BlueInk℠

STAY CURRENT WITH THE LATEST NEWS FROM WELLMARK® BLUE CROSS® AND BLUE SHIELD®

Information for Iowa and South Dakota physicians, hospitals and health care providers

JUNE 2022

Visit us at **Wellmark.com/BlueInk**

FEATURE

Changes to the Wellmark Drug List beginning July 1, 2022

ADMINISTRATION AND POLICY

Orthognathic surgery will require prior approval

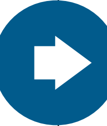
CLAIMS AND CODING

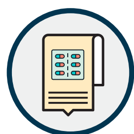
Anatomical modifiers

Automation for Professional (837P) and Facility (837I) Electronic Claim Corrections

EDUCATION AND RESOURCES

Understanding the importance of recredentialing





Changes to the Wellmark Drug List beginning July 1, 2022

Here's what you need to know.

Wellmark Blue Cross and Blue Shield along with a committee of pharmacists and physicians review the Wellmark Drug List several times a year. This review enables us to identify drugs that are the safest and most effective, while reducing costs and ensuring members have access to the drugs they need.

Some of the formulary and utilization management (UM) updates will change member coverage and/or cost share for certain drugs. Members affected negatively by these changes will be notified by mail and instructed on next steps. Providers will also be notified for changes that require prior authorization or a new prescription.

The chart below outlines the formulary and UM changes effective July 1, 2022.

DRUG	FORMULARY CHANGE/UM
Hemangeol®	**MOVING FROM TIER 4/LEVEL 4 TO SPECIALTY PREFERRED/LEVEL 4.**
Sirturo®	**MOVING FROM TIER 4/LEVEL 5 TO SPECIALTY PREFERRED/LEVEL 5.**
Gleostine®	**MOVING FROM TIER 2/LEVEL 3 TO SPECIALTY PREFERRED/LEVEL 3.**
methylergonovine	**ADDING QUANTITY LIMIT;** 28 tablets per fill, 2 fills per 365 days
Androderm®	**ADDING QUANTITY LIMIT;** 1 patch per day
testosterone gel 1% 2.5 g packet	**ADDING QUANTITY LIMIT;** 2 packets per day
testosterone gel 1% 5 g packet	**ADDING QUANTITY LIMIT;** 2 packets per day
testosterone gel 1% 75 g pump bottle	**ADDING QUANTITY LIMIT;** 4 pump bottles per 30 days
testosterone gel 1.62% 1.25 g packet	**ADDING QUANTITY LIMIT;** 1 packet per day

continued on next page

continued from previous page

DRUG	FORMULARY CHANGE/UM
testosterone gel 1.62% 2.5 g packet	**ADDING QUANTITY LIMIT;** 2 packets per day
testosterone gel 1.62% 75 g pump bottle	**ADDING QUANTITY LIMIT;** 2 pump bottles per 30 days
testosterone gel 2% 60 g pump bottle	**ADDING QUANTITY LIMIT;** 2 pump bottles per 30 days
Natesto®	**ADDING QUANTITY LIMIT;** 3 pump bottles per 30 days
testosterone solution 30 mg/1.5 mL 90 mL pump bottle	**ADDING QUANTITY LIMIT;** 2 pump bottles per 30 days
Striant®	**ADDING QUANTITY LIMIT;** 2 systems per day
Testim® gel 1% 5 g tube	**ADDING QUANTITY LIMIT;** 2 tubes per day
Vogelxo® gel 1% 5 g tube	**ADDING QUANTITY LIMIT;** 2 tubes per day
Vogelxo® gel 1% 5 g packet	**ADDING QUANTITY LIMIT;** 2 packets per day
Vogelxo® gel 1% 75 g pump bottle	**ADDING QUANTITY LIMIT;** 4 pump bottles per 30 days

Wellmark updates its drug lists in January and July and posts notices of changes at Wellmark.com. You can view all updates to the drug list on Wellmark.com (For Providers > Drug Information > Wellmark Drug List) or request a copy by contacting Provider Service.

Orthognathic surgery will require prior approval

FOR DATES OF SERVICE ON AND AFTER AUG.12, 2022, orthognathic surgery will be added to the list of treatments, procedures and services that require prior approval. Moving the review to preservice gives both providers and members the opportunity to know medical necessity prior to the services being performed. Wellmark medical policy will be used to determine medical necessity for orthognathic surgery. The Wellmark Authorization Table will be updated to allow authorization requests for this procedure to be accepted via the online Utilization Management Tool beginning July 28, 2022.

