

What is the status of  
your HIPAA 5010 testing?

PAGE 2

Change affects medical policy  
effective July 1

PAGE 3

# Blueink

June 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

Providing acute care  
discharge date helps patient

PAGE 6

Improving compliance by reducing  
costs with Asmanex<sup>®</sup> or Qvar<sup>®</sup>

PAGE 10

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

Current Procedural Terminology (CPT) is copyright 2010 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT<sup>®</sup> is a registered trademark of the American Medical Association.

M-2164 06/11 PC11010

## Table of Contents

### EDUCATION & TRAINING

Select a TRICARE® Educational Option that Fits Your Needs . . . . . 3

Prepare Your Office by Attending Electronic Transaction Teleconference . . . . . 3

### MEDICAL POLICY

Change Affects Medical Policy Effective July 1 . . 3

Note Medical Policy Updates . . . . . 4

Claims to Process Using New Vitamin D Testing Medical Policy . . . . . 4

### ADMINISTRATION & POLICY

What Happens when Patients Call? . . . . . 5

Providing Acute Care Discharge Date Helps Patient . . . . . 6

Statement of Intent on Health Management Decision-Making Policies . . . . . 6

Wellmark Utilization Management Decisions . . 6

Service Options Available During Holidays . . . 6

### CLAIMS & CODING

Benefits for School or Sports Physicals Determined by Care Provided . . . . . 7

Changes for Outpatient Claims . . . . . 7

Avoid Unnecessary Outpatient Facility Denials . 7

Receive Correct Reimbursement by Using Appropriate Surgical Modifiers . . . . . 8

Seeking Your Feedback for Draft iCAP Specialty Policies . . . . . 9

Services Payable in Outpatient Setting . . . . . 9

### PHARMACY

Pharmacy Corner: Improving Compliance by Reducing Costs with Asmanex® or Qvar® . . . . 10

Prescribing Colcrys™ at a Lower Cost-Share . . 10

Keeping Current with Wellmark Drug List Changes . . . . . 10

### TRICARE

Improve Your Knowledge of the TriWest Website . . . . . 11

### IOWA ONLY

PCP After-Hours Arrangements Checked Yearly . . . . . 11

### SOUTH DAKOTA

Health Insurance Mandate Affects Member Liability . . . . . 12

## FEATURE

# What is the Status of Your HIPAA X12 Version 5010 Testing with Wellmark?

## Electronic transactions must be in new format by January 1, 2012

**Have you begun testing with your vendors, billing service or clearinghouse? If not, please contact them immediately to confirm their HIPAA X12 5010 readiness and get a testing plan in place.**

Federal regulation mandates that current transaction standard version 4010A1 be replaced with the new version 5010 by **January 1, 2012**. At that time, you or your vendors, billing service, or clearinghouse and Wellmark and other health insurance payers must use HIPAA X12 version 5010 for electronic transactions.

### Testing for 837P and 837I transactions

- ▶ Wellmark continues to test files for 5010 medical claims transactions (837P and 837I) including the June 2010 addenda.
- ▶ Following the CMS testing guidelines, Wellmark recommends testing a minimum of 25 claims and receiving a 100 percent acceptance rate for the transaction summary (.txn report), and a 95 percent acceptance rate for Wellmark's acceptance report (.Z16 report).
- ▶ **Wellmark anticipates being able to start accepting HIPAA X12 version 5010 production files on August 1, 2011, from providers who have successfully completed testing.**

### Testing for additional transactions

Testing of additional HIPAA X12 version 5010 transactions, including 270/271, 276/277 and 278, as well as 837D and 835, will begin later this summer. Please watch for updates to be posted on Wellmark.com (*Provider > Claims & Payment > HIPAA 5010*).

If you need information regarding steps to complete prior to testing, please refer to the HIPAA 5010 page on Wellmark.com (*Provider > Claims & Payments > HIPAA 5010*).

**Learn More** 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

## Select a TRICARE® Educational Option that Fits Your Needs

Learn about the program throughout the year, whether you're a new or experienced staff member

Benefit from TRICARE® training that suits your learning style and meets your time constraints when selecting an option offered by TriWest Healthcare Alliance (TriWest).

There is no charge for the following training options. Visit [Triwest.com/provider](http://Triwest.com/provider) for details.

