



PROVIDER

Newsletter

CLAIMS CORNER

CODING FOR WELL AND SICK VISITS

The American Medical Association (AMA) CPT coding manual defines preventive medicine services as age- and gender-appropriate history and exam with anticipatory guidance and counseling. Included in preventive care services are:

- History and exam appropriate for age and gender
- Anticipatory guidance and risk factor reduction
- Ordering of appropriate immunizations, lab/diagnostic procedures
- Treatment and management of insignificant problems

The AMA CPT coding guidelines allow a provider to bill for both a preventive medicine code and a medically necessary evaluation & management (E/M) code when there is “significant” extra work required in the diagnosis or treatment of a problem during a routine (annual) examination. Correct coding guidelines require the addition of modifier -25 to the medically necessary E/M service (99201 – 99215).

A provider should bill ONLY the PREVENTIVE MEDICINE code when:

- The patient’s status/history shows the patient in good health
- The patient has a minor “stable” problem
- The history of present illness (HPI) is “Doing well, no complaints”
- When the assessment & plan (A/P) addresses only preventive medicine issues

A provider should bill BOTH the PREVENTIVE MEDICINE code and the MEDICALLY NECESSARY E/M service when:

- The patient has chronic medical problems, one or two in poor control
- The patient has three serious chronic problems, all in good control, if they are addressed
- HPI documents poor control of chronic disease or status of stable diseases
- Exam shows unexpected, abnormal findings
- Acute problem treated
- A/P shows treatment of diseases

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 Web site:

- Ohio Medicaid Provider Manual Update
- New Unit Limit Claim per Lab Code
- Medicare Star Rating System Can Help Guide Patient Treatment
- Revised Filing Claims and EDI Job Aids Now Posted

You can find copies of some of these correspondences when you log in to the secure area of www.wellcare.com (Medicare) or ohio.wellcare.com (Medicaid). Use the white box on the right labeled “Member/Provider Secure Sign-In,” then click on the Provider tab. You will see *Messages From WellCare* located in the right-hand column. Remember to check the messages regularly to receive new and updated information.

ASSESS POTENTIAL HEALTH CONCERNS FOR YOUR OLDER PATIENTS

WellCare encourages you to dedicate a few minutes during a patient visit to discuss the following health concerns with your older patients.

FALL RISK MANAGEMENT

- **Ask your patients if they have fallen or almost fell, but were caught by someone or managed to grab hold of something just in time.**

Fall prevention is one of the biggest safety concerns for older patients, especially those who live alone. Slip and fall accidents are one of the leading causes of seniors having to go to the hospital. An important aspect of patient education and injury prevention is to alert your patients of ways to prevent falling—including wearing sensible shoes and using an assistive device—which is especially important for seniors because their balance may be impaired, leading to increased falls.

ASSESS PHYSICAL ACTIVITY AND KEEP YOUR PATIENTS MOVING

- **Talk to your patients about their physical activity. For example, do they exercise regularly or take part in physical exercise?**

You may want to advise them to start, increase or maintain their level of exercise or physical activity to maintain and/or improve their health. Physical activity can improve strength, balance, coordination and flexibility, and can go a long way toward fall prevention.

URINARY INCONTINENCE (UI)

- **In addressing a topic as sensitive as this, it is important to put patients at ease so they will feel comfortable discussing such a private issue with you.**

Loss of bladder control is common among older patients. Urinary incontinence may be underreported because patients do not believe that anything can be done about it. Underlying health problems may contribute to incontinence, such as menopause for women and enlarged prostate for men.

If the patient is experiencing symptoms of urinary incontinence, discuss treatment options that may include bladder training, physical therapy or, sometimes, just a simple change in toileting habits may bring relief.



CHECK FOR OSTEOPOROSIS

- **Assess your patients' bone health. Because osteoporosis can be asymptomatic for a prolonged period of time, do bone mineral density (BMD) testing if applicable.**

With age, bones tend to shrink in size and density, which weakens them and makes them more susceptible to fracture. The U.S. Preventive Services Task Force (USPSTF) recommends BMD testing on all women age 65 and older, all men age 70 and older, and other patients based on their clinical profile.

You may want to provide tips on what they can do to prevent bone loss or the progression of osteoporotic bones. For example, tell patients to include plenty of calcium and vitamin D in their diets, and to consider strength training to increase bone density and reduce the risks of osteoporosis. Medication management is a treatment option to slow bone loss and maintain bone mass, when applicable.