Required documentation will include the following:

- **High-quality photograph(s) of the patient's occlusion (frontal/full face and lateral views);** all photographs must be labeled with the date taken and the patient's name and ID number on each photograph. Submission of the photograph(s) can be submitted by attaching to the episode request.
- **Appropriate clinical studies/tests including cephalometric radiographs and diagrams** with standard computer-generated measurements and analysis of the physical and/or physiological abnormality that confirms its presence and the degree to which it is causing impairment. When applicable radiologic film interpretations including AP radiograph and panoramic radiography. Include a concise summary of how the patient's facial skeletal deformities and malocclusions when applicable meet the anatomical requirements listed in the medical necessity criteria in addition to detailed information regarding related functional impairment(s)/deficit(s) due to the anatomic abnormalities

For all other required documentation for orthognathic surgery refer to the Wellmark Medical Policy on Wellmark.com, on and after Aug.12, 2022.

Save time for you and your coworkers by encouraging them to sign up for *BlueInk*

Is everyone in your office subscribed to BlueInk, our primary source of provider news and information? If not, encourage them to sign up today so they can receive the issues as soon as they are released.

Spread the word!

Currently, many *BlueInk* subscribers forward the latest issue to others in the office. But, did you know anyone in the office can subscribe to *BlueInk*? It does not require an account on the secure provider portal. Tell your colleagues to sign up now.

BlueInk helps our providers stay up to date on policy changes, new or revised tools, changes in process, and more!

Anatomical modifiers

Anatomical modifiers are an important aspect of claim code editing. Without the proper anatomical modifier applied to the procedure code, other edits, such as duplicate editing or frequency editing, may not function properly.

Wellmark requires all codes with a Centers for Medicare & Medicare (CMS) Medicare Physician Fee Schedule (MPFS) bilateral indicator '1' to be billed with an anatomical modifier.

Wellmark will deny codes requiring anatomical modifiers when the claim line is submitted without an anatomical modifier (50, LT, RT, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, LC, LD, RC, LM, RI). A listing of these modifiers and their complete descriptions can be found in Appendix 2 of the HCPCS book.

This includes using anatomical modifiers with surgical procedures performed on eyelids, fingers and toes.

EXAMPLES:		
Arthroscopy, shoulder, surgical	Rotator cuff repair of right shoulder was performed.	Correct coding is 29827-RT.
Drainage of finger abscess of right thumb	Simple was performed.	Correct coding is 26010-FA.
Professional component of ultrasound	Breast, unilateral; complete was performed.	Correct coding is 76641-26-RT

Automation for Professional (837P) and Facility (837I) Electronic Claim Corrections

Providers are encouraged to submit electronic claim corrections for both professional and facility claims that are identified by the frequency code of 5, 7 or 8 for Wellmark members and Blue Card® out-of-state members. Through the use of automation, claims for Wellmark members and Blue Card members are adjusted quicker than through the electronic claim inquiry process. This facilitates administrative time savings and quicker reimbursement for covered services.

Submitting the appropriate frequency code will indicate that the claim is an adjustment of a previously adjudicated (approved or denied) claim. The claim frequency codes are as follows:

FREQUENCY CODE	WHEN TO USE	DESCRIPTION
5	**Late charges only**	Submit only late charges that need added to original claim. Do not submit any other changes.
7	**Replacement claim**	The claim is a replacement or corrected claim. The information present on this bill represents a complete replacement of the previously processed claim.
8	**Void/cancel request**	The claim is a voided/canceled claim and the original claim should be voided. If the void is requested because a new claim needs to be submitted, the new claim must be received according to Wellmark timely filing guidelines — refer to Chapter 1: Timely Filing for more information.