### Live Seminars

Live seminars provide face-to-face contact with a live instructor. Each medical/surgical session is approximately 2.5 hours long.

- › June 28 – Des Moines
- › June 30 – Rapid City

Register in advance at [Triwest.com/provider](http://Triwest.com/provider).

### eSeminars

eSeminars allow you to learn at your own pace in the comfort of your own office, home, or any other location with Internet access.

To take an eSeminar, you need headphones or speakers on your computer.

### Webinars

Save travel time and enjoy the benefit of a live instructor when you access an interactive webinar. Attendees can ask questions during the session.

In addition to a computer, you'll need a phone for the conference call.

**Learn More** For more information and schedules, visit the *Stay Updated* section of [Triwest.com/provider](http://Triwest.com/provider).

"TRICARE" is a registered trademark of the TRICARE Management Activity. All rights reserved.

## Prepare Your Office by Attending Electronic Transaction Teleconference

Discover the latest about 5010 testing, electronic reports, Wellmark's self-help tools, and other topics

With the mandated change to HIPAA X12 Version 5010 only six months away, now is the ideal time to attend an educational session about electronic transactions. Bring your questions about 5010 testing or any other electronic transaction, as each session includes time for questions and answers.

### Preregistration

Preregistration is required at least 48 hours in advance of the educational session you wish to join. Once registered, you will receive an e-mail with the materials and the phone number you'll need to participate.

#### Teleconference Schedule – Summer 2011

SESSION DATES	TIME
Wednesday, August 24	10 a.m. – 11:30 a.m.
Thursday, August 25	2 p.m. – 3:30 p.m.
Tuesday, August 30	11 a.m. – 12:30 p.m.
Wednesday, August 31	1 p.m. – 2:30 p.m.
Wednesday, September 7	10 a.m. – 11:30 a.m.
Thursday, September 8	9 a.m. – 10:30 a.m.

*The material covered will be the same in each session.*

To register, visit [Wellmark.com](http://Wellmark.com) (*Provider > Communication & Resources > Education*).

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



## MEDICAL POLICY Change Affects Medical Policy Effective July 1

### Wellmark adopts InterQual® criteria

Stating July 1, 2011, InterQual Criteria will be used to support Wellmark's medical policy.

- › If you have already received a prior approval for a service not yet provided, the prior approval continues to be valid according to the information on your specific approval.
- › The process for submitting a prior approval is not changing.
- › Continue to access medical policy information by visiting [Wellmark.com](http://Wellmark.com) (*Provider > Medical Policies & Authorizations > Medical Policies*).

\*Interqual® criteria is developed using industry standard evidence-based research. Interqual is a product of McKesson.



## Note Medical Policy Updates

### Changes may affect your practice

For complete information, visit [Wellmark.com](http://Wellmark.com) (*Provider > Medical Policies & Authorization*).

#### New Policies

- › Ipilimumab (Yervoy™)
- › Myoelectric Prosthesis for the Upper Limb\*
- › Vitamin D Testing (see story this page)

#### Revised Policies

##### **Cetuximab\***

Wellmark considers cetuximab medically necessary for treatment of non-small cell lung cancer. Previously considered investigational.

##### **Continuous or Intermittent Monitoring of Glucose in Interstitial Fluid**

- › Removed prior approval recommendation from continuous monitoring effective immediately. Wellmark will continue to apply medical policy requirements and monitor utilization.
- › Removed age minimum of 18 years old from medically necessary language for continuous interstitial glucose monitoring.
- › No changes made to intermittent monitoring.

##### **Small Bowel Transplant\* and Small Bowel/Liver and Multivisceral Transplant\***

Wellmark considers the transplant of living donor intestine medically necessary.

##### **Spinal Fusion\***

- › Incorporated the medical policies for all spinal fusions, including minimally invasive approaches, into one Spinal Fusion medical policy.
- › Now recommend prior approval for all spinal fusions.
- › XLIF® (minimally invasive approach) now considered medically necessary if the criteria in the policy are met. AxialLif® remains investigational.

##### **Tocilizumab (Actemra)\***

Wellmark considers tocilizumab medically necessary for active systemic idiopathic juvenile arthritis, also known as Still's disease, in children age 2 years and older.

