WellCare

TEXAS | 2010 | ISSUE IV

PROVIDER Newsletter

CULTURE OF COMPLIANCE

The WellCare Code of Conduct and Business Ethics (the Code) enunciates the basic principles governing our business activities and relationships, and includes principles of fraud, waste and abuse. Values that guide activities, good judgment, personal honesty and sound business ethics are described in the Code. As an extension of WellCare, all delegated vendors must adhere to and comply with the principles in the Code. Delegated vendors must attest to training and compliance with the Code. The Code may be accessed at the following link: **http://www.wellcare.com/AboutUs/default**.

All delegated and contracted providers who render benefits or services for Medicare Part C and Part D programs must complete Fraud, Waste and Abuse training, affirming a commitment of compliance with all applicable federal and state standards to include the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), False Claims Act and the Anti-Kickback Statute. As a WellCare delegated and/or contracted provider, this training requirement applies to you and your staff.

Topics addressed in the training include:

- Laws and regulations related to Medicare Advantage (MA) and Medicare Part D fraud, waste and abuse (i.e., False Claims Act, Anti-Kickback Statute HIPAA, etc.)
- Obligations of the first-tier, downstream and related entities to have appropriate policies and procedures to address fraud, waste and abuse
- Process for reporting suspected fraud, waste and abuse of first-tier, downstream and related entities to the organization or prescription drug plan (PDP) sponsor
- Protections for employees of first-tier, downstream and related entities who report suspected fraud, waste and abuse
- Types of fraud, waste and abuse that can occur in first-tier, downstream and related entities

FWA training requirements are detailed in federal regulations at 42 C.F.R. § 422.503 and 42 C.F.R. § 423.504.

The link to the training may be accessed at **www.wellcare.learnsomething.com**, the WellCare Web site at **www.wellcare.com** and the WellCare Provider Portal at **www.wellcare.com/provider**.

FWA and HIPAA trainings are an annual requirement. It is important that you maintain documentation of the training to evidence compliance if requested.

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:

- TX Paper Claims Submission Guidelines and SNIP Edits
- 2010–2011 Provider Flu Notice
- WellCare Specialty Pharmacy Benefits and Forms
- 2011 D-SNP Provider Directory Requirement

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.

ACETAMINOPHEN

A FEW POINTS TO CONSIDER

A growing number of serious liver injury cases are caused by unintentional acetaminophen (APAP) overdoses each year. Recently, the Food and Drug Administration (FDA) has been enhancing awareness that the maximum recommended daily dose of APAP should not exceed four grams in healthy adults. Unfortunately, many people are overusing the drug. Here are some factors that may contribute to APAP over-utilization:

- The availability of APAP in many prescription combination medications, and in single-agent and combination over-the-counter (OTC) products
- The lack of patient knowledge and/or awareness
- Patients seeing multiple prescribers who are unaware of what is in the medications the other practitioners have prescribed for them
- The possibility of prescriber or pharmacist oversight
- The use of multiple pharmacies

Beginning in the 1990s, APAP over-utilization emerged as a leading factor in cases of unintentional acute liver failure in the United States. One chief cause can be attributed to the fact that the majority of consumers are unaware they are exceeding the maximum recommended dosages. As mentioned above, APAP is available in numerous combination products with varying indications. As a result, much of this problem is flying “under the radar.” While some patient populations are already at a higher risk for liver damage, including those who consume greater than or equal to three alcoholic beverages daily, or already have some degree of liver dysfunction, this amount of liver failure is certainly cause for concern.

The following tables detail select analgesics, both with and without acetaminophen, that are indicated for moderate to severe pain. For your reference, there is also a table indicating the maximum acetaminophen use for common strengths of analgesics that contain acetaminophen.

