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

APRIL 2021

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EFT requirements go into effect July 1, 2021

Reduce the time to get paid by Wellmark.

Sign up for electronic funds transfer (EFT)

EFFECTIVE JULY 1, 2021, providers will be contractually required to sign up for EFT with Wellmark. EFT is a safe, more efficient digital alternative to paper checks. By **signing up for EFT** providers will experience:

- Reduced amount of paper in the office
- Elimination of the risk of paper checks 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**

How will providers know when EFT payments are deposited?

Wellmark does not send out notifications when funds are sent to your bank. EFT payments are sent to each provider's bank account no later than Wednesday of each week for claims that finalize the prior Friday. It is recommended that you contact your bank directly to find out what options they offer in regard to notifications when the funds are made available. The Provider Claim Remittances (PCR), which are available on Wellmark.com no later than Monday morning, will indicate the ACH/EFT amount that will be transferred to your bank on Wednesday. If a provider does not have a PCR available on Wellmark.com for any given week, they will not have a payment deposited for that week, as that means claims did not finalize and pay out the week prior.

Dental providers

This requirement is for dentists contracted with Wellmark Blue Cross and Blue Shield of Iowa and South Dakota for the Federal Employee Program (FEP) and not dentists contracted with Wellmark Blue Dental℠. Therefore, if you do not hold a contract with Wellmark for any line of business, you are not required to enroll for EFT. If you have questions on how to enroll with Wellmark Blue Dental, please contact Blue Dental directly at 877-258-3685 on how to do this.

How do I sign up for EFT and find FAQ resources?

You may sign up for **EFT by submitting this form**. Please note that the EFT form is on the secure portion of the provider portal so providers must either register (if they don't have access) or login using their secure provider portal credentials. These credentials are different than E-Credentialing Central credentials. Wellmark has also created a **Frequently Asked Questions on EFT** document to answer a variety of common questions from providers on the EFT process. For further questions related to EFT, please contact Provider Services. Sign up for the Create and Submit tool **here**.

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

For more information, sign up for WINS, go **here**.

Wellmark is using a multi-phase the Automation for Professional (837P) and Facility (837I) Electronic claim corrections. We are currently in the testing phase and piloting with a small group of providers within the Wellmark Blue Cross and Blue Shield network to ensure this enhancement works seamlessly for all. The initial phase is planned to conclude in May. The next phase will consist of engaging a subset of providers in June and then subsequently entering the final phase in early July. The goal is to begin accepting electronic claim corrections for professional submitters (837P) and automating adjustments for the electronic claim corrections for both professional submitters (837P) and facility submitters (837I) by early July of 2021. Watch for WINS notification for official go live date. To sign up for WINS, go **here**.

Medical record requests for the HHS Risk Adjustment Data Validation Program (HHS-RADV) forthcoming

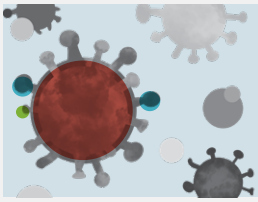
Medical records must be received within 40 days of the date on the request letter.

Wellmark and Cognisight have begun issuing requests for 2019 medical records. It is important the instructions included with the request are followed and records submitted appropriately. According to the information distributed, "the Centers for Medicare & Medicaid Services (CMS) is responsible for annually validating the accuracy of risk adjustment data submitted by a health insurance company with risk adjustment covered plans in the individual and small group health insurance markets through the validation of medical records for States where HHS operates the risk adjustment program." Referred to as, the HHS-operated Risk Adjustment Data Validation (HHS-RADV) program.

This audit is specific to services rendered throughout the 2019 benefit year. Medical records must be received within 40 days of the date on the request letter. Wellmark does not reimburse for the submission or copies of medical records.

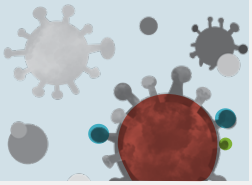
Wellmark's annual provider payment update

Effective for dates of service on and after July 1, 2021.



COVID-19 update

Due to limited office access for both providers and Wellmark, all payment update communications will be delivered electronically this year.



