5010 COMPLIANCE IS REQUIRED BY JANUARY 1, 2012. ARE YOU READY?

HIPAA legislation mandates that the health care industry use standard formats for electronic claims and related transactions. The current format, 4010A1, is in the process of being replaced by 5010, a new standard format. All covered entities (health plans, health care clearinghouses and certain health care providers) will be required to use the 5010 standard when conducting electronic transactions, including: claims (professional, institutional and dental), claims status requests and responses, payment to providers, eligibility requests and responses, referral requests and responses, enrollment and disenrollment in a health plan, coordination of benefits, and premium payments.

Are you a health care provider:

- Who submits claims (837) electronically?
- Who receives remittances (835) electronically?
- Who electronically sends and receives eligibility statuses (270/271) or claim statuses (276/277)?

If so, your trading partners (clearinghouse, vendor, vendor websites, vendor software, billing service, etc.) involved with processing your transactions (inbound and outbound) have likely been in contact to ensure 5010 changes have been tested and are ready for implementation on or before January 1, 2012.

If your trading partners have not been in contact regarding 5010, WellCare of Georgia, Inc. recommends that you make contact now. By 3rd quarter 2011, your clearinghouse, software vendors and billing service should be able to confirm their 5010 implementation plans. WellCare also recommends that you discuss the specific changes for your organization, as your particular business needs may differ from your vendor’s standard implementation plan (see CMS documentation below for helpful hints).

Remember, 5010 adoption is mandated per HIPAA legislation. As of January 1, 2012, use of 4010A1 transactions will be discontinued and only version 5010 will be accepted for electronic claims and related transactions.

For additional information and assistance, please contact:

- E-mail: 5010_Questions@WellCare.com
WAYS TO REDUCE YOUR PATIENTS’ RISK OF COMPLICATIONS FROM DIABETES MELLITUS

The following national statistics and other general information on diabetes were adapted from the Centers for Disease Control and Prevention (CDC) National Diabetes Fact Sheet: National estimates and general information on diabetes in the United States.

- 25.8 million Americans have diabetes — 8.3 percent of the U.S. population. Of these, 7 million people are undiagnosed.
- In 2010, about 1.9 million people ages 20 or older were diagnosed with diabetes.
- The number of people diagnosed with diabetes has risen from 1.5 million in 1958 to 18.8 million in 2010, an increase of epidemic proportions.
- Cardiovascular disease is the leading cause of death among people with diabetes — about 68 percent die of heart disease or stroke.
- The overall risk for death among people with diabetes is about double that of people of similar age without diabetes.
- Total health care and related costs for the treatment of diabetes run about $174 billion annually.
- Of this total, direct medical costs (e.g., hospitalizations, medical care and treatment supplies) account for about $116 billion.
- The other $58 billion covers indirect costs such as disability payments, time lost from work and premature death.

As you can see from the facts listed above, diabetes is becoming more prevalent. Please educate your patients on a self-care plan so they can take control of their disease and lower their risk of complications.

ENCOURAGE DIABETICS TO USE THE FOLLOWING AS A GUIDE TO SELF-CARE:

- Know their diabetes ABCs.
  - A is for the A1C (blood glucose) test. Results should be < 7.
  - B is for Blood pressure. It should be below 120/80.
  - C is for Cholesterol. LDL should be less than 100 and HDL above 40 to lower the patient’s chances of having a heart attack, stroke or other associated diabetic problems.
- S is for Smoking. Encourage patients to be nicotine free and provide them with the Quit Smoking website www.smokefree.gov.
- Stay at a healthy weight by staying on a diet that achieves a BMI in the normal range.
- Check their blood glucose during the day; know their blood glucose targets and how to use the results to manage their diabetes.
- Participate in 30 minutes of physical activity 2–4 days per week.
- Abstain from alcohol or consume it in moderation.
- Schedule periodic medical checkups to include an annual retinal eye exam by either an ophthalmologist or optometrist, and an annual dental examination to find and treat any problems early.
- Be mindful of their foot care, being sure to check their feet every day for cuts, blisters, red spots and swelling, and call you right away about any sores that don’t go away.
- Report any changes in their eyesight.
- Stay up to date with their age-appropriate vaccinations.
- Use stress management techniques that reinforce positive health care behaviors.

