BlueInk℠

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

JUNE 2021

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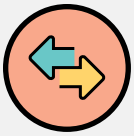
Wellmark intends to offer Medicare Advantage product beginning Jan. 1, 2022

Wellmark Advantage Health Plan, Wellmark's new affiliate, will have new Medicare Advantage options available to Iowans and South Dakotans during this year's annual election period (Oct. 15 through Dec. 7), pending Centers for Medicare & Medicaid Services' (CMS) approval. The plans will be available for coverage beginning Jan. 1, 2022.

What is Medicare Advantage?

Medicare Advantage (MA), also known as Medicare Part C, combines traditional Medicare — parts A and B — into one comprehensive, easy-to-manage plan along with additional health-enhancing benefits. Plans often include coverage for prescription drugs, routine vision and eyewear coverage, dental coverage, hearing aids, fitness center memberships, over-the-counter medications/supplies, and clinical support.



Why is Wellmark intending to enter the MA market?

Offering MA plans, in addition to Wellmark's Medicare supplement plans, allows more Iowans and South Dakotans greater access to a variety of options that best fit their unique needs. This includes a range of affordable price points, benefit designs and network access — backed by the quality, value and trust you expect from Wellmark.

Which providers will be part of the network?

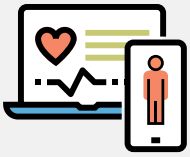
For its inaugural year, Wellmark Advantage Health Plan intends to offer coverage in select Iowa and South Dakota counties.

Providers located outside those counties may not have received a network participation agreement. In the future, there is potential for expansion into additional counties. However, if you are located outside our proposed service area and are interested in participating in our network, please let us know. Our goal is to develop a robust network of doctors and hospitals to serve the needs of our MA members.

Training and education resources

As some processes will differ for MA providers, training, education, and updates will be made available for participating providers late summer or early fall 2021 through the following resources:

- Webinars — sign up for **WINS messages** to receive more information.
- BlueInk articles
- DSC Connection — Wellmark's monthly e-publication sent to designated security coordinators at each provider.
- **WINS messages** — Wellmark's real-time notification system for providers.



2020 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.

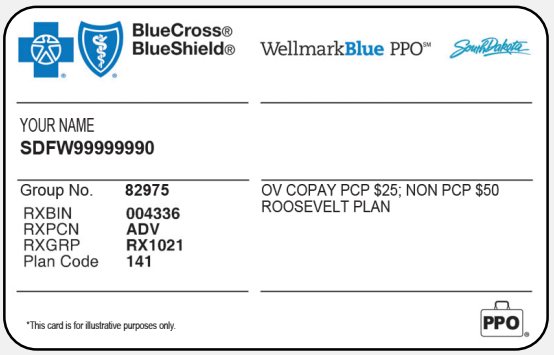
Wellmark and Cognisight issued requests for 2019 medical records earlier this year. Beginning in July, requests for 2020 medical records will be issued. It is important the instructions included with the request are followed and records are submitted appropriately. According to the information distributed, "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 2020 benefit year. Medical records must be received within 40 days of the date on the request letter.

Remember, Wellmark does not reimburse for the submission or copies of medical records. Be sure to pass this information on to any vendors handling medial record requests from Wellmark to avoid delays in releasing records.

State of South Dakota health plan will be administered by Wellmark beginning July 1, 2021

Member ID cards will be issued in advance of the July 1, 2021 effective date.

Beginning July 1, 2021, Wellmark will be the health plan administrator for the State of South Dakota. Work continues to ensure a smooth transition for providers and members. Helpful information for providers is below.



Member identification cards will be issued in advance of the July 1, 2021 effective date. The member ID card will read South Dakota in the upper right-hand corner.

Wellmark always recommends using the **Check Member Information Tool** on **Wellmark's secure provider portal** to check member benefits and eligibility.

Claim processing

Wellmark will only process claims for dates of service from July 1, 2021, and after. Any questions related to claim denials tied to authorizations from the previous vendor will follow Wellmark's normal procedure and can be addressed through a provider inquiry.

