



# PROVIDER MANUAL

January 2024

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# REVISION LOG

Updates are regularly made to the information in this manual. The grid below outlines changes that have been made to the manual from its immediate predecessor version. Refer to the [Historical Revision Log](#) as a reference to past revisions.

Description of Change	Link	Page
<b>Added:</b> Information regarding new payer ID 41822		All
<b>Added:</b> Customer Service IVR information <b>Updated:</b> Customer Care Phone Numbers	<a href="#">Directory</a>	6
<b>Updated:</b> Dean Health Plan’s relationship with Medica.	<a href="#">About Dean Health Plan</a>	8
<b>Updated:</b> Provider information components to ensure current and accurate provider information is in the Provider Directory.	<a href="#">Provider Changes for Directory Accuracy</a>	10
<b>Updated:</b> Sample member ID card images for IFB product	<a href="#">Examples of Member Identification Cards</a>	20
<b>Updated:</b> Sample member ID card image for the Medica SSM Employee Health Plan.	<a href="#">Examples of Member Identification Cards</a>	22
<b>Updated:</b> Health Plan Provider News as a monthly newsletter.	<a href="#">Health Plan Communications for Providers</a>	26
<b>Updated:</b> Credentialing processes	<a href="#">Credentialing Processes</a>	28
<b>Added:</b> Availity Essentials Portal for payer ID 41822	<a href="#">Provider Portal</a>	29
<b>Updated:</b> Case management information throughout to reflect current program offerings and contact information	<a href="#">Case Management</a>	73
<b>Updated:</b> Contact information for Grievance and Appeals	<a href="#">Member Grievance and Appeals Process</a>	78

# WELCOME!

Welcome to the Dean Health Plan provider network. Thank you for participating in our network of physicians, clinics, hospitals, and other healthcare professionals. We are delighted to work with you. As an in-network provider, you are part of our comprehensive network that encourages patients to seek their health care locally and will be listed in our online Provider Directory easily accessible to members from the Find a Doctor link located at the top of [Dean Health Plan web pages](#). You also have access to our [Provider Network Consultants](#) who are personnel dedicated to supporting our in-network providers.

## ABOUT THIS MANUAL

### **Not an in-network provider, but would like to become one? \***

The information in this Provider Manual is applicable to in-network providers contracted with Dean Health Plan to provide services to Dean Health Plan members. Request to join the network by submitting our online Provider Network Application, located at the bottom of the Dean Health Plan Providers page at [DeanCare.com/Providers](#). Our Provider Network Services team contacts interested providers upon receipt of the request.

This Dean Health Plan Provider Manual is a resource for policies and practices for claim submission and procedural expectations to support in-network providers serving patients enrolled in Dean Health Plan benefit plans. It also includes important phone numbers, website URLs, and references to provider resources and how to access them. This manual is intended to be an extension of the provider contract. As such, providers should also refer to their contract agreement, the member's benefit certificate, summary plan description, medical policy, and applicable state and federal laws for specific coverage information.

Dean Health Plan began transitioning to a new claims processing platform in January 2024. As a part of this multi-year migration, payer ID 41822 was created to gradually transition our business to this new platform by member plan type. The information in this manual is meant to apply broadly across all plans and payer IDs, but will indicate when different processes are required based on the use of payer ID 41822 or 39113, the payer ID used most commonly in our legacy business platforms. Beginning with our Individual and Family Business (IFB/ACA plans) on January 1, 2024, those that have transitioned to our new claims platform and processes will utilize payer ID 41822. Plans utilizing legacy payer ID 39113 and Dean Administrative Services Only (ASO) payer ID 75261 will remain the same, using processes and resources that were effective prior to January 1, 2024. New plan types set to make the transition and use payer ID 41822 will be broadly announced and documented.

Dean Health Plan offers separate, supplemental provider manuals for certain products such as Dean (MA) Advantage, Dean Administrative Services Only (ASO), DeanCare Gold (Cost), and Dean Health Plan BadgerCare Plus. These provider manuals are cited in the "[Products](#)" section of this manual when available and can be consulted for additional product specific detail.

Please note that the processes outlined in this and our supplemental manuals apply to Dean Health Plan Networks  
\*These processes do not apply or carry over to our affiliate Medica, with a home office in Minnetonka, MN.

Updates to this manual are made on a regular basis. New changes that have been made to the manual from its immediate predecessor version are documented in the Revision Log. Refer to the [Historical Revision Log](#) as a reference to recent past revisions.

Providers are strongly encouraged to refer to the online version of this manual to ensure they have the most current information.

## TIPS ON NAVIGATING THE MANUAL

### **Clarification of Terms**

In this manual, “you,” “your,” “practitioner,” or “provider” refers to any healthcare provider subject to the information in this manual, including physicians, healthcare professionals, facilities, and ancillary providers, except when indicated otherwise.

“We” and “our” refers to the health plan.

“Members” and “patients” refer to individuals enrolled in Dean Health Plan benefit plans.

### **Finding Information**

The Table of Contents links to the applicable section within the manual. To search using a specific keyword:

1. Select CTRL+F.
2. Type in the key word.
3. Click Enter.

### ***We are here to help!***

If you have questions about information in this manual or can't find the information that you are seeking, please refer to the directory on the next page to contact the appropriate department or to access the applicable resource. When in doubt, please don't hesitate to contact our Customer Care Center using the phone number on the member ID card.

# DIRECTORY

<b>CUSTOMER SERVICE</b>		
Dean Health Plan Commercial	(608) 828-1301	(800) 279-1301
Dean BadgerCare	(608) 828-1301	(800) 279-1301
Dean Gold (Medicare Cost) & Dean Select		(888) 422-3326
Dean MA (Medicare Advantage)		(877) 232-7566
Dean Health Plan IFB/ACA after 1/1/2024	800-458-5512	(877) 379-7605 VDN 29598
Dean IFB/ACA prior to 12/31/2023		(800) 279-1302
Medica Employee Health Plan		(833) 942-2159
SSM Employee Health Plan		(877) 274-4693
Dean ASO		(877) 234-4516
Hours of Operation: Monday – Thursday 7:30 am to 5:00 pm Friday 8:00 am to 4:30 pm		
Operator — Callers enter an extension, or during business hours get an operator, and are routed to Customer Care.	(608) 836-1400	
<b>Nurse Advice Line &amp; Language Assistance</b>		
Nurse Advice Line — Dean Health Plan Commercial/MAPD/IFB/Gold/Select	(800) 576-8773	(800) 57-NURSE
Nurse Advice Line – SSM Health Employee Plan & Medica Employee Health Plan	(833) 925-0398	
Language Assistance Line for In-Network Providers Available 24 hours a day, 7 days a week	(844) 526-1386	
<b>HEALTH SERVICES</b>		
Utilization Management	(608) 827-4455	(800) 356-7344 ext. 4455
Point of Service Prior Authorizations	(608) 836-1400	(800) 356-7344 ext. 4455
Care and Disease Management	(866) 905-7430	
Care and Disease Management Fax Number	(952) 992-3589	
<b>CLAIMS</b>		
Claims Manager	(608) 827-4432 (800) 356-7344, ext. 4432	
Information Systems for Electronic Claims Transmission	• <a href="mailto:dhpedi@deancare.com">dhpedi@deancare.com</a>	
<b>ELECTRONIC DATA INTERCHANGE</b>		
Information about Electronic Data Interchange (EDI) transactions	• <a href="#">HIPAA transactions web page</a> • <a href="mailto:edi@deancare.com">edi@deancare.com</a>	
Electronic Payor ID	39113	
Electronic Payer ID	41822	
<b>DRUG PRIOR AUTHORIZATIONS</b>		
Dean Health Plan Drug Prior Authorizations	(608) 828-1301	(800) 279-1301
Drug Prior Authorization and Reconsiderations Fax	(855) 668-8551	
Navitus Health Solutions	(866) 333-2757 (toll free)	
Drug Denial Appeals – Non-MAPD (Formulary, Non-Formulary, Medical Injectables)	608-252-0812	
<b>WEBSITES AND MAILING ADDRESSES</b>		

Dean Health Plan Website	<a href="http://DeanCare.com">DeanCare.com</a>
Navitus Pharmacy Benefits Website	<a href="http://Navitus.com">Navitus.com</a>
Address – Dean Health Plan by Medica Hub	Dean Health Plan PO Box 56099 Madison, WI 53705
<b>PROVIDER NETWORK CONSULTANTS</b>	
Find the assigned Provider Network Consultant by specialty. If the specialty does not have a designated Provider Network Consultant, contact the Provider Network Consultant by county.	Go to <a href="http://DeanCare.com/Providers">DeanCare.com/Providers</a> and scroll to the bottom of the web page.

