Provider Guide to a Smooth 5010 Transition (**www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf**)

PROVIDER UPDATES AND RESOURCES

Did you know that you can get the most up-to-date information and resources on Harmony Health Plan of Missouri's provider Web portal? You can find information on:

- Clinical Practice Guidelines
- Quick Reference Guides
- Provider Manual
- Utilization Management
- Statement About Financial Incentives
- Quality Improvement Program
- Quick Reference Guide
- Services Needing Prior Authorization
- Forms and Informational Documents

Visit **www.harmonyhpm.com** frequently for updates on these and other resources.

SEPTEMBER IS NATIONAL CHOLESTEROL EDUCATION MONTH

Cardiovascular disease (CVD) is a leading cause of preventable illness, disability and death in adults. There are social, environmental and genetic components that all contribute to the onset of CVD. Some of these factors can be modified, treated and controlled, while others cannot.

Non-modifiable Risk Factors:

- Age (men > age 55 & women > age 65)
- Familial history and genetics
- Gender

Modifiable Risk Factors

- Smoking
- Uncontrolled hypertension
- Uncontrolled dyslipidemia
- Physical inactivity
- Obesity and excessive weight
- Poor diet
- Uncontrolled diabetes mellitus
- Stress
- Excessive alcohol consumption

As a health care provider, it is essential to properly screen and identify those patients who are at an increased risk of having CVD. This includes comprehensive health risk assessments, positive health-related behavior changes, management of lipid levels, evidence-based treatment interventions and patient education. To help patients control their cholesterol and decrease their risk of having a CV-related event, the Centers for Disease Control and Prevention (CDC) – Division of Heart Disease and Stroke Prevention (DHDSP) encourages all health care providers to participate in the overall management of cardiovascular disease.

A comprehensive approach includes a cardiovascular risk assessment, patient monitoring and treatment protocols.

Patient-specific treatment plans should include the following components:

- Patient education on lifestyle modifications — the cornerstone of CVD prevention;
- Implementation of evidence-based treatment interventions for patients with a clinical diagnosis of coronary artery disease, other atherosclerotic diseases and diabetes;
- Pharmacological treatment options for patients with elevated risk factors, including the prescription of statin drugs to lower LDLs.

For individuals with a clinical diagnosis of diabetes, the CDC recommends the following cholesterol levels:

- Total cholesterol under 200
- LDL (“bad” cholesterol) under 100
- HDL (“good” cholesterol) above 40 in men and above 50 in women
- Triglycerides under 150

As a health plan, we appreciate your actions to help patients maintain a healthy lifestyle and reduce the incidence of cardiovascular-related diseases to improve their overall quality of life.

References: Centers for Disease Control & Prevention (CDC)-Division for Heart Disease and Stroke Prevention. Page last reviewed March 24, 2011, page last updated: March 24, 2011.

MEMBER NON-COMPLIANT LISTS

Harmony Health Plan of Missouri provides all primary care physicians with a listing of members that are non-compliant with health promotion, HEDIS® measures and disease prevention services. Member non-compliant lists are an important tool for increasing the HCY/EPSDT and HEDIS® rates. When the non-compliant lists arrive in your office, please review them and reach out to Harmony members to schedule an appointment for needed services.

TIMELY FOLLOW-UP CARE AFTER BEING HOSPITALIZED FOR MENTAL ILLNESS

The National Committee for Quality Assurance (NCQA) developed several HEDIS® measures of mental health quality that are used by health care consumers and regulatory agencies to monitor the performance of managed care organizations.

Outpatient follow-up care post-discharge is an important component of the continuum of care to assist an individual with their transition from hospital back into their family, work and community. Follow-up care may also reduce re-hospitalizations or facilitate a necessary readmission before an individual reaches the crisis stage. Follow-up care may be even more important, and perhaps more problematic, for patients who have been hospitalized for a serious mental illness.

Primary care physicians (PCPs) should always recommend early post-discharge follow-up visits for their hospitalized patients. Directing your staff to facilitate outpatient visits, to you and the behavioral health providers within seven days of a hospital discharge, will help reduce readmissions and improve the continuity of care for your patients.

If your patient misses his/her early follow-up appointment, it is imperative that the outpatient visit is rescheduled and completed no later than 30 days after the recent hospital discharge. Medication reconciliation to confirm the patient understands his/her medicines, management of co-morbidities, step-action treatment plans and co-management of mixed illness diseases to include how the patient can get help, especially after normal office hours, are all important topics that need to be discussed at the time of the post-discharge follow-up visit.

Together, you can help your patient to continue to live at home and/or work while being in treatment.