Refer diabetic members to WellCare’s Disease Management program by calling 1-866-635-7045. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

References:
1 http://ndep.nih.gov/i-have-diabetes/KnowYourABCs.aspx

SPIROMETRY TESTING
A SIMPLE BREATHING TEST TO ASSESS AND DIAGNOSE COPD

While there is no cure for Chronic Obstructive Pulmonary Disease (COPD), early detection of the disease might help change its course and disease progress. That’s why we encourage you to take steps in early detection to help you and your patients manage their disease by getting physical exams, and carefully monitoring medical and family health history, the presence of symptoms, and airway obstruction (also called airflow limitation).

The Global Initiative for Chronic Lung Disease (GOLD) international COPD guidelines¹, as well as national guidelines², advise spirometry as the gold standard for accurate and repeatable measurement of lung function. Evidence-based practice guidelines indicate that when spirometry confirms a COPD diagnosis, doctors initiate more appropriate treatment. Spirometry is also helpful in making a diagnosis in patients with shortness of breath and other respiratory symptoms and for screening in high-risk environments.

Consider utilizing spirometry as a diagnostic tool if you have patients that are experiencing some of the more common symptoms:

- A cough that doesn’t go away
- Coughing up lots of mucus
- Shortness of breath, especially with activity upon exertion
- Wheezing
- Tightness in the chest
- Limitations in activity

If a diagnosis is confirmed, please educate your patients about avoiding the most common causes of COPD, such as cigarette smoking, being around second-hand smoke, long-term exposure to other home and workplace air pollutants, and chronic respiratory infections.

The goal of COPD treatment is to ease the symptoms, slow progression, prevent and treat any complications, and improve the patient’s overall quality of life.

Refer COPD members to WellCare’s Disease Management program by calling 1-866-635-7045. This program is at no cost to the member. The program provides members with telephonic education from a registered nurse. One of the goals of the program is to empower members to further increase their self-management skills and follow your prescribed plan of care.

REFERENCES


OTHER SOURCES:
SEPTEMBER IS NATIONAL CHOLESTEROL EDUCATION MONTH

Cardiovascular disease (CVD) is a leading cause of illness, disability and death in adults. There are social, environmental and genetic components that all contribute to the onset of CVD. Some of these factors can be modified, treated and controlled, while others cannot.

NON-MODIFIABLE RISK FACTORS:
- Age (men > age 55 & women > age 65)
- Familial history and genetics
- Gender

MODIFIABLE RISK FACTORS
- Smoking
- Uncontrolled hypertension
- Uncontrolled dyslipidemia
- Physical inactivity
- Obesity and excessive weight
- Poor diet
- Uncontrolled diabetes mellitus
- Stress
- Excessive alcohol consumption

As a health care provider, it is essential to properly screen and identify those patients who are at an increased risk of having CVD. This includes comprehensive health risk assessments, positive health-related behavior changes, management of lipid levels, evidence-based treatment interventions and patient education. To help patients control their cholesterol and decrease their risk of having a CV-related event, the Centers for Disease Control (CDC) – Division of Heart Disease and Stroke Prevention (DHDSP) encourages all health care providers to participate in the overall management of cardiovascular disease. A comprehensive approach includes a cardiovascular risk assessment, patient monitoring and treatment protocols.

Patient-specific treatment plans should include the following components:
- Patient education on lifestyle modifications — the cornerstone of CVD prevention;
- Implementation of evidence-based treatment interventions for patients with a clinical diagnosis of coronary artery disease, other atherosclerotic diseases and diabetes;
- Pharmacological treatment options for patients with elevated risk factors, including the prescription of statin drugs to lower LDLs.

For individuals with a clinical diagnosis of diabetes, the CDC recommends the following cholesterol levels:
- Total cholesterol under 200
- LDL (“bad” cholesterol) under 100
- HDL (“good” cholesterol) above 40 in men and above 50 in women
- Triglycerides under 150

As a health plan, we appreciate your actions to help patients maintain a healthy lifestyle and reduce the incidence of cardiovascular-related diseases to improve their overall quality of life.

References:
1 http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_cholesterol.htm

Other sources: Centers for Disease Control & Prevention (CDC)-Division for Heart Disease and Stroke Prevention-Cholesterol. Page last reviewed March 24, 2011, page last updated: March 24, 2011.

SUBMISSION OF MEMBER GRIEVANCES

Do you know the process members go through when filing a grievance? A member or a member’s representative may file a grievance either verbally or in writing. A verbal request may be followed up with a written request, but the time frame for resolution begins the date WellCare receives the verbal filing. WellCare will send an acknowledgement of receipt to the person filing the grievance within ten (10) business days. WellCare will also make a determination on the grievance notification within ninety (90) calendar days. At times, WellCare may reach out to you and request specific details regarding the grievance. WellCare is committed to ensuring the appropriate process and timelines associated with closing member-generated grievances.
SOME FACTS ABOUT LEAD SCREENING REQUIREMENTS

Blood Lead Level (BLL) screening is a required component of an EPSDT Health Check screen. Since 1989, federal law has required that children enrolled in Medicaid and PeachCare for Kids MUST have their blood lead level measured at both 12 months and 24 months of age. Children between the ages of 36 and 72 months of age must receive a blood lead test if they have not been previously tested for lead poisoning, regardless of whether the child has been determined to be at low or high risk for lead exposure.

