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# Dean Health Plan Hospital Manual

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## Health Plan Overview

### Welcome to Dean Health Plan!

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

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

#### Customer Service

<b>Customer Service Department</b>	(608) 828-1301 (800) 279-1301
<b>Monday – Thursday</b>	<b>7:30 am to 5:00 pm</b>
<b>Friday</b>	<b>8:00 am to 4:30 pm</b>
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

<b>Utilization Management Department</b>	(608) 827-4455 (800) 356-7344 ext 4455
Utilization Management I Fax Number	(608) 836-6516
Point of Service or PPO Prior Authorizations	(608) 827-4455 (800) 356-7344 ext 4455

#### Claims



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**Claims Manager**

(608) 827-4247  
(800) 356-7344, EXT 4247

Information Systems for Electronic Claims  
Transmission

(800) 356-7344 x4320  
[dhpedi@deancare.com](mailto:dhpedi@deancare.com)

CPT-4 & ICD-9, HCPCS Coding

(608) 836-1400  
(800) 356-7344

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

**Address:**

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



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## Who is Dean Health Plan?

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

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

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

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



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

**The Dean Health Insurance/Dean Health Plan Vision Statement is as follows:**

**Dean will be the highest quality, most effective Managed Care Organization in its market. As part of the Dean Health System and SSM Health Care System, we will be consumer driven and dedicated to provide a "seamless delivery" of service and care to our customers.**

## Dean Health Systems Website

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

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

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



The screenshot shows the 'Providers - Dean Health Plan - WI' page in Internet Explorer. The page features a navigation menu with links for 'About Dean', 'Contact Us', 'Careers', 'Search', 'MyChart', and 'Dean Connect'. Below the navigation is a 'Welcome...' message and a list of services: Patient Care, Pharmacy Services, Manuals, and Forms. The 'Provider Resources' section includes 'What's New' (New Tobacco Cessation Program), 'Provider Services' (Select a Location), and 'Provider News'. A 'Helpful Links' sidebar contains links to 'DeanConnect - Navinet', 'Confirmation Reports Portal', 'Prior Authorization Form', 'Quality Commitment', 'Referral Request Form', and 'Your Patient's Plan Benefits'.

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## Interactive Voice Response Line (IVR)

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

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

There are currently three options available. They are:

- **Member Eligibility**

To check member eligibility you must enter:

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

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

- **Claims Status**

To check claims status you will be prompted to enter:

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

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

You will be given:

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

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

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- **Other Health Insurance**

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

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

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

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

You can reach our IVR system by dialing:

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

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

## The Provider Services Department

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

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

Provider Services maintains:

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

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

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## Provider Relations Specialists Territory Assignments

### Becky Bongard

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

### Judy Jabs

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

### Sandy Hayes

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

### Brandi Parcel

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

### Paul Schiller

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

## Hospital Updates/Changes

All of the following requests need to be submitted in writing to the attention of your Provider Relations Specialist. Please provide as much **ADVANCE NOTICE** as possible to avoid any disruption to your patients or claim payments.

- **Facility Demographic Changes:**
  - ✓ Facility Name
  - ✓ Location and/or address
  - ✓ Phone number
  - ✓ Accreditation changes
- **Request to expand or add new clinics and/or office locations.** These requests to expand are required to have prior approval through the Provider Services Department.
- **Request to add additional services and/or programs.** These requests are required to have prior approval through the Provider Services Department.
- Practitioner requests to terminate a patient/doctor relationship must be **sent in writing** to the Provider Services Department stating the reasons for the request. Dean Health Plan will review the request and notify the provider of the determination whether to approve or deny their request to terminate the patient/doctor relationship. To avoid concerns of abandonment, the provider is requested to continue seeing the patient for 30 days from the termination notice, if the patient seeks urgent or emergent care. This will give the member time to choose a new primary care practitioner.



## **“Dean On Call”**

### **(24-hour Nurse Line)**

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

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

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

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

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

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## Products

### Dean Health Plan's Products

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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## BadgerCare Plus Identification (ID) Card

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

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

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

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

### Forward Card Features (Resembles an automated teller card)



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

## DHP Identification (ID) Card

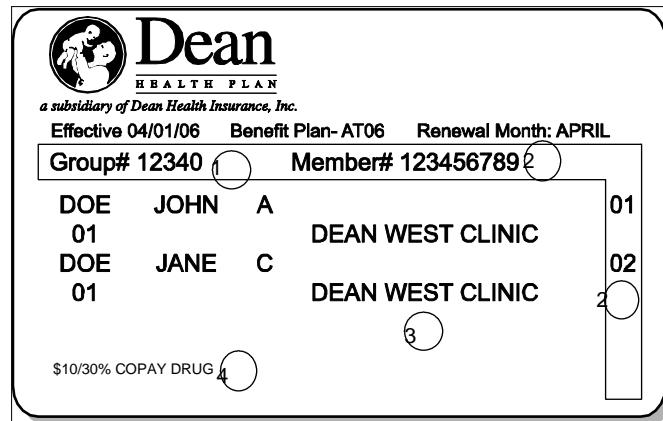
Your role as a Dean Health Plan (DHP) Provider is to identify which plan a member has to assure that the correct referral, prior authorization, and pre-certification guidelines are followed.

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

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

Questions regarding member benefits and member identification may be directed to our Customer Care Center.

### Example of Identification Card



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

Group # begins with:	Type of Product
20000	Senior/Select
C	<u>Gold</u> <u>C220 - Enhanced with State Drug Mandated Benefit</u> <u>C22D – Enhanced, Basic &amp; Shared Value plans w/o State Drug Mandated Benefit</u>
Y	Point of Service (POS)
GE	Dean Focus Plan (EPO)

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

## 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 Care Center at 800-279-1301.

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## Claims, Timely Filing & EOPs

### Claims Submission

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

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

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



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

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

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

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

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.



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If you have questions regarding required fields on a claim, please contact our Customer Care Center 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 or other short term circumstances. Such requests may be made, in writing, to the DHI/DHP director of claims.
- Coordination of Benefit (COB) claims must be received within the TF limit outlined in your agreement with DHI/DHP; beginning with the date noted on the primary payor's explanation of benefits.
- Crossover claims are exempt from the filing limit. Crossover claims are those claims that are initially filed with CMS, and forwarded by CMS to DHI/DHP.
- If the provider had difficulty obtaining DHI/DHP coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the DHI/DHP coverage is identified, but not longer than 180 days from the date of service. Provider shall submit supporting documentation to demonstrate measures the provider has taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the filing limit outlined in their agreement.

- Claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately due to a change in physician and need to be submitted within timely filing limit, beginning with the date of delivery. Dean Health Insurance/Dean Health Plan will not accept a global obstetrical charge from a provider.

## Timely Filing Guidelines for Claim Resubmissions/Corrections

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

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 our error can be resubmitted/corrected up to one year after the run date of the Rejected Claims Reports or the EOP date.
- If the provider is hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital based provider who must wait for the inpatient discharge of the member, the provider must submit claims within the timely filing limit from the discharge date of the inpatient confinement for DHI/DHP to consider payment.
- The provider discovers new or additional information and requests additional payment on a processed and paid claim. Provider must submit this information within the timely filing limit in order for DHI/DHP to consider additional payment.
- Medical Assistance HealthCheck claims are exempt from the timely filing limit.
- Newborn claims must be received no later than fourteen (14) months from the date of birth.

## Confirmation of All Claims Submitted

Dean Health Insurance (DHI)/Dean Health Plan (DHP) will provide confirmation on all new claim submissions. For every claim received by DHI/DHP, whether it is filed on paper or through

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Electronic Claims Transmission (ECT), a confirmation of receipt will be generated and available to the provider of service.

DHI/DHP currently generates a nightly report for all claims received by DHI/DHP. There are three reports generated nightly by DHI/DHP based on claims received in the DHP Claims Department:

- Rejected ECT report for those claims which fail to enter our processing system. These will come in the form of a paper letter of explanation along with a copy of the specific claim, or via the Provider Confirmation Portal (if provider has access).
- Confirmation Report via paper or the Provider Confirmation Portal (if provider has access), Rejected Claims Report via paper or confirmation portal (if provider has access).

## Electronic Claims Transmission (ECT) Confirmation Report

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

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

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

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

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

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

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



The following is an example of our ECT Confirmation Report:

DEAN HEALTH PLAN ECT CONFIRMATION REPORT

MADISON, WI 53718  
Tax Id:

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE
			06/12/2011	1	126.80	06/22/2011		NA
			06/12/2011	1	126.80	06/22/2011		NA
			06/12/2011	1	126.80	06/22/2011		NA

## Confirmation Reports

If a provider has access to the claims confirmation portal found on deancare.com, all submitted claims will be listed.

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

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

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

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



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

## Rejected Claims Reports

The Rejected Claims Reports will show you **any** claim that is not able to enter our claims processing system, whether it was submitted on **paper or electronically**. **If you have access to the provider confirmation portal, you will receive electronic notice of the rejected claims via the portal. If you do not have access, you will receive a paper report listing the specific claims as well as an associated error code in addition to a copy of the paper claim.**

- Error codes will be used to show why the claim did not pass the initial editing process.
- **Based on the error codes provided, please resubmit the claims with the necessary changes.**

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

The following is an example of the ECT Rejected Claims Report:

Rejected UB Claims

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	REJECT REASON
			06/10/2011	1	93.30	06/22/2011		NA	FAKE TEST REJECT

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



## Problem Claim Request Form

Below is an example of the online DHI/DHP Problem Claim Request Form. The purpose of this form is to make claim payment adjustments more efficient. When a claim has been paid incorrectly (zero payment, underpayment, or overpayment) this form can be completed in lieu of resubmitting the claim or sending a refund check. When this form is used, follow the outline bullet points on the top of the form for completion. Once submitted, adjustments are made on future remittances. You will also receive electronic confirmations that the form was received, and another when the desired action has been completed.

### Provider Information

\* Facility or Clinic

\* Phone Number  
Example: 123-123-1234 x123

NPI1  
Example: 123456789A

\* NPI2  
Example: 123456789A

Who should Dean Health Plan contact with questions regarding the information provided on this form?

First Name  Last Name

Phone Number  
Example: 123-123-1234 x123

\* Email

### Claim #1

\* Reason for Contact  \* Date of Service  
(mm/dd/yyyy)

Claim Number  \* Plan Type  
(Select one)

Do NOT include any member information or numbers in the description.

