



An Independent Licensee of the Blue Cross and
Blue Shield Association

Practitioner Guide

Laboratory, Pathology, & Radiology

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December 2011
Replaces: September 2011

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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Laboratory, Pathology, and Radiology Services Section

Summary of Changes – September and December 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

Wellmark applies multiple procedure reductions to radiology services with a multiple procedure indicator of four in the Medicare Relative Value Unit (RVU) file, and to therapy services with a multiple procedure indicator of 5 in the Medicare RVU file.

Page 4

Clarification of information on coding handling or transfer of specimens.

Page 5

Refer to Wellmark's medical policy for the appropriate codes when billing prostate-specific antigen.

Page 6

Update on billing post-op diagnostic mammography.

Page 8

Always obtain a referral for out-of-network services for members with Blue Advantage and Blue Access coverage, including *hawk-i* Blue Access members. These members do not have coverage for out-of-network services except in a medical emergency, or when the services are approved through the Wellmark Health Plan of Iowa referral process. Blue Choice members also benefit by having services preapproved, as they then have a lower out-of-pocket cost.

Page 9

Effective with date of service January 1, 2012, preauthorization is no longer needed for TTE (resting thoracic echocardiography).

Page 10

Effective January 1, 2012, preauthorization for outpatient diagnostic imaging can only be requested online or by phone. Faxing the request is less efficient, and no longer an option.

Laboratory, Pathology, and Radiology

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I Introduction

This section of the *Practitioner Guide* explains how to bill laboratory, pathology, and radiology services. For information on Wellmark's *Radiology Utilization and Quality Management Program*, turn to page 9.

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.

II Billing Information for Laboratory, Pathology, and Radiology Services

Diagnosis Coding
Diagnosis coding Submit an ICD-9-CM diagnosis when billing a laboratory, pathology, or radiology service. If tests or X-rays are ordered in response to an accident, provide the type of accident (employment, auto, other) and the date of the accident, as well as details about other insurance, if applicable.

Units of Service

Report units of service in whole numbers. To determine the appropriate number, follow the *CPT**[®] narrative that reflects the service provided.

Radiologists—billing number of views While it may seem logical to submit the number of views performed as the units of service, *this is not always appropriate*. Read the CPT code description carefully. If the description for the procedure code includes a number of views, submit 1 as the unit of service.

For example, procedure code 70210 is for a radiological examination, sinuses, paranasal, *less than three views*. If the practitioner performs up to two views, bill this procedure code with 1 as the unit of service.

If the practitioner performs an X-ray with *three or more views*, bill procedure code 70220 (which is a radiological exam, sinuses, paranasal, complete, minimum of three views) with 1 as the unit of service.

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Multiple Procedure Reduction—Radiology and Therapy Services

Effective with dates of service July 1, 2011, and after, Wellmark applies multiple procedure reductions (MPR) to certain radiology and therapy services.

Radiology

For radiology, Wellmark applies the reduction to services with a multiple procedure indicator of four in the Medicare Relative Value Unit (RVU) file. This reduction for the technical component of diagnostic imaging procedures applies if the procedure is billed with another diagnostic procedure in the same family (according to the diagnostic imaging family indicator). If the procedure is reported in the same session on the same day as another procedure with the same family indicator, the procedures will be ranked by the highest RVU for the technical component. The highest priced procedure will be paid at 100 percent, and each subsequent procedure will be paid at 50 percent.

Therapy services

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

Repeat Laboratory Tests

91 modifier

In some situations, it may be necessary to repeat the same laboratory test on the same day to obtain multiple test results. Under these circumstances, use modifier 91 (Repeat clinical diagnostic laboratory test) with the CPT code to identify it as a repeat test.

To avoid a denial for duplicate billing, do not bill the repeat lab test with a 76* (Repeat procedure by same physician) or 77 (Repeat procedure by another physician) modifier, because modifier 91 is specifically for lab tests.

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Interpretation and the Technical Component

Wellmark maintains a policy that one interpretation of a diagnostic test or X-ray is all that is medically necessary. A physician may elect to have diagnostic or radiologic services interpreted by another physician.