*\*Prior Approval Recommended*

## Claims to Process Using New Vitamin D Testing Medical Policy

### Services considered medically necessary for evaluating patients with certain indications

Vitamin D testing provided on and after **NOVEMBER 1, 2011**, will process using the following medical policy.

#### Background

The term "vitamin D" is broad and includes several metabolically interrelated sterol substances that have hormonal activity. Vitamin D has 2 distinctive forms: vitamin D2 and vitamin D3.

Currently, no evidence-based clinical practice guideline recommends vitamin D screening of persons without a clinically documented underlying disease or condition specifically associated with the risk of decreased bone density or osteoporosis. While the serum concentration of 25-hydroxyvitamin D [25(OH)D] is established as the best indicator of vitamin D status, there is significant uncertainty associated with its measurement.

#### Policy

Wellmark may consider **25-HYDROXYVITAMIN D [25(OH)D]**

##### **SERUM TESTING:**

- › **MEDICALLY NECESSARY** in patients with a clinically documented underlying disease or condition which is specifically associated with vitamin D deficiency or decreased bone density/osteoporosis.
- › **NOT MEDICALLY NECESSARY** for routine or initial screening in the absence of clinical documentation of an underlying disease or condition specifically associated with vitamin D deficiency.

Wellmark may consider **1,25 DIHYDROXYVITAMIN D [1,25(OH)2D]**

##### **SERUM TESTING:**

- › **MEDICALLY NECESSARY IN EVALUATING PATIENTS** with a clinically documented underlying disease or condition associated with increased or decreased 1,25(OH)2D. Examples of such conditions include sarcoidosis, cat-scratch disease, lymphomas, hyper- or hypoparathyroidism, pseudohypoparathyroidism, hypercalcemia of malignancy, renal failure, and granulomatous diseases.
- › **NOT MEDICALLY NECESSARY** for testing and screening for vitamin D deficiency for all indications.

#### Procedure Codes

- › To report, use appropriate CPT®,\* HCPCS, revenue, and/or ICD-9-CM diagnostic codes
- › CPT 82306: Vitamin D; 25 hydroxy, includes fraction(s), if performed
- › CPT 82652: Vitamin D; 1,25 dihydroxy, includes fraction(s), if performed

To view more complete details, visit [Wellmark.com](http://Wellmark.com) (*Provider > Medical Policies & Authorizations > Medical Policies > Vitamin D Testing*).

\*CPT® is a trademark of the American Medical Association. Current Procedural Terminology © 2010 American Medical Association. All Rights Reserved.

## What Happens when Patients Call?

### Improve quality and reduce costs using appropriate arrangements

When you provide patients appropriate access to covered care, you protect their health and eliminate unnecessary costs. This includes giving them the ability to reach you during and after standard office hours and on weekends when seeking care or needing information about a condition that does not appear to be life-threatening.

#### Examples

Examples of what Wellmark considers **APPROPRIATE** primary care coverage during non-office hours include:

- 1 The regular office phone number is answered by an on-call, triage, or advice nurse with direct access to the on-call physician.
- 2 The regular office phone number is answered by an answering service, which may be hospital staff, which patches the call through to an on-call physician.
- 3 The regular office phone number is answered by an answering service that takes a message and pages the physician who then returns the patient's call.

Examples of **INAPPROPRIATE** primary care coverage during non-office hours include:

- 1 An answering machine with a message that recommends calling back during business hours or only calling 911.
- 2 An unanswered telephone (no answer after 10 rings).
- 3 Machine message says to stay on the line if emergency, with no further instruction provided on what to do if caller does not have an emergency.

#### Learn More

Wellmark Health Plan of Iowa providers will find more information about member access to nonemergency after-hours care:

- › In the article “PCP After-Hours Arrangements Checked Yearly” on page 10 of this *Blue Ink*.
- › At Wellmark.com (*Provider > Medical, Dental, & Pharmacy > Medical > Wellmark Health Plan of Iowa > After-Hours Nonemergency Care*), which includes a complete list of acceptable and unacceptable methods of primary care coverage during non-office hours.



By providing appropriate access to covered care during and after standard office hours, you protect patients' health and eliminate unnecessary costs.

