



An Independent Licensee of the Blue Cross and
Blue Shield Association

Guide to Billing Facility Services

Outpatient Services

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Service Contacts

August 2011
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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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We invite you to print Wellmark's provider guides from the website. However, if you prefer to order a paper copy, simply complete a Provider Forms Order (IA: B-0002; SD: B-3001) found on [Wellmark.com > Provider > Communication & Resources > Forms](#), or in the Member and Service Information section of the *Wellmark Provider Guide*. If you do not have a forms order blank, contact a Provider/Customer Service representative for assistance. We will inform you of guide updates in the *Blue Ink* newsletter or on the Provider page of our website.

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Outpatient Section – Facility Services Guide Summary of Changes – May and August 2011

Throughout: Updated URLs and instructions for finding tools and information on the redesigned Wellmark.com. While these updates appear in blue print, they are merely navigational changes, and are not listed individually on this page.

Page 2

iCap edits now apply to BlueCard claims, and to claims where Wellmark is the secondary payer. Those categories were removed from the list of exceptions.

Page 3

Information added on using modifiers 50* and 51.

Page 6

The Federal Employee Program (FEP) no longer requires precertification/notification for **outpatient** behavioral health/chemical dependency services. However, **inpatient** behavioral health/chemical dependency services for FEP members now require precertification.

Page 9

Home Medical Equipment (HME) must be billed using the HME provider's National Provider Identifier (NPI).

Page 10

Details on billing observation services for separate payment.

Page 12

Billing guidance for Outpatient Services/Observation Bed/Inpatient Admissions.

Hospital outpatient departments and ambulatory surgical centers must report and bill supplies described by HCPCS codes as provided incident to a physician's service.

Page 13

All outpatient services provided during a visit are processed using Enhanced Ambulatory Patient Groupings (EAPG) methodology. *Exception: Drugs and ambulance services.* Outpatient therapy claims are subject to consolidation.

Information on denial line message codes M376 and M003.

Page 15

Added instruction for billing Not Otherwise Classified drugs on 5010 formatted institutional claims.

Page 16

Preauthorization not required for radiologic guidance imaging, just for outpatient diagnostic imaging services.

Page 17

When possible, always refer a patient to a network provider. When referring a Wellmark Health Plan of Iowa (WHPI) member to an out-of-network provider, you must also submit a referral to WHPI for preservice review and approval.

Page 18

Before performing an outpatient diagnostic imaging procedure, verify that the procedure has been preauthorized.

Page 20

Billing instructions for revenue codes 36X, 49X, and 75X.

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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, 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.

FAI

This section contains information about outpatient services provided to Wellmark members. 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, behavioral health and chemical dependency facilities, freestanding substance abuse facilities, renal dialysis centers and ambulatory surgery centers in Iowa and South Dakota.

I Outpatient Services

Billing Information for Outpatient Facility Services

Bill outpatient services on UB-04

Outpatient facility services are typically billed electronically. They may also be billed on the UB-04 (CMS-1450) using the most appropriate revenue code(s) and CPT®* or HCPCS codes when required. Be sure to include the hour of admission in the appropriate field.

Besides the billing information in this section, we encourage you to reference the Claims Filing section of the *Wellmark Provider Guide* for general billing instructions and information on how to bill outpatient services with date spans and series claims usually submitted for outpatient therapy or chemotherapy treatment.

Billing behavioral health/chemical dependency services

For detailed information that explains how to bill outpatient behavioral health and chemical dependency services, please refer to Wellmark's *Behavioral Health Guide* [on Wellmark.com](http://Wellmark.com) > Provider > Communication & Resources > Billing Guides.

Wellmark pays for covered outpatient facility services according to the terms of the member's benefit contract. Payment rates are based on your facility's contract and the payment rate in effect at the time you provide services.

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iCAP Edits

iCAP edits apply to outpatient facility services

Wellmark applies *iCAP* (Improve the Claims Adjudication Process) edits to outpatient facility claims. *iCAP* edits allow for greater consistency in claims processing, improve claims accuracy, and align Wellmark's policy with national coding and billing guidelines. Outpatient services billed by the following facilities are subject to *iCAP* edits:

- hospitals
- ambulatory surgery centers
- dialysis centers
- psychiatric mental institutes for children
- behavioral health/chemical dependency centers
- Veteran's Administration hospitals
- skilled nursing facilities
- birthing centers

iCAP edits apply to all Wellmark outpatient claims and adjustments *except*:

iCAP exceptions

- Medicare supplement
- MedicareBlueSM PPO

iCAP policies apply to Federal Employee Program (FEP) professional and outpatient facility claims.

Wellmark adopts CCI edits to process claims

Wellmark uses CMS' (Centers for Medicare & Medicaid Services) CCI (the National Correct Coding Initiative) edits. CCI edits only apply to services performed by the same facility on the same date of service. A complete list of CCI edits can be viewed online at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>.

