



Dean Health Plan Skilled Nursing Facility Manual

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Welcome to Dean Health Plan!

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

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

Customer Care Center

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

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

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

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

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

Care Management

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

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

Case & Disease Management Referrals (608) 827-4132

Care Management Fax Number (608) 836-6516

Claims

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

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

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



Drug Prior Authorizations

	(608) 828-1301
Dean Health Plan Drug Prior Authorizations	(800) 279-1301
	(608) 827-7535
DHP Drug Prior Authorization Fax	(866) 333-2757 (toll free)
Navitus Health Solutions	www.deancare.com
Dean Health Systems Website	

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

Who is Dean Health Plan?

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

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

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

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



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

Dean Health Insurance Mission Statement is as follows:

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



Dean Health Systems Website

www.deancare.com

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>





Automated Response Line (IVR)

Dean Health Plan has an automated phone system to answer certain types of provider calls. It is called Automated 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 System 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 IVR will help us accomplish this.

Automated 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 four options available. They are:

- **Member Eligibility** - To check member eligibility you must enter the 10 digit member number for Medicaid & Badger Care members or 11 digit member number for all other members. Once you have entered the member number and verified the member's date of birth, it will give you information pertaining to eligibility:
 - Effective & expiration dates of the member's policy
 - Group number
 - If the policy has a preexisting condition clause, and if so, the dates effective
 - The Primary Care Practitioner/Clinic
- **Copayment Information** - After checking member eligibility, you will have the option to check copayment information. The most common policy copayments are available. Copayment information:
 - Office copay
 - Drug copay
 - Hospital inpatient or outpatient/ambulatory surgery copay
 - Durable medical equipment copay
 - Diabetic durable medical equipment copay

You will not be able to obtain copayment information on members enrolled in a Point of Service or Point of Enrollment (indicated by a group number that ends in P or Y) because benefits vary based on the provider of services.

- **Claims Status** - To check claims status you will be prompted to give the 10 or 11 digit member number and verify the member's date of birth, your DHP provider number, and the date of service in question. This option will give you the following information:
 - If we do not have record of a claim



-
- The received date of the claim
 - If the claim is currently in review and the approximate processing time
 - Reason for an error on a claim
 - If the claim has been denied
 - If full or partial payment has been made
 - The process date of the claim
 - Who the claim was paid to

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

- **Other Health Insurance** - You have the option to check other health insurance (OHI) information we have listed for a member. To check OHI information you will be prompted to enter 10 or 11 digit member number and verify the member's date of birth. Once this information has been verified, this option will give you the following information:
 - If DHP has other health insurance listed that is currently in effect and primary to the DHP coverage
 - If the coverage is for medical services, prescription drug coverage, or both

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 3, during normal business hours

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.

Provider Relations Specialists Territory Assignments

Becky Bongard

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

Judy Jabs

Dane
(608) 827-4327
(800) 356-7344, ext. 4327
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

Brandi Parcel

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

Paul Schiller

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



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

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

- Physically injured or threatened a practitioner or other member of the clinic staff;
- Repeatedly and materially refused to pay coinsurance, copayments, or deductibles associated with DHP/Premier claims after all reasonable collection efforts have been exhausted;
- Displayed verbally abusive behavior or harassment towards a practitioner or other member of the clinic staff;
- Repeatedly refuses to cooperate with the practitioner.
- Fails to attend or late cancel 3 or more scheduled appointments after having received a written warning.

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

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

Practitioner-Member Communication

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

Other Situations

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

- **Provider Demographic Information:**
 - *Name
 - *Specialty
 - *Office locations
 - *Gender
 - *Hospital Affiliations



- **Medical Group Affiliations**
- **Relocation/Retirement of a provider** (DHP provides member notification to ensure continuity of care).
- **Request to expand or add new clinics and/or office locations.** These requests to expand are required to have prior approval through the Provider Services Department.
- **Request to add additional services and/or programs.** These requests are required to have prior approval through the Provider Services Department.
- When a physician finds it necessary to discontinue accepting new patients or limit his/her practice (following this page is a *Patient Acceptance Form* that is required to be completed to communicate this information). This does not apply to practitioners who are with a Dean Medical Center/St. Marys Dean Venture Clinic site.
- When a physician will be out of the office, vacationing or on extended leave and another facility or location will be covering his/her practice. DHI/DHP requires **written notification** to include name, location, and duration of the covering physician or facility. **The covering physician must be a plan provider and have completed the credentialing process.**

“Dean On Call” (24-hour Nurse Line)

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

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

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

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

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



Dean Health Plan's Products

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

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

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

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

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

Dean Focus (EPO) (Small Group Product) is a small group plan with a limited service area of Dane County. The Dean Health Plan network for this product will be limited to Dean Health System (Dean Medical Center) providers and St. 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.

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



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

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

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

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

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

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

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

BadgerCare Plus Identification (ID) Card

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

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

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

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

Forward Card Features
(Resembles an automated teller card)



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

DHP Identification (ID) Card

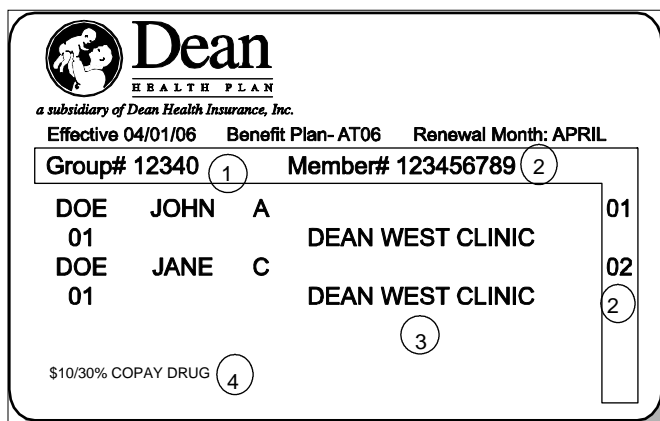
Your role as a Dean Health Plan (DHP) Provider is to identify which plan a member has to assure that the correct referral, prior authorization, and pre-certification guidelines are followed.

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

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

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

Example of Identification Card



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

Group # begins with:	Type of Product
20000	Senior/Select
C	Gold C2300D (Shared Value w/o catastrophic drug coverage) C3300D (Shared Value w/o catastrophic drug coverage) C2200 (Enhanced) C2200D (Enhanced w/o catastrophic drug coverage) C3200D (Enhanced w/o catastrophic drug coverage) C3200 (Enhanced) C1200D (Basic w/o catastrophic drug coverage) C3100D (Basic w/o catastrophic drug coverage)
Y	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 Service at 800-279-1301.

Wisconsin Education Association (WEA) Point of Service (POS) Product

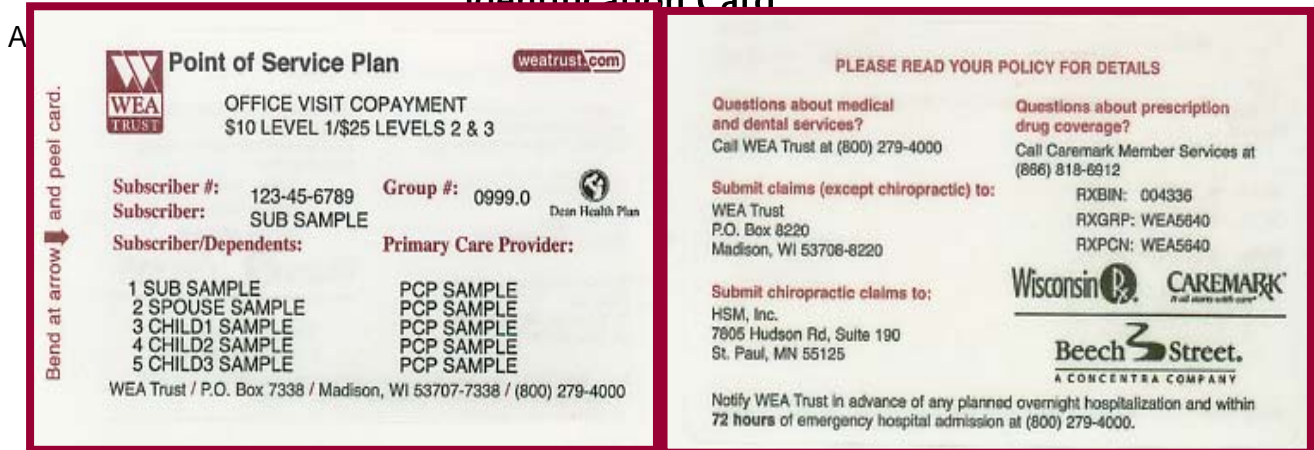
Dean Health Plan’s provider network is contracted for *WEA Trust POS members*. DHP provides a discount network for WEA Trust’s POS product. Benefit limitations apply to all WEA Trust enrollees.

