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# Dean Health Insurance, Inc/Dean Health Plan Chiropractic Manual

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## Welcome to Dean Health Plan!

Dean Health Plan (DHP), a subsidiary of Dean Health Insurance, Inc. (DHI) would like to take this opportunity to welcome you into the Provider Network!

The DHP Chiropractic manual is to serve as a resource for policies and procedures that affect claim submission. If you have questions relating to this information, or are unable to find information that you are looking for, please refer to the phone directory below or access [www.deancare.com](http://www.deancare.com) to contact the appropriate department for assistance.

### Customer Care Center

**Customer Care Center Department** (608) 828-1301  
(800) 279-1301

**Monday – Thursday** 7:30 am to 5:00 pm  
**Friday** 8:00 am to 4:30 pm

Operator (608) 836-1400  
(608) 356-7344

Automated Response Line (IVR) (608) 827-4420  
(800) 356-7344, ext 4420

Dean On Call (608) 250-1393  
(800) 57-NURSE (800) 576-8773

### Care Management

**Utilization Management** (608) 836-1400  
(800) 356-7344 ext. 4455

Point of Service Prior Authorizations (608) 836-1400  
(800) 356-7344 ext 4455

**Case & Disease Management Referrals** (608)827-4132

Care Management Fax Number (608) 836-6516

### Claims

**Claims Manager** (608) 827-4247  
(800) 356-7344, EXT 4247

Information Systems for Electronic Claims  
Transmission (800) 356-7344 x4320  
[dhpedi@deancare.com](mailto:dhpedi@deancare.com)

CPT-4 & ICD-9, HCPCS Coding (608) 836-1400  
(800) 356-7344




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## **Drug Prior Authorizations**

	(608) 828-1301
<b>Dean Health Plan Drug Prior Authorizations</b>	(800) 279-1301
	(608) 827-7535
DHP Drug Prior Authorization Fax	(866) 333-2757 (toll free)
Navitus Health Solutions	<a href="http://www.deancare.com">www.deancare.com</a>
<b>Dean Health Systems Website</b>	

**Address: Dean Health Insurance, Inc.**  
**Dean Health Plan**  
**P.O. Box 56099**  
**Madison, WI 53705**

## **Who is Dean Health Plan?**

Dean Health Plan (DHP), a subsidiary of Dean Health Insurance, Inc. (DHI), is a managed care organization that promotes healthy lifestyles and facilitates high quality medical care for our members.

Often people assume that Dean Health Plan and Dean Medical Center are one and the same, when actually they are two separate entities jointly owned by Dean Health System.

Dean Health Plan was incorporated in August of 1983 as a group model HMO (Health Maintenance Organization) with Dean Medical Center physicians. Contractual agreements were entered into with hospitals, primary care physicians, and specialty care providers located throughout our service area. Dean Medical Center, together with contracted providers, have assisted DHI/DHP in becoming the second largest HMO in the state of Wisconsin.

In July of 1995, SSM Health Systems purchased a minority interest of DHP, and in July 2005, the name of DHP's parent company changed to Dean Health Insurance, Inc. This allowed us to expand the types of services offered, and operate in states outside of Wisconsin.



We are proud of the fact that we have been able to maintain a high level of reimbursement to a diverse group of providers and provide high quality care to our members.

### **Dean Health Insurance Mission Statement is as follows:**

***DHI will improve our members' health and create peace of mind with insurance products and health programs that feature our caring partners at DHS, SSMWI/HC, and other quality providers. We will promote the right care, at the right place, at the right time, and with the right person.***



## Dean Health Systems Website

[www.deancare.com](http://www.deancare.com)

Dean Health Plan offers a wealth of information through the Dean Health Systems Website. Dean Health Systems' affiliates can access information by clicking on:

<http://www.deancare.com/providers/index.aspx>





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## Interactive Voice Response Line (IVR)

Dean Health Plan has an automated phone system to answer certain types of provider calls. It is called Interactive Voice Response Line (IVR). You probably have used an IVR system when calling a business such as your bank, utility company, or cable company. The IVR walks you through the system by giving you options and instructions and asking you to press a key on your phone to indicate the information you wish to access. You will then receive the information requested from the IVR system. Our goal is to give you the best service possible and the IVR will help us accomplish this.

Interactive Voice Response Line has many advantages. Not only do you get a speedy response time by using the IVR system, you are able to access information 24 hours a day, seven days a week. Of course, IVR will give you the option of pressing "0" to talk to a Customer Care Center Representative during normal business hours, if you choose.

There are currently three options available. They are:

- **Member Eligibility**

To check member eligibility you must enter:

1. Your 10 digit NPI number
2. The member's 8 digit date of birth
3. The member's zip code

Once you have entered the above information, and it has been verified, you will be able to check the effective date of the policy.

- **Claims Status**

To check claims status you will be prompted to enter:

1. Your 10 digit NPI number
2. The member's 8 digit date of birth
3. The member's zip code

Once this information is entered and verified, you will be able to check claim status by date of service, claim number or listen to most recent claims.

You will be given:

- Claim Number
- Date of Service
- Total Charge
- Amount paid
- If claim is denied
- Date paid
- Amount paid
- Check number

**The option to check claim status is available 24 hours a day, seven (7) days a week.**



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- **Other Health Insurance**

You have the option to check other health insurance (OHI) information we have listed for a member. To check OHI information you will need to enter:

1. Your 10 digit NPI number
2. The member's 8 digit date of birth
3. The member's zip code

Once the information has been entered and verified, you will be given a message about whether or not the member has other insurance

**Other Health Insurance information should be verified with the member as DHP is not always notified of changes in a member's coverage.**

You can reach our IVR system by dialing:

- (608) 827-4420 or (800) 356-7344, extension 4420
- (608) 828-1301 or (800) 279-1307
  - Option 1 for provider
  - Then option 1 for the Automated System

We request that you use IVR for eligibility, copayment, and claims status whenever possible.



## The Provider Services Department

The Provider Services Department is responsible for educating all existing and new plan providers within the DHI/DHP provider network. Provider education includes:

- Workshops that introduce providers to new policies and procedures
- Orientations for new practitioners and facilities
- Ongoing education for network providers (i.e. Quality Improvement, Utilization Management, and Customer Relations processes, NaviNet Training, etc...)

Provider Services maintains:

- Provider files
- Administration in the provider contracting process
- Practitioner manual

Provider newsletters are coordinated and distributed by Provider Services to keep providers up to date on any changed health plan procedures, benefits, or other areas of interest involving the health plan. The *Provider News* is now available on the Dean Health Systems Website at [www.deancare.com](http://www.deancare.com).

### Provider Relation Specialists Territory Assignments

**Becky Bongard**

Crawford, Grant, Iowa, Lafayette,  
(608) 827-4292  
(800) 356-7344, ext. 4292  
[Rebecca.Bongard@deancare.com](mailto:Rebecca.Bongard@deancare.com)

**Judy Jabs**

Dane  
(608) 827-4327  
(800) 356-7344, ext. 4327  
[Judy.Jabs@deancare.com](mailto:Judy.Jabs@deancare.com)

**Sandy Hayes**

Adams, Dodge, Fond du Lac, Green  
Lake, Marquette, Waukesha  
(608) 827-4110  
(800) 356-7344, ext. 4110  
[Sandy.Hayes@deancare.com](mailto:Sandy.Hayes@deancare.com)

**Brandi Parcel**

Green, Jefferson, Rock, Walworth  
(608) 827-4461  
(800) 356-7344, ext. 4461  
[Brandi.Parcel@deancare.com](mailto:Brandi.Parcel@deancare.com)

**Paul Schiller**

Columbia, Juneau, Sauk, Richland, Vernon  
(608) 827-4106  
(800) 356-7344, ext. 4106  
[Paul.Schiller@deancare.com](mailto:Paul.Schiller@deancare.com)



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## Provider Updates/Changes

To ensure that DHP has the most current demographic information for our network provider, contact your Provider Relations Specialist for any of the following situations:

### New Physicians:

- When multi-specialty or independent clinic physicians add to their staff; requests to consider this physician for plan provider status should be directed, in writing, to Provider Services. Approval by DHI/DHP Senior Administration is required before an application will be sent for completion.

All applications must be the original, a photocopy, or faxed copy. Furthermore, DHP does not allow practitioners to see DHP members until they have completed the credentialing process. No retroactive effective dates are granted.

### Physician Extenders & Locum Tenens:

- Dean Health Plan welcomes physician extenders (Physician Assistants or Nurse Practitioners) to participate in the plan provider network.

Physician Assistants/Nurse Practitioners are required to complete the credentialing process when a supervising physician is not physically on-site at the clinic location.

- **Dean Health Plan requires our plan providers notify us IN ADVANCE of the need for a locum tenens.** The plan provider utilizing a locum tenens should inform their Provider Relations Specialist with the name of the locum tenen and the expected coverage time involved.

A physician extender form should be completed and returned to your designated Provider Services Representative to assure proper claim payments before any services are rendered to DHI/DHP members.

[http://www.deancare.com/healthplan/documents/Dean\\_Physician\\_Extender\\_Form.pdf](http://www.deancare.com/healthplan/documents/Dean_Physician_Extender_Form.pdf)

## Dean Health Plan Termination of Patient/Doctor Relationship Policy & Procedure

A practitioner may terminate the care of a member only for good cause, as determined by Dean Health Plan (DHP). Examples of good cause include such instances as a member:

- Physically injured or threatened a practitioner or other member of the clinic staff;
- Repeatedly and materially refused to pay coinsurance, copayments, or deductibles associated with DHP/Premier claims after all reasonable collection efforts have been exhausted;
- Displayed verbally abusive behavior or harassment towards a practitioner or other member of the clinic staff;
- Repeatedly refuses to cooperate with the practitioner.



- Fails to attend or late cancel 3 or more scheduled appointments after having received a written warning.

Practitioner requests to terminate a patient/doctor relationship must be sent in writing to the Provider Services Department stating the reasons for the request. Dean Health Plan will review the request and notify the provider of the determination. To avoid concerns of abandonment, the provider is requested to continue seeing the patient for 30 days from the termination notice if the patient presents for urgent or emergent care. This will give the member time to choose a new practitioner. The termination letter sent to the member should include the DHP Customer Care Center phone number (800)-279-1301 as a resource. DHP will assist the member in choosing a new provider and setting up transportation to appointment if necessary. The member will also be sent correspondence explaining their options and providing a Medical Record Release Form.

The following process applies to Members with commercial policies, including State of Wisconsin and federal employees. If the member is a recipient of Medicaid or BadgerCare, please contact Babette Casey member advocate at (608)827-4221.

### Practitioner-Member Communication

- Dean Health Plan shall ensure that DHI/DHP allows open Practitioner-Member communication regarding appropriate treatment alternatives and shall not penalize Practitioners for discussing medically necessary or appropriate care with Members.

## Other Situations

All of the below requests need to be submitted in writing to the attention of your Provider Relations Specialist. Please provide as much **ADVANCE NOTICE** and information regarding the new practitioner and/or change to the practitioner's status, as soon as possible, to avoid any disruption to your patients or claim payments.

- **Provider Demographic Information:**
  - \*Name
  - \*Gender
  - \*Specialty
  - \*Hospital Affiliations
  - \*Office locations
- **Medical Group Affiliations**
- **Relocation/Retirement of a provider** (DHP provides member notification to ensure continuity of care).
- **Request to expand or add new clinics and/or office locations.** These requests to expand are required to have prior approval through the Provider Services Department.
- **Request to add additional services and/or programs.** These requests are required to have prior approval through the Provider Services Department.



- When a physician finds it necessary to discontinue accepting new patients or limit his/her practice (following this page is a *Patient Acceptance Form* that is required to be completed to communicate this information). This does not apply to practitioners who are with a Dean Medical Center/St. Marys Dean Venture Clinic site.
- When a physician will be out of the office, vacationing or on extended leave and another facility or location will be covering his/her practice. DHI/DHP requires **written notification** to include name, location, and duration of the covering physician or facility. **The covering physician must be a plan provider and have completed the credentialing process.**

## **“Dean On Call” (24-hour Nurse Line)**

Dean on Call is a free telephone service that's available to Wisconsin residents 24 hours a day, 365 days a year. If you're not sure you need to see a doctor, or you're wondering if you have a problem, give us a call.

- (608) 250-1393
- Toll Free 1-800-57-NURSE (1-800-576-8773)

The call center is staffed 24 hours a day, 7 days a week by registered nurses who take patient calls and use a computerized program with tested algorithms developed by physicians to help the patient access the most appropriate care based on the patient's symptoms. The call center can help the patient decide whether symptomatic treatment, a trip to the emergency room, or a call to you is necessary. “Dean On Call” also directs patients where to go if further care is needed.

This is not a substitute for ongoing care a patient may currently be receiving. A patient may be advised to contact the provider of care directly.

The algorithms are approved by the Dean Medical Center. Questions regarding the algorithms or “Dean On Call” can be directed to the following number: (608) 241-9736.

## **Dean Health Plan's Products**

Dean Health Plan offers a variety of products for members; each designated to serve specific needs. Below is an overview of the products that are available to Dean Health Plan members.

**Dean Classic (HMO)** is a group plan based on the philosophy of a managed care organization - a primary care provider (PCP) oversees all aspects of an individual's healthcare needs, both for regular check-ups and for emergency or extended care needs. Employees will be expected to visit physicians listed in our extensive provider directory. Specialty care is also coordinated through the PCP, thus leaving your employee virtually free from paperwork and claims to file.

**Dean Choice Point Plans (POS)** not only offer HMO coverage, but also a more flexible benefit package to employees that chooses not to select a primary care provider. This gives employees the option to see any Dean plan practitioner without the need of a referral as well as the freedom to see non-Dean providers.



**Dean Health Plan PPO Product** was developed with suggestions from Employer Groups who have employees living outside of the Dean Health Plan service area. The PPO product will utilize extensive provider networks by Dean Health Plan, WPPN/MultiPlan, and Coalition America to provide local, regional, and national coverage. Using providers within the PPO network saves money; however, services rendered by providers who are not part of the PPO network are reimbursed at a lower rate (dependent upon plan chosen).

PPO members can be identified by their DHP-PPO ID card, which will show both the DHP and MultiPlan/WPPN logos. All PPO group numbers end with a “V” and “PPO” is specified on the card.

**Dean Focus (EPO) (Small Group Product)** is a small group plan with a limited service area of Dane County. The Dean Health Plan network for this product will be limited to Dean Health System (Dean Medical Center) providers and St. Mary’s Hospital, along with the necessary specialty providers required to cover the full realm of health care services. This product is an HMO design, so plan providers must be used to obtain coverage.

Members under the Focus Plan can be identified by an ID card that mirrors the standard HMO ID card. The ID card also specifies on the back that the network is limited to Dane County.

**Dean Consumer Driven Plans** were developed to provide options that encourage consumers (members) to become more involved in health care decision making. These plans feature deductibles, coinsurance and copays on most services and are sold with an option to include a healthcare reimbursement account (HRA) to offset the employee’s out of pocket costs to some degree. The HRA portion of the plan is administered through Employee Benefits Corporation (EBC), which we have partnered with to provide an integrated product for employers and employees alike.

**Individual Plan** is for those individuals who do not have health insurance coverage through an employer. DHI offers multiple plans with a variety of deductible and benefit levels to meet an individual’s needs.

**Dean Care Gold Product:** This product is offered under *DHP only* and is a “cost plan” currently offered to Columbia, Dane, Dodge, Grant, Iowa, Jefferson, Rock and Sauk County members’ eligible for Medicare. If you are a DeanCare Gold Provider please refer to the “Dean Care Gold Provider Manual” for information on the ID card and specific referral and prior authorization guidelines.

**Dean Health Plan Senior Select Product:** This product is offered under *DHP only*, and is a Medicare Supplement Plan currently offered to Medicare eligible members *in and outside of Dane County*. **Claims must be submitted to the fiscal intermediary as primary.**

Senior Select member’s package will begin with a “Z” and their group number will be in the 20000 range.

**BadgerCare Plus** is a state sponsored program that provides healthcare coverage to qualified members. BadgerCare Plus combined Family Medicaid, BadgerCare, and Healthy Start into a single program. To qualify for BadgerCare Plus members must meet income requirements and fall into one of the following groups:



- Uninsured Children
- Pregnant Women
- Parents and Caretaker Relatives
- Parents with children in foster care who are working to reunify their families
- You adults exiting out-of-home care, such as foster care, because they have turned 18 years of age.
- Certain Farmers and other self-employed parents and caretaker relatives.

Not all BadgerCare Plus members will be enrolled in HMOs. Some members will remain straight Medicaid or Fee-for-Service (FFS), where they have access to any BadgerCare Plus Certified Provider.

This product is offered under *DHP only*. This is an HMO product that follows most of the HMO guidelines. Please refer to the "DHP Medicaid Manual" for information on the specific referral and prior authorization guidelines.

## BadgerCare Plus Identification (ID) Card

Wisconsin BadgerCare Plus members receive a "ForwardHealth" Medicaid ID card upon initial enrollment into Wisconsin BadgerCare Plus. Each individual in a BadgerCare Plus family is enrolled with their own individual ID number and card.

It is important that providers or their designated agents determine the member's eligibility and HMO enrollment status **prior** to each visit. Providers should verify eligibility for each date of service and cannot charge a member for doing so. This is important because members can move between the Standard and Benchmark Plans, thus copays and benefits may change between appointments.

The ForwardHealth card is designed to be kept indefinitely by members, who are encouraged to always keep their cards even though they may have periods of ineligibility. It is possible a member will present a card when he or she is not eligible; therefore, it is essential providers confirm eligibility before providing services.

If a card is lost, stolen or damaged, Wisconsin BadgerCare Plus will replace the card at no cost to the member. Members should contact EDS Recipient Services at (800) 362-3002, on the back of the card, for replacement cards.

### Forward Card Features

*(Resembles an automated teller card)*



**Dean Health Plan will not issue members a separate ID card; the ForwardHealth card will serve as their insurance card.**



## DHP Identification (ID) Card

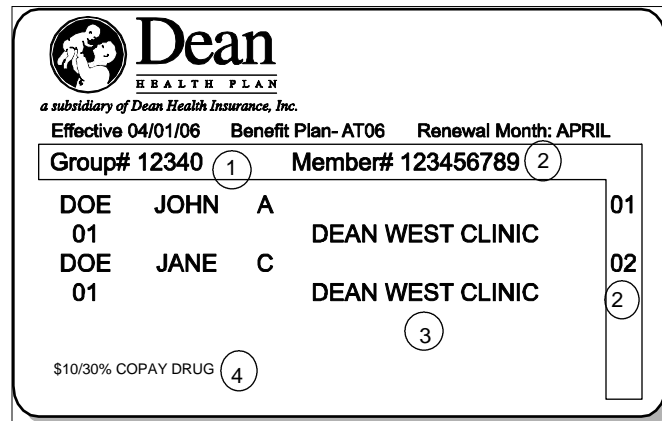
Your role as a Dean Health Plan (DHP) Provider is to identify which plan a member has to assure that the correct referral, prior authorization, and pre-certification guidelines are followed.

To help you and your staff identify the different plans that DHP offers, we have included examples of the different ID Cards that our members may present.

We recommend checking the member's ID Card at every visit to verify DHP coverage.

Questions regarding member benefits and member identification may be directed to our Customer Service Department.

### Example of Identification Card



- Key:**
1. Group Number
  2. Subscriber Number and Relationship Code
  3. Primary Care Location and Number
  4. RX Pharmacy Copayment

Group # begins with:	Type of Product
20000	Senior/Select
C	<b>Gold</b> C2300D (Shared Value w/o catastrophic drug coverage) C3300D (Shared Value w/o catastrophic drug coverage) C2200 (Enhanced) C2200D (Enhanced w/o catastrophic drug coverage) C3200D (Enhanced w/o catastrophic drug coverage) C3200 (Enhanced) C1200D (Basic w/o catastrophic drug coverage) C3100D (Basic w/o catastrophic drug coverage)
Y	<b>Point of Service (POS)</b>
GE	<b>Dean Focus Plan (EPO)</b>

Referral and prior authorization/pre-certification requirements can be located in the Referral/Prior Authorization section of this manual.



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## Claims Submission

To allow for more efficient processing of your claims, we ask for your cooperation with the following:

- When a physician or a clinic becomes a “Plan Provider” they agree to accept payment made by Dean Health Insurance/Dean Health Plan (DHI/DHP) as payment in full. Discounts and withholds are not to be billed to the member or the secondary insurance company. Members may be billed for copayments, coinsurance, deductible amounts, and non-covered services.
- DHI/DHP requires the use of correct and complete member number. Families share the first nine digits of their subscriber number. The remaining two digits signify the individual member, (i.e., spouse, dependents). Using the correct member numbers on the claims submitted to DHI/DHP will help us ensure correct claim payment.
- DHI/DHP requires plan providers to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. **Refer to the Timely Filing Guidelines in this section for further instructions.**
- All claims for services related to work related injuries or illness should be submitted to the worker’s compensation carrier. If claims are denied by the worker’s compensation carrier, you may submit the claim along with the denial for consideration by DHI/DHP. **All referral and/or prior authorization guidelines apply in this situation.** You must submit the claim (s) in a timely manner along with the denial as outlined in the timely filing guidelines.
- Submit subrogation claims (where the third party may have caused the injury or illness due to an auto accident, a slip or fall, and/or a defective product) to DHI/DHP for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. **All referral and/or prior authorization guidelines apply in this situation.** You must submit the claim (s) in a timely manner as outlined in the timely filing guidelines.
- DHI/DHP requires that all services billed be appropriately documented in the patient’s medical records in accordance with DHP’s Medical Records Policy. If the services billed are not documented in the patient’s medical record, in accordance with the policy, they will not be considered reimbursable by DHP/DHI. DHP’s Medical Records Policy can be found in the Quality Improvement Section of this manual.



