



An Independent Licensee of the Blue Cross and
Blue Shield Association

Podiatry Guide

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April 2011

Replaces: December 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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Podiatry Guide

Summary of Changes - April 2011

Page 6: Added ICD-9-CM code to list of primary diagnoses to be used when billing Unna boots.

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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.
- FAI*

I Introduction

This guide provides information about billing podiatry services and explains Wellmark's general podiatry benefits.

Information in this guide applies to Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa (WHPI), and Wellmark Blue Cross and Blue Shield of South Dakota products. When a policy applies to all Wellmark products, "Wellmark" will be indicated. Any guidelines that are different or unique to a specific product are identified and explained.

Note: Wellmark Blue Cross and Blue Shield of Iowa products include Alliance SelectSM, Classic Blue[®], Blue TraditionsSM, and Senior Blue[®]. Wellmark Health Plan of Iowa products include Blue Access[®], Blue Choice[®], and Blue Advantage[®]. Wellmark Blue Cross and Blue Shield of South Dakota products include Blue Select[®], Classic Blue[®], and Senior Blue[®].

We encourage you to use this billing information along with coding information available in *CPT*^{®*} or *HCPCS*. Ordering information for *CPT* and *HCPCS* books can be found in the "Claims Filing" section of the *Wellmark Provider Guide*.

II Benefits

Benefits for any foot care treatment depend on the nature of the services, the diagnosis of the patient's condition, the medical necessity of the services, and Wellmark's medical policy. To read Wellmark's definition of medical necessity, refer to the "Claims Filing" section of the *Wellmark Provider Guide*. Information on how Wellmark's medical policy is formed and/or Wellmark's medical policy on a specific service or procedure can be found at www.wellmark.com ([Provider > Medical Policies & Authorizations](#)). "Non-routine" office calls, some physical medicine modalities and procedures, radiology, pathology and surgical services are payable to correct an ankle/foot injury or improve the function of the ankle/foot.

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The following information explains Wellmark's general coverage and billing guidelines for certain podiatric procedures or services.

Concurrent Care

Concurrent care refers to professional services provided by two or more physicians at the same time to a hospital inpatient. Concurrent care is most often classified as *related* and *unrelated* care.

Unrelated concurrent care

Unrelated concurrent care means that two or more physicians provide services to a patient for separate and distinct conditions that require the skills of more than one doctor.

Example: An internist treats the patient for uncontrolled diabetes while the patient is under the care of a surgeon for surgical treatment.

In this case, benefits for the services of both physicians would be considered by Wellmark.

Related concurrent care

Related concurrent care means that two or more physicians provide services to a patient for the same or a similar condition that requires the skill of multiple physicians.

Example: A severe illness, such as myocardial infarction with severe pulmonary problems, may require the skills of more than one M.D./D.O. for all or part of the hospitalization.

Wellmark covers related concurrent care only when:

- the patient's condition requires the services of more than one physician on an attending rather than consultative basis, and
- the services provided by each physician are reasonable and medically necessary for the management of the patient's condition, as determined by our Medical department.

Nail Debridement

Wellmark covers nail debridement (procedure codes 11720* and 11721) *if* the patient's diagnosis indicates that a metabolic, neurological or peripheral vascular disease is present. If the patient has nondystrophic nails that require trimming at the same visit, bill procedure code 11719 or G0127 in addition to 11720.

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Nail Trimming

Wellmark covers nail trimming (procedure codes 11719* or G0127) performed by a professional as a stand-alone procedure for members with a metabolic, neurological, or peripheral vascular disease.

Frequency of care If 11719 or G0127 are billed greater than one time within a 59-day period and the diagnosis is not 681.10 – 681.11 or 686.9, Wellmark will deny additional claims for nail trimming.

Payable diagnoses for nail debridement and trimming available online Payable diagnoses for nail debridement and nail trimming are available on the secure Wellmark Web pages. Log in to www.wellmark.com. Under Payment Policies, select Professional Claims (CMS-1500) > iCAP > iCAP Specialty Policies).

To obtain access to Wellmark's Payment Policies, apply by selecting the [Register for www.wellmark.com](#) link on our Web site's Provider page. In addition to the Payment Policies, you will receive online access to all our online tools.

Additional podiatric services for the diseases/conditions listed on the iCAP Specialty Policies grid may be covered if the treatment is medical or surgical.

Diabetic Shoes and Multiple-Density Inserts

Wellmark provides benefits for diabetic shoes (shoes, fitting, and modifications), and for multiple-density inserts used in conjunction with diabetic shoes, when a medical condition of the foot related to diabetes is present. Payable conditions are represented by the following ICD-9-CM codes:

<i>Payable conditions for diabetic shoes and multiple-density inserts</i>	ICD-9-CM	Description
	250.6	Diabetes with neurological manifestations
	250.7	Diabetes with peripheral circulatory disorders
	250.8	Diabetes with other specified manifestations

Billing instructions **Diabetic shoes:** To bill for diabetic shoes and the fitting and modification of those shoes, submit HCPCS codes **A5500–A5507**. Wellmark allows benefits for two pairs of diabetic shoes per calendar year. Wellmark does not allow benefits for deluxe features code A5508.

