Provider Newsletter

Kentucky | 2018 | Issue I

Quality

Quality Stars

WellCare values everything you do to deliver quality care to our members – your patients – to make sure they have a positive health care experience. That's why we're asking you to join us in giving your patients optimal care to help improve quality scores!

WellCare's Quality Improvement Program monitors multiple measures that reflect your patients' experiences and health. The following measures are used to reflect the quality of patient care:

CAHPS® Survey, HOS Survey, HEDIS® Measures and Pharmacy Measures.

The Stars Score is a summary of many of these measures and may affect Pay-for-Performance (P4P) provider incentives. You can help us improve scores by taking the actions suggested below. Please contact your Provider Relations representative if you have questions or need assistance. We're here to help you.

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Availability of Criteria

The review criteria and guidelines are available to the providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling Customer Services department at the number listed at the end of this newsletter.

Also, please remember that all Clinical Coverage Guidelines, detailing medical necessity criteria for several medical procedures, devices and tests, are available via the provider resources link at: **www.wellcare.com/en/Kentucky/Providers/Clinical-Guidelines**.

In This Issue

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.

We're in this together: *Quality Health Care*

WellCare®
Beyond Healthcare. A Better You.

Independent External Review

In accordance with 907 KAR 17:035, if you receive an adverse final decision of a denial, in whole or in part, of a health service or claim for reimbursement related to this service, you may request an external independent third-party review. You may only do so after first completing an internal appeal/dispute process with WellCare of Kentucky. Provider requests for external review will only be considered for dates of service on or after December 1, 2016.

You must submit your request for external independent third-party review within 60 days from the date of receipt of the notice. You may submit your request to WellCare of Kentucky via one of the following methods:

- Email: **kyexternalreview@wellcare.com**
- Fax: **1-800-509-8203**
- Mail: **WellCare Health PlansAttention: External Independent Third-Party Review13551 Triton Park Blvd. Suite 1800Louisville, KY 40223**

WellCare will confirm receipt of your request for external third-party review within five business days of receiving your request.

As required by 907 KAR 17:035, if you request an external third-party review, WellCare will forward to the Department for Medicaid Services all documentation submitted by you during the appeal/dispute process within 15 business days of receiving your request. No additional documentation will be allowed for consideration by the external independent third-party review.

Additionally, if WellCare's decision is upheld by the external independent third-party review, you have the right to request an administrative hearing in accordance with 907 KAR 17:040 within 30 calendar days of the Department's written notice. You must submit your request for administrative hearing to:

Cabinet for Health and Family Services Department for Medicaid Services Division of Program Quality and Outcomes 275 East Main Street, 6C-C Frankfort, KY 40621

Updated Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) are best practice recommendations based on available clinical outcomes and scientific evidence. They also reference evidence-based standards to ensure that the guidelines contain the highest level of research and scientific content. CPGs are also used to guide efforts to improve the quality of care in our membership. CPGs on the following topics have been updated and published to the Provider website:

- Acute and Chronic Kidney Disease: HS-1006
- ADHD: HS-1020
- Adolescent Preventive Health: HS-1051 **NEW**
- Adult Preventive Health: HS-1018
- Anxiety Disorders: HS-1057 **NEW**
- Asthma: HS-1001
- Behavioral Health Conditions and Substance Use in High Risk Pregnancy: HS-1040
- Behavioral Health Screening in Primary Care Settings: HS-1036
- Bipolar Disorder: HS-1017
- Cancer: HS-1034
- Cardiovascular Disease: HS-1002
- Child and Adolescent Behavioral Health: HS-1049 **NEW**
- Cholesterol Management: HS-1005
- Congestive Heart Failure: HS-1003
- COPD: HS-1007
- Dental and Oral Health: HS-1065
- Depressive Disorders in Children, Adolescents and Adults: HS-1022
- Eating Disorders: HS-1046
- Fall Risk Assessment: HS-1033
- Frailty and Special Populations: HS-1052 **NEW**
- Hepatitis: HS-1050 **NEW**
- HIV Screening & Antiretroviral Treatment: HS-1024
- Hypertension: HS-1010
- Managing Infections: HS-1037
- Neonatal and Infant Health: HS-1072 **NEW**
- Neurodegenerative Disease: HS-1032 (previously Alzheimer's Disease)
- Obesity in Children and Adults: HS-1014
- Older Adult Preventive Health: HS-1063
- Osteoporosis: HS-1015
- Palliative Care: HS-1043
- Pediatric Preventive Health: HS-1019
- Persons with Serious Mental Illness and Medical Comorbidities: HS-1044
- Pneumonia: HS-1062
- Post-Traumatic Stress Disorder: HS-1048 **NEW**
- Rheumatoid Arthritis: HS-1025
- Sickle Cell Anemia: HS-1038
- Schizophrenia: HS-1026
- Substance Use Disorders: HS-1031
- Suicidal Behavior: HS-1027
- Traumatic Brain Injury (TBI): HS-1065 **NEW**