Dean Health Plan no longer provides medical management for WEA POS members. DHP only offers WEA members a discount on Dean Health Plan services.

Please be aware that all of the terms of your current agreement with DHP will apply to services to WEA Trust POS members, however you will need to follow the preauthorization and referral requirements for WEA Trust. If you have any questions concerning the WEA Trust POS product, please contact the WEA Customer Service Department at (800) 279-4000.

Identification (ID) Card, Explanation of Payment (EOP), Claims

Identification Card



Please note that the front of the card says WEA Trust POS Plan and displays the Dean Health Plan (DHP) logo. This is how you will be able to distinguish WEA Trust POS members from other WEA Trust group health plan enrollees.



Provider Enrollment History Report

At the end of each month, DHP mails a “Monthly Provider Listing” to Primary Care Practitioners (PCP) for WEA Trust enrollees. The cover memo will designate this listing as being for WEA Trust POS members. This listing is the same type of listing the DHP PCPs currently receive for DHP enrollees.

The listing identifies WEA Trust POS members who have been added to, or deleted from, the PCP roster. In addition, the report lists all WEA Trust POS members who have designated you or your facility as their PCP.

Please note that the list for WEA Trust POS members will not include updated Advanced Directive information.

Claims Submission

When submitting claims for WEA Trust POS members, please follow these guidelines:

- All claims for WEA Trust POS members should be mailed to (or filed with) the WEA Insurance Trust. The claim filing address is included on the back of the member’s ID Card and reads as follows:

All Claims (Except Chiropractic)

WEA Trust
PO Box 8220
Madison, WI 53708-8220

Chiropractic Claims:

Health Services Management, Inc. (HSM)
—————7805 Hudson Road, Suite 190
St. Paul, MN 55125

- All claims must be submitted in accordance with the claim filing limit stipulated in your DHP Provider Agreement/Contract from the date of service. In the event that the WEA Trust POS Plan is the secondary insurer, claims must be submitted in accordance with the claim filing limit stipulated in your DHP Provider Agreement/Contract from the date of the Explanation of Benefits (EOB) provided by the primary insurance carrier. **For an outline of the DHP Timely Filing guidelines and exceptions - Refer to the *Claims, Timely Filing & EOPs* section of this manual.**
- Claims for WEA Trust POS members should be submitted with the DHP provider name, provider number (placed in box 33 on the CMS-1500 claim form in the PIN # field), and the assigned facility name and vendor number (placed in box 33 on CMS-1500 claim form in the GRP# field).
- If you need to resubmit a claim for any reason, these claims need to be filed with the WEA Trust.
- Subrogation claims for the WEA Trust POS members should be submitted to the WEA Trust.



- Providers should contact WEA Trust to obtain the most current guidelines for filing claims electronically.
- Please note that the Explanation of Payment your clinic will receive is titled as the WEA Trust POS Provider Remittance. This is how you will know that the remittance is for WEA Trust POS members.

Reimbursement

The WEA Trust reimburses services for WEA Trust POS members at three different levels. The level of reimbursement is based on how the WEA Trust POS members access care.

LEVEL 1

Level 1 reimbursement is the highest level of reimbursement. Services will be reimbursed at Level 1 only if the services are a covered benefit, members have chosen a plan PCP, and services were rendered by the member's PCP/site or another Dean plan provider.

Referrals

Referrals are not a requirement to obtain the highest level of reimbursement as long as the patient is utilizing a Dean plan provider. If you have questions regarding referral requirements, contact the WEA Trust Customer Service Department at (608) 276-4000.

Prior Authorization Requirements

Trust members must obtain prior preauthorization for specific services. Trust POS members should refer to their Benefit Summary for questions regarding prior authorizing specific services. If you or the member has questions regarding preauthorization requirements, you may contact or call the WEA Trust Customer Services Department at (800) 279-4000 or (608) 276-4000 or visit the WEA Trust website at: www.weatrust.com; to find the current preauthorization listing.

Chiropractic Care

The WEA Trust has established their own network of chiropractic providers. Although chiropractic care is a covered benefit for WEA Trust POS members, it is not being managed by DHP. Trust POS members should consult their POS Provider Directory for assistance in selecting chiropractic services. Any questions concerning chiropractors should be directed to WEA Trust's Customer Service Department at (800) 279-4000 or (608) 276-4000.



Durable Medical Equipment

Home Health United is the main plan provider for durable medical equipment (DME) for WEA Trust POS members. Please refer WEA Trust POS members to Home Health United for their DME needs.

For additional guidelines concerning DME, you should contact WEA Trust's Customer Service Department at (800) 279-4000 or (608) 276-4000.

Hospital Admission Notification

WEA Trust POS members are required to notify WEA Trust of any overnight hospitalizations. Requirements for hospital admission notification are as follows:

Planned Admissions

A planned admission is an admission that is, or reasonably can be, planned in advance. WEA Trust POS members are required to notify the WEA Trust at least five (5) day in advance, whenever possible.

Emergency Admissions

An emergency admission is one that is necessitated by an accidental injury, or the sudden and unexpected onset of severe symptoms of an illness. WEA Trust POS members are required to notify the WEA Trust within 72 hours of being admitted or as soon as it is medically feasible, whichever is later.

Maternity Admissions

Trust POS members hospitalized for childbirth must notify the WEA Trust of their admission within 72 hours of hospitalization for childbirth.

WEA Trust POS members will be assessed a penalty if they do not comply with hospital admission notification requirements.

Vision

WEA Trust POS members should consult their POS Provider Directory for assistance in selecting a vision care provider for non-routine services.

The following services are covered for all WEA Trust POS members:

- Diagnosis and treatment of eye pathology
- Eye surgery to cure an illness or heal an injury to the eye
- The initial lens after cataract surgery



-
- Therapeutic contact lenses for treating an illness or injury
 - The initial artificial eye to replace an eye lost because of illness or injury while the member is covered by this policy

Routine vision care may be covered for WEA Trust POS members. Members should refer to their Benefit Summary for questions regarding vision benefits or call the WEA Trust Customer Services Department at (800) 279-4000 or (608) 276-4000.

Pharmacy

The WEA Trust has established their own network of plan pharmacies. Although the WEA Trust POS Plan does provide a comprehensive drug benefit, it is not managed by DHP.

Caremark, is the administrator for the WEA Trust's prescription drug program. Members may purchase prescriptions at any pharmacy. Reimbursement is limited to the amount the WEA Trust reimburses a Caremark participating pharmacy.

Any questions concerning pharmaceutical services should be directed to the WEA Customer Service Department at (800) 279-4000 or (608) 276-4000.

Member Complaints/Grievance

All WEA Trust POS member complaints are handled by the WEA Trust. Most questions about benefits and claims payments can be resolved on an informal basis. If a WEA Trust POS member is dissatisfied with an answer they have received and wish to register a complaint, they are encouraged to call the WEA Trust ombudsperson at (800) 279-4000 or (608) 276-4000 (Voice/TDD).

If a member complaint concerns a provider, the WEA Trust ombudsperson will notify the Quality Improvement Analyst at DHP.

The Quality Improvement Analyst at DHP will inform the facility, individual, or subcontractor involved that a complaint has been filed regarding his/her care or service. The facility, individual, or subcontractor is asked to investigate the grievance and respond to the patient, and carbon copy DHP with their findings within thirty (30) days of the WEA Trust's receipt of the complaint. If a provider wishes to register a complaint, he/she should contact the DHP Customer Service Department at (608) 828-1301 or (800) 279-1301.

Providers do not have the right to grievances. They can ask for things to be reviewed but not a grievance.



