Provider NEWS

WellFirst Health®

Fall 2023
A newsletter for WellFirst Health providers

Calling all providers! As we align with our partner Medica, we're gradually moving to new, long-term business platforms. Effective for dates of service on and after Jan. 1, 2024, Medica (formerly known as WellFirst Health) Individual and Family (IFB) plans (both Marketplace and direct) will move onto these platforms, with Commercial plans following in phases throughout 2024. We will be transitioning plans gradually so that providers can acclimate to changes involving smaller patient populations while continuing to use current platforms for other lines of business.

Look for articles marked with the small compass icon in this edition of *Provider News* for more information, as well as for resources and updates available on our Provider Communications web page throughout the year.

More for 2024

Announcing Availity as our new electronic data interchange (EDI) clearinghouse and provider portal vendor! Plus, what you should know about our new member ID cards and customer care phone numbers and technology.

EDI under our new payer ID

As part of our move to an updated claims processing platform, effective for 2024 dates of service for IFB plans, Availity will be our EDI clearinghouse for our **new payer ID 41822 – Medica/Dean Health Plan/Prevea360** for the following HIPAA transactions:

- 837 Health Care Claims: 837I (institutional) and 837P (professional) claim submissions
- 270/271 Eligibility & Benefit Inquiry and Response
- 276/277 Health Care Claim Status Request and Response

As an EDI clearinghouse, Availity will facilitate the transfer of electronic HIPAA transactions exchanged between us and providers under our new

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This Issue

New look and schedule for WellFirst Health Provider News
Starting in November 2023, the WellFirst Health Provider News will be released monthly under the Medica brand. This fall newsletter is the final quarterly edition. Expect the same information you receive from us quarterly, but packaged in our new monthly newsletter as Medica Provider News.

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payer ID. Check with your clearinghouse to see if they have connectivity with Availity to ensure that your organization will be ready to exchange transactions with us next year.

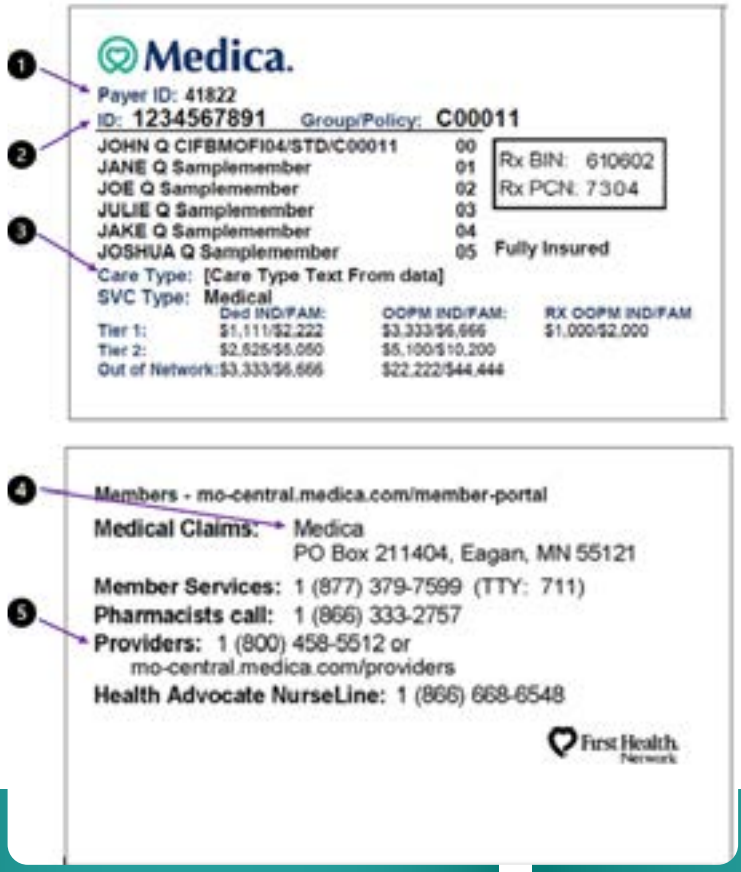
Coming soon - our Availity web page for payer ID 41822. This page will host links and information for all our health plans that fall under the Medica family which includes Dean Health Plan, Prevea360 Health Plan, and Medica (formerly known as WellFirst Health).