## Providing Acute Care Discharge Date Helps Patient

### Your help assists with planning post-discharge insurance coverage needs

When a facility notifies Wellmark of an acute admission, we help the member by checking benefits for the inpatient stay and planning for post-discharge arrangements. When you notify us of the discharge date, we can continue the dialogue with our member in a more informed way.

That's why it's important to notify us of both the acute admission and the discharge.\*

Please provide discharge information by:

- › **CALLING** 800-552-3993
- › **COMPLETING OUR NOTIFICATION FORM AND FAXING** to 515-376-9013
- › **SUBMITTING OUR SECURE ONLINE FORM** at Wellmark.com (*Notify/Precertify Admissions*)

You'll find a general summary of requirements and our Notification form at Wellmark.com (*Provider > Medical Policies & Authorizations > Authorizations*).



**\*NOTE:** Please check benefits to determine your patient's precertification or notification requirements for an admission.

## Statement of Intent on Health Management Decision-Making Policies

### Decisions based on appropriateness of care and services

Wellmark staff members and our contracting providers make health care recommendations and decisions for the utilization of services based only on appropriateness of care and services. Wellmark reviews appropriate decision-making through continual monitoring for under- and overutilization of services. If data reflects either, we communicate with providers and members to identify strategies and implement interventions to achieve appropriate use of services.

Wellmark does not reward its staff or providers for making utilization management decisions resulting in denials of coverage or services. Further, Wellmark provides no financial incentives for utilization management decision-makers who encourage decisions that result in underutilization of services.

## Wellmark Utilization Management Decisions

### Information about medical necessity reviews

Wellmark Medical Directors or a physician reviewer makes utilization management decisions. Decisions are based on whether or not services meet the definition of medical necessity defined in the beginning of the Claims Filing Section of the *Wellmark Provider Guide*.

When a service is denied because it does not meet the definition of medical necessity, we will notify you in writing or by phone. If you wish to speak to the physician who made the determination, please let us know at the time you receive the telephone notification. If you receive written notice, please call Wellmark Blue Cross and Blue Shield's Utilization Management Unit at 800-552-3993, and ask to speak with the case manager whose signature is on your written notice.



## Service Options Available During Holidays

### Locate information you need even when phone center is closed

To check benefits or claim status when Wellmark offices are closed, access these tools:

- › **WEBSITE TOOLS**
- › **INTERACTIVE VOICE RECOGNITION (IVR)** phone system

Our offices will be closed on:

- › **MONDAY, JULY 4** – Independence Day
- › **MONDAY, SEPTEMBER 5** – Labor Day

**THE PHARMACY SERVICE CENTER (800-600-8065)** will be available on both holidays during its regular Monday business hours (7 a.m.–7 p.m., CT) for prior authorization requests.

## Benefits for School or Sports Physicals Determined by Care Provided

### Preventive care may be covered if it includes essential components of a full health maintenance exam

For preventive care services to be covered by most of our plans, the services provided must be comprehensive. To determine a member's preventive benefits, access our secure "Check Patient Eligibility & Benefits" tool at Wellmark.com.

#### How to Bill

If the school or sports physical you provide **MEETS** all the requirements of a full health maintenance exam:

- Submit the claim with diagnosis code V70.0 and the appropriate preventive medicine services CPT®\* code.
- Follow the billing guidelines published in the 1999 edition of *The CPT Companion*:

**AMA COMMENT:** *If the physician performs a comprehensive history and examination, then you should report the age appropriate code from the preventive medicine series. If the physician performs a problem focused, expanded problem focused, or detailed history and examination, then report the appropriate level office or other outpatient evaluation and management visit code.*

- Document the care provided by recording essential components in the member's medical record.

If the service **DOES NOT MEET** all the requirements of a full health maintenance exam, submit the claim with diagnosis code V70.3 (Other medical examination for administrative purposes [includes school admission and sports competition]) and procedure code 99429 (Unlisted preventive medicine services). Unless a sports or school physical is specifically covered by the member's contract, the claim will deny as member liability with message code E590, which indicates the service is not covered.

#### PCP Requirement for Wellmark Health Plan of Iowa Members

- Blue Advantage and Blue Choice provide preventive benefits only when the exam is performed by the member's primary care provider (PCP) or the PCP's backup provider.
- Blue Access provides preventive benefits only if care is received from a network general or family practice physician, obstetrician/gynecologist, physician assistant, nurse practitioner, pediatrician, or internal medicine physician.

