BlueInk℠

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

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Three services are moving review from post service to preservice

Hyperbaric oxygen therapy, cellular immunotherapy for prostate cancer and tumor treatment field therapy will soon require preservice review.

For dates of service on and after March 28, 2022, hyperbaric oxygen therapy, cellular immunotherapy for prostate cancer and tumor treatment field therapy will be added to the list of treatments, procedures and services that require prior approval. We currently administer medical necessity for these services on a post-service basis. Moving the review to preservice gives both providers and members the opportunity to have a medical necessity review completed prior to the services being performed. InterQual® criteria will be used to determine medical necessity for hyperbaric oxygen therapy. Wellmark medical policy will continue to be used to determine medical necessity for cellular immunotherapy for prostate cancer and tumor treatment field therapy. The Wellmark Authorization Table will be updated to allow authorization requests for this procedure to be accepted via the online Utilization Management Tool beginning March 14, 2022.

To help you prepare for this transition, the InterQual criteria (SmartSheets™) for hyperbaric oxygen therapy will be available for practitioners to view on Feb. 28, 2022. To access the SmartSheets™, log in to the secure Provider tab on **Wellmark.com**, click "Utilization Management Tools and Resources," then click "InterQual Criteria".

42 Code of Federal Regulations (CFR) Part 2 update

Moving forward, providers who offer behavior health services should use the **Authorization to Use or Disclose Protected Health Information form**.

The protection of the privacy of health records that would identify, directly or indirectly, an individual as having been diagnosed, treated, or referred for treatment for a substance use disorder (SUD) is part of 42 Code of Federal Regulations (CFR) Part 2.

Release of behavioral health information — as noted in Wellmark's provider agreement —includes the provision that Wellmark may request that a provider furnish and submit all reasonably required information. This includes a member's medical record, to verify the provision of services to that member. The agreement also requires the provider to obtain any consents and authorizations needed from a patient for the provider to give this information to Wellmark.

Please use the **Authorization to Use or Disclose Protected Health Information form** moving forward and not the Authorized Representative form.

Coming soon: An updated public provider experience

Make sure to update your bookmarks and embedded links as soon as this update occurs.

Wellmark Blue Cross and Blue Shield will be enhancing our **public provider** experience in the coming months.

Because the provider site is your go-to resource for doing business with us, delivering a first-rate user experience is a top priority. The new enhancements will do just that, as well as create a more intuitive site overall.

We're excited to present the new site soon!

What you need to do in the meantime

Please continue to monitor upcoming *BlueInk* and *DSC Connection* publications to get the latest updates on the enhanced **public provider** pages.

Once the enhancements are made, the URLs will change. This means you will soon need to update your Wellmark provider portal bookmarks and embedded links. Doing so will prevent providers from experiencing any issues with their systems, as there will not be a redirect feature.

NOTE: the secure **Provider Portal** will not be undergoing any updates at this time.

The correlation between eye health and diabetes

Check out the three actions that can improve continuity and coordination of care.

According to the American Diabetes Association, **approximately 225,000 Iowans** and **52,000 South Dakotans have been diagnosed with diabetes**, and an additional 34 percent of residents have prediabetes.

For members with type 1 or 2 diabetes, eye exam screenings may help identify diabetic retinal disease. Providing the eye exam and communicating the results to the patient's primary care physician supports the continuity and coordination of the diabetes care.

The following actions have been identified to improve continuity and coordination of diabetic eye care:

1. Review your patients' medical history during their annual retinal eye exam screenings.
2. Educate your diabetic patients about the importance of an annual retinal eye exam.
3. Document and code completed retinal eye exam screenings with the date and the results in your patient's medical records and share the results with the patient's primary care physician. For more information on codes for eye exams, please refer to the **"Eye Care" section of the *Wellmark Provider Guide***.

To stay up to date on standards of care for diabetic and prediabetic patients, please see **the American Diabetes Association website**.

Jiva and InterQual® best practices

Along with the Jiva Medical Authorization Tool, Wellmark applies InterQual® clinical decision support criteria for medical necessity determinations. Providers can use Wellmark's JIVA tool and InterQual® to obtain automatic approval or pended episode decisions based on medical necessity.

Depending on the episode type and details, providers may be instructed to launch an InterQual® medical review to answer additional clinical questions related to the member's condition. The questions answered through InterQual® must be able to be supported by clinical documentation. As a reminder, the criteria selected through InterQual is part of the member's permanent medical record.

