THANK YOU NOTE FROM WELLCARE OF GEORGIA COO STEVE MEEKER

As 2015 continues to fly by, it is easy for us to be so focused on our “to do” lists that we forget to stop and reflect on what we’ve already accomplished. The most important part of reflecting on our achievements is to honor those who have partnered with us in our endeavors.

WellCare has achieved a great deal over the past 10 years as we serve the health care needs of more than 30,000 Medicare members and more than 600,000 Medicaid members across the state. We take seriously our responsibility to efficiently deliver quality health care to our members.

As I reflect on the achievements of our organization, I wanted to say “thank you” from all of us at WellCare for partnering with us to meet the needs of our members every day. We fully recognize that we would not be where we are today without your engagement, commitment and partnership.

We wish you a happy and healthy 2015 and look forward to partnering with you to serve the health care needs of our members in the future.

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QUARTERLY EPSDT AND CPG MEDICAL RECORD AUDITS

QUARTERLY EPSDT MEDICAL RECORD AUDITS

The state of Georgia uses the Bright Futures Periodicity Schedule as guidance for Early Periodic Screening, Diagnosis and Treatment (EPSDT) preventive health screenings – formerly known as health checks. The Periodicity Schedule that is the key driver for preventive health screenings represents a consensus by the American Academy of Pediatrics (AAP) and Bright Futures for pediatric preventive care.

WellCare conducts a quarterly medical record audit to measure the effectiveness of EPSDT screenings for both PeachCare for Kids (birth to 19 years of age) and Medicaid members (birth to 21 years of age). The EPSDT medical record audit uses a randomized sampling process to guarantee a fair distribution of providers and members across the state of Georgia. The audit is used to observe how well providers perform the required screening components. The screening examination is designed to identify and treat conditions that may impede early childhood development. It is our goal at WellCare to ensure that children of all ages obtain these screenings, and that timely interventions are implemented.

We have identified the following areas of concern during our quarterly EPSDT medical record audits: providers who still maintain paper medical records with poor documentation; lack of documentation of anticipatory guidance; failure to obtain alcohol and drug assessment at age appropriate intervals; and failure to document sexually transmitted infection (STI) screening and associated referrals. For additional screening metrics and to view the 2014 Bright Futures/AAP Periodicity Schedule and Summary of Changes, please visit the Bright Futures page at www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.

QUARTERLY CPG MEDICAL RECORD AUDITS

Clinical Practice Guidelines (CPGs) are designed to support the decision-making processes in patient care. Guideline content is based on a systematic review of clinical evidence – the main source for evidence-based care. The movement towards evidence-based health care has increased over the past few years, motivated by clinicians, regulatory agencies and management concerns about quality, consistency and costs. CPGs, based on standardized best practices, have been shown to support improvements in quality and consistency in health care.

WellCare currently performs random audits for our members on the use of CPGs for three prevalent chronic conditions: ADHD, Diabetes, and Asthma, in which the findings are reported to the Department of Community Health. Overall, most providers adhere to the clinical practice guidelines, achieving a score of 80% when audited, but there are components within each CPG where documentation or evidence of services is an issue that pulls down the overall score for compliance with the CPGs.

The Diabetes CPG requires that five components be completed in the medical record to meet the audit, which includes: labs, history and physical, patient education, diabetic retinal eye exam (DRE) and influenza vaccine. It has been noted that two components, influenza and DRE, are sometimes not documented in the medical record. This results in a provider score of less than 80% when audited. More than likely, members have had the services, but the information is not documented in the member’s chart at the PCP’s office where it can be counted during the audit. Thus, the old adage “if it is not documented, it is not done!” If DREs and influenza vaccines are offered by the provider, but declined by the member, providers will be compliant for those two components. To improve the outcomes on the Diabetes CPG, we ask that providers document when services are provided or declined, obtain a report, or document any findings based on conversations with specialists showing the outcomes and plan of action. This ensures that communication and coordination of care is taking place.

Regarding the audits for the Asthma and ADHD CPGs, documentation of the Asthma Action Plan needs to be completed and entered in the medical record at least annually, and the ADHD rating scale needs to be completed and entered into the medical record on the initial visit or with noted changes in condition.