## Customer Care Center IVR

For plans under our new payer ID 41822, we are implementing an automated phone system technology, Interactive Voice Response (IVR). The IVR system offers 24/7 self-service for member eligibility, benefits, or claim status information through pre-recorded prompts, and menu options. You'll always have the option to exit the IVR and speak with a live call agent during business hours. To utilize the IVR system have the following information ready:

- Organization 9-digit tax ID number
- Member's Group and ID numbers for 2024.

# ABOUT DEAN HEALTH PLAN

Headquartered in Madison, WI, Dean Health Plan was established in 1983 and joined the SSM Health system in 2013. SSM Health is a St. Louis-based order which also owns several hospitals nationwide. In 2021, SSM Health formed a strategic partnership with Medica, an independent, non-profit health plan headquartered in Minnetonka, MN. This affiliation brings Dean Health Plan into the Medica family, reflected in our Dean Health Plan by Medica logo design. The Medica family includes Medica headquarter in Minnetonka, MN, as well as Prevea360 Health Plan and Medica Health Plan, previously WellFirst Health with coverage in southern Illinois, Missouri and select areas in Oklahoma.

Dean Health Plan provides access to high-quality providers through a network of clinics, hospitals, and health care partners. Dean Health Plan maintains an Integrated Delivery Network (IDN) relationship with SSM Health, providing compassionate care through SSM partners including, but not limited to, Dean Medical Group, SSM Health Davis Duehr Dean Eye Care, and SSM Health Hospitals including SSM Health St. Mary's Hospital – Madison, SSM Health St. Mary's Hospital – Janesville, and SSM Health St. Clare Hospital – Baraboo.

## HEALTH EQUITY AND DEAN HEALTH PLAN

Health equity means that every person has the opportunity to be as healthy as possible. As a health plan, we recognize that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. In support of this, Dean Health Plan espouses the [National Standards for Culturally and Linguistically Appropriate Services \(CLAS\) in Health and Health Care](#) to advance health equity and help eliminate health care disparities.

Understanding and implementing the National CLAS Standards ensures higher quality care to all patients. Dean Health Plan expects all network providers to support health equity standards and deliver honest, unbiased, and respectful care regardless of a patient's race, ethnicity, language, sexual orientation, or gender identity.

Dean Health Plan encourages providers to collect information regarding a patient's race, ethnicity, preferred language, sexual orientation, and gender identity to ensure health care services are meeting the multi-cultural needs of that individual. Requests for this information should be conducted respectfully in a sensitive and unbiased manner that also upholds a patient's privacy.

For more information, trainings, and other resources regarding health equity, please visit [Dean Health Plan's Cultural Awareness & Health Equity web page](#).

### ***Language Line***

To address diverse language needs and enable important communications between providers and patients, Dean Health Plan offers a free telephonic Language Line for language assistance/interpreter services. The Language Line is available to in-network providers who do not have access to language assistance services and need to interact with Health Plan members who have limited English language proficiency.

Providers may request language assistance by calling 844-526-1386, available 24 hours a day, 7 days a week. See the Language Line Instructions on the Cultural Awareness web page for more information on how to use the service.



# VISIT OUR WEBSITE

Dean Health Plan offers provider information and resources from the Providers home page. This page is directly accessible at [DeanCare.com/Providers](https://DeanCare.com/Providers) or by hovering over **For Providers** located on the top, right of the screen and clicking **Provider Home**.

For the SSM Employee Health Plan and the Medica Employee Health Plan, use the Provider home page located at [MO-Central.Medica.com/Providers](https://MO-Central.Medica.com/Providers).

DeanHealthPlan  
by Medica

Find a doctor ▾ Shop plans ▾ Members ▾ Medicare ▾

Type to search. 🔍

LOGIN

⚠️ Dean Health Plan is now Dean Health Plan by Medica.  
There's no change to your Dean Health Plan benefits, providers, or ID card. New name, same great coverage! You may see both logos for a time as we complete the brand change.

Home / Providers

## Providers

By working together, we can deliver an exceptional and well-coordinated health care solution for your patients' medical and financial needs.

- Provider portals**  
Log into any of the provider portals you need.  
[GO TO PORTALS](#)
- Manuals**  
Discover more information about policies and procedures that affect claim submission.  
[SEE MANUALS](#)
- Medical management**  
Gain access to our medical policies and prior authorization requirements.  
[FIND OUT MORE](#)
- Forms**  
Browse, download and print the forms you need for your patient, billing, claims or credentialing.
- Code review**  
Research information about policies and procedures that affect claim submission. See [outpatient facility](#) and [provider](#).
- Provider news**  
Learn all the latest Dean Health Plan news for health care providers.
- Helpful links**
  - [COVID-19 health plan information for providers](#)
  - [Medical policies](#)
  - [Drug policies](#)

# PROVIDER NETWORK SERVICES

Dean Health Plan's Provider Network Services' main purpose is to support in-network providers. This includes maintaining provider files, administering the provider contracting process, updating provider manuals, and issuing [provider communications](#). These processes or contract designations do not apply or carry over to our affiliate Medica, with a home office in Minnetonka, MN.

## PROVIDER NETWORK CONSULTANTS

The Provider Network Services Department includes our Provider Network Consultants (PNCs), who are responsible for educating all existing and new in-network Dean Health Plan providers. Provider education includes:

- Updating our providers on new policies and procedures distributed via email, the monthly [Provider News](#) newsletter, provider mailings, or workshops.
- Orientations for new practitioners and facilities.
- Ongoing education for network providers such as processes for day-to-day interaction with the health plan.

Go to [DeanCare.com/Providers](https://DeanCare.com/Providers) and scroll to the bottom of the web page to find the Provider Network Consultant for your specialty. If your specialty does not have a designated Provider Network Consultant, contact the Provider Network Consultant for your county.

## NETWORK SETUP AND PROVIDER STATUS

Dean Health Plan is a closely managed health maintenance organization (HMO) comprised of contracted in-network providers to provide health care services to our members. In order to provide quality coverage and cost savings to our members, there are two distinct statuses for providers based on how they are contracted with Dean Health Plan:

- **Plan** — primarily referred to as an in-network provider in this manual. This is a provider with a “Plan” status who is contracted as an in-network Dean Health Plan provider who can provide health care services to Dean Health Plan members and is listed in our provider directory.
- **Non-Plan with Agreement** — primarily referred to as an out-of-network provider in this manual. This is a provider with a “Non-Plan with Agreement” status who is contracted to provide services to Dean Health Plan members. However they are not considered to be a “Plan” or in-network provider due to their specific contract language. These providers require a prior authorization to be submitted to the Health Plan by an in-network provider on their behalf for approval before providing services to Dean Health Plan members. (Unless the member has a PPO or POS plan – then an authorization is only needed if the service requires authorization).

Providers contracted with Dean Health Plan may only be allowed to provide care to Dean members for specific products, practitioners, services, and/or locations. It's important for providers to be familiar with their provider agreement and always check member eligibility prior to providing services in order to prevent claims payment issues.

A non-plan/non-contracted provider is an out-of-network provider that does not have a signed contract with Dean Health Plan. The Health Plan has no liability or responsibility for the quality of care provided by an out-of-network provider.

Out-of-network providers can [request to join the Dean Health Plan network](#) by completing and submitting the online Provider Network Application.

# PROVIDER CHANGES FOR DIRECTORY ACCURACY

We are committed to ensuring that our provider directories are accurate and current for the members who rely on this information to find in-network providers for their care. Additionally, the Centers for Medicare & Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories.

