SMOKING CESSATION IN PREGNANCY

According to 2011 New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS) data, 5.7% of women in New Jersey reported smoking throughout pregnancy, leading to higher risk of pregnancy complications, preterm delivery and stillbirth. Smoking cessation counseling by clinicians has been shown to be effective in improving tobacco quit rates.

SMOKING DOCUMENTATION TIPS:
• Smoking history
• Education/counseling regarding smoking cessation
• Document if and when (the date) your patient has stopped smoking prior to delivery.
• Referral to a smoking cessation program such as Quit Line:
  – NJ Quit Line at 1-866-657-8677
  – Mom’s Quit Connection at 1-888-545-5191

Sources:
2016–2017 OB ENHANCED PAYMENT PROGRAM

WellCare Health Plans of New Jersey is pleased to announce a new program to recognize OB providers (participating providers only) who collaborate with us to provide quality care to our expectant members. WellCare is offering an OB Enhanced Payment Program (OBEPP) to our OB providers that help us drive improved quality and better birth outcomes by meeting the quality metrics outlined below.

You will be able to earn an additional $1,000 per delivery in addition to the compensation you receive for the individual services provided under your Participation Agreement.

Please note the following requirements to qualify:

• Member has 10 or more visits per delivery
• Postpartum visit within 6 weeks of delivery
• Provide evidence of predelivery pertussis vaccination

Once the above requirements are met and WellCare receives an eligible bill code 59400 for a vaginal birth or code 59510 for a C-section delivery, the code will trigger payment of the enhanced fee in addition to reimbursement for each individual service you bill. Please note: all claims filed with these codes will be subject to medical record review and standard quality measures to ensure appropriate documentation that the requirements of the program are met.

WellCare's OBEPP is discretionary and subject to modification at any time. WellCare is not making any changes to any other compensation provisions in your agreement. We encourage you to contact expectant members and schedule these appointments as appropriate.

If you have any questions about this program, please contact your Provider Relations representative. You can reach us Monday–Friday from 8 a.m. to 5 p.m. Thank you for working with us to deliver quality health care to our members.

IMPORTANT INFORMATION ABOUT WELLCARE LIBERTY (HMO SNP) IN NEW JERSEY

WellCare Health Plans of New Jersey would like to thank our contracted providers for your partnership, support and dedication in delivering quality health care to beneficiaries eligible for our Medicare Advantage and managed Medicaid plans.

WellCare Liberty (HMO SNP) is a dual-eligible Special Needs Plan, which means only beneficiaries eligible for both Medicare and Medicaid may enroll in the plan. In addition, WellCare Liberty (HMO SNP) further qualifies as a Fully Integrated Dual Eligible (FIDE) SNP, which means that members receive their Medicare benefits from the plan and their full Medicaid benefits, including, when eligible, Long Term Services and Supports.

As a FIDE SNP, WellCare Liberty (HMO SNP) is a zero cost-share plan. This means members, so long as they are active with the plan, owe nothing for covered services and may not be balance-billed for covered services. Claims for WellCare Liberty members will be adjudicated first through their Medicare benefits and then through their Medicaid benefits. Services not covered by Medicare may in turn be covered by the members’ Medicaid benefits. This includes cost shares (i.e., deductibles, co-payments and coinsurance) for Medicare-covered services.

LIBERTY MEMBERS ARE NOT RESPONSIBLE FOR MEDICARE COST SHARES

Therefore, although member deductibles, co-payments or coinsurance may appear on your Explanations of Payment (EOPs) or Remittance Advices (RAs), those amounts may not be billed to plan members. WellCare Liberty (HMO SNP) members are cost share protected by the state, which means they must not be billed. Instead, the Medicare cost shares will be adjudicated through the members’ Medicaid benefits to determine what, if anything, is still owed by the plan. WellCare payment for covered services for which the members’ Medicare benefit is primary must be considered payment in full and will be the lesser of the Medicare or Medicaid allowable amounts.
REDUCING RISK OF PRETERM BIRTH

Preterm birth, defined as birth at less than 37 weeks of gestation, is the single leading cause of newborn death, with many survivors facing a lifetime of disability.

