

PROVIDER

Newsletter

CHECK MEMBER ELIGIBILITY NOW IN REAL TIME!

WellCare/Harmony (the Plan) has partnered with Availity, LLC, a premier health information network, to offer real-time HIPAA 270 Eligibility Request and 271 Payer Response transactions to providers. This service improves data interchange, provides an innovative solution to provider requests and will be leveraged to implement other HIPAA-compliant transactions in the future.

Benefits and Advantages:

- **Free** for providers to use
- Participation is **optional**
- **“One-stop shopping”**—view eligibility information for all participating health insurance companies from one Availity Web site with a single log-in
- Reduces the need to call Customer Service to check eligibility

You now have the option to access the Eligibility and Benefit Inquiry transactions via the Availity secure transaction interchange. You are able to check member eligibility information for all Plan lines of business.

To gain access to the Availity real-time eligibility transactions, you need to register on the Availity Web site at www.availity.com and follow these simple steps:

1. Click *Eligibility and Benefits | Eligibility and Benefits Inquiry* in the Availity menu.
2. Select the applicable WellCare/Harmony plan name in the Payer field.

Availity offers free online training Webinars for several topics, including eligibility and benefits transactions. To register for one of these Webinars, visit the Availity Web site and navigate to the Demo tab.

If you have any questions, please call Provider Services at 1-866-822-1340 (Medicaid) or 1-866-687-8994 (Medicare). You may also call Availity at 1-800-AVAILITY (1-800-282-4548).

PROVIDER MATERIALS UPDATE

The following correspondence was faxed to providers or was posted on the WellCare/Harmony Web site's Messages since our last newsletter published:

- Missouri's Summer Provider Newsletter
- Check Member Eligibility in Real Time!
- Helping Members Schedule Important Preventive Care

When you log in to www.wellcare.com/ www.harmonyhpm.com, 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.

WEB RESOURCES

WellCare's/Harmony's Preventive and Clinical Practice Guidelines, Quick Reference Guides, Pharmacy Guidelines, Cultural Competency Plan and other helpful resources are available at www.wellcare.com/www.harmonyhpm.com.

HELP PREVENT THE SPREAD OF THE FLU

Influenza season is here! We encourage providers to help make sure that all members get a flu vaccination.

Vaccination is the first and most important step in protecting against influenza. It is recommended that the following groups get vaccinated each year:

- Children ages 6 months up to their 19th birthday
- Pregnant women
- People 50 years of age and older
- People of any age with certain chronic medical conditions
- People who live in nursing homes and other long-term care facilities
- People who live with or care for those at high risk for complications from flu, including:
 - Health care workers
 - Household contacts of persons at high risk for complications from the flu
 - Household contacts and out-of-home caregivers of children younger than 6 months of age (these children are too young to be vaccinated)

Providers who administer the flu vaccine in their offices will be reimbursed for administration based on their contractual agreement with the Plan, medical group and/or IPA.

Note that your WellCare Medicare patients can receive a free flu vaccination at any Walgreens Pharmacy or Maxim clinic location. All they have to do is present their WellCare ID card. Direct your WellCare Medicare patients to call **1-866-WHI-FLUI** to find a Walgreens Pharmacy or **1-877-962-9358** to find a Maxim clinic location near them.

Harmony Medicaid patients may receive a free flu vaccination through their primary care providers.

Source: Centers for Disease Control and Prevention

ADVANTAGES OF ELECTRONIC FUNDS TRANSFER

WellCare/Harmony encourages participating providers to take advantage of electronic funds transfer (EFT) in receiving payment for claims.

Five reasons to sign up today for 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!**

Set-up is easy and takes about five minutes to complete. Please call your Provider Relations representative or Provider Services at **1-866-822-1340** (Medicaid) or **1-866-687-8994** (Medicare) with any questions.

EFT is set up only to transfer funds into your account, never out.

PHARMACY UPDATE

GENERIC NEWS

The generic drugs listed below are now available to Medicare members at the lowest cost-sharing benefit:

BRAND NAME	GENERIC NAME	THERAPEUTIC NAME
Cellcept® Capsules	Mycophenolate Mofetil Capsules (with a Prior Authorization)	Immunosuppressant Agent
Cytomel® Tablets	Liothyronine Tablets	Thyroid Agent
Topamax® Sprinkle Capsules	Topiramate Sprinkle Capsules	Anticonvulsant Agent
Topamax® Tablets	Topiramate Tablets	Anticonvulsant Agent
Zerit® 1mg/mL Oral Solution	Stavudine 1mg/mL Oral Solution	Antiviral Agent

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

ADDITIONS

Afinitor® Tablets (with a Prior Authorization)

Degarelix 80mg (with a Prior Authorization and Quantity Limit of 1/28 days)

Degarelix 2 x 120mg (with a Prior Authorization and Quantity Limit of 2/180 days)

Eliphos™ Tablets

Ipratropium-Albuterol 0.5-3mg/3mL nebulizer solution (with a Prior Authorization)