\*Current Procedural Terminology © 2010 American Medical Association. All Rights Reserved.

## Changes for Outpatient Claims

Updates affect facilities whose services are processed using EAPG payment methodology

### One Claim per Date of Service Not Required

You will not be required to submit one outpatient claim per date of service as reported in the February and April issues of Blue Ink. The change was to be effective July 1, 2011.

Because Wellmark's July 1, 2011, payment update for EAPGs did not include updated weights, Wellmark will NOT require one claim at this time. Wellmark will work toward requiring one claim with the July 2012 payment update.

### Modifier 59

Effective with claims processed on and after July 1, 2011, Wellmark will no longer use the 59 modifier to determine payment within Wellmark's EAPG Grouper. Providers should continue to use the 59 modifier when appropriate.

## Avoid Unnecessary Outpatient Facility Denials

### Include CPT/HCPCS codes with revenue codes when required

If you bill outpatient revenue codes 280 and 289, be sure your claim includes a CPT or HCPCS code, beginning with date of service July 1, 2011.

#### Additional Services Requiring CPT/HCPCS Code

REVENUE CODE	DESCRIPTION
280	Oncology – General
289	Oncology – Other

This requirement applies to all facilities, regardless of your payment arrangement.

For a list of the most current list of revenue codes that require a CPT or HCPCS code, visit Wellmark.com (*Provider > Claims & Payment > Payment and Coding Policies for Billers > Outpatient Facility Claims*).

## Receive Correct Reimbursement by Using Appropriate Surgical Modifiers

### Co-surgeon and assistant-at-surgery claims requirements

To determine benefits requirement and claims filing guidelines, review the following information. You'll find these topics covered in the General Surgery section of the *Practitioner Guide* at Wellmark.com (*Provider > Quick Links > Billing Guides*).

#### Co-Surgeons

Co-surgery involves a surgical procedure that requires:

- › Two surgeons of two different specialties, such as Gynecology and Urology, General Surgery and ENT.

OR

- › Two surgeons performing parts of the procedure simultaneously.

The second surgeon is not acting as an assistant-at-surgery (identified using modifier 80\* or AS) or as part of a surgical team (modifier 66).

#### Accessing the Co-Surgeon List

Access the Co-Surgeon list at [Cms.hhs.gov/PhysicianFeeSched](http://Cms.hhs.gov/PhysicianFeeSched) (PFS Relative Value Files). Information in the file is posted chronologically by year. The most current information is usually the last entry posted within any given year. Select the file that is effective for the date of service.

When co-surgeon modifier (62) is submitted, Wellmark uses Medicare's indicators in the Co-Surg column of the PFS Relative Value File to determine payment:

<b>Indicator 0:</b>	Co-surgeons not permitted for this procedure
<b>Indicator 1:</b>	Co-surgeons may be paid with documentation to establish the medical necessity of two surgeons for the procedure
<b>Indicator 2:</b>	Co-surgeons permitted and no documentation required if the two-specialty requirement is met

#### Benefit Requirements

The following criteria must be met:

- › Both providers should normally be surgeons of different specialties.
- › The service must be medically necessary and an accepted standard of care.
- › Each surgeon must perform a distinct portion of the surgery.

#### Claims Filing/Claims Review Instructions

Submit co-surgery services using the appropriate CPT surgical procedure code with the 62 modifier. If you are reporting more than one modifier, *list modifier 62 first*.

An operative report is not required to be submitted with the claim, but may be submitted to review denied services. The operative report:

- › Must support the use of the 62 modifier.
- › Should be attached to each surgeon's Provider Inquiry Form. Include a distinct operative report from both co-surgeons, or use the same operative report for both surgeons as long as the responsibilities of each surgeon are identified in the operative report.

#### Assistant Surgeons

A second surgeon may also be present when a surgical procedure requires the services of an assistant.

#### Benefit Requirements

Wellmark allows benefits for an assistant surgeon for all surgeries on Medicare's Assistant Surgeon list, plus the following CPT/HCPCS procedure codes: 15002, S2075, and S2077. Services of an assistant surgeon for other procedures, including knee arthroscopy, are not considered medically necessary under Wellmark's health plans.