Practitioners

Participating providers can access the practitioner fee schedules for dates of service on and after July 1, 2021, as well as the practitioner update letter, on the **Annual Payment Update Notice section** of the **secure provider portal**. Letters and fee schedules for ambulance, home infusion therapy, home health, and hospice are available as well.

If you do not have access to the **secure provider portal**, take one of the following steps:

- If your taxpayer identification number (TIN) is not registered, select "Register now" on the provider page at **Wellmark.com**.
- If your TIN is registered and you want to expand or change your user access, contact your office's designated security coordinator (DSC).

Facilities

Letters, rate sheets, and supporting exhibits were available to participating facilities on the secured 3M website on April 1. Please note that the 3M website is only compatible with the Google Chrome browser.

To avoid delays, Wellmark has re-activated user accounts. If you are unable to login, please contact: **PaymentAccessT@wellmark.com**. If you have questions about the annual payment update, contact your Network Engagement Business Partner. Links to partner contact information are below:

- **Iowa**
- **South Dakota**

Wellmark's response to COVID-19- provisions related to required authorizations to expire on April 30

Here's what you need to know.

Wellmark has been suspending precertification requirements for all in-network, eligible Iowa and South Dakota providers since Oct. 23, 2020, due to the COVID-19 pandemic. The suspension of precertification and concurrent reviews for Wellmark members will expire on April 30, 2021, for the following provider types:

- Acute rehabilitation
- Home health
- Psychiatric medical institution for children (PMIC)
- Residential treatment centers (RTC)
- Skilled nursing facility (SNF)

If there is no pre-certification in place already, one will need to be obtained for dates of services on May 1, 2021, and after. For example, if you are providing home health services to a Wellmark member and have not completed a pre-certification on the Jiva utilization management tool, and those services continue to be provided in May, you will need to complete a precertification on Jiva prior to any additional services being performed on or after May 1, 2021.

Current home health approvals in Jiva will be honored until their expiration date. However, if services need to be extended beyond that expiration date in May, you will need to complete a new pre-certification in Jiva rather than submitting an extension request for this scenario, as a one-time change.

If you are an inpatient facility and have a Wellmark member for whom there is no pre-certification and they remain inpatient on or after May 1, 2021, you will need to revert to your pre-Covid-19 exemption process and contact Wellmark's Health Care Management department at 800-552-3993 to complete the necessary pre-certification. As a reminder, home health providers will need to submit requests through Jiva. Jiva resources and user guides can be found on the **Manage Authorizations** page on **Wellmark.com**.

Any new prior approval request received after April 30, 2021, for the below services, if approved, will revert to an approval end date of 90 days. Previously these had been extended out 180 days to give both providers and members additional time to complete the service:

- Abdominal panniculectomy
- Bariatric surgery
- Blepharoplasty
- BRCA testing
- Cochlear implant
- Facility-based sleep studies and multiple sleep latency test (MSLT)
- Gender reassignment surgeries
- Implantable bone conduction hearing devices
- Knee arthroplasty
- Laminectomy/Hemi-laminectomy
- Percutaneous neuroblation
- Reduction mammoplasty and mastectomy for gynecomastia
- Rhinoplasty
- Speech therapy
- Spinal fusion
- Subcutaneous implantable cardioverter defibrillator
- Transcranial magnetic stimulation (150 days)
- Varicose vein treatment

Coming soon: Electronic claim submissions via Availity® provider portal

Availity connects over one million providers and health plans around the United States to help facilitate the business side of health care.

Wellmark will soon be transitioning to Availity for electronic data interchanges (EDI) transactions for electronic claim submissions (837), electronic remittance advices — ERA (835), and requests and responses for eligibility and benefits (270/271).

What is Availity?

Availity is a company that operates a multi-payer provider portal with easy-to-use online tools for health care providers. Availity connects more than one million providers and health plans around the United States to help facilitate the business side of health care.

When will Wellmark move to Availity?

Beginning in July 2021, Wellmark will begin transitioning to Availity. Providers will begin using Availity's online provider portal to submit a single claim or add to a batch and send multiple claims to Wellmark at the same time. Once submitted, providers will be able to confirm Wellmark's receipt of the claim(s), check claim status in real-time and check real-time eligibility within the Availity portal. Providers who currently use Wellmark's Create and Submit Tool to submit claims will also transition to Availity for direct data entry, beginning in August 2021.

