Georgia

Medicaid Provider Newsletter

2019 • Issue I

Quality

Starting the New Year with a Health Assessment

The beginning of a new year is a great time to reach out to patients who did not come in for their annual physical during 2018. According to the CDC, Americans use preventive services at about half the recommended rate. Chronic diseases, such as heart disease, cancer and diabetes, account for 7 of every 10 deaths and about 75% of the healthcare spending. Chronic diseases can be managed, prevented or detected through appropriate screenings.

Yet despite the benefits of preventive care, too many Americans go without needed screenings and care. WellCare would like to partner with you to help increase the number of our members getting preventive care. WellCare's Case and Disease Management Teams can help members overcome barriers to care and manage their chronic conditions. Our Quality Practice Advisors are available to answer your questions and provide you with educational materials.

We are available to help. Together, we can strive to help our members manage their health. Case and Disease Management: **1-800-CDC-INFO (1-800-232-4636)** (TTY **1-888-232-6348**)

Source: Centers for Disease Control and Prevention. (2017). Preventive health care. Retrieved from https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/preventivehealth.html

In This Issue

As of 9/15/2018, a new Georgia BH Master Authorization Grid is now available on our website at **www.wellcare.com/Georgia/Providers/Medicaid/Behavioral-Health/Authorization**

Affirmative Statement

WellCare's Utilization Management Program decision-making is based only on appropriateness of care, service and existence of coverage. WellCare does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

If you have questions about this program, please call Provider Services at the number at the end of this newsletter.

Join the Conversation on Social Media

Join our digital and social communities for up-to-date information on how we're working with you and others to help our members live better, healthier lives.

Communicating Effectively for Continuity of Care

Effective collaboration between health care providers is essential for patients' well-being. WellCare encourages all providers – medical and behavioral – to initiate communication that facilitates and enhances continuity and coordination of care, relapse prevention, member safety, and member satisfaction.

PCPs should hold the most complete medical record, including information related to continuity of care from all medical providers and behavioral health specialists - including psychiatrists, therapists, and social workers. Lack of information received from peer providers is a common concern of medical and behavioral health providers alike.

Medication Adherence and RxEffect™

To help with medication adherence, WellCare engages our members with refill reminder phone calls, off-therapy (missed dose) phone calls and letters, as well as using our network pharmacies to help counsel our members. However, there is nothing as powerful as a reminder from the member's primary care provider about the importance of medication adherence.

Community

Connections HELP Line

1-866-775-2192

We offer non-benefit resources such as help with food, rent and utilities.

Quality Quick Tip

Remember to document the second blood pressure reading when you perform the recheck of a member's initial high blood pressure reading.

Updated Claims and Payment Policies: Post-Payment Review and Technical Denials

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits.

The goal of WellCare's Post-Payment medical review program is to increase the payment accuracy of Medicare and Medicaid claims.

WellCare (or its designee) conducts post-payment reviews of provider's records related to services rendered to our members. During such reviews, the provider should allow access to, or provide, the medical record and billing documents requested that support the charges billed.

For post-payment reviews, medical records and/or related documentation will be reviewed as per the specific reason the records were requested. Upon completion of the medical record review, either the payment will stand or we will issue a recovery request letter.

The timeline for the requests of records is as follows:

- **Initial request:** A letter will be mailed to the provider asking that records be provided within 30 days from the date of the letter.
- **Second reminder:** If the requested records are not received within 30 days of the initial letter, a second letter may be mailed or outbound calls may be made to the provider, allowing the provider an additional 30 days to respond. If the records are not received by the 60th day after the initial request, we will issue a technical denial with a request for repayment, and the recoupment process will begin directly following the 60-day period for the amount stated in the letter, or per state Medicaid rules, as applicable.

If the requested documentation is received after a technical denial has been issued, but within the dispute period outlined as per applicable contractual, State or Federal guidelines, the records will be reviewed. If the records submitted support payment of the original claim, the review will be closed. If the records submitted do not justify payment, a finding letter with a request for payment, with dispute rights, if applicable, will be issued to the provider.

Claims & Payment Policy: Pre-Payment and Post-Payment Review

Policy Number: CPP-102

Reducing Diabetic Agents Adverse Drug Events

Patients receiving diabetic agents are known to be at a higher risk of adverse drug events (ADEs), specifically, hypoglycemia. A study of emergency department (ED) visits for ADEs estimated that diabetic agents were associated with 13.3 percent of the visits, with 38.5 percent resulting in hospitalization.

Prescriber Tips:

- Patient's adherence should be addressed. Barriers may include patient factors (e.g., remembering to obtain or how to appropriately take medications), medication factors (e.g., complexity, multiple daily dosing, cost or side effects) and system factors (e.g., inadequate follow-up or support system).
- Carefully evaluate hypoglycemia risk. Less stringent glycemic goals may be appropriate for individual patients.
- Ask patient to document frequency of hypoglycemic episodes and circumstances surrounding it.
  - Patients on any hypoglycemia-inducing medication should be taught to carry carbohydrates to treat hypoglycemia.