To help accomplish this, providers must notify their Provider Network Consultant of any updates to their information on-file with us as soon as they are aware of them. Notify your assigned Provider Network Consultant if there are changes to the following data elements:

Practitioner Data Elements	Location Data Elements
Practitioner Name	Location Name
Degree/Title	Address
Specialty	Phone Number
Ability to Accept New Patients	Handicap Accessible
Board Certification	Website URL
Gender	Accepted Plan Types at Location
Language(s) Spoken by Practitioner	Language(s) Spoken at Location
Telehealth Available <ul style="list-style-type: none"> <li>○ Telehealth Optional / Telehealth Only</li> <li>○ Modalities (chat, phone &amp; video)</li> <li>○ 3<sup>rd</sup> Party Caregiver</li> </ul>	Handicap Accessible
Language(s) Spoken by Practitioner	Services
Participating Hospital Affiliation(s)	
Practice Locations	

On a quarterly basis, outreach is provided by our vendor BetterDoctor requesting providers to validate their information on-file with us is current and accurate. Providers should not wait for these reminders to update their information with the Health Plan.

Providers must notify the Health Plan of terminations for individual practitioners, clinics, facilities, and any other locations under an organization. Communicate the termination in writing to your assigned Provider Network Consultant with as much advance notice as possible.

As we prepare our provider directories to accommodate additional information for our in-network providers and additional requirements in the future, please review your directory information regularly at [DeanCare.com/Find-A-Doctor](http://DeanCare.com/Find-A-Doctor) to verify it reflects current and accurate information for you and your organization.

Providers are encouraged to review and update their National Plan and Provider Enumeration System (NPPES) information when they have changes. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format. NPPES data serves as an important resource to improve provider directory reliability and accuracy.

# REQUESTING TO JOIN THE NETWORK

Providers can request to join Dean Health Plan's network of contracted providers by completing and submitting our online Provider Network Application, located at the bottom of the Dean Health Plan Providers page at [DeanCare.com/Providers](https://DeanCare.com/Providers).

Our Provider Network Services team contacts interested providers upon receipt of the request. Requests are reviewed internally by Dean Health Plan and may take extended time to review and make a determination. The determination will be communicated to you by the [Provider Network Consultant](#).

Providers are not considered in-network providers until they have satisfied all credentialing requirements, completed the credentialing process (whether at the organization or practitioner level), have a signed agreement, and are configured in Dean Health Plan's system. Once these are all completed, the provider will be notified, generally via email, of the date they are approved to begin providing services to Dean Health Plan members and submit claims for these services. For information on credentialing and recredentialing, refer to the [Credentialing Process](#) section in this document.

# REQUESTING A NEW PRACTITIONER, LOCATION, OR SERVICE

In-network providers must formally request new practitioners, office or practice locations, and services/specialties through their assigned [Provider Network Consultant](#) in writing. Requests should be communicated and submitted **in advance** to your assigned Provider Network Consultant, whose information can be found at [DeanCare.com/Providers](https://DeanCare.com/Providers) by scrolling to the bottom of the web page.

The request process is as follows:

1. Provider requests a new practitioner, location, or specialty in writing to their Provider Network Consultant. Providers should also specify if the new practitioner is replacing a practitioner in the organization. If so, include the practitioner's name, specialty, degree, and term date in the request.
2. The Provider Network Consultant may require the provider to provide additional information or documentation, which will then be submitted to Dean Health Plan for review.
3. Dean Health Plan reviews and makes a determination on the request:
  - If denied:
    1. The Provider Network Consultant will notify the provider of the denial. Denials remain on file for 12 months and therefore providers must wait for that time period before submitting a new request.
  - If approved:
    1. The Provider Network Consultant will notify the provider of the approval and instruct on whether the new practitioner must undergo credentialing.
      - If credentialing is not required, the new practitioner's credentialing effective date is the same as the notification date.
      - If credentialing is required, the new practitioner will receive a credentialing application to complete and submit.
        - The new practitioner cannot provide services to Dean Health Plan members until their credentialing is approved.
        - No retroactive effective dates are granted.
    2. The new practitioner will be notified once credentialing is successfully passed, and they can begin providing services to Dean Health Plan members and claims can be submitted for the new practitioner, location, or service.

## ***Mid-Level Practitioners and Locum Tenens Physicians***

The Dean Health Plan network is composed of many practitioner types, including locum tenens physicians and physician extenders/mid-level practitioners such as nurse practitioners (NP/APNP) and physician assistants (PA/PA-C).

- Mid-level practitioners and locum tenens physicians are required to complete the credentialing process.
- DHP requires in-network providers to send **advance** notification of the need for a locum tenens physician. Please contact your Provider Network Consultant to request a locum tenens physician and their expected time coverage.
- Mid-level practitioners must have a supervising physician. When requesting a mid-level practitioner, please include the supervising physician's name, degree, specialty, and practice location.

## ***Replacement Practitioner***

If requesting a practitioner who will be replacing an existing practitioner who is terming from your organization, please ensure the terming practitioner's name, specialty, degree, and term date is included in the request.

# ORGANIZATION AND PRACTITIONER UPDATES

It is important to report organization and practitioner changes to Dean Health Plan. Failure to do so may impact claims processing and payments. Report any of the following changes or updates to your assigned Provider Network Consultant for your organization with as much **advance notice** as possible to avoid claims payment issues:

## ***Practitioner-Related***

- Name change
- Adding or discontinuing specialty
- Moving locations – including when moving to another in-network organization
- Hospital affiliations
- Leave of absence, vacation, or extended leave
- Medicare certification/decertification (claims will not be retroactively paid)
- Terminating from your organization (see next section)

## ***Organization-Related***

- Name change
- Accreditation or decertification
- Billing information (TIN or NPI)
- Taxonomy
- Physical change to billing or practice location addresses on file with Dean Health Plan
- Selling or transferring ownership
- Clinic closure
- Facility handicap accessibility
- Website URL

# PRACTITIONER TERMINATIONS

Providers must notify their patients in writing in advance when terming from an organization. Notifying Dean Health Plan of practitioner terminations is also required, as Dean Health Plan adheres to the state statute for Continuity of Care. Please communicate any practitioner terminations in writing to your Provider Network Consultant with as much **advance notice** as possible (minimum of 30 days prior to the termination), and include the following info:

- Practitioner name and degree
- Practice location(s)
- Termination date
- Reason for termination (i.e., moving to a new practice, retirement, etc.)
- Where the practitioner will be providing services (if still actively practicing)
- A copy of your member notification letter communicating the practitioner's termination

# FACILITY TERMINATIONS OR CLOSURES

Providers must notify their patients in writing in advance if a site is closing permanently. Notifying DHP of clinic or practice site terminations/closures is necessary, as Dean Health Plan adheres to the state statute for Continuity of Care. Please communicate any in-network clinic terminations or closures in writing to your Provider Network Consultant with as much **advance notice** as possible (minimum of 60 days prior to the termination), and include the following info:

- Location name
- Address
- Termination date
- If practitioners at that site are moving to another location
- A copy of your member notification letter communicating the termination/closure

## OTHER SITUATIONS

Please communicate the following situations to your Provider Network Consultant in writing:

- Leave of Absence/Vacation: when a practitioner will be out of the office, vacationing, or on extended leave, and another facility or location will be covering their practice. Dean Health Plan requires **written** notification to include:
  - Name
  - Location
  - Duration of the covering practitioner or facility

The covering practitioner must be an in-network **provider** and have completed the credentialing process.

- Panel Status: when a practitioner finds it necessary to discontinue accepting new patients or limit their practice. This update must be received to the Provider Network Consultant in writing. This does not apply to practitioners who are with a Dean Medical Group site.

## PROVIDER SERVICE OBJECTIONS

Providers in the Dean Health Plan network who refuse to provide a service to members based on moral or religious objections must notify their Provider Network Consultant in writing of the objection and its basis in a timely manner. Dean Health Plan will notify the member so that the member can seek another like in-network provider that is available to provide the service in question.

## TERMINATION OF PATIENT/PRACTITIONER RELATIONSHIP POLICY AND PROCEDURE

In-network providers are required by Dean Health Plan to send copies of member termination of care notification letters to their assigned Provider Network Consultant.

Practitioners may terminate a member's care only with good cause. The following are examples of good cause, in which 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 Dean Health Plan 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 refused to cooperate with the practitioner, was non-compliant with medical care, or there was a breakdown in the practitioner-patient relationship.
- Failed to attend or late-cancel three or more scheduled appointments after having received a written warning.
- Communicated to the practitioner that they would like to select a different practitioner.

