Provider NEWS

WellFirst Health®

Spring 2021
A newsletter for WellFirst Health providers

Military Mindset Helps SSM Health's Dr. Garza Manage Pandemic Challenges

Battle-tested is a valid way to describe Alexander Garza, MD. If anybody is well positioned to lead during a health care crisis, it's this SSM Health emergency medicine specialist who serves with the U.S. Army Reserve.

Alexander Garza, MD

Not only is Dr. Garza a colonel who has served in combat, he's also the former Chief Medical Officer for the Department of Homeland Security. Currently, Dr. Garza is Chief Community Health Officer for SSM Health (parent company of WellFirst Health), having planned and led the organization's overall response to the COVID-19 pandemic.

We spoke to him on January 26, when he reflected on what it's like to be a health care leader amid a pandemic.

You've been a prominent voice in the national news media. How important is media communication in getting information out about the pandemic?

Being in the military for over 20 years, and being in a combat environment, I can tell you that communication is half the battle when dealing with the public, helping them understand what is going on. [It's important to be] transparent with them, just speaking the truth about what best practices are.

You have military experience and experience at Homeland Security. How does that inform your work now when you essentially are at war with a virus?

When we first started forming the pandemic task force here in St. Louis, there were a lot of unknowns and ambiguities circulating around the country about how are we going to deal with this pandemic? If

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Military Mindset Helps SSM Health's Dr. Garza ... (continued)

there's one thing that the military does very well is to create order out of chaos. And there are numerous examples of that. The military going into Hurricane Katrina, is one example, so we're very good at developing plans. I use some of what I learned in the military. It's just a way of being disciplined about thinking about how you plan.

How are you doing with managing the stress and strain on your health care staff?

I'm lucky that we have a great team at SSM Health that takes care of practitioners and staff. The biggest thing I can do for them is to be their advocate and be their voice. That's part of my role in St. Louis, talking to the media, advocating for public health measures that will make their lives easier, trying to make things less stressful for them.

How are you managing your personal stress?

I try to make sure that when I leave the office that when I'm with family, I try to compartmentalize. There certainly have been moments when there have been higher stress than others but I try to balance it all out. I'm doing okay. This changes every day. The latest issue we have to deal with is vaccinations. In the beginning it was testing, then PPE, so this is just another issue with the pandemic. We'll get through it. We'll figure it out.

What are the major milestones we need to achieve before we can reach normalcy?

It ends when the virus ends. It's not really up to us. In military planning, you always ask, what does my end state look like? What am I working towards? If you can firmly plant that in your head and on a piece of paper, then you can work towards it. You hear about herd immunity where 80% of the population is either immunized or has developed immunity to the virus. Certainly, that is one metric for when we'll be done with this pandemic. So, we have to immunize but at a certain rate to get to that point. And the other one is when is the health care system no longer under threat from COVID-19? It becomes like a flu outbreak that we deal with every year and it's no longer a complete burden on the community. And the third one is fully reopening of the economy with no restrictions—no need for face masks, no need for a decrease in venue sizes, social distancing and things like that.

Can you reflect on whether anything positive has come from this pandemic? We've become a virtual society in many ways.

It literally forced us into doing more telemedicine because it was the only way we were going to be able to do it. We were very fortunate at SSM Health to be able to do that and amp up our bandwidth to accommodate the volume. It was sort of interesting to see what we planned for volume in 10 years to develop in 3 months.

How often have you been inspired seeing your team working under these conditions?

Every time I meet with them, really. When a certain crush of patients come, there have been times when it's been very stressful. Every time I walked out of our local facilities in St. Louis, I always walked out more humbled and in awe of what was going on than when I went in. I was struck by how giving everyone was, how compassionate they were and how driven they were. It's amazing.

We put a tremendous burden on our health care providers and on their families, as well. Even after the more acute phase of the pandemic is over, people will still have some residual trauma from seeing so much death and seeing so many people sick and dealing with the families. This pandemic is going to have a long tail. Some people are going to have health conditions long into the future. [Plus,] that psychological burden from the workforce will have a long tail, as well. So it will be important to advocate for people after the pandemic is over.

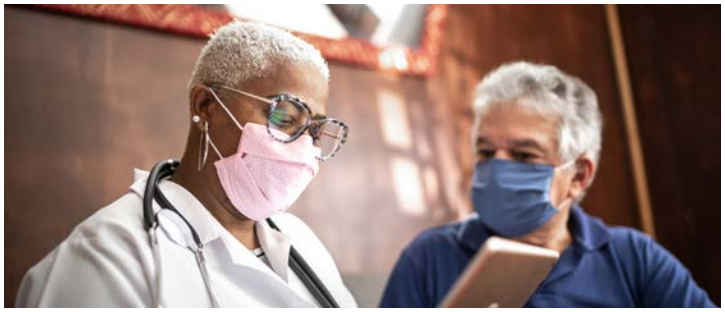
	1 month/30 day		3 month/90 day	
Initial Coverage Copay and Coinsurance	Preferred Retail	Standard Retail and Mail order	Preferred Retail	Standard Retail and Mail order
Tier 1	$0	$7	$0	$7
Tier 2	$5	$12	$10	$24
Tier 3	$40	$47	$100	$117.50
Tier4	$90	$100	$270	$300
Tier5	33%	33%	Not Applicable	Not Applicable
Tier 6 (Vaccines ONLY)	$0	$0	-	-

New 2021 Medicare Advantage Pharmacy Benefit Changes

- **Over-the-Counter Allowance:** We are offering WellFirst Health Medicare Advantage members $60 per quarter to spend on useful over-the-counter supplies like bandages, pain relievers and much more. They can use their OTC card to shop online, at participating stores, or over the phone. Participating stores include Walgreens, CVS and Walmart.
  - Visit wellfirstbenefits.com/extrabenefits for a full list of eligible products, participating stores and links to online shopping.
- **Preferred Pharmacies** Members will save money on copays when they fill their prescriptions at preferred pharmacy network. The preferred network includes:
  - **CVS, Walmart, Target, Schnucks, SSM pharmacies**
- **90-Day Medication Supply – WellFirst Health members can save time and money by purchasing a three-month supply** of maintenance drugs in one transaction at their local pharmacy or through Costco Mail pharmacy services. The Medicare Advantage formulary can be found on wellfirstbenefits.com.
- **Insulin Savings -** Members only pay a $30 copay per 30 days of an insulin prescription at preferred pharmacies, or $35 at standard retail pharmacies, until they reach the catastrophic coverage stage. These savings apply through the deductible and copay stages and the Medicare "donut hole."
- **Continuous Glucose monitoring Benefits –** your patients are now able to receive Dexcom and FreeStyle Libre from their local pharmacy with a $0 coinsurance. In order to receive a continuous glucose monitoring system, the following guidelines must be followed:
  - Member has a diagnosis of diabetes mellitus
  - Member has previous use with a blood glucose machine
  - Member performs testing four or more times a day
  - Member injects insulin three or times a day or uses a Medicare covered subcutaneous insulin infusion pump
  - Member requires multiple adjustments to insulin regimen on the basis of their test results
  - Within six months prior to ordering the CGM, an in-person visit to evaluate diabetes control to determine all criteria is met
  - Ongoing every six months, patient will need a visit to assess adherence to testing
- **Part D vaccines**: Shingles and Tdap
  - WellFirst Health members with Part D coverage can get their Shingles and Tdap vaccines at $0 cost to them in a retail pharmacy.