The current EDI transactions and payment services under our existing payer ID 39113 will continue to be used for all non-IFB plans initially.

Your essential tool- 2024 member ID cards

You'll use our new and existing platforms next year based on your patient's benefit plan. The Medica member ID card will help you find your way! Remind your patients to bring their member ID card with them to their appointments.

As plans are moved to our new business platforms under payer ID 41822, we will issue new member ID cards with new group numbers and member IDs. Obtaining an ID card from the patient will assist you in identifying which resources and systems apply to that patient. Here's what you'll see on those member ID cards:



1. Payer ID 41822 — associated to Availity's EDI Clearinghouse and Availity Essentials Provider Portal
2. Member IDs — members will be assigned 10-digits ID numbers starting with a "3"
3. Care Type — will list the member's benefit plan name
4. Paper claim mailing address — Medica, P.O. Box 211404, Eagan, MN, 55121
5. Provider Customer Care phone number — 1 (800)-458-5512

All 2024 cards will have the Medica logo. **There is a possibility that a patient may present a Medica branded Medicare Advantage card this year.** We will issue Medica branded member ID cards to new Medicare enrollees with 2023 effective dates or current members requesting replacement cards for this year. **This is a brand change only and you can continue to see your WellFirst Health (now Medica) patients and use our provider resources as you do today.**

Initially, the new formatted cards will be for IFB members only. As we move commercial plans to our new platforms under payer ID 41822 throughout 2024, new cards with the information listed above will be issued to those members.

Note that the member portal web address listed at the top of the backside of the new member ID cards will vary. The card image to the right shows the web address for Missouri. For Illinois it will be central.medica.com/login.

Introducing a new provider portal for 2024

We are gradually moving to a new provider portal and implementing functionality in increments. For dates of service on and after Jan. 1, 2024, we are migrating IFB business to the secure Availity Essentials Provider Portal. In some cases, interim processes may be in place to ensure Medica (formerly known as WellFirst Health) providers and their support teams can conduct business while future portal functions are being activated.

Availity Essentials will only be for IFB plans initially with Commercial plans following in phases throughout 2024. You must retain your accounts in the WellFirst Health Provider Portal for all other plans.

What is the Availity Essentials Provider Portal?

Availity Essentials is a secure, multi-payer portal for health care providers and their support teams to exchange administrative and clinical information with their payers.

Why the move to Availity Essentials?

As a multi-payer portal, Availity Essentials will streamline workflows as we implement additional functions and bring other lines of business onto the Availity platform in the future. Plus, many of our providers and their support teams already use Availity Essentials for other payers and are likely familiar with its features.

How will I get connected to Availity Essentials?

- If your organization uses Availity Essentials for another payer, our new payer ID 41822 will be added as an option to your dashboard. There's nothing you need to do.
- If your organization doesn't use Availity Essentials, visit the Availity Essentials web page.

How will I know how to use Availity Essentials functions?

To support your transition to Availity Essentials, Availity will provide reference guides and offer trainings later this year. Look for more information in the future.

We're moving this quarterly newsletter to monthy

Get ready for a new look and schedule for WellFirst Health *Provider News.*

Starting in November 2023, the WellFirst Health *Provider News* will be released monthly under the Medica brand. This fall newsletter is the final quarterly edition. Expect the same information you receive from us quarterly, but packaged in our new monthly newsletter as Medica *Provider News*.

Changing the newsletter to a monthly release will allow us to communicate timely information to you which will be especially important as we move to our new, long-term business platforms. Additionally, our new branding of the newsletter aligns with the WellFirst Health to Medica name change announced in August.

Our new Medica *Provider News* will be published on our Provider News web page.

