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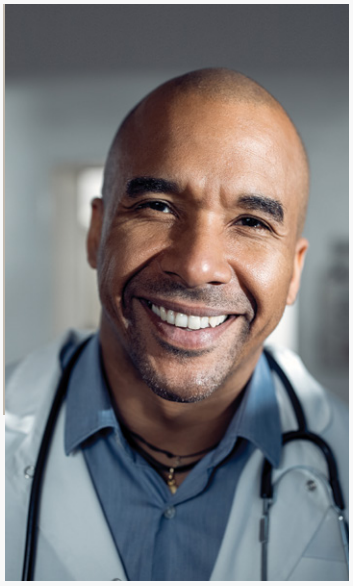
Information for Iowa and South Dakota physicians, hospitals and health care providers

FEBRUARY 2021



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FEATURE

Jiva inpatient and outpatient quick guides contain easy-to-follow screenshots

Jiva best practices for successful authorization submissions

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Jiva inpatient and outpatient quick guides contain easy-to-follow screenshots

Subscribe to WINS and use digital resources for latest updates on Jiva

There are two Jiva™ quick guides available for submitting both inpatient (IP) and outpatient (OP) requests within the new medical authorization tool. They contain screenshots to help guide providers through the process and can be found on the **Manage Authorizations page**, as well as via the following links:

- **Jiva quick guide for submitting inpatient (IP) requests**
- **Jiva quick guide for submitting outpatient (OP) requests**

As a reminder, the following training resources are available for Jiva:

- **Comprehensive user guide**
  - It contains helpful step-by-step guides and screenshots on all aspects of using Jiva, including submitting requests, performing InterQual reviews, and extending requests.
  - The guide is broken up into easy-to-navigate chapters.
  - To easily find the keywords you are looking for, type Ctrl+F, then type the keyword. This will work in Google Chrome, Internet Explorer, and Adobe.
- **Pre-recorded webinars**
- **Questions and answers document**
- **Troubleshooting document**

Wellmark encourages providers to view these training materials and use the User Guide as a supplement to the training by serving as a step-by-step guide for successful submissions.

The majority of Jiva login and authorization request submission issues have now been resolved. Using Jiva is the most efficient means of submitting and getting authorization requests processed and approved. If you have issues submitting authorization requests in Jiva, contact Wellmark Technical Support at 800-407-0267.

Faxed requests

If Jiva is experiencing a technical issue where the tool is not available, there is a fax option for requests defined as expedited. Wellmark is **only** accepting faxed medical authorization requests that are defined as expedited. Requests are considered expedited when a delay in medical care or treatment can:

- Seriously jeopardize the life or health of the member or the member's ability to regain maximum function, OR
- Subject the member to severe pain that cannot be adequately managed without the care or treatment requested.

Encourage coworkers to subscribe to WINS

The best way to get the latest information on Jiva is to **subscribe to WINS**, Wellmark's real-time notification system for providers. Encourage your coworkers to subscribe as well!

Jiva best practices for successful authorization submissions

Review these tips for successful Jiva submissions.

Since Wellmark's new medical authorization tool, Jiva™, launched on December 7, more than 30,000 requests have been submitted. In addition to encouraging providers to utilize resources found on the **Manage Authorizations** page, this article includes key steps within Jiva to ensure successful authorization submissions. Please pay close attention to the final tip for instructions on completing the InterQual® medical review.

- Select the correct **request type** depending on the review requirement indicated in the **Medical Authorization Table**. For example, "prior approval" is not the same as "precertification" in Wellmark terminology. There could be an impact to the status of the submission if the required request type is not selected for the service you are requesting. Some common definitions for these terms are outlined in the **Jiva Guidance and Troubleshooting Document**.
- **Attach providers** and select appropriate roles based on the type of request you are submitting*:
  - Inpatient requests require **Admitting** and **Facility/Vendor** provider roles
  - Outpatient requests require **Treating** and **Facility/Vendor** provider roles
  - Out-of-network requests require Requesting, Treating, and Facility/Vendor provider roles
    *If you are unable to locate the provider address you are looking for, try the advanced search feature and include additional search parameters such as the provider's NPI and city. Screenshots of the advanced search feature can be found in the **Jiva Guidance and Troubleshooting Document**.
- If you have submitted multiple episodes with the same procedure for a member, enter a Web Note on the episode you wish to void that explains the request is a duplicate and Wellmark health services staff needs to void it. This is the most efficient means of communication to health services for this scenario and will prevent Wellmark from reviewing a duplicate request.
- **InterQual medical review**
  - This is a critical component of the medical authorization process. The InterQual medical review has been missing on multiple submissions, which leads to pended submissions and delays in processing due to the additional communication required between Wellmark health services and the provider.
  - Screenshots of how to launch the medical review and mark it complete so that it is pulled into the Jiva episode can be found within the new Jiva quick guides that have been placed on the **Manage Authorizations** page. Additionally, below are the steps showing how to perform the InterQual medical review for an outpatient service request:

HOW TO PERFORM THE INTERQUAL MEDICAL REVIEW FOR AN OUTPATIENT SERVICE REQUEST

After the procedure codes have been added into the Jiva episode, the details will display in a table at the bottom of the **Service Request** section, as shown here:

Service Request

Action	Service Code	Requested#	Start Date	End Date	Service Type	Place of Service
⊖	73218(CPT)	1	01/12/2021	01/13/2021	Imaging	

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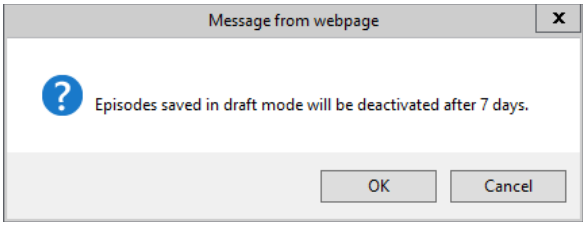
Once all services are entered, click the Check for Review button, which is found just below the table shown above.

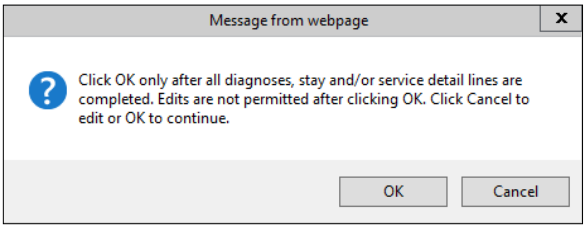
Check For Review

You will see a pop-up regarding episodes in draft mode. This does not impact your request. Click OK.



The system will refresh and take you to the top of the request screen. Scroll down to the **Service Request** section. Check the box in the grey row to select all appropriate services. This will activate green button that says Review.
Click this button to launch InterQual (IQ).

You will see another pop-up regarding edits.
No edits are allowed once you click OK.



Once you are finished entering IQ details, you will see a View Recommendations button.

VIEW RECOMMENDATIONS

InterQual will populate in a new tab in your web browser. Click Medical Review to begin the review process.

MEDICAL REVIEW

Depending on the results, a recommendation will be provided. Click Review Summary to view a final summary.

REVIEW SUMMARY

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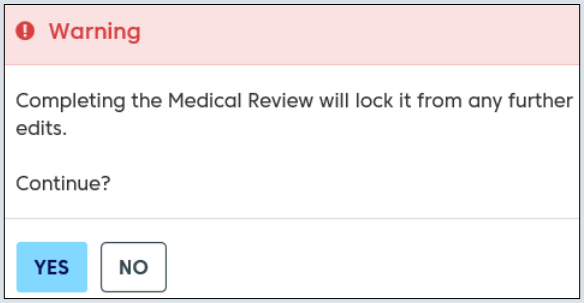
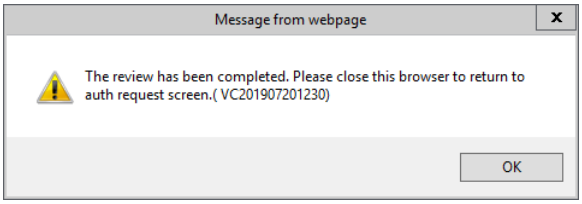
After reviewing the IQ summary, click Complete to save and complete the IQ.

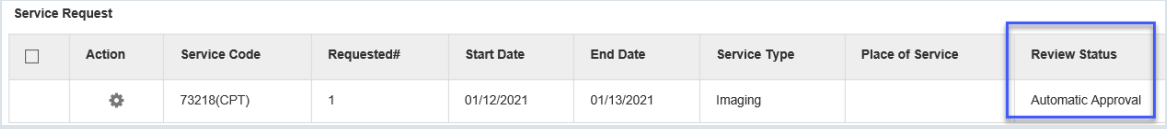
Click YES on the warning box acknowledging completion of the review.



You will see one final pop-up. Click OK and then close the tab that has IQ open. Do not close the entire browser window.



Jiva will update the Review Status field.



