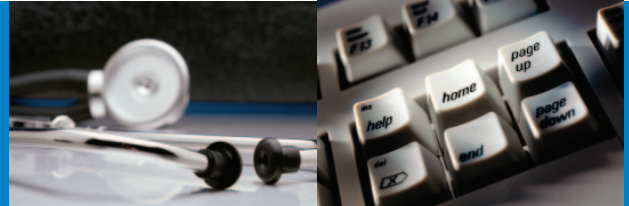




Information for IOWA and SOUTH DAKOTA
Physicians and Health Care Providers



Electronic Transaction 5010 Requirements

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) required the adoption of specific standards for electronic health care transactions, e.g., claims, eligibility inquiries, claims status requests and responses, etc.

The current transaction standard is version 4010A1. Federal regulation mandates that it 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 5010 X12 version 5010 for electronic transactions.

This deadline may appear to be distant, but significant work must be accomplished to prepare for the mandatory conversion. Meeting the following objectives will help you prepare for the 5010 deadline.

If you transmit direct to Wellmark/BES:

1. Identify the differences between versions 4010A1 and 5010, and determine what applications, systems and operating protocols need to change. This should be complete or underway now.
2. Implement changes to systems and protocols, and test the changes.
3. Schedule and complete tests with your external trading partners (such as Wellmark and other health insurance payers), and transition with them to the 5010 transactions, including any addenda, by the compliance date of January 1, 2012.

If you submit through a vendor, billing service, or clearinghouse:

1. Review your contracts to determine what terms apply when major federally mandated data set changes must be made.
2. Ask your vendor, billing service, or clearinghouse what preparations they are making to support your 5010 business requirements for the January 1, 2012, compliance date.
3. Request details, such as a project plan and timeline.

continued on page 2

VISIT OUR WEBSITE AT: www.wellmark.com

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December 2010

- 1 Electronic Transaction
5010 Requirements

PHARMACY

- 2 Pharmacy Updates

PLANS & BENEFITS

- 3 Pharmacy Changes for
Wellmark Employee Plan
- 4 New Alliance SelectSM Option
- 5 Benefit Options Represent Shift
- 5 FEP 2011 Benefit Updates

MEDICARE ADVANTAGE

- 7 Clinical Practice Guidelines

CLINICAL QUALITY

- 7 One Call Connect Provides Outreach
- 8 Combating Antibiotic Overuse

E-BUSINESS

- 9 Introducing Quick Look-Up
- 9 Contact Us by December 30 to
Reactivate Disabled Account
- 9 Electronic vs. Paper Claims

BLUECARD®

- 10 iCAP Processing BlueCard®
Host Claims

ADMINISTRATION & POLICY

- 10 Draft iCAP Specialty Policies
- 10 Provider Billing Guide Updates
- 11 Wellmark Contact Information
- 11 Wellmark Holiday Phone Support Hours

CLAIMS & CODING

- 12 Billing Observation Services
- 12 Influenza Vaccines
- 13 Utilizing Out-of-State Providers for
Telemedicine Services
- 14 Updates in Claims Filing Instructions for
HME Purchase and/or Repair
- 14 Health Care Reform-Related Claim Review
- 14 Several Revenue Codes Require
Detailed Coding
- 15 Filing a Corrected vs. a New Claim

MEDICAL POLICY

- 15 Thermal Capsulorrhaphy as a Treatment
of Joint Instability
- 15 Noncovered Allergy Testing Services
- 16 Medical Policy Update

TRICARE

- 17 Web Claims Correspondence and Mail
- 17 Verification Mailing Needs Your Response
- 18 TRICARE Webinars

IOWA

- 18 Wellmark Health Plan of Iowa Practitioner
Availability Standards
- 19 HEDIS® Results for Acute Respiratory
Care Measures

continued from page 1

Wellmark is preparing for the implementation of 5010, and will notify you when we are ready to begin testing. We anticipate that we will be ready to test HIPAA X12 version 5010, including the June 2010 addenda, with you or your vendor, billing service, or clearinghouse by April 2011.

We have added information, including a Q&A, to www.wellmark.com (*Providers > Claims & Payment > HIPAA 5010*). As more details become available, we'll post updates in the *Blue Ink* and on our website.

Note about 5010 Technical Reports: The HIPAA 5010 guides Wellmark will be posting are not 5010 Technical Reports. To purchase the Technical Reports Type 3 (TR3s) and addenda for each transaction, visit the Washington Publishing (WPC) website at www.wpc-edi.com. Under 4010, these reports were called Implementation Guides (IGs) and were free. Wellmark cannot provide these documents as they are copyrighted by X12.

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

Hours: 7:00 a.m. to 5:30 p.m., CT, Monday–Friday (except holidays)

Phone: 800-407-0267

Email: ECsolutionsDSM@hp.com

Pharmacy Updates

Drugs Moving to Tier 3

Effective January 1, 2011, the brand-name medications listed below will move from Tier 2 to Tier 3 because a generic equivalent is now available for most strengths and dosage forms.

By prescribing generic options, you often help our members lower their out-of-pocket costs.

Brand Name Drugs Moving to Tier 3

Arimidex (anastrozole)
Casodex (bicalutamide)
Venlafaxine ER (venlafaxine HCL ER)
Exelon (rivastigmine)

We have notified members whose pharmacy claims show record of recently filling a prescription for one of these drugs.

Wellmark normally makes changes to its Drug List in January and July. We post notice of these changes at www.wellmark.com (*Provider > Medical, Dental, & Pharmacy > Learn more about our pharmacy programs > Updates to Wellmark Drug List*).

The Pocket Wellmark Drug List includes the most commonly prescribed medications. You may access at www.wellmark.com (*Provider > Medical, Dental, & Pharmacy > Learn more about our pharmacy programs > Wellmark Drug List*), or request a copy by contacting Provider Service.

Prior Authorization for Pradaxa

As of December 2, 2010, a prior authorization is required for members who are newly prescribed the drug Pradaxa, a drug used for the prevention of stroke and blood clots in patients with abnormal heart rhythm (atrial fibrillation).

The prior authorization form for Pradaxa is available at www.wellmark.com (*Provider > Forms*).

Pharmacy Changes for Wellmark Employee Plan

Starting January 1, 2011, Wellmark employees will be piloting a new pharmacy benefit. This pharmacy benefit is based on comparative efficacy to promote use of high-quality, low-cost alternatives. This will be the standard pharmacy benefit for Wellmark employees regardless of the health benefit plan they choose.