*Note:* this process applies to members with commercial policies, including State of Wisconsin and federal employees. If the member is a recipient of Medicaid or BadgerCare, contact the Dean Health Plan Medicaid Member Advocate.

### **The following should be included in the termination of care letter, per Dean Health Plan guidelines:**

1. Member's full name, including middle name (not just initial)
2. Member's date of birth (optional)
3. Member's address, which can be in address line
4. Clinic/facility name
5. Practitioner name
6. Notice in the body of the letter stating that the member may see the practitioner for 30 days from the date the member received the termination notice if the member presents for urgent or emergent care
7. Reason for the termination
  - If reason is due to the member missing or late-canceling appointments, include when their initial warning letter was sent to them

- If reason was due to non-payment, include proof of attempts to collect payment
8. Dean Health Plan's Customer Care Center phone number using the phone number on the member ID card
    - If the member is under the Dean (MA) Advantage plan, please call 877-232-7566 in lieu of the listed number above.
  9. Copy of a patient authorization form, as the member may want to transfer care to a different clinic/facility



# 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. Please note that sample ID cards are provided when available, but this manual does not contain every possible variation.

- **Dean HMO** is a group plan based on the philosophy of a managed care organization – a primary care provider oversees all aspects of an individual's health care needs, both for regular check-ups and for emergency or extended care needs. Members are expected to receive their care using the physicians listed in our extensive provider directory. Specialty care is also coordinated through the primary care provider, thus leaving members virtually free from paperwork and claims to file. [See a sample Member ID card for this product.](#)
- **Dean Point of Service (POS)** not only offers HMO coverage, but also a more flexible benefit package to members that chose not to select a primary care provider. This gives members the option to see in-network Dean Health Plan providers as well as out-of-network providers.  
**Note:** In some instances, POS product information is different from other products and is indicated in this manual where applicable. However, this information should not be used as a description of specific coverage or policy. Please also refer to the medical management information and the member benefit certificate for health plan policies, requirements, and member coverage.
- **Individual Family and Business(IFB)/ACA On-and-off exchange Plan** is for individuals who do not have health insurance coverage through an employer. Dean Health Plan offers multiple plans with a variety of deductible and benefit levels to meet an individual's needs. [See a sample Member ID card for this product.](#) As of 1/1/2024 these plans will use payer ID 41822.
- **Dean Preferred Provider Organization (PPO)** is for employer groups who have employees living outside of the Dean Health Plan service area and therefore may not have nearby access to the Dean Health Plan provider network. To provide Dean PPO members access to local, regional, and national provider networks, Dean Health Plan contracts with wrap network First Health. First Health has a robust network of physicians and facilities outside of the Dean Health Plan service area. Dean Health Plan PPO member ID cards have both the Dean Health Plan and First Health logos. [See a sample Member ID card for this product.](#)  
**Note:** In some instances, PPO product information is different from other products and is indicated in this manual where applicable. However, this information should not be used as a description of specific coverage or policy. Please also refer to the medical management information and the member benefit certificate for health plan policies, requirements, and member coverage.
- **Dean Focus Exclusive Provider Organization (EPO)** is a narrow network product limited to members residing in Dane, Sauk, Dodge, Green, Rock, and Fond du Lac counties. The Dean Health Plan network for this product is Dean Medical Group providers and SSM Health St. Mary's Hospital - Madison, SSM Health St. Mary's Hospital - Janesville Hospital, and SSM Health St. Clare Hospital – Baraboo along with the necessary specialty providers required to cover the full realm of health care services. Members must receive their services from in-network providers. The member ID card lists the network as "Focus."  
**Note:** In some instances, Focus product information is different from other products and is indicated in this manual where applicable. However, this information should not be used as a description of specific coverage or policy. Please also refer to the medical management information and the member benefit certificate for health plan policies, requirements, and member coverage.
- **Dean Administrative Services Only (ASO)** is a self-funded insurance arrangement whereby an employer provides benefits to employees with its own funds. This is different from fully insured plans where the employer contracts an insurance company to cover the employees and dependents. In self-funded health care, the employer assumes the direct risk for payment of the claims for benefits. The terms of eligibility and covered benefits are set forth in a plan document which includes provisions similar to those found in a typical group health insurance policy.

Refer to the [Administrative Services for Plan Providers](#) web page for more ASO information including links to medical policies and the *Dean Administrative Services Only (ASO) Provider Manual*. These plans utilize payer ID 75261.

**Note:** In some cases, self-funded ASOs employer groups are not required to follow State or Federal health care mandates. Therefore, Dean ASO self-funded employer groups policies may be different from those for other products. Please contact the Customer Care Center at 877-234-4516 or online at [deancare.com/contact-us/contact](https://deancare.com/contact-us/contact) to obtain coverage information for a specific employer group.

- **DeanCare Gold** is a Dean Health Plan “Cost” plan for Medicare-eligible members residing in Columbia, Dane, Dodge, Grant, Iowa, Jefferson, Rock, and Sauk County who are already enrolled in DeanCare Gold. There are no new enrollments allowed for the DeanCare Gold Plan and no reinstatements to the plan if a member chooses to disenroll from the DeanCare Gold plan. At this time, and until further notice, DeanCare Gold will continue to be supported for existing members who continue to pay premiums and live in an eligible service area. [See a sample Member ID card for this product](#). Refer to the *Dean Care Gold Provider Manual* for rules, processes, and resources specific to this product that may differ from those in this provider manual.
- **Dean Advantage Medicare Advantage** plans offer an “all-in-one” alternative to Medicare Part A and Medicare Part B, often referred to as Original Medicare. Dean Advantage plans are Medicare-approved replacement products that include Medicare Part A and Part B benefits plus additional value-added coverage and supplemental benefits, all bundled into a single, convenient plan. Dean Advantage is available to eligible Medicare beneficiaries residing in Columbia, Dane, Dodge, Fond du Lac, Green, Iowa, Jefferson, Rock, and Sauk County. [See a sample Member ID card for this product](#). Refer to the *Dean Health Plan Medicare Advantage Provider Manual* for Medicare Advantage rules, processes, and resources that differ from those for Commercial products.
- **Dean Health Plan Select plans** are Medicare Supplement plans for Medicare-eligible members residing in eligible service areas. Dean Health Plan no longer offers Select plans to new enrollees but does support them for current enrollees. Because Select plans are Medicare supplement plans, claims for Select enrollees must be submitted to Medicare first. After Medicare has determined that the service(s) are covered and has paid their portion of the claim, a claim can be submitted to Dean Health Plan for adjudication of the remaining balance.
- **BadgerCare Plus** is a state-sponsored program that provides health care 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
  - Young 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
- **Dean Health Plan BadgerCare Plus** is an HMO product that follows most of the HMO guidelines, however, not all BadgerCare Plus members are enrolled in HMOs. Some members are enrolled in straight Medicaid or Fee-for-Service (FFS), where they have access to any Medicaid (BadgerCare Plus) enrolled provider. Dean Health Plan BadgerCare Plus HMO product is currently available in Columbia, Dane, Dodge, Fond du Lac, Green, Adams, Lafayette, Iowa, Jefferson, Rock, Sauk, Green Lake, Juneau and Marquette counties. Please refer to the *Dean Health Plan BadgerCare Plus Provider Manual* for Advantage rules, processes, and resources.
- **Medica SSM Health Employee Health Plan (previously WellFirst Health)** is a product that is available to SSM Health employees and their dependents in Illinois, Missouri, Oklahoma, and Wisconsin. In Wisconsin, Medica leverages the Dean Administrative Services Only (ASO) network for both Medica and SSM employer groups. Dean ASO providers in Wisconsin are to refer to the policies and procedures in this Dean Health Plan Provider Manual and use Dean Health Plan resources for this product. These plans continue to use payer ID 39133 after January 1, 2024.

**Note:** The Medica SSM Health Employee Health Plan is not the same as the self-funded [Dean Administrative Services Only \(ASO\) product](#), detailed in the beginning of this section, that Dean Health Plan offers to other employer groups.

