

MISSOURI | SPRING 2008

PROVIDER

Newsletter

ELECTRONIC FUNDS TRANSFER AVAILABLE TO PROVIDERS

The Plan is pleased to offer EFT/ERA (Electronic Funds Transfer/Electronic Remittance Advices) services to its providers. This free service is available through PaySpan Health and is managed by our partners, Payformance and Chase.

By signing up for EFT/ERA, you will enjoy many benefits, including:

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

Enrolling is quick and simple. Using the registration code sent to you in your enrollment letter, go to the PaySpan Health Web site dedicated to WellCare/Harmony providers. Please call the Provider Hotline at or your Provider Relations representative with any questions. Should you elect not to receive your payments or vouchers electronically, you will continue to receive paper copies generated from the Payformance payment processing center.

THE *TRUST* PROGRAM IS HERE FOR YOU!

A culture of compliance and integrity is essential to Harmony/WellCare. The *Trust* Program, our corporate ethics and compliance program, promotes the prevention, detection, and resolution of conduct that violates federal or state laws or our high standards of business ethics. The *Trust* Program applies to Harmony/WellCare associates, providers, and members.

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

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

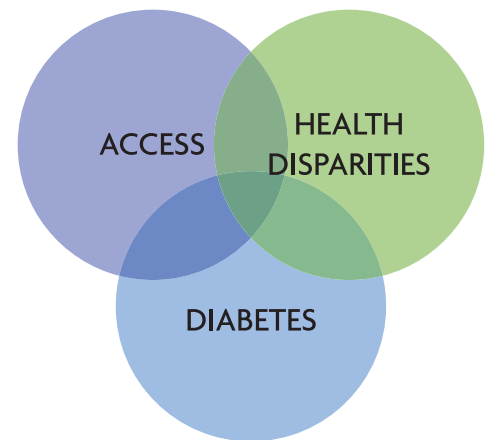
TACKLING DIABETES

PARTNERSHIP, EDUCATION AND PREVENTIVE CARE CAN PAY OFF

THE PLAN'S ROLE

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

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



CHALLENGES: DISPARITIES AND ACCESS

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

HEALTH CARE DISPARITIES

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

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

- Diabetes rates are more than 30 percent higher among Hispanics than whites³
- 2.5 million, or 9.5 percent, of Hispanics 20 or older were diagnosed with diabetes in 2002⁴
- In 1999, 11,927 African-Americans died from diabetes—more than twice the number of whites⁵

ACCESS TO HEALTH CARE

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

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

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

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THE PLAN'S RESPONSE

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

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

References:

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

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

UPDATED QUICK REFERENCE GUIDES ON THE WEB

Be sure to refer to the Quick Reference Guides (QRGs) posted under the Provider area of our Web sites, www.wellcare.com and www.harmonyhpm.com.

As these documents are updated, they are automatically posted to the Web site. Using the online version of the QRG ensures you are using the most up-to-date version.

PREVENTING COLORECTAL CANCER

COLONOSCOPY EVERY 10 YEARS COULD PREVENT MANY DEATHS

Colorectal cancer is the third most common cancer among both men and women in the U.S. In 2007, it was estimated that 112,000 new cases would be diagnosed, resulting in 52,000 deaths. Colorectal cancer accounts for about one in 10 new cancer cases and cancer deaths in the U.S. Treatment for early-stage colorectal cancer is extremely effective, with a five-year survival rate over 90 percent. Fewer than one in six cases are associated with a family history of the disease.

Place of birth, ethnicity, education, health coverage, smoking and gender have all been shown to affect prevalence of colorectal cancer screening rates.

Screening methods for detecting early stages of colorectal cancer include colonoscopy every 10 years, sigmoidoscopy every 10 years, annual fecal occult blood testing (three slides) (FOBT) and double contrast barium enema every 10 years. Persons at high risk for colorectal cancer should begin screening with colonoscopy at age 40 or younger.

Clinician recommendation remains one of the most powerful determinants of whether a patient undergoes colorectal cancer screening. Physicians can prevent most of the deaths from colorectal cancer by recommending regular screening.

Sources:

New York City Department of Health and Mental Hygiene, National Committee for Quality Assurance, State of Health Care Quality 2007

MEDICARE

POINT-OF-SERVICE OPTION AVAILABLE TO MEMBERS

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

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

What the POS option means to PCPs:

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

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

MISSOURI PHARMACY UPDATE

ASTHMA MEDICATION MANAGEMENT

In 2007, the National Asthma Education and Prevention Program (NAEPP) in coordination with the National Heart, Lung, and Blood Institute (NHLBI) updated the asthma guidelines in Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma—Full Report 2007.

The new guide restated that patients with persistent asthma (symptoms more than twice a week during the day or more than twice a month at night) need both long-term and quick-relief medications. It reaffirmed that inhaled corticosteroids (ICS) continue to be the most effective, long-term control medicine for asthma patients. The guideline focuses on a stepwise approach to managing asthma, and in terms of medication, doses should be stepped up or down as needed. Included in the guide is the creation of a new age group for treatment: children ages 5 to 11, who were previously included in the adult group. New evidence on medication effects shows children don't respond in the same way as adults.

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

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

Reference:

(2007). *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma*. Retrieved January 11, 2008.