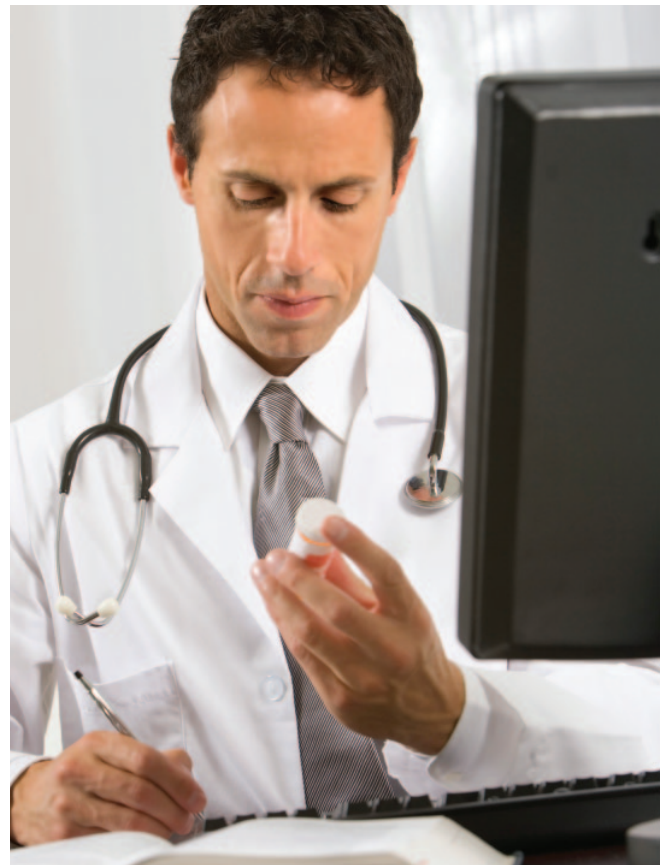
The new Wellmark employee benefit will not cover the following brand name drugs:*

- **Antidepressants:** Aplenzin, Cymbalta, Lexapro, Pristiq, Pexeva, Luvox CR
- **High Blood Pressure Medications:** Atacand, Atacand HCT, Avalide, Avapro, Azor, Benicar, Benicar HCT, Diovan, Exforge, Exforge HCT, Micardis, Micardis HCT, Teveten, Teveten HCT
- **Statins:** Advicor, Lescol, Lescol XL, Lipitor, Vytorin
- **Proton Pump Inhibitors:** AcipHex, Dexilant, Nexium, Zegerid

Other medications will be covered as follows:

Wellmark Drug List Medication	Cost-Share for Covered Wellmark Employees
Generics	\$5
Brand (no generic available)	30%, maximum of \$50 per prescription
Brand (generic available)	\$5 plus difference in cost between brand and generic

Covered Wellmark employees who are currently taking one of the noncovered brand name medications listed above have been notified that they should consult with their physician or other health care professional to determine the most appropriate treatment option. Please work with your patients who will have this new pharmacy benefit program so they can experience the lowest cost-share while maintaining optimal care.



**The drugs selected for the Wellmark Drug List have been reviewed by the Wellmark Blue Cross Blue Shield Pharmacy and Therapeutics (P&T) Council. The P&T Council includes 11 independent, practicing, licensed physicians and pharmacists representing a wide spectrum of practices from family practice to oncology in both Iowa and South Dakota. These independent clinicians evaluate the clinical effectiveness of medications and provide recommendations regarding coverage. The inclusion or exclusion of drugs on the formulary relies heavily on the Council's clinical recommendation coupled with cost considerations.*

Wellmark Employees May Choose New Alliance SelectSM Option

Wellmark employees in Iowa and South Dakota may elect to be covered by a new Alliance Select benefit design that is focused on helping employees better understand the true cost of care.

Some of the benefit design changes may affect the collection of member's cost share at the time of services. That's why we are initially piloting this new plan design with Wellmark, Inc. employees. The pilot will help us determine if the design helps reduce costs and what communications are needed to help the transition go smoothly.

A few differences follow.

Deductible and Out-of-Pocket Maximum

This benefit plan does not have a deductible for any health care service.

The annual out-of-pocket maximum for one person covered on the contract is \$2,000; the family out-of-pocket maximum is \$4,000. Coinsurance for both PPO and non-PPO provider services will apply toward the out-of-pocket maximum, while the emergency department copayment will not apply.

Office Services

Covered preventive services provided by a PPO provider will not be subject to the coinsurance and will process at 100 percent of the Maximum Allowable Fee (MAF).

For office services, including x-ray and laboratory services, maternity, physical medicine, and behavioral health care, and care provided at walk-in clinics, members will be responsible for a coinsurance amount, based on Wellmark's MAF.

- **PPO providers:** 30 percent MAF, to a maximum of \$50 in coinsurance per visit

BlueCross® BlueShield®		AllianceSelect SM
Member Name Here XQH 123AD4567		
Group No.	12345	PPO OV 30% MAF MAX \$50
RxBIN	123456	
Rx Grp	WellRX	
Plan Code	640/140	
PPO		

- **Non-PPO providers:** 40 percent MAF, to a maximum of \$65 in coinsurance per visit

Once the out-of-pocket maximum is met, office services will process at 100 percent of Wellmark's MAF.

The office visit information will be reflected on the member's identification card (see sample).

Other Services

This product includes the same percentage of member responsibility for outpatient or inpatient care, including hospital, skilled nursing facility, home health services, as well as ambulance services, durable medical equipment, and prostheses. However, the member's maximum liability is different.

- **PPO providers:** 30 percent MAF, to the annual out-of-pocket maximum
- **Non-PPO providers:** 40 percent MAF, to the annual out-of-pocket maximum
- **PPO and Non-PPO providers:** \$200 copayment for each emergency department visit, which is waived if the member is admitted to the hospital

Check Member Identification Cards

Remember to check for changes for all of your patients by requesting member identification cards periodically. Since benefits may change, we encourage you to stay up-to-date using our secure tools at www.wellmark.com.

New Benefit Options Represent Shift for Wellmark Employee Group

It starts with us.

That's the message Wellmark employees are hearing as they make their 2011 benefit elections.

With Wellmark employee health care costs rising at nearly 13 percent this year and 14 percent in 2009, Wellmark employees have the opportunity to lead by example and reduce their own costs by becoming more knowledgeable health care consumers and by taking better care of their health.

We realize that making benefit changes can cause confusion for your staff, especially when determining how much to collect from patients at the point of service. But Wellmark believes these benefit changes are a step in the right direction to help slow health care and health insurance costs.

Wellmark is focused on helping transform the health care system in Iowa and South Dakota, and that transformation includes changing benefit designs so consumers better understand the true cost of care and become more engaged and involved in their health care decisions.

Wellmark's pharmacy director Matt Hosford, RPh, said the new pharmacy plan design for Wellmark employees is focused on lowering the overall cost of care for particular therapies.