Multiple-density inserts: To bill multiple-density inserts, use HCPCS code A5512 or A5513. Wellmark allows benefits for two pair of multiple-density inserts per year. We will not allow benefits for multiple-density inserts when code A5510 is submitted.

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<i>Educational supplies</i>	<p>Educational Services</p>
	<p>Wellmark contracts do not provide coverage for educational services unless a group specifically purchases that benefit or it is a state mandate (e.g., diabetes education). Bill educational supplies, such as books, tapes, and pamphlets, using CPT code 99071*.</p>
<i>Orthotics defined</i>	<p>Orthotics and Prosthetic Devices</p>
	<p>Orthotics are usually rigid or semirigid devices that provide stability and support weak or debilitated body parts. Wellmark covers leg braces, trusses, and prosthetic limbs when the services are medically necessary.</p>
<i>Prosthetic devices defined</i>	<p>Prosthetic devices replace all or part of a body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ.</p>
	<p>Wellmark recommends that you request a prior approval for certain orthotics and prosthetic devices to obtain a medical necessity determination, regardless of cost. For a list of services, supplies, procedures, or treatments Wellmark recommends receive prior approval, visit www.wellmark.com > Providers > Medical Policies & Authorizations > Prior Approvals. To submit a prior approval, complete the Prior Approval form found at www.wellmark.com > Provider > Communication & Resources > Forms > Prior Approval Medical Forms.</p>
<i>Medical policy and medical necessity for orthotics and prostheses</i>	<p>Specific medical policy and guidelines for determining medical necessity of orthotics and prostheses can be found at www.wellmark.com (Providers > Medical Policies). <i>Wellmark's HME, Orthotics, and Prostheses Billing Guide</i> also addresses guidelines for orthotics and prostheses in greater detail, and can be viewed at www.wellmark.com > Provider > Communication & Resources > Billing Guides.</p>
	<p>To verify a member's benefits for these services, you may use Wellmark's secure Web tools, or call the appropriate provider service area for assistance. Provider service phone numbers are listed at the back of this guide.</p>
<i>Secure online tools</i>	<p>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.</p>
<i>Items that are usually noncovered</i>	<p>Ace bandages, elastic stockings, support hose, Spenco boots, leotards, knee supports, surgical leggings, gauntlets, and other similar devices, are normally not covered because they do not fall within the definition of an orthotic appliance.</p>

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Wellmark *normally does not cover* these items **unless** coverage is a benefit of the member's contract:

- arch supports
- custom molded shoes
- durable plantar foot orthotics
- inlays and impression casting
- corrective (orthopedic) shoes
- plaster impressions
- shoe inserts
- shoe padding

Certain situations allow coverage

However, Wellmark contracts provide benefits for the following items in these situations:

- orthopedic shoes and other supportive devices of the feet when an integral part of a leg brace
- orthopedic shoe and inlay for partial foot amputation
- custom molded shoes with amputation
- fracture boots for fracture management
- walking boots for severe soft tissue injuries to the ankle/foot
- compression stockings (billed using HCPCS codes A6530–A6538 and A6542–A6543) that are fitted to the patient for the treatment of:
 - burns
 - lymphedema
 - post-surgery
 - thrombophlebitis,
 - severe edema
 - venous stasis ulcers
 - post venous stasis ulcer treatment

Wellmark allows coverage for up to 12 stockings, or 6 pairs per year.

Physical Medicine Modalities and Procedures

Wellmark provides benefits for physical medicine modalities and procedures performed by podiatrists. Please see the *Physical Medicine Guide* for further information about Wellmark's coverage of these services.

Supplies Associated With Office Surgery

The majority of supplies related to office surgery are considered part of the surgical procedure. If a surgery performed in the office requires casting material, you may bill these supplies *in addition to* the surgical procedure code, on a separate line(s). When appropriate, you may use the following HCPCS codes to bill casting material:

<i>HCPCS casting codes</i>	A4580	Plaster Cast
	A4590	Fiberglass Cast
	Q4037–Q4051	Cast/splint supplies (fiberglass or plaster, by age)

Supplies Associated With an Office Visit

Supplies are normally considered part of the office visit/surgery charge and should not be billed separately. Examples of supplies we consider part of the office call/surgery include, but are not limited to:

- cotton balls
- facial tissue
- tongue depressors
- topical ointments
- gloves
- cotton swabs
- gowns
- paper sheets/towels

Wellmark considers nonprescription or over-the-counter drugs, vitamins, minerals, or nutritional supplements noncovered materials.