The following is a list of data elements which are required on each claim submission. The table below indicates the appropriate box number from the CMS-1500 and UB04 claim forms for each required element. The newly required elements are identified by bold print.

Required Information	CMS 1500 (08-05) Claim Form	Note
Member Name	Box 2	
Date of Birth	Box 3	
<b>Member Number</b>	<b>Box 1.A</b>	<b>11 digits/10 for MA</b>
Diagnosis Code	Box 21	
Date of Service	Box 24.A	
<b>Place of Service</b>	<b>Box 24.B</b>	<b>2 digit</b>
Type of Bill	N/A	
Service Code	Box 24.D	
Billed Amounts	Box 24.E	
Units	Box 24.G	
<b>Doctor Indicator</b>	<b>G2 in Box 24.I</b>	
<b>Individual Doctor Number</b>	<b>Top of Box 24.J</b>	
<b>NPI Type 1</b>	<b>Bottom of Box 24.J</b>	
Provider Name	Box 31	
Service Facility Location	Box 32	
Provider Billing Address	Box 33	
<b>NPI (Type 2)</b>	<b>Box 33.A</b>	
<b>Individual Vendor ID</b>	<b>Box 33.B</b>	
<b>Vendor Indicator</b>	<b>BQ Box 33.B (just before DHP vendor ID)</b>	

**No space, hyphen, or separator is to be used between the qualifier and the number. Dean Health Plan is not requiring the two digit qualifier.**

DHP requires that all electronic claim submissions for DHP Products include NPI Type 1 and Type 2; which ever is applicable to the appropriate claim form being submitted. For paper claims submissions the DHP Legacy number(s) is still required.

Required Information	UB04 Claim Form	Note
Member Name	Box 8	
Date of Birth	Box 10	
<b>Member Number</b>	<b>Box 60</b>	<b>11 digits/10 for MA</b>
Diagnosis Codes	Box 66	
Date of Service	Box 6	
HCPCS Code	Box 44	
Type of Bill	Box 4	
<b>Revenue Code</b>	<b>Box 42</b>	<b>4-digit required</b>
Billed Amounts	Box 47	
Units	Box 46	
<b>NPI (Type 2)</b>	<b>Box 56</b>	
<b>DHP Vendor ID</b>	<b>Box 57</b>	



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DHP requires that all electronic claim submissions for DHP Products include the NPI Type 2 in Box 56. DHP Vendor ID number is still required for paper claims submissions.

Failure to use the correct provider identification could result in claim payment denials or reduction in benefits. It is also possible that claims will be returned to your office if they lack the above requested information.

**If you have questions regarding required fields on a claim, please contact our Customer Service Department at (608) 828-1301 or (800) 279-1301.**

## Timely Filing (TF) Guidelines for Initial Submission

The initial submission of a claim is subject to the timely filing guidelines outlined in your agreement with Dean Health Insurance (DHI)/Dean Health Plan (DHP).

When a provider's claims (paper and/or electronic) are received in our Claims Department, DHI/DHP will provide proof of receipt and return confirmation via the Electronic Claims Confirmation Report, Paper Confirmation Report, and Rejected Claims Reports to the submitting provider. This confirmed receipt will include the date that DHI/DHP received the paper or electronic claim.

If a claim fails initial editing before reaching our claims processing system and is rejected, the claim is returned to the provider for correction and must be refiled to DHI/DHP. Corrections can be made on the Rejected Claims Reports and returned to DHI/DHP for processing. **If a claim is denied for improper submission, resubmission must be completed by the provider within the filing limit outlined in your agreement with DHI/DHP.**

When you receive your confirmation reports back from DHI/DHP, retain them for your records in the event that you need to file an untimely filing waiver request. **Please be aware that when a provider fails to submit a claim timely, rights to payment from DHI/DHP are forfeited and the provider may not seek payment from the member as compensation for these covered services.**

### Exceptions to Timely Filing Guidelines on Initial Claim Submission

- Requests for temporary waiver of the TF limit must be made **in advance** due to computer system conversions or other short term circumstances. Such requests may be made, in writing, to the DHI/DHP director of claims.
- Coordination of Benefit (COB) claims must be received within the TF limit outlined in your agreement with DHI/DHP; beginning with the date noted on the primary payor's explanation of benefits.
- Crossover claims are exempt from the filing limit. Crossover claims are those claims that are initially filed with CMS, and forwarded by CMS to DHI/DHP.



- If the provider had difficulty obtaining DHI/DHP coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the DHI/DHP coverage is identified, but not longer than 180 days from the date of service. Provider shall submit supporting documentation to demonstrate measures the provider has taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the filing limit outlined in their agreement.
- Claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately due to a change in physician and need to be submitted within timely filing limit, beginning with the date of delivery. Dean Health Insurance/Dean Health Plan will not accept a global obstetrical charge from a provider.

## Timely Filing Guidelines for Claim Resubmissions/Corrections

All resubmitted/corrected claims need to be received by DHI/DHP within the filing limit outlined in your agreement. The first day of the filing limit for resubmissions/corrections begins with the date upon which DHI/DHP notifies the Provider a claim has failed processing. You will find this date on the Explanation of Payment (EOP) or Rejected Claims Reports.

Resubmissions and/or corrections can be made by the provider:

- Directly on the Rejected Claims Reports
- On the Explanation of Payment received, or
- By utilizing the “yellow corrected claim” stickers (indicating the claim number). These are available upon request.

**All resubmissions and/or corrections should be clearly identified and should be returned to the attention of the Claims Department. This will prevent a provider’s claims from being denied as a duplicate submission.**

For confirmation that DHI/DHP received a provider’s resubmissions and/or corrections, the provider may choose to utilize the Corrected Claim Confirmation Receipt Form. Please contact the Provider Services Department in order to obtain a copy of this form.

### Exceptions to Timely Filing Guidelines on Claim Resubmissions

- Resubmitted claims as a result of our error can be resubmitted/corrected up to one year after the run date of the Rejected Claims Reports or the EOP date.
- If the provider is hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital based provider who must wait for the inpatient discharge of the



member, the provider must submit claims within the timely filing limit from the discharge date of the inpatient confinement for DHI/DHP to consider payment.

- The provider discovers new or additional information and requests additional payment on a processed and paid claim. Provider must submit this information within the timely filing limit in order for DHI/DHP to consider additional payment.
- Medical Assistance HealthCheck claims are exempt from the timely filing limit.
- Newborn claims must be received no later than fourteen (14) months from the date of birth.

## Confirmation of All Claims Submitted

Dean Health Insurance (DHI)/Dean Health Plan (DHP) will now be providing 100 percent confirmation on all new claim submissions. For every claim received by DHI/DHP, whether it is filed on paper or through Electronic Claims Transmission (ECT), a confirmation of receipt will be generated and sent to the provider of service.

DHI/DHP currently generates an ECT Confirmation Report nightly for claims filed electronically. DHI/DHP provides a similar report that is generated nightly for all paper claims received by DHI/DHP.

There are now four reports generated nightly by DHI/DHP based on claims received in the DHP Claims Department:

- ECT Confirmation Report,
- Paper Confirmation Report,
- Rejected ECT,
- Rejected Paper Claims Report.

## Electronic Claims Transmission (ECT) Confirmation Report

There are several advantages in submitting claims electronically. A few examples of these advantages are as follows:

- Reduced paper, thus the need for less file space, postage, envelopes, etc.
- Faster turnaround time on claims
- Increased quality
- An electronic audit trail is created

Providers who submit their claims electronically will receive a Confirmation Report showing **ALL** claims that were loaded into our claims system. The Confirmation Report shows that the claim was received into our processing system.



All claims that DHP receives from a provider’s transmission will be on this report. The ECT Report is used as a confirmation of the number of claims received and the total dollar amount associated with those claims. Claims submitted on a CMS-1500 (837 professional) form will be listed **alphabetically** and **totaled**. Claims submitted on a UB04 (837 facility) form will be listed together in **alphabetically** and **totaled**.

It is very important that the provider verifies the totals on this report. If the totals on the report do not match the provider’s totals, this may indicate that there was a problem with the transmission.

Dean Health Plan can accept electronic claims submissions in different methods and formats. If you are interested in discussing the possibility of your facility transferring claims electronically, please contact the DHP Information Systems (IS) Department. They will be able to answer any questions that you may have regarding ECT.

If you have questions on how to get set up to submit electronically or are experiencing problems with transmitting, **please contact DHP at (608) 827-4128**.

The following is an example of our ECT Confirmation Report:

ECT CONFIRMATION REPORT		RUN DATE	06/07/2005	PAGE	2	
ABC Clinic 123 Main Street Anywhere, WI 55555						
VENDOR #: 12345						
MEMBER NAME	MEMBER #	PAT ACCT#	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER
Bessy Dressy	12345678901	B123	02/17/2005	1	\$250.15	060705 007 52
Jones Sally	98765432101	J456	01/15/2005	2	\$213.25	067005 007 51
Smith Johnny	45632178901	S789	02/01/2005	5	\$456.21	060705 007 50
TOTAL 837 PROFESSIONAL TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:		\$919.61	
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER
Cosmo Killian	12544789201	C458	01/01/2005	1	\$2,504.00	060705 010 15
Know Cooper	78521469801	K759	01/15/2005	1	\$3,567.33	060705 010 16
Sullivan Sammy	23658471901	S478	01/31/2005	6	\$23,467.99	060705 010 14
TOTAL 837 FACILITY TRANSACTIONS: 3			TOTAL DOLLARS TRANSMITTED:		\$29,539.32	



## Paper Confirmation Report

If a provider currently submits their claims electronically, the provider is familiar with receiving a nightly ECT Confirmation Report for claims filed to DHP. Providers who submit paper claims also receive a Paper Confirmation Report for claims filed to DHP.

The Paper Confirmation Report replaces the current process that providers who bill on paper use to receive confirmation of their claims: Paper Confirmation Form that was mailed, which providers were required to fill-out by hand. Dean Health Plan date-stamped the form and returned it to the provider confirming receipt of the claim(s).

The Paper Confirmation Report is formatted similarly to the ECT Confirmation Report, except that the new Paper Confirmation Report does indicate the “received date” of each claim.

As a result of this process, providers no longer need to forward the Paper Confirmation Form as DHP provides every provider and/or facility with the new report indicating that **ALL** paper claims were received.

**Providers should review the Paper Confirmation Report, as well as each report received, to confirm that all claims were received by DHP and were entered into claims processing system.**

PAPER CONFIRMATION REPORT		RUN DATE	06/07/2005	PAGE	2		
ABC Clinic 123 Main Street Anywhere, WI 55555							
VENDOR #: 12345							
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE
Bessy Dressy	12345678901	B123	02/17/2005	1	\$250.15	060705 600 52	5/15/2005
Jones Sally	98765432101	J456	01/15/2005	2	\$213.25	067005 607 51	4/30/2005
Smith Johnny	45632178901	S789	02/01/2005	5	\$456.21	060705 640 50	6/1/2005
TOTAL CMS 1500 TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$919.61	
MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	CLAIM NUMBER	RCVD DATE
Cosmo Killian	12544789201	C458	01/01/2005	1	\$2,504.00	060705 610 15	5/15/2005
Know Cooper	78521469801	K759	01/15/2005	1	\$3,567.33	060705 600 16	4/30/2005
Sullivan Sammy	23658471901	S478	01/31/2005	6	\$23,467.99	060705 620 14	6/1/2005
TOTAL UB TRANSACTIONS: 3				TOTAL DOLLARS TRANSMITTED:		\$29,539.32	

**The reports should be retained by the provider in the event that a timely filing waiver is requested. DHP will honor only this report in disputes relating to the timely filing receipt of claims.**



## Rejected Claims Reports

The Rejected Claims Reports will show you **any** claim that is not able to enter our claims processing system, whether it was submitted on **paper or electronically**.

- Error codes will be used to show why the claim did not pass the initial editing process.
- **You may make corrections directly to the report and return it to DHP for processing.**

Please refer to the timely filing guidelines when submitting your corrections. **There is no need to submit the correction with an Untimely Filing Waiver Request Form unless you are submitting the corrections more than 60 days from the RUN DATE on the report.**

The following is an example of the ECT & Paper Rejected Claims Reports and also a key of our edit codes:

REJECTED CLAIMS REPORT: ELECTRONIC SUBMISSION OR PAPER SUBMISSION										RUN DATE 06/07/05		PAGE 2	
VENDOR #	PROV #	CLAIM #	GROUP #	MEMBER #	PAT ACC #	MEMBER NAME	DATE OF BIRTH						
SVCDAT	POS SVCCOD	UNITS	CHARGES										
PRCCODE1	PRCDATE1	PRCCODE2	PRCDATE2	PRCCODE3	PRCDATE3	PRCCODE4	PRCDATE4	PRCCODE5	PRCDATE5	PRCCODE6	PRCDATE6		
DIAGN1	DIAGN2	DIAGN3	DIAGD1	DIAGD2	DIAGD3	DIAGD4	DIAGD5	DIAGD6	DIAGD7	DIAGD8	DIAGD9	ADMTDG	
12345	123	100105	001 01	125	12345678901	15410000901M	JONES	JENNY			111722		
09/01/2005	11 88309	1	\$45.65						ERROR CODES: 03			00000	
00000			00000		00000					00000			
239.0													
08/01/2005	11 88331	2	\$34.56						ERROR CODES: 09			00000	
00000			00000		00000				00000	00000			
162.9													
			TOTAL BILLED:	\$80.21									
12345	256	100105	002 56	356	98765432101	S546	S546	SMITH	JOHNNY		120347		
10/01/2005	11 250	1	\$46.78						ERROR CODES: 06			00000	
93.54	110900		00000		00000				00000	00000			
239.0													
10/01/2005	11 356	2	\$15.78						ERROR CODES: 05			00000	
81.54	110900		00000		00000				00000	00000			
162.9													
			TOTAL BILLED:	\$62.56									

- 01- INVALID PROVIDER NUMBER
- 02- INVALID CLAIM NUMBER
- 03- INVALID MEMBER NUMBER
- 04- NO AVAILABLE GROUP FOR MEMBER
- 05- INVALID SERVICE NUMBER
- 06- INVALID DIAGNOSIS CODE (\*)
- 07- INVALID PLACE OF SERVICE CODE
- 08- INVALID CHARGE AMOUNT (-)
- 09- COVERAGE NOT IN EFFECT FOR THE DATE OF SERVICE
- 10- INVALID ENDING SERVICE DATE
- 11- INVALID OTHER DATE
- 12- PROVIDER NAME DOES NOT MATCH PREFIX
- 13- VENDOR NAME DOES NOT MATCH PREFIX
- 14- INVALID VENDOR NUMBER
- 15- INVALID VENDOR FOR PROVIDER
- 16- INVALID UNIT NUMBER
- 17- INVALID TYPE OF SERVICE CODE
- 18- INVALID COB AMOUNT (-)
- 19- INVALID COB INSURANCE CARRIER
- 20- INVALID LOCALITY CODE
- 21- RESUBMIT THIS CLAIM ON PAPER
- 22- BILL TYPE MISSING OR INVALID
- 23- ADMISSION SOURCE INVALID
- 24- PATIENT STATUS MISSING
- 25- PROVIDER & SERVICE DATE DO NOT MATCH CNHMAS
- 26- INVALID HOSPITAL ENDING DATE
- 27- INVALID BIRTHDATE
- 28- INVALID MEDICAID TYPE OF SERVICE
- 29- NO ACTIVE CONTRACT FOR GROUP
- 30- INVALID MEDICAID HEALTH CHECK INDICATOR
- 31- INVALID MEDICAID FAMILY PLANNING INDICATOR
- 35- SERVICE DATE NOT WITHIN LIMITS ON CNHMAS
- 36- SERVICE DATE NOT WITHIN LIMITS ON CNHMAS
- 37- PRVORG NOT PRESENT ON ENPMAS
- 38- POSSIBLE DUPLICATE SERVICE LINE
- 39- ANESTHESIA MIN; MUST BE CONVERTED (AN HOLD CODE)
- 49- EXPIRED TYPE OF BILL
- 45- PROVIDER NUMBER NOT VALID FOR VENDOR
- 47- PROCEDURE DATE OUTSIDE HOSP ADMIT/DSCHRG DATES
- 48- INVALID PROCEDURE CODE
- 49- NO MEDIGAP NUMBER OR PRV/VEN NUMBER MISSING
- 50- BILLED AMOUNT NOT = ALLOWED AMOUNT
- 51- MEDIGAP RESUBMIT
- 52- INVALID PERFORMING SITECD
- 99- ERRORS ON OTHER SERVICE LINES FOR THIS CLAIM

PLEASE INDICATE CORRECTIONS IN THE RIGHT HAND COLUMN OR BELOW THE CLAIM AND RETURN THIS REPORT TO:  
 PLAN\* THE ECT DEPARTMENT AT DEAN HEALTH


The ECT & Paper Rejected Claims Report will only show claims that require the provider to make a correction. All claims on the both Rejected Claims Report require action on the provider's end. **Providers are required to make corrections on the actual report and return it within 60 days from the date of receipt.**

Each claim on both the ECT & Paper reports are totaled, but **the reports are not totaled** as the function to verify submission totals.



## Problem Claim Request Form/Claim Resubmission

Below is an example of DHI/DHP Problem Claim Request Form. The purpose of this form is to make claim payment adjustments more efficient. When a claim has been paid incorrectly (zero payment, underpayment, or overpayment) this form can be completed in lieu of resubmitting the claim or sending a refund check. When this form is used, follow the outline bullet points below for completion. Once submitted, adjustments are made on future remittances.



1277 Deming Way Madison, WI 53717  
 (608) 828-1301 (800) 279-1301  
 www.deancare.com

*Problem Claim Request Form*

If confirmation of receipt for this submission is desired, please indicate how you wish to receive confirmation:  mail  fax

Provider/vendor name \_\_\_\_\_ Vendor# \_\_\_\_\_  
 Provider address \_\_\_\_\_  
 Fax number \_\_\_\_\_  
 Date sent \_\_\_\_\_  
 Who should Dean Health Plan contact with questions regarding the information provided on this form?  
 \_\_\_\_\_, at (\_\_\_\_) \_\_\_\_\_, extension \_\_\_\_\_

Claim Number	Date of Service	Patient Name	Member Number	Amount to Reverse	Description of Problem

Reversals of overpayments will result in an automatic offset against future payments

Dean Health Plan, Inc.
I:\Claims\wpfiled\forms\PrblmClm

To obtain more copies of this form, contact our Customer Service Department, or go to <http://www.deancare.com/healthplan/providers/forms.asp>

If possible, please indicate the claim number of the denied claim (indicated on your EOP). This procedure will assist in preventing the resubmitted claim from being denied as a duplicate or for untimely filing. **This form must be resubmitted within 60 days of the date of the denial.**



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## Explanation of Payment

Dean Health Insurance/Dean Health Plan produces Explanation of Payments (EOP) on a weekly basis. If your office would like to check the status of a claim or questions an item on the EOP, please contact our Customer Service Department or call our Integrated Voice Response (IVR) system for assistance. The examples that follow will display:

- Dean Health Plan's EOP - paid service
- Dean Health Plan's EOP - denied service
- Dean Health Plan's EOP - claim reversal and adjustment - Key fields that are affected by a claim reversal or adjustment.

When either DHP or a provider determines that payment has been made for services for which payment should not have been made, the provider should promptly return such overpayments to DHP. Upon the discovery of any such overpayments, DHP may alternatively offset such overpayments against any amounts then otherwise due or thereafter becoming due from DHP.

The offset adjustments are made to provider's claims on DHP's claims processing system. These adjustments will appear on the provider's EOP following the processing of a provider's claims. You will find the adjustments, as they appear on your EOP in the "negative" (-) adjustment field.

The negative adjustments deduct payments from the provider's future claims. Overpayments may be taken from the same EOP, as the adjusted claims appears or may be on future EOPs. Dean Health Plan will continue to offset the negative amount on a provider's future claims until the overpayment is satisfied.

- Dean Health Plan's EOP - claim overpayment, refund and adjustment fields affected by an overpayment of a claim where a provider has submitted a refund. The "Advice Page" is included.
- **Any denial received that has an X, Y, or Z in the two digit denial code indicates that the charge should be written off, versus charging the member. If the provider feels the claim was denied in error, he or she can request a review, resubmit with the requested information, or resubmit with a corrected code. Contact our Customer Service Department with any questions.**



## Explanation of Payment – paid service

000008-005-000008

DATE: September 1, 2005

PAGE 1

Dean Health Plan, Inc.  
 P.O. Box 56099  
 Madison, WI 53705-9399  
 Customer Service Department  
 608-828-1301 OR 800-279-1301

Provider

① FIRST MEDICAL CLINIC  
 801 MAIN STREET  
 MADISON, WI 53717

② CHECK NUMBER 00000000  
 ③ VENDOR NUMBER Z55

④

PROVIDER NUMBER/NAME: 12345-CAMPBELL, VIVIAN A.