\* Description of Inquiry

\* Billed Claim Amount

\* Add an additional claim

To complete and submit the form online, please go to  
<http://www.deancare.com/healthplan/providers/forms.asp>

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

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## Explanation of Payment

Dean Health Insurance/Dean Health Plan produces Explanation of Payments (EOP) on a weekly basis. If your office would like to check the status of a claim or questions an item on the EOP, please call our Integrated Voice Response (IVR) system or complete a status request on the electronic Problem Claim Request Form found on [deancare.com](http://deancare.com) for assistance. The examples that follow will display:

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

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

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

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

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



## Explanation of Payment - paid service

000008-005-000008

DATE: September 1, 2005

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

Explanation of Payments  
Provider

① FIRST MEDICAL CLINIC  
801 MAIN STREET  
MADISON, WI 53717

② CHECK NUMBER 00000000  
③ VENDOR NUMBER Z55

④

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

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

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

ACCOUNT NUMBER: 645789T

CLAIM NUMBER: 135029880324

070505	99203	76.00	⑦ 72.00	0.00	0.00	0.00	0.00	0.00	3.60	(42C 50)	68.40
070505	81000	15.00	14.00	0.00	0.00	0.00	0.00	0.00	0.70	(42C 50)	13.30

CLAIM TOTALS: 91.00 86.00 0.00 0.00 0.00 0.00 0.00 0.00 4.30 81.70

PROVIDER TOTALS: 91.00 86.00 0.00 0.00 0.00 0.00 0.00 0.00 4.30 81.70

VENDOR TOTALS: 91.00 86.00 0.00 0.00 0.00 0.00 0.00 0.00 4.30 81.70

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

⑨

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

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



## Explanation of Payment - denied service

000008-005-000008  
 Dean Health Plan, Inc.  
 P.O. Box 56099  
 Madison, WI 53705-9399  
 Customer Service Department  
 608-828-1301 OR 800-279-1301

DATE: September 1, 2005      PAGE 1

Explanation of Payments  
 Provider

① FIRST MEDICAL CLINIC  
 801 MAIN STREET  
 MADISON, WI 53717

② CHECK NUMBER 00000000  
 ③ VENDOR NUMBER Z55

④

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

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCT-IBLE	COPAY-MENT	COINSUR-ANCE	⑤ OTHER ADJUSTMENTS COB      NONCOV      WITHHOLD	REMARKS	PAID
--------------	--------------	----------------	----------------	-------------	------------	--------------	--	---------	------

PATIENT: CHRIS K. COOPER	⑥	SUBSCRIBER: CHRIS K. COOPER	SUBSCRIBER ADDRESS: 584 D'ONOFRIO DR., MADISON, WI 53719
MEMBER #: 39688436101		SUBSCRIBER #: 39688436101	GROUP #: 74571

ACCOUNT NUMBER: 68489B

CLAIM NUMBER: 135029880330

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

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

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

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



## Explanation of Payment-Claim Reversal/Adjustment

000008-005-000008

DATE: September 1, 2005

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

Explanation of Payments  
Provider

① FIRST MEDICAL CLINIC  
801 MAIN STREET  
MADISON, WI 53717

② CHECK NUMBER 00000000  
③ VENDOR NUMBER Z55

④

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

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

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

ACCOUNT NUMBER: 68490B			CLAIM NUMBER: 135029880431								
070505	99214	50.00-	⑦ 50.00-	0.00	0.00	0.00	0.00	50.00-	0.00	(63C 76)	0.00
070505	99214	50.00	50.00	0.00	0.00	0.00	0.00	0.00	2.50	(63C RV)	47.50
CLAIM TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50
PROVIDER TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50
VENDOR TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00-	2.50		47.50

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

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

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



## Explanation of payment & Advice Page—Claim overpayment, refund & adjustment

000008-005-000008

DATE: September 1, 2005

PAGE 1

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

Explanation of Payments  
Provider

① FIRST MEDICAL CLINIC  
801 MAIN STREET  
MADISON, WI 53717

② CHECK NUMBER 00000000  
③ VENDOR NUMBER Z55

④

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

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

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

ACCOUNT NUMBER: 68490B	CLAIM NUMBER: 135029880431
070505 99214 50.00- ⑦ 50.00- 0.00 0.00 0.00 0.00 0.00 0.00 0.00 2.50- (63C 76) 47.50- 070505 99214 50.00 50.00 0.00 0.00 0.00 50.00 0.00 0.00 0.00 (28A FF) 0.00	
CLAIM TOTALS:	0.00 0.00 0.00 0.00 0.00 0.00 0.00 50.00 2.50- 47.50-
PROVIDER TOTALS:	0.00 0.00 0.00 0.00 0.00 0.00 50.00 2.50- 47.50-
VENDOR TOTALS:	0.00 0.00 0.00 0.00 0.00 0.00 50.00 2.50- 47.50-

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

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

⑩ DEAN HEALTH PLAN ADVICE REPORT  
FOR VENDOR NUMBER Z55

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

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

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## Claims Coding

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

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

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

American Medical Association  
515 North State Street  
Chicago, IL 60610

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

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

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

### ICD-9-CM coding:

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

### CPT (procedure) coding:

- Documentation is required when submitting codes that are unlisted, not otherwise classified (NOC), or not elsewhere specified. Either office or operative notes are required in these cases.
- Due to the CMS billing form changes we will no longer be able to identify the specific service which is being billed when code 99070 is used. If the correct HCPCS code is not used,

services billed with 99070 will be denied. Claims should be submitted with an appropriate Level II code if there is no other Level I code to identify the service.

- Category III (temporary) codes are not reimbursable unless specifically covered under a DHP medical policy.
- **If you are unable to locate an appropriate code, you must submit the description of the supply you are submitting under the unlisted Level II code.**

#### Modifiers:

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

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

Modifiers are listed in CPT/HCPCS manuals. DHI/DHP utilizes a coding editing vendor to ensure appropriate use of modifiers on claims.

#### Bilateral Procedures:

Bilateral procedure should be billed on one line on the CMS-1500 form with one unit, the correct modifier, and your normal retail amount. If there are multiple bilateral procedures, follow the same rule, but bill the -51 modifier on the second and subsequent bilateral procedures.

#### Multiple Surgeries:

***DHP applies standard multiple surgery processing rules to claims submitted for payment. Providers must bill the primary procedure on the first line of the claim to ensure accurate claims adjudication by DHP. Reference your provider contract that may contain additional details regarding multiple surgery processing.***

This also applies to ambulatory surgery claims as well. Again, refer to the terms of your provider agreement for specifics regarding reimbursement.

Assistant Surgeon claims will be processed as follows:

- 20 percent of the global surgical approved amount will be allowed for M.D. or D.O. assistants
- 10 percent of the global approved amount will be allowed for a non physician practitioner (Nurse Practitioner (N.P.) and Physician Assistant (P.A.) assistants)

The “AS” modifier may be used on claims for surgical assists that are provided by non physician practitioners. As with the “51” modifier, this should be entered into the first modifier field on the CMS 1500 claim form.

**NOTE: For services submitted on a UB04 all applicable reductions for multiple and/or bilateral procedures will be applied based on standard CPT coding guidelines. CPT codes should be included on the UB04 claim form when billing surgical services.**

## Admissions/Concurrent Review

### Urgent/Emergent Admission Notification

Hospitals are responsible for notifying Dean Health Insurance (DHI)/Dean Health Plan (DHP) Utilization Management Department within 24 hours after admission or if on a weekend or holiday, the next business day, when a member requires emergent/urgent inpatient admission to an acute hospital from any of the following settings:

<ul style="list-style-type: none"> <li>• Home</li> <li>• Doctor's office</li> <li>• Emergency room</li> <li>• Observation bed</li> <li>• Surgical day care (SDC) unit</li> </ul>	<ul style="list-style-type: none"> <li>• Transfer from another facility <i>(including neonatal intensive care unit admission from another facility)</i></li> </ul>
--	--

The following information is required for notification of an urgent/emergent admission:

- Patient name *(middle initial if available)*
- Subscriber number and date of birth
- Admission date *(must be the actual date the member was admitted to inpatient status)*
- Admitting physician
- Admission diagnosis
- Type of admission: ER, direct admit, day of surgery

Plan Hospitals with Navinet access must notify of emergent/urgent admissions by submitting the authorization request through Navinet.

All other hospitals without Navinet access may:

- Fax admitting information to: 608-836-6516, OR
- Phone admitting information to: 800-356-7344, extension 4147 or 4455.

## Elective Admission Notification

**Elective Admissions defined as non-urgent/emergent services that are planned and able to be scheduled in the future at the member's convenience.**

Hospitals must notify Dean Health Insurance (DHI)/Dean Health Plan (DHP) when a member is scheduled for an inpatient elective service.

Notification by the servicing provider (i.e., the hospital) is required at least 5-7 days before the admission or date of service. **Please note:** this is specific to non-urgent/emergent conditions. If the member's condition is urgent/emergent and could not have been anticipated 5-7 days prior to admission, this is considered an urgent/emergent situation<sup>231</sup> please refer to "Urgent/Emergent Admission Notification Process" as stated above.

- The hospital should submit notification of an elective admission to DHI/DHP.
- The appropriate surgical CPT code(s), consistent with the surgical service, **must** be included.

The following information is required for notification of an elective admission:

- 
- Patient name (*middle initial if available*)
  - Subscriber number and date of birth
  - Admitting physician/specialist's name
  - Hospital's name
  - Diagnosis and clinical information
  - Service requested (*i.e., admission, procedure, etc.*)
  - CPT code(s) appropriate to the type of admission (*medical or surgical*)
  - Admission/Procedure date

Plan Hospitals with Navinet access must notify of elective admissions by submitting the authorization request through Navinet.

All other hospitals without Navinet access may:

- Fax admitting information to: 608-836-6516, OR
- Phone admitting information to: 800-356-7344, extension 4147 or 4455.

## Concurrent Review

The DHI/DHP standard is to begin Concurrent Review within 24 hours or the next business day of the date the admission was reported to DHI/DHP. Concurrent Review information should be provided to the Utilization Management Case Manager and can be faxed or telephoned. All Utilization Management Case Managers have confidential voice mail. **Please provide the following information:**

- Patient name and subscriber number
- Admission diagnosis and/or change in diagnosis
- Surgical procedures or other proposed procedures
- Pertinent clinical information including: medical, nursing, laboratory, or X-ray which support continued acute inpatient stay.
- Clinical information from other disciplines involved in the member's care. [Example: Physical Therapy, Occupational Therapy, Speech Therapy, Respiratory Therapy, and Social Services]
- Proposed discharge date, discharge plans in progress, and follow-up appointments made
- Discharge Disposition: Utilization Management Nurse Reviewers will assist with discharge planning to help coordinate the appropriate services. These services may include:
  - ✓ Home Health Care (name of agency is required)
  - ✓ Durable Medical Equipment
  - ✓ Skilled Nursing Care (name of facility is required)
  - ✓ Swing Bed Admissions
  - ✓ Outpatient follow-up appointments
- **For Mental Health Admissions**, the following additional information is needed:
  - ✓ Reason for the admission/DX (Axis I-V), Voluntary or Emergency Detention admit.
  - ✓ List of medications prior to the admission and/or any changes made to the patient's medication
  - ✓ Previous outpatient and inpatient mental health treatment
  - ✓ Treatment the patient is currently receiving/current symptoms and progress made
  - ✓ Discharge follow-up plan

Prior Authorization is required for the following services that may be needed upon discharge:

• Durable Medical Equipment	• Home Health Care
• Hospice	• Acute Inpatient Rehabilitation
• Skilled Nursing Facility Admits	• Swing Bed Admissions
• Transfers to Non-plan Facilities	• Pre-operative inpatient days that are scheduled
• Inpatient Alcohol and Other Drug Abuse (AODA) rehabilitation (not detox)	• AODA or Mental Health Day Treatment/Partial Hospitalization Program

## Continued Inpatient Hospital Stay

Plan hospitals are required to contact DHP upon admission of DHP members to receive an initial authorization of their stay. Physicians supervising the care of hospitalized patients should assume that continuing inpatient care is approved unless the DHP Utilization Management (UM) Department contacts you indicating otherwise. Should this occur, we may request additional clinical information which supports that member's need to stay. If a continued stay is not approved, you may request information regarding alternative care available to the member to assist you in expediting a timely discharge.

If you have any questions regarding this information or any UM processes, please contact the Utilization Management Department at 800-356-7344, extension 4455.

## Observation Stays

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. **Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge.**

Observation stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose **diagnosis and treatment are not expected to exceed 24 hours, but may extend to 48 hours**, and the need for an inpatient admission can be determined within this specific period.