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

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

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

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

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



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

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

Timely Filing (TF) Guidelines for Initial Submission

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

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

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

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

Exceptions to Timely Filing Guidelines on Initial Claim Submission

- Requests for temporary waiver of the TF limit must be made **in advance** due to computer system conversions or other short term circumstances. Such requests may be made, in writing, to the DHI/DHP director of claims.
- Coordination of Benefit (COB) claims must be received within the TF limit outlined in your agreement with DHI/DHP; beginning with the date noted on the primary payor's explanation of benefits.
- Crossover claims are exempt from the filing limit. Crossover claims are those claims that are initially filed with CMS, and forwarded by CMS to DHI/DHP.
- If the provider had difficulty obtaining DHI/DHP coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the DHI/DHP coverage is identified, but not longer than 180 days from the date of service. Provider



shall submit supporting documentation to demonstrate measures the provider has taken to obtain this information. Upon receipt of such information, provider must submit claims and supporting documentation within the filing limit outlined in their agreement.

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

Timely Filing Guidelines for Claim Resubmissions/Corrections

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

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

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

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

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

Exceptions to Timely Filing Guidelines on Claim Resubmissions

- Resubmitted claims as a result of our error can be resubmitted/corrected up to one year after the run date of the Rejected Claims Reports or the EOP date.
- If the provider is hospital-based providers (radiology, anesthesiology, etc.) or is submitting claims for a hospital based provider who must wait for the inpatient discharge of the member, the provider must submit claims within the timely filing limit from the discharge date of the inpatient confinement for DHI/DHP to consider payment.
- The provider discovers new or additional information and requests additional payment on a processed and paid claim. Provider must submit this information within the timely filing limit in order for DHI/DHP to consider additional payment.



- Medical Assistance HealthCheck claims are exempt from the timely filing limit.
- Newborn claims must be received no later than fourteen (14) months from the date of birth.

Confirmation of All Claims Submitted

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

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

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

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

Electronic Claims Transmission (ECT) Confirmation Report

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

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

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

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



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

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

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

The following is an example of our ECT Confirmation Report:

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



Paper Confirmation Report

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

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

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

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

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

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

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



Rejected Claims Reports

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

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

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

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

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

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

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


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

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



Problem Claim Request Form/Claim Resubmission

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



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

Problem Claim Request Form

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

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

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

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

Dean Health Plan, Inc.
I:\Claims\wfiles\form\PrblmClm

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

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



Explanation of Payment

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

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

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

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

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

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



Explanation of Payment – paid service

000008-005-000008

DATE: September 1, 2005

PAGE 1

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

Provider

① FIRST MEDICAL CLINIC
 801 MAIN STREET
 MADISON, WI 53717

② CHECK NUMBER 00000000
 ③ VENDOR NUMBER Z55

④

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

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ OTHER ADJUSTMENTS COB	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	4.30		81.70
PROVIDER TOTALS:		91.00	86.00	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	4.30		81.70

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

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

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



Explanation of Payment – denied service

000008-005-000008

DATE: September 1, 2005

PAGE 1

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

Explanation of Payments
 Provider

① FIRST MEDICAL CLINIC
 801 MAIN STREET
 MADISON, WI 53717

② CHECK NUMBER 00000000
 ③ VENDOR NUMBER Z55

④

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

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

PATIENT: CHRIS K. COOPER	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	0.00	50.00	0.00	(46A NC)	0.00
070505	81000	14.00	14.00	0.00	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	0.00	64.00	0.00		0.00
PROVIDER TOTALS:		64.00	64.00	0.00	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	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

- | | |
|--|--|
| <p>Key:</p> <ul style="list-style-type: none"> 1. Vendor name and mailing address 2. Check number 3. Vendor number 4. Provider number and name 5. Headerline | <ul style="list-style-type: none"> 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

PAGE 1

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

Explanation of Payments
 Provider

① FIRST MEDICAL CLINIC
 801 MAIN STREET
 MADISON, WI 53717

② CHECK NUMBER 00000000
 ③ VENDOR NUMBER Z55

④

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

SERVICE DATE	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	DEDUCTIBLE	COPAYMENT	COINSURANCE	⑤ COB	OTHER ADJUSTMENTS NONCOV WITHHOLD	REMARKS	PAID
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PATIENT: RACHEL HUNTER MEMBER #: 39370838401	⑥	SUBSCRIBER: RACHEL HUNTER SUBSCRIBER #: 39370838401	SUBSCRIBER ADDRESS: 709 PIKE LANE, STOU GHTON, WI 53589 GROUP #: 74671
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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
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 & 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 COB	OTHER ADJUSTMENTS 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	0.00	2.50-	(63C 76)	47.50-
070505	99214	50.00	50.00	0.00	0.00	0.00	0.00	50.00	0.00	(28A FF)	0.00
CLAIM TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-
PROVIDER TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-
VENDOR TOTALS:		0.00	0.00	0.00	0.00	0.00	0.00	50.00	2.50-		47.50-

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

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

⑩ DEAN HEALTH PLAN ADVICE REPORT
FOR VENDOR NUMBER Z55

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

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



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

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. A description in box 19 on the CMS-1500 form is also acceptable.
- Due to the CMS billing form changes we will no longer be able to identify the specific service 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 uses Medicare reimbursement methodology based on the Medicare Physician Fee Schedule Database. This can be obtained through: www.cms.hhs.gov/physicianfeeschedule.

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.

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.



The following pages contain an overview of some of the most common coverages for Dean Health Insurance (DHI)/Dean Health Plan (DHP). These descriptions are intended to provide an overview only and should not be construed as a description of coverage for all members. Please contact our Customer Service Department at (800) 279-1301 for member benefits.

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 \$200. This includes all Coordination of Benefits (COB) claims when the billed amount is more than \$200.
- 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 Service Department at (800) 279-1301. To access the most up-to-date DME policies regarding prior authorization requirements go to:

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Home Health Care

Dean Health Insurance, Inc/Dean Health Plan provides coverage for Home Health Care. A plan Home Health Care provider must establish a "Home Health Care Plan" for the member and approve it in writing. Once the attending physician has approved the "Home Health Care Plan," the services must be prior authorized through DHP Medical Affairs Division. If a non-plan provider is used **the member is responsible for obtaining prior authorization**, as specified by their benefits contract from DHP. Point of Service members are not required to use plan providers.

The attending physician is required to review the "Home Health Care Plan" at least every two (2) months to determine whether less frequent visits are needed.

Home Health Care will not be covered unless the attending physician certifies that:

- Hospital confinement or confinement in a skilled nursing facility would be needed if home health care was not provided.
- The Health Plan member's immediate family or others living with the Health Plan member cannot provide the needed care and treatment without undue hardship.
- A state licensed or Medicare certified Home Health agency or certified rehabilitation agency will provide or coordinate the home care.
- The member is confined to residence;
 - ✓ Unable to leave residence without demanding effort,
 - ✓ Illness or injury restricts ability to leave residence with assistance or special transportation, or
 - ✓ Unable to leave residence without jeopardizing health or condition.



Home Health Care includes one or more of the following:

- Home nursing care is given part-time or from time-to-time. It must be given or supervised by a registered nurse.
- Home health aid services that are given part-time or from time to time. They must be medically necessary as part of the home care plan. They must consist of solely of caring for the patient in a skilled care capacity. A registered nurse or medical social worker must supervise them.
- Physical, respiratory, occupational, and speech therapy.
- Administration of drugs and medicines prescribed by a physician are covered under the pharmacy benefit which cannot be self administered by other caregivers. They are covered to the same extent as if the Health Plan member was hospital confined.
- The assessment of the need for a Home Health Care plan and its development. A registered nurse, physician extender, or medical social worker must do this. The attending physician must ask for or approve this service.
- If a member was confined in a hospital just before care began, the home care plan must be approved, at its start, by the primary provider of care during the hospital confinement.
- Home Health Care benefits are limited to the maximum number of visits in the Health Plan member's Schedule of Benefits. Each period up to four (4) hours within a 24-hour period of home health care services counts as one home health visit.
- All prior authorization guidelines of DHI/DHP must be followed. (These guidelines can be found in the Referral/Prior Authorization Section of this manual.) Please contact our Medical Affair Division by calling (608) 827-4314 or (800) 356-7344 with any further questions.