Wellmark's iCAP hospital outpatient payment policies

In addition to using CCI edits, Wellmark also has developed *iCAP* hospital outpatient payment policies. These policies are published on the secure Wellmark provider Web pages at Wellmark.com (Providers > Payment Policies > UB-04). If you need security access, complete the application available at the [Register for Wellmark.com](#) link on our website's Provider page.

Modifiers

With the implementation of iCAP, Wellmark is now able to process modifiers for outpatient facility claims. We can process up to four modifiers per claim line. Our processing may change the order of the modifiers based on an established priority. Modifiers that affect payment (i.e., modifiers 52* or 73) will be listed first, with informational modifiers secondary.

Requesting a Modifier Correction

Do not request a review of a claim denied for one of these edits by submitting medical records. Please review the patient's medical records first to see if the correct codes and modifiers were submitted. If the claim was not processed correctly because of a missing or inappropriate modifier, please:

- [log in to Wellmark.com](#). Select Check Claims Status and choose *Ask a Question* from the drop-down menu at the upper right. Complete the form, asking that a modifier be added and the claim reprocessed,
- submit a provider inquiry form (Provider > Forms > [Provider Claim Review Forms \[#B5403 for IA or #B3402 for SD\]](#)), or
- call a Provider/Customer Service representative (see back cover)

Claims corrections appear on your remittance advice as an adjustment to the original claim number so you can easily track and reconcile corrections.

Inappropriate use of modifiers will cause a claim to deny. Providers who receive an electronic remittance advice will see up to four modifiers on their report; paper remittances will not include modifiers.

50 modifier To bill a bilateral procedure, report the procedure with the 50 modifier on one claim line with one unit of service. [This modifier will process at 150 percent of Wellmark's Maximum Allowable Fee \(MAF\) when appropriate. Wellmark uses the CMS bilateral indicators found in the Physician Fee Schedule file to determine correct billing.](#)

51 modifier [Wellmark processes surgeries applicable to multiple surgery reduction at 50 percent of Wellmarks's MAF. These are defined by the Enhanced Ambulatory Patient Groupings \(EAPGs\) as multiple significant procedures.](#)

52 and 73 modifiers Modifiers 52 (reduced services) and 73 (discontinued procedure prior to the administration of anesthesia) are paid at 50 percent of the maximum allowable fee.

Bypassed modifiers Wellmark recognizes CMS' list of modifiers that can be bypassed, including: 25, 59, LT, RT. Modifiers 78 and 79 **are not** bypassed.

Add-On Codes

Add-on codes Add-on codes are performed in addition to the primary service, and must never be reported as stand-alone codes. Add-on codes are found in Appendix D of *CPT*. Add-on codes reported inappropriately are denied.

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iCAP edits on PRAs

iCAP Edits on Provider Remittance Advice Reports

If a claim is altered because of an iCAP edit, a Claim Adjustment Reason Code and its corresponding ANSI message will appear on the Electronic Remittance Advice (835 Report). A list of the ANSI messages and their corresponding, detailed "I" messages are available on Wellmark.com > (Provider > Claims & Payment > Outpatient Facility Claims (UB-04)). Paper remittances provide "I" messages to explain iCAP edits.

The following information explains how to bill services usually performed in the outpatient department of a hospital or an ambulatory surgery center. The information is listed in alphabetical order.

Accidents caused by external force

Accident Care

Wellmark defines an accidental injury as "injury, independent of disease or bodily infirmity of any other cause, that happens by chance and requires immediate medical attention." Under this definition, accidents are viewed as originating from some outside factor. For example, a bee sting is considered an accident, just as a fall from a tree is an accident. Both injuries were caused by an external force causing injury to the insured member.

E-codes

External causes of accidents are identified by the E-codes in ICD-9-CM. E-codes should never be used as primary diagnoses. Currently, Wellmark does not require you to use E-codes when billing for accidental injuries.

Accident vs. medical condition

The difference between an accident and a medical condition is important for accurate processing of claims. ICD-9-CM codes can help to differentiate between the two by identifying the source of the patient's complaint.

For example, ICD-9-CM code 847.2, lumbar sprain or strain, relates that the patient suffered an accidental injury to the lower back. A sprain or strain is caused by an external force. This claim requires an accident date to show when the external force caused the injury.

However, if the patient complains of pain without an external force, the physician may code that patient's condition as 724.2, lumbago. This claim does not require an accident date since the code indicates the patient has had the condition for an indefinite period of time.

*How to bill
accident care*

Complete the following Form Locators (FLs) on the UB-04 when billing out-patient accident care:

UB-04 Required Fields for Accident Claims	
FL	Description
67	Diagnosis
31 – 34	Occurrence Codes Note: The date associated with these occurrence codes cannot be after the "through" date of the Statement Covers Period (FL 6).
31	Accident/injury date

Some contracts require that patients report accidental injuries within 24 hours to obtain accident care benefits.

