



Dean Care Gold Manual

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Overview of Coverage

What is DeanCare Gold?

DeanCare Gold (Gold) is a Medicare approved HMO product and is available to eligible Medicare beneficiaries residing in the service area. This Medicare contract is between Dean Health Insurance (DHI)/Dean Health Plan (DHP) and the Centers for Medicare and Medicaid Services, (CMS), and agency of the U.S. Department of Health and Human Services. DeanCare Gold has three plans, Enhanced, Shared Value and Basic. The Enhanced plan offers the required basic Medicare coverage and includes Wisconsin mandated and additional benefits. The Shared Value Plan also includes benefits beyond what is covered by Medicare but incorporates cost sharing. The Basic plan offers only the required basic Medicare coverage. No health screenings or physicals are required for membership.

The purpose of this manual is to serve as a resource for policies and procedures that affect DeanCare Gold (Gold) members and its providers. All information listed in this manual applies, unless noted otherwise. If you have any questions relating to this information, or are unable to find the information you need, please contact DHP at (800) 279-1301 or refer to the www.deancare.com website.

Information presented in this manual is unique to the Gold plan.

DeanCare Gold ID Card Sample

<u>Dean Health Plan</u>		
<i>a subsidiary of Dean Health Insurance, Inc.</i>		
SAMPLE	SAMPLE	SAMPLE
Effective 01/01/04	Renewal Month: January	
<hr/>		
Group # C22D	Member 34567892301	
<hr/>		
DOE JOHN E		01
H3	RIVERVIEW CLINIC	
SAMPLE	SAMPLE	SAMPLE
	H5264-003	

The cardstock for DeanCare Gold Members will be “white”

KEY:

① Group Number – Gold members’ group number will be either **C220** or **C22D**.

Automatic Assignment of Primary Care Practitioner

If a member does not designate a PCP site and/or practitioner, DHI/DHP will automatically assign one based upon the Member's residence if one is not selected. In these situations DHI/DHP will send a letter to the member informing them of the PCP site or practitioner assigned. If the member has additional questions, the member can contact Customer Service at 800-279-1301.

DeanCare Gold Benefit Overview

Please see the following for the overview of benefits: <http://www.deancare.com/Medicare/members/>

Summary of Exclusions

This is a brief summary only. Please contact DHP Customer Service Department if you have questions on any services or procedures not listed in this manual.

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan to not be generally accepted by the medical community.
- Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
- Private room in a hospital, unless medically necessary.
- Private duty nurses.
- Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
- Nursing care on a full-time basis in your home.
- Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets and supervision of medication that is usually self-administered.

-
- Homemaker services.
 - Charges imposed by immediate relatives or members of your household.
 - Meals delivered to your home.
 - Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
 - Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
 - Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
 - Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine) and is limited according to Medicare guidelines.
 - Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
 - Supportive devices for the feet. Exception Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
 - Hearing aids and routine hearing examinations.
 - Eyeglasses (except after cataract surgery), routine eye exams, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
 - Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.
 - Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
 - Acupuncture.
 - Naturopath services.
 - Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
 - Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.
 - Charges for missed appointments.
 - Services received from a non-plan provider (except for care for a medical emergency or urgently needed care) without a referral from a plan provider or a prior authorization from our Plan (however,

these services may be covered under Original Medicare). Section 3 gives a definition of prior authorization.

- Replacement of lost or stolen prescription drugs, and covered take-home drugs and supplies dispensed at the time of hospital discharge, unless a written prescription is obtained.
- Services for holistic medicine or other programs with an objective to provide personal fulfillment.
- Charges for cosmetic Retin-A, Rogaine, anorexic agents or any medications principally designed for weight loss, smoking cessation products, oral Progesterone and all over-the-counter drug items, except nicotinic acid.
- Maintenance or long term therapy; swim or pool therapy; oxygen therapy, and other inhalation therapy for home use, unless authorized by our Plan.
- Chelation therapy for atherosclerosis.
- Biofeedback for psychosomatic conditions or treatment of ordinary muscle tension states.
- Nursing home care costs beyond what is covered by Original Medicare and the Wisconsin 30-day skilled nursing mandate.
- Hospital stays for “rest cures” or convalescence in a nursing home

Additional Benefit Information

Dean Health Plan, Inc. provides a free (24 hours/7 days a week) Nursing Hotline.

Dean Health Plan, Inc. also offers the Wellness Incentives Now (WIN) Program for weight management, acupuncture, and health club memberships. Please contact us for additional information about this program. Our Customer Service Department telephone numbers are shown in the introduction.

There are also services that are limited or not covered by DeanCare Gold Basic. These services include, but are not limited to: homemaker services; private duty nursing; surgical treatment for morbid obesity, unless medically necessary and covered under Original Medicare; routine dental care; routine foot care; acupuncture; hearing aids; cochlear implants, unless medically necessary according to Original Medicare guidelines; and custodial care, such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicine. For a complete list of limited or excluded services, please contact our Customer Service Department at the number shown in the Introduction.

Communicating with Dean Health Plan

DHP Regulatory Compliance Department

Dean Health Plan's Compliance Department is responsible for overseeing the development, implementation, and ongoing operation of DeanCare Gold. It serves as a liaison between DHP and CMS and works with DHP Provider Services to assist providers in understanding Gold policies and procedures. The Compliance Department is actively involved in the development and oversight of the Gold plan, and ensures that DHP complies with all federal and state requirements.