To access the most up-to-date Home Health policy regarding the prior authorization requirements go to

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Hospice

HMO & POS Policies

All hospice services are 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 Medical Affairs Division by calling (608) 827-4314 or (800) 356-7344 to provide information regarding the member.

To access the most up-to-date Hospice policy regarding the prior authorization requirements go to www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp



Chiropractic Care

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

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

Maintenance Therapy - means ongoing therapy delivered after the acute phase of an illness or injury has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated.

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

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

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 (800) 356-4147 or (800) 356-4053 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.

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 Service Department 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).



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

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Physical, Speech, and Occupational Therapy

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
- Delayed articulatory development
- Delayed language development
- Dysarthria
- Dyslexia
- Dysphagia
- Laryngectomy
- Stuttering
- Tongue thrust
- Voice disorder
- Recurrent otitis medica
- 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.

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 www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Podiatry

Dean Health Insurance/Dean Health Plan provides coverage for Podiatry services when a referral has been obtained to a plan podiatrist. Members with Point of Service are not required to use plan providers.

Podiatry services that are specifically excluded from coverage are:

- Routine examinations, treatments, or removal (paring) of all or part of corns, calluses, hyperplasia of the skin or subcutaneous tissue of the feet.
- Routine foot care including, but not limited to clipping, trimming, and debriding of toenails.
- Hypertrophy of the nails.
- Treatment of flexible flat feet.
- Excision of hyperkeratoses.
- Removing other excrescences.
- Hygienic and preventive maintenance:
 - ✓ Cleaning feet
 - ✓ Soaking feet
 - ✓ Use of skin creams
- Services rendered in connection with the above listed exclusions.



The above procedures may be considered medically appropriate and therefore are covered for members at risk of developing a serious infection.

A letter of medical necessity is required to our Medical Affairs Division for members with a systemic condition or who are at high risk of developing serious infections.

These specific systemic conditions include:

- Alcoholism
- Arteriosclerosis Obliterans
- Amyloid neuropathy
- Buerger's Disease (thromboangiitis obliterans)
- Chronic Thrombophlebitis
- Diabetes Mellitus
- Fabry's Disease
- Malabsorption (celiac disease, tropical sprue)
- Malnutrition (general, pellagra)
- Peripheral Neuropathies
- Raynaud's Disease/Phenomenon (with documented tissue loss)
- Severe deforming arthritis
- Vasculitis
- Long-term oral anticoagulant therapy

Treatment of plantar warts is considered medically appropriate and is a covered benefit.

Orthotics

Foot orthotics are considered medically appropriate (without prior authorization) for the treatment of significant pain or when deformity is present with the following conditions:

- Bunions
- Calcaneal apophysitis
- Cavovarus deformities
- Cavus deformities
- Diabetes mellitus
- Fasciitis
- Flexible flat foot
- Hallux rigidus
- Hallux valgus
- Hammer toes
- Heel spur
- Intractable plantar keratoma
- Metatarsalgia
- Morton's neuroma
- Neurologically impaired feet
- Osteoarthritis
- Patellofemoral syndrome
- Plantar fibromatosis
- Plantar grade metatarsal
- Posterior tibial tendon dysfunction
- Posterior tibial tendonitis
- Post arthrodeses procedures
- Post lower extremity amputations
- Post open reduction internal fixation procedures
- Rheumatoid arthritis
- Rigid Flat Feet
- Scleroderma
- Sesamoiditis
- Stress fracture
- Tarsal tunnel syndrome
- Taylor's bunion
- Tendonitis
- Vascular conditions

Foot orthotics for diagnoses not listed above **require prior authorization** through the Medical Affairs Division with review by a medical director.

Foot orthotics must be supplied by a plan orthopedist, podiatrist, sports medicine specialist, or DME vendor.



The following items are **not** considered medically necessary and therefore are not covered:

- Off-the-shelf foot orthotics
- Foot orthotics for:
 - ✓ Back pain
 - ✓ Calluses
 - ✓ Corns
 - ✓ Knee conditions other than patellofemoral syndrome

Specific member certificate exclusions for foot orthotics are:

- Athletic related conditions
- Work related conditions

Requests to replace medically appropriate foot orthotics (only one orthotic per foot is covered) are considered at 18 month intervals. **All** requests for orthotic replacement within less than 18 months, due to growth or significant modification because of surgery, **require** prior authorization through the Medical Affairs Division.

For members enrolled in a Medicare supplemental plan, foot orthotics are a non-covered benefit.

Custom Molded/Corrective/Therapeutic Shoes

Custom molded shoes are considered medically appropriate **only when** any of the following conditions exist:

- It has been documented that surgery would be prevented.
- There is a patient history of poorly healing foot ulcers.
- Advanced polyneuropathy with high risk of ulceration/infection.
- For children following surgery for the treatment of clubfoot, and
- Shoe modifications such as metatarsal bars, rocker bottoms, and wedges.

Special shoes and shoe modifications are limited to one pair per calendar year. All custom shoes and shoe modifications require prior authorization through the Medical Affairs Division.

Bebax corrective shoes are not considered medically appropriate and therefore are not a covered benefit.

For members enrolled in the DHP Medicare supplemental plans, DHP pays when Medicare also covers a benefit. For DHP Gold members, a provider should follow the benefit coverage found in the DME Regional Carrier Supplier Manual.

All requests for custom molded, corrective, or therapeutic shoes **require** prior authorization through the Medical Affairs Division. **EXCEPTION:** Members on a Medicare supplemental plan are not required to obtain prior authorization.

To access the most up-to-date policies regarding routine foot care, foot orthotics, and corrective/therapeutic shoes go to

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp



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 Medical Affairs Division. The number to call is (608) 827-4053/4147 or (800) 356-7344 ext. 4053/4147.

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 www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

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 DHI/DHP Customer Service 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.

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 members are not required to use a plan provider.)



St. Marys 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. Marys 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 is prior authorized. 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 our Medical Affairs Division. 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 you have any questions about transferring one of your patients, please contact our Customer Service Department 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.

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 ambulance services, please contact our Customer Service Department at (800) 279-1301

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 Service Department 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.

Vision

Dean Health Insurance/Dean Health Plan provides coverage for one routine eye exam per year for those members whose benefit package includes routine vision coverage, if provided by a plan provider. (This may not apply to DHI/DHP Point of Service members.)

The components of a routine eye examination are the medical exam and the refraction.

Senior Select Policies (20000 groups) have routine vision coverage.

Dean Health Plan does not provide coverage for:

- Eyeglasses
- Lenses
- Frames
- Contact lens fitting
- Contact lenses
- Replacement lenses

Exception: Patients who have had cataract surgery may receive one lens per operative eye. Senior Select Plan members may receive one lens per operative eye, as well as one set of frames.

The following coverage guidelines apply for eyeglasses and contact lenses:



DHI/DHP Senior Select Policy Holders (20000 groups)

Dean Health Insurance, Inc/Dean Health Plan covers one contact lens per surgical eye or one pair of eyeglasses per surgery after surgery with insertion on an intracular lens for the following diagnoses:

- Pseudoaphakia (V43.1)
- Aphakia (379.31)
- Congenital Aphakia (743.35)

For patients who are aphakic (diagnosis codes 379.31 and 743.35) and do not have an intracular lens, the following types of lenses are covered:

- Bifocal lenses in frames; or
- Lenses in frames for far vision and lenses in frames for near vision; or
- Contact lenses to be worn for far vision and a set of eyeglasses to be worn at the same time for near vision. A set of eyeglasses to be worn when the contacts have been removed would be covered.

DHI/DHP Non-Senior Select Policy Holders (all other groups)

Dean Health Insurance/Dean Health Plan will cover one contact lens per surgical eye or one pair of eyeglass lenses (excluding frames) per surgery, not to exceed two pair per individual. These services are covered for the following diagnoses:

- Pseudoaphakia (V43.1)
- Aphakia (379.31)
- Congenital Aphakia (743.35)

The following guidelines apply to Senior and Non-Senior policies:

- Refractive lenses are covered when they are medically necessary to restore the vision normally provided by the crystalline lens of the eye or an individual lacking the organic lens because of surgical removal or congenital absence.
- Hydrophilic contact lenses (bandage's lenses) are covered for bullous keratopathy, dry eyes, corneal ulcers, erosion, and keratitis.
- Dean Health Insurance/Dean Health Plan will pay for contact lenses to treat Keratoconus, in an attempt to avoid the need for a corneal transplant. The ophthalmologist needs to submit a letter describing the patient's condition to DHI/DHP for approval.
- Ultraviolet tint is covered when it is medically necessary for the individual patient.