"Where there is a clear clinical advantage to one medication in a therapeutic class over another, those drugs will be covered," said Hosford. "It is not the intent to simply remove expensive brand name medications, but it is vital to the sustainability of our health care system that we do not cover drugs that provide no clinical value when compared to similar drugs that are more cost-effective. Pharmaceutical companies, through direct advertising, physician sampling, and strategic marketing tactics have, in a number of cases, misled providers and members into believing there is value in a product when most often, the claims are simply not supported by the clinical literature."

Wellmark is providing lots of education to its employees and family members to help them understand the health and pharmacy benefit design changes.

Federal Employee Program (FEP) 2011 Benefit Updates

To help you identify changes, we are listing some FEP benefit updates effective for services furnished in the 2011 calendar year. Please refer to the 2011 Blue Cross and Blue Shield Service Benefit Plan brochure located at www.fepblue.org for the entire statement of Federal Employee Program (FEP) benefits. You'll find a summary of benefit changes included on pages 9 through 11.*

As always, a team of customer service representatives dedicated to the FEP program is available to answer provider questions or talk with an FEP member at 800-532-1537.

Precertification and Prior Approval Requirements

Key changes in the precertification and prior approval requirements beginning in 2011 follow. Please see the *Wellmark Provider Guide* or the *2011 Service Benefit Plan* brochure (pages 17-18) at www.fepblue.org for a complete listing of services requiring precertification/prior approval for FEP reimbursement.

Note the following changes effective with services being provided on or after January 1, 2011:

- Precertification will be required before an FEP member is admitted to a hospital for inpatient care, including mental health/substance abuse admissions and admissions for other medical care, or within two business days following a hospital admission for emergency care. Maternity stays that extend beyond two days for vaginal or four days for cesarean delivery require precertification, as do extended stays for newborns. Benefits for the hospital stay will be reduced by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.
- The process of precertification includes both preadmission review for elective admissions and admission review or certification for emergency admissions. Precertification is required by both

continued on page 6

continued from page 5

the Standard and Basic Options. To begin the precertification process, the provider must call (800) 552-3993. **Please note new phone number.**

- You will no longer need to notify us before providing outpatient mental health and substance abuse treatment, including partial hospitalizations and intensive outpatient services. You will no longer need to complete the Outpatient Treatment Report.
- A prior approval is no longer required for outpatient intensity-modulated radiation therapy (IMRT) related to the treatment of head (not brain), neck, breast, or prostate cancer. A prior approval will continue to be required for IMRT related to the treatment of the brain. Previously, prior approval was required for all outpatient IMRT services.
- New specific presurgical criteria must be met to receive prior approval for outpatient surgery for morbid obesity. For criteria, please see the "Health Management" section of the online *Wellmark Provider Guide*, or page 53 of the *2011 Service Benefit Plan* brochure located on the website www.fepblue.org.

A prior approval form is located on www.wellmark.com (*Providers > Forms > Prior Approval Medical Forms > FEP Medical/Surgical Prior Approval Form*) and can be completed online and faxed to our office. To avoid printing and faxing, submit a prior approval request online using Wellmark's secure tools.

Preventive Care

There will be no member cost-share for covered preventive services performed by a Preferred provider. Preventive benefits will be limited to one per year for most services. Coverage has been added for the following services:

- Adult screenings for gonorrhea infection, Human Immunodeficiency virus (HIV) infection, and syphilis infection
- Nutritional counseling services
- Up to 4 mental health visits per year for treatment of maternity-related depression
- Smoking cessation treatments
- Osteoporosis screening for women age 60 and over
- Genetic counseling and evaluation for women with family history of breast and/or ovarian cancer

- Aspirin for men age 45 through 79 and women age 55 through 79
- Folic acid. 0.4 mg to 0.8 mg, for women capable of becoming pregnant
- Iron supplements for children ages 6 months through 12 months
- Oral fluoride supplements for children ages 6 months through 5 years

Benefit Changes

FEP will provide benefits:

- Up to \$1,000 per hearing aid per ear each calendar year for youth up to 22 years of age, every 36 months for those 22 and older.
- Up to \$1,000 per calendar year for speech-generating devices.
- For donor screening tests and donor search expenses related to blood or marrow stem cell transplants when performed on three potential donors, whether the donor is a full sibling or not. Previously benefits were only available for donor screening tests and donor search expenses for full siblings and the actual donor.
- For osteopathic and chiropractic manipulative treatment, including extraspinal manipulations performed by chiropractors, limited to a combined total of 12 manipulation visits per calendar year under Standard Option, and 20 manipulation visits per calendar year under Basic Option.

The program will not cover services performed or billed by residential treatment centers, including schools or halfway houses, and members of their staff.

Additional Benefit Changes

The FEP member cost-sharing amounts are changing for both the Standard and the Basic Options in 2011. We will be updating this information in the "Member and Services Information" section of the *Wellmark Provider Guide* at www.wellmark.com (*Providers > Guides > Wellmark Provider Guide > Member and Service Information*).

For additional information, access www.fepblue.org (*2011 Benefit Changes*).

*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.

MedicareBlueSM PPO – Clinical Practice Guidelines

The MedicareBlue PPO product available to the Medicare-eligible population in Iowa and South Dakota has adopted the following clinical practice guidelines:

- American College of Cardiology/American Heart Association (ACC/AHA) Chronic Heart Failure Clinical Practice Guideline. To access this guideline, visit www.yourmedicareolutions.com (see “For Providers” link at bottom of page > Case & Disease Management > case management services > Heart Failure Program > 2005 guideline).
- Global Initiative for Chronic Obstructive Lung Disease (GOLD) as part of its Chronic Care Improvement Program. To access this guideline, visit www.yourmedicareolutions.com (see “For Providers” link at bottom of page > Clinical Practice Guidelines).
- Adult breast and cervical cancer preventive guidelines from the Institute for Clinical Systems Improvement (ICSI)—refer to the table below. To access the abridged guidelines, visit www.YourMedicareSolutions.com (For Providers [see link at bottom of page] > Clinical Practice Guidelines). As a reminder, there is no member copayment under the MedicareBlue PPO benefit for these in-network services. The contracts also provide coverage for one physical examination per calendar year.

	Age 19–39 Years	40–64 Years	Over 65 Years
Cervical Cancer Screening Pap Smear	Beginning at age 21 or three years after first sexual intercourse, whichever is earlier; every 3 years after 3 consecutive normal results.	Every 3 years after 3 consecutive normal results.	Women with a new sexual partner.
Breast Cancer Screening		Annual mammogram for women age 40–49 years with high-risk factors; every 1–2 years for women age 50 and older.	Every 1–2 years.

To receive a paper copy of any of the guidelines, contact Sharon Newman, R.N. at 515-376-4831.

