# Provider NEWS

WellFirst Health™

Spring 2020
A newsletter for WellFirst Health providers

## Smarter Care Important to Serve Growing Patient Numbers

**Dang (Don) Tran, MD**
**President of SSM Health Medical Group, St. Louis**

There are only so many primary care doctors to go around. Nobody knows that better than Dang (Don) Tran, MD, the president of SSM Health Medical Group in St. Louis. He oversees both medical groups in St. Louis and Illinois.

"It's a challenge to recruit," Dr. Tran explains. "And that's true for physicians and all primary care."

### Aging Boomers

The demand for primary care providers remains strong, as baby boomers age and require more health care services. Similarly, more doctors are aging out of the profession and beginning their retirements, making it more difficult to fill those open positions.

Nevertheless, Dr. Tran says he feels "fairly good" about how primary care recruitment is going, as well as the available options for addressing the patient demand.

"We've had to shift and focus more on PAs (physician assistants) and Nurse Practitioners," he says, as team-based care becomes increasingly important. "We must focus more on physicians being the leader of the team and that they don't have to do it all. Physicians need to leverage their skills a bit more."

### Team Care

With a team approach, social workers, nurse practitioners, physician assistants, advance practice clinicians, pharmacists and others take on a greater role. *continued on pg 2*

## This Issue



**WellFirst Health continues to monitor the coronavirus COVID-19 outbreak. Refer to our COVID-19 provider web page linked at the top of all web pages at wellfirstbenefits.com for new measures or updated health plan information based on any new developments.**

## Smarter Care Important... (continued)

This model helps provide the right care at the right time, meaning patients who may require urgent care are not seeking that in the much costlier ER setting. This also means providing more personalized guidance to those with chronic conditions, helping them navigate the health care system more successfully.

"We can provide high-quality care but also be cognizant of the cost of that care and be sure to provide care that is high value," explains Dr. Tran. "We should have better outcomes, with more seamless care and payers should see this saves everybody money."

### Telemedicine

Another way to better leverage the physician workforce is to recruit retired doctors to practice part-time but not in an office setting anymore.

"Telemedicine is a substantial win for both of us," says Dr. Tran. "They can continue to serve but be able to do it from home."

### Smarter Testing

Becoming more efficient also means practicing in a manner that is best for the patient.

"Certain screenings beyond a certain age don't add a lot of value to a person's life," says Dr. Tran. "How do you get the outcomes, and do it in an economic, less-wasteful manner but also balance that with the harms that come to patients with over-ordering."

So, cutting waste and duplication offer plenty of opportunity. For example, sometimes tests are ordered because a provider can't access tests another doctor previously ordered.

Similarly, becoming truly value-based means limiting the variation of treatments that are well-established by following best-practice guidelines. ⊕


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## Mission of *Provider News*

WellFirst Health publishes *Provider News* to facilitate communication between WellFirst Health and our network of contracted providers. Regular features for this publication include updates to or creation of medical policies by the Utilization Management Committee during the previous quarter.

Moreover, each issue contains information that is valuable to a WellFirst Health network provider. This is consistent with the goals of *Provider News*:

- Educate the WellFirst Health provider network regarding new or changed guidelines that affect the care of our members.
- Introduce new services that benefit our members and affect our provider network.
- Create an extension of the Provider Manual to share information that is needed by the WellFirst Health provider network.

If you have any questions or suggestions on how to improve *Provider News*, or if someone in your organization is not on our mailing list, please contact your assigned Provider Network Consultant. ⊕

## Health and Physical Form to be Submitted with all Behavioral Health Authorizations

Effective January 1, 2020, providers must include clinical information supporting the need for Behavioral Health authorizations to WellFirst Health. This includes a copy of the patient's Health and Physical form, rationale for the requested service(s), as well as timely information regarding transitions of care and discharge planning, including detailed follow up arrangements. Our goal is to ensure that follow-up care is in place before the patient is discharged, which will ensure that we are providing the care that our patients need.

### More Help Available

Another way to better address complex patient needs is to refer them to our Care Management Department. WellFirst Health offers free, voluntary telephone care management services for members with complex behavioral health needs.