Providers who score less than 80% on either audit will be placed on a Corrective Action Plan (CAP) for both failed EPSDT and CPG medical record audits. A re-audit will be performed within 90 days to ensure compliance with the standards.
ANNUAL AMBULATORY MEDICAL RECORD REVIEW (AMRR)

In recognizing our provider network for delivering the highest quality of care at the lowest risk, WellCare relies on supporting documentation. WellCare of Georgia is required to annually assess our Medicare, D-SNP, and Medicaid members’ medical records to ensure compliance with established regulatory and accreditation guidelines. Ambulatory Medical Record Review (AMRR) audits are performed annually and follow the parameters outlined in the WellCare Provider Handbook and the AMRR records request letter to assess quality of care delivered and documented. This review and audit may be in addition to the EPSDT medical record review that your office receives.

The AMRR is comprised of 30 general and additional Adult or Child measures in these following categories:

- Member identifying information
- Standard record and patient safety documentation
- Preventive services/risk screenings
- Assessment
- Follow-up care
- Adult or child health screenings and vaccinations

Reviews of 5 members’ medical records per provider are conducted by experienced medical record reviewers, either onsite at the providers’ offices or in house using medical records submitted to WellCare by the providers. To be compliant, each provider must pass with an average score of 80% or higher for all 5 members in all applicable review items.

ADDRESSING DEFICIENCIES

Individual providers are given Corrective Action Plans (CAPs) for reviews that did not meet the required 80% or higher score. If a medical record review reveals areas for improvement, the provider will receive a notification letter and a report of the members’ ratings for each measure. Providers will have an opportunity to respond within 30 days.

Here are some basic guidelines for achieving compliance with your medical record documentation:

1. Ensure complete documentation in the medical record.
2. Provide clear, concise, consistent, complete and legible documentation.
3. Ensure documentation of medical history and clinical information.
4. If a member has a reported condition, ensure documentation clearly reflects how the reported condition was monitored, evaluated, assessed/addressed or treated.
5. Incorporate and document laboratory results and diagnostic testing results into the progress note with your clinical findings for supporting documentation.
6. Document all applicable health screenings the member received based on their age, gender and other criteria.
7. Incorporate consultation notes and information from specialists and collaborating providers.
8. Incorporate appropriate follow-up care and documentation of ER visits and hospital admissions into the medical record, when applicable.
9. If you receive a notification letter requesting medical records for this audit, please provide the complete medical record with all requested items to WellCare as instructed in the letter.

If you are chosen to be in the record review audit, please look for the notification and medical records request letters for the AMRR audit either in third or fourth quarter.
Q2 2015 PROVIDER FORMULARY UPDATE

MEDICAID:
Updates have been made to the WellCare of Georgia Preferred Drug List (PDL). Please visit [georgia.wellcare.com/provider/pharmacistervices](georgia.wellcare.com/provider/pharmacistervices) to view the current PDL and pharmacy updates.

You can also refer to the Provider Handbook available at [georgia.wellcare.com/WCAssets/georgia/assets/ga_caid_providerhandbook_eng_11_2014.pdf](georgia.wellcare.com/WCAssets/georgia/assets/ga_caid_providerhandbook_eng_11_2014.pdf) to learn more about our pharmacy Utilization Management (UM) policies/procedures.

MEDICARE:
There are updates to the Medicare Formulary. Find the most up-to-date complete formulary at [www.wellcare.com/medicare/medication_guide](www.wellcare.com/medicare/medication_guide).

You can also refer to the Provider Manual available at [www.wellcare.com/WCAssets/corporate/assets/na_care_providermanual_eng_01_2015.pdf](www.wellcare.com/WCAssets/corporate/assets/na_care_providermanual_eng_01_2015.pdf) to learn more about our pharmacy UM policies/procedures.

WELCOME RYAN VOISEY, MEDICARE VICE PRESIDENT FOR WELLCARE OF GEORGIA AND SOUTH CAROLINA

Ryan Voisey has joined WellCare as VP for Georgia and South Carolina. He will be responsible for planning, organizing, directing and managing activities associated with the company’s Medicare product line. In addition, he will oversee the implementation of Medicare strategies for those states.

Voisey has an extensive health care background and has worked in leadership roles at managed care companies for more than 18 years. His experience includes strategic planning for managed care networks and products, and for commercial and Medicare Advantage plans. He also has experience in quality improvement strategies related to star scores, including building effective provider networks, product design and development, and other managed care initiatives. Ryan has been directly involved in overseeing complex negotiations and relationship building.