ANALGESICS WITHOUT ACETAMINOPHEN
Tramadol
Oxycodone (Immediate Release)
Methadone Methadose
Hydromorphone
Morphine (Immediate Release or Extended Release)

ANALGESICS WITH ACETAMINOPHEN
Codeine/Acetaminophen
Oxycodone/Acetaminophen
Hydrocodone/Acetaminophen

MAXIMUM ACETAMINOPHEN USAGE		
Acetaminophen Strength (mg)	Maximum Tablets/Day	Maximum Tablets/Month
300	13	390
325	12	360
500	8	240
650	6	180
750	5	150

Acetaminophen-induced liver toxicity is an easily avoidable injury that has gained escalating attention in the health care industry. Increased awareness in both health care professionals and patients will facilitate prevention of this undesirable outcome.

Reference: http://www.fda.gov/advisorycommittees/calendar/ucm143083.htm

CHANGES TO YOUR 835 EXPLANATION OF BENEFITS

WellCare of Texas, Inc., has enhanced its claims systems to capture claims that have been finalized (F-processing status) and processed in our system but have not been included on an EOP (explanation of payment) due to one of the reasons noted below. You may now see more details on your claims and EOPs that were not there in the past. Processes for submitting claims remain the same.

Claims may be in F-processing status for one of the following reasons:

- If your vendor has a negative balance due to retroactivity with payable or denied claims. A refund request letter was initiated and sent by the Cost Containment Department in regards to the claims that were overpaid that created the F-processing status on the payable and denied claims.
- If the claims are capitated.
- In the event the claims have been processed, but have not passed completely through the A/P cycle.
- If the claim has no payables and all of your claims have been denied. In the past you have received a mailed nonpayable EOP that included these claims. With the enhancement, these will be included in your 835.

WellCare asks that you contact Customer Service at **1-866-687-8878** with any questions on the EOPs that you receive from this enhancement or any other questions you may have in regards to the claims in the F-processing status.

FIVE REASONS TO SIGN UP FOR EFT

Five reasons to sign up today for Electronic Funds Transfer (EFT):

1. No interrupting your busy schedule to deposit a check.
2. No waiting in line at the bank.
3. No lost, stolen or stale-dated checks.
4. YOU control your banking information.
5. Immediate availability of funds—NO bank holds!

Five reasons to use Electronic Remittance Advice (ERA):

1. Quick posting of claims that we pay.
2. Accurate posting of claims that we pay.
3. HIPAA-compliant file format (835) imports into most practice management systems.
4. Multiple Data Exchange Partners (DEPs) are registered users of PaySpan Health (Avisena, Gateway EDI, GHN Online, Quadax, Relay Health and SSI Group; RealMed and ZirMed are coming soon).
5. Register for multiple payers.

To view a list of payers that use PaySpan Health, please visit their Web site **www.payformance.com/for-providers/participating-health-plans**.

PROVIDER DIRECTORY CHANGE

In 2011, Dual Special Needs Plans (D-SNPs) will be required to display the Medicaid indicator in the provider directory when they have contracts with state Medicaid agencies. WellCare will be populating the flag on network providers in all states where we have D-SNPs to provide the most comprehensive information to members, even if we are currently still not contracted with the state. We will direct members to contact your office first to ensure you are still accepting Medicaid patients prior to making appointments.

Source: 42 CFR 422.111(b)(3)(i), 422.111(e)

CLAIMS CORNER — PAPER CLAIM SUBMISSION GUIDELINES AND SNIP EDITS

WellCare of Texas, Inc., is updating its Medicare Provider Manual to reflect further details on regulatory requirements and industry standards for submissions of health care claims and encounters. The purpose of this additional information is to promote compliance with standards for claims and encounters submission.