REVISED APRIL 2011: MISSOURI MEDICAID PROVIDER MANUAL

Harmony Health Plan of Missouri, Inc. (Harmony) recognizes that, at times, the administrative requirements of managing your patients' health care can be complex. Provider Manuals are furnished to answer questions you may have about health plan coverage procedures, policies and other facts related to your provision of health care services to our members.

PURPOSE

Harmony's Provider Manual is an extension of the participation agreement between Harmony and all provider types, including but not limited to physicians, hospitals and ancillary health care providers, and furnishes such providers and their office staff with information concerning policies and procedures, claims, and guidelines used to administer Harmony health plans.

The revised April 2011 Provider Manual will replace and supersede the previous version dated October 2008. Provider Manuals can be accessed on our website at **www.harmonyhpm.com/Provider/ProviderManual**. A paper copy may also be obtained by contacting your local Provider Relations representative or calling the Provider Services number at **1-866-822-1340**.

CANCER SCREENING AWARENESS

October is Breast Cancer Awareness Month. Encourage your female patients to get all their preventive health exams completed during October if they have not already done so this year.

According to the Centers for Disease Control and Prevention (CDC), many deaths from breast and cervical cancer could be avoided by increasing cancer screening rates among women. The CDC reports that deaths from these diseases occur disproportionately among women who rely on public health programs like Medicaid or are uninsured.

WellCare/Harmony covers all regular preventive tests and screenings for women without requiring a referral or prior approval. Help us ensure that our members stay healthy by recommending appropriate preventive tests and screening.

Please continue to encourage women to obtain an annual mammography for breast cancer screening and a Pap smear for cervical cancer screening.

COMMUNICATING EFFECTIVELY FOR CONTINUITY OF CARE

WellCare encourages all providers — medical and behavioral — to initiate communication that facilitates and enhances continuity of care, relapse prevention, member safety and member satisfaction. Few would challenge the hypothesis that effective integration and collaboration between primary care physicians (PCPs) and mental health specialists (to include psychiatrists, social workers and ARNPs) is essential for patient well-being. Yet it is not uncommon to hear medical providers and behavioral health providers complain they do not receive information from the opposite discipline. Barriers often cited are time and resource limitations. However, when one considers the potential impact on optimal member care, communication is clearly a critical necessity.

WHAT YOU CAN DO AS THE INDIVIDUAL PRACTITIONER

- Get to know your fellow physicians, PCPs and psychiatrists. Go to meetings whenever possible where you can get to know one another.
- Pick up the phone. Colleagues will appreciate the time and effort taken for communication.
- Request copies of records from physicians who have cared for the patient before your involvement.
- Set up systems in your office and hospital units that enhance and automate patient communication and permit transition of care in a safe and effective way.
- Include the PCP on admission and discharge reports, letting your colleague know about discharge appointments, medications and any specialty consultations required post-hospitalization.
- Utilize health plan Care Manager resources to assist you in making appointments and arranging follow-up care. Our staff can also work with the member to make sure he/she makes his/her appointments.

If you have questions or feedback about physician communication or quality-related topics, please contact the health plan or your local Provider Relations representative.

SPIROMETRY TESTING

A SIMPLE BREATHING TEST TO ASSESS AND DIAGNOSE COPD

While there is no cure for Chronic Obstructive Pulmonary Disease (COPD), early detection of the disease might help change its course and disease progress. That's why we encourage you to take steps in early detection to help you and your patients manage their disease by carefully monitoring medical and family health history, the presence of symptoms, and airway obstruction (also called airflow limitation).

The Global Initiative for Chronic Lung Disease (GOLD) international COPD guidelines[1], as well as national guidelines[2], advise spirometry as the gold standard for accurate and repeatable measurement of lung function. Evidence-based practice guidelines indicate that when spirometry confirms a COPD diagnosis, doctors initiate more appropriate treatment. Spirometry is also helpful in making a diagnosis in patients with shortness of breath and other respiratory symptoms and for screening in high-risk environments.

Consider utilizing spirometry as a diagnostic tool if you have patients that are experiencing some of the more common symptoms:

- A cough that doesn't go away
- Coughing up lots of mucus
- Shortness of breath, especially with activity upon exertion
- Wheezing
- Tightness in the chest
- Limitations in activity

If a diagnosis is confirmed, please educate your patients about avoiding the most common causes of COPD, such as cigarette smoking, being around second-hand smoke, long-term exposure to other home and workplace air pollutants, and chronic respiratory infections.

The goal of COPD treatment is to ease the symptoms, slow the progress, prevent and treat any complications, and improve the patient's overall quality of life.

