

Begin HIPAA 5010 testing

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Blue Distinction® Centers**

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fee schedules online**

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Blueink

April 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

Save time by . . . waiting

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**Reactivate secure account
to maintain access**

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Begin HIPAA X12 Version 5010 Testing with Wellmark Today

Submit test files for medical claim transactions (837 Professional and 837 Institutional)

You or your vendor, billing service, or clearinghouse can begin submitting test files for 5010 medical claim transactions (837 Professional and 837 Institutional), including the June 2010 addenda.

You'll find more details about testing preparations on page 2 of the February 2011 *Blue Ink*, or at Wellmark.com (*Provider > Claims & Payment > HIPAA 5010 > Prepare for HIPAA 5010 Testing* *handout*).

Wellmark.com will identify future testing dates for other HIPAA transactions as they become available.

Production Files

After you successfully test these claim transactions, you'll be prepared to submit production files. We anticipate being ready to accept HIPAA X12 version 5010 production files for medical claims this fall. Watch for notices in future *Blue Ink* newsletters and on the Web Bulletin Board.

Compliance Date

Electronic transactions will not be accepted after January 1, 2012, unless they are in the new HIPAA X12 version 5010 format, so we encourage you to test early. This is particularly important since the United States will change to the ICD-10 coding system from ICD-9. Version 5010 accommodates the new ICD-10 code structure; version 4010A1 does not.

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

Referring Patients to Blue Distinction® Centers

Some members' coverage may require the services of a designated Center

In addition to receiving quality health care from a Blue Distinction Center, some patients may receive a financial incentive.

Although not required for most Wellmark contracts, some Blue Plans or larger employer group policies require the use of a designated Center, or provide a higher level of benefits for their services. Please check your patient's benefits before referring a patient for the following types of care:

- › knee/hip replacement surgery
- › spine surgery
- › bariatric surgery
- › cardiac care
- › complex and rare cancers
- › transplants

To locate an Iowa or South Dakota hospital designated as a Blue Distinction Center, visit Wellmark.com (*Health & Wellness > Choose Care Wisely > Compare Quality > Top Centers for Specialty Care*).

The Blue Distinction Program

The Blue Distinction Program recognizes facilities that meet objective, evidence-based thresholds for clinical quality, developed with input from expert physicians and medical organizations. To view selection criteria in detail, visit BCBS.com/bluedistinction.

Three Iowa hospitals received one or more new designations this year (below). For a complete list of Iowa and South Dakota hospital designations, visit Wellmark.com.

Newly Received Designations

| BLUE DISTINCTION DESIGNATION | IOWA FACILITIES |
|--|---|
| Blue Distinction Center for Spine Surgery SM | Iowa Methodist Medical Center, Des Moines |
| Blue Distinction Center for Knee and Hip Replacement SM | |
| Blue Distinction Center for Knee and Hip Replacement SM | Methodist West Hospital, West Des Moines |
| Blue Distinction Center for Spine Surgery SM | Mercy Medical Center, Des Moines |



View New Clinician Fee Schedules Online

Locate July 1 updates using secure tools

Using the Provider Fee Schedules tool, you can view the updated fee schedules relative to your specialty and your Wellmark contract. Multispecialty groups can access multiple fee schedules, based on the contracted specialties represented in their office.

By accessing the updated fee schedules online, you can see the current year's and two previous years' fee schedules.

How to Access the Fee Schedules

- › If your office is registered but your access does not permit you to view the fee schedules, contact your office's Designated Security Coordinator (DSC). The DSC can expand or change your user access, if appropriate.
- › If you are the office DSC and you need to assign a staff member access to the fee schedules, log into our secure site at Wellmark.com. Select the *Update User Security for Your Office or Practice* tool, and choose *Provider Fee Schedule*.
- › If your taxpayer identification number is not registered, your organization must first select a Designated Security Coordinator (DSC) to manage your account. The DSC selects **Register now** from the Provider home page at Wellmark.com. Online steps make it easy to follow, and are summarized below:
 1. **SELECT REGISTER FOR ONLINE ACCESS.**
 2. **SELECT THE APPROPRIATE LINK** (Iowa or South Dakota).
 3. **CHOOSE THE TERMS AND CONDITIONS** link at the bottom of the page.

Wellmark notifies the DSC when registration is complete. Then, the Designated Security Coordinator can assign access as appropriate so staff members can start using the tools. If you have questions during the process, contact the EC Solutions help desk at 800-407-0267.

Multiple Procedure Reductions for Office Radiology and Therapy Services

Review the following for more specific payment information

Depending on the radiology or therapy services provided, Wellmark will pay the highest priced procedure at 100 percent of the Maximum Allowable Fee (MAF) and a percentage of MAF for each subsequent procedure, effective with service date July 1, 2011.

The services included in this payment arrangement require no additional significant patient preparation or set-up other than that required for the main procedure.

This change will not require any coding or billing change and does not affect hospital-billed services because of their unique payment arrangements.

Radiology – Technical Component

Wellmark will apply the reduction to services with a multiple procedure indicator of 4 in the Medicare Relative Value Unit (RVU) file.

This reduction for the technical component of diagnostic imaging procedures applies if the procedure is billed with another diagnostic imaging procedure in the same family (diagnostic imaging family indicators below).

If the procedure is reported in the same session on the same day as another procedure with the same family indicator, the procedures will be ranked by the highest RVU for the technical component. The highest priced procedure will be paid at 100 percent, and each subsequent procedure at 50 percent.

Therapy (Physical, Occupational, or Speech in Office Setting)

Wellmark will apply the reduction to therapy services with a multiple procedure indicator of 5 in the Medicare RVU file. If the procedure is reported in the same session on the same day as another procedure with the 5 indicator, the procedure will be ranked by the highest RVU. The highest priced procedure will be paid at 100 percent, and subsequent procedures are subject to a 20 percent reduction of the practice expense component.

Locating Information

To locate the multiple procedure indicators, check out the National Physician Fee Schedule Relative Value File on the Centers for Medicare & Medicaid Services' (CMS) website.