NEW WEB SITES AVAILABLE

If you haven't visited our Web sites recently, you're in for a pleasant surprise. They have been redesigned to give you immediate access to what you need most. Our goal is to help you perform daily administrative tasks quickly and easily. With the Web sites' new features and enhanced layout, you will have the ability to:

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

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



MEDICAL RECORD DOCUMENTATION

MEDICAL RECORD REVIEW

In accordance with our contract with Missouri HealthNet and requirements from federal and state regulatory agencies, Harmony Health Plan is required to periodically assess the medical records of our members to demonstrate parameters as outlined in the Harmony Provider Manual. Our mutual success in achieving recognition for delivery of quality of care relies on supporting documentation. **All physicians are subject to a medical record review every two years.**

Some opportunities for improvement were identified in the past year through medical record reviews, which include the following:

MEDICAL RECORD CONTENT (APPLIES TO ALL RECORDS)

- All entries dated and signed with name and profession
- Medication allergies or “no known allergies” are prominently noted in the record
- Medical records from the previous provider (old MRR)
- There is a list of all medications the member is on, along with start and stop dates
- There is a problem list with past and current diagnosis and procedures listed
- There is documentation of screenings for domestic violence and substance abuse (tobacco, alcohol, and drugs) with appropriate counseling or referrals as needed
- The member was asked about advanced directives and documentation of acceptance or refusal (age 20 and older)
- The member’s primary language

CONTINUITY OF CARE

- Documentation of consultations along with follow-up
- Follow-up plans for abnormal diagnostic test
- Documentation of patient education verbal or written
- Age-appropriate mental health screenings

PEDIATRIC HEALTH SCREENINGS

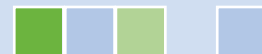
- Height, weight, and growth charting documented
- Unclothed physical exam head to toe

- Health and developmental history
- Developmental assessment completed
- Vision screening that includes an exam and standardized testing
- Documented hearing screening
- Documented nutritional assessment
- Lead risk assessment done (prior to ages 12 and 24 months) and referral for abnormal results
- Annual hemoglobin and hematocrit (H&H) blood tests for all menstruating adolescents
- Immunization record with immunizations and dates
- WIC referral

ADULT HEALTH SCREENINGS

- Physical exam including blood pressure, height, and weight
- Vision and hearing screening for members age 65 and older
- PAP test (ages 21-65) with documented results
- Annual influenza vaccine for members age 50 and older with medical indications
- Pneumococcal vaccine every five years for members age 65 and older or with medical conditions
- Mammogram (baseline ages 35-39, annually age 40 and older)
- Counseling for Hormone Replacement Therapy, age 65 and older for peri-/post-menopausal women
- Thyroid function test for females age 65 and older
- H&H screening with report on record. Required for Medicaid.
- Screening for dyslipidemia (men age 35 and older, women age 45 and older)
- UA dipstick age 65 and older. Required for Medicaid.
- Colorectal cancer screening (ages 50 and older)
- Prostate screening (African-American male with family history age 40 and older, asymptomatic males age 50 and older)

Through accurate documentation, we can assure that members are receiving quality care and the services they need.



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

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

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

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

The ICD-9-CM Official Guidelines for Coding and Reporting are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. These guidelines are based on the coding and sequencing instructions in Volumes I, II, and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The ICD-9-CM Official Guidelines for Coding and Reporting are available at www.cdc.gov/NCHS/datawh/ftpserv/ftpicd9/icdguide07.pdf

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

HEDIS 2008 MEDICAL RECORD REVIEWS

It's that time of year again...medical record reviews for HEDIS (Health Plan Employer Data Information Set)! We want to remind all of our providers that over the next two months, you may be contacted to have your medical records reviewed for HEDIS. The process has changed a little this year; here are the details

- Our quality nurses are getting an earlier start. We may be contacting you to set up appointments to come to your office and collect the medical records we need to give you credit toward HEDIS. You need only schedule an agreed-upon time with the nurse(s) and provide them with any requested documentation. It is very important that physicians and offices allow the nurse(s) access to the charts they request. Medical record reviews are our last opportunity to capture the services that physicians provided in 2007. The information gathered from the medical records will be a reflection of each physician's performance in 2007.

- For those providers our quality team has not reached, an outside vendor may be contacting you. The outside vendor will be sending out contracted nurses to review charts for HEDIS services provided in 2007.

We hope that this year's chart reviews will run smoothly and easily. We know, however, that this can be a busy and stressful time. In an effort to make this process as smooth as possible, we hope that you will treat our contracted nurses with respect and patience, and report to us any difficulties that may arise. We expect that our contracted nurses will act professionally and respectfully toward your staff and office. If any problem should arise, however, please note the name of the nurse as well as the nature of the problem and contact our Quality Improvement department at 1-800-608-8156 Ext. 2427.

ENCOURAGE MAMMOGRAMS

The American Cancer Society recommends that women have a baseline screening mammogram between the ages of 35 and 40, and receive a mammogram once a year after age 40. Women at high risk should have mammograms even more often.

The risk of breast cancer increases as a woman ages, if she has never had children, or if she had her first child after age 30. Studies also suggest that the risk may be higher for women who eat high-fat diets and those who smoke cigarettes.

It is important to remember that 80 percent of breast cancers occur in women with no risk factors. One in eight American women will develop breast cancer in her lifetime, and another woman is newly diagnosed with the disease every three minutes.

Source: American Society of Radiologic Technologists



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