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Healthy Rewards Program

The Healthy Rewards Program rewards members for taking small steps that will help them live healthy lives. For simple tasks like completing prenatal visits, preventive dental visits and certain health checkups, members can earn rewards that are placed on prepaid debit cards. Members can use these cards at a variety of locations to purchase healthy items they use every day. The more services members complete, the more they can earn.

Now is a good time to remind your patients to take advantage of this program and their dental benefits by scheduling a dental visit. Providers can also encourage their patients to participate in the Healthy Rewards Program by signing and including their provider ID on applicable activity reports.

For more information on WellCare's Healthy Rewards Program, please contact your Provider Relations representative or call one of the Provider Services phone numbers at the end of this newsletter.

Provider Formulary Updates

Medicaid:

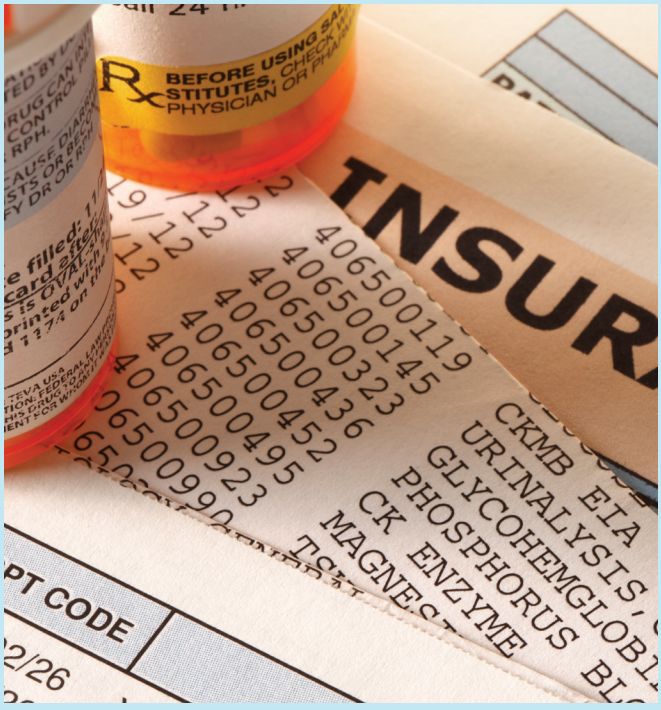
The WellCare Medicaid Preferred Drug List (PDL) has been updated. Visit **www.wellcare.com/Kentucky/Providers/Medicaid/Pharmacy** to view the current PDL and any pharmacy updates.

