



An Independent Licensee of the Blue Cross and  
Blue Shield Association

# Guide to Billing Facility Services

# Inpatient. Services

**Preface**

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***May 2011***

*Replaces: October 2010*

# Preface

The *Wellmark Provider Guide* and specialty guides are billing resources for providers doing business with Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota. The guides are referenced in your provider agreement, and include information that applies to all benefit plans in Iowa and South Dakota unless specified within the text.

## Explanation of Terminology

Wellmark	Throughout the guides, the term Wellmark indicates Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., and Wellmark Blue Cross and Blue Shield of South Dakota.
Member	Individuals with health coverage through Wellmark are referred to as members.

## Provider Guide Updates

Wellmark's provider guides are continually updated to bring you the most current information. The following items identify when the guide or section was last changed.

- The most current date is printed on the front cover and inside pages. The date of the version replaced is also printed on the front cover.
- A *Summary of Changes* page lists all the substantial changes made in the most current update. The page(s) affected and a brief explanation of the change is linked from the *Summary of Changes* page to the change within the document.
- Changed text is in blue type.

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# **Guide to Billing Facility Services Inpatient Services Summary of Changes, May 2011**

## **Page 3**

PMIC (Psychiatric Medical Institute for Children) added to list of services requiring precertification.

Precertification is also required for FEP inpatient services.

## **Page 4**

Details on precertification requirements for FEP members, and precertification directions.

Continued Stay Review required for more than 30 days of PMIC (Pediatric Medical Institute for Children) services.

## **Page 5**

Inpatient precertification/notification matrix updated.

## **Page 6**

Notification/precertification requirements for behavioral health/chemical dependency.

## **Page 11**

Instructions for electronic billing of leave days.

## **Page 12**

Billing instructions for patients progressing from acute care to skilled level services.

# Inpatient. Services

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**Scope** Information in this guide applies to networks and products offered or administered by Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Blue Cross and Blue Shield of South Dakota, and Wellmark Health Plan of Iowa, Inc. The guidelines may also apply to Select First,\* the network administered by First Administrators, Inc., but as guidelines will vary, please check Select First coverage at <http://www.firstadministrators.com/> or call the phone number on the back of the member’s ID card for details.

**Use of terms** This section contains information about inpatient services provided to Wellmark members in Iowa and South Dakota. All contracting providers must comply with the requirements identified below as a term of their provider contracts. Unless otherwise noted, in this section the term “facility” refers to hospitals, skilled nursing facilities, and freestanding substance abuse facilities.

## I Covered Benefits

*Verify eligibility on the Web or by phone*

Inpatient benefits may vary, depending on the patient’s benefit contract. Typically, a member has benefits for inpatient services that may require a deductible and/or coinsurance. To check a patient’s benefits, use the secure online tools available on our website. You may also call Wellmark’s Iowa Provider Service at **800-362-2218** or **515-376-4688**; or Wellmark Blue Cross and Blue Shield of South Dakota’s Provider/Customer Service at **800-774-3892** or **605-373-7292**.

*Standard SNF benefit limit*

Wellmark’s *standard* inpatient skilled nursing facility (SNF) benefit is limited to 90 days per member per benefit period. This does not affect members covered by individual contracts or most Medicare Supplement plans. Some large employer groups may also choose benefits that differ from the standard. To determine a member’s coverage, log in to [www.wellmark.com](http://www.wellmark.com) and select *View Eligibility & Benefits*.

*First-time access to our secure online tools*

To gain first-time access to our secure online tools, apply by selecting the [Register for www.wellmark.com](http://www.wellmark.com) link on our website’s Provider page.

*Note: FEP members under age 65 do not have SNF benefits*

Federal Employee Program (FEP) employees under age 65 do not have a skilled nursing benefit. However, there may be exceptions when medically necessary, as determined by Case Management.

\*Select First® applies only to health plans administered by First Administrators, Inc.

