Dean Health Plan by Medica

DEANCARE GOLD MANUAL

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Changes are periodically made to the information in this manual.

OVERVIEW OF COVERAGE

WHAT IS DEANCARE GOLD?

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

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

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

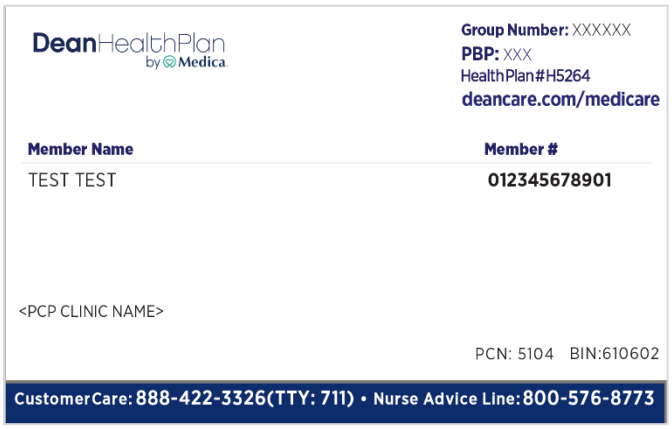
DEANCARE GOLD SERVICE AREA

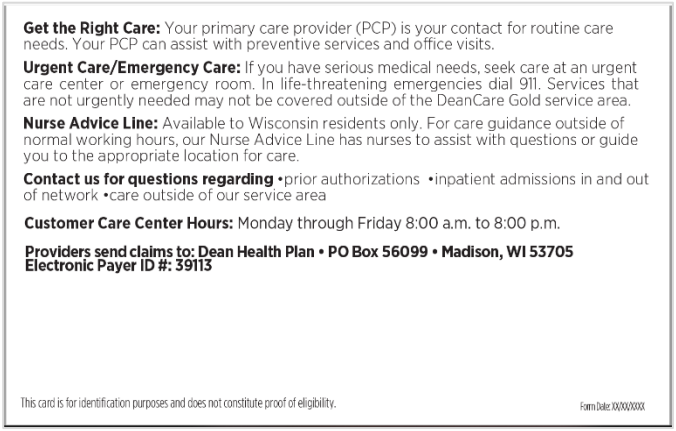
The following counties are included in the DeanCare Gold service area:

- **Columbia**
- **Dane**
- **Dodge**
- **Grant**
- **Iowa**
- **Jefferson**
- **Rock**
- **Sauk**

All ZIP codes are included for each county listed above

DEANCARE GOLD ID CARD





FRONT **BACK**

AUTOMATIC ASSIGNMENT OF PRIMARY CARE PRACTITIONER

If a member does not designate a PCP site and/or practitioner, Dean Health Plan will automatically assign one based upon the member's residence. In these situations, Dean Health Plan will send a letter to the member informing them of the PCP site or practitioner assigned. If the member has additional questions, the member can contact Customer Care Center at (888) 422-3326.

DEANCARE GOLD BENEFIT OVERIEW

Please see the following for the overview of benefits: deancare.com/Medicare/members/

This is a brief summary of exclusions for the Shared, Basic, and Enhanced Plans. Please contact Dean Health Plan Customer Care Center if you have questions on any services or procedures not listed in this manual.

SUMMARY OF EXCLUSIONS

Services not covered by Medicare	Not covered under any	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare.	√	
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		√ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.
Private room in a hospital.		√ Covered only when medically necessary.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	√	
Full-time nursing care in your home.	√	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	√	
Fees charged for care by your immediate relatives or members of your household.	√	
Cosmetic surgery or procedures.		√ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings, or dentures.		√ Up to two routine preventive dental exams and cleanings and 1 x-ray are covered in-network annually. (Enhanced and Shared Value members only.)
Non-routine dental care.		√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care.		√ • Manual manipulation of the spine to correct a subluxation. • Medically necessary routine chiropractic services are covered *(for Shared Value and Enhanced Plans*).
Routine foot care.		√ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Home-delivered meals.	√	
Orthopedic shoes.		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet.		√ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids.		√ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Our plan pays up to $250 every 2 years for eyeglasses, frames, lenses, and contact lenses. Our plan also covers one routine eye exam every year. *(Enhanced and Shared Value Plans Only.)*
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture.		√ You may claim reimbursement for up to $100 in total combined services annually for acupuncture services, gym memberships, and weight management program fees such as Weight Watchers under the WIN program. Meals and food are not included.
Naturopath services (uses natural or alternative treatments).	√	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

