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# Blueink

February 2011

Information for Iowa and South Dakota  
Physicians, Hospitals, and Health Care Providers



Stay current with the latest news from Wellmark Blue Cross and Blue Shield

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Visit our website at: [Wellmark.com](http://Wellmark.com)

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M-2164 02/11

## Prepare for Electronic Transaction Changes

### Ensure a smooth transition to 5010 by testing early and frequently

You'll soon be able to begin testing transactions with Wellmark using the mandated HIPAA X12 version 5010, the new required standard for all electronic transactions beginning January 1, 2012.

#### Anticipated test date for 837 transactions

We anticipate being ready to receive test 5010 medical claims transactions (837), including the June 2010 addenda, from you or your vendor, billing service, or clearinghouse by **APRIL 2011**. We will post the exact dates for testing the 837 transaction for medical claims and other HIPAA transactions, including dental claims, on Wellmark.com (Provider > Claims & Payment > HIPAA 5010).

#### Steps to complete for testing medical claims

If you use a clearinghouse or billing service to submit medical claims to Wellmark, you will need to work with them to coordinate all of your testing.

If you submit direct to Wellmark through the Web BBS:

- A** Contact EC Solutions prior to testing for a valid testing Web BBS ID and password ID. Passwords are created specifically for testing and are valid for 30 days. To reset your password or for assistance with your Web BBS ID, please contact EC Solutions at 1-800-407-0267.
- B** Connect to the Web BBS testing region at Mo.ebx-eds.com and submit your test transaction.
- C** Check the results by reviewing the following electronic reports you will receive as a result of your submission. Note:
  - The full file rejection report .997 has changed; instead you will receive report .999 if the entire file is rejected.
  - The claim acceptance and rejection report (Transaction Summary.TXN) is being updated to provide more information when a claim is rejected.
  - The Wellmark payer response is not changing (Wellmark Payer Report.Z16).

If you have questions, please contact the EC Solutions help desk.

**HOURS:** 7 a.m. to 5:30 p.m. CT (Central time),  
Monday–Friday (except holidays)

**PHONE:** 800-407-0267

**EMAIL:** ECSolutionsDSM@hp.com



## A Match Made in Accounting

### Waiting for the one, the only?

Within the next few weeks, you'll receive **ONE PAYMENT** regardless of the number of claims processed on your remittance.\*

For those of you who submit a large number of claims each week, this change signals an end to reconciling several payments against one remittance. Today, for every 620 claims processed, another payment is issued.

*\*Claims processed under the same group or individual National Provider Identifier.*

**NOTE:** At this time, the PCR and the associated payment for Federal Employee Program (FEP) members' claims will continue to process separately from other Wellmark claims.

## Note ID Number and Copayment Changes for University of Iowa Members

### Avoid unnecessary refunds and claim problems

Please note the following two changes for University of Iowa employees enrolled in the UIChoice, UIGradcare and House Staff plans.

### Do not collect office visit copayment or coinsurance for MHCD services

**EFFECTIVE JANUARY 1, 2011**, the copayment and coinsurance for mental health and chemical dependency (MHCD) office services is waived. Please do not collect a copayment from the member for these services.

### Alpha prefix number change

**EFFECTIVE IMMEDIATELY**, please submit claims for members covered by these plans with the alpha prefix of **XQW**. Previously, these plans used an XQI alpha prefix which was often misread, resulting in misfiled claims.

Wellmark mailed over 15,000 identification cards to these members at the end of January.



### Test Your Knowledge of Claims and Coverage Guidelines

#### Now you'll find a new online training course specifically for behavioral health providers

Knowing behavioral health coverage and requirements can help you as you work with patients covered by Wellmark.

Topics covered for behavioral health providers:

- Member eligibility, including precertification or notification requirements
- Provider contracting
- Coding
- Noncovered services

To locate the class, visit [www.wellmark.com](http://www.wellmark.com) (*Provider > Communication & Resources > Education > Specialty Online Training > Behavioral Health Course*).