## Management of Inpatient Services

*Wellmark's  
Care Coordination Unit*

Wellmark's Care Coordination Unit encompasses the activities of *utilization* management and *case management* in one unit. We combine these services to provide a seamless, member-centered experience for our customers. Our team of triage coordinators and case managers assist with coordinating inpatient and home services in accordance with the utilization and case management provisions of our Wellmark contracts. Throughout this document we will use the term "case management" to describe these services.

*Case Management  
provisions*

Most Wellmark contracts contain case management provisions. These provisions focus on the use of health care services that meet criteria for medical necessity. Wellmark's Care Coordination Unit monitors these case management provisions:

- notification of admission to critical care units
- precertification of admission for behavioral health/chemical dependency treatment
- precertification of admission for skilled nursing, swing-bed, and acute rehabilitation services
- notification of emergency admissions for behavioral health/chemical dependency
- case management
- precertification for home health, hospice, and home infusion services

*Wellmark's  
Care Coordination Unit*

The unit also conducts behavioral health and chemical dependency review, and home health, hospice, and home infusion therapy review. (See the section on Home Services for home health, hospice, and home infusion therapy information.)

*Benefit reduction for  
failure to precertify or  
notify of admission*

If the admitting facility or service provider has a provider contract with Wellmark, the facility or service provider is responsible for obtaining precertification or providing the required notices. A facility which fails to provide notification of or, where required, to obtain precertification for a medically necessary admission or service shall receive a benefit reduction of up to 50 percent, not to exceed \$5000. A contracting facility shall not bill the member for the benefit reduction.

*FEP benefit reduction  
for failure to precertify*

When a contracting facility or service provider fails to obtain the required precertification or to provide notification on behalf of a Federal Employee Program member, Wellmark is required to apply a \$500 benefit reduction. The member cannot be billed for this amount.

*Send discharge  
summary to PCP*

**Discharge Summary**

Hospital discharge summaries contain important information about a patient's history, condition, and discharge plan of treatment. Please make sure this information becomes part of the patient's permanent medical record by sending a copy of the discharge summary to the patient's Primary Care Practitioner (PCP).

# III

## Recording of Telephone Calls

*Creating a verifiable record*

Wellmark records all case management phone calls with providers and members. Our recording equipment produces a beep you may hear during conversations with our Case Management staff. This feature creates a verifiable record of our communication.

# IV

## Notification/Precertification Procedures

### Precertification

Precertification requires the patient's physician or the facility to precertify with Wellmark *prior to* providing these services:

- acute rehabilitation
- home health
- home infusion therapy
- hospice
- [PMIC \(Psychiatric Medical Institute for Children\)](#)
- skilled nursing

*Precertify online or by phone*

If you have security access, you can precertify/notify us of an admission online. Log in to Wellmark and click on *Notify/Precertify Admissions*. You may also call **800-552-3993** in Iowa or **800-642-9273** in South Dakota, or fax the information to **515-376-9013**.

To gain first-time access to our secure online tools, apply by selecting the [Register for \*www.wellmark.com\*](#) link on our website's Provider page.

*FEP Mental Health/ Substance Abuse services*

To precertify an FEP member's out-of-state inpatient admission for mental health or substance abuse, call **800-978-3222**. [Precertification is also required when inpatient services](#) are received at an Iowa or South Dakota facility. [You may precertify online, or by fax or phone. For details, see page 4 of this guide.](#)

*Inpatient admission notification requested*

### Inpatient Admissions

In response to requests from our employer groups, Wellmark has put in place a voluntary inpatient hospital admission notification program for our participating hospitals in Iowa and South Dakota. Under the program, Wellmark is requesting notification from hospitals of the admission of Wellmark members on the business day following admission. This program does not have a penalty or benefit reduction for noncompliance.

The purpose of this notification is to collaborate with the primary care provider in identifying the types of member health support programs appropriate and available for the member following hospitalization. Notification also enables Wellmark to maximize members' benefits.