*Use code "05" when
no other party involved*

Occurrence Code 05 indicates "Other Accident" and is appropriate to use when no other party is involved in causing the accident. If the other occurrence codes are used, or if our records show a history of other coverage, the patient will receive a letter asking if other coverage exists.

Report other coverage

If the patient has other coverage, please note the name of the payer in FL 50. It is important that you give us as much information on other coverage as possible to allow for coordination of benefits.

Claims for non-accident medical care could have a date of onset indicated in FL 32. However, Wellmark requests that you use this Form Locator **only when** the medical condition appears to be a medical emergency. (See the information on medical emergency.)

Ambulance (Hospital-Based Services)

Bill hospital-based ambulance services by using either revenue code 0540 for ground ambulance or 0545 for air ambulance in FL 42, and a CPT*/ HCPCS code in FL 44, as indicated in the "Transportation Services Including Ambulance" section in HCPCS. Use valid ambulance origin and destination modifiers with all transportation service codes. When billing ground ambulance, indicate the number of miles in FL 46 (service units). Ambulance services must meet medical necessity guidelines to be reimbursable by Wellmark. The Type of Bill (FL 4) must be outpatient (013X).

42 Rev CD	43 Description	44 HCPCS	45 Serv Date	46 Serv Units
0540	Ambulance	A0426		1
0540	Mileage	A0425		32

*iCAP Specialty
Policies*

Log in to access additional details under iCAP Specialty Policies on Wellmark's secure provider pages at https://ebusiness.wellmark.com/provider/securecontents/paymentpolicies/UB_04.htm.

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Transport services

Hospital-based ambulance services to transport the patient from the scene of an accident or a home should not be included with an inpatient claim since it is not part of the hospital's per case payment rate. If ambulance services are required to transport an inpatient from the hospital to a freestanding service, such as MRI, the charge for the ambulance is included in the case payment and should not be billed separately.

*Bill CRNA services on
CMS-1500*

Anesthesia Services

To receive proper reimbursement for professional services, submit certified registered nurse anesthetist (CRNA) professional services on a CMS-1500 claim form. The reimbursement is intended to allow for the technical services provided and will not include payment for any professional services performed during the procedure, including hospital-employed CRNA professional services.

*Behavioral health/
chemical dependency
precertification
requirements*

Behavioral Health/Chemical Dependency

The Federal Employee Program (FEP) **no longer requires** precertification/ notification for **outpatient** behavioral health/chemical dependency services. **However, inpatient** behavioral health/chemical dependency services for FEP members **now require precertification**.

To verify a member's benefits online, [log in to Wellmark.com](#). Select [View Eligibility & Benefits](#). You may also verify benefits by calling the appropriate provider service area.

*Cardiac Rehabilitation
Phase II*

Cardiac Rehabilitation

Cardiac Rehabilitation Phase II programs structure the cardiac patient's adjustment to a healthier lifestyle while monitoring the patient's medical condition. Phase II programs are a benefit for Wellmark covered members. Wellmark identifies revenue code 0943 for Cardiac Rehabilitation Phase II services. Use CPT code 93798* in FL 44 to bill Cardiac Rehabilitation Phase II.

93798 Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)

42 Rev. CD	43 Description	44 HCPCS/Rates	45 Serv. Date
0943	CARDIAC REHAB	93798	

*Cardiac Rehabilitation
Phase III*

Bill Phase III services as revenue code 0942, Education and Training. Because these services are educational in nature, Wellmark does not provide benefits for Phase III services.

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Colonoscopies

The following information explains how to file a claim for colonoscopy services, depending on the diagnosis.

General Screening

When a member receives a general screening and does not require any other service at the time of the visit, and has no personal or family history, submit ICD-9 code V76.51 as the primary diagnosis.

Note: Wellmark does not cover office visits or consultations billed with ICD-9 code V76.51 prior to the colonoscopy. These visits/consultations deny as a participating provider's liability.

General Screening Scheduled—Colonoscopy and Other Surgery Performed

If a member is scheduled for a routine colonoscopy, but upon examination the physician removes a tumor or polyp, or performs a biopsy, bill these services in the following manner:

- Bill V76.51 as the primary diagnosis. The screening should be listed as the first diagnosis when a patient with no personal history of gastrointestinal disease and no signs and symptoms has a screening colonoscopy performed, and a polyp is revealed and removed.
- Select a code from CPT code range 75379–45392* that most accurately describes the service performed.
- Do not submit CPT code 45355 or 45378 when a more specific CPT code is available.