Dean Health Systems Website

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>



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.

- **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.

DeanCare Gold Service Area

The following counties are included in the DeanCare Gold service area:

- | | |
|-------------------|--------------------|
| • Columbia | • Iowa |
| • Dane | • Jefferson |
| • Dodge | • Rock |
| • Grant | • Sauk |

All ZIP codes are included for each county listed above



DeanCare Gold Contacts

The DeanCare Gold 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 to contact the appropriate department for assistance.

Customer Service

Customer Service 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

Utilization Review

Utilization Management Department	(608) 836-1400 (800) 356-7344
Home Health & Hospice	Extension 4117
Mental Health/AODA/Detox	Extension 4102 or 4054
Durable Medical Equipment	Extension 4227 or 4449
St. Marys Medical Center	Extension 4117
All Other Hospital Admissions Referral Fax Number	Extension 4024 or 4357 (608) 836-6516
Health Services Fax Number	(608) 827-4300
Point of Service or Point of Enrollment Prior Authorizations	(608) 836-1400 (800) 356-7344



Claims

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

Drug Prior Authorizations

Dean Health Plan Drug Prior Authorizations (608) 828-1301
(800) 279-1301

DHP Drug Prior Authorization Fax (608) 827-7535

Navitus Health Solutions (866) 333-2757 (toll free)

Dean Health Systems Website www.deancare.com

Address:

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

Provider Relations Specialists Territory Assignments

Becky Bongard

Crawford, Grant, Iowa, Lafayette,
(608) 827-4292
(800) 356-7344, ext. 4292
Rebecca.Bongard@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

Judy Jabs

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

Brandi Parcel

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

Paul Schiller

Columbia, Juneau, Sauk, Richland, Vernon
(608) 827-4106
(800) 356-7344, ext. 4106
Paul.Shiller@deancare.com

Reimbursement

Medicare Coding Requirements

Dean Health Plan (DHP) requires that all providers follow Medicare's coding requirements when billing for covered services under the DeanCare Gold plan. The provider shall utilize all applicable revenue codes and related HCPCS codes on the UB-92 form or its successor form and all appropriate CPT-4 codes on the CMS-1500 form.

Physician Incentive Plans

Provider agrees to comply with all regulations relating to physician incentive models. Dean Health Plan is required to disclose physician incentive arrangements throughout its network to CMS on an annual basis. Disclosure is regulated even if there are no incentive arrangements. ^{42CFR417.479}

Practitioner Reimbursement

Reimbursement for covered services rendered to Gold members will be subject to the reimbursement terms of your provider agreement with DHP.

Dean Health Plan is primary for the following services. Claims should be submitted to Dean Health Plan:

- Inpatient physician Part B services (including mental health)
- Ambulatory Surgery Centers in Wisconsin
- Durable Medical Equipment (DME) not billed by a hospital and/or facility
- Any charges not listed in the Medicare primary section are processed by Dean Health Plan.

Medicare is primary for the following services. Claims should be submitted to the carrier:

- Outpatient Psychiatric (Facility charges and physician charges)
- Independent Physical Therapists
- Outpatient Blood
- Services related to end-stage renal disease (ESRD)
- Hospice
- **All** Part A and B charges from a hospital or nursing home, including facility charges.
- All ambulance charges billed from a hospital
- DME billed by a hospital/facility.

Claims and Timely Filing

Claims Processing

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

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 is requiring that all claim submissions for DHP Products include DHP Legacy number and Vendor ID. When available include your NPI Type 1 and Type 2 along with the DHP Legacy Number.

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

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 Portal, 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 resubmitted to DHI/DHP. **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, natural disaster, or other short-term circumstances. Such requests may be made, in writing, to your Provider Services Representative.
- 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.
- Medicare Crossover claims are exempt from the filing limit. Medicare 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 member, 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.

- 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.
- 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).

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

- Via the problem claims webform found on Deancare.com (see below),
- 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.

Exceptions to Timely Filing Guidelines on Claim Resubmissions

- Resubmitted claims as a result of DHI error can be resubmitted/corrected up to one year after the run date of the Rejected Claims Report 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, claims must be received 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. This information must be received within the timely filing limit in order for DHI/DHP to consider additional payment.

Confirmation of All Claims Submitted

Dean Health Insurance (DHI)/Dean Health Plan (DHP) provides 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 is generated and sent to the provider.

The following reports are 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.

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. 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 Care Center 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.

Coordination of Benefits (COB)

The order of benefits paid for DeanCare Gold members with other insurance, is often dependent on the type of other insurance coverage the member has. Many of these rules are set by Medicare. Some of them take into account whether the member has a disability or has ESRD. The number of employees who are covered by an employer's group insurance also is considered.

Please note that DHP follows the Medicare primary and secondary payor rules. In addition, DeanCare Gold will always process/pay claims immediately following Medicare. For example, when a member has Medicare, DeanCare Gold, and a group retiree policy, we still apply the Medicare COB rules.