Voisey most recently served as general manager/coach, Medicare Advantage for the Aetna Mid-America region after Aetna acquired Coventry Health Care in 2013. Prior to the acquisition, Ryan worked in several leadership positions at Coventry, including vice president, Network Development for Missouri and Illinois, and vice president, Medicare Advantage, in those states.

He earned an M.B.A. from Fontbonne University in Clayton, Mo., and a bachelor’s degree from Missouri State University in Springfield, Mo.

REPORTING FRAUD, WASTE AND ABUSE

Providers can report suspected Medicaid or Medicare fraud to WellCare’s 24-Hour Fraud Hotline at 1-866-678-8355.

You can report suspected Medicaid fraud by calling the Department of Community Health’s (DCH) Medicaid Program Integrity Hotline at 1-800-533-0686 or by emailing oiganonymous@dch.ga.gov or ReportMedicaidFraud@dch.ga.gov.

You can report suspected Medicare fraud by calling 1-800-447-8477, faxing 1-800-223-8164, emailing HHSTips@oig.hhs.gov, visiting forms.oig.hhs.gov/hotlineoperations or www.cms.gov/Research-Statistics-Data-and-Systems/监测-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.
WELCOME DR. JOHN ALEXANDER JOHNSON,
GEORGIA’S NEW SENIOR MEDICAL DIRECTOR

We are pleased to formally introduce John Alexander Johnson, MD, MBA as Senior Medical Director for the state of Georgia. Dr. Johnson joined WellCare in September 2014 and has hit the ground running in his new role. He is responsible for market operations of Utilization Review, Care Management, Quality Improvement and Clinical Outcomes. Dr. Johnson graduated from the University of Medicine and Dentistry of New Jersey (UMDNJ) in 1997 and completed his Internal Medicine Residency training at Emory University Hospital in Atlanta in 2000. He owned and operated an Internal Medicine practice in Douglasville, Ga., for more than 13 years, caring for patients with acute and chronic medical conditions. In 2013, Dr. Johnson was appointed as Blue Cross Blue Shield of Georgia Medical Director overseeing Utilization Review and Care Management for more than 600,000 members under the State Health Benefit Plan (SHBP). He is Board Certified in Internal Medicine and holds active medical licenses in Georgia and Alabama. Dr. Johnson has a Master of Business Administration with a concentration in Healthcare Management obtained from Emory University Goizueta School of Business. He is also a colonel in the U.S. Army Reserves Medical Corps and has served our country for almost 18 years.

If you need any additional information on programs we offer or have concerns, please contact our office for assistance.

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:

- Education and understanding of his or her specific condition
- 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 along the way
- Improved communication with the member’s primary care provider (PCP) and health care team

Disease Management can assist your members with the following conditions:

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

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

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.
ANTIPSYCHOTIC DRUG USE IN CHILDREN

Of the young children on Medicaid who take an antipsychotic medication, three-fourths of those children are taking it for an indication that is not approved by the Food and Drug Administration (FDA), according to the Centers for Medicare & Medicaid Services (CMS). This is in large part due to doctors prescribing antipsychotic drugs to treat behavior problems such as attention deficit/hyperactivity disorder (ADHD), attention deficit disorder (ADD) and aggressive behavior, which are not uses approved by the FDA*. One of the biggest concerns of the use of antipsychotics in children is the side effects of the medication, including weight gain, high cholesterol and an increased risk of type 2 diabetes. There are certain antipsychotic drugs that have been approved by the FDA for use in children. These include Abilify®, Seroquel®, Zyprexa®, Invega®, Geodon™ and Risperdal®. However, the FDA has only approved the use of such drugs for conditions such as schizophrenia, autism and bipolar disorder with mixed or manic episodes. Schizophrenia is rarely diagnosed until adulthood and bipolar disorder is estimated to affect less than 3% of teens according to the National Institute of Mental Health.

QUALITY ASSURANCE MEASURES

The National Committee for Quality Assurance (NCQA) has announced an update to quality measures for 2015. The update includes assessing the percentage of children who are taking two or more antipsychotic drugs; the percentage of children who receive metabolic testing with ongoing use of antipsychotics; and the percentage of children who had a new prescription for an antipsychotic medication without a primary indication for it and had documentation of psychosocial care as the first line of treatment.

In essence, close monitoring in collaboration with a qualified behavioral health provider is needed to ensure safe prescribing practices. Given the significant adverse side effects of antipsychotic medications and the limited knowledge of their long-term effects on children’s health, open communication with parents about the potential risks, benefits, adverse effects and the need for follow-up assessments is essential.