2021 Bariatric Surgery and Maternity Care Blue Distinction® Center Designations

30 new Blue Distinction facility designations announced

The Blue Distinction Specialty Care program was created in 2006 to help members find quality care and encourage providers to improve their overall delivery of care. Each year, providers that show expertise in delivering improved patient safety and better health outcomes are recognized with a Blue Distinction Center (BDC) designation. Those who further distinguish themselves with cost efficiency receive a Blue Distinction Center+ (BDC+) designation.

Members who receive specialized care from a BDC or BDC+ have the security of knowing they've increased their likelihood for a smooth recovery following certain complex and high-dollar services.

New designations

This year, Wellmark Blue Cross and Blue Shield has designated over 20 hospitals as Blue Distinction Center or Blue Distinction Center+ in bariatric surgery and maternity care.

Bariatric surgery

PROVIDER/HEALTH SYSTEM	CITY	STATE	BDC/BDC+
Avera McKennan Hospital	Sioux Falls	SD	BDC+
Genesis Medical Center	Davenport	IA	BDC+
Grinnell Regional Medical Center	Grinnell	IA	BDC+
Iowa Methodist Medical Center	Des Moines	IA	BDC+
Iowa Specialty Hospital	Belmond	IA	BDC
Mercy Hospital Iowa City	Iowa City	IA	BDC+
MercyOne North Iowa Medical Center	Mason City	IA	BDC+
MercyOne West Des Moines Medical Center	West Des Moines	IA	BDC+
Sanford USD Medical Center	Sioux Falls	SD	BDC+
University of Iowa Hospitals and Clinics	Iowa City	IA	BDC+

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Maternity care

PROVIDER/HEALTH SYSTEM	CITY	STATE	BDC/BDC+
Alegent Mercy Health Hospital	Council Bluffs	IA	BDC+
Allen Memorial Hospital	Waterloo	IA	BDC+
Avera McKennan Hospital	Sioux Falls	SD	BDC+
Avera Queen of Peace Hospital	Mitchell	SD	BDC
Avera Sacred Heart Hospital	Yankton	SD	BDC+
Avera St. Luke's Hospital	Aberdeen	SD	BDC+
Avera St. Mary's Hospital	Pierre	SD	BDC+
Genesis Medical Center	Davenport	IA	BDC+
Iowa Lutheran Hospital	Des Moines	IA	BDC
Iowa Methodist Medical Center	Des Moines	IA	BDC+
Jennie Edmundson Memorial Hospital	Council Bluffs	IA	BDC+
Mercy Hospital Iowa City	Iowa City	IA	BDC+
Mercy Medical Center	Cedar Rapids	IA	BDC+
MercyOne Clinton Medical Center	Clinton	IA	BDC+
MercyOne Des Moines Medical Center	Des Moines	IA	BDC+
MercyOne Dubuque Medical Center	Dubuque	IA	BDC+
MercyOne Waterloo Medical Center	Waterloo	IA	BDC+
Methodist West Medical Center	West Des Moines	IA	BDC+
Monument Health Rapid City Hospital	Rapid City	SD	BDC
Sanford USD Medical Center	Sioux Falls	SD	BDC+
St. Luke's Methodist Hospital	Cedar Rapids	IA	BDC+
University of Iowa Hospitals and Clinics	Iowa City	IA	BDC
Waverly Health Center	Waverly	IA	BDC+

For a listing of all facilities currently designated as centers for specialty care, please visit Wellmark.com/Finder and click "Find a Blue Distinction Center."

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. National criteria for BDC and BDC+ 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 or other provider finder information or care received from Blue Distinction or other providers.

Coming Soon: Automation for Professional (837P) and Facility (837I) Electronic claim corrections

The changes are planned to go into effect throughout the first half of 2021.

Wellmark is working on an automated process to accept claim corrections from both professional (837P) and facility claim (837I) submitters that will allow claim corrections to be submitted electronically using the appropriate frequency codes and also automate the adjustment to finalize based on the claim corrections received. While Wellmark currently accepts electronic corrections for facility (837I) claims, these claim corrections are processed manually internally. When this process becomes available, Wellmark will no longer require an inquiry to be submitted for professional claim corrections. Automation of these adjustments for both professional and facility claims will save administrative time, increase accuracy by eliminating manual intervention on these claim corrections and decrease the turnaround time for the adjustments related to claim corrections.

What can providers do to get ready for this?

We understand all professional and some facility claim corrections are submitted using Wellmark's **Ask and Track a Question tool**. Providers can start by assessing their internal processes for which they currently submit claim corrections and start thinking about how that work will shift internally when Wellmark allows these corrections to be submitted electronically. An inquiry will no longer need to be submitted as a corrected claim with the appropriate frequency code (i.e., 5,7 or 8). Wellmark will automate the adjustment to the original claim associated with the correction.