- If Medicare is the primary payor, then Medicare "pays" first, DeanCare Gold pays following Medicare, and then any remaining amounts, if applicable, are paid by the group retiree policy.
- However, if Medicare is the secondary payor, then the group retiree policy pays first, Medicare pays second, and DHP pays following Medic

Referral/Prior Authorization

Referral/Prior Authorization Process

DeanCare Gold (Gold) members must choose a primary care practitioner (PCP) or clinic site from which to obtain routine and ongoing care.

In an effort to streamline our referral process, Dean Health Plan (DHP) has reduced the referral and authorization requirements for members enrolled in the Gold plan. The following services **do not** require prior authorization or a referral:

- Written referrals to Gold in-network providers for outpatient services covered by Medicare
- Prior authorization of outpatient Medicare covered services
- Inpatient admissions to Gold in-network hospitals for services that are covered by Medicare
- DME obtained from a Gold in-network DME provider
- Emergency Care and Out-of-Area Urgent Care.

The following services **require prior authorization**:

- All skilled nursing facility admissions
- All inpatient mental health admissions
- Admissions to non-plan facilities

The following services **require a referral**:

- Services provided by non-plan provider (i.e. any provider who is not listed in the Gold Provider Directory).

Services received without prior authorization or referral in the above circumstances, where it is required, will not be covered by DHP. Medicare will pay its portion, and the members will be responsible for their cost sharing amounts. DHP encourages the PCP and the patient to discuss any specialty care the member may be receiving even when a written referral is not required. If you have any questions regarding DHP's referral guidelines, please contact DHP Customer Service at (608) 828-1301 or 1-800-279-1301.

Electronic Referral Submissions

If you are a DHP NaviNet™ enabled office, all referral request submissions are sent to DHP electronically via the secured Internet site <https://navinet.navimedix.com>. You will receive the response to your request electronically via DHP's NaviNet™. The member and referred to physician will receive DHP's response to the request via written correspondence.

If you are not a DHP NaviNet™ enabled office, then you must complete and submit the Referral Request Form and fax to Utilization Management at (608) 836-6516.

Paper Referral/Prior Authorization Request Submissions

Once you have determined that you will need to complete a Written Referral Request Form, follow the guidelines below:

- The Referral Request Form can be found on [deancare.com](http://www.deancare.com/pdf/providers/referral-request-form.pdf) under For Providers > Forms at: <http://www.deancare.com/pdf/providers/referral-request-form.pdf>
- Referral/prior authorization request forms should be mailed or faxed the date the request has been completed to insure timely processing of the referral request.
- When submitting the form to DHP, please complete **ALL** fields on the top part of the form in their entirety. **If all of the required fields on the Referral Request Form are not completed, the DHP Utilization Management Department will return it to the referring physician for completion.**
- Referral/prior authorization requests must be signed by the ordering clinician.
- When a referral/prior authorization is requested to a **non-plan** provider the instruction sheet will assist providers in completing the single page referral form correctly. The **Utilization Management Department** will review the referral to ensure appropriate care had been requested. Any changes or rejections will be communicated to the referring physician, consultant, and the member.

All copies of these referrals must be mailed to:

Dean Health Insurance, Inc./Dean Health Plan
Attn: Utilization Management
P.O. Box 56099
Madison, WI 53705

Only services that are not provided within the DHP provider network are considered for approval with a non-plan network provider.

Referral Submission Tips

All fields on the paper and electronic referral form must be filled out completely. This will ensure that DHP has all the information necessary to process the referral request. Referrals for an extended duration are allowed for medically necessary services that cannot be performed within the Gold service area, or as determined and approved by DHP's Medical Affairs Division.

- Referral Requests to non-plan providers are considered only when requested services are not provided within the Gold plan provider network. All requests for services with non-plan providers require prior authorization and must be approved in writing by DHP prior to the member receiving services. Call DHP Customer Services if you need to determine the participation status of the physician/facility.
- All necessary labs, X-rays or other diagnostic testing needed either prior to or after the visit should be performed within the Gold plan network. Results should be sent with member. If the consultant(s) needs to order tests to complete the evaluation, they will be informed of the need to contact the Referral Department to obtain approval before providing these services.

- Requests for 2nd opinions are approved with plan providers. Request for 2nd opinion with Non-plan providers will be considered for approval if the services are not available within the Gold network. If approved, approval will be for one (1) visit, for physician services only.

Hospital Admissions

Pre-certification for planned hospital admissions in a Gold in-network plan hospital is not necessary.

Planned admissions to non-plan hospitals require prior authorization and are reviewed for medical necessity and appropriateness of site. If care meets the Medicare definition of emergency, prior authorization is not necessary to treat or admit.

Second and Third Opinions

Gold members are allowed to get a second and third opinion from Gold plan providers. Requested second and third opinions from non-plan providers will be reviewed by a Medical Director for prior approval.

Accelerated Review

If the member requests an accelerated review, and the time frame for the standard review process could jeopardize the member's health, DHP will make a decision within one business day of receiving all the necessary information. Accelerated review must be clearly indicated if faxed or requests may be called in to DHP's Medical Affairs Division. If the member's plan physician requests the accelerated review, or supports the member's request, the request for the accelerated review is automatically granted.

