BlueInk℠

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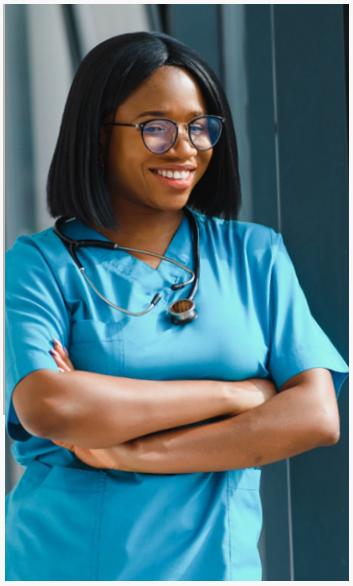
Information for Iowa and South Dakota physicians, hospitals and health care providers

OCTOBER 2020



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

New medical authorization tool, Jiva, launches November 16

Enroll for the webinars set for later this week.

Wellmark will be transitioning online medical authorizations from Clear Coverage™ to Jiva™ **on Nov. 16.** The new tool will bring an improved medical prior authorization (PA) process to providers.

Some PAs that are currently submitted via paper or fax will transition to an electronic submission this year. To prepare for this, Wellmark encourages all those who submit PAs to register at Wellmark.com for access to the secure provider portal.

To help prepare you for this transition, Wellmark will be providing a number of training and educational resources, including:

- **BlueInk articles**
- DSC Connection articles
- Home health provider outreach
- Jiva user guide
  - A link to the user guide will be located under "User Guides" on the **Manage Authorizations page**
- Updated **Provider Guide**
- **Webinars**
- **WINS messages**

Webinars

The training webinars will take place over the next few days and also be available on the provider portal afterward. Through these webinars, you will:

- Learn how to access Jiva and understand the implementation timeline.
- Receive an overview of Jiva functionalities and learn about dashboard information available to the providers and their teams.
- View the step by step process to submit a request.

Three separate webinars will be held and are tailored for specific provider audiences, as detailed below. Providers that currently submit requests through Clear Coverage and Home Health Care providers need to attend the applicable Jiva webinar.

Each webinar will be held at 12 p.m. CDT on the dates specified below. Register today by pasting the URL below into your web browser or clicking the active link.

- **WEBINAR 1: TUESDAY, OCT. 27** — Outpatient Providers (Procedures and DME)
  - Register here: **https://attendee.gotowebinar.com/register/2748287997747223824**
- **WEBINAR 2: WEDNESDAY, OCT. 28** — Inpatient Providers* (Notification and Precertification)
  - Register here: **https://attendee.gotowebinar.com/register/3634405309293501709**
- **WEBINAR 3: THURSDAY, OCT. 29** — Outpatient Providers (Home Health Care)
  - Register here: **https://attendee.gotowebinar.com/register/4684418414615413 89**

**For Skilled Nursing, Acute Rehabilitation, and Residential Treatment requests, training and go live dates will be announced at a later time.*

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Home health providers

Home health providers will be one of the provider user groups transitioning from paper/fax authorization submissions to a fully electronic process. It will be important that all home health providers stay informed on the new system and have access to all training materials. For this, we recommend:

- If you are a home health provider, please encourage your coworkers to **subscribe to BlueInk** if they aren't already
- If you are a home health provider, please **subscribe to WINS** to stay informed on the latest training opportunities
- Register at **Wellmark.com** to access to the secure provider portal
- If you have a home health agency department in your organization, please forward them this issue of BlueInk and **encourage them to subscribe**

New designated security coordinator (DSC) roles

The two Clear Coverage provider roles will be removed from all provider users and removed from the DSC screen. These roles include:

- "Utilization Management Tool — Procedures and DME"
- "Utilization Management Tool — Inpatient"

A single corresponding Jiva provider role will replace the two Clear Coverage roles:

- "Provider — Manage Authorizations."

This role will grant access to both Jiva and SmartSheets, and all providers with the Clear Coverage roles will automatically be transitioned into the new Jiva role.

