WellCare®

NEW YORK | 2011 | ISSUE IV

PROVIDER Newsletter

PROVIDER UPDATE

Since our last newsletter was published, the following correspondence was sent to providers via fax or was posted on the secure section of the WellCare website:

- Important Changes in Electronic Data Interchange (EDI) Process
- NY 2011 Issue II Provider Newsletter Now Available
- WellCare Specialty Pharmacy Can Help You Fight HCV

You can find copies of all of these correspondences when you log in to the secure area of **www.wellcare.com** (via the sign-in on the right that says "Member / Provider Secure Sign-In"). Then click on the Provider tab and you will see Messages from WellCare located on the right-hand side. Remember to check the messages regularly to receive new and updated information.

Preventive and Clinical Practice Guidelines, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) documents, Pharmacy guidelines, the Cultural Competency Plan highlighted in the Provider Manual and other helpful resources are also available at **www.wellcare.com**.

New guidelines include:

- ADHD Clinical Care Guidelines
- Schizophrenia Clinical Care Guidelines
- Depressive Disorders in Children and Adolescents AACAP

KEEP AN EYE ON GLAUCOMA

As a WellCare provider-partner, you can help to prevent or delay the problems caused by glaucoma. Glaucoma can lead to vision problems and may even result in blindness. The condition is more common in people who are older than age 45.

Early treatment — including medications, surgery or a combination of both — can prevent or delay the serious vision problems caused by glaucoma. Your patients should be tested for glaucoma if they have any of these risk factors:

- Severe near-sightedness
- Diabetes mellitus
- A family history of glaucoma
- Are older than age 65, or older than age 40 and are African-American

Source: www.ahrq.gov/ppip/50plus/checkups.htm

CLINICAL COVERAGE GUIDELINES AVAILABLE ON THE WEB

VISIT REGULARLY FOR UPDATES TO NEW YORK-SPECIFIC GUIDELINES

WellCare has Clinical Coverage Guidelines (CCGs) available via our Web site, **www.wellcare.com**. The CCGs are clinical evidence-based documents that define the medical conditions for coverage and/or exclusions of given procedures or technologies. The guidelines reflect evidence-based criteria for establishing the coverage parameters of a procedure or technology, leading to greater consistency and efficiency in clinical decision-making. This consistency and efficiency results in more accurate clinical determinations, better provider-company interactions and increased quality of health care services provided to our members.

Follow this path to access the guidelines, **www.wellcare.com/Provider/CCGs**.

The guidelines are arranged alphabetically and are formatted as PDF files. If you wish to search by keyword or acronym to find a particular CCG, please type CTRL+F and in the Find and Replace dialog box, type the keyword or acronym you wish to search.

MEDICARE

DISCUSS ADVANCE DIRECTIVES WITH YOUR PATIENTS BEFORE IT'S TOO LATE

More often than not, the subject of advance directives is often left to hospital staff members to discuss with patients — and usually when patients are already dealing with a stressful situation. WellCare encourages you to help our members prepare their advance directives when their focus and judgment are less clouded, by providing them with information about the policies that govern execution of the document. Encouraging patients to discuss their health care decisions and views about end-of-life care prior to becoming incapacitated gives them peace of mind and empowers them to think through important decisions amid normal circumstances. If a crisis should arise, hospitals can then request a copy of the patient's advance directives for their medical record during acute hospitalization stays, clarifying the patient's wishes concerning medical treatment protocols for the hospital staff.

Providers' offices and health care facilities must make advance directive forms available to patients and, as a provider, you cannot require a member to execute or waive an advance directive. As a health care advocate, please document any conversations you have concerning our members' advance directives, discussion outcomes and encourage them to discuss their advance directive instructions with their family, representative or health care surrogate. By having this discussion with our members and documenting their health care decisions, it will lend support to what the patient and their families want. The more people who are aware of their health care decisions, the less likely conflict, arguments, feuding and speculation among practitioners and family during times of duress will arise.

For more information on advance directives, please call WellCare's Case and Disease Management department at **1-866-635-7045**. Nurses are on hand to help the member navigate the advance directives process.

As patient advocates, it is in your best interests to help ease the difficulty of the moment for your patients and help make the arduous decisions easier for their families and the health care team. Please encourage WellCare members to take control of their final health care decisions without ultimately leaving the important decisions to chance. You can make a significant difference by having this discussion with our members, documenting it, and if they choose to complete an advance directive, placing a copy of it in their file.

USE OF HIGH-RISK MEDICATIONS IN THE ELDERLY — UPDATE

The Centers for Medicare & Medicaid Services (CMS) has developed performance and quality measures to ensure that Medicare beneficiaries receive the best health care and prescription drug coverage. One such gauge is the High Risk Medications Measure that tracks elderly beneficiaries who receive potentially inappropriate medications. Criteria for the potentially inappropriate medications in the elderly have been developed by Beers, et al[1] and the National Committee for Quality Assurance (NCQA)[2].

WellCare is making an intense effort to remind clinicians about these drugs and provide useful information to help avoid their use in the elderly population. Below you will find the most often prescribed examples from the NCQA list of drugs to avoid in the senior population, as well as safer alternatives available for your consideration.