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ OTHER ADJUSTMENTS			REMARKS	PAID
							COB	NONCOV	WITHHOLD		

PATIENT: JOE DiMAGGIO	⑥ SUBSCRIBER: JOE DiMAGGIO	SUBSCRIBER ADDRESS: 1451 MAPLE GROVE ST. MADISON, WI 53715
MEMBER #: 12345678901	SUBSCRIBER #: 12345678901	GROUP #: 12345

ACCOUNT NUMBER: 645789T

CLAIM NUMBER: 135029880324

070505	99203	76.00	⑦ 72.00	0.00	0.00	0.00	0.00	0.00	0.00	3.60	(42C 50)	68.40
070505	81000	15.00	14.00	0.00	0.00	0.00	0.00	0.00	0.00	0.70	(42C 50)	13.30
CLAIM TOTALS:		91.00	86.00	0.00	0.00	0.00	0.00	0.00	0.00	4.30		81.70
PROVIDER TOTALS:		91.00	86.00	0.00	0.00	0.00	0.00	0.00	0.00	4.30		81.70
VENDOR TOTALS:		91.00	86.00	0.00	0.00	0.00	0.00	0.00	0.00	4.30		81.70

REMARKS 42C 50 CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT ⑧

⑨	BALANCE FORWARD	.00
	LINE ITEMS PAID	81.70
	LINE ITEMS REVERSED	.00
	ADJUSTMENTS (-)	.00
	ADJUSTMENTS (+)	.00
	NET TOTAL	81.70

- |  |  |
|--|--|
| <p><b>Key:</b></p> <ul style="list-style-type: none"> <li>1. Vendor name and mailing address</li> <li>2. Check number</li> <li>3. Vendor number</li> <li>4. Provider number and name</li> <li>5. Headerline</li> </ul> | <ul style="list-style-type: none"> <li>6. Patient information</li> <li>7. Claim information</li> <li>8. Remark codes</li> <li>9. Explanation of Payment summary</li> </ul> |
|--|--|



## Explanation of Payment – denied service

000008-005-000008

DATE: September 1, 2005

PAGE 1

Dean Health Plan, Inc.  
 P.O. Box 56099  
 Madison, WI 53705-9399  
 Customer Service Department  
 608-828-1301 OR 800-279-1301

Explanation of Payments  
 Provider

① FIRST MEDICAL CLINIC  
 801 MAIN STREET  
 MADISON, WI 53717

② CHECK NUMBER 00000000  
 ③ VENDOR NUMBER Z55

④

PROVIDER NUMBER/NAME: 12345-CAMPBELL, VIVIAN A.

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ COB	OTHER ADJUSTMENTS NONCOV WITHHOLD	REMARKS	PAID
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PATIENT: CHRIS K. COOPER MEMBER #: 39688436101	⑥	SUBSCRIBER: CHRIS K. COOPER SUBSCRIBER #: 39688436101	SUBSCRIBER ADDRESS: 584 D'ONOFRIO DR., MADISON, WI 53719 GROUP #: 74571
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ACCOUNT NUMBER: 68489B

CLAIM NUMBER: 135029880330

070505	99203	50.00	⑦ 50.00	0.00	0.00	0.00	0.00	50.00	0.00	(46A NC)	0.00
070505	81000	14.00	14.00	0.00	0.00	0.00	0.00	14.00	0.00	(46A NC)	0.00
CLAIM TOTALS:		64.00	64.00	0.00	0.00	0.00	0.00	64.00	0.00		0.00
PROVIDER TOTALS:		64.00	64.00	0.00	0.00	0.00	0.00	64.00	0.00		0.00
VENDOR TOTALS:		64.00	64.00	0.00	0.00	0.00	0.00	64.00	0.00		0.00

REMARKS 46A NC THIS SERVICE IS NOT COVERED SERVICE/DIAGNOSIS NOT COVERED ⑧

⑨	BALANCE FORWARD	.00
	LINE ITEMS PAID	.00
	LINE ITEMS REVERSED	.00
	ADJUSTMENTS (-)	.00
	ADJUSTMENTS (+)	.00
	NET TOTAL	.00

- |   |  |
|---|--|
| <b>Key:</b> 1. Vendor name and mailing address<br>2. Check number<br>3. Vendor number<br>4. Provider number and name<br>5. Headerline | 6. Patient information<br>7. Claim information<br>8. Remark codes<br>9. Explanation of Payment summary |
|---|--|



## Explanation of Payment–Claim Reversal/Adjustment

000008-005-000008

DATE: September 1, 2005

PAGE 1

Dean Health Plan, Inc.  
 P.O. Box 56099  
 Madison, WI 53705-9399  
 Customer Service Department  
 608-828-1301 OR 800-279-1301

Explanation of Payments  
 Provider

① FIRST MEDICAL CLINIC  
 801 MAIN STREET  
 MADISON, WI 53717

② CHECK NUMBER 00000000  
 ③ VENDOR NUMBER Z55

④

PROVIDER NUMBER/NAME: 12345-CAMPBELL, VIVIAN A.

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ OTHER ADJUSTMENTS COB NONCOV WITHHOLD	REMARKS	PAID
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PATIENT: RACHEL HUNTER	⑥	SUBSCRIBER: RACHEL HUNTER	SUBSCRIBER ADDRESS: 709 PIKE LANE, STOUTON, WI 53589
MEMBER #: 39370838401		SUBSCRIBER #: 39370838401	GROUP #: 74671

ACCOUNT NUMBER: 68490B

CLAIM NUMBER: 135029880431

070505	99214	50.00-	⑦ 50.00-	0.00	0.00	0.00	0.00	50.00-	0.00	(63C 76)	0.00
070505	99214	50.00	50.00	0.00	0.00	0.00	0.00	0.00	2.50	(63C RV)	47.50
CLAIM TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50
PROVIDER TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50
VENDOR TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50

REMARKS 63C 76 CORRECTION TO A PRIOR CLAIM ⑧  
 63C RV CORRECTION TO A PRIOR CLAIM

⑨

BALANCE FORWARD	.00
LINE ITEMS PAID	47.50
LINE ITEMS REVERSED	.00
ADJUSTMENTS (-)	.00
ADJUSTMENTS (+)	.00
NET TOTAL	47.50

- Key:**
- |                                    |                                   |
|------------------------------------|-----------------------------------|
| 1. Vendor name and mailing address | 6. Patient information            |
| 2. Check number                    | 7. Claim information              |
| 3. Vendor number                   | 8. Remark codes                   |
| 4. Provider number and name        | 9. Explanation of Payment summary |
| 5. Headerline                      |                                   |



**Explanation of payment & Advice Page – Claim Overpayment, refund & adjustment**

000008-005-000008

DATE: September 1, 2005

PAGE 1

Dean Health Plan, Inc.  
 P.O. Box 56099  
 Madison, WI 53705-9399  
 Customer Service Department  
 608-828-1301 OR 800-279-1301

Explanation of Payments  
 Provider

① FIRST MEDICAL CLINIC  
 801 MAIN STREET  
 MADISON, WI 53717

② CHECK NUMBER 00000000  
 ③ VENDOR NUMBER Z55

④

PROVIDER NUMBER/NAME: 12345-CAMPBELL, VIVIAN A.

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ OTHER ADJUSTMENTS	REMARKS	PAID
							COB NONCOV WITHHOLD		

PATIENT: RACHEL HUNTER	⑥ SUBSCRIBER: RACHEL HUNTER	SUBSCRIBER ADDRESS: 709 PIKE LANE, STOU GHTON, WI 53589
MEMBER #: 39370838401	SUBSCRIBER #: 39370838401	GROUP #: 74671

ACCOUNT NUMBER: 68490B

CLAIM NUMBER: 135029880431

070505	99214	50.00-	⑦ 50.00-	0.00	0.00	0.00	0.00	0.00	2.50-	(63C 76)	47.50-
070505	99214	50.00	50.00	0.00	0.00	0.00	0.00	0.00	50.00	(28A FF)	0.00
CLAIM TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-
PROVIDER TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-
VENDOR TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-

REMARKS 63C 76 CORRECTION TO A ⑧  
 28A FF PRIOR CLAIM  
 COVERAGE WAS NOT IN EFFECT AT THE TIME THE SERVICE  
 WAS PROVIDED

⑨  
 BALANCE FORWARD .00  
 LINE ITEMS PAID 47.50-  
 LINE ITEMS REVERSED .00  
 ADJUSTMENTS (-) .00  
 ADJUSTMENTS (+) .00  
 NET TOTAL 47.50-

⑩ DEAN HEALTH PLAN ADVICE REPORT  
 FOR VENDOR NUMBER Z55

Voucher#	Reference#	TranDat	Gross	TranBal	Deductions	Net
9801999	135029880431	113098	47.50	47.50	.00	47.50
VENDOR TOTALS:			47.50	47.50	.00	47.50

- Key: 1. Vendor name and mailing address      6. Patient information  
 2. Check number                                      7. Claim information  
 3. Vendor number                                    8. Remark codes  
 4. Provider number and name                    9. Explanation of Payment summary  
 5. Headerline                                        10. Advice report showing adjustments (refund checks, etc.)



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## Claims Coding

This section outlines claim coding guidelines to ensure that timely filing and reimbursement of a claim occurs. Due to the revised CMS billing form and the increased requirements to provide medical data, it is imperative for services to be coded accurately. The new CMS-1500 form does not have a place for procedure descriptions; therefore, claims will be processed, based on the most current CPT or HCPCS codes. As a result, DHI/DHP requires valid ICD9-CM, CPT, and HCPCS codes on all claims.

Dean Health Insurance/Dean Health Plan will accept **two digit place of service codes only**. DHI/DHP may be contacted if you would like a listing of the place of service codes.

Please verify that your office uses current coding books to assist in timely submission and reimbursement. If you do not have current coding manuals, we suggest that you obtain one from the following list of potential suppliers:

American Medical Association  
515 North State Street  
Chicago, IL 60610

Practice Management Information Corp.  
727 Wilshire Boulevard  
Los Angeles, CA 90010

Ingenix  
P.O. Box 27116  
Salt Lake City, UT 84127-0116  
(800) 464-3649  
[www.IngenixOnline.com](http://www.IngenixOnline.com)

University Bookstore  
711 State Street  
Madison, WI 53703  
(608) 257-3784

ICD-9-CM coding:

- DHI/DHP requires claims to be submitted with current, valid ICD-9-CM codes that are extended to the maximum number of legitimate digits.
- The primary diagnosis should be the code which justifies the primary reason a patient is being treated. The “**E**” codes should never be submitted as the primary diagnosis code.



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#### CPT (procedure) coding:

- When a patient has reached long term or maintenance therapy status, as determined by the chiropractor, the code **S8990 (physical or manipulative therapy performed for maintenance rather than restoration)** should be utilized for billing, to reflect services provided.
- Documentation is required when submitting codes that are unlisted, not otherwise classified (NOC), or not elsewhere specified. Either office or operative notes are required in these cases. A description in box 19 on the CMS-1500 form is also acceptable.
- Due to the CMS billing form changes we will no longer be able to identify the specific service that is being billed when code 99070 is used. If the correct HCPCS code is not used, services billed with 99070 will be denied. Claims should be submitted with an appropriate Level II code if there is no other Level I code to identify the service.
- Category III (temporary) codes are not reimbursable unless specifically covered under a DHP medical policy.
- **If you are unable to locate an appropriate code, you must submit the description of the supply you are submitting under the unlisted Level II code.**

#### Modifiers:

To ensure correct reimbursement, it is imperative providers submit claims with appropriate modifiers.

DHI/DHP will not accept a modifier as a separate code (099--). When using modifiers, please place the two digit modifier behind the specific CPT code.

Modifiers are listed in CPT/HCPCS manuals. DHI/DHP uses Medicare reimbursement methodology based on the Medicare Physician Fee Schedule Database. This can be obtained through: [www.hhs.cms.gov/paymentsystem](http://www.hhs.cms.gov/paymentsystem).

## Special Coding Reminders

The following reminders have been taken out of your current contract with Dean Health Plan:

- ✓ For HMO/POS members claims coding should follow current CPT guidelines.
- ✓ For Administrative Services Only (ASO) members, claim coding must follow the fee schedule located in your current contract
- ✓ **All DME** coding must follow the fee schedule located in your current contract.



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## Chiropractic Care

Dean Health Insurance, Inc/Dean Health Plan provides coverage for chiropractic care at a plan provider with the exception of long-term and maintenance therapy. (Dean Health Plan Point of Service and Point of Enrollment members are not required to use plan providers.) For emergent/urgent chiropractic care by a non-plan provider, refer to emergent and urgent care services in this section. A **referral request** from a member's primary care provider is not required in order to see a plan chiropractor.

**Long-Term Therapy:** Therapy extending beyond 2 months that is determined, by our Medical Affairs Division, to be primarily maintenance therapy.

**Maintenance Therapy:** means ongoing therapy delivered after the acute phase of an accident or illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by our Medical Affairs Division after reviewing an individual's case history or treatment plan submitted by a health care provider.

The determination of what constitutes "maintenance/long-term therapy" is made by the chiropractor. Dean Health Insurance, Inc/Dean Health Plan Managed Care Division would review the case history or treatment plan of the patient if a questionable situation would arise.

**\*\*\*\*When a patient reaches long-term/maintenance therapy you should give them a copy of our "Chiropractic Handout." This will give the patient a brief description of benefits that are not available for long-term/maintenance therapy.**

See example of the "Chiropractic Handout" on the following page.



## CHIROPRACTIC HANDOUT

**Dean Health Plan (DHP) covers chiropractic services provided by a plan provider. Refer to a Member's Group Member Certificate to determine if the patient is required to pay an office co-payment for each visit.**

Items supplied by your chiropractor may or may not be covered benefit. **Examples of covered supplies are:**

- Slings
- Rib Belts
- Lumbar-sacral orthosis
- Wrist Cock-up Splint
- Cervical Collars
- Sacroiliac Support
- Elbow Orthoses
- Air Cast

**Examples of non-covered supplies are:** Orthopedic pillows, cushions, and other convenience items.

**Services not covered for chiropractic care:**

- Long-term and/or maintenance therapy
- Chiropractic care provided by a non-plan chiropractor

If you need further assistance in understanding your chiropractic benefits, contact the DHP Customer Service Department at (608) 828-1301 or toll free at (800) 279-1301.

### **The following definitions have been taken from the Dean Health Plan (DHP) Group Member Certificate**

Dean Health Insurance/Dean Health Plan (DHI/DHP) provides coverage for chiropractic care at a plan provider with the exception of long term and maintenance therapy. (Dean Health Plan Point of Service members are not required to use plan providers.)

- **Long-Term Therapy** - means therapy extending beyond two months which is determined, by the DHI/DHP Medical Affairs Division, to be primarily maintenance therapy.
- **Maintenance Therapy** - means ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated.

The determination of what constitutes "maintenance therapy" is made by the chiropractor and/or DHI/DHP Medical Affairs Division after reviewing an individual's case history or treatment plan submitted by a provider of healthcare.

**Services are not covered if the member seeks chiropractic care at a non-plan provider, unless it is urgent or emergent.**



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## Emergent and Urgent Care Services

### Emergent Care

**Emergent Care** - is care which is needed for the sudden and unexpected onset of an illness or injury. Some examples of emergent care cases are: heart attack, cerebrovascular accidents or strokes, poisoning, loss of consciousness, and inability to breath.

These and other acute conditions are emergencies when: they require medical care for accidental injury or illness; and severe symptoms are sudden and unexpected. They must be severe enough to cause a person to seek medical help right away, no matter what time it is; and immediate care must be received. If the condition does not meet this criteria, it will not be deemed as an emergency. The diagnosis or the symptoms themselves must show that the problem was one that required immediate medical care.

### Emergency Care from Dean Health Insurance, Inc/ Dean Health Plan Providers

Most of the time, your patient will get emergency care from a Dean Health Insurance, Inc/Dean Health Plan Provider. If a patient is unable to contact their Primary Care Practitioner, they should go to the nearest appropriate medical facility to receive care.

### Emergency Care from Non-Plan Providers

If your patient must go to a non-plan provider for care, they should call Dean Health Insurance, Inc/Dean Health Plan Customer Service as soon as possible and tell us where they received emergency care. **Such care must be documented in the patient's records and submitted with the claim so Dean Health Insurance, Inc/Dean Health Plan can verify that it was indeed an emergent situation.** *Follow-up must be received from a plan provider.*

**Urgent Care** - is care that your patient needs sooner than a routine doctor's visit. Some examples of urgent care cases are: most broken bones, sprains, non-severe bleeding, minor cuts, most drug reactions, and minor burns.

Your Dean Health Insurance, Inc/Dean Health Plan patient must receive urgent care from a Dean Health Insurance, Inc/Dean Health Plan Provider if they are in the health plan service area. If they are out of the health plan service area, they should go to the nearest appropriate medical facility unless they can safely return to the health plan service area to receive care from a plan provider.

If your patient resides outside of the health plan service area and receives urgent care services from a non-plan provider, they must notify our **Customer Service Department as soon as possible.**



There are no any available benefits for follow-up care with a non-plan provider unless such care is necessary to prevent further health risks. **Such care must be documented in the patient’s records and submitted with the claim so Dean Health Insurance, Inc/Dean Health Plan can verify that it was indeed an urgent situation.** Care that can be safely postponed until your patient can return to the health plan service area to receive such care from a plan provider is not considered to be urgent care. (The above guidelines do not apply to Dean Health Insurance, Inc/Dean Health Plan Point of Service and Point of Enrollment members; they are not required to use plan providers.)

## Chiropractic Supplies

Dean Health Insurance, Inc/Dean Health Plan will provide coverage for most supplies when:

- Prescribed by a plan provider for diagnosis of illness or injury (Point of Service and Point of Enrollment members are not required to use plan providers).
- Medically necessary and not solely for comfort or convenience of the member.

Dean Health Plan will provide coverage for the following chiropractic supplies listed below:

Code	Description
A4565	Slings
L0120	Cervical Collars
L0220	Rib Belts
L0628	Lumbar-sacral
L0629	Sacroiliac Support
L3710	Elbow Orthoses
L3908	Wrist Cock-up Splint
L4350	Air Cast

Other supplies should be obtained through Dean Health Plan’s durable medical equipment suppliers.

A list of these specific supplies with their appropriate HCPCS codes are also referenced in your Chiropractor Agreement with Dean Health Plan.



## Services That Are Usually Not Covered

The following is a list of services that are usually not covered. Please note that this list is not all inclusive.

- **Any service where a referral and/or prior authorization was needed and not obtained**
- Acupuncture
- After hours care
- Any surgical treatment or hospitalization for the treatment of morbid obesity
- Autopsy
- Batteries for Hearing Aids
- Chelation therapy for atherosclerosis
- Consultation for, or procedures in connection with, in vitro fertilization, embryo transplantation, and/or any other assistive reproductive technique (e.g., GIFT, ZIFT)
- Cranial bands for misshapen heads
- Cytotoxic testing in conjunction with allergy testing
- Donor sperm
- Educational supplies
- Hair analysis (unless lead or arsenic poisoning is suspected)
- Holistic medicine—services or other programs with an objective to provide personal fulfillment
- Internet consultations by and between providers and members
- Interpretation of psychiatric reports
- Lyme disease vaccination
- Environment intervention
- Hypnotherapy
- Training for activities of daily living
- Massage therapy
- Medical testimony
- Missed appointments
- Services provided by members of the subscriber's immediate family or any person residing with the subscriber
- Orthoptics (e.g., eye exercise training)
- Preparation of reports
- Refractive eye surgery and radial keratotomy
- Reversal of voluntary sterilization, and related, procedures
- Services and/or supplies related to a non-covered benefit or service, denied referral or prior authorization, or denied admission
- Services or supplies rendered outside the scope of a provider's license
- Special reports
- Swim or pool therapy
- Tattooing
- Telephone calls
- Transplants not specifically addressed as covered in the Group Member's Certificate
- Travel Immunizations (exceptions; coverage for Employers Trust Fund and School Districts)
- Treatment for Gambling addiction
- Weight loss programs, including dietary and nutritional treatment
- Work hardening
- Work related preventive treatment (e.g., Hepatitis vaccinations and Rabies vaccinations)



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## Chiropractic Capitation

Beginning in February each year, the Chiropractic Capitation Pool (CCP) is funded during the first week of each month based on the total member months for the year (for the period ending with the previous month) multiplied by a per member, per month (PMPM) rate. From this gross amount, all year-to-date reimbursement to non-Dean Health Plan (DHP) chiropractors for urgent/emergent care services provided to Members within the service area are deducted. 10 percent of the remaining amount will be withheld. Dean Health Plan funds the CCP at a per member, per month rate that is established by the Dean Health Insurance (DHI)/DHP Chiropractic Agreement. The member months is calculated based upon DHI/DHP Members only.

Funding of and distributions from the CCP will be based on calendar year-to-date information.

Distributions to chiropractors from the CCP are based on the chiropractor's year-to-date estimated unique patient counts, rather than actual unique patient counts. While not specifically addressed in the contract, we believe the use of estimates is necessary in order to avoid subjecting chiropractors to large variations in their monthly payments. Distribution from the CCP is based on the chiropractor's percentage share of unique patients to the total unique patient count.

