HFMA PAYOR PANEL

MARCH 27, 2019

PRESENTED BY
NICKY COONEY
Network Engagement Business Partners
1 OPERATIONS
WELLMARK SYSTEM MIGRATION

• Migration is complete for all Wellmark members as of January 1, 2019
• Members and employer groups may select new benefits at renewal time; many renewals occur in January and July
• New claim system requires quality and accuracy checks
• Our goal is to ensure accurate payment to health care providers in an effort to avoid future remediation of claims
FEP: BLUE FOCUS

• New product offering beginning January 1, 2019
• In addition to Standard and Basic Option products
• In-network preventive services are covered; many other benefits are subject to a 30% coinsurance after the deductible has been met
• Closed formulary with two tiers
• Non-covered services include dental care, non-preferred drugs, skilled nursing care, hearing aids, and long term care
FEP BLUE FOCUS: MEMBER ID CARD

Member Name
** QC - DO NOT MAIL ** ** Q

Member ID
R99993044

Enrollment Code
131
Effective Date
01/01/2019

www.fepblue.org

RxIN
610239
RxPCN
FEPRX
RxGrp
65006500
FEP PRIOR APPROVAL

• Expanded list of services requiring prior approval
• Information regarding prior approval for FEP Blue Focus is on the Prior Approval - Federal Employee Program (FEP) page
• If prior approval is not requested, there will be a $100 provider payment penalty
FEP RESOURCES

• 2019 Blue Cross Blue Shield Service Benefit Plan brochures for all product options available at www.fepblue.org

• FEP drug list is updated periodically during the year. You may check this list at www.fepblue.org/pharmacy

• FEP customer service representatives are also available to answer provider questions at 800-532-1537
FARM BUREAU HEALTH PLAN: GENERAL INFORMATION

OVERVIEW

• The Farm Bureau Health Plan is a health benefits plan available to Iowans that is different from Affordable Care Act (ACA) health insurance. This plan is sponsored by the Iowa Farm Bureau Federation and administered by Wellmark Administrators, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

• Wellmark Administrators, Inc., will administer the Farm Bureau Health Plan consistent with Farm Bureau Federation terms and conditions. Wellmark Administrators, Inc., will process claims and provide access to the Wellmark Blue HMO℠ network of clinics, doctors and hospitals. Wellmark Administrators, Inc. has no financial risk or obligation for claims.
FARM BUREAU HEALTH PLANS: OVERVIEW (CONTINUED)

• Wellmark Blue HMO℠ Network is the network for the Farm Bureau Health Plan, but Farm Bureau Health Plan is not an HMO and is not health insurance

• Available to Iowans who meet certain eligibility and underwriting criteria
  • Membership with the Iowa Farm Bureau Federation is required for application

• Earliest effective date for a member with Farm Bureau Health Plan coverage is 1/1/19
  • No open enrollment timeframe; individuals can apply year-round
FARM BUREAU HEALTH PLANS: MEMBER ID CARD
FARM BUREAU HEALTH PLANS: FAILURE TO DISCLOSE/POST CLAIMS REVIEW

- Members enrolling in the Farm Bureau Health Plan will complete a health questionnaire as part of the underwriting process
- Farm Bureau Health Plan will monitor claims for a period of time following enrollment
- Claims may be flagged if they appear to be for a condition the member may not have disclosed at the time of application
- Letters will be sent to the provider who submitted the claim, the member, and the member’s agent notifying them that medical records are required
- The claim in question and all subsequent claims will be held pending review
FAILURE TO DISCLOSE: POST CLAIMS REVIEW PROCESS

- Providers should be aware that members of this plan will be reaching out to gather ALL medical records for a two-year period, if they experience a claim stop due to possible failure to disclose.

- The medical records should be for the member’s entire history for the previous two years, not limited to just services received for the condition that triggered the review.

- Medical records should be sent back to the member and NOT TO WELLMARK. The *member* is responsible for sending all medical records to the address included in the letter they receive within 30 days of the request from Farm Bureau Health Plan.