Providers may also reach out to their clearinghouse to have early discussion as to any technical requirements that also may need to occur internally.

When will this be implemented?

Wellmark is still in the developing and testing phases of this project, however, we anticipate all providers will be able to submit electronic claim corrections for both facility and professional claims by second quarter 2021. We will roll this out in a phased approach to ensure this is a seamless process for Wellmark and providers.

Please watch for more information in the April Issue of *BlueInk*.

New changes to cosmetic and reconstructive services medical policy

To view this and all Wellmark medical policies, visit **Wellmark.com**.

As a result of the standard annual policy review, Wellmark has made changes to the content and administration of the Cosmetic and Reconstructive Services medical policy.

What's changing?

Administration of claims has been updated to more closely align to benefits with regard to non-covered cosmetic services.

Additional post service review may be needed for some procedures or services to determine if the procedure or service is cosmetic or reconstructive.

Documentation as outlined in the policy, will be required in order to complete the review.

For more information on these recent changes, please review the updated medical policies on **Wellmark.com**.

Save time and money with electronic transactions

Reduce the time to get paid from Wellmark by 10 days.

Sign up for electronic funds transfer (EFT)

EFFECTIVE JULY 1, 2021, Wellmark will no longer be sending paper checks to in-network providers. EFT is a safe, digital alternative to paper checks. By **signing up for EFT** providers will experience:

- Reduced amount of paper in the office
- Paper checks no longer being lost or stolen in the mail
- Valuable time savings for staff and avoidance of the hassle associated with going to the bank to deposit a check
- Easier reconciliation of payments with bank statements
- **Faster access to funds**

EFT can reduce payment time by up to 10 days

Not only does EFT make claims payment more efficient, it also reduces the average time it takes for providers to receive payment from Wellmark **by 10 days**. With EFT, Wellmark claims that process on Friday are generally deposited into provider accounts by the following Wednesday. With paper checks, claims that process Friday must be printed the following Monday and mailed through the postal service. This process takes, on average, an **additional 10 days**.

You may sign up for **EFT by submitting this form**. Wellmark has also created a **Frequently Asked Questions on EFT** document to answer a variety of common questions from providers on the EFT process.

Send claims electronically

Sending claims electronically can save significant time and money for providers. Did you know that it takes providers an average of **six minutes** to submit a claim manually versus only **two minutes** to **submit claims electronically**? Providers could save an average of four minutes per transaction if they completed a claim electronically instead of manually.*

According to a recent study, a manual claim costs a provider $3.30 to submit and an electronic claim only costs $0.97, a savings of $2.33 per transaction. This equates to cost savings of:

- 100 transactions — $233
- 500 transactions — $1,165
- 1,000 transactions — $2,330

Estimates based on the* **2019 CAQH Index™ Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed

continued on next page

Get paid quicker as well

Not only does sending claims electronically save you money, it will also shorten the time it takes for Wellmark to receive and process your claim. An electronic claim is received and processed, on average, 24 days quicker than a paper claim.

You can sign up for **electronical claims submission on the Wellmark provider portal**.

What if you don't use a clearinghouse or practice management system to submit electronic claims?

Wellmark offers our Create and Submit tool to professional providers to submit electronic claims. Sign up for the Create and Submit tool **here**.

Count the Kicks and Wellmark announce millennial pregnancy webinar

See link below to register for March 9 webinar.

MILLENNIAL WOMEN MAKE UP 85 PERCENT OF ALL PREGNANCIES, and while most will experience a healthy pregnancy, a recent analysis of Blue Cross Blue Shield data shows this generation is experiencing some of the highest increases in health conditions that could lead to higher risks of pregnancy and childbirth complications. Because of this, Count the Kicks and Wellmark Blue Cross and Blue Shield are partnering to educate expectant parents and the health care providers who care for them about trends in pregnancy outcomes for millennial women.

The public and health care providers are invited to join us for the Millennial Health and Pregnancy webinar on Tuesday, March 9 from 12-1 p.m. (CST). This free webinar will explore tangible ways for millennial moms to improve pregnancy outcomes as they navigate pregnancy during the ongoing COVID-19 pandemic.

Mark Talluto, Vice President, Strategy and Analytics for Blue Cross Blue Shield Association, will discuss the latest trends in pregnancy data for this generation, and Dr. Tim Gutshall, Chief Medical Officer at Wellmark, will talk about reasons behind these trends and share tangible ways to improve pregnancy outcomes. They will be joined by Vu-An Foster, a *Count the Kicks* Ambassador and millennial maternal health professional whose life's work is centered on improving birth outcomes. She will share her experiences with pregnancy as a millennial and discuss the impact of COVID-19 on women who are currently pregnant.