Family History/Screening Examination

When a colonoscopy is scheduled and performed because the patient has a family history of colon cancer or polyps, use V76.51 as the primary diagnosis and V16.0 (Family history of malignant neoplasm; gastrointestinal tract) as an additional diagnosis. The screening should be billed as the primary diagnosis *as long as the patient has no personal history of gastrointestinal disease and is without signs and symptoms.*

Personal History/Following Surgery

When a colonoscopy is scheduled and performed because the patient has a personal history of colon cancer or polyps, use V67.0 (Following surgery) as the primary diagnosis, and one of the V codes as an additional diagnosis:

V10.05 - Personal history of malignant neoplasm; large intestine

V12.72 - Diseases of digestive system; colonic polyps

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If more cancer or a polyp is found at the time of the follow-up exam, bill the principal diagnosis as 153.x or 211.3 with the secondary diagnosis of V10.05 or V12.72, depending on the situation.

153.x - Malignant neoplasm of colon
211.3 - Benign neoplasm of other parts of digestive system; colon

Revenue Codes Used to Bill Colonoscopy

Revenue Code	Description
0360	Operating room services
0490	Ambulatory surgery center
0750	Endoscopy room

Diagnostic Testing Lab and X-ray

Iowa
*Deductible waived on
diagnostic laboratory
or x-ray services*

In **Iowa**, some Wellmark members are not required to pay a deductible for most diagnostic laboratory or x-ray services received in the outpatient department of a contracting hospital. This waiver also applies to interpretations provided by a practitioner when the member is sent to the outpatient department of a contracting hospital by his or her physician. The waiver does not apply to emergency room (ER) services.

The waiver of deductible for diagnostic tests applies to Iowa members with Alliance SelectSM, Blue Access[®], Blue Choice[®], and Blue Advantage[®] health benefits. It does not apply to FEP members or groups that choose not to have it as a benefit enhancement.

*Billing services with
waived deductible*

Effective with date of service October 1, 2010, the provider should no longer use Type of Bill 0141 when submitting these services. Wellmark has implemented a process which identifies claims that qualify for a waived deductible.

Iowa
*Deductible waived for
physician
interpretations*

In **Iowa**, we will waive deductible for physician interpretations performed and billed from the outpatient hospital department on a CMS-1500 for the following CPT codes:

70010–70332*	72170–72190	74190–74775	76075–76092
70350–70390	72200–73140	75600–75940	76095–76350
71010–71130	73500–73660	75960–75984	80048–89399
72010–72120	74000–74022	75992–76066	

Although the deductible is waived, members are still required to pay the coinsurance or copayment amount. Deductible continues to apply for the following radiology services:

- computerized tomography (CT) scans
- magnetic resonance angiographies (MRA)
- magnetic resonance imaging (MRI)
- ultrasounds
- radiation therapy

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Home medical equipment

Home Medical Equipment (HME)

Home medical equipment provided to patients for home use may be covered by the member's contract. However, HME items must be billed by the HME provider on the HCFA-1500, [using the HME provider's NPI \(National Provider Identifier\)](#). HME will no longer be reimbursable when billed under the hospital's acute NPI.

Medical emergencies defined

Medical Emergencies

Wellmark defines a medical emergency as the sudden and acute onset of a condition of sufficient severity, including severe pain, that a prudent lay-person, possessing an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy
- serious impairment to bodily function
- serious dysfunction of any bodily organ or part

Medical emergency examples

Some examples of medical emergencies include:

- acute seizures
- acute hemorrhage
- loss of consciousness
- suffocation
- stroke
- heart attack
- acute appendicitis
- drug overdose

This category also includes other acute conditions Wellmark may determine to be a *medical emergency*. Medical emergency does not include emergency room care for conditions that are not acute and do not demand treatment on an emergency basis, such as arthritis, bronchitis, chronic asthma, migraine attacks, colds, cystitis or impetigo.

Use code 11 in FL 31–34

If you or the patient feel that the patient's condition meets the medical emergency criteria, then code the claim with “11—onset of symptoms/illness” in FLs 31–34. Identify the diagnosis code and secondary diagnosis as a life-threatening medical emergency.

31 Occurrence		32 Occurrence		33 Occurrence	
Code	Date	Code	Date	Code	Date
11	0224YYYY				

Observation Bed

Observation services are those reasonable and necessary services provided on a hospital's premises for the purpose of evaluating the condition of a patient to determine whether he/she should be admitted for more intensive inpatient care, discharged, or transferred to another facility.

Observation bed services should not exceed 24 hours. On rare occasion, the use of the observation bed may be extended to 48 hours. The observation bed period begins when the physician orders an observation bed for the patient.

*South Dakota
non-EAPG hospitals*

Note for South Dakota Non-EAPG hospitals only:

Because observation bed status is transitory, Wellmark's payment for the observation room is based on the hospital's outpatient payment percentage or capped at twice the hospital's semi-private room rate, whichever is less. The hospital will also be paid for any ancillary charges associated with the outpatient observation stay using the hospital's outpatient payment percentage or the appropriate fee schedule amount, depending on the service.