Ketoprofen ER Capsules (with a Quantity Limit of 31/31 days)

Levemir® 100 units/mL vial (with a Quantity Limit of 60mL/31 days)

Levemir Flexpen® 100 units/mL (with a Quantity Limit of 60mL/31 days)

Norpace® CR 150mg Capsules

Tekturna® Tablets (with a Step Edit)

Tekturna HCT® Tablets (with a Step Edit)

Vimpat® Tablets (with a Prior Authorization)

We have increased the quantity limit per month for the following medication on WellCare's **Medicare Formulary**:

QUANTITY LIMIT INCREASE

Zyvox® Tablets QL has been increased to 56 tablets per 28 days

TESTMINDER HELPS PATIENTS COMPLY WITH STANDING ORDERS

E-MAILS PATIENTS WHEN THEIR NEXT TEST IS DUE

The TestMinder e-mail reminder program, offered exclusively by Quest Diagnostics, is designed to work with the standing orders that providers prescribe for testing. TestMinder prompts patients to schedule their lab appointments by sending them timely e-mails each time they are due for a lab test.

TestMinder can help manage patients with chronic illnesses or on a particular drug regimen and can save office staff time and effort.

CONVENIENT APPOINTMENT SCHEDULING

Your patient will receive an e-mail reminder from Quest Diagnostics seven days before their next standing order. The e-mail will have a link to the online Quest Diagnostics PSC appointment scheduler so an appointment can be easily scheduled. Each e-mail reminder will include a “Find a Patient Service Center” link so the patient can find the center closest to where he/she works or lives.

BRINGING VALUE TO YOUR PRACTICE

TestMinder can be a valuable tool for your practice. It can help you:

- **Improve patient management:** Patients will be more inclined to follow through on standing-order lab testing, helping to improve patient outcomes.
- **Increase patient convenience:** E-mail reminders with helpful links to online appointment scheduling are an easy way for patients to make appointments.
- **Reduce administrative time:** Your staff can spend less time calling patients to remind them to schedule lab tests.
- **Increase Healthcare Effectiveness Data and Information Set (HEDIS®) scores:** Improved patient care can also help increase HEDIS scores and grow your practice.

Talk to your Quest Diagnostics account executive for more information about TestMinder.



WELLCARE/HARMONY CLAIMS INFORMATION

From time to time WellCare/Harmony (the Plan) reviews its reimbursement policies to maintain close alignment with industry standards and coding updates released by health care industry sources, including the Centers for Medicare and Medicaid Services (CMS) and nationally recognized health and medical societies.

Please note that the Plan publishes periodic reimbursement policy updates. To obtain a copy of our current policies, please visit the Provider Resources area of our Web site at www.wellcare.com/www.harmonyhpm.com, and select the *Claims Updates* link.

Thank you for your participation with WellCare/Harmony. We appreciate the high quality of care you provide to our members.

SUBMIT AUTHORIZATION REQUESTS ONLINE

WellCare/Harmony encourages you to submit inpatient and outpatient authorization requests via our secure Web site, www.wellcare.com/www.harmonyhpm.com. Registered Web users have immediate access to pertinent information regarding authorizations, claims and more.

Once you have logged in, you may access the Authorizations tool a couple of ways:

1. On the *Providers* main page, you can select the *Submit Authorization* link under the *Authorizations* heading, or
2. You may select the *Authorizations* tab along the top of the page. From there, select the *Authorization Request* link.

Simply enter the necessary information requested to complete the transaction. The tool also allows you to attach clinicals, or you can type in any relevant clinical information supporting the request.

Please note that Authorization/Certification determinations are made based on medical necessity and appropriateness and reflect the application of the Plan's approved review criteria guidelines. Once you complete each authorization request, you will get an instant acknowledgement of receipt of your request in your Web inbox. You can also download or print a summary report for your records.

All Medicare-expedited requests should be submitted via fax or telephone in order to be addressed appropriately.

Conducting transactions online provides useful information on demand while saving you time. Please contact your local Provider Relations representative if you have any questions.



PROMOTE CANCER AWARENESS

October is Breast Cancer Awareness Month. WellCare/Harmony asks providers to encourage women 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. Deaths from these diseases occur disproportionately among women who rely on public health programs like Medicaid or are uninsured, the CDC reports.

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. Women should also have an annual Chlamydia screening test if they are sexually active.

MEDICARE

HELP MEMBERS SCHEDULE IMPORTANT PREVENTIVE CARE

Beginning July 20, 2009, WellCare is partnering with Care Management International (CMI) to help members schedule and receive important preventive care.

Providers should expect to receive either a phone call or a fax from CMI asking for your assistance in scheduling appointments for certain members.

WHAT YOU NEED TO DO

When you are contacted by CMI, please help your patient set up an appointment to receive the needed tests and/or screenings. If you receive a fax form, please reach out to the member(s) according to the contact information provided.

CMI follows up four weeks after their initial contact to determine if the member has been seen or if they have a scheduled appointment.

Please contact your local Provider Relations representative with any questions.



