



PROVIDER

Newsletter

TRANSITION OF CARE

Transition of care has been recognized widely as a source of major vulnerability for patient safety. WellCare, Harmony and Harmony Behavioral Health encourage physicians to keep this in mind when treating members.

The Joint Commission's National Patient Safety Goals address transition of care in two instances:

- Improve the effectiveness of communication among caregivers
- Accurately and completely reconcile medications across the continuum of care

In addition to affecting patient safety, transition of care also has a significant influence on patient outcomes. Interruption of care and the frequent switching of medications are two common causes of relapse among the most disabled of our mental health consumer population.

Transition of care from one provider, location or service intensity to another should be coordinated and integrated to create a seamless continuum of care for the patient. Early anticipation of transition, active involvement of providers, members, community resources and the health plan, as well as adequate communication among all involved parties, are key factors in creating the seamless continuum of care.

In alignment with this practice, Harmony Behavioral Health has created Discharge Planning teams. For assistance with transition planning, call **1-888-684-2026** and ask for one of our Missouri discharge coordinators, who are happy to assist you.

For more information regarding transition of care, the American Association of Community Psychiatrists has published a position statement detailing best practice guidelines at psychservices.psychiatryonline.org/cgi/reprint/55/11/1271.

Reference: AACP Continuity of Care Guidelines: Best Practices for Managing Transitions Between Levels of Care, 8/26/01.

PROVIDER SURVEYS: WE WANT TO HEAR FROM YOU

Participate in a Customer Service survey today and tell us how we're doing. WellCare and Harmony's goal is to provide excellent service to all physicians, providers and facilities. When you call us, you may be asked if you would agree to participate in a very brief customer satisfaction survey when your call has been completed. We encourage and appreciate your participation.

Simply follow these steps:

1. Press 1 on your telephone keypad when asked if you would like to participate.
2. Enter a 10-digit phone number where you can be reached.
3. You will then be connected to a Customer Service representative who is unaware if you chose to take the survey.
4. Once your call ends, you will be contacted shortly and asked the survey questions.
 - ✓ Your feedback is valuable
 - ✓ Your responses are critical to the enhancement of our service delivery
 - ✓ Your input drives performance improvement through training and agent development

FDA UPDATE ON SINGULAIR

The FDA is investigating the possible association between the use of Singulair and behavior/mood changes, suicidal behavior and suicide. Singulair is a leukotriene receptor antagonist used to treat asthma and the symptoms of allergic rhinitis and to prevent exercise induced asthma. Patients should not stop taking Singulair before talking to their doctor, if they have questions about the new information. Patients taking Singulair should be monitored for changes in behavior and mood, and thoughts of suicide. The FDA's investigation may take up to nine months to conclude and will be communicated to the public.

Source: FDA Web site. Available at www.fda.gov/cder/drug/early_comm/montelukast.htm



CLINICAL GUIDELINES FOR ASTHMA

Clinical guidelines are available to you as a provider for the management of asthma and other diseases. The Clinical Guidelines for Asthma include the critical aspect of an asthma assessment for lung function measurement to determine asthma severity and therapeutic course monitoring.

The guidelines suggest that to establish a diagnosis of asthma, an evaluation should include medical history, a physical exam and supportive diagnostic lung function testing. Ongoing assessment and monitoring should include spirometry and peak flow. Contributing factors should also be assessed when making the diagnosis, including environmental and lifestyle factors, as well as other disease processes.

Pharmacotherapy should be used to maintain optimal outcomes and is based on individual needs and severity of the disease.

Continual patient education is a key component and should include an asthma action plan that is evaluated at least annually, or more often for changing status. Patients should be instructed on self-monitoring of peak flows and daily logs. Basic facts should be given about asthma, stressing the implementation of environmental controls.

Frequent follow-up should be encouraged, focusing on education on the use of controller versus rescue medications, as well as observing and demonstrating use of inhalers during each visit.

For more information, contact your local Provider Relations representative and request a copy of the Clinical Guidelines. You can also obtain a copy by calling one of the registered nurses in the Quality Improvement Department:

Bev Terveer at 1-800-608-8156, ext. 2417

Jo David at 1-800-608-8156, ext. 2419

Source: WellCare/HHP Clinical Guidelines for the Management of Asthma.

CASE MANAGEMENT AND DISEASE MANAGEMENT

MAINTAINING THE MEMBER'S WHOLE HEALTH

WellCare and Harmony encourage providers to advise members to take advantage of our Case Management and Disease Management programs to help enhance quality of life while managing overall health costs.

CASE MANAGEMENT

The Plan's Case Management team facilitates collaborative relationships between members, providers, members' support systems and the plan, ensuring continuity of care and a smooth transition for the member through the care process. The Case Management team advocates for member preferences and the members' unique health service needs through assessment, planning and anticipating future health care requirements to promote positive outcomes, prevent complications and aid eventual recovery.