Examples considered appropriate for Observation Stay include, but not limited to:

• Abdominal pain	• Asthma	• Back pain	• Bronchitis
• Chest pain	• Croup	• Concussion	• Dehydration
• Drug overdose	• False labor	• Gastroenteritis	• Migraine headache
• Pneumonia	• Renal colic/calculus	• Seizure	• Sepsis
• Syncope	• Upper limb closed fracture or dislocation		

Hospitals are responsible for notifying Dean Health Insurance (DHI)/Dean Health Plan (DHP) Utilization Management Department within 24 hours after admission to observation status or if on a weekend or holiday, the next business day.

Plan Hospitals with Navinet access must notify of observation admissions by submitting the authorization request through Navinet.

All other hospitals without Navinet access may:

- Fax admitting information to: 608-836-6516, OR
- Phone admitting information to: 800-356-7344, extension 4147 or 4455

## Outpatient Surgery

**Surgical Day Care Services (SDC)/Surgical Day Care with Overnight (SDCON)** are services generally more invasive than ambulatory/minor surgery and usually requires incision or excision procedures. General anesthesia and recovery room services are frequently required. SDC services are usually performed either in a hospital setting or ambulatory surgical center (ASC) and can frequently require an overnight stay (not expected to exceed 23 hours post procedure) as part of the routine recovery period.

**Please note:** members who may need more than 23 hours of monitoring but do not have an acute medical need which meets inpatient criteria guidelines and are discharged home that same day **cannot** be admitted to observation status for continued stay.

**Ambulatory/Minor Surgery Service (ASC)** is classified as surgery that usually does not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.

## Transferring Patients

If it is medically necessary that a patient receiving inpatient hospital services be transferred to another inpatient hospital facility, a plan facility should be used whenever possible. (Point of Service and Point of Enrollment members are not required to use a plan provider.)

St. Mary's Hospital in Madison is equipped to handle most critical medical, surgical, and adult psychiatric conditions for our members. It also offers a Pediatric Intensive Care Unit, which includes a pediatric surgeon, perinatology services for high risk pregnancy, and an inpatient intensive care unit for premature infants. St. Mary's accepts patients if air ambulance is required.

When transfer to a non-plan facility is determined to be appropriate for emergency specialty care unavailable in plan, the admission will be authorized with appropriate documentation that care required is not available with plan providers. However, DHI/DHP must be notified within 24 hours or the next business day. For all other transfers to non-plan facilities, prior authorization is required by the Utilization Management Department. Examples of non-plan transfers to non-plan facility include the UW Hospital Burn Unit for extensive burns and Meriter Hospital for adolescent inpatient psychiatric care.

If transferring one of your patients during DHI/DHP's regular business hours, please contact the Utilization Management Department at 800-356-7344, extension 4455.

If transfer occurs outside DHI/DHP's regular business hours, please notify the Utilization Management Department by the next business day at the above number.



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## Ambulance Services

Dean Health Plan will cover medically necessary ambulance services, as determined by the Utilization Management Department. Ambulance transportation is covered, as outlined in a member's Schedule of Benefits, to or from a hospital, when it is clear that the transportation is emergent or urgent in nature and medical attention is required en route.

Any ambulance service (air or land) that is not for emergent or urgent situations is not considered a covered service, unless it is prior authorized by the Utilization Management Department.

Charges for or in connection with any other forms of travel, except for the ambulance transportation, are not a covered service, unless otherwise stated in a Group Member's Certificate.

If you have any questions regarding this information or any UM processes, please contact the Utilization Management Department at 800-356-7344, extension 4455.

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## Hospital Services

### Referrals/Prior Authorizations/Pre-Certification

The importance of understanding the difference between DHI/DHP's products is necessary to insure proper referral/prior authorization/pre-certification guidelines are followed. **Failure to understand or follow these guidelines will result in claim payment denials or reduction of benefits.** Some products require a referral and/or prior authorization, while others may only require prior authorization or pre-certification.

#### What is a referral?

**Referral** - A DHI/DHP form that is completed in full and signed by a Primary Care Practitioner (PCP) and requests approval of outpatient treatment for an HMO member by an adjunctive and/or non-plan provider of healthcare. The completed form is submitted to the DHI/DHP Utilization Management for determination of approval. **The referral must be approved prior to the member obtaining services.** A verbal or written request for services **does not** constitute a referral.

#### What is Prior Authorization?

**Prior Authorization** - Written approval from the DHI/DHP Utilization Management prior to the member receiving services. (*This applies to HMO and POS members for services that require prior authorization.*) The authorization will state the type and extent of the treatment or benefit authorized. Failure to complete the required prior authorization may result in a denial of a claim (HMO) or reimbursement of a claim as a lesser benefit. A verbal or written request for services **does not** constitute prior authorization.

#### What is Pre-Certification?

**Pre-Certification** - Approval of an admission to a facility and/or the approval of a specified number of days for a facility confinement prior to the services being rendered. (*This applies to POS.*) Pre-Certification does not guarantee coverage and/or payment. Failure to obtain pre-certification, when required, may result in a denial of a claim (HMO) or reimbursement of a claim as a lesser benefit.

#### How can I verify that a referral/prior authorization/pre-certification has been processed by DHP?

- You will receive a copy of the referral that will indicate if it was denied, approved, or if the member has been redirected to another provider.
- Contact our Customer Care Center for status of the referral/prior authorization/pre-certification.

**Approved requests do not authorize payment of non-covered or exhausted benefits.**

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### What is a Plan Provider?

**Plan Provider** - A provider that has a signed Provider Agreement with Dean Health Systems to provide one or more services and is listed in the most current edition of the **Provider Directory**. (The Provider Directory is accurate at the time of printing.) This includes, but is not limited to, physicians, surgeons, optometrists, chiropractors, podiatrists, and pharmacies.

<http://www.deancare.com/healthplan/Providers/index.asp?V=4>

### What is an Adjunctive Provider?

**Adjunctive Provider** - A provider that has a signed Letter of Agreement with Dean Health Systems to provide one or more services at a specific location only. This is limited to specialty care.

### What is a Non-Plan Provider?

**Non-Plan Provider** - A provider that does not have a signed Provider Agreement with Dean Health Systems and is not listed in the most current edition of the Provider Directory. (The Provider Directory is accurate at the time of printing.) The Health Plan has no liability or responsibility for the quality of care provided by a non-plan provider. Only services that are not available within the DHP provider network are considered for approval with non-plan providers. If you have a question regarding a provider's participation within the DHP network, contact our Customer Care Center.

## DHI/DHP HMO Referral & Prior Authorization Guidelines

As an HMO, DHI/DHP requires that members choose a PCP or primary clinic. The PCP acts as a "gatekeeper" to ensure members receive appropriate, high quality care in a cost effective manner. ***Primary care practitioners should assist members with completing a referral to an adjunctive or non-plan provider. The provider of service is responsible for prior authorizing services when necessary.***

Dean Health Plan no longer requires referral requests to the following locations and physicians:

- All Plan-to-Plan clinic referrals
- Dean Medical Center locations
- Clinics in association with Dean Medical Center (SMDV-St. Marys Dean Ventures)
- Dean Medical Center/SMDV physicians performing services at outreach locations
- Plan mental health clinics and plan physical, occupational and speech therapy facilities
- Plan Alcohol and Other Drug Abuse (AODA) clinics and/or facilities

Prior authorization may be still be required due to a medical policy for a specific service or due to fee schedule limitation.

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

- All services provided by a non-plan provider require a referral or prior authorization. An approved referral (one that has been processed by a Utilization Management Department prior to care being provided) constitutes prior authorization. **These requests are only considered for services that cannot be provided within the DHI/DHP network of providers.** It is recommended that an appointment to a non-plan provider is not made until prior authorization has been obtained.

Referral Request forms can be found under For Providers >Forms:

<http://www.deancare.com/pdf/providers/referral-request-form.pdf>

- \*All services provided by a non-plan or out of network mental health provider will still require a referral request and/or prior authorization. Please contact DHP's Customer Care Center at (800) 279-1301, if you have any questions.
- Dean Health Plan encourages communication between the PCP and the member regarding mental health services. If the PCP determines mental health services are medically necessary and is not certain which mental health practitioner is most clinically appropriate, the PCP may contact Dean Medical Center (DMC) Psychiatry Department at (608) 252-8226 during normal business hours for assistance in determining the practitioner or office site that will best meet their patient's needs.
- Magnetic Resonance Imaging (MRI) is required to be performed at an approved **plan facility**.

For services that require prior authorization, refer to additional guidelines within this section. They are as follows:

- Ambulance
- Back Pain Invasive Procedures
- Durable Medical Equipment (DME)
- Home Health Services
- Hospice Services
- Hospital Admissions/Continued Inpatient Hospital Stay
- Occupational Therapy
- Radiology Prior Authorization
- Physical Therapy
- Respiratory Therapy
- Skilled Nursing Facility/Swing Bed
- Speech Therapy
- Transfers
- Transplants

For specific criteria in regard to prior authorizing services, you may also reference:

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

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## Medicare Supplemental Plan Referral/Prior Authorization Guidelines

Dean Health Plan has reduced the referral and prior authorization requirements for members enrolled in our Medicare supplemental plans.

Written referrals and prior authorization will no longer be required for outpatient services provided by a plan provider for services covered by Medicare. Because a PCP acts as the “gatekeeper” to ensure members receive appropriate, high quality care, we encourage you to discuss any specialty care that your patients may be receiving, even when a referral is not required. In addition, plan hospitals are no longer required to authorize inpatient admissions covered by Medicare.

Members on our Medicare supplemental plans are identified by a Dean Care ID Card with a group number in the 20000 range or a Dean Care Gold ID Card with a group number beginning with a “C”.

**Members who have Medicare as primary insurance and DHP as secondary insurance through an employer (or former employer) will continue to follow our current referral guidelines for HMO members. Please refer to the HMO Referral/Prior Authorization guideline chart.**

**\*\*In the event a member has a DHI/DHP policy that is secondary to Medicare (through an employer or former employer), therapies are subject to the retiree plan benefits and HMO guidelines.**

- A written referral will continue to be required if DHP members on one of our Medicare supplemental plans seeks care from **non-plan** providers.
- Prior authorization will continue to be required for all **non-plan** admissions.
- Dean Care Gold members are required to utilize Dean Care Gold providers and will continue to require a written referral or prior authorization prior to obtaining services from providers outside of the Dean Care Gold network.

If you have questions regarding our referral requirements for our Medicare supplemental plans, please contact our Customer Care Center at (800) 279-1301.

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## Dean Health Insurance, Inc (DHI)/Dean Health Plan (DHP) Point of Service (POS) Prior Authorization/PreCertification Guidelines

Members of DHI/DHP who are enrolled in the POS Plan are not required to select a PCP or clinic. They have the option to use plan and non-plan providers, but may receive a different level of benefits based on what type of provider they obtain services from. Because these members have the option to use plan or non-plan providers, referrals are not required. However, some services require prior authorization or pre-certification. Services that require prior authorization or pre-certification from the provider of care are outlined in this section

**The information applies to services rendered by a plan provider.** If a member seeks services from a non-plan provider, the member is responsible for prior authorization and pre-certification.\*\*

Contact our Utilization Management Dept. if a service requires prior authorization or pre-certification. A Referral Specialist will assist you with your request.