Always remind your patients that it's never too late to adopt a healthy lifestyle. As their physician, you cannot stop the aging process, but your patients can minimize the impact by making healthy lifestyle choices with your guidance.

MEASURE BONE LOSS

In agreement with the U.S. Preventive Services Task Force (USPSTF) recommendations for postmenopausal women, The National Osteoporosis Foundation (NOF) recommends bone density imaging on:

- All women age 65 and older
- All men age 70 and older
- Younger postmenopausal women and men ages 50 to 69 about whom you may have concern based on their clinical risk factor profile
- Women in the menopausal transition if there is a specific risk factor associated with increased fracture risk, such as low body weight, prior low-trauma fracture or high-risk medication
- Adults who have had a fracture after age 50
- Adults with a condition (e.g., rheumatoid arthritis) or taking a medication (e.g., glucocorticoids in a daily dose more than or equal to 5mg prednisone or equivalent for more than or equal to three months) associated with low bone mass or bone loss
- Anyone being considered for pharmacologic therapy for osteoporosis
- Anyone being treated for osteoporosis, to monitor treatment effect
- Anyone not receiving therapy in whom evidence of bone loss would lead to treatment

People with osteoporosis are frequently asymptomatic—sometimes for a prolonged period of time—until they suffer a fracture, which can lead to even more complications. Not uncommonly, the fracture occurs following minimal trauma. Although a fracture may be followed by a full recovery, chronic morbidity, disability and even death are all too common. Osteoporotic fractures may lead to psychological symptoms, most notably depression and loss of self-esteem, as patients grapple with pain, physical limitations and the need for lifestyle changes.

Osteoporosis-related fractures create both a personal and communal economic burden, necessitating more than 432,000 hospital admissions, almost 2.5 million medical office visits, and about 180,000 nursing home admissions annually in the U.S. Interventions that focus on early detection (radiologist-supervised bone density imaging) and treatment of osteoporosis, and prevention of falls, should be a routine focus of primary care office visits for at-risk patients.

Source:

National Osteoporosis Foundation Clinician's Guide to Prevention and Treatment of Osteoporosis. Washington, DC: National Osteoporosis Foundation; 2010. http://www.nof.org/sites/default/files/pdfs/NOF_ClinicianGuide2009_v7.pdf.

BALANCE BILLING OF “ZERO COST-SHARE” DUAL-ELIGIBLES IS PROHIBITED

There are two classes of zero cost-share beneficiaries: Qualified Medicare Beneficiaries without Medicaid benefits (QMB) and QMB with full Medicaid benefits (QMB+). Individuals who are categorized as QMB or QMB+ have a zero-cost liability and should never receive a bill. In fact, the Centers for Medicare & Medicaid Services (CMS) can impose sanctions for the practice.

If you are a provider who serves the QMB and/or QMB+ population, it is highly recommended that you participate in your state's Medicaid program and gain access to any billing system the state uses. This will allow you to easily balance bill the state for your fees.

WellCare's Access Plan is composed entirely of QMB and/or QMB+ individuals who are not responsible for

co-payments, coinsurance and/or deductibles and should never be directly billed. While the EOP you receive from WellCare may indicate that the member has a payment responsibility, this is intended only as a means for you to submit documentation to the state's Medicaid agency and should not be taken as an instruction to bill the member.

For more information, please contact your local Provider Relations representative.

In states that have capitation agreements with WellCare, the Plan will process the Medicaid payment responsibility on behalf of the state.

Q1 2011 FORMULARY UPDATE

GENERIC NEWS

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

BRAND NAME	GENERIC NAME	THERAPEUTIC CLASS
ASTELIN Nasal Spray*†	Azelastine HCl 137mcg Spray	Antihistamine
Exelon® 1.5mg, 3mg, 4.5mg and 6mg Capsules	Rivastigmine 1.5mg, 3mg, 4.5mg and 6mg Capsules	Cholinesterase Inhibitor
Zegerid® 20mg Capsule†	Omeprazole/Sodium Bicarbonate 20mg Capsule	Proton Pump Inhibitor
Zegerid® 40mg Capsule	Omeprazole/Sodium Bicarbonate 40mg Capsule	Proton Pump Inhibitor

*Not covered on the 2011 Medicare formulary.

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

ADDITIONS	
Afinitor® 2.5mg tablet (PA)	HalfLytely® & Bisacodyl Tablets Bowel Prep Kit
Amikacin Sulfate 100mg/2mL, 500mg/2mL and 1,000mg/4mL Vials	Methylphenidate 5mg/5mL and 10mg/5mL Oral Solutions
Ceftazidime 500mg Vial	Suboxone® 2mg-0.5mg and 8mg-2mg SL Films (PA)
Epinephrine 0.15mg and 0.3mg Auto-Injectors	Tasigna® 150mg Capsule (PA)
Gianvi™ 3mg-0.02mg Tablet	

PA = Prior Authorization

Please visit www.wellcare.com to view the current formulary and pharmacy updates.