Dialing in - new customer care numbers and automated phone technology to get the information you need

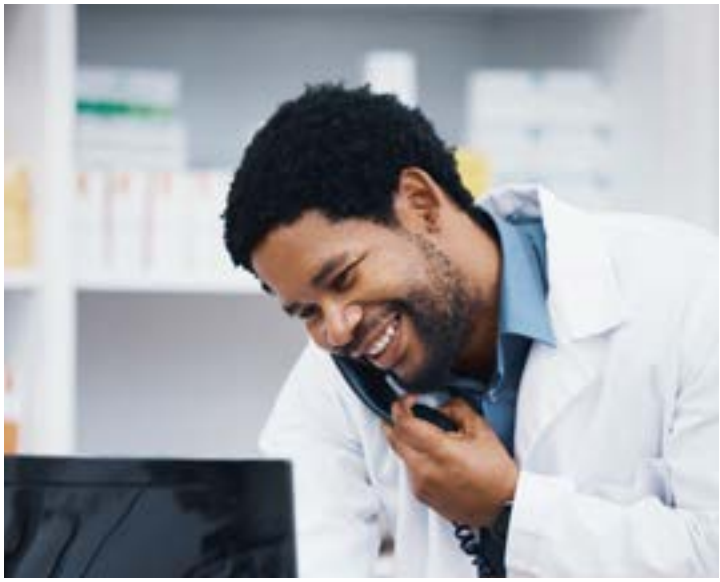
For business platforms under our new payer ID 41822, we are adding new customer care phone numbers, expanded hours, and automated phone system technology to support both providers and members.

Provider Customer Care

- **Starting Dec. 1, 2023, Medica (formerly known as WellFirst Health) providers can call 800-458-5512 for 2024 Individual & Family (IFB) plan inquiries.** Hours of operation will be Monday – Friday, 7 a.m. – 5 p.m. (Closed Mondays 8 – 9 a.m. for training.)
  - Initially, this phone number will replace the current 866-514-4194 number for IFB plan inquiries only for 2024 dates of service.
  - Current provider customer care phone numbers will continue to be in place and should be used for all 2023 dates of service inquiries, including 2023 IFB inquiries.
  - In the future, the 800-458-5512 number will also be the provider phone number for commercial plans for dates of service as they move to business under our payer ID 41822 throughout 2024.

Member Customer Care

- **Starting Oct. 2, 2023, Medica (formerly known as WellFirst Health) members can call 877-379-7599 for 2024 IFB inquiries.** Hours of operation will be Monday – Friday, 8 a.m. – 6 p.m. (Closed Thursdays 8 – 9 a.m. for training.)
  - This number will replace the current 866-514-4194 number for IFB inquiries only for 2024 dates of service and will be on our 2024 IFB member ID cards.
- Current member customer care phone numbers will continue to be in place and should be used for all 2023 dates of service inquiries, including 2023 IFB inquiries.
- As we move commercial products to payer ID 41822 throughout 2024, new member customer care phone numbers will be assigned, effective for dates of service as of when the member's plan moved to business under our payer ID 41822. The new member customer care phone number will be on re-issued member ID cards.



Introducing Interactive Voice Response

We are implementing an automated phone system technology, Interactive Voice Response (IVR), for our new customer care phone lines. The IVR system offers 24/7 self-service for member eligibility, benefits, or claims status information through pre-recorded prompts and menu options. You'll always have the option to exit the IVR and speak with a live call agent during business hours.

While the IVR call flow and prompts are designed to be intuitive, here are some initial tips for navigating our new **provider** customer care phone number when it goes live later this year:

✓ Be prepared to respond to IVR prompts by having the following ready when calling:
  - Your organization's 9-digit tax ID number. (Our current provider customer care numbers will still require NPI.)
  - The member's group and ID numbers that are effective for 2024.

✓ Be sure you are calling the phone number that aligns with your patient's benefit plan and date of service:

- IFB plans for 2023 dates of service (and therefore under payer ID 39113) – **866-514-4194**.
- IFB plans for 2024 dates of service (and therefore under payer ID 41822) – **800-458-5512**.