Health services

- The State of South Dakota's existing care management vendor will be responsible for performing all authorizations for members through June 30, 2021. Providers should continue to contact the State of South Dakota's current vendor through June 30, 2021, with any questions required for your records.
- Wellmark will be honoring all approved authorizations completed prior to June 30, 2021, for services rendered on or after July 1, 2021. Please note that only the authorization decisions will be sent to Wellmark. Treatment records will not be sent to Wellmark.
- Wellmark is working with the existing care management vendor to transition all approved authorizations and will be loading those to Jiva. Providers associated with an authorization will be able to view this activity in Jiva.
- The approved authorizations will be manually loaded, which will automatically create an authorization number. Please use the authorization number created by the previous care management vendor. When the claim comes in, if there is not a match based on authorization number, the claim will match the authorization on other data elements such as date of service, service type, etc. Providers can search for the authorization in **Jiva** using the member name and date of birth.
- If a current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) code did not previously require an authorization and is anticipated to be delivered or provided after July 1, 2021, you will want to verify that Wellmark does not have an authorization requirement for the particular service by accessing the Medical Prior Authorization Table, **https://www.wellmark.com/Provider/MedPoliciesAndAuthorizations/ManageAuthorizations.aspx** and complete the necessary steps on the Wellmark portal to avoid a denial.
- Wellmark will begin completing authorizations for our standard set of services that require a pre-service

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review for State of South Dakota members beginning July 1, 2021, and after.

- Please note any authorizations that were approved prior to July 1, 2021 will be subject to the approved CPT code or services and timeframe determined by the prior vendor, which may differ from Wellmark. The approval timeline does not start over and the service must be completed within the approved timeframe or a new authorization will need to be obtained through Wellmark.
- For members who are inpatient or in an episode of care prior to July 1, 2021, that extend beyond July 1, 2021, providers will conduct their next review or update of the patient with Wellmark as an extension of services.

Pharmacy

Members who have open authorizations will transition from the previous vendor to Wellmark. These members will be entered into **Novologix** and will mirror the established approval dates. For those members who are taking a medically benefitted drug that did not require prior authorization before, but will under Wellmark, both the prescriber and the member will receive a letter notifying them. Those members are being granted a three-month grace period, so they will have until October 1, 2021 to request a prior authorization.

Questions?

Please contact Provider Service at 800-774-3892.

PCP to specialist definition change

An evaluation of services leads to changes for PCP to specialist definition.

As part of an ongoing process to evaluate provider services and reimbursements, Wellmark recently reviewed the services of **genetics, hyperbaric medicine and osteopathic manipulative medicine** providers who were categorized as primary care providers when applying member benefits. This review allowed us to ensure these providers were properly defined and that members were paying the correct cost share for services.

After evaluating the scope of services for these providers, we determined that some are providing specialized care, not primary care. To better reflect their services, providers who are credentialed with Wellmark as this specialty only, per billing location, will no longer be considered a PCP in terms of benefits when a member has split copay. Beginning July 1, 2021, they will be more appropriately categorized as a specialist and take the higher copay. This update will ensure that patients' cost shares are reflective of the level of care being provided.

We recently sent a mailing to approximately 450 members notifying them of the benefits change in our system for the above provider types.

Please note for osteopathic manipulative medicine, some Doctors of Osteopathic Medicine (DO) can perform and bill for osteopathic manipulative medicine (OMM) based on their training/qualifications. If a DO specializes in OMM and is credentialed with Wellmark as an OMM specialist only, they will be categorized as an OMM under this evaluation process and categorization.

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

Check out the best practices for submitting electronic claim corrections.

Wellmark will begin accepting electronic claim corrections for both 837P and 837I that are identified by the claim frequency code 5,7, or 8 in late July or early August 2021 for Wellmark members of BlueCard out of state member's claims. In addition, Wellmark will begin automating the adjustments relating to these corrections beginning with Wellmark Member's claims. To fully automated process for BlueCard out of state member's claims is targeted to be implemented early third quarter 2021. Watch for upcoming notifications for implementation dates via **WINS**.