There are referral options available:

- Call the Care Management Department at **800-635-9233, ext. 4132** or **608-827-4132**.
- Members may self-refer by calling the Customer Care Center number listed on their benefits card. ⊕


## Non-Covered Services Reminder

Certain services are not covered. Providers may render these services to members if a member is interested in paying out-of-pocket. Prepare to share information with members about noncovered services, including:

- Establishing a usual and customary charge or retail rate for the total cost of the service that can be shared with the member before rendering the service.
- Ensuring members are aware in advance that the service is a non-covered service and therefore the member will be responsible for payment.
- Informing members that their payment for the cost of the service will not count toward their maximum out-of-pocket.

Organizations should not collect payment from members in advance. We recommend that providers submit a claim after rendering services and receive the appropriate denials before billing members.

For more information, please contact our Customer Care Center at **877-274-4693**. ⊕

## Follow-up After Mental Illness Hospitalization Leads to Lower Readmission Rates

Checking in on patients who were recently hospitalized for mental health conditions pays off in multiple ways. Proper follow-up care is associated with lower rates of readmissions and a greater likelihood that gains made during hospitalization are retained. Because hospitalization may stabilize patients with acute behavioral conditions, timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital.

Patients (age 6 and older) should see an outpatient psychiatric or behavioral health specialist within 7 days after a hospital discharge for mental illness, but no later than 30 days after discharge. (Follow-up can be a telepsych visit.)

HEDIS (Healthcare Effectiveness Data and Information Set) monitors the percent of patient discharges who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days and 30 days. (Joint Commission and CMS also monitor follow-up after hospitalizations.)

Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtain accurate current contact information, coordinate with WellFirst Health's Customer Care Center or visit **wellfirstbenefits.com/find-a-doctor** for help finding a provider).

### Tips for provider and staff to improve follow-up engagement rates:

#### Inpatient Providers:

- Discharge planning should begin at the time of admission and continue throughout the inpatient stay.
- Schedule the patient's after-care appointment prior to discharge. If there is an obstacle to setting up an appointment within 7 days from discharge, please call the WellFirst Health behavioral health utilization management team to discuss.
- Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtain accurate current contact information, coordinate with WellFirst Health).
- Ensure the member's discharge paperwork is sent to the outpatient provider and to WellFirst Health within 24 hours.
- Invite care coordinators to meet members so that aftercare planning can occur.

#### Outpatient Providers:

- Be flexible when scheduling appointments for patients who are being discharged from acute care. Schedule the appointment within seven days of discharge.
- Review medications with patients to ensure they understand the purpose, appropriate frequency and method of administration.
- Submit claims in a timely manner.

**Please note:** Outpatient visits conducted on the same day of discharge from an inpatient hospitalization unit are no longer reportable as part of the quality measure. Scheduling follow-up appointments between the first and seventh day *after* hospital discharge ensures meaningful, effective engagement.

Remember, when providers recommend follow-up care, most patients comply. Remind your patients that there is no stigma for having a mental health diagnosis and that consistent follow-up care ensures their treatment progress.

## Provider Network Consultants are Here to Help

Provider Network Consultants (PNCs) are a team of specialized individuals who are often the first interaction a provider has when contracting with the health plan.

We value our relationships with providers and have established PNCs to better serve you. While **wellfirstbenefits.com**, self-service resources and the Customer Care Center are always a provider's first sources of information, our PNCs are here to assist providers with their more in-depth inquires to provide information beyond these resources when necessary.

PNCs are particularly skilled at guiding providers through contracting and orientation education. Moreover, a PNC's primary focus is in guidance and education. They also provide:

- Ongoing education on new policies and procedures to their in-network providers.
- Stay informed of changes important to a provider's claims adjudication.
- Assist with complex billing and claims processing questions.

Staying informed is a two-way relationship. Providers should advise their PNC of any changes to their demographic information, practitioners, office or practice locations, and services/specialties.

Contact the WellFirst Health PNC team at **314-994-6262** or email **ProviderRelations@wellfirstbenefits.com**.

## Personalized Help for Patients with Complex Care Needs

When patients have complex, acute or chronic health conditions, multiple emergency department visits or are frequently hospitalized, Case Management helps them get the care they need.

Nurses and social workers work with providers to best meet the patient's needs while also supporting high-quality, cost-effective care.

### Care Management Team:

- Navigate access to services within a complex health care system.
- Provide education on member's condition and how to access resources to best manage your health.
- Support and guide members in setting achievable goals as they work toward improving quality of life and overall health and well-being.
- Help members to understand their individual health care plan including how to maximize benefits.
- Connect with services and community resources necessary for members to self-manage their health care needs.
- Serve as an advocate to help members achieve optimal physical and mental health.

