

Information for IOWA and SOUTH DAKOTA
Physicians and Health Care Providers



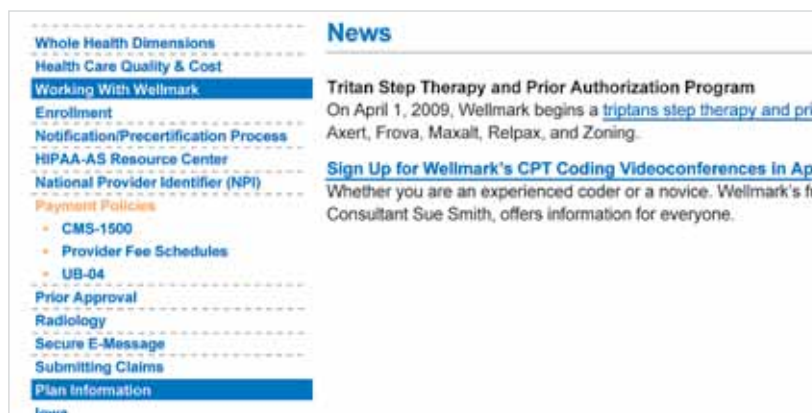
Registered for access? Clinician Fee Schedules Coming This Month

In April, participating clinician offices with BlueConnection® access will be able to view fee schedules relative to their specialties and their Wellmark contracts at www.wellmark.com (Providers > Payment Policies > Provider Fee Schedules). Multispecialty groups will have access to multiple fee schedules, based on the contracted specialties represented in their office.

Fee schedules may be accessed by selecting a fee schedule year. We will display two years of previous fee schedules and the most current fee schedule.

We encourage you to register today for BlueConnection access at www.wellmark.com (Providers > Register Now!) to gain access to these tools and others. Our Web site will announce when the fee schedules are available.

If you're already registered, get full use of the tools available, including the new features of the *View Eligibility and Benefits* tool. You'll find more information on page 10 of this *Blue Ink*.



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VISIT OUR WEB SITE AT: www.wellmark.com

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Coming Soon: The Reduction of Paper Claims

Wellmark to Accept COB Information on Electronic Claims

Good news for electronic filers: The change you've been asking for is coming soon.

This summer, Wellmark Blue Cross and Blue Shield will begin to accept and process HIPAA 837 transactions containing a primary payer's coordination of benefits (COB) information. Today, electronic COB claims are rejected, as Wellmark requires a paper claim and copy of the primary carrier's statement to process benefits as a secondary payer.

If you are interested in submitting COB claims electronically to Wellmark, please work with your software vendor to verify that your billing system is set up to enter and transmit this information.

Electronic Submission Exception: If a claim does not cross over from Medicare to Wellmark, you must continue to submit a paper claim with a copy of the official Medicare remittance notice. Typically, when you submit Medicare claims to the appropriate Medicare contractor, the claim will cross over to Wellmark for benefit consideration. If the claim is rejected by the Centers for Medicare & Medicaid Services' Coordination of Benefits Contractor, the claim will not cross over. Wellmark will continue to reject electronic Medicare COB claims submitted by providers.

If you have questions, please contact EC Solutions at 800-407-0267. You will also find information using electronic transaction guides available at www.wellmark.com (Providers > Billing Guides > Other Guides/Electronic Transaction and HIPAA Guides), where you'll find a link to the EDS BES login for authorized users.

Check the June issue of *Blue Ink* for the implementation date.

Additional External Review Option Begins April 21

Beginning with appeal decisions dated April 21, 2009, an external review process will be available for the review of medical necessity, investigational, and experimental disputes.

Iowa and South Dakota physicians (M.D.s and D.O.s only) who meet certain criteria are eligible for the external review process, as long as the claim in question is for a Wellmark member. The review is also available to out-of-state M.D.s and D.O.s who contract with Wellmark Health Plan of Iowa, when the claim is for a Wellmark Health Plan of Iowa member. Claims for members covered by self-funded groups are not eligible for the external review process.

To be eligible for an external review, the physician must exhaust Wellmark's provider inquiry and post-service appeals process. Qualifying physicians will receive a notification in the provider post-service appeal response letter advising that they may request a medical necessity, experimental, or investigational external review.