*For example, if you have a question regarding a patient enrolled in a Medica (formerly known as WellFirst Health) IFB plan, for a 2024 date of service, you will need to call **800-458-5512** and provide the patient's group and ID numbers effective for 2024.*

*If your question is regarding that same patient, but for a 2023 date of service, you will need to call **866-514-4194** and provide the patient's group and ID numbers effective for 2023.*

✓ Keep business hours in mind. A benefit of IVR for our new customer care phone numbers is the ability to conduct aspects of business after-hours; however, the option to speak with a live call agent will only be available during business hours.

Formulary management procedures

Our 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. We employ a closed formulary. If a drug is not listed on the formulary, the product is not covered by the member's pharmacy benefit. However, an Exception to Coverage request may be submitted if non-formulary medication is medically necessary.

Mandatory Generic Substitution. If a drug is available in a generic version, we 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 our Pharmacy services for health care providers web page.

Step Therapy. Step edits (when the Health Plan requires certain steps happen before approving a drug) are often used within a therapeutic class to require generic or preferred drug use prior to a non-preferred drug. When a step edit requirement is in place, the patient must have trialed therapy with a preferred drug(s) prior to receiving approval for the non-preferred drugs. Step edits are verified as part of the real-time 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 pharmacy resources, including the drug formulary, can be found on our Pharmacy services for health care providers web page.

Medicare Advantage Corner

Welcome to the Medicare Advantage Corner! This section of the newsletter highlights information and timely topics regarding our Medicare Advantage plans with drug (Part D) MAPD coverage.

2024 Medicare Advantage Plans Preview

Maintenance Drug Savings

In 2024, Medica Medicare Advantage members with Part D coverage can save money by filling prescriptions through our preferred retail pharmacy network or mail order pharmacy.

Effective Jan. 1, 2024, members will be eligible for:

- $0 copay for Tier 1 drugs for 30, 60, or 100 days supply when obtained from a preferred retail pharmacy.
- $0 copay for Tier 1 and Tier 2 drugs with 90-day or 100-day supplies when obtained through the Costco Mail Order Pharmacy Program.

Members don't have to be a Costco member to sign up for the mail order program. Refer to the mail order information on our website for more information about how a member can get their prescriptions through the mail order program, including a link to the online or paper enrollment form. Members can call Costco's customer care help line at 877-232-7566 (TTY:711) for assistance.

100-Day Refill Cycle

For 2024, we will continue to focus on helping members with Part D coverage stay on track with refilling their maintenance medications and help promote their medication adherence. Members will be able to receive a 100-day supply of their maintenance medications when filled through a pharmacy or mail order for Tiers 1, 2, 3, and 4 drugs. This means they will be able to get more medication at the same cost as a 90-day prescription and save one copay per year. Narcotics and Specialty medications are excluded.

To start a patient toward realizing these savings, providers should write a new prescription that specifies a 100-day

supply instead of a 90-day supply (e.g., Lisinopril 5 mg 1 qd #100 days with 3 refills) and send to the patient's pharmacy.

Diabetic supplies –blood glucose meters and continuous glucose monitors BGM and CGM –

Effective Jan. 1, 2024, blood glucose meters (BGMs) and continuous glucose monitors (CGMs) will be available at $0 copay when obtained at a preferred retail pharmacy or through the Costco Mail Order Pharmacy program. $0 copay is available through the gap coverage phase. This includes:

- Supplies such as insulin syringes, needles, alcohol swabs, lancets, and lancet devices.
- Covered CGM products Dexcom G6 and G7 and Freestyle Libre 2. Members can switch between CGM products when they have had their product for five years or more.
- Covered BGM products which includes all Accu-Check machines and test strips.