2021 Medicare Advantage Plans

On January 1, 2021, WellFirst Health launched our 2021 Medicare Advantage plans packed with supplemental benefits which were introduced in our Winter 2020 *Provider News*. Now that the year is underway, this article provides information around direct outreach to our members for supplemental benefits and our Point of Service benefits to assist providers and support staff who are working directly with members enrolled in these plans.



Member outreach for supplemental benefits

We encourage providers to become familiar with the supplemental benefits available to members so they can help support these programs with their patients. Members are able to initiate participation in supplemental benefits. Additionally, in some cases, our supplemental benefit partners do reach out to members to ensure that they are taking full advantage of their benefits which may prompt questions about the legitimacy of these calls. Our vendors identify themselves when contacting members and will not ask for personal information beyond what is necessary to serve the member.

We have contracted with Papa, a company that connects screened and trained staff (called Papa Pals) with members needing assistance with transportation, meal preparation, house chores, technology lessons, companionship and other senior services. Papa staff calls eligible members to offer services and match members based on shared interests and communication style. If members are concerned about the legitimacy of the call they receive from Papa and would like to take advantage of services, they can call Papa directly at **888-840-1609**.

We've already heard positive feedback from our members on the Papa program:

"I enjoyed the help and how she did everything I needed. She did a great job helping with my tech needs, setting up my computer and new tablet. I am happy to have her as my preferred Pal," said one member.

"I was impressed, the Pal was delightful, helpful and incredible with helping with my tech issues as well as the conversation we had during the visit. I would definitely like to have her again," said another member.

Point of Service Benefit

Some of the 2021 Medicare Advantage plans include a Health Maintenance Organization (HMO) benefit with a Point-of-Service (POS) benefit. Under the HMO benefit of the plan, members have access to providers in the health plan's provider network. Under the POS benefit members may also seek out-of-network care from any provider licensed/certified to accept Medicare patients and willing to provide them services.

Members with a POS benefit do not need an authorization or referral to see an out-of-network provider; however, the out-of-network provider may require the member to obtain a referral from their primary care provider under their HMO benefit before they will provide services under the member's POS benefit.

While Medicare Advantage plans with a POS benefit offer members flexibility in where they can seek their care, members may have a richer benefit under the HMO benefit of their plan and generally will incur higher out-of-pocket costs if they choose to pursue care under the POS benefit.

The following WellFirst Advantage plans include a POS benefit:

- Integrity
- Harmony

Look for the shortened plan name (e.g., Harmony, Integrity, etc.) and "HMO/POS" on member ID cards for those members enrolled in a plan option with a POS benefit.

Go to the **Medicare Advantage Provider Manual** and refer to the **WellFirst Health Medicare Advantage 2021 additional benefits** web page for more details on all the benefits available to members this year. ⊕

Follow-Up Care for Children Prescribed ADHD Medication

Managing attention-deficit/hyperactivity disorder (ADHD) doesn't end with a medication and treatment plan. Although an adult or child with ADHD may be thriving at home, in school, and with friends, he or she needs ongoing care to live well with the condition. ADHD is one of the most commonly diagnosed and extensively studied childhood behavioral health disorders.

ADHD follow-up care is monitored by NCQA using the Healthcare Effectiveness Data and Information Set (HEDIS*). The goal is to ensure children, ages 6-12 have at least three follow up visits within 10 months when they are newly prescribed ADHD medication or returning to a prescription after a break of four or more months. Visit timelines are:

- 1 Visit within 30 days of new prescription, with a prescriber
  - Can be a telehealth, telephone or face to face visit
- 2 additional visits in the following nine months, with any practitioner
  - One of which can be a telehealth or telephone visit

A few recommendations to improve follow-up visit compliance:

- If you prescribe ADHD medication, consider limiting the first prescription to a 30-day supply.
- Consider not refilling unless follow-up appointments are kept.
- Schedule follow-up appointment(s) before they leave the office.
- Discuss the importance of follow-up appointments with the parent/guardian.
- Educate the parent or guardian that the child must be seen within 30 days of starting the medication to evaluate if the medication is working as expected and assess any adverse effects.
- Verify the parent or guardian understands the requirement above and keeps the appointment for refill prescriptions.

Tips for Talking with Patients about Safe ADHD Medication Use:

- Educate families on the expected response to the medication, known side effects and potential adverse effects.
- Advise parents to lock all medications in a safe place, and to have a responsible adult directly monitor administration whenever possible.
- Avoid sharing this, or any medication with others.
- Provide education on taking medication as prescribed, including what to do if a dose is missed, and when to call the provider.

Discuss the signs and symptoms of stimulant misuse, including under and overuse:

- Lack of expected therapeutic response, especially after achieving a target dose and clinical stability.
- Unexpected increased arousal, irritability, decreased appetite, sleep changes, hyperactivity or behavioral changes.
- School reports of new or unexpected behavioral and/or academic performance concerns.
- Running out of medications early; unexplained new possessions or access to spending money.
- Monitor patterns of "lost" medications and early refill requests by parents of children on stimulant medications as diversion does occur within the patient home as well.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

The Importance of Mental Health Screenings

According to the National Alliance on Mental Illnesses (NAMI), early mental health screenings can lead to early detection and treatment of mental health concerns – leading to better health outcomes. NAMI also found that early treatment may lesson long-term disability and prevent years of patient suffering.

If a screen is positive, it is essential to have the capability to ensure effective treatment and appropriate follow-up. It's equally essential to coordinate care with a behavioral health provider.