Although a hospital may require an assistant to be present at every surgery because of malpractice liability, Wellmark considers benefits for an assistant surgeon only for the procedures listed on Centers for Medicare & Medicaid Services' website, plus the three codes listed above.

#### Accessing the Assistant Surgeon List

Access the Assistant Surgeon list at [Cms.hhs.gov/PhysicianFeeSched/](http://Cms.hhs.gov/PhysicianFeeSched/) (PFS Relative Value Files). Information in the file is posted chronologically by year. The most current information is usually the last entry posted within any given year. Select the file that is effective for the date of service.

When assistant surgeon modifiers (AS, 80, 81, or 82) are submitted, Wellmark uses Medicare's indicators on the PFS Relative Value File to determine payment:

<b>Indicator 0:</b>	Assistant surgeon may be paid with documentation to support medical necessity
<b>Indicator 1:</b>	Assistant surgeon may not be paid
<b>Indicator 2:</b>	Assistant surgeon may be paid
<b>Indicator 9:</b>	Not applicable concept (e.g., service is not a surgery)

\*Current Procedural Terminology © 2010 American Medical Association. All Rights Reserved.

**Claims Filing/Claims Review Instructions**

Submit the appropriate modifier with the surgical code. An operative report is not required to be submitted with the claim, but must be attached to a Provider Inquiry form when requesting a review of a denied service.

As evidence of medical necessity for the services, the surgeon is required to note the following in the body of the operative report:

- The specific nature of the assistant’s services.
- The reason the assistant’s services were required.

This is required even if the surgery is listed by CMS as appropriate for an assistant surgeon. Listing the assistant’s name in the heading of the operative report is insufficient to validate medical necessity.

**AS Modifier**

The AS modifier identifies assistant-at-surgery services provided by a physician assistant (P.A.), nurse practitioner (N.P.), or clinical nurse specialist (C.N.S.). Services provided by these practitioners must be:

- 1 **WITHIN THE SCOPE OF THEIR LICENSE**, and
- 2 **RENDERED AS ASSISTANCE TO THE OPERATING SURGEON** in the performance of a covered procedure.

**NOTE:** Although the AS modifier definition includes services performed by clinical nurse specialists, Wellmark does not recognize clinical nurse specialists as contracting or payable providers in South Dakota.

**80 MODIFIER** – Add an 80 modifier to the surgery code to indicate that an M.D. or D.O. performed assistant-at-surgery services. This modifier is not intended for use by non-licensed physicians or non-physicians in the operating room.

**81 MODIFIER** – Though the 80 modifier is the most common modifier for an assistant-at-surgery service, the 81 modifier may apply when:

- the procedure requires the services of an M.D. or D.O. as a second or third assistant surgeon, or
- the assistant-at-surgery is not present for the entire procedure.

**82 MODIFIER** – Bill the 82 modifier for assistant-at-surgery services provided by an M.D./D.O. only when a qualified resident surgeon is not available.



**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](mailto: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](http://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
Billing for Wart Removal	Professional and Outpatient	Nov. 1, 2011	Oct. 15, 2011



**Services Payable in Outpatient Setting**

**Four CPT\* codes will be removed from Wellmark’s Inpatient Only List**

You will no longer need to submit medical records to review the following services if provided in an outpatient setting on and after July 1, 2011.

22551	Arthrodesis, anterior transoral or extraoral technique, clivus-C1-C2 (atlas-axis), with or without excision of odontoid process
47300	Marsupialization of cyst or abscess of liver
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(ies)
93463	Pharmacologic agent administration . . .

Providers whose outpatient claims process using EAPGs (Enhanced Ambulatory Patient Groupings) will see these codes added to EAPG 994.

You'll find Wellmark’s Inpatient Only List of codes at Wellmark.com (*Provider > Claims & Payment > Payment and Coding Policies for Billers > Outpatient Facility Claims*).

\*Current Procedural Terminology © 2010 American Medical Association. All Rights Reserved.



Pharmacy Corner

**Improving Compliance by Reducing Costs with Asmanex® or Qvar®**

**Drugs move to tier 1 and provide affordable brand-name options for daily asthma control**

When you write a prescription for Asmanex, Qvar, or any tier 1 drug, you reduce a Wellmark member's out-of-pocket expense at the pharmacy, which may also improve your patient's compliance. These two drugs moved to tier 1 effective June 1, 2011.