Completing a lead risk assessment questionnaire DOES NOT count as a lead screening and does not meet Medicaid and PeachCare for Kids requirements. The child’s medical record must document all lead-testing services rendered, the dates of service and the resulting values. If the lead-test results are not included in the medical record, the provider’s office may receive a request for a Corrective Action Plan (CAP).

In addition to the BLL screening, please consider the following situations:

- Does the child live in or regularly visit a house or building built before 1978 that has chipping paint?
- Does the child live in or often visit a house or apartment that is being remodeled or is having paint removed?
- Does the child live with or often visit another child that has or had an elevated blood lead level?
- Does the child live with anyone that works at a job where lead may be found or has a hobby that uses lead?
- Does the child live near an active lead smelter, battery recycling plant or other industry likely to release lead?
- Are home remedies such as greta, azarcon, or pay-loo-ah, or cosmetics with kohl in them used in the home?
- Does the child chew on or eat non-food items like paint chips or dirt?
- Does anyone in the family use ethnic or folk remedies, cosmetics or eat candies from Mexico?
- Is the child a recent immigrant, refugee or a member of a minority group?

Thank you for your assistance in documenting BLL test results in the members’ medical records.

EPSDT HIPAA REFERRAL CODES

The Centers for Medicare & Medicaid Services (CMS) defines an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) referral as members who are scheduled for another appointment with the current provider, or referred to another provider, for further needed diagnostic and treatment services as a result of at least one health problem identified during the EPSDT screen.

Effective with HIPAA implementation, CMS requires documentation of EPSDT Referral Codes when submitting claims for EPSDT services. There are four HIPAA compliant EPSDT Referral Codes: AV, NU, S2, or ST. If the screening exam is normal, Referral Code NU must be documented. Codes AV, S2, and ST are to be reported when a follow-up visit is necessary to further evaluate an abnormal finding identified during an EPSDT screening.

- AV: When a referral is needed, but was refused by the patient/parent
- NU: When a referral is not needed
- S2: When the patient is already under care
- ST: When the patient has been referred

When submitting paper EPSDT claims to WellCare, enter the appropriate Referral Code in Field 19 of the CMS-1500 claim form. If submitting electronically, WellCare advises that you contact your EDI vendor to confirm their ability to transmit within loop 2300.
CHIL D PREVENTIVE HEALTH GUIDELINES

The 2008 Recommended s for Preventive Pediatric Health Care (Periodicity Schedule) can be viewed by accessing the AAP website at http://practice.aap.org/content.aspx?aid=1599, on the georgia.wellcare.com portal or by contacting your Provider Relations representative. It is very important to use the 2008 Bright Futures/American Academy of Pediatrics guideline for the appropriate health check and risk assessment during the member’s well child checkup.

CDC GUIDELINES

The Centers for Disease Control and Prevention (CDC) has released the 2011 Advisory Committee on Immunization Practices (ACIP) schedule for immunization. It can be viewed by accessing the CDC website at www.cdc.gov/vaccines/recs/schedules, on the georgia.wellcare.com portal or by contacting your Provider Relations representative.

CL AIMS CORNER

ADD-ON CODES

When primary procedures are conducted, oftentimes there are certain additional procedures that must also be conducted. When this happens, these procedures are categorized as “add-on” codes. Add-on codes are always performed in conjunction with a primary procedure and should never be reported as a stand-alone service(s). The additional procedures are designated as an add-on code by the + symbol located next to the code in the AMA CPT Manual.

WellCare of Georgia, Inc. will not reimburse add-on code(s) if the primary procedure code has not been submitted on the same claim. If the primary procedure code is not allowed or is denied for any reason, then the add-on code associated with that base code will also not be allowed. This concept applies only to procedures performed by the same physician.

Please reference the AMA CPT Manual for additional information on appropriate billing of add-on codes.

TIMELY FOLLOW-UP CARE AFTER BEING HOSPITALIZED FOR MENTAL ILLNESS

The National Committee for Quality Assurance (NCQA) developed several HEDIS® measures of mental health quality that are used by health care consumers and regulatory agencies to monitor the performance of managed care organizations.