Behavioral Health

Inpatient Services

Behavioral health admissions require prior authorization by our Medical Affairs Department. Call (608) 836-1400 or 1-800-356-7344 to obtain a member's benefits, and then you will be connected with a Behavioral Health Coordinator.

AODA Services

Members can self-refer to a plan AODA provider for an *initial* assessment and recommendations for treatment. *The AODA Authorization/Treatment Form in required to be completed and returned to DHP's Medical Affairs Department by the provider of service.*

Federal Regulations

Gold members have unique appeal rights, including the ability to appeal to CMS when the appeal process does not resolve an issue fully in their favor. Gold members also have the right to an immediate Quality Improvement Organization (QIO) review if they feel they are being prematurely discharged from a hospital. These rights are discussed in detail in the "Member Complaint, Appeal, and Grievance Procedures"

Complaint/Appeals Procedures

Member Complaint, Appeal, and Grievance Procedures

DeanCare Gold (Gold) members can appeal if they do not agree with Dean Health Insurance (DHI)/Dean Health Plan (DHP) decisions about their medical bills or health care. Members have a right to appeal if they think:

- DHP has not paid part, or all, of a claim
- Their hospital stay is ending to soon
- They are experiencing other problems such as:
 - Problems with the quality of the medical care they receive, including quality of care during a hospital stay
 - If they believe that mistakes have been made
 - If they feel that they are being encouraged to leave (disenroll from) DeanCare Gold
 - If they feel that they are being discouraged from seeking the care they think they need
 - Problems with the customer service received
 - Problems with how long they have to spend waiting on the phone, in the waiting room, or in the exam room
 - Problems with getting appointments when they need them, or having to wait a long time for an appointment
 - Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff
 - Cleanliness or condition of doctor's offices, clinics, or hospitals

DHI/DHP normally has 60 days to process the appeal. In some cases, the member has a right to a faster, 72-hour appeal. The member can get a fast appeal if their health or ability to function could be seriously harmed by waiting 60 days for a standard appeal. If a member asks for a fast appeal, DHI/DHP will decide whether or not to approve a 72-hour/fast appeal. If not, the appeal will be processed within 60 days. If any doctor asks DHP to grant a fast appeal, or supports the request for a fast appeal, DHI/DHP must honor the request.

60 Day Appeal Process

If a member wants to file an appeal, they must do one of the following within 60 days of the date of service or date of denial of payment of services:

- Mail a written request to: Dean Health Insurance, Inc., Attn: Appeals, P.O. Box 56099, Madison, WI 53705 or with the local Social Security Administration Office; or if a member is a railroad annuitant, with the Railroad Retirement Board.
- FAX the request to DHP at (608)827-4212. If a member is in a hospital or a nursing facility, please provide assistance in having the written appeal transmitted to DHP by FAX.
- The member may hand deliver the request to Dean Health Insurance, Inc., 1277 Deming Way, Madison, WI 53717.

DHI/DHP will provide a response to an appeal request within 60 days of the receipt of the appeal.

72 Hour Appeal Process

(Does not apply to denials of payment)

If a member wants to file an appeal, they must do one of the following within 60 days of the date of service denial:

- File an oral or written request for a 72-hour appeal which specifically states that the member wants an expedited appeal, fast appeal or 72-hour appeal; or that the member believes that his or her health could be seriously harmed by waiting 60 days for a normal appeal.
- File an oral request by calling 1-800-279-1301. DHP will document the oral request in writing.
- Hand deliver the request to Dean Health Insurance, Inc., 1277 Deming Way, Madison, WI, 53717.
- FAX the request to (608) 827-4212. If the member is in a hospital or a nursing facility, please provide assistance in having the written appeal transmitted to DHP by FAX.
- Mail a written request to Dean Health Insurance, Inc., Attn: Appeals., P.O. Box 56099, Madison, WI, 53705. However, the 72-hour review time will not begin until the request for appeal is received.
- Members may contact Customer Service, with any questions, at 1-800-279-1301.

10-Day Extension

An extension of up to 10 working days is permitted for a 72-hour appeal, if the extension of time benefits the member (e.g. if the member needs time to provide DHI/DHP with additional information or if DHI/DHP needs to have additional diagnostic tests completed). DHI/DHP will make a decision on the appeal and notify the member of that decision within 72 hours of receipt of the request. However, if the decision is not fully in the member's favor, DHI/DHP will automatically forward the appeal request to the CMS's contractor for an independent review. CMS's contractor will send a letter with their decision within 10 working days of receipt of the case from DHI/DHP.

Support for the Appeal

Members are not required to submit additional information to support the request for services or payment for services already received. DHI/DHP is responsible for gathering all necessary medical information. However, it may be helpful to the member to include

additional information to clarify or support the appeal, such as medical records or physician opinions in support of their appeal. Medical records should be obtained, via written request, from the PCP. If medical records from specialist physician(s) are not included in the PCP's medical records, a separate written request to the specialist physician(s) who provided medical services may have to be made. DHI/DHP will provide an opportunity for the member to provide additional information in person or in writing.