**\*\*When a member is required to obtain prior authorization or pre-certification, they should contact the DHI/DHP Utilization Management Department to obtain instructions on how to prior authorize or pre-certify their care, unless a separate guideline exists in this section.**

### POS Exception Policy

Members who have the POS plan are required to prior authorize some services as stated on their Schedule of Benefits and are liable for 50 percent up to \$500 of the covered charges if authorization is not obtained. DHI/DHP gives notification on the Explanation of Payment to the member and the provider if a benefit reduction occurs.

If the member disagrees with the determination or has additional information to be submitted, they are encouraged to submit this information to the DHI/DHP Medical Affairs Division for review.

Upon review the following may take place:

- If prior authorization was required for a service with a plan provider, DHP may allow a **ONE TIME** exception and pay the services as if prior authorization was obtained.
- If prior authorization or pre-certification was needed to a non-plan facility or a non-plan provider, DHP **WILL NOT** make an exception.
- If pre-certification was required to a plan facility, DHP may pay the claim as a **ONE TIME** exception.

No reduction in Mental Health/AODA benefits apply to this exception.

**EXCEPTION:** Prescription drugs and DME supplies are NOT covered if prior authorization has not been obtained

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## Radiology Prior Authorization

Prior authorization is required for the following outpatient radiology procedures through NIA.

You can contact NIA's customer service representatives Monday through Friday from 7am to 7pm (CST) at (866) 307-9729.

- **CT SCAN**
- **NUCLEAR EXERCISE TOLERANCE TEST (ETT)**
- **MRI/MRA**
- **PET SCAN**

It is the responsibility of the ordering physician or clinic to obtain authorization.

Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of your claim.

Imaging Procedures ordered by Emergency room and urgent care providers or in observation and inpatient facilities do not require authorization.

Other information regarding prior authorization of the above radiological services can be found under the following link:

<http://www.deancare.com/providers/patient-care/radiology-prior-authorization.aspx>

## Cardiac Rehabilitation Authorization Guidelines

### HMO and Point of Service

Cardiac Rehabilitation (Phase II) services are considered medically appropriate for up to 18 visits during a 12-month period when:

- Provided by an approved plan facility
- Patient has other cardiac conditions requiring supervised progressive exercise or rehabilitation to ensure patient safety.

In addition, Cardiac Rehabilitation (Phase II) services are covered when prescribed by a **cardiac rehabilitation specialist or physician within 90 days of the date** a patient has been diagnosed with, or undergone a procedure for, any of the following:

- Myocardial Infarction,
- Cardiac Transplantation,
- Coronary Artery Bypass Grafting,
- New diagnosis of Arterial Sclerotic Heart Disease (ASHD) with Angina Pectoris,
- New diagnosis of Cardiomyopathy, or
- New diagnosis of Congestive Heart Failure.

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The 18 visit program is designed to provide the following services:

- One evaluation visit, including:
  - ✓ Preparation and review of patient records,
  - ✓ Comprehensive patient history,
  - ✓ Individual treatment plan including those elements described above,
  - ✓ Monitored exercise (blood pressure and electrocardiogram-(EKG)), and
  - ✓ One-on-one patient/therapist ratio with usual time spent about 90 minutes.
- The next five visits include:
  - ✓ Individual exercise sessions with EKG and blood pressure monitoring,
  - ✓ Continued implementation of individual's treatment program including exercise prescription, and
  - ✓ One-on-one therapist to patient session usually lasting 90 minutes each.
- The final twelve visits include:
  - ✓ Group supervised activities (education and exercise),
  - ✓ Electrocardiogram and blood pressure monitored exercise sessions (EKG may be optional depending on patient risk), and

After completing the Cardiac Rehabilitation program, patients should be encouraged to continue their risk reduction efforts and exercise independently thereafter.

Some patients may wish to continue their exercise efforts within the cardiac rehabilitation program. However, these additional visits would not be a covered benefit unless specific criteria is met.

If additional cardiac rehabilitation services are needed, prior authorization is required beyond the initial 18 visits. Refer to Medical Policy (MP) 9079 at:  
[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

## Transferring Patients

If it is medically necessary that a patient receiving inpatient hospital services be transferred to another inpatient hospital facility, a plan facility should be used whenever possible. (Please note that Dean Health Plan Point of Service or PPO members are not required to use a Dean Health Plan participating provider.)

St. Mary's Hospital & Medical Center in Madison is equipped to handle most critical medical, surgical, and adult psychiatric conditions for our members. It also offers a Pediatric Intensive Care Unit, which includes a pediatric surgeon, perinatology services for high risk pregnancy, and an inpatient intensive care unit for premature infants. St. Mary's accepts patients if air ambulance is required. Please contact St. Mary's Hospital prior to transferring to a non-plan facility if you are unsure if a service is or is not available. If services are available with plan hospital facilities, Dean Health Plan HMO members are required to be transferred to the plan facility.

When transfer to a non-plan facility is determined to be appropriate for emergency specialty care that is unavailable in plan, the admission is authorized. However, DHI/DHP must be notified within 24 hours or the next business day of the transfer as well as reason. For all non-emergent transfers to non-plan facilities, prior authorization is required by our Medical Affairs Division before transfer to the non-plan facility occurs. If a Dean Health Plan HMO member is emergently admitted to a non-plan facility it may be requested that the member be transferred to a plan inpatient facility once they are medically stable. This may require the assistance of a plan PCP or specialty provider. In these cases, the Utilization Case Manager will contact the appropriate plan provider for assistance with coordination of specialty care or services that may be needed.

If you have any questions about transferring one of your patients, please contact our Customer Care Center at (800) 279-1301.

## **Ambulance Services**

Dean Health Plan will cover medically necessary ground ambulance services, as determined by the Medical Affairs Division. Ambulance transportation is covered, as outlined in a member's Schedule of Benefits, to or from a hospital, when it is clear that the transportation is emergent or urgent in nature and medical attention is required en route.

Coverage of air ambulance will be based on criteria established by the Medical Affairs Division as medically appropriate. Air transportation that does not meet the established criteria will not be a covered service.

An ambulance service that is not an emergency transportation is not considered a covered service, unless it is prior authorized by the Medical Affairs Division.

## **Continued Inpatient Hospital Stay**

Plan hospitals are required to contact DHP upon admission of DHP members to receive an initial authorization of their stay. Physicians supervising the care of hospitalized patients should assume that continuing inpatient care is approved unless the DHP Utilization Management (UM) Department contacts you indicating otherwise. Should this occur, we may request additional clinical information which supports that member's need to stay. If a continued stay is not approved, you may request information regarding alternative care available to the member to assist you in expediting a timely discharge.

If you have any questions regarding this information or any UM processes, please contact the Utilization Management Department at (608) 827-4455

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## Durable Medical Equipment (DME) & Supplies

Our plan DME providers that will conduct prior authorization with DHI/DHP are as follows:

- Home Health United
- Eye Prosthetics of Wisconsin (for prosthetic eyes only)
- Global Prosthetics
- Aljan Company (for prosthetic limbs and braces only)
- Morfey's Limbs and Braces (for prosthetic limbs and braces only)

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

- Prescribed by a plan provider for treatment of illness, a condition, or injury. (Point of Service members are not required to use plan providers.) If non-plan providers are used, the member is responsible for obtaining prior authorization, as specified by their benefits contract from DHP.
- Medically necessary and not solely for comfort or convenience of the member.
- Provided by a plan DME provider (Point of Service members are not required to use plan providers). If non-plan providers are used, the member is responsible for obtaining prior authorization, as specified by their benefits contract from DHP.
- If the DME item is received within a physician's office prior authorization is needed only if the item is over \$500. This includes all Coordination of Benefits (COB) claims when the billed amount is more than \$500.
- Glucose meters may be provided by any DHI/DHP pharmacy when prescribed by a diabetic specialist or physician. The plan pharmacy will then prior authorize with DHI/DHP.
- If a member is being discharged from an inpatient stay and will need DME equipment at home, the facility will be required to contact a plan DHP DME provider to obtain prior authorization.
- **The prescribing physician or health professional may contact the DME vendor directly to arrange for the necessary equipment.**
- **Plan DME providers will deliver to rural communities.** If our DME providers are unable to meet the member's needs, they will work with other DME providers on an as needed basis.

Any questions about coverage of DME and supplies or a member's benefits can be directed to our Customer Care Center at (800) 279-1301. To access the most up-to-date DME policies regarding prior authorization requirements go to:

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

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## Emergent and Urgent Care Services

### Emergent Care

**Emergent Care** - is care needed due to the onset of a medical condition that, if an individual does not seek medical attention, could result in death or serious injury. Some examples of emergency care are heart attacks, strokes, severe shortness of breath, or significant blood loss. The symptoms, if sudden and unexpected, must be severe enough to cause a person to seek medical help right away, no matter what time it is; and immediate care must be received

**(Prior authorization for these services is not required).** If the condition does not meet this criteria, it will not be deemed as an emergency. The diagnosis or the symptoms themselves must show that the problem was one that required immediate medical care.

### Emergency Care from DHI/DHP Providers

Most of the time, your patient will get emergency care from a DHI/DHP plan provider. If a patient is unable to reach a plan provider, they should go to the nearest medical facility to receive care.

### Emergency Care from Non-Plan Providers

If your patient must go to a non-plan provider for care, they should call the DHI/DHP Customer Care Center as soon as possible and tell us where they received emergency care. **Follow-up must be received from a plan provider** unless it is prior authorized by the DHI/DHP Utilization Management Department.

Applicable emergency room copayments apply whenever emergency services are received at an emergency room.

### Urgent Care

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

Your DHI/DHP patient should always receive urgent care from a DHI/DHP plan provider when they are in the service area **(Prior authorization for these services is not needed)**. If they are out of the health plan service area, they should go to the nearest appropriate medical facility unless they can safely return to the service area to receive care from a plan provider.

If your patient resides outside of the health plan service area and receives urgent care services from a non-plan provider, they must notify the DHI/DHP Customer Care Center at (800) 279-1301 as soon as possible.

There are no available benefits for follow-up care with a non-plan provider unless such care is necessary to prevent further health risks. **Such care must be prior authorized through the DHI/DHP Utilization Management Department.** Care that can be safely postponed until your patient can return to the service area to receive such care from a plan provider is not considered

to be urgent care. (The above guidelines do not apply to DHI/DHP Point of Service members, they are not required to use plan providers.)

If the diagnosis or symptoms were urgent, payment for covered services will be based on our maximum allowable fee. The patient will be responsible for any fees that exceed this amount.

## Home Health Authorization Guidelines

### HMO and POS Policies

Home healthcare services must be ordered by a physician through a plan home health provider and must be prior authorized. Obtaining prior authorization is the responsibility of the home healthcare provider, and if not obtained, coverage will be denied leaving the provider financially liable for any services rendered.

Once the physician has ordered home healthcare services, the home healthcare provider will contact the DHI/DHP Utilization Management Department. When requesting prior authorization, the Home Health provider needs to contact the DHP Customer Care Center to verify benefits. The Home Health provider will then be transferred to the Utilization Management Department, who will then acquire the following information:

- Provider Contact Information:
  - ✓ Date sent to Dean Health Plan
  - ✓ Contact name
  - ✓ Phone and Fax Number
  - ✓ Provider Name and assigned DHP Provider number
- Patient Information:
  - ✓ Patient Name
  - ✓ Member Number
  - ✓ Date of Birth
  - ✓ Benefit Year
  - ✓ Diagnosis (ICD-9) – list all applicable diagnosis'
  - ✓ Referring physician
  - ✓ Referring physician's main clinic site
  - ✓ Address, City, St., & Zip
  - ✓ Start date of Care

**It is essential the provider gives the correct start date for accurate claim payment.**

The home healthcare provider is required to contact DHP Utilization Management Department if a member uses 20 or more visits. This contact is not to approve additional visits. It is to confer about the member's current needs.