Outpatient follow-up care post-discharge is an important component of the continuum of care to assist an individual with their transition from hospital back into their family, work and community environment. Follow-up care may also reduce re-hospitalizations or help facilitate a necessary readmission before an individual reaches the crisis stage. Follow-up care may be even more important, and perhaps more problematic, for patients who have been hospitalized for a serious mental illness.

Primary care physicians (PCPs) should always recommend early post-discharge follow-up visits for their hospitalized patients. Directing your staff to facilitate outpatient visits with you and the behavioral health providers within seven days of a hospital discharge will help reduce readmissions and improve the continuity of care for your patients.

If your patient misses his/her early follow-up appointment, it is imperative that the outpatient visit is rescheduled and completed no later than 30 days after the recent hospital discharge. Medication reconciliation to confirm the patient understands his/her medicines, management of co-morbidities, step-action treatment plans and co-management of mixed illness diseases to discuss how the patient can get help, especially after normal office hours, are all important topics that need to be discussed at the time of the post-discharge follow-up visit.

Together, you can help your patient to continue to live at home and/or work while being in treatment.
TAKING CARE OF DIABETES

Correct treatment of diabetes can help your patients live a longer and healthier life. If you have diagnosed one of your patients with diabetes and would like him or her to learn more, please contact our Case/Disease Management department at 1-866-635-7045.

Please make sure that your patients with diabetes are aware of the following information:

KNOW THE SYMPTOMS OF DIABETES

Millions of people have diabetes, but many don’t know they have it. It is a serious disease that should not be ignored. If you have diabetes, your body can’t make or use insulin, which helps change sugar into energy to keep you alive. Although there are different kinds of diabetes, Types 1 and 2 are the most common, so you should become familiar with the dangers of each type:

TYPE 1 DIABETES
This type of diabetes is mostly found in children and young adults. The bodies of people suffering from Type 1 diabetes do not make insulin. Instead, they must take insulin shots every day. People with Type 1 diabetes may experience the following:

- Frequent urination
- Tremendous thirst
- Tremendous hunger
- Rapid weight loss
- Lack of energy
- Irritability
- Blurred vision
- Trouble seeing

TYPE 2 DIABETES
Type 2 diabetes is the most common form of the disease. Type 2 is usually found in people who:

- Are over 45
- Have diabetes in their family
- Are overweight
- Don’t exercise
- Have cholesterol problems

It is also common in certain racial and ethnic groups, particularly African Americans, American Indians and Hispanics, and in women who had gestational diabetes when they were pregnant. With Type 2 diabetes, patients’ bodies cannot make enough insulin or use it correctly. Treatment is diabetes pills and sometimes insulin injections, as well as diet and exercise.

Patients who suffer from Type 2 diabetes may experience the following:

- Any of the symptoms of Type 1 diabetes
- A lot of infections
- Cuts or bruises that heal slowly
- Tingling or numbness in their hands or feet
- Skin, gum or bladder infections that keep coming back

If not treated, diabetes can cause infections that will not heal. It can also hurt your eyes, kidneys, nerves and heart. Make sure to see your provider often and follow his or her advice on treating diabetes.
INCREASE YOUR PATIENTS’ ADHERENCE TO PRESCRIBED TREATMENT AFTER A HEART ATTACK

One quality measure for patients’ myocardial infarction (MI) is the use of beta-blockers. Evidence-based practice has shown a decrease in the rate of re-infarction and mortality in heart attack sufferers when they are prescribed beta-blockers. The American Heart Association/College of Cardiology 2006 Update of Guidelines for Secondary Prevention for patients with coronary vascular disease recommends the indefinite use of beta-blockers after heart attack unless contraindicated.1

The WellCare formulary includes the following beta-blocker drugs: acebutolol, atenolol, betaxolol, bisoprolol/hydrochlorothiazide, metoprolol, nadolol, sotalol and timolol. For a complete list, please refer to the formulary at www.wellcare.com.

The National Committee for Quality Assurance (NCQA) recommends the use of beta-blockers post myocardial infarction to measure how well physicians are providing quality care to their patients with heart disease. However, despite provider education and prescriptions for the indefinite use of beta-blockers when indicated, data still shows our members have a low adherence to their treatment plan. We’d like to work with you to increase our members’ persistent use of their medications, break down barriers and improve our patients’ outcomes.