*Billing observation
bed charges*

If the patient does not need to be admitted to acute or skilled inpatient care, the observation bed and ancillary charges should be billed to Wellmark as outpatient services. The hospital should bill revenue code 0762 in FL 42 on the UB-04.

42 Rev. CD	43 Description	44 HCPCS/Rates
0762	Treatment/Obsv Room	

To consider observation services for separate payment, the EAPG Grouper requires an observation admission code and an observation time code. Without this information, the system will return 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 under observation.
- When billing observation which was not a direct admission, report the CPT* code that describes the observation services being provided (99217–99220, 99234–99236, 99281–99285). Include the observation time code (G0378) and the number of hours the patient was under observation.

For additional information on billing observation services, please see **Learn about** Observation Claim Processing at <http://Wellmark.com/Provider/ClaimsAndPayments/EAPG.aspx>

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Observation bed status is not appropriate for:

- ✓ elective or non-emergent preoperative care
- ✓ *routine* outpatient diagnostic testing
- ✓ patients that meet medical necessity criteria for acute level of care
- ✓ outpatient surgery with postoperative medical complications that meet Wellmark's admission criteria
- ✓ outpatient surgery and outpatient diagnostic services that require *routine* recovery
- ✓ patients who meet medical necessity guidelines for Intensive Care Unit/Critical Care Unit

Billing observation bed charges with 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 (see the Inpatient Services section of this *Guide*). The admission date is the date the physician orders the patient to inpatient acute care.

Billing Outpatient Services with Subsequent Inpatient Admissions

Outpatient procedures on inpatient claim

Effective with dates of service on or after February 1, 2010, bill an outpatient service and associated charges on an inpatient claim when:

- the patient is subsequently admitted after the procedure
- the outpatient procedure is performed within one day of the admission
- the first three digits of the principal diagnosis are the same on the outpatient and inpatient claims

When Wellmark receives two separate claims with the same principal diagnosis, and the date of service on the outpatient claim is the same day as or one day prior to the admission date of February 1, 2010, or after, Wellmark will deny both claims. We will automatically recoup payment made on the first claim processed, and deny payment on the second claim. Once you have received both claim denials, resubmit the outpatient procedure and associated charges on the inpatient claim. If the outpatient claim included services more than one day prior to the inpatient admission date, submit those charges on an outpatient claim.

Billing Exception for Outpatient Services/Observation Bed/Inpatient Admission

There are different billing guidelines when an observation bed is involved. When a patient is admitted to an observation bed between the outpatient service and inpatient admission, bill the services as follows:

- submit an outpatient claim for the outpatient service and any other ICD-9 procedure provided more than one day prior to the inpatient admission
- submit an inpatient claim for all of the inpatient services, which includes:
 - the observation bed admission through to the acute care discharge date
 - all ancillary services performed in the outpatient setting provided in connection with the principal diagnosis that necessitated the patient's inpatient admission

Billing guidance for the above situations can be found at [Wellmark.com](http://www.wellmark.com) > Provider > Claims and Payment > Enhanced Ambulatory Patient Grouping (EAPG).

Outpatient Revenue Codes That Require CPT*/HCPCS Codes

Outpatient hospital and ambulatory surgery centers must bill a CPT/HCPCS code in FL 44 when certain revenue codes are billed in FL 42. A list of these codes is available on our website at http://www.wellmark.com/Provider/CommunicationAndResources/NewsUpdates/PDFs/PC09143_S2001_EAPG_%20RevCodeReq.pdf

Billing Medical and Surgical Supplies In the Outpatient Facility Setting

Bill supplies provided incident to physician's service

Medical and surgical supplies described by HCPCS codes as provided by a hospital outpatient department or ambulatory surgical center, *incident to a physician's service*, must be reported and billed by the facility. The facility should include the charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is calculated into payment for the associated procedures/services.

Example 1: Hospital staff in the emergency department initiate intravenous administration of a drug through an infusion pump, complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department. Charges for the infusion pump should be included on the claim. As this was used as a supply with the drug administration, it would be paid through payment of the drug administration service.

Example 2: Hospital outpatient staff or ambulatory surgery center staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary. The hospital/ambulatory surgery center should include the charge associated with the urinary catheter on the claim. As the catheter was used as a supply in conjunction with the surgery, it would be paid through payment of the surgical procedure.

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*Outpatient therapy
billing instructions*

Outpatient Therapy Services

Wellmark requires hospitals to bill outpatient physical, occupational, and speech therapy services using CPT*/HCPCS codes. This requirement is consistent with Medicare's current billing practice for these services and applies to revenue codes 042X, 043X, and 044X (X = 0–9).