If you have any questions on prior authorizing home healthcare, contact our Customer Care Center at (800) 279-1301.

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## Mental Health and Chemical Dependency

Dean Health Insurance/Dean Health Plan provides coverage of mental health and alcohol and chemical dependency treatment for those members whose benefit package includes mental health/AODA services.

All mental health/AODA services must be obtained from a plan provider. (Except for DHI/DHP Point of Service members, who are not required to use plan providers.) Point of Service and members are required to prior authorize all of the following services:

- **Inpatient Care** - means medically necessary treatment for mental health/AODA conditions in an inpatient setting. This does not include medically necessary inpatient detoxification services and inpatient AODA treatment, which is considered elective and non-emergent.

**Admitting providers are required to call DHP Utilization Management Department at 608-827-4147 or (800) 356-7344 to inform us of the admit notification or prior authorization request.**

**The admitting facility is required to call DHP by the next business day for admission notification/approval of admission.**

- **Outpatient Care** - means medically necessary treatment for mental health/AODA conditions in an outpatient setting.
- **Transitional Care** - means medically necessary treatment for mental health/AODA conditions in a less restrictive manner than inpatient care, but a more intensive manner than outpatient care.
- **Residential Treatment Program** - A residential treatment program is a live-in facility which operates 24 hours a day, 7 days a week and is staffed by professional and paraprofessional persons who offer a therapeutic program for alcohol or drug dependent persons or both. Long-term residential treatment is not a covered benefit. Short-term residential stays may be considered if medical necessity criteria are met.
- **Day Treatment Program** - A nonresidential program in a medically supervised setting that serves either adults or children with mental health/alcohol or other drug problems and that provides case management, counseling, medical care, and therapies on a routine basis for a scheduled portion of a 24-hour day and a scheduled number of days per week to alleviate those problems. Services must include individual, family, and group counseling, but not aftercare.

### Court Ordered Care

Court ordered care is covered if it is medically necessary and provided by a plan provider. Services at a non-plan provider are not covered unless provided pursuant to an emergency detention or an emergency basis and the provider notifies DHI/DHP within 72 hours after the initial provision of service. (This does not apply to Point of Service members.)

### Full Time Students

Those dependent members who are attending school in Wisconsin, but outside of the DHI/DHP service area are granted one clinical assessment, by a non-plan provider that we designate, of mental health or chemical abuse problems. Authorization of no more than five (5) outpatient visits may be approved with a written referral which has been prior authorized by the DHI/DHP Medical Affairs Division (This does not apply to Point of Service members.)

Coverage is not available if:

- It is determined the recommended treatment will prohibit the dependent student from attending school on a regular basis.
- The dependent student has terminated his or her enrollment in school.

Once the initial five (5) visits have been exhausted, the DHI/DHP Medical Affairs Division and the clinician treating the dependent student shall review the student's progress and determine whether it is appropriate to continue treatment, as long as the student has not exhausted their benefits.

### Eating Disorders

Outpatient clinic and physician charges for the treatment of eating disorders will be applied to a member's mental health benefit, with the exception of outpatient lab charges which would be paid as a medical expense.

If a hospitalized member requires intensive medical treatment (i.e., ICU, IV Hydration), the intensive care portion of the hospital claim would be considered medical. Other inpatient services provided would be applied to the mental health benefit.

### Electroshock Therapy

The following issues should be taken into consideration when determining the medical appropriateness of electroshock therapy as an inpatient or outpatient service:

- For outpatient electroshock therapy to be appropriate, the patient should be a Cardiac Class I or Class II.
- Family must be available to transport and supervise the patient when not at the hospital.
- For outpatient electroshock therapy to be safe, there must be a minimal risk of suicide.
- A patient's first electroshock treatment should be done in an inpatient setting, allowing them to be observed for a 24-hour period. This would not necessarily apply if the patient has had electroshock therapy in the past.

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## Mental Health/AODA Exclusions

The following services are excluded from coverage:

- Hypnotherapy
- Phototherapy
- Marriage & Family Counseling
- Family counseling for non-medical reasons
- Residential Care, except for transitional care
- Halfway houses, exception for transitional care
- Biofeedback
- Gambling addiction
- Long term or maintenance therapy
- Unauthorized post discharge follow-up

## Oral Surgery

Dean Health Insurance,/Dean Health Plan provides coverage for oral surgery when services are obtained from a plan provider. (Point of Service members are not required to use plan providers.)

### Approved surgical procedures are as follows:

- Surgical removal of impacted teeth;
- Non-surgical removal of impacted teeth (pulling). Contact our Customer Care Center for additional clarification regarding coverage on surgical removal of impacted and/or infected teeth for State of Wisconsin and local government employees;
- Surgical removal of tumors and cysts;
- Surgical treatment for accidental injuries of the jaw, cheeks, lips, tongue, roof and floor of mouth;
- Apicoectomy;
- Surgical removal of exostosis of the jaw and hard palate;
- Treatment of fractured facial bones;
- External and internal incision and drainage of cellulitis;
- Cutting of accessory sinuses, salivary glands or ducts;
- Reducing dislocations;
- Alveotomy;
- Frenectomy;
- Vestibuloplasty;
- Residual root removal (State of Wisconsin and local government employees do not receive coverage for this service);
- Temporomandibular Disorders (TMD)-- requires prior authorization and provided by a plan provider designated by DHP to treat TMD;
- Gingivectomy or osseous surgery is covered if performed in place of a gingivectomy for excision or loss gum tissue to eliminate infection (for State of Wisconsin and local government employees only).

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## Dental Services

Dean Health Insurance/Dean Health Plan will cover dental services, provided by an appropriate provider, required to treat sound natural teeth that are injured. The term “injured: does not include conditions resulting from eating, chewing, or biting. Covered treatment must begin within 90 days after the accident and covered services for tooth extractions must begin within 18 months after the accident.

Dean Health Insurance, Inc/Dean Health Plan may allow for the initial examination and/or x-rays to determine a diagnosis. Any services or treatment requested beyond that must be prior authorized by our Medical Affairs Division. A “Pre-Treatment Estimate” should be submitted to DHI/DHP for review.

In most cases, benefits are limited to the extraction and replacement of teeth. Restorations, such as crowns, are not covered. (Coverage varies between policies and some members may have different coverage for these types of services.)

**Preventive dental services are not covered, with the exception of State employees who have chosen DHP insurance coverage.** These members have separate dental benefits through Ameritas.

Coverage will also be provided in connection with dental care that is provided to a member in a hospital or ambulatory surgery center if any of the following applies:

- The member is a child under the age of 5.
- The member has a chronic disability.
- The member has a medical condition that requires general anesthesia in a supervised setting for dental care.

**These services must be prior authorized by the Medical Affairs Division.**

To access the most up-to-date Dental and Oral Surgery policies regarding the prior authorization requirements go to

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

### **Epidural Steroid Injection (ESI) Medical Policy has been Discontinued**

**Refer to the New Policy named Back Pain Invasive Procedures for the prior authorization guidelines.**

Dean Health Plan prior authorization guidelines can be found under the Back Pain Invasive Procedures at:

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

## Services That Are Usually Not Covered

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

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

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## Skilled Nursing Facility Care/Swing-Bed

Dean Health Insurance/Dean Health Plan provides coverage for care in a licensed Skilled Nursing Facility or Swing-Bed. Benefits are limited to the number of days specified in the Member's Schedule of Benefits. The care being given must be skilled care. Custodial care is not a covered benefit. Confinement in a swing bed setting in a hospital is considered the same as a skilled nursing facility confinement under the member's Schedule of Benefits. All Skilled Nursing Facility and Swing-Bed admissions must be prior authorized by the Utilization Management Department. The number to call is (608) 827-4443 / or (800) 356-7344 ext. 4443.

**Skilled Care** - means medical services rendered for the purpose of providing restorative and recuperative care by:

- Registered nurses or licensed practical nurses
- Physical, occupational, and speech therapists
- Physical or occupational therapy aides

Patients receiving skilled care are usually quite ill and often have recently been hospitalized. Some examples are patients with:

- Hip replacement
- Knee replacement
- Fractures of the hip
- Complicated Diabetes
- Recent stroke resulting in speech or ambulatory difficulties
- Patients requiring complicated wound care
- Traumatic brain injury

In the majority of the cases, "Skilled Care" is necessary for only a limited period of time. After that, most patients have recuperated enough to be cared for by "non-skilled" persons such as spouses, children, or other family or relatives. Examples of care provided by "non-skilled" persons include:

- Passive range of motion exercises
- Strengthening exercises
- Wound care
- Ostomy care
- Tube and gastrostomy feedings
- Administration of medications
- Maintenance of urinary catheters
- Activities of daily living

**Services that are non-covered for skilled nursing facilities are:**

- **Custodial Care** - means the type of care when the basic goal is to help a person with the activities of daily living. This includes, but is not limited to:
  - Assistance getting out of bed
  - Help in walking
  - Bathing
  - Dressing
  - Eating
  - Maintenance of bowel and bladder functions
  - Preparing special diets
  - Assisting patients with taking their medicines
  - 24-hour supervision for potentially unsafe behavior
- **Any nursing facility other than skilled. This includes community reentry programs, assisted living facilities, and community based residential facilities (CBRF).**

- **Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by DHI/DHP.**

To access the most up-to-date medical policy regarding the prior authorization requirements for skilled care go to

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

## **Therapies (Occupational, Physical, Respiratory, and Speech)**

### **Prior Authorization Guidelines HMO Policies Only**

Dean Health Plan's goal is to provide high quality, cost effective care for its members. One method of controlling the increasing cost of medical care is to manage services through monitoring the therapy services provided to our members.

When a member requires therapy services, the plan therapy provider should follow the prior authorization process outlined below. If requests are made to a ***non-plan therapy provider***, prior authorization must be approved prior to services being rendered.

**Primary care practitioners are still required to prior authorize ultrasonic treatment performed in their office.**

## **Physical, Speech, & Occupational Therapy Services**

**The Therapy Provider's responsibilities are to:**

- The patient's physician will assess the need for physical, speech, or occupational therapy and write a prescription for an evaluation and treatment to a plan DHP therapy provider.
- **ALL plan physical, occupational, and speech therapy visits require prior authorization by the plan therapist. Visits are limited to medically necessary treatment.**
- The therapist will conduct the initial evaluation and be required to complete a written referral request form. The therapist will send the written referral request form to DHP to include the patient's diagnosis and estimated plan of care for DHP approval. **Following the completion of the evaluation, the request for therapy should be immediately faxed to DHP for processing. Requests received later than seven (7) days of being written will be considered late and denied.**

- Dean Health Plan will approve the requests for covered services and note any limitations regarding non-covered services or limited benefits (e.g.; developmental delay). A copy of the approved request will be sent to the therapist, ordering physician, and DHP member.
- If, at any time, the therapist begins to treat the member for a new condition or provides more than one type of therapy (within the same therapy session); A new referral request form must be submitted to DHP for approval.
- Requests for additional medically necessary therapy visits require submission of a written treatment plan.
- Contact our Customer Care Center at (800) 279-1301 or (608) 828-1301, with any additional questions.

**Care is terminated when services are no longer medically necessary.** Please also note that keeping the treating physician apprised of the member's progress is strongly recommended to ensure the best coordination of care for the member.