Physicians must request an external review regarding a medical necessity, experimental, or investigational determination within 60 days of the date of Wellmark's post-service provider appeal decision. Medical Review Institute of America (MRIoA) has been selected to be the medical necessity, experimental, or investigational external reviewer. You may access the external review form and more information beginning April 21 at www.wellmark.com (Providers > Forms > Provider Appeal Forms) .

Attn: Drug and Biological Billers
(CMS-1500 and UB-04)

Drug and Biological iCAP Policies

Effective August 1, 2009, Wellmark will be implementing Drug and Biological iCAP policies. These payment policies include guidelines based on a drug or biological's administration frequency, patient age, and patient diagnosis.

You can review the policies at www.wellmark.com (Providers > Payment Policies > UB-04 or CMS-1500 > draft iCAP Specialty Policies). When selecting this link, your office personnel will be asked to enter the User ID and Password for accessing BlueConnection® tools.

If you do not have BlueConnection access, we recommend that you apply today at www.wellmark.com (Providers > BlueConnection > Register Now!). You will be able to access and download draft and implemented iCAP specialty policies, and use a variety of valuable BlueConnection tools.

If you cannot apply for access, you may request a draft of your specialty's iCAP policies using the following information.

iCAP Specialty Policies, Station 139
Wellmark Blue Cross and
Blue Shield
P.O. Box 9232
Des Moines, Iowa 50306-9232
Fax: 515-248-5316

Wellmark Formulary Will Soon Be Available through DrFirst™ e-Prescribing Software

Beginning May 1, 2009, the Wellmark Blue Cross and Blue Shield Drug List will be available electronically for clinicians who use e-prescribing from DrFirst™ through Rcopia. The same formulary information can be found on Wellmark.com (Providers > Pharmacy > Wellmark Drug List > 3 Tier Wellmark Drug List).

Member Eligibility Also Available

Also on May 1, 2009, physicians will be able to check member eligibility using the patient name through Rcopia.

Why e-Prescribing?

- Safety: Handwriting interpretation errors are avoided
- Security: Content is PHI protected with strict privacy and security measures
- Savings: Cutting down on paperwork and phone calls saves time and increases productivity
- Convenience: It takes just seconds to enter an e-prescription and send it directly to the pharmacy

Program Features

Rcopia interfaces with most Practice Management and Electronic Medical Records software platforms. The software allows the clinician to send prescriptions directly to the pharmacy. If the pharmacy cannot receive the prescription electronically, the prescription is faxed. Both transactions are seamless to the member. Wellmark will cover the cost associated with downloading Wellmark information.*

Help for CoQ Primary Care Program Participants

Use of e-prescribing is one of the measures in the 2009 Collaboration on Quality® Primary Care Program. Because information on generics will be easily available with e-prescribing, it is easier to be successful in meeting the program's generics goal.

Are you Connected to DrFirst? You already have access to the Wellmark formularies. Just download the information and go.

If you are not connected to DrFirst, or need more information? Call **888-271-9898**, e-mail sales@drfirst.com, or go online to www.DrFirst.com.

**DrFirst connectivity costs are the responsibility of the clinician.*

Generic Utilization Initiatives

Recently, Wellmark implemented several programs to encourage generic drug utilization (descriptions follow). Throughout 2009, Wellmark will continue to implement similar initiatives, focusing on drug classes with high brand-name drug utilization and generic options.

Letters about pharmacy programs are mailed in advance to members who have filled a prescription for one of the affected drugs. Prescribers also receive a letter with a list of their patients who are impacted by the change.

For more information about Wellmark pharmacy initiatives, visit www.wellmark.com (Providers > Pharmacy).

Step Therapy Program

Step therapy programs encourage the safe and cost-effective use of prescription drugs by requiring a step approach for coverage of certain high-cost medications. If you want a patient to skip these steps, you will need to submit a prior authorization request, or the drug will not be covered. As long as a member follows the steps or has claims data showing prior use of the step therapy drug(s), a prior authorization is not required.