Unna Boots

Unna boots are commercially prepared, medically impregnated material used as a support dressing. Use CPT code 29580* to bill Unna boots. Unna boots are a covered benefit when billed with one of these *primary* diagnoses:

Primary Diagnoses for Unna Boots				
454.0	707.06	726.72	845.02	892.0
454.1	707.07	726.79	845.03	892.1
454.2	707.12	727.06	845.09	892.2
459.11	707.13	727.68	845.11	924.20
459.12	707.14	727.81	845.12	924.21
459.13	707.15	728.86	845.19	948.00
459.19	707.9	733.94	891.0	998.83
459.31	719.07	733.95	891.1	
459.33	726.70	824.0–827.1	891.2	
686.00–686.9	726.71	845.01		

III. Coding

Accidental Injury

An accidental injury is an unforeseen event or external force resulting from carelessness, unawareness, or unavoidable causes. Lacerations, fractures and dislocations are the more common injuries that occur as a result of an accident. However, other injuries we classify as accidental include, but are not limited to, abrasions, contusions, punctures, sprains, or strains.

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Field 14: date of accident

If the services are accident-related, complete field 10 (identifies if the accident is employment or auto accident related) and field 14 (provides the date the accident occurred) on the CMS-1500 claim form. Some contracts include benefits for greater payment for some accident care, so providing this information helps process claims correctly.

The removal of sutures or casts is normally considered part of the total service if provided by the same physician or by another physician in the same office. Bill for these services separately only if your office did not perform the initial suturing or cast application.

Must be medically necessary and documented in medical record

Consultations

A consultation occurs when the attending physician or other appropriate source asks the advice or opinion of another physician for the evaluation and/or management of the patient's specific problem. In order for Wellmark to determine benefits for these services, the need for the consultation must meet medical necessity criteria and be documented in the referring physician's patient's medical record. Wellmark follows Medicare's guidelines to determine whether there is a "transfer of care" or the request for a "consultation."

A physician consultant may initiate diagnostic and/or therapeutic services as a part of, or during, the consultation process. The request for a consultation from the attending physician or other appropriate source, and the need for consultation, must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record, and communicated to the requesting physician or other appropriate source. Use CPT codes 99241–99245* (office/outpatient) or 99251–99255 (hospital/facility) to bill a consultation.

Follow-up to a consultation

Bill a follow-up to a consultation as an established office visit (99211–99215) or a subsequent hospital visit (99231–99233).

A consultation initiated by a patient and/or family and not requested by the physician, should not be reported using consultation codes. Report using the codes for office visits as appropriate.

Note: Only one inpatient consultation per member, per specialty, per admission is payable.

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<i>Consultation for opinion or advice</i>	<p>Confirmatory Consultations</p> <p>Sometimes a confirmatory consultation is required by a third party payer, to get a physician’s opinion on the necessity or appropriateness of the recommended medical treatment or surgical procedure. In cases where the consultation is required for coverage purposes, submit a 32* modifier with the appropriate procedure code. The 32 modifier identifies services related to mandated consultation and/or related services.</p>
<i>Unscheduled services</i>	<p>Emergency Room Services</p> <p>CPT defines an emergency department as an organized hospital-based facility for the provision of <i>unscheduled</i> episodic services to patients who seek immediate medical attention.</p> <p>Bill procedure codes 99281–99285 to report evaluation and management services provided in the emergency department. Include the patient’s condition date or the date of the medical emergency in field 14 of the CMS-1500 claim form.</p>
<i>Injection billing information</i>	<p>Hospital Inpatient Services</p> <p>Use procedure codes 99221–99223 to report initial hospital care, and 99231–99233 for subsequent hospital care.</p> <p>Injections</p> <p>Any time you bill injection services other than therapeutic musculoskeletal injections, bill the administration code (90772–90779) in addition to the appropriate HCPCS code for the medication and dosage being injected.</p>
<i>Report units in whole numbers</i>	<p>A current list of “J” and “S” codes can be found in <i>HCPCS</i>. If an injection code cannot be found, submit code J3490 (unclassified drugs). If you use this code, include the National Drug Code (NDC) in your description of services when filing either electronically or on paper.</p> <p>There may be times when the dosage for the drug identified in the description does not equal the dosage ordered. In this case, use the units of service field (field 24G of the CMS-1500) to adjust the dosage. Remember to report all units in whole numbers. If providing a partial unit, round up to the nearest whole number when reporting units on your claim. Wellmark will return CMS-1500 claims that include partial units in the units of service field.</p>

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Trigger Point Injections

Bill trigger point injections with CPT code 20552* or 20553:

- 20552 Injection; single or multiple trigger point(s), one or two muscle group(s)
- 20553 Injection; single or multiple trigger point(s), three or more muscle groups

Choose the correct code for the injection and bill **one** unit of service, regardless of the number of sites injected.