**Charges for services that have not been prior authorized by the provider of service are not billable to DHI/DHP or the member.**

## Physical, Occupational, & Speech Therapy Prior Authorization Guidelines

### POS Policies

**The therapy provider is responsible for prior authorizing care (this includes the initial evaluation, even if this is the only visit a member has).**

To access the most up-to-date medical policies regarding the prior authorization requirements for physical, speech, and occupational therapy go to

[http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

### Non-Covered Therapy Services

- Vocational Rehabilitation including work hardening programs.
- Long-term and maintenance therapy. Examples of long-term/maintenance conditions include, but are not limited to:
  - ✓ Attention deficit
  - ✓ Hyperactivity disorder
  - ✓ Sensory defensiveness
  - ✓ Auditory defensiveness
  - ✓ Mental retardation

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## LIMITED BENEFIT FOR DEVELOPMENTAL DELAY

- Hearing therapy for communication delay, therapy for perceptual disorders, mental retardation and related conditions, and other long-term special therapy.
- Recreational and educational therapy or physical fitness and exercise programs.
- Biofeedback, except as provided by PT for treatment of headaches, and spastic tortocollis.
- Services to enhance athletic training or performance.

## **Physical, Occupational and Speech Therapy Services when Medicare is the Primary Insurer**

### **The Therapy Provider should:**

When Medicare is primary, **authorization is given only for services that meet Medicare Part A or Part B guidelines.**

DHI/DHP authorizes services secondary to Medicare for a specific number of visits. If additional visits are necessary, a new referral must be generated by the Primary Care Practitioner.

**In the event a member has a DHI/DHP retiree policy which is secondary to Medicare (except for the Medicare Select Policy), therapies provided are subject to the retiree plan benefits.**

## **Other Physical, Speech, and Occupational Therapy Information**

The outpatient physical, speech, and occupational therapy benefits for DHI/DHP enrollees covers medically necessary services as a result of illness or injury. Outpatient physical, occupational, speech, and rehabilitation therapy benefits for a member are only for treatment of those conditions that, in the judgment of the attending physician, are expected to yield significant patient improvement within two months after the beginning of treatment. Services must be provided by a plan physical, occupational, or speech therapist.

**Speech Therapy** – may be considered medically appropriate for treatment of conditions resulting from illness or injury when significant improvement is expected within two months after beginning treatment.

One evaluation visit is medically appropriate upon receipt of a written referral request for conditions including but not limited to:

- Aphasia
- Apraxia of speech
- Articulation disorders secondary to malocclusion and/or oral defects
- Cleft lip or palate
- Cognitive retraining
- Dysphagia
- Laryngectomy
- Stuttering
- Tongue thrust
- Voice disorder
- Recurrent otitis medica

- Delayed articulatory development
- Delayed language development
- Dysarthria
- Dyslexia
- Other significant communicative disorders resulting from illness or injury will be considered on a case by case basis

### **Physical, Speech, and Occupational Therapy - Exclusions and Limitations**

Long-term and maintenance therapy or related reevaluations are not a covered benefit unless there is documentation for medical appropriateness on a case-by-case basis.

**Long-Term Therapy** - means therapy extending beyond two months which is determined by the DHI/DHP Medical Affairs Division to be primarily maintenance therapy.

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

**Biofeedback Physical or Occupational Therapy** is medically appropriate when more conventional treatments have been unsuccessful for treating:

- Muscle contraction, migraine or post traumatic headaches
- Muscle spasms of any type, particularly low back pain when refractory to conventional therapy (such as exercise, heat or cold therapy, massage, or support)
- Pelvic floor retraining for:
  - ✓ Fecal incontinence (anorectal retraining)
  - ✓ Genuine urinary incontinence
  - ✓ Urge incontinence

**All** biofeedback for physical and occupational therapy **requires** prior authorization through the Medical Affairs Division **except for**:

- Pelvic floor retraining for fecal incontinence (anorectal retraining) when ordered by a Colorectal Specialist.

In addition, biofeedback physical therapy is covered for members enrolled in a Medicare Supplemental plan for these specific diagnoses:

- Anal spasms
- Intrinsic urinary incontinence
- Muscle wasting

**Group biofeedback training is not a covered benefit.**

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**Developmental Delay for physical, occupational, and speech therapy** is a limited benefit that consists of an evaluation visit and a maximum of three (3) follow-up visits per therapy. The purpose of the therapies is for home instruction and monitoring of long-term and/or maintenance conditions. **Actual treatment of developmental delay conditions is not covered.**

To access the most up-to-date medical policies regarding the prior authorization requirements for physical, occupational (including biofeedback), and speech therapy go to [http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

## **Miscellaneous Prior Authorization Guidelines**

### **Audiology Services**

#### **HMO**

A referral request from the member's PCP is needed (only when services are provided in a clinic setting). Prior authorization is not required.

#### **POS**

Prior authorization is not required for audiology services.

### **Cosmetic Surgeries**

#### **HMO and POS Policies**

Prior authorization is required for any surgical procedure that may be considered cosmetic. A letter of medical necessity must be submitted to the DHI/DHP Utilization Management Department for review prior to scheduling the procedure (please refer to the *Health Plan Overview* section for phone number and fax number).

### **Diagnostic Tests**

#### **HMO**

Health Maintenance Organization policies do not require a referral or prior authorization for diagnostic tests. Refer to MRA and Breast Imaging policies for specific guidelines.

#### **POS**

Prior authorization is needed for certain diagnostic tests (refer to MRI policy for specific guidelines). Most routine tests do not require subsequent authorization, however, examples that would require prior authorization include a biopsy and lesions scraping since these fall under the surgery classification. When unsure if a procedure will require prior authorization, you may call our Customer Service Department.

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## **Hospice**

### **HMO & POS Policies**

All hospice services are prior authorized on a case by case basis subject to the policy limitations outlined in the Member's Certificate. Prior authorization can be requested by contacting the DHI/DHP Utilization Management Department at (608) 827-4455 or (800) 356-7344 ext. 4455 to review your case.

## **New Technologies**

### **HMO & POS Policies**

For any new technology or procedure not commonly accepted as standard care within the health profession, a letter describing the procedure or technology and the appropriateness of utilizing such techniques, must be submitted to the DHI/DHP Medical Affairs Division for review prior to scheduling the procedure.

## **Pulmonary Rehabilitation**

### **HMO & POS Policies**

Phase I and II Pulmonary Rehabilitation is medically appropriate when:

- The rehabilitation is prescribed by the patient's physician and is provided at an approved facility

The program incorporates teaching and exercises with a goal for patients to resume home, recreational, and occupational activities, along with education to encourage lifestyle changes, thus preventing future hospitalizations.

Pulmonary Rehabilitation for other diseases such as pulmonary vascular disease and lung resections may be covered if the patient has any of the following:

- Chronic and restrictive lung disease
- Pulmonary vascular disease
- Lung resections

Treatment is limited to 16 visits along with the following ancillary services:

- Initial assessment (allowed to medically assess the patient prior to entering the program)
- 16 oximetries
- 4 blood gases

For additional information, please refer to MP9077 at [http://apps.deancare.com/healthplan\\_apps/MedPolicySearch/medsearchpolicy.asp](http://apps.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp)

## **Respiratory Therapy**

### **HMO & POS Policies**

Policies do not require a referral and/or prior authorization/pre-certification.

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## Surgery HMO

In general, HMO policies do not require prior authorization for surgeries or hospital services. Exceptions to this include cosmetic surgery or pre-op stays. Other requirements may exist for outpatient physician services.

### POS

The member is responsible for prior authorization and pre-certification of surgeries performed outside of a physician's office.

## Transplants HMO

The provider is required to prior authorize all services, including transplant work ups, by contacting our Utilization Management Department .

### POS

The member is required to prior authorize all services, including transplant work ups, by contacting our Medical Affairs Division.

## Referral Requests 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 Department 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) 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.**



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- 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.

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## Pharmacy

### **Dean Health Plan Pharmacy Management**

Dean Health Insurance (DHI)/DHP provides a comprehensive drug benefit for those members in a plan with prescription drug coverage. The member's identification card will assist you in identifying those members with a drug benefit.

Dean Health Plan (DHP) provides all pharmacy information to practitioners, clinics and facilities via our external Website: [www.deancare.com](http://www.deancare.com). Dean Health Plan notifies clinics of new pharmacy information, DHP Pharmacy & Therapeutics (P&T) Committee activities, or reports through notification on [deancare.com](http://deancare.com) and the Provider Newsletter.

Please refer to the *Health Plan Overview* section of this manual for instructions on the Dean Health Systems Website.

Pharmacy Management includes but is not limited to:

- Formulary
- Targeted Utilization Reporting
- Prior Authorization

### **Drug Prior Authorization Process**

Providers can start the Prior Authorization process by accessing: [www.navitus.com](http://www.navitus.com)

Once in Navitus, go to Provider Section for Formularies, Prior authorization and frequently asked questions.

The drug prior authorizations should be faxed to (920) 735-5350 . For questions: Dean Customer Care Center 1-800-279-1301.

Should a member or practitioner disagree with a prior authorization decision, or if more information becomes available, the prior authorization request will be reconsidered. Ultimately, the member has the opportunity to pursue the grievance process for any drug prior authorization request that is redirected to other covered drugs or denied. Providers can start the Prior Authorization process by accessing:

### **Dean Health Plan Formulary Available on ePocrates**

The DHP formulary is accessible via ePocrates. Versions of this application are available for PDA and personal computer users. The basic service is free if one has a Palm but there is a charge for any services for those using a PDA other than with the Palm platform. This version will allow one to download the DHP Formulary file. The expanded handheld version, as well as the Web-based personal computer version, is available for an annual user's fee. Please visit the ePocrates Website, [www.epocrates.com](http://www.epocrates.com), to register for this service and to download the DHP Formulary.

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## Three Tiered Drug Formulary

Beginning May 1, 2005, DHP began providing a three-tier formulary pharmacy benefit for members. DHP will continue to offer the traditional two tier formulary pharmacy benefit.

A three tier formulary offers a much greater choice for both clinicians and patients. Drugs placed on the third tier require a very significant copay or co-insurance. For example, the new three tier formulary benefit will have the following copay structure:

- Tier 1: copay dependent on policy
- Tier 2: copay dependent on policy
- Tier 3: 50 percent coinsurance with a minimum payment per prescription of \$50 and a maximum payment of \$150.

Dean Health Plan patients might be on either a 2 or 3 tier formulary benefit. The following rules are the same for both 2 and 3 tier formularies:

- Tier 1 contains all generics
- Tier 2 contains preferred brand drugs
- Tier 3 contains expanded formulary brand and select generics
- Drugs requiring prior authorization will be the same for both the 2 and 3 tier formularies

However, all drugs on the third tier will not be covered for those with a 2 tier formulary benefit. **There is not a copay exception policy for drugs on the 3rd tier.**

The *Quick Reference Guide* is available online at [www.deancare.com/healthplan/shared/drug\\_pharmacy/index.asp](http://www.deancare.com/healthplan/shared/drug_pharmacy/index.asp)

If you have any questions, please contact Daniel Lewis, Pharmacy Practice Leader at (608) 827-4348 or [Daniel.lewis@deancare.com](mailto:Daniel.lewis@deancare.com).