To locate these materials at Cms.gov/PhysicianFeeSched/, select:

1. **PFS RELATIVE VALUE FILES** (left navigation)
2. **2011** – the most recent calendar year listed for the most current information
3. **RVU FILE** listed under “Downloads” (zipped file)
4. **PPRRVU** (choice of two excel documents) – look for the document’s DIAGNOSTIC IMAGING FAMILY INDICATOR column for radiology services, MULT PROC for therapy
5. **RVUPUF** (word document) – provides information to interpret the file

Diagnostic Imaging Family Indicators

DIAGNOSTIC SERVICE FAMILY INDICATORS FOR HCPCS CODES WITH A MULTIPLE PROCEDURE INDICATOR OF 4

| | | | |
|----|---|----|---|
| 01 | Ultrasound (Chest/Abdomen/Pelvis–Non-Obstetrical) | 08 | MRI and MRA (Lower Extremities) |
| 02 | CT and CTA (Chest/Thorax/Abd/Pelvis) | 09 | CT and CTA (Lower Extremities) |
| 03 | CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck) | 10 | MR and MRI (Upper Extremities and Joints) |
| 04 | MRI and MRA (Chest/Abd/Pelvis) | 11 | CT and CTA (Upper Extremities) |
| 05 | MRI and MRA (Head/Brain/Neck) | 88 | Subject to the reduction of the TC diagnostic imaging (effective for services January 1, 2011, and after) |
| 06 | MRI and MRA (Spine) | 99 | Concept does not apply |
| 07 | CT (Spine) | | |



Do Not Submit Preauthorization for Radiologic Guidance Scans

Complete a preservice request when CT or MRI scans are for diagnostic imaging purposes

To determine if you need to submit a preauthorization request, consider the purpose of the Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI) scan:

- **DIAGNOSTIC IMAGING PURPOSES** – Submit a request.
- **RADIOLOGIC GUIDANCE** – Do not submit a request; codes listed below:

Preauthorization Not Required

| RADIOGRAPHIC GUIDANCE SCANS | CPT®* CODES |
|-----------------------------|---------------|
| Computerized Tomography | 77011 – 77014 |
| Magnetic Resonance Imaging | 77021 – 77022 |

For a complete list of services (and their CPT codes) that require preauthorization, visit Wellmark.com (*Providers > Medical Policies & Authorizations > Authorizations > Radiology Preauthorization > 2011 CPT Codes*).

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Keeping Up with Health Care Reform

View timely information from a provider, a member, or an employer perspective

Quickly access the latest information on the Affordable Care Act (ACA) using the new Health Care Reform section on Wellmark.com, a single point of entry for all audiences. Just click on the Capitol Dome icon in the right column from our home page.

When you need information of specific interest to providers, visit our Provider Health Care Reform page. This recently updated page is accessible through the Provider tab at the top of the new Health Care Reform page, or from the existing Provider section of Wellmark.com (Communication & Resources).

Quickly access the latest information on the Affordable Care Act (ACA) using the new Health Care Reform section on Wellmark.com



Eat & Play the 5-2-1 Way Helps You Address Adolescent Weight Issues

Visit Eatplay521.com to locate nutrition and activity information and Iowa resources

The new *Eat & Play the 5-2-1 Way* website includes:

- free educational materials and tools that focus on creative nutrition and physical activity ideas for patients and families
- an online continuing medical education module focused on motivational interviewing and supporting patients in healthy behavior change
- a list of community resources in Iowa to share with patients, including an interactive link to “Find a Registered Dietitian in your Area”

The site was recently developed by the Iowa Department of Public Health (IDPH) using AAP Pediatric Obesity 5210 Clinical Guidelines on overweight and obesity, survey and focus group responses from health care providers, and the expertise of the Health Care work group of the Iowans Fit for Life partnership at IDPH.

Evaluation of the tool will be conducted throughout 2011.

Additional Information

FOR ADDITIONAL INFORMATION ON *Eat & Play the 5-2-1 Way* visit Eatplay521.com, contact the IDPH at 515-242-5813, or send an e-mail to iowansfitforlife@idph.state.ia.us. *Eat & Play the 5-2-1 Way* was created by the IDPH with funding from Iowa Health Systems.

Improving Community Health

Wellmark donates \$84,570 to local parks and recreation departments


“A vigorous five-mile walk will do more good for an unhappy but otherwise healthy adult than all the medicine and psychology in the world.”

— *Paul Dudley White (1886-1973) American cardiologist, viewed by many medical authorities as the founder of preventive cardiology*

We know that a good walk cannot replace health care, but sometimes it's what the doctor orders. When you prescribe “a vigorous walk,” you also remind patients that their personal choices affect health outcomes.

While we can't control personal choices, we can remove possible barriers. That's why Wellmark launched its 3-Point Play program with the Division I universities in Iowa and South Dakota. As a result, six communities have a little more money to spend on their parks and recreation projects.

To find a breakdown of the donations, and a description of how some of the schools are using their funds, visit Wellmark3pointplay.com. Select the school logo, then *Find Out More*.



We know that a good walk cannot replace health care, but sometimes it's what the doctor orders.

Precertify Hospital Admissions to Avoid Benefit Reduction

Penalty begins in July for Federal Employee Program (FEP) Members

Beginning with July 1 admissions, a \$500 penalty will apply if a hospital admission of an FEP member is not precertified. Because the contracting hospital is required to precertify, the member cannot be billed for the reduction.


Requirements

Hospital precertification is required before elective admissions and following emergency admissions for all FEP members:

- › Before being admitted for inpatient care, including mental health/substance abuse admissions and admissions for other medical care
- › Within two business days following a hospital admission for emergency care
- › When a maternity stay extends beyond two days for vaginal or four days for cesarean delivery
- › For extended newborns stays

To Precertify

To begin the process:

- ›  Submit a prior approval request using our secure tools at Wellmark.com.
- › Complete, print, and fax the prior approval form located on our public site at Wellmark.com (*Providers > Forms > Prior Approval Medical Forms > FEP Medical/Surgical Prior Approval Form*).
- › Call **800-532-1537**.

Other Services Requiring Precertification

In addition to hospital admissions, the following continue to require precertification for FEP members. Please contact us before these admissions:

- › Skilled nursing
- › Hospice
- › Acute rehabilitation

More Information

Please see the “Member and Service Information” section of the *Wellmark Provider Guide* for an overview of FEP benefits. For a complete listing of services requiring precertification/prior approval for FEP reimbursement, look for the *2011 Service Benefit Plan* brochure (pages 16–17) at Fepblue.org.

If you have questions, contact our FEP Customer Service area at **800-532-1537**.

This is a summary of the features of the Blue Cross and Blue Shield Service Benefit Plan. Before making a final decision, please read this plan's federal brochure, RI 71-005. All benefits are subject to the definitions, limitations, and exclusions set forth in the federal brochure.