BREAKING DOWN WALLS

EFFECTIVE COMMUNICATION WITH PATIENTS

It can be very stressful when patients do not understand what their doctors are telling them about their condition. Good communication can help alleviate fear or anxiety they might experience.

Here are some things providers can do to communicate more effectively with their patients:

- Keep the patient's culture in mind; it may differ from yours. The way you communicate both verbally and nonverbally may mean something different to them.
- Assess what the patient already knows by asking questions; encourage patients to keep you informed.
- Assess what the patient wants to know.
- Be empathetic.
- Take the time to explain all treatment options and ensure the patient understands the benefits and risks of each option.
- Keep it simple; explain medical information in easily understood language.
- Be sure to answer all of the patient's questions.

KEEPING PREGNANT MEMBERS AND THEIR UNBORN BABIES HEALTHY

As a health plan, we have an obligation to help our pregnant members and their unborn babies stay healthy. One of the ways we accomplish this is through our Maternity Education and Member Incentive Program, a component of our Quality Improvement program.

The **Maternity Education and Member Incentive Program's** goals are to:

- Engage expectant mothers in managing, maintaining and/or improving their current state of health
- Improve compliance with timely scheduling and attendance of prenatal and postpartum care visits
- Decrease the likelihood of negative consequences associated with not achieving a healthy outcome

As a part of the program, we will provide expectant mothers on our Medicaid plans with the educational booklet, **“Mommy and Baby Matters: Taking Care of Yourself and Your Baby.”** This booklet provides basic prenatal and postpartum tips to enhance the expectant mother’s awareness of taking good care of herself and her baby during and after pregnancy. To view a copy of the booklet, please visit ohio.wellcare.com/provider/quality.

As a component of the Maternity Education Program, WellCare is offering a Prenatal Reward Program that will reward expectant mothers for receiving timely prenatal visits. If a member chooses to participate in



this voluntary program, **she must attend at least six prenatal visits.** As the provider of care, you will need to confirm compliance and fax proof of the visits to WellCare. If the member meets her visits and other eligibility criteria, her reward is a free baby stroller.

We would like you to emphasize to each expectant mother the importance of taking care of herself during her pregnancy. More important, reinforce the need to schedule and keep her appointments so you can monitor both her health and her baby’s development.

LAST MENSTRUAL PERIOD DATE REQUIRED ON ALL DELIVERY CLAIMS

In order to meet Ohio Department of Job and Family Services (ODJFS) regulatory requirements, WellCare of Ohio requires the member’s Last Menstrual Period (LMP) date on all delivery claims submitted by providers. This requirement applies to all health care providers who submit professional claims on a CMS-1500 form. Delivery claims are rejected if the member’s LMP is not included on the claim.

ODJFS encounter data specifications and CMS-1500 billing instructions mandate that the LMP date must be entered

into the L2300_DTP_03_484_D8_LSTMENST_DT segment in the 2300 loop of the 837 on an EDI submitted claim or in Box 14 (Occurrence Date) for all delivery claims.

Please forward this information to your billing staff to ensure proper claims submittal for all your delivery claims, and to avoid claim rejections and delays in reimbursement for services provided to WellCare members. If you have any questions regarding this required information, please contact your Provider Relations representative.

MIGRATING TO 5010 FOR ELECTRONIC TRANSACTIONS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that the health care industry use standard formats for electronic claims and related transactions. The current format, 4010A1, is in the process of being replaced by 5010, a new standard format.

All covered entities (health plans, health care clearinghouses and certain health care providers) will be required to use the 5010 standard when conducting electronic transactions. These include:

- Claims (professional, institutional and dental)
- Claims status requests and responses
- Payments to providers
- Eligibility requests and responses
- Referral requests and responses
- Enrollment in and disenrollment from a health plan
- Coordination of benefits
- Premium payments

For the majority of the year 2010, the 5010 project focus was achieving Level I compliance. The Centers for Medicare & Medicaid Services (CMS) defines Level I compliance as follows: *a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing.*

For the year 2011, focus is shifting to testing and becoming Level II compliant. CMS defines Level II compliance as follows: *a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.*

TESTING SCHEDULE: WHO AND WHEN

A testing schedule was developed for providers who submit electronic transactions directly to, or receive electronic transactions directly from, WellCare. Testing began in January 2011 and will proceed through quarter two of 2011, depending on the provider and their transaction utilization.