When billing outpatient therapy services under these revenue codes, submit one of the following modifiers in FL 44 of the UB-04:

<u>Modifier</u>	<u>Description</u>
GP – OP	Physical therapy services
GO – OP	Occupational therapy services
GN – OP	Speech Language services

Wellmark's physical medicine guidelines apply to therapy services performed in the outpatient setting. In accordance with the physical medicine guidelines, members may receive up to 20 medically necessary physical therapy (PT) or occupational therapy (OT) visits within a calendar year without notifying Wellmark. For details, see the *Physical Medicine Guide* on our website at Wellmark.com > Provider > Communication & Resources > Billing Guides.

If PT or OT services will exceed 20 visits in a calendar year, a *Physical Medicine Treatment Plan* should be submitted for review of medical necessity of future care. This form is available online at Wellmark.com > Provider > Communication & Resources > Forms.

*EAPGs and
outpatient services*

All outpatient services provided during a visit are processed using Enhanced Ambulatory Patient Groupings (EAPG) methodology. *Exception: Drugs and ambulance services.* Outpatient therapy claims are subject to consolidation. Consolidated lines are assigned line message code M376, and are not eligible for additional review and payment. Payment for those lines is included in the payment for the visit.

Denial Code M003

Providers may submit Provider Inquiries for lines denied with reason code M003, which indicates an approved Physical Medicine Treatment Plan was not on file for medically necessary PT or OT services exceeding 20 visits in a calendar year.

Pap Test

When billing a Pap test on the UB-04, use specific revenue codes to indicate the reason for the test rather than a general lab code:

Revenue Code	Description
0923	For a screening/preventive Pap test
0311	For a diagnostic Pap test

Outpatient Psychiatric or Psychological Services

Below is a description of some of the revenue codes used to bill behavioral health/chemical dependency (BH/CD) services:

	Revenue Code	Description
<i>Outpatient psychiatric services</i>	0911	Rehabilitation
	0912	Partial hospitalization - less intensive
	0913	Partial hospitalization - intensive
	0914	Individual Therapy
	0915	Group Therapy
	0916	Family Therapy
	0918	Testing

Note: Revenue code 0910 is reserved for national use and is no longer accepted by Wellmark.

Activity therapy performed in conjunction with partial hospitalization is a non-covered service. Revenue code 0904 is for activity therapy, which includes art, music, dance, and movement therapy. These services are not considered essential treatment for the patient's condition. They should be billed on separate lines (unbundled) and not rolled into one of the partial hospitalization codes.

The EAPG (Enhanced Ambulatory Patient Groupings) methodology requires providers to submit a CPT*/HCPCS code *and* a diagnosis (ICD-9) code in order to generate the appropriate BH/CD full or partial-day EAPG. A complete listing of EAPG/diagnosis code matches can be found at http://Wellmark.com/Provider/CommunicationAndResources/NewsUpdates/20091216_NewOutpatient.aspx.

Pharmacy Revenue Codes

Pharmacy revenue codes and descriptions

When filing outpatient drug claims, use the appropriate pharmacy revenue code for the specific situation as indicated in this chart.

Pharmacy Revenue Codes	Description
063X	Units, Pharmacy Note: Requires specific identification
0631	Single source drug
0632	Multiple source drug
0633	Restrictive prescription
0634	EPO, less than 10,000 units
0635	EPO, 10,000 or more units
0636	Drugs requiring detailed coding
0637	Self-administrable drugs not requiring detailed coding

Submit a HCPCS code with revenue codes 063X

When you submit revenue code 063X, include a HCPCS code for the drug. Use the appropriate units for the corresponding HCPCS code descriptions.

Please include the National Drug Code (NDC) or, if you are submitting a Not Otherwise Classified (NOC) code, include the drug description, dosage, and strength. [On 5010 formatted institutional claims, provide this information in the Description of Service field, SV202-7.](#)

Report outpatient chemotherapy drugs using 063X rather than 025X.

Scheduled Services Performed by a Visiting Specialist at a Rural Hospital

How to bill scheduled visits by specialists performed in the outpatient setting of a rural hospital

When an outpatient department of a rural hospital is used by a practitioner as an office or clinic to perform "scheduled visits," bill one of two ways.

1) If Physician is Renting Space from the Hospital

If the specialist is renting space from the hospital for scheduled visits, we would expect the physician to bill on a CMS-1500, place of service (POS) office (11). The hospital should not submit a claim for use of the facility. However, the hospital may bill for ancillary charges related to the visit (e.g., labs, X-rays, medical supplies) on a separate UB-04 claim.

2) If the Physician Does Not Rent Space from the Hospital

If the specialist does not rent space from the hospital for scheduled visits, both the specialist and hospital can submit claims using place of service (POS) outpatient.

Use revenue code 051X for clinic services or revenue code 036X to bill minor outpatient surgery. Minor outpatient surgery is defined on Medicare's ASC list at <http://www.cms.hhs.gov/apps/ama/license.asp?file=/ascpayment/>. The hospital may include ancillary charges that relate to the services performed when either revenue code is billed.