PAPER CLAIMS GUIDELINES – EFFECTIVE OCTOBER 28, 2010

- Submit "clean claims" pursuant to your Provider Agreement using the UB-04 and CMS-1500 claim forms. For detailed information about paper claim submissions, refer to the National Uniform Claim Committee (NUCC) – CMS-1500 forms and the National Uniform Billing Committee (NUBC) – UB-04 forms. Refer to the 837 Institutional Implementation Guide by Washington Publishing Company (March 2003) for any EDI-related issues. Please visit our Web site at **www.wellcare.com** to find sample CMS-1500 and UB-04 forms and other helpful guidelines.
- Paper claim forms must not be handwritten or have any extraneous data printed or stamped on them.
- Medicare/Medicaid resubmission refers to the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
- "Corrected Claim" in the instance of a re-submission must have the appropriate bill frequency code in the left-hand side of Box 22 and the original reference number in the right-hand side on the CMS-1500. The frequency code is located in the bill type at the top of the UB-04 form.
  - CMS-1500 allows for the entry of 11 characters in the Code area and 18 characters in the Original Ref. No. area in Box 22. Please see example below:

    7 – Replacement of Prior Claim

    8 – Void/Cancel of Prior Claim

22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
7 OR 8	123456789012A33456

  - UB-04 allows for the frequency code to be entered as the third digit of the bill type. An example of this is 127, with the 7 being the frequency code for the Replacement of Prior Claim.

7–Replacement of Prior Claim
8–Void/Cancel of Prior Claim

The codes listed above for the CMS-1500 and UB-04 are not intended for use for original claim submission.

- Encounter submission—"Encounter" stamped in red on the paper claim is allowed only if it does not obscure any of the claim's information.
- Any missing, incomplete or invalid information in any field will cause the claim to be rejected.
- The font should be legible, typed in black ink, and in large, dark font in capital letters. The font should not have broken characters; script, italics or stylized font; red ink; mini font; or dot matrix font.

STANDARDS FOR CLAIMS AND ENCOUNTERS, AND SNIP – EFFECTIVE NOVEMBER 1, 2010

- Electronic Claims and Encounters—Submit with updated HIPAA Electronic Transaction and Code Sets, included in the Provider Manual(s). Additional guidance can be found at: **http://www.cms.hhs.gov/**.
- Strategic National Implementation Process (SNIP)—All claims and encounters will require validation of transaction integrity/syntax at levels 4 and 5.

WellCare will start enforcing additional SNIP 4 and 5 edits to comply with federal and state mandates. This applies to all submission types: paper, electronic claims (EDI) and direct data entry (DDE).

Below are general descriptions of each level:

- **SNIP Type 4**—Situational Requirements. Refer to the frequent examples below:
  1. Physical address of service location is required for all places of service billed.
  2. Additional present on admission (POA) indicator qualifier edits on the 2300 K3 segment.
  3. Total purchased service amount in the 2300 loop.
  4. Purchased service provider name when a purchased service is rendered in the 2300 loop (see #3 above).
  5. Service location address may not contain a P.O. Box.
  6. Taxonomy information is required for rendering and/or bill-to provider.
  7. Patient's date of birth cannot be greater than the date of service.
- **SNIP Type 5**—External Code Set Validation (e.g., procedure codes, ICD-9 codes, state and ZIP codes, taxonomy codes)

WHAT DO THESE CHANGES MEAN TO YOU?

It is important that you/your organization comply with these submission requirements in order for your claims/encounters to be processed in a timely manner and to avoid rejections. WellCare is aware that it will take you some time to update your systems accordingly.

- Claims received after the effective date of **October 28, 2010**, that do not adhere to the **paper claim guidelines** outlined above will be rejected.
- Full compliance with the SNIP edits described above went into effect November 1, 2010.
- Please note that all other WellCare claim submission requirements, such as timely filing, are not affected by these additional standards.
- Updated copies of the Provider Manual(s) will be available via the Plan's Web site(s) at **www.wellcare.com**. For questions, please contact your Provider Relations representative or call Provider Services at **1-866-687-8878**. We appreciate your attention and preparation for these changes.

ACCESS AND AVAILABILITY PROVIDER AUDITS

To ensure that WellCare members have timely access to their physicians, WellCare conducts random, annual telephone audits of its provider network. This audit is required by our regulatory partners in Medicare and Medicaid. WellCare must be able to report the annual results of these audits to these regulatory partners upon request.

