HELP YOUR PATIENTS MAINTAIN THEIR HEALTH INSURANCE COVERAGE

Each year patients enrolled in Medicaid health plans must renew their health care coverage through a recertification process. On their Medicaid anniversary date, each member will receive a packet to re-apply for Medicaid. The Medicaid recipients must then submit the review form back to Healthy Connections within the required 30-day period listed on their form.

As a Medicaid provider, member recertification can have a significant impact on your office.

- If your patient experiences a loss Medicaid eligibility, it can create a gap in coverage. This not only impacts the health of our members, but it also drastically impacts your financial bottom line.
- Claims that are submitted for patients who have lost their eligibility due to a failure to recertify in a timely manner will be rejected due to a lack of coverage.

WellCare of South Carolina is fully committed to providing assistance for our members through various channels of communication to help educate them on the importance of annual recertification. We need your help in communicating this very important message to our members to help ensure continuity of care.

How can you help:

- Use every opportunity to remind WellCare members of the importance of their annual health care coverage recertification. Your front desk staff, nursing staff and providers can look for opportunities to communicate this important message to our members.
- Utilize the recertification reminder materials provided by WellCare in your lobby and exam rooms to help promote timely recertification.

Help our members maintain their coverage by joining us in promoting annual health care recertification.
CLAIMS PAYMENT POLICY REMINDERS

Timely claims payments are important to WellCare and our partner providers. In order to ensure this timeliness, we have identified some areas for improvement in claims submissions.

MODIFIER 25

All E&M services provided on the same day as a procedure are part of the procedure, and WellCare only makes separate payment if an exception applies.

Modifier 25 is used to describe a significant, separately identifiable E&M service that was performed at the same time as a procedure.

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have documented that Modifier 25 is one of the most frequently misused modifiers by medical providers. WellCare may require medical records prior to payment for E&M services to which Modifier 25 is appended in certain situations to validate that the documentation demonstrates that the E&M service is significant and separately identifiable.

A member’s medical documentation must clearly show that the E&M service that was performed and billed was unique and distinct from the usual preoperative and postoperative care associated with the primary procedure performed on the date of service.

Providers should reference the NCCI Policy Manual for guidance on correct submission of Modifier 25.

PLACE OF SERVICE CODING

According to CMS policy, the place of service code (POS) used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered, in the case of an interpretation. However, when a patient is in a registered inpatient status, all services billed by all providers should reflect and acknowledge the patient’s inpatient status.

When a physician/provider/supplier furnishes services to a registered inpatient, payment is made under the physician fee schedule at the facility rate. A physician/provider/supplier furnishing services to a patient who is a registered inpatient shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter, according to the WellCare policy.

Providers should reference MLN Matters MM7631 for place of service coding instruction.

LOCAL COVERAGE DETERMINATIONS

Unless a more restrictive WellCare Clinical Coverage Determination exists, WellCare relies on guidance published in Local Coverage Determinations (LCDs), respective to the state in which the service is rendered, to determine coverage requirements.
HOW CARE MANAGEMENT CAN HELP YOU

Care Management helps members with special needs by pairing a member with a care manager. The care manager is a registered nurse (RN) or licensed clinical social worker (LCSW) who can help the member with issues such as:

• Complex medical and behavioral health needs
• Solid organ and tissue transplants
• Chronic illnesses such as asthma, diabetes, hypertension and heart disease
• Children with special health care needs
• Lead poisoning

We’re here to help you! For more information about Care Management, or to refer a member to the program, please call us at 1-866-635-7045. This no-cost program gives access to an RN or LCSW Monday–Friday from 8 a.m. to 5 p.m.

Q2 2015 PROVIDER FORMULARY UPDATE

The WellCare of South Carolina Preferred Drug List (PDL) has been updated. Visit southcarolina.wellcare.com/provider/pharmacy to view the current PDL and pharmacy updates.

You can also refer to the Provider Manual available at southcarolina.wellcare.com/WCAssets/southcarolina/assets/sc_medicaid_provider_manual_05_2015.pdf to view more information regarding WellCare of South Carolina’s pharmacy Utilization Management policies and procedures.
BETTER QUALITY IS OUR GOAL

Our Quality Improvement (QI) program is dedicated to finding ways to help deliver better care and services to our members in collaboration with our providers.

