Provider Newsletter
New Jersey

WellCare®
Beyond Healthcare. A Better You.

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EPSDT Dental Services by Licensed Medical Staff

Dental screening by the licensed medical staff in this context means, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection.

Dental screening by licensed medical staff includes:

- ✓ Completion of the American Academy of Pediatrics (AAP) Oral Health Risk Assessment Tool. The tool helps in the implementation of oral health risk assessment during health supervision visits. (Please retain a copy of the assessment in the medical record)
- ✓ Mandatory referral to a dentist, by age 1 year or soon after the eruption of the first primary tooth.
- ✓ Follow-up at well child visits through age 20 years to determine at a minimum, dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided. (Document the dental referral in the medical record).
- ✓ NJ Smiles Program allows trained licensed medical staff to provide oral health services to children through the age of 3 years old

Find referral forms at:
https://www.wellcare.com/New-Jersey/Providers/Medicaid/Forms

Tool-kits on Fluoride Varnish and Bidirectional referrals at:
https://www.wellcare.com/New-Jersey/Providers/Medicaid/Training

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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.

EPSDT Dental Services by Licensed Medical Staff Continued

Fax or Email Referrals to:

1-813-865-6759

NJDentalServices@wellcare.com

Find a Medical Provider:

WellCare

1-888-453-2534

https://www.wellcare.com/en/New-Jersey/Find-a-Provider#/Search

Find a Dental Provider:

LIBERTY Dental Plan *(WellCare's Dental Vendor)*

1-888-352-7924

https://client.libertydentalplan.com/wellcare/wellcarenj

WellCare NJ Medicaid and Medicare Good Measures Program

A Recipe for Effective Diabetes Prevention: Good Measures

More than 1 in 3 Americans have prediabetes and most of them don't even know it.

That's unfortunate because this large population is at increased risk of developing type 2 diabetes, heart disease, and stroke.

Diabetes Prevention Programs can help people lower their risk of developing type 2 diabetes by as much as 58%— and 71% if they are over age 60—according to the Centers for Disease Control and Prevention.

Fortunately, WellCare of New Jersey Medicaid and Medicare members have access to the Good Measures Diabetes Prevention Program. It's easy, and comes at no cost for eligible members to participate from home. Members can participate in the program by computer at times best for them, or they can join scheduled sessions by Zoom or phone.

Good Measures Program Details

The goal of the Good Measures Diabetes Prevention is to support participants in building healthy lifestyle habits that stick. This will help them lose 5% to 7% of their body weight and do at least 150 minutes a week of brisk walking or similar physical activity. Participants receive support from their CDC-trained lifestyle coach and from their peers in the program.

The sessions, which start weekly and then decrease in frequency over 12 months, cover topics such as:

- Increasing physical activity;
- Eating well to prevent type 2 diabetes;
- Making better-for-you food swaps;
- Managing stress;
- Getting support for healthy changes;
- Weight loss strategies;
- Self-care; and
- Maintaining a healthy lifestyle for the long term.

Program Eligibility Criteria

WellCare of New Jersey Medicare and Medicaid adult members are eligible based on the following criteria:

- ✓ Must be at least 18 years old;
- ✓ Must be overweight (Body Mass Index (BMI) >25; >23 if Asian);
- ✓ Have no previous diagnosis of type 1 or type 2 diabetes;
- ✓ Have a blood test result in the prediabetes range within the past year;
- ✓ Hemoglobin A1C: 5.7%–6.4%;
- ✓ Fasting plasma glucose: 100–125 mg/dL;
- ✓ Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL; and
- ✓ Have been previously diagnosed with gestational diabetes

The program is NOT for members with a confirmed diagnosis of type 1 or type 2 diabetes.

Referring Members is Easy

Complete the secure referral form on **www.goodmeasures.com/physicians; OR**

Download the form and it fax to Good Measures at **617-507-8576**

Sources:
https://www.cdc.gov/diabetes/basics/prediabetes.html
https://www.cdc.gov/diabetes/library/features/truth-about-prediabetes.html

Appointment Access and Availability

WellCare is required by the Centers for Medicare & Medicaid Services and state regulations to administer appointment access and availability audits. Appointment Access standards are documented below.

Emergency services: Immediately upon presentation

Urgent Care: Less than 24 hours

Symptomatic acute care: Less than 72 hours

Routine non-symptomatic visits, including annual gynecological examinations or pediatric and adult immunization visits: Less than 28 days

Specialist referrals: Less than 4 weeks

Urgent Specialty Care: Within 24 hours of referral

Baseline physicals for new adult enrollees: Within 180 calendar days of initial enrollment

Baseline physicals for new children enrollees and adult clients of DDD: Within 90 days of initial enrollment, or in accordance with EPSDT guidelines.