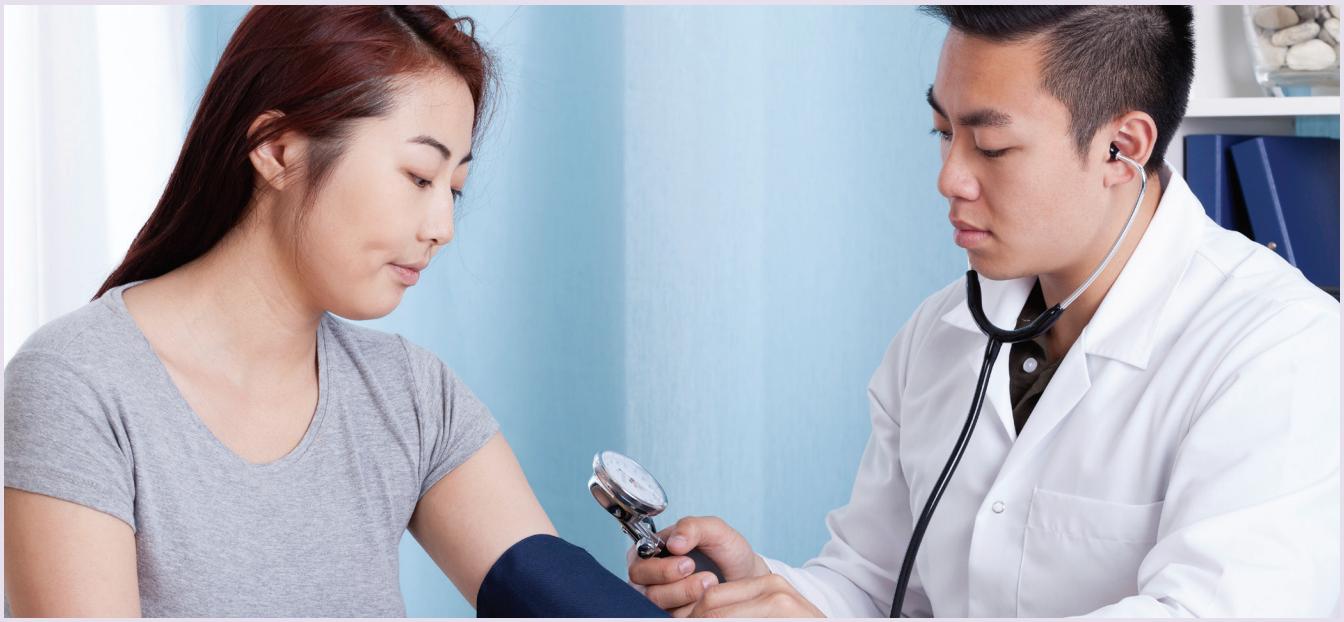
You can also refer to the Provider Manual available at **www.wellcare.com/Kentucky/Providers/Medicaid** to view more information regarding WellCare's pharmacy Utilization Management (UM) policies and procedures.

Medicare:

The Medicare Formulary has been updated. Find the most up-to-date complete formulary at **www.wellcare.com/Kentucky/Providers/Medicare/Pharmacy**.

You can also refer to the Provider Manual available at **www.wellcare.com/Kentucky/Providers/Medicare** to view more information regarding WellCare's pharmacy UM policies and procedures.





Getting Needed Care

Access to medical care, including primary care, specialist appointments and appointment access, are key elements of quality care. Each year, CAHPS® surveys patients and asks questions like:

- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?
- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last 6 months, how often did you see the doctor you were scheduled to see within 15 minutes of your appointment time?

To ensure your patients are satisfied with their ease of access:

- See members within access and availability standards
- Schedule appointments in a reasonable window for each request
- Follow up with members after referral to specialists to ensure care is coordinated
- Provide all information for specialists, tests and procedure authorizations and follow up as necessary
- Reduce time in the waiting room to no more than 15 minutes from appointment time

Care Coordination

These are also helpful 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 specialists on their care. Ensure you receive notes from specialists about the patient's care and reach out to specialists 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

Formulary News: Statin Use in Diabetes

The use of statin medications in patients ages 40–75 with diabetes and LDL from 70–189 mcg/dL is recommended by the American College of Cardiology (ACC) and the American Heart Association (AHA). This recommendation is included in the most recent Adult Treatment Panel (ATP) IV guidelines.

For your patients diagnosed with diabetes, consider starting the patient on a moderate- or high-intensity statin medication, depending on the patient's risk factors. For your convenience, we have listed the moderate and high-intensity statin medications that are preferred on WellCare's formulary:

HIGH INTENSITY
Atorvastatin 40, 80 mg
Rosuvastatin 20, 40 mg
MODERATE INTENSITY
Atorvastatin 10, 20 mgw
Rosuvastatin 5, 10 mg
Simvastatin 20, 40 mg
Pravastatin 40, 80 mg

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 Provider Relations 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 the updated information to **KY_ProviderCorrection@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.