Because there are time lags between the date of service, the submission of a claim, and the processing of a claim, credit for an actual unique patient may or may not occur during the month in which the patient was seen. This is particularly true if claims are submitted on paper, rather than electronically. As a result, if DHI/DHP used actual patient visits for a particular month, some chiropractors would receive no payment, while others (especially those who submit electronically) would receive a very large payment. It is the goal of the Provider Services Department to have all plan chiropractors submit their claims electronically to avoid some of lag problems.

The estimates are based on claims lag data from the previous year and applying it to the current year patient counts. DHI/DHP anticipates having to use estimates each year when addressing the lag issue. When feasible, DHI/DHP will revert to the use of actual patient counts. Even though the lag issue will always be a factor, the variability in patient counts should smooth out over the course of a year, allowing DHI/DHP to calculate the monthly capitation payment based on actual unique patient numbers.

From the year-to-date distribution amount, all previous month's distributions to the chiropractor (excluding supplies) will be subtracted; the remaining amount will be distributed to the chiropractor by the fifteenth (15th) of the month. Distribution amounts may vary from year-to-year based on changes to the PMPM rate.



A final, year-end payment will be made to the chiropractor, including distribution of its share of the 10 percent withhold, and will be based upon the Chiropractor's pro rata share of **actual** unique patients seen during the year. Distribution of the final year-end settlement will occur following completion of an annual reconciliation and will be paid no later than six (6) months after the end of the calendar year.

## Reimbursement for Medicare Select

The chiropractor should submit claims for services provided to Medicare Select Members directly to the Medicare Part B fiscal intermediary.

Reimbursement for Medicare Select claims is as follows:

- Copayments, deductibles, & coinsurance:
  - ✓ Provider will receive payment directly from the Medicare B fiscal intermediary for Medicare-covered services.
  - ✓ DHI/DHP will reimburse the provider for all applicable copayments, deductibles, and coinsurance as specified on the Explanation of Benefits form the Medicare Part B fiscal intermediary.
- Non-Medicare Covered Services (i.e. supplemental benefits)
  - ✓ DHI/DHP shall reimburse Provider for Covered Services which are not Medicare-covered services (i.e. services that are supplemental benefits under the Medicare Select Product) at the Medicare par prevailing rate. Covered Services for which there is no Medicare par prevailing rate shall be paid at DHI/DHP's maximum allowable rate.

Medicare Select services are not paid under the Chiropractic Capitation Pool.



## Example of How Distribution of Monthly Capitation is Calculated

Refer to Explanation of Chiropractic Capitation Allocation example.

### Total Allocation of Capitation Revenue for the entire chiropractic network:

Member months (Commercial Member Months Year to Date (YTD))  
 x Commercial Member Months at the Per Member Per Month (PMPM) rate  
 = Gross Chiropractic Capitation Pool (CCP)

- Non-plan urgent/emergent care (within service area)  
 = Net Capitated Revenue before Withhold

- 10% Withhold  
 = Net Capitation Revenue YTD

+ Supplies YTD  
 = *YTD Allocation for entire chiropractic network*

### Allocation for Dean Health Plan Sample Chiropractic Office:

Actual + Accrued chiropractic unique patients YTD  
 ÷ Actual + Accrued total unique DHP Chiropractic patients YTD  
 = % of Unique Patients

x Net Capitation Revenue YTD  
 = Net Capitation Revenue for individual chiropractor YTD

- Prior Capitation Payments YTD  
 - Supplies  
 = Monthly YTD Capitation Payment for Sample Chiropractic Office

***Payments will be distributed before or on the 15<sup>th</sup> of the following month.***

Key	
+	plus
x	multiply
-	minus
÷	divided
=	equals



**Explanation of Chiropractic Capitation Allocation**

CONFIDENTIAL BUSINESS INFORMATION

Dean Health Plan, Inc.

**Allocation of Capitation Revenue**

Period Ending January 01, 2006 - September 30, 2006

Gross Capitation Revenue(Commercial Member Months @ \$1.87) YTD	(1)	\$3,257,164.13
Commercial Member Months YTD =	1,741,799 (2)	
Less: Urgent/Emergent-Care services rendered to Managed Care Population by Non-Plan	(3)	
Non-Defunct Chiropractors within DHP Service Area: YTD		\$10,165.74
Equals: Net Capitated Revenue before Withhold YTD	(4)	\$3,246,998.39
Less: Withhold @ (10%) YTD	(5)	\$324,699.84
Equals: Net Capitation Revenue YTD	(6)	\$2,922,298.55
Plus: Supplies YTD	(7)	\$7,364.89
<b>Total YTD Allocation</b>	<b>(8)</b>	<b>\$2,929,663.44</b>

**Allocation of Capitation Revenue for the Month of September**

Gross Capitation Revenue(Commercial Member Months @ \$1.87)	(9)	\$368,683.59
Commercial Member Months =	197,157 (10)	
Less: Urgent/Emergent-Care services rendered to Managed Care Population by Non-Plan	(11)	
Non-Defunct Chiropractors within DHP Service Area:		\$2,096.17
Equals: Net Capitated Revenue before Withhold	(12)	\$366,587.42
Less: Withhold @ (10%)	(13)	\$36,658.74
Equals: Net Capitation Revenue	(14)	\$329,928.68
Plus: Supplies	(15)	\$812.43
<b>Total September 2006 Allocation</b>	<b>(16)</b>	<b>\$330,741.11</b>

Allocation for: *Dean Health Plan Sample Chiropractic Office* (17)

YTD									
Your Actual + Accrued unique patients YTD	437	(18)							
Actual + Accrued total unique DHP Chiro. pat. YTI	17,164	(19)							
% of unique patients	2.5460078%	(20)							
Net Cap. Revenue YTD	\$74,401.95	(21)							
Plus: Supplies YTD	\$66.45	(22)							
Plus: Medicare Select YTD	\$0.00	(23)							
Total 2006 Revenue YTD	\$74,468.40	(24)							
Less Prior Capitation Payments	\$67,445.65	(25)							
Less Prior Supply Payments	\$107.83	(26)							
Less Prior Medicare Select Payments	\$0.00	(27)							
<b>Total Paid \$'s in September 2006</b>	<b>\$6,914.92</b>								

	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)
	Accrued	Accrued %	Prior Pymts	Prior Pymts	Prior Pymts	Current YTD	Current YTD	Current YTD	Monthly
(28)	Pat. YTD	Pat YTD	Sup \$'s	Cap \$'s	Med Select	Sup \$'s	Cap \$'s	Med Select	Payment
January YTD	38	2.18%	\$0.00	\$0.00	\$0.00	\$0.00	\$7,148.61	\$0.00	\$7,148.61
February YTD	76	2.18%	\$0.00	\$7,148.61	\$0.00	\$0.00	\$14,150.05	\$0.00	\$7,001.44
March YTD	113	2.18%	\$0.00	\$14,150.05	\$0.00	\$52.58	\$21,163.42	\$0.00	\$7,065.95
April YTD	272	2.63%	\$52.58	\$21,163.42	\$0.00	\$107.83	\$33,900.11	\$0.00	\$12,791.94
May YTD	343	2.88%	\$107.83	\$33,900.11	\$0.00	\$107.83	\$46,395.97	\$0.00	\$12,495.86
June YTD	381	2.87%	\$107.83	\$46,395.97	\$0.00	\$107.83	\$55,650.11	\$0.00	\$9,254.14
July YTD	405	2.74%	\$107.83	\$55,650.11	\$0.00	\$107.83	\$62,030.88	\$0.00	\$6,380.77
August YTD	415	2.60%	\$107.83	\$62,030.88	\$0.00	\$107.83	\$67,445.65	\$0.00	\$5,414.77
<b>September YTD</b>	<b>437</b>	<b>2.55%</b>	<b>\$107.83</b>	<b>\$67,445.65</b>	<b>\$0.00</b>	<b>\$66.45</b>	<b>\$74,401.95</b>	<b>\$0.00</b>	<b>\$6,914.92</b>
October YTD									
November YTD									
December YTD									




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## Explanation of Chiropractic Capitation Allocation Key

1. Year-to-date gross capitation dollars
2. Total year-to-date months for Dean Members. A Member is allocated one month, per each month they are on the plan
3. Urgent/Emergent services rendered by non-plan chiropractor in Dean service area
4. Net capitated revenue (gross revenue minus urgent/emergent payments)
5. Contracted withhold held by Dean Health Plan (DHP)
6. Net capitated revenue minus the withhold.
7. Payment for covered supplies year-to-date
8. Total dollars paid year-to-date
9. Refer to #1
10. Total members counted for the current period/month
11. Refer to #3
12. Refer to #4
13. Refer to #5
14. Refer to #6
15. Refer to #7
16. Refer to #8
17. Chiropractor's name
18. Total unique patient counts -- year-to-date for each individual chiropractor
19. Total unique patient counts -- year-to-date for entire DHP network
20. Individual chiropractor percentage of unique patients
21. Individual chiropractor net capitation revenue year-to-date
22. Total supplies paid year-to-date
23. Total Medicare Select dollars (not included and paid on separate remittance)
24. Individual chiropractor total revenue year-to-date
25. Individual chiropractor's prior capitation payments
26. Individual chiropractor's prior supply payments
27. Individual chiropractor's Medicare Select payments
28. Month -- year-to-date
29. Accrued patients -- year-to-date (including patient estimates)
30. Accrued percentage of unique patients -- year-to-date
31. Prior payments for supply dollars
32. Prior payments for capitation dollars
33. Prior payment for Medicare Select payment
34. Current year-to-date supply dollars
35. Current year-to-date capitation dollars
36. Current year-to-date Medicare Select payment
37. Monthly payment to Chiropractor



### Explanation of Chiropractic Payment

Dean Health Plan, Inc.

CONFIDENTIAL BUSINESS INFORMATION

Payment for:

*Dean Health Plan Sample Chiropractic Office*

2006 Capitation Payment:	38	\$6,956.30
2006 Supplies Payment:	39	(\$41.38)
2006 Medicare Select Supplies & Services Payment:	40	\$0.00
2005 Supplies and Medicare Select Payments:	41	\$0.00
<b>Total Check for September:</b>	<b>42</b>	<b>\$6,914.92</b>

### Explanation of Chiropractic Payment Key

- 38. Current periods capitation payment
- 39. Current periods supplies payment
- 40. Current periods Medicare Select payment (not included on separate remittance)
- 41. Prior year supplies payment for current period
- 42. Total payment for period/month



Dean Health Plan, Inc.									
2006 Plan Chiropractic Supplies Paid in September 2006									
43	44	45	46	47	48	49	50	51	52
<u>Billing Doctor</u>	<u>Service Date</u>	<u>Patient Name</u>	<u>Member No.</u>	<u>Service Code</u>	<u>Description</u>	<u>Units</u>	<u>Claimed</u>	<u>Copay</u>	<u>Paid</u>
Dean Health Plan Sample Chiropractic Office	2/20/06	DOE J	999999999	L3700	Elbow Orthoses	-1	(\$51.72)	(\$10.34)	(\$41.38)
<b>Total</b>						-1	(\$51.72)	(\$10.34)	(\$41.38)

### Chiropractic Supplies Paid Key

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>43. Billing Chiropractor</li> <li>44. Service Date</li> <li>45. Patient Name</li> <li>46. Member Number</li> <li>47. Service Code</li> </ul> | <ul style="list-style-type: none"> <li>48. Supply Description</li> <li>49. Number of Units</li> <li>50. Dollar Amount Claimed</li> <li>51. Copay Amount</li> <li>52. Total Amount Paid for Supplies</li> </ul> |
|---|--|



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## Member Complaint, Appeal and Grievance

The Complaint, Appeal, and Grievance Procedure is used to resolve member issues. We ask that our providers familiarize themselves with this process, and refer all complaints to Dean Health Insurance (DHI)/Dean Health Plan (DHP), with consent from their patients, this process may also be used by providers to file appeals or grievances on behalf of their patients.

When a complaint, appeal, or grievance has been submitted, DHP may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from DHP. This will assist us in providing a timely response and resolution to complaints, appeals or grievances filed with our office. To ensure a fair decision, DHP gives our practitioners the opportunity to discuss decisions that are based on medical necessity with a DHP Medical Director. The treating physician will be informed at the time of the denial by the Medical Affairs Division how to initiate this process should he/she want to discuss the decision.

The procedure for filing a complaint, appeal, or grievance is defined below. This information is located in the Member Certificates.

Your understanding of this process will assist us in resolving member issues in a timely manner.

### **Complaint**

Dean Health Plan takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner.

If a member has a complaint regarding any aspect of care or decision made by you, please contact the Customer Service Department at **(608) 828-1301** or **(800) 279-1301**. We will document and investigate the member complaint and notify the member of the outcome of the complaint. If the complaint is not resolved to their satisfaction they can file a grievance.

Any written expression of dissatisfaction will automatically be addressed as a grievance (see Grievance subsection).

### **Grievance**

To file a grievance, a member can submit it to us in writing or contact the Customer Service Department at:

**Dean Health Plan  
P.O. Box 56099  
Madison, WI 53705  
(608) 828-1301/(800) 279-1301**

Upon receipt of the grievance, the Grievance Committee will acknowledge it within five business days. Our acknowledgment letter will advise the member of their right to submit written comments, documents or other information regarding their grievance, to be assisted or



represented by another person of their choice, to appear before the Grievance Committee, and the date and time of the next scheduled meeting, which will not be less than seven calendar days from the date of their acknowledgment and within 30 calendar days of receiving the grievance. If the member chooses to appear before the committee, they must notify us. If they are unable to appear before the committee, they do have the option of scheduling a conference call.

Their grievance will be documented and investigated. All grievances will be resolved within 30 calendar days of receipt.

### **Independent External Review**

You may be entitled to an independent external review of a final adverse determination involving care which has been determined not to meet the Plans' requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of care, or where the requested services have been found to be experimental treatment.

In order to request an independent external review the following criteria must be met;

1. The amount of the total claim liability must exceed \$250.
2. Unless the reason for an independent external review is urgent, the request must be submitted to us in writing and the request must include:
  - a. The name of the certified Independent Review Organization (IRO).
  - b. A \$25 fee payable to the IRO you have chosen  
You can obtain a list of the certified IRO's by calling our Customer Service Department at (608) 828-1301 or (800) 279-1301, or by contacting the Office of the Commissioner of Insurance at (608) 266-3585, or (800) 236-8517, or by accessing their Website at: [www.oci.wi.gov](http://www.oci.wi.gov).
3. The request for an independent external review must be made within four months of the date of the completion of the grievance process.
4. You must exhaust all appeal/grievance options before requesting an independent external review. However, if we agree that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize life or health, you may ask to bypass our internal grievance process. In urgent and emergent situations, your request will be processed on an expedited basis.

You may designate another person or party to appeal on your behalf. However, you must give permission in writing.

The decision of the IRO is binding on both the insurer (the Plan) and the insured. If our decision is overturned in part or in whole, the \$25 fee will be refunded.

Requests for benefits beyond those in your benefit package are not eligible for independent external review.

Please contact our Customer Service Department for information regarding availability, filing fees, and the process for initiating the review.



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### **Urgent Grievance**

If the initial grievance involves the need for urgent care, we will resolve those within 72 hours of receiving the grievance according to DHP's criteria which is based upon the urgent care grievance provisions of state law. The request may be oral or written.

### **Office of the Commissioner of Insurance**

Problems may be resolved by taking the steps outlined on the previous pages. You may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the Office of the Commissioner of Insurance by writing to:

**Office of the Commissioner of Insurance  
P.O. Box 7873  
Madison, WI 53707-7873**

Or, you can call (608) 266-0103 Madison, or (800) 236-8517 outside Madison, and request a complaint form.

## **Provider Appeals Process**

DHI/DHP has the authority to establish, modify and implement various policies and procedures with regard to such matters as clinical practice guidelines, quality assurance, utilization management, quality improvement, credentialing, and coding.

DHI/DHP will accept proposals to modify or make an exception to an established policy or procedure. If DHI/DHP denies a claim or benefit that results in a partial payment, denial to a practitioner, or makes a determination that is unsatisfactory to the practitioner, the practitioner of care is entitled to appeal the denial. If a claim is specifically denied for timely filing, please reference the process below.

Appeal requests will be considered, if submitted in writing, by an appropriate representative of DHI/DHP. We require that practitioners respond promptly to any requests for information regarding their appeal. This will assist Dean Health Plan in providing a timely response to the appeal filed with our office.

If the practitioner is dissatisfied with the decision made by the DHI/DHP representative, the provider will be advised of their subsequent appeal rights, as outlined in their agreement, to request that the decision be reviewed by the president of DHI/DHP, or his or her designee, who shall have the right to uphold or overturn the decision. The results of the final review shall be considered final and binding upon DHP and provider.



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## Timely Filing Appeals

Dean Health Plan considers timely filing appeals separately from Provider and Coding Appeals. If the timely filing guidelines and/or exception guidelines were not met and the claim(s) remained denied, the provider may appeal the timely filing denial to the Timely Filing Committee (**refer to ID card, EOP, Claims section for the TF guidelines**). The provider must submit additional documentation to support filing their claim timely, in writing, in order for it to be review by the Timely Filing Committee (TFC). The TFC is a cross divisional group consisting of staff from Provider Services, Customer Service and Claims. A member of the Committee will communicate, in writing, the TFC's decision to the Provider, specifying the reason(s) for the decision, advising the Provider of his/her right to discuss the decision. The TFC is the designee, who shall have the right to uphold or overturn a timely filing denial; based on the documentation provided and final review.

The results of the final review by the TFC shall be considered final and binding upon DHP and Provider.



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## Practitioner Credentialing/Recredentialing Process

Dean Health Plan has developed and implemented a credentialing/recredentialing process for selecting and evaluating practitioners who practice within the DHP delivery system. DHP policies specify the process used to evaluate practitioners, departments responsible for evaluating provider applications and the committee responsible for approval of providers.

The Credentialing/ Recredentialing process will be completed within 180 days of the date of the practitioner's signature on the application. If the time of the process exceeds 180 days, Network Services & Credentialing will return the application to the practitioner for review and updating of signatures.

Practitioners must be approved by the Credentialing Committee or its delegate at least every three (3) years to be authorized to provide services to DHP members.

Dean Health Plan credentials MD, DOs, DDSs, DPMs, DCs, ODs, Mental Health practitioners (Ph.D.s, Masters level practitioners and Alcohol and Other Drug Abuse (AODA) and other licensed Independent mid-level practitioners. Practitioners who practice exclusively within the inpatient setting and who provide care for members only as a result of members being directed to the hospital or another inpatient setting do not fall under the scope of credentialing by DHP as they are credentialed by the hospital.

Practitioner Credentialing and Recredentialing applications must be reviewed and approved by the DHP Credentialing Committee or its delegate prior to being authorized to provide services to DHP members. All credentialing/recredentialing will be conducted in a non-discriminatory manner. DHP's policies provide practitioners with an opportunity to review and correct any information used in the credentialing/recredentialing process and ensures that all information obtained in the credentialing/recredentialing process is kept confidential. All practitioners have the right, upon their request, to be informed of the status of their credentialing/recredentialing application.

Network Services & Credentialing will notify any applicant of any information obtained during the credentialing/recredentialing process that varies substantially from the information provided to DHP by the applicant. Network Services & Credentialing will allow an applicant to correct erroneous information submitted as a part of their application.

Network Services & Credentialing will allow any applicant to review the information submitted in support of their credentialing/recredentialing application. Applicants have the right, upon request, to be informed of the status of their credentialing/recredentialing application. The applicant can arrange for a review of their individual application at the office of DHP.

Network Services & Credentialing may request additional information from the applicant or other parties that relates to the information submitted in support of the application or verification of the applicant's credentials and qualifications. This includes, but is not limited to:



- Information that is missing or incomplete on the application.
- Clarification of information obtained during the process that varies substantially from the information provided by the applicant.
- Correcting erroneous information.

All applicants must complete an application that includes personal identifiers, professional information, education and experience, medical licensure information, medical specialty, hospital privileges, disciplinary actions, malpractice carrier, and conditions of the application. The application includes statements by the applicant regarding:

- Ability to perform the essential functions of the position, with or without accommodation, for any condition, physical or mental.
- Lack of current illegal use of drugs.
- History of loss of license.
- History of felony convictions.
- History of loss or limitation of privileges or disciplinary activity.
- Attestation to the correctness and completeness of the application.
- Dates and amounts of current malpractice insurance coverage.

Network Services & Credentialing verifies that the applicant has completed statements on the application regarding:

- Any inability to perform the essential functions of the position, with or without accommodation.
- Lack of present illegal drug use.
- History of loss of license and/or felony conviction.
- History of loss or limitation of privileges or disciplinary activity.
- The applicant's attestation to the correctness and completeness of the application.
- Dates and amounts of current malpractice insurance coverage.

Applicants must provide the following information with the application:

- Signed AUTHORIZATION FOR RELEASE OF INFORMATION form.
- Completed curriculum vitae form or equivalent information provided.
- A copy of current malpractice declaration with amounts and dates of coverage.
- A copy of current Drug Enforcement Agency licensure (as applicable).