One Call Connect Provides Outreach on Your Behalf

Do you ever feel that there’s not enough time to effectively reinforce patient behavior between visits? Or perhaps you’d like to refer a patient to someone who can identify beneficial community resources or answer Wellmark benefit or coverage questions.

These services and more are available when you contact One Call Connect.

One Call Connect is a dedicated, 24/7 toll-free number that can lighten the workload for your staff, and help current Wellmark members achieve better health. And it allows for interaction between your patient and One Call Connect staff—something automated recordings cannot do.

Outbound Calls and Referrals

One Call Connect can provide services to Wellmark members you identify who may benefit from:

- Personalized reminder calls encouraging them to schedule follow-up appointments and take their medications.
- Referrals to Wellmark’s disease management and complex case management programs, Pregnancy Support, and Wellness or Advocacy services.
- Information about health care resources that have statewide reach in Iowa and South Dakota, as well as national resources.

How to Get Started

- Call 1-888-780-1862
Or
- Complete the referral form found on [Wellmark.com](http://www.wellmark.com) at <http://www.wellmark.com/Provider/HealthManagement/OneCallConnect.aspx>

If you haven’t used this service before, try it today and evaluate the benefits for yourself.

Combating Antibiotic Overuse

The Institute of Medicine estimates the annual cost of infections caused by antibiotic resistant bacteria to be 4–5 billion dollars.¹ More importantly, repeated antibiotic use may lead to antibiotic resistance, which increases your risk of getting an infection later that resists antibiotic treatment.

“Antibiotics are good drugs if taken for the right reasons, but they’re not a magical cure-all,” says Paul Karazija, M.D., Wellmark’s chief medical officer. “While it’s not always the most convenient option, the best care is usually time and a parent’s attention.”

When it comes to appropriate testing and prescribing, how are we doing?

The chart below reflects the 2010 Iowa and South Dakota PPO Healthcare Effectiveness Data and Information Set (HEDIS®) results and indicates the percentage of members who received appropriate testing or treatment for pharyngitis, upper respiratory infection (URI), and bronchitis. Keep in mind, higher values represent better performance. Although the Iowa and South Dakota PPO HEDIS results are not audited by NCQA, the data is collected in a manner similar to that used to compile data for Wellmark Health Plan of Iowa.

Note: For a specific description of each measure and Wellmark Health Plan of Iowa’s 2010 HEDIS results, see the article on page 19.

To help you battle antibiotic overuse, Wellmark has developed child-friendly posters and handouts for parents that you can view and print from www.wellmark.com (Health & Wellness tab > Resist Antibiotics).

The CDC’s website also provides a number of documents you can share with your patients, supporting your decision not to prescribe an antibiotic. You’ll find these items at the following URL under the heading “Get Smart materials for the general public”: <http://www.cdc.gov/getsmart/campaign-materials/print-materials.html>

Are parents demanding an antibiotic for their child’s viral infection?

Consider a document that includes recommendations by CDC/AAP to promote appropriate antibiotic use in children and has tips for when parents are demanding an antibiotic.

In addition, the CDC offers a form that you can complete, giving parents some education and your instructions for home care and when to follow up.

Perhaps the child’s daycare provider requires antibiotics before the child can return.

Send a completed “Dear Child Care Professional” letter home with the parent. The letter verifies that the child has a viral infection and can return to daycare once the fever has subsided.

¹Institute of Medicine. *Antimicrobial drug resistance: issues and options. Workshop report.* Washington: National Academy Press, 1998, cited by John E. McGowan, Jr., “Economic Impact of Antimicrobial Resistance,” *Emerging Infectious Diseases*, n.d., <<http://www.cdc.gov/ncidod/eid/vol7no2/mcgowan.htm>> (November 17, 2010).

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

The source for data contained in this publication is Quality Compass® 2010 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2010 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

	2008	2009	2010	2010 GOAL
Pharyngitis Appropriate testing for children ages 2 – 18 years old				
Iowa PPO	59.23%	61.10%	▲ 61.67%	88.70%
South Dakota PPO	61.00%	62.37%	▲ 66.42%	
URI Appropriate treatment for children ages 3 months–18 years				
Iowa PPO	69.49%	70.77%	▲ 70.99%	91.18%
South Dakota PPO	71.12%	72.79%	▼ 72.01%	
Bronchitis Avoidance of antibiotic treatment for adults age 18–64 years				
Iowa PPO	21.10%	21.11%	▼ 20.17%	29.52%
South Dakota PPO	33.26%	22.89%	▼ 21.15%	

The screenshot shows the Wellmark Providers portal. At the top, there's a navigation bar with 'Members | Employers | Providers | Brokers | About Wellmark'. The main heading is 'Providers Personalized Tools & Information for Providers'. Below this, there are several sections:

- Provider Service Hours and Numbers Change**: Includes links for 'Influenza Vaccine', 'Wellmark Holiday Phone Support Hours', and 'More News'.
- Claims and Benefits Quick Look-Up**: A form with fields for 'Patient Last Name', 'Patient First Name', 'Identification Number', and 'Date of Birth (mm/dd/yyyy)'. Below these are 'Dates of Service (mm/dd/yyyy)' with 'From' and 'To' fields. There are two buttons: 'Benefit Status' and 'Claim Status'.
- Claims**: Includes 'Check a Claim' and 'Create & Submit a Claim'.
- Payment Policies**: Includes 'Payment Policies for Professional Claims (CMS-1500)', 'Payment Policies for Outpatient Facility Claims (UB-04)', and 'Provider Fee Schedules'.
- Eligibility & Benefits**: Includes 'Check Patient Eligibility & Benefits'.
- Authorizations**: Includes 'Submit a Prior Approval', 'Manage Radiology Preauthorizations', and 'Notify/Pre-certify Admissions'.
- Wellmark.com Quick Links**: A list of links including 'Billing Guides', 'Medical Policies', 'Forms', 'Authorizations', 'Find a Doctor or Hospital', 'Drug Information', 'News', 'Publications', and 'Education'.
- Frequently Asked Questions**: Includes 'Where can I find the definitions for the BAPG codes listed on my remittance?' and 'FAQ Archives'.
- Have a Question for Us?**: Includes 'Ask a Secure Question', 'Track a Question', 'Iowa Provider Contacts', and 'South Dakota Provider Contacts'.
- COO Program Tools & Materials** and **Administrative Tools** are also visible at the bottom.

e tip Introducing Quick Look-Up

Now you can use Wellmark's new Quick Look-Up feature to access a Wellmark member's claims or benefits direct from the secure provider home page.

Simply enter all the displayed fields and select Benefit Status or Claim Status. As long as you have access to the secure information, your information will display with just one click.

Note: The first time you view the secure provider home page, if the Quick Look-Up option does not display, you may need to refresh your screen.