Refer COPD members to WellCare's Disease Management program by calling **1-866-635-7045**. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

REFERENCES

[1]Global Initiative for Chronic Obstructive Lung Disease. Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. (Updated 2007). http://www.goldcopd.org.

[2]National Collaborating Centre for Chronic Conditions. Chronic obstructive pulmonary disease: national clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care. Thorax 2003, 59 (Suppl 1); 1-232.

OTHER SOURCES:

American Lung Association: "Chronic Obstructive Pulmonary Disease (COPD) Fact Sheet." National Heart Lung and Blood Institute: "COPD" and "COPD: Learn More, Breathe Better." American Academy of Family Physicians: "Chronic Obstructive Pulmonary Disease (COPD)." Journal of the American Medical Association: "Chronic Obstructive Pulmonary Disease.

FREE UP YOUR FAX MACHINE!

WELLCARE/HARMONY HAS LAUNCHED PROVIDER E-MAIL COMMUNICATIONS

WellCare Health Plans, Inc./Harmony Health Plan of Missouri, Inc. (the plan) has launched the use of outbound e-mail communications for our provider community!

If you have already registered for the secured website, thank you for your participation. You should have received the plan's first two e-mails on April 28 regarding respiratory diseases, and May 19 regarding childhood and adolescent wellness and preventive physician visits.

If you have not yet registered for the website, we encourage you to participate by following the simple process outlined below.

HOW TO OPT IN TO E-MAIL COMMUNICATIONS

1. Visit **www.wellcare.com/provider/default** or **www.harmonyhpm.com/provider/default** and click on the *"Provider Sign Up"* link under *"Not Registered?"* on the right-hand side of the page. You will reach the **www.wellcare.com/registration/provider** or **www.harmonyhpm.com/registration/provider** page where you will begin the simple, three-step Web registration process.
   - By registering for the plan's website, you and your staff will have secure Web access to a variety of easy-to-use tools created to streamline your day-to-day tasks, including:
     - Submitting and checking the status of claims
     - Accessing member eligibility and co-pay information
     - Submitting and checking the status of authorization requests
2. During the Web registration process, you will be asked to supply an e-mail address. The website 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 and recommend you provide the main e-mail account for your practice in addition to any other e-mail addresses you wish to provide. The use of personal e-mail addresses (such as yahoo.com, aol.com, gmail.com, etc.) to receive official communications from the plan is not recommended.
3. Within 24 hours of registration, you will receive an e-mail with a temporary password. Use this password to log in to the plan's site and create a password of your preference. Please make note of your login and password information for future use. If you register for the secured website, you will soon begin receiving e-mail communications with information regarding the Healthcare Effectiveness Data and Information Set (HEDIS®) measures, information and reminders about WellCare/Harmony initiatives, and other quality-focused communications.

If there are other providers in your practice who are not registered users of the Provider website, we suggest encouraging them to register so they may receive future e-mail communications as well.

We will never e-mail you Protected Health Information (PHI) or HIPAA-related communication. If you do receive an e-mail containing sensitive information, please contact the plan's iCare Compliance Hotline at **1-866-364-1350**.

TO UNSUBSCRIBE/OPT OUT

- You may unsubscribe from the e-mail communications at any time by scrolling down to the bottom of any WellCare/Harmony e-mail and clicking the "One-Click Unsubscribe" link.
- If you have previously provided your e-mail address to the plan during the secured website registration or credentialing process, it may automatically be included in this initiative. If you wish to opt out, please unsubscribe by following the step above.

Please note that contractual and regulatory-based communications will continue to be delivered via other methods, including mailings and faxes.

If you have any questions, please call Provider Services at **1-866-822-1340** (Medicaid) or **1-866-687-8994** (Medicare).

Fast, secure, at your fingertips — Register for the secured website and e-mail communications today!

PROTOCOL FOR CHANGING A MEMBER'S PRIMARY CARE PHYSICIAN

As outlined in the Provider Manual, Plan members have the right to change their Primary Care Physicians (PCP) at any time by contacting the Customer Service department. However, there is a certain protocol to follow to ensure the member's request is completed in a seamless and efficient manner, and it's important for both our providers and members to be aware of these requirements. The following will serve as a guideline:

- Retroactive PCP changes made within the same month are available from the **1st** to the **10th** of the month.
- PCP change requests made after the **10th** of the month will not be made effective until the **1st** of the following month (extenuating circumstances may allow for exceptions).
- Any PCP change request call to Customer Service that is made by a provider must be made with the member present in order to verify acceptance. If the member is **not** present, the change request will not be honored.

We appreciate your continued participation in providing superior care to our members. Please keep the requirements listed above in mind as you work with our members to honor their PCP change requests. Should you have any questions or concerns about this matter, please contact Customer Service at **1-866-687-8994** (Medicare) or **1-866-822-1340** (Medicaid), or contact your local Provider Relations representative.