- If a condition is found to be pre-existing and was not disclosed at time of application, the member’s coverage could be rescinded or the member could receive an increase in their monthly rate.
EXCLUDES AND LATERALITY CONCEPTS

• Wellmark implemented iCAP edits for the ICD-10-CM Excludes 1 Note and Laterality concepts in October 2018

• The iCAP edits for the Excludes 1 Note and Laterality logic are coding concepts in the ICD-10-CM coding manual

• The specific section that references these two concepts is the ICD-10-CM Official Guidelines for Coding and Reporting

• This information regarding this topic is accessible in the following:
  • June 2018 *Bluelink*
  • August 8, 2018 Provider Webinar: ICD-10-CM Coding Concepts
  • February 2019 *Bluelink*
  • Claims Filing Provider Guide
PRIOR AUTHORIZATIONS

- Wellmark monitors utilization trends to identify opportunities for medical management to ensure the most appropriate use of Wellmark members’ health care dollars and as a result may add or remove preservice review requirements to services.

- Wellmark is removing the requirement for prior authorization for hysterectomies (other than when done as part of Gender Reassignment Surgery) effective for claims processed May 23, 2019:
  - If services are for gender reassignment surgery, please access the Prior Authorization table to determine if PA is required.
PEER-TO-PEER PROCESS CHANGES FOR UTILIZATION MANAGEMENT DENIAL DECISIONS

• March 1, 2019 Wellmark updated the peer-to-peer process providers may use after they receive a pre-service management denial

• Wellmark will call the requesting provider on the day a service denial is issued

• The requesting provider will be notified if there is any missing information with their utilization management (UM) submission

• The provider will be offered the opportunity to speak with a Wellmark medical director on a peer-to-peer phone call

• A toll free number and 3 different time options will be offered
UPCOMING PEER-TO-PEER PROCESS CHANGES CONTINUED

• The provider has one business day to confirm moving forward with the call
• If they do not move forward, they will no longer be able to move forward with a peer to peer call for this U.M. decision
• If they move forward, they will contact the toll free number offered at one of the times offered
• The provider must complete the peer-to-peer call within the time provided
• If not completed or the provider chooses not to discuss with a medical director they may request an appeal
• Additional information is accessible in February BlueInk and the Health Management Provider Guide
NEW ONLINE PLATFORMS

Wellmark transitioning drug and medical pre-service review to new online platforms

**PRE-SERVICE REVIEW CHANGES COMING IN 2019**

New drug and medical utilization management tools will give providers improved experience.

In 2019, providers will see several major changes to the way they submit pre-service reviews to Wellmark:

**Spring 2019**
- New drug utilization management (UM) tool launches.
- A real-time submission and tracking feature will allow providers to check on all drug-related prior authorization (PA) requests.
- The new tool will automate the current manual PA process for medically benefited drugs.

**Fall 2019**
- New medical UM tool launches.
- The new UM tool will give providers a completely different, yet improved, experience when seeking medical PA requests.
- All PA requests will be automated when the new tool launches, increasing efficiency.

Look for more communications and educational resources to be sent leading up to the launch of each new tool.
WEB UPDATES TO THE PROVIDER PORTAL

• On March 1, 2019, the Medical Policies and Prior Authorizations Page was revised
  • Some links have been rearranged
  • The secure “Utilization Management Tool” page is now titled ‘Manage Authorizations’
  • The ‘Manage Authorizations’ page serves as a guide for both medical and drug PAs
  • There is a change in terminology from ‘Pre-service review’ to ‘Authorization’
## PROVIDER PORTAL: NEW LOOK

### Manage Authorizations

Some medical services, procedures, durable medical equipment (DME), and drugs require approval before they can be covered by your patients’ benefits.

- View important details about authorization
- Out-of-Area Member Authorizations

### Start the Authorization Process

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Verify if authorization is required. Use the medical or drug authorization table to determine if you need authorization.</td>
</tr>
<tr>
<td>Medical Authorization Table (Procedures, Imaging, and DME) Drug Authorization Table (Medications and drugs)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Submit an authorization request</td>
</tr>
<tr>
<td>Submitting online using Wellmark's secure tools is easy and only takes a few minutes.</td>
<td></td>
</tr>
<tr>
<td>Log in to submit an authorization request</td>
<td></td>
</tr>
<tr>
<td>Medical - Inpatient Medical - Procedures and DME Medical - Servicing Providers Drug</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Check the status of an authorization</td>
</tr>
<tr>
<td>Log in to check the status or see if further action is needed.</td>
<td></td>
</tr>
<tr>
<td>Medical - Inpatient Medical - Procedures and DME Medical - Servicing Providers Drug</td>
<td></td>
</tr>
<tr>
<td>Learn more about response times and notifications</td>
<td></td>
</tr>
</tbody>
</table>
NOVOLOGIX: DRUG UTILIZATION TOOL