A new study from Vanderbilt University Medical Center showed that the proportion of patients on potentially inappropriate or actually inappropriate medications increased by 20 percent after a critical illness and that about half of these were started in the intensive care unit (ICU). The most common inappropriate drugs were anticholinergics, but the authors also note that antipsychotic agents, often used to treat delirium in the ICU, are also often continued after discharge. Please also consider this information when seeing patients soon after their hospital stay.

EXAMPLES OF POTENTIALLY INAPPROPRIATE MEDICATIONS IN THE ELDERLY	AVAILABLE ALTERNATIVES[3]
Premarin®, Estrace® (oral estrogens)	Hot flashes: SSRIs, gabapentin, venlafaxine Bone density: calcium, vitamin D, bisphosphonates
Soma® (carisoprodol), Flexeril® (cyclobenzaprine), Robaxin® (methocarbamol)	Spasticity: baclofen, tizanidine
Valium® (diazepam)	Anxiety: Shorter acting benzodiazepines, buspirone
Benadryl® (diphenhydramine), Atarax® (hydroxyzine)	Cetirizine, fexofenadine, loratadine, levocetirizine

1. *Fick DM, Cooper JW, Wade WE, Waller JL, Maclean JR, Beers MH. Updating the Beers criteria for potentially inappropriate medication use in older adults: results of a US consensus panel of experts. Arch Intern Med. 2003 Dec 8-22;163(22):2716-24.*
2. *National Committee for Quality Assurance (NCQA). Use of High-Risk Medications in the Elderly. HEDIS 2011. Healthcare Effectiveness and Data Information Set. Washington DC. Available at http://web.ncqa.org/tabid/210/Default.aspx.*
3. *Potentially Harmful Drugs in the Elderly: Beers List and More. Pharmacist's Letter/Prescriber's Letter 2007; 23:1-12.*

2011–2012 FLU SEASON AND THE PNEUMONIA VACCINE

The influenza season is quickly approaching, and WellCare is encouraging providers to take measures to ensure that each of their patients receives a flu and pneumonia vaccine if they fall into certain categories.

Here are some important updates:

- Vaccination recommendations for adults have expanded to include all adults unless contraindicated. It is important that all people, ages 6 months and older, receive the annual influenza vaccine no matter how healthy they may be. Among older adults living outside chronic-care facilities, such as nursing homes, and for those individuals with long-term (chronic) medical conditions, such as asthma, diabetes or heart disease, the flu shot has been shown to be 30–70 percent effective in preventing hospitalization stays for pneumonia and influenza. Among healthy people under age 65, the vaccine has been shown to prevent influenza outbreaks by about 70–90 percent.
- The 2011 vaccines will also provide protection against H1N1. **WellCare offers most flu vaccinations at no cost to its members.** Please encourage our members to receive the flu vaccine either in your office, at a participating retail pharmacy, or have them call the Customer Service number located on the back of their member ID card. They can also visit **www.wellcare.com** to locate a network provider near them.

Antiviral drugs are especially beneficial for people who are sick with the flu. Those who may have a greater chance of serious flu complications include:

- Children younger than 2 years old
- Adults 65 years of age and older
- Pregnant women and women who have given birth within the last two weeks
- People with chronic medical conditions (such as asthma, heart failure, chronic lung disease and diabetes) and people with a weak immune system (due to illnesses such as HIV)
- People younger than 19 years of age who are receiving long-term aspirin therapy

PNEUMONIA VACCINE

In addition to the flu vaccine, pneumococcal vaccination, unless otherwise contraindicated, should be considered for people in the following groups:

- Adults: 65 years of age and older
- Persons who are older than 2 years of age with chronic heart or lung disorders, including congestive heart failure, diabetes mellitus, chronic liver disease, alcoholism, spinal fluid leaks, cardiomyopathy, chronic bronchitis (COPD) or emphysema
- Persons who are older than 2 years of age with either asplenia, or those who have a severe spleen dysfunction (such as sickle cell disease), blood malignancy (leukemia), multiple myeloma, kidney failure, organ transplantation or immunosuppressive conditions, including HIV
- Alaska natives and certain American Indian populations
- If elective surgical removal of the spleen (splenectomy) or immunosuppressive therapy is planned, the vaccine is given two weeks prior to the procedure, when possible.

Source: Centers for Disease Control and Prevention; www.flu.gov

REAP THE BENEFITS OF WELLCARE SPECIALTY PHARMACY

Helping your patients manage their long-term and/or rare conditions is never an easy task, especially considering the unique challenges each patient presents and the vast array of medications available to address those challenges. That's why it's important for you to partner with a pharmacy that will work with you and your patients to manage health condition and therapy.

When you refer your patients to WellCare Specialty Pharmacy (WSP) Mail-Order Pharmacy for their maintenance medications, they will enjoy the ease and convenience of two-step ordering and reduced cost on their prescriptions for, among other things, anemia, ankylosing spondylitis, cancer, Crohn's disease, hemophilia, hepatitis, HIV, multiple sclerosis, organ transplant, and psoriasis. However, patients aren't the only ones to reap countless benefits. With just one simple call, both you and your office staff can also benefit from a team that will:

- Help manage medication side effects and symptoms
- Order medication refills and supplies
- Work closely with your office to provide the right information in order to obtain the medication promptly
- Provide educational materials
- Research alternative funding when needed
- Assist in teaching how to administer the medication
- Answer any questions regarding medication or condition
- In rare cases, quickly triage the order to another pharmacy while informing the patient and your office staff

For your patients to begin receiving the benefits of WellCare Specialty Pharmacy, just call in their specialty medication order to **1-866-458-9246**, Monday–Friday, 8 a.m. to 6:30 p.m. or fax the order to **1-866-458-9245**.