Patient Education:

- **Self-monitoring of blood glucose (SMBG):** allows patients to evaluate their individual response to therapy and assess if glycemic targets are being achieved. Provide education, evaluate, and review patient's technique, testing frequency, BG target range, and recording of daily results.
- **Hypoglycemia awareness:** allows patients to understand the signs and symptoms of hypoglycemia and how to treat and prevent it.

Insulin Safety:

- Whenever possible, simplify insulin regimens.
- Provide insulin administration education (e.g., supplies, dose preparation, injection procedures, selection and rotation of site, needle disposal, storage). Observe patient's insulin injection technique to identify errors and to improve technique.
- Encourage patients who use multiple types of insulin to verify each product prior to administration to prevent mixing up insulin products.
- Confirm patient's knowledge through teach-back regarding appropriate insulin/meal timing, as well as insulin adjustment in the presence of reduced caloric intake to prevent meal-related problems.

SOURCE: Shehab N, Lovegrove M, Gellar A, et al. U.S. Emergency Department Visits for Outpatient Adverse Drug Events. JAMA. 2016: 2115-2125.

Corner Updates

WellCare Health Plans, Inc. is committed to continually improving its claims review and payment processes with a goal of collecting the best health data for our members and assuring appropriate reimbursement to our providers. WellCare Health Plans is expanding our claims edit library with additional policies. Periodic updates of our edits ensures claims are processed accurately and efficiently based on our medical coverage policies, reimbursement policies, benefit plans and industry-standard coding practices, mainly Centers for Medicare & Medicaid Services (CMS).

We would like to share a few of the upcoming coding edits guidelines for 2019.

WellCare E&M Program

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have documented that evaluation and management (E&M) services are among the most likely services to be incorrectly coded, resulting in improper payments to practitioners. The OIG also has recommended that payers continue to help to educate practitioners on coding and documentation for E&M services, and develop programs to review E&M services billed for by high-coding practitioners.

Providers should report E&M services in accordance with the American Medical Association's CPT Manual and CMS guidelines including "Documentation Guidelines for Evaluation and Management Services" for billing E&M codes.

Overview of WellCare E&M Program:

- Evaluates and reviews high-level E&M services for high-coding practitioners, which appear to have been incorrectly coded based upon diagnostic information that appears on the claim and peer comparison.
- Applies the relevant E&M policy and recoding of the claim line to the proper E&M level of service.
- Allows reimbursement at the highest E&M service code level for which the criteria is satisfied based on our risk adjustment process.

ICD-10 Laterality

According to the ICD-10-CM Manual guidelines, there are diagnosis codes that by definition indicate laterality, specifying whether the condition occurs on the left or right, or is bilateral.

ICD 10 Coding conventions outlines guidance in reporting diagnosis code that indicate laterality. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

WellCare will perform two categories of diagnosis editing related to laterality:

- Consistency of Diagnosis-to-Modifier comparison assesses the lateral diagnosis associated to the claim line to determine if the procedure modifier matches the lateral diagnosis.
- Consistency of Diagnosis-to-Diagnosis comparison assesses lateral diagnoses associated to the same claim line to determine if the combination is inappropriate.

Excludes 1 Notes

ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.

New edits focus on Excludes notes 1 validation, an Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Anatomical Modifiers

Anatomical modifiers are important in facilitating correct coding for claims processing and data collection. Modifiers may be appended to HCPCS/CPT codes when the clinical circumstances justify the use of the modifier. According to the AMA CPT Manual, the HCPCS Level II Manual and Wellcare policy, the anatomic-specific modifiers, such as FA, TA, and LC, designate the area or part of the body on which the procedure is performed.

Certain procedures require an anatomical modifier i.e. CPT code 13151 Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm) done on the right upper eyelid requires modifier E3 (upper right eyelid) to be appended.

Multiple Procedure Reductions

Under the Medicare Physician Fee Schedule (MPFS), Multiple Procedure Payment Reduction (MPPR) was introduced with the basis that there are savings associated with multiple procedures performed during the same patient encounter. More information is at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf**

CMS has added different types of multiple procedure reductions over the years. The Physician Fee has an indicator identifying which type of MPPR applies to each CPT®/HCPCS Level II code.

The multiple procedure indicators are:

- **Multi Proc 0** = no reduction applies
- **Multi Proc 1** = does not apply to any current codes (was used pre-1995)
- **Multi Proc 2** = standard payment adjustments
- **Multi Proc 3** = endoscopic reductions
- **Multi Proc 4** = diagnostic imaging reduction
- **Multi Proc 5** = therapy reductions
- **Multi Proc 6** = diagnostic cardiovascular services
- **Multi Proc 7** = diagnostic ophthalmology services
- **Multi Proc 9** = concept does not apply

Application of MPPR:

Multiple Procedure Reduction Surgery

(Multiple Procedure Indicator 2-MPFS)

Multiple procedures are ranked in descending order by the Medicare fee schedule amount.