Medicare

Medicare Access & CHIP Reauthorization act of 2015.

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires the removal of Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions such as billing, eligibility status and claim status.

This mandate is required by CMS. Providers should review their practice management systems and business processes to determine what changes you need to use the new Medicare Beneficiary Identifier (MBI). You'll need to change and test your system/process by April 2018, before CMS mails out new Medicare cards.

If you use vendors to bill Medicare, you should contact them to find out about their MBI practice management system changes.

For more information and requirements, please click on this link: **https://www.cms.gov/Medicare/New-Medicare-Card/index.html**

Access to Staff

If you have questions about the utilization management program, please call Customer Service at **1-866-231-1821**. TTYusers call **711**. Language services are offered.

You may also review the Utilization Management Program section of your Provider Manual. You may call to ask for materials in a different format. This includes other languages, large print and audio tapes. There is no charge for this.

CommUnity Assistance Line

CAL NUMBER **1-866-775-2192**

VIDEO RELAY **1-855-628-7552**

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

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Adult BMI – Help your patients live healthier by discussing their weight, diet and physical activity levels during preventive care visits.

Be sure to record calculated body mass index (BMI) in all patient medical records as well as height and weight. Explain BMI to your patients and help them reach a healthy BMI.

Care for Older Adults: Medication Review – Use these strategies to make sure your patients' medications are current, non-conflicting and being taken appropriately:

- Encourage your patients to bring in all their medications and supplements for the patient's annual wellness visits. Review what they're taking and why.
- When explaining medication instructions, ask each patient to repeat the instructions back to you to ensure total comprehension.
- Eliminate unnecessary or outdated medications. Simplify medications when possible.

Care for Older Adults: Functional Status Assessment – Bring your patients in for a preventive care visit and to complete a functional status assessment.

Adults ages 66 and older can struggle to do basic tasks as they age. As a health care provider, you should understand what your patients are going through and help them understand the difficulties they may face as they age. See how well they can do activities of daily living, such as dressing, eating and bathing.

Care for Older Adults: Pain Assessment – During your regular visits with older patients, conduct a pain screening. Help them develop a pain management plan at least once during the year.

High-Risk Medication – Review everything your patients are taking and consider alternatives to high-risk drugs. Consult the WellCare formulary for a comprehensive list of high-risk drugs.

MTM Program Completion Rate for CMR – Some plan members are a Medication Therapy Management (MTM) program to help them manage their prescription drugs. Advise patients to participate in an MTM program when offered (based on eligibility). Members are selected for this CMR program based on eligibility.

Statin Therapy for People with Cardiovascular Disease

Prescribe statin drugs for patients with cardiovascular disease. A 90-day supply might improve adherence.

Select lowest-tier medications from the formulary for your patient. Use our formulary search tool at **www.wellcare.com** to identify the best medication.

Prescribe the medication electronically to the patient's pharmacy of choice.

Make it easier for the patient to adhere to treatment by prescribing a 90-day supply, mail order or auto-refills, especially for patients stable on therapy.

Controlling Blood Pressure

Schedule quarterly visits with your patients with hypertension to help them control their blood pressure.

Encourage patients to make healthy lifestyle changes to help control their blood pressure:

- Achieve and maintain a healthy body weight
- Participate in some form of physical activity each day
- Reduce salt intake to 1500 mg a day. Beware of fast foods and prepackaged, processed foods, which are often high in salt
- If blood pressure remains out of control, consider medication therapy

Medication Adherence for Hypertension

Please remind your patients about medication adherence. Help them understand the importance of each medication and why they take it.

These points can improve adherence:

- Talk with your patients about adherence and identify their barriers
- Reduce pill burden when appropriate and help your patient set reminders and routines
- Make sure patients understand the instructions for taking the medication
- If cost is an issue, consider lower-tier medications in the same drug class
- Write 90-day supplies for patients who are stable at their current dose

Medication Adherence for Cholesterol (Statins)

Utilize the RxEffect portal to easily identify patients with high cholesterol who require medication adherence support.

Consider statin drug therapy for high-cholesterol patients. Statin drugs help lower cholesterol and reduce the risk of cardiac events and stroke.