A 2002 Vanderbilt University study determined that patients younger than 75 with a discharge order for beta-blocker therapy were more likely to fill their prescription within the first 30 days post discharge than people older than 75. Of the 85 percent that would fill their prescription within 30 days of discharge, the refill compliance would drop down to 61 percent after the first year. Patients who receive a prescription for beta-blockers while they are still in the acute facility have the greatest probability of continued use post discharge.

WHAT CAN YOU DO?
You can start with something as simple as listening to your patients’ concerns, answering their questions and empowering them to take appropriate action. The following can serve as a guide:

• Be involved with your patients’ plan of care while they are in the hospital. Stay involved with the attending doctors to help bridge the gap in care post discharge.
• Identify the member or caretaker that may need additional educational reinforcement about the increased risk for another heart attack or stroke if they discontinue taking their medication.
• If financial constraints are an issue to their adherence, consider prescribing a generic or utilize ½ tablet prescription (also known as pill splitting) when appropriate.
• Send the member a prescription refill reminder by mail or place a courtesy call.

(continued on next page)
Address adverse effects that may be the cause for their discontinuation of the medication.

Quality improvement efforts will need to continue to be a focus so that our post-acute MI patients stay on their beta-blockers for no less than six months if indefinite therapy is not planned.


HIGH BLOOD PRESSURE: THE SILENT KILLER

As you’re well aware, one in three adults suffers from high blood pressure. What’s worse, most of these people don’t even know it. That’s because high blood pressure can damage the human body without ever making its presence known until it’s often too late. It’s for this reason that many people refer to high blood pressure as “the silent killer,” raising your patients’ chances of stroke, heart disease, heart failure, kidney disease and blindness.

While there are some medications that can help lower blood pressure, the reality is that ensuring your patients make the right lifestyle choices to lower and maintain their blood pressure is the best bet for a long and healthy life. Encourage your patients to follow the steps below:

- **Maintain a normal blood pressure.** Normal blood pressure is 120/80 or lower. While there are many things that can impact your patients’ blood pressure, working with them to keep it below this range is an important first step.
- **Quit smoking.** While smoking has not been proven to cause long-term high blood pressure, it does temporarily raise blood pressure for up to several minutes after each cigarette. Encourage your patients to avoid this added strain on the heart.
- **Be active.** Advise your patients to get at least 30 minutes of exercise per day, which could include a brisk walk around the block.
- **Eat less salt.** Too much sodium can lead to excess fluid in the body, straining the heart to work overtime.
- **Maintain a healthy weight.** Work with your patients to attain and maintain their optimal weight. If your patients need to lose weight, encourage them to do so slowly and by eating right.
- **Take medicine.** For those patients who take blood pressure medications, be sure they’re not skipping any doses.
- **Consume less caffeine.** Tell patients to skip the colas, teas and coffee in favor of water or more healthy caffeine-free options.
- **Eat at least five servings of fruit and vegetables every day.** Eating a heart-friendly diet is an important part of maintaining low blood pressure that you should emphasize to your patients.
- **Avoid stress.** Similar to smoking, stress has a temporary impact on the body that can yield some damaging long-term results.

We appreciate your efforts in helping your patients take these steps toward maintaining a healthy blood pressure level.

*Source: OSF Saint Francis Medical Center*
2011 Q3 PROVIDER FORMULARY UPDATE

GENERIC NEWS

The generic drug listed below is now available to WellCare of Georgia Medicaid members ONLY at the lowest co-payment (if applicable), and the brand-name drug has been removed from the WellCare of Georgia Medicaid Preferred Drug List:

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>THERAPEUTIC CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gemzar® 200mg, 1gm, 2gm powder for injection</td>
<td>Gemcitabine HCl 200mg, 1gm, 2gm powder for injection (PA)</td>
<td>Antimetabolite</td>
</tr>
</tbody>
</table>

The generic drug listed below is now available to WellCare of Georgia Medicaid and Medicare members at the lowest co-payment (if applicable), and the brand-name drug has been removed from the WellCare of Georgia Medicaid Preferred Drug List:

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC NAME</th>
<th>THERAPEUTIC CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nardil® 15mg tablet</td>
<td>Phenelzine Sulfate 15mg tablet</td>
<td>Non-selective MAO Inhibitors</td>
</tr>
</tbody>
</table>

The following changes have been made to the WellCare of Georgia Medicaid Preferred Drug List:

**ADDITIONS**

- Denavir® 1% cream
- Fortical® nasal spray
- Intelence® 200mg tablet
- Pantoprazole 20mg, 40mg tablets