Through coordination of services, member education, improving access to quality services and maximizing the time members spend in productive, rewarding activities, case management ultimately helps lower overall health-related costs.

The case management process consists of four phases:

EVALUATION—Upon entry into the program, a nurse will determine what the member's needs are and whether they are being met. The nurse case manager looks for available resources and family support. At this stage, the nurse case manager identifies possible gaps in care. This leads to the next phase of the case management process: planning.

PLANNING—The nurse case manager constructs and implements a member care plan and shares it with primary care physicians and specialists.

FACILITATION—The nurse case manager works to ensure a member follows the established plan of care. This may include coordination of care, assistance in obtaining PCPs and/or specialists and any other services a member may need for follow-up care.

ADVOCACY—Understanding health care can be confusing for our medically and behaviorally challenged members. The nurse case manager can have a positive effect and guide the member throughout the case management process.

PCPs and specialty care providers are vital members of the Case Management team. Nurse case managers work with the PCP's and specialist's office staffs to ensure that all the member's needs are addressed and met. The Plan's Case Management team can save valuable time by guiding members to the right level of care at the right time.

DISEASE MANAGEMENT

The Disease Management program provides superior education and support systems to eligible members with certain chronic diseases. The disease manager empowers members to make behavioral changes that will improve health, reduce complications and decrease severity of illness, striving to prevent unnecessary medical complications whenever possible.

The disease manager educates the member on appropriate action plans, preventing reoccurrences, and takes all measures that will decrease the likelihood of adverse outcomes. Disease managers assist members in dealing with the stress of chronic illness, helping them understand how to manage the health care experience and working with their PCPs and specialists in the most effective ways.

Disease managers are sensitive to the emotional and psychological needs of members and their support systems to maximize their adherence to the treatment plan mutually agreed upon with their PCP and/or specialist.

To refer a member to Case Management or Disease Management, please call:

Toll-free: 1-866-635-7045

TTY/TDD: 1-888-505-1194

PHARMACY UPDATE

GENERIC DRUG UTILIZATION

According to the Food and Drug Administration (FDA), generic drugs account for about half of all prescription drug purchases in the United States. This provides a huge cost-savings for not only the patient, but also for the Medicare program and taxpayers. In fact, in many states, generics are to be dispensed by the pharmacy unless the patient asks for brand or the prescriber indicates that the brand is medically necessary.

Most Medicare plans and private prescription plans offer very low co-payment amounts for generic drugs. Some even offer generics at no cost to the patient.

Physicians play a major role in educating patients on the safe and effective usage of generics. You can assure patients that the FDA requires generics to have the “same high quality, strength, purity and stability as brand name drugs.” And while differences may exist between brand and generic drugs in terms of inactive ingredients, the chances of having a reaction to an inactive ingredient are very low.

Although some patients may only have small differences between the co-payment amounts for brand and generic, using a brand medication will put the patient at a higher risk for going into the coverage gap (commonly called the “doughnut hole”). Once a patient reaches the coverage gap, he or she is responsible for paying for 100 percent of their drug costs (some plans may cover generics during this time). According to a study done by Walgreens Health Services, the coverage gap was estimated to have reduced medication utilization by approximately 188 days, while increasing costs by approximately \$796.

We encourage you to speak with your patients about generic drugs and prescribe them when appropriate.

Sources

McClellan MB. *Generic Drug Utilization in the Medicare Prescription Drug Benefit* [testimony before US Senate]. Available at www.hhs.gov/asl/testify/t060921.html. 2006.

Sun SX, Lee KY. *The Medicare Part D doughnut hole: effect on pharmacy utilization. Manag Care Interface.* 2007; 20: 51-55, 59.





PCP COMMUNICATION

WellCare and Harmony encourage 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 notion that effective integration and collaboration between primary care physicians (PCPs) and mental health specialists (including psychiatrists, social workers and ARNPs) is essential for consumer well-being. Yet throughout the state, PCPs and specialists frequently express the concern that “the psychiatrists do not send us any information.” Similarly, psychiatrists say, “The PCP and/or specialist do not often contact us with information about the patient they are referring to us.”

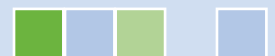
Barriers often cited for the dearth of provider communications are time and resource limitations. It seems that there is never enough time or an adequate number of resources to send an e-mail, write a letter, or make a phone call. However, when one considers the potential effect on optimal member care, it is clear that communication is critical.

In the age of advanced technology, many options are available to make communication with colleagues a routine, integral part of every referral, admission, transfer and discharge.

What else can you do as the individual practitioner?