Note: Overreads for quality checks are the responsibility of the physician referring the diagnostic tests and are not considered covered benefits by Wellmark.

The following billing instructions clarify when the radiology test should be billed as a global charge, and when it is appropriate to bill the technical component (TC modifier) and/or the interpretation (26* modifier) charges separately.

Situations

*Total charge billed by
one physician*

1. If Physician A and Physician B have signed a clinical agreement for billing purposes, only one physician can bill Wellmark for the complete procedure. The technical and professional services may not be claimed separately.
2. If Physician A performs both the radiology test and the interpretation, bill the services as a global charge. The technical and professional services may not be claimed separately.

*Technical and
interpretation
services billed
separately*

3. If Physician A performs the technical service and Physician B performs the interpretation *and no clinical agreement exists*, there are two options for billing purposes:

Option 1: Physician A may contract directly with Physician B to perform specific interpretive services. This contract would include provisions for Physician A to compensate Physician B directly for work performed. The contract should also include a provision that precludes Physician B from attempting to collect or bill any party for the services provided. Physician A would bill Wellmark for the global effort (no modifier necessary).

Option 2: Physician A performs the diagnostic test or X-ray (technical component) and refers the results to Physician B for interpretation (professional component). Both physicians elect to bill for their services individually. Physician A must submit services with a TC modifier (technical component only) and Physician B submits services with a 26 modifier (professional component only).

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III. Billing Specific Laboratory or Pathology Tests

*Iowa law affects
billing for anatomic
pathology services*

FEP

*Handling or transfer
of specimen*

Venipuncture

*Billing specific
laboratory or
pathology tests*

Iowa Pathologists Must File Claims for Anatomic Pathology Services

Iowa law provides that anatomic pathology services performed in an Iowa facility must be billed and submitted by the facility. In the past, physicians were allowed to bill for tests performed by an outside lab if they had an agreement with that laboratory, but this is no longer the case. The only time a physician can bill for anatomic pathology services is if he/she actually performs the service. This applies to services provided patients in the state of Iowa, regardless of the location of the laboratory. The legislation also applies to FEP members who receive these services in Iowa.

Handling or Transfer of Specimen—99000 & 99001*

Wellmark does not pay separately for the handling and/or conveyance of specimen for transfer (CPT codes 99000 and 99001).

Venipuncture for the Collection of Specimen(s)—36415

Wellmark provides reimbursement for venipuncture in addition to the E/M service or laboratory fee, whichever the physician provides.

Global OB Urinalysis—81000–81003

Charges for urinalysis of an OB patient performed in the office are included in the global OB maximum allowable fee. Therefore, do not bill 81000–81003 separately. Global services do not include ancillary testing, such as other laboratory tests, fetal non-stress tests, and ultrasounds.

Glucose Tolerance Testing—82951–82952

To bill glucose tolerance testing, use procedure code 82951 for *up to* three specimens and enter 1 as the unit of service. For additional specimens beyond three for services on the same day, bill procedure code 82952 and indicate the number of additional tests provided.

Hemoccult Tests—82270

A Hemoccult test is usually classified as a screening, and is therefore not covered unless the patient has preventive benefits. When you bill Hemoccult labs, according to *CPT*, bill 1 unit of service for every three cards.

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Prostate-Specific Antigen

To bill this antigen, refer to Wellmark's medical policy for the appropriate CPT*/HCPCS codes. Wellmark will consider payment for immunoassay for tumor antigen (e.g., prostate-specific antigen) when used as follows:

- As a screening for patients at high risk for prostate cancer (i.e., African-American men over age 40 or men with another family member diagnosed with prostate cancer)
- As a test for men with abnormal rectal examinations
- As a test before medical or surgical treatment of benign prostatic hyperplasia (BPH)
- As part of a work-up for men with metastatic undifferentiated adenocarcinoma of unknown origin, primary
- As a test for a patient with known prostate cancer before and after treatment, by any method

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IV. Billing Specific Diagnostic Radiology

Refer to the beginning of this section for general radiology billing information.

Mammograms

Wellmark allows payment for a screening and diagnostic mammography performed on the same day when an abnormality is detected on the screening mammography. Wellmark will not allow 2 diagnostic mammograms on the same day for pre- and post-op mammograms.