Contact Us by December 30 to Reactivate Disabled Account

If your account was disabled on November 1, your staff can no longer access Wellmark's secure online tools. To quickly reactivate your account and avoid completing a new application, contact us before December 30.

Once reactivated, your office's Designated Security Coordinator must immediately recertify the account.

Accounts not recertified by December 30 will be deleted. At that point, you must complete a new Web-Based Application Access Agreement to receive access to the secure tools.

For assistance with this process, e-mail Wellmark's Web Security at websecurity@wellmark.com. Please include your Taxpayer Identification Number (TIN) in your e-mail request.

Mythbusters: Electronic vs. Paper Claims

Claims that once required a paper submission can now be submitted electronically. Make sure your office is filing the following claims electronically to eliminate payment delays:

- Non Medicare COB Claims
- Medicare Crossover
- Modifiers 24, 25, 59
- Vaccines
- Subrogation
- Medicare Exhaust
- Medicare Advantage
- Dental

If you have electronic transmission barriers or ideas on how to increase electronic transmissions, contact EC Solutions.

Hours: 7:00 a.m. to 5:30 p.m., CT, Monday-Friday (except holidays)

Phone: 800-407-0267

Email: ECsolutionsDSM@hp.com

iCAP Processing BlueCard® Host Claims

Effective with processing date December 17, 2010, professional and outpatient facility BlueCard host* claims will edit through the iCAP system. This provides more consistent processing of claims filed with Wellmark.

Some iCAP policies are based on specific Wellmark member contract language or Wellmark's medical policies. Such iCAP policies will not be used to process BlueCard claims. To identify when an iCAP policy applies, access our secure site at www.wellmark.com (Providers > Payment Policies for Professional Claims OR Payment Policies for Outpatient Facility Claims > iCAP Specialty Policies) and look for the BlueCard Host Claims column.

This is a change to the previously communicated effective date of January 1, 2011.

Please note: The iCAP edits will apply to BlueCard claims based on Wellmark's processing date, not the date of service. Claim adjustments that are processed on or after December 17 will also be subject to iCAP edits, regardless of how or when the original claim processed.

**Claims for members of Blue Plans other than Wellmark.*

Seeking Feedback for Draft iCAP Specialty Policies

Wellmark is seeking feedback on the following professional (CMS 1500) and outpatient (UB-04) policies to take effect April 1, 2011.

- Additional Drug and Biological edits for J1440 and J1141 (Filgrastim)
- Additional Drug and Biological edits for J2505 (Pegfilgrastim)

Deadline for comments: March 15, 2011.

Draft policies are available on the Provider secure website under Payment Policies at <https://ebusiness.wellmark.com/provider/BlueConnection/welcome.htm>. Paper copies may be requested by writing to the address below. Send comments to iCAPSpecialtyPolicies@wellmark.com, or to:

iCAP Specialty Policies
Wellmark Blue Cross and Blue Shield
PO Box 9232
Des Moines IA 50306-9232
Fax: 515-376-9041

Provider Billing Guide Updates

The following billing guides or guide sections were updated during the second half of 2010:

Wellmark Provider Guide

- Contracts and Credentialing
- Health Management
- Payment and Reports

Guide to Billing Facility Services

- Home Services
- Inpatient Services
- Outpatient Services

Practitioner Guide

- General Medical
- General Surgery
- Gynecology and Maternity

- Laboratory, Pathology, and Radiology

Specialty Guides

- Anesthesia Services
- Behavioral Health
- Eye Care
- Home Infusion Therapy
- HME, Orthotics, and Protheses
- Physical Medicine
- Podiatry Services

The billing guides are all available on www.wellmark.com > Provider > Billing Guides. Each guide contains a page listing the changes, with links to the pages where changes appear.



Wellmark Contact Information Checklist

All Wellmark staff in Des Moines is in our new location. Please use the following checklist to make sure that you are using the correct information to contact us.

- Toll-free phone numbers, toll-free fax numbers, and post office boxes did not change.
- Wellmark's general corporate post office box address is:
Wellmark Blue Cross and Blue Shield of Iowa
PO Box 9232
Des Moines, IA 50306-9232
- If shipping an item that requires a street address, use:
Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue
Des Moines, IA 50309-2901
- All Des Moines area phone numbers (515 area code) have changed to a 376 prefix; extensions remain unchanged. For example, Provider Service's local phone number has changed from 515-245-4688 to 515-376-4688.
- Fax numbers in the Des Moines location will change by the end of December 2010. The numbers begin with a 376 prefix.
- To ensure that you are using the correct fax number, access Wellmark forms as needed at www.wellmark.com (Provider > Forms) and discard previously preprinted and stored forms, or forms saved to your computer desktop.
- Des Moines area fax numbers entered into the speed dial of your fax machine need to be updated.
- Local fax numbers in other Wellmark locations will be changing in early 2011.

Wellmark Holiday Phone Support Hours

Wellmark offices will be closed on the following dates:

- Thursday, December 23, and Friday, December 24
- Friday, December 31

During the holidays, you can continue to:

- submit electronic transactions and download reports
- use all secure online tools (if you have access)
- obtain basic information using the Interactive Voice Response (IVR) phone system when calling the Provider Service number
- request a prescription drug prior authorization¹

You will find more information about regular business hours at www.wellmark.com (Providers > Contact Wellmark > Business Hours).

¹On December 25, the prior authorization phone line (800-600-8065, option 1) for prescription drugs will be available from 8:30 a.m. – 5:30 p.m., Central time (CT).

EAPG UPDATE

Billing Observation Services

In most situations, the payment for observation services is included in the Enhanced Ambulatory Patient Grouping (EAPG) payment of another service or procedure, and is accounted for in the Relative Weights.

To consider the observation services for separate payment, the EAPG Grouper requires an observation admission code and an observation time code. Without this information, you will receive an Observation Admission Error.

- When billing a **direct admission for observation care**:
Bill the observation admission code (G0379) and the observation time code (G0378). Include the number of hours the patient was in observation.
- When billing observation which was **not a direct admission**:
Report the CPT® code that describes the observation services provided (99217, 99218, 99219, 99220, 99234, 99235, or 99236). Include the observation time code (G0378) and the number of hours the patient was in observation.

This is a correction to information published in the December 2009 issue of *Blue Ink*.

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Influenza Vaccines

Wellmark covers the seasonal influenza vaccine and its administration, including those provided outside your office, such as at a school or an employer's worksite. To be covered:

- the member must have coverage for immunizations*
- Wellmark must recognize the provider performing the service

Last year, Wellmark expanded its place of service options to include the following providers, giving more coverage access for members with immunization benefits:

- public health agencies (PHA)
- visiting nurse associations (VNA)
- certified pharmacists employed by pharmacies (covered as a drug card benefit)

To check a member's benefits online, use your access to secure *View Eligibility & Benefits* tools at www.wellmark.com.