Now, more than ever, medicine needs a team approach and Care Management is here to assist. Patients notice the difference and appreciate it.

"My case manager was accessible and communicated with me in a way that helped me understand differing opinions from doctors, prevent ED visits, and improve my declining health status. Case Management staff were outstanding!"

To refer a WellFIrst Health patient into the program, call **800-635-9233, ext. 4132**.

## Spring 2020 Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by WellFirst Health's Medical Policy Committee, are shown below. The Medical Policy Committee meetings take place monthly. We appreciate contributions by specialists during the technology assessment of medical procedures and treatments.

To view all of WellFirst Health's medical policies, go to **wellfirstbenefits.com**, ▶**For Providers**, and then ▶**Medical Management** ▶**Search WellFirst Health's Medical Policies**. **Wellfirstbenefits.com** is updated as the medical policies become effective. For questions regarding any medical policy or if you would like copies of a complete medical policy, please contact our Customer Care Center at **877-274-4693**. All other WellFirst Health clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at **800-356-7344, ext. 4012**.

### General Information

Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note, that prior authorization through the Health Services Division of WellFirst Health is required for some treatments and procedures.

For radiology, physical medicine and musculoskeletal surgery prior authorizations, please contact National Imaging Associates (NIA)/Magellan.

**Radiology:**
Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 am to 7 pm CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program on the medical management page on **wellfirstbenefits.com**.

**Physical Medicine:**
Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the physical medicine prior authorization program on **wellfirstbenefits.com**.

**Musculoskeletal**
Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the musculoskeletal prior authorization program on **wellfirstbenefits.com**.

### Genetic Testing MP9012

Testing is covered if test results provide a direct medical benefit or guides reproductive decision-making. Prenatal testing is covered without a prior authorization. Multi-gene testing panels may be considered medically necessary if category 1, 2A or 2 B National Comprehensive Cancer Network (NCCN) level of evidence guidelines are met.

### Total Knee Arthroplasty (Unilateral) Level of Care MP9550

Effective June 1, 2020, Utilization Management will retrospectively review medical necessity for the site of care for elective, unilateral knee arthroplasty. Patients that meet select criteria MP9550 will be reviewed for inpatient vs. outpatient level of care. This retrospective review will determine the appropriate place of service.

### Shingrix (RZV), Non-Routine Use MP9549

Effective May 1, 2020, prior authorization requests should be submitted to Navitus.

Effective January 1, 2020

### Genetic Testing for High-Penetrance Breast and/or Epithelial Ovarian Cancer Susceptibility MP9478

Genetic testing for high-risk breast cancer genes may be indicated when an individual is from a family with a known deleterious BRCA1/BRCA2 mutation. The policy was updated to align with NCCN Guidelines for testing criteria for high-penetrance breast and/or ovarian cancer susceptibility genes.

## Medical Policy Changes

Effective January 1, 2020

### Plastic and Reconstructive Surgery MP9022

Prior authorization is required for an otoplasty to improve hearing when the ears are absent or deformed due to trauma, surgery, disease or a congenital defect. Otoplasty to correct prominent, protruding, lop, cupped or constricted ears is considered not medically necessary.

### Genetic Testing for Hereditary Cardiac Disease MP9472

Testing for arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVC) is considered medically necessary when a diagnosis is unable to be confirmed by other means. QT syndrome or catecholaminergic polymorphic ventricular tachycardia testing criteria was added to the policy.

### Genetic Testing for Reproductive Carrier Screening MP9679

Twin zygosity testing is considered experimental and investigational and therefore not medically necessary.

### Genetic Testing for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) MP9487

Testing is considered medically necessary for members with a personal history of colorectal or endometrial cancer.

### Genetic Testing for Neurological Disorders MP9497

Friedreich Ataxia and Myotonic Dystrophy gene testing is considered medically necessary when the individual to be tested has a family history and is asymptomatic. Testing of an asymptomatic individual (age 18 and older) who has a family history of Amyotrophic Lateral Sclerosis, is considered medically necessary when the proband individual is deceased or unavailable for testing.

### Myocardial Imaging, Positron Emission Tomography (PET)

Effective February 1, 2020, prior authorization requests for outpatient myocardial imaging, positron emission tomography (PET), metabolic evaluation studies (CPT codes 78429 to 78434) will be processed by Magellan Healthcare.