Network Services & Credentialing collects and reviews information about the applicant's credentials and qualifications, including verification of the following items from primary sources, as applicable:

- Verification of a valid state license to practice from the appropriate medical licensing authority.
- Verification of hospital privileges (if applicable). Credentialing look-back period is five (5) years and recredentialing two (2) years.

- Verification of the applicant's valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate, as applicable for MDs, DOs, DPMs, DDSs, and ODs.
- Verification from a physician applicant's residency training program verifying completion, as applicable. Internships, residencies and fellowships are verified during initial credentialing. If a fellowship is completed post credentialing, DHP should be notified so that the fellowship can be verified and added to credentialing file.
- Verification of Board certification if the physician applicant states that he/she is board certified. Board certification can be verified using the most current version of *The Official ABMS Directory of Board Certified Medical Specialists*, the AOA Official Osteopathic Physicians Profile Report or AOA Physicians Master File, or verification from either ABMS or AOA specialty board(s).
- Verification through application or curriculum vitae (CV) with a minimum of (5) five years work history in the health care field or since completion of medical or professional school to current. For practitioners who have practiced fewer than 5 (five) years, verification begins with the completion of education to current. Any gap exceeding (6) six months must be clarified either verbally or in writing. The CV or application must include the month and year for each position in the history. If there has been continuous employment for (5) years or more, no month or year are required. Any gap exceeding (1) year must be verified in writing. During recredentialing you will be asked to indicate your work history for previous (3) years.
- Verification of the applicant's malpractice insurance to verify it is current and adequate, according to DHP policy.
- Review of the applicant's history of professional liability claims which result in settlements or judgments paid by or on behalf of the applicant. Network Services & Credentialing reviews the information supplied by the applicant and receives information from the National Practitioner Data Bank (NPDB), which includes previous sanction activity by Medicare and Medicaid.

Physician applicants who have not completed at least one residency that made them eligible for ABMS or AOA board certification in that specialty must apply as a general practitioner. Network Services & Credentialing will verify the following during initial credentialing. Practitioner status will remain the same unless DHP is notified of any changes.

- The applicant's training program after receiving their medical degree.
- The applicant's work experience as a practitioner.
- References from three practitioners familiar with the applicant's practice of medicine who attest to the applicant's performance as a physician and the quality of care and professional conduct of the applicant.

Network Services & Credentialing prepares a credentialing/recredentialing file of all of the information provided by or on behalf of the applicant or obtained in the process of reviewing the application.

Network Services & Credentialing forwards applicant credentialing/recredentialing files to members of the Credentialing Committee when the department staff has determined that information received in support of the applicant meets the DHP requirements for

credentialing/recredentialing and all information and verification required for credentialing has been completed.

The Credentialing Committee members review applicant credentialing/recredentialing files. Credentialing Committee members may return the application to Network Services & Credentialing and request additional information.

The Credentialing Committee has sole discretion to approve or deny applications. Criteria that may be used by the committee to review credentials include, but are not limited to:

- History of illegal or unethical conduct.
- History of felony convictions.
- History of acts of dishonesty, fraud, deceit, or misrepresentation.
- History of involuntary termination of professional employment.
- History of professional disciplinary action or sanction by a managed care organization, hospital, medical review board, licensing agency, or other administrative body.
- History of NPDB adverse action report.
- History of misrepresentation, misstatement, or omission of relevant facts.
- History of physical or mental condition, chemical dependency or substance abuse that may interfere with the ability to practice in their specialty or may jeopardize patient health or safety.
- History of malpractice lawsuits, judgments, settlements, or other incidents that might indicate problems with competence or quality of care.
- Demonstrated unwillingness to practice their specialty in a managed care environment and to cooperate with DHP in administrative procedures and other matters.
- Debarment or termination from the Medicare and Medicaid programs by the US Office by Personnel Management.

The DHP Credentialing Committee reserves the right to request detailed information when reviewing credentialing or recredentialing applications. Failure to provide information as requested may be the basis for denying participation with DHP.

Credentialing Committee members may recommend approval, denial or postponement of a decision until the applicant's qualifications are further clarified. The Credentialing Committee may instruct Network Services & Credentialing to obtain additional information in support of the applicant.

### **Initial Credentialing Applications:**

Network Services & Credentialing may close the applicant's file during the initial credentialing process at any time if the QI Director or Credentialing Supervisor determines that the applicant does not meet the standards of this or any other DHP Credentialing policy. This can include, but is not limited to:

- The applicant does not meet all DHP requirements to be approved as a plan practitioner.
- The applicant is unable or unwilling to provide Network Services & Credentialing with accurate or complete information regarding questions on their application.



- The applicant is unable or unwilling to provide Network Services & Credentialing with verifiable information to support the credentialing process.
- The applicant is unable or unwilling to provide Network Services & Credentialing with requested information relating to their credentials, qualifications, history as a medical practitioner, criminal, or illegal activities.

The closing of an applicant's credentialing file terminates the credentialing process for that applicant. In the event of closing an applicant's credentialing file, Network Services & Credentialing will notify the applicant, in writing, stating the reason(s) for closing the file, and returning the applicant's original application materials.

The applicant may withdraw their application at any time during the credentialing process.

An applicant may reapply for DHP credentialing at any time they are able to demonstrate they can meet all requirements for credentialing under this or any other DHP credentialing policy.

Providers denied by the Credentialing Committee during initial credentialing may reapply with DHP after twelve (12) months.

### **Recredentialing Applications:**

Providers denied during the recredentialing process will be notified in writing of the decision for denial, and of their rights to appeal the decision. All decisions made by the appeal committee are final. For more detail regarding denials, see section Altering Participation Status.

All material obtained in the credentialing process, including complete applications, will be retained by Network Services & Credentialing. Network Services & Credentialing maintains strict confidentiality of all information obtained during the credentialing process, except as otherwise provided by law. Access to the credentialing information is limited to Network Services & Credentialing staff involved in the credentialing process, and the Credentialing Committee members. All credentialing applications, files and other materials and information are kept in locked files, except when being reviewed or processed by Network Services & Credentialing staff or members of the Credentialing Committee.

## **Altering Participation Status**

Any decision to alter participation pursuant to this policy will be based on quality of care issues, professional competence or conduct. This policy shall not apply to actions taken pursuant to a practitioner's Participating Provider Agreement with DHP that do not relate to the above.

The action of altering a practitioner's participation with DHP will be recommended by the DHP Credentialing Committee. Reasons for altering of participation include, but are not limited to:

- Professional state licensure revocation, suspension or limitation.
- Drug Enforcement Agency licensure revocation or limitation.
- Debarment or termination from the Medicare or Medicaid programs by the U.S. Office of Personnel Management.



- Loss or suspension of medical staff membership or restrictions on clinical privileges at any DHP participating hospital for reasons related to quality, professional competence or conduct.
- Notification which involve imminent danger and/or concerns of quality to members.
- Notification from DHP Medical Peer Review Committee (MPRC) indicating quality concerns that warrant altering participation.
- Reported suspensions from the National Practitioner Data Bank (NPDB).

Information received regarding a practitioner or organization will be fully investigated by the credentialing staff, Provider Service Practice Leader and/or the Credentialing Committee Chairperson. All compiled information received will be reviewed by the Credentialing Committee.

Forms of investigation may include but are not limited to:

- Correspondence with practitioner; written and/or verbal.
- Documentation from previous employers.
- Documentation from current or past facilities that clinical privileges were held.

In the event that the investigation reveals concerns about quality, professional competence-or conduct that do not rise to the level of requiring immediate termination, the Credentialing Committee may recommend appropriate actions.

Any recommendation of the Credentialing Committee involving the reduction of privileges, suspension or termination of a practitioner or organizational provider shall be reviewed within 30 business days by the DHP Executive Staff members: President and Chief Operating Officer, Senior Vice President and Chief Medical Officer and the Vice President of Corporate Strategy and Contracting. The Executive Staff will:

- Approve the Credentialing Committee decision; or
- Disapprove the Credentialing Committee recommendation and stipulate alternate action to be taken.

Upon approval of the Credentialing Committee's recommendation, notification of the adverse action shall be sent to the affected practitioner in accordance with Section 1 of DHP Credentialing Policy *CR 3017: Practitioner Appeal Process for Decisions Resulting in Reduction, Suspension or Termination*.

The affected practitioner shall remain listed as a participating provider until he or she has waived or exhausted his or her right to an appeal of the adverse action as set forth in DHP Credentialing Policy *CR 3017: Practitioner Appeal Process for Decisions Resulting in Reduction, Suspension or Termination*. Reporting of quality of care issues to the National Practitioner Data Bank (NPDB) and Wisconsin Department of Regulation & Licensing will be made in accordance with DHP Credentialing Policy *CR3018: Reporting Serious Quality Deficiencies*.



The Executive Staff decision is final, subject to any appeal by the practitioner. In the event the Executive Staff does not agree with the recommendation of the Credentialing Committee, the rationale for taking alternate action will be provided in writing to the Credentialing Committee. The Executive Staff decision will be communicated to the affected provider in accordance with Section 1 of DHP Credentialing Policy *CR3017: Practitioner Appeal Process for Decisions Resulting in Reduction, Suspension or Termination*.

The range of actions that can be taken by the Credentialing Committee or the Executive Staff includes but is not limited to:

- Continued Medical Education (CMEs) as appropriate;
- Proctoring;
- Communication by DHP Chief Medical Officer;
- Ongoing Practice Assessments; or
- Reduction, suspension or termination of practitioner's participation.

In the event that immediate action is required to prevent harm to DHP members, employees or other participating providers, DHP Executive Staff and Credentialing Committee Member may approve an immediate-termination action. These Committee Members will include the President and Chief Operating Officer, Senior Vice President and Chief Medical Officer, Vice President of Corporate Strategy and Contracting, and the Credentialing Committee Chairperson. Reasons for immediate termination include but are not limited to:

- Professional state license revocation;
- Drug Enforcement Agency licensure revocation;
- Debarment or termination from the Medicare or Medicaid programs by the U.S. Office of Personnel Management; or
- Loss or suspension of medical staff membership or restrictions on clinical privileges at a DHP participating hospital for reasons related to quality, professional competence or conduct.

In the event that DHP takes immediate action, DHP will provide the practitioner written notice of the action, including reasons for the action. Upon receiving the notice, the practitioner may request a hearing as described in DHP Credentialing Policy *CR3017: Practitioner Appeal Process for Decisions Resulting in Reduction, Suspension or Termination*.

In order to initiate an appeal, the plan practitioner must submit a written request identifying the reason he/she believes the decision was made in error, within 30 days of notification, to the Chief Medical Officer (CMO) or Vice President of Managed Care. The practitioner may submit any substantiating documentation pertinent to the Appeals Committee's review.

The Appeals Committee will consist of no less than two DHP physicians, who are not in direct competition with the plan practitioner and who are not members of the Credentialing Committee, the Chairperson of the DHP Credentialing Committee, and a DHP non-physician officer.

The Appeals Committee will meet within 15 days of receiving a request for appeal and will conclude its deliberations within 30 days of receipt of the request for an appeal. The practitioner has the right to appear and present information to the Appeals Committee. If the practitioner chooses not to be present at the Appeals Committee meeting, the Appeals Committee will make their final decision based on the information available. This decision will be communicated in writing to the practitioner within 14 days from conclusion of the appeals committee's deliberations.

Again, the decision of the Appeals Committee is final. Based on that decision, DHP will coordinate proper notification to the NPDB and the Department of Regulation and Licensing.

Dean Health Plan, Inc. will complete the Adverse Action Report Form developed by the NPDB and will forward the information to the NPDB.

Dean Health Plan, Inc. (DHP) shall follow a standardized policy and procedure for altering a practitioner's participation in the DHP network for reasons relating to quality of care, competence or professional conduct.

## Annual Practitioner Office Site Assessment

Dean Health Plan performs an annual Practitioner Office Site Assessment of all Primary Care practitioner (PCP) sites within the DHP network. A self-assessment reporting tool is provided to the practitioner office site for completion. The self-assessment ensures compliance with the performance expectations DHP has set regarding site and medical recordkeeping standards of participation.

When a completed application for credentialing is received from a practitioner, Network Services & Credentialing will review the application to determine if a structured review is necessary to evaluate the clinical site characteristics, medical recordkeeping practices, facility policies and procedures against DHP standards of participation.

Dean Health Plan will require an assessment of the site and medical recordkeeping practices for all practitioners prior to their credentialing. An initial site assessment must occur prior to the opening of a new clinic site.

Each element of the site review will be evaluated to determine if the facility is in compliance with the DHP standards of participation. Network Services & Credentialing has established a scoring mechanism for rating performance. A total score of compliance with the standards of participation will be computed and be available to the Credentialing Committee in reviewing the practitioner's credentials, if requested.

All facilities with a total compliance score of 90 percent or greater will be encouraged to improve in any areas of partial or noncompliance. All facilities with a total compliance score of less than 90 percent will be required to submit an action plan to DHP within 30 days, addressing their plans for improving in all areas of partial or noncompliance with DHP standards of participation.

DHP evaluates the effectiveness of action plans for improvement at least every 6 months until the site has demonstrated compliance in areas of deficiency sufficient to raise the total compliance score to 90 percent or above.

Sites that do not make improvements to raise the total score to 90 percent or greater after 12 months will be referred to the Credentialing Committee Chairman for review and follow-up actions.

Network Services & Credentialing will communicate the scoring summary and recommendations for improvement to the facility.

The Credentialing Committee may delay credentialing approval of a practitioner until the facility has submitted an acceptable action plan to address needed improvements.

The Credentialing Committee may deny credentialing approval of a practitioner if the facility fails to submit an acceptable action plan for improvement.

## Site Visits for Practitioner Office Sites

DHP conducts monthly medical recordkeeping and documentation audits of at least two Primary Care practitioner office sites to assess compliance with DHP medical recordkeeping and documentation standards. Network Services & Credentialing has established a scoring mechanism for rating compliance. The review evaluates the site against the DHP standards for:

- Medical Recordkeeping Standards
- Medical Record Documentation

The record documentation review will be performed by DHP staff with appropriate clinical training and experience to evaluate the elements that pertain to medical practice and health management.

Each element of the site review will be evaluated to determine if the facility is in compliance with the DHP standards of participation. Network Services & Credentialing has established a scoring mechanism for rating performance. A total score of compliance with the standards of participation will be computed and be available to the Credentialing Committee in reviewing the practitioner's credentials, if requested.

All facilities with a total compliance score of 90 percent or greater will be encouraged to improve in any areas of partial or noncompliance. All facilities with a total compliance score of less than 90 percent will be required to submit an action plan to DHP within 30 days, addressing their plans for improving in all areas of partial or noncompliance with DHP standards of participation.

DHP evaluates the effectiveness of action plans for improvement at least every 6 months until the site has demonstrated compliance in areas of deficiency sufficient to raise the total compliance score to 90 percent or above.

Sites that do not make improvements to raise the total score to 90 percent or greater after 12 months will be referred to the Credentialing Committee Chairman for review and follow-up actions.

Network Services & Credentialing will communicate the scoring summary and recommendations for improvement to the facility.

The Credentialing Committee may delay credentialing approval of a practitioner until the facility has submitted an acceptable action plan to address needed improvements.

The Credentialing Committee may deny credentialing approval of a practitioner if the facility fails to submit an acceptable action plan for improvement.

## Clinical Site Standards

Most care for DHP members is provided in Primary Care practitioner offices. For this reason, DHP conducts annual Practitioner Office Site Assessments of all Primary Care practitioner office sites to review the quality of the facility in which the care is provided.

Dean Health Plan requires that all clinic facilities meet the following minimum site characteristics:

- Overall appearance is clean and orderly.
- Office is easy to locate.
- Handicapped parking is available.
- Facility is handicapped assessable.
- Adequate waiting room space.
- Exam room(s) are adequate for providing patient care.
- Exam room(s) allow for privacy.
- Exits are clearly marked.
- Fire extinguishers are accessible.
- Record of fire inspection in the last year.

Dean Health Plan recommends that all clinic sites establish the following minimum facility policies and procedures:

- **Quality Assurance (QA) Committee and/or Process:** Dean Health Plan recommends establishment of a formal QA Committee/Process. The Committee or person responsible should respond to quality issues referred by DHP and other facilities. The review and/or response should be performed by practitioners or staff members other than the practitioner/staff member cited in the potential quality issue.
- **Complaint and grievance process:** Dean Health Plan recommends establishment of a formal grievance and complaint process. The person responsible should respond to all grievances and complaints received from patients or referred by DHP. *NOTE: The process description should be available to patients.*

- **Confidentiality:** Dean Health Plan requires establishment of a formal policy for ensuring the confidentiality of all patient information and medical records documentation. The policy should be in writing and signed by all staff members. *NOTE: The statement of the policy should be available to patients.*
- **Patient rights and responsibilities policy:** A "Rights of the Patient" policy, which addresses basic patient rights, such as the right to receive or refuse treatment, confidentiality of medical records, right to second opinions, etc., should be written and available to all patients.
- **Education Materials:** If applicable, patients should have materials accessible to them which address basic health concerns, such as DHP preventive health guidelines, childhood immunization recommendations, etc.
- **Fee and Payment Policies:** Written description available to patients, including dispute resolution.
- **After hours care access policy:** Dean Health Plan requires that a mechanism be in place for patients to access care 24 hours a day. Dean Health Plan recommends that either a handout or other service be in place to direct the patient to care from the practitioner's office. Dean Health Plan has adopted the standard that PCP sites must return phone calls to members within 30 minutes of being notified the member needs a call back.
- **Appointment No-Show, Late Arrival Policy:** Policy for documenting no-shows and late arrivals and efforts to follow-up. *NOTE: This policy should be known by patients.*
- **Waiting Time:** Dean Health Plan has adopted the standard that, when a patient arrives on time for a scheduled appointment, waiting time before they are seen by the practitioner should be less than 30 minutes.
- **Staff CPR training:** Dean Health Plan recommends that at least one staff member with current CPR certification is on duty at all times patients are present in the building.
- **Drugs and Medications:** If applicable, Dean Health Plan requires that all facilities keep drugs and medications in a safe, secure location away from patient access, and that a routine inventory count is done on all drugs and medications.
- **Universal Precautions:** Written policy on the use of universal precautions and evidence of staff training and monitoring.
- **Infection Control:** If applicable, written policy on infection control procedures and evidence of staff training and monitoring.
- **Code blue, fire, and tornado policies:** There should be facility policies regarding code blue, fire, and tornadoes that are written and well known by the staff at the facility, to avoid confusion or delay in a potentially life threatening situation.
- **Appointment Availability:** If applicable, Dean Health Plan has established the following standards:

### Primary Care Appointment Availability

<b>Preventative Care:</b> (physical exams and preventive health visits)	30 Days
<b>Routine:</b> (follow up visits, blood pressure checks, suture removal, etc.)	14 Days
<b>Symptomatic, non-urgent:</b> (colds, headaches, join/muscle pain, etc.)	4 Days
<b>Urgent:</b> (persistent fever, sore throat, diarrhea, vomiting)	24 hours

**Access to after-hours care:** Primary care sites must have information available and accessible to members regarding after-hours care and 24-hour emergency room access.

### Behavioral Health Appointment Availability

Routine office visit	Within 10 days
Urgent care visit	Within 48 hours
Emergency, including life-threatening & non life-threatening services	Immediately

## Medical Recordkeeping Standards

A consistent, complete and available medical record is an essential component of quality patient care. Dean Health Plan requires clinics and other facilities to have policies and procedures regarding medical recordkeeping practices and to maintain medical records in accordance with DHP standards of participation.

Each element of the medical recordkeeping standards is evaluated by use of the self-assessment reporting tool to determine if the facility is in compliance, with the DHP standards of participation. Network Services & Credentialing has established a scoring mechanism for rating performance.

A medical record must be maintained for every patient seen for care. No family charts or combined charts (e.g., several children in the same chart) are allowed.

1. The facility must have written policies and procedures for collection, storage and use of medical records to safeguard against loss, destruction or unauthorized use. The following policies are required:
  - A specific individual is identified for maintaining records.
  - Records are maintained in a designated area, inaccessible to patients.
  - All medical records are clearly labeled with a patient name or ID.
  - All materials are fastened in the medical record.
  - The facility meets the DHP standard of 90 percent of records available at the time of visit.
  - The facility has a policy for tracking medical records that are in use.
  - The facility has a policy for retention of active and inactive records.
  - The facility has a policy for release of medical record information.
2. The contents of the medical record should be current, detailed and arranged in a manner that facilitates the retrieval of pertinent clinical information. The following written policies are required:



- The facility has a policy for filing current information in medical records.
- The facility has a policy for dating and signing all entries in the medical record.
- Information in the medical record is divided into sections (tabbed) for easy use and reference.
- The facility has a procedure for documentation of drug and other allergies.
- If applicable, the facility uses problem lists and/or flow sheets for preventive health, immunizations, etc.
- The facility uses consent forms for receiving/refusing treatment and authorizing treatment of minors.
- Patient care information is recorded in accordance with DHP medical record documentation standards.
- If applicable, the facility has a policy for documenting in the medical record the existence of an advance directive when informed of such by the member or DHP and includes a copy of any advance directives received in the medical record.

Network Services & Credentialing will inform the facility of their compliance with DHP medical recordkeeping standards and their total compliance score.