Continuation of our compliance with the Inflation Reduction Act

- **Insulin Savings –** Members with formulary insulins for Part D and Part B will pay $30 per month supply when obtained through our preferred pharmacies and $35 per month supply when obtained through a non-preferred pharmacy. In 2024, members will have a lower cost share without Part D deductibles or impacts within their coverage gap.
- **Insulin Formulary therapy for 2024 –** Includes therapy insulin to the formulary: Insulin Aspsart Biosimilars, Novolog, Fiasp, Lantus, Toujeo, Levemir, Tresiba, Xultrophy, and Soliqua. Monthly copay will be $30 per month through a preferred pharmacy and $35 per month through a non-preferred pharmacy.
  - Members who choose a insulin that's not on our formulary will need to submit an Exception Request and if approved the member will pay $35 for a month's supply of each insulin as a prescription benefit (Part D) or medical benefit (Part B when they have a pump).

GET Vaccinationed Program

We're continuing our $0 Part B vaccines *(Influenzas, Pneumococcal) OR Part D vaccines (Shingles, TDAP or others listed on the drug formulary)* when administered either at the doctor's office or at an in-network pharmacy. We don't restrict where a member can receive their vaccines.

2024 formulary updates

Below are some formulary updates and changes effective Jan. 1, 2024. Please visit our Pharmacy services for health care providers web page for more information and the most current formularies.

Expanded coverage of medication in lowering drugs from higher levels to Tier 1, Tier 2 in the following categories:

- Common Chronic medications (i.e., Hypertension, Diabetes, Cholesterol and Depression)
- Pain medications
- Generic HIV medications
- Generic Specialty medications

Insulin therapy:

- Included Insulin Aspsart Biosimilars, Novolog, Fiasp, Lantus, Toujeo, Levemir, Tresiba, Xultrophy, and Soliqua to the formulary $30 per month at preferred pharmacy.

Other notable items:

- Brand name Lantus will remain as preferred (instead of a biosimilar) on the formulary at $30 per month when obtained through a preferred pharmacy.
- Removed Advair Diskus and placed Wixela or generic on Tier 1.
- Removed Symbicort, Xopenex, and Flovent inhaler and placed generics on Tier 1.
- Kept Ventolin, 17 grams, and Albuterol, 8.5 grams (17grams), with two inhalers for one copay on Tier 1.
- **New Guidelines for** glucagon-like peptide-1 (GLP-1) agonists:
  - Prescribing a GLP-1 (Mounjaro, Byetta, Trulicity, Bydureon, Victoza, and Ozempic) will require a diagnosis of diabetes with an authorization request submitted by the pharmacy for the medication so that the request can be adjudicated.

New comprehensive Medical Benefit Drug Program

We are launching the Comprehensive Medical Benefit Drug Program with Magellan Rx (MRx), a division of Magellan Health, Inc., for dates of service on and after October 1, 2023. This program offers comprehensive medical benefit drug policies with advanced clinical criteria, dose optimization, and drug wastage components. It also allows the Health Plan access to and support from specialists in specialty areas such as oncology, rheumatology, dermatology, gastroenterology, and many others, as well as board-certified pharmacists to assist the Health Plan with prior authorization clinical recommendations.

Medical Benefit Drug Policies

New and updated medical benefit drug policies will be co-branded with MRx and Medica logos and available on Clinical Guidelines MRx webpages on and after October 1, 2023.

Prior Authorization Submission and Form

For dates of service on and after October 1, 2023, providers will **continue to** submit prior authorization requests to the Health Plan, but using one, simplified prior authorization form for oncology and non-oncology-related medication authorization requests.

Not Changing for Dates of Service On and After October 1, 2023

For dates of service on and after October 1, 2023, the following **will continue** under the same requirements and/or processes as today:

- Medical benefit drug policies and prior authorization form will be accessible via the Health Plan's Medical Injectable List.
- Prior authorization requests will be accepted via fax to 608-252-0814 and determination letters will be returned from the Health Plan.
- Clinical notes and supporting documentation for prior authorization requests will be required.
- The current peer-to-peer process will be available for consultation and clinical review of potential denials and appeals.
- Prior authorizations approved before October 1, 2023, will be grandfathered under the previous policy and exempt through the prior authorization expiration date.