## Technology Assessments

The following treatments, procedures, or services are considered experimental and investigational, and therefore not medically necessary:

- Aquablation therapy prostate (AquaBeam robotic system)
- AngelMed Guardian System implantable intracardiac ischemia monitor
- Bioidentical hormone testing
- Breast thermography for breast cancer screening
- Colaris (Myriad Genetics) cancer risk
- PancraGEN

The following treatments, procedures, or services were determined to be medically necessary. Prior authorization is not required:

- Absorbable perirectal spacer (SpaceOAR hydrogel)
- Fractional Flow Reserve (FFCRct)
- Elastography for distinguishing hepatitis cirrhosis is a covered indication ⊕

## Spring 2020 Pharmacy and Therapeutics / Drug Policy / Formulary Change Updates

Highlights of recent drug policy revisions, as well as any new drug policies approved by WellFirst Health's Medical Policy Committee, are shown below. **Note: All changes to the policies may not be reflected in the written highlights below. We encourage all prescribers to review the current policies.**

All drugs that have written WellFirst Health policies must be pre-authorized by sending requests to Navitus, unless otherwise noted in the policy. Please note that most drugs noted below and with policies require specialists to prescribe and request authorization.

Policies regarding medical benefit medications may be found on **wellfirstbenefits.com**. From the home page, drop down from the ▶**I am**... screen to ▶**Provider** and then ▶**Pharmacy Services**. ▶**Under Up to Date Drug policies**, click ▶**See Library** and search.

Criteria for pharmacy benefit medications may be found on the prior authorization form located in the Provider Portal. Pharmacy benefit changes may be found on **wellfirstbenefits.com**. From the home page, drop down from the ▶**I am**... screen to ▶**Provider** and then ▶**Pharmacy Services**. Under ▶**Covered Drugs/Formulary**, there is a change notices link below each formulary.

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar. Medical injectable drugs may also be searched using the appropriate J-code (e.g., J9301 for Gazyva).

**Note: On January 1, 2020,** we began sending a monthly letter to providers highlighting any changes that require a 90-day notification. The effective date of any changes is clearly stated in each monthly letter. In addition to the monthly letters, we will continue to communicate these changes here in *Provider News*, published quarterly.

### New Drug Policies

#### BAVENCIO (avelumab) MB1936

Effective January 1, 2020, BAVENCIO, which is used to treat metastatic merkel cell carcinoma, urothelial carcinoma and renal cell carcinoma, will require a prior authorization. It is restricted to oncology prescribers.

#### NULOJIX (belatacept) MB1937

Effective April 1, 2020, NULOJIX, which is used for prophylaxis of organ rejection in kidney transplant patients, will require a prior authorization. It is restricted to renal transplant or immunosuppressive therapy specialists.

#### ADCETRIS (brentuximab vedotin) MB1945

Effective April 1, 2020, ADCETRIS, which is used to treat Classical Hodgkins Lymphoma, Systemic anaplastic large cell lymphoma, primary cutaneous anaplastic large cell lymphoma or CD30 expressing mycosis fungoides, and CD30 expressing peripheral T-cell lymphomas, will require a prior authorization. Dose for ADCETRIS must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. It is restricted to oncology or hematology prescribers.

#### POLIVY (polatuzumab vedotin-piiq) MB1938

Effective January 1, 2020, POLIVY, which is used to treat diffuse large B-cell lymphoma, will require a prior authorization. It is restricted to oncology prescribers.

#### ZULRESSO (brexanolone) MB1939

Effective January 1, 2020, ZULRESSO, which is used to treat moderate to severe postpartum depression, will require a prior authorization. It is restricted to a psychiatrist or an obstetrician-gynecologist.

#### BEOVU (brolucizumab-dbll) MB1944

Effective January 1, 2020, BEOVU, which is used to treat Neovascular (Wet) Age-related Macular Degeneration, will not require a prior authorization. Providers should review the criteria for use, as claims audits can be performed to ensure appropriate utilization, even without a prior authorization requirement. Correct HCPCS code for BEOVU is J0179.