The following items would not be covered because they are either deluxe or not considered medically necessary:

- Photochromatic tint
- Progressive lenses
- Cataract sunglasses purchased in addition to the regular untinted glasses
- Scratch resistant coating
- Deluxe frames
- Saline
- Oversize lenses
- Any other non-medically necessary accessory



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.

- Acupuncture
- Any surgical treatment or hospitalization for the treatment of morbid obesity
- Autopsy
- Batteries for Hearing Aids
- Chelation therapy for atherosclerosis
- Consultation for, or procedures in connection with, in vitro fertilization, embryo transplantation, and/or any other assistive reproductive technique (e.g., GIFT, ZIFT)
- Cranial bands for misshapen heads
- Cytotoxic testing in conjunction with allergy testing
- Donor sperm
- Educational supplies
- Hair analysis (unless lead or arsenic poisoning is suspected)
- Holistic medicine – services or other programs with an objective to provide personal fulfillment
- 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
- Any service where a referral and/or prior authorization was needed and not obtained
- 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
- Treatment for Gambling addiction
- Weight loss programs, including dietary and nutritional treatment
- Work hardening
- Work related preventive treatment (e.g., Hepatitis vaccinations and Rabies vac



Skilled Nursing Facility Prior Authorization Guidelines

HMO (including Medicare Supplemental), DeanCare Gold, POS Policies

Dean Health Plan requires skilled nursing facilities (SNF) to prior authorize **ALL** admissions for DHP members. The SNF should first contact our Customer Service Department to verify a member's benefits. Once the member's benefits have been identified, the SNF will be transferred to the DHP Utilization Management (UM) Division to give notice of the admission.

A SNF is required to notify DHP by telephone or facsimile transmission of any admission of a DHP member within twenty-four (24) hours of the admission. If the admission takes place on a holiday or weekend, notification of the admission must take place by the next business day.

When notifying or requesting prior authorization for an admission to a skilled nursing facility the following information needs to be provided:

- Name and subscriber number of member,
- Proposed date of admission,
- Admitting Physician's name,
- Diagnosis,
- Name of hospital or facility member is currently confined in, if appropriate, and
- Name of contact person to assist in Utilization Management (UM) process.

Once DHP has received a notice of admission, the DHP UM Coordinator, in a consultation with the member's practitioner and SNF, shall determine the appropriate level of care and will authorize the number of days a member shall receive care.

If the DHP UM Coordinator determines that the member's condition does not meet the skilled nursing guidelines, the member and the SNF will receive a notice from DHP. This also applies to members who have Benefit Contracts that extend beyond the maximum allowed Medicare days.

The SNF, after the stay has been approved, will be required to report a member's health status (such as, therapeutic progress, goals, and discharge plans) to the DHP UM Coordinator. As noted in your agreement, more frequent communication may be required between the facility and DHP UM Coordinator, if needed. Based on the update of a member's health status, the DHP UM Coordinator will authorize any changes in the level and/or duration of coverage, as they determine to be necessary.

If the SNF does not obtain prior authorization for the admission, neither the member nor DHP shall be responsible for the services rendered to the member. However, the SNF should contact DHP immediately if the initial notice of admission was not obtained within the required period so



the prior authorization may be issued from the day of notification if the care is deemed skilled and all other guidelines have been met.

If DHP is covering the SNF stay, skilled therapies (physical, occupational, and speech) are included in the reimbursement. Reimbursement for covered SNF stays are outlined in your DHP SNF Agreement.

For a member with Medicare Supplemental or Dean Care Gold, if the care is “skilled”, DHP needs to know when the 100th day of Medicare’s coverage will be reached and which Medicare day the member is currently on. The SNF needs to notify DHP when the member is no longer meeting Medicare coverage criteria. If the care is not skilled, the SNF will need to inform DHP as to the reason why the member is being admitted for care.

All skilled nursing facilities are required to notify DHP when a member is discharged or transferred from the SNF to a hospital, lower level of care, another SNF, or home. If the member is going to receive outpatient services, as directed by the SNF, the SNF must assist in the referral of the member to a Dean Care Gold provider, if the member desires continued payment for services from DHP.

Please contact our Customer Service Department if you have questions in regard to a member’s coverage under Dean Health Plan.



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 Service Department for status of the referral/prior authorization/pre-certification.

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



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 Service Department.

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.

www.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.
- *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 Service Department 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:

- Cardiac Nuclear ETT
- Durable Medical Equipment (DME)
- Drugs
- General Surgery
- Home Health Services
- Hospice Services
- Hospital Admissions
- Occupational Therapy
- Back Pain Invasive Procedures
- Oral Surgery
- PET Scans
- Physical Therapy
- Podiatry
- Respiratory Therapy
- Skilled Nursing Facility/Swing Bed
- Speech Therapy
- Transplants

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

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

This policy applies to initial and interim referrals.



If a physician determines the need for a referral at the time of service, but neglects to complete the Referral Request, a referral will be authorized, given that all referral guidelines have been met. Physician and office errors must be indicated on the Referral Request.

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 **C2300D (Shared Value)**, **C2200 (Enhanced with catastrophic drug coverage)**, **C2200D (Enhanced without catastrophic drug coverage)** or **C1200 (Basic)**.

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 Service Department at (800) 356-7344 or (608) 836-1400.



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.

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.

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, please refer to MP9079 at www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

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 Director of Utilization Management at (608) 827-4169.

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 fax DHI/DHP Utilization Management Coordinator (UMC) a form that request the following required information: When requesting prior authorization, the Home Health provider needs to contact the DHP Customer Service Department to verify benefits. The Home Health provider will then be transferred to the Utilization Management Coordinator, 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
 - ✓ If they are a Wisconsin Educational Association (WEA) Point of Service Member
 - ✓ Diagnosis (ICD-9) – list all applicable diagnosis'
 - ✓ Referring physician
 - ✓ Referring physician's main clinic site
 - ✓ Address, City, St., & Zip
 - ✓ Start date of Care

Once the form is completed and faxed by the home healthcare provider to DHP, a UMC will be designated to receive the form. The UMC will verify the member has coverage with DHP. The authorization will then be approved with the start date of service given by the provider and a stop date of the end of the member's benefit year. **It is essential the provider gives the correct start date for accurate claim payment.**

The DHP UMC will fax back to the home healthcare provider the approved authorization with the UMC signature and the original faxed notification form with the dates of the authorization entered.

Home healthcare providers will manage the care and benefit following DHP contract language regarding medical necessity. No phone calls from providers are necessary to authorize visits. However, the home healthcare providers are encouraged to contact the DHP UMC with questions or to request assistance with a member's situation.

The home healthcare provider will be required to contact DHP UMC if a member uses 20 or more visits so the UMC can offer assistance, as needed. 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 Service Department at (800) 279-1301.

Durable Medical Equipment (DME) and Supplies

All DME and supply items must be obtained through a plan DHP DME provider. Dean Health Plan will not be responsible for any items not obtained through a plan provider. It is the responsibility of the DME supplier to prior authorize services.



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: www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Positron Emission Tomography (PET) Scans Authorization Guidelines

HMO & POS

The newest type of radiographic technique that is being utilized to diagnose members is PET scans. Currently, there is a growing application of PET scans being used to study and diagnose cancer, cardiac applications, lung disease, and in the studies for neurologic application.

Dean Health Insurance/Dean Health Plan has developed the following guidelines in an effort to provide utilization management for PET scans. Dean Health Plan requires **ALL** PET scans to be prior authorized through the Medical Affairs Division.

The following are basic guidelines for the types of PET scans that are covered if prior authorization has been obtained by the plan provider ordering the scan.

