Nebraska

Provider Newsletter

December 2020

Quality

WellCare to Anthem Transition: Important Dates

As announced on January 23, 2020, ownership of WellCare of Nebraska, Inc. transferred from WellCare to Anthem, Inc. through its affiliate ATH Holding Company, LLC. (Anthem).

For plan year 2020, WellCare of Nebraska will continue to serve our members and providers through December, 31, 2020. At this time, there are no changes to provider contracts, member benefits or how members are served. Please make note of these key transition dates:

- Beginning in October 2020, Anthem will communicate with you about what to expect during this transition.
- On January 1, 2021, Anthem will begin servicing this plan. WellCare will only support transactions that occurred before January 1, 2021.

Learn more at **www.wellcare.com/Nebraska/Providers/Medicaid/WellCare-and-Anthem**. Or you may call Provider Services at **1-855-599-3811**, Monday through Friday, from 8 a.m. to 5 p.m. Central Time.

Thank you for serving our members over the past few years. Our success is, in large part, because of you, and we thank you for your support and care of our members.

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Operational

Nebraska Medicaid Expansion

Medicaid eligibility will be expanded to Nebraska residents ages 19-64 whose income is at or below 138% of the federal poverty level. This equates to about $16,000 per year for an individual. Applications were accepted on August 1, 2020, and benefits began on October 1, 2020.

Learn more at the DHHS website: **http://dhhs.ne.gov/Pages/Medicaid-Expansion.aspx**

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.

BLOG

WellCare® | HERITAGE HEALTH

WellCare of Nebraska Transition

Starting on **1/1/2021**, WellCare of Nebraska will be operating on Anthem systems, which will require that providers submit claims in accordance with their Nebraska Medicaid enrollment profile. Common provider data incongruence includes NPI, taxonomy, address including ZIP+4, and group affiliation. Please visit **Maximus** to review your Medicaid enrollment profile to ensure all data is correct.

****Failure to correct inaccurate information, or bill utilizing Medicaid enrollment profile data, will result in claim rejections as of 1/1/2021.**

CAHPS® – Your Opinion Matters

CAHPS® stands for Consumer Assessment of Healthcare Providers and Systems. CAHPS surveys ask members to share their opinions about the plan and its providers. In 2019, we improved our ratings in:

- Customer service
- Ease of filling out forms
- Rating of personal doctors
- Rating of health care
- Getting care quickly
- Rating of health plan
- Rating of specialist

We improved in 7 out of 12 categories! We always encourage our providers to get involved and place CAHPS posters and information in their offices.

The CAHPS survey is a national survey that not only measures the health plan, but also the providers and how quickly a member gets an appointment and whether coordination of care was discussed. We hope to work together more closely in 2020-2021 to provide more tools for providers to help increase our scores overall.

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

Care Coordination

Here are more tips to provide the needed care to your patients:

- ☑ Review medications with your patients.
- ☑ Offer to schedule specialist and lab appointments while your patients are in the office.
- ☑ Remind your patients about annual flu shots and other immunizations.
- ☑ Make sure your patients know you also are working with specialist on their care. Ensure you receive notes from specialists about the patient's care and reach out to specialist if you have not gotten consultation notes. Tell your patient the results of all test and procedures. Share decision making with patients to help them manage care. And please follow up on all authorizations requested for your patient.
- ☑ Call or contact your patients to remind them when it's time for preventive care services, such as annual wellness exams, recommended cancer screenings and follow-up care for ongoing conditions such as hypertension and diabetes.

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.

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 1 Notes validation, an Excludes 1 Note indicates that the code excluded should never be used at the same time as the code above the Excludes 1 Note. An Excludes 1 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 epair, 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.

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.

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

Application of MPPR:
Multi Proc 4 = diagnostic imaging reduction
Multi Proc 5 = therapy reductions
Multi Proc 6 = diagnostic cardiovascular services
Multi Proc 7 = diagnostic ophthalmology services

Electronic Prior Authorization Is Here!

If you haven't already noticed, the Cover My Meds Electronic Prior Authorization solution for all of our members is live. You can easily sign up for a free account on the Cover My Meds Prior Authorization Portal. The portal makes it easy to submit fully electronic prior authorization requests for all WellCare Medicare members.

Learn more about Electronic Prior Authorization at: **https://www.covermymeds.com/main/solutions/electronic-prior-authorization/**

Get started now at: **https://www.covermymeds.com/main/prior-authorization-forms/wellcare/**

Updating Provider Directory Information

We rely on our provider network to advise us of demographic changes so we can keep our information current.

To ensure our members and Care Management staff have up-to-date provider information, please give us advance notice of changes you make to your office phone number, office address or panel status (open/closed). Thirty-day advance notice is recommended.

New Phone Number, Office Address or Change in Panel Status:

Please call us at **1-855-599-3811**. Thank you for helping us maintain up-to-date directory information for your practice.

Electronic Funds Transfer (EFT) through PaySpan®

Five reasons to sign up today for EFT:

1. **You** control your banking information.
2. **No** waiting in line at the bank.
3. **No** lost, stolen, or stale-dated checks.
4. Immediate availability of funds – **no** bank holds!
5. **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,** Monday–Friday 8am–8pm EST, with any questions.

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

Provider Resources

1-855-599-3811 **www.wellcare.com/Nebraska/Providers**

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/Nebraska/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 many areas such as Claims, Appeals, Pharmacy, etc. These are located at **www.wellcare.com/en/Nebraska/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/Nebraska/Providers/Clinical-Guidelines**.

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