- **Trilipix** – As of March 15, 2009, a member must try a generic fibrate (fenofibrate, fenofibrate micronized, or gemfibrozil) without success before coverage is available for Trilipix.
- **Triptans** – As of April 1, 2009, members must try sumatriptan (generic Imitrex) without success before coverage is available for a brand-name triptan (Amerge, Axert, Frova, Maxalt, Relpax, or Zomig).
- **PPI** – As of March 6, 2009, Kapidex was added to the existing PPI step therapy program, a three-step program.
- **Antidepressants** – On July 1, 2009, Wellmark will introduce a step therapy program for new prescriptions for an SSRI/SNRI antidepressant. New users must try a generic antidepressant before coverage is available for a brand-name antidepressant. Members already taking an SSRI/SNRI antidepressant will be excluded from the program's requirements.

Dose Optimization Program

The Dose Optimization program increases patient compliance with drug therapies and slows the rising cost of prescription drugs. The program includes only drugs approved by the U.S. Food and Drug Administration (FDA) for once daily dosing. The medication must have similar pricing across multiple strengths.

Three new drugs were added to the Dose Optimization program as of April 1, 2009: Venlafaxine ER, Toviaz, and Rapaflo.

Quantity Limit Program

As of April 1, 2009, the following monthly quantity limits apply for these six pain medications. Prescriptions written by oncologists are exempt from the quantity limits for these drugs.

Drug	Quantity Limit
Avinza	60
Duragesic	20
Kadian	60
MS Contin	60
Opana ER	60
OxyContin 80mg	120
OxyContin (all other strengths)	60

Prior Authorization

As of April 1, 2009, new users of Actiq and Fentora, two pain medications, are subject to prior authorization requirements. Existing users will be subject to the requirements beginning July 1, 2009.

To request a prior authorization, complete the appropriate form at www.wellmark.com (Providers > Forms > Prior Authorization Pharmacy Forms) or call 800-600-8065, option 1.

Copay Waiver Program

This drug card program offers members a limited opportunity to have their cost-share waived for certain drugs. Members who have a drug plan with a deductible must meet the deductible before the coinsurance or copayment can be waived, unless their plan design waives the deductible for generics or for drugs on an HSA Preventive Drug List.

Antidepressants – The program waives the member’s first cost-share for a one-month supply of one of the following generic antidepressants if he or she has not tried a generic antidepressant since April 1, 2008:

- citalopram (generic Celexa)
- fluoxetine (generic Prozac)
- fluvoxamine (generic Luvox)
- paroxetine (generic Paxil or Paxil CR)
- sertraline (generic Zoloft)
- venlafaxine (generic Effexor)

Program dates: April 1, 2009 – September 30, 2009

Fibrates – The program waives the member’s first cost-share for a one-month supply of one of the following generic fibrates if he or she has not tried a generic fibrate since May 1, 2008:

- fenofibrate
- fenofibrate micronized
- gemfibrozil

Program dates: May 1, 2009 – June 30, 2009

Moving Away from the Distribution of Free Drug Samples

The practice of giving free drug samples to patients has come under scrutiny across the health care industry. Recently, the University of Iowa Hospitals & Clinics announced they would be ending the practice, and they are not alone. There are a variety of reasons why drugs initially obtained through a prescription are seen as a better option.

Increases Patient Medication Adherence Because Patient Out-of-Pocket Costs are Decreased

The cost of prescription drugs is one reason patients cite for being nonadherent with their treatment regimens.¹ Drugs available as samples are typically the newest and most expensive medications on the market, and are often prescribed for chronic conditions requiring ongoing therapy. Recent studies show that the use of drug samples can lead to more expensive brand-name medications being prescribed when generic alternatives exist, thereby increasing patients’ out-of-pocket costs after receiving “free” samples. By prescribing generics, physicians can drive good health outcomes and reduce

the potential risk of nonadherence associated with patient costs.

Includes the Benefits of the Pharmacy Database

When a prescription is filled at a pharmacy, the information goes into a database that alerts the pharmacist to possible drug interactions. Pharmacies also track medication recalls using this database, and can quickly notify patients about the recalls or other safety concerns. Free drug samples are not included in pharmacy records, so patients with drug samples do not receive the benefits offered by the database.

Reduces Risk of Unexpected Safety Concerns

Drug samples are typically for the newest products on the market, and have been tested on a limited number of people. When those new medications come to market and are used by thousands to millions more patients, additional safety concerns may arise.