Under the program, hospitals that contract directly with Wellmark are asked to notify us of the following admissions:

- acute medical and surgical admissions
- maternity stays that extend beyond the two-day vaginal or four-day cesarean delivery time frames
- extended stays for newborns

*Exceptions to voluntary notification program*

The voluntary notification program applies to all Wellmark benefit plans, **with the exception of** health coverage through the Federal Employee Health Benefits Program (FEP). It does not apply to Medicare Supplement or Select First®<sup>1</sup> members. Please follow the specific benefit requirements for precertification or notification required for these members. In addition, Blue Card® members, to the extent indicated on their ID card, continue to require precertification for every admission, or notification within 24 hours of an emergency admission.

*FEP inpatient precertification*

Precertification is required before an FEP member is admitted for inpatient care, including behavioral health/chemical dependency admissions and admissions for other medical care, or within two business days following a hospital admission for emergency care. Maternity stays extending beyond 2 days for vaginal or 4 days for cesarean delivery require precertification, as do extended stays for newborns.

*FEP precert online or by fax or phone*

To precertify, access the FEP prior approval form at [www.wellmark.com](http://www.wellmark.com) > Provider > Medical Policies & Authorizations. Providers with secure access to [www.wellmark.com](http://www.wellmark.com) may complete and submit the form online. The completed form may also be printed, signed, and mailed or faxed to Wellmark at the address/fax number on the form. Failure to precertify will result in a benefit reduction of \$500. The member cannot be billed for this reduction. If the stay is not medically necessary, no benefits will be paid. The phone number for FEP precertification is **800-532-1537**.

*Benefit reduction for failure to precertify*

*PMIC continued stay review*

If a Wellmark member requires more than 30 days of PMIC (Psychiatric Medical Institute for Children) services, we require a review for medical necessity, based on inpatient acute care criteria. Please call the case manager who completed the admission review to determine whether inpatient acute care criteria are being met.

*Out-of-state facilities*

Wellmark requires members to precertify admissions to out-of-state facilities.

*Notify Wellmark online, by fax, or by phone*

To precertify or notify Wellmark of an inpatient admission, complete the notification online if you have security access at [www.wellmark.com](http://www.wellmark.com). Select *Notify/Precertify Admissions*, or call **800-552-3993** in Iowa or **800-642-9273** in South Dakota. You may also fax the information to **515-376-9013**.

<sup>1</sup>Select First® applies only to health plans administered by First Administrators, Inc.

*Online notification/  
precertification* **Admission Notification/Precertification Overview Table**  
Below is a table outlining notification/precertification requirements for various types of contracts. You may notify Wellmark of admissions using the *Notify/Precertify Admissions* tool on the secure *Provider* page of [www.wellmark.com](http://www.wellmark.com), or by calling the phone numbers in the chart below.

<b>Inpatient Precertification/Notification</b>					<b>Provider Benefit Reduction for Failure to Precertify or Notify</b>
<b>Type of Care Type of Contract</b>	<b>Scheduled Acute Care; Obstetrics/ Gynecology; Critical Care Units</b>	<b>Skilled Nursing and Rehabilitation</b>	<b>Behavioral Health/ Chemical Dependency</b>	<b>Home Health; Hospice; Home Infusion Therapy</b>	
<b>Wellmark Blue Cross and Blue Shield</b>	Notification requested; not required. No penalty applies.	Precertification: online, or call <b>Iowa:</b> 800-552-3993 515-248-4429 <b>South Dakota:</b> 800-642-9273	Notification requested; not required. No penalty applies.	Precertification: online, or call <b>Iowa:</b> 800-552-3993 515-248-4429 <b>South Dakota:</b> 800-642-9273	Benefit reduction of the lesser of 50% or \$5000; member not to be billed
<b>Federal Employee Program</b>	Precertification required. \$500 penalty applies.	Precertification; online, or call phone # on ID	Precertification required. \$500 penalty applies.	Precertification; online, or call phone number on ID	\$500 penalty; member not to be billed

**Obstetrical Admissions**

Wellmark does not require admission notification for a normal maternity stay. However, hospitals that contract directly with Wellmark are asked to notify us when the stay exceeds 2 days for a vaginal delivery or 4 days for a cesarean section, and when newborns remain hospitalized for an extended stay. These guidelines apply to FEP members as well.