What do providers need to do to prepare for this transition?

Providers who already use Availity with other payers will not need to do anything. When Wellmark information is available on Availity, they will have access to it.

Providers who are not currently registered with Availity will need to register. Please watch for additional information in the June *BlueInk℠*, WINS notifications, DSC Connection, and direct communications sent to your designated security coordinator (DSC) for detail on when to register for Availity and other important implementation dates.

Submit one claim per inquiry

Submitting multiple claims on an inquiry can lead to processing delays

When using the Ask and Track a Question Tool on **Wellmark.com** to correct a professional claim or submit a question on a claim, include only one claim per inquiry. By submitting only one claim, Wellmark can more easily identify and resolve the issue. Submitting multiple claims on an inquiry can lead to processing delays.

UB form locator 60 — Identification number

This information is accessible through the UB-04 Specification Manual.

Submitting COB claims to the appropriate insurance can sometimes feel confusing. Wellmark Blue Cross and Blue Shield has given instruction on submitting these claims, within the **Claim Filing section of the Provider Guide, page 67**. If the patient has multiple carriers, follow the instructions within the guide. We've recently updated the guide specifically for Form Locator (FL) 60:

- Line A: Enter the prefix and identification (ID) number for the primary payer as it appears on the patient's ID card. (Required)
- Lines B & C are required when other health plans are known to potentially be involved in paying this claim:
  - Line B: Enter the prefix and ID number from the patient's secondary ID card. (Required if there is a secondary payer)
  - Line C: Enter the prefix and ID number from the patient's tertiary ID card. (Required if there is a tertiary payer)

This information is accessible through the **UB-04 Specification Manual.**

FEP PCRs for Medicare claims have different look

Network savings will no longer be displayed

In support of the Federal Employee Program (FEP) Operations Center, Wellmark will be revising FEP provider claim remittances (PCRs) for Medicare-related claims. Effective immediately, FEP PCRs for Medicare-related claims will no longer display network savings. The PCR will continue to display:

- Medicare approved
- Medicare paid
- Amount paid by the plan

Additionally, the provider will continue to see the network savings on the original Medicare PCR. Medicare-related savings on the PCR will continue to show for regular business. The view will be different for FEP Medicare-related PCRs only.

Prolonged services in an office or outpatient setting

Make sure to use the appropriate billing codes for prolonged services.

When a physician provides a prolonged service in an office or outpatient setting that is beyond the usual service, bill these services with add-on codes. Wellmark covers prolonged services when billed with appropriate codes; CPT 99417 or HCPCS G2212.

Wellmark will follow CMS guidance on billing for time. Per CMS, the listed time ranges for 99205 (i.e., 60–74 minutes) and 99215 (i.e., 40–54 minutes) represent the complete range of time for which each code may be reported. Wellmark will accept 99417 or G2212 for prolonged services in an office or outpatient setting.

- When reporting 99417 or G2212 for prolonged services, the initial time unit of 15 minutes should be added only once the ***maximum time*** indicated in the primary E/M code has been surpassed by 15 minutes.
- Do not bill 99417 or G2212 for prolonged time less than 15 minutes.

NEW PATIENT:	
PROCEDURE CODES	**TOTAL TIME REQUIRED FOR REPORTING***
99205	60–74 minutes
99205 x 1 unit and 99417 x 1 unit (or G2212)	89–103 minutes
99205 x 1 unit and 99417 x 2 units (or G2212)	104–118 minutes
99205 x 1 unit and 99417 x 3 units (or G2212)	119 or more
*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service.	

ESTABLISHED PATIENT:	
PROCEDURE CODES	**TOTAL TIME REQUIRED FOR REPORTING***
99215	40–54 minutes
99215 x 1 unit and 99417 x 1 unit (or G2212)	69–83 minutes
99215 x 1 unit and 99417 x 2 units (or G2212)	84–98 minutes
99215 x 1 unit and 99417 x 3 units (or G2212)	99 or more
*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service.	

These details can also be found in the **"General Medical" section of the Provider Guide**.

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**.