- A PET scan to evaluate whether or not an invasive procedure is necessary are considered medically appropriate for staging:
 - ✓ Thyroid Cancer
 - ✓ Esophageal Cancer
 - ✓ Head & Neck Cancer
 - ✓ Breast Cancer
 - ✓ Cervical Cancer
 - ✓ Colorectal carcinomas
 - ✓ Malignant lymphoma
 - ✓ Melanoma
 - ✓ Lung Cancer
- A PET scan for cardiac applications is considered medically appropriate when:
 - ✓ Evaluation of Coronary Artery Disease following an inconclusive SPECT scan (i.e., the results of the SPECT are equivocal, technical unable to interpret, or discordant with a member's other clinical data).
 - ✓ Assessment of myocardial viability prior to revascularization, either as:
 - *A primary or initial diagnostic study, or
 - *Following an inconclusive SPECT scan or nuclear ETT



- A PET scan is considered medically appropriate to determine the likelihood of malignancy in solitary pulmonary nodules after detection by another method (usually Computed Tomography (CT) scan) and when used to plan future management and treatment for the patient.
 - ✓ A PET scan should not be used if a biopsy is planned regardless of the results.
- A PET scan is considered medically appropriate for the initial staging of pathologically diagnosed non-small cell lung carcinoma after a CT scan and pathology report document the presence of a cancer.
- A PET scan is considered medically appropriate for localization of seizure foci in subjects with intractable epilepsy if there is a reasonable chance of avoiding deep electrode study and requires:
 - ✓ Prior authorization through the Medical Affairs Division with:
 - Medical Director review, and
 - A consultation with an appropriate plan Neurologist.

For members enrolled in DHP Medicare supplemental plan, DHP pays when Medicare also covers the benefit.

Dean Health Plan does not consider the following PET scans medically appropriate. Therefore, they are not a covered benefit:

- Whole body PET scans for cancer screenings.
- Using a PET scan for detection or follow-up of ovarian cancer.
- Use of a PET scan for determining the progress of a lung tumor during treatment.

Contact the Customer Service Department with any additional questions in regard to the coverage of PET scans.

For additional guidelines related to the diagnosing, staging, and restaging of specific cancer related diagnoses, reference the medical policies at:

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchresults.asp?txtMedSearch=pet

Cardiac Nuclear Exercise Tolerance Tests (ETT) Authorization Guidelines

HMO & POS Policies

Dean Health Plan requires prior authorization for **ALL outpatient** nuclear ETTs.

The prior authorization process for an outpatient nuclear ETT requires the ordering physician to complete and return a "Prior Authorization Check Sheet." The check sheet has five (5) "yes/no"



questions, which will help DHP to determine if a patient's condition would favor choosing a nuclear ETT over a regular ETT. Most patients without documented coronary artery disease needing an ETT should start with a regular (non-imaging) ETT, rather than a nuclear ETT.

The criteria for approval of a nuclear ETT are as follows:

- Has the patient had a previous MI or previous cardiac catheterization showing coronary artery disease?
- Has the patient had a prior abnormal ECG response to exercise during an ETT?
- Is the patient unable to exercise but still needs an ETT?
- Does the patient also need assessment of left ventricular function (assumes a cardiac echo has not recently been done)?
- Does the resting ECG have any of the following abnormalities:
 - ✓ Electronically paced rhythm
 - ✓ Significant Q waves (at least 0.4 mm wide)
 - ✓ Left bundle branch block (complete or incomplete)
 - ✓ Left ventricular hypertrophy
 - ✓ Resting ST depression greater than 1mm
 - ✓ ST depression and patient on digoxin

The ordering physician should submit the completed check sheet to DHP for approval. This information can be faxed or mailed.

Please note that the facility performing the nuclear ETT has the final responsibility to ensure that prior authorization has been granted. Otherwise, DHP may deny or recoup payment for outpatient nuclear ETTs performed without prior authorization.

Please contact our Customer Service Department for any questions regarding this process or to obtain a "Prior Authorization Check Sheet."

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

www.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 **nonplan 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 Service Department 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 www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp.

Respiratory Therapy HMO & POS Policies

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

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:
 - ✓ Autism and learning disabilities
 - ✓ Attention deficit
 - ✓ Hyperactivity disorder
 - ✓ Sensory defensiveness
 - ✓ Auditory defensiveness
 - ✓ Mental retardation

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.

Miscellaneous Prior Authorization Guidelines

Cosmetic Surgeries

HMO and POS Policies

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

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.

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 Medical Affairs Division at (608) 827-4024 or (800) 356-7344 ext. 4177 to review your case.

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 www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Transplants

HMO

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

POS

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

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.

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. Referral 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.

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.



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 Health Services at (608) 827- 4300.

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:

- 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 Coordinator will return it to the referring physician for completion.**
- Referral/prior authorization requests must be signed by a physician, not a physician assistant or nurse practitioner.
- When a referral/prior authorization is requested to an **adjunctive or non-plan** provider the instruction sheet will assist providers in completing the single page referral form correctly. A **Utilization Management Coordinator** 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.



REQUEST FOR REFERRAL INFORMATION

Tear off “member” information section below and give to member at the time the request for referral to a non network provider is completed

Physician/Office

This “Request For Referral” form is to be used when referring a member for medically necessary services away from their Primary Site/Provider. Please follow the steps outlined below to help avoid delays:

- ✓ This form **must be completed in full**. Attach or document all necessary information that will assist in making a determination.
- ✓ Referrals for 12 month duration are allowed for medically necessary services except physical, occupational, and speech therapy, and certain mental health services.
- ✓ Send the completed form to Dean Health Insurance, Inc./Dean Health Plan at the address listed on the bottom of the form. Requests **must be received in our office within seven (7) days of being written** to avoid possible claim denial(s), and meet our member’s processing expectations. Requests received later than seven (7) days will be considered late.
- ✓ Backdated requests **must indicate whether it is office or member error**. Backdated requests to non-network providers are not allowed.

Member Error Criteria

- Covered benefit.
- Services were provided by a network provider.
- You agree the request is medically appropriate.

Office Error Criteria

- Covered Benefit
- Services were with a network provider
- Member was referred by you, however paperwork was not submitted.
- ✓ Referral Requests to non-network providers are considered only when requested services are not provided within our plan provider network. All requests for services with non network providers require prior authorization and must be approved in writing by Dean Health Insurance, Inc./Dean Health Plan prior to the member receiving services. Call Dean Health Insurance, Inc./Dean Health Plan Customer Services if you need to determine the participation status of the physician/facility.
- ✓ **Requests for urgently needed services with a non-network provider can be faxed to (608) 836-6516 for review.**
- ✓ All necessary labs, X-rays or other diagnostic testing needed either prior to or after the visit should be performed within the plan network. **Results should be sent with member. If the consultant(s) needs to order tests to complete the evaluation, they will be informed of the need to contact the Utilization Management to obtain approval before providing these services.**
- ✓ Requests for 2nd opinion are approved with network providers. **Request for 2nd opinion with non-network providers will be considered for approval if the services are not available within the network. If approved, approval will be for one (1) visit, for physician services only.**

Dear Dean Health Plan/Premier member:

You have been referred to a healthcare practitioner outside of your primary care site.

For a Dean Health Plan Practitioner - you receive services for covered benefits without prior approval from Dean Health Plan.

For a non Dean Health Plan Practitioner - You MUST OBTAIN WRITTEN APPROVAL from Dean Health Insurance, Inc./Dean Health Plan **before you receive services to receive coverage for this requested referral. We will mail a copy of your processed request within one (1) working day following our receipt of all necessary information needed to reach a decision.** If more than five (5) working days have passed since your referral was written, you may contact our Customer Service Department at (800) 279-1301 between the hours of 7:30 AM to 5:00 PM, Monday through Thursday, Fridays between 8:00 AM to 4:30 PM regarding the status of your referral. For TDD assistance, call 608-827-4086.



Dean Health Plan

a subsidiary of Premier Medical Insurance Group

1-800-279-1301 (Phone) 608-828-1301 (Phone) 608-836-6516 (FAX)



Referral Request Form* (Outpatient Services Only)

*Requests to non-plan providers must be approved by the Referral Department prior to obtaining services.