A mental health patient self-screen can be found here: screening.mhanational.org/screening-tools/.

Having a well-rounded patient-centered mental and physical health approach not only improves quality of care but can also enhance the quality of life for many patients.

Referring to Telepsychiatry

Telepsychiatry appointments may be available to your patients. In some areas, a primary care provider referral is needed. Search our directory at wellfirstbenefits.stet/find-a-doctor to find a psychiatry or behavioral health provider in your area.

Screening Helps Prevent Unnecessary Maternal Deaths

Maternal death rates are higher than previously thought, though most are preventable. The rate of death for women in the US (2008-2017) during pregnancy, delivery and up to 1-year postpartum was 32%, according to a study released by the Centers for Disease Control (CDC) in February 2020. The finding was significantly higher than previous studies have indicated.

One explanation for the difference in findings is that previous studies pulled data from death certificates only, which did not accurately capture deaths caused by maternal suicide or drug overdose. The new CDC study includes data from death certificates as well intensive case reviews conducted by state maternal mortality review committees. This shines a new light on the high prevalence of maternal deaths due to mental health conditions, and how such causes have historically been overlooked.

According to the study, a mental health disorder resulting in suicide or drug overdose was the leading underlying cause of maternal death among non-Hispanic White women (14.9%). The top causes of death varied by

race and ethnicity. By comparison, the two underlying causes of pregnancy-related deaths among non-Hispanic Black women were cardiomyopathy (13.9%) and cardiovascular conditions (13.9%).

After examination of all deaths in the study, it was determined that 2 out of 3 were preventable. There was no significant difference in the percentages of preventable deaths between non-Hispanic Black and non-Hispanic White women nor between Hispanic and non-Hispanic White women.

Screening for mental health disorders at OB appointments is an effective way to identify at-risk women and potentially prevent unnecessary deaths. Current national standards-of-care recommendations now include regular mental health screenings throughout the pregnancy and postpartum periods, using evidence-based tools such as the Edinburgh Postnatal Depression Screen (EPDS) or Patient Health Questionnaire (PHQ-9). These formal, scored depression screenings are covered benefits under WellFirst Health.

Postpartum Support International (PSI) recommends performing patient screenings in the clinic setting at the following intervals:

- First prenatal visit
- At least once in second trimester
- At least once in third trimester
- Six-week postpartum obstetrical visit (or at first postpartum visit)
- Repeated screening at 6 and/or 12 months in OB and primary care settings
- 3, 9 and 12-month pediatric visits
- Rescreen any time there is a concern by the patient or patient's family about the patient's ability to function

Additionally, a study published by the *American Journal of Obstetrics and Gynecology* (AJOG) in June 2019 concluded that 74% of mothers in the study that died by suicide or drug overdose within 1 year of giving birth had 1 or more emergency room or inpatient hospital admissions between times of delivery and death. This indicates that screening in the hospital setting in addition to routine clinic visits may serve as a point of identification of these high-risk women as well.

Resources for providers

The Periscope Project (Perinatal Specialty Consult Psychiatry Extension): Free provider-to-provider perinatal psychiatry teleconsultation:

- *Enrolled providers have access to consult with a perinatal psychiatrist via the provider line **877-296-9049**.
- Within 30-minutes, a perinatal psychiatrist will contact the inquiring provider at the number provided. **On average, the response time is less than 9 minutes.**
- The providers will have a case-based conversation. The perinatal psychiatrist will offer evidence-based education and recommendations to the provider based on the information provided during the conversation.
- Staffing perinatal psychiatrists are certified by the American Board of Psychiatry and Neurology in Psychiatry with clinical experience in perinatal psychiatric settings.

*Providers can enroll with The Periscope Project at **the-periscope-project.org**.

WellFirst Health/Care Management: OB and Behavioral Health nurse case managers, social workers and program outreach specialists can help patients navigate the health care system, locate community resources and coordinate care to meet individual needs to help achieve optimal health outcomes. Our certified lactation counselors can provide the support moms need to be successful with breastfeeding and pumping.

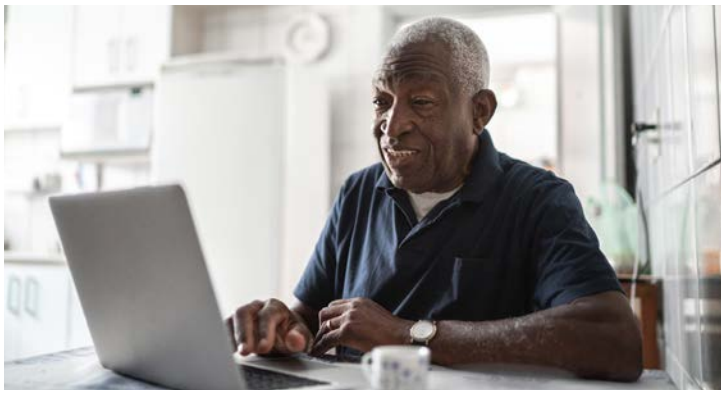
Providers can call our Care Management Provider Referral Line at **800-356-7344, Ext. 4132.**

Members can receive more information or self-refer by calling Strong Beginnings at **1-800-356-7344, ext. 5908** or by visiting **wellfirstbenefits.com/strong beginnings**.

Tips for Submitting Prior Authorization Requests

Help us help you get the fastest service

Submitting a complete prior authorization request lessens the chance that the health plan will have to follow up for additional information before rendering a determination and can expedite approval for increased member satisfaction.



Please consider these tips when submitting a prior authorization request:

- Submit your prior authorization requests through the Provider Portal whenever possible. The portal promotes efficiencies in business and streamlines electronic transactions. Register for a Provider Portal account from the WellFirst Health **Account Login web page**. See the *"Get to Know your WellFirst Health Provider Portal!" article in this issue.*
- Always provide a contact name and phone number with the request in the Additional Information field in the portal or on the fax cover sheet so we can reach out with questions, if needed.
- Note what is specifically being requested in the Additional Information field in the portal or on the fax cover sheet. For example: Left L4 SNRB, please see notes from office visit on August 31, 2019.
- Include all relevant clinical documentation at the time of submission if we do not have access to your electronic medical records (EMR). This will prevent us from having to reach out to you for documents which can cause delays in the determination review.
- Include dates of office visits, previous procedures, etc. if relevant to the request; note any specific dates in the EMR and/or on the paper documentation that support the request. Refer to the **WellFirst Health document library** to review Health Plan Medical Policies. These documents outline the criteria being reviewed and will help to identify what documentation to submit along with the request.
- Indicate if this is a member request or a physician request.
  Examples:
  - "Request is for John Doe to continue services with ABC Transplant Services through December 31, 2021. Has current authorization to ABC Transplant through December 31, 2020. Kidney transplant on 6/15/2018. Please contact Mary Jones at 888-888-8888 for any questions related to this request. This is a physician request."
  - "Request is for Jane Doe to see Dr. Jones at XYZ Clinic Cardiology. This is a member request. Please see XYZ Cardiology note dated 12/1/2020 for additional information. Please contact Mary Jones at 888-888-8888 for any questions related to this request."
  - "Request is for endovenous laser ablation (EVLT) of both right and left greater saphenous vein. See Vascular Surgery note dated 12/1/2020 and ultrasound report dated 11/15/2020 for additional information. Please contact Mary Jones at 888-888-8888 for any questions related to this request."
- We contract with other entities for prior authorization of certain services, such as Navitus/ Navi-Gate for authorization of medical injectables and NIA Magellan Healthcare for authorization of physical and occupational therapy, certain high-end radiology services and musculoskeletal services. These requests should not be submitted to the health plan. To verify where a prior authorization request should be submitted, refer to the Master Services List (MSL) and the Medical Injectables list on the **WellFirst Health Medical Management page**.

New Video Promotes Advance Care Planning

Discussing end-of-life care is never an easy conversation but a new health plan video helps explain why taking the time to do so could be the most important decision of a patient's life. The video resource is available in coordination with National Health Care Decision Day on April 16, 2021.

Russ Hermus, MD

"Most patients are very receptive to thinking about it, to hear about it," according to Russ Hermus, MD, a WellFirst Health Medical Director who has endorsed the presentation. "We provide the forms to patients, then I would say 75% take the forms home and never do it. They don't get around to it."

Dr. Hermus, a WellFirst Health Medical Director, hopes the 25-minute video will inspire patients to act. He urges colleagues to recommend patients watch it by searching Advance Care Planning (ACP) on **wellfirstbenefits.com**.

The common misconception is that ACP is primarily for the elderly or terminally ill. The reality of life's journey, however, suggests we're all better when prepared than not. While older patients are more likely to be involved in situations where they lose their ability to communicate, sudden illness or accidents can happen to anybody of any age.

The importance of every adult discussing his or her wishes and signing the appropriate documents is clearly explained in the video presentation. It features Therese Morrissey, a social worker who specializes in this area. She walks through all of the major considerations and makes the process understandable and easy to complete.

"Advance Care Planning is extremely important," said Dr. Hermus. "It's the thing we really need to have and hope we never need, like insurance. When it's done and done well, it makes very difficult situations much easier for the family members who have to make those decisions."

Advance Care Planning may well be patients' most important insurance plan, and one that doesn't even require a premium. ⊕

Provider Network Consultant Embraces Working with Providers

Regina Spruill

Her previous work experience has prepared Regina Spruill for her current role as a Senior Provider Network Consultant (PNC). Regina joined the WellFirst Health PNC team last year and sees similarities in what she does now to her past experience. "My PNC role here is close to identical to what I was doing before," said Regina. "I was the Provider Reimbursement Specialist, but it really was a liaison role as I worked with configuration and contracting as well resolving provider claim issues."

Regina enjoys being part of the close-knit PNC team, a team that has been heavily involved in provider outreach and training, as WellFirst Health continues to introduce new markets and products. [See the above article titled "We are Growing."] "Working closely with the other PNCs allows me to stay abreast of updates and changes," Regina said. "We all work very well together."

Even more so, Regina enjoys her interactions with WellFirst Health providers and draws on her experience to support them. Her goal is for providers to have positive experiences with the Health Plan and she understands how that can affect their interactions with members. "I want providers to have the answers they need so that our members are supported as well," Regina said.

Contact the WellFirst Provider Network Consultant Team at **314-994-6262** or **ProviderRelations@wellfirstbenefits.com**. ⊕

Asthma: Are Your Patients Overdue for Action Plan Review?

Many studies indicate that regular follow-up visits, with patients of all ages, reduce the risk for asthma exacerbation requiring hospital admission. This is consistent with guidance from national expert groups including the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health, and the American Academy of Pediatrics (AAP).

AAP practice guidelines specifically recommend regular follow-up for children diagnosed with asthma. These visits should occur at least every 3-6 months depending on symptom severity. These groups also recommend that every asthma patient have an asthma action plan.

A key purpose of these follow-up visits is that patient asthma action plans be reviewed and updated at least once each year. [See the link at the end of this article for a downloadble template for an action plan.] In patients for whom a controlled medication is indicated, it is also important to educate them on the importance of managing their asthma with the combination of controller and rescue medications vs. solely relying on their rescue inhaler.

Talk with patients about setting asthma goals, such as

- Going most days of the week without symptoms: asthma is considered under control if there are symptoms on two days a week or less that require use of a rescue inhaler
- Preventing asthma attacks, which could result in needing emergency care, by limiting exposure to known asthma triggers

Discuss importance of the combination of long-term and rescue asthma medicines in controlling asthma.

Example of an Asthma Action Plan for patients

When you're in the "**Green Zone**," you're doing well. You should:

- Have no coughing, wheezing, chest tightness, or difficulty breathing
- Be able to work, play, exercise, or do your everyday activities with no symptoms
- Have a peak-flow reading 80 to 100 percent of your personal best

When you're in the "**Yellow Zone**," you should take caution. This means you are:

- Coughing, wheezing, feeling tightness in your chest, or having difficulty breathing
- Able to do some, but not all, usual activities
- Waking up at night due to asthma
- Getting 50 to 79% of your personal best when you use your peak flow meter

When you're in the "**Red Zone**," contact your health care

provider immediately. If you cannot reach him or her, go to the nearest emergency department or call 911. This means you are:

- Very short of breath
- Having problems walking or talking due to asthma symptoms
- Not responding to quick-relief medicines
- Experiencing symptoms that are the same or getting worse after 24 hours in the "Yellow Zone"
- Getting a peak-flow reading less than 50% of your personal best

Action plans can be downloaded from **Regional Asthma Management & Prevention (RAMP)**. RAMP is a project of the Public Health Institute.

Visit **nhlib.nih** or **pediatrics.aappublications.org** to learn more.

Foodsmart- Healthy food has never been more important

Last year, WellFirst Health partnered with Foodsmart to offer a variety of tools to our members to create personalized solutions that address a wide variety of nutrition challenges. From education to customized meal planning and convenient grocery ordering, Foodsmart empowers users to reclaim their time, save money and improve their health. Members can sign up for FREE **wellfirstbenefits.com/foodsmart**.