## Items Not Covered by Wellmark

### You may bill our member for these services

If you submit one of the codes below, it will deny as member responsibility if processed on or after February 25, 2011.

Wellmark contracts do not typically cover items that can be purchased without a prescription. Other items may be specifically excluded from a member coverage. To ensure we cover services per member contracts, we periodically review claims and coding edits, and make adjustments as necessary.

These services may be eligible for consideration by a patient's health care spending account, if he or she has one.

#### NONCOVERED CODES

E0231	E0455	S0516
E0232	E0639	S1001
E0247	E0640	S8210
E0248	E0755	S8265
E0350	E0761	S8270
E0352	S0510	S8460



### Find Health Care Reform Information Online

#### Access our new Web page for tools and resources

Using our new Web page can help your staff find answers about the federal health care reform Affordable Care Act.

You'll find a link to the new page on the Communications & Resources provider page. The site provides a brief overview of health care reform and links to a variety of resources, including AskBlue Healthcare Reform<sup>SM</sup>. The AskBlue Healthcare Reform tool provides targeted information about health care reform for both individuals and businesses.

The interactive tool developed by the Blue Cross and Blue Shield Association is also accessible from Wellmark's home and member pages.

## Upcoming EAPG Changes

**Changes begin with date of service July 1, 2011**

If your outpatient facility claims are processed through the Enhanced Ambulatory Patient Groupings (EAPGs) payment methodology, look for the following changes effective later this year.

### Single Outpatient Claim for One Date of Service

If you are billing multiple outpatient facility visits for one patient on the same date of service, Wellmark will require one claim for services provided on or after July 1, 2011.

### Recovery Room Services

Services billed under revenue code 45X (Emergency Room) or 762 (Observation Bed) group as one visit even if the patient's stay and subsequent billed dates of service span more than one day. Effective July 1, 2011, services billed under revenue code 71X (Recovery Room) will similarly group as one visit.

## Home Health and Hospice Agencies

### Single Date of Service Required for each Claim Line

**Date spanned lines will process incorrectly**

So that your home health or hospice facility (UB-04) claims process correctly, please submit detailed claim lines using a single date of service. If a claim line is billed with a date span, only one date of service will be paid.

Home health and hospice claims for date of service on and after October 1, 2010, process through iCAP.

## Review Zero Charge Requirements

### Receive correct reimbursement

To properly reimburse you for the services you provide, Wellmark requires a charge on each line of an outpatient facility claim. *In most situations*, claim lines should not include a zero charge (see exception below).

**IF A CLAIM LINE HAS AN INAPPROPRIATE ZERO CHARGE**, the entire claim will reject with the following denial message if processed before May 1, 2011:

X004	There is missing or invalid information on claim. Please correct and submit new claim.
------	--

If processed on May 1, 2011, or after, such lines will not be used to determine payment.

This edit applies to all facility outpatient claims, regardless of the payment methodology used to calculate payment for your particular claims.

### Exception: Billing Two or More Surgical Procedures on the Same Claim

If a claim includes two or more surgical procedures with revenue codes 36X, 49X, or 75X:

- › Include an itemized charge for each procedure (line item).

**OR**

- › Roll up the surgery charges to one line and zero bill the subsequent line items included in the global charge.

REVENUE CODES	DESCRIPTION
36X	Operating Room Services
49X	Ambulatory Surgical Care
75X	Gastrointestinal Services



## Iowa: Are Patient Care and Service Improving?

### Find the answer using Wellmark's quality management program evaluation for 2010

Learn about Wellmark's clinical and service initiatives and quality management programs in our Quality Management Program Evaluation. The evaluation includes HEDIS® results from the 2010 data.

The evaluation is included with the 2010 HEDIS Report, and is available at Wellmark.com (Providers > Medical, Dental, & Pharmacy > Wellmark Health Plan of Iowa > Health Plan Ratings). Scroll to the end of the document to locate links to the program description and evaluation.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

To order a paper copy of the 2010 Wellmark Quality Management Evaluation, call 515-376-4831, or e-mail [newmansr@wellmark.com](mailto:newmansr@wellmark.com).