*Home health visit  
FEP exception*

Mothers and babies who are discharged after a normal obstetrical stay have a benefit for a home health visit within three days of discharge. FEP members are *not* eligible for this benefit.



**Behavioral Health/Chemical Dependency  
Scheduled and Emergent Admissions**

*Voluntary notification* Wellmark’s voluntary notification program is in effect for admissions to behavioral health/chemical dependency (BH/CD) services in hospitals, nursing facilities, and freestanding substance abuse facilities.

*Exceptions* Some groups require precertification for behavioral health/chemical dependency services. Always check benefits as described in our members’ benefit certificates.

*FEP inpatient precert required* The Federal Employee Program (FEP) requires precertification of all *inpatient* behavioral health/chemical dependency services. See **Inpatient Admissions** in this guide for details. FEP no longer requires precertification for outpatient behavioral health/chemical dependency services, including partial hospitalizations and intensive outpatient services.

Verify a member’s benefits online by logging onto [www.wellmark.com](http://www.wellmark.com). Under Provider Tools, select View Eligibility & Benefits. You may also call the appropriate provider service area. For details, see Wellmark’s Behavioral Health Services Guide on [www.wellmark.com](http://www.wellmark.com) > Provider > Billing Guides.

**Skilled Nursing Facility, Acute Rehabilitation Facility,  
Acute Care (FEP only), and Swing-Bed Admissions**

*Skilled nursing facilities (SNF), rehabilitation, acute care (FEP only) and swing-bed* Wellmark requires precertification before a patient receives services at a **skilled nursing facility (SNF) or an acute rehabilitation facility, or is admitted to a swing-bed**. Contracting facilities are responsible for obtaining precertification. This allows Care Coordination staff to verify that the services are being performed in the most medically appropriate setting.

*FEP exception* Note that Federal Employee Program members under age 65 do not have SNF benefits. However, there may be exceptions when medically necessary, as determined by Case Management.

*Benefit reduction for failure to precertify* A facility which fails to obtain precertification for a medically necessary admission or service shall receive a benefit reduction of up to 50 percent, not to exceed \$5000. A contracting facility shall not bill the member for the reduction of benefits.

*FEP penalty for failure to precertify* FEP regulations require Wellmark to assess the facility a \$500 penalty for failure to precertify an elective admission.

*Notification/  
precertification online,  
or by phone or fax*

Notify Wellmark of the admission using our secure Web tool on the Provider page of [www.wellmark.com](http://www.wellmark.com), or by phone: **In Iowa, call 800-552-3993 or 515-376-4409; in South Dakota, 800-642-9273.** Precertification may also be initiated from both states by faxing the request to Wellmark at **515-376-9013**, using the appropriate form available on [www.wellmark.com](http://www.wellmark.com) > Provider > Forms.

Wellmark requests specific information during the phone call, such as:

- patient's name and address
- patient's date of birth
- member identification number
- plan member's name
- patient's diagnosis
- plan of treatment

If the case manager is unable to approve benefits for the admission, he or she refers the case to a physician consultant. The physician consultant and the attending physician may conduct a telephone review to discuss the case.

## V Case Management

### *Definition of case management*

Case management helps patients with potentially long-term or high-cost medical conditions to preserve and best utilize their health care benefits. By offering alternatives to high-cost settings or treatment, case management provides an opportunity to contain costs and still maintain the appropriate level of needed services. The following are examples of medical situations that may benefit from case management:

- Ventilator dependency
- Bronchopulmonary dysplasia
- Neonatal congenital anomalies
- Muscle deterioration diseases
- Spinal cord injuries
- Traumatic brain injuries
- Osteomyelitis
- Cancer
- Severe burns
- AIDS
- Cystic Fibrosis

### *Employer participation*

An important facet of case management is the flexibility of benefit restrictions. Benefits may be expanded where treatment, even though outside the scope of covered services, clearly supports more cost-effective care. This may include coverage for services such as extensive training for family members, or medical equipment not traditionally reimbursed.