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:

CLAIM FREQUENCY CODES		
5	**LATE CHARGES ONLY**	Indicates the claim has ONLY late charges that need added to the original claim. DO NOT submit any other changes other than late charges. **To submit with frequency 5 (late charges only)** ***Your submission:*** • Must only have the late charge on the claim submission. Do not include all lines from original claim or any other charges.
7	**REPLACEMENT CLAIM**	Indicates the claim is a replacement or corrected claim, the information present on this bill represents a complete replacement of the previously issued bill. **To submit with frequency 7 (replacement claim)** ***Your submission:*** • Must contain corrected information for an original claim. • Must serve as a full replacement of that claim. You cannot submit one replacement claim for multiple original claims. • Must represent the entire new claim—not just the line or item that you are changing. • Can include changes to the original claim, plus new charges for services not previously submitted.
8	**VOID REQUEST**	Indicates the claim is a voided/canceled claim and the original claim should be voided. **To submit with frequency 8 (void of original claim)** ***Your submission:*** • Must be submitted exactly as it was submitted previously, along with frequency code of 8 to indicate the claim should be voided/removed from our system. • If the intent is to void and resubmit a NEW claim, please make sure the new claim is submitted within Wellmark's timely filing guidelines as outlined in the **Claims Filing Section of the Wellmark Provider Guide**.

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Best practices for submitting corrections electronically

- Must contain corrected information for an original claim that can be adjusted. Do not submit corrections on a claim rejected for a clean claim rejection. Reference claim rejections in the **Claims Filing Section of the Wellmark Provider Guide**.
- Must serve as a full replacement of that claim. You cannot submit one replacement claim for multiple original claims.
- Must represent the entire new claim—not just the line or item that you are changing.
- Can include changes to the original claim, plus new charges for services not previously submitted. However, it must meet the timely filing guidelines outlined in the **Claims Filing Section of the Wellmark Provider Guide**.
- If claim corrections do not meet Wellmark's clean claim requirements, they will be rejected back to you at the clearinghouse on the z16/277CA or equivalent report for Wellmark member's claims. A PCR will not be generated for these claims. please check with your clearinghouse on how to obtain this detail.
- BlueCard out of state member's claims will clean claim reject on a PCR until the fully automated process is implemented.
- Wellmark will not accept electronic corrections for claims that were originally clean claim rejected; a new claim will need to be submitted for processing.

For more information, please refer to the following resources:

- **Claims Filing Section of the Provider Guide**
- **Electronic Transaction and HIPPAA Guide**

Wellmark is moving its EDI and claims portal processing to Availity

Here's what you need to know.

Wellmark has partnered with Availity®, an independent company, to operate and service your electronic data interchange (EDI) transactions and offer a new tool for claims submission. Transitioning to Availity will give you a simpler and more transparent process for exchanging information — reducing waste, supporting cost and quality goals, and improving outcomes.

EDI — highlights of what you will be able to do beginning in mid-July:

- Electronic data interchange (EDI) transactions for electronic claim submissions (837)
- Electronic remittance advices — ERA (835), and
- Requests and responses for eligibility and benefits (270/271)

The payer name and IDs are not changing:

- Payer Name: Wellmark
- The payer IDs are 88848 and 88851

Wellmark and Availity are working with your trading partner to update connections. **There is no action needed by you at this time.**

Wellmark's Create and Submit Claims tool users

- Providers may begin using Availity's direct data entry tool on Aug. 2. Wellmark will retire the Create and Submit Claims tool on Aug. 31.
- Providers will submit professional, institutional, and dental claims using the Availity portal

When will Wellmark move to Availity and what do I need to do?

PROVIDER SUBMISSION TYPE	WHAT DO I NEED TO DO?*	WHEN WILL IT HAPPEN?
You submit EDI Transactions through a clearinghouse or trading partner today	No action needed for EDI transactions; register on the Availity portal for additional tools	Availity will be working with your trading partners beginning in mid-July to make the appropriate changes. Look for additional information from Availity and your trading partners.
You submit EDI Transactions directly to Wellmark today (not using a clearinghouse or trading partner)	Your Property Management System (PMS) vendor or your IT department will need to adjust the EDI routing (see info below); register on the Availity portal for additional tools; re-enroll with Availity for ERAs as needed.	Beginning mid-July; a communication was sent directly to your DSC and Availity will be reaching out to you to make the appropriate changes.
You submit claims to Wellmark using the Create and Submit Claims tool only	Register on the Availity portal to gain access to the Availity claims tool	Providers may begin using Availity's direct data entry tool on August 2. Wellmark will retire the Create and Submit Claims tool on August 31.