Send Lifestyle Prescriptions Home with Your Patients

Record nutrition, exercise, and preventive care using new online form

Save time and keep a reminder of your patient instructions by completing our new prescription form during your patient discussions. The interactive form has these benefits:

- › It's printable, enabling you to send reminders home with your patient.
- › It's readable, making it easier for patients to review at a later date.
- › It's electronic, eliminating the need to store more paper—you could even e-mail it to your patient instead of printing.

The three options focus on different needs and patient ages:

- › Adolescent Health
- › Adult Prevention/Screening
- › Adult Lifestyle Change

These forms are only available online. To locate, visit Wellmark.com (*Providers > Wellmark.com Quick Links > Forms > My Prescription for You*).

Avoid Denials:**Bill Bilateral Services on One Claim Line with 50 Modifier****Required for outpatient facility services**

Report bilateral procedures on one line with a 50 modifier on your outpatient facility claims. Bilateral procedures reported on two lines will deny as provider liability as of April 26, 2011 (process date). This applies to procedures listed with a bilateral surgery indicator of 1 in Medicare's RVU file.

This billing method is required for outpatient facility claims. Wellmark began accepting the 50 modifier on outpatient facility claims on October 1, 2010.

Find more information

To learn more, check out the Centers for Medicare & Medicaid Services' (CMS) website. You'll find the National Physician Fee Schedule Relative Value File and guidance on how to interpret the file.

To locate these materials at Cms.gov/PhysicianFeeSched/, select:

1. **PFS RELATIVE VALUE FILES** (left navigation)
2. **2011** – the most recent calendar year listed for the most current information
3. **RVU FILE** listed under “Downloads” (zipped file)
4. **PPRRVU** (choice of 2 excel documents) – look for the document's BILAT SURG column
5. **RVUPUF** (word document) – provides information to interpret the file

Change Begins May 1 for Claims with Zero Charge Lines***In most situations, outpatient facility claims should include a charge for each service billed***

To receive proper reimbursement for the services you provide, include a charge on each line of an outpatient facility claim (see *Exception* below).

If your claim has an inappropriate zero charge line:

- **PROCESS DATE BEFORE MAY 1, 2011** – The entire claim will reject with the following message: X004 – There is missing or invalid information on claim. You will need to submit a new claim that includes the missing information.
- **PROCESS DATE ON OR AFTER MAY 1, 2011** – The zero-billed lines will not be used to determine payment.

NOTE: This edit applies to all outpatient facility 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 (operating room services), 49X (ambulatory surgery care), or 75X (gastrointestinal services):

- 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.

If the primary surgery code includes one or more add-on codes, the primary and add-on code(s) must have a charge.

**Processing Recovery Room Charges****Services billed under revenue code 71x will group as one visit**

Services billed under revenue code 71x (Recovery Room) will group as one visit even if the patient's stay and subsequent billed dates of service span more than one day. This change begins with date of service July 1, 2011.

This applies to claims processed through the Enhanced Ambulatory Patient Groupings (EAPG) payment methodology. The change mirrors the process currently used by EAPG to process services that span dates billed under revenue code 45x (Emergency Room) or 762 (Observation Bed).

Hospital Claims to Process as Transfers Instead of Discharges

Update due to reevaluation of patient discharge status code definitions

Hospitals will receive the APR-DRG (All Patient Refined Diagnosis Related Groups) specific transfer per diem instead of a case payment for most claims submitted with patient discharge status code 05, 43, or 65. This will be effective with dates of service July 1, 2011.

Wellmark updated its payment methodology based on the codes' definitions below.

| PATIENT DISCHARGE STATUS CODE | DEFINITION |
|-------------------------------|--|
| 05 | Discharged/Transferred to a Designated Cancer Center or Children's Hospital (updated definition) |
| 43 | Discharged/Transferred to a Federal Health Care Facility |
| 65 | Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital |

Update Filing Process: Submit One Claim per Date of Service

Change affects outpatient facility claims processed through EAPG

If a patient visits your outpatient facility multiple times on the same day, Wellmark will require one claim beginning with services provided on or after July 1, 2011.

If you submit more than one claim:

- Wellmark will pay one claim and deny subsequent claims.
- You will need to submit an adjustment to the paid claim for additional payment consideration.

NOTE: These claims will not require an admission hour after July 1.

This information applies only to claims processed through the Enhanced Ambulatory Patient Groupings (EAPG) payment methodology.

Exceptions

Please review the following exceptions:

- Outpatient series bills
- Preventive screening services when also providing services on the same day that are related to an illness or injury

Watch for additional communication about July 1 billing changes.



How to Bill Discarded Drugs, Biologicals

Professionals and facilities may have two options with the same payment results

Beginning with claims processed on or after May 31, 2011, Wellmark will process discarded drug and biological units when identified with modifier JW (see examples).

JW – Drug amount discarded/not administered to any patient

Examples of Correct and Incorrect Billing

Drug and biological code descriptions include dosage descriptions. Depending on the drug, **one service unit** may represent any of several doses, such as 5 mg, 25 mg, or greater.

When you administer a dose that is less than a billing unit, you cannot bill the discarded amounts separately.

CORRECT: A single-use vial contains 100 units of a drug. You administer 95 units and discard 5 units. Your Wellmark reimbursement will be the same, regardless of how you bill.

- Identify units separately:
 - 95 units of service (administered amount)
 - 5 units of service (discarded amount) with the JW modifier

OR

- Bill 100 units of service (administered and discarded portions combined) *without* the modifier.

INCORRECT: A single-use vial contains 1 unit of a drug. You administer a 7 mg dose and discard 3 mg. You must bill the 7 mg dose as 1 unit of service. Because that unit of service represents the full 10 mg dose, you cannot bill another service unit separately with a JW modifier.

Use KX Modifier to Identify Medically Necessary PAP Devices

Required to identify members who meet medical policy requirements

When submitting a claim for a medically necessary positive airway pressure (PAP) device, include the modifier if appropriate.

| MODIFIER | DEFINITION |
|----------|--|
| KX | Requirements specified in the medical policy have been met |

By including the KX modifier on your claim for a positive airway pressure (PAP) device, you signify:

- › Our member meets the medical necessity requirements as specified in our medical policy.
- › You would be able to, if asked, supply the documentation supporting the medical necessity based on our medical policy guidelines.