Comes with More Information

When a prescription is filled at a pharmacy, the pharmacist provides information about the drug—both verbally and in writing. Drug samples typically do not come with printed drug information.

Eliminates the Time and Cost Associated with Sample Management

A significant amount of time is spent managing the sample closet, from record keeping and stocking, to drug recalls and disposal of expired products.

¹Harris Interactive HealthDay Poll, “Majority of U.S. Adults Worried about Cost of Medical Care and Insurance,” March 9, 2009, <http://www.harrisinteractive.com/news/pubs/harris_healthday_poll_2009_03_09.pdf> (March 13, 2009).

Questions About Our Pharmacy Management Programs?

Wellmark works with Catalyst Rx, our pharmacy benefit manager, to assess current utilization management practices regarding pharmaceuticals. Prescribing practitioners are encouraged to use the Wellmark Drug List on www.wellmark.com (Providers > Pharmacy) for information on drug tiers and requirements for certain drugs. Other information about special pharmacy programs, such as prior authorization, quantity limits, step-therapy edits, copayment waiver programs, and specialty drugs, is also available at www.wellmark.com. If you have questions, call Wellmark Pharmacy Services at 800-600-8065.

Prior Approval for Motorized Wheelchairs and Other Power Operated Vehicles

Wellmark recommends that you obtain a prior approval before submitting claims for motorized wheelchairs or other power operated vehicles and add-on features for our members.

Information Needed with the Prior Approval

Include the following information with the Prior Approval form:

- a letter from the prescribing physician that indicates the medical necessity for each item
- physical therapy and/or occupational therapy (PT/OT) documentation that supports medical necessity

Both the Prior Approval and a PT/OT Evaluation Form are available online at www.wellmark.com (Providers > Forms). Therapists may use Wellmark’s online PT/OT Evaluation Form or their own form to supply the needed information.

The following HCPCS codes are the only codes Wellmark will accept for prior approval.

HCPCS Code	Description
E1230	Power operated vehicle
E2301	Power wheelchair accessory, power standing system
E2331	Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware
K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control
K0012	Lightweight portable motorized/power wheelchair
K0014	Other motorized/power wheelchair base
K0800-K0812	Power operated vehicle
K0813-K0898	Power wheelchair

Claim Filing Information

After the prior approval is granted:

- Submit the appropriate HCPCS code(s) listed above for the motorized wheelchair or power operated vehicle and any add-on features using the CMS-1500 claim form.
- Attach to the claim an invoice that includes the manufacturer’s suggested retail price if an item is billed using K0108 (wheelchair component or accessory, not otherwise specified).

Update: Outpatient Cardiology Diagnostic Imaging Services Preauthorization

Beginning with date of service May 1, 2009, the following outpatient cardiac diagnostic imaging services will require preauthorization review. The servicing providers’ claims will process based on the preauthorization determination:

- **Stress Echocardiography** (CPT®* codes 93350–93351)
- **Resting Transthoracic Echocardiography** (93303–93304, 93306–93308)
- **Transesophageal Echocardiography** (93312–93317)

Today as long as advance notification and clinical information are provided for these services, claims are eligible for benefits.

Note: Beginning May 1, the ICD procedures will no longer require a preauthorization, and claims will pay based on the member’s benefits. ICDs (codes 33216, 33217, 33240, 33249) will continue to require a notification until May 1.

For more information about our radiology program, including a complete list of services and codes requiring preauthorization and a list of coverages not included in this program, visit www.wellmark.com (Providers > Radiology). We will update the information to reflect the changes noted shortly.

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Reduced Payment for Colonoscopies Billed with a 53 Modifier

Effective for dates of service on or after July 1, 2009, Wellmark will reduce payment when colonoscopy procedure codes 45378,* G0105, and G0121 are billed with a 53 modifier on the CMS-1500. The Maximum Allowable Fee (MAF) will be reduced by the following percentages, depending on the place of service:

Facility setting

28 percent of MAF

Nonfacility setting

34 percent of MAF

53 Modifier Billing Guidelines

The 53 modifier indicates that the physician elected to terminate the procedure because there were extenuating circumstances threatening the well-being of the patient. When the modifier is used for that reason, we will pay according to the percentages given above.