MEDICARE

ANNUAL NOTICE OF CHANGE LETTERS ARE IN THE MAIL

ANOC letters, which list the changes to WellCare member benefits between 2011 and 2012, were mailed to members the week of September 12. If a WellCare member has a question about benefit changes, please have him or her contact our Customer Service department at **1-800-278-5155**.

WellCare has conditional CMS approval for expansion in the following counties for 2012: Suffolk and Niagara. There has also been a new plan added to Bronx, Kings, Nassau, New York, Queens and Suffolk counties. The plan is called the WellCare Rx plan and it is designed for members who have their Part D premium paid for through the EPIC, state SPAP, program. It offers richer benefits in several categories than most other WellCare non-SNP plans. There is also a new meals benefit that is offered through the Liberty and Access plans. This benefit provides 10 meals for nutritional support after hospitalization for certain members.

2011 GUIDELINES FOR MANAGING DIABETES

The American Diabetes Association published its 2011 Standards of Medical Care for Diabetes in the January edition of *Diabetes Care*. The following is a partial listing of these guidelines:

Glycemic, Blood Pressure and Lipid Control

Recommended monitoring schedule:

- A1C: perform testing at least two times per year for patients who are meeting their goals and who have stable glycemic control. Perform A1C test quarterly for patients whose therapy has changed or for those individuals who are not maintaining adequate glycemic goals.
- Lipids: For most adult patients, measure fasting lipid profile at least annually.
- For adults with low-risk lipid values (LDL <100 mg/dl, HDL>50 mg/dl, triglycerides <150 mg/dl), lipid assessments may be repeated every two years.
- Blood pressure should be measured at every routine diabetes visit.

Summary of recommendations for glycemic blood pressure and lipid control for most adults with diabetes:

A1C: less than 7.0%

- Glycemic goals may be adjusted for each patient. Goals should be individualized based on the onset and duration of diabetes, age/life expectancy, co-morbid conditions, known cardiovascular disease (CVD) or advanced microvascular complications, patients' lack of knowledge regarding hypoglycemic and hyperglycemic events, and individual patient considerations.

LDL cholesterol: less than 100 mg/dl (less than 2.6 mmol/l)

- For those individuals with overt CVD, a lower LDL cholesterol goal of less than 70 mg/dl (1.8 mmol/l) is optimal and using a high-dose statin medication may be an option for goal attainment.

Blood pressure: less than 130/80 mmHg

- Based on patient characteristics and their therapeutic response, adjustment of blood pressure targets may be appropriate.

Nephropathy Screening

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with a diabetes duration of five years or more, and in all type 2 diabetic patients upon diagnosis of the disease.
- Screening for micro-albuminuria can be performed through measurement of the albumin-to-creatinine ratio in a random spot collection.

Retinopathy Screening

- Annual dilated eye examinations are recommended for type 1 and type 2 diabetic patients.

Neuropathy Screening

- All patients should be screened for distal symmetric polyneuropathy (DPN) at least annually.

Foot Care

- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations.
- Provide general foot self-care education to all patients with diabetes.

Smoking Cessation

- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care. The full text of the Executive Summary, "Standards of Medical Care in Diabetes—2011," may be found at the American Diabetes Association's Diabetes Care website at **care.diabetesjournals.org**.

Source: Diabetes Care, Volume 34, Supplement 1, January 2011.

DIABETES AND EYE DISEASE

EIGHT FACTS YOUR PATIENTS NEED TO KNOW

Discussing information about diabetic eye complications and motivating your patients to engage in self-directed care may lower their risk of developing diabetes-associated vision loss.

1. **Diabetes May Lead to Eye Disease.** Several factors influence whether patients suffer from diabetic eye disease (diabetic retinopathy and premature development of cataracts), including adequate blood glucose control, systemic blood pressure levels and genetic influences. Keeping blood glucose and A1C levels within a normal range may reduce their chances of developing diabetic eye disease.
2. **There May Be No Warning.** While some diabetic patients receive no warning signs of an impending catastrophic vision loss, it's important to recognize the early warning symptoms that a significant eye disease may be developing:
   a. Blurry vision
   b. Double vision
   c. Rings, flashing lights or blank spots
   d. Dark spots or floaters
   e. Pain or pressure in the eyes
   f. Trouble seeing out of the corners of their eyes
3. **Diabetic Patients Need Annual Dilated Eye Exams.** Regular eye exams by an eye care professional are important for early detection of eye disease associated with diabetes. If identified at an early stage, diabetic eye disease can be successfully treated before severe vision loss occurs.
4. **Controlling Diabetes Won't Prevent Diabetic Eye Disease.** Unfortunately, even if your patient's blood glucose levels are adequately controlled, diabetic eye disease can still develop. However, successful management of a patient's blood glucose levels may slow the onset and progression of diabetic retinopathy.
5. **Patients With Diabetes May Develop Glaucoma.** Patients with diabetes are 40 percent more likely to suffer from glaucoma than people without the disease. The longer a patient has diabetes, the more common it is for glaucoma to develop.
6. **Patients With Diabetes May Develop Cataracts.** Having diabetes increases an individual's likelihood of developing cataracts. Patients with diabetes are more likely to be diagnosed with cataracts at a younger age and it progresses faster than those individuals without the disease.
7. **Diabetic Retinopathy Damages the Retina.** Diabetic retinopathy is caused by changes in the blood vessels of the retina. When blood glucose levels remain elevated, the blood vessels that are located within the retina weaken, causing fluid to leak out of them. As this occurs, new but fragile blood vessels begin to grow (neo-vascularization). The new vessels are prone to fluid leakage, which results in the overgrowth of light-sensing retinal cells. The additional retinal cells cause damage to the retinal tissue and consequently result in vision loss and/or blindness.
8. **Laser Surgery Slows the Progression of Diabetic Eye Disease.** Laser surgery can be utilized to decrease the size of the abnormal blood vessels or seal leaking blood vessels that are located within the retina. The risk of vision loss from diabetic retinopathy is greatly reduced in some patients after having laser surgery.