- March 1, 2019: Prescribers with secure access to Wellmark.com may start using the online drug PA tool, NovoLogix, for Wellmark and BlueCard members only; you may still submit via phone or fax
  - PA requests for FEP members must be submitted via phone or fax
  - Information regarding required use of the tool will be forthcoming
  - For additional information, please refer to the January 9th Provider webinar, “Online Prescription Drug Prior Authorizations” accessible via the Wellmark Provider Portal
JIVA: NEW UTILIZATION MANAGEMENT TOOL

- Jiva will be available for medical prior authorizations beginning this fall
- Additional communication will be forthcoming in *BlueInk* publications
- Test environment will be available in August along with user guides
3 CREDENTIALING
E-CREDENTIALING CENTRAL

• The full application is available on E-Credentialing tool
• Paper applications no longer available on Wellmark.com
• Educational Webinars available on wellmark.com
• Please email Provider Credentialing if you have any questions regarding credentialing/recredentialing or contact your Business Partner
4 TELEHEALTH AND TELEMEDICINE
BACKGROUND

• Wellmark makes the following distinction between telemedicine and telehealth:

**Telehealth:**
• Telehealth (virtual visit) is a method to provide health care services to patients through real time video interaction between a provider and the patient. Virtual visit involves only the patient at the originating site and a provider at the distant site.
TELEHEALTH: CREDENTIALING AND NETWORK PARTICIPATION APPLICATIONS

- Telehealth is not considered a provider type or specialty for network participation
- Practitioners **must** be located within Wellmark’s geographic service area
- Practitioners that are only providing telehealth services are **not** required to meet the Practice Location requirements in Iowa or South Dakota*
- Practitioners that are only providing telehealth services are **not** required to have a physical presence at an approved Practice Location(s) in order to participate in Wellmark Networks*
- Practitioners that are only providing telehealth services will **not** show up in the Provider directory
- If you are currently working with or considering working with a vendor (i.e. MDLIVE, American Well, Teledoc, etc.) to provide services through telehealth to your patients please reach out to your Network Engagement Business Partner to discuss network participation and billing limitations.

*A provider must still be within Wellmark’s geographic service area
TELEHEALTH: CLAIMS FILING REQUIREMENTS

- Professional services provided via telehealth must be submitted using the appropriate CPT or HCPCS code for the professional service
  - Submit with Place of Service 02, (Telehealth)
  - Do not use a 95 or GT modifier
  - Services billed with a POS 02 and a 95 or GT modifier will be denied
TELEHEALTH: PAYMENT POLICIES

• Telehealth services provided by Wellmark participating providers will be paid at a percentage of the maximum allowable fee based on the provider’s applicable professional fee schedule

  • https://ebusiness.wellmark.com/provider/securecontents/claims/PaymentPoliciesProfessionalClaimsCMS1500.aspx

• Covered services that are delivered through telehealth will be subject to the same scope of practice and payment policies that are administered for covered services provided in person

Requirement to bill:

• As a participating provider with Wellmark, you are required to bill for all services that you provide to our covered members. This includes telehealth and telemedicine services.
**BACKGROUND**

- Wellmark makes the following distinction between telemedicine and telehealth:

**Telemedicine:**

- Telemedicine is a method to provide health care services to patients which involves a provider with a patient at an originating site and a provider at a distant site. Telemedicine involves a provider using interactive audio/video and/or electronic images to treat patients.
TELEMEDICINE: CURRENT CREDENTIALING PRACTICE

• Telemedicine is not considered a provider specialty for network participation

• Practitioners must be located within Wellmark’s geographic service area

• Practitioners that are providing telemedicine services will continue to be required to meet the Practice Location requirements in Iowa or South Dakota

• Practitioners that are providing telemedicine services will continue to be required to meet the Physical Presence requirements in Iowa or South Dakota

• The Practice Location is where the provider is located
TELEMEDICINE: CLAIMS FILING REQUIREMENTS (ORIGINATING SITE)

• The following are authorized originating sites for telemedicine:
  • Office of an approved provider type;
  • Hospital (inpatient or outpatient);
  • Critical access hospital (CAH);
  • Hospital-based or CAH-based renal dialysis center (including satellites);
  • Skilled nursing facility (SNF); and
  • Community mental health center (CMHC)
TELEMEDICINE: CLAIMS FILING REQUIREMENTS
(ORIGINATING SITE)

• The originating site must have an individual with an appropriate clinical training and background (determined by originating site) who is trained in the use of the telemedicine equipment, presents the patient, manages the cameras, and performs any physical activities to successfully complete the exam.