Even though the request may be filed with the Social Security Administration or Railroad Retirement Board office, that office will transfer the request to DHI/DHP for processing. DHI/DHP is responsible for processing the appeal request within 60 days from the date DHI/DHP receives the request. If DHI/DHP does not rule fully in the member's favor, DHI/DHP will forward the appeal request to the CMS contractor for a decision.

Who May File an Appeal

- The member may file an appeal.
- If a member wants someone to file an appeal on their behalf:
 - Give DHP the member's name, Medicare number, and a statement which appoints an individual as the member's representative. (Note: Any provider may be appointed.)
 - For example: "I [member name] appoint [name of representative] to act as my representative in requesting an appeal from DHI/DHP and/or CMS regarding DHI/DHP's (denial of services or denial of payment for services).
 - The member must sign and date the statement.
 - The member's representative must also sign and date this statement.
 - Include this signed statement with the appeal.
- A Non-plan provider may file a standard appeal of a denied claim if he/she completes a waiver of liability statement which says he/she will not bill the member regardless of the outcome of the appeal.
- A court appointed guardian, or an agent under a health care proxy, to the extent provided under Wisconsin law.

Help with the Appeal

If a member decides to appeal and wants help with the appeal, the member may have a doctor, friend, lawyer, or someone else help with their appeal. There are several groups that can help. A member can contact the Medicare helpline at 1-800-MEDICARE (1-800-633-4227) or the Wisconsin Board on Aging and Long-Term Care 1-800-242-1060.

Formal Grievances

A grievance is a complaint or concern about problems a member may observe or experience with DHI/DHP. A member has the right to file a grievance anytime they have a complaint or concern with DHI/DHP. The types of situations in which a member can file a grievance include:

- complaints regarding such issues as wait times, physician behavior and demeanor, adequacy of facilities, and other similar member concerns;
- involuntary disenrollment situations (disenrollment for cause requires prior CMS approval);
- complaints concerning the quality of services a member received.

Please Note: Any written expression of dissatisfaction will automatically be addressed as a formal grievance. A member can file a grievance by submitting in writing to:

Dean Health Insurance, Inc.
ATTN: Appeals
P.O. Box 56099
Madison, WI 53705

Final Appeal of Grievance Decision

If a member declines to accept the decision of the Grievance Committee, a final appeal can be made. The Grievance Appeal Committee consist of 3 persons; a DHP member, a physician director, and a person appointed by the Board of Directors. The Grievance Appeal Committee has 20 calendar days in which to deliberate and issue a final decision.

Urgent Care Complaint, Appeal, or Grievance

If the initial complaint, appeal, or grievance involves the need for urgent care, DHI/DHP will resolve those within 72 hours of receiving the grievance or appeal, according to DHI/DHP's criteria which is based upon the urgent care grievance provisions of Wisconsin law.

Independent External Review

The Wisconsin mandated benefits addressed in the Gold Evidence of Coverage are subject to Wisconsin's statutes and regulations. Members have the right to an Independent External Review (IER) of any final adverse determination involving (mandated benefits) care DHI/DHP determines does not meet Plan requirements for medical necessity, appropriateness of care, level of care, effectiveness of care, the health care setting, or where the requested services have been found to be experimental treatment. In order to request an IER, the amount of the total claim liability must exceed \$250. **Requests for Medicare benefits are not eligible for IER; refer to the above appeals information for Medicare appeal rights.**

Office of the Commissioner of Insurance

Members may seek grievance resolution by taking the above outlined steps. Member's may also contact the Office of the Commissioner of Insurance, which enforces Wisconsin's insurance laws, and file a complaint. The member may write or call:

**Office of the Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103 or 1-800-236-8617**

Provider Appeals Process

Dean Health Insurance (DHI)/Dean Health Plan (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. DHI/DHP will consider the appeal raised, but the decision whether to effect or continue the action will rest solely with DHI/DHP. If a claim is specifically denied for timely filing, please reference the section of this manual noted Timely Filing Appeals for specific information.

Written appeal requests will be considered 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.

Utilization Management/Credentialing/Quality Improvement

Utilization Management Program

Dean Health Insurance (DHI)/Dean Health Plan (DHP) strives to facilitate the delivery of appropriate care. Therefore, 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 service care nor does it provide financial incentives for UM decision makers which encourage decisions that result in underutilization. All DHP practitioners, providers, and employees making UM decisions have been made aware of this policy.

DHP established the Utilization Management (UM) Program to ensure appropriate utilization of medical resources to maximize the effectiveness of care provided to members. DHP practitioners are responsible for cooperating with UM program activities, including, but not limited to, the following:

- Surveys on UM processes and services, and other efforts to evaluate UM program effectiveness
- Concurrent review, retrospective review, and referral/prior authorization processes
- Case management
- Discharge planning
- Monitoring for over-utilization, under-utilization, and continuity and coordination of care
- Quality of care issue resolution
- Development of new medical technology policies
- Complaint and appeal investigation and resolution
- UM and Medical Peer Review Committee activities
- Pharmacy management

DHP Medical Policies are available on-line at www.deancare.com or will be provided upon request.

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.