Billing criteria for scheduled services

The specialist and service must meet all of the following criteria in order for the hospital to submit the claim for payment:

- The physician or practitioner is a visiting specialist. Visiting is defined as a physician or practitioner who has a primary practice located outside of the hospital setting and is not employed by the hospital in which he or she is using space; and
- The office/clinic visit is a scheduled visit. A scheduled visit is defined as a visit that is planned, and where the patient has an appointment for a specific day and time; and
- The physician or practitioner does not pay rent to the hospital for the use of space.

II Wellmark's Radiology Utilization and Quality Management Program

Preauthorization for Outpatient Diagnostic Imaging Services

Wellmark requires preauthorization for the following **outpatient diagnostic imaging services**:

Outpatient diagnostic procedures requiring preauthorization

- CT (Computed Tomography) scans, including CT chest
- CTA (Computed Tomographic Angiography) scans, including CTA chest
- Nuclear Cardiology (e.g., SPECT scans, cardiolyte stress tests)
- PET (Positron Emission Tomography)
- MRI (Magnetic Resonance Imaging), including MRI upper extremity joint and MRI upper extremity non-joint; MRI lower extremity and MRI pelvis
- MRA (Magnetic Resonance Angiography)
- Echocardiography (stress, resting transthoracic)

Services requiring preauthorization

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

Radiologic guidance scans

Preauthorization Not Required for Radiologic Guidance Scans

Preauthorization is required for diagnostic imaging purposes only. If the CT or MRI scan is for radiologic guidance, do not submit a preauthorization request.

To ensure proper claim processing, bill radiologic guidance scans with the following codes:

RADIOLOGIC GUIDANCE SCANS	CPT CODES
Computerized Tomography	77011–77014
Magnetic Resonance Imaging	77021–77022

To Whom Does Preauthorization Apply?

With some exceptions, preauthorization applies to all members who have non-emergency outpatient imaging services ordered by providers contracting with Wellmark, with health benefits through:

- Wellmark Blue Cross and Blue Shield of Iowa
- Wellmark Blue Cross and Blue Shield of South Dakota
- Wellmark Health Plan of Iowa, Inc.
- some products/services offered by First Administrators, Inc., such as Select First® (Please check benefits by calling number on back of member ID)

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¹Select First® applies only to health plans administered by First Administrators, Inc.

Check eligibility of patients with coverage through Select First

Exceptions are:

- Federal Employee Health Benefits Program (FEP)
- Some products/services offered by First Administrators, Inc., such as Select First® (Please check benefits by calling number on back of member ID¹)
- BlueCard® (which includes BlueCard Host, BlueCard Point of Service BlueCard Home, BlueCard Preferred Provider Organization; **see note**)
- Medicare Supplement
- MedicareBlueSM PPO (Medicare Advantage)
- Medicare Prime

Check eligibility of BlueCard Host members

Note: Some members covered by a Blue Plan other than Wellmark may have a preauthorization requirement through their home Plan. Check a member's identification card or call **800-676-2583** for BlueCard eligibility and benefits information.

To Order Imaging Procedures

It is in the patient's best interest to direct him/her to a *network* provider to have the test(s) performed. If an out-of-network provider is chosen, the member may incur higher costs and in some cases, may be responsible for the total cost. [When referring a Wellmark Health Plan of Iowa \(WHPI\) member to an out-of-network provider, you must also submit a referral to WHPI for preservice review and approval. The WHPI Referral Form \(M-8721\) may be found at Wellmark.com > Provider > Communication & Resources > Forms.](#)

Required information for a preauthorization request

The following information is needed for every preauthorization request:

- insurance information, such as the member's ID number
- patient's name and date of birth
- ordering provider's name, address, and telephone number
- type of service and/or CPT* code (if available)
- patient's symptoms, reason (indication) for the imaging procedure and/or ICD-9-CM diagnosis code
- results of pertinent previous studies (labs, X rays, etc.) and treatments, including their duration

Ways to request preauthorization

To request preauthorization, do one of the following (for Select First, see footnote)¹:

- log in to Wellmark.com. Under *Provider Tools*, select *Manage Radiology Preauthorizations* and complete the request online
- call **888-800-4497** between the hours of 7:30 a.m.– 6 p.m. CT, M–F
- fax a completed *Radiology Preauthorization Fax Form* (Provider > Communication & Resources > Forms) to 800-610-0050

Make sure the procedure is preauthorized before scheduling the patient's imaging appointment. The preauthorization is valid for 60 days from the date granted.

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¹ For members with Select First coverage, log in to <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

Go online or call to verify a preauthorization

How to Verify a Preauthorization

To verify that a preauthorization is in place before performing the procedure, do one of the following (for Select First, see footnote)¹:

- log in to Wellmark.com. Under *Provider Tools*, select *Manage Radiology Preauthorizations*. Choose *Request* and check *Preauthorization*.