• Originating site submits a claim to Wellmark using HCPCS code Q3014 (Telemedicine originating site fee)
  
  • The originating site should bill Q3014 without the GT or 95 modifier.
  • The originating site should bill the Place of Service in which the patient is located.
TELEMEDICINE: CLAIMS FILING REQUIREMENTS (DISTANT SITE)

- Professional services provided via telemedicine are required to contain a GT or 95 modifier (Interactive Telecommunications).
- The Practice Location is where the provider is located and rendering service. This determines where the professional services are billed.
- The Distant Site should bill the Place of Service in which the patient is located along with the GT or 95 modifier.
  - For example, if the patient is located in:
    - Office, POS 11
    - Outpatient setting, POS 22
- As of January 1, 2019, if you bill with POS 02 (Telehealth), the claim will deny.
WORKING WITH WELLMARK
JULY 1, 2019 PAYMENT UPDATE

- Annual Payment Update letter
  - Log in to secure provider portal
  - April 1, 2019
  - Notification of the annual review and highlights the revisions made for the July 1, 2019

- Reach out to your Business Partner with questions
ANNUAL PAYMENT UPDATE NOTICE

CLAIMS AND BENEFITS QUICK LOOK-UP (all fields required)
- Patient Last Name
- Patient First Name
- Identification Number
- Date of Birth (mm/dd/yyyy)
- Dates of Service (mm/dd/yyyy)
  From:  
  To:  
  Benefit Status
  Claim Status

CLAIMS
- Check a Claim
- Create & Submit a Claim
- View Provider Claim Remittance (PCR)

ELIGIBILITY, BENEFITS & ACCUMULATIONS
- Check Member Information
- Update Information for Coordination of Benefits

DOING BUSINESS WITH WELLMARK
- Credentialing and Network Participation
- E-credentialing Central (requires logout)
- User Security
- Forms
- Provider Guide
- Provider Experience Council Insights
- Treating patients in Wellmark’s new networks

PRE-SERVICE REVIEW
- Authorization Table
- Utilization Management Tools and Resources
- SmartSheets™
- Pre-service Review for Out-of-Area Members

COMMUNICATION AND LEARNING
- Blueink Magazine
- WINS - Wellmark Information Notification System
- Education and Training
- How-to Videos for Secure Tools
- Clinical Guidelines

PAYMENTS
- Professional Fee Schedules
- Annual Payment Update Notice
- Payment Policies for Professional and Outpatient Facility Claims

QUALITY & TRANSPARENCY
- Value Index Score (VIS)
BlueInk Magazine now available only online at Wellmark.com
EDUCATIONAL WEBINARS

• Archived Webinars
  • November 14, 2018—Telehealth
  • December 12, 2018—Network Update
  • January 9, 2019—Online Prescription Drug Prior Authorizations

• Register at Wellmark.com/provider/webinars

Your topic suggestions are welcome!
WELLMARK INFORMATION NOTIFICATION SYSTEMS (WINS)

• Real time notification

• Messaging focuses on:
  • Wellmark policy changes that impact you and your business and/or business processes — including Medical Policy Updates
  • Issues that impact how Wellmark does business with the provider community

• How Do Providers Sign-up for WINS?
  • Log into Wellmark.com secure portal
  • Click on Wellmark Information Notification System (WINS) under Quick Links
  • Complete basic demographic information
  • Select message categories in which you are interested
NETWORK ENGAGEMENT TEAM

Front row (left to right): Melissa Sudman, Kathy Johnson, Nicky Cooney, Charlene Fairchild (network operations coordinator). Back row (left to right): Deb Wilcke, Nat Kongtahworn, Jackie Landers, Shanna Kenworthy (network operations coordinator).
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THANK YOU!

Deb Wilcke & Jackie Earles