Pregnant women with a previous preterm birth are at higher risk for subsequent preterm deliveries. Women with higher risk for preterm birth who receive progesterone injections, or 17 alpha hydroxyprogesterone caproate (17P), weekly beginning in the 16th to 20th week of gestation and continuing until delivery can reduce their chances of having another preterm birth by 33 percent. WellCare has contracted with Optum for Makena® (hydroxyprogesterone caproate) Administration Nursing and Care Management Services to help reduce the rate of preterm births. This will be done by maximizing orders of progesterone injections for women who meet indications for use. The injections will be readily obtainable on a weekly basis for those pregnant members who will benefit from them.

Optum’s services provide:

- Weekly, IM administration (via Z-track) of Makena by an OB nurse, in the home or at work
- Weekly, in-person preterm labor/high-risk assessment by a skilled OB nurse
- Telephonic access (24/7) to an OB nurse and patient education materials related to preterm labor/pregnancy complications
- Education and encouragement specific to the importance of completing the full course of therapy
- Compliance management, with scheduled injections to meet patient needs

To make a referral for Makena Administration:

Use the Makena Prescription Form, which can be downloaded at [www.makena.com/pdf/makena-prescription-form.pdf](http://www.makena.com/pdf/makena-prescription-form.pdf). Under STEP 4, check the box “Makena@Home by Optum,” and then fax the completed form to Makena Care Connection at 1-800-847-3413.

Sources:
- CDC “Preterm Birth” [www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm](http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm)

APPONITMENT ACCESS AND AVAILABILITY AUDITS

WellCare is required by the Centers for Medicare & Medicaid Services (CMS) and state regulations to administer appointment access and availability audits. The audits are conducted by a third-party vendor, SPH Analytics, and keep us compliant with NCQA and other accreditation entities. Auditors identify themselves when calling providers’ offices and provide appointment examples for existing members.

If an audit of your office reveals areas for improvement, you will receive a notification letter and an outline of the appointment types and standards. You will be provided an opportunity to respond, and will be re-audited in 90 days.

Appointment access and availability standards can be found on pages 27–29 in your Provider Manual posted at [www.wellcare.com/New-Jersey/Providers](http://www.wellcare.com/New-Jersey/Providers).

For more information on appointment access and availability audits, please contact your Provider Relations representative or call one of the Provider Services phone numbers at the end of this newsletter.
CODING CORNER

NOTIFICATION OF CLAIM EDITING UPDATE

The information outlines updates to claim editing. Please refer to the WellCare provider portal for the specific start date.

<table>
<thead>
<tr>
<th>Claim Editing Update</th>
<th>Description of Service</th>
<th>Updates Effective</th>
<th>Deny Reason Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Manifestation Code As Principal Diagnosis</td>
<td>According to WellCare’s policy, which is based on National Coding Standard as designated by the U.S. Department of Health and Human Services, manifestation codes cannot be used as the principal diagnosis. Manifestation is a condition that is an extension of the primary illness in question. When a particular condition (manifestation) is due to another underlying causal condition, the underlying condition (etiology) code is sequenced first, followed by the code for the manifestation.</td>
<td>WellCare Health Plans will deny claims when a diagnosis code that is designated as a manifestation code is used as a principal diagnosis on a claim. Dispute rights will be provided.</td>
<td>CE139 Denied: Inpatient Manifestation Code as Principal Diagnosis</td>
</tr>
<tr>
<td>Facility Inpatient Unacceptable Principal Diagnosis</td>
<td>According to WellCare's policy, which is based on National Coding Standard as designated by the U.S. Department of Health and Human Services, an Unacceptable Principal Diagnosis describes a circumstance that influences an individual’s health status but is not a current illness or injury; therefore, it is unacceptable as a principal diagnosis. In a few cases, some unacceptable codes will be acceptable as principal diagnoses if a secondary diagnosis is coded.</td>
<td>WellCare Health Plans will deny claims if the principal diagnosis on a claim has a designation as an unacceptable principal diagnosis. Dispute rights will be provided.</td>
<td>CE141 Denied: Inpatient Unacceptable Principal Diagnosis</td>
</tr>
<tr>
<td>Facility Inpatient Unacceptable Other Diagnosis</td>
<td>According to WellCare's policy, which is based on National Coding Standard as designated by the U.S. Department of Health and Human Services, an Unacceptable Principal Diagnosis describes a circumstance that influences an individual’s health status but is not a current illness or injury; therefore, it is unacceptable as a principal diagnosis. In a few cases, some unacceptable codes will be acceptable as principal diagnoses if a secondary diagnosis is coded.</td>
<td>WellCare Health Plans will deny claims if the principal diagnosis on a claim has a designation as an unacceptable principal diagnosis, unless a required secondary diagnosis is included on the claim. Dispute rights will be provided.</td>
<td>CE142 Denied: Inpatient Unacceptable Principal Diagnosis, requires Secondary Diagnosis</td>
</tr>
</tbody>
</table>