SOME 2014 QI PROGRAM GOALS WE ACCOMPLISHED INCLUDE:

• Offered initial and follow-up HEDIS® education to providers in collaboration with Provider Relations and later with POD teams
• Presented, reviewed and evaluated Care Gap and Emergency Room Utilization Reports with providers
• Developed a Provider Education Assessment Survey
• Developed a Continuity of Care Survey addressing both clinical and behavioral care
• Developed a member outbound call center engaging in more than 1,200 outbound calls
• Collaborated with Utilization Management in connection with the Directional Care Program pilot
• Developed a High Involvement Outreach Process by assisting providers with new member roster and EPSDT (120 day) lists
• HEDIS Practice Advisor attended PCMH conference/training and will sit for PCMH Certification Exam in June 2015
• Captured additional preventive care services by managing and auditing pseudo-claims

OUR GOALS FOR 2015 INCLUDE:

• Reach out to providers with our HEDIS outreach team
• Achieve NCQA commendable accreditation
• Improve member and physician satisfaction levels
• Identify and assist with cultural needs of membership
• Continue to expand network
• Update and distribute clinical practice and preventive care guidelines to network physicians

We look forward to continuing our work with our providers to ensure members get the best care. To receive a copy of our QI Program Description, please call our Customer Service department at 1-888-588-9842.

REPORTING FRAUD, WASTE AND ABUSE

Providers can report suspected fraud of the Medicaid program by emailing fraudres@scdhhs.gov or calling 1-888-364-3224 or 1-866-678-8355. To learn more about fraud and abuse, visit www.scdhhs.gov, call the WellCare FWA Hotline at 1-866-678-8355 or refer to the Quick Reference Guide at southcarolina.wellcare.com/provider/resources.

APPOINTMENT 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, The Myers Group, to keep us compliant with the National Committee for Quality Assurance (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 you will be re-audited in 90 days.

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.
INTERACTIVE HEDIS ONLINE PORTAL

Thank you for being a WellCare provider and giving our members the very best care. We want you to be aware of a tool that will allow you to submit medical records and get real-time credit for care given. The iHOP (Interactive HEDIS® Online Portal) is an interactive website that allows you to see needed services (CareGap reports) and enter clinical data for WellCare members, along with the supporting medical records. This can help improve the quality of member care and allow WellCare to collect data for HEDIS reporting in a timely manner.

iHOP Overview
The WellCare interactive Healthcare Effectiveness Data and Information Set (HEDIS) Online Portal, called iHOP, will help providers identify and close gaps in members’ health care. This Web-based tool allows providers to readily see overdue, needed care according to HEDIS standards. Providers can use the iHOP to find a member and identify important medical care that the member may need. Then, they can make sure members receive these services while they are in the office. Or, if members have already had the service, their information can be updated in the portal as well.

For example, if a member is identified as needing colorectal cancer screening, but had that service while with another health plan, the provider can document that in iHOP and upload the medical record for WellCare to use. Likewise, if a member needs an immunization, the physician can provide that service while the member is still in the office and use the iHOP tool to update the member’s information immediately. These real-time updates allow WellCare to collect data required for HEDIS reporting much sooner than before.

An iHOP online training module is available on the Training tab of the Secure Provider Portal. We encourage you to use iHOP to help you better manage your practice and members’ health care needs.

BALANCE-BILLING REQUIREMENTS

Participant providers are required to accept payment directly from WellCare. This includes payment in full, with the exception of applicable co-payments, deductibles, coinsurance and any other amounts listed as member responsibility on your Explanation of Payment (EOP). Any bill generated to a member to collect for cost sharing other than those outlined above is prohibited. Balance billing of “zero costshare” dual eligibles is prohibited, including co-payments, etc., as listed above.

Please consider the following scenarios that may unintentionally create a balance billing problem:

- You have a billing/practice management system that automatically generates a bill to a member if you have not received an EOP from the plan within a certain time frame or if the expected amount received (in some cases zero, for denials) is less than the remitted amount.
- You have sent a lab test or other services out of network without proper authorization, creating a situation where our member may be inappropriately billed.
- You have not confirmed eligibility with WellCare, resulting in the incorrect classification of a member as self-pay, which in turn generates a bill to the WellCare member for services rendered. You can avoid this scenario by requiring all patients to present their ID cards at the time of their visit.