Source:
* Pathak, West, Martin, Hel, & Henderson, 2010/CMS, 2013
WELLCARE INTRODUCES MYWELLCARE MOBILE APPLICATION

WellCare is committed to providing benefits to keep our members healthy. That is why we have created the MyWellCare mobile application to make it even easier for them to keep track of their health. The app puts members’ health information right in their pockets.

With this app on their cellphone or tablet, finding a provider, quick care clinic or hospital is easy. Members can search by location, ZIP Code or provider name, or by using the advanced search. They can access their member ID card, which also allows them to email their ID card directly from the app. Members can also use the app to view Wellness Services, where they can see the top three preventive services they should complete, ranked in order of importance. Members can download the app using their mobile app store. The app is available to Apple and Android users.

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).

BETTER QUALITY IS OUR GOAL

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

SOME 2014 QI PROGRAM GOALS WE ACCOMPLISHED INCLUDE:

• Collaborated with community agencies to improve the health care of our members, contributing to improve quality outcomes
• Partnered with key providers to improve satisfaction levels
• Hired additional Quality staff to increase onsite visits to the providers’ offices and to provide tools to increase compliance with quality measures
• Implemented statewide provider summits to highlight improvements based on provider feedback

OUR GOALS FOR 2015 INCLUDE:

• Involve contracted providers in data-driven clinical initiatives to improve quality outcomes
• Initiate collaborative multidisciplinary visits to key providers in an effort to improve satisfaction
• Promote member engagement through member incentives

We look forward to continuing to partner with our providers to ensure members get the best care. To receive a copy of our QI Program Description, please call our QI Department at 1-866-231-1821.
CLAIMS PAYMENT POLICY REMINDERS

In order to ensure timely claims payments, WellCare has identified some areas for improvement in claims submissions.

**PLEASE NOTE:** Only ONE E&M code is permissible for a single date of service. Submitting more than one E&M code will result in a **REJECTION** of the claim/encounter.

**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 and 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. Prior to payment, WellCare may require medical records that confirm that E&M services to which Modifier 25 is appended are significant and identifiable.

The 25 modifier is required for the preventive health/office visit when vaccines are administered during those visits.

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.

WellCare relies on guidance published in Local Coverage Determinations (LCDs), respective to the state in which the service is rendered, to determine coverage requirements.

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**PROVIDER OFFICE OPERATIONS**

If you have EDI questions on claim submissions or claim rejections, you can contact our EDI team directly at **EDI-Master@wellcare.com**. The EDI team will help identify, test and correct any issues. You can also find companion guides for both institutional and professional claims at [georgia.wellcare.com/Provider/ClaimsUpdates](http://georgia.wellcare.com/Provider/ClaimsUpdates).

WellCare offers local Provider Relations representatives and Hospital Services specialists to personally assist you. For contact information, refer to the county and facility assignment lists at: [georgia.wellcare.com/WCAssets/georgia/assets/ga_caid_PRlist_eng_04_2014.pdf](http://georgia.wellcare.com/WCAssets/georgia/assets/ga_caid_PRlist_eng_04_2014.pdf) and [georgia.wellcare.com/WCAssets/georgia/assets/ga_hospital_services_specialist_assignments_12_2013.pdf](http://georgia.wellcare.com/WCAssets/georgia/assets/ga_hospital_services_specialist_assignments_12_2013.pdf).

**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 PR rep or call one of the Provider Services phone numbers at the end of this newsletter.
Section 6401 (a) of the Affordable Care Act (ACA) established a requirement for all enrolled providers and suppliers to revalidate their enrollment information under new enrollment screening criteria. This revalidation initiative applies to those providers and suppliers who were enrolled on or prior to December 31, 2012. Providers who were enrolled as of January 1, 2013, will be required to revalidate their enrollment in the second phase of this process no later than December 31, 2018. They will receive their revalidation notice at a later time.

Hewlett-Packard Enterprise Services (HP) began mailing notices to initiate the revalidation process for each provider and supplier in June 2014 and will conclude on December 31, 2015. Providers and suppliers must not begin the revalidation process prior to notification by HP. Please note that 42 CFR 424.515(d) authorizes the Georgia Department of Community Health (DCH) to conduct off-cycle revalidations.

Providers will have 60 days from the date of their revalidation letter to complete the revalidation process. Providers must complete revalidation timely or their Georgia Medicaid Fee-For-Service and Georgia Families/Georgia Families 360° program participation will be suspended and subsequently, your enrollment with WellCare of Georgia will be suspended or terminated. During your suspension period, claims will not be paid.