Clear Coverage shut-down information

As part of the transition to Jiva, Clear Coverage will be decommissioned on the following timeline:

1. **WEDNESDAY, NOV. 11, 5:00 P.M.**
   a. Wellmark will stop accepting acute notifications/outpatient prior approvals, and will only accept urgent requests on Clear Coverage.

2. **THURSDAY, NOV. 12, 5:00 P.M.**
   a. Access to Clear Coverage will shut down, including urgent requests.
   b. Providers may submit urgent requests via phone or fax, but standard requests must wait until Nov. 16.

Submit a current W-9 if you have a change of address

Did you have an address change this year?

If you have had an address change this year, submit a current W-9 form via email to **1099reporting@wellmark.com**, so we can update our tax software and ensure your 2020 tax form 1099 is sent to the correct address. Please note, even if you have multiple business locations, you only need to submit one W-9 form with the address you need your tax forms mailed to. This information is NOT automatically updated when your address is updated with Wellmark's Provider Credentialing team, so this step is crucial to avoid delays in receiving your tax forms.

Medical policy format changing

The content, however, will remain the same.

We will be changing the format of Wellmark medical policies from webpages to PDFs later this year. There will be no change to the location or content of the medical policies as a result of this change and you should only notice a slight difference in the appearance. We anticipate this change occurring sometime in Dec. 2020.

Tips for more efficient claims processing

Follow the tips below for best results.

Wellmark recently identified opportunities to improve manual claim pricing. Claims submitted by participating providers were evaluated to identify best practices. Following the tips below will facilitate efficient and accurate claim pricing and adjudication.

- **GRADIENT COMPRESSION STOCKINGS**
  Wellmark allows coverage of gradient compression stockings of up to six stockings per leg, per calendar year. Some codes, A6530 – A6531 and A6549 require the use of modifier "Right Side" (RT) or "Left Side" (LT). In addition, A6549 requires supporting pricing documentation in the form of an invoice or manufacturer suggested retail pricing (MSRP). Please include the applicable modifier and supporting pricing documentation.
- **HEARING AIDS**
  If the member's benefits include hearing aid coverage, Wellmark requires the anatomical modifiers of right or left on certain hearing aid HCPCS codes. Claims without the appropriate modifier will be denied. If you are billing for a bilateral hearing aid, please do not submit anatomical modifiers. Be sure to validate that the correct number of units is being billed based on the HCPCS code.
- **A9999**
  If a provider needs to file A9999 (Miscellaneous DME supply or accessory, not otherwise specified) please break out the number of individual units; do not lump sum together. A description is needed for each line item billed with A9999.
- **B9998**
  When filing B9998, make sure the description on the invoice matches the description on the claim. For example, if you are billing for a case, the number of units in the case needs to be reflected.
- **D2199**
  If filing D2199 for a single vision lens not otherwise classified, be sure to include the description on the claim.
- **E1399**
  Wellmark often receives claims with code E1399 (durable medical equipment, miscellaneous). Providers should always file the specific HCPCS code if one is available. E1399 should only be used if there isn't a specific HCPCS code to use.
  If filing E1399, submit a complete narrative description with the nonspecific code. The description on the claim must match the description on the invoice. The narrative description must include whether the item is purchased or rented. If rented, please include the "RR" modifier. If a member receives two of the same item, use the modifiers "RT" (right side) and "LT" (left side) with the procedure code to indicate that the item is being purchased or rented for both sides. Because there could be multiple lines filed with E1399, please make sure any hand- written notes on the invoice are legible and correlate to a specific line on the claim.
- **K0108**
  Wheelchairs may include add-on features and accessories that can be filed with specific HCPCS codes. If an item is billed using HCPCS K0108 (Wheelchair component or accessory, not otherwise specified), attach an invoice to the claim that includes the direct cost associated with the item supplied. Because there could be multiple lines filed with K0108, please make sure any handwritten notes on the invoice are legible and correlate to a specific line on the claim.
- **VALID INVOICES AND MANUFACTURER'S SUGGESTED RETAIL PRICING**
  For claims to be manually priced accurately, invoices and manufacturer's suggested retail pricing (MSRP) documents must meet requirements. Information regarding Invoice requirements and MSRP pricing documentation can be accessed in the HME, Orthotics and Prostheses Section of the Provider Guide on the Wellmark Provider Portal. If filing the claim and pricing based on an invoice, for each line, please make sure the description on the invoice matches the description on the claim.