PROCESS IMPROVEMENT PROJECTS

As part of its commitment to improving member health outcomes, Harmony Health Plan of Missouri will be assessing certain activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions targeting health care providers, practitioners and/or members.

Harmony Health Plan of Missouri currently assesses the following:

- Improving Asthma Management Ages 5–50
- Increasing Adolescent Well Visits
- Improving Oral Health
- Increasing Lead Screenings in Children Aged 0–2
- Managing Weight in Children

Harmony Health Plan will provide intervention results based on HEDIS® outcomes in these areas in the next issue of the Missouri provider newsletter. If you would like to be considered as part of a pilot project for any of these areas, please contact Ramona Kaplenk, Manager, Quality Improvement at **1-314-444-7502** or **Ramona.Kaplenk@wellcare.com**.

IMPORTANT CHANGES IN ELECTRONIC DATA INTERCHANGE (EDI) PROCESS

As of **July 24, 2011**, WellCare Health Plans Inc./Harmony Health Plan (the Plan) will be accepting electronic claims only through RelayHealth's pre-adjudication platform. WellCare/Harmony has selected RelayHealth, a division of McKesson, to manage EDI connectivity between the Plan and our providers. We believe this choice will expand electronic-based real-time services for our providers, increase EDI volume, and simplify EDI administration. We also believe this kind of arrangement drives efficiencies and leads to lower overall costs for health care, and that it is becoming commonplace in the health benefits market.

We have requested that our previous partners transfer — at no charge — their EDI connection for WellCare/Harmony claims to RelayHealth's pre-adjudication platform. Although most have agreed, some are no longer accepting or sending transactions to WellCare/Harmony following our switch to RelayHealth on July 24; so you may experience issues with adjudication or payment of those claims.

In most cases, the transition will be seamless; however, we strongly encourage you to contact your practice management vendor, billing service or clearinghouse immediately and obtain their assurance for continued electronic claims submission to the Plan via RelayHealth to ensure your practice is prepared for this transition. Upon confirmation from your vendor, billing service or clearinghouse of continuous electronic claims submission to WellCare/Harmony via RelayHealth, no further action is necessary.

If you have any questions regarding submission of EDI transactions through RelayHealth, you may call **1-888-743-8735**, and they will provide you assistance and recommendations regarding the transition. For further details, you may contact us via e-mail at **EDI-MASTER@wellcare.com**, and WellCare/Harmony will respond to your inquiries in a timely fashion.

We feel strongly that our relationship with RelayHealth will expand our EDI service levels for you, and improve your experience with WellCare/Harmony and our members.

CONTINUITY AND COORDINATION OF CARE BETWEEN HEALTH AND PRIMARY CARE PRACTITIONERS

Continuity and coordination between physical and behavioral health is an important aspect in the delivery of quality health care, as behavioral and medical disorders can interact to affect an individual's health. The following guidelines will help you learn the kind of information that should and should not be shared among practitioners:

	PCP TO BH PRACTITIONER	BH PRACTITIONER TO PCP
Do Share	• Acknowledgement of BHP's: – attempt to coordinate care – preferred method of communication – contact information • Treatment of chronic conditions • Medication prescription and management • Results of clinical tests • Serious concerns/changes in mood/affect/thoughts observed during office visits • Concerns/observations regarding medication interactions/side effects prescribed by the BHP • Patient no longer on your panel	• Admission to and discharge from any BH service. Include date and reason • Diagnosis (all 5 axes) • Brief treatment plan • Significant change in treatment plan • Concerns/observations regarding medication interactions/side effects prescribed by the PCP • Any medication changes made by the BHP • Results of clinical tests • Progress notes, if deemed necessary for care coordination
Don't Share	• Any medical information deemed irrelevant to coordination of care • Any information if the patient signed a "Do Not Release" form	• Psychotherapy notes – documenting or analyzing a conversation during counseling – without written authorization of patient • Any information if the patient signed a "Do Not Release" form

Finally, the HIPAA Privacy Rule permits uses and disclosures for *"treatment, payment and health care operations"* as well as certain other disclosures without the individual's prior written authorization. Disclosures not otherwise specifically permitted or required by the HIPAA Privacy Rule must have an authorization that meets certain requirements. With certain exceptions, the HIPAA Privacy Rule generally requires that uses and disclosures of PHI be the minimum necessary for the intended purpose of the use or disclosure.