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. SPEC. Fcny Ref	I. ID. QUAL.	J. RENDERING PROVIDER ID #
	From MM	DD	YY	To MM	DD	YY			(Explain Unusual Circumstances)	MODIFIER						
1	07	10	XX	07	10	XX	22		20553			1			NPI	0123456789
2															NPI	

One injection, per site, per week, up to three locations per session

Wellmark pays the lesser of the actual charge or the maximum allowable fee (MAF). We provide a maximum benefit for six weeks of trigger point injections. If we receive a claim for injections administered beyond the sixth week, we will deny the claim.

To request a review of a denied claim, complete a *Provider Inquiry* form and submit medical documentation supporting the need for the additional treatment. For further claim review instructions, refer to the "Claims Filing" section of the *Wellmark Provider Guide* under the heading Claims Adjustments.

Treatment may require multiple injections with the same needle to get the therapeutic results for a given anatomical site. Document the injection site in the patient's medical record and bill the injections as one unit of service.

Bilateral trigger points

Do **not** bill the 50 modifier with trigger point injections. It is inappropriate based on the description of these codes.

Joint Injections

Wellmark provides benefits for joint injections when billed with the following codes:

- 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes)
- 20605 intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
- 20610 major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa)

In addition to the joint injection code, you may bill a separate HCPCS code for the medication.

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Bilateral Joint Injections

Bill bilateral joint injections on one line of the CMS-1500 with a 50* modifier and 1 unit of service.

You may bill the medication (drug) in addition to the injection. Choose a HCPCS code beginning with the letter J (or S) to describe the medication used. If the same drug is used for both injections, combine the dosage and bill on one line. For example, if the code indicates 50mg and the total injected is 200mg, use "4" in the units of service.

Bilateral Tendon Injections

To submit bilateral tendon injections, bill each injection on a separate line using procedure code 20550 or 20551. Submit the 59 modifier on the second injection when performed on the same limb. To indicate the right or left limb, use the RT/LT modifier.

Note: *If the word bilateral is included in the CPT code description, do not use the 50 modifier.* Bill the procedure with one unit of service.

New vs. established patient

Office or Outpatient Services

Use procedure codes 99201–99205 to bill office or outpatient services for *new* patients. New patients are defined as those who have not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. Established patients are those who have received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years. Bill established office or outpatient services using codes 99211–99215.

Billing scheduled visits in the outpatient department of a hospital

When an outpatient department of a hospital is used by a practitioner as an office or clinic for the provision of *scheduled* visits, bill these services as place of service "11," the same place of service you would use for the doctor's office.

"Scheduled" means the visit is planned and the patient has an appointment with the practitioner for a specific day and time. For example, a specialist may come to a rural hospital one day a week to see patients who have previously scheduled an appointment. Even though the location may be the outpatient department of the hospital, the service is considered a "scheduled office visit" for billing purposes.

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Orthotics

Bill orthotics using the description in *HCPCS*. For example, if you are billing for two inserts for the same foot using code L3030 (foot insert, removable, formed to patient foot, each), you should bill a 2 in the units of service field because "each" is included in the description. If you are billing one insert for each foot, it is acceptable to bill these codes using an RT and LT modifier on separate lines with one unit of service. Do not use a 50* modifier when billing devices.

Prolonged Services

When a physician provides prolonged service with *face-to-face* patient contact that is beyond the usual service in the inpatient or outpatient setting, bill these services with codes 99354–99357. Wellmark covers prolonged services *only* when the physician provides direct face-to-face contact with the patient. Prolonged care *without direct contact* (99358– 99359) is not a covered service.

IV Wellmark's Radiology Utilization and Quality Management Program

Wellmark requires preauthorization for the following outpatient diagnostic imaging services:

Outpatient diagnostic procedures that require 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)

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, and who have 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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- 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 ID)
 - BlueCard® (which includes BlueCard Host, BlueCard Point of Service BlueCard Home, BlueCard Preferred Provider Organization)
 - Medicare Supplement
 - MedicareBlueSM PPO (Medicare Advantage)
 - Medicare Prime

Check eligibility of BlueCard Host members

Some BlueCard Host members 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.

- 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 pre-authorization*
- To request preauthorization, do one of the following (for Select First, see footnote)¹:
- log in to www.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.

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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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 www.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 www.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.**

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.

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 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.

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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*Pre-service appeals***Radiology Preauthorization Appeal Process**

If your request for preauthorization is denied and you want to appeal the decision, contact AIM within 180 days of receiving the denial by:

- calling **888-800-4497** between the hours of 7:30 a.m.–6 p.m. CT, M–F
- faxing supporting clinical information to AIM at 800-798-2068
- mailing supporting information to AIM at:

Attention: Provider Appeals Suite 200
American Imaging Management Inc.
540 Lake Cook Road
Deerfield IL 60015

Post-service appeals

To request an appeal after the service has been provided, please follow the claims adjustment guidelines in the Claims Filing section of the *Wellmark Provider Guide*.