Source: Understanding Diabetes-Related Eye Conditions, Royal National Institute of Blind People (RNIB), 10 Jun 2006.

Troy Bedinghaus, O.D., About.com; Updated April 1, 2009. About.com Health's Disease and Condition content is reviewed by the Medical Review Board

EXPLORE A WORLD OF LEARNING THROUGH OUR ONLINE TRAINING PORTAL

As a managed care organization targeted exclusively to government-sponsored health care programs, the Plan has an obligation to meet federal and state contractual requirements. These requirements include offering training and communications to assist our partners as they serve our members. As part of WellCare's network of providers, you and your staff can take advantage of our training courses available at your fingertips. Just log on to our secure portal at **www.wellcare.com** and click on the Training Portal tab/link. We are proud to offer this service to better manage your training needs.

Curriculum currently available on the Training Portal includes:

- Model of Care Overview
- Cultural Competency Training
- Medicare STAR Rating System Overview

By accessing and completing trainings through the secure portal, a record of completion is retained for each course you or your staff has completed. This record verifies your part in ensuring compliance with federal and/or state contracts, and helps us further our mission of serving our members.

A user name and password are required to access our secure portal. If you are not a registered provider and would like to be, go to **www.wellcare.com** and click on the "Provider Sign-up" link. It's quick, easy and FREE, and provides features, in addition to training, such as:

- Member eligibility and co-pay information
- Authorization requests
- Claims status and inquiry
- Your own inbox, with specific messages from the Plan
- Provider news
- More

EVALUATION AND MANAGEMENT (E&M) CLAIMS CODING

WellCare's Health Analytics Department, Health Services Department, and Special Investigations Unit recently completed a review of evaluation and management ("E&M") coding in claims submitted to WellCare for the incurred period January 2010 through December 2010. As a result of that review, WellCare sent educational letters to physicians whose E&M services exceeded CMS-published benchmarks.

For this review, WellCare reviewed incurred claims from January 2010 through December 2010 for E&M services (new and established patient visits only) for its individual physicians in all markets. After retrieving these claims, we compared, by specialty, how our individual physicians' claims matched corresponding E&M distribution data published by CMS. (For the CMS distribution data, we used the Medicare Part B Physician/Supplier National Data Calendar Year 2009: Evaluation and Management Codes by Specialty.) We next remapped individual physician visit data to match the CMS code distributions.

WellCare recognizes there may be variance with any individual provider's practice that may warrant E&M coding distributions that differ from the CMS published distribution. We note, however, that the CMS distributions are mapped by specialty which would serve to mitigate specialty-related reasons for variances.

As indicated, the letters were sent to physicians for educational purposes so that they could review their E&M billing practices to ensure appropriate coding commensurate with the level of service and time provided for our members. Regardless of whether your practice received a letter, we ask that our providers continue to pay close attention to appropriate E&M coding. CMS has published the *Evaluation and Management Services Guide* as a reference for providers. It is available @ https://www.cms.gov/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf. WellCare anticipates repeating this analysis periodically and will conduct more focused audits on those providers who consistently fall in the highest range of E&M coding distribution variance.

QUALITY IMPROVEMENT HIGHLIGHTS FROM 2010

The WellCare of New York, Inc., Medicaid, Family Health Plus and Child Health Plus Health Plan Quality Improvement (QI) program is an ongoing, comprehensive and integrated system that exists to actively initiate, monitor and evaluate standards of health care practice and infrastructures essential to the delivery of quality clinical care and service to members.