### *How case management works*

Case management requires the patient and family, health care team members and case manager to work together toward agreed-upon common goals. If there are benefits for the services described in the treatment plan, the case manager will communicate this agreement to the primary health care provider and the patient and then implement the plan.

Case managers usually identify case management candidates during the hospital admission and will work with hospital discharge planners; however, family members, the attending physician, home health agencies, or another source may make the initial contact.

The case manager and the patient's treatment team review all of the patient care needs and determine the level of support that is medically indicated and cost-effective. Each case management plan is unique and designed to meet the particular needs of each patient.

After accepting a patient for case management and implementing the treatment plan, the case manager monitors the patient's condition and medical needs. He or she revises the treatment plan if the patient's needs or condition changes, working with hospital discharge planners to facilitate the member's transition of care to an alternative setting when appropriate.



## VI Reimbursement for Covered Services

### Overview of how services are paid

Wellmark reimburses covered inpatient services based on the provider contract and payment rate in effect at the time your facility provides services. Wellmark does not use the rate in effect when you submit the claim to us or when we process the claim.

### Refer to the Provider Guide

#### Billing on the UB-04

To bill Wellmark, follow the guidelines in the Claims Filing Section of the *Wellmark Provider Guide*. A list of revenue codes for freestanding substance abuse facilities is found at the end of this section.

### Observation bed services

The use of an observation bed allows the physician to observe and evaluate a patient to determine the need for inpatient care. An observation bed may be used when the patient is presenting symptoms or conditions that are potentially life-threatening or emergent, or do not meet the criteria for acute care.



Observation bed services are generally provided for less than a 24-hour period, but may on rare occasion be extended to 48 hours. The observation bed period begins when the physician makes the decision to place the patient in an observation bed.

Observation bed status is **not appropriate** when used for:

- Elective or non-emergent preoperative care
- Outpatient surgery with postoperative medical complications that meet Wellmark's criteria for acute level of care
- Outpatient surgery
- Members undergoing outpatient diagnostic treatment who require *normal recovery*
- Patients who meet medical necessity guidelines for Intensive Care Unit/Critical Care Unit

### Inpatient admission

If the health status of a member admitted to an observation bed changes so that an inpatient admission is necessary, the observation bed charges and associated ancillary charges should be billed as part of the overall inpatient stay. The admission date is the date the physician orders the admission of the patient to inpatient acute care. See sample claim.

If a procedure is performed more than one day prior to the admission date, please see "Billing an Outpatient Procedure that Results in a Subsequent Admission" in the *Outpatient Services* section of the *Guide to Billing Facilities Services*.

## Sample Inpatient Claim

Patient was placed in an observation bed on 7/18/YYYY. On 7/19/YYYY the patient was admitted as an inpatient. The patient was discharged on 7/21/YYYY.

1 PATIENT NAME		2 PATIENT ADDRESS		3 PATIENT PHONE		4 TYPE OF BILL	
Jane Doe						0719yyyy 0721yyyy	
10 BIRTHDATE		11 SEX		12 DATE OF ADMISSION		13 ICD-9 CODE	
10171934		F		719yyyy			
14 OCCURRENCE CODE		15 OCCURRENCE DATE		16 OCCURRENCE CODE		17 OCCURRENCE DATE	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
0762		Observation Bed				\$\$\$cc	
0120		Room-Board				\$\$\$cc	
0270		Med./Surg Supplies				\$\$\$cc	
0300		Lab				\$\$\$cc	
0320		DX X-Ray				\$\$\$cc	
0001		PAGE OF		CREATION DATE		TOTALS \$\$\$cc	
38		39		40		41	
42		43		44		45	
46		47		48		49	
50		51		52		53	
427.90						786.50	
54		55		56		57	
58		59		60		61	
62		63		64		65	
66		67		68		69	
70		71		72		73	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	

*Private room charge/  
isolation room charges*

Currently Wellmark allows a private room charge *only* for isolation of infectious conditions, reverse isolation, radiation implant therapy and eclamptic OB patients.