Payment is based on 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and

- 50 percent of the fee schedule amount for the second-through the fifth-highest valued procedures; or
- If more than five procedures with an indicator of "2" are billed, pay for the first five according to the rules above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, "by report." Payment determined on a "by report" basis for these codes should never be lower than 50 percent of the full payment amount.

	MFS Amount	Total Payment	MPR Payment
Surgery 1	$520.00	$260.00	**Paid 50%**
Surgery 2 Highest Value	$750.00	$750.00	**Paid 100%**
Surgery 3	$325.00	$162.50	**Paid 50%**
Total		$1172.50	

Did you know?

We removed member cost-share when done as a screening colonoscopy AND when done as a follow up after a positive FIT test. Details below.

WellCare **removed all member cost-share** for colonoscopies, including polypectomies when performed with screening colonoscopies using CPT code 45378 and ICD 10 diagnosis code Z12.11- (Encounter for screening for malignant neoplasm of colon).

- This includes screening colonoscopies done as a follow up to positive FIT tests.
- These services have no member cost share responsibility when performed at a participating facility.

Additionally, WellCare Medicare members are eligible for a "Healthy Rewards" gift card up to $50.00* for completing their colon cancer screening.

Evidence-based "best practice" notes that screening rates for colorectal cancer are the highest when multiple screening options are offered. We hope you will use this information to encourage your members to complete their cancer screenings to improve health outcomes. The following screenings will count toward colorectal cancer screening quality measures: Annual FIT screening test, (you can obtain the FIT test kits to give to your patients from your Quest Rep), flexible sigmoidoscopy every 5 years, colonoscopy every 10 years.

Please educate your patients about their testing options and help them choose the test that is best for them. Remember, a recommendation from your provider is often the single-most important factor in a patient's decision to screen for cancer.

**Gift card dollar amount varies by Market.*

Updating Provider Directory Information

At WellCare, we value everything you do to deliver quality care to our members – your patients – and ensure they have a positive healthcare experience. We want to make sure your practice receives timely information to help you do business with us.

To ensure we have the most up to date demographic information for your practice, there are two easy ways to submit important updates including, but not limited to, name, address, phone number, e-mail, physician joining the group or physician leaving the group.

Option 1:

Staff members with an Administrative role can submit these changes online using the secure provider portal at **www.wellcare.com/georgia**

After logging in, go to the "My Practice" area of the portal.

Click the "Manage Practice Information" link on the right side of the screen.

Select the action you want to take, complete the form and submit.

-or-

Option 2:

As of Nov. 1, 2018, you can send changes via email to **www.GAProviderUpdateRequest@wellcare.com**

WellCare will send an email confirming your request has been received. A follow-up email will be sent when the request has been completed.

We're here to help, and we continue to support our provider partners with quality incentive programs, quicker claims payments and dedicated local market support. Please contact your local **Provider Relations Representative** with any questions.

Electronic Funds Transfer (EFT) through PaySpan®

Five reasons to sign up today for EFT:

- ☑ **You** control your banking information.
- ☑ No waiting in line at the bank.
- ☑ No lost, stolen, or stale-dated checks.
- ☑ Immediate availability of funds – **no** bank holds!
- ☑ No interrupting your busy schedule to deposit a check.

Setup is easy and takes about five minutes to complete. Please visit **www.payspanhealth.com/nps** or call your Provider Relations representative or PaySpan at **1-877-331-7154** withany questions.

We will only deposit into your account, **not** take payments out.

Provider Formulary Updates

The WellCare of Georgia Preferred Drug List (PDL) has been updated. Visit **www.wellcare.com/Wellcare/Georgia/Providers/Medicaid/Pharmacy** to view the current PDL and pharmacy updates.

You can also refer to the Provider Handbook available at **www.wellcare.com/Wellcare/Georgia/Providers/Medicaid** to learn more about our pharmacy Utilization Management (UM) policies and procedures.

We're Just a Phone Call or Click Away

Medicaid: 1-866-231-1821 **www.wellcare.com/Georgia/Providers**

Provider Resources

Provider News – Provider Portal

Remember to check messages regularly to receive new and updated information. Access the secure portal using the Secure Login area on our homepage. You will see Messages from WellCare on the right. Provider Homepage - **www.wellcare.com/en/Georgia/Providers**.

Resources and Tools

You can find guidelines, key forms and other helpful resources from the homepage as well. You may request hard copies of documents by contacting your Provider Relations representative.

Refer to our Quick Reference Guide, for detailed information on areas including Claims, Appeals, and Pharmacy. These are located at **www.wellcare.com/Wellcare/Georgia/Providers/Medicaid**.

To locate your Provider Relations Representative, please visit: **https://www.wellcare.com/Georgia/Providers/Medicaid**

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available on our website at **www.wellcare.com/en/Georgia/Providers/Clinical-Guidelines**.

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