If a clinic or a county VNA or PHA provides the service, place of service 60 (mass immunization center) is appropriate (submitted electronically or on a HCFA-1500). Wellmark will apply a member's office visit benefits for services billed with this place of service, so copayments may apply.*

List the seasonal influenza virus vaccine with the appropriate CPT** code (90660–90662), and code 90471 or 90473 for its administration. All of these codes are payable as long as the patient has benefits for the service provided.

Remember, Wellmark does not accept roster billing; submit individual claim forms for each patient. Wellmark pays contracting providers for the service provided. If the provider is noncontracting, Wellmark sends payment to the member.

2010–2011 Seasonal Influenza Vaccine

The U.S. 2010–2011 seasonal influenza vaccine will protect against an H3N2 virus, an influenza B virus, and the 2009 H1N1 virus that emerged last year. The Centers for Disease Control and Prevention (CDC) recommends that everyone 6 months and older get a 2010–2011 flu vaccine for the upcoming season, as vaccine is available.

*While Health Care Reform preventive care legislation will affect some of your patients' benefits, it does not affect all patients at the same time, and it will not apply to everyone.

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BILLING REQUIREMENTS

Utilizing Out-of-State Providers for Telemedicine Services

Imaging and Monitoring Telemedicine

Due to Blue Cross and Blue Shield licensing rules, Wellmark cannot contract with providers based outside of our service area. If an Iowa or South Dakota provider subcontracts with an out-of-state provider for technical or interpretive services, the local (Iowa or South Dakota) provider should bill Wellmark for the entire service (both technical and professional components). The out-of-state provider should not bill another Blue Plan but rather receive payment from the local provider for any services performed for his or her patients.

For example, your hospital subcontracts with an out-of-state radiology group to provide imaging reads on nights, weekends, and holidays. A Wellmark member or a member from another Blue Plan has an imaging service at your hospital during the hours the out-of-state radiology group is providing coverage. From a billing perspective, the hospital should bill both the technical and professional services to Wellmark. The out-of-state radiology group would receive payment for services from the hospital. The out-of-state radiology group should not bill Wellmark or another Blue Plan for those services.

Imaging/Monitoring Services				
Technical Site (Member's physical location at time of service)	Professional Site (Provider Location)	Plan Billed		Services Billed
		Technical Site	Professional Site	Global or Split Bill (with TC or 26 modifier, as appropriate)
Wellmark Plan area	Wellmark Plan area	Wellmark	Wellmark	Either global or split
Wellmark Plan area	Other Blue Plan area	Wellmark	Wellmark	Global bill from par physicians; facilities bill an institutional claim for technical component and professional claim for professional component

Audio-Visual Telemedicine

If you are an originating site for a patient, submit a claim to Wellmark with Q3014 (Telehealth originating site facility fee). The provider at the distant site will submit a claim to the local Blue Plan for the service provided.

For example, your hospital has the equipment to be an originating site. A Wellmark member or member from another Blue Plan comes to your hospital for a face-to-face (audio-visual) appointment with a practitioner in Ohio. From a billing perspective, your hospital would bill Wellmark for the originating service using Q3014. The practitioner in Ohio would bill the Ohio Blue Plan for the professional services performed.

Interactive Audio-Visual Services					
Originating Site (Member's physical location at time of service)	Distant Site (Provider Location)	Plan Billed		Services Billed	
		Originating Site	Distant Site	Originating Site	Distant Site
Wellmark Plan area	Wellmark Plan area	Wellmark	Wellmark	Q3014	Professional CPT + GT modifier
Wellmark Plan area	Other Blue Plan area	Wellmark	Other Blue Plan	Q3014	Professional CPT + GT modifier

If you have any questions regarding this policy, please contact your Network Relations Manager at 515-376-5167 (Iowa) or 800-700-9137 (South Dakota).

Updates in Claims Filing Instructions for HME Purchase and/or Repair

Please review the following updated home medical equipment (HME) payment guidelines and billing information.

Documentation Requirements, Payment Guidelines

Providers may submit either the Manufacturer's Suggested Retail Price (MSRP) or the invoice associated with the HME when no appropriate HCPCS code exists, or if the item has been customized so that no CMS price is available. The following payment guidelines apply for services provided on and after July 1, 2010:

- When an invoice is submitted, Wellmark's maximum allowable fee (MAF) is the equivalent of 120 percent of the invoice price.
- When the MSRP is submitted, Wellmark's MAF is the equivalent of 60 percent of the retail price.

Please note, both the invoice and/or the MSRP documentation must provide the price or cost as well as the description of the item(s) or part(s) being purchased, rented, or repaired. Information submitted cannot be handwritten or altered, and must be on the manufacturer, wholesaler, or biomedical technician's business letterhead.

We will be updating the HME, Orthotics & Prostheses provider billing guide, available at www.wellmark.com (Providers > Billing Guides > HME, Orthotics, and Prostheses Guide).

Health Care Reform-Related Claim Review

Recent coverage changes required by the new federal health care reform Affordable Care Act resulted in the addition of benefits to some individual policyholders effective September 23, 2010, or after.

Wellmark, like other health issuers, intended to implement ACA-related provisions on a "Policy Year" basis (January 1) for individual policies. This meant that Wellmark would not implement the ACA requirements in Wellmark individual policies until January 1, 2011. The Department of Health and Human Services (HHS) recently issued guidance advising that the provisions of ACA are applicable to individual policies issued as of September 23, 2010.

We are updating our system as quickly as possible to pay claims according to the recent HHS guidance. Until the updates are complete, some claims may process based on pre-ACA benefits.

We expect to have our system changes completed by first quarter 2011. To confirm that we have provided all of the benefits consistent with ACA, we will review all claims processed for those members who either purchased a policy or changed their existing plan on or after September 23, 2010, for dates of service on or after that date.

For Wellmark individual policies issued or changed on or after September 23, 2010, claims potentially affected include:

- Preventive care claims that resulted in a member liability.
- Services denied due to a preexisting condition for individuals up to age 19.
- Services in which payment was restricted by an annual dollar limit.
- Out-of-network emergency department services that were processed with an out-of-network cost-share.

If you are a participating provider, additional payments will be sent to your office.

We are notifying our members of the claims review.

Several Revenue Codes Require Detailed Coding

Some revenue codes require detailed coding. Claims received without the required CPT or HCPCS code will be denied. The requirement applies to services billed by all facilities, regardless of a facility's payment arrangement.

Wellmark has posted an online list of revenue codes requiring CPT or HCPCS codes, available at www.wellmark.com (Providers > Claims & Payment > Payment and Coding Policies for Billers > Outpatient Facility Claims).