The access audit consists of several questions to determine the next available appointment times for our members, and the average wait time in the provider's office once the member arrives for his/her appointment. The availability audit verifies whether members have access to their provider, an on-call physician or an advice nurse after office hours.

Audit calls take only a few minutes to complete and participation in these audits is a condition of your contract with WellCare. (Additional information regarding your responsibilities as a WellCare provider can be found in the WellCare Provider Manual.)

We appreciate you and your staff participating in this effort. If you have any questions regarding these audits, please contact your Provider Relations representative.

WINTER 2010 PROVIDER 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
Arimidex® 1mg Tablet	Anastrozole 1mg Tablet	Aromatase Inhibitor
Cardizem® LA 180mg, 240mg, 300mg, 360mg, 420mg Extended-Release Tablets	Diltiazem HCl 24HR 180mg, 240mg, 300mg, 360mg, 420mg Extended-Release Tablets	Calcium-Channel Blocker
Keppra® 500mg/5mL Solution for Injection	Levetiracetam 500mg/5mL Solution for Injection	Anticonvulsant

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

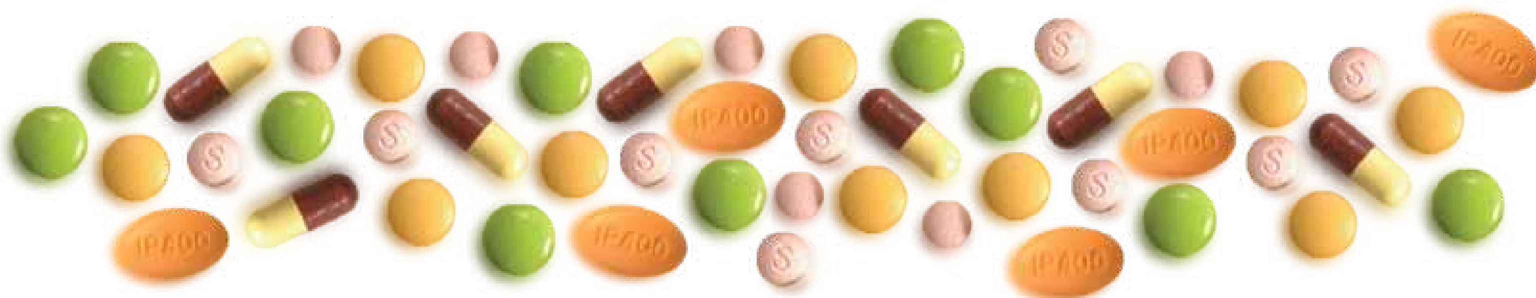
ADDITIONS	
Ampicillin Sodium 125mg, 250mg, 500mg, 2gm Powder for Injection	Rapamune® 0.5mg Tablet (PA)
Ciclopirox 1% Shampoo	Ribasphere® 200mg Tablet (PA)
Clindamycin Phosphate 1% Foam	
Creon® 6,000 USP units of lipase, 12,000 USP units of lipase, 24,000 USP units of lipase Delayed-Release Capsules	Sumatriptan 4mg/0.5mL, 6mg/0.5mL Syringes (QL: 8mL (16 syringes)/31 days)
Hydromorphone 2mg/mL Vial	Vimpat® 10mg/mL Oral Solution (PA)
NovoPen® 3 Insulin Device	
Ondansetron 32mg/50mL Bag (PA)	Zortress® 0.25mg (PA; QL: 62 Tablets/31 days), 0.5mg (PA), 0.75mg (PA) Tablets
Pfizerpen® 5,000,000 Units, 20,000,000 Units for Injection	

PA = Prior authorization required QL = Quantity limit

The prior authorization associated with the following medication has been removed for the WellCare Medicare Formulary:

DRUG NAME
Lovaza® 1gm Capsule

Continued



PLANNED MARKET DRUG WITHDRAWALS

COMPANY NAME	DRUG NAME	DATE OF REMOVAL	COMMENTS
Novo Nordisk	Vagifem® 25mcg Vaginal Tablets	July 30, 2010	Novo Nordisk decided to discontinue Vagifem® 25mcg because medical societies have recommended that the lowest effective dose of estrogen consistent with treatment goals, benefits and risks for the individual woman should be the therapeutic goal. Novo Nordisk has recently launched low-dose Vagifem 10mcg. The Vagifem 25mcg vaginal tablets that Novo Nordisk is going to be withdrawing and the recently launched Vagifem 10mcg vaginal tablets are not a covered benefit for members of WellCare Medicare.
Pfizer	Mylotarg® 5mg Powder for Injection	October 15, 2010	Pfizer has announced it will be discontinuing commercial availability of Mylotarg® in the U.S. Patients who are currently taking Mylotarg and those patients who have been prescribed Mylotarg may continue their course of therapy in consultation with their physicians. However, Pfizer recommends no new patients in the U.S. be prescribed Mylotarg. Future use of Mylotarg for new patients in the U.S. will require physician submission of an Investigational New Drug (IND) application to the U.S. Food and Drug Administration (FDA).

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

THE PROVIDER'S ROLE IN DATA GATHERING

Prior to billing Medicare, providers must ensure that they are billing the correct primary payer. A few minutes during each visit can help save time and money later. When collecting this data, the provider must indicate if the health care coverage is due to retirement and a supplemental policy.

Providers should be considering questions similar to the following:

- Does the patient have any group health plan (GHP) coverage based upon his/her current employment? (Medigap coverage should not be indicated.)
- Does the patient have any GHP coverage based upon his/her former employment?
- How many employees, including the patient, work for the employer from whom the patient has health insurance?
- Does the patient have any GHP coverage based upon his/her spouse's or another family member's current employment?
- Does the patient have any GHP coverage based upon his/her spouse's or another family member's former employment?
- How many employees, including the patient's spouse or other family members, work for the employer from whom the patient has health insurance?
- Is the patient receiving Black Lung benefits?
- Is the patient receiving workers' compensation benefits?
- Is the patient receiving treatment for an injury or illness for which another party could be held liable or is covered under automobile no-fault insurance?

IMPROVE YOUR PATIENTS' CARE WITH THE GUIDANCE OF THE MEDICARE STAR RATING SYSTEM

In order to arm members with the knowledge needed to make sound decisions about their health care, the Centers for Medicare & Medicaid Services (CMS) implemented a rating system that evaluates the relative quality of the private plans being offered to Medicare beneficiaries. Scored on a one- to five-star scale, with five stars representing the highest quality, members can use these ratings as a collective gauge of the quality of care, ease of access to care, provider responsiveness and beneficiary approval of the plan. However, while these ratings were designed with members in mind, providers may also reap tremendous benefits from reviewing these scores and learning how to best help their Medicare patients receive improved customer service and quality care.

That's why it's important for our providers to familiarize themselves with the Medicare Star Rating System, as well as the important measures that will help improve our patients' care. Currently, the rating system exists for both Part C and Part D, focusing on a variety of quality and service metrics that result from the following sources:

Healthcare Effectiveness Data and Information Set (HEDIS®): One of the most widely used set of health care performance measures in the United States, these scores are derived from the combination of the administratively compliant members and the medical record review compliant members.

- **Key HEDIS Measures:**
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Cardiovascular Care
  - Diabetes Care
  - Glaucoma Testing

Consumer Assessment of Healthcare Providers and Systems (CAHPS): This program uses standardized surveys that ask patients to report on and evaluate their experiences with health care, including accessibility of services and their provider's communication skills.

- **Key CAHPS Measures:**
  - Timely Access to Appointments and Care
  - Effective Communication
  - Annual Flu Vaccine
  - Customer Service
  - Overall Rating of Health Care Quality

Health Outcomes Survey (HOS): Survey designed to evaluate physical and mental health, as well as quality of life, of Medicare beneficiaries currently enrolled in Medicare Advantage plans; a follow-up survey is also conducted two years later.