Incorporating these best practices will facilitate efficient claims processing and payment.

Submitting corrected claims

How to submit corrections, including late charges/credits on a facility claim (UB-04).

All facility claims should be corrected and submitted electronically, regardless of how they were filed initially, saving the provider time and expediting any adjustments.

If corrections are needed on a previously processed claim for inpatient and outpatient services, use the appropriate Type of Bill (TOB) in Field Locator (FL) 4 on the UB-04. Be sure to use the correct TOB, as defined below, to indicate the changes being made to the previously processed claim.

Adding late charges only to a previously processed claim

"Late charges" are services submitted on a corrected claim, for the same date of service, at a later date than the original claim submission. When late charges are the only change needed on a claim, submit a corrected claim with TOB XX5 for the additional charges only. Do not include any charges billed on the original claim or any other changes (e.g., diagnosis change, revenue code change, statement dates, etc.).

Replacement of a prior claim

A replacement corrected claim (TOB XX7) is used if there are corrections other than, or in addition to, late charges that need to be made to a previously processed claim. When submitting a TOB XX7, include all charges for the date span billed. Corrections to the claim submitted may include, but not be limited to, one or more of the following examples: late credits (removing a charge from a claim), diagnosis change, revenue code change, billed charge, and can include late charges. If the provider is only adding late charges to a previously processed claim, refer to the "Adding Late Charges Only" section above.

A corrected claim may only be submitted after the original claim has finalized and generated a Provider Claim Remittance (PCR). Submitting a correction to a claim prior to the original claim finalizing will cause the corrected claim to deny.

Void/cancel of a prior claim to submit a corrected claim

When a paid claim needs to be voided or cancelled, submit the original charges on a corrected claim with TOB XX8. Examples of needing to have a claim voided or cancelled include:

- The claim was originally billed in error.
- There was a change in the Place of Service.

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Note:

If changes need to be made to the first two digits of the TOB (with the exception of 131 and 141), the claim must be voided by submitting TOB XX8. Submit a new claim with the correct TOB for processing.

- Exceptions: TOB 131 and 141
  - When submitting corrections to change the TOB on a claim from 131 to 141, the corrected claim must be submitted as TOB 147.
  - When submitting corrections to change the TOB on a claim from 141 to 131, the corrected claim must be submitted as TOB 137.

Key reminders for facility billers

- A corrected claim may only be submitted after the original claim has finalized and generated a Provider Claim Remittance (PCR). Submitting a correction to a claim prior to the original claim finalizing will cause the corrected claim to deny.
- If a facility claim is changing from outpatient to inpatient or vice versa, TOB must be submitted with the final digit "8" and then resubmitted as a new claim.
- If Wellmark is the secondary payer on "late charges" or "replacement of a prior claim," submit the corrected primary carrier payment information along with the corrected claim. More information on submitting coordination of benefits claims can be found in the "Claims Filing" section of the Provider Guide on Wellmark.com.
- If a TOB other than XX5 is received, but no changes other than late charges have been added, the claim will be rejected.
- If the original claim denies with a clean claim denial (a denial requesting a new claim), a corrected claim may not be submitted. Please make any corrections on the claim and resubmit a new claim to Wellmark. If a corrected claim TOB ending in XX5, XX7, or XX8 is received on an original claim that denied with a clean claim denial, TOB ending in XX5, XX7 or XX8 will be denied.

Professional claim corrections (CMS-1500)

Wellmark receives many professional corrected claim requests annually. Unlike institutional corrected claims, which are submitted electronically for processing, professional claim corrections must be submitted via an inquiry using the Ask and Track a Question tool on Wellmark.com.

Consistent with Wellmark's intent to be the easiest payer to work with, a new project recently launched that will facilitate a more efficient process for professional claim corrections. Watch for more information in the upcoming issues of the *BlueInk* publications!

Additional information on correcting claims can be found within the Claims Filing **Provider Guide** located within the secure tools on Wellmark.com.

Help members find you by using the Provider Directory Validation Tool

Updates can be made using E-credentialing Central.