WAYS TO REDUCE YOUR PATIENTS' RISK OF COMPLICATIONS FROM DIABETES MELLITUS

The following national statistics and other general information on diabetes were adopted from the Centers for Disease Control and Prevention (CDC) National Diabetes Fact Sheet: National estimates and general information on diabetes in the United States.

- 25.8 million Americans have diabetes — 8.3 percent of the U.S. population. Of these, 7 million do not know they have the disease.
- In 2010, about 1.9 million people ages 20 or older were diagnosed with diabetes.
- The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 18.8 million in 2010, an increase of epidemic proportions.
- Diabetes is the seventh leading cause of death listed on U.S. death certificates.
- Cardiovascular disease is the leading cause of death among people with diabetes — about 68 percent die of heart disease or stroke.
- The overall risk for death among people with diabetes is about double that of people without diabetes.
- Total health care and related costs for the treatment of diabetes run about $174 billion annually.
- Of this total, direct medical costs (e.g., hospitalizations, medical care and treatment supplies) account for about $116 billion.
- The other $58 billion covers indirect costs such as disability payments, time lost from work and premature death.

As you can see from the facts listed above, diabetes is becoming more prevalent. Please educate your patients on a self-care plan so they can take control of their disease and lower their risk of complications.

Encourage diabetics to use the following as a guide to self-care:

1. Know their diabetes **ABCs**.
   - **A** is for the **A**1C (blood glucose) test. Results should be < 7.
   - **B** is for **B**lood pressure. It should be below 120/80.
   - **C** is for **C**holesterol. LDL should be less than 100 and HDL above 40 to lower the patient's chances of having a heart attack, stroke or other associated diabetic problems.
   - **S** is for **S**moking. Encourage patients to be nicotine free and provide them with the Quit Smoking website **www.smokefree.gov**.
2. Maintain a healthy weight by staying on a diet that achieves a BMI in the normal range.
3. Check their blood glucose during the day; know their blood glucose targets and how to use the results to manage their diabetes.
4. Participate in 30 minutes of physical activity 2–4 days per week.
5. Abstain from alcohol or consume it in moderation.
6. Schedule periodic medical checkups to include an annual retinal eye exam by either an ophthalmologist or optometrist, and an annual dental examination to find and treat any problems early.
7. Be mindful of their foot care, being sure to check their feet every day for cuts, blisters, red spots and swelling, and call you right away about any sores that don't go away.
8. Report any changes in their eyesight.
9. Stay up to date with their age-appropriate vaccinations.
10. Use stress management techniques that reinforce positive health care behaviors.

Refer diabetic members to WellCare's Disease Management program by calling **1-866-635-7045**. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

Sources: Centers for Disease Control and Prevention (CDC) National Diabetes Fact Sheet: National estimates and general information on diabetes in the United States, Updated January 2011. National Diabetes Education Program (NDEP) at http://www.ndep.nih.gov/publications

CASE AND DISEASE MANAGEMENT PROGRAMS

WellCare's Case Managers support you and your hectic schedules, freeing you to spend more time with your patients by:

- Collaborating with providers and physicians to create a targeted assessment and treatment plan for the patient's condition
- Maintaining communication between the patients and their families, and the team of physicians
- Identifying opportunities for interventions such as ineffective treatment plans or lack of financial resources to meet the needs
- Assisting with patient transition when discharged from the program

The types of cases targeted by our Case Management program include, but are not limited to, the following types of patients:

- Complex case needs requiring coordination of multiple outpatient services
- Transplants
- Frequent inpatient admissions and readmissions
- Prolonged or debilitating illness or injuries

WellCare's Disease Managers support you and your hectic schedules too, freeing you to spend more time with your patients by:

- Educating them on how to deal with challenges of their disease
- Documenting progress in clinical notes and alerting your patients to significant changes or findings

Our Disease Management program targets the following conditions:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV
- Hypertension

Our Case and Disease Management programs identify potential candidates based on available data and referrals from multiple sources:

- Claims or encounter data
- Pharmacy
- Laboratory data
- Utilization Management, Case Management, Disease Management and Discharge Planner referrals
- Practitioner and member referrals
- Behavioral health vendors

If you would like to refer your WellCare patients to either or both of these programs, please call the Case and Disease Management Referral Line at **1-866-635-7045** Monday through Friday, from 8 a.m. to 5 p.m. Eastern.