COMMUNICATING WITH DEAN HEALTH PLAN

DEAN HEALTH PLAN REGULATORY COMPLIANCE DEPARTMENT

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

DEANCARE GOLD CONTACTS

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

CUSTOMER CARE CENTER	
Customer Care Center Department Monday – Thursday 7:30 am to 5:00 pm Friday 8:00 am to 4:30 pm	(888) 422-3326 | (888) 422-3326
Operator	(608) 836-1400 | (608) 356-7344
Dean On Call	(608) 250-1393 | (800) 57-NURSE (800) 576-8773
CARE MANAGEMENT	
Utilization Management	(608) 827-4455 | (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) 827-4432 (800) 356-7344, ext. 4432
Information Systems for Electronic Claims Transmission	dhpedi@deancare.com
DRUG PRIOR AUTHORIZATIONS	
Dean Health Plan Drug Prior Authorizations	(608) 828-1301 | (800) 279-1301
Drug Prior Authorization Fax	(920) 735-5350
Navitus Health Solutions	(866) 333-2757 (toll free)
Dean Health Systems Website	deancare.com
Address	Dean Health Plan P.O. Box 56099 Madison, WI 53705

PROVIDER NETWORK CONSULTANT TERRITORY ASSIGNMENTS

Please see deancare.com/providers for most up-to-date service area listing.

REIMBURSEMENT

MEDICARE CODING REQUIREMENTS

Dean Health Plan requires that all providers follow Medicare's coding requirements when billing for covered services under the DeanCare Gold plan. Refer to the Dean Health Plan Provider Manual "Claims Coding Process" section for information on coding guidelines. Please find the most current information on code editing on www.deancare.com/providers/code-review/.

PHYSICIAN INCENTIVE PLANS

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

PRACTITIONER REIMBURSEMENT

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

Dean Health Plan is primary for the following services; claims should be submitted to Dean Health Plan:

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

Medicare is primary for the following services; claims should be submitted to the carrier:

- All facility services except non-covered services (hearing aids, for example)
- Out-of-area services that do not have an authorization (emergency, urgent, etc.)
- DME claims from HHU
- Home health
- Home therapy (PT/OT/ST in home setting)
- Hospice
- ESRD – Dialysis or infusion therapy

CLAIMS AND TIMELY FILING

Refer to Dean Health Plan Provider Manual "Claims, Timely Filing, and EOP" section.

AUTHORIZATION PROCESS

PRIOR AUTHORIZATION PROCESS

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

Dean Health Plan has reduced the prior authorization requirements for members enrolled in the Gold plan. The following services **do not** require prior authorization:

- Prior authorization to Gold in-plan providers for services covered by Medicare
- Prior authorization of outpatient Medicare covered services when provided by an in-plan provider
- Inpatient admissions to Gold in-network hospitals for services that are covered by Medicare
- DME covered by Medicare obtained from a Gold in-network DME provider
- Emergency care and out-of-area urgent care.

The following services **require prior authorization:**

- All skilled nursing facility admissions
- Elective admissions to non-plan facilities
- Services provided by non-contracted providers (i.e., any provider who is not listed in the Gold Provider Directory).

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

PRIOR AUTHORIZATION SUBMISSIONS

ELECTRONIC

If you are a Dean Health Plan Provider Portal-enabled office for prior authorization submission, all prior authorization request submissions are sent to Dean Health Plan electronically via Dean Health Plan's Provider Portal (deancare.com/providerportal). You will receive the response to your request electronically within Dean Health Plan's Provider Portal. The member and servicing physician will receive Dean Health Plan's response via written correspondence.

If you are not a Dean Health Plan Provider Portal-enabled office for prior authorization submission, you must complete and submit the Dean Health Plan Prior Authorization Form (http://www.deancare.com/providers/medical-management/) by fax to the Dean Health Plan Utilization Management Department at 608-252-0830.

PAPER/FAX

Prior Authorization requests that need to be submitted on paper have different forms based on the type of service that is being requested. Please follow the guidelines below for submission:

- The Prior Authorization Request Form can be found on the Dean Health Plan Medical Management page at: deancare.com/providers/medical-management.
- Prior authorization forms should be faxed the date the request has been completed to ensure timely processing of the request.
- When submitting the form to Dean Health Plan, please complete ALL fields on the top part of the form in their entirety. If all of the required fields on the Prior Authorization Request Form are not completed, the Dean Health Plan Utilization Management Department will return it to the referring physician for completion.
- Prior authorization requests must be faxed to (608) 252-0830.

PRIOR AUTHORIZATION PRIORITIES AND TURNAROUND TIME

Dean Health Plan will follow CMS-mandated priorities and turnaround times for prior authorizations. The priority of your prior authorization request must be indicated during the authorization submission process. If you are submitting the authorization electronically, you must choose the applicable prior authorization priority in the field titled "Priority." If you are submitting your authorization on paper, please check the applicable box at the top of the prior authorization form.

- **Medically Urgent/Expedited**
  A prior authorization request should be submitted as Expedited if the physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be completed as expeditiously as the enrollee's health condition might require, but no later than 72 hours after receiving the prior authorization request.

- **Non-Urgent/Standard**
  A prior authorization request should be submitted as Standard in any scenario where the request is for routine services that do not meet the definition of an Expedited request. Standard requests will be completed as expeditiously as the enrollee's health condition might require, but no later than 14 calendar days after the date the organization receives the request for standard organization determination.