A total score of compliance with medical recordkeeping practice standards will be computed and be available to the Credentialing Committee in reviewing the practitioner's credentials, if requested.

## Medical Records Documentation Standards

Dean Health Plan requires consistent and complete documentation in the medical record as an essential component of quality patient care for all practitioner sites. Dean Health Plan will perform a medical record documentation review of random Primary Care practitioner office sites. The visit is to assess compliance with DHP site and medical record documentation standards.

DHP conducts monthly medical recordkeeping and documentation audits of at least two Primary Care practitioner office sites to assess compliance with DHP medical recordkeeping and documentation standards. Network Services & Credentialing has established a scoring mechanism for rating compliance.

The record documentation review will be performed by DHP staff with appropriate clinical training and experience to evaluate the elements that pertain to medical practice and health management.

Each element of the medical record documentation standards will be evaluated at the time of the site visit to determine if the facility is in compliance with the DHP standards. Network Services & Credentialing has established a scoring mechanism for rating performance.

1. Each page in the record contains the patient's name or ID number.

2. Personal/biographical data include the address, employer, home and work telephone numbers, and marital status.
3. All entries in the medical record contain author identification.
4. All entries are dated.
5. The record is legible by someone other than the writer. A second reviewer may examine any record judged to be illegible by one physician reviewer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. If applicable, medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. If applicable, past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years of age and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. If applicable, for patients 14 years of age and older seen three or more times, there is appropriate notation concerning use of tobacco, alcohol, and substances.
10. The history and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is no evidence of under utilization and over utilization of consultants.
17. If a consultation is requested, there a note from the consultant in the record.
18. All significantly abnormal lab or imaging reports and all consultations are initialed by the primary care physician to signify review; or there is representation of physician review in the progress notes, as appropriate.
19. There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic problem.

20. An immunization record for children is up to date.
21. There is evidence preventive screening and services are offered in accordance with DHP's health maintenance guidelines:
- Six or more well-child visits in the first 15 months of life
  - Annual well-child visits ages 2-6 years.
  - Patient and/or family member education is appropriate for patient history and/or risk, e.g. diet and exercise, safety and injury prevention, tobacco use, alcohol and other drug abuse.
  - An immunization record is present and up-to-date for all adults.
  - Blood pressure reading is recorded at least every two years.
  - A mammogram is performed at least every two years for women ages 50-75.
  - A Pap test is performed at least every three years for women (with cervix) ages 18-65.

Each element of the medical record documentation review will be evaluated to determine compliance with DHP standards.

A total score of compliance with medical record documentation standards will be computed and be available to the Credentialing Committee in reviewing the practitioner's credentials, if requested.

All facilities with a total compliance score of 90 percent or greater will be encouraged to improve in any areas of non-compliance.

All facilities with a total compliance score of less than 90 percent will be required to submit an action plan to DHP within 30 days addressing their plans for improving in all areas of noncompliance with DHP standards. Dean Health Plan evaluates the effectiveness of action plans for improvement at least every six (6) months until the site has demonstrated compliance in areas of deficiency sufficient to raise the total score to 90 percent or greater.

Sites that do not make improvements to raise the total score to 90 percent or greater after 12 months will be referred to the Credentialing Committee Chairman for review and follow-up actions.

Network Services & Credentialing will communicate the scoring summary and recommendations for improvement to the facility.

The Credentialing Committee may delay recredentialing approval of a practitioner until the facility has submitted an acceptable action plan to address needed improvements.

The Credentialing Committee may deny recredentialing approval of a practitioner if the facility fails to submit an acceptable action plan for improvement.

The Network Services & Credentialing will compile a report to the Credentialing Committee summarizing the results of all site visits performed and action plans requested, received, and not received (as scheduled) during the previous period.

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## Quality of Care Issues

Dean Health Plan identifies and investigates all instances of concern for the quality of care provided to DHP members. Dean Health Plan identifies quality of care issues through member complaints, inpatient and outpatient review, studies, reports, and referrals from providers and practitioners.

All issues relating to quality of care provided to DHP members are referred to the Network Services & Credentialing for investigation. Network Services & Credentialing logs all incoming issues concerning quality of care, noting the date of receipt and the source (member complaints, inpatient and outpatient review, studies, reports, and referrals from providers and practitioners).

Network Services & Credentialing will determine if the individual(s) involved was a DHP member at the time of service. If not, the quality of care concern is referred to the practitioner clinic and/or medical facility for investigation and resolution. This referral is documented in Network Services & Credentialing.

If the issue is an unresolved member complaint, Network Services & Credentialing will coordinate efforts to investigate the quality of care issue with the parties involved in resolving the complaint to avoid interfering with the resolution process. A brief summary of the issue is documented by Network Services & Credentialing.

Network Services & Credentialing will investigate the issue and verify the concern for quality of care provided to members. Quality of care issues are investigated by contacting the appropriate DHP staff, as well as medical and administrative staff at practitioner clinics and medical facilities.

Network Services & Credentialing will review the following as they pertain to the issue:

- Dean Health Plan complaint and/or grievance documentation.
- Referral and/or prior authorization information.
- Utilization review information.
- Medical records.
- Any documentation of the issue at appropriate practitioner clinics and medical facilities.
- Any other available information relevant to the issue.

Network Services & Credentialing will conduct and complete the investigation within 30 working days of receipt. A shorter time frame may be requested by the Medical Affairs Division if there is a potential for significant risk to members or other urgent situation. If delays are encountered that will prevent timely completion of the investigation, Network Services & Credentialing will notify the CMO.

Network Services & Credentialing will document a summary of the investigation and determine the appropriate disposition of the issue. Categories of disposition include:



- **Issue Resolved:** The issue has been appropriately resolved by DHP and/or the clinic or medical facility, or an appropriate plan of action for improvement has been implemented that will resolve the issue and prevent future occurrences.
- **Monitoring:** A plan of action for improvement has been or will be requested and the clinic and/or medical facility will be required to submit the plan to Network Services & Credentialing for approval. The clinic and/or medical facility will be monitored and required to report progress on the plan to Network Services & Credentialing for a specified period.
- **Refer to Peer Review:** The issue represents: a) a serious breach of professional conduct, potential malpractice, incompetence, or poor quality of care, **OR** b) follow up monitoring of the issue indicates that the clinic and/or medical facility has not responded or adequately implemented an appropriate improvement plan, **OR** c) the reoccurrence of an issue indicates that previous preventive actions have not been adequately implemented or there is a systemic concern for the quality of care.

All issues designated for referral to Peer Review process will be routed to the CMO for a second level of review.

The purpose of the Medical Peer Review Committee is to provide a review of medical practitioners by peers in the areas of quality of care and effective utilization of services. The outcome of the review process should be to educate practitioners on issues identified as needing improvement and to initiate and follow up on issues needing remedial or disciplinary action.

Members of the DHP Peer Review committee are senior medical practitioners from various specialties. The responsibilities of the committee include:

- Review all issues of quality of care identified through sentinel events monitoring, referred by peers and the QA and complaint processes of HMOs, hospitals, and other medical facilities.
- Determine appropriate remedial steps or discipline needed.
- Establish a plan for practitioner education and follow up to assure future improvements and compliance.
- Monitoring data and statistical reports on identified quality issues.
- Provide recommendations to medical management, as needed, about individual practitioner and/or group trends or patterns relating to quality issues.

The Medical Peer Review Committee will review the quality of care issues referred by Network Services & Credentialing and determine the appropriate corrective actions. Network Services & Credentialing staff will attend the Medical Peer Review Committee meeting to support the presentation of the quality of care issues.

The Medical Peer Review Committee will specify the activities, responsible parties, time frame, and reporting requirements for implementing corrective actions.

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Network Services & Credentialing will update the log of quality of care issues, noting the actions taken by the Medical Peer Review Committee. Any actions to reduce, suspend or terminate a DHP practitioner will follow the process outlined in the policies listed below:

- *CR 3016: Altering Participation Status*
- *CR 3017: Practitioner Appeal Process for Decisions Resulting in Reduction, Suspension or Termination*

To obtain a copy of these policies, contact your Provider Services Representative. Please reference the *Health Plan Overview* section of this manual for the representative in your geographic area.

Network Services & Credentialing will monitor, and as appropriate, implement corrective action plans. Network Services & Credentialing will document all activities and progress of corrective action plans.

## Preventive Health Program

Dean Health Plan is dedicated to providing quality healthcare to all members. In an effort to achieve this goal, we have developed health maintenance guidelines for adult, pediatric, and prenatal care. These guidelines can be found at <http://www.deancare.com/providers/patient-care/clinical-guidelines.aspx>

## HEDIS Reporting Requirements

HEDIS (Health Employer Data and Information Set) is a standardized set of performance measures that assess plans' performance on a number of elements, including such things as financial stability, access, and quality of care.

Dean Health Plan annually collects data and reports on performance measures from HEDIS relevant to the commercial, Medicaid, and Medicare populations. Dean Health Plan uses HEDIS information to assess the quality of care delivered by plan practitioners and providers and identify improvement projects and studies.

All plan practitioners and providers are expected to cooperate with DHP in the accurate and timely reporting, collection of data, and review of medical records. Dean Health Plan will collect data according to HEDIS specifications and notify practitioners and providers of any additional information requirements. Dean Health Plan will also identify and communicate the names of patients for medical record review. All practitioners and providers are expected to provide DHP with photocopies and/or access to medical records, as requested.



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## Dean Health Insurance, Inc./Dean Health Plan Care Management Department

### Overall Care Management Program Summary

Dean Health Care Plan's (DHP) Care Management Programs review and evaluate the health care members receive to make sure that the member care is coordinated, and that appropriate levels of service are available to members. This includes preauthorization of select services, inpatient care services, complex case management, and disease management.

**The DHP Care Management Department includes the following:**

- **Utilization Management (UM)**
- **Case and Disease Management**

The Care Management Department is staffed by non-licensed personnel, licensed registered nurse care specialists, nurse reviewers, and physician reviewers who are available to our network physicians.

### Utilization Management Program Hours of Operation

DHP staff is available to members and practitioners seeking information about UM processes and authorization of care. UM staff is available for inbound and outbound communication from 7:30 a.m. to 5:00 p.m. (CST) Monday through Thursday; and from 8:00 a.m. to 4:30 p.m. (CST) Fridays for calls regarding UM issues.

Members may access DHP via (800)279-1301 or (608)828-1301 to the Customer Care Center or via (800) 356-7344, ext. 4455 or (608)827-4455 to the UM Department. The Customer Care Center handles general inquiries, but callers with questions regarding specific UM decisions are direct to the UM staff. UM staff identifies themselves by name, title, and the organization when receiving or initiating calls to members and practitioners regarding UM issues.

If you have an urgent need after hours or on the weekend, you can call the Utilization Management Department and leave a voice message on our secure voicemail. Your call will be returned within the next business day.



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## Program Purpose

Dean Health Plan's goal is to have members receive high quality care that is the most appropriate care, in the most appropriate setting, by the most appropriate provider, in the most cost effective manner. Therefore, DHI/DHP encourages all practitioners, providers, and DHP employees making utilization decisions to base their decisions on the appropriateness of care and service, and the existence of coverage. Dean Health Plan does not specifically reward practitioners or other individuals making UM decisions for issuing denials of coverage or care nor does it provide financial incentives for UM decision makers which encourage decisions that result in under utilization. All DHI/DHP practitioners, providers, and employees making UM decisions have been made aware of this policy.

The purpose of the Utilization Management (UM) Program is to ensure that health care resources are used efficiently and effectively to provide the best value to individuals and organizations purchasing health care and services. UM involves the evaluation of requests for coverage by determining the medical necessity, appropriateness, and efficiency of the health care services under the applicable health benefit plan. The UM Program directs utilization management activities for all business products of the Health Plan, including membership in the Commercial population, ASO/self-funded, BadgerCare Plus, and Medicare Cost contracts.

## Program Objectives

- A. Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards.
- B. Monitor potentially avoidable admissions and develop appropriate mechanism to address identified areas of concern;
- C. Focus inpatient review activities on problem areas determined by appropriate data sources;
- D. Trend and monitor data to identify areas of possible over and under utilization. Areas may include but are not limited to procedure utilization, pharmacy utilization (certain medications and classes of medications), ER utilization, inpatient utilization, laboratory utilization, and physician practice utilization;
- E. Assess provider satisfaction with Utilization Management activities and address areas of provider dissatisfaction when appropriate;
- F. Assess member satisfaction with Utilization Management activities and address areas of member dissatisfaction when appropriate;
- G. Integrate Utilization Management with Disease and Case Management as appropriate when identified during UM activities;



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- H. Monitor and analyze variations in the delivery of care in the network for which evidence based standards of appropriate care exist, and consider opportunities for the Utilization Management programs that will improve quality of care and reduce medical costs;
  - I. Implement or maintain policies and procedures in accordance with applicable regulatory and accreditation requirements and standards;
  - J. Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence;
  - K. Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness;
  - L. Maintain a process to ensure that relevant information is collected to review medical necessity requests for coverage;
  - M. Utilize qualified health professionals to assess the clinical information used to support UM decisions;
  - N. Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations of coverage in accordance with federal and state requirements, and accreditation standards;
  - O. Provide access to staff for members and practitioners seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers;
  - P. Implement and maintain mechanisms for objective and systematic monitoring, evaluation, and improvement of UM processes and services;
  - Q. Implement and maintain mechanisms and policies and procedures that assist in monitoring the quality of utilization management decisions. These mechanisms include but are not limited to: inter-rater reliability and manageability, case audits and the identification of potential adverse events.

## Scope of the UM Program

The Utilization Management (UM) Program incorporates the review and evaluation of patient care for medical, dental, and managed behavioral health. The UM Department maintains processes to ensure: (a) equitable access to care across the network and (b) the most appropriate use of medical services in accordance with benefit coverage.

### A. Major Categories of UM

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The scope of UM activities include the following major categories:

1. Concurrent Review and Evaluation/ Discharge Planning
  - Hospital inpatient admissions
  - Skilled Nursing Facility (SNF) care and rehabilitation
  - Home healthcare
  - Hospice
  - Behavioral health outpatient care/AODA services
3. Retrospective Review
  - Hospital inpatient admissions
  - Skilled Nursing Facility care
  - Home healthcare
  - Hospice
  - Behavioral health/AODA services
  - Ambulatory care
4. Referral Management/Prior Authorization
  - Plan ambulatory care
  - Out-of-plan care
  - Behavioral health/AODA services
  - Home healthcare
  - Hospice
  - Durable medical equipment (DME)
  - Targeted Utilization Reporting
  - Prior Authorization

Utilization management is performed for the following DHI/DHP products:

- Commercial Health Maintenance Organization (HMO)
- Point of Service plans
- Medical Assistance (Medicaid)
- Senior plans including Medicare supplemental
- Administrative Services Contracts
- Self-Funded Companies

## B. Quality of Care Monitoring

The UM program coordinates quality of care monitoring with the Quality Improvement (QI) Program and reviews service using the following indicators.

### Clinical Indicators

- Sentinel events
- Under utilization and over utilization
  - ✓ Member complaint and appeal data analysis

- ✓ Review of practitioner utilization profiles
- ✓ Adverse event and sentinel diagnoses data analysis
- ✓ Member satisfaction surveys
- ✓ High volume/high cost drug use
- Continuity and coordination of care monitoring
  - ✓ Application of case management selection criteria
  - ✓ Member complaint and appeal data analysis
  - ✓ Adverse event and sentinel diagnoses data analysis
  - ✓ Member satisfaction surveys
  - ✓ Member claims for out-of-network services
  - ✓ Retrospective reviews
- Monitoring ancillary services (Pharmacy, Lab, Imaging, DME, Physical, Occupational, and Speech Therapy)

### Service

- Member satisfaction surveys
- Practitioner satisfaction surveys

### C. Quality Assurance

DHI/DHP is committed to QI and assumes responsibility for assisting practitioners to improve the health status of its members. DHI/DHP recognizes there is an important place for traditional quality assurance activities. Recognition of single or sentinel events through generic screening can indicate trends as well as highlight areas requiring QI study and possible intervention

The following Divisions/Departments actively monitor the quality of care provided to DHI/DHP members:

- **Medical Affairs Division**, which consists of:
  - ✓ Associate/Assistant Medical Directors
  - ✓ Managed Care Division (Utilization Management, Case Management, & Quality Improvement)
  - ✓ Medical Cost Trend Analysis
  - ✓ Pharmacy Department
- **Customer Operations Division**, which consists of:
  - ✓ Customer Care Center (Enrollment)
  - ✓ Claims Department
  - ✓ Subrogation & Third Party Liability Department
- **Executive Division**, which consists of:
  - ✓ Provider Services Department
  - ✓ Corporate Compliance Department
  - ✓ Contracting Department



Quality Assurance review monitors care delivered in the following areas:

- Hospital admissions and subsequent care
- Care in outpatient and inpatient settings
- Monitoring of under utilization and over utilization
- Laboratory services
- Medical imaging
- Prescription drugs
- Durable medical equipment
- Behavioral health care including AODA
- Care by non-physicians
- Care provided by tertiary care referral centers
- Ambulatory surgery
- Home healthcare
- Rehabilitation
- Urgent care
- Emergency care
- Physical therapy
- Occupational therapy

Utilization review, tracking and follow-up of sentinel events and quality of care issues, is accomplished through the review process and regular meetings of the Medical Peer Review (MPR) Committee. Summaries of events and trends are analyzed and practitioner committee members conduct a retrospective review to identify practice patterns that can be improved.

## **Program Authority and Responsibility**

### **A. Program Authority**

The UM Committee provides program oversight, review, and direction to the UM Department and Pharmacy Department. Its activities and recommendations are reported to the Quality Improvement Committee (QIC). Based upon the information provided, the QIC recommends changes or revisions to the UM program, and as necessary, forwards their recommendations to the Board of Directors for their review and approval.



## **B. Program Responsibility**

### **Utilization Management**

The UM Department is responsible for carrying out all utilization management activities. Activities pertaining to peer review for medical practitioners and feedback to provider organizations in the area of quality and utilization are reported to the MPR Committee. All other UM activities are reported as required to the UM Committee.

The UM review process is conducted by licensed Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Registered Health Information Technicians (RHITs), and physician staff. Physician staff are supervised and directed by the Sr. VP of Medical Affairs/CMO of Medical Affairs, a full-time board certified physician. Assistant Medical Directors, who review issues brought to them by UM staff, are licensed, board certified physicians who actively practice in their specialties. Other board certified specialists are consulted as necessary when specific expertise is required to provide specialty peer review. Utilization Management staff are supervised by the Manager of UM, the Director of Care Management, who reports directly to the Sr. VP of Medical Affairs Division/CMO.

### **UM Committees**

#### **1. Medical Peer Review Committee**

The MPR Committee is responsible for providing peer review for medical providers and practitioners in the areas of quality and utilization. The MPR Committee identifies acceptable levels of utilization and quality performance for DHI/DHP practitioners and facilities, and sets performance thresholds for referral of cases to the MPR Committee for review. Once a case is referred, the MPR Committee takes action as necessary, including requesting an action plan or imposing a sanction upon a practitioner or provider. The MPR Committee activities are reported to the QIC quarterly and the Committee notifies other DHI/DHP committees of their actions as appropriate.

#### **2. Utilization Management Committee**

The UM Committee's role is to set policies regarding utilization for hospitals, physicians, and non-physician practitioners; ensure optimal availability of health care without over or under use of services; review and approve benefit coverage and limitations pertaining to utilization management; develop DHP policies which interpret contract language affecting utilization management; and clarify current benefit limitations, and comply with state and federal mandated services. This Committee reports its activities to the QIC quarterly.

#### **3. Pharmacy and Therapeutics Committee**

DHI/DHP uses an established P & T Committee (composed of physicians and pharmacists) to evaluate new and existing products, determine formulary, and coverage status. Determinations are based on the uniqueness, medical necessity, efficacy, safety, and cost of each drug product



reviewed. Relevant information is obtained from primary literature, expert physician input, accepted medical standards of practice, and other sources as needed.

The P & T Committee is also responsible for developing guidelines for the use of various drug products and coordination with the Value of Care Initiative. Guidelines are developed using an “evidence based” approach. Where evidence is lacking, expert opinion is used.

The Pharmacy & Therapeutics Committee reports to the UMC and is evaluated annually. Recommendations for improvement are reviewed and approved by the UM Committee and considered in future work plan development.

Pharmacy management is delegated to Navitus and the UM Committee is responsible for the oversight of all activities delegated.

## Utilization Management (UM) Criteria

Dean Health Insurance (DHI)/Dean Health Plan (DHP) utilize written criteria based on medical evidence in making its determination of medical necessity. We would like our providers to know that information about our criteria is available upon request. If you have a question about the criteria used in a specific determination, you may contact the Utilization Management Department by calling (800) 356-7344 or (608) 836-1400. We will be happy to provide you with information about our criteria.

Furthermore, Medical Directors are available to review new technologies for determinations of coverage and to discuss medical policies or decisions made on specific requests. Please contact our Customer Care Center at (608) 828-1301 or (800) 279-1301 for assistance with this process or mail information/requests to Dean Health Plan, Attn: Medical Affairs Division.