ATTENTION DEFICIT/HYPERACTIVITY DISORDER

Attention Deficit/Hyperactivity Disorder (ADHD) affects 5 to 8 percent of school-aged children—with 60 percent of the cases experiencing symptoms persisting into adulthood. Since 2006, 4.5 million children between the ages of 5 and 17 received a diagnosis of ADHD (Bloom, Cohen, 2007).[1] A national epidemiological study found the prevalence of ADHD with the predominantly inattentive type at 8.7 percent, 2.2 percent combined, and 2 percent predominantly hyperactive-impulsive type (Langberg, J. M., et al, 2008).[2]

CLASSIFICATIONS

DSM IV classifies ADHD in the following ways:

- **Predominantly Inattentive Type:** It is hard for the individual to organize or finish a task, to pay attention to details, or to follow instructions or conversations. The person easily is distracted or forgets details of daily routines.
- **Predominantly Hyperactive-Impulsive Type:** The person fidgets and talks a lot. It is hard for the individual to sit still for long (e.g., for a meal or while doing homework). Smaller children may run, jump, or climb constantly. The individual feels restless and has trouble with impulsivity.
- **Combined Type:** Symptoms of the above two types are equally present in the person.[3]

POSSIBLE SYMPTOMS

The American Psychiatric Association's DSM IV manual lists possible symptoms of ADHD as follows:

- Has difficulty paying attention
- Does not listen
- Easily distracted
- Forgetful
- Unable to stay seated
- Squirms or fidgets
- Talks excessively
- Not able to play quietly
- Acts and speaks without thinking
- Has trouble taking turns
- Interrupts others

DIAGNOSIS

There is no single test to diagnose ADHD. Consequently, the ADHD diagnostic process requires obtaining information from multiple sources including school, parents, and an individual evaluation of the child. A medical evaluation also should be completed as part of the evaluation process. The American Academy of Pediatrics (AAP) issued practice guidelines related to ADHD assessment and treatment.[4]

There are several screening tools for evaluating ADHD.

- The Connor's Rating Scale uses observer ratings and self-report ratings to help assess ADHD and evaluate problem behavior in children and adolescents. There are three versions—parent, teacher, and adolescent self-report—all of which have a short and long form available.
- The Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales are used to rate symptoms and impairments in academic and behavioral performance.

CO-MORBIDITIES

Two-thirds of children with ADHD have at least one of the following coexisting conditions: disruptive behavior, mood abnormality, anxiety disorders, tics, Tourette Syndrome, and learning disabilities. Studies identify an increased risk for early nicotine use followed by alcohol and drug abuse (Molina and Pelham, 2003). Current research demonstrates the rate of cocaine and stimulant abuse is not higher among individuals with ADHD who were previously treated with ADHD medication as a child.

TREATMENTS

Available treatments for ADHD include combining medication with behavioral or educational therapy. Close monitoring and follow-up also is part of the treatment plan.

A study in the American Psychological Association showed when children are treated with behavioral interventions, along with their parents being trained how to manage the child's behavior, that medication is used less often (Munsey, 2008).

NCQA HEDIS® ADHERENCE MEASURES

Performance related to care and service can be measured by Healthcare Effectiveness Data and Information Set (HEDIS®) results. HEDIS® results can be used to identify where to focus improvement efforts in quality of care and service. Follow-up care for children prescribed ADHD medication is a HEDIS® measure for commercial and Medicaid populations.

- **Initiation Phase:** Percentage of patients ages 6 to 12 taking ADHD medication, and had a follow-up visit with a prescribing practitioner within a month of receiving their first prescription.
- **Continuation & Maintenance Phase:** Percentage of children 6 to 12 years of age who remained on ADHD medication for at least 210 days, and had at least two follow-up visits in nine months after the initiation phase.

ADHD MEDICATIONS

Non-stimulant

- Intuniv Oral (Guanfacine)
- Strattera Oral (Atomoxetine)
- Kapvay (Clonidine hydrochloride)

Stimulant

- Adderall (Amphetamine/ Dextroamphetamine)
- Ritalin Oral (Methylphenidate HCI)
- Concerta Oral (Methylphenidate)
- Vyvanse Oral 5 (Lisdexamfetamine dimesylate)

MEDICATION MONITORING

- Check height/weight/BP/pulse and complete percentile chart for growth
- Check if medication side effects are present, and administer an ECG if there is a family history of cardiac arrhythmia and early death.

TAKING ADHD MEDICATION DURING VACATIONS

An article from the American Psychiatric Association show teens with ADHD on ADHD medication have fewer accidents compared to adolescents not taking medication (Rosack, 2004). An article in *Health Central*[6] indicates ADHD medication has little long-term impact on a child's growth and weight. Therefore, many practitioners feel it is not necessary for a child to take a vacation from ADHD medication during school breaks or the summer months. Questions a parent should ask when determining if his or her child should take a vacation from medication:

- Are the child's social skills impacted in a negative way without medication?
- Will hyperactivity, impulsivity, or being distracted interfere with the child's success in summer camp?