### Changes to Drug Policy

#### NUCALA (mepolizumab) MB9914

Effective January 1, 2020, added criteria for eosinophilic granulomatosis with polyangiitis including baseline blood eosinophil count greater than 1,000 cells/µL or baseline blood eosinophil count greater than 10% of the total leukocyte count, trial of oral corticosteroid therapy was ineffective, contraindicated, or not tolerated, and trial of one of the following was ineffective, contraindicated, or not tolerated: Azathioprine, Cyclophosphamide, Leflunomide, or Methotrexate.

Updated criteria for eosinophilic asthma to include only the following: Age 6 years or older; and documented baseline blood eosinophil concentration of ≥ 150 cell/mm$^3$; and within the last year, member has greater than or equal to 2 asthma exacerbations requiring treatment with systemic corticosteroids, emergency department visits, or hospitalization despite adherent utilization of medium or high dose inhaled corticosteroids in combination with a long-acting beta agonist and either a leukotriene receptor antagonist or tiotropium; and prescriber attests to ALL of the following: member adherence to controller medications; and member is a non-smoker or is adherent to an attempt at smoking cessation; and member will not be using in combination with omalizumab, dupilumab, or other interleukin-5 agents.

Prior authorization is required and is restricted to pulmonology, immunology, or allergy prescribers for Eosinophilic Asthma and pulmonology, immunology, allergy, or rheumatology prescribers for Eosinophilic granulomatosis with polyangiitis.

#### OPDIVO (nivolumab) MB1844

Effective January 1, 2020, removed indications for Merkel Cell Carcinoma, Resected Advanced Melanoma, Non-Small Cell Lung Cancer, Small Cell Lung Cancer, and Mesothelioma. Updated criteria for Unresectable or Metastatic Melanoma, Metastatic Non-Small Cell Lung Cancer, Metastatic Colorectal Cancer, and Classical Hodgkin Lymphoma. Prior authorization is required and is restricted to oncology prescribers.

#### Infliximab Infusions MB9231

Effective February 1, 2020, updated criteria for moderate to severe hidradenitis suppurativa to include only the following: prescribed by a dermatology specialist; and total abscesses or inflammatory nodule count of ≥ 3; and patient has documented tried and failed at least one oral antibiotic. Added indication for diagnosis of NCCN category 1, 2a, or 2b for off-label uses or FDA indications. Prior authorization is required.

#### YERVOY (ipilimumab) MB9945

Effective February 1, 2020, dose for YERVOY must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology or dermatology prescribers.

#### Rituximab Products MB9847

Effective February 1, 2020, dose for RITUXAN and TRUXIMA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

#### ABRAXANE (paclitaxel albumin-bound) MB1801

Effective February 1, 2020, dose for ABRAXANE must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

#### Trastuzumab Products MB1805

Effective February 1, 2020, dose for Trastuzumab products must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

#### VECTIBIX (panitumumab) MB1810

Effective February 1, 2020, dose for VECTIBIX must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

## Spring 2020 Pharmacy and Therapeutics (continued)

### DARZALEX (daratumumab) MB1832

Effective February 1, 2020, dose for DARZALEX must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

### ALIMTA (pemetrexed for injection) MB1837

Effective February 1, 2020, dose for ALIMTA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

### CYRAMZA (ramucirumab) MB1918

Effective February 1, 2020, dose for CYRAMZA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Criteria added that if first infusion is tolerated, subsequent infusions may be administered over 30 minutes. Prior authorization is required and is restricted to oncology prescribers.

### ARANESP (darbepoetin alpha) MB9799

Effective February 1, 2020, included statement that dosing amount and intervals are required to stay within FDA approved limitations. Prior authorization is required and is restricted to oncology, infectious disease, hematology, or nephrology prescribers.

Effective March 1, 2020, removed requirement of a trial and failure or intolerance to Procrit or Epogen. Prior authorization is required and is restricted to oncology, infectious disease, hematology, or nephrology prescribers.

### Botulinum Toxin MB9020

Effective March 1, 2020, removed requirement that there is no infection at the proposed injection site. Prior authorization is required, and prescriber restrictions are listed separately under each botulinum toxin product in the policy.

### Antihemophilia Factors and Clotting Factors MB1802

Effective March 1, 2020, updated policy to include FDA approved indication for Wilate when member has hemophilia A. Prior authorization is required and is restricted to hematology prescribers.

### KEYTRUDA (pembrolizumab) MB1812

Effective March 1, 2020, added new indication for bladder cancer, non-muscle invasive with carcinoma in situ with or without papillary tumors. Prior authorization is required and is restricted to urology or oncology prescribers.