- **Medica Employee Health Plan** is the product for Dean Health Plan employees, who are now under the blanket of Medica employees, in Wisconsin that became effective January 1, 2023. (*SSM Health employees* are covered under the Medica SSM Health Employee Health Plan, detailed above.) Policies and procedures in this Dean Health Plan Provider Manual apply to the Medica Employee Health Plan, unless otherwise noted. [See a sample Member ID card for this product.](#)
  - Timely filing limits and rates of reimbursement in new and existing provider contracts apply to the Medica Employee Health Plan.
  - Providers verify member eligibility, submit authorization requests and claims, verify claim acceptance and claim status, and receive payments for services delivered to Medica Employee Health Plan enrollees in the same way they do for the SSM Health Employee Health Plan and Dean Health Plan Commercial plans.
  - Dean Health Plan and Medica branded policies, medical management, and procedures apply to this product, unless otherwise noted.
  - For Medica Employee Health Plan members in Wisconsin, ‘Dean ASO’ is listed as the plan network in the provider portal eligibility application and the 271 Eligibility and Benefit Response transaction.
  - Decision notices are branded as Medica, including those from our authorization vendors (e.g., Navitus, NIA Magellan).
  - Payments for services to Medica Employee Health Plan enrollees are issued separately from other lines of business.

## AUTOMATIC ASSIGNMENT OF PRIMARY CARE PROVIDER

Members enrolled in an HMO benefit plan have access to providers in the Dean Health Plan provider network and choose a primary care provider from the network to manage their care. If a member does not designate a primary care provider 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 assigned primary care provider site or practitioner. Members can contact the Customer Care Center at the phone number on the member ID card with questions..

Members enrolled in a POS or PPO benefit plan have access to providers in the Dean Health Plan provider network, but also have the option to go outside of the provider network for primary or specialty care. A prior authorization maybe required for certain services. Members incur higher out-of-pocket costs if they choose to pursue care under the POS benefit, but have more flexibility for their care.

# EXAMPLES OF MEMBER IDENTIFICATION CARDS

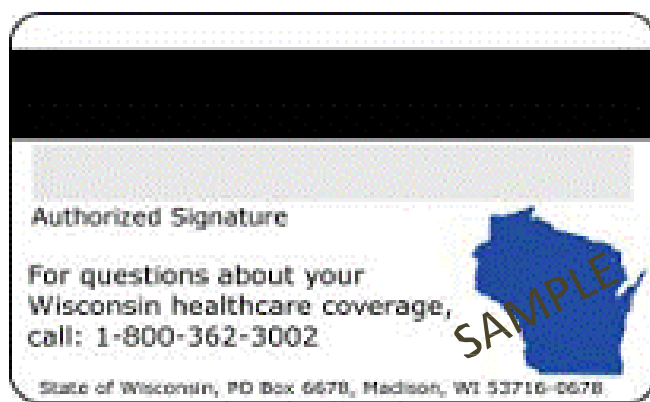
## BADGERCARE PLUS IDENTIFICATION (ID) CARD

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.

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 that 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 ForwardHealth Member Services at 800-362-3002, also listed on the back of the member ID card, shown below, for replacement cards.



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Dean Health Plan does not issue members a separate Dean Health Plan-branded member ID card; the ForwardHealth card serves as their member ID card.

## MEMBER IDENTIFICATION CARD EXAMPLES

Dean Health Plan member ID cards are differentiated per product and network type (such as HMO, POS, or FOCUS). Members who have a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount also have their deductible/coinsurance maximum amount listed on their member ID card, as shown in the member ID card image for Commercial and ACA on the following page.

The member ID card images shown on the following pages are provided as examples only. Member ID cards vary and may differ from the images shown.

# COMMERCIAL HMO ID CARD



**Network:** Dean  
**Group Number:** XXXXXXXXXXXX  
**Product Type:** HMO  
**deancare.com**

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

**Deductible\*:** Individual \$XXXXX Family \$XXXXX  
**Ded/Coinsurance Max\*:** Individual \$XXXXX Family \$XXXXX  
**Out of Pocket Max\*:** Individual \$XXXXX Family \$XXXXX

PCN: 5104 • BIN: 610602

**Customer Care: 800-279-1301 (TTY: 711) • Nurse Advice Line: 800-576-8773**

**FRONT**


**Get the Right Care:** Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

**Urgent Care/Emergency Care:** If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

**Nurse Advice Line:** Available to Wisconsin residents only. For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.

**Contact us for questions regarding** • prior authorizations • inpatient admissions in and out of network • care outside of our service area and help finding a First Health provider.

**\*Please refer to your plan materials for your additional financial responsibility.**  
**Providers send claims to: Dean Health Plan • PO Box 56099 • Madison, WI 53705**  
**Electronic Payer ID #: 39113**



This card is for identification purposes and does not constitute proof of eligibility. Form Date: XX/XX/XXXX

**BACK**

# POS ID Card



**Network:** Dean  
**Group Number:** XXXXXXXXXXXX  
**Product Type:** POS  
**deancare.com**

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

**In/Out Network Deductible\*:** Individual \$XXXXX Family \$XXXXX  
**In/Out Network Ded/Coinsurance Max\*:** Individual \$XXXXX Family \$XXXXX  
**In/Out Network Out of Pocket Max\*:** Individual \$XXXXX Family \$XXXXX

PCN: 5104 • BIN: 610602

**Customer Care: 800-279-1301 (TTY: 711) • Nurse Advice Line: 800-576-8773**

**FRONT**


**Get the Right Care:** Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

**Urgent Care/Emergency Care:** If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

**Nurse Advice Line:** Available to Wisconsin residents only. For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.

**Contact us for questions regarding** • prior authorizations • inpatient admissions in and out of network • care outside of our service area and help finding a First Health provider.



**\*Please refer to your plan materials for your additional financial responsibility.**  
**Providers send claims to: Dean Health Plan • PO Box 56099 • Madison, WI 53705**  
**Electronic Payer ID #: 39113**



This card is for identification purposes and does not constitute proof of eligibility. Form Date: XX/XX/XXXX

**BACK**

# PPO ID CARD

**Network:** Dean  
**Group Number:** XXXXXXXXXXXX  
**Product Type:** PPO  
**deancare.com**

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

**In/Out Network Deductible\*:** Individual \$XXXXX/\$XXXXX Family \$XXXXX/\$XXXXX  
**In/Out Network Ded/Coinsurance Max\*:** Individual \$XXXXX/\$XXXXX Family \$XXXXX/\$XXXXX  
**In/Out Network Out of Pocket Max\*:** Individual \$XXXXX/\$XXXXX Family \$XXXXX/\$XXXXX

PCN: 5104 • BIN: 610602

**Customer Care: 800-279-1301 (TTY: 711) • Nurse Advice Line: 800-576-8773**

**FRONT**

**Get the Right Care:** Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.

**Urgent Care / Emergency Care:** If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.

**Nurse Advice Line:** Available to Wisconsin residents only. For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.



**Contact us for questions regarding** • prior authorizations • inpatient admissions in and out of network • care outside of our service area and help finding a First Health provider.

**\*Please refer to your plan materials for your additional financial responsibility.**  
**Providers send claims to: Dean Health Plan • PO Box 56099 • Madison, WI 53705**  
**Electronic Payer ID #: 39113**

This card is for identification purposes and does not constitute proof of eligibility. Form Date: XX/XX/XXXX

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## INDIVIDUAL AND FAMILY BUSINESS/ACA HMO ID CARD

				Members - <a href="https://deancare.com/member-login">deancare.com/member-login</a>															
Payer ID: 41822 ID: <b>1234567891</b> Group/Policy: <b>C00010</b>				<b>Medical Claims:</b> Medica - Dean PO Box 211404, Eagan, MN 55121															
JOHN Q CIBWIFI04/STD/C00010 00 JANE Q Samplemember 01 JOE Q Samplemember 02 JULIE Q Samplemember 03 JAKE Q Samplemember 04 JOSHUA Q Samplemember 05		Rx BIN: 610602 Rx PCN: 5304		<b>Member Services:</b> 1 (877) 394-9080 (TTY: 711) <b>Pharmacists call:</b> 1 (866) 333-2757 <b>Providers:</b> 1 (800) 458-5512 or <a href="https://deancare.com/providers">deancare.com/providers</a> <b>Nurse Advice Line:</b> 1 (800) 576-8773															
Care Type: [Care Type Text From data] SVC Type: Medical																			
		<table border="1"> <tr> <th>Ded IND/FAM:</th> <th>OOPM IND/FAM:</th> <th>RX OOPM IND/FAM:</th> </tr> <tr> <td>Tier 1: \$1,111/\$2,222</td> <td>\$3,333/\$6,666</td> <td>\$1,000/\$2,000</td> </tr> <tr> <td>Tier 2: \$2,525/\$5,050</td> <td>\$5,100/\$10,200</td> <td></td> </tr> <tr> <td>Out of Network:\$3,333/\$6,666</td> <td>\$22,222/\$44,444</td> <td></td> </tr> </table>		Ded IND/FAM:	OOPM IND/FAM:	RX OOPM IND/FAM:	Tier 1: \$1,111/\$2,222	\$3,333/\$6,666	\$1,000/\$2,000	Tier 2: \$2,525/\$5,050	\$5,100/\$10,200		Out of Network:\$3,333/\$6,666	\$22,222/\$44,444					
Ded IND/FAM:	OOPM IND/FAM:	RX OOPM IND/FAM:																	
Tier 1: \$1,111/\$2,222	\$3,333/\$6,666	\$1,000/\$2,000																	
Tier 2: \$2,525/\$5,050	\$5,100/\$10,200																		
Out of Network:\$3,333/\$6,666	\$22,222/\$44,444																		