Key Features:

- Nutrition Assessment based on National Institutes of Health research
- Customized meal planning for members and their families
- Meal plans and recipes integrated with online grocery ordering through Walmart, Amazon Fresh and Instacart
- CookItNow - cook recipes based on ingredients on hand
- Prepared meal kits or frozen meal delivery

For more information, visit Foodsmart online via **wellfirstbenefits.com/foodsmart**.

Spring 2021 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, visit **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 **866-514-4194**.

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 WellFirst Health Health Services Division is required for some treatments or procedures.

Prior authorization requirements for Self-funded plans (ASO) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

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

Radiology:
Providers may contact NIA by phone at **866-307-9729**, Monday-Friday from 7 a.m.-7 p.m. CST or via **RadMDSupport@MagellanHealth.com**. View details about the **radiology prior authorization program** on **wellfirstbenefits.com**.

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

General Information

- Fixed, semi-electric, and variable height hospital beds without side rails and/or mattresses require prior authorization.

Technology Assessments

Effective January 1, 2021, the following are considered experimental and investigational, and therefore not medically necessary:

- Breast CT including 3D rendering
- Computed Tomographic Angiography (CTA), coronary atherosclerotic plaque
- Cryoablation nasal tissue and/or nerves
- Intravertebral body fracture augmentation with implantable DME
- Neurostimulator generator (implantable) with carotid sinus baroreceptor stimulation lead
- Percutaneous AVF creation by tissue approximation using thermal resistance energy (e.g., Ellipsys)
- Percutaneous injection of allogenic cellular and/or tissue-based product, lumbar intervertebral disc
- Thermal anisotropy measurement and assessment of cerebrospinal fluid shunt flow (e.g., Flowsense)
- Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies

- Transcutaneous visible light hyperspectral imaging measurement (e.g., TransQ)
- WavelinQ endovascular AV fistula for hemodialysis

Revised Medical Policies

Effective December 1, 2020

Genetic Testing MP9012

Comprehensive, pan-cancer multigene next generation testing (e.g., Oncotype MAP Pan-Cancer Tissue Test) is considered experimental and investigational, and therefore not medically necessary.

Transport of Members (Ambulance) MP9137

Planned ground ambulance transport does not require prior authorization when a member is discharged from an acute inpatient facility to home or residence (e.g., skilled nursing facility). An ambulance may be utilized for transport in lieu of a stretcher van if a stretcher van can't be arranged in a timely manner.

High Frequency Chest Compression MP9235

High frequency chest compression is considered medically necessary for immotile cilia syndrome, bronchiectasis (not due to cystic fibrosis) and chronic neuromuscular disease.

Genetic Testing for Pharmacogenetics MP9479

FoundationOne CDx is considered medically necessary to identify advanced cancer in solid tumors which are tumor mutational burden-high and are appropriate to treat with KEYTRUDA (pembrolizumab). Testing is also considered medically necessary for women with epithelial cancer, fallopian tube or primary peritoneal cancer when treatment with RUBRACA (rucaparib) is being considered or for men with advanced, recurrent or metastatic prostate cancer who have been treated with androgen-receptor directed therapy and a taxane-based chemotherapy. Prior authorization is not required.

FoundationOne CDx is considered not medically necessary, and therefore not covered for the following: Assessing candidacy of persons with non-small cell lung cancer for treatment with TAGRISSO (osimertinib) or IRESSA (gefitinib) or for persons with prostate cancer who are being considered for treatment with RUBARCA (rucaparib).

Somatic Tumor MP9486

Cutaneous melanoma gene expression profiling is considered experimental and investigational, and therefore not medically necessary (e.g., DecisionDx-Melanoma, myPath Melanoma). Uveal melanoma gene expression profiling is considered medically necessary for risk stratification in members with localized uveal melanoma (e.g., DecisionDx-UM). Prior authorization is not required.

Whole Exome and Genome Sequencing MP9548

Whole exome sequencing (WES) testing in the general population is considered not medically necessary, and therefore not covered.

Effective January 1, 2021

Port Wine Stain Laser Treatment MP9207

Treatment of lesions located on the face, neck, trunk or extremities is considered medically necessary. Prior authorization is required.

Services Related to Dental Care MP9271

Prior authorization is dependent on applicable laws and provisions per state as outlined in the member benefit certificate or summary plan description. Hospital, ambulatory surgical treatment center and office charges related to dental procedures and/or general anesthesia for dental care do not require prior authorization when indicated in the member's benefit certificate or summary plan document. Unless specifically indicated in the member certificate or summary plan description, anesthesia for dental procedures and/or hospital, ambulatory surgical treatment center and office charges require prior authorization and are considered medically necessary if the member meets any of the following (not an all-inclusive list): member is severely disabled; conscious sedation would be inadequate or contraindicated; the member has a medical or behavioral condition that requires hospitalization or general anesthesia for dental care, such as those individuals with an American Society of Anesthesiologists (ASA) Physical Status Classification of P3 or greater; the member requires extensive dental procedures with a medical history of uncontrolled bleeding, severe cardiac or respiratory conditions or another medical condition that renders in-office treatment not medically appropriate.

Effective February 1, 2021

Limb Prosthesis MP9103

Above or below the knee prosthesis socket insert (either custom or prefabricated from an existing mold made of silicone gel for use with locking mechanism) is limited to two (2) inserts per twelve months per prosthesis. Prosthetic sheath/sock (including a gel cushion layer) for use below or above the knee, is limited to a quantity of twelve per twelve months per prosthesis.

Refractive and Therapeutic Keratoplasty MP9461

Phototherapeutic keratoplasty requires prior authorization.

Spring 2021 Medical Policy Updates ... (continued)

Electroretinogram and Electroretinography (ERG) MP9542

ERG is considered experimental and investigational, and therefore not medically necessary for the following (not an all-inclusive list): diagnosis of psychiatric disorders and evaluation of rhegmatogenous retinal detachment. Pattern electroretinography is considered experimental and investigational, and therefore not medically necessary for the diagnosis of glaucoma and all other indications.

Effective March 1, 2021

Genetic Testing MP9012

Envisia Genomic Classifier (Veracity) gene expression analysis to determine the diagnosis of idiopathic pulmonary fibrosis utilizing transbronchial biopsies is considered experimental and investigational, and therefore not medically necessary.⊕

Spring 2021 Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

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 prior authorized** by sending requests to Navitus unless otherwise noted in the policy. Please note that most drugs listed below and with policies require specialists to prescribe and request authorization. It is encouraged all prescribers review the current policies.