Prenatal care:
- Within 3 weeks of a positive pregnancy test
- Within 3 days of identification of high-risk
- Within 7 days of request in first and second trimester
- Within 3 days of first request in third trimester

Routine physicals: Within 4 weeks

Lab and radiology services:
- Within 3 weeks for routine
- Within 48 hours for urgent care

Initial pediatric appointments: Within 3 months of enrollment

Dental appointments:
- **Emergency:** No later than 48 hours, or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider
- **Urgent:** Within 3 days of referral
- **Routine:** Within 30 days of referral

MH/SA appointments:
- **Emergency services:** Immediately upon presentation at a service delivery site
- **Urgent:** Within 24 hours of the request
- **Routine:** Within 10 days of the request

Maximum number of intermediate/limited patient encounters for PCPs and Pediatricians: 4 per hour for adults and children.

Waiting time in office: Less than 45 minutes

For additional information, please refer to the Provider Manual posted on the WellCare Provider Portal located at: **www.wellcare.com/New-Jersey/Providers/Medicaid**.

Annual CAHPS® Survey – What Matters Most to Your Patients

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual survey mailed to an anonymous select sample of our health plan members. The purpose is to assess member experience with their providers and health plan to improve the quality of care provided. This survey focuses on asking your patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding how to take their medications, and the coordination of their healthcare needs. **We hope you will encourage your patients to participate if selected.**

The pharmacy team can affect the member experience, whether we interact with members directly or not, by ensuring that we address the following items that are addressed in the annual CAHPS survey:

- ✓ Assist members in understanding and accessing their pharmacy benefits (i.e. what medications are/are not covered),
- ✓ Identify (and mitigate) barriers to members obtaining and taking their medications.
- ✓ Ensuring appropriate communications with providers and health plans occur to complete the processing of timely authorizations

These factors are important for our members (your patients) to take their medications on time but also to ensure adherence of their medication regimen(s).

We value and appreciate the excellent care you provide to our members and look forward to partnering with you.

Source: Centers for Medicare & Medicaid Services. Consumer Assessment of Healthcare Providers & Systems (CAHPS).
https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS

Advance Directives: Having the Talk with Your Patient

A PATIENT'S COMFORT IN EVEN DISCUSSING AN ADVANCE DIRECTIVE CAN GREATLY DEPEND ON WHAT YOU, AS THE HEALTHCARE PROVIDER, HAVE TO SAY AND OFFER.

Your WellCare contract requires documentation in the patient's medical record of whether the individual has executed an advance directive.

It is often an awkward situation, in large part because many patients only see the advance directive process in terms of suffering and death. You, as the healthcare provider, need to approach advance care planning from the perspective of living well and quality of life. If you approach the subject in this way, the patients will more likely engage with you in discussing what matters most to them so their wishes will be honored. You may start the conversation by asking about the kinds of treatments wanted if the patient becomes very ill, is unable to recognize family, is unable to perform self-care or is unlikely to get better.

All states have their own advance directive forms, which can be found on line and do not require an attorney to complete them. Every state has a witnessing requirement for advance directive – often two witnesses or a notary.

You should know that the AMA has developed training materials and ethical guidelines that provide understanding as to what patients want and physicians are able to provide. You can find those guidelines at **https://www.ama-assn.org**.

Additionally, effective January 1, 2016, Medicare offers payment for a voluntary advance-care planning (ACP) consultation in the office or hospital (CPT billing code 99497) to a physician or other qualified healthcare professional.

Advance directives are legal documents that take effect when someone is no longer able to speak for himself or herself. They include living will and durable power of attorney for healthcare (DPA). The living will is a legal document that guides healthcare professional, family members and trusted friends in understanding the types of life-sustaining members wanted or not wanted. The DPA allows a person to legally designate a trusted person to make medical decisions on his or her behalf if he or she is unable to do so.

Sources:
AMA. "Advance directives: How to talk with patients about them."
Retrieved from ***https://www.ama-assn.org/delivering-care/patient-support-advocacy/advance-directives-how-talk-patients-about-them***

WebMD. "Advance Directives: Having the Talk."
Retrieved from ***https://www.webmd.com/palliative-care/features/advance-directives-having-the-talk***

The Hospitalist. "New Medicare Rule Will Reimburse Physicians for Advance Care Planning."
Retrieved from ***https://www.the-hospitalist.org/hospitalist/article/122030/health-policy/new-medicare-rule-will-reimburse-physicians-advance-care***

Point of Care Formulary Information for Providers

PRESCRIBE WITH CONFIDENCE – EVERY DRUG. EVERY PLAN. EVERY TIME.
MEDICARE ONLY

Are you and your team spending valuable time processing prior authorizations?

We have expanded our relationship with MMIT to deliver comprehensive drug coverage information directly to your desktop and mobile devices. In addition to WellCare's extensive support resources, providers can identify plan-specific drug coverage and restriction criteria as well as alternative therapies with these medical applications.

Epocrates®, an athenahealth service, is the #1 point of care medical app among U.S. physicians. It is trusted by over 1 million healthcare professionals. Just download the free app or search from your desktop with epocrates® web at **www.epocrates.com**.

MMIT's Coverage Search is a top-rated drug coverage search application. Download the free app or search from your desktop at **www.FormularyLookup.com**.

Quickly obtain the details you need to select the best therapeutic option, eliminate denials and reduce administrative drain on you and your team with epocrates® and Coverage Search.

Provider Bulletins

Remember to view the online Provider Bulletins regularly for important updates and notices.