If you are not already registered on the Availity portal, go to the* ***welcome page and click Register Today.*

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Updated submission information

After the transition to Availity, providers should use the below, updated payer information to update management systems.

LOOP	FIELD	FIELD DESCRIPTION	837 PROFESSIONAL	837 INSTITUTIONAL	837 DENTAL
Header	ISA05	Sender ID Qualifier	ZZ	ZZ	ZZ
Header	ISA06	Sender ID	AV09311993 <+5 spaces>	AV09311993 <+5 spaces>	AV09311993 <+5 spaces>
Header	ISA07	Receiver ID Qualifier	01	01	01
Header	ISAS08	Receiver ID	030240928 <+6 spaces>	030240928 <+6 spaces>	030240928 <+6 spaces>
Header	GS02	Application Sender Code	AV01101957	AV01101957	AV01101957
Header	GS03	Application Receiver Code	030240928	030240928	030240928
1000A	NM109	Submitter ID	HIPAA-compliant identifier of the submitter's choice (TIN, Duns, etc.) otherwise default to 999999999	HIPAA-compliant identifier of the submitter's choice (TIN, Duns, etc.) otherwise default to 999999999	HIPAA-compliant identifier of the submitter's choice (TIN, Duns, etc.) otherwise default to 999999999
1000B	NM103	Receiver Name	Wellmark Blue Cross and Blue Shield	Wellmark Blue Cross and Blue Shield	Wellmark Blue Cross and Blue Shield
1000B	NM109	Receiver ID	88848	88848	88851
2010BB	NM109	Payer ID	88848	88848	88851

Get to know Availity

To learn more about how Availity is working with Wellmark, access the following webpages:

- **Availity welcome page**
- **Updated Welcome to Wellmark page**
- **Frequently Asked Questions on Availity document**

Are any of Wellmark's secure provider tools besides the Create and Submit Claims tool going away?

No. All secure provider tools will remain on the Wellmark provider portal. The only secure tool going away is the Create and Submit Claims tool. Providers will no longer access reports through business exchange services (BES) if they do so today.

Changes to the Wellmark Drug List beginning July 1, 2021

Check out the changes below.

Wellmark and a statewide 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 changes effective July 1, 2021.

DRUG CATEGORY/CLASS	DRUG/S	FORMULARY CHANGE/UM
Ophthalmic Anti-Allergy Agents	Pazeo 0.7% (olopatadine hcl) ophthalmic solution	No longer covered since it's now available over the counter as Pataday® once daily relief extra strength.
Dermatological Agents	Ilumya®	Moving from specialty non-preferred/level 4 to specialty medical.
Genitourinary Agents, Other	Thiola Generic tiopronin tablets	Change to specialty. Moving from tier 2 to specialty preferred for generic and specialty non-preferred for brand (no level change for BlueSimplicity℠).
Genitourinary Agents, Other	Thiola EC®	Change to specialty. Moving from tier 2 to specialty preferred (no level change for BlueSimplicity℠).
Genitourinary Agents, Other	Penicillamine tablets	Change to specialty. Moving from tier 1 to specialty preferred (no level change for BlueSimplicity℠).

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.

The National Drug Code (NDC) numbers will be required for professional and outpatient facility drugs on the fee schedule

Keep an eye out for more information about these changes in the Wellmark **Provider Guide**.

The National Drug Code (NDC) numbers are the industry standard identifier for drugs. The NDC number identifies the manufacturer, drug name, dosage, strength, package size and quantity.

Effective Oct. 1, 2021, the NDC, NDC unit of measure (UOM) and NDC units will be required for all fee-scheduled drugs submitted on professional claims and those submitted under revenue code 63X on outpatient facility claims in addition to the current HCPCS/CPT© information. A claim without valid NDC information will be rejected in its entirety.

837 REQUIREMENTS: In addition to the applicable HCPCS or CPT© code and units, enter the following qualifier and NDC information.

FIELD NAME	FIELD DESCRIPTION	LOOP ID	SEGMENT
Product ID Qualifier	Enter **N4** in this field	2410	LIN02
National Drug Code	Enter the 11-digit NDC billing format assigned to the drug administered	2410	LIN03
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure. Valid entries include: • **UN (unit)** • **ML (milliliter)** • **GR (gram)** • **F2 (international unit)**	2410	CTP05

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