1. Get to know your fellow physicians, PCP’s and psychiatrists. Attend meetings where you can get to know one another whenever possible.
2. Pick up the phone. As a professional courtesy, your colleague will appreciate the time and effort for communication.
3. Request copies of records from physicians who have cared for the patient before your involvement.
4. Set up systems in your office and hospital units that enhance and automate patient communications and permit transition of care safely and effectively.
5. Include the PCP on admission and discharge reports, letting your colleague know about discharge appointments, medications and any specialty consultations required post hospitalization.
6. Use your Harmony Behavioral Health care manager and Discharge Coordinator to assist you in making appointments and arranging follow up care. Our Discharge Coordinators can also work with members to make sure they make their appointments.

If you have questions or feedback about physician communications or quality-related topics, please contact Harmony Behavioral Health at **1-866-684-2026**.



DISRUPTIVE DISORDERS

IDENTIFYING AND TREATING BEHAVIORAL PROBLEMS IN CHILDREN

WHAT IS “NORMAL”?

The development of an infant is amazing because there is constant change from the first day of life, with new behaviors evident every day. Every child is unique and develops at his or her own rate, depending both on genetic and learned factors. Children are expected to reach certain milestones at certain specific ages that indicate to the doctor that the child's growth and development are proceeding normally.

First 3 months of age: During the first three months of life, an infant should be sucking, grasping and turning his/her head. Social behaviors are limited to turning the head, smiling, crying, and, at 3 months exhibiting a social smile.

First year to 18 months of age: Children begin to recognize and acknowledge the world around them. They begin to relate and differentiate themselves from their surroundings.

By 3 years of age: Three-year old children can move from solitary play to active engagement with other children.

By 5 years of age: Children are able to engage in organized group activities.

IDENTIFYING BEHAVIORAL ISSUES REQUIRING INTERVENTION

When a child begins to exhibit behavioral problems that significantly affect his/her life at home or school on a regular and consistent basis, it meets the criteria for an evaluation by a professional.

There are three behavioral disorders classified by the American Academy of Child Psychiatrists. These conditions include:

1. Attention Deficit Disorder: inattention and hyperactivity.
2. Oppositional Defiant Disorder: negativistic, defiant, hostile behavior.
3. Conduct Disorder: aggression, destruction of property, lying, disobeying rules.

Other conditions that might account for such behaviors need to be considered:

- Psychotic disorders
- Mood disorders

- Learning disabilities
- Autism or other developmental disorders
- Mental retardation

EFFECTIVE TREATMENT

Providers should:

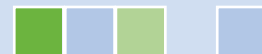
- Establish a diagnosis with the proper history from the parents, the use of standardized testing, screening tools and rating scales (i.e., Conner's rating scales)
- Develop a treatment plan that includes and actively involves the child, family and relevant community agencies (schools, for example)
- Develop a multimodal approach to treatment using psychotherapy, family therapy and medication management

MEDICATION MANAGEMENT

Proper behavioral health medication management includes:

- Avoiding polypharmacy
- Avoiding off-label use of psychotropics
- Making sure the diagnosis and treatment match
- Using the lowest effective dose
- Following a step-therapy approach
- Weighing the benefits versus the risks of treatment for individual patients





CAPTURE A WELL VISIT EVERY TIME!

It is often difficult to get a well child or adult to visit his or her doctor. It is generally not until a patient is sick that he or she will schedule an appointment or come in. However, we know as health care providers that there are many preventative services that should be provided annually. 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 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 history
- A physical exam
- Anticipatory guidance (wellness education appropriate to the age of the patient)

How do I code?

- There has been much confusion surrounding the area of coding for a well visit when the patient actually comes in because he or she is sick, but components of a well visit are provided.
- Harmony and the State of Missouri encourage all practitioners to code for BOTH a sick and well visit if the patient came in because he or she was sick and 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 just 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!

Source: 2008 HEDIS technical specifications

MISSING OPPORTUNITIES TO IMMUNIZE

To provide the best possible care to our members, particularly children and adolescents, Harmony Health Plan encourages primary care physicians to assess and administer immunizations when hard-to-reach members visit the office.

Here are some simple tips to help identify children needing immunizations:

- When receiving a call scheduling a new pediatric or adolescent child visit, have the office staff ask the parent or guardian to bring a copy of the immunization record to the appointment. Document the date of the request in the chart.
- Place a copy of the child's immunization record in the chart.
- Encourage the parent or guardian to bring in a copy of the updated immunization record to every visit, especially for those children receiving immunizations at another site.
- Assess the immunization records at every visit for the need of additional immunizations.
- Provide education for parents, guardians, children and adolescents receiving immunizations in your office or at another site, stressing the importance of getting timely immunizations.