For providers who submit electronic transactions through a third-party vendor, please note that WellCare is also testing with vendors during the same time frame. The specific types of vendor testing are listed below.

- 837I, 837P, 837D (Claims) – WellCare will test with clearinghouses
- 276/277 (Claim Status) – WellCare will test with clearinghouses and providers
- TA1, 999, 277CA (Response Files) – WellCare will test with clearinghouses
- Outbound 834 (Eligibility) – WellCare will test with providers
- 835 (Payments) – WellCare will test with payment vendor and providers
- NCPDP D.0 (Pharmacy) – WellCare will test with pharmacy claims vendors
- Encounters – WellCare will test with vendors and providers

KEEP COMMUNICATION LINES OPEN

Notify WellCare regarding any software and/or vendors that are not 5010 test-ready for external partners by e-mailing the EDI department at EDI-Master@WellCare.com.

Designate a primary contact (i.e., office manager, billing manager) who is familiar with 5010 and its implications for your office. A single point of contact will ensure communications to and from WellCare are received timely.

RESOURCES

- CMS checklist for a smooth 5010 transition:
www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
- CMS presentations from the National Provider calls:
www.cms.gov/Versions5010andD0/V50/list.asp#TopOfPage

For inquiries related to your electronic claim submissions to WellCare and related transactions, please contact our EDI team via e-mail at EDI-Master@WellCare.com.

DENTAL SERVICES ARE VITAL FOR TOTAL HEALTH

WellCare of Ohio encourages providers to reinforce the importance of dental services to our members.

Dental services are an important part of well-child screenings, which are completed annually from birth to 21 years of age. Dental services must be provided at intervals that meet reasonable standards of dental practice, as determined after consultation with recognized dental organizations involved in child health and at other intervals, as indicated by medical necessity, to determine the existence of a suspected illness or condition.

Services must include, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services.

Oral screening may be part of a physical exam but does not substitute for a dental examination performed by a dentist as a result of a direct referral to a dentist. A direct dental referral is required for every child in accordance



with the periodicity schedule set by the state. All services coverable under the Medicaid program must be provided to recipients if determined to be medically necessary.

If a condition requiring treatment is discovered during a screening, the necessary services must be provided to treat that condition. Please remind patients to make annual dental visits.

WHAT IS HEDIS®?

Healthcare Effectiveness Data and Information Set (HEDIS®) consists of a set of performance measures utilized by more than 90 percent of American health plans. This information is used to compare how well a plan performs in these areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors

WHY HEDIS IS IMPORTANT

HEDIS ensures health plans are offering quality preventive care and service to members. It also allows for a true comparison of the performance of health plans by consumers and employers.

VALUE OF HEDIS TO PROVIDERS

HEDIS can help save you time while also potentially reducing health care costs. By proactively managing patients' care, you are able to effectively monitor their health, prevent further complications and identify issues that may arise with their care.

HEDIS can also help you:

- Identify at-risk members to ensure they receive preventive screenings

- Understand how you compare with other WellCare providers as well as with the national average

VALUE OF HEDIS TO PATIENTS

HEDIS works to ensure that members receive preventive and quality care. It gives members the ability to review and compare plans' scores, helping them to make informed health care choices.

WHAT YOU CAN DO

- Encourage your patients to schedule preventive exams.
- Remind your patients to follow up with ordered tests.
- Conduct outreach calls to members who do not get their annual screenings.

If you have questions about HEDIS or need more information, please contact your Provider Relations representative.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Source: www.ncqa.org



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UPDATED INFORMATION? LET US KNOW!

Please provide WellCare any updated information or changes that would affect your status with the Plan. Inform the Plan in writing immediately of:

- Any revocation or suspension of your DEA number, and/or
- Suspension, limitation or revocation of your license, certification or other legal credential authorizing you to practice in the state of Ohio.

Inform the Plan in writing immediately of changes related to:

- Licensure status
- Tax identification numbers
- Telephone and fax numbers

- Addresses
- Status at participating hospitals
- Loss of liability insurance

By keeping your information up to date, you are helping to improve member accessibility.

Any changes to your data should be sent to:

WellCare of Ohio, Inc.
Attention: Provider Relations
6060 Rockside Woods Blvd., Suite 300
Independence, OH 44131

A copy should also be sent to your IPA if you are contracted with us through an IPA relationship.