To obtain more detailed information about the Radiology Program, visit www.wellmark.com > Provider > Medical Policies & Authorizations > Authorizations.

Billing Units of Service vs. Views

Billing units of radiology service is not always simple. While it may seem logical to submit the number of views performed, *that may not be correct*. Read the CPT* code description carefully. If the description for the procedure code includes a number of views, only submit one (1) unit of service.

For example, procedure code 73620 is for a radiological examination, foot, *two views*. If the practitioner performs up to two views, bill this procedure code with one in the units of service. If performed on both feet, bill two lines with 73620 and one unit of service on each line. You may include the RT modifier with one line and the LT modifier with the other line. Do *not* use a 50 modifier when billing X-ray services.

If the podiatrist performs this X-ray with *three or more views*, the correct procedure code is 73630 (radiological exam, foot, complete, minimum of three views) with one in the units of service. If more than three views were taken, you would still bill procedure code 73630 with only one in the units of service field because of the CPT description.

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Use of the 26* and TC Modifiers

Wellmark maintains a policy that one interpretation of a diagnostic test or X-ray is all that is medically necessary. There are situations where a physician may elect to have diagnostic or radiologic services interpreted by another physician. When the technical component of a service is performed by one physician and the interpretation is performed by another physician, follow the billing instructions below that fit the particular situation.

Situations

Clinical agreement exists

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. In this case, you would not use a modifier.

No clinical agreement exists

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

One physician bills

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 direct 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 total effort (no modifier necessary).

Both physicians bill

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).

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

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Re–X-Ray of Fractures

Normally, most fractures heal within 90 days. There are some fractures or fracture complications that 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 allows extended evaluation past the normal 90 days if the healing of a fracture is complicated by mal-union, delayed union, or non-union.

Medical policy for bone stimulators

For information on Wellmark's medical policy regarding the use of bone stimulators to enhance healing, visit www.wellmark.com > Provider > Medical Policies & Authorizations > Medical Policies - Alphabetical Listing.

V Surgery and Surgical Modifiers

Global Billing

Surgical procedures described in *CPT** normally include three integral components:

- 1) normal, uncomplicated postoperative care
- 2) the administration of local or topical anesthesia
- 3) the surgery itself

Editing logic for processing surgical claims

Combining the charges for these integral components and billing them under a single fee is referred to as *global billing*. If integral components are billed separately, Wellmark's processing system totals the charges and settles benefits based on the maximum allowable fee for the primary procedure. To learn more about Wellmark's claims editing software, refer to the *Wellmark Provider Guide*, "Claims Filing" section, Payment Policies.

Visit Medicare's Web site to determine pre- and postoperative days

Wellmark follows Medicare guidelines for pre- and postoperative days for all surgeries, regardless of the place of service. To find the number of pre- and postoperative days Medicare considers part of the global surgical fee, refer to Medicare's Physician Fee Schedule at <http://www.cms.hhs.gov/PhysicianFeeSched/> (PFS Relative Value Files).

According to *CPT*, diagnostic procedures are usually billed separately from the global surgical charges.

The following information explains when to submit certain modifiers associated with surgery.

Modifier 54

If the *only* service a practitioner provides is the surgery, with pre-and/ or postoperative care provided by another practitioner, bill the surgical procedure code with a 54 modifier.

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Billing Preoperative Services

Preoperative care provided by a practitioner other than the surgeon must be fully itemized and billed separately with an evaluation and management (E/M) code, rather than in a global fee. Do not use the 56* modifier with preoperative care.

Modifier 56 For major procedures (90-day global period), the surgeon's preoperative services the day before and the day of the procedure are included in the global period. The "decision for surgery" Evaluation and Management (E/M) code should be billed separately from the global fee using a 57 modifier.

Modifier 25 For minor procedures (0 or 10-day global period), Wellmark includes preoperative services performed the same day as the procedure in the global period. If a service is significant and separately identifiable, submit the procedure with modifier 25* as an exception to the preoperative services rule.

If preoperative care is performed by a practitioner other than the surgeon, we recommend that you submit an appropriate E/M code. Services must be itemized and billed separately, and are not considered part of global billing.

Postoperative Services

All postoperative services are included in the global period.

Modifier 55 If postoperative care (but not the entire global surgical package) is provided, submit the 55 (Postoperative Management Only) modifier with the surgical procedure code and one in the units of service field, even when the member was seen multiple times. Enter the first date of service for postoperative care in the "From" and "To" Dates of Service field (24A) when the care includes multiple visits.