## Major Billing Change with Codes 90460 and 90461

### Report each vaccine component

So that your immunization administration services process correctly, please review the following filing guidelines for CPT®\* codes 90460 and 90461. These codes became effective January 1, 2011.

90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine/toxoid component (List separately in addition to code for primary procedure)

### Billing Requirements

The new codes require *each component* of a vaccine to be reported separately. CPT defines a component as all antigens in a vaccine that prevents disease(s) caused by one organism. Combination vaccines are those vaccines that contain multiple vaccine components.

- › **USE CODE 90460** to report the *first (or only)* vaccine/toxoid component of each vaccine.
- › **USE CODE 90461** to report *each additional* component of that particular vaccine.

**EXAMPLE:** An 18-year-old patient is counseled on each of the following vaccine components.

VACCINE	DESCRIPTOR	NUMBER OF COMPONENTS	ADMINISTRATION CODE
90670	Pneumococcal Conjugate Vaccine	1	90460 x 1
90723	Diphtheria, Tetanus Toxoids, Acellular Pertussis, Hepatitis B, Poliovirus Vaccine	5	90460 x 1 90461 x 4
90680	Rotavirus Vaccine	1	90460 x 1

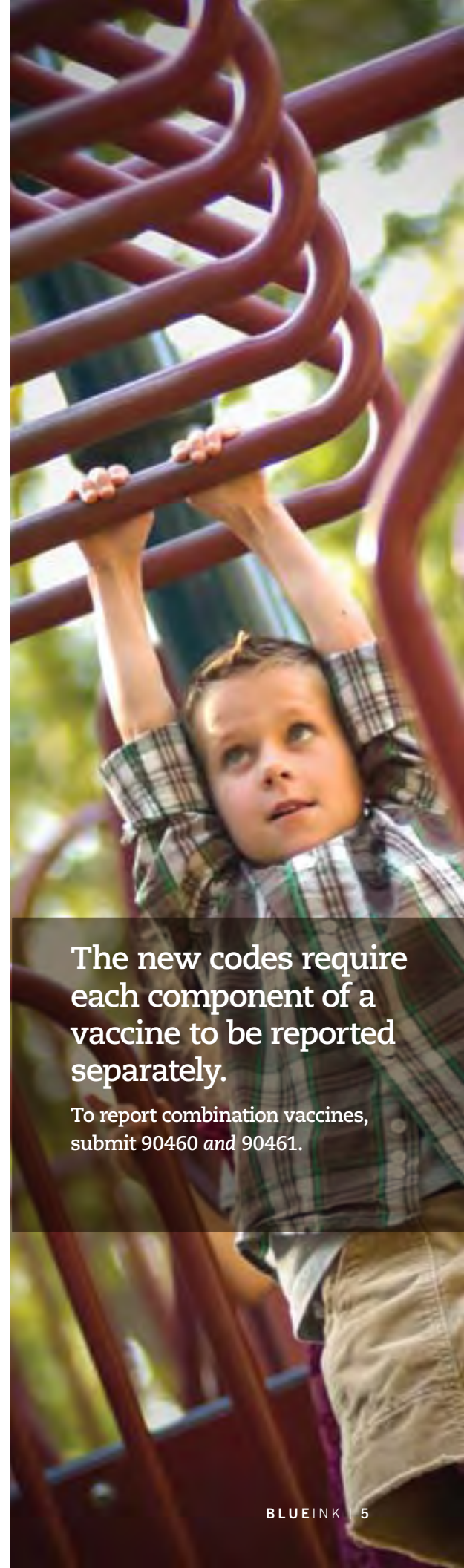
**TO RECEIVE PROPER REIMBURSEMENT** in this case, the patient's claim should list 90460 and 90461 once, with multiple units of service for each code:

- › **90460 x 3 UNITS**
  - 3 units represent the *only* component of pneumococcal and rotavirus vaccine, and *first* component of DtaP-HepB-IPV
- › **90461 x 4 UNITS**
  - 4 units represent each additional component of DtaP-HepB-IPV; no other vaccine has more than one component to report

If 90460 or 90461 is listed on a claim more than once, repeated administration code(s) will deny as duplicate services.