Practitioners who fall under the scope of credentialing/ recredentialing for DHP:

A. *Medical practitioners*

- Medical Doctors (MD)
- Dentists (DDS/DMD)
- Chiropractors (DC)
- Osteopaths (DO)
- Podiatrists (DPM)
- Optometrists (OD)

B. Licensed Independent Mid-Level practitioners

- Certified Nurse Midwives (CNM)
- Advance Practice Nurse Practitioners (APNP)
- Speech Therapists (SLP)
- Audiologists (AUD)

C. *Behavioral Health practitioners*

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists who are state certified or licensed
- Master's-level clinical social workers who are state certified or licensed
- Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently
- Master's- Level Qualified Treatment Trainees who are licensed and work at behavioral health facilities that are certified as DHS 35 by the State of Wisconsin
- Master's- Level Autism Spectrum Disorder (ASD) Providers- who meet training requirements as set forth in Wisconsin Administrative Code 3.36 (exclusion: Qualified Paraprofessional)

Credentialing and Recredentialing Policies:

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, APNPs 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 applicant states that he/she is board certified. Board certification can be verified using the following websites:
 - 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).
 - American Board of Oral and Maxillofacial Surgery
 - American Board of Podiatric Surgery
 - American Board of Professional Psychology
 - American Board of Professional Neuropsychology
 - National Boards of Certified Counselors
- 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 Station.

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 Relations 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 *CR3017: 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.

Clinical Site Policies

Most care for DHP members is provided in Primary Care practitioner offices. For this reason, DHP has set Clinical Site and Medical Record Standards for all Primary Care practitioner office sites to ensure 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:** Dean Health Plan has established standards related to Primary Care Practitioners and Behavioral Health appointment accessibility, please see section: Accessibility of Services

Medical Recordkeeping Policies

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.

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.

Medical Records Documentation Policies

Dean Health Plan requires consistent and complete documentation in the medical record as an essential component of quality patient care for all practitioner sites.

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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.

Practitioner Office Site Quality

DHP Quality Assurance continually tracks and trends practitioner office sites for complaints received against the Clinic Site and Medical Record Standards. DHP has established a complaint threshold regarding Clinic Site and Medical Record Standards of three (3) or more complaints met or exceeded annually for the following categories:

- Facility Physical Accessibility
- Facility Physical Appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/record keeping

DHP conducts site visits of office(s) in which it receives a threshold of quality complaints. DHP's Quality Improvement staff in conjunction with DHP Provider Relations staff will conduct site visits for complaints related to office site criteria and/or medical/treatment record-keeping categories listed above. A site visit will be conducted within 30 days of meeting the threshold.

Upon review of documentation gathered during the site visit, a determination will be made if a corrective action plan is appropriate. The Quality Improvement staff will provide a summary to the facility as to the outcome of the visit. If an action plan is required the facility will have 30 days in order to submit the action plan.

Quality Improvement will evaluate the effectiveness of the actions at least every six months, until the office meets DHP's performance standards.

DHP will conduct a follow-up visit of any previously deficient office if the practice site meets the complaint threshold in more than one standard. A review and assessment will be done based on the initial complaint subsequent to correcting the initial deficiencies. Sites that do not make sufficient

improvement in the complaint areas within 12 months will be referred to the Quality Improvement Committee Chair for review and follow-up action. The Quality Improvement Committee may recommend that the Credentialing Committee delay recredentialing approval of a provider until the facility has submitted an acceptable action plan to address the complaints.

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

Quality of Service Issues

Dean Health Plan identifies and investigates all instances of concern for the quality of service provided to DHP members. Dean Health Plan typically identifies quality of service issues through member complaints.

DHP categorizes quality of service issues as follows:

- Access To Care
- Communication/Incorrect Information
- Provider/Staff Behavior
- Privacy Breach
- Facility Physical Accessibility
- Facility Physical Appearance
- Adequacy of Space in Facility
- Adequacy of Treatment Record Keeping

All issues relating to quality of service provided to DHP members are referred to the Quality Improvement Department for investigation. Quality Improvement logs all incoming issues concerning quality of service, noting the date of receipt and the source.

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

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

Quality Improvement will review the following as they pertain to the service 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.

Quality Improvement will document a summary of the investigation which is reviewed by Quality Improvement Management to determine the appropriate disposition of the issue. Quality Improvement will conduct and complete the investigation within 30 working days of receipt.

Quality Improvement will update the log of quality of service issues, noting the actions taken by the Quality Improvement Management. Quality Improvement will monitor, and as appropriate, implement corrective action plans. Quality Improvement will document all activities and progress of corrective action plans.

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.

DHP categorizes quality of care issues as follows:

- Coordination/Continuity of Care
- Technical Competence or Appropriateness
- Patient Safety
- Privacy Breach
- Surgical/Procedure Complication

All issues relating to quality of care provided to DHP members are referred to the Quality Improvement Department for investigation. Quality Improvement 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).

Quality Improvement 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 Quality Improvement.

Quality Improvement 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.

Quality Improvement 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.

Quality Improvement will conduct and complete the investigation within 30 working days of receipt. Quality Improvement will document a summary of the investigation and a DHP Medical Director and/or Medical Peer Review Committee will determine the appropriate level of severity and disposition of the issue. Levels of Severity include:

- Level 1- Minor Substandard Care with benign consequences for the patient requiring no specific treatment or intervention.