These drugs will help your patients only if taken correctly.

CDC Recommendations for the Prescribing of Opioid Pain Medications

Attention DEA-Registered Practitioners:

In March 2016, the Centers for Disease Control and Prevention (CDC) published its "CDC Guideline for Prescribing Opioids for Chronic Pain" to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care and end-of-life care.

The CDC Guideline is part of a comprehensive approach to address the opioid overdose epidemic and is a step toward a more systematic approach to the prescribing of opioids, while ensuring that patients with chronic pain receive safer and effective pain management. According to the CDC, The Guideline's 12 recommendations, published in August 2017, are based on three key principles:

1. Non-opioid therapy is preferred for chronic pain outside of active cancer, palliative and end-of-life care. Opioids should only be used when their benefits are expected to outweigh their substantial risks.
2. When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose. Clinicians should start low and go slow.
3. Providers should always exercise caution when prescribing opioids and monitor all patients closely. Clinicians should minimize risk to patients, whether checking the state prescription drug monitoring program or having an 'off-ramp' plan to taper.

You are receiving this email as part of DEA's effort to improve its communication with its more than 1.7 million registrants while simultaneously improving the dissemination of the CDC Guidelines to those authorized to prescribe opioids.

A copy of CDC's publication entitled, "Guideline for Prescribing Opioids for Chronic Pain: Recommendations" may be found at: **https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf**.

Additionally, an Interactive Training Webinar for providers who prescribe opioids may be found at: **https://www.cdc.gov/drugoverdose/training/index.html**.

Cancer Screening Saves Lives

Screening for colorectal cancer can help find cancer early, when it might be easier to treat. Physicians and other clinicians are well aware of the benefits of screening, but many patients are not up to date with screening.

Colorectal cancer is the second-leading cause of cancer deaths in the United States among men and women combined, but screening can help prevent colorectal cancer. About 135,000 new cases and more than 50,000 deaths were estimated in 2017.

Talking with a physician or other clinician is one of the biggest factors that influences whether a patient is screened for colorectal cancer. You can help more patients get screened by discussing screening options and the risks and benefits of those options with your patients. Patients are often aware of colonoscopy as an option for screening, but they might not know as much about stool testing.

Did you know?

- Studies have shown that annual high-quality stool tests, such as high sensitivity GUIAC and fecal immunochemical tests can lower the risk of developing and dying from CRC
- Use stool tests only for average risk patients (no personal or family history of CRC, adenomas or genetic syndromes)
- Make sure patients perform annual stool testing if they selecting gFOBT or FIT tests and that they understand the instructions in the kit they are using
- Stool samples should never be used for CRC screening if they are obtained by digital rectal exam because they have a low sensitivity for cancer
- All patients who have a positive stool test must have a follow-up colonoscopy
- WellCare covers one screening test a year
- WellCare has provided over 70,000 FIT kits to patients for easy screening

- **Review ACS CRC Screening guidelines to determine your patient's risk category and screening recommendations.**
- **Review the risks and benefits of all CRC screening tests with your patients. If they are at average risk, discuss high-quality stool-based testing and offer them the choice that is right for them. Make sure they understand the risks and benefits of high-quality stool-based testing.**

Thank you for working with WellCare to make sure our members — your patients — get the care they need.

PCP Request to Transfer a Member

WellCare Health Plans, Inc. would like to ensure our Providers are aware of the appropriate process for requesting Members to be removed from their patient panel. Primary Care Physicians (PCPs) may request that a Member be removed from their patient panel if the physician feels that the Member is non-compliant with the physician's treatment plan or plan of care, if there is evidence of abusive or inappropriate behavior, or if the physician is unable to adequately address the Member's needs. WellCare Health Plans, Inc., and its affiliates and subsidiaries ("WellCare" or the "Company") has established a uniform policy to ensure the proper evaluation and processing of physician requests to transfer/reassign Members from their patient panel.

It is the policy of WellCare to comply with specific State and/or Federal contractual requirements that allow the PCPs to request the transfer of a Member. The Provider shall continue to provide medical care for the WellCare Member until such time that written notification is received from WellCare stating that the Member has been transferred from the Provider's practice.