Do not use the 53 modifier to bill:

- an elective cancellation of the procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite
- a laparoscopic or endoscopic procedure that is converted to an open procedure, or changed or converted to a more extensive procedure

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Preventive Care and Noncovered Diagnostic Procedures

On and after July 1, 2009, CPT* codes 81002 and 81003 will be added to the list of diagnostic procedures not eligible for coverage when billed as part of a preventive exam. The other codes on the list, which have not been covered since 2005, are outlined below.

The diagnostic procedures and current codes Wellmark considers a participating provider's liability¹ if provided as part of a preventive exam for asymptomatic patients ages 19 years and older include:

- **Urinalysis (UA)**² – 81000, 81001, 81002, 81003
- **Complete Blood Count (CBC)**² – 85025, 85027
- **Chest X-ray** – 71010, 71015, 71020
- **Electrocardiogram (EKG)** – 93000, 93005, 93010, G0403, G0404, G0405

If you perform one of these tests for a Wellmark member because of the patient's symptoms or history, be sure the CMS-1500 includes the appropriate information:

- **Field 21** – In addition to the preventive ICD-9-CM code for the routine services, include medical diagnosis code(s) for the diagnostic procedure(s) performed.
- **Field 24E** – For each line item, indicate the appropriate medical diagnosis code listed in field 21.

The United States Preventive Health Services Task Force recommended that providers stop administering these tests during routine preventive care exams. The Task Force identified the tests as not generally beneficial for persons 18 years or older, in the absence of symptoms or a history that necessitates such testing. **Note:** *This guideline does not apply to FEP members.*

When to Bill a Separate E/M Code

If an insignificant condition or symptom is discovered or presents itself during a health maintenance exam, the service is considered part of the health maintenance Evaluation and Management (E/M) code. A separate E/M should not be billed.

If the diagnosis and treatment of this condition or symptom involve significant additional effort that requires the performance of the key components of a problem-oriented service, the clinician may bill an E/M code in addition to the health maintenance exam.

When billing laboratory, radiology, or other procedures related to a condition or symptom, indicate the appropriate diagnosis code in field 24E.

For more details about billing health maintenance examinations, please see pages 7–10 of the General Medical section of the Practitioner Guide at www.wellmark.com (Providers > Guides > Practitioner Guide).

¹ If a patient does not have coverage for preventive care services, all routine services will deny as member liability.

² CBCs and UAs are appropriate under certain conditions for members age 18 and below.

New Processing Guidelines for Claims Containing Preventive and Surgical Services

Beginning with claims processed on or after June 1, 2009, claims containing surgery services performed during a routine health maintenance exam will reject unless the appropriate diagnosis for each line item is indicated in field 24E of the CMS-1500.

Example: A member schedules an annual health maintenance exam. During the visit, the clinician removes a wart.

- Field 21 must list all applicable diagnosis codes.
- Field 24E for each line item must refer to the appropriate diagnosis code(s) found in field 21.
 - The routine exam and related services must refer to the appropriate routine diagnosis code (e.g., V70.0).
 - The wart removal and related services must refer to the appropriate medical condition diagnosis (e.g., wart, 078.0–078.19).
 - If more than one diagnosis is appropriate for a service, the first number listed in 24E must indicate the primary diagnosis for that service.

If the services are not billed this way, the entire claim will be rejected and will need to be resubmitted with the appropriate primary diagnosis for each claim line. Field 24E has been added as a conditionally required field in the *Wellmark Provider Guide's* CMS-1500 filing instructions.

LINE	ICD-9-CM CODE	ICD-9-CM DESCRIPTION	UNIT	QUANTITY	UNIT PRICE	TOTAL CHARGE	REMARKS
1	01 01 XX 01 01 XX 11	99396*	1	XX XX	1		
2	01 01 XX 01 01 XX 11	86316	1	XX XX	1		
3	01 01 XX 01 01 XX 11	17110	2	XX XX	1		

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Filing and Tracking TRICARE Claims Just Got Easier

Take advantage of new enhancements on the TriWest secure provider Web site to expedite the processing of TRICARE claims, reduce the time spent tracking submitted claims, and eliminate the need to submit duplicate or tracer claims.