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## INDIVIDUAL AND FAMILY BUSINESS/ACA FOCUS ID CARD

				Members - <a href="https://deancare.com/member-login">deancare.com/member-login</a>															
Payer ID: 41822 ID: <b>1234567891</b> Group/Policy: <b>C00010</b>				<b>Medical Claims:</b> Medica - Dean PO Box 211404, Eagan, MN 55121															
JOHN Q CIBWIFI04/STD/C00010 00 JANE Q Samplemember 01 JOE Q Samplemember 02 JULIE Q Samplemember 03 JAKE Q Samplemember 04 JOSHUA Q Samplemember 05		Rx BIN: 610602 Rx PCN: 5304		<b>Member Services:</b> 1 (877) 394-9080 (TTY: 711) <b>Pharmacists call:</b> 1 (866) 333-2757 <b>Providers:</b> 1 (800) 458-5512 or <a href="https://deancare.com/providers">deancare.com/providers</a> <b>Nurse Advice Line:</b> 1 (800) 576-8773															
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Ded IND/FAM:	OOPM IND/FAM:	RX OOPM IND/FAM:																	
Tier 1: \$1,111/\$2,222	\$3,333/\$6,666	\$1,000/\$2,000																	
Tier 2: \$2,525/\$5,050	\$5,100/\$10,200																		
Out of Network:\$3,333/\$6,666	\$22,222/\$44,444																		

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# MEDICARE ADVANTAGE ID CARDS

<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">  <p>Customer Care Center: 1-877-232-7566 (TTY: 711)</p> </div> <div style="text-align: center;">  </div> </div> <p>H9096-XXX HMO/POS <b>Member Name:</b> TEST TEST <b>Member Number:</b> A1100000000 <b>Issuer:</b> 80840 <b>Product:</b> PLAN NAME <b>Group Number:</b> C00305923 <b>PCP:</b> PCP NAME</p> <div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <p><b>RxBIN:</b> 610602 <b>RxPCN:</b> NVTD <b>RxGrp:</b> DHID</p>  </div> </div> <p style="text-align: center;">Copays*: <b>PCP:</b> \$XX    <b>Specialist:</b> \$XX *Please refer to your plan materials for your additional financial responsibility including, but not limited to, deductible, coinsurance and other out-of-pocket costs. <b>deancare.com/medicare</b></p>	<p><b>Get the Right Care:</b> Your primary care provider (PCP) is the appropriate contact person for routine care needs. Your PCP can assist with preventative services, office visits, and overall guidance to the right care.</p> <p><b>Urgent/Emergency Care:</b> If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies, dial 911 or seek immediate medical care.</p> <p><b>Nurse Advice Line</b> 1-800-576-8773: (available to Wisconsin residents only). For care guidance outside of normal working hours, our Nurse Advice Line has registered nurses who can assist with care questions or guide you to the appropriate location for care.</p> <p>Notify us for emergency or out-of-state admissions.</p> <p><b>Providers send claims to:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159</td> <td style="width: 50%; border: none;"><u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215</td> </tr> </table> <p><b>Pharmacy Technical Help Desk Number:</b> 1-866-270-3877</p>	<u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159	<u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215
<u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159	<u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215		

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<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">  <p>Customer Care Center: 1-877-232-7566 (TTY: 711)</p> </div> <div style="text-align: center;">  </div> </div> <p>H9096-XXX HMO/POS <b>Member Name:</b> TEST TEST <b>Member Number:</b> A1100000000 <b>Issuer:</b> 80840 <b>Product:</b> PLAN NAME <b>Group Number:</b> C00305925 <b>PCP:</b> PCP NAME</p> <div style="display: flex; justify-content: space-between; align-items: center;">  <div style="text-align: center;"> <p><b>RxBIN:</b> 610602 <b>RxPCN:</b> NVTPARTB <b>RxGrp:</b> 9154</p> </div> </div> <p style="text-align: center;">Copays*: <b>PCP:</b> \$XX    <b>Specialist:</b> \$XX *Please refer to your plan materials for your additional financial responsibility including, but not limited to, deductible, coinsurance and other out-of-pocket costs. <b>deancare.com/medicare</b></p>	<p><b>Get the Right Care:</b> Your primary care provider (PCP) is the appropriate contact person for routine care needs. Your PCP can assist with preventative services, office visits, and overall guidance to the right care.</p> <p><b>Urgent/Emergency Care:</b> If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies, dial 911 or seek immediate medical care.</p> <p><b>Nurse Advice Line</b> 1-800-576-8773: (available to Wisconsin residents only). For care guidance outside of normal working hours, our Nurse Advice Line has registered nurses who can assist with care questions or guide you to the appropriate location for care.</p> <p>Notify us for emergency or out-of-state admissions.</p> <p><b>Providers send claims to:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159</td> <td style="width: 50%; border: none;"><u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215</td> </tr> </table> <p><b>Pharmacy Technical Help Desk Number:</b> 1-866-270-3877</p>	<u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159	<u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215
<u>Medical Claims:</u> (Payer ID: 39113) Dean Health Plan - Claims PO Box 852159 Richardson, TX 75085-2159	<u>Dental Claims:</u> (Payer ID: WIMAN) Delta Dental PO Box 9215 Farmington Hills, MI 48333-9215		

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# DEANCARE GOLD ID CARD

<div style="display: flex; justify-content: space-between;"> <div style="text-align: center;">  </div> <div style="text-align: center;"> <p><b>Group Number:</b> XXXXXX <b>PBP:</b> XXX <b>HealthPlan#</b>H5264 <b>deancare.com/medicare</b></p> </div> </div> <table style="width: 100%; border: none; margin-top: 10px;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Member Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Member #</th> </tr> </thead> <tbody> <tr> <td style="border-bottom: 1px solid black;">TEST TEST</td> <td style="border-bottom: 1px solid black;">012345678901</td> </tr> </tbody> </table> <p style="margin-top: 20px;">&lt;PCP CLINIC NAME&gt;</p> <p style="text-align: right; margin-top: 10px;">PCN: 5104    BIN: 610602</p>	Member Name	Member #	TEST TEST	012345678901	<p><b>Get the Right Care:</b> Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.</p> <p><b>Urgent Care/Emergency Care:</b> If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911. Services that are not urgently needed may not be covered outside of the DeanCare Gold service area.</p> <p><b>Nurse Advice Line:</b> Available to Wisconsin residents only. For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.</p> <p><b>Contact us for questions regarding</b> •prior authorizations •inpatient admissions in and out of network •care outside of our service area</p> <p><b>Customer Care Center Hours:</b> Monday through Friday 8:00 a.m. to 8:00 p.m.</p> <p><b>Providers send claims to:</b> Dean Health Plan • PO Box 56099 • Madison, WI 53705 <b>Electronic Payer ID #:</b> 39113</p>
Member Name	Member #				
TEST TEST	012345678901				

**Customer Care: 888-422-3326(TTY: 711) • Nurse Advice Line: 800-576-8773**

**FRONT**

This card is for identification purposes and does not constitute proof of eligibility. Form Date: 09/09/2020

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# SSM HEALTH EMPLOYEE HEALTH PLAN ID CARD (WI) (PREVIOUSLY WELLFIRST HEALTH)



Network: DEAN ASO (WI)  
 Group Number: XXXXXXXXXXXXX  
 Product Type: EPO  
[medica.com/ssmhealth](http://medica.com/ssmhealth)

**Get the Right Care:** Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits. Find an SSM Health PCP by visiting [medica.com/ssmhealth](http://medica.com/ssmhealth).  
**Urgent Care/Emergency Care:** If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.  
**Nurse Advice Line:** For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.  
**Contact us for questions regarding** •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

\*Please refer to your plan materials for your additional financial responsibility.  
 Providers send claims to: Medica • PO Box 56099 • Madison, WI 53705  
 Electronic Payer ID #: 39113



This card is for identification purposes and does not constitute proof of eligibility.