A summary of our current medical policy requirements for PAP follows:

- › Continuous positive airway pressure (CPAP) may be considered medically necessary in adult or pediatric patients with clinically significant obstructive sleep apnea.
- › Bilevel positive airway pressure (BiPAP) or auto-adjusting CPAP (APAP) may be considered medically necessary in patients with clinically significant obstructive sleep apnea who have failed a prior trial of CPAP.

To locate the most current medical policy information, including our requirements for sleep studies and related treatment, refer to our medical policies at Wellmark.com. Look for “Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome and Upper Airway Resistance Syndrome” (*Provider > Medical Policies & Authorizations > Medical Policy*).

You’ll also find iCAP Specialty Policies on our Payment Policy Web page for CMS-1500 billers.

When Outpatient Facility Therapy Claims are Eligible for Review

EAPG payments consolidate physical, occupational, and speech therapy services

When therapy services are processed through the Enhanced Ambulatory Patient Grouping (EAPG) payment methodology, consolidated lines are not eligible for additional review and payment. This includes physical, occupational, and speech therapy services billed on a hospital outpatient claim.

EAPG payment is determined based on the amount and type of resources used in an ambulatory visit. Patients in each EAPG have similar clinical characteristics and similar resource use and cost. This means that the same therapy lines consolidate for all patients within a particular grouping, regardless of individual variations.

Identify Consolidated Services Ineligible for Review

Line messages M376 identifies consolidated therapy services within the EAPG payment methodology. We do not review therapy services denied with M376.

| CODE | DENIAL MESSAGE |
|------|---|
| M376 | Procedure packaged due to consolidation of same significant procedure or clinical significant procedure |

Physical or Occupational Therapy Services Eligible for Review

Therapy services denied with M003 can be reviewed to determine if additional care should be covered. This message identifies physical or occupational therapy visits exceeding our medical necessity threshold.

| CODE | DENIAL MESSAGE |
|------|---|
| M003 | Care exceeds the established guidelines |

For many members,¹ Wellmark covers up to 20 visits in a calendar year before requiring a medical necessity review. Unless an approved physical medicine treatment plan is on file, services exceeding that number will deny.

Information at Wellmark.com

- › **EAPG RESOURCES:** Provider > Communication & Resources > Claims & Payment > Enhanced Ambulatory Patient Grouping (EAPG)
- › **PHYSICAL MEDICINE TREATMENT PLAN:** Provider > Communication & Resources > Physical Medicine Form
- › **PHYSICAL MEDICINE GUIDE:** Provider > Communication & Resources > Billing Guides

¹Members have different benefits.

Seeking Your Feedback for Draft iCAP Specialty Policies

Mail or e-mail comments before the deadline

To send Wellmark your comments about the following professional (CMS-1500) and outpatient (UB-04) draft policies, e-mail iCAPSpecialtyPolicies@wellmark.com, or write:

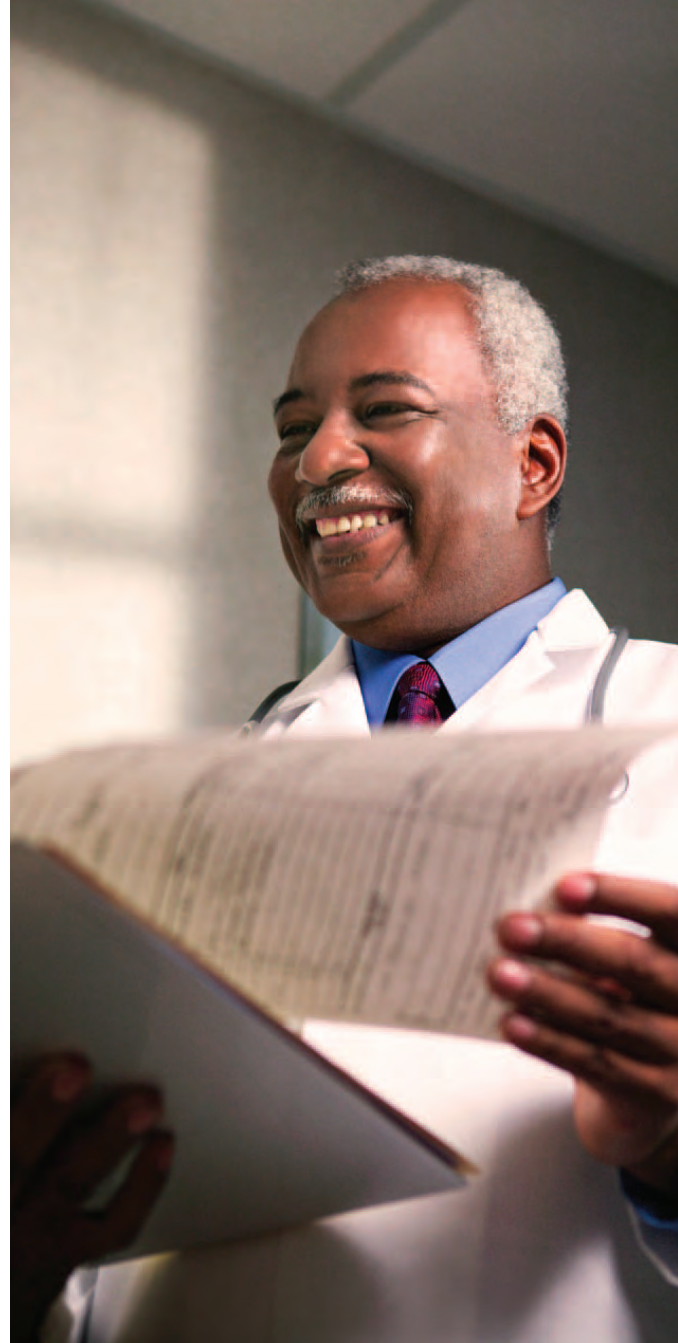
iCAP SPECIALTY POLICIES

Wellmark Blue Cross and Blue Shield
 PO Box 9232
 Des Moines IA 50306-9232
FAX: 515-376-9041

You'll find the draft policies on our secure Provider website under Payment Policies at Ebusiness.wellmark.com/provider/BlueConnection/welcome.htm. To request a paper copy, contact us at the address above.

| iCAP POLICY | PROFESSIONAL/ OUTPATIENT | DATE OF SERVICE EFFECTIVE | DEADLINE FOR COMMENTS |
|---|-----------------------------|---------------------------|-----------------------|
| Supplement to Multiple Procedure Reduction Policy | Professional | July 1, 2011 | June 15, 2011 |
| Surgical Pathology | Professional and Outpatient | September 1, 2011 | August 15, 2011 |
| E/M Service with Anesthesia Services | Professional | September 1, 2011 | August 15, 2011 |
| Kidney Disease Patient Education Services | Professional and Outpatient | September 1, 2011 | August 15, 2011 |