Visit www.wellcare.com; select your state, click on *Providers*, scroll down and click on *READ BULLETINS*.

Electronic Funds Transfer (EFT) Through PaySpan®

FIVE REASONS TO SIGN UP TODAY FOR EFT:

1. **You** control your banking information.
2. **No** waiting in line at the bank.
3. **No** lost, stolen, or stale-dated checks.
4. Immediate availability of funds - **no** bank holds!
5. **No** interrupting your busy schedule to deposit a check.

Setup is easy and takes about five minutes to complete. Please visit **https://www.payspanhealth.com/nps** or call your Provider Relations representative or PaySpan at **1-877-331-7154** with any questions.

We will only deposit into your account, **not** take payments out.

Provider Formulary Updates

Medicaid:

The Preferred Drug Lists (PDL) has been updated. Visit **www.wellcare.com/WellCare/New-Jersey/Providers/Medicaid/Pharmacy** to view the current PDL and pharmacy updates.

Medicare:

There have been updates to the Medicare formulary. Find the most up-to-date, complete formulary at **www.wellcare.com/New-Jersey/Providers/Medicare/Pharmacy**.

You can also refer to the Provider Manual to view more information regarding our pharmacy Utilization Management (UM) policies and procedures. Provider Manuals are available at **www.wellcare.com/New-Jersey/Providers/Medicaid** and **www.wellcare.com/New-Jersey/Providers/Medicare**.

It Benefits Your Practice To Keep Your Provider Demographic Information Current

As a WellCare participating provider, it is very important for you to keep your demographic information current.

When you update your information with WellCare to keep it current, it helps:

- ✓ Ensure you and your practice/facility receive proper notifications from WellCare
- ✓ Avoid claim payment issues caused by outdated demographic information
- ✓ Ensure you receive proper referrals based on your specialty and/or subspecialty
- ✓ Ensure members who need to contact you for services have your correct address/phone number

To ensure this occurs, if any of the following changes, please tell us in advance or as soon as possible:

- Office phone number
- Fax Number
- Office address
- Correspondence Address
- Office Hours
- Hospital Affiliation
- Panel status (Are you accepting new Medicare/Medicaid patients?)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- Group Name

To submit your updated information:

Per your contract, at least 30 days' advance notice is required and you should include contact information in case we need to follow up with you.

Emailing:
NJPR@wellcare.com

Call:
1-855-538-0454

Mail a letter on your letterhead with the updated information to:

WellCare Health Plans of NJ
550 Broad St. 12th floor
Newark, NJ 07102
Attention: Provider Relations Department

Thank you for keeping your information up to date with us. WellCare appreciates everything you do to improve the health and well-being of our members.

21st Century Cures Act

ALL PARTICIPATING PROVIDERS MUST ENROLL WITH NJFC MEDICAID FEE-FOR-SERVICE (FFS) PROGRAM IN ACCORDANCE WITH THE 21ST CENTURY CURES ACT REQUIREMENTS.

The State of New Jersey Department of Human Services Division of Medical Assistance & Health Services sent the Medicaid Newsletter Volume 28 No. 06, which notified network providers of the requirement that they enroll in the NJFC Medicaid FFS program. The 21st Century Cures Act, 42 U.S.C. 1396u-2(d), requires that network providers complete the 21st Century Cures Act provider application. Compliance is mandatory and failure to comply may result in a provider's contract with an MCO being terminated per the Medicaid Newsletter.

Network providers must submit a completed 21st Century Cures Act application to DXC Technology. Providers under contract with multiple MCOs are only required to submit a single 21st Century Cures Act application to DXC Technology. To download a 21st Century Cures Act application, go to **www.njmmis.com**, select "Provider Enrollment Applications," and then select 21st Century Cures Act Application as the "Provider Type."

Frequently Asked Questions

1 Whom can I contact if I have questions about the application?

Contact the DXC Technology Provider Enrollment Unit at **1-609-588-6036**.

2 Where can I submit the 21st Century Cures application?

The mailing address for submitting the application and credentials is:

DXC Technology Provider Enrollment Unit
P.O. Box 4804
Trenton, NJ 08650

The completed application with credentials may also be faxed to **1-609-584-1192**.

Provider Resources

Provider News – Provider Portal

Remember to check messages regularly to receive new and updated information. Access the secure portal using the *Secure Login* area on our home page. You will see *Messages from WellCare* on the right.

Resources and Tools

Visit **www.wellcare.com/New-Jersey/Providers** to find guidelines, key forms and other helpful resources for both Medicare and Medicaid. You may also request hard copies of documents by contacting your Provider Relations representative. Refer to our Quick Reference Guide for detailed information on many areas such as Claims, Appeals, Pharmacy, etc. These are located at **www.wellcare.com/New-Jersey/Providers/Medicaid** or **www.wellcare.com/New-Jersey/Providers/Medicare**.

Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available on our website at **www.wellcare.com/New-Jersey/Providers/Clinical-Guidelines.**

We're Just a Phone Call or Click Away

Medicare:
1-855-538-0454

Medicaid:
1-888-453-2534

www.wellcare.com/New-Jersey/Providers