Keeping information in Wellmark's Provider Directory up to date is important because it helps members search for in-network providers. Using the **Provider Directory Validation Tool** within **E-credentialing Central** is the easiest way to access, review, and validate the information for your organization.

Did you know?

As a network provider, you are contractually obligated to keep your information current. Every six months, Wellmark will send a Provider Directory validation email notice to all directory validation email addresses on file, as well as primary organizational security coordinators (OSCs) and backup OSCs. This email notice signals it is time for recipients to validate their organization's provider information.

Making changes to the Provider Directory

If a change needs to be made to the Provider Directory, providers should use the E-cred Central, **Change Request Tool**. Updates can be made to address, TIN, specialty, or email address. The submission will automatically be sent to Wellmark for review and completion.

Use online resources for the latest updates regarding coronavirus (COVID-19)

Wellmark continues to update its provider-specific webpage.

Wellmark Blue Cross and Blue Shield continues to use several digital resources to send out the most up-to-date information on coronavirus (COVID-19):

- **This page on the public provider portal** to give provider-specific updates on COVID-19. It can be found in Provider > Communication and Resources >COVID-19 Updates.

  Some of the most recent updates have been made to the following pages within this section:

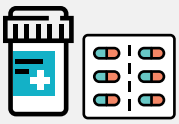
  — **Virtual visits (telehealth)**

  — **Testing and treatment**

  — **Required authorizations**

  — **FAQ**
- Additional provider correspondence regarding COVID-19 may be sent through the **Wellmark Information Notification System (WINS)**.
- Wellmark continues to maintain a member-facing webpage, which can be found at: **Wellmark.com/Coronavirus**.

Wellmark continues to use the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), Iowa Department of Public Health (IDPH), and South Dakota Health Department as our official sources of information. For the latest U.S. impacts of COVID-19, please see the data reported by the CDC.



Changes to the Wellmark Drug List

Beginning Jan. 1, 2021

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 and utilization management changes effective Jan. 1, 2021.

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.

Pharmacy formulary/UM changes

DRUG CATEGORY/CLASS	DRUG/S	FORMULARY CHANGE/UM
Central Nervous System Migraine Acute — Oral	**Nurtec™ and Reyvow®**	**CHANGING TO PREFERRED PRODUCTS AND MOVING FROM TIER 4 TO TIER 3.**
	Ubrelvy™	**CHANGING TO NON-PREFERRED PRODUCT.** No change to formulary placement.
Central Nervous System Migraine CGRP receptor antagonists	**Aimovig®**	**CHANGING TO PREFERRED** in parallel with Ajovy® and Emgality®.
Endocrine and Metabolic Antidiabetics GLP-1 Receptor Agonists, Oral	**Rybelsus®**	**MOVING FROM TIER 4/LEVEL 4 TO TIER 2/LEVEL 3.**
Endocrine and Metabolic Antidiabetics GLP-1 Receptor Agonists, Oral	**Glyxambi® and Trijardy® XR**	**MOVING FROM TIER 4/LEVEL 4 TO TIER 2/LEVEL 3.**