SOME HIGHLIGHTS FROM THE 2010 QI PROGRAM INCLUDE:

- Established on-site provider QARR/HEDIS education and outreach in coordination with Provider Relations
- Implemented Pay-for-Performance Program for QARR 2010 PCPs
- Increased staff to include nurses who conducted medical record review throughout 2010 in addition to provider outreach and education
- Reduced Readmission via a Multiple Admission Program (MAP) to decrease the overall readmission rate by focusing on a group of high-risk members who had a history of multiple admissions
- Piloted program to encourage physician involvement with members during and after a hospital stay, with the intent of preventing readmissions due to preventable care gaps after discharge
- Trained Post-Service Utilization Management (UM) Review team to conduct UM reviews after service had been delivered, and/or after claim denial when allowed by contract or if provider demonstrates good cause for not requesting a pre-service or concurrent review
- Analyzed data integrity report to ensure that the Case Manager is consistently documenting the member's acuity level
- Revised the Case Management Audit Tool to include the acuity criteria and the appropriateness of the documented acuity level
- Improved Identification and Screening/Assessment of HIV/AIDS Members
- 99.83 percent of all NY Medicaid grievances cases closed within compliance timeframes

HIGHLIGHTS OF OUR GOALS FOR 2011 INCLUDE:

- Improve communication to members for whom cultural and/or linguistic barriers exist
- Increase education regarding the disease process and standards of care to reduce barriers and improved HEDIS® rates
- Demonstrate or sustain statistically significant improvements in HEDIS® measures
- Improve the quality and accessibility of health care for all the members as evidenced by an overall 10 percent increase in provider compliance with appointment availability standards
- Improve member satisfaction as evidenced by a 10 percent increase in overall satisfaction scores
- Reduce claims processing complaints as evidenced by a 10 percent reduction in the number of complaints received
- Promote member and provider awareness of preventive measures through the identification and distribution of educational literature
- Recredential all providers within the 36-month timeframe

SUBSTANCE ABUSE AND TREATMENT

THE POWER OF INTERVENTION

There are growing empirical data that support the success of incremental interventions targeting patients who are not sufficiently motivated to undergo full and comprehensive treatment plans that will lead to recovery. Several studies show that even small interventions can have lasting effects on behaviors.

Interventions that are respectful, directive and empathetic can impact patient behaviors. Advice given empathetically and skillfully—without judgment—can increase the likelihood that a patient will accept a referral to substance abuse treatment and increase the likelihood that they will attend the initial appointment.

Resources
For information concerning Rehabilitation Therapy
Statewide:
New York State Office of Alcoholism and Substance Abuse Services
1-800-522-5353
www.oasas.state.ny.us
NYC:
The Mental Health Association of New York City (MHA-NYC) LifeNet's network
1-800-543-3638
www.800lifenet.org

Source: New York State Department of Health, publication – Substance Abuse and Treatment: Information for Practitioners

REQUIRED REPORTING TO NEW YORK IMMUNIZATION REGISTRIES

IN NEW YORK STATE

The New York State's Immunization Registry Law requires providers to report immunizations administered to patients under age 19 (along with the patient's immunization history) to the New York State Department of Health using the **New York State Immunization Information System (NYSIIS)** within 14 days of administration.

Health care providers should be aware that New York State Public Health Law 2168 (posted at **http://www.health.state.ny.us/regulations/public_health_law/section/2168/index.htm**) mandates reporting statewide. For more information, contact NYSIIS at **1-518-473-2839**.

IN NEW YORK CITY

The New York City Health Code mandates that health care providers who order the administration of immunizations to children and adolescents from birth through age 18 years in New York City must report the immunizations to the **Citywide Immunization Registry (CIR)** within 14 days of administration.

New York City providers continue to report to the CIR, even if the patient lives outside of New York City. The CIR and NYSIIS will exchange data regularly on shared patients.

Immunizations administered to individuals aged 19 years or older may be reported to the CIR, with the patient's written consent. Consent may be obtained by having the patient sign the consent form. Health Care Providers may also use the Online Registry to report immunity to, or history of, vaccine-preventable disease, vaccine adverse events, and blood lead test results.

For more information, or to set up online access to the CIR for reporting immunizations and/or for obtaining patient or plan member immunization and lead test histories, call **1-212-676-2323**.

CAHPS®

ASSESSING HEALTH CARE QUALITY FROM A HEALTH PLAN MEMBER'S PERSPECTIVE

The Agency for Healthcare Research and Quality (AHRQ) is the leading federal agency responsible for developing standardized, evidence-based surveys and the related survey tools that are used to assess consumers' experiences with the United States health care system. The Agency's Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is the focal point of a national effort to measure, report and improve the quality of health care by utilizing respondents' feedback about their experiences with the health care system.

While CAHPS® surveys include both ratings and encounter reports, the emphasis is on the respondents' experiences with the health care system by providing health plans, providers and facilities an analysis that is specific, actionable, understandable and objective.

The survey tools and reporting measures are standardized, which allows for valid comparisons and benchmarking across all health care settings.

Every year, WellCare works collaboratively with The Myers Group, an NCQA-Certified HEDIS®[1] Survey Vendor, to administer the CAHPS®[2] survey to members or parents/guardians of members. The survey is used to rate their satisfaction regarding their experiences with several categories related to health care and the services provided by the health plan. Topics in the CAHPS® 4.0H Survey include the following:

- Access to Getting Needed Care
- Access to Getting Care Quickly
- Patient Utilization of the Health Care System
- How Well Doctors Communicate
- Health Plan Customer Service Ratings
- Shared Decision Making
- Health Promotion and Education
- Coordination of Care
- Provider and Health Plan Ratings

The CAHPS® 4.0H survey results will outline what the health plan's strengths are and identify opportunities for improvement related to these categories.

WellCare will publish highlights of our respective results in a future newsletter. We would like to encourage you and your staff to join our efforts to improve our member satisfaction, specifically in the areas outlined and identified as opportunities for improvement.