As a registered provider, you can perform a variety of self-service functions when visiting www.triwest.com/provider:

- verify patient eligibility
- view your patient panel report (primary care managers only)
- determine the status of referrals and authorizations
- submit, view and check claim status
- download explanations of benefits
- see which payments have been issued

Registered users can also submit professional and institutional claims online and receive real-time processing results. Currently, clean claims (i.e., those that do not require investigation or development before adjudication) submitted online are processing within the following time frames:

- 71 percent immediately
- 97 percent in 15 days or less
- 99.7 percent in 30 days or less

Second submissions and tracer claims can delay claims processing, influence the accuracy of claims payment, and cost your practice valuable time. To avoid these problems, allow:

- at least 45 days from the date the claim is received at Wisconsin Physicians Service (WPS) before generating second submissions or tracers
- WPS time to receive the claim from your office or billing service and process all clean claims
- time for the U.S. Postal Service to deliver your payment
- your office time to post the payment

If you are not registered to use TriWest's secured provider tools, please register today at www.triwest.com/provider.

Still Time to Sign Up for TRICARE Seminars

This spring, TriWest Healthcare Alliance Corp. will host a series of TRICARE educational medical-surgical seminars for health care providers and staff. TriWest's TRICARE experts will share the latest information on TRICARE programs, policies, and procedures. The sessions will be held on the following dates (see more information at www.triwest.com/provider):

Location	Date	Time
Holiday Inn Downtown at Mercy Campus 1050 6th Avenue Room: Northview Des Moines, IA	Wednesday, May 6	9–11:30 a.m., C.T.
Holiday Inn Conference Center Des Moines Airport 6111 Fleur Drive Room: Westview Des Moines, IA	Thursday, May 7	1–3:30 p.m., C.T.

If you have difficulty in registering online, e-mail pseminar@triwest.com. If you have questions regarding the content of the seminars, e-mail providerservices@triwest.com, or call 888-TRIWEST (888-874-9378).

The seminar will run approximately 2½ hours; however, the end time may vary based on the level of audience participation.



Member Search Tool Helps Locate Wellmark ID Number

You can find the identification number for a Wellmark Blue Cross and Blue Shield member by entering a name and a corresponding birth date. The name and birth date can be for anyone covered by the Wellmark contract.

Self-Help Tools Provide Benefit Accumulation Details

Now you can access even more details using the Eligibility & Benefits BlueConnection® tool on www.wellmark.com. In addition to deductible and out-of-pocket maximum totals, now you can also see benefit accumulation details, including both the amount satisfied and the remaining balances (scroll down and select either **View More Accumulations** or **View Family Accumulations**; see screen shot). Members may also access this information for their personal use.

When a Wellmark member's contract has a limited number of visits or a maximum dollar amount for a certain medical service per benefit period, the tool displays both:

- The number of visits used or the dollar amount credited toward the maximum benefit. (Information not available for BlueCard® members.)
- The remaining number of visits or dollar amount. (Information also available for BlueCard members.)

To appropriately use this information, check the member's benefits using the Eligibility and Benefits BlueConnection tool. Although you will be able to see a member's benefits for mental health and alcohol and chemical dependency care, we suppress accumulation information for these diagnoses due to privacy concerns and issues. If you are a behavioral health provider, please contact Wellmark for information.

To sign up for BlueConnection tools, check out our Web site at www.wellmark.com (BlueConnection > Register Now!).

Check These Out

These online tools have also been updated:

- **Contact Us/Ask a Question** – When you are faxing medical records to us, send the related inquiry direct to the Medical Records review area by selecting the new button. This eliminates routing time, allowing your inquiry and your faxed medical records to arrive at the correct review location at the same time.
- **Check Claim Status** – We have recently added the date of the initial remittance to our online Accounts Receivable (A/R) information. Remember, you can also find the claim's date of service, reason for the adjustment, and any past recoupments taken to help settle the A/R.

If you'd like more information about online tools, view our training slides at www.wellmark.com (Providers > Training > BlueConnection—Wellmark's Web Tools Online Training).