VITAMIN D TESTING

Description of Service:

According to the Centers for Medicare & Medicaid Services (CMS), providers performing Vitamin D testing should only do so when the diagnosis supports medical necessity. Additionally, Vitamin D testing (82306) should not be performed more than four times per year. Also, Vitamin D 1, 25 testing (82652) should not be performed more than once per year.

Updates effective: Please refer to the WellCare provider portal for the specific start date.

Per WellCare Claims Edit Guideline, if a covered indication for Vitamin D testing is not present on the claim line, the Vitamin D test (82306 or 82652) will be denied. Additionally, WellCare will deny Vitamin D testing (82306) if billed more than four times per year and Vitamin D 1, 25 testing (82652) if billed more than once per year.
DENTAL RECOMMENDATIONS FOR PEDIATRIC MEMBERS

WellCare makes the following dental recommendations for pediatric members:

- Complete a “Caries Risk Assessment” tool up to four times per year (located at www.wellcare.com/New-Jersey/Providers).
- Fluoride varnish can be applied to children ages 0–6 years and billed using CPT99188 ICD-10 code Z41.8.
- Refer children to a dentist by age 1 or soon after the eruption of the first primary tooth.
- During well-child visits, educate parents/guardians on the importance of a dental visit twice a year.
- Discuss good oral health habits (avoiding: thumb sucking, overutilization of bottles and pacifiers).
- Evaluate necessity of fluoride supplementation.

For more information, please contact your Provider Relations representative or call one of the Provider Services phone numbers at the end of this newsletter.

Q4 2016 PROVIDER FORMULARY UPDATE

MEDICAID:
The WellCare of New Jersey Medicaid Preferred Drug List (PDL) has been updated. Visit www.wellcare.com/New-Jersey/Providers/Medicaid/Pharmacy to view the current PDL and any pharmacy updates.

You can also refer to the Provider Manual available at www.wellcare.com/New-Jersey/Providers/Medicaid to view more information regarding WellCare’s pharmacy Utilization Management (UM) policies and procedures.

MEDICARE:
The Medicare formulary has been updated. Find the most up-to-date complete formulary at www.wellcare.com/New-Jersey/Providers/Medicare/Pharmacy.

You can also refer to the Provider Manual available at www.wellcare.com/New-Jersey/Providers/Medicare to view more information regarding WellCare’s pharmacy UM policies and procedures.
HOW TO IMPROVE PATIENT SATISFACTION AND CAHPS® SCORES, PART 3 OF 3

As a WellCare provider, you will be rated on the CAHPS survey by our WellCare members who are your patients. You can improve patient perception of key aspects of their care.

The CAHPS survey measures the patient’s health care experience.

The 2016 Medicaid Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results are in. The goal of the CAHPS survey is to obtain information from the person receiving care regarding satisfaction levels with providers, the health plan and the quality of the health care the member receives.

Overall, WellCare members are happy with their primary care providers (PCPs), and they rate you favorably.

• Thank you for helping members feel good about their PCPs.

Overall, WellCare members say that it’s not always easy to get needed care.

• Please be sure your members can get routine and urgent appointments when needed.