Follow these coding methods to bill these services:

- G0204-GG or G0206-GG for diagnostic mammography the same day as G0202 for the screening mammography
 - G0204 or G0206 for the pre-op diagnostic mammography and 77055* or 77056 for the post-op diagnostic mammography

Re-X-Ray of Fractures

Normally, most fractures heal within 90 days. Some fractures or fracture complications may require evaluation after a 90-day period.

The bones that most often require further evaluation are the navicular, femur, tibia, fibula, and os calcis. Wellmark will allow extended evaluation past the normal 90 days if the healing is complicated by mal- or non-union.

Ultrasound in Maternity Care

Wellmark does not cover ultrasounds for women experiencing normal pregnancies, except as medically necessary to determine gestation dates, allowed once per pregnancy.¹ We do cover ultrasound for diagnoses other than normal pregnancy, including twins and other multiple births (after the first trimester). We also provide ultrasound benefits when medically necessary for complications of pregnancy. For details, check the "Gynecology and Maternity" section of this Guide.

Re-X-rays of fractures will be allowed past 90 days for certain situations

Ultrasound in complicated pregnancy

¹Some employer groups purchase routine ultrasound benefits for their employees. Please verify each patient's benefits.

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Ultrasound—76506–76999*

We consider the use of ultrasound a covered benefit for the following procedures:

Situations in which Wellmark allows benefits for ultrasounds

- abdominal aorta sonography (B-scan)
- retroperitoneal sonography (B-scan)
retroperitoneal sonography does not include planning of fields for radiation therapy
- urinary bladder sonography (B-scan)
urinary bladder sonography does not include staging of bladder tumors
- arterial flow study, peripheral (Doppler)
- arterial aneurysm, peripheral (B-scan)
- radiation therapy planning sonography (B-scan)
- thyroid echography (A-mode)
- thyroid sonography (B-scan)
- breast sonography (B-scan)
- hepatic sonography (B-scan)
- gall bladder sonography
- renal sonography
- two-dimensional echocardiography (B-mode)

Coding Nonobstetrical

Transvaginal/Transabdominal Ultrasounds

Use CPT code 76856 or 76857, as appropriate, to bill the pelvic ultrasound procedure. Add 76830 for the transvaginal ultrasound.

*Transabdominal/
Transvaginal in a
single setting*

Wellmark will pay for both studies when necessary, if these studies are done to acquire additional clinical information not evident from the initial study, or to further investigate an area that appears suspicious or problematic. When coding for both transabdominal and transvaginal studies in a single setting, clearly state in the report the indication for performing the second examination: for example, for better assessment of the endometrium and/or adnexa, etc. Bill a 59 modifier to indicate a distinct procedural service.

Billing Procedure for Hip X-Rays

Unilateral

When billing CPT codes 73500 and 73510 for unilateral studies, include an LT (left side) or RT (right side) modifier with the procedure code. If the appropriate modifier is not present with these codes, Wellmark will deny the line.

Bilateral

The LT and RT modifiers are not needed when you bill a bilateral study of the hip. When a bilateral study is done, submit CPT code 73520. If a component of the study is not done, append a 52 modifier to 73520. An example is where the bilateral x-ray (two views of each hip) was performed, but the anteroposterior (AP) view was not completed, you would bill 73520 with the 52 modifier to indicate that the study was not performed in its entirety.

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Billing Pelvis X-Rays with Hip Examination

When billing CPT codes 72170* and 72190 for pelvis studies, a hip study 73500 is included. Billing 73500 in addition to 72170 or 72190 done at the same session is considered duplicative. When one study is performed and it is determined another study is then needed (separate session) appending modifier 59 would be appropriate.

**WHPI Referral and Billing Information for X-ray
and Laboratory Services**

*No referral needed for
in-network services*

Primary Care Physicians (PCPs) should not complete a referral form when ordering diagnostic tests, including X-ray and laboratory services, from a Wellmark Health Plan of Iowa (WHPI) *in-network* provider.