**Asthma Copay Waiver Program**

To provide additional support for members trying Asmanex or Qvar for the first time, Wellmark will waive the cost-share for their first month's supply. This applies to prescriptions filled at a retail pharmacy between **JUNE 1, 2011, and SEPTEMBER 30, 2011.\***

You may be asked to consider writing a new prescription in response to requests for members who were notified of the Copay Waiver Program in May.

**Background Information**

- **DAILY CONTROL MEDICATIONS** are the bedrock of treatment for people with moderate to severe asthma.
- **HIGH MEDICATION COSTS** can make daily treatment difficult to maintain, especially when a limited number of generic asthma medications are available.
- **QVAR AND ASMANEX** are approximately 41 percent less costly than other brand-name asthma medications.
- **ASTHMA MEDICATIONS** are one of the top five classes of drugs driving Wellmark's annual prescription drug trend, costing nearly \$27 million a year.

*\*Does not apply to mail service pharmacy. If a drug plan has a deductible, the deductible must be met before the cost share is waived, unless the plan waives deductible for generics or for preventive drugs on a HSA Preventive Drug List. Does not apply to members of self-funded plans who have opted out of the copay waiver program.*

**Prescribing Colcrys™ at a Lower Cost-Share**

**Change from tier 3 to tier 2 on Wellmark Drug List reduces member expense**

Depending on the coverage with Wellmark, the drug's change from tier 3 to tier 2 may translate into patient savings at the pharmacy. The change was effective June 1, 2011.

Colchicine, commonly used to treat acute gout attacks, has been available in the United States since the early 1920s. Prior to the 1950s, drug manufacturers only had to prove drugs were safe versus both safe and effective. Due to the lack of proven efficacy, the U.S. Food and Drug Administration (FDA) has recently ordered the removal of all generic versions.

Colcrys™, a recently approved brand-name version of the longtime generic, recently entered the market after being granted FDA approval for marketing. Colcrys is priced at more than 50 times the cost of the generic, and was granted exclusive patent rights for at least 3 years.

**Keeping Current with Wellmark Drug List Changes**

**Assist your patients in keeping their costs down**

To determine appropriate drug options that could also reduce a Wellmark member's pharmacy expense, access our Drug List at Wellmark.com for the most current information. Wellmark is making its biannual Drug List change on July 15, 2011.

Typically, a drug's tier affects a member's out-of-pocket costs. For example, tier 1 typically includes generic drugs and a few brand-name drugs for the lowest member cost-share.

Drugs that are not in the Wellmark Drug List are not covered by a member's policy unless a medical exception is made.

**NOTE:**

- Iowa members covered by *hawk-i* benefits are responsible for the full cost of branded medications not included on the *hawk-i*\* Wellmark Drug List.
- Wellmark employees are not covered for some brand name antidepressants, high blood pressure medications, proton pump inhibitors, and statins. (Please see article on page 3 of the December 2010 *Blue Ink* for details).
- The *hawk-i* and Wellmark Employee Plans are both options when selecting which Drug List to view online.

You'll find the Wellmark Drug List at Wellmark.com (*Provider > Medical, Dental, & Pharmacy > Learn more about our pharmacy programs > Wellmark Drug List*). Remember to select the Drug List option appropriate for your patient.

*\*The Healthy and Well Kids in Iowa (hawk-i) Program provides free or low-cost health, prescription drug, and dental benefits to Iowa children in families whose income falls between 133 and 300 percent of the federal poverty level.*



## Improve Your Knowledge of the TriWest Website

### Save time by using one of the online demos

Learn more about the tools available and how to use them by accessing the TriWest website demonstrations at [Triwest.com/provider](http://Triwest.com/provider).