### SPRAVATO (esketamine) MB1921

Effective March 1, 2020, updated HCPCS codes to G2082 and G2083. Prior authorization is required and is restricted to psychiatrist or psychiatric nurse practitioner prescribers.

### Rituximab Products MB9847

Effective March 1, 2020, updated age requirement for Granulomatosis with Polyangiitis and Microscopic Polyangiitis from 18 years of age or older to 2 years of age or older. Prior authorization is required and is restricted to rheumatology prescribers.

### STELARA (ustekinumab) IV MB9891

Effective March 1, 2020, updated criteria to include only the following: Documented diagnosis of moderate to severe Crohn's disease or ulcerative colitis; AND Symptoms have remained active despite failure of, or intolerance to, treatment with: 6-mercaptopurine, azathioprine, methotrexate or corticosteroids. Prior authorization is required and is restricted to gastroenterology prescribers.

## Retired Policies

### CIMZIA (certolizumab pegol) PA9875

## Member Rights and Responsibilities

To promote effective health care, WellFirst Health clearly states its expectations for the rights and responsibilities of its members to foster cooperation among members, practitioners and WellFirst Health.

To view these rights and responsibilities, visit **wellfirstbenefits.com/member-rights**.

## Policy Change Increases Access to Substance Use Treatment

Suboxone and Narcan have gone from a Tier 2 drug to a Tier 1 drug with quantity limits removed. The tier change will reduce copays for our members and help increase access to substance use treatment.

Drugs used for addiction and overdose reversal do not require a prior authorization.

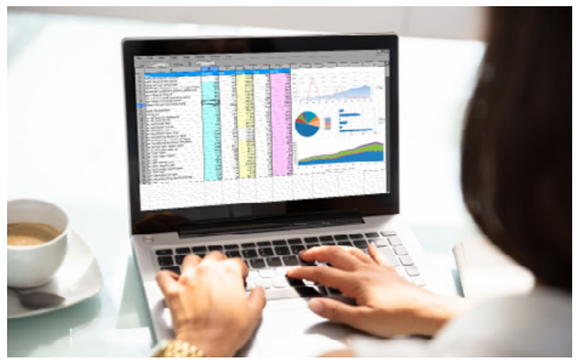
## Pre-Payment Review of Unbundling Modifiers

Effective July 1, 2020, WellFirst Health will manually review claims submitted with certain modifiers on a pre-payment basis to determine if the modifier has been appended appropriately.

Using nationally-sourced guidelines, Professional Coders - including RNs - will use a combination of the submitted claim information and the patient's related-claim history, to determine if the circumstances warrant the use of a modifier that typically prevents the bundling of services, such as 25, 59, 79 and 24.

The guidelines for the correct use of overriding modifiers are well documented in Current Procedural Terminology (CPT) manuals and Coding with Modifiers manual both published by the American Medical Association (AMA); and by the Centers for Medicare and Medicaid Services (CMS) in the Correct Coding Initiatives (CCI) manual and the CMS claims processing manuals. The correct use of these modifiers may encompass the appending to services that do not require a modifier to allow separate reimbursement. For example, we frequently see modifier 59 appended to code combinations that are not considered Procedure-to-Procedure (PTP) edits under CCI.

This review is designed to not only promote accurate claims payment for the provider, but to ensure appropriate out-of-pocket amounts are assigned to our members.



## Unspecified ICD-10 CM Codes

The ICD-10-CM code assigned to each procedure, service or item should reflect the diagnosis or reason for the visit as documented in the medical record. If the procedure code reflects what was performed, the diagnosis code (ICD-10-CM) indicates the why.

Accurate and specific diagnosis coding may not only impact whether the claim is paid or denied, but also what benefit is assigned. For example, a cholesterol test reported with Z13.220 - Encounter for screening for lipoid disorders – may be paid in full under the member's preventive benefit. However, a cholesterol test performed to monitor a patient's high cholesterol would no longer be a screening service and member out-of-pocket would apply.

In order to ensure appropriate reimbursement of the Women's Contraceptive benefit, the following unspecified ICD-10-CM codes will no longer be reimbursed effective 07/01/2020. Instead, the more specific code will be required.