Wellmark considers isolation medically necessary when:

- the patient's health or recovery might otherwise be compromised
- other patients may be affected by the patient's symptoms or treatment, or by the spread of infection

Submit revenue code 0164 to identify patient care for services provided in isolation or in a sterile environment.

A written statement by the doctor ordering a private room is not the controlling factor in establishing medical necessity for isolation. The question is whether isolation is necessary for the health of the patient or of other patients. Do not bill for an isolation rate if it does not meet the medical necessity criteria discussed above.

*Leave days*

Bill leave days with revenue code 0180 [in loop 2400 SV201 on electronic claims](#) or in form locator (FL) 42 on the UB04. This code indicates a patient went home from the hospital for a brief period of time. Wellmark does not cover leave days; however, leave days must be reported for the accommodations units to match the Statement Covers Period field ([loop 2300 DTP03 where DTP01 = 434 on the electronic claim](#) or FL 6 on the UB04).

*Outpatient services  
as inpatient care*

Bill outpatient services performed at your facility within 1 (one) calendar day of an admission on the inpatient claim when the services are related to the admission. These services are considered related to the inpatient admission if they are provided in connection with the principal diagnosis that necessitates the admission.

*Mother/child claims*

Bill all obstetrical claims on two separate claim forms, one for the mother and one for the baby. Use the infant's full name on the claim. Remember that many new mothers qualify for a home health visit within three (3) days of discharge. When the mother's stay does not exceed the normal length of stay for vaginal delivery (2 days) or Cesarean delivery (4 days), the physician should order a home health visit to review mother's and baby's health in the home.

*Discharge from acute care to skilled*

When an acute care patient progresses to a skilled level of care while remaining in an acute bed, it is important to first “discharge” the patient from acute care. Bill the skilled claim separately using your NPI.

*Submit two bills for skilled level services*

Facilities billing for skilled level services must submit two separate bills.

1. Discharge the patient from acute care with the correct patient status listed in [status loop 2300 CL103 for electronic claims](#) or in form locator (FL)17 on the UB-04 claim form. Bill any acute services on this claim. Use the facility’s acute care NPI.
2. File a second claim for the skilled level services and reflect the NPI in [loop 2010AA NM109 for electronic claims](#) or in FL 56 on the UB-04 claim form.

Remember that the Type of Bill ([loop 2300 CLM05](#) or FL 4) on a swing-bed claim should include a “1” as the first digit, “8” as the second, and an appropriate third digit. Use this Type of Bill even if the patient remains in an acute bed but receives skilled care. For a list of Type of Bill digits, consult the Claims Filing section of the *Wellmark Provider Guide*.

### **Rehabilitation Services**

*Rehabilitation services use special NPI*

Hospitals with a Medicare certified rehabilitation unit are assigned a separate NPI. Use this provider number with Type of Bill 0111 when billing inpatient services provided in this unit. These services must be submitted on a separate claim from acute care services the patient may have received in the hospital setting. First bill the acute care services and indicate the patient’s discharge from this setting in loop 2300 CL03 on an electronic claim, or by entering 62 (Acute Claim) in the Patient Status field (FL 17 on a paper claim form). Next, bill the inpatient rehabilitation services, using the date the patient entered the Medicare certified unit as the new admit date. The Admit date is found in loop 2300 DTP01 = 435 DTP02 = D8 then DTP03 = CCYYMMDD or if DTP02 = DT, DTP03 = CCYYMMDDHHMM. On a paper claim, enter the date in FL 12. (Example: Patient is discharged from acute care on 01/15/07 and admitted on 01/15/07 to the Medicare certified rehabilitation unit.)