- **ACCOUNT ADMINISTRATION** – learn to manage your online account
- **ELIGIBILITY** – learn how to check beneficiary eligibility
- **WEST REGION BENEFIT LOOKUP TOOL** – learn to research covered benefits and check referral/authorization and medical review requirements for specific codes
- **ONLINE REFERRAL/AUTHORIZATION SUBMISSION** – choose between two website demonstrations on online referral/authorization submission: medical/surgical and behavioral health
- **ONLINE REFERRAL/AUTHORIZATION STATUS** – learn how to check the status of a referral or authorization online
- **ONLINE CLAIMS SUBMISSION** – choose between two website demonstrations on electronic claims submission: UB-04 and CMS-1500
- **ONLINE CLAIMS STATUS** – learn how to check the status of your claims online
- **ONLINE CLAIMS CORRESPONDENCE/WEBMAIL** – learn how to correspond with TriWest online regarding claims issues/inquiries and your secure account
- **PROVIDER CONNECTION** – take a tour of the Provider Connection Web page
- **BEHAVIORAL HEALTH PORTAL** – take a tour of the Behavioral Health Web page

### Not Registered?

Sign up today at [Triwest.com/provider](http://Triwest.com/provider).

“TRICARE” is a registered trademark of the TRICARE Management Activity. All rights reserved.



## PCP After-Hours Arrangements Checked Yearly

### Primary care provider (PCP) offices to be surveyed for phone responses

In the upcoming weeks, your after-hours answering service may be contacted by an independent market research firm to survey how phone calls are handled during non-office hours. Calls will be made to Wellmark Health Plan of Iowa PCP offices, and will only take a few minutes.

We appreciate your cooperation in helping us collect this information.

### Purpose of the Survey

Following the survey, Wellmark will contact offices with inappropriate arrangements to discuss possible improvements for meeting the standards for after-hours care.

As a network goal, Wellmark Health Plan of Iowa strives to have every primary care clinician's office equipped to appropriately handle patients' after-hours questions or requests for nonemergency care 24 hours a day, 7 days a week.

### Learn

### More

To read descriptions of what Wellmark considers acceptable and unacceptable ways clinicians' offices may provide patient access to nonemergency after-hours care:

- Visit [Wellmark.com](http://Wellmark.com) (*Provider > Medical, Dental, & Pharmacy > Medical > Wellmark Health Plan of Iowa > After-Hours Nonemergency Care*).
- Read “What Happens When Patients Call?” on page 5 of this *Blue Ink*.



Presorted Standard  
U.S. Postage  
**PAID**  
Wellmark Blue Cross  
and Blue Shield

**Wellmark Blue Cross Blue Shield of Iowa**  
**Wellmark Blue Cross Blue Shield of South Dakota**

Independent Licensees of the Blue Cross and Blue Shield Association

Mail Station 3W749  
PO Box 9232  
Des Moines, IA 50306-9232

# Blueink

Blue Ink is published by Wellmark Blue Cross and Blue Shield's Corporate and Marketing Communications Department.

**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

Blue Cross®, Blue Shield®, the Cross® and Shield® symbols, and BlueCard® are registered marks, and Blue Ink<sup>SM</sup> is a service mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Wellmark® is a registered mark of Wellmark, Inc.

## SOUTH DAKOTA ONLY

# Health Insurance Mandate Affects Member Liability for Chiropractic Office Visits

## Notice of benefit changes effective July 1, 2011

If you are a doctor of chiropractic (D.C.) contracting with Wellmark Blue Cross and Blue Shield of South Dakota's Preferred Provider Organization (PPO), you may soon notice changes in the way Wellmark reimburses some members' office services. This may affect the amount you collect from Wellmark members at the time of service.

### How to identify members with this benefit

For the most part, the benefit changes will affect Wellmark Blue Cross and Blue Shield of South Dakota members with Primary Care Provider (PCP) and Non-PCP copayments reflected on their ID card. To determine if your patient's benefits are affected by the change, access our secure tools at Wellmark.com and select Check Patient Eligibility & Benefits. Look for the copayment noted for DC office services.

### What you should know about the benefit

- › Some plans apply the copayment to all office services. Other plans may apply the copayment to the *office exam charge* only, subjecting other office services, such as x-rays and labs, to deductible and coinsurance.
- › Plans with more than one office visit copayment amount will apply the lower copayment to eligible chiropractic services.
- › Members are responsible for the lesser of charge or copayment. If a member's copayment is greater than your charge, he or she will be responsible for your charge, up to the Maximum Allowable Fee.
- › The benefit update applies to services provided on or after July 1, 2011.
- › Services by a non-PPO provider, regardless of provider type, specialty, or participation in other Wellmark networks, are subject to deductible and coinsurance amounts.