Changing for Dates of Service On and After October 1, 2023

For dates of service on and after October 1, 2023, the following **will change**:

- One prior authorization form will replace the current separate forms for specific drugs.
- Policies will be available at the Health Plan's webpage that is administered by MRx.
- Providers may receive a phone call from MRx supporting the Health Plan during the authorization review process if additional information is necessary to render a determination on the request.
- Affected medical benefit drug policies will be co-branded.

Providers are encouraged to review new and changed medical benefit drug policies, when available. Questions regarding the Comprehensive Medical Benefit Drug Program can be directed to Pharmacy Services at DHP.Pharmacyservices@deancare.com.

New Process for Annual Centers for Medicare and Medicaid Services-Based Fee Schedule Updates

We are changing our timeframe for implementing annual Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS) and Relative Value Unit (RVU) fee schedule updates. Beginning in 2024, we will implement CMS's annual RVU file updates for affected provider services in our administrative systems with an April 1 effective date.

This change will apply to provider agreements whose commercial products reimbursement terms are based upon RBRVS and RVUs established by CMS. As a result, for next year, CMS 2024 RVU-based reimbursement adjustments will be effective for dates of service on and after April 1, 2024.

This change only applies to our commercial products (fully-insured, self-funded administrative services only [ASO], ACA individual and family, and ACA small group plans). Medicare Advantage products will continue to implement CMS's RVU changes using the effective date CMS established for its updates.

We are making this change to accommodate the release of RVU updates by CMS each year. There is considerable analysis that goes into capturing the impact of these RVU changes in advance of fee schedule updates. We can no longer complete the needed analyses and fee schedule adjustments before Jan. 1 due to the timing of CMS's updates. This change allows us to continue to pay claims without having to implement claim holds. It also aligns with overall payor practices and the timing of Medica's standard fee schedule updates as we begin to migrate to our new, shared claims processing platform.

If you have any questions regarding this change, please contact your assigned provider networks consultant.

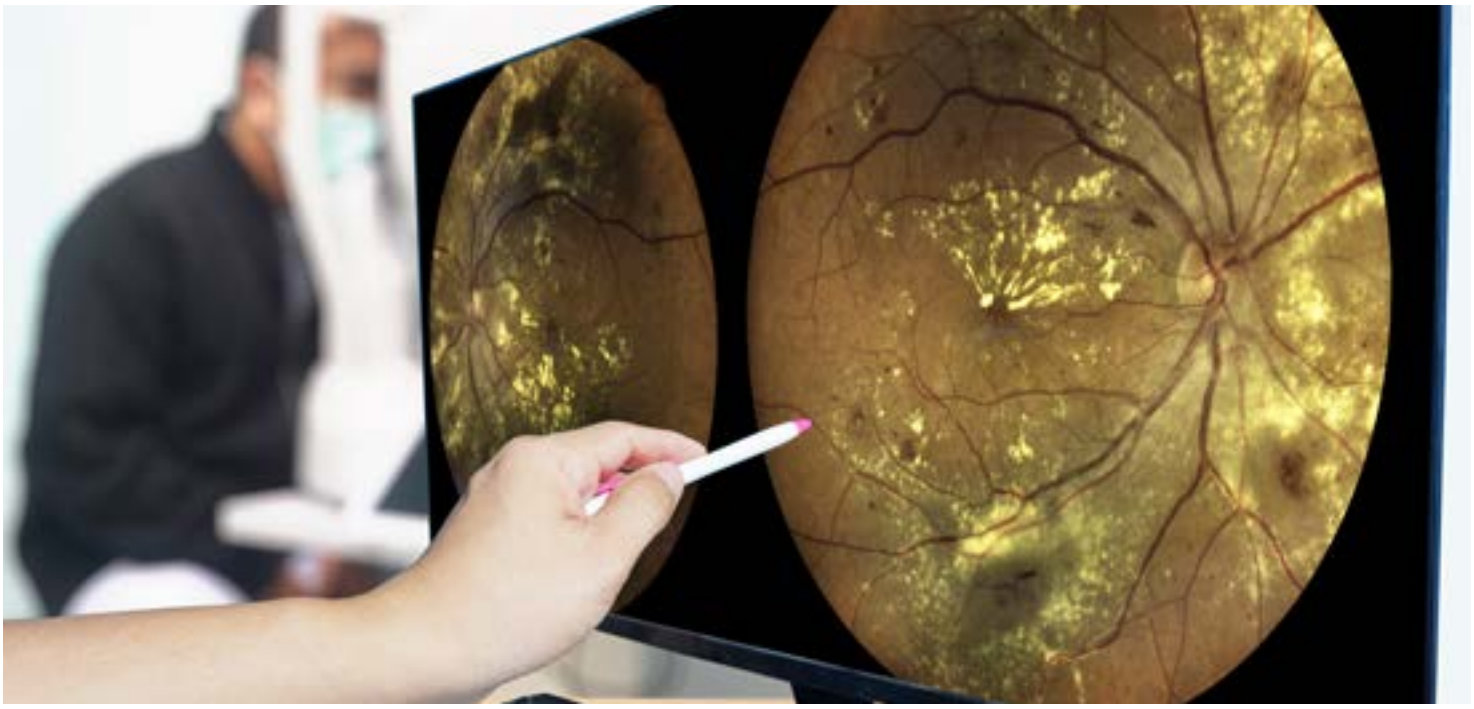
Race and ethnicity during provider recredentialing