If more than one practitioner provides the postoperative care, the allowance will be divided according to the number of days each practitioner was responsible for the member's care.

Complications of Surgery

Follow-up care for therapeutic procedures is usually considered part of the surgical procedure. If there are complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services outside the postoperative period, bill the additional services using modifier 24 for unrelated E/M services and modifiers 58, 76, 77, 78, and 79 for procedural services.

To report services outside the postoperative period

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<p><i>Attach documentation when submitting the 22 modifier</i></p>	<p>Complicated or Increased Procedural Services</p> <p>The 22* modifier appended to the surgery code indicates that the work required to provide a service was substantially greater than typically required. Always attach additional documentation (e.g., an operative report) to the claim that supports the need for the additional work when you submit this modifier. After Wellmark reviews the documentation submitted with the claim, increased payment beyond the usual amount for that procedure may be made if our medical staff agrees that it is warranted.</p>
<p><i>Definition of increased procedural services</i></p>	<p>Each procedure has a range of difficulty—some may be easier, some more difficult. The surgeon is not expected to charge less for a case that is easy. Similarly, he/she is not expected to charge more when the procedure is more difficult, within reason, since both types of cases will "average out" over time as a surgeon performs many cases. Use the 22 modifier only when the procedure is <i>clearly</i> out of the range of ordinary difficulty for that type of procedure.</p> <p>If additional documentation is not received when the 22 modifier is billed, we will use the Maximum Allowable Fee (MAF) to process the service. After the claim has been processed, if you feel additional payment is warranted, complete a <i>Provider Inquiry</i> form, attach supporting documentation, and submit it to the address given on the form.</p>
<p><i>Modifier 51</i></p>	<p>Multiple Procedures</p> <p>When multiple surgeries are performed on the same day by the same provider, enter the primary procedure on the first line of the claim and "1" in the Units of Service. Enter additional surgical procedure code(s) on separate lines, attach a 51 modifier, and "1" in each Unit of Service. Use this modifier only when procedures do not share inclusive elements.</p> <p>Note: Appendix D in the <i>CPT</i> book lists CPT add-on codes (+) that do not require a 51 modifier and can be billed with multiple units on the same day. Appendix E lists codes that are exempt from modifier 51.</p> <p>To determine payment for multiple surgeries performed on the same day, Wellmark calculates the most complicated surgical procedure at 100 percent of the MAF for that service and additional surgical procedures at 50 percent of the MAF, unless the procedures are incidental to the primary surgical procedure. Wellmark considers incidental surgeries part of the primary procedure.</p> <p>Procedures included in the multiple surgery payment rules are listed on the National Physician Fee Schedule Relative Value File with a "2" in the Multiple Procedure field. This file is published by the Centers for Medicare and Medicaid Services (CMS) and can be accessed online at www.cms.hhs.gov/PhysicianFeeSched/.</p>

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Modifier 59 The 59* modifier indicates that a procedure is distinct or independent from other services that would otherwise be a component of the main procedure performed on the same day. These procedures, not normally reported together, may be appropriate under unique circumstances. They may represent a procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same physician. The patient's medical record must support use of the 59 modifier.

Bilateral Procedures

Definition of bilateral Bilateral procedures are defined as two surgical procedures that are mirror images of each other performed on both sides of the body at the same operative session.

Modifier 50 Submit the procedure code with a 50 modifier and one unit of service on one line of the claim form. If the procedure code has "unilateral or bilateral" in its description, do not submit the 50 modifier.

Wellmark allows up to 150 percent of the MAF when a surgical procedure is billed with a 50 modifier. An exception to this rule is when there are multiple surgeries in addition to the bilateral procedure.

Assistant-at-Surgery Services

Wellmark uses Medicare's Assistant Surgeon indicators on the Physician Fee Schedule Relative Value File to process claims submitted with an 80 or 81 modifier. To view the Physician Fee Schedule online, visit www.cms.hhs.gov/PhysicianFeeSched/.

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

When an M.D., D.O., or D.P.M. assists at a surgery and his/her services are billed on the same claim as the surgery using either the surgeon's or the group billing number, submit the assist with an 80 modifier and each physician's National Provider Identifier (NPI) number in field 24J.

Modifier 81 The 81 modifier may apply when:

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

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Modifier 62 The 62* modifier for co-surgeons is appropriate when two surgeons, usually of different specialties, participate as co-surgeons for a specific procedure. Wellmark follows the same guidelines for this modifier as Medicare; therefore, if Medicare approves co-surgeon services for a procedure, Wellmark will also provide benefits.

To find out if Medicare approves co-surgeons for a procedure, call your local Medicare Part B Provider Service or visit the Centers for Medicare and Medicaid Services (CMS) Web site at www.cms.hhs.gov/PhysicianFeeSched/.