Please contact your software vendor for an update if your software is unable to accommodate these coding requirements.

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The new codes require each component of a vaccine to be reported separately.

To report combination vaccines, submit 90460 and 90461.



### How Ambulance Claims Process

#### Fractional mileage reported will round up to nearest whole number

Ambulance claims reported with a fraction of a mile submitted for MedicareBlue<sup>SM</sup> PPO or Wellmark members will round up to the nearest whole number.

When submitting claims for ambulance services, report mileage to the nearest tenth of a mile when the trip is shorter than 100 miles, beginning with service dates on and after January 1, 2011.



### Billing Influenza Vaccines to MedicareBlue PPO

#### Use HCPCS codes instead of CPT\* code 90658

For dates of service on and after January 1, 2011, the Centers for Medicare & Medicaid Services (CMS) no longer accepts influenza CPT code 90658 (Influenza virus vaccine . . . when administered to individuals 3 years and older, for intramuscular use).

Instead, when billing for a patient covered by Medicare or MedicareBlue<sup>SM</sup> PPO, use the following HCPCS codes:

#### Virus Vaccine Codes for Medicare Billing

HCPCS	DESCRIPTION
Q2035	Afluria vaccine, 3 yrs & older, intramuscular
Q2036	FluLaval vaccine, 3 yrs & older, intramuscular
Q2037	Fluvirin vaccine, 3 yrs & older, intramuscular
Q2038	Fluzone vaccine, 3 yrs & older, intramuscular
Q2039	NOS flu vaccine, 3 yrs & older, intramuscular



If billing for a Wellmark member, you may use one of the HCPCS codes above, or code 90658.

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## Stay Current Medical Policy Updates

### Note several recent revisions

The following summary provides information about Wellmark's recent changes.

#### Revised Policies

##### Neovascular Macular Degeneration Treatment

- **ADDED:** Photodynamic therapy with verteporfin may be considered medically necessary as a treatment of central serous chorioidopathy.
- **REMOVED:** Photodynamic therapy with verteporfin is considered investigational as monotherapy for other ophthalmologic disorders, including choral neovascularization secondary to central serous chorioretinopathy.

##### Phototherapeutic Keratectomy (PTK)

- **ADDED:** Salzmann's corneal degeneration as one of the conditions for which a PTK may be considered medically necessary.

##### Radiofrequency and Cryoablation of Liver Tumors

- **UPDATED:** Language around medical necessity indications.
- **REMOVED:** Requirements pertaining to the number of tumors and sizes of tumors.
- **ADDED:** Use as a bridge to transplant in patients who are already on a waiting list for a liver transplant as medically necessary.
- **ADDED:** Use as a means to downstage a patient's disease in order to meet the criteria for liver transplant as investigational.

##### Serum Tumor Marker in the Management of Malignancies

- **ADDED:** HE4 as investigational for all indications including screening, diagnosis, and monitoring disease progression in women with ovarian cancer.
- **EXPANDED:** Medical necessity indications for CA 19-9 to include aiding in the detection of cholangiocarcinoma in patients with primary sclerosing cholangitis.
- **UPDATED:** Language around AFP, b-HCG, and LDH in germ cell tumors to be consistent with new practice guidelines published by the American Society of Clinical Oncology (covered indications did not change).

##### Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD)

- **ADDED:** Transoral incisionless fundoplication using the EsophyX device as investigational.

Learn More

You'll find more information at [Wellmark.com](http://Wellmark.com) (Providers > Medical Policies & Authorizations).

## Faster TRICARE Payments with EFT

### Enjoy the benefits of direct deposit and electronic remittance

Take advantage of the electronic options for your TRICARE claims and receive your payments more quickly while reducing the amount of paper you receive.