**REMOVALS**

- Aluminum Acetate solution
- Auro Eardrops 6.5% solution
- Bacitracin 500unit/gm ointment
- Bacitracin Zinc 500 unit/gm ointment
- Ceron-DM syrup
- Clonazepam 0.125mg, 0.25mg, 0.5mg, 1mg, 2mg orally disintegrating tablets
- De-Chlor DR syrup
- Ear Drops Earwax Removal Aid 6.5% solution
- Ear Wax Drops 6.5% solution
- E-R-O Ear Drops 6.5% solution
- Eurax® 10% cream, lotion
- Lansoprazole 15mg, 30mg capsules
- Lipase Concentrate-HP 600unit capsule

PA = Prior Authorization

**PA = Prior Authorization**
The following additions have been made to the WellCare Medicare Formulary:

**ADDITIONS**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alphagan® P 0.1% and 0.15% ophthalmic solution</td>
<td>Intelence® 200mg tablet (QL; 124 tablets/31 days)</td>
</tr>
<tr>
<td>A-Methapred® 40mg, 125mg solution</td>
<td>Moxeza™ 0.5% ophthalmic solution</td>
</tr>
<tr>
<td>Amitiza® 8mcg, 24mcg capsules (ST)</td>
<td>Pataday™ 0.2% ophthalmic solution</td>
</tr>
<tr>
<td>Dexilant™ 30mg, 60mg capsules</td>
<td>Patanol® 0.1% ophthalmic solution</td>
</tr>
<tr>
<td>Duetact® 30mg/2mg, 30mg/4mg tablets (QL; 31 tablets/31 days)</td>
<td>Potassium Chloride 10% liquid</td>
</tr>
<tr>
<td>Enoxaparin Sodium solution 30mg/0.3mL, 40mg, 0.4mL, 60mg/0.6mL, 80mg/0.8mL, 100mg/1mL, 120mg/0.8mL, 150mg/mL (QL varies depending on strength)</td>
<td>Sprycel® 80mg, 140mg tablets (PA)</td>
</tr>
<tr>
<td>Fortical® nasal spray</td>
<td>Zymaxid™ 0.5% ophthalmic solution</td>
</tr>
</tbody>
</table>

Due to FDA action and their mandatory removal of unapproved cough and cold medications, several cough and cold medications were removed from the Preferred Drug List (PDL) in February. Please refer to the Medicaid Cough and Cold Alternative List at [http://georgia.wellcare.com/WCAssets/georgia/assets/MCD_GEORGIA_CoughColdAlternativesDL.pdf](http://georgia.wellcare.com/WCAssets/georgia/assets/MCD_GEORGIA_CoughColdAlternativesDL.pdf) to view the cough and cold products covered on the WellCare of Georgia Medicaid PDL.

The utilization management criteria have changed for the following medications as noted below for the WellCare of Georgia Medicaid Preferred Drug List:

**REMOVALS**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polycin B ointment</td>
<td>Pramoxine HCl 1% foam</td>
</tr>
<tr>
<td>Potassium Chloride 0.15% NACL 0.9%</td>
<td>Thera-Ear 6.5% solution</td>
</tr>
<tr>
<td>Potassium Chloride 0.15%/NACL 0.9%/viaflex</td>
<td>Vasoclear® 0.02% ophthalmic solution</td>
</tr>
<tr>
<td>Potassium Chloride 0.3%/NACL 0.9%/viaflex</td>
<td>Zegerid® 20mg, 40mg capsules</td>
</tr>
<tr>
<td>Potassium Phosphate 3m mole/mL solution</td>
<td></td>
</tr>
</tbody>
</table>

Please refer to your provider manual available at [http://www.wellcare.com/provider/pharmacieservicesgeorgia](http://www.wellcare.com/provider/pharmacieservicesgeorgia) to view more information regarding WellCare’s pharmacy utilization management policy/procedures and medication co-payments and coinsurance requirements that may apply. The most up-to-date complete preferred drug list can be found at [http://georgia.wellcare.com/WCAssets/georgia/assets/MCD_GEORGIA_PDL.pdf](http://georgia.wellcare.com/WCAssets/georgia/assets/MCD_GEORGIA_PDL.pdf).

The following additions have been made to the WellCare Medicare Formulary:
The utilization management criteria have changed for the following medications as noted below for the WellCare Medicare Formulary:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spiriva® HandiHaler®</td>
<td>ST removed</td>
</tr>
<tr>
<td>Vancomycin HCl 1000mg, 10gm solution</td>
<td>PA added</td>
</tr>
</tbody>
</table>

PA = Prior Authorization  ST = Step Edit

Please refer to your provider manual available at [http://www.wellcare.com/Provider/Resources_GAMedicareProviderManual](http://www.wellcare.com/Provider/Resources_GAMedicareProviderManual) to view more information regarding WellCare’s pharmacy utilization management policy/procedures and medication co-payments and coinsurance requirements that may apply. The most up-to-date complete formulary can be found at [http://www.wellcare.com/medicare/medication_guide](http://www.wellcare.com/medicare/medication_guide).