- Level 2 - Moderate Substandard Care with modest clinical intervention required to reverse or treat the condition. No hospitalization or invasive therapy required (excepting routine venipuncture).
- Level 3 – **Peer Review Review Required** - Serious substandard care with temporary impairment. Significant medical intervention maybe required to treat or reverse the condition. May involve hospitalization or invasive corrective therapy. No permanent irreversible patient disability attributable.
- Level 4 – **Peer Review Review Required** - Serious substandard care with permanent patient impairment. Irreversible injury or serious impairment resulting from substandard care. May involve loss of limb or permanently impaired bodily function.
- Level 5 – **Peer Review Review Required** - Fatal substandard care with death directly related to the clinical misadventure. This may involve acts of commission as well as acts of omission.

Issues designated for referral to Peer Review process may be routed to independent review organization (IRO) 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 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 Quality Improvement and determine the appropriate corrective actions. Quality Improvement 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.

Quality Improvement 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 Relations Representative. Please reference the *Health Plan Overview* section of this manual for the representative in your geographic area.

Quality Improvement will monitor, and as appropriate, implement corrective action plans. Quality Improvement will document all activities and progress of corrective action plans.

Accessibility of Services

DHP has set standards for member access to services provided by Primary Care Practitioner (PCP) office sites and Behavioral Health Practitioner sites. Dean Health Plan performs an annual Appointment Accessibility Assessment of all Primary Care practitioner and Behavioral Health Practitioner sites within the DHP network. A self-assessment reporting tool is provided by DHP's Quality Improvement dept to these practitioner office sites for completion. This self-assessment is reviewed by the Quality Improvement dept which tracks and trends annual compliance with the performance expectations DHP has set regarding member access by individual office sites and overall network access averages.

Primary Care Appointment Accessibility

DHP has defined the following practitioners as PCPs: Internal Medicine, Family Practice, General Practice, Pediatrics and OB/GYN. The access standards for PCP office sites are as follows:

Preventative Care: (physical exams and preventive health visits)	30 Days
Routine: (follow up visits, blood pressure checks, suture removal, etc.)	14 Days
Symptomatic, non-urgent: (colds, headaches, joint/muscle pain, etc.)	4 Days
Urgent: (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 Accessibility

DHP assesses Behavioral Health care accessibility with any of the following providers: physicians, PhD's, PsyD's, Mid-Level Mental Health Providers (LPC, LCSW, LMFT, MS) and AODA Counselors. The access standards for Behavioral Health sites are as follows:

Routine office visit: (any request for an established or new patient intake)	10 Days
Urgent care visit: (Medication assessment following side effects or patients with increased systems of distress due to a recent event)	48 Hours
Non-Life Threatening services: (not suicidal, but potential for high-risk Situation or self-harm)	6 Hours

Each element of the appointment accessibility self-assessment will be evaluated to determine compliance with DHP standards.

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

Facilities with a total compliance score of less than 90 percent may be required to submit an action plan to DHP within 30 days addressing their plans for improving in areas of noncompliance with DHP accessibility 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.

Identified sites that do not make requested improvements to raise the total score to 90 percent or greater after 12 months will be referred to the Quality Improvement Committee (QIC) for review and follow-up actions.

A report compiling total site and overall network average scores of compliance with accessibility of services standards summarizing the results of all action plans requested, received, and not received during the previous period will be computed and presented annually to the QIC.

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.

Gold Policy Statements

Advanced Directives

(Living Will, Power of Attorney for Health Care document, or other similar directive)

Federal law requires us to document in each patient's medical record whether an advance directive exists and provides for community and staff education on advance directives. Patient Self-Determination Act of 1990 (PSDA)

Wisconsin law states that an individual is responsible for notifying his or her physician of the existence of an advance directive. Once a patient provides the physician with an advance directive the PCP is required to include that document in the patient's permanent medical record. Wis. Stat. §154.03(1)

The Wisconsin Living Will statute requires that an attending physician comply with the Living Will document unless: **(a)** the attending physician believes that withholding or withdrawing life-sustaining procedures or feeding tubes would cause pain that cannot be alleviated through pain relief measures, or **(b)** the patient is pregnant. If the physician feels he or she cannot comply with the document, the physician must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct. Wis. Stat. §154.03 – ANNOT.

The PCP is responsible for documenting the patient's medical record to indicate the existence of any advance directive. On the standard advance directive forms, it suggests that the member keep the document on file with their physician. PCPs must also include a copy of all advance directives the patient has provided to the PCP in the patient's permanent medical record.

PCPs are responsible for getting advance directive information to specialists, if applicable. There is an advance directive box on the referral request form. The PCP must indicate, in the advance directive box, if the member has an advance directive. In addition to checking the member's medical record, specialists or other contracted providers may verify the existence of a member's advance directive by contacting DHP's Customer Service Department.

If you would like a monthly listing of new DeanCare Gold members, please contact your designated Provider Relations Specialist.

DeanCare Gold Member's Rights and Responsibilities

Dean Health Plan (DHP) members deserve the best service and health care 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.