The Difference between Filing a Corrected vs. a New Claim

One benefit of electronic claim submissions is the quick and easy identification of claims that did not transmit due to incomplete or inappropriate information. Such claims are listed on your Z16 report from Wellmark under the heading Claim Error Report. Typically, the Z16 report is sent within one day of your transmission.

If you submit a paper claim that is missing information, we reject the services on your Provider Claims Remittance (PCR) with an F or X code. The F or X code message will tell you to resubmit the claim with corrected or added information. At that point, you should edit the original submission and send to our office as you would if filing a brand new claim.

Remember, do not mark the resubmission as a “corrected claim,” and do not attach the claim to a provider inquiry form. Both indicate that you are submitting a request for an adjustment. Because the original submission did not pass Wellmark’s initial processing edits, these claims cannot be adjusted. Wellmark will return such resubmissions with a letter asking you to file as a new claim.

Note:

- The resubmitted claim can be submitted electronically, even if the first submission was a paper claim.
- Resend the completed claim as soon as possible to avoid timely filing issues.

MEDICAL POLICY REVISION

Thermal Capsulorrhaphy as a Treatment of Joint Instability

Effective October 1, 2010, thermal capsulorrhaphy is considered not medically necessary as a treatment of joint instability, including but not limited to the shoulder, knee, and elbow. The literature does not support the use of thermal capsulorrhaphy alone, or in combination with other arthroscopic procedures.

Noncovered Allergy Testing Services

The following services are not covered based on Wellmark’s Allergy Testing medical policy.

86001*	Allergen specific IgG quantitative or semiquantitative, each allergen
86343	Leukocyte histamine release test (LHR)
95065	Direct nasal mucous membrane test

For a complete list of allergy tests considered investigational because scientific literature has not provided proof of efficacy, visit www.wellmark.com (Providers > Medical Policies & Authorizations > Medical Policies > Allergy Testing).

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Medical Policy Update

Wellmark Blue Cross and Blue Shield’s medical policy team has recently updated or added the following medical policies. These and other policies can be viewed online at www.wellmark.com (*Providers > Medical Policies & Authorizations*). To find a specific policy, use the alphabetical list or enter a key word in the search field.

Remember, you can now view the medical policies of other Blue Plans using the Medical Policies and Authorizations Finder at www.wellmark.com (*Providers > Medical Policies and Authorizations*). Simply enter the member’s alpha prefix and select the type of information being requested—medical policy or general precertification/preauthorization information.

Revised Policies

Abdominoplasty and Panniculectomy*

- Added clarifying language to address when the removal of redundant skin and/or adipose tissue on other parts of the body is considered medically necessary.
- Added clarifying language on skin integrity criteria, including documentation requirements.

Bariatric Surgery for Morbid Obesity*

Added sleeve gastrectomy criteria to the medical policy.

Bevacizumab*

- Metastatic ovarian cancer, fallopian tube cancer, and primary peritoneal cancer in patients experiencing relapse or recurrence following primary cytotoxic chemotherapy has been added as a medically necessary indication.
- Newly diagnosed ovarian cancer has been added as one of the indications for which bevacizumab is considered investigational.

Biventricular Pacemakers for the Treatment of Congestive Heart Failure

Expanded medical necessity indications for all biventricular pacemakers.

Botulinum Toxin*

- Deleted “all headache types including migraines” from medical policy language.

- Effective November 1, 2010, added that the use of onabotulinum toxin A may be considered medically necessary for the prophylaxis of headaches in adult patients with chronic migraine (at least 15 days per month with headaches lasting four hours a day or longer).
- Added the following as investigational indications:
 - As prophylaxis or acute treatment of all other types of migraine headache including, but not limited to, episodic migraine.
 - As prophylaxis or acute treatment of all other types of headache including, but not limited to, chronic tension-type headache.

Extracorporeal Photopheresis

The treatment of cardiac allograft rejection that is recurrent or refractory to standard immunosuppressive treatment has been added as a medically necessary indication.

Minimally Invasive Spinal Fusion

- Axial lumbar interbody fusion (AxiaLIF® or AxiaLIF II®) is considered investigational.
- Extreme lateral interbody fusion (XLIF®) is considered investigational

Temsirolimus

- The second-line therapy as a single agent for relapsed, refractory, or progressive mantle cell lymphoma has been added as a medically necessary indication.

Thermal Capsulorrhaphy as a Treatment of Joint Instability

See story on page 15.

Transcatheter Arterial Chemoembolization (TACE) of the Liver

Added transcatheter arterial chemoembolization of the liver as neoadjuvant or adjuvant therapy in resectable hepatocellular cancer as an investigational therapy.

Retired Policies

The following medical policies were removed from our medical policy pages.

- Extracorporeal Immunoabsorption Using Protein A columns
- Double balloon enteroscopy

*Prior approval recommended

TriWest Offers Online Claims Correspondence and Webmail

You have shared your desire to correspond electronically with TriWest for resolution of TRICARE claims issues and inquiries. As a result, TriWest Healthcare Alliance introduces two tools for registered providers—online claims correspondence and Webmail. Available from the secure provider portal, these tools allow registered users to electronically submit claim-specific and general inquiries. Registered users can enter the Secure Message Center from the secure provider portal at www.triwest.com/provider by selecting *Send/View Webmail*.

Online Claims Correspondence

Registered users can use online claims correspondence for appeals, claim checks, and claim reviews. They will be prompted to enter claims-related information (e.g., a beneficiary's Social Security number and/or claims number). Users may also electronically upload supporting documentation, if required, to process their claims inquiry, appeal, or review.

Webmail

Webmail allows users to submit inquiries regarding general secure website topics (e.g., User Administration, Personal Profile, and Eligibility) that don't necessarily require an immediate resolution.

Note: For referral/authorization issues, users should continue to use the TriWest Online Service Center Tool by clicking *Technical Assistance with Submission Requests*.

Additional Secure Features

To take advantage of exciting new time-saving features, make sure you are registered for the secure provider portal at www.triwest.com/provider/registration. Registered users may:

- Verify patient eligibility.
- Research covered benefits and check referral/authorization and medical review requirements for specific codes.
- Submit referrals/authorizations online and check their status regardless of how the request was submitted.
- Submit claims online and check claim status regardless of how the claim was submitted
- Download remittance advices.
- Download claims status reports.
- Receive Electronic Funds Transfer (EFT)

Verification Mailing Needs Your Response

We need your help.

Beginning February 2011, Wellmark will be mailing or e-mailing TRICARE contracted providers their provider data, such as name and address, as listed on our database.

When contacted, please review the information to verify its accuracy, and return to us **within two weeks of receipt** whether changes are required or not. You may respond using the e-mail, fax, or mail contact information as listed on your notice.