Form Date: XXX/XXX/XXXX

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

**Deductible\*:** Individual \$XXXXX Family \$XXXXX  
**Ded/Coinsurance Max\*:** Individual \$XXXXXX Family \$XXXXXX  
**Out of Pocket Max\*:** Individual \$XXXXXX Family \$XXXXXX

PharmacyQuestions: [navitus.com](http://navitus.com) • 844-268-9789 PCN: 8104 • BIN: 610602

CustomerCare: 877-274-4693 (TTY: 711) • NurseAdviceLine: 833-925-0398

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# MEDICA EMPLOYEE HEALTH PLAN



Network: DEAN ASO (WI)  
 Group Number: XXXXXXXXXXXXX  
 Product Type: EPO  
[mo-central.medica.com/medicaemployees](http://mo-central.medica.com/medicaemployees)

Member Name	Member Number
TEST TEST	012345678901
TEST TEST 1	012345678902
TEST TEST 2	012345678903
TEST TEST 3	012345678904

**Deductible\*:** Individual \$XXXXX Family \$XXXXX  
**Ded/Coinsurance Max\*:** Individual \$XXXXXX Family \$XXXXXX  
**Out of Pocket Max\*:** Individual \$XXXXXX Family \$XXXXXX

PharmacyQuestions: [navitus.com](http://navitus.com) • 844-268-9789 PCN: DHE • BIN: 610602

CustomerCare: 833-942-2159 (TTY: 711) • NurseAdviceLine: 833-925-0398

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**Get the Right Care:** Your primary care provider (PCP) is your contact for routine care needs. Your PCP can assist with preventive services and office visits.  
**Urgent Care/Emergency Care:** If you have serious medical needs, seek care at an urgent care center or emergency room. In life-threatening emergencies dial 911.  
**Nurse Advice Line:** For care guidance outside of normal working hours, our Nurse Advice Line has nurses to assist with questions or guide you to the appropriate location for care.  
**Contact us for questions regarding** •prior authorizations •inpatient admissions in and out of network •care outside of our service area and help finding a First Health provider.

\*Please refer to your plan materials for your additional financial responsibility.  
 Providers send claims to: Medica • PO Box 56099 • Madison, WI 53705  
 Electronic Payer ID #: 39113



This card is for identification purposes and does not constitute proof of eligibility.

Form Date: XXX/XXX/XXXX

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## CHECKING MEMBER ELIGIBILITY

Providers should verify member eligibility for each date of service and cannot charge a member for failing to do so and providing services. Because Dean Health Plan products vary and members can move between eligibility groups, it is important that providers determine member eligibility using real-time eligibility sources only — the 270/271 Eligibility and Benefit Inquiry and Response transaction **or** the Eligibility application in the [Dean Health Plan Provider Portal](#) accessible from the [Account Login](#) page for payer ID 39113. For payer ID 41822, use the [Availity Essentials Portal](#) or when necessary, contact the Customer Care Center. The information in these transactions also includes real-time details about a member's cost share, deductible, copay, and coinsurance amounts.

Member health plan benefit information, including certificate of coverage, member policy, or certificate can be viewed at [MemberBenefits.DeanCare.com](#) by entering the full member ID or group number.

Providers can access the Member Summary Plan Description (SPD) for SSM Health's Employee Health Plan and Medica Employee Health Plan at [MemberBenefits.MO-Central.Medica.com](#)

Providers may call our Customer Care Center at the phone number on the member ID card with any questions about a member's eligibility and coverage.

# HEALTH PLAN COMMUNICATIONS FOR PROVIDERS

Dean Health Plan issues a variety of communications to providers about changes to health plan procedures, benefits, and other areas of interest involving health plan products and services:

- [Dean Health Plan Provider News](#) — a monthly health plan newsletter specifically for Dean Health Plan in-network providers. The Dean Health Plan *Provider News* informs providers of changes to health plan procedures, benefits, and other areas of interest involving health plan products and services.
- **As-needed communications** — to communicate changes outside of the monthly newsletter schedule due to the planned implementation date or for larger initiatives that require more detail.
- **Policy update provider notifications** – emailed monthly to communicate select medical benefit drug policy and medical policy updates, as well as Health Plan initiatives when applicable. Monthly provider notifications are also published to the [Provider Communications page](#).
- [Provider Communications page](#) — links to a variety of our past and current provider notifications that were originally communicated via postal mailings or emails to serve as an on-demand communications repository. Examples of the notifications that are available from this page are monthly policy update provider notifications and the annual plan and benefit changes information. Published communications contain information that was accurate when the notification was originally released and may not reflect current information. The Provider Communications page is the hub for updates and communications regarding updated interim process for self-service as we transition to our new business platforms.
- **Provider Onboarding Guide** — useful reference for all in-network providers, accessible from the [Provider Communications page](#). The brief document highlights specific areas of business or functionality in “grab and go” sections. Also, includes a Quick Reference for easy access to a variety of resources. Please note that information in the Onboarding, while useful for all in-network providers for Dean Health Plan, features processes only applicable for member plans that utilize payer ID 39113.
- **Portal Messages** — accessible from the Dean Health Plan Provider Portal (as relevant for payer ID 39113) to temporarily communicate general messaging regarding topics such as system outages or directing providers to resources or more detailed communications for full information. These messages are archived in the provider portal and available for review after acknowledgement.

In most cases, we communicate to providers through email. Providers are encouraged to select the [Opt In](#) option to receive provider communications via email from Dean Health Plan. Opt In is available in the [Dean Health Plan Provider Portal](#) during the registration process and also can be selected after registration through Account Settings. The opt-in captures contact information for providers providing services for all plan types, including those utilizing payer ID 41822.

## MEMBER INFORMATION FOR PROVIDERS

Dean Health Plan offers a wide range of programs and services to improve the overall health of members and to support providers caring for individuals enrolled in Dean Health Plan benefit plans. While the available member services and programs are intended for patients who are enrolled in Dean Health Plan benefit plans (and some are even available regardless of insurance), providers are encouraged to be familiar with member resources and promote them to their patients, when appropriate.

A wealth of details regarding member programs and services are featured on the Dean Health Plan website ranging from behavioral health resources, nutritional programs, health and wellness webinars and events, preventive care, and more. To assist providers in finding this online information, the [Dean Health Plan Member Resources Reference Guide for Providers](#) is published on the Dean Health Plan Provider Communications page. The reference guide is organized alphabetically by the name of the Program/Service with a brief description. Direct links are provided in the reference guide for use if viewing the document online, as well as the navigational path to access the online information if viewing the printed document.

# CREDENTIALING PROCESS

## PRACTITIONER CREDENTIALING AND RECREDENTIALING PROCESS

The Health Plan adheres to a credentialing/rec credentialing process for evaluating and selecting practitioners who practice within the Health Plan delivery system. The Health Plan is National Committee on Quality Assurance (NCQA) accredited, and therefore requires specific documentation is reviewed within established timelines during the credentialing/rec credentialing process. Practitioner credentialing applications are reviewed and approved by the Health Plan's Credentialing Subcommittee or its delegate prior to being authorized to provide services to Health Plan members. Recredentialing applications are required to be completed and approved by the Health Plan Credentialing Subcommittee at least every 36 months to continue to provide services to Health Plan members. The attached link includes the full Credentialing Plan shared by the Medica family of brands: [Partner.Medica.com/-/Media/Documents/Provider/Programs-and-Resources/Medica-Credentialing-Plan.pdf?la=en](https://Partner.Medica.com/-/Media/Documents/Provider/Programs-and-Resources/Medica-Credentialing-Plan.pdf?la=en)

If an organization has entered into a Delegation of Credentialing Agreement with Dean Health Plan, credentialing/rec credentialing for practitioners within that organization are delegated to their organizational group. In these cases, the terms of the credentialing/rec credentialing process are outlined in the delegation agreement and may differ slightly from the process overview in this manual.