HOSPITAL ADMISSIONS

If care meets the Medicare definition of emergency, prior authorization is not necessary to treat or admit.
Prior authorization for planned hospital admissions in a Gold in-network plan hospital is not necessary when Medicare is the primary insurance.

Planned admissions to non-plan hospitals **require prior authorization** and are reviewed for medical necessity and appropriateness of site.

SECOND AND THIRD OPINIONS

Gold members are allowed to get a second and third opinion from Gold plan providers without authorization. Requested second and third opinions from non-contracted providers require prior authorization and will be reviewed by a Dean Health Plan Medical Director for determination.

FEDERAL REGULATIONS

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

COMPLAINT/APPEALS PROCEDURES

MEMBER COMPLAINT, APPEAL, AND GRIEVANCE PROCEDURES

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

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

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

60 DAY APPEAL PROCESS

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

- Mail a written request to: Dean Health Plan, Attn: Appeals, P.O. Box 56099, Madison, WI 53705, the local Social Security Administration Office, or if a member is a railroad annuitant, with the Railroad Retirement Board.
- Fax the request to Dean Health Plan at (608) 252-0812. If a member is in a hospital or a nursing facility, please provide assistance in having the written appeal transmitted to Dean Health Plan by fax.
- The member may hand deliver the request to Dean Health Plan, 1277 Deming Way, Madison, WI 53717.

Dean Health Plan will provide a response to an appeal request within 60 days of the receipt of the appeal.

72 HOUR APPEAL PROCESS

(Does not apply to denials of payment)

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

- File an oral or written request for a 72-hour appeal which specifically states that the member wants an expedited appeal, fast appeal, or 72-hour appeal, or that the member believes that their health could be seriously harmed by waiting 60 days for a normal appeal.
- File an oral request by calling 1-800-422-3326; Dean Health Plan will document the oral request in writing.
- Hand deliver the request to Dean Health Plan, 1277 Deming Way, Madison, WI, 53717.
- Fax the request to (608) 252-0812. If the member is in a hospital or a nursing facility, please provide assistance in having the written appeal transmitted to Dean Health Plan by Fax.

- Mail a written request to Dean Health Plan, Attn: Appeals, P.O. Box 56099, Madison, WI, 53705. However, the 72-hour review time will not begin until the request for appeal is received.
- Members may contact Customer Service with any questions at 1-888-422-3326.

14-DAY EXTENSION

An extension of up to 14 calendar days is permitted for a 72-hour appeal, if the extension of time benefits the member (e.g. if the member needs time to provide Dean Health Plan with additional information or if Dean Health Plan needs to have additional diagnostic tests completed). Dean Health Plan will make a decision on the appeal and notify the member of that decision within 72 hours of receipt of the request. However, if the decision is not fully in the member's favor, Dean Health Plan will automatically forward the appeal request to CMS's contractor for an independent review. CMS's contractor will send a letter with their decision within 10 working days of receipt of the case from Dean Health Plan.

SUPPORT FOR THE APPEAL

Members are not required to submit additional information to support the request for services or payment for services already received. Dean Health Plan is responsible for gathering all necessary medical information. However, it may be helpful to the member to include additional information to clarify or support the appeal, such as medical records or physician opinions in support of their appeal. Medical records should be obtained via written request from the PCP. If medical records from specialist physician(s) are not included in the PCP's medical records, a separate written request to the specialist physician(s) who provided medical services may need to be made. Dean Health Plan will provide an opportunity for the member to provide additional information in person or in writing.

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

WHO MAY FILE AN APPEAL

- The member may file an appeal.
- If a member wants someone to file an appeal on their behalf:
    - Give Dean Health Plan the member's name, Medicare number, and a statement which appoints an individual as the member's representative. (Note: Any provider may be appointed.)
    - For example: "I [member name] appoint [name of representative] to act as my representative in requesting an appeal from Dean Health Plan and/or CMS regarding Dean Health Plan's (denial of services or denial of payment for services)."
    - The member must sign and date the statement.
    - The member's representative must also sign and date this statement.
    - Include this signed statement with the appeal.
    - Failure to include the required signatures and dates in an appeal may result in a delay of the appeal or dismissal of the appeal to the CMS contractor.

- A Non-plan provider may file a standard appeal of a denied claim if they complete a waiver of liability statement which says they will not bill the member regardless of the outcome of the appeal.
    - Failure to include the required waiver of liability statement may result in a delay of the appeal or dismissal of the appeal to the CMS contractor.

- A court appointed guardian or an agent under a health care proxy, to the extent provided under Wisconsin law.

HELP WITH THE APPEAL

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

FORMAL GRIEVANCES

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

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

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

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

FINAL APPEAL OF GRIEVANCE DECISION

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

URGENT CARE COMPLAINT, APPEAL, OR GRIEVANCE

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

OFFICE OF THE COMMISSIONER OF INSURANCE

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

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