[1]HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Source: To learn more about the CAHPS® program and its products and services, visit www.cahps.ahrq.gov.

5010 COMPLIANCE: PRODUCTION READINESS AND CONTINGENCY PLANNING

While you may not be familiar with technical aspects of 5010, it is important to understand that your clearinghouse, practice management software or other software must be 5010 compliant. If it isn't, you could experience a disruption in service related to verifying a patient's eligibility and benefit information, or with submitting a medical claim for reimbursement. In the fourth quarter of 2011, you should have validation of your vendors' 5010 compliance and finalized plans to move to 5010 production.

Keep in mind, the compliance date is **not** date-of-service driven; it is receipt-date driven. WellCare will not accept claims after December 31, 2011 if they are not 5010 compliant. Regardless of whether your vendors have certified their compliance, your 5010 strategy should include a contingency plan.

MOVING TO 5010 PRODUCTION

Once testing is complete and certified/approved between you and your trading partners (software vendors, clearinghouse, etc.), ongoing review and monitoring of transactions should continue for all providers submitting transactions through the clearinghouse. Items to monitor include:

- Claim processing
- Claim adjudication
- Return of requested benefit information
- Accurate claim status inquiries
- Accurate payment remittance advice
- Similar percentage of clean claims

CONTINGENCY PLANNING

Good or bad, all stakeholders must recognize that we will hit a few bumps on the road to 5010 compliance. Some vendors will establish a testing environment that will be utilized solely for 5010 testing. Others who are limited in resources and funding may opt to use an existing test environment that may not totally mimic their production environment. Consequently, the results you may see during the 5010 testing phase may not be the same results you can expect in the production environment once you go live on 5010.

One hundred percent testing is preferred but not always practical, given a project as large and complex as 5010. Therefore, a solid backup plan is highly recommended. To establish a backup plan, you must recognize events that may be at risk, such as impacts to member care, revenue and regulatory reporting.

- Consider the following:
  - What if certain claims previously accepted are now rejected or denied?
  - What is your revenue impact if your claims cannot be processed?
  - Are multiple updates necessary for your practice management system to become 5010 compliant? Timelines may not coincide with compliance timelines.
  - Assess if you will need to augment staff (full-time, contractor, etc.). Will your support needs increase with the management of denied claims?
- Some potential solutions:
  - Direct Data Entry (DDE) for submission of claims
  - Contact your clearinghouse partner about alternative solutions and assistance.

For additional information and assistance, please contact:

- **5010_Questions@wellcare.com**
- CMS assistance: Provider Guide to a Smooth 5010 Transition **(http://www.cms.gov/Versions5010andD0/Downloads/w5010PvdrActionChklst.pdf)**
- **www.WEDI.org** Resources >> White Papers >> Transactions and Code Set White Papers

From: www.WEDI.org: 5010 Testing and Implementation from the Provider Perspective: Is Your Practice Truly Ready?

COMING SOON: NEW YORK STATE DEPARTMENT OF HEALTH PROVIDER DIRECTORY SURVEY

As you may know, the New York State Department of Health (DOH), or an entity designated by the DOH, performs Managed Care Provider Directory Surveys twice a year. These surveys are conducted by way of phone calls to provider offices.

As a WellCare participating provider, you need to be informed that the NYS DOH Fall 2011 Provider Directory Survey is about to commence, and this year the DOH has designated IPRO to serve as the vendor to conduct these calls. It is possible that your office may receive one of these calls over the next 30–45 days.

The purpose of these calls is to verify the provider's knowledge of their participation with Medicaid Managed Care Plan(s). Please be sure that your office staff responds accurately to calls regarding your participation in WellCare's Medicaid, Family Health Plus or Child Health Plus products.

Typically the caller will ask:

- Does Dr. _____ accept/participate with WellCare Medicaid Managed Care?
- Does Dr. _____ accept/participate with WellCare Child Health Plus (CHP)?
- Does Dr. _____ accept/participate with WellCare Family Health Plus (FHP)?

As always, WellCare members or potential members may also call your office to verify participation. It is important that your office staff respond to all inquiries with accurate information.

If you have any questions regarding your participation in WellCare-specific products or if you have any questions on the Fall 2011 Provider Directory Survey, please call WellCare's Customer Service Department at 1-800-288-5441 or contact your Provider Relations Representative.

CERVICAL CANCER SCREENING

HOW REGULAR TESTING MAY SAVE LIVES

WellCare supports our network physicians to help reinforce the importance of cervical cancer screening for our female members. Our Pap test recommendations follow guidelines from the National Cancer Institute, US Department of Health and Human Services, and the American Cancer Society. These guidelines include the following:

- Females should receive an initial Pap test within three years of first sexual activity or at age 21—whichever comes first.
- Cervical cancer screenings should occur once every three years until age 65.
- Women older than 65 should discontinue Pap testing only after they have had several negative tests and are not otherwise at risk for cervical cancer.
- Women living with HIV/AIDS should have a Pap test twice in the first year, and if the tests are normal, Pap tests should continue at least every year.
- A woman who has had a total hysterectomy (in which the cervix was removed) no longer needs Pap tests, unless the surgery was done as a treatment for cervical abnormalities or cancer.
- Health care providers should encourage patients who may be less likely to get Pap tests to be screened regularly.
- All primary care providers, not just gynecologists, should check if women need to have a Pap test and, if so, either perform the test or refer appropriately.
- Targeted outreach toward older, foreign-born, low-income and uninsured women is recommended.
- All women 21 and older should be screened at least every three years, regardless of sexual activity.