Wellmark uses Medicare's indicators in the Co-Surg column of the PFS Relative Value File to determine payment:

Indicator 0: Co-surgeon cannot be paid

Indicator 1: Co-surgeon may be paid with documentation

Indicator 2: Co-surgeon can be paid

If two surgeons of different specialties did not participate as co-surgeons for a specific procedure, consider using an assistant surgeon modifier rather than 62. If two surgeons perform two distinct surgeries, there is no need to bill with a modifier.

VI Anatomical Modifiers

HCPCS provides modifiers podiatrists can use to identify which foot you are treating, and more specifically, which toe.

Modifiers LT/RT To identify that a procedure was performed on the left or right foot, use the RT (right side) or LT (left side) modifier.

T modifiers To identify that a procedure was performed on the left or right foot and to a particular toe, use the following T modifiers:

T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
TA	Left foot, great toe

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VII Billing Procedures for Lesion Removal & Closure

The Integumentary section of *CPT** provides codes for lesion removal. In 2007, *CPT* revised its code definitions for lesion destruction codes 17000–17004, and 17110–17111 and made the definitions more specific to the type of lesion. For example, 17000–17004 should only be used to bill premalignant lesions, where in the past, these codes could have been used to bill premalignant or benign lesions. Now use procedure code 17110 and 17111 to bill benign lesions.

Common or Plantar Wart Removal

Use procedure codes 17110 or 17111 to bill common or plantar wart destruction. To bill these codes, do the following:

If the number of warts removed is 14 or less, bill procedure code 17110, and one in the units of service field.

Codes to use for wart removal

If 15 or more warts are removed, bill procedure code 17111 with one in the units of service field. Do not bill both codes on the same claim or submit either code with more than one unit of service.

Premalignant Lesion Removal

Procedure code 17003 is an add-on code and is considered part of a series used to bill the destruction of premalignant lesions. These minor procedures may increase in quantity, but often decrease in complexity. You can identify add-on codes by the terms "each," "each additional," or "second, third" etc. in the definition of the code.

Billing add-on codes

Always bill these codes in sequence and progress from a single procedure (code 17000 with one in the units of service) to "each additional" procedure (17003 with the number of lesions removed entered in the units of service field). Never bill a secondary code without first billing the primary code. **Note:** These codes do not require a 51 modifier.

If the patient has 15 or more lesions destroyed, bill procedure code 17004 (Destruction . . . premalignant lesions . . . ; 15 or more lesions) with "1" in the units of service field. Do not bill codes 17000 and 17003 when billing procedure code 17004, since 17004 is a major procedure.

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Paring or Cutting of Corns or Calluses

Codes 11055*, 11056, and 11057 are not add-on codes. When billing for this service, select the appropriate code, based on the number of lesions involved, and bill that CPT code with one unit of service:

- 11055 – Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- 11056 two to four lesions
- 11057 more than four lesions

Simple closure is part of the global procedure

Excision and Closure of Benign or Malignant Lesions

For those procedure codes that include the size of the lesion in the description, bill each lesion separately by size. If a benign or malignant lesion is excised, followed by simple closure, Wellmark considers the closure part of the global procedure. We also consider a subcutaneous and skin closure a simple repair.

- simple repair involves one-layer closure/suturing (12001–12021)

Bill the *primary* code without a modifier. You may add a 51 or 59 modifier to each lesion code in addition to the primary procedure.

Intermediate/complex repair or tissue transfer

You may bill a separate charge for intermediate or complex repair involving multiple layers, or for tissue transfer or rearrangement.

- intermediate repair includes multiple layers of sutures (12031–12057)
- complex repair includes multiple layers of sutures (13100–13300)
- adjacent tissue transfer or rearrangement (14000–14350)

Fracture Care

Fracture care codes include the application of the first cast, strap, or splint. The physician who applies the initial cast, strap or splint also assumes all of the subsequent care and should not use the application of casts and strapping codes (29000–29799) as an initial service code in addition to the fracture care codes. Removal of the initial and subsequent casts by the treating physician is not billable, and is bundled with the cast application.

When a physician replaces a cast or performs a cast application or strapping service without a restorative closed/open reduction procedure for a fracture, injury, or dislocation, bill a casting or strapping code *instead of* a surgical casting code. Codes for cast removals or repairs (29700–29750) should be used only for casts applied by another physician.

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Cast applications When you bill a fracture care code or the application of a cast, you may also bill for casting supplies and materials. See page 5 for more information.

VIII. Referral & Prior Approval

When supplying Blue Advantage, Blue Choice, and Blue Access patients with HME, prostheses, or orthotics, select a vendor from the Wellmark Health Plan of Iowa (WHPI) network. By staying in-network, members receive their maximum benefit under their health plan.

A prior approval is also recommended to obtain a medical necessity determination, regardless of cost, for HME, prostheses, and orthotics.