ADHD MEDICATION AND SUBSTANCE ABUSE

In 2003, Biederman compared medicated and non-medicated adolescents age 15 and older diagnosed with ADHD for substance use: 75 percent not taking medication reported using illegal substances compared to 25 percent of the adolescents on medication, and 20 percent from the control group.[7] It is important for parents to monitor their child's medication as a rising problem with teen ADHD stimulant medication abuse was identified (Setlik, Bond, & Ho, 2009). A study in the American Academy of Pediatrics showed ADHD medication abuse increased by 76 percent from 1998 to 2005.

[1] Bloom B, Cohen RA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006. National Center for Health Statistics. Vital Health Stat 10(234). 2007

[2] Langberg, Joshua M, et al. "Assessing children with ADHD in primary care settings." Expert Review of Neurotherapeutics 8.4 (2008)

[3] http://www.cdc.gov/ncbddd/adhd/facts.html

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INCREASE YOUR PATIENTS' ADHERENCE TO PRESCRIBED TREATMENT AFTER A HEART ATTACK

One quality measure for patients' myocardial infarction (MI) is the persistent use of beta-blockers. Evidence-based practice has shown a decrease in the rate of re-infarction and mortality in heart attack sufferers when they are prescribed beta-blockers. The American Heart Association/College of Cardiology 2006 Update of Guidelines for Secondary Prevention for patients with coronary vascular disease recommends the indefinite use of beta-blockers after heart attack unless contraindicated.[1]

The WellCare Formulary includes the following beta-blocker drugs: acebutolol, atenolol, betaxolol, bisoprolol/hydrochlorothiazide, metoprolol, nadolol, sotalol and timolol. For a complete list, please refer to the medicare formulary at **www.wellcare.com**.

The National Committee for Quality Assurance (NCQA) recommends the use of beta-blockers post myocardial infarction as one way to measure how well physicians are providing quality care to their patients with heart disease. However, despite provider education and prescriptions for the indefinite use of beta-blockers when indicated, data still shows our members have a low adherence to their treatment plan. We'd like to work with you to increase our members' persistent use of their medications, break down barriers, and improve our patients' outcomes.

A study conducted in 2002 by Vanderbilt University was designed to determine adherence to outpatient beta-blocker therapy following an acute MI. Patients younger than 75 with a discharge order for beta-blocker therapy were more likely to fill their prescription within the first 30 days post discharge than people older than 75. Of the 85 percent that would fill their prescription within 30 days of discharge, the refill compliance would drop down to 61 percent after the first year. In contrast, of those patients discharged from the hospital without a beta-blocker, only 8 percent would fill a new prescription within the first 30 days after an acute MI[2], indicating that patients who receive a prescription for beta-blockers while they are still in the acute facility have the greatest probability of continued use post discharge.

WHAT CAN YOU DO?

You can start with something as simple as listening to your patients' concerns, answering their questions and empowering them to take appropriate action. The following can serve as a guide:

- Be involved with your patients' plan of care while they are in the hospital. Stay involved with the attending doctors to help bridge the gap in care post discharge.
- Identify the member or caretaker that may need additional educational reinforcement about the increased risk for another heart attack or stroke if they discontinue taking their medication.
- If financial constraints are an issue to their adherence, consider prescribing a generic or utilize ½ tablet prescription also known as pill splitting when appropriate.
- Send the member a prescription refill reminder by mail or place a courtesy call.
- Address adverse effects that may be the cause for their discontinuation of the medication.

Quality improvement efforts will need to continue to be a focus so that our post-acute MI patients stay on their beta-blockers for no less than six months if indefinite therapy is not planned.

Sources:

1. *Gottlieb SS, McCarter RJ, Vogel RA. Effect of beta-blockade on mortality among high-risk and low-risk patients after myocardial infarction N Engl J Med 1998; 339:489-497. [CrossRef][Web of Science][Medline] .*
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APPOINTMENT STANDARDS

The primary care practitioner is central to the provision of preventive care services and most acute and chronic care services. Harmony Health Plan of Missouri appointment standards for medical care are as follows:

APPOINTMENT TYPE	APPOINTMENT STANDARD
PRIMARY CARE ADULT	
Urgent Sick Visit	< / = 24 Hours
Sick Care Visit	< / = 1 Week / 5 Business Days
Routine Care	< / = 30 Calendar Days
Wait Times	1 Hour or Less
PEDIATRICIAN	
Urgent Sick Visit	< / = 24 Hours
Sick Care Visit	< / = 1 Week / 5 Business Days
Routine Care	< / = 30 Calendar Days
Wait Times	1 Hour or Less
OB-GYN	
1st Trimester	< / = 7 Calendar Days
2nd Trimester	< / = 7 Calendar Days
3rd Trimester	< / = 3 Calendar Days
High Risk	< / = 3 Calendar Days
Wait Times	1 Hour or Less
AFTER-HOURS COVERAGE	
After-Hours Coverage	24-hour coverage (includes answering service or paging system after hours) and vacation coverage. Answering machines are not an acceptable means of providing after-hours coverage.