*Acute care services*

*Rehabilitation services*

*Payment reduction for failure to precertify*

If the admitting facility or service provider has a provider contract with Wellmark, the facility or service provider is responsible for obtaining precertification for acute rehabilitation services. Failure to obtain precertification for a medically necessary service shall result in the following payment/benefit reductions:

*When service provider is responsible*

When a service provider is responsible for obtaining the precertification and fails to obtain it, the service provider shall receive a payment reduction of the lesser of 50 percent of the maximum allowable fee (MAF) or \$5000. The service provider cannot bill the member for this payment reduction.

*Payment reduction when member is responsible*

When a member is responsible for obtaining precertification and fails to obtain it, the member shall receive a benefit reduction of the lesser of 50 percent of the maximum allowable fee (MAF) or the dollar amount specified in the member's contract.

*Billing employed or contracted CRNA services*

**Anesthesia Services**

- Bill hospital employed and/or contracted certified registered nurse anesthetist (CRNA) professional services on a CMS-1500. Wellmark's facility reimbursement allows for the technical services provided, but does not include settlement for professional services.

*Bill actual minutes*

- Bill the actual time spent administering anesthesia services electronically in loop 2400 SV104 where SV103 = MJ (minutes), or in the Units of Service field (24G) on the CMS-1500.
- Submit *actual minutes* only—do not add base units to the time
- Use CPT\* codes 00100–01999 to report anesthesiology services; do not use surgical CPT codes.
- Use modifier QY (medical direction of one CRNA by an anesthesiologist), AD (medical supervision by a physician; more than four concurrent anesthesia procedures), QK (medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals), or QX (CRNA service: with medical direction by a physician) when an anesthesiologist is directing the CRNA service and there is no employer/employee relationship.

For more specific information on how to bill anesthesiology services, please refer to the *Wellmark Anesthesia Services Guide*.

*Removal of impacted teeth*

**Dental Procedures**

Many Wellmark contracts *exclude* inpatient hospital services for surgical removal of teeth, except when the patient has a non-dental, physical condition that makes hospitalization medically necessary to safeguard the patient's health. To check dental benefits, contact Provider Service at **800-362-2218** or **515-376-4688 (Iowa)**; or **800-774-3892** or **605-373-7292 (South Dakota)**.

*Bill appropriate revenue codes*

**Nursing Facility Revenue Codes**

Do not bill for any services not performed in your facility. For example, a nursing facility would not bill for diagnostic or surgical services normally provided in an acute care setting.

*Hospital-acquired conditions*

**Noncovered Services**

Inpatient services related to hospital-acquired conditions (HAC) will be provider liability. For a complete list of CMS HAC diagnosis codes, please visit the CMS website at <http://www.cms.hhs.gov/HospitalAcqCond/Downloads/HACFactsheet.pdf>.

# VII. Freestanding Substance Abuse Facility Revenue Codes

Revenue codes for  
FSAFs

The revenue codes listed below are the specific codes to be used in form locator 42 on a UB-04 claim. Wellmark reimburses services according to the member's contract.