MEDICAID

PERINATAL DEPRESSION SCREENING

Harmony Health Plan of Missouri (the Plan) encourages women's health professionals and pediatricians to screen women for prenatal and postpartum depression. The Plan supports utilization of the Edinburgh Depression Screening Tool and encourages providers to comply with the screening instructions. The Plan recommends you provide the patient with the tool just prior to the actual visit and review her responses with her during the visit.

Billing, Coding and Documentation

- Billing for reimbursement is available for both prenatal and postpartum depression screening, as a "risk assessment." When billing for prenatal depression screening, use codes H1000 and 99420.
- If a woman is postpartum, the perinatal depression screening should be billed using procedure code 99420 with modifier HD (pregnant/parenting women's program).
- Keep copies of the Edinburgh Depression Screening Tool results in the patient'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 99420 with modifier HD (pregnant/parenting women's program). 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), not in the infant's file.

Positive Depression Screening Results

- If a patient screens positive for depression, refer her to a behavioral health provider as appropriate. The telephone number to coordinate behavioral health service may be found on the Quick Reference Guide.
- Harmony Health Plan's member services (1-866-822-1340) may also provide assistance.
- For more information on screening tools, risk factors and treatment contact the Harmony HUGS social service specialist at 1-866-776-9876.

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.



CULTURAL COMPETENCY PROGRAM: PROVIDER NETWORK AND EDUCATION ARE KEY COMPONENTS

The objectives of the Cultural Competency program are to:

- Identify members who have potential cultural or linguistic barriers for which alternative communication methods are needed;
- Utilize culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken;
- Ensure resources are available to meet the unique language barriers and communication barriers that exist in the population;
- Ensure providers care for and recognize the culturally diverse needs of the population; and
- Ensure associates are educated and value the diverse cultural and linguistic differences in the organization and the populations served.

The components of the Plan's Cultural Competency program include:

Data Analysis

- Analysis of claims and encounter data to identify the health care needs of the population
- Collection of data on race, ethnicity and language spoken for members

Community-based Support

- Outreaches to community-based organizations which support minorities and the disabled to be sure that the existing resources for members are being utilized to their full potential

Diversity of Health Plan Associates

- The Plan does not discriminate with regards to race, religion or ethnic background when hiring associates.
- The Plan recruits diverse talented associates in all levels of management.
- The Plan ensures that bilingual associates are hired for areas that have direct contact with members to meet the needs identified.

Diversity of Provider Network

- Providers are inventoried for their language abilities and this information is housed in the Diamond system and printed in the Provider Directory, so that members can choose a provider who speaks their primary language.

- Providers are recruited to ensure a diverse selection of providers to care for the population served.

Linguistic Services

- Providers will identify members who have potential linguistic barriers for which alternative communication methods are needed and contact the Plan to arrange appropriate assistance.
- Members may receive interpreter services at no cost when necessary to access covered services through a vendor, as arranged by the Customer Service department.
- Interpreter services available include verbal translation, verbal interpretation for those with limited English proficiency and sign language for the hearing impaired. These services will be provided by vendors with such expertise and are coordinated by the Plan's Customer Service department.
- Written materials are available for members in large print format, and certain non-English languages prevalent in the Plan's service area.

Electronic Media

- Telephone system adaptations—members have access to the TTY/TDD line for hearing-impaired services. The Customer Service representatives have responsibility for any necessary follow-up phone calls to the member.

Provider Education

- Educated regarding the Cultural Competency Program through the Provider Manual
- Receive a Cultural Competency Checklist to assess their office's Cultural Competency

Determination of Performance Improvement Projects

- Focused assessments to identify opportunities for improvement
- Setting priorities and assignments

Please call Provider Services at **1-866-822-1340**

(Medicaid) or **1-866-687-8994** (Medicare) for questions about WellCare's/Harmony's Cultural Competency Program.

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CHECK THE STATUS OF A CLAIM ONLINE

WellCare/Harmony encourages you to check the status of your claims online via our secure Web sites, www.wellcare.com/www.harmonyhpm.com. As a registered user, you have immediate access to all pertinent information regarding your submitted claims. This valuable online feature provides useful information on demand while saving you time.

Simply follow the steps below. If you have any questions, please contact your Provider Relations representative.

Step 1

For the *Find by* menu, filter your search criteria by *Provider ID*, *Member ID* or *Claim Number*.

Step 2

In the *Member | Provider ID | Claim Number* box (depending on the option chosen in Step 1), enter the appropriate number.

Please note that you can click *Lookup Provider* or *Lookup Member* if you do not know the ID number.

Step 3

For *Service Date*: Select one of the following date ranges from the *Within* drop-down box:

- Last day,
- Last 2 days,
- Last week,
- Last 2 weeks, or
- Last month

OR

Enter any 30-day date range with the *From* option.

Step 4

Click the *Check Claim Status* button. The claim results are displayed at the bottom of the screen.

Please note that, in addition to checking claims status, you can submit a new claim or resubmit a corrected claim via the Web. Simply select the appropriate link under *Claims*.