The full detailed outline of this process is in the Provider Manual under the 'Termination of a Member' section. Primary care physicians can now ask to transfer a member from their patient panel based on one of the above-mentioned qualifying reasons via the New Provider Portal. This new online submission option replaces the previous fax form process.

Providers can log onto the secured provider portal via **https://provider.wellcare.com/**. Once on the home screen, providers will select "My Patients" at the top; choose the member; then select the Action: "Request Member Transfer." Supporting documentation such as office notes and/or clinicals are required for completion of each submission. Requests to transfer a member are reviewed for accuracy and completion. Requesting providers will receive confirmation from Customer Service once the transfer is completed.

This Is A Reminder Of Current Policy

Notification when a WellCare member is admitted to a facility:

As a reminder, WellCare requires notification by the next business day when a member is admitted to a facility. Notification is necessary for WellCare to obtain clinical information to perform case management and ensure coordination of services. Failure to notify WellCare of admissions or observation stays may result in denial of the claim.

Prior authorization for outpatient services:

WellCare has enhanced and standardized the provider portal authorization look-up tool with respect to place of service and clinical appropriateness. To reflect industry best practices and reduce the administrative burden on providers, the number of procedures requiring prior authorization has been reduced. Please remember to consult the authorization look-up tool on the provider portal and obtain appropriate prior authorization. Failure to obtain prior authorization where required may result in denial of the claim.

We value your partnership and work to ensure that every WellCare member receives quality health care.

Updated Clinical Practice Guidelines from page 3

Clinical Policy Guiding Documents

- CPG Hierarchy
- Health Equity, Literacy, and Cultural Competency **NEW**

The following CPGs have been retired and have been removed from the website:

- Acute Kidney Injury: HS-1069
- Antipsychotic Drug Use in Children: HS-1045
- Behavioral Health and Sexual Offenders in Adults: HS-1039
- Imaging for Low Back Pain: HS-1012
- Lead Exposure: HS-1011
- Motivational Interviewing & Health Behavior Change: HS-1042
- Pharyngitis: HS-1021
- Psychotropic Use in Children : HS 1047
- Screening, Brief Intervention, & Referral to Treatment (SBIRT): HS-1056
- Transitions of Care: HS-1054
- Major Depressive Disorder in Adults: HS-1008
- Substance Use Disorders in High Risk Pregnancy: HS-1041*

To access other CPGs related to Behavioral, Chronic, and Preventive Health, visit **https://www.wellcare.com/en/Kentucky/Providers/Clinical-Guidelines**.

WellCare®
Beyond Healthcare. A Better You.

WellCare of Kentucky, Inc.
13551 Triton Park Blvd.
Suite 1800
Louisville, KY 40223

WellCare Office Locations

www.wellcare.com/Kentucky/Providers

WellCare has various offices throughout Kentucky where you will find your local Provider Relations and Health Services team members.

Ashland
1539 Greenup Avenue
5th Floor
Ashland, KY 41101-7613
Main Office Number: **1-606-327-6200**

Bowling Green
360 East 8th Ave.
Suite 311
Bowling Green, KY 42101-2135
Main Office Number: **1-270-793-7301**

Hazard
479 High Street
2nd Floor
Hazard, KY 41701-1701
Main Office Number: **1-606-436-1500**

Lexington
2480 Fortune Drive
Suite 200
Lexington, KY 40509-4168
Main Office Number: **1-859-264-5100**

Louisville
13551 Triton Park Boulevard
Suite 1800
Louisville, KY 40223-4198
Main Office Number: **1-502-253-5100**

Owensboro
The Springs, Building C
2200 E. Parrish Ave., Suite 204
Owensboro, KY 42303-1451
Main Office Number: **1-270-688-7000**

Important reminder
You can use the member's Kentucky Medicaid ID number when the WellCare member ID number is not available when billing a claim.

Please remember to use the Kentucky MMIS, **www.kymmis.com**, as your primary source of Managed Care Organization (MCO) assignment and eligibility for WellCare members. We encourage all providers to use KYMMIS as their primary source as it contains the most updated eligibility and MCO assignment information on each individual member.

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