"With changes to prenatal appointment schedules and a shift to some telehealth appointments, now is an especially important time for women and providers to have ongoing conversations about fetal movement throughout the third trimester of pregnancy. It is also important for expectant women to understand some of the potential pregnancy complications that can arise. We hope this webinar will equip millennial moms with ways to focus on their own health and the health of their baby," said Emily Price, Executive Director of *Healthy Birth Day, Inc.,* the 501(c)(3) nonprofit organization that created the *Count the Kicks* campaign.

The *Millennial Health & Pregnancy* webinar is the first in a series of webinars being organized by *Healthy Birth Day, Inc.* to explore the impact of COVID-19 on pregnancy and birth outcomes. The organization hopes to educate expectant parents about the unique challenges of expecting a baby during the ongoing pandemic, and equip them with tools and resources, like the FREE *Count the Kicks* app, to help them navigate their pregnancy.

The webinar is free and open to all. Interested participants can **register for the webinar here.**

Using old member ID numbers can lead to denied claims and longer processing times

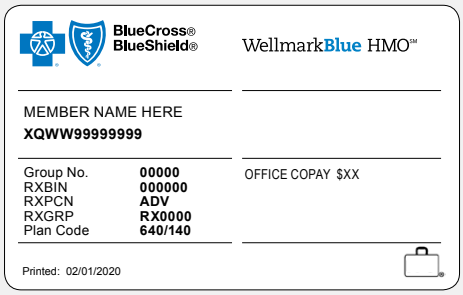
The importance of filing claims with the correct member ID number.

Asking for a patient's insurance ID card at the time of service should always be a priority because it ensures the correct member ID number is used when submitting claims. We ask that you help prevent claim processing and payment delays by ensuring you are submitting claims with the correct member prefix and ID number.

Please consider reviewing your internal processes for ensuring the correct member ID number is used for the appropriate date of service when submitting claims. This may include:

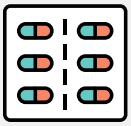
- Strengthening the protocols for asking the patient for their current ID card at each visit
- Increased use of Wellmark's secure online **Check Member Information tool**
  - This tool will display the member's accurate ID number
- It is also important to include the correct prefix when submitting a claim.

Thank you for your efforts in maintaining accuracy when filing claims to Wellmark.



New medical preferred drug strategies with biosimilars

Reminder for remaining changes that will go into effect April 1, 2021.



As previously communicated in the December *BlueInk,* new preferred drug strategies for medically benefited drugs with available biosimilars are being implemented in the first half of 2021. Wellmark's preferred drug strategies are amended to help control drug spending, create a sustainable health care system, and achieve affordability for our members. Biosimilars, or biologics, are highly similar to the reference product, more affordable, and possess no clinically meaningful differences in terms of the safety, purity, and potency compared to the reference product.

Preferred drug strategy details

You can view all drug prior authorization policies on Wellmark.com *(For Providers > Drug Information > Drug Authorization and Quantity Limits)* or request a copy by contacting Provider Service.

Below are the remaining drugs included in the new medical preferred drug strategies that will be implemented on April 1, 2021.

DRUG CATEGORY/CLASS	PREFERRED DRUG DETAILS
Erythropoiesis Stimulating Agents	**PREFERRED BIOSIMILAR:** Retacrit® **PREFERRED BRAND:** Aranesp® **NON-PREFERRED BRANDS:** Epogen®, Procrit®, and Mircera®
Oncology	**PREFERRED BIOSIMILARS:** Mvasi™ and Zirabev™ **NON-PREFERRED BRAND:** Avastin®
Oncology	**PREFERRED BIOSIMILARS:** Herzuma®, Kanjinti™, Ogivri™, Ontruzant® and Trazimera™ **PREFERRED BRAND:** Herceptin Hylecta™ **NON-PREFERRED BRAND:** Herceptin®

Prior authorizations

Prior authorization (PA) will be required in Novologix if prescribing a non-preferred drug after the new medical preferred drug strategy goes into effect. Coverage of non-preferred products is based on clinical circumstances that would exclude the use of the preferred products (i.e., history of intolerance, contraindication, or adverse event to the preferred products that would not be expected to occur with the respective non-preferred product) and may be based on previous use of a product.

For patients who are currently receiving and already established on a non-preferred drug, PA will not be required to continue coverage. However, due to the complexity of grandfathering under the medical benefit and the potential to not capture all current utilizers, the PA criteria will allow continued coverage of a non-preferred drug if your patient was not grandfathered to bypass PA.

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

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