AFFIRMATIVE STATEMENT ABOUT INCENTIVES

Utilization Management staff is responsible for verifying that medical services that are requested for authorization by participating physicians meet the medical necessity criteria. Harmony Health Plan of Missouri affirms that:

- Utilization Management decision making is based on appropriateness of care and services, and existence of coverage.
- WellCare/Harmony Health Plan of Missouri does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
- Financial incentives for Utilization Management decision makers do not encourage decisions that result in under-utilization.

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CLAIMS CORNER

ADD-ON CODES

When primary procedures are conducted, oftentimes there are certain additional procedures that must also be conducted. When this happens, these procedures are categorized as “add-on” codes. Add-on codes are always performed in conjunction with a primary procedure and should never be reported as a stand-alone service(s). The additional procedures are designated as an add-on code by the + symbol located next to the code in the AMA CPT Manual.

WellCare Health Plans Inc./Harmony Health Plan of Missouri will not reimburse add-on code(s) if the primary procedure code has not been submitted on the same claim. If the primary procedure code is not allowed or is denied for any reason, then the add-on code associated with that base code will also not be allowed. This concept applies only to procedures performed by the same physician.

Please reference the AMA CPT Manual for additional information on appropriate billing of add-on codes.

2011 Q3 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
Nardil® 15mg tablet	Phenelzine Sulfate 15mg tablet	Non-selective MAO Inhibitors

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

ADDITIONS	
Alphagan® P 0.1% and 0.15% ophthalmic solution	Moxeza™ 0.5% ophthalmic solution
A-Methapred® 40mg, 125mg solution	Pataday™ 0.2% ophthalmic solution
Amitiza® 8mcg, 24mcg capsules (ST)	Patanol® 0.1% ophthalmic solution
Dexilant™ 30mg, 60mg capsules	Potassium Chloride 10% liquid
Duetact® 30mg/2mg, 30mg/4mg tablets (QL; 31 tablets/31 days)	Sprycel® 80mg, 140mg tablets (PA)
Enoxaparin Sodium solution 30mg/0.3mL, 40mg/0.4mL, 60mg/0.6mL, 80mg/0.8mL, 100mg/mL, 120mg/0.8mL, 150mg/mL (QL varies depending on strength)	TobraDex® ST 0.3%-0.05% ophthalmic suspension
Fortical® nasal spray	Zymaxid™ 0.5% ophthalmic solution
Intelence® 200mg tablet (QL; 124 tablets/31 days)	

PA = Prior Authorization QL = Quantity Limit ST = Step Edit

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

DRUG NAME	CHANGE
Spiriva® HandiHaler®	ST removed
Vancomycin HCl 1000mg, 10gm solution	PA added

PA = Prior Authorization ST = Step Edit

PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Endo Pharmaceuticals	Opana® ER 7.5mg, 15mg extended-release tablets	On or about May 1, 2011	Please be advised that Endo Pharmaceuticals will discontinue the sale and distribution of two strengths of Opana® ER (oxymorphone HCl) Extended-Release Tablets CII. Endo estimates these two strengths will no longer be on retail shelves on or about May 01, 2011. Due to increased demand for Opana ER, Endo is streamlining operations to focus on the most commonly prescribed dosages, enabling us to serve the needs of our customers while continuing to supply a wide range of dose strengths. Opana® ER dose strengths of 5mg, 10mg, 20mg, 30mg and 40mg will continue to be available at your local pharmacy.
Allergan, Inc.	ZYMAR®	February 28, 2011	The anti-infective activity of fluoroquinolones, such as gatifloxacin, is concentration-dependent. ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5% has a greater concentration of the active agent gatifloxacin when compared with ZYMAR® (gatifloxacin ophthalmic solution) 0.3% formulation. Therefore, effective February 28, 2011, Allergan, Inc. discontinued ZYMAR® (gatifloxacin ophthalmic solution) 0.3%. Allergan will continue to manufacture ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5%.

Please refer to your provider manual available at **www.wellcare.com/Provider/ProviderManuals** to view more information regarding WellCare's pharmacy utilization management policy/procedures and medication co-payments and coinsurance requirements that may apply. The most up-to-date complete formulary can be found at **www.wellcare.com/medicare/medication_guide**.