- For a list of services, supplies, procedures, or treatments Wellmark recommends receive prior approval, visit www.wellmark.com > Provider > Medical Policies & Authorizations > Prior Approvals).
- To submit a prior approval, complete the Prior Approval form found at www.wellmark.com > Provider > Communication & Resources > Forms > Prior Approval Medical Forms.

Out-of-network services If members need nonemergent care from out-of-network providers, take the following steps, prior to the service, to ensure they receive maximum benefits.

Blue Advantage

- obtain a referral from the member's primary care physician (PCP); and
- receive Wellmark approval

Blue Choice

- For a higher level of benefit, obtain a referral from the member's PCP; and receive Wellmark approval

Blue Access

- nonemergent out-of-network services are not covered unless preapproved by Wellmark Health Plan of Iowa, Inc., through the referral process.

IX Pharmacy Requirements and Programs

Dispensing Drugs from Your Office

Wellmark members with an RxBin number in the right corner of their ID card are not covered for oral prescription drugs dispensed by provider offices. If a drug is dispensed by a provider's office, the charge is denied, and the member is responsible for the entire cost of the prescription. Members with drug benefits included in their health insurance coverage can continue to receive reimbursement for drugs dispensed by provider offices. Benefits can be checked using Wellmark's online secure *View Eligibility and Benefits* tool or by calling the appropriate provider service area.

How to file oral drugs

To avoid processing delays, please include the following information on claims when submitting oral drugs:

- the National Drug Code (NDC) in:
 - the comment section of an electronic claim
 - field 24D of a paper claim
- the quantity dispensed
- the appropriate HCPCS code:
 - S5000 Prescription drug, generic
 - S5001 Prescription drug, brand name

Unclassified drugs require the NDC

In addition, when you submit an **injectable** drug claim with HCPCS J3490 (Unclassified drugs), you will need to include the NDC.

Wellmark Drug List

The Wellmark Drug List is a list of medications that helps guide physicians and pharmacists in selecting the medications that provide an appropriate treatment at the best price.

Some benefit plans have a tiered design. This means the amount the member pays to have a prescription filled depends on what tier the drug is on. To help the member avoid paying additional out-of-pocket expenses, prescribe generic whenever possible, and/or choose a drug on Wellmark's Drug List.

hawk-i program's drug coverage

hawk-i Wellmark Drug List

Wellmark members with **hawk-i** (Healthy and Well Kids in Iowa) health and prescription drug insurance are covered under a managed generic prescription drug program. Generic medications are available at no cost to **hawk-i** members. Members who purchase a brand-name drug when a generic therapeutic equivalent is available will pay the full cost of the drug.

*Searching the **hawk-i**
Wellmark Drug List*

There are exceptions in which Wellmark will provide coverage for brand medications and Narrow Therapeutic Index (NTI) drugs at no cost to the member. To find the most current list of drugs covered for **hawk-i** members, go to www.wellmark.com > Health & Wellness > Drug Information > Wellmark Drug List > Choose a Drug List. Select the **hawk-i** Wellmark Drug List. Enter the name of the drug or choose a drug class, and then click on Search.

*Call 800-600-8065
for a drug prior
authorization*

Wellmark Prior Authorization and Quantity Limit List

When a drug requires prior authorization, call **800-600-8065**. This number is answered 24 hours a day, 7 days a week.

The prior authorization and quantity limit lists are available at www.wellmark.com > Provider > Drug Information. Then, under Related Information on the right hand side, select Prior Authorization or Quantity Limits.

X Summary

Please refer to this guide when you have questions about how to bill or code specific podiatric services or procedures. If you have additional questions, please call a provider service representative, using one of the phone numbers listed on the back page.

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

Servicing: Alliance SelectSM, Classic Blue[®], Senior Blue[®],
MedicareBlue SupplementSM, Blue Traditions[®], Blue Access[®],
hawk-i Blue Access[®], Blue Choice[®], Blue Advantage[®]

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

Network Relations

.... 800-700-9137 or 605-373-7460

Fax Number

..... 605-373-7498

Contact to discuss contracting opportunities in your area

Admission Notification, Precertification, and Case Management

..... 800-642-9273

EC (Electronic Commerce) Solutions*

..... 800-407-0267

Providing: Electronic claims and reports information

Pharmacy Department

..... 800-600-8065

BlueCard[®] Program

Out-of-state members' claim status or payment information

..... 800-722-1631 or 605-373-7474

Out-of-state members' eligibility information

.... 800-676-2583

Network Administration*

.... 800-708-1342

Providing information about

network participation	provider number
address change	application status
taxpayer identification number change	

Pregnancy Program*

..... 866-460-9742

Disease Management Program*

..... 866-816-5264



An Independent Licensee of the Blue Cross and
Blue Shield Association

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