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Save Time: Correct Institutional Claims Electronically

Include the type of bill on 837 Institutional transmissions to assure accurate processing

AS OF MAY 1, 2011, institutional claim corrections will not require a completed provider inquiry form. Simply file the corrected claim electronically using one of the following as the final digit of the claim's type of bill:

Final Digit, TOB

| TOB | WHEN TO USE |
|-----|----------------------------|
| 5 | Late Charges Only Claim |
| 6 | Adjustment of Prior Claim |
| 7 | Replacement of Prior Claim |
| 8 | Void/Cancel of Prior Claim |

NOTE:

- The type of bill must be appropriate to the claim and the change. For example, the final digit of "5" means late charges only; no other charges can be listed on the claim.
- Claims originally submitted on paper may be corrected electronically.
- Corrected claims submitted on paper need to be attached a completed provider inquiry form.

Save Time by . . . Waiting

Denials, delays due to duplicate Medicare secondary claims

You can eliminate unnecessary filing costs and receive reimbursement sooner when you wait for us to process Medicare crossover claims. Not only will you reduce the number of claims we process, you'll reduce the time your staff spends researching denied claims and inquiries from confused patients.

If your Medicare remittance indicates that a claim was sent to a Blue Plan, please allow approximately 20–30 business days for the secondary claim to process. Do not bill Wellmark unless:

- You receive a written confirmation from Medicare that the claims will not be crossed over.
- You receive a special notification letter explaining why specified claims cannot be crossed over.
- Your remittance does **NOT** indicate that the claim was forwarded.

How Many Duplicate Claims Does Wellmark Receive?

Wellmark receives more duplicate claims than you might think. (Compare your guess with the real answer in the article “What’s Our Most Popular Denial Message?” on page 13.)

Now, you’ll be able to locate those that are duplicates of a Medicare crossover claim with our new denial message. This message is being used for Wellmark, Federal Employee Program (FEP), and BlueCard® members:

| CODE | NEW DENIAL MESSAGE (PCR) |
|------|--|
| U332 | This claim is a duplicate of a Medicare crossover claim. |

If you notice a large number of claims denying with this message code, check with your billing department or vendor to identify process improvement opportunities.

To Locate Pending Claims Before Submitting

To determine a Wellmark, FEP, or BlueCard claim’s status, use our secure tools at Wellmark.com:

1. Enter the specific claim information on the secure Home page and select Claim Status. If you prefer to see a list of your pending claims, select the Check a Claim link.
2. Look for the column titled “Claim Status.”
3. Select the claim for more information
 - **PENDE CLAIMS:** locate a general description of why the claim is waiting to be processed
 - **FINALIZED CLAIMS:** view additional processing information, including member responsibility

To view this information, you must have access to the “Claim Status Inquiry User” role. Please see your Designated Security Coordinator if you need to expand your access.

If a Claim Needs to be Submitted

You should rarely need to submit a claim that has crossed over from Medicare to the secondary insurer. If you do, submit your claim electronically.

Medicare Secondary Electronic Claims

| ELECTRONIC SUBMISSION GUIDELINES | INFORMATION |
|---|--|
| Submit Payer/Receiver ID 88848MC in the ISA08 and GS03 segments | Claims submitted with an incorrect Payer/Receiver ID will reject with Edit 0028 – “Medicare COB, contact ECS at (800) 407-0267.” |
| Submit these claims in a separate transaction. | |

If you file paper claims, submit your claim with the detailed Medicare Remittance Notice. Your submission must include the Medicare dollar amounts and Medicare CAS codes (explanation of Medicare denials or cuts). We do not accept Medicare Summary Notices.



To Find More Information

For more electronic filing details and paper claim requirements, see pages 14–15 of the Claims Filing section of the Wellmark Provider Guide at Wellmark.com (*Providers > Wellmark.com > Quick Links > Billing Guides*). You’ll also find electronic filing information in our HIPAA-AS Wellmark Companion Guides (*Claims & Payment > Electronic Transaction/HIPAA Guides > 837 COB*).



How Noncovered Services Process

Corrected information: Services billed on practitioners' claims deny as member liability

We recently published code updates of noncovered items or supplies. Please review the following corrections to the information provided.

February 2011, page 3

- › Codes listed deny as member liability when billed on a practitioner claim.
- › Codes process as part of a significant procedure when billed on a facility claim and are not member liability.

Claims processed according to the guidelines above.

October 2010, page 10

- › Codes listed deny as member liability when billed on a practitioner claim.
- › Codes process as part of a significant procedure when billed on a facility claim and are not member liability.

We started denying these services as member liability beginning with process date December 18, 2010.

Facility claims with one of these codes (reprinted below) processed incorrectly. We will reprocess affected facility claims to determine correct payment and member liability. You do not need to submit a request for a review.

NONCOVERED CODES

| | | |
|-------|-------|-------|
| A4450 | A6412 | A6456 |
| A4452 | A6413 | A6457 |
| A4455 | A6441 | A7018 |
| A4456 | A6442 | A9152 |
| A4465 | A6443 | A9153 |
| A4466 | A6444 | A9155 |
| A4470 | A6445 | A9180 |
| A4480 | A6446 | E0160 |
| A4601 | A6447 | E0161 |
| A4630 | A6448 | E0162 |
| A4637 | A6449 | E0200 |
| A4639 | A6450 | E0205 |
| A4660 | A6451 | E0210 |
| A4663 | A6452 | E0215 |
| A4670 | A6453 | E0217 |
| A6410 | A6454 | E0605 |
| A6411 | A6455 | E1310 |



What's Our Most Popular Denial Message?

Last June, more than 38,000 claims denied for this reason—and it's always #1

Wellmark receives hundreds of thousands of duplicate claims each year. It's the number one reason we deny claims—and it's not just an issue with Medicare-related claims (see page 12).

If resubmitting claims unnecessarily is causing your staff needless work, time, and expense, today may be a good day to review your process for resubmitting claims.

When should you resubmit a claim?

Once you file a claim with Wellmark, you should never need to resubmit it. However, sometimes an initial claim has incomplete or inappropriate information, requiring you to update the claim and send it in as you would a brand new claim:

- › **IF YOU FILE ELECTRONICALLY**, you'll know quickly if your claim needs to be corrected and resubmitted because it will appear on your Z16 report under Claim Error Report.
- › **IF YOU FILE PAPER CLAIMS** and your remittance message instructs you to submit the claim a second time, simply update the information and send us the claim. To avoid processing delays, do not mark your claim as resubmitted or corrected.