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DRUG CATEGORY/CLASS	DRUG/S	FORMULARY CHANGE/UM
Endocrine and Metabolic Antidiabetics SGLT2 Inhibitors Combinations	**Farxiga®**	**MOVING FROM TIER 4/LEVEL 4 TO TIER 2/LEVEL 2.** Removing MN-PA.
	Xigduo® XR	**MOVING FROM TIER 4/LEVEL 4 TO TIER 2/LEVEL 3.** Removing MN-PA.
	Invokana®, Invokamet®, and Invokamet XR	**MOVING FROM TIER 2/LEVEL 3 TO TIER 4/LEVEL 4.** Adding MN-PA.
Medical Devices Blood Glucose Test Strip	**Contour Test Strips**	**CHANGING TO PREFERRED PRODUCT IN PARALLEL WITH ONETOUCH AND MOVING FROM TIER 3/LEVEL 4 TO TIER 2/LEVEL 3.** Removing PA. Quantity limits and post-limit PA will remain in place.
Respiratory Short Acting Beta Agonists	**Brand ProAir® HFA**	**MOVING FROM TIER 1/LEVEL 2 TO TIER 4/LEVEL 4.** Product selection penalty will apply based on benefit design. Generic will remain on Tier 1/Level 2.
	Brand Proventil HFA and Ventolin HFA	**MOVING FROM TIER 2 TO TIER 4 AND REMAIN ON LEVEL 4 (NO LEVEL CHANGE FOR BLUESIMPLICITY).** Product selection penalty will apply based on benefit design. Generic will remain on Tier 1/Level 2.
	ProAir RespiClick®	**MOVING FROM TIER 1/LEVEL 2 TO TIER 4/LEVEL 4.**
Respiratory Steroid Beta Agonist Combinations	**Symbicort®**	**MOVING FROM TIER 4/LEVEL 3 TO TIER 2/LEVEL 2.** Removing MN-PA.
	Dulera®	**MOVING FROM TIER 2/LEVEL 2 TO TIER 4/LEVEL 4.** Adding MN-PA.
Endocrine and Metabolic Osteoporosis — Parathyroid Hormone Analogs	**Tymlos and Forteo®**	**MOVING FROM SP-P/LEVEL 4 TO SP-NP/LEVEL 5.**
Endocrine and Metabolic Chelating Agents	**Trientine**	**MOVING FROM TIER 1 TO SP-P.** No level change to BlueSimplicity.

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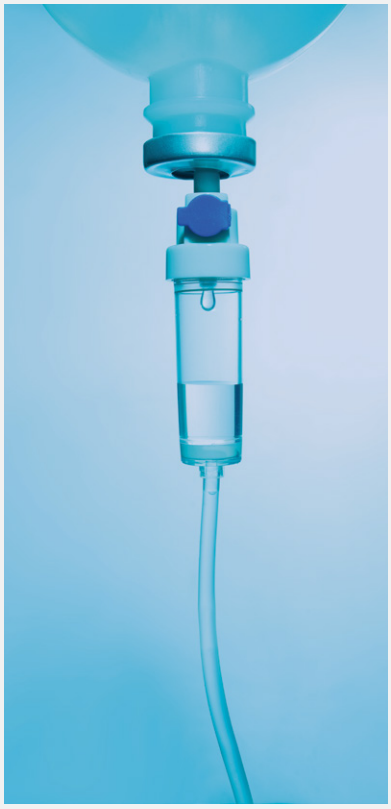
DRUG CATEGORY/CLASS	DRUG/S	FORMULARY CHANGE/UM
Anti-Infective Agents Tetracyclines	**Doxycycline Hyclate, 50mg tablets**	**MOVING FROM TIER 1/LEVEL 2 TO NOT COVERED.** Doxycycline hyclate 50mg capsules and doxycycline monohydrate 50mg tablet/capsules will remain on Tier 1/Level 2.
Cardiovascular Agents Vasodilators — Nitrates	**Isosorbide Dinitrate, 40mg**	**MOVING FROM TIER 1/LEVEL 2 TO NOT COVERED.** Isosorbide dinitrate 20mg tablets will remain on Tier 2/Level 2.
Topical Rosacea Agents	**Mirvaso® and Rhofade®**	**ADDING QUANTITY LIMIT (1 [30 GM] TUBE/PUMP BOTTLE PER 30-DAY).**

MN-PA = Medically necessary prior authorization; SP-P = Specialty preferred; SP-NP = Specialty non-preferred

New medical preferred drug strategies with biosimilars

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



New preferred drug strategies for medically benefited drugs with available biosimilars will be 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.

Drugs and planned effective dates

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.

Below are the drugs included in the new medical preferred strategies, changes to existing medical preferred strategies, and the planned implementation timeline.