In an effort to improve efficiency and timeliness of the revalidation process, DCH requires all providers to revalidate online only using the Georgia Medicaid Management Information System (GAMMIS) at www.mmis.georgia.gov. The use of paper applications is prohibited during the revalidation process. The revalidation process will require minimal data input and will focus on verification of a provider’s current enrollment status. Providers will be required to verify their name, date of birth, Social Security Number, NPI, Tax ID number and license numbers. Most providers should be able to complete the revalidation process in approximately 20 minutes or less.

For access to GA Revalidation FAQs (Frequently Asked Questions), click here.

If there is a possibility you have not revalidated your Georgia Medicaid enrollment, please visit GAMMIS Provider Notices to review the latest active listing and take immediate actions if your name/organization is recorded. In the event your revalidation letter was not received, confirm the mailing address and/or email address on file with HP. If your preferred contact information is incorrect, access your GAMMIS account to update or submit to HP the Medicaid PeachCare Provider Information Change form to prevent future mailing issues – click here. The deadline for provider revalidation was April 1, 2015, to prevent suspension from the aforementioned Medicaid programs.

WellCare understands the importance of helping members stay healthy. That’s why we offer smoking cessation counseling as a covered benefit for WellCare members who are trying to kick the habit. Providers may counsel their patients on smoking cessation.

Here are some details on WellCare’s smoking cessation counseling program:

- Members are allowed one 12-week smoking cessation treatment period.
- Counseling should be in-person and documented in the member’s medical record every 30 days.
- Smoking cessation counseling codes 99406 and 99407 are covered benefits under the WellCare plan.

In addition to counseling, providers can direct members who wish to quit smoking to call WellCare’s Disease Management line at 1-877-393-3090 to learn about additional resources available to help them quit smoking.

Beginning in June 2015, WellCare will offer a Healthy Behaviors Rewards Program to reward members for taking small steps that will help them live healthy lives. For simple tasks like completing primary care provider (PCP) visits, prenatal visits, and certain health checkups, members can earn rewards which are placed on reloadable Visa® cards. The more services members complete, the more they can earn.

Providers can encourage their patients to participate in the Healthy Behaviors Rewards Program by signing and including their provider ID on applicable activity reports.

For more information on WellCare’s Healthy Behaviors Rewards Program, please contact your PR rep or call one of the Provider Services phone numbers at the end of this newsletter.

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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 healthcare 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 more accurate 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 (Medicaid) or 1-855-880-7016 (Medicare), 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.

COMING IN JULY! NEW PROVIDER SERVICES TECHNOLOGY

WellCare is excited to announce some major technology improvements within our call centers, designed to make it easier for providers to do business with us. You will see a difference in speed and quality of service when you call us.

One component of this multimillion dollar technology investment is CAREChannels, a multiphased initiative designed to enhance WellCare’s communication channels and provide a better customer experience. Callers can bypass speaking with an associate to check eligibility, check the status of a claim or check the status of an authorization. This new Interactive Voice Response (IVR) system will provide enhanced features and functionality, which include:

• New technology to expedite verification and authentication within the IVR
• Enhanced self-service functionality via touch-tone
• Virtual hold and callback, allows callers to hang up, yet stay in queue and receive a call back when the next associate is available
• Screen-Pop – Member demographic information is sent directly to the agent desktop from the IVR validation process – saving you time
• Improve real-time escalation procedures adopted through speech analytic technology

Future improvements include full speech capability, allowing our customers to use touch-tone or speak their information and requests, and multimedia queuing for Web chat, email and text.

To prepare for these changes, we want to remind you to have the following information available with each call:

• Your WellCare provider ID number
• NPI or tax ID number for validation if you do not have your WellCare provider ID number
• For claims inquiries – the member’s ID number, date of birth, date of service and dollar amount
• For authorization and eligibility inquiries – the member’s ID number and date of birth

We look forward to better serving our provider partners with these technology improvements.
**PROVIDER RESOURCES**

**WEB RESOURCES**
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**ADDITIONAL CRITERIA AVAILABLE**
Please remember that all Clinical Coverage Guidelines detailing medical necessity criteria for certain medical procedures, devices and tests are available on our website at [www.wellcare.com/provider/ccgs](http://www.wellcare.com/provider/ccgs).