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 current 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).

New Drug Policies

Blenrep (belantamab mafodotin-blmf) MB2012

Effective January 1, 2021, Blenrep, which is used to treat adult patients with relapsed or refractory multiple myeloma, will require a prior authorization. It is restricted to oncology prescribers.

Tecartus (brexucabtagene autoleucel) MB2013

Effective January 1, 2021, Tecartus, which is used to treat mantle cell lymphoma, will require a prior authorization. It is restricted to oncology prescribers

Monjuvi (tafasitamab – CXIX) MB2016

Effective January 1, 2021, Monjuvi, which is used to treat adult patients with relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from low grade lymphoma, and who are not eligible for autologous stem cell transplant (ASCT). Will require a prior authorization. It is restricted to oncologist prescribers.

Trogarzo (ibalizumab) MB2014

Effective February 1, 2021, Trogarzo, which is used to treat for the treatment of human immunodeficiency virus type 1 (HIV-1) infection in heavily treatment-experienced adults with multidrug resistant HIV-1 infection failing their current antiretroviral regimen, will require a prior authorization. It is restricted to infectious disease specialists.

Zepzelca (lurbinectedin) MB2015

Effective January 1, 2021, Zepzelca, which is used to treat adults with a kind of lung cancer called small cell lung cancer (SCLC), will require a

prior authorization. It is restricted to oncology prescribers.

Changes to Drug Policy

Antihemophilia Factors and Clotting Factors MB1802

Effective January 1, 2021, updated HCPCS code for Sevenfact to J7212. Prior authorization is required and is restricted to a hematology specialists.

DARZALEX (daratumumab) MB1832

Effective January 1, 2021, updated HCPCS code for Darzalex Faspro to J9144. Prior authorization is required and is restricted to oncology prescribers.

ORENCIA (abatacept) IV Formulation MB9457

Effective January 1, 2021, updated to change preferred agent from Cosentyx to Taltz. Prior authorization is required and is restricted to rheumatology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective January 1, 2021, updated with multiple indications to match FDA-label indications/updates (CHL, PMBCL, Urothelial Carcinoma, Triple Negative Breast Cancer). Prior authorization is required and is restricted to oncology prescribers.

Pertuzumab Products (formerly PERJETA & PHESGO) MB9438

Effective February 1, 2021, updated HCPCS Code for PHESGO to J9316. Prior authorization is required and is restricted to oncology or hematology prescribers.

Scenesse (afamelanotide) MB2002

Effective January 1, 2021, updated HCPCS code to J7352. Prior authorization is required and is restricted to a porphyria specialists who has completed training for Scenesse.

Trastuzumab Products MB1805

Effective February 1, 2021, updated HCPCS Code for PHESGO to J9316 and removed Kanjinti from preferred list. Prior authorization is required and is restricted to oncology or hematology prescribers.

Trastuzumab Products MB1805

Effective April 1, 2021, updated HCPCS Code for PHESGO to J9316 and removed Kanjinti and Ogivri from preferred list. Prior authorization is required and is restricted to oncology or hematology prescribers.

TRODELVY (sacituzumab govitecan) MB2009

Effective January 1, 2021, updated HCPCS code to J9317. Prior authorization is required and is restricted to oncology prescribers.

Immune Globulin MB9423

Effective May 1, 2021, added dose rounding statements. Prior authorization is required and is restricted to medically appropriate for the treatment of the following indications when the listed criteria have been met.

NUCALA (mepolizumab) MB9914

Effective February 1, 2021, updated criteria to Navitus prior authorization document. Prior authorization is required and is restricted to hematology, pulmonology, or immunology prescribers.

Pegfilgrastim and biosimilars MB1808

Effective February 1, 2021, addition of non-preferred biosimilar Nyvepria. No prior authorization is required for the preferred products (Fulphila and Ziextenzo) but products must be prescribed by a hematologist or oncologist.

SIMPONI ARIA (golimumab) MB9874

Effective February 1, 2021, updated preferred product from Cosentyx to Taltz and updated age limits for indications to language found in package insert. Prior authorization is required and is restricted to rheumatology prescribers or gastroenterology prescribers.

Xolair (Omalizumab) MB9309

Effective February 1, 2021, addition of indication of chronic rhinosinusitis with nasal polyposis. Prior authorization is required and is restricted to immunology, pulmonology, otolaryngology, or dermatology prescribers.

Actemra-IV (tocilizumab) MB9405

Effective March 1, 2021, addition of indication for sub-que formulations. Prior Authorization is required and is restricted to rheumatology prescriber.

Benlysta IV (belimumab) MB1820

Effective March 1, 2021, addition of indication for 200 mg supplies and NDC codes. Prior Authorization is required and is restricted to rheumatology or dermatologist prescriber.

Botulinum Toxin MB 9020

Effective March 1, 2021, removal of seven criteria under Anal Fissure (No inflammatory bowel disease, no hemorrhoids, no HIV disease, no anal fistula, no perianal abscess, no perianal cancer, and no previous perianal surgery). Prior Authorization is required.

Enhertu (fam-trastuzumab deruxtecan-nxki) MB2007

Effective March 1, 2021, addition of indication under Unresetcable or metastatic HER2-positive cancer. Prior Authorization is required and is restricted to oncology prescriber.

Entyvio (vedolizumab) MB9453

Effective March 1, 2021, removed requirement of adult age. Prior Authorization is required and is restricted to gastroenterology prescriber.

INFLIXIMAB Infusions MB9231

Effective June 1, 2021, added unit limits of up to 68 units per date of service when the member age is less than 18 years and the diagnosis is pediatric regional enteritis (Crohn's disease). Prior Authorization is required and is restricted to dermatology, rheumatology or gastroenterology specialists.

LUPRON-ELIGARD (leuprolide) MB1842

Effective June 1, 2021, added J1950 coverage is limited to three combined units in 12 weeks when the diagnosis on the claim is benign prostatic hyperplasia, breast cancer, endometriosis, premenstrual syndrome, or uterine leiomyomata. Prior Authorization is not required and is restricted to oncology, urology, OBGYN, internal medicine, family medicine, or pediatrics specialists.

ONCASPAR (pegaspargase) MB1903

Effective March 1, 2021, removed continuation criteria that is not applicable (renewal authorization will only be allowed for the max duration of use specific to the indication being treated.) Prior Authorization is required and is restricted to oncology or hematology prescriber.