## Review Criteria and Guidelines

Criteria used in determining medical necessity are reviewed at least annually by the UM Committee. Criteria currently used are:

### A. Milliman Care Guidelines

The Milliman Care Guidelines allow for the individual needs of each patient. The Milliman Guidelines consider demographics as they pertain to the given condition, co-morbidities, complications and progress of treatment, as well as the home environment.

The Milliman Care Guidelines Criteria are developed by Milliman’s clinical research staff, which includes physicians, registered nurses, and other health care professionals. The criteria’s clinical content is evidenced-based, achievable in real-life situations, and annually reviewed and updated.



All coverage determinations are the responsibility of DHP. All clinical care decisions are strictly and solely the obligation and responsibility of the health care provider. The Milliman Care Guidelines criteria are used for the following types of services which include but are not limited to:

- Acute inpatient services;
- Skilled nursing facilities services;
- Rehabilitation services;
- Homecare services;
- Select inpatient surgeries;
- Select outpatient surgical services; and
- Mental health and substance abuse services for acute inpatient services, partial hospitalization services, acute residential treatment, and intensive outpatient treatment

## B. Medicare Coverage Guidelines

DHP Gold (Medicare Cost Plan) must at a minimum provide coverage for all services and items covered by Medicare. DHP Gold utilizes National Coverage Decisions (NCD), Medicare Interpretive Manuals (such as the Medicare Benefit Policy Manual), and Local Coverage Determinations (LCDs) to make coverage determinations for DHP Gold members. NCDs, Medicare Interpretive manuals, and LCDs are available on the Center for Medicare Services website.

## C. Wisconsin Uniform Placement Criteria (WI UPC) for AODA

WI UPC is utilized to assess the appropriateness of services for Alcohol and Other Drug Abuse (AODA) treatment. These criteria assess the appropriateness of the level of service requested, the type of facility needed, and the need for continued stay according to the level of the member's impairment and the benefit plan offered by the employer. All coverage determinations are the responsibility of DHP. All clinical care decisions are strictly and solely the obligation and responsibility of the behavioral health care provider. The WI UPC criteria are used for the following types of services which include but are not limited to:

- Inpatient substance abuse treatment;
- Partial hospitalization treatment (PHP);
- Day treatment

## D. American Society of Addiction Medicine (ASAM) Criteria

ASAM is utilized to guide medical appropriateness decisions related to substance abuse diagnoses, primarily for inpatient care and determination of appropriate level of care. These criteria may also be used to determine the need to transition care to a different level. All coverage determinations are the responsibility of DHP. All clinical care decisions are strictly



and solely the obligations and responsibility of the behavioral health care provider. The ASAM criteria are used for the following types of services which include but are not limited to:

- Inpatient substance abuse treatment;
- Partial Hospitalization treatment (PHP)
- Day treatment

#### E. Dean Health Plan Medical Policies

The UM and P&T Committees develop medical policies based on existing technology assessment resources and on input from network practitioners. These medical policies are reviewed at least annually. The process for review is addressed by the Utilization Management Issues policy.

Practitioner and member feedback is periodically reviewed to determine if any revisions to the procedures or criteria are necessary. DHI/DHP will make these criteria available to practitioners upon their request. DHP medical policies are also available via the web at [http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

New policies and procedures pertaining to UM and benefit issues are distributed to practitioners as necessary, through the quarterly Provider Newsletters and yearly departmental or specially arranged meetings.

## Evaluation of Medical Technologies

DHI/DHP routinely evaluates and monitors new medical technologies and new applications of existing technologies to determine coverage decisions and benefits. All non-urgent policy requests for the use of medical technologies are reviewed and approved or denied by the UM Committee. Technology assessments include the review of medical technologies for medical devices, procedures (including behavioral health), and pharmaceuticals. New pharmaceuticals are primarily reviewed by the P&T Committee. Revisions are made periodically based on new input from the sources noted below.

Several review organizations' published technology assessments are regularly reviewed by the medical directors. When responding to a request for evaluation, at least two medical directors review the information pertinent to the technology and consult with appropriate specialists as needed.

DHI/DHP has established processes for proactive technology assessments (new technology reviews identified by published sources) and reactive technology assessments (practitioner or member request for a planned service or procedure), which includes the process for urgent or emergency technology reviews. Each identified technology assessment undergoes an investigation and consideration process, and an approval process.



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## Utilization Management for Pharmacy

For information regarding DHP/DHI Pharmacy Management please refer to the Pharmacy Management section of the Practitioner Manual.

### Specific UM Methods

The Utilization Management (UM) staff reviews all hospital inpatient admissions for quality and utilization issues. They perform case management as needed, handling cases where the member is in need of inpatient behavioral health/AODA, home health care, skilled nursing care or DME. They coordinate cases between the members, practitioners, and organizational providers to ensure quality services are provided in a timely manner.

The UM staff screens all written referrals and prior authorization requests, based on criteria established by the UM Committee and on the member's health plan certificate. All cases requiring review of medical necessity are referred to a Medical Director or the Chief Medical Officer of Medical Affairs. Members, practitioners, and organizational providers are informed of the final decision on all referral and prior authorization requests.

Specific methods for each of the major categories of UM activities are outlined below, followed by an overview of the denial and appeal processes.

#### A. Concurrent Review

DHI/DHP members are not at financial risk for non-acute days determined through the review process. These issues are addressed concurrently with the physician or provider when care is delivered by a plan provider, and retrospectively, if necessary, through the MPR Committee.

##### 1. Utilization Issues

The following are reviewed concurrently by the UM Department staff:

- Hospital inpatient admissions
- Skilled Nursing Facility (SNF) care and rehabilitation
- Home health
- Hospice
- Behavioral health outpatient care

As part of concurrent review and referral/prior authorization request reviews, UM staff review inpatient and outpatient care for potential UM issues. All UM issues are investigated and monitored. When a provider, facility, or department reaches an established threshold, all of their UM issues are forwarded to the Medical Affairs Division for review. The Medical Affairs Division reviews the information and determines the appropriate action. The categories of disposition are:



- Issue resolved - no further action needed on the case issue
- Issue monitored - the established criteria was not met and the issue will continue to be monitored for trends and thresholds
- Refer to MPR Committee for further review and/or action

The UM Department will monitor any corrective action(s), document any progress, or lack of reports. The information is then presented to the UM and Credentialing Committee.

All plan hospitals are contractually required to notify the UM Department of a DHP member's admission by the next business day. The member is not financially responsible for non-covered days if this notification does not take place. However, for emergency or approved admissions to non-plan facilities, the member is responsible for assuring that notification takes place within the next business day, or as soon as practical (in case of an emergency admission).

Skilled Nursing Facility services require prior authorization. DHI/DHP applies appropriate criteria to all inpatient hospital and skilled nursing facility admissions.

## 2. Quality of Care Issues

Quality of care issues may be concurrently identified by UM staff according to sentinel events determined by DHI/DHP, Care Management staff, and Medical Director review.

Issues pertaining to potential quality of care are forwarded to the QI Department with copies of pertinent medical records. Quality issues are addressed concurrently when possible, but retrospective reviews may be necessary. The process for review of these issues is documented in the QI Program Description.

In each case requiring retrospective review, pertinent information or research is collected and the issue is summarized. A Medical Director then makes a determination regarding disposition and action to be taken, which can be one of the following:

- 1) resolution and tracking
- 2) development and implementation of an action plan for improvement by the practitioner or facility
- 3) referral to the Medical Peer Review Committee for discussion and/or action

The QI Department monitors the actions listed above to ensure that quality of care issues are appropriately resolved.

## B. Discharge Planning

Utilization Management staff work closely with the attending physicians, social service departments, and facility discharge planners to ensure a smooth transition to alternative care or outpatient treatment methods.



Discharge planning is provided for all hospital inpatient admissions, SNF care, home health care, rehabilitation, and behavioral health inpatient/AODA services.

### C. Retrospective Review

Retrospective medical record review is conducted on cases where DHI/DHP was not notified either prior to, or at the time that services were provided. Questionable hospital admissions and non-acute days are referred to a Medical Director for review for appropriateness of admission and continued stay.

Care that does not meet established criteria may be denied or benefits may be reduced according to certificate provisions if non-plan practitioners or providers were used when plan practitioners and providers were available, and it was determined that member could have reasonably been expected to comply with the notification requirements.

The member cannot be held financially responsible for services delivered by a plan practitioner or provider which require prior authorization or notification if the practitioner or provider fails to comply with the terms of their DHI/DHP contract.

Retrospective review may be performed for the following:

- Hospital inpatient admissions
- Skilled Nursing Facility (SNF) care
- Home health care
- Hospice
- Behavioral health/AODA services
- Ambulatory care

### D. Referral Management/Prior Authorization

As a managed care organization, DHP requires members to choose a primary location/clinic. Prior authorization is required for targeted services and medical necessity is reviewed.

Prior authorization is required for a non-plan referral if services cannot be provided within the DHP provider network. Follow-up with a non-plan provider for emergency services or urgent care requires an approved referral or prior authorization.

All referrals and prior authorizations are screened to determine if they meet DHP criteria. If a case does not meet the criteria, it is presented to a Medical Director, who reviews the case and issues a final decision. Enrollees and practitioners are informed of the final decision on all referral and prior authorization requests.

**For more specific details regarding Referral Management and Prior Authorization, refer to the Prior Authorization Referral section of the Practitioner Manual.**



## E. Denial Process

Denials occur under the following circumstances:

- when services are not a covered benefit
- when medical necessity has not been demonstrated by Medical Director review determination
- when services do not meet DHI/DHP guidelines, intensity of services, and severity of illness (IS/SI) criteria

This information is conveyed to the practitioner. The member is not held financially responsible for charges related to a denied inpatient admission unless the member refuses to follow physician's orders. In this instance, the member would be informed of the Health Plan's decision verbally and in writing.

In many instances, care is not approved based on benefit limitations and exclusions in the Plan Certificate. These determinations are made by non-physician staff and the reason for the non-approval or redirection, along with appeal information, are provided in writing to the member, the referring practitioner, and the servicing practitioner.

## F. Appeal Process

### 1. Members

DHI/DHP members may file an appeal or grievance relating to any aspect of the Health Plan by following the formal grievance procedure outlined in their member certificate. The Member Services Department is responsible for the research and resolution of the grievance.

### 2. Practitioners

Whenever a practitioner proposes modifications or exceptions to DHI/DHP policies or procedures, the proposal is considered by an appropriate health plan representative.

**Please refer to Grievance Tab in your Practitioner Manual for the Provider Appeal Process for more detailed information.**

## Program Evaluation

The UM Department annually evaluates the UM Program and submit their UM Program Evaluation to the UM Committee for review and approval. The evaluation includes a review of the UM Program using member complaint, grievance and appeal data; the results of member satisfaction surveys; practitioner complaint, grievance, and appeal data; and the results of practitioner satisfaction surveys, as appropriate. The evaluation includes both program accomplishments and limitations/barriers. Recommendations from the annual Program Evaluation are incorporated into the next year's UM Program Description and QI Work Plan as appropriate.



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## Case and Disease Management Department

### Hours of Operation

The Case and Disease Management Department is available to members and practitioners seeking information about the Case and Disease Management Programs. Case Management staff is available for inbound and outbound communication from 8:00 a.m. to 4:30 p.m. (CST). Members may access DHP by calling (800)279-1301 or (608)828-1301 to the Customer Care Center. The Member Services Department handles general inquiries, but callers with questions regarding specific case or disease management programs are directed to the Case Management Staff. The Case Management staff identifies themselves by name, title, and the organization when receiving or initiating calls to members and practitioners regarding Case and Disease Management Programs.

### Case Management Program Description

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost-effective outcomes.

DHP's Case Management program serves in a support capacity to the Primary Care Physician (PCP) and assists in coordinating care actively linking members to providers, medical services, residential, social & other support services as needed. DHP's Case Management staff adheres to the Case Management of America (CMSA) standards of practice.

DHP's Case Management staff is comprised of specially qualified nurses who assess the member's risk factors, develop an individualized treatment plan, establish treatment goals, monitor outcomes, and evaluate the outcome for possible revisions of the treatment plan utilizing sound principles of practice and evidence-based guidelines.

DHP has incorporated case management programs that manage members with specific health care needs such as catastrophic disease (adult and pediatric) and transplant. Member participation in case management is voluntary and members may opt out at any time. Referral into the Case or Disease Management Program may be requested by the provider. Go to <http://www.deancare.com/providers/patient-care/care-management.aspx> for more information on how to refer a member for a Case or Disease Management Program or call the Case and Disease Management Department at (800)279-1301, ext. 4132 or (608)827-4132.

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## Case Management Programs

### Complex Case Management (CCM)

DHP's Complex Case Management Program is a multi-disciplinary approach to the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The CCM Program is a process directed at the coordination and integration of resources to create cost-effective options for catastrophically ill or injured members on a case-by-case basis. The aim is to use available resources in the most effective manner to facilitate quality treatment goals.

The Complex Case Management Program supports the practitioner-patient relationship and plan of care. The CCM Program continuously evaluates the clinical, humanistic, psychosocial and economic outcomes with the goal of helping members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. The essential elements of complex case management include comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Conditions, diseases or high-risk groups most frequently managed by the CCM Program include, but are not limited to the following:

- Multiple/frequent ER visits (2 or more ED/UC Facility visits in one month)
- Multiple/frequent acute inpatient admissions
- Multiple Referrals and/or Providers
- Multiple Providers, in and out of network
- Multiple/severe disabilities
- Chronic Diseases w/ co-morbidities
- Transplants (evaluation, pre-transplant, transplant, and post-transplant phase)
- Leukemia
- High Dose Chemotherapy at a Tertiary Care Facility
- Out of Network (OON) Services related to a Cancer Diagnosis
- Spinal Cord Injuries
- Traumatic Brain Injuries
- Second and Third Degree Burns
- Multiple Congenital Defects

Identification of members for possible CCM services includes:

- Direct referral by the primary care physician or specialist
- Discharge Planners
- Pharmacy data
- Claims



- Hospital discharge data
- Internal referrals from other departments
- Family/Member self-referral
- DHP's Utilization Management

## Disease Management Programs

### Overview

Dean Health Plan's (DHP) Disease Management Programs are multi-disciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions.

**The following conditions are currently being targeted for management by DHP:**

- **Diabetes**
- **Heart Failure**
- **Asthma**
- **COPD**
- **BadgerCare Plus pregnant members**
- **High Risk Prenatal (starting 2<sup>nd</sup> Qtr 2010)**

The Disease Management Programs support the practitioner-patient relationship and plan of care; emphasize the prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies such as self-management. The DHP programs continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health status. The essential elements of disease management include understanding the course, clinical implications, and trajectory of specific diseases; identifying and targeting members likely to benefit from intervention; focusing on prevention; and working toward resolution of resource-intense problems.

Each disease management program includes condition monitoring that is ongoing and proactive. This allows the member, the practitioner, and the disease/case manager to assess how well the condition is being managed. Monitoring is done through the use of regular clinical assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member's knowledge of the condition itself as well as the related co morbid conditions likely to affect overall health status.

Member adherence to the program's treatment plan is an integral part of disease management. Members are followed to determine their success with self-management, self-monitoring activities, and medication compliance. High risk members are called at periodic intervals. Detailed questions are asked about the member's condition and information is gathered regarding health status, treatment plan adherence, functional status, and quality of life. A specific plan of care is developed based on the findings from a clinical assessment and functional inventory. Ongoing monitoring by the disease/case manager ensures timely intervention when a change in risk status is identified. The frequency of outbound calls to participants by the disease/case manager is determined by the severity of symptoms. This may result in daily contact in times of high risk or concern. If home care



or other services are needed in high risk-cases, the disease/case manager works with the practitioner and appropriate agencies to coordinate the necessary care and services.

In all instances, disease management programs must give consideration to other health conditions that directly affect the member's overall health status. A multidisciplinary approach to disease management enables the disease/case manager to develop a treatment plan that includes condition monitoring of co morbid conditions frequently associated with chronic medical conditions.

Because lifestyle issues are strongly linked with chronic disease and high risk pregnancy, strategies to address current lifestyle and the need to modify behavior are addressed in every program. Whether members need interventions addressing issues such as smoking cessation or weight loss management, the disease/case manager is able to address readiness to change and to provide additional resources to affect needed change.

DHP's Disease Management Program elements include:

- Identification of evidence-based standards of care, best practices, evidence-based intervention strategies, and targeted outcomes.
- Identification of the member and assessment of health status.
- Proactive intervention to include the application of appropriate therapies and systematic surveillance of appropriateness of medication, education and counseling about daily self-management, and symptom management.
- Tracking of the member's clinical and functional status over time.
- Assessment of effectiveness of treatment and sharing of knowledge gained to achieve optimal member outcomes.
- Coordination of behavioral health care services.
- Routine reporting, including feedback to members and health care providers.

**For more specific information on any of the Disease Management Programs contact the Case and Disease Management Department at (800)279-1301, ext. 4132 or (608)827-4132. A copy of the specific targeted condition's program content, method of identification, and program goals is provided upon request.**

## Statement of Confidentiality

DHI/DHP has a Corporate Confidentiality policy that states that employees have a responsibility to ensure that all personal, member and employee information remains confidential. Earning the trust and confidence of our members and fellow employees is a responsibility each employee shares. Every employee has an obligation to comply with DHI/DHP policies on confidentiality and with laws and regulations that apply to us and our industry. Disclosure of confidential information at work or elsewhere about members or employees violates a valued trust and that individual's legal right to confidentiality.

If an employee is found to have violated any confidentiality policy, disciplinary action, up to and including immediate termination of employment, may result.



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## Statement of Conflict of Interest

Employees and consultant practitioners are prohibited from reviewing cases and request that pertain to themselves, family members, or acquaintances in which the case/request that is being reviewed and the decision reached would be influenced by personal knowledge. Employees are also prohibited from reviewing cases in which they have provided care. The case/request must be deferred to another reviewer.

Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Employees are prohibited from working for other companies, while employed with DHI/DHP, where that employment may be construed as a conflict of interest.

## Program Evaluation

The Care Management Departments of UM, Pharmacy, and Case & Disease Management annually evaluate their respective programs. The UM and Pharmacy Departments submit their UM Program Evaluation to the UM Committee for review and approval; Case & Disease Management Program Evaluations are reported to the QI Committee. Recommendations from the annual Program Evaluations are incorporated into the next year's Program Description and QI Work Plan as appropriate.



## Dean Administrative Services Only (ASO)

Dean Health Plan (DHP), a subsidiary of Dean Health Insurance, Inc. (DHI) would like to take this opportunity to welcome you to the Dean Exclusive Network under the Dean Administrative Services Only (ASO) product line!

**ASO Product** means “administrative services only” Benefits Contracts through which DHI provides self-funded employers access to DHI/DHP’s provider network, assistance in administering health care plans, and arranging for the delivery of health care services to their employees. It is also referred to as **Dean Third Party Administration (DeanTPA)**.

- TPA – or Third Party Administrator/Administration – describes a vendor (Dean TPA) who administers the plan on behalf of the employer.

The purpose of this manual is to serve as a resource for policies and procedures that affect you as an ASO Chiropractor. If you have questions relating to this information, or are unable to find information that you are looking for, please refer to the phone directory below or access [www.deantpa.com](http://www.deantpa.com) to contact the appropriate department for assistance.

### Contact Information

Dean ASO Group Summary								
Name	Effective Date	Group#	CS Telephone#	SL Carrier/ Paper	Primary Network	Wrap Network	PBM	Plan Type
Ballweg Automotive Group	7/1/2008	DHP37050	800-759-7143	Starline Group/ Lloyds of London	Dean ASO	MultiPlan	Navitus	EPO - Middleton/Sauk
					HealthEOS	MultiPlan		PPO - Wausau
City of Janesville (COJ)	1/1/2008	DHP33640	(888) 577-7724	Greenwood International/ Chubb	Dean COJ Network	HealthEOS/ MultiPlan	Navitus	EPO/ EPO Select
					Alliance/ DeanASO/ MultiPlan	None		Dental
								Basic *no network
Jones Dairy Farm	1/1/2008	DHP33950	(888) 779-2432	RBS, Re/ HM Life	HealthEOS MultiPlan	MultiPlan HealthEOS	Serve-You-Rx	PPO - inside of WI PPO - outside of WI
Landmark Services, Inc.	5/1/2008	DHP34560	(877) 651-2432	RBS, Re/ HM Life	Dean ASO/ HealthEOS	MultiPlan	Navitus	PPO
Lands' End	1/1/2007	DHP33240	(877) 559-2432	None	Dean ASO	HealthEOS/ MultiPlan	MedCo Health	EPO
Sauk Prairie Memorial Hospital & Clinics (SPMHC)	1/1/2008	DHP33810	(888) 795-2432	Summit Re/ Companion Life	Dean ASO	HealthEOS/ MultiPlan	Navitus	EPO
Trek Bicycle Corporation	1/1/2007	DHP332930	(800) 965-2432	RBS, Re/ HM Life	Alliance	Beech Street	Navitus	PPO/PPO - HSA
					HealthEOS	Beech Street		PPO/PPO - HSA
						Beech Street		PPO/PPO - HSA

### Dean TPA Identification (ID) Cards

Your role as a Dean Health Plan (DHP) provider is to identify which plan a member has to ensure that the correct referral, prior authorization, and pre-certification guidelines are followed.