Otherwise, do not resubmit a claim unless you are sure that Wellmark did not receive your initial submission. Learn how to use our secure tools and determine if a claim is being processed by reading *Save Time by . . . Waiting* on page 12.

Sustaining Health Care Costs with Step Therapy

Coverage requires members to try other options first

Please review the following updates for coverage of prescription allergy drugs and tetracyclines. If you have questions about the changes, contact Wellmark's Pharmacy Service at 800-600-8065.

Allergy Drugs – Effective March 15, 2011

Members are required to try alternative over-the-counter (OTC) allergy drugs to be eligible for coverage of Clarinex, Clarinex-D, Xyzal, or one of their respective generics:

- › **CLARINEX:** OTC attempts required for all members who use Clarinex
- › **XYZAL:** OTC attempts not required for members using the drug before March 15

If you determine that the available OTC drugs were ineffective, submit a prior authorization requesting coverage.

Why the Change?

Allegra is now available as an OTC drug. The change provides our members with convenient access to three effective OTC medication treatments of allergy symptoms: Allegra/D, Claritin/D, and Zyrtec/D. Patients may also reduce out-of-pocket costs at the pharmacy by taking an OTC product.

Tetracyclines – Effective April 15, 2011

All members must try the following generic without success before we will consider coverage of:

- › **ADOXA** – doxycycline
- › **DORYX** – doxycycline
- › **ORACEA** – doxycycline
- › **SOLODYN** – doxycycline *and* minocycline

If you believe that a generic is inappropriate for a member to try, submit a prior authorization requesting coverage so we can review for benefits. If a Wellmark member tries a generic and you determine the drug is ineffective, you do not need to submit a prior authorization request as long as the generic drug(s) were filed with us.*

Why the Change?

There is no clinical evidence that brand-name tetracyclines are superior to generic doxycycline and minocycline. Also, the cost of brand tetracyclines has been steadily rising. By prescribing generic medications to your patients, you contribute to sustaining health care costs, and could assist your patients in lowering their out-of-pocket costs.

The chart below compares costs of the brand with costs of generic tetracyclines.

Tetracycline Products: Drug, Average Cost

| DRUG: BRAND (GENERIC) | AVERAGE COST/RX |
|---|-----------------|
| Adoxa (doxycycline monohydrate) | \$510.47 |
| Doryx (doxycycline hyclate) | \$453.55 |
| Dynacin/Minocin (minocycline) | \$34.71 |
| Monodox (doxycycline monohydrate) | \$35.87 |
| Oracea (doxycycline) | \$363.75 |
| Oraxyl (doxycycline hyclate) | 8.26 |
| Solodyn (minocycline ER) | \$673.60 |
| Tetracycline (tetracycline) | \$6.29 |
| Periostat/Vibramycin (doxycycline hyclate) | \$8.26 |

Boldface = all strengths generically available

**Wellmark will not have record of a generic prescription when a Wellmark member has prescription coverage with another health care provider, or if the member receives a sample from your office. Submit a prior authorization in these instances.*



Wellmark.com Resources

Wellmark.com Resources

- › **STEP THERAPY PROGRAMS:** Provider > Medical, Dental, & Pharmacy > Pharmacy > Special Pharmacy Programs > Step Therapy
- › **PRIOR AUTHORIZATION/TREATMENT REQUEST FORMS:** Provider > Communication & Resources > Forms
- › **WELLMARK DRUG LIST:** Provider > Medical, Dental, & Pharmacy > Pharmacy > Wellmark Drug List



Pharmacy Corner:

Reduce Follow-up When Prescribing Drugs

Take care of prior authorizations when the patient is in the office to eliminate calls to your staff

Visit Wellmark.com (*Provider > Communication & Resources > Forms*) for a list of the drugs that require prior authorization.

To request a prior authorization, complete, print, and fax the form to the number provided. Each form includes:

- › Information needed for us to make a coverage decision
- › Resource for questions
- › Associated Utilization Management Prior Authorization (UMPA) or medical policy information*

Turnaround time is typically three business days.

**Those marked with an asterisk also have an associated medical policy. The medical policy is typically listed by the generic name. You'll find our medical policies online (*Provider > Medical Policies & Authorizations > Medical Policies*).*

Change in Prescription Mail Service Vendor

You may need to write a prescription for some patients

Because Wellmark is changing mail order pharmacy vendors, you may be asked to write a new prescription for some of your patients. The transition from Walgreens Mail Service to Immediate Pharmaceutical Services (IPS) is effective July 1, 2011.

In most cases, prescriptions will transfer from Walgreens to IPS, as long as the member has registered with IPS.* Since the following are considered non-transferable, members will be required to obtain new prescriptions for:

- › Expired prescriptions
- › Prescriptions with no refills remaining
- › Controlled substances
- › Compounded medications

**All members using mail-order pharmacy services are required to register with IPS. Members may access registration information and prescription order forms from the IPS website at Ipsrx.com.*



Wellmark is changing mail order pharmacy vendors; you may be asked to write a new prescription for some of your patients.



Change Affects Compound Drugs with Non-FDA Approved Bulk Chemical Powders

Your patients may ask your advice about acceptable alternative medications

Compounds containing non-FDA approved bulk chemicals are no longer covered under Wellmark's prescription drug coverage. Our members have been responsible for the entire cost of such drugs since April 15, 2011.

Often, the same medication is available in capsules, tablets, or liquid form. Our members should ask their pharmacists for an FDA-approved alternative form.

We sent letters about this change to members who previously filled a prescription containing a non-FDA approved bulk chemicals.

Note Recent Medical Policy Revisions and Additions

Review medical necessity guidelines changes that may affect your practice

For quick reference, check the following summary of Wellmark's recent medical policy changes. Because this is a summary, we encourage you to review complete information about a policy at Wellmark.com (Provider > Medical Policies & Authorization).

New Policies

- › Cooling Devices (see article on the following page)
- › EGRIFTA™
- › Epidermal Growth Factor Receptor
- › Fecal Calprotectin Testing
- › Injectable Clostridial Collagenase (Xiaflex™) for Fibroproliferative Disorders

Revised Policies

Bariatric Surgery for Morbid Obesity*

UPDATED:

- › Adjustable gastric banding (Lap Band procedure)
Consistent with FDA-expanded label indications for the Lap-Band® System, we have revised our criteria to consider the procedure medically necessary for those with BMIs over or equal to 30 mg/kg² and one comorbid condition. Members must also meet the policy's general criteria.