Patient Name: _____

Referring Physician: _____

Referred To Provider: _____

Alternate Facility _____ Provider # _____

Authorization Number _____

Date: _____

DOB: _____ Benefit Package _____

Member # _____

Yes No – Advanced Directive on File

Physician Signature Required _____

Telephone # _____ Provider # _____

Specialty _____ Telephone # _____

Provider # _____ Provider Status _____

Is this related to a third party liability? W/C MVA Other DX code required: _____

of visits _____

Duration: _____ From _____ To _____

Diagnosis: _____

Service Requested: _____

••• Approval expires when the visit limit or time limit is reached – which ever occurs first.

If referring to non-plan provider – list plan specialist seen: _____

- Approved request does not authorize payment of non-covered or exhausted benefits.
- You have a right to appeal this decision. Please refer to your member certificate or plan summary document which outlines the procedure or call the Customer Service Department at -800-279-1301/828-1301 for assistance. For TDD assistance 608-827-4086.

HEALTH PLAN USE ONLY

Approved Approved with Modification Not Approved Denied Written Treatment Plan Requested

Processed By: _____ Date: _____

Comments: _____

Service Class _____ Hold Code _____ Place of Service _____ Auth _____

Payment Level _____

MAIL TO: DEAN HEALTH PLAN, INC./PREMIER REFERRAL DEPARTMENT
BOX 56099, MADISON, WI 53705

2011-1199

The "Health Plan Use Only" section on the Referral Form is completed by Dean Health Plan Referral Specialists only.



Dean Health Plan Pharmacy Communications

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

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

Pharmacy and Therapeutics Committee

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.

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.

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

If you have any questions, please contact Thomas Hirsch, MD, MS at (608) 827-4244 or thomas.hirsh@deancare.com

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, to register for this service and to download the DHP Formulary.

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.**



Drug Prior Authorization Process

Dean Health Plan (DHP) Pharmacy Department does not accept drug prior authorization requests by paper, fax or voicemail **from provider sites that have NaviNet™ availability**. Please call NaviNet™ Customer Care at (888) 482-8057 if you are having difficulties with the NaviNet™ drug prior authorization system, require retraining or if you have application questions.

Providers who do not have access to Dean Health Plan NaviNet are to take advantage of DHP's fax or voice mail lines for submitting drug prior authorizations requests.

The drug prior authorizations should be faxed to (608) 827-7535 or via verbal request through the DHP prior authorization voice mail line (608) 827-4156 or (800) 356-7344, ext. 4156.



Dean Health Plan, Inc.
PO Box 56099 • Madison, WI 53705
1-800-279-1301 • 608-828-1301 • Fax: 608-827-7535

Drug Prior Authorization Request Form

Patient Name
Address
City State Zip

Member #	Person Code	
Group Number	Plan Type	SEX M <input type="checkbox"/>
Date of Birth		F <input type="checkbox"/>

MD Name (please print)
Clinic Name/Mailstop
Address
City, State, Zip

MD Telephone #	Date
MD Fax #	
Physician Signature:	

Drug Name	Strength	Directions for Use	Quantity

Diagnosis for which the drug is prescribed

Describe the clinical condition that relates to the drug requested. List all medications used to treat this condition, the dosage, the dates given, and the outcome:	<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuing	Estimated Duration of Therapy

DATA INTAKE FORMS are available for most prior authorized drugs. ALL the information on the data intake forms must be included with the prior authorization request.
(Do Not Write In the Space Below)

- Approved – Effective Date: _____ Expiration Date: _____
- Denied:
- Exceeds benefit limitations
- Not a covered benefit
- Doesn't meet medical criteria: _____
- Explanation: _____
- Other: _____
- Redirected to Formulary Alternatives such as: _____
- Comments: _____
- Quantity is limited to _____ capsules/tablets per copay.
- DHP's criteria for this medication is included for physician review

Date: _____ Authorized Signature: _____



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, 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
Customer Service	Call Dean Customer Service (608) 828-1301 or (800) 279-1301	Call Navitus Customer Service (920) 225-7010 or (866) 333-2757
ID Cards	One ID Card for both Medical and Pharmacy	Two ID Cards Dean : Medical ID Card Navitus: Pharmacy ID Card
Mail Order	Mail order is available for selected groups through WellDyne www.WellDyneRx.com	Mail order is available through WellDyne www.WellDyneRx.com
Prior Authorizations	May submit via DHP's NaviNet™	Prior authorization forms on Web site www.navitus.com DHP's NaviNet™ cannot be used for this population Unique prior authorization list. Associated criteria
On-Line Formulary	Dean Formulary: www.deancare.com	Navitus Formulary: www.navitus.com
Epocrates with Formulary	Dean Formulary: Register at www.epocrates.com More information is available in provider newsletters.	Navitus Formulary: Register at www.epocrates.com Also available on the Navitus Website.



Other Helpful Information Relating to the Pharmacy Section

- 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.



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

Overall Care Management Program Summary

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

The DHP Care Management Department includes the following:

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

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

Utilization Management Program

Hours of Operation

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

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

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

Program Purpose

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



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

Program Objectives

- A. Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards.
- B. Monitor potentially avoidable admissions and develop appropriate mechanism to address identified areas of concern;
- C. Focus inpatient review activities on problem areas determined by appropriate data sources;
- D. Trend and monitor data to identify areas of possible over and under utilization. Areas may include but are not limited to procedure utilization, pharmacy utilization (certain medications and classes of medications), ER utilization, inpatient utilization, laboratory utilization, and physician practice utilization;
- E. Assess provider satisfaction with Utilization Management activities and address areas of provider dissatisfaction when appropriate;
- F. Assess member satisfaction with Utilization Management activities and address areas of member dissatisfaction when appropriate;
- G. Integrate Utilization Management with Disease and Case Management as appropriate when identified during UM activities;
- H. Monitor and analyze variations in the delivery of care in the network for which evidence based standards of appropriate care exist, and consider opportunities for the Utilization Management programs that will improve quality of care and reduce medical costs;
- I. Implement or maintain policies and procedures in accordance with applicable regulatory and accreditation requirements and standards;
- J. Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence;
- K. Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness;
- L. Maintain a process to ensure that relevant information is collected to review medical necessity requests for coverage;



-
- M. Utilize qualified health professionals to assess the clinical information used to support UM decisions;
 - N. Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations of coverage in accordance with federal and state requirements, and accreditation standards;
 - O. Provide access to staff for members and practitioners seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers;
 - P. Implement and maintain mechanisms for objective and systematic monitoring, evaluation, and improvement of UM processes and services;
 - Q. Implement and maintain mechanisms and policies and procedures that assist in monitoring the quality of utilization management decisions. These mechanisms include but are not limited to: inter-rater reliability and manageability, case audits and the identification of potential adverse events.

Scope of the UM Program

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

A. Major Categories of UM

The scope of UM activities include the following major categories:

1. Concurrent Review and Evaluation/ Discharge Planning
 - Hospital inpatient admissions
 - Skilled Nursing Facility (SNF) care and rehabilitation
 - Home healthcare
 - Hospice
 - Behavioral health outpatient care/AODA services
3. Retrospective Review
 - Hospital inpatient admissions
 - Skilled Nursing Facility care
 - Home healthcare
 - Hospice
 - Behavioral health/AODA services
 - Ambulatory care
4. Referral Management/Prior Authorization
 - Plan ambulatory care



- Out-of-plan care
- Behavioral health/AODA services
- Home healthcare
- Hospice
- Durable medical equipment (DME)
- Targeted Utilization Reporting
- Prior Authorization

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

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

B. Quality of Care Monitoring

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

Clinical Indicators

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

Service

- Member satisfaction surveys
- Practitioner satisfaction surveys



C. Quality Assurance

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

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

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

Quality Assurance review monitors care delivered in the following areas:

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



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

Program Authority and Responsibility

A. Program Authority

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

B. Program Responsibility

Utilization Management

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

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

UM Committees

1. Medical Peer Review Committee

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



2. Utilization Management Committee

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

3. Pharmacy and Therapeutics Committee

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

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

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

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

Utilization Management (UM) Criteria

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

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

Review Criteria and Guidelines

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

A. Milliman Care Guidelines



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

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

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

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

B. Medicare Coverage Guidelines

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

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

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

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

D. American Society of Addiction Medicine (ASAM) Criteria

ASAM is utilized to guide medical appropriateness decisions related to substance abuse diagnoses, primarily for inpatient care and determination of appropriate level of care. These



criteria may also be used to determine the need to transition care to a different level. All coverage determinations are the responsibility of DHP. All clinical care decisions are strictly and solely the obligations and responsibility of the behavioral health care provider. The ASAM criteria are used for the following types of services which include but are not limited to:

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

E. Dean Health Plan Medical Policies

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

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

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

Evaluation of Medical Technologies

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

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

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

Utilization Management for Pharmacy

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

Specific UM Methods

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

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

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

A. Concurrent Review

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

1. Utilization Issues

The following are reviewed concurrently by the UM Department staff:

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

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

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

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

All plan hospitals are contractually required to notify the UM Department of a DHP member's admission by the next business day. The member is not financially responsible for non-covered days if this notification does not take place. However, for emergency or approved admissions to non-plan



facilities, the member is responsible for assuring that notification takes place within the next business day, or as soon as practical (in case of an emergency admission).