PROLIA, XGEVA (denosumab) MB9409

Effective June 1, 2021, added maximum of one administration and office visit per month for use in multiple myeloma or bone metastases. Approval duration for initial and renewal authorizations reduced to one year, subject to formulary changes. Prior authorization is required and is restricted to oncology, rheumatology, internal medicine, family medicine, orthopedic surgery, or endocrinology prescribers.

RITUXIMAB-CONTAINING PRODUCTS MB9847

Effective March 1, 2021, addition of new drug Rabni, J Code J999, coverage of RITUXAN or RIABNI requires a failed trial or contraindication of both TRUXIMA and RUXIENCE unless otherwise noted. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

FASENRA (benralizumab) MB1813

Effective March 1, 2021, updated criteria to Navitus prior authorization document. Prior authorization is required and is restricted to pulmonology allergy, or immunology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective March 1, 2021, removal of duplicate indication of PMBCL. Prior authorization is required and is restricted to oncology prescribers.

RADICAVA (edaravone) MB9948

Effective March 1, 2021, updated criteria from 'one of the following' to 'all of the following.' Prior authorization is required and is restricted to neurology prescribers.

Online Educational Tool Available for Providers to Share with Patients

WellFirst Health offers free online educational programs that all our in-network providers can use to further educate their patients. Emmi® is a series of evidence-based online programs that walk patients through important information about a health topic, condition or procedure. In-network providers can sign up for an account through WellFirst Health and then send interactive educational content directly to their patients via email.

Members enrolled in any WellFirst Health product are eligible to access Emmi®. By clicking the link in the email sent by their provider, members will be prompted to create a login to access the content. Each program runs from 15-30 minutes. Members can watch at their convenience and refer back as often as they wish.

To sign up for a provider account, contact Emmi customer support by calling 866-294-3664 or via support@my-emmi.com.

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.

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**.

Unbundled Modifier Claim Review

Effective July 1, 2021, WellFirst Health will evaluate claims submitted with unbundling modifiers 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 59, 79 and 24.

The guidelines for the correct use of unbundling 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 National Correct Coding Initiatives (NCCI) manual. 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 NCCI.

This review is designed to not only promote accurate claims payment for the provider, but to ensure appropriate cost share is applied to our member claims.

Get to Know your WellFirst Health Provider Portal!

Get the most from your WellFirst Health provider portal interactions with these grab and go tips!

Provider portal access and login

Individuals must have an established account under their organization in order to log in and have access to the WellFirst Health Provider Portal features and applications.

1. *When is portal access approved?*
Individuals receive a confirmation email once they complete online registration; however, this is not final approval for portal access. Portal access is granted once registration information is reviewed and approved by the organization's Portal Site Administrator. At that time, a second email is generated confirming portal access.

2. *Forget your password?*
Click the **Need help signing in?** link at the bottom of the Portal Sign In screen. Then, click the **Forgot Password link?**

3. *What is your username?*
Your username is the email address that you used to create your Individual provider portal account.

4. *Still experiencing login issues?*
Please consider the following when troubleshooting login issues:

- Always use internet browser Google Chrome for optimum performance when using the Provider Portal.
- You may need to adjust your Chrome cookie settings.
- Consult with your IT department before adjusting settings or to identify any internal barriers that may affect your portal access.

Portal Administration of NPIs and TINs

1. *Who can request to have NPIs and TINs added to a portal account?*
Portal Site Administrators can submit requests to WellFirst Health to add NPIs and TINs to portal accounts for their organization. Please consider the following before submitting a request:

- Is the NPI or TIN appropriate to be added to the account? NPIs and TINs must be associated to the organization and covered under the provider contract with the health plan.
- Is the NPI or TIN related to those already included in the account? If not, this is an indication that it should not be added to the account. While the same TIN can be added to multiple accounts for organizations with non-centralized billing practices; consider the applicability of the addition to the account.

Ex: If an organization has an account for its hospital billing and another for its clinical billing, consider these separate lines of billing. Is an NPI that is used for the hospital billing appropriate to be combined with the clinical billing for the organization?

- Is the NPI already under an Organization account? If so, it will not be approved to be added to another Organization account.
- Will adding the TIN create a duplicate account?
- Is the NPI or TIN assigned to an out-of-network organization? If so, it will not be approved to be added to an in-network organization's account.
- Is the addition related to a third-party biller? Third-party billers should be added as an Individual account under each applicable Organization account and used for that organization only. Third party billers should not be using one account for multiple organizations.

2. *How can requests be submitted?*
Portal Site Administrators can submit requests to add NPIs and TINs through the Provider Admin application.

3. *What happens after a request is submitted?*
WellFirst Health reviews the request and will contact the Portal Site Administrator if more information is needed. Decisions are sent through the secure Notifications feature, available from the portal Home Page.

Account Settings and Notification

Account setting options can be used to toggle between multiple portal accounts or to update user information. The Notifications feature tracks recent account updates as well as houses health plan acknowledgements and decisions related to specific portal submissions.

1. *How to navigate between multiple accounts?*

Users with access to more than one portal account for their organization can navigate between accounts without having to log out of one account and then log in to another.

- Through the **Provider Selection** option, available under the **Settings** dropdown located at the top of the Provider Portal home page, select **Change Provider ID**.
- The Organization Details box will appear. From the **Entity** dropdown, select the desired entity and applicable Tax Identification Number (TIN) and National Provider Identifier (NPI) from the dropdowns. The selected TIN and NPI will display in the green "banner" above the applications. (Users can only select a TIN and NPI that is registered under the Entity that is first selected and will only have access to information available on that account.)
- Click **Save Changes** once completed.

2. *How to update user information?*

- Through the **Provider Selection** option available under the **Settings** dropdown located at the top of the Provider Portal home page, select **Account Settings**. This allows users to update their Individual Account Profile including changes to usernames, password, name, opt in preference, and multi-factor enrollment.
- Click **Save Changes** once completed.

4. *What is the Notifications feature?*

The Notifications page stores communications that are delivered through the provider portal, including updates to account access, claim appeals letters (both acknowledgement and decision notices), and past and present flash messages.

At Your Own Pace

Get more portal information from our available provider resources:

- **Registration User Guide** — Details the registration process to create individual and organization Provider Portal accounts.
- Provider Portal User Guide — Details how to use the Provider Portal applications and is available in the secure portal.