Cancer Clinical Trials

REMOVED: Prior approval recommendation.

Ozurdex®/Dexamethasone Intravitreal Implant

ADDED:

May be considered medically necessary for the treatment of:

- › macular edema occurring after branch retinal vein occlusion
- › macular edema occurring after central retinal vein occlusion
- › non-infectious uveitis affecting the posterior segment of the eye

Ozurdex®/dexamethasone intravitreal implant for any other indication, including the treatment of diabetic macular edema, is considered investigational because of insufficient evidence of its effectiveness.

Electrical/Magnetic Neuro Stimulators

ADDED:

Transcranial Magnetic Stimulation (TMS) to the list of stimulators included in the medical policy:

- › TMS: TMS is a noninvasive method of delivering electrical stimulation to the brain. A magnetic field is delivered through

the skull, where it induces electric currents that affect neuronal function. Repetitive TMS (rTMS) is being evaluated as a treatment of depression and other psychiatric/neurologic brain disorders.

TMS is considered investigational as a treatment of depression and other psychiatric/neurologic disorders.

Pneumatic Compression Devices

ADDED:

- › Lymphedema: Pneumatic compression devices for the treatment of lymphedema may be considered medically necessary if the patient has undergone a four-week trial of conservative therapy, and the physician determines there has been no significant improvement or if significant symptoms remain after the trial.
- › Chronic Venous Insufficiency With Venous Stasis Ulcers: Pneumatic compression devices for the treatment of chronic venous insufficiency with ulcers may be considered medically necessary if the patient has one or more venous stasis ulcers which have failed to heal after a six-month trial of conservative therapy.

THE FOLLOWING REMAINS UNCHANGED:

- › Peripheral Arterial Disease: Pneumatic compression devices for the treatment of peripheral arterial disease are considered investigational.

Proton Beam Radiation Therapy

ADDED:

Proton beam therapy as a treatment for non-small cell lung cancer (NSCLC) is considered investigational.

Radioimmunotherapy for Non-Hodgkin's Lymphoma:

Ibritumomab Tiuxetan (Zevalin®) and Tositumomab (Bexxar®)

ADDED: To list of investigational uses of Zevalin® and Bexxar®: including when used as part of a preparatory regimen prior to hematopoietic stem cell transplantation in patients with non-Hodgkin's lymphoma.

Rituximab*

ADDED:

To list of medically necessary indications:

- › Treatment of antineutrophil cytoplasmic antibody (ANCA)-associated vasculitides (e.g., Wegner's granulomatosis, renal vasculitis, microscopic polyangiitis, Churg-Strauss syndrome)
- › As single-agent maintenance therapy in patients with follicular, CD20-positive, B-cell NHL who have achieved a complete or partial response to Rituxan in combination with chemotherapy

* Prior approval recommended.

Change in Processing of Cooling Devices

Cooling devices will deny as provider liability with introduction of new medical policy

Wellmark will deny cooling devices as not medically necessary beginning with date of service **October 1, 2011**. As a participating provider, you cannot bill Wellmark members for these devices beginning October 1.

Until the medical policy is effective, however, Wellmark will deny cooling devices as member liability.

If your patient wishes to assume financial responsibility for the item, you must obtain a patient waiver. Without a waiver, you cannot bill a Wellmark member. You'll find waiver criteria on pages 2 and 3 of the "Claims Filing" section of the *Wellmark Provider Guide* at Wellmark.com (*Provider > Quick Links > Billing Guides*).

We will post the medical policy with more details early this fall at Wellmark.com (*Provider > Medical Policy > Cooling Devices*).

Description of Cooling Devices

Cooling devices use chilled water to decrease the local temperature of tissue. These devices are typically used when ice packs would normally be applied, e.g., after musculoskeletal or soft tissue injuries and orthopedic surgical procedures.

Examples of active and passive cooling devices:

- > AutoChill®
- > Hot/Ice Thermal Blanket
- > Game Ready™ Accelerated Recovery System
- > CryoCuff®
- > Polar Care Cold Therapy Products

Filing a Claim

When filing a claim, please use the appropriate codes:

| CODE | DEFINITION |
|-------|--------------------------------------|
| E0218 | Water circulating cold pad with pump |
| E0236 | Pump for water circulating pad |

Avoid Claim Payment Delays Use Correct Alpha Prefix

Read identification cards carefully to distinguish small differences

BlueCard® claims are denied when an incorrect alpha prefix is submitted. When the right alpha prefix is on the claim, the correct Blue Plan is contacted for member benefits.

Incorrect alpha prefixes can also cause your claims for Wellmark members to deny.

Tips

- > **PATIENT DETAILS** are used to determine if the correct identification number was used.
 - The patient name and date of birth must match the member record.
 - The complete date of birth must be provided, including the century (e.g., 05/01/1965).
- > **ALPHA PREFIXES** include three alpha characters and no numbers.
 - *Example:* University of Iowa members' alpha prefix was recently changed to **XQW**. The previous alpha prefix included a letter that was often misidentified as the number one.
- > **CERTAIN CHARACTERS** are more challenging to identify.
 - *Example:* Gerdau Ameristeel members have coverage with the Illinois Plan. Their alpha prefix includes a middle character of **Q**: GQX and GQY. Their claims are being *misfiled* with an **O**: GOX and GOY.
- > **FEDERAL EMPLOYEE PROGRAM (FEP)** members have a unique identification number.
 - These numbers begins with "R" and are eight digits long.



Reactivate Secure Account to Maintain Access

You will need to reapply unless the Designated Security Coordinator (DSC) updates and approves secure users

By periodically reviewing and updating the list of users who have been granted secure access to our site, you help safeguard protected information for your organization.

Key Dates

- **ACCOUNTS NOT RECERTIFIED** in April were disabled effective May 1.
- **DISABLED ACCOUNTS** can be reactivated by sending an e-mail requesting reactivation within 60 days—before June 30. Include both the organization name and taxpayer identification number in the body of your e-mail and send to websecurity@wellmark.com.
- **ONCE REACTIVATED**, the DSC must recertify the account by immediately following the steps below.

To recertify, the main DSC for your organization must follow these steps:

1. Access our secure provider site at Wellmark.com.
2. Select *Certify User Information* link.
3. Review and update the list of users.
4. Select “I accept.”