The generation of a balance bill to a Medicaid Managed Care enrollee is not only against WellCare policy, but is also strictly prohibited according to CMS guidelines.

If you have any questions or concerns regarding claims, please call one of the Provider Services phone numbers at the end of this newsletter or your Provider Relations representative.

Note: A provider may charge a member for services not covered by WellCare only when both parties have agreed prior to the service being rendered that the member is being seen as private pay. The provider must obtain the member’s written consent that he or she will be financially responsible for the non-covered service, and that consent must be signed and dated on or before the date of service.
EMERGENCY DEPARTMENT SUPER UTILIZER PROGRAM

In conjunction with the National Governors Association, WellCare promotes both efficient and effective Emergency Department (ED) management. We share the goals of all providers, to improve health care access and outcomes for the people we serve.

- WellCare offers intensive care management for patients with multiple ED visits. This effectively decreases the burden of non-emergent patients seen in the ED.
- Our care managers can assist your patients’ access to community resources such as shelters, utilities, transportation and support groups.
- Care management improves member adherence with the primary care provider’s treatment plan and improves quality outcomes.
- Care managers are able to assist with substance abuse disorders and behavioral health issues. Please refer your patients for these services if needed.
- WellCare’s Provider Relations representatives are able to assist providers who identify patients with excessive ED utilization. Lists of provider-specific super-utilizers are available upon request.
- You may call our Member Engagement Unit, 1-866-635-7045 to refer a patient to our care management program.
- The demographic information we receive is at times inaccurate. Your trusting relationship with your patients often allows you to obtain this information. Please share this with our case managers to optimize collaborative efforts.
- Providers are most able to identify which patients need additional social support and assistance, especially for those members who initially decline case management services. Please discuss this valuable option with your patients.
- As an added service, members may call our 24-hour nurse line, 1-800-919-8807, to answer any concerns. This service often helps to direct your patient to your office.
- Please remind your patients about the availability of weekend and evening clinics, urgent care centers, and covering physicians when the patient’s doctor is not available.
DISEASE MANAGEMENT — IMPROVING MEMBERS’ HEALTH

Disease Management is a free, voluntary program to assist members with specific chronic conditions. These members are assigned a disease nurse manager who can help them with:

- Identification of adherence barriers and ways to overcome them
- Individualized lifestyle modification suggestions to improve daily life
- Self-management of the member’s condition to improve health outcomes
- Motivational coaching for encouragement with member struggles
- Improved communication with the member’s primary care provider (PCP) and health care team
- Diabetes
- Hypertension
- Obesity

Disease Management can assist your members with the following conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Smoking cessation
- Coronary artery disease (CAD)
- Coronary artery disease
- Diabetes
- Hypertension
- Obesity

For more information, or to refer a member to Disease Management, please call us at 1-877-393-3090.

2015 CAHPS SURVEY

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is designed to collect important information from patients about the care they receive from their doctors and health plans. The survey was mailed to members in early March 2015.

Members (your patients) will be asked to rate their experiences with getting needed care, getting appointments and care quickly, how well their doctor communicates, the coordination of their care and their overall rating of the health care they received. Please consider how patients perceive your practice and the care they receive. Our goal is to partner with you to help your patients get the best health care possible. We want to work with you to achieve this.

The following suggestions are based on feedback from your colleagues on how to improve patient experience ratings:

- Let patients know your office hours and how to get care after hours.
- Offer to schedule specialist appointments while your patients are in the office.
- Make sure your contact information is correct in the WellCare directory.
- Offer extended, evening or weekend hours.
- If you are running late, have your staff let your patients know and apologize.
- Consider offering email or text communication, particularly for medication refills.
- Remember, almost everyone can receive and benefit from a flu shot.
- It’s just as important to explain why you are not doing something as it is to explain what you are doing.
- Invite questions and encourage your patients to make notes — research shows most patients forget two out of three things you tell them when they walk out of the exam room.

Remember: People don’t care how much you know until they know how much you care!

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

WEB RESOURCES
Visit southcarolina.wellcare.com 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 southcarolina.wellcare.com/provider.

PROVIDER NEWS
Remember to check messages regularly to receive new and updated information. Visit the secure area of southcarolina.wellcare.com (Medicaid) to find copies of the latest correspondence. Access the secure portal using the “Member/Provider Secure Sign-In” area on the right. You will see Messages from WellCare located in the right hand column.

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/provider/ccgs.