As part of our National Committee on Quality Assurance (NCQA) accreditation, the Health Plan follows credentialing and recredentialing processes to select and maintain a high-quality provider network. Providers must successfully complete recredentialing within specific time frames to continue delivering services to Medica (formerly known as WellFirst Health) members.

Health equity means that every person has the opportunity to be as healthy as possible. We recognize that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. As such, we are deeply committed to Health Equity and the CLAS standards.

Understanding the race, ethnicity, and language demographics of our provider network is an important part of our ability to support our members. While race and ethnicity fields are optional fields in the recredentialing process, please consider providing this information so that we can better connect members to practitioners that meet their cultural needs and preferences. For more information about Health Equity, visit our Cultural Awareness & Health Equity web page.

Want to know more about recredentialing? See "The Facts About Provider Recredentialing" article in our 2023 Spring Newsletter and the "Credentialing Process" section in the Provider Manual.



Screening patients for diabetic retinopathy

To best care for patients, the American Diabetes Association recommends that individuals with diabetes be screened or monitored for diabetic retinopathy. Diabetes is the leading cause of new cases of blindness in adults, the vast majority caused by diabetic retinopathy. A recent study, supported by the Centers for Disease Control (CDC), found that the prevalence of diabetic retinopathy was high, affecting almost one-third of adults over age 40 years with diabetes, and more than one-third of African Americans and Mexican Americans with diabetes.

Diabetes-related blindness costs the nation about $500 million annually. While individuals with diabetes are clearly at a higher risk for vision loss and eye diseases, 60% do not get annual eye exams. Impaired vision and blindness caused by diabetic retinopathy may be prevented through good glycemic and blood pressure control, and by early detection and treatment of eye diseases.

At least annually, ask your diabetic patients about their eye health and educate about symptoms. Ensure their understanding by asking them to repeat back what they heard.

The Health Plan recommends medical eye exam screenings for:

- Patients with type 1 diabetes, an initial comprehensive examination by an ophthalmologist or optometrist within the first five years of diagnosis.
- Patients with type 2 diabetes, an initial comprehensive examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes is made.
- The frequency of follow-up examinations should be individualized, with more frequent follow-ups, at least once annually for patients who have abnormal findings or if retinopathy is progressing.

If your patients have an eye exam at an outside facility, ask them to bring in a printout of their evaluation and scan it into their medical record/MyChart to help providers more comprehensively manage their diabetic care and ensure their patients are staying current on their screenings. ⊕

Notification Necessary for Provider Demographic Changes

Please don't forget to update NPPES information too!