InterQual® clinical review updates made to Jiva™ tool

Manage Authorizations page has been updated with new, related Jiva content

Effective now, when appropriate InterQual clinical review is needed, it must be launched and completed in Jiva to enable the submit button on requests. A new pop-up message will display as a reminder when clicking on "check for review" button after services have been added to a request. The submit button will be disabled if the full review process has not been completed and the InterQual page closed.

As a reminder, if additional documentation is required as part of the review process, please make sure to upload complete information for the Wellmark clinical reviewer. This may include examination details, laboratory, imaging, and other ancillary studies that are necessary to inform a decision. While the preferred method is to upload and attach the documentation, if the Web Note function is used, please be sure to copy/paste the detailed information from the record versus a high-level summary of the visit.

The Manage Authorizations page has been updated with materials to help guide providers through the new process. Updates include:

- Added a new, short (seven minutes) **InterQual clinical review training video**
- Updated the **Medical Authorization user guide (Jiva)**
- Updated the **Jiva Guidance and Troubleshooting document**

Updates made to Wellmark Blue Cross and Blue Shield's ACA Preventive Services List

As always, the services identified on this list are recommendations by the ACA to clinicians, not mandated services.

The Affordable Care Act (ACA) mandates that all non-grandfathered group and non-grandfathered individual health plans must provide coverage for preventive services with no member cost share when provided by in-network or participating providers. In accordance with this ACA requirement, Wellmark provides coverage at no member cost share for certain preventive services.

Preventive services are routine health care services that prevent illness, disease or other health problems before symptoms occur.

To help our members understand what qualifies as a preventive service, Wellmark developed **a list of services** that are generally covered at no member cost share, based on recommendations from the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), Bright Futures, and the federal Centers for Disease Control (CDC). This list is not all-inclusive, and benefits are not guaranteed. Clinicians are best able to determine which services to provide. All information is dependent upon member-specific benefits, outlined in the coverage manual, and is also contingent upon accurate claims submission by the provider, including diagnosis and procedure codes.

We recently updated the list. This list is updated at least bi-annually. The most recent change includes:

Additions

Adults

- Pre-Exposure Prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition

Pregnant people

- Anxiety screening in adolescent and adult individuals including those who are pregnant or postpartum
- Provide or refer persons at increased risk of perinatal depression to counseling interventions

Verify Wellmark member benefits by using the **Check Member Information Tool** found under the *"Eligibility, Benefits & Accumulations"* section of the secure Provider tab of Wellmark.com.

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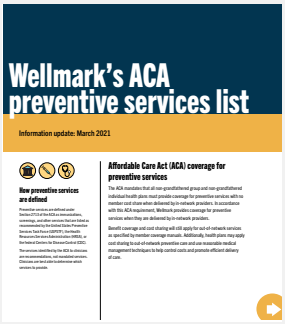

Members can access the preventive services list on our website at **Wellmark.com/ACAPreventive**.

Newborns/children/adolescents

- Anxiety screening – See Women only

Women only

- Anxiety screening in adolescent and adult women including those who are pregnant or postpartum

Changes (new text is in bold and strikethroughs mark deleted text)

Adults

- Colorectal cancer screening **and bowel preparation medicine**
- Immunizations: **COVID-19;** Diphtheria, Tetanus, Pertussis**; Haemophilus influenza type b**; Hepatitis A; Hepatitis B; Herpes Zoster **(age 50 and older)**; Human Papillomavirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Varicella (as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) on the CDC Immunization Schedules)

Newborns/children/adolescents

- Behavioral assessments for children* (footnote no longer applicable)
- Immunizations: **COVID-19**; Diphtheria, Tetanus, Pertussis; Haemophilus influenza type b; Hepatitis A; Hepatitis B; Human Papillomavirus; Inactive Poliovirus; Influenza (Flu Shot); Measles, Mumps, Rubella; Meningococcal; Pneumococcal; Rotavirus; Varicella (as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) on the CDC Immunization Schedules)

Women only

- HPV DNA test: women age 30 and older, ~~may receive high-risk HPV screening every three years,~~ regardless of pap test results

Removals

Newborns/children/adolescents

- Iron supplements for at risk infants 6–12 months (prescription required for full coverage)

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