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

2. Quality of Care Issues

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

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

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

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

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

B. Discharge Planning

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

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

C. Retrospective Review

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

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



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

Retrospective review may be performed for the following:

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

D. Referral Management/Prior Authorization

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

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

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

For more specific details regarding Referral Management and Prior Authorization, refer to the Prior Authorization Referral section of the Skilled Nursing Facility Manual.

E. Denial Process

Denials occur under the following circumstances:

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

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

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

F. Appeal Process

1. Members



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

2. Practitioners

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

Please refer to Grievance 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 2nd Qtr 2010)**

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

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

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



severity of symptoms. This may result in daily contact in times of high risk or concern. If home care or other services are needed in high risk-cases, the disease/case manager works with the practitioner and appropriate agencies to coordinate the necessary care and services.

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

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

DHP's Disease Management Program elements include:

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

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

Statement of Confidentiality

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

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

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.



Skilled Nursing Facility and Rehabilitation Center Standards of Participation

Dean Health Plan requires the following standards be met for accredited skilled nursing facilities and rehabilitation centers to receive approval and to continue participation as a Plan Facility.

Licensure

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

Medicare/Medicaid Sanctions

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

Most Recent Quality Indicators Report

- The Facility must provide a current OSCAR (Online Survey Certification And Report) and a recent Quality Indicator Profile, developed by Center for Health Systems Research and Analysis (CHSRA).

Malpractice Liability Insurance

- The facility must acquire and maintain adequate malpractice liability insurance.

Accreditation

- The facility must be accredited by an appropriate nationally recognized accreditation agency [i.e. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities or (CARF)].

Dean Health Plan requires the following standards be met for non-accredited skilled nursing facilities or rehabilitation centers to receive approval and to continue participation as a Plan Facility.

Licensure

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

Medicare/Medicaid Sanctions

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



Malpractice Liability Insurance

- The facility must acquire and maintain adequate malpractice liability insurance.
- The facility must supply Dean Health Plan with a written job description/contract of the SNF/RCs Medical Director.

Most Recent Quality Indicators Report

- The Facility must provide a current OSCAR (Online Survey Certification And Report) and a recent Quality Indicator Profile, developed by CHRSA.

Governing Body

- The facility must provide a written description of the defined level of responsibility of the governing body or designated party who functions as the governing body, as it relates to the operation of the facility.

Administrator

- The facility must provide Dean Health Plan with the name and job description of the facility's Administrator.

Medical Director

- The facility must supply Dean Health Plan with a written job description/contract of the Skilled Nursing Facility/Rehabilitation Center's Medical Director.

Medical Staff Service Plan

- The facility will need to provide Dean Health Plan with a written copy of the facility's medical staff service plan that includes the process for verifying the credentials of all licensed and certified staff who provide services to members.

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

All licensed and certified staff must have at least the following verifications completed (where applicable): Active state license.

- Criminal background check.
- Nursing aide registry.
- Medicare/Medicaid Sanctions

The Dean Health Plan Quality Improvement Department may review a sample of the records verifying the credentials of licensed and certified staff.

Quality Assurance Plan

- The facility is required to provide Dean Health Plan with a written copy of the facility's Quality Assurance Process description including:
- Monitoring and evaluating quality of care and services.
- Documenting and investigating complaints and grievances.



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- Communicating and reporting all results to its governing body.
 - Identifying and documenting actions taken per deficiency.

Medical Records

- Dean Health Plan requires copies of the facility's policies and procedures documenting medical record keeping practices, verifying that:
 - Medical records are maintained for every patient admitted for care, and
 - That the facility has written policies and procedures for collection, storage and use of medical records to safeguard against loss, destruction or unauthorized use.
- Interdisciplinary Care Planning: Dean Health Plan requires a written description of the interdisciplinary care planning process to ensure that there is a cost-effective and appropriate internal process for attaining and maintaining the highest practical physical, mental, and psychological well being for each resident.

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

- Patient identification on each page of the record
- Identification/summary sheet
- Results of any pre-admission screening conducted by the state
- Physician documentation
- Nursing service documentation
- Ancillary service records, i.e. social service, activities, rehabilitation services, dietary assessment, diagnostic services
- Plan of care
- Authorization or consent
- Discharge or transfer of records



Hospital Quality Assurance Review

Dean Health Plan's Utilization Review Coordinators review hospital records for quality assurance issues. Once a week, cases with potential quality assurance issues are presented to Dean Health Plan's Utilization Review Committee.

Dean Health Plan's Utilization Review Committee is comprised of four physicians, the Utilization Review Coordinators, the Concurrent Review Supervisor, and the Quality Improvement Analyst.

The Utilization Review Coordinators present the cases with all identifiable information blacked out, i.e., patient, physician, and facility name. This ensures an unbiased review for all involved. The physicians review the Health Plan's patient control form and ask pertinent questions before they decide whether there is or is not a potential quality assurance issue involved. If there is a potential quality assurance issue, the case will be assigned to one of the following categories:

- a. Quality Assurance Issues which the Health Plan wishes to monitor. No investigation is performed; this category is for monitoring only.
- b. Quality Assurance Issues which the Health Plan wishes to refer to an outpatient setting for monitoring; i.e., clinic.
- c. Quality Assurance Issues which the Health Plan wishes to refer to the hospital.

In the case of outpatient or hospital issues, the facility's Quality Assurance Committee is informed in writing of the case which requires review. The facility is asked to respond to the Dean Health Plan Quality Assurance/Utilization Review Committee with their findings and actions. The physician who is responsible for the potential quality assurance issue is informed in writing that an investigation is being performed.



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 located in the Member Certificates.

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

Complaint

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

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

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



Grievance

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

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

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

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

Independent External Review

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

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

1. The amount of the total claim liability must exceed \$250.
2. Unless the reason for an independent external review is urgent, the request must be submitted to us in writing and the request must include:
 - a. The name of the certified Independent Review Organization (IRO).
 - b. A \$25 fee payable to the IRO you have chosen
You can obtain a list of the certified IRO's by calling our Customer Service Department at (608) 828-1301 or (800) 279-1301, or by contacting the Office of the Commissioner of Insurance at (608) 266-3585, or (800) 236-8517, or by accessing their Website at: www.oci.wi.gov.
3. The request for an independent external review must be made within four months of the date of the completion of the grievance process.



4. You must exhaust all appeal/grievance options before requesting an independent external review. However, if we agree that the matter should proceed directly to independent review, or if you need immediate medical treatment and believe that the time period for resolving an internal grievance will cause a delay that could jeopardize life or health, you may ask to bypass our internal grievance process. In urgent and emergent situations, your request will be processed on an expedited basis.

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

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

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

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

Urgent Grievance

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

Office of the Commissioner of Insurance

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

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

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



Provider Appeals Process

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

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

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

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

Timely Filing Appeals

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

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



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



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

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

Dean Health Plan's Member Privacy Policy

Protecting the Privacy of Personal Health Information

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

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

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

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



How Does DHP Protect This Information?

We limit the collection of nonpublic personal information to that which is necessary to administer our business, provide quality service, and meet regulatory requirements.

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

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

How may DHP Use or Share Your Information?

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

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

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



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.