Kentucky

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: **1-877-389-9457** (TTY **711**).

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

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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®
Beyond Healthcare. A Better You.

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.

Opportunities for Patient Education:

January is Cervical Health Awareness Month.

According to the CDC, each year approximately 12,000 women in the United States get cervical cancer.

January provides a good opportunity to remind your female patients about the importance of getting a Pap and HPV test. In addition, for younger patients (boys and girls) who are 11 to 12 years of age the importance of getting the HPV vaccine.

https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf

February is American Heart Month

Heart disease, and associated risk factors, can occur at any age. According to the CDC, high rates of obesity and high blood pressure among younger adults (ages 35-64) are putting them at risk for heart disease earlier in their life.

The month of February is a good time to talk with your patients about any risk factors they may have for heart disease and steps to take to prevent heart disease in the future. In addition, remind your patients with high bloodpressure and on medication, the importance of medication adherence. A 90-day prescription may be an option.

https://www.cdc.gov/features/heartmonth/index.html

March is National Colorectal Cancer Awareness Month

According to the CDC, colorectal cancer is the second leading cancer killer in the United States. March provides a chance for you to discuss the importance of colorectal cancer screening with your patients
(50 to 75 years of age) and any risk factors they may have and how they can reduce their risk of developing colorectal cancer.

https://www.cdc.gov/cancer/colorectal/basic_info/

Welvie®: Improving Members' Health Care Experience

In 2015, WellCare began offering the Welvie online surgery shared-decision making program to its **Medicare Advantage members**.

Welvie's six-step program curriculum helps participants decide on, prepare for and recover from surgery. Through information, Q&As and videos, patients learn how to work with their doctors to explore treatment options – both surgical and non-surgical – when considering "preference-sensitive" surgeries like spine fusion, knee arthroscopy, prostatectomy and other elective procedures. Preference-sensitive surgeries are defined as those that have two or more viable alternatives for a presenting condition. If the patient, along with their doctor, decides surgery is right for them, Welvie then helps patients prepare for surgery and recovery with robust tools including checklists, calendars and other information and helpful tips to help them have error- and complication-free results.

Welvie participants receive a $25 amazon.com gift card for completing the first three steps of the program (reward is available once per member per 365 days).

The program's goal is to support member/physician interaction and preparation for surgery, as well as to promote improved health literacy.

After three years, the program has received high satisfaction marks from members. 95% of WellCare members have reported they felt the Welvie program helped them speak with their doctor about their treatment options and 97% said the Welvie program better prepared them for surgery.

To refer your **WellCare Medicare Advantage** patients to Welvie, just send them to **www.welvie.com** to register and engage in the program.

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 healthcare 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

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 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

Coding Corner

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.

Coding Edit Policies

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

Example 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	

Operational

Did you know?

We have removed member cost-share for screening colonoscopies with polypectomies & when done as a follow up after a positive FIT.

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.

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.

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

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.

Operational

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.

To access CPGDs and CPGs related to Behavioral, Chronic, and Preventive Health, visit **www.wellcare.com/Kentucky/Providers/**.

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.

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.

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.

2019 Medicare Advantage Provider Manual Update

WellCare's 2019 **Medicare Advantage Provider Manual** has been updated, effective January 1, 2019. The manual can be viewed online at **www.wellcare.com**. If you have any questions, please contact your Provider Relations representative or call the Provider Services phone number that can be found in this newsletter.

Community
Connections HELP Line
1-866-775-2192
We offer non-benefit resources such as help with food rent and utilities

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, Suite 501
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: **1-270-793-7300**

Hazard
450 Village Lane
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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