## Excluded or Nonformulary Drug Policy

Dean Health Plan has an established policy for handling requests for drugs excluded from the formulary. Physicians may request consideration for excluded drugs on an exception basis. Exception requests should be submitted using the “other” drug selection in NaviNet™. Exception requests will be considered for approval only **after all formulary alternatives have been tried and failed**. A contraindication to a specific formulary alternative drug constitutes a failure of the formulary alternative drug without a trial of that drug. **All drugs are excluded from the formulary until they have been reviewed and approved by DHP Pharmacy & Therapeutics Committee.**

## Navitus Health Solutions

State of Wisconsin Employees who have medical coverage through Dean Health Plan do not have pharmacy coverage through Dean Health Plan. Navitus Health Solutions is the pharmacy benefit manager (PBM) for State of Wisconsin Employees. State of Wisconsin Employees have their own unique formulary and prior authorization process. The Navitus Web site, [www.navitus.com](http://www.navitus.com), and Navitus Customer Service (toll free, 866-333-2757) should be consulted regarding formulary and benefit information for this population.

The following table highlights the differences between your Dean patients and your Dean patients that are State of Wisconsin Employees.

	Dean Patients	Dean State of Wisconsin Employees
<b>Customer Service</b>	Call Dean Customer Service (608) 828-1301 or (800) 279-1301	Call Navitus Customer Service (920) 225-7010 or (866) 333-2757
<b>ID Cards</b>	One ID Card for both Medical and Pharmacy	Two ID Cards Dean : Medical ID Card Navitus: Pharmacy ID Card
<b>Mail Order</b>	Mail order is available for selected groups through Welldyne <a href="http://www.WellDyneRx.com">www.WellDyneRx.com</a>	Mail order is available through Welldyne <a href="http://www.WellDyneRx.com">www.WellDyneRx.com</a>
<b>Prior Authorizations</b>	<a href="https://prescribers.navitus.com-Navitus-PrescriberLogin.aspxReturnUrl=-_layouts-aauthenticate.aspxSource=-Source=.url">https—prescribers.navitus.com-Navitus-PrescriberLogin.aspxReturnUrl=-_layouts-aauthenticate.aspxSource=-Source=.url</a>	Prior authorization forms on Web site <a href="http://www.navitus.com">www.navitus.com</a> <b>DHP's Prior Auth Forms cannot be used for this population</b> Unique prior authorization list. Associated criteria
<b>On-Line Formulary</b>	Dean Formulary: <a href="http://www.deancare.com">www.deancare.com</a>	Navitus Formulary: <a href="http://www.navitus.com">www.navitus.com</a>
<b>Epocrates with Formulary</b>	Dean Formulary: Register at <a href="http://www.epocrates.com">www.epocrates.com</a> More information is available in provider newsletters.	Navitus Formulary: Register at <a href="http://www.epocrates.com">www.epocrates.com</a> Also available on the Navitus Website.

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## Other Helpful Pharmacy Information

- Copayments can be identified on the member's identification card. For example, a "\$10/30%" indicates that the member has a \$10 copayment for Tier 1 drugs and a 30 percent copayment for Tier 2 drugs.
- When a member requests a brand name prescription when a generic is available, the member will be responsible for the brand name copayment along with the difference in cost between the generic and brand drug.
- Generic substitutions will be made by the pharmacy when Food and Drug Administration (FDA) approved generics are available. Insulin and diabetic supplies are a covered benefit for all members, including groups that do not have a drug benefit. The amount of coverage varies depending on the member's benefit.
- Infertility medications may be subject to 50 percent coinsurance when considered a covered benefit under the plan.
- Take-Home Drugs - Only retail pharmacies with an active DHI/DHP Pharmacy Agreement may provide outpatient drugs to DHP members. Discharge medications or emergency room/urgent care take home drugs are considered outpatient prescriptions. These medications are not a covered benefit unless dispensed by the institution's retail pharmacy who is a contracted pharmacy provider.
- When a member has more than one insurance, coordination of benefits for pharmacy claims shall occur. If DHI/DHP is the member's primary carrier, all pharmacy charges should be submitted according to the DHP filing guidelines.

In situations where DHI/DHP members treated for urgent/emergent care require medications and they do not have access to a plan pharmacy, the following guidelines apply:

- The member should be given a quantity of medication to last until they are able to access a plan pharmacy (usually a one day supply).
- The member should be given a written prescription for the remaining medication needed.
- They should be instructed to have the prescription filled at a plan pharmacy.

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## **Pharmacy and Therapeutics Committee**

DHI/DHP uses an established P & T Committee (composed of physicians and pharmacists) to evaluate new and existing products, determine formulary, and coverage status. Determinations are based on the uniqueness, medical necessity, efficacy, safety, and cost of each drug product reviewed. Relevant information is obtained from primary literature, expert physician input, accepted medical standards of practice, and other sources as needed.

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

The Pharmacy & Therapeutics Committee reports to the UMC and is evaluated annually. Recommendations for improvement are reviewed and approved by the UM Committee and considered in future work plan development. Pharmacy management is delegated to Navitus and the UM Committee is responsible for the oversight of all activities delegated.

## **Statement of Conflict of Interest**

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

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

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

## **Program Evaluation**

The Pharmacy Department annually evaluates their program. The Pharmacy Department submits their Program Evaluation to the UM Committee for review and approval. Recommendations from the annual Program Evaluations are incorporated into the next year’s Program Description and QI Work Plan as appropriate.

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## **Member Grievance, Provider Appeals & Timely Filing Appeals**

### **Member Complaint, Appeal, and Grievance Procedure**

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

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

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

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

#### **Complaint**

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

If a member has a complaint regarding any aspect of care or decision made by you or the Health Plan, please contact the Customer Care Center at **(608) 828-1301** or **(800) 279-1301**. We will document and investigate the member complaint and notify the member of the outcome of the complaint. If the complaint is not resolved to their satisfaction they can file a grievance. Because most concerns can be addressed informally, we encourage either you or the member to contact Customer Service first for discussion before taking any formal action.

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

#### **Grievance**

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

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

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Upon receipt of the grievance, DHP's Grievance and Appeal Department will acknowledge it within five business days. Our acknowledgment letter will advise the member of their right to submit written comments, documents or other information regarding their grievance, to be assisted or represented by another person of their choice, to appear before the Grievance and Appeal Committee if they wish to do so, and the date and time of the next scheduled meeting, which will not be less than seven calendar days from the date of their acknowledgment and within 30 calendar daytime frame of receiving the grievance. If the member chooses to appear before the committee, they must notify us. If they are unable to appear before the committee, they do have the option of scheduling a conference call.

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

### **Independent External Review**

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

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

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

The Member may designate another person or party to appeal on their behalf. However, they must give permission in writing.

The decision of the IRO is binding on both the insurer (the Plan) and the insured. Requests for benefits beyond those defined in the benefit package are not eligible for independent external review.

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Please contact our Customer Care Center for information regarding availability, and the process for initiating the review.

### **Urgent Grievance**

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

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

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

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

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

## **Provider Appeals Process**

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

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

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

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

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## Timely Filing Appeals

Dean Health Plan considers timely filing appeals separately from Provider and Coding Appeals. If the timely filing guidelines and/or exception guidelines were not met and the claim(s) remained denied, the provider may appeal the timely filing denial to the Timely Filing Committee (***refer to ID card, EOP, Claims section for the TF guidelines***). The provider must submit additional documentation to support filing their claim timely, in writing, in order for it to be reviewed 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.

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## **Dean Health Plan's Quality Improvement Program**

### **Hospital Standards of Participation**

Dean Health Plan requires the following standards be met for accredited and non-accredited hospitals to receive approval and to continue participation as a Plan Facility.

#### **Licensure**

The hospital must have a current, active license issued by the state regulatory agency.

#### **Medicare/Medicaid Sanctions**

The hospital should not have current or recent sanctions by Medicare or Medicaid programs that would prevent the hospital from providing services to Dean Health Plan members.

#### **Malpractice Liability Insurance**

The hospital must acquire and maintain adequate malpractice liability insurance.

#### **Accreditation**

The hospital must be accredited by an appropriate nationally recognized accreditation agency [i.e. Joint Commission on Accreditation of Healthcare Organizations (JCAHO)].

Dean Health Plan requires the following standards be met for non-accredited hospitals to receive approval and to continue participation as a Plan Facility.

#### **Licensure**

The hospital must have a current, active license issued by the state regulatory agency.

#### **Medicare/Medicaid Sanctions**

The hospital should not have current or recent sanctions by Medicare or Medicaid programs that would prevent the hospital from providing services to Dean Health Plan Members.

#### **Malpractice Liability Insurance**

The hospital must acquire and maintain adequate malpractice liability insurance.

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## **Governing Body**

The hospital must provide the names of the members and by-laws of the established governing body which Dean Health Plan will use to verify who has responsibility to provide care to patients.

## **Executive Officer**

The hospital must supply Dean Health Plan with the name and job description of the hospital's Executive Office.

## **Medical Staff Service Plan**

The hospital will need to supply Dean Health Plan with a copy of the hospital's medical staff service plan that includes the process for verifying the credentials of the medical staff who provide services to members.

We require members of the medical staff to be legally and professionally qualified for the positions they are appointed to.

All physician practitioners must be credentialed, be in good standing and have current hospital privileges. Dean Health Plan standards for verification of credentials include:

- Active state medical license.
- National Practitioner Data Bank verification.
- Current DEA license
- Board eligibility and certification status.
- Hospital privileges.
- Absence of Medicare/Medicaid Sanctions

The Dean Health Plan Quality Improvement Department may review a sample of the records verifying the credentials of physician practitioners.

## **Quality Assurance Plan**

The hospital is required to supply Dean Health Plan with a copy of the hospital's Quality Assurance Program description and how it is monitored to make improvements.

## **Utilization Review Plan**

The hospital is required to submit a copy of their Utilization Review Plan to insure there is a mechanism for examining and improving appropriate and cost effective utilization of patient care services.

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## Medical Records

Dean Health Plan requires copies of the hospital's policies and procedures documenting medical record keeping practices, verifying:

- Medical records are maintained for every patient admitted for care, and
- The hospital's policies and procedures for collection, storage and use of medical records to safeguard against loss, destruction or unauthorized use.

For new facilities or hospitals seeking reapproval, the Dean Health Plan Quality Improvement Department may review a sample of records to insure they include the following:

- Patient identification on each page of the record.
- Conditions of the admissions signed by the patient.
- Chief complaint documented.
- Patient history or physical examination within 24 hours of admission.
- Admitting diagnosis documented.
- Treatment plans are consistent with diagnosis.
- Medication allergies and adverse reactions are prominently noted in the record, including no known allergies or adverse reactions.
- Physician orders dated and signed.
- Progress notes dated and signed.
- Nursing notes dated and signed.
- Ancillary services (lab, radiology, therapy, etc.) in chart.
- Discharge planning documented.
- There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

## Hospital Provider Site Review Standards

DHP conducts regular site reviews to assess the quality of the facility within which the care is provided.

DHP requires that all 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 accessible
- 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

DHP requires that all facilities have the following minimum facility policies and procedures:

- **QA Committee and/or Process:** DHP 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. In addition, the Committee/staff member is responsible for reviewing the DHP facility audit results sent to them.
- **Complaint and grievance process:** DHP 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.
- **Confidentiality:** DHP 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.
- **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:** 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:** DHP requires that a mechanism be in place for patients to access care 24 hours a day. DHP recommends that either a handout or other service be in place to direct the patient to care from the practitioner's office.
- **Appointment No-Show, Late Arrival Policy:** Policy for documenting no-shows and late arrivals and efforts to follow-up.
- **Waiting Time:** DHP 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:** DHP 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:** DHP requires that all facilities keep drugs and medications in a safe, locked, secure location 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:** 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.