Contract Accumulations					
Accumulation Type	Coverage Level	Time Period	From Date	To Date	In/Out Network
Deductible	Individual	Calendar Year	1/1/2008	12/31/2008	
Deductible	Family	Calendar Year	1/1/2008	12/31/2008	
Lifetime Amount	Individual	Lifetime			
Member Out Of Pocket Maximum For Covered Services	Individual	Calendar Year	1/1/2008	12/31/2008	
Member Out Of Pocket Maximum For Covered Services	Family	Calendar Year	1/1/2008	12/31/2008	
Accumulation Type	Service Type				
Copy	Hospital - Emergency Medical				Vi
Copy	Professional (Physician) Visit - Office				Vi
Copy	Other Medical				Vi
Accumulation Type	Time Period	In/Out Network			
Concourse	Calendar Year	In-Network			
View More Accumulations		View Family Accumulations			

New Medicare Advantage Education Requirements

Effective January 1, 2009, organizations that contract with Wellmark to provide health, prescription, or administrative services on behalf of our Medicare Advantage enrollees must meet new education and training regulations. The education is focused on fraud, waste, and abuse, and related to the compliance program requirements of Medicare Advantage and Part D programs with the Centers for Medicare and Medicaid Services (CMS).

As a Medicare Advantage Organization, Wellmark is responsible for oversight and monitoring of the education and training. Providers are responsible for initiating, documenting, and including the education in annual and new employee training programs.

Training Options

Providers may take the training offered by an organization or may administer their own training. You will find Wellmark's free compliance training module at www.yourmedicareolutions.com (For Providers > Provider Guide). This module includes an attestation form to be completed by a representative of your organization as documentation that your staff completed the training. If applicable, complete this same attestation form indicating that your organization completed training sponsored by a different organization. Send the completed form to Wellmark at:

Fax: 515-235-4471

Mail: Network Administration
Wellmark Blue Cross and Blue Shield
P.O. Box 14509
Des Moines, IA 50306-3509

Upon request, your organization may be required to submit copies of employee training logs demonstrating that employees complied with the training requirement.

If your organization has contracted with other entities to provide health and/or administrative services on behalf of Wellmark Medicare Advantage and Part D members, you need to obtain attestations that they have completed FWA training. Upon request, those entities will also need to provide you training logs.

If you have questions, please contact MedicareBlueSM PPO Provider Service at 888-457-3009.

Medical Policy News

Please review the following medical policies.

New Medical Policies

- Mechanical Stretching Devices for Contracture and Joint Stiffness
- Foot Care Services

The following two policies will take effect July 1, 2009:

- Granulocyte Colony-Stimulating Factors and Granulocyte-Macrophage Colony-Stimulating Factor
- Anesthesia Services for Gastrointestinal Endoscopic Procedures

Updated Medical Policies

- Electrical Neuro Stimulators
The Vagus Nerve Stimulation medical policy has been combined with the Electrical Stimulators for Pain, Seizures, Movement Disorders or Cerebral Palsy medical policy. The new name for the combined policy is Electrical Neuro Stimulators.
- Viscosupplementation for Osteoarthritis
Beginning June 1, 2009, we will no longer require a prior approval for this treatment. Wellmark will allow HCPCS codes J7321-J7324 to process through our claims system for the first and second course of viscosupplementation without documentation. Submit claims with an appropriate diagnosis consistent with the treatment of painful osteoarthritis of the knee for patients who are unable to find relief using conventional methods. Third and subsequent treatment courses will be reviewed for medical necessity.
- Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid*
Intermittent monitoring
 - policy now states an age criteria of 18 years or older
 - removed the insulin pump requirement*Continuous monitoring*
 - added "multiple daily doses of insulin" to the existing criteria which requires the member to be on an insulin pump

*Prior Approval recommended.



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If you have questions about information in this newsletter, please contact Provider Service in Iowa at (515) 245-4688 or (800) 362-2218, in South Dakota at (800) 774-3892.

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Attention: Wellmark Health Plan of Iowa PCPs
Documentation Needed for Out-of-Network Referrals

When an out-of-network referral is needed to treat a Blue Choice® or Blue Advantage® member, please submit the following:



- The Wellmark Health Plan of Iowa Referral Form available online at www.wellmark.com (Providers > Referrals).
- Supporting documentation that explains the reason(s) the member must be seen by an out-of-network physician. This is especially important when there are physicians of like specialty within the WHPI network.

Wellmark's medical director uses this information to determine the medical necessity of the request so that benefits can be approved or denied.

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