Should you have any questions or need a current immunization schedule, please feel free to call one of the nurses in the Quality Improvement Department:

Bev Terveer at 1-800-608-8156, ext. 2427

Jo David at 1-800-608-8156, ext. 2419

FDA PATIENT SAFETY NOTICES

SIGN UP FOR HEALTH CARE NOTIFICATION NETWORK ALERTS

We encourage you to sign up for a new electronic service that furnishes clinicians with instantaneous FDA (Food and Drug Administration) patient safety alerts. The Health Care Notification Network (HCNN) service provides a quick and systematic way for your practice to improve patient safety by getting important alerts, including product recalls and warnings.

To register for the free service, please go to www.hcnn.net/Registration/registration.aspx. You can designate other staff members to receive the online alerts and you can opt out at any time.

The HCNN initiative is being launched by the iHealth Alliance and managed by Medem, a health information technology firm founded by the American Medical Association and state medical societies. For more information, visit www.hcnn.net.



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NPI STANDS ALONE

The May 23, 2008, federal deadline for National Provider Identifier (NPI) compliance has passed. If you are not yet in compliance, you must become compliant immediately to avoid rejection of claims.

WellCare/Harmony's new claims submission policy took effect as of the federal deadline to comply with the Health Insurance Portability and Accountability Act (HIPAA) requirement to use only the NPI and taxonomy codes to identify providers on standard transactions like health care claims. This policy serves as a modification to your provider manual's specifications on claims submissions.

WELLCARE/HARMONY NPI CLAIM/ENCOUNTER SUBMISSION POLICY

The NPI is required in the primary and secondary provider fields for all electronic, direct data entry (DDE) and paper health care claims, and encounter submissions. Claims and encounter submissions will not be processed and will be rejected if they:

- Lack NPI when required per Implementation Guides and CMS requirements
- Contain an invalid NPI
- Contain only legacy identifiers (i.e. UPIN, Medicaid ID or WellCare/Harmony ID)
- Contain both legacy identifiers and NPIs

STEPS PROVIDERS MUST TAKE TO ENSURE NPI COMPLIANCE

1. If you have not already done so, you **MUST** supply your NPI and taxonomy information to the Plan immediately.
2. Provide NPI information to your clearinghouse and/or software vendor and ensure problems evident in your billing systems and processes are quickly resolved.
3. For electronic claims, comply with electronic loop and data segment instructions. For paper claim submissions, utilize the new paper claims forms. You may download this information from WellCare's Web site, www.wellcare.com.
4. Consult the Electronic Data Interchange Transaction Set Implementation Guides for electronic claim transactions.

You may download instructions for submitting your NPI as well as information on claim submissions from the WellCare Web site at www.wellcare.com.

For questions regarding NPI, please access www.cms.hhs.gov/.

NPI FAQs

Q: Which transactions require NPI?

A: Your NPI is required in all HIPAA transactions, including claim submissions, claim payment, coordination of benefits, eligibility, referrals and claim status.

Q: Does the NPI mean I need to change the way I bill WellCare/Harmony?

A: Yes, the NPI should now be included for primary and secondary provider types on your claims and encounter submissions. Legacy identifiers should no longer be included on the claim or encounter submission.

Q: What legacy identifiers will NPI replace?

A: The NPI will replace all legacy identifiers that identify health care providers. This includes WellCare/Harmony IDs, Medicaid and Medicare IDs and UPINs. It does not replace Tax IDs (TIN), which will continue to be required on all claims.

Q: What are the primary and secondary providers?

A: Providers are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, rendering or attending. Secondary providers include supervising and operating physicians, referring providers, facility, care plan oversight, purchase services and others.

Q: Can a provider or organization have more than one NPI?

A: Yes. Some health care provider organizations are made up of components or business units that function somewhat independently of the "parent" health care organization of which they are a part of. These are referred to as "subparts" in the regulation and might be at the same or at a different address than the organization provider "parent," might conduct their own standard transactions and might furnish a type of service different than the organization provider "parent." These subparts might be required by federal regulations to have unique identifiers for billing purposes. Each organization must make a determination regarding the status of its subparts, and apply for NPIs as appropriate.

Q: My organization or group obtained its NPI. As a physician with this organization, do I have to also obtain an NPI?

A: Yes. Even though the organization that you are working with has enumerated, you need to obtain an NPI as an individual provider.

Q: How can I be sure I am providing the NPI in the correct format for electronic billing?

A: For electronic claim submissions, consult the Electronic Data Interchange Transaction Set Implementation Guides adopted as HIPAA standard requirements for compliant completion of transactions. Provide NPI information to your clearinghouse and/or software vendor. Additionally, you may access any published companion guides and related instructions on www.wellcare.com.