*Blue Advantage and
Blue Access have
no benefit for
out-of-network
providers*

Blue Advantage and Blue Access (including **hawk-i**) members do **not** have benefits for services, including laboratory or X-ray services, performed by *out-of-network* providers, unless services are a medical emergency or are preapproved through the WHPI referral process. Blue Choice members receive a higher level of benefits for out-of-network services when these services are preapproved through the WHPI referral process.

*Obtain referral for
out-of-network
services*

The Wellmark Health Plan of Iowa Referral form is available at [Wellmark .com](http://Wellmark.com) > Provider > Forms, and may be faxed or mailed using the contact information on the form. Include documentation detailing the reason[s] out-of-network services are required. This is especially important when there are physicians of like specialty within the WHPI network. When out-of-network services are provided without Wellmark approval, except in a medical emergency, Blue Advantage and Blue Access members, including **hawk-i** Blue Access members, are liable for the full charge, and Blue Choice members have a higher out-of-pocket cost than they otherwise would.

Facility Billing Instructions

To bill X-ray and lab services, include the ordering physician's NPI number in the *Attending Physician ID* or *Other* field.

Professional Billing Instructions

Physicians who interpret X-rays and independent labs filing a professional claim need to include the referring physician's name and NPI.

Filing the UB-04 and the CMS-1500 with the ordering/referring provider's name/NPI is vital to correct claims processing. We use this information to match the hospital or interpreting provider's claim with the patient's PCP. Without the correct information, we may deny the claim because there is no referral on file. This causes unnecessary processing time and additional work for the provider of service and the referring physician.

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VI. Wellmark's Radiology Utilization and Quality Management Program

Outpatient diagnostic procedures requiring preauthorization

Wellmark requires preauthorization for the following outpatient diagnostic imaging services:

- CT (Computed Tomography) scans, including CT chest
- CTA (Computed Tomographic Angiography) scans, including CTA chest
- Nuclear Cardiology (e.g., SPECT scans, Cardiolite 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)
- Stress Echocardiography
- TTE (Resting Transthoracic Echocardiography). **Note:** *TTE will no longer require recertification effective with date of service January 1, 2012.*

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 offered by First Administrators, Inc., such as Select First® (Please check benefits by calling number on back of member ID.)

Exceptions are:

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

Check eligibility of patients with coverage through Select First

Check eligibility of other Blue Plan 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 *Authorizations*, select *Manage Radiology Preauthorizations* and complete the request online.
- call **888-800-4497**¹ between the hours of 7:30 a.m.– 6 p.m. CT, M–F.

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

*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 *Authorizations*, 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** (for Select First, see footnote)¹

¹For 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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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 verify 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)

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 contract.

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.

¹For 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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To Order Additional Imaging Procedures

If a radiologist is delivering a test, and decides an additional test is needed that has not been authorized, the radiologist or his/her staff member must preauthorize that service. If this occurs during call center hours (7:30 a.m.–6 p.m. CT), call **888-800-4497**¹ to request approval for the additional test. If the call center is closed, you may call in a retrospective request within two business days from when the service was given.

*Required information
for a preauthorization
request*

The information required when submitting a preauthorization request can be found at the top of page 10 of this guide.

If the additional test is not approved, payment for that service will be denied.

Patient Presents at a Facility Not Selected on the Initial Preauthorization Request

The preauthorization approval is not tied to a specific facility, but rather to an individual member. If a member presents at your facility, even though you were not selected on the preauthorization request, you may deliver the test once you verify that a preauthorization has been approved. To verify the preauthorization, log in to Wellmark.com. Under **Authorizations**, select **Manage Radiology Preauthorizations**. Choose **Order Inquiry** and check **Preauthorization**. You may also call **888-800-4497**.¹

VII Summary

If you have questions about billing laboratory, pathology, or radiology services, please call the appropriate Wellmark number listed on the Iowa and South Dakota Service Contacts page. We also encourage you to check Wellmark's medical policies as they relate to these services by going to Wellmark.com > Provider > Medical Policies & Authorizations.

¹For 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.

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.*

Provider Service

..... 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*

..... 800-532-1537

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



An Independent Licensee of the Blue Cross and
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.