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## Dean Health Plan's Medical Records Policy

Dean Health Plan has been cooperating with other area HMO's in order to adopt medical record standards recommended by the National Committee for Quality Assurance. The benefit of this joint effort is that consistent standards will be reviewed among the health plans.

### Medical Recordkeeping Standards

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

Each element of the medical recordkeeping standards will be evaluated at the time of initial site visits and recredentialing site visits to determine if the facility is in full compliance, partial compliance or noncompliance with the DHP standards. The QI Department has established a scoring mechanism for rating performance.

1. 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.
2. The facility must have policies and procedures for collection, storage and use of medical records to safeguard against loss, destruction or unauthorized use.
  - 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 85% of records available at the time of visit
  - The facility has a process 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
3. The contents of the medical record should be current, detailed and arranged in a manner that facilitates the retrieval of pertinent clinical information.
  - The facility has a procedure 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.
  - A patient ID is on all pages of the medical record.
  - The facility has a procedure for documentation of drug and other allergies.

- The facility uses problem lists and/or flowsheets for preventive health, immunizations, etc.
- The facility uses consent forms for receiving/refusing treatment; authorizing treatment of minors.
- Patient care information is recorded in accordance with Dean Health Plan medical record documentation standards.
- The facility has a policy for documenting in the medical record whether or not the patient has executed an advanced directive.

The QI or Provider Services Department will inform the facility of their compliance, partial compliance and non-compliance with DHP medical recordkeeping standards and their total compliance score.

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

### **Hospital Medical Record Documentation Standards**

1. The medical record has patient identification on each page of the record.
2. The medical record contains conditions of the admission, signed by the patient.
3. The chief complaint and significant illnesses are documented.
4. A patient history and physical examination are documented within 24 hours of admission.
5. The admitting diagnosis, consistent with findings, is documented.
6. Treatment plans are consistent with diagnoses.
7. 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. Physician orders are dated and signed.
9. Progress notes are dated and signed.
10. Nursing notes are dated and signed.
11. Ancillary services (lab, radiology, therapy, etc.) reports are included in the chart.
12. Discharge planning is documented.

13. There is no evidence the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.

## 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 has categorized 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 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.

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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.

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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.

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## **Care Management**

### **Dean Health Plan Care Management Program Summary**

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

The DHP Care Management Department includes the following:

- Utilization Management (UM)
- Case and Disease Management

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

### **Utilization Management Program**

#### **Utilization Management Hours of Operation**

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

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

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

#### **Utilization Management Program Purpose**

Dean Health Plan's goal is to have members receive high quality care that is the most appropriate care, in the most appropriate setting, by the most appropriate provider, in the most cost effective manner. Therefore, DHI/DHP encourages all practitioners, providers, and DHP

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employees making utilization decisions to base their decisions on the appropriateness of care and service, and the existence of coverage. Dean Health Plan does not specifically reward practitioners or other individuals making UM decisions for issuing denials of coverage or care nor does it provide financial incentives for UM decision makers which encourage decisions that result in under utilization. All DHI/DHP practitioners, providers, and employees making UM decisions have been made aware of this policy.

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

## Utilization Management Program Objectives

- A. Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards.
- B. Monitor potentially avoidable admissions and develop appropriate mechanism to address identified areas of concern;
- C. Focus inpatient review activities on problem areas determined by appropriate data sources;
- D. Trend and monitor data to identify areas of possible over and under utilization. Areas may include but are not limited to procedure utilization, pharmacy utilization (certain medications and classes of medications), ER utilization, inpatient utilization, laboratory utilization, and physician practice utilization;
- E. Assess provider satisfaction with Utilization Management activities and address areas of provider dissatisfaction when appropriate;
- F. Assess member satisfaction with Utilization Management activities and address areas of member dissatisfaction when appropriate;
- G. Integrate Utilization Management with Disease and Case Management as appropriate when identified during UM activities;
- H. Monitor and analyze variations in the delivery of care in the network for which evidence based standards of appropriate care exist, and consider opportunities for the Utilization Management programs that will improve quality of care and reduce medical costs;
- I. Implement or maintain policies and procedures in accordance with applicable regulatory and accreditation requirements and standards;

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

## **Scope of the UM Program**

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

### **A. Major Categories of UM**

The scope of UM activities include the following major categories:

1. Concurrent Review and Evaluation/ Discharge Planning
  - Hospital inpatient admissions
  - Skilled Nursing Facility (SNF) care and rehabilitation
  - Home healthcare
  - Hospice
  - Behavioral health outpatient care/AODA services

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

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

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

## B. Quality of Care Monitoring

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

### **Clinical Indicators**

- Sentinel events
- Under utilization and over utilization
  - ✓ Member complaint and appeal data analysis
  - ✓ Review of practitioner utilization profiles
  - ✓ Adverse event and sentinel diagnoses data analysis
  - ✓ Member satisfaction surveys
  - ✓ High volume/high cost drug use
- Continuity and coordination of care monitoring
  - ✓ Application of case management selection criteria
  - ✓ Member complaint and appeal data analysis
  - ✓ Adverse event and sentinel diagnoses data analysis
  - ✓ Member satisfaction surveys
  - ✓ Member claims for out-of-network services

- ✓ Retrospective reviews
- Monitoring ancillary services (Pharmacy, Lab, Imaging, DME, Physical, Occupational, and Speech Therapy)

### **Service**

- Member satisfaction surveys
- Practitioner satisfaction surveys

### **C. Quality Assurance**

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

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

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

Quality Assurance review monitors care delivered in the following areas:

- Hospital admissions and subsequent care
- Care in outpatient and inpatient settings
- Monitoring of under utilization and over utilization
- Laboratory services
- Medical imaging
- Prescription drugs
- Durable medical equipment
- Behavioral health care including AODA

- Care by non-physicians
- Care provided by tertiary care referral centers
- Ambulatory surgery
- Home healthcare
- Rehabilitation
- Urgent care
- Emergency care
- Physical therapy
- Occupational therapy

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

## **Program Authority and Responsibility**

### **Program Authority**

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

### **Program Responsibility**

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

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

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## UM Committees

### 1. Medical Peer Review Committee

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

### 2. Utilization Management Committee

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

### 3. Pharmacy and Therapeutics Committee

DHI/DHP uses an established P & T Committee (composed of physicians and pharmacists) to evaluate new and existing products, determine formulary, and coverage status. Determinations are based on the uniqueness, medical necessity, efficacy, safety, and cost of each drug product reviewed. Relevant information is obtained from primary literature, expert physician input, accepted medical standards of practice, and other sources as needed.

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

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

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

## Utilization Management (UM) Criteria

Dean Health Insurance (DHI)/Dean Health Plan (DHP) utilize written criteria based on medical evidence in making its determination of medical necessity. We would like our providers to know that information about our criteria is available upon request. If you have a question about the

criteria used in a specific determination, you may contact the Utilization Management Department by calling (800) 356-7344 Ext 4455 or (608) 827-4455.. We will be happy to provide you with information about our criteria.

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

## Review Criteria and Guidelines

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

### A. Milliman Care Guidelines

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

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

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

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

### B. Medicare Coverage Guidelines

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

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members. NCDs, Medicare Interpretive manuals, and LCDs are available on the Center for Medicare Services website.

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

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

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

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

ASAM is utilized to guide medical appropriateness decisions related to substance abuse diagnoses, primarily for inpatient care and determination of appropriate level of care. These criteria may also be used to determine the need to transition care to a different level. All coverage determinations are the responsibility of DHP. All clinical care decisions are strictly and solely the obligations and responsibility of the behavioral health care provider. The ASAM criteria are used for the following types of services which include but are not limited to:

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

#### E. Dean Health Plan Medical Policies

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

Practitioner and member feedback is periodically reviewed to determine if any revisions to the procedures or criteria are necessary. DHI/DHP will make these criteria available to practitioners upon their request. DHP medical policies are also available via the web at:

<http://www.deancare.com/providers/forms-and-documents-search-results>

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

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## Evaluation of Medical Technologies

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

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

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

## Utilization Management for Pharmacy

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

## Specific UM Methods

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

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

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

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## A. Concurrent Review

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

### 1. Utilization Issues

The following are reviewed concurrently by the UM Department staff:

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

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

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

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

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

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

### 2. Quality of Care Issues

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

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

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

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

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

## **B. Discharge Planning**

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

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

## **C. Retrospective Review**

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

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

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

Retrospective review may be performed for the following:

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

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## **D. Referral Management/Prior Authorization**

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

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

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

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

## **E. Denial Process**

Denials occur under the following circumstances:

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

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

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

## **F. Appeal Process**

### **1. Members**

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

## 2. Practitioners

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

**Please refer to “*Member Grievance, Provider Appeal & Timely Filing Appeals*” Section in this manual for the Provider Appeal Process for more detailed information.**

## Program Evaluation

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

## Case and Disease Management Department Hours of Operation

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

## Case Management Program Description

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

DHP’s Case Management program serves in a support capacity to the Primacy Care Physician (PCP) and assists in coordinating care actively linking members to providers, medical services,

residential, social & other support services as needed. DHP's Case Management staff adheres to the Case Management of America (CMSA) standards of practice.

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

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

## **Case Management Programs**

### **Complex Case Management (CCM)**

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

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

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

- Multiple/frequent ER visits (2 or more ED/UC Facility visits in one month)
- Multiple/frequent acute inpatient admissions
- Multiple Referrals and/or Providers
- Multiple Providers, in and out of network
- Multiple/severe disabilities
- Chronic Diseases w/ co-morbidities
- Transplants (evaluation, pre-transplant, transplant, and post-transplant phase)

- Leukemia
- High Dose Chemotherapy at a Tertiary Care Facility
- Out of Network (OON) Services related to a Cancer Diagnosis
- Spinal Cord Injuries
- Traumatic Brain Injuries
- Second and Third Degree Burns
- Multiple Congenital Defects

Identification of members for possible CCM services includes:

- Direct referral by the primary care physician or specialist
- Discharge Planners
- Pharmacy data
- Claims
- Hospital discharge data
- Internal referrals from other departments
- Family/Member self-referral
- DHP's Utilization Management

## Disease Management Programs Overview

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

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

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

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

Each disease management program includes condition monitoring that is ongoing and proactive. This allows the member, the practitioner, and the disease/case manager to assess how well the condition is being managed. Monitoring is done through the use of regular clinical

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assessments with surveillance of pharmacological management, lifestyle management, and assessment of the member's knowledge of the condition itself as well as the related co morbid conditions likely to affect overall health status.

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

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

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

DHP's Disease Management Program elements include:

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

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

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## Statement of Confidentiality

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

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

## Statement of Conflict of Interest

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

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

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

## Program Evaluation

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

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## **Publications**

### **Member Rights & Responsibilities**

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

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

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

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

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

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

These rights and responsibilities are available for you to access on our Website at <http://www.deancare.com/insurance/members/rights-and-responsibilities/>

## **Dean Health Plan's Member Privacy Policy**

### **Protecting the Privacy of Personal Health Information**

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

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

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

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

#### **How does Dean protect this information?**

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements. We maintain physical, electronic, and procedural safeguards that comply with federal and state regulations to protect your nonpublic personal information. We limit the internal use of oral, written, and electronic nonpublic personal information about you and ensure that only authorized staff with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.

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

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

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

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

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

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

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

## Summary Statement of Your Health Information Rights

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

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

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

### Questions?

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

## Dean Health Plan's Affirmative Action Statement

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

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

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

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