Planned Market Drug Withdrawals:

<table>
<thead>
<tr>
<th>COMPANY NAME</th>
<th>DRUG NAME</th>
<th>DATE OF REMOVAL</th>
<th>ADDITIONAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endo Pharmaceuticals</td>
<td>Opana® ER</td>
<td>On or about May 1, 2011</td>
<td>Please be advised that Endo Pharmaceuticals will discontinue the sale and distribution of two strengths of Opana® ER (oxymorphone HCl) Extended-Release Tablets CII. Endo estimates these two strengths will no longer be on retail shelves on or about May 01, 2011. Due to increased demand for Opana ER, Endo is streamlining operations to focus on the most commonly prescribed dosages, enabling us to serve the needs of our customers while continuing to supply a wide range of dose strengths. Opana® ER dose strengths of 5mg, 10mg, 20mg, 30mg and 40mg will continue to be available at your local pharmacy.</td>
</tr>
<tr>
<td>Allergan, Inc.</td>
<td>ZYMAR®</td>
<td>February 28, 2011</td>
<td>The anti-infective activity of fluoroquinolones, such as gatifloxacin, is concentration dependent. ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5% has a greater concentration of the active agent gatifloxacin when compared with ZYMAR® (gatifloxacin ophthalmic solution) 0.3% formulation. Therefore, effective February 28, 2011, Allergan, Inc. discontinued ZYMAR® (gatifloxacin ophthalmic solution) 0.3%. Allergan will continue to manufacture ZYMAXID™ (gatifloxacin ophthalmic solution) 0.5%.</td>
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COORDINATION OF BEHAVIORAL CARE MAXIMIZES OUTCOMES

WellCare of Georgia, Inc. reminds providers that continuity and coordination of care are appropriate for all disciplines at all levels of care, including inpatient-outpatient, medical-behavioral, PCP-specialty and intra-disciplinary. Communication and coordination/integration of care among health care providers is a best practice principle essential to optimizing consumer safety and clinical outcomes. Patients with co-morbid medical and behavioral health conditions can be particularly vulnerable to complications that may result from inadequate coordination of care between treating providers. All providers, all disciplines, are expected to initiate communication that facilitates and enhances continuity of care, relapse prevention, patient safety and satisfaction. It must be noted, though, that health care providers can only coordinate care to the extent permitted by confidentiality requirements. There may be occasions when the patient refuses to sign consent for release of information.

Keeping in mind the ultimate goal of enhanced patient well-being, it behooves all parties to take the necessary steps for continuity and coordination of care.

COMMUNICATING EFFECTIVELY FOR CONTINUITY OF CARE

WellCare of Georgia, Inc. encourages all providers — medical and behavioral — to initiate communication that facilitates and enhances continuity of care, relapse prevention, member safety and member satisfaction. Few would challenge the hypothesis that effective integration and collaboration between primary care physicians (PCPs) and mental health specialists (to include psychiatrists, social workers and ARNPs) is essential for consumer well-being. Yet it is not uncommon to hear medical providers and behavioral health providers complaining they do not receive information from the opposite discipline. Barriers often cited for the scarcity of provider communication are time and resource limitations. However, when one considers the potential impact on optimal member care, communication is clearly a critical necessity.

WHAT YOU CAN DO AS THE INDIVIDUAL PRACTITIONER

• Get to know your fellow physicians, PCPs and psychiatrists. Go to meetings whenever possible where you can get to know one another.
• Pick up the phone. Colleagues will appreciate the time and effort taken for communication.
• Request copies of records from physicians who have cared for the patient before your involvement.
• Set up systems in your office and hospital units that enhance and automate patient communication and permit transition of care in a safe and effective way.
• Include the PCP on admission and discharge reports, letting your colleague know about discharge appointments, medications and any specialty consultations required post-hospitalization.
• Utilize health plan Care Manager resources to assist you in making appointments and arranging follow-up care. Our staff can also work with the member to make sure he/she makes his/her appointments.