Options offered by TriWest Healthcare Alliance and its claims processor, Wisconsin Physicians Service Insurance Corporation (WPS):

**ELECTRONIC FUNDS TRANSFER (EFT)** – process that allows your TRICARE claim payments to be deposited directly into your checking or savings account, and eliminates any delays encountered with mail. EFT replaces paper checks.

**ELECTRONIC REMITTANCE ADVICE (ERA)** – the electronic equivalent of the paper remittance advice (also known as Explanation of Benefits or EOB) that provides details on how your claims were processed.

### EFT Requirements

To be eligible to receive an EFT from TriWest, you need to:

- › Be a network provider who receives ERAs (see below)
- › Complete an EFT application form and send it to WPS

Once the completed application is received, WPS will complete a pre-note process with your bank and work directly with your office to ensure a smooth conversion.

### ERA Details

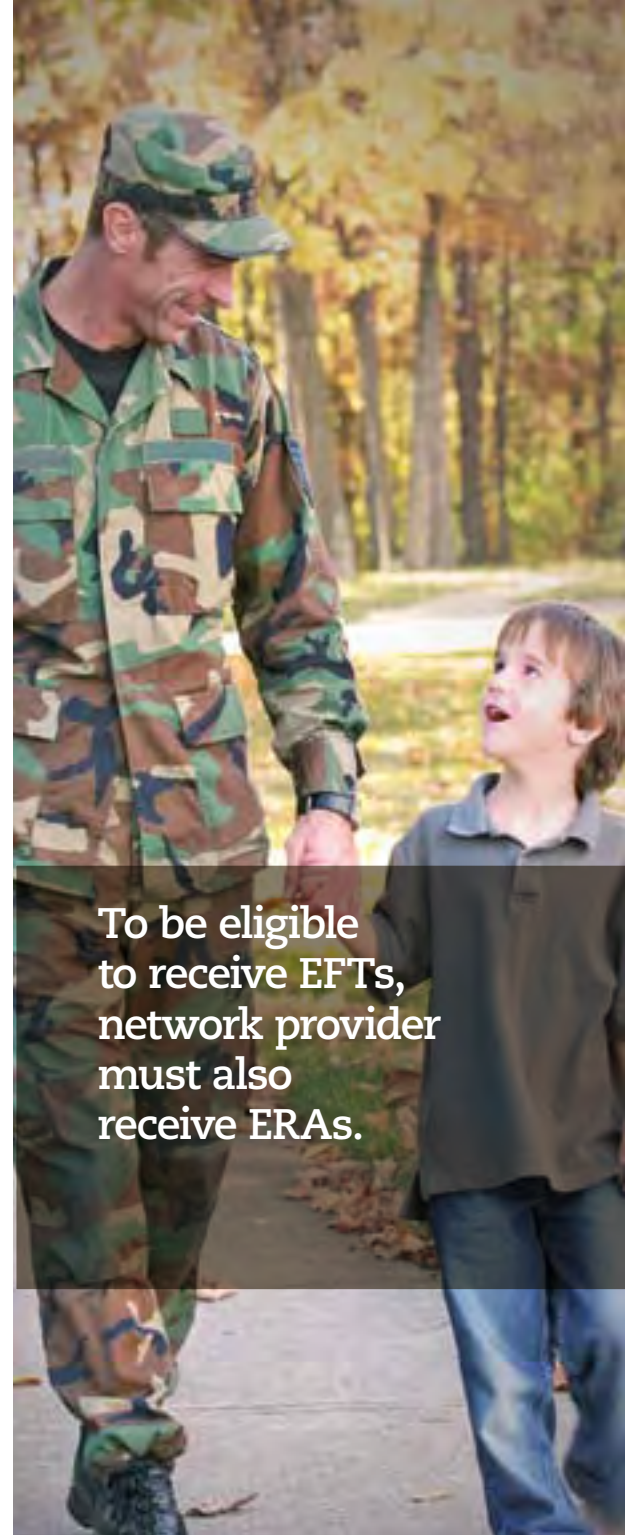
An ERA can reduce the time spent reconciling accounts receivable and eliminates:

- › Manual data entry and paper processing
- › Errors associated with manual posting of paper remittance advices
- › The need to store and file paper copies

ERAs are sent to you in the ANSI X12 835 format, version 4010A1. Download ERAs from the WPS Bulletin Board System (BBS) or through the WPS secure FTP process. You will receive both the ERA and the paper remittance for 45 days.