*If you need further assistance, please contact a WellFirst Health Provider Network Consultant at **314-994-6262** or **ProviderRelations@wellfirstbenefits.com**.*

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** and will also be provided in writing upon request. Written copies can be obtained by contacting WellFirst Health (**866-514-4194**) and requesting that a copy be mailed or faxed to you.

WellFirst Health also licenses MCG Guidelines, which are nationally recognized evidenced- based guidelines for medical necessity determinations. The specific MCG Guideline utilized in making a denial determination is available upon request by contacting WellFirst Health and requesting that a copy be mailed or faxed to you.

Care Management Takes Health Insurance to the Next Level

Patients are often surprised to hear that a health insurance company would assist in areas that are not directly related to coverage issues. An example would be a social worker employed by WellFirst Health helping a homeless member find housing.

"I help patients apply for Foodshare and other government programs," explained Sarah Blake, one of those social workers. When she entered the profession, did she expect to work for an insurance company?

"No!" says Blake with a laugh. "There is a moral structure here. A strong mission and values. Do the right thing," said Blake. "How do you care for the whole person?"

The health plan has free programs to support WellFirst Health members. When members have complex, acute or chronic health conditions, multiple emergency department visits or are frequently hospitalized, Care Management helps them get the care they need.

Our specially trained nurse case managers, social workers and support staff can help patients navigate insurance, find community resources or set goals to improve self-management of their health condition.

Having health coverage means helping members stay healthy, as well as dealing with the illnesses and health care situations that arise. That's why WellFirst Health has an array of professionals on our team.

Visit **wellfirstbenefits.com/wellness/care-management** to view our programs and resources. You can also refer patients to Care Management by calling **800-356-7344, ext. 4132**.

WellFirst Health *Provider News*

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Mission of *Provider News*

WellFirst Health publishes *Provider News* to facilitate good 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 contacts 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 the newsletter, or if someone in your organization is not on our mailing list, please contact a WellFirst Health Provider Network Consultant.

Formulary Management Procedures

The WellFirst Health drug formulary is reviewed every month. With the approval of newer generic entities, changes and updates are made on a regular basis. In addition to updating the formulary status of covered drugs, formulary restrictions are also modified as necessary. Here is an update of restrictions and limitations associated with the drug formulary:

Closed formulary. WellFirst Health employs a closed formulary. If a drug is not listed on the drug formulary, the product is not covered by the member's pharmacy benefit. If the member chooses a product not on the formulary, the member is responsible for 100 percent of the cost of the drug.

Mandatory Generic Substitution. If a drug is available in a generic version, WellFirst Health may require the use of the generic version. If the generic version of the drug is mandated and the patient chooses to receive the brand, the patient is responsible for the highest tier branded copay plus the ingredient cost difference between the brand and generic versions. If the patient's physician requests the branded version, the patient is only responsible for the highest tier branded copay.

Prior Authorization. When a drug is prior authorized, the physician must receive approval prior to prescribing the drug. The list of prior authorized drugs and the request forms are available on wellfirstbenefits.com.

Step Therapy. Step edits are often used within a therapeutic class to require generic or preferred drug use prior to a non-preferred drug. When a step edit is in place, the member must have trialed therapy with a preferred drug(s) prior to receiving approval for the non-preferred drugs. Step edits are completed point-of-service at the pharmacy, and there are no prior authorization requirements.

Specialist Restrictions. Specialist restrictions limit the prescribing of a drug to a unique specialty. These decisions are based on the indications and uses for the specific drug.

Quantity Level Limits. Quantity level limits restrict the supply of drug product that may be dispensed either per prescription or per a specific amount of time.

Specialty Pharmacy. If a drug is available or mandated to be dispensed by a specialty pharmacy, the specialty pharmacy designation will be applied.

A complete listing of the all WellFirst Health pharmacy resources, including the drug formulary, can be found at: wellfirstbenefits.com.

Spring 2021

Visit wellfirstbenefits.com

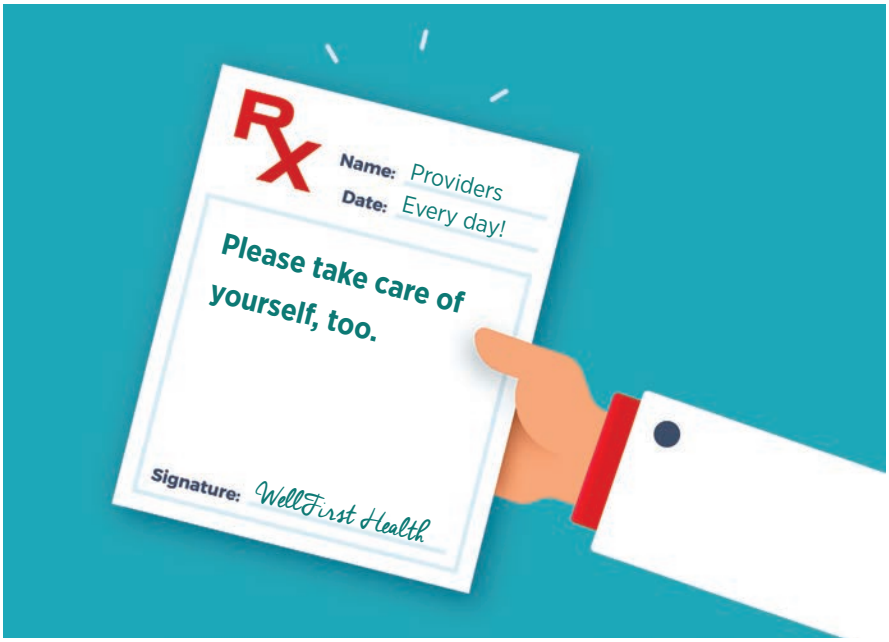
ACA Individual Customer Care Center
866-514-4194

Employee Health Plan Customer Care Center 877-274-4693
Monday –Thursday 7:30 a.m.-5 p.m.
Friday 8 a.m.-4:30 pm

877-301-3326 for Medicare Advantage
Monday – Friday, 8 a.m.-8 p.m.
Weekends: October 1 – March 31, 8 a.m.-8 p.m.

Contact a Provider Network Consultant

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



Provider Network Consultants

While online self-service resources and the Customer Care Center are your first sources of information, Provider Network Consultants (PNCs) are here to support our in-network providers with more in-depth inquiries.

WellFirst Health | SSMHealth

Provider Relations
12312 Olive Blvd., 4th floor
St. Louis, MO 63141

Visit **wellfirstbenefits.com**