Source: National Cancer Institute; U.S. Department of Health and Human Services; American Cancer Society

2011 Q4 PROVIDER FORMULARY UPDATE

GENERIC NEWS:

The generic drugs listed below are now available:

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
Antabuse® 250mg tablet	Disulfiram 250mg tablet	Alcohol Deterrent
Aromasin® 25mg tablet	Exemestane 25mg tablet	Aromatase Inhibitor, 3rd Generation
Xibrom™ 0.09% eye drops* (QL: 2.5 mL/31 days-Medicare only)	Bromfenac Sodium 0.09% eye drops (QL: 2.5 mL/31 days-Medicare only)	Ophthalmic Anti-Inflammatory
Carbatrol ER 100mg, 200mg and 300mg capsules*	Carbamazepine ER 100mg, 200mg and 300mg capsules*	Anticonvulsants
Concerta® ER 18mg, 27mg, 36mg and 54mg tablets*	Methylphenidate HCl ER 18mg, 27mg, 36mg and 54mg tablets*	Anorexigenics, Respir. & Cerebral Stimulants, Misc.
Methergine® 0.2mg/mL solution*	Methylergonovine Maleate 0.2mg/mL solution*	Oxytocic
Neurontin 250mg/5mL oral solution	Gabapentin 250mg/5mL oral solution	Gamma-aminobutyric Acid (GABA) Augmenting Agent
Xalatan® 0.005% ophthalmic solution (QL: 5 mL/31 days-Medicare only)	Latanoprost 0.005% eye drops (QL: 5 mL/31 days-Medicare only)	Ophthalmic Prostaglandin
Xodol® 5/300, 7.5/300, 10/300 tablets*	Hydrocodone Bitartrate/ Acetaminophen 5mg/300mg, 7.5mg/ 300mg, and 10mg/300mg tablets	Acetaminophen/Opiate Agonist Combination

*Not covered on the 2011 Medicare Formulary.

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

ADDITIONS	
Alendronate 5mg and 10mg tablets	Methylphenidate 5mg/5mL and 10mg/5mL oral solutions
Banzel™ 40mg/mL suspension (PA)	Neupogen® 300mcg/mL (PA)
Briellyn 0.4mg/0.035mg tablet	Nevanac® 0.1% eye drops
Ciprodex® 0.3%-0.1% otic suspension	Next Choice™ 0.75mg tablet (QL: #4 tablets/31 days)
Durezol® 0.05% emulsion	Pacerone® 200mg tablet
Edurant™ 25mg tablet (QL: 31 tablets/31 days)	Prolia® 60mg/mL solution (PA)
Enbrel® 25mg kit (PA)	Sabril® 500mg packet (LA, PA)
Enbrel® 25mg/0.5mL and 50mg/mL solutions (PA)	Syeda™ 28 tablet
Enbrel® Sureclick 50mg/mL solution (PA)	Sylatron™ 296mcg, 444mcg and 888mcg kits (PA)
Jinteli™ 1mg/5mg tablet	Vandetanib 100mg and 300mg tablets (PA)
Klor-Con® M10 10mEq tablet	Viibryd™ 10mg, 20mg and 40mg tablets (ST)
Loryna™ 3mg/0.02mg tablet	Voriconazole 50mg and 200mg tablets (PA)
Matzim™ LA 180mg, 240mg, 300mg, 360mg and 420mg tablets	Zytiga™ 250mg tablet (PA)

LA = Limited Access PA = Prior Authorization QL = Quantity Limit ST = Step Edit

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

DRUG NAME	CHANGE
Diovan® 40mg, 80mg, and 160mg tablets	QL changed (#62 tablets/31 days)
Diovan HCT® 160mg/12.5mg and 80mg/12.5mg tablets	QL changed (#62 tablets/31 days)

QL = Quantity Limit

Please refer to your provider manual available at **www.wellcare.com/WCAssets/corporate/assets/WellCare_Medicare_Advantage_Provider_Manual.pdf** 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**.

PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Teva Pharmaceutical	Lansoprazole orally disintegrating tablets (ODT)	April 15, 2011	The FDA has received reports that Teva Pharmaceuticals' lansoprazole orally disintegrating tablets (ODT) clogged and blocked oral syringes and feeding tubes, including gastric and jejunostomy types, when administered as a suspension through these devices. The tablets may not fully disintegrate when water is added to them, and/or they may disintegrate but later form clumps that can adhere to the inside walls of oral syringes and feeding tubes. Lansoprazole is a proton pump inhibitor for the treatment of gastric and duodenal ulcers, gastroesophageal reflux disease, erosive esophagitis, and Zollinger-Ellison syndrome. Teva has voluntarily withdrawn its lansoprazole ODT product. Instruct patients and caregivers not to administer the product through oral syringes and/or feeding tubes. Any adverse events that may be related to the use of this product should be reported to the FDA's MedWatch Adverse Event Reporting program **online**, by returning the postage-paid **FDA form 3500** by mail (to MedWatch, 5600 Fishers Lane, Rockville, MD 20852-9787) or fax (**1-800-332-0178**).