For assistance with recertification, or to reassign the main DSC of an organization, e-mail Wellmark’s Web Security at websecurity@wellmark.com.

Learn about Electronic Transactions, Online Self-Help Tools

Registration required to attend teleconferences scheduled for May and June

Discover more about electronic reports, 5010 testing, online self-help tools, and related topics by attending one of our teleconference sessions. As time permits, the teleconference will include a general question and answer session.

To attend, register at least 48 hours in advance of the session you wish to join. Once registered, you will receive an e-mail with materials and the teleconference phone number.

Teleconference Schedule

Material covered will be the same at each session.

| 2011 DATES | TIME — 1.5-HOUR SESSIONS |
|-------------------|--------------------------|
| Wednesday, May 18 | 10 – 11:30 am |
| Thursday, May 19 | 2 – 3:30 pm |
| Tuesday, May 24 | Noon – 1:30 pm |
| Thursday, June 2 | 1 – 2:30 pm |
| Tuesday, June 7 | 10 – 11:30 am |
| Wednesday, June 8 | 9 – 10:30 am |

To register, visit Wellmark.com (*Providers > Communication & Resources > Education > Electronic Transaction Teleconference*).

If you have questions, call EC Solutions at 800-407-0267, Monday – Friday, 7 a.m. – 5:30 p.m.



Educational Option Covers Payment Change for Freestanding SNFs

Register online to participate in the June 15 conference call

Effective July 1, 2011, outpatient services at freestanding skilled nursing facilities (SNFs) will process through the Enhanced Ambulatory Patient Grouping (EAPG) payment system, while inpatient services will be reimbursed using a Per Diem payment method.

To help your coding and billing staff prepare for the changes, Wellmark will hold an educational conference call on Wednesday, June 15, 2011. The session will begin at 11 a.m. and end by 1 p.m., Central time.

Registration

REGISTRATION IS REQUIRED. Register at Wellmark.com (*Provider > Communication & Resources > Education > EAPG Conference Call for Freestanding SNFs*) if you have not already registered by mail or fax.

Registrants will receive the conference call number and handouts via e-mail the Monday preceding the call.

Learn More about TRICARE at Live Seminar

Register today for upcoming Medical/Surgical Seminar; seating limited

For the latest information on TRICARE programs, policies, and procedures, attend the spring and summer educational sessions. To register, look for the *Stay Updated* section of Triwest.com/provider.

- › For those new to TRICARE, these seminars are a great opportunity to learn about the TRICARE program.
- › For those who have previously attended, a seminar serves as a good refresher.

If you have recently attended a seminar and feel comfortable with the TRICARE program, consider sending another team member or bring a less experienced coworker with you.

There is no charge to attend.

Seminar Dates

There are two medical/surgical seminars scheduled for June in Iowa and South Dakota:

- › **JUNE 28** – Des Moines
- › **JUNE 30** – Rapid City

If you are unable to attend a live seminar, consider registering for a webinar or taking an eSeminar course at Triwest.com/provider.

What to Expect

When you attend a seminar, you will receive:

- › the newest Provider Handbook and Quick Reference Guides.
- › updates on the latest enhanced functionality of the secure provider portal.

The seminars, presented by TriWest Healthcare Alliance Corp. (TriWest) staff, last approximately 2.5 hours. End times may vary based on audience participation.

Benefits of Online Registration

Registering online is the most convenient way to preregister, and includes these benefits:

- › Immediate e-mail confirmation of your registration
- › Reminder e-mail notice prior to your scheduled seminar
- › Eligibility to participate in a drawing for a small prize at the seminar

Questions

Please e-mail pseminar@triwest.com if you:

- › have questions about the content of the seminars
- › have questions about registration
- › need to change your registration
- › wish to register six or more people from your practice or facility



Receive Efficient TRICARE Communication via E-mail

Avoid time delays and eliminate paper by sharing your e-mail address with TriWest

When TriWest Healthcare Alliance has your e-mail address, you'll receive a TRICARE eNewsletter every 2–3 weeks along with the information you need to:

- › **RECEIVE REIMBURSEMENT** quickly and efficiently.
- › **HELP YOU CARE** for TRICARE beneficiaries, including active duty Service members who may have recent combat experience.
- › **KEEP ABREAST** of educational opportunities in your community.
- › **UNDERSTAND** the TRICARE program and TriWest processes.

Register

Share your e-mail address with TriWest by completing one of the following:

- › Registering for the secure website at Triwest.com/provider.
- › Signing up for the TRICARE eNews at Triwest.com/provider.
- › Providing your e-mail address to a TriWest representative when calling 888-TRIWEST.
- › Responding to any e-mail request to complete your online profile for purposes of e-mail communications.

TriWest will not sell or distribute your e-mail address to other companies, and will not send spam e-mails or overload your e-mail accounts.



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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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Wellmark Activates New South Dakota Fax Numbers

Ensure your faxes are received; stop using fax numbers with area code 605

If you fax information to a specific individual or area located in our South Dakota office using area code 605, please check for an updated number before faxing your documents. Wellmark has now changed all local fax numbers in our Iowa and South Dakota locations, and will finish disconnecting old fax numbers soon.

You can identify new fax numbers for all Wellmark locations, including South Dakota, using this format: 515-376-9xxx. You may continue using toll-free numbers (800, 888, 877); these numbers did not change.

Reminders:

- **ACCESS FORMS AS YOU NEED THEM** at Wellmark.com (*Providers > Forms*) to assure you're using the most current form.
- **DISCARD FORMS COPIED FROM OLD ORIGINALS**, and delete old versions saved to your computer.
- **USE CONTACT INFORMATION ON EACH FORM** to ensure prompt delivery to the correct area.
- **UPDATE OLD NUMBERS** stored on your fax machine today.

To access commonly used contact information for South Dakota providers, including fax and phone numbers, visit Wellmark.com (*Providers > Have a Question for Us? > South Dakota Provider Contacts*).

If you occasionally fax items to one of the following areas in South Dakota, note the toll-free number or the new fax number listed and the number it replaces.

- **CUSTOMER SERVICE:** 515-376-9098 (replaces 605-373-7231)
- **BLUECARD®:** 877-505-3298 or 515-376-9097 (replaces 605-373-7279)
- **TYSON:** 800-590-1812 (discontinuing 605-373-7288)
- **NETWORK RELATIONS:** 888-517-9419 or 515-376-9039 (replaces 605-373-7498)