If you have questions or feedback about physician communication or quality-related topics, please contact the health plan or your local Provider Relations representative.
CASE AND DISEASE MANAGEMENT PROGRAMS

WellCare’s Case Managers support you and your hectic schedules, freeing you to spend more time with your patients by:

- Collaborating with providers and physicians to create a targeted assessment and treatment plan for the patient’s condition
- Maintaining communication between the patients and their families, and the team of physicians
- Identifying opportunities for interventions such as ineffective treatment plans or lack of financial resources to meet the needs
- Assisting with patient transition when discharged from the program

The types of cases targeted by our Case Management program include, but are not limited to, the following types of patients:

- Complex case needs requiring coordination of multiple outpatient services
- Transplants
- Frequent inpatient admissions and readmissions
- Prolonged or debilitating illnesses or injuries

WellCare’s Disease Managers support you and your hectic schedules too, freeing you to spend more time with your patients by:

- Educating them on how to deal with challenges of their disease
- Documenting progress in clinical notes and alerting their patients of significant changes or findings

Our Disease Management program targets the following conditions:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- HIV
- Hypertension

Our Case and Disease Management programs identify potential candidates based on available data and referrals from multiple sources:

- Claims or encounter data
- Pharmacy
- Laboratory data
- Utilization Management, Case Management, Disease Management and Discharge Planner referrals
- Practitioner and member referrals
- Behavioral health vendors

If you would like to refer your WellCare patients to either or both of these programs, please call the Case and Disease Management Referral Line at 1-866-635-7045 Monday through Friday, from 8 a.m. to 5 p.m. Eastern.

ATTENTION PCPs: P4Q BONUS PAYOUT INFORMATION

The Pay for Performance Quality Incentive Program was designed to promote the timely completion of health care and wellness services, and improve the quality of care for WellCare’s Medicaid and Medicare managed-care members under the care of their Primary Care Physician.

All PCPs that are contracted with WellCare were eligible to participate in the fourth quarter 2010 bonus payment award for the provision of certain preventive services. These services were to be delivered by December 31, 2010, and claims must have been received and processed by WellCare on or before January 7, 2011. Each service performed on an identified non-compliant member equaled an additional $20. The total bonus was then calculated and will be reimbursed in a separate check.

Pay out of these bonuses is forthcoming. Please ask your Provider Relations representative for details.
IMPORTANT CHANGES IN ELECTRONIC DATA INTERCHANGE (EDI) PROCESS

As of July 24, 2011, WellCare Health Plans, Inc. (WellCare) will only accept electronic claims through RelayHealth’s pre-adjudication platform. WellCare has selected RelayHealth, a division of McKesson, to manage EDI connectivity between WellCare and our providers. We believe this choice will expand electronic-based real-time services for our providers, increase EDI volume and simplify EDI administration. We also believe this kind of arrangement drives efficiencies and leads to lower overall costs for health care, and that it is becoming commonplace in the health benefits market.

We have requested our previous partners transfer — at no charge — their EDI connection for WellCare claims to RelayHealth’s pre-adjudication platform. Although most have agreed, some are no longer accepting or sending transactions to WellCare following our switch to RelayHealth on July 24, so you may experience issues with adjudication or payment of those claims. Please note that as of the date of this letter, two vendors have opted not to carry WellCare claims — ACS effective June 12, 2011 and Emdeon effective July 25, 2011.

In most cases, the transition will be seamless; however, we strongly encourage you to contact your practice management vendor, billing service or clearinghouse immediately and obtain their assurance for continued electronic claims submission to WellCare via RelayHealth on and after July 24 to ensure your practice is prepared for this transition. Upon confirmation from your vendor, billing service or clearinghouse of continuous electronic claims submission to WellCare via RelayHealth, no further action is necessary.

If you have any questions regarding submission of EDI transactions through RelayHealth, you may call 1-888-743-8735, and they will provide you assistance and recommendations regarding the transition. For further details, you may contact us via e-mail at EDI-MASTER@wellcare.com, and WellCare will respond to your inquiries in a timely fashion.

We feel strongly that our relationship with RelayHealth will expand our EDI service levels for you, and improve your experience with WellCare and our members.
CANCER SCREENING AWARENESS

October is Breast Cancer Awareness Month. Encourage your female patients to get all their preventive health exams completed during October if they have not already done so this year.

According to the Centers for Disease Control and Prevention (CDC), many deaths from breast and cervical cancer could be avoided by increasing cancer screening rates among women. The CDC reports that deaths from these diseases occur disproportionately among women who are uninsured or underinsured.

WellCare covers all regular preventive tests and screenings for women without requiring a referral or prior approval. Help us ensure that our members stay healthy by recommending appropriate preventive tests and screening.

Please continue to encourage women to obtain an annual mammography for breast cancer screening and a Pap smear for cervical cancer screening.