To learn more about these options:

- › Check the frequently asked questions documents at [Triwest.com/provider](http://Triwest.com/provider)
- › Contact a WPS EDI Marketing Consultant at 1-800-782-2680
- › Visit the WPS website at [Wpsic.com/edi/tricare.shtml](http://Wpsic.com/edi/tricare.shtml)



To be eligible to receive EFTs, network provider must also receive ERAs.



## TRICARE Beneficiaries Benefit from New Program

### Patients with major depression condition may be eligible for additional support

To help beneficiaries suffering from depression, TriWest now offers a Major Depression Program.

#### Eligibility

To be eligible for participation, beneficiaries must be referred to TriWest by the Department of Defense (DoD). Eligibility is determined by patient health, based on claims history. Beneficiaries may not self-refer, nor may they be referred by providers or military clinics.

TriWest's Condition Management personnel contact each candidate by phone, conduct an initial phone assessment, explain how the program works, and invite them to participate.

Learn [More](#)

Visit [Triwest.com/depression](http://Triwest.com/depression) for more information and resources.



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# Blueink

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**EDITOR:**  
Kathy Dean

**CONTRIBUTING EDITOR:**  
Marie Quanbeck

**ART DIRECTOR:**  
Susan Anderson-Smith

**DESIGNER:**  
Elisa Conklin

If you have questions about information in this newsletter, please contact Provider Service:

**IN IOWA**  
(515) 376-4688 or  
(800) 362-2218;

**IN SOUTH DAKOTA**  
(800) 774-3892

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## Notice Anything Different?

We've made changes to *Blue Ink* to make it easier to read and use. The new design is printed on recycled paper to control cost and save our environment. We hope you enjoy the new look.



## ATTENTION: Wellmark Health Plan of Iowa Physicians

# Your Office Medical Records May be Part of HEDIS® Review

### Response or action needed if selected

You'll receive a letter within the next few weeks if your medical records are randomly selected to be part of the annual Healthcare Effectiveness Data and Information Set (HEDIS) review. The review will involve records belonging to patients covered by Wellmark Health Plan of Iowa.

The review begins in March. Because your response may be necessary, please review the letter.

**EIGHT OR MORE SELECTED MEDICAL RECORDS:** We'll conduct an on-site medical record review. The letter will include the date of our visit and a list of members whose medical records require review.

**SEVEN OR FEWER SELECTED MEDICAL RECORDS:** You'll be instructed which address or fax number to use when sending the medical records direct to Wellmark for review.



### Data Collection

The records selected are reviewed for the following measures using criteria from the National Committee for Quality Assurance (NCQA):

- › Adolescent Immunization Status
- › Adult BMI Assessment
- › Childhood Immunization Status
- › Cholesterol Management for Members with Cardiovascular Conditions
- › Colorectal Cancer Screening
- › Comprehensive Diabetes Care
- › Controlling High Blood Pressure
- › Prenatal and Postpartum Care
- › Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

The data collected in HEDIS provides physicians and Wellmark a snapshot of where we are meeting or exceeding quality care measures, and where we need to work together to improve health care in Iowa. Although HEDIS measurements require the review of member-specific information, Wellmark only reports aggregate data representing the entire Wellmark Health Plan of Iowa population.

The 2011 Wellmark HEDIS® results will be available this fall on our Web site at [Wellmark.com](http://Wellmark.com).

*HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization that evaluates and reports on health care quality in the United States.*