Your provider data is significant because TRICARE beneficiaries access the information when searching for a provider. The information is also used for the Referral Authorization process.

Thank you in advance for your prompt attention in providing this vital information. We appreciate your participation in the Wellmark and TRICARE Networks.

TRICARE Webinars

Are you new to TRICARE or do you have new staff in your office? Or do you want to save time submitting your referral and authorization requests? Then participate in one or more of the upcoming TRICARE Provider Webinars.

Developed by TriWest Healthcare Alliance Corp. (TriWest), TRICARE webinars are designed for provider staff members who need to understand the basics of TRICARE programs but have a limited amount of time. The webinars offer participants a condensed version of our live seminars and the convenience of accessing the presentation from their own computer while listening to the instructor via conference call.

The **Secure Website – Referrals and Authorizations** webinar is one hour long, and will show you how to streamline your work relating to referrals and authorizations for your TRICARE West Region patients. Save time when submitting your requests!

The **TRICARE 101 Webinar** is approximately one hour long and covers the following topics:

- TRICARE Overview
- TRICARE Programs
- Clinical Programs
- Referrals and Authorizations
- Claims and Reimbursement
- Provider Resources

The **TRICARE Behavioral Health 101 Webinar** is approximately 90 minutes long and covers the following topics:

- TRICARE/TriWest Overview
- TRICARE Programs/Behavioral Health Benefits
- Clinical Programs
- Referrals and Authorizations
- Claims and Reimbursement
- Provider Resources

The **TRICARE Vision Benefit Webinar**, developed for vision providers, is approximately one hour long and provides a comprehensive review of the TRICARE vision coverage.

Advance Registration Required to Reserve Your Seat

To register for upcoming webinars, select Webinar from the “Stay Updated” section of www.triwest.com/provider. Then, select your preferred webinar. It’s that easy! Space for each session is limited, so register today.

Wellmark Health Plan of Iowa Practitioner Availability Standards

Wellmark Health Plan of Iowa, Inc., strives to ensure that all members have access to sufficient numbers and appropriate types of health care practitioners within reasonable proximity of their home. For this reason, Wellmark Health Plan of Iowa coverage—Blue Access®, Blue Choice®, and Blue Advantage®—is now available in most Iowa counties.

Before opening a new county for sales, Wellmark reviews the availability of primary care and selected specialty care clinicians. Tools that are used to verify availability include our provider directories, member enrollment counts, and maps that show the locations of practitioners in Iowa and in counties contiguous to Iowa.

The only Iowa counties **not** open to Wellmark Health Plan of Iowa are:

- Allamakee
- Dubuque
- Fayette
- Winneshiek

continued on page 20

2010 Wellmark Health Plan of Iowa HEDIS® Results for Acute Respiratory Care Measures

Wellmark Health Plan of Iowa 2010 Healthcare Effectiveness Data and Information Set (HEDIS®) results are finalized and available at www.wellmark.com. HEDIS is used by more than 90 percent of America's health plans. It is sponsored and supported by the National Committee for Quality Assurance (NCQA), and evaluates performance for clinical quality and member satisfaction.

Wellmark Health Plan of Iowa strives to obtain measurement rates in the 90th percentile, a benchmark based on national results. This article focuses on three measures in the category of "Getting Better" from the NCQA Health Plan Report Card, where 2010 results show that Wellmark Health Plan of Iowa is now even further from its goals.

In each case that follows, a higher value represents better performance.

Appropriate Testing for Children with Pharyngitis

This measures the percentage of children ages 2–18 years old who were:

- Diagnosed with pharyngitis
- Given a strep test
- Dispensed an antibiotic

2008	2009	2010	2010 Goal
67.87%	70.73%	▼ 67.86%	88.70%

In this case, a higher value means that more providers are prescribing antibiotics after the patient receives a strep test. The highest rate achieved in Iowa by another health plan was 82.25 percent.

Appropriate Treatment of Children with URI

This measures the percentage of children ages 3 months–18 years who were:

- Diagnosed with Upper Respiratory Infection
- NOT dispensed an antibiotic

2008	2009	2010	2010 Goal
77.10%	77.0%	▼ 76.40%	92.18%

A higher rate indicates appropriate treatment of children with URI. The highest plan rate for this measure in Iowa was 84.65 percent.

Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis

This measures the percentage of adults from 18–64 years of age with:

- A diagnosis of acute bronchitis
- NO antibiotics dispensed

2008	2009	2010	2010 Goal
22.62%	21.05%	▼ 19.0%	29.52%

A higher rate indicates appropriate treatment of adults with acute bronchitis. The highest plan rate in Iowa was 37.04 percent.

How Wellmark Ranked with Other Health Plans

Wellmark Health Plan of Iowa achieved the 10th percentile for all three of these measures, which means that 90 percent of the reporting health plans had better performance on these measures.

To help promote appropriate antibiotic use and support your plan of treatment, the CDC has available reference tools for your use. In addition, Wellmark has created posters and handouts appropriate for children and parents. For details, including how to respond to parents or daycare requests, please see the article "Combating Antibiotic Overuse" on page 8.

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

The source for data contained in this publication is Quality Compass® 2010 and is used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2010 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).



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continued from page 18

In 2010, Wellmark Health Plan of Iowa met all of its availability standards.



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If you have questions about information in this newsletter, please contact Provider Service in Iowa at (515) 376-4688 or (800) 362-2218; in South Dakota at (800) 774-3892.

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PASS IT ALONG!

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Availability Standards	Category	Standard	Goal
Primary Care Practitioner Standards Health care provider specialties eligible for PCP status are: general practice, family practice, internal medicine, and pediatrics. In some areas, physician assistants and advanced registered nurse practitioners may be available for selection as a PCP. Although a particular PCP specialty may not be available in a specific area, adequate PCPs are available to care for our members.	Number of PCPs per member	1 per 500 members*	100%
	Distance to PCP	1 every 20 miles*	100%
OB/GYN Provider Standards Providers eligible for this status include: obstetricians, gynecologists, advanced registered nurse practitioners, certified nurse midwives, and certified physician assistants.	Number of OB/GYN providers per member	1 per 2,000 members*	100%
	Distance to OB/GYN provider	1 every 45 miles*	100%
Specialty Services Standards Network Administration staff annually review member visit data to determine high-volume specialties. High-volume specialties for 2010 were orthopedic surgery, dermatology, otolaryngology, ophthalmology, psychiatry, psychology, and social work.	Number of specialists per member	1 in each identified specialty per 3,000 members*	100%
	Specialists (identified above)	1 in each identified specialty every 45 miles*	100%
Hospital Standards	Distance to hospital	1 every 45 miles	100%

*Practitioners must accept new patients/members to be counted within the compliance ratio.

VISIT OUR WEBSITE AT: www.wellmark.com