The Health Plan is committed to ensuring that our provider directories are accurate and current for the members who rely on this information to find in-network providers for their care. Additionally, Centers for Medicare & Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories.

To help accomplish this, providers must notify the Provider Network Consultant team of any updates to their information on-file with us as soon as they are aware of the change.

On a quarterly basis, outreach is provided by our vendor BetterDoctor requesting providers to validate that their information on-file with us is current and accurate. Information regarding a provider's ability to provide services via telehealth are part of these attestations. Providers should not wait for these reminders to update their information with the Health Plan.

As our provider directories accommodate additional information for our in-network providers and additional requirements in the future, please review your directory information regularly at wellfirstbenefits.com/Find-A-Doctor to verify it reflects current and accurate information for you and your organization. Report any updates for the following to your Provider Network Consultant:

- Ability to accept new patients
- Practice location address
- Location phone number
- Provider specialty
- Languages spoken by provider
- 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 office staff
- Provider website URL

Providers are also encouraged to review and update their National Plan and Provider Enumeration System (NPPES) information when they have changes. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format. NPPES data serves as an important resource to improve provider directory reliability and accuracy.

Accessibility of services standards

It is important for Medica (formerly known as WellFirst Health) network providers to understand the Accessibility of Services standards. We are committed to ensuring that members using the provider network for their care have appropriate appointment accessibility.

The Accessibility of Services standards for members pertain to services provided by primary care, specialty care, and behavioral health care clinic locations and can be found under the Quality Improvement section of the Provider Manual.

Online educational tool for providers to share with patients

We offer Emmi®, free online educational programs, that all in-network providers can use to further educate their patients. Emmi is a series of evidence-based online programs that walk patients through valuable information about a health topic, condition, or procedure. All educational material is available in both English and Spanish, and in other languages for select content. In-network providers can sign up for an account by contacting Emmi customer support at 866-294-3664 or support@my-emmi.com. Once a provider has established an account, they can send interactive educational content directly to their patients via email.

Members enrolled in any Health Plan 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 to 30 minutes. Members can watch at their convenience and refer back as often as they wish.

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 published alongside our quarterly newsletter. *Drug policies are applicable to all WellFirst Health products, unless directly specified within the policy.* 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 with documented WellFirst Health policies must be prior authorized, unless otherwise noted in the policy. Please note that most drugs with documented policies require specialists to prescribe and request authorization.

To view WellFirst Health pharmacy medical benefit policies, visit wellfirstbenefits.com ➤ select the Providers link at the top of the web page ➤ Pharmacy Services. From the Pharmacy services for health care providers page, click the See library link located under the Current policies section.

Criteria for pharmacy benefit medications may be found on the associated prior authorization form located in the Prescriber Portal.

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar.

Fall 2023 Pharmacy and Therapeutics Updates

The Fall 2023 Pharmacy and Therapeutics Updates are published alongside this newsletter on our WellFirstHealth Provider news web page at WellFirst Health Provider News. Please call the Customer Care Center at **866-514-4194** if you have questions aboutaccessing the updates.

Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by WellFirst Heath's Medical Policy Committee, are published alongside our quarterly newsletter. The Medical Policy Committee meetings take place monthly. As always, we appreciate the expertise by medical and surgical specialists during the technology assessment of medical procedures and treatments.

To view WellFirst Health medical policies, visit wellfirstbenefits.com ➤ select the Providers link at the top of the web page ➤ Medical Management. From the Medical Management page, click the Medical policies link located under the WellFirst Health policies section. The document library 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 (also called ASO plans) 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 (PT/OT) 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. to 7 p.m. CST or via **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program.

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.

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.

Fall 2023 Medical Policy Updates

Fall 2023 Medical Policy Updates are published alongside this newsletter on our WellFirst HealthProvider news page at wellfirstbenefits.com/Providers/Provider-news. Please call the Customer Care Center at **866-514-4194** if you have questions about accessing the updates.