To help you and your staff identify the ASO/TPA plans that are offered, it is imperative to review and copy the ID card for each covered person. **Each ID card contains information and requirements specific to each member’s plan.**



We recommend checking the member's ID Card at every visit to verify DHP coverage.

Please refer to the contact information on the ID Card for the appropriate Customer Services Department for member eligibility and identification.


**The claims address is determined by the plan the Covered Person chooses.** Please refer to the Covered Person's ID Card.

### Identification Card Examples

<p><b>LANDS' END</b> Dean Exclusive Network Plan</p> <p style="text-align: right;"></p> <p><b>Group No.</b> DHP33240  <b>Member No.</b> «eligibility_ud»  <b>Member Name</b> «mbrname»  <b>Coverage Level</b> Medical <span style="float: right;"><b>Plan: EPO</b></span></p> <hr/> <p style="text-align: center;">To Verify Eligibility, Provider or Claims: Call 1-877-559-2432 or Visit <a href="http://www.deantpa.com">www.deantpa.com</a></p> <p style="text-align: center;">For Dean On Call Dial 1-800-57-NURSE (8773), Your 24 Hour Nurse Advice Line</p> <hr/> <p style="font-size: small;">The Dean Exclusive Network is the primary network. Referrals and/or pre-authorizations are required for any non-emergency or routine follow-up care outside of the primary network.</p>	<p>If you are outside of the Dean Exclusive Network you may call 1-800-279-9776 or online at <a href="http://www.healtheos.com">www.healtheos.com</a> for providers in Wisconsin, or <a href="http://www.multiplan.com">www.multiplan.com</a> for providers outside of Wisconsin. Report any urgent or emergency care, or out-of-state inpatient admissions to Dean TPA at 1-877-559-2432 by the next business day.</p> <p style="font-size: x-small;">See your Plan Document for a description of your benefits, terms, conditions, limitations and exclusions of coverage. When submitting inquiries always include your Group Number.</p> <hr/> <p style="text-align: center;"><b>Send medical claims to the following:</b></p> <table style="width: 100%; font-size: x-small;"> <tr> <td style="width: 50%;"> <b>Primary Network</b>  <b>Dean Exclusive Network</b>                  Dean TPA                  P.O. Box 99906                  Grapevine, TX 76099-9706                  WebMD/Envoy Payer ID 75261             </td> <td style="width: 50%;"> <b>Wrap Networks</b>  <b>HealthEOS+MultiPlan</b>                  HealthEOS+MultiPlan                  P.O. Box 6090                  DePere, WI 54115-6090             </td> </tr> </table> <p style="text-align: center;"> </p>	<b>Primary Network</b> <b>Dean Exclusive Network</b> Dean TPA P.O. Box 99906 Grapevine, TX 76099-9706 WebMD/Envoy Payer ID 75261	<b>Wrap Networks</b> <b>HealthEOS+MultiPlan</b> HealthEOS+MultiPlan P.O. Box 6090 DePere, WI 54115-6090
<b>Primary Network</b> <b>Dean Exclusive Network</b> Dean TPA P.O. Box 99906 Grapevine, TX 76099-9706 WebMD/Envoy Payer ID 75261	<b>Wrap Networks</b> <b>HealthEOS+MultiPlan</b> HealthEOS+MultiPlan P.O. Box 6090 DePere, WI 54115-6090		

<p><b>TREK</b></p> <p style="text-align: right;"></p> <p><b>Group No.</b> DHP332930  <b>Member No.</b> «eligibility_ud»  <b>Member Name</b> «mbrname»  <b>Coverage Level</b> Medical <span style="float: right;"><b>Plan: PPO</b></span></p> <hr/> <p style="font-size: x-small;">Benefits, Eligibility or Claim Status: 1-800-965-2432          For a Health Network Provider: <a href="http://www.deantpa.com">www.deantpa.com</a> or 1-800-965-2432          Precertification: 1-800-965-2432          Dean On Call: 1-800-57-NURSE (8773), 24 Hour Nurse Advice Line</p> <hr/> <p style="font-size: x-small;">The Alliance Network is the primary network. Pre-authorizations are required for any non-emergency or routine follow-up care outside of the primary network. Your ID card must be presented each time services are requested.</p> <p style="font-size: x-small;">See your Plan Document for a description of your benefits, terms, conditions, limitations and exclusions of coverage. When submitting inquiries always include your Group Number.</p>	<p style="text-align: center;"><b>Pharmacy Benefit Manager (PBM)</b></p> <p>Pharmacy: 1-866-333-2757          RxBIN = 610602          RxPCN = NVT          RxGrp = TBC</p> <p style="text-align: right;"> </p> <hr/> <p style="text-align: center;"><b>Send medical claims based on the following:</b></p> <p style="text-align: center; font-size: x-small;">(Primary Network is The Alliance)</p> <table border="1" style="width: 100%; font-size: x-small; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <b>The Alliance</b>                  ATTN: Claims                  P.O. Box 44365                  Madison, WI 53744-4365  </td> <td style="width: 50%; padding: 5px;"> <b>HealthEOS</b>                  P.O. Box 6090                  DePere, WI                  54115-6090  </td> </tr> </table>	<b>The Alliance</b> ATTN: Claims P.O. Box 44365 Madison, WI 53744-4365 	<b>HealthEOS</b> P.O. Box 6090 DePere, WI 54115-6090 
<b>The Alliance</b> ATTN: Claims P.O. Box 44365 Madison, WI 53744-4365 	<b>HealthEOS</b> P.O. Box 6090 DePere, WI 54115-6090 		




**TREK** 

**Group No.** DHP332930  
**Member No.** «eligibility\_ud»  
**Member Name** «mbrname»  
**Coverage Level** Medical **Plan:** PPO

Benefits, Eligibility or Claim Status: 1-800-965-2432  
 For a Health Network Provider: [www.deantpa.com](http://www.deantpa.com) or 1-800-965-2432  
 Precertification: 1-800-965-2432  
 Dean On Call: 1-800-57-NURSE (8773), 24 Hour Nurse Advice Line

The HealthEOS Network is the primary network. Pre-authorizations are required for any non-emergency or routine follow-up care outside of the primary network. Your ID card must be presented each time services are requested.

See your Plan Document for a description of your benefits, terms, conditions, limitations and exclusions of coverage. When submitting inquiries always include your Group Number.

**TREK** 

**Group No.** DHP332930  
**Member No.** «eligibility\_ud»  
**Member Name** «mbrname»  
**Coverage Level** Medical **Plan:** PPO


Benefits, Eligibility or Claim Status: 1-800-965-2432  
 For a Health Network Provider: [www.deantpa.com](http://www.deantpa.com) or 1-800-965-2432  
 Precertification: 1-800-965-2432  
 Dean On Call: 1-800-57-NURSE (8773), 24 Hour Nurse Advice Line

The BeechStreet Network is the primary network. Pre-authorizations are required for any non-emergency or routine follow-up care outside of the primary network. Your ID card must be presented each time services are requested.

See your Plan Document for a description of your benefits, terms, conditions, limitations and exclusions of coverage. When submitting inquiries always include your Group Number.



**Pharmacy Benefit Manager (PBM)**

Pharmacy: 1-866-333-2757  
 RxBIN = 610602  
 RxPCN = NVT  
 RxGrp = TBC

**NAVITUS** 

Send medical claims based on the following:

(Primary Network is the HealthEOS)

<p><b>HealthEOS</b>                  P.O. Box 6090                  DePere, WI 54115-6090</p> 	<p><b>The Alliance</b>                  ATTN: Claims                  P.O. Box 44365                  Madison, WI 53744-4365</p> 
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**Pharmacy Benefit Manager (PBM)**

Pharmacy: 1-866-333-2757  
 RxBIN = 610602  
 RxPCN = NVT  
 RxGrp = TBC

**NAVITUS** 

Send medical claims to:  
 Dean TPA  
 PO Box 99906  
 Grapevine TX 76099-9706  
 WebMD/Envoy Payer ID 75261

**Beech Street Corporation Nationwide PPO and Affiliated Networks:**

 **BEST CARE Network**  **Healthcare PREFERRED** **First Choice** 

LA, MS AL IA, NE MT, WA WV

Neither the Lands' End nor Trek plans require Covered Persons to select a Primary Care Practitioner. This requirement will vary by each employer's plan design. If PCP selection is required, it will be noted on the ID Card.

## DeanTPA Claims Submission

To allow for more efficient processing of your DeanTPA claims, we ask for your cooperation with the following:

- DeanTPA requires the use of correct and complete member number. Using the correct member numbers on the claims submitted to Dean TPA will help us ensure correct claim payment. Each member has their own individual ID card and corresponding member number.
- DeanTPA requires plan providers to file claims in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. **Refer to the Timely Filing Guidelines in this section for further instructions. Claims can be submitted to:**



<p><b><u>For Lands' End:</u></b></p> <p>DeanTPA 1-877-559-2432 <a href="http://www.deantpa.com">www.deantpa.com</a></p> <p>PO Box 99906 Grapevine, TX 76099-9706</p>	<p><b><u>For Trek:</u></b></p> <p>DeanTPA 800-965-2432 <a href="http://www.deantpa.com">www.deantpa.com</a></p> <p>*The claims address is determined by the plan the Covered Person chooses. Please refer to the Covered Person's ID Card.</p>
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- Self-insured groups have the ability to determine how their subrogation claims, including Worker's Compensation, are handled. Lands' End has decided that all Third Party claims for Lands' End DeanTPA, including Worker's Compensation, should be submitted to Dean TPA.
- The employer determines benefits on ASO plans. **Utilize DeanTPA Customer Service or [www.deantpa.com](http://www.deantpa.com) for specific benefits information.** The phone number is direct to our Texas location and is located under the Contact Information found in the Health Plan Overview Section of the manual.

**The timely filing guidelines apply in your contract to ASO business as well. ECT and Paper Confirmation reports will not be distributed under the ASO product. DeanTPA will accept alternate documentation for proof of timely submission.** For example, you may include screen prints from your system showing the date the system generated a claim to Dean TPA, or that there were written or verbal attempts to obtain insurance information from a Covered Person.

A copy of the claim denial and supporting documentation may be sent to the DeanTPA – Texas location.

DeanTPA prefers to receive a new claim when corrections are needed, but will also accept corrections made directly on the Explanation of Payment (EOP).

The provider will not receive Rejected Claim Reports, ECT or Paper Confirmation Reports from DeanTPA for ASO business. This means that claims errors you typically see on a Rejected Claim Report for DHP (invalid member or provider number, coverage not in effect) will now be presented on an Explanation of Payment (see example below):



<p>LANDS END P O, BOX 1808 GRAPEVINE TX 76099-1808 XXX - XXX -</p> <p style="text-align: center;">000001-001-000001 SPXS 2000058 DEC. 000010008408077 TESTCHECK VENDOR 1 8500 FREEPORT PARKWAY SOUTH SUITE 400 IRVING TX 75063</p>	<p>LANDS' END, INC. EXPLANATION OF PAYMENT</p> <p>VENDOR NUMBER 00000001-001 CHECK NUMBER 1000 DATE 12/01/2006</p> <div style="text-align: right;"> </div>		
<p>INV#TEST CHECK 01. LANDS END TEST CHECK. DHP33240. \$1.00</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">VENDOR NUMBER 00000001-001</td> <td style="padding: 2px;">EOP NUMBER 000010008408077</td> </tr> </table> <p>LANDS' END, INC.</p> <p>ADMINISTERED BY LANDS END P O, BOX 1808 GRAPEVINE TX 76099-1808 XXX - XXX -</p> <p>PAY <b>ONE AND 00/100</b></p> <p>TO THE ORDER OF TESTCHECK VENDOR 1 8500 FREEPORT PARKWAY SOUTH SUITE 400 IRVING TX 75063</p> <p>SPX-M</p>	VENDOR NUMBER 00000001-001	EOP NUMBER 000010008408077	<div style="text-align: center;"> <h2 style="margin: 0;">LANDS' END</h2> </div> <p style="text-align: right;">CHECK NO: 1000 12-5/750</p> <p style="text-align: right; font-size: small;">M&amp;I MARSHALL &amp; ILSLEY BAN MILWAUKEE WI 53201</p> <p style="text-align: right;">DATE: 12/01/2006    AMOUNT*****1.00</p> <div style="text-align: right; margin-top: 20px;"> <p style="font-size: x-small;">VOID AFTER SIX MONTHS FROM DATE OF ISSUE</p> </div> <div style="text-align: center; margin-top: 20px;"> <p style="font-size: 2em; opacity: 0.5; transform: rotate(-45deg);">VOID</p> <p style="font-size: 2em; opacity: 0.5; transform: rotate(45deg);">VOID</p> </div> <p style="text-align: center; font-size: small;">⑈ 1000⑈ ⑆ 07500005 ⑆ 00396⑈ 6 2590⑈</p>
VENDOR NUMBER 00000001-001	EOP NUMBER 000010008408077		

## DeanTPA Subrogation

Self-insured groups have the ability to determine how their subrogation claims including Worker's Compensation, are handled. All Third Party claims for DeanTPA including Worker's Compensation should be submitted to DeanTPA for processing.

DeanTPA initially denies all claims billed with diagnoses possibly related to a third party and request additional information from the patient in order to make payment determination. If the patient returns the letter clearing any potential for subrogation the claim is paid within 10 days of receiving this information. Dean Health Plan encourages providers to allow this period of time



before billing the patient and/or subscriber. This will encourage members who do not return the letter timely to take the necessary action to return it to DeanTPA.

If the member and/or subscriber does not return the letter to DeanTPA within 10 days, providers can bill the initial denials to the patient and/or subscriber.

## DeanTPA Member Complaint, Appeal and Grievance

**Forward ASO appeals to Dean TPA, PO Box 99906 Grapevine, TX 76099-9706 or contact Dean TPA at 1-877-559-2432.**

### DeanTPA Utilization Management Process

Dean Medical Management (DMM), located at DeanTPA – Madison, provides Concurrent Review & Referral Services for the ASO product. Dean Health Plan referral, prior authorization and pre-certification guidelines apply to the Lands' End plan.

Referrals to Dean Exclusive Network providers are NOT required, but are required for services provided by providers who are not within the Dean Exclusive Network. Select services, treatments, or procedures require prior authorization to determine the medical necessity of the service. Dean Exclusive Network providers are responsible for requesting prior authorization/pre-certification for these services. You can access these specific services at [http://www.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

DMM will review the request and notify the Covered Person as well as the provider of the determination.

Providers submit referral and prior authorization requests on the DeanTPA Outpatient Services Request Form. DeanTPA Covered Persons are not available in NaviNet.

Trek requires prior authorizations for non-emergency or follow-up care outside the primary network. Please refer to the patient's ID Card for specific information.

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## Member Rights & Responsibilities

Dean Health Plan, Inc. (DHP) members deserve the best service and healthcare possible. DHP is committed to maintaining a mutually respectful relationship with its members. To promote effective health care, DHP makes clear its expectations for the rights and responsibilities of its members, to foster cooperation among members, practitioners and DHP. These **Member Rights and Responsibilities**, outlined below, also appear annually in the DHP provider and member newsletters.

### Dean Health Plan members have the right to:

- Be treated with respect and recognition of their dignity and right to privacy.
- Receive a listing of DHP participating practitioners in order to choose a Primary Care Physician.
- Present a question or complaint or grievance to DHP, about the organization or the care it provides, without fear of discrimination.
- Receive information on procedures and policies regarding their healthcare benefits.
- Timely responses to requests regarding their healthcare plan.
- Request information regarding Advance Directives.
- Participate with practitioners in making decisions about their healthcare.
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Receive information about the organization, its services, its practitioners and providers, and members' rights and responsibilities.
- Make recommendations regarding the organization's members' rights and responsibilities policies.

### Dean Health Plan members have the responsibility to:

- Read and understand the materials provided by DHP concerning their healthcare benefits. DHP encourages members to contact the Plan if they have any questions.
- Present their ID Card in order to identify themselves as DHP members before receiving healthcare services
- Notify DHP of any enrollment status changes such as family size or address.

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow plans and instructions for care that they have agreed on with their practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Fulfill financial obligations as it relates to any co-pays, deductibles and/or premiums as outlined in your policy.

These rights and responsibilities are available for you to access on our Website at [http://www.deancare.com/healthplan/members/rights\\_responsibilities.asp](http://www.deancare.com/healthplan/members/rights_responsibilities.asp)

## Dean Health Plan's Member Privacy Policy

### Protecting the Privacy of Personal Health Information

The privacy of your nonpublic personal information is very important to us at Dean. This Notice describes how we protect the confidentiality of the nonpublic personal information we receive on all members, including former members. The following is a brief explanation of the manner in which we obtain, use, and protect your nonpublic personal information.

#### What types of nonpublic personal information does Dean collect about you?

We collect a variety of nonpublic personal information needed to administer health insurance coverage and benefits. We collect nonpublic personal information about you from some of the following sources:

- Information we receive directly or indirectly from you or your employer or benefits plan sponsor through applications, surveys or other forms. The information may be received in writing, in person, by telephone, or electronically. Examples include name, address, social security number, date of birth, marital status, and medical history.
- Information about your transactions with us, our affiliates, our providers, our agents, and others. This includes information from health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information.
- Information you authorize us to collect from others.

#### How does Dean protect this information?

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to protect your nonpublic personal information. We limit the internal use of oral, written, and electronic nonpublic



personal information about you and ensure that only authorized staff with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.

## When Dean May Not Use or Disclose Your Health Information

We will not disclose your nonpublic personal information unless we are allowed or required by law to do so. If required by law, we will obtain your authorization prior to using or disclosing your health information. You may revoke this authorization in writing at any time. The following categories describe the ways that Dean may use and disclose your nonpublic personal information. In carrying out the functions listed below, Dean may transmit your nonpublic personal information to people or organizations outside of Dean as allowed under the law. When Dean transmits or releases nonpublic personal information to another organization, Dean requires the other organization to protect your information from unauthorized and inappropriate use or disclosure. Not every use or disclosure we might make will be listed.

**Payment Functions:** We may use or disclose your health information to make or collect payment for treatment or services you receive. For example, we may use or disclose your health information to determine your eligibility for plan benefits, obtain premiums, and collect payment from third parties such as other health plans or providers for the care you receive.

**Health Care Operations:** We may use and disclose your health information to carry out necessary insurance-related activities and to provide coverage and services to you. Health care operations include such activities as: underwriting, premium rating, case management and care coordination, fraud and abuse detection programs, medical reviews, business planning and development, and general administrative activities such as customer service efforts and resolution of internal grievances.

**Treatment Alternatives:** We may contact you or your health care providers with information about treatment alternatives and other related functions that may be of interest to you.

**Distributing Health-Related Benefits and Services:** We may use or disclose your health information to provide information on health-related benefits and services that may be of interest to you.

**Disclosure to Plan Sponsors:** If applicable, we may disclose certain health information to the sponsor of your group health plan for purposes of administering benefits under the plan or to determine whether you are participating in the health plan.

## Summary Statement of Your Health Information Rights

All requests to exercise the rights listed below must be submitted in writing to the Privacy Officer, or you can call Dean Health Plan Customer Care Center to request the appropriate form to complete. You have the right to:

- Request restrictions on certain uses and disclosures of your health information.
- Receive your health information through a reasonable alternative means or at an alternative location.



- Inspect and copy certain health information about you.
- Request that Dean amend health information held by Dean that you believe is incorrect or incomplete.
- Receive a list of certain disclosures of your health information.

### Questions?

If you would like a paper copy of this Notice, want more information about our privacy practices, have questions about any part of this Notice, or you have a complaint regarding our privacy practices, please contact the Privacy Officer at the following address, or call the Dean Customer Care Center at (800) 279-1301: Privacy Officer, 1277 Deming Way, Madison, Wisconsin 53717.

## Dean Health Plan's Affirmative Action Statement

**Compliance with Equal Opportunity Laws, Regulations and Rules and Other Laws.** It is the policy of Dean Health Insurance (DHI)/Dean Health Plan (DHP) to implement Affirmative Action (AA) measures designed to eliminate present effects of past discrimination and to ensure equal opportunity for women, racial or ethnic minorities, and persons with disabilities. DHI/DHP recognizes the need to identify job groups and classifications with under-representation, and to set goals and timetables for increasing the employment of under-represented groups; and to develop an AA Plan for implementing those reasonable goals through outreach, recruitment, training and other activities and commitments.

DHI/DHP is in compliance with the equal opportunity policy and standards of the Department of Workforce Development, Department of Health and Family Services, and all applicable State and Federal statutes and regulations relating to nondiscrimination in employment and service delivery.

No otherwise qualified person shall be excluded from employment, be denied by the benefits of employment or otherwise be subject to discrimination in employment in any manner on the basis of age, race, religion, color, sex, national origin or ancestry, disability or association with a person with a disability, arrest or conviction record, sexual orientation, marital status or pregnancy, political belief or affiliation, military participation, or use or non use of lawful products off the employers premises during working hours. All employees are expected to support goals and programmatic activities relating to nondiscrimination in employment.

No otherwise qualified applicant for service or service participant shall be excluded from participation, be denied benefits, or otherwise be subject to discrimination in any manner on the basis of race, color, national origin or ancestry, sex, religion, age, political belief or affiliation, disability or association with a person with a disability. This policy covers eligibility for the access to service delivery, and treatment in all of the programs and activities.