Interqual® is driven by the diagnosis that is entered on the episode and may populate one or more guidelines to select based on diagnosis.

- If the appropriate InterQual® guideline doesn't populate, you are not required to complete any of the criteria in the medical review if it's not applicable. Click complete, which will close the InterQual and submit your request as pending.
- If the questions or interventions in the selected guideline cannot be supported by the members clinical documentation, do not choose those questions or interventions. You should click only the options that can be supported by clinical documentation. Finally, click complete, which will close the InterQual and submit your request as pending.
- In both scenarios, you must attach clinical documentation to the episode so the Wellmark nurse has information to review to get a decision back to you as soon as possible.

Coming Soon: additional services to be transitioned to the Jiva™ Medical Authorization tool

Wellmark's health services team continues plans to transition other inpatient levels of care to the online medical authorization tool, Jiva™, in the coming months. It will be important for providers who currently submit precertification requests via phone or fax to make sure they will have the appropriate access to Jiva (i.e., acute rehab, skilled nursing).

To prepare for this, these providers should work with their designated security coordinator (DSC) to register for secure access to the Wellmark Provider Portal with the user role of "Manage Authorizations" to make sure they will have access to this tool. For more information about registering for access to the secure Wellmark Provider Portal, visit the **Welcome to Wellmark** page. Please continue to watch for Jiva updates via Wellmark communications in the coming months.

MEDICARE ADVANTAGE

Understanding star ratings

Here's what you should know about the Centers for Medicare & Medicaid Services star ratings program.

The Centers for Medicare & Medicaid Services (CMS) developed the Medicare star ratings program to help consumers compare Medicare Advantage (MA) health plans based on quality and performance. The program includes a set of quality performance ratings developed by the National Committee for Quality Assurance and CMS for all MA health plans. CMS rates the relative quality of service delivered by health plans and care delivered by providers based on a five-star rating scale, where five stars indicate the highest score.

How are CMS star ratings determined?

The ratings include specific clinical, member perception and operational measures. There are approximately 40 measures in the star rating framework.

To best capture a range of quality metrics, star ratings are determined using different data sets including, but not limited to the following:

- **Health Effectiveness Data and Information Set (HEDIS®)** that collects primarily clinical outcomes and data. This HEDIS® data best reflects care delivered by the provider and staff.
- **PRESCRIPTION DRUG EVENT** data collected by health plans to provide insight for prescription drug-related measures.
- **THE CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS)** is an annual survey sent to a random sample of members every spring to measure their experience with care delivered and the health plan. This data focuses on the member's accessibility to quality care.
- **THE HEALTH OUTCOMES SURVEY (HOS)** is sent every summer to a random sample of members to measure self-reported health status and the quality of their health care. A follow-up survey is sent to these same members two years later to measure changes in health perception.
- **OPERATIONS DATA** from health plans is used to assess the quality of customer service and other services health plans are providing to their members.

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CMS star ratings: What is your role as a provider?

By providing high-quality care to patients in a timely manner, providers play a critical role in the star ratings program. There are different opportunities for providers to engage with patients to help ensure high quality and timely care while helping patients manage their health.

Areas of opportunity to align provider practices with the CMS star ratings program:

- Promote timely and appropriate screenings, tests and treatment
- Provide education to staff members for proper documentation of care delivered
- Strengthen patient and provider relationships through open communication regarding health care needs and quality of care
- Collaborative development of chronic condition care plan
- Follow-up with patients regarding medications
- Assess timeliness of care and work with office staff to optimize scheduling
- Reference HEDIS measure tip sheets

These practices promote patient safety, preventive medicine, early disease detection and chronic disease management, which is especially beneficial for this population.

Star ratings help members enhance relationships with providers and health plans by ensuring accessibility to care, enhanced quality of care and optimal customer service.

Healthcare Effectiveness Data Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Gain insight from CAHPS research on improving the patient experience

The Centers for Medicare & Medicaid Services (CMS) can help providers better understand their Medicare patients' needs and expectations through research from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. CMS annually compiles findings about improving the patient experience and understanding health outcomes.

You can access reports, articles and case studies through the **Agency for Healthcare Research and Quality (AHRQ): Research on Improving the Patient Experience**.

Read the **CAHPS survey tip sheet** to learn more about why this annual survey is important, how it's conducted, what questions are asked and ways you can successfully address care opportunities for patients.

CAHPS® is a registered trademark of the Agency for Healthcare Quality and Research (AHQR).

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