- **Key HOS Measures:**
  - Testing for Osteoporosis
  - Monitoring of Physical Activity
  - Improving or Maintaining Physical and Mental Health
  - Reducing the Risk of Falling
  - Improving Bladder Control

While the STAR ratings provide a tremendous benefit to members seeking exceptional medical care, it also serves as a reminder for you, as medical professionals, to never forget your primary goal: caring for your patients. Since WellCare's scores are tied to important HEDIS® initiatives such as the ones listed above, we may be able to improve our ratings simply by effectively serving our patients. Please keep these scores in mind as you work with our members.

MEDICARE ADVANTAGE PLANS 2011

Each year, WellCare must resubmit Medicare Advantage plan bids to the Centers for Medicare & Medicaid Services (CMS). As a result, WellCare's plans may change service areas, plan names or both. Members who have been impacted by a change in service area will need to re-enroll during the Annual Enrollment Period (AEP). Members who have had only a plan name change will be rolled-over into a new plan that offers similar benefits.

Members who are currently enrolled in a terminating plan were notified by letter on September 22. There has been some confusion regarding these notifications that some of your patients may have received. **Please note that WellCare is not exiting any counties and has alternative products available for all members who received this communication.**

If a member has questions about the notification, please advise them to contact WellCare Customer Service at **1-866-687-8878**. Customer Service has talking points on this communication and will direct them to the appropriate staff that can help them get enrolled in an alternate WellCare plan.

As a provider, please continue to perform the same services to members on your panel as you normally would.

To ensure a successful new plan year transition, please remember these helpful tips:

- Always check the member's ID card and verify eligibility at each office visit.
- You can identify a WellCare Medicare Advantage member by looking at his or her member ID number. It should only contain numerals.
- If a member makes an appointment with you before receiving an ID card, you may contact Customer Service for plan-specific information.
- An enrollee's membership is effective the first day of the month following receipt of his or her application.

To validate eligibility of WellCare Medicare Advantage members, please call the Customer Service telephone number listed on the back of the ID card. As a registered user, you can also check on the plan's Web site at **www.wellcare.com**. If you are not a registered user, you can easily register by following steps outlined below:

1. Go to **www.wellcare.com/provider/default** and click on the *Sign Up Here* link next to *Register Today!* You will reach the **www.wellcare.com/registration/provider** page, where you will begin the simple, three-step process.
2. You will be asked to supply an e-mail address. The WellCare Web site allows you to have as many administrative users as needed, and you can tailor views, downloading options and e-mail details. For security purposes, we encourage the use of business e-mail accounts (instead of personal e-mail addresses).

For more information on WellCare's 2011 Medicare Advantage plans, please visit the Plan's Web site at **www.wellcare.com**.

WellCare of Texas, Inc.
2211 Norfolk Street, Suite 300
Houston, TX 77098

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HELPFUL TIPS FOR CONTACTING THE WELLCARE OF TEXAS CUSTOMER SERVICE DEPARTMENT

WellCare of Texas, Inc., wants you to know where to turn for the answers you need to effectively serve your patients: Customer Service.

Our award-winning Customer Service department is here to help you. Please utilize the means below to locate the tools and resources you need to properly service our members.

1. **Visit our Web site at www.wellcare.com**. By far our most convenient and quick form of customer service information, **www.wellcare.com** is an invaluable resource for those in need. Once you become a registered user on **www.wellcare.com**, you can verify eligibility, check claims status and receive updates on authorization requests. And if you still have questions, you can submit an e-mail form under the “Contact Us” option.
2. **Utilize our automated phone system (IVR) available 24 hours a day, seven days a week**. Through the automated system, you can check member eligibility, claims status and authorization status.
3. **Contact a Customer Service representative at the number designated for your line of business**.
   - Texas Medicare: **1-866-687-8878**