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

- Call **888-800-4497**

Verify the patient's benefits. **Please note preauthorization does not guarantee coverage. All of the terms and limitations of the members' benefit certificate apply.**¹

Ordering physicians will be advised whether or not preauthorization is granted. If granted, an authorization number is given. The authorization number does not need to be filed on a patient's claim.

Verify that the test you plan to perform is preauthorized

While you are verifying the preauthorization, also make sure the test you plan to perform is the test that is preauthorized. From the Preauthorization Inquiry screen, scroll down to Exam Information, CPT Group. To ascertain if a particular CPT code is included under the test description (e.g., CT Abdomen), click on the description. A list of CPT codes that are preauthorized for that test will appear. If the CPT code for the test you plan to perform is not listed, the service will be denied.

If you are calling to verify the preauthorization, ask a representative to identify the CPT codes authorized.

Settings where preauthorization is required

If you perform a test without preauthorization, you risk not being paid for the service if the test is performed at a:

- freestanding imaging center,
- hospital outpatient department, or
- physician's office.

Settings where preauthorization is not required

The preauthorization requirement does not apply to the following care:

- inpatient (includes observation stays)
- emergency room (medical emergencies)

¹ For members with Select First coverage, log in to <http://www.firstadministrators.com/> or call the phone number on the back of the member's ID card for details.

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Radiology Interpretations

A provider who performs the professional component (billed with a 26* modifier), does not need to validate that a preauthorization is in place. Most often, the interpretation fee will be covered unless:

- the radiology test is considered experimental or investigational; or
- the service is not a benefit of the member's contact.

If you are required to global bill radiology services (e.g., the test and the interpretation) and payment for the global charge is denied because a preauthorization was not in place, you cannot collect payment for the interpretation charge separately.

III. Additional Cardiac Outpatient Diagnostic Imaging Services that Require Preauthorization

Wellmark requires preauthorization for the following additional cardiac diagnostic imaging services:

Outpatient diagnostic procedures requiring preauthorization

- stress echocardiography
- resting transthoracic echocardiography
- transesophageal echocardiography
- implantable cardioverter defibrillator

These services will have a two-phase implementation process.

Required information for a preauthorization request

Notification

Notification and requested clinical information is required and preauthorization will be performed, resulting in the approval or denial of benefits for the requested services. Servicing providers' claims will process based on the approval or denial.

As with other outpatient diagnostic services, servicing providers may check for a preauthorization before providing services, and ordering physicians may request a preauthorization:

- at Wellmark.com > Medical Policies & Authorizations > Authorizations > Prior Authorizations
- by calling American Imaging Management (AIM) Call Center at 888-800-4497
- by faxing the Radiology Fax Form to 800-610-0050

A list of codes requiring preauthorization, the clinical guidelines, and additional information can be found at Wellmark.com > Medical Policies & Authorizations > Authorizations > Prior Authorizations.

IV. Freestanding Ambulatory Surgery Centers/ Hospital Outpatient Surgery

This portion of the outpatient section addresses billing and payment information when surgery is performed in the hospital or ambulatory surgery center.

Billing an Outpatient Procedure that Results in a Subsequent Admission

Outpatient procedure and subsequent admission—same day

When a patient undergoes outpatient procedure, develops complications, and is admitted to inpatient acute care *the same day*, submit an inpatient claim for all the services the patient received in the outpatient and inpatient setting, including the surgery. Since you are filing one claim, submit the appropriate procedure code on the inpatient claim.

Outpatient procedure and subsequent admission—separate days

If the outpatient procedure occurs more than one (1) day *prior to the inpatient admission date*, file a separate claim for the outpatient procedure. File all ancillary services performed in the outpatient setting and related to the admission on the inpatient claim.

Billing Two or More Surgical Procedures on the Same Claim

Payment logic for multiple surgical procedures

If the claim includes two or more surgical procedures, enter these services on the UB-04 by either:

- including an itemized charge for **each** procedure (line item on the claim), or
- rolling up surgery charges to one line and zero billing the line items included in the global charge

If you bill each procedure on a line, repeat the revenue codes with respective CPT* codes as appropriate with one unit each. Enter itemized charges for each line in FL 47.

If you "roll up" the charges for multiple surgeries to the primary surgical procedure, report zero charges for the other procedures performed in the same surgical setting. Do not bill greater than one unit on each surgery procedure line.

Revenue codes included in surgical payment

REVENUE CODES	DESCRIPTION
36X	Operating Room Services
49X	Ambulatory Surgical Care
75X	Gastrointestinal Services

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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 Number
..... 605-373-7498

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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Blue Shield Association

*You will find e-mail links to these areas from our website at
Wellmark.com > *Contact Us (top right of page)*. Select
For Providers and on the next screen, choose your state.