- Z30.019 – Encounter for initial prescription of contraceptives, unspecified
- Z30.40 – Encounter for surveillance of contraceptives, unspecified
- Z30.9 – Encounter for contraceptive management, unspecified

While these denials may be appealed with supporting documentation, reporting accurate and specific diagnosis codes will help to ensure your claim is paid correctly the first time.


## Notification Necessary for Provider Demographic Changes

WellFirst Health is committed to ensuring accurate provider information is displayed within its provider directories. As a health plan, we are required to keep provider information up-to-date by CMS and other regulatory and accreditation entities.

To ensure we have the most current, accurate provider information available for our members, we require providers to notify their designated Provider Network Consultant as soon as staff are aware of any of the following changes:

- Ability to accept new patients
- Practicing address
- Phone number
- Provider terminations
- Other changes that affect publicly posted provider accessibility and demographics information. This includes, but is not limited to:
  - Practice location's handicap accessibility status
  - Hospital affiliation
  - Provider specialty
  - Languages spoken by provider
  - Provider website URL

WellFirst Health is committed to ensuring that we present accurate provider information. Communication between the health plan and providers will assist in maintaining excellent quality of care and customer service to our members and patients.

Please review the current listing of practitioners and locations included in the online provider directory at **wellfirstbenefits.com/find-a-doctor** to ensure we are posting the most current information.

## Requesting Utilization Management Criteria

WellFirst Health's prior authorization requirements, medical policies and the current medication formulary are all available for online viewing at **wellfirstbenefits.com**. The printed formulary is also available upon request. For a printed copy, contact WellFirst Health at **877-274-4693** (Employee Health Plan) or **866-514-4194** (ACA Individual) and we will either mail it or fax it to you.

WellFirst Health also licenses MCG Guidelines, which are nationally recognized, evidenced-based guidelines for medical necessity determinations. The specific MCG Guideline used in making a denial determination is available upon request by contacting WellFirst Health at **877-274-4693** (Employee Health Plan) or **866-514-4194** (ACA Individual).

"Do you solemnly swear to listen to my advice?"

## Spring Ahead

Welcome to the spring 2020 edition of WellFirst Health's *Provider News*, published quarterly to keep you current on health plan procedures, medical policies, benefits and other areas of interest.

With the launch of WellFirst Health this year, resources and tools that providers were introduced to are now live! Spring is a good time to review all that WellFirst Health has to offer and look ahead to the coming months with a new checklist.

In the November 2019 Welcome to **WellFirst Health Newsletter** on page 2, a short Go-Live Checklist was published and included important start-up items like creating your Portal account, verifying that you are credentialed to provide services to WellFirst Health members, and attending a training. It is not too late to do these things!

### Post Go-Live Checklist

When you have completed the Go-Live Checklist, prepare for what is next.

- ☑ Verify individual practitioners under your organization who require credentialing have fully completed the credentialing process before seeing WellFirst Health patients, even if their organization is fully credentialled.
- ☑ Request more training. If you and your organization already had training, but now have more questions, contact **providerrelations@wellfirstbenefits.com**.
- ☑ Bookmark your self-service tools for easy access.

  Build your online self-service library with the quick access links listed in the November 2019 Welcome to WellFirst Health Newsletter and **WellFirst Health 2020 Quick Reference**.
- ☑ Know where to submit authorization requests.

  Submit to WellFirst Health for most services with some exceptions:

  - NIA Magellan Health for authorization of physical therapy, occupational therapy, high-end radiology services, and musculoskeletal (MSK) services
  - Submit to Navitus for authorization of pharmacy benefits.
- ☑ Understand authorization determination turnaround times.

  Time frames vary by product and State. Refer to the Authorization Process section in the applicable WellFirst Health Provider Manual.
- ☑ Know how to address authorization denials.

  Refer to the applicable WellFirst Health Provider Manual about the peer-to-peer review process for a denied authorization request.
- ☑ Know how to address claim rejections and denials.

  Refer to the applicable WellFirst Health Provider Manual on how to submit a corrected claim, view claim status, or submit a claim appeal.

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**Visit wellfirstbenefits.com**

**ACA Individual Customer Care Center**
**866-514-4194**

**Employee Health Plan Customer Care Center**
**877-274-4693**

Monday–Thursday 7:30 am – 5 pm
Friday 8 am – 4:30 pm

**Contact a Provider Network Consultant**

**Call 314-994-6262 or email ProviderRelations@wellfirstbenefits.com**