CLAIMS CORNER: PAYMENT POLICIES FOR AMBULANCE SERVICES

Introduction

WellCare has adopted policies consistent with those of CMS that govern the billing and payment of ambulance services to our members. These policies enforce:

- Clinical conditions for which life support and emergency transport services are appropriate
- Origin and destinations for which ambulance transport services are appropriate
- Coverage of supplies and other services related to ambulance transportation

Coverage of Ambulance Services & Documentation Requirements

To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that use of any less medically comprehensive method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, no payment may be made for ambulance services.

When submitting a claim for payment, it is essential that providers supply claims information that will substantiate (1) the patient's need to be transported by ambulance versus other forms of transportation, and (2) the level of service utilized. In all cases, the appropriate documentation must be kept on file and presented upon request. Neither the presence nor absence of a signed physician's order for an ambulance transport necessarily justifies the transport as medically necessary.

Appropriate Designation of Level of Service

The need for emergency transport is justified based on the condition of the patient. Emergency transport services are appropriate when the condition of the patient requires immediate response by the ambulance provider. Advanced life support (ALS) or basic life support (BLS) transport services, whether for emergency or non-emergency services, are expected to be billed with an appropriate diagnosis indicating the condition of the patient and the need for either ALS or BLS services.

CMS has developed guidelines that outline which diagnoses are appropriate for ALS and BLS services. These guidelines are further subdivided into diagnoses that are appropriate for emergency and non-emergency transport. WellCare will generally apply these same guidelines when approving coverage for the various levels of ambulance transport. If the diagnoses supplied do not justify the patient's need for life support services, payment will be denied. CMS's Medical Conditions List can be found at **www.cms.hhs.gov/manuals/downloads/clm104c15.pdf**.

Ambulance Services for Deceased Patients

When a patient is pronounced dead after the ambulance is called, payment will be based on the BLS rate (BLS, non-emergent). Modifier QL (patient pronounced dead after ambulance called) should be used to indicate this situation. If a provider bills for ALS services or BLS, emergent, with modifier QL (patient pronounced dead after ambulance called), then these services will be denied or recoded to **A0428** (BLS, non-emergent). If the patient is pronounced dead after pickup, prior to or upon arrival at the receiving facility, the medically necessary level of service furnished will be allowed.

Origins & Destinations

Origin & Destination Modifiers

All ambulance services claims require the presence of origin and destination modifiers. These are single characters used in combination to create a two-character modifier. The first character of the modifier represents the origin of the service while the second character represents the destination. It is inappropriate for providers to bill a single character modifier. If a valid origin and destination modifier is not submitted, the service will be denied.

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Ambulance origin and destination modifier definitions are:

- D – Diagnostic or therapeutic site, other than P or H
- E – Custodial facility
- G – Hospital-based dialysis facility
- H – Hospital
- I – Site of transfer (i.e., helipad) between ambulances
- J – Non-hospital dialysis facility
- N – Skilled nursing facility
- P – Physician's office
- R – Residence
- S – Scene of accident or acute event
- X – Intermediate stop at physician's office en route to hospital

Non-Covered Origins and Destinations
Certain origins and destinations are not covered, consistent with CMS's coverage rules. Non-covered origins and destinations include, but are not limited to, transportation between:

- A patient's residence and any location other than a hospital or dialysis facility
- A physician's office and any location other than a hospital or nursing facility
- A dialysis facility and any location other than a custodial or nursing facility, or patient's residence

Dialysis Transports
A beneficiary receiving maintenance dialysis on an outpatient basis does not ordinarily require ambulance transportation for dialysis treatment, whether the facility is independent or part of a hospital. Ambulance services furnished to a maintenance dialysis patient are not payable unless documentation submitted with the claim shows that the patient's condition required ambulance services and the facility meets the destination requirements.

Reimbursement for Ambulance Supplies, Mileage and Related Services

Related Services Require Billing of Primary Transport Service
When ambulance supplies, mileage or other related services are billed and there is either no ambulance transport code billed for the same date of service or the ambulance transport code has been denied (i.e., it was billed without an appropriate diagnosis), then the ambulance supplies, mileage and related services will be denied.

Bundled Services
Certain services are bundled as part of the ground ambulance transport service. Payment for such services as ECG tracing, drugs, intubation, oxygen, extra attendants and pulse oximetry services are included in the fee for the ground ambulance transport and will not be separately reimbursed.

Ambulance Waiting Time
Ambulance waiting time is included in primary ambulance service. Additional payment will only be allowed in unusual circumstances with supporting documentation.

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PROTOCOL FOR CHANGING A MEMBER'S PRIMARY CARE PHYSICIAN

As outlined in the Provider Manual, WellCare members have the right to change their primary care physician (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:

- PCP change requests made from the **1st** to the **10th** of the month will be made effective retroactively to the **1st** of the same month.
- PCP change requests made after the **10th** of the month will be made effective the **1st** of the following month (extenuating circumstances may allow for exceptions).
- When a provider's office calls Customer Service with a PCP change request, the call 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 **1-800-278-5155 (Medicare)** or **1-800-288-5441 (Medicaid)**, or contact your local Provider Relations representative.