UB-92 Category	Revenue Code	Service Units	Standard Revenue Code Description
011X	0114	# of Days	Private Room Psychiatric
	0116	# of Days	Private Room Detoxification
012X	0124	# of Days	Semi-Private Psychiatric
	0126	# of Days	Semi-Private Detoxification
<ul style="list-style-type: none"> <li>Submit ancillary revenue codes in addition to the room and board codes listed above.</li> </ul>			
<b>Ancillary Revenue Codes</b>			
025X	0250		Pharmacy
	0253		Take Home Drugs
	0256		Experimental Drugs
	0257		Nonprescription Drugs
	0259		Other Pharmacy
027X	0270	CPT*/HCPCS	Medical Supplies
	0273		Take Home Supplies
030X	0300	CPT/HCPCS	Laboratory
043X	0430	CPT/HCPCS	Occupational Therapy
063X	630		General
	631		Single Source Drug
	632		Multiple Source Drug
	633		Restrictive Prescription
	634		Erythropoietin (EPO) less than 1,000 units
	635		Erythropoietin (EPO) 1,000 units or more
	636		Drugs requiring detailed coding
637		Self-administrable drugs	
091X	0914	CPT/HCPCS	Individual Therapy (OP)
	0915	<i>and</i>	Group Therapy (OP)
	0944	# of Sessions	Drug Rehabilitation
	0945		Alcohol Rehabilitation

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*Questions?* With questions about topics in this section, **Iowa** providers should call Wellmark's Provider Service Center at **515-376-4688** or **800-362-2218**; **South Dakota** providers should call our Provider Service Center at **800-774-3892** or **605-373-7292**.

## Iowa Service Contacts

Wellmark Blue Cross and Blue Shield of Iowa  
Wellmark Health Plan of Iowa, Inc.  
Des Moines, IA 50306-9232

**Wellmark Blue Cross and Blue Shield of Iowa\***  
**Wellmark Health Plan of Iowa, Inc.\***  
..... 800-362-2218 or 515-376-4688

**Federal Employee Program\***  
..... 800-532-1537 or 515-376-4784

**Tyson Foods**  
..... 800-526-5710

**Iowa Bankers** *for benefit questions only*  
..... 800-258-1415 (call 800-362-2218 for claims issues)

**UI Care, UI GradCare, and UI Select**  
..... 800-355-2031

**Ford Retirees**  
Physicians ... 800-344-8525; Facilities ... 800-249-5103

**Admission Notification, Precertification, and Case Management**  
..... 800-552-3993

**Network Relations**  
..... 515-376-5167

Contact to discuss contracting opportunities in your area

**Pregnancy Program\***  
..... 866-460-9742

**Disease Management Program\***  
..... 866-816-5264

**Network Administration\***  
.... 800-708-1342 or 515-376-5100

Providing information about:  
network participation      provider number  
address change              application status  
credentialing/recredentialing status  
taxpayer identification number change

**BlueCard® Program\***  
*Out-of-state members' claim status or payment information*  
..... 800-362-2218 or 515-376-4688  
*Out-of-state members' eligibility information*  
.... 800-676-2583

**EC (Electronic Commerce) Solutions\***  
..... 800-407-0267  
Providing: Electronic claims and reports information

**Pharmacy Department**  
..... 800-600-8065

## South Dakota Service Contacts

Wellmark Blue Cross and Blue Shield of South Dakota  
Sioux Falls, SD 57104

**Wellmark Blue Cross and Blue Shield of South Dakota\***  
*Provider/Customer Service Center*  
..... 800-774-3892 or 605-373-7292

**Federal Employee Program\***  
..... 888-800-1359

**Tyson Foods**  
..... 800-526-5710

**Admission Notification, Precertification, and Case Management**  
800-642-9273

**Network Relations**  
.... 800-700-9137 or 605-373-7460

*Fax Numbers*  
..... 888-517-9419 or 515-376-9039  
Contact to discuss contracting opportunities in your area

**Pregnancy Program\***  
..... 866-460-9742

**Disease Management Program\***  
..... 866-816-5264

**Network Administration\***  
.... 800-708-1342

Providing information about:  
network participation      provider number  
address change              application status  
taxpayer identification number change

**BlueCard® Program**  
*Out-of-state members' claim status or payment information*  
..... 800-774-3892

**EC (Electronic Commerce) Solutions\***  
..... 800-407-0267  
Providing: Electronic claims and reports information

**Pharmacy Department**  
..... 800-600-8065



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\*You will find e-mail links to these areas from our website at  
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For Providers and on the next screen, choose your state.