DeanCare Gold members have the right to:

- Be treated with fairness and respect.
- The privacy of their medical records and personal health information.
- See plan providers and get covered services within a reasonable period of time.
- Know their treatment choices and participate in decisions about their health care.
- Use advance directives (such as a living will or a power of attorney).
- Make complaints.
- Get information about their health care coverage and costs.
- Right to get information about plan providers.

DeanCare Gold members have the responsibility to:

- To get familiar with their coverage and the rules they must follow to get care as a member. They can use their Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow.
- To give their doctor and other providers the information need to care for them, and to follow the treatment plans and instructions that they and their doctors agree upon. Members should ask your doctors and other providers if they have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- To pay their cost sharing amounts owed for the covered services they receive.
- To let DHP know if you have any questions, concerns, problems, or suggestions.

Dean Health Plan's Member Privacy Policy

Protecting the Privacy of Personal Health Information

The privacy of the nonpublic personal health and financial information (collectively referred to as "nonpublic personal information") of our members is of utmost importance to us at Dean Health Plan (DHP). This Notice describes how we protect the confidentiality of the nonpublic personal information we receive on all members, including former members. A brief explanation of the manner in which we obtain, utilize, and protect this nonpublic personal information follows.

What Types of Nonpublic Personal Information Does DHP Collect About You?

We collect a variety of nonpublic personal information needed to administer health insurance coverage/benefits. Some of the following sources that we collect nonpublic personal information from include:

- Information we receive directly or indirectly from our member or benefits plan sponsor through applications, surveys or other forms, in writing, in person, by telephone or electronically (e.g., name, address, social security number, date of birth, marital status, dependent information, employment information, and medical history).
- Information about our members' transactions with us, our affiliates, our providers, our agents and others (e.g., health care claims, medical history, eligibility information, payment information, service request, and appeal and grievance information).
- Information our member may authorize us to collect from others

How Does DHP 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 regulations to safeguard your nonpublic personal information. We limit the internal use of nonpublic personal information about our members whenever possible and ensure that only authorized staff with the need to know have access to it. Safeguards are maintained for nonpublic personal information and are reviewed regularly to ensure that member privacy is protected. We have policies to direct, and procedures to limit, the access of a member's information only to those who have a need and legal right to see that information. We also have a Privacy Committee which has overall responsibility for training, oversight, and enforcement of privacy policies and procedures to safeguard against inappropriate access, use, and disclosure consistent with applicable law.

Only our member will be able to access your own nonpublic personal information. The only way you can obtain access to someone else's nonpublic personal information is if you have an authorization form from the individual who is the subject of the information.

How may DHP Use or Share Your Information?

We will not disclose your nonpublic personal information unless we are allowed or required by law to make the disclosure. Following is a listing of categories of entities that we may make disclosures to as allowed or required by law:

- We may disclose information we collect such as your policy coverage, premiums, and other related transactions to our affiliates or others that offer insurance and related services.
- We may disclose information that we collect to service companies (both affiliates and non-affiliates) that perform insurance functions on our behalf, such as third party administrators, insurance agents, auditors, benefit consultants, or care management specialists for utilization management, quality improvement, or other health plan activities as permitted by law.
- We may disclose summary health information without names or other identifying data to the sponsor of your group health plan for purposes of administering benefits under the plan, soliciting premium bids from health insurers, or modifying, amending, or terminating the plan. We also may disclose to the plan sponsor information on who is participating in the health plan.
- We may use and disclose your health information as required by any federal, state, or local law.

If you have any questions about our privacy policies, please feel free to call us at 1-800-279-1301.

Dean Health Plan's Affirmative Action Statement

It is the policy of Dean Health Plan, Inc. to employ and advance in employment qualified persons without discrimination against any employee or applicant for employment because of race, color, religion, sex, physical or mental disability, developmental disability, sexual orientation, age, or status as a special disabled veteran or veteran of the Vietnam era. I wish to reaffirm and reemphasize that this policy applies throughout Dean Health Plan.

To effectuate our commitment to this policy, Dean Health Plan has established affirmative action programs under which we undertake that:

- 1) We will recruit, hire, train, and promote qualified persons in all job titles, and ensure that all other personnel actions are administered without regard to race, color, religion, sex, national origin, disability, or status as a special disabled veteran or Vietnam era veteran.
- 2) We will ensure that all employment decisions are based on valid job requirements so as to further the principle of equal employment opportunity.
- 3) We will ensure that promotion decisions are in accord with principles of equal employment opportunity by imposing only valid requirements for promotional opportunities.
- 4) We will ensure that all personnel actions such as compensation, benefits, transfers, layoffs, return from layoff, company-sponsored training education, tuition assistance, social and recreational programs, will be administered without regard to race, color, religion, sex or national origin.
- 5) We will take affirmative action to employ and advance in employment qualified individuals with a disability and qualified special disabled veterans and veterans of the Vietnam era at all levels of employment, including the executive level.
- 6) Employees and applicants shall not be subjected to harassment, intimidation, threats, coercion, or discrimination because they have engaged in or may engage in any protected activity or exercised any protected right under equal employment opportunity or affirmative action laws or regulations.

Overall responsibility for effectuation of this policy rests with the President; however, each employee, especially department directors, is expected to support the above efforts. The Equal Employment Coordinator will be responsible for the day-to-day administration and interpretation of the program.