Best Practices for Submitting Corrected Claims Electronically

- **Must contain corrected information for an original claim** that can be adjusted for the same dates of service submitted on the original claim.
- **Do not submit corrections on a claim rejected for a clean claim rejection.** Reference Wellmark's clean claim rejection message codes in the Claims Filing Section of the Wellmark Provider Guide.
- **Each electronic corrected claim correction must serve as a full replacement of the claim it is submitted for.** You may not submit one replacement claim for multiple original claims.
- **If claim corrections do not meet Wellmark's clean claim requirements,** they will be rejected back to you at the clearinghouse on the 277CA report for Wellmark member's claims. Please check with your clearinghouse on how to obtain this detail.
- **Wellmark will not accept electronic corrections for claims that were originally clean claim rejected;** a new claim will need to be submitted for processing within Wellmark's timely filing guidelines.
- **All claim corrections submitted electronically must be received within 18 months** from the date of the original Wellmark remittance on which the original claims in question appear.
- **For frequency code 7 submissions you can include changes to the original claim** for the same date span submitted, plus new charges for services not previously submitted.

Understanding the importance of recredentialing

Learn about the recredentialing process.

What is recredentialing?

Practitioners, facilities, and entities are required to be recredentialed every 36 months from the initial application acceptance date, for all Wellmark networks.

Recredentialing is a critical step providers must take to help avoid negative consequences. These negative consequences can include:

- Termination from Wellmark networks
- Removal from the Provider Directory
- Claim denials or payment as out-of-network
- Inability for members to select provider as a primary care practitioner (PCP)

How are contracted providers notified about recredentialing?

Approximately four months prior to a provider's recredentialing due date, the first recredentialing notification is sent to all credentialing contact email addresses that Wellmark has on file for the provider. Please note that only one recredentialing application is required. The second notification is sent three months before the recredentialing deadline, and the final notification is sent two months before the recredentialing deadline. Providers that do not respond after the final notification will be terminated 60 days after the final notification is sent.

How do I complete recredentialing?

Once the recredentialing notification is received, log in to **E-cred Central** and click on the Recredentialing Tool. You will be led through the application, which consists of answering a series of questions.

Resources

For additional information on recredentialing refer to the following resources.

- **"Credentialing and Network Participation"** section of the Provider Guide
- E-cred Central User Guide (Available in the **E-cred Central** menu after you log in)
- **April 2022 webinar**

BlueInk is published by Wellmark Blue Cross and Blue Shield's Marketing Department.

EDITOR: Victoria Clausen

GRAPHIC DESIGNER: Elisa Conklin

If you would like to subscribe to *BlueInk*, visit **Wellmark.com/DigitalBlueInk**.

For other questions, visit **Wellmark.com**.

Blue Cross®, Blue Shield® and the Cross® and Shield® symbols, and are registered marks and BlueInk℠ is a service mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Wellmark® is a registered mark of Wellmark, Inc.

Blue Distinction Centers (BDC) met overall quality measures, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. Total Care providers have met national criteria based on provider commitment to deliver value-based care to a population of Blue members. Total Care+ providers also met a goal of delivering quality care at a lower total cost relative to other providers in their area. Program details are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for noncovered charges or other losses or damages resulting from Blue Distinction, Total Care or other provider finder information or care received from Blue Distinction, Total Care or other providers.

CVS Caremark® is a registered trademark of CVS Health Corp., an independent company that provides pharmacy services on behalf of Wellmark Blue Cross and Blue Shield. This website contains references to brand-name prescription drugs that are trademarks or register trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark.

Optum® is a separate company that provides payment integrity services on behalf of Wellmark Blue Cross and Blue Shield.

Availity® is a separate company that operates and services providers' electronic data interchange (EDI) transactions.

Jiva™ is a separate company that provides medical authorization services on behalf of Wellmark Blue Cross and Blue Shield.

The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a registered trademark of the American Medical Association.

Wellmark is not providing, and does not provide, any legal advice with regard to your compliance with the requirements of the Affordable Care Act (ACA), or any other federal or state law. This document is not intended, and shall not be construed, to provide any legal advice, and may not be relied upon as such. Regulations and guidance on specific provisions of the ACA and other federal laws have been and will continue to be provided by the U.S. Department of Health and Human Services (HHS) and/or other agencies. The information provided in this document reflects Wellmark's understanding of the most current information and is subject to change without further notice. For specific information regarding the application of these rules to your facts, or other compliance issues under applicable law, please consult your legal and/or tax advisors.

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc., Wellmark Value Health Plan, Inc., Wellmark Advantage Health Plan, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

M-2620128 06/22