DRUG CATEGORY/CLASS	PREFERRED DRUG DETAILS	PLANNED EFFECTIVE DATE
Autoimmune	**PREFERRED BIOSIMILARS:** Avsola™, Inflectra®, Ixifi™ and Renflexis® **PREFERRED BRANDS:** Entyvio, Simponi Aria, Stelara **NON-PREFERRED BRANDS:** Remicade®, Actemra IV, Orencia IV	01/01/2021
Colony Stimulating Factor Long Acting	**PREFERRED BIOSIMILARS:** Fulphila®, Nyvepria™, Udenyca® and Ziextenzo® **NON-PREFERRED BRAND:** Neulasta® *Neulasta® Onpro® excluded from strategy*	01/01/2021
Erythropoiesis Stimulating Agents	**PREFERRED BIOSIMILAR:** Retacrit® **PREFERRED BRAND:** Aranesp® **Non-preferred Brands:** Epogen®, Procrit®, and Mircera®	04/01/2021
Oncology	**PREFERRED BIOSIMILARS:** Ruxience® and Truxima® **PREFERRED BRAND:** Rituxan Hycela® **NON-PREFERRED BRAND:** Rituxan®	01/01/2021

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DRUG CATEGORY/CLASS	PREFERRED DRUG DETAILS	PLANNED EFFECTIVE DATE
Oncology	**PREFERRED BIOSIMILARS:** Mvasi™ and Zirabev™ **NON-PREFERRED BRAND:** Avastin®	04/01/2021
Oncology	**PREFERRED BIOSIMILARS:** Herzuma®, Kanjinti™, Ogivri™, Ontruzant® and Trazimera™ **PREFERRED BRAND:** Herceptin Hylecta™ **NON-PREFERRED BRAND:** Herceptin®	04/01/2021
Acromegaly	Sandostatin® LAR changing to preferred **PREFERRED PRODUCTS:** Sandostatin LAR and Somatuline® Depot **NON-PREFERRED PRODUCTS:** Signifor® LAR and Somavert®	01/01/2021
Asthma	Xolair changing to preferred **PREFERRED PRODUCTS:** Fasenra, Nucala and Xolair **NON-PREFERRED PRODUCT:** Cinqair	
Lysosomal Storage Disorders — Gaucher Disease	Cerezyme® changing to Non-Preferred and Elelyso® changing to Preferred. **PREFERRED PRODUCT:** Elelyso **NON-PREFERRED PRODUCTS:** Cerezyme and VPRIV®	01/01/2021

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 **other than Neulasta,** PA will not be required to continue coverage.

NOTE: Neulasta Onpro is excluded from the strategy but since it shares a HCPCS code with Neulasta, it will require PA.

THIS ARTICLE WAS UPDATED ON NOV. 16, AFTER THE INITIAL PUBLICATION DATE.

Wellmark's semi-annual drug payment update made available

The drug fee schedule is reviewed semi-annually.

In accordance with provisions of the Wellmark Blue Cross and Blue Shield provider services agreement, the drug fee schedule is reviewed semi-annually, and any changes are communicated to providers 90 days prior to the effective date. This update is effective for dates of service on and after Jan. 1, 2021, through June 30, 2021. Complete drug fee schedules were made available on or after Oct. 3, 2020, via the following distribution depending on provider type.

Practitioners

Participating practitioners can access the semi-annual drug payment update on the secure provider portal at Wellmark.com. If you do not have secure access to Wellmark.com, take one of the following steps:

1. **IF YOUR TAXPAYER IDENTIFICATION NUMBER (TIN) IS NOT REGISTERED,** select "Register now" on the provider page at Wellmark.com.

2. **IF YOUR TIN IS REGISTERED** and you want to expand or change your user access, contact your office's designated security coordinator.

Facilities

Participating facilities may access the drug fee schedule exhibits on the secured 3M website. If you are a new user to the 3M website, you may request access **here**.

Home infusion therapy providers

Semi-annual drug fee schedules will be communicated to providers via e-mail.

Your agreement with Wellmark requires that you and anyone acting on your behalf maintain the confidentiality of all fee schedules, payment arrangements, payment manuals and other Wellmark proprietary information. All information provided or available on Wellmark.com is for your use only and is not to be disclosed to anyone not authorized to access this information.

We value your continued participation as a network provider. If you have any questions about the semi-annual drug payment update, additional questions regarding accessing the 3M (Treo) website, or are a Home Infusion Therapy provider and do not receive the email, contact your Wellmark Network Engagement Business Partner. To identify your Business Partner based on the county in which you practice, use the map available through the "Contact Us" link on Wellmark.com.

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