HERE ARE SOME TIPS THAT CAN IMPROVE THE MEMBER EXPERIENCE AND YOUR CAHPS SCORES:

• Make sure your members know:
  – Your office hours
  – How and where to get care and treatments after hours
  – Who the on-call staff is and how to contact them
  – How to contact WellCare’s 24-hour Nurse Advice Line

• When appropriate, be prepared to offer the following value-added assistance to WellCare members:
  – CommUnity Assistance Line: Helps to connect members with services in the community, 1-866-775-2192
  – Care Management at 1-866-635-7045 and Disease Management at 1-877-393-3090

• Call or contact your patients to remind them when it’s time for services, such as annual wellness exams, recommended cancer screenings, immunizations and follow-up care for ongoing conditions.

• Follow up after tests/screenings by calling/contacting your patients with results as soon as possible.

• Maintain contact information for community service alternatives in your area such as:
  – Local crisis centers, including 24/7 suicide and domestic violence lines
  – Local youth and family service center/Department of Children & Family Services
  – Local homeless services
  – Student counseling
  – Smoking cessation services
  – Medication assistance programs

Thank you for all you do to help our members reach and maintain good health.
WELLCARE REQUESTS CPT II CODES

WellCare works diligently to make sure our members are receiving comprehensive care. Please ensure that you are not inadvertently omitting or removing CPT II codes from your claims or encounters submitted to RelayHealth. WellCare wants to stress to all providers, billers and clearinghouses the importance of these services and the subsequent inclusion of the data on their claims and encounter submissions.

WHAT ARE CPT II CODES?
CPT II Codes are quality data codes which translate clinical actions so they can be captured in the administrative process. These codes relay that a measure requirement was met or not met. In addition, these are “tracking” codes, which facilitate data collection for the purpose of performance measurement.

WHY ARE THESE CODES NEEDED?
- These codes are used to track quality measures and monitor patient care.
- CPT II codes improve quality of care but are not “billable.”
- CPT II codes reduce the administrative encumbrance of HEDIS® chart reviews.
- Capturing CPT II codes helps drive HEDIS performance.

WILL I BE REIMBURSED FOR THE SUBMISSION OF A CPT II?
At this time, WellCare does not provide reimbursement for the submission of any CPT II code. However, the reimbursement of CPT II codes may be embedded within some WellCare quality initiatives.

HOW DO I SUBMIT CPT II CODES?
CPT II codes are billed in the procedure code field just as CPT Category I codes are billed.

CPT Category II codes are arranged according to the following categories and are comprised of four digits followed by the letter “F”.

- Composite Measures 0001F - 0015F
- Patient Management 0500F - 0575F
- Patient History 1000F - 1220F
- Physical Examination 2000F - 2050F
- Diagnostic/Screening Processes/Results 3006F - 3573F
- Therapeutic, Preventive or Other Interventions 4000F - 4306F
- Follow-up or Other Outcomes 5005F - 5100F
- Patient Safety 6005F - 6045F
- Structural Measures 7010F - 7025F

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:

MEDICAID
Send a letter on your letterhead with updated information to NJPR@wellcare.com. Please include contact information if we need to follow up with you.

MEDICARE
Call: 1-855-538-0454

Thank you for helping us maintain up-to-date directory information for your practice.
PROVIDER RESOURCES

WEB RESOURCES
Visit www.wellcare.com/New-Jersey/Providers to access our Preventive and Clinical Practice Guidelines, Clinical Coverage Guidelines, Pharmacy Guidelines, key forms and other helpful resources. You may also request hard copies of any of the above documents by contacting your Provider Relations representative. For additional information, please refer to your Quick Reference Guide at www.wellcare.com/New-Jersey/Providers/Medicaid or www.wellcare.com/New-Jersey/Providers/Medicare.

PROVIDER NEWS
Remember to check messages regularly to receive new and updated information. Visit the secure area of www.wellcare.com/New-Jersey/Providers to find copies of the latest correspondence. Access the secure portal using the secure provider login area in the Provider drop-down menu on the top of the page. You will see Messages from WellCare located in the column at the right.

ADDITIONAL CRITERIA AVAILABLE
Please remember that all Clinical Coverage Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available on our website at www.wellcare.com/New-Jersey/Providers/Clinical-Guidelines/CCGs.