# PROVIDER PORTAL

## USING DEAN HEALTH PLAN PROVIDER PORTALS

Dean Health Plan uses two provider portals to ensure providers have access to 24/7 self-service. For payer ID 39113, our health plan-specific provider portal registration and functionality is described in detail below. Beginning January 1, 2024, multi-payer solution Availity Essentials will serve as the main location to exchange clinical and administrative data for members in plans under payer ID 41822, indicating they have transitioned to our new claims platform. Please note that providers will need to continue to do business out of both portals until all of our membership has transitioned off of the legacy systems. While full functionality is being activated within Availity Essentials, interim processes may be utilized and will be detailed on our Provider Communications [page](#).

## OVERVIEW AND RESOURCES FOR AVAILITY ESSENTIALS

Availity Essentials enables provider teams to perform transactions for multiple payers from a single account. Essentials will be available for all member transactions as plan types transition to payer ID 41822, beginning with IFB in January 2024. Availity Essentials is a widely utilized provider portal between health plan payers and providers. If your organization uses Availity Essentials for another payer, our new payer ID 41822 for Dean Health Plan will be added as an option to your dashboard. There's nothing you need to do. If your organization doesn't use Availity Essentials, visit the Availity Essentials [web page](#).

### ***Logging-in, Training and Troubleshooting with Availity***

Availity's Dean Health Plan provider set-up and resource page can be found [HERE](#) or at [availity.com/medica-health-plans](http://availity.com/medica-health-plans). This page also allows you to sign up for live webinars, or play a Dean Health Plan-specific recorded training to get to know a particular application or function better. Please note that not all Availity functionality will be available during our member transition, but updates on additional available functionality will be located on our Provider Communications [page](#).

## OVERVIEW OF THE HEALTH PLAN'S PORTAL FUNCTIONALITY

The Dean Health Plan Provider Portal is a 24/7 online resource for our in-network providers free of charge to assist with managing key patient data, simplifying everyday tasks, promoting efficiency in business, and streamlining electronic transactions. It has functionality to check HIPAA-compliant real-time transactions along with web-based self-service applications. While the health plan transitions to a new claims platform, this portal only applies to information for members in plan types utilizing payer ID 39113. Work pertaining to members in plan types utilizing payer ID 41822 is available in Availity Essentials.

### ***We encourage providers to establish a Provider Portal Account!***

If you are not interacting with the Health Plan through the Provider Portal for payer ID 39113, we strongly encourage you to establish a Portal account. Once a Portal account is created, users can access information and perform tasks specific to their assigned Portal role(s). Individuals need to register in order to create a secure Provider Portal account. Refer to the Dean Health Plan Provider Portal Registration User Guide for the simple step-by-step process on how to create Individual and Organizational Provider Portal accounts. The Portal Registration User Guide and other account setup resources including a short video are available from the Dean Health Plan Account login page at [DeanCare.com/Account-Login-Page#Providers](http://DeanCare.com/Account-Login-Page#Providers).

**Note:** Dean Health Plan ASO member information is **not** on the Dean Health Plan Health Plan Provider Portal. Refer to the [Administrative Services Only Product Manual](#) for portal information and the [Administrative Services for Plan Providers](#) web page for more information.

# ACCESS THE PROVIDER PORTAL

There are two ways to access the Provider Portal:

1. Directly at [ProviderAuth.DeanCare.com](https://ProviderAuth.DeanCare.com)
2. From the Providers Home page at [DeanCare.com/Providers](https://DeanCare.com/Providers) and click the Go To Portals link

## PROVIDER PORTAL APPLICATIONS

This section details options available in the Dean Health Plan Provider Portal applicable to business using payer ID 39113. As we transition business to payer ID 41822, check the Provider Communications page to verify availability of the applications listed here in the Availity Essentials and any applicable interim solutions.

### ***Eligibility & Benefits (270/271 EDI) Transactions***

This application provides human readable real time Electronic Data Interchange (EDI) 270/271 Eligibility & Benefit Inquiry and Response transactions, including detail regarding eligibility, benefit plan coverage, co-payments, and deductibles for a member. It also provides the member's primary health plan, if applicable.

### ***Authorization***

Submit electronic prior authorization requests through the Provider Portal's Authorization application, for most services. There are some exceptions to the type of authorization requests that can be submitted through the Provider Portal. Dean Health Plan contracts with the following entities for authorization review and approval of certain services, applicable to both payer ID 39113 and 41822:

- Navitus/Navi-Gate — for pharmacy benefit drug authorization requests
- NIA Magellan — for authorization of high-end radiology services, and musculoskeletal services

Links to the Navitus/Navi-Gate portal and NIA Magellan portal are conveniently available on our [Account Login](#) page.

Refer to the [Submitting Prior Authorization Requests](#) for more information as well as tips for prior authorization submissions.

### ***Authorization View***

See your authorization requests that have been started and saved, and authorizations that have been completed and submitted.

### ***Claim Status (EDI 276/277) Transactions***

This application provides human readable real-time EDI 276/277 Health Care Claim Status Request and Response transactions, which allows providers to check the status of a claim to see if it is pending, processed, or in a finalized status. *Note:* Claims cannot be submitted via the Dean Health Plan Provider Portal.

### ***Claim Payments***

This application will allow a user to view electronic remittance files or search by a variety of criteria including a Keyword search.

### ***Claim Appeals***

This application allows users to appeal processed claims with a finalized status (paid-denied).

### ***Provider Admin***

Allows Provider Portal Site Administrators to make updates to Individual user or Organization account information.

### ***Provider Resources page***

Repository of convenient links to provider resources such as medical policies, user guides, provider manuals, and partner portals.

For more information on applications, refer to the Dean Health Plan [Provider Portal User Guide](#) for payer ID 39113 available on the secure Provider Resources page once you have established your Portal account.

### ***Opt In/Opt Out for Electronic Communications in the Provider Portal***

The Opt In for electronic communications option is available in the Dean Health Plan Provider Portal in “Account Settings.” By selecting Opt In, providers will receive direct and expedited provider email communications from Dean Health Plan. No communication preferences are available specific to Dean Health Plan in the Availity Essentials portal, so please ensure that your Dean Health Plan portal account reflects this preference to ensure that your email is collected for this purpose.

Communications include notifications about changed or new policies or upcoming changes that may affect daily operations, for example. Opt In will not replace all paper communications. Email addresses that are provided to the health plan through Opt In will not be shared with outside organizations or used for purposes other than the electronic distribution of health plan communications.

Dean Health Plan will email communications to the email address that was provided during registration. Check your email “junk” or “spam” folders periodically to ensure that communications are not being filtered as spam. Dean Health Plan will not send a high volume of emails, but you may want to consult your IT department if you have not received an email from Dean Health Plan after three months of your Portal registration.

While Opt In is available through the Portal, opting out after selecting Opt In can be done through the “Unsubscribe” link at the bottom of email communications that you will receive from Dean Health Plan. Once you unsubscribe, your email address is automatically inactivated from the system and further electronic communications cannot be sent to that address.

# EDI TRANSACTIONS

## ***Electronic Data Interchange (EDI)***

Dean Health Plan offers HIPAA-compliant electronic transactions to providers to meet consistent documentation, handling, and privacy standards, as well as for efficiency. Go to the [HIPAA Transactions page](#) to view the Dean Health Plan supported transactions, companion guides, EDI setup forms, and additional information. This page is organized by payer ID. Please be sure to establish new payer ID 41822, access through the Availity gateway, with your clearinghouse to ensure that transactions can be performed for IFB beginning January 1, 2024 and plans transitioning to our new business platform.

## ***Eligibility and Benefit Inquiry and Response (270/271)***

The most timely and accurate way to confirm a member's benefits and coverage amounts is to submit an eligibility request transaction. Dean Health Plan supports this transaction in either real-time or batch. To engage in EDI transmission, please complete an EDI setup form or if you use a clearinghouse or billing service, have them reach out to us to arrange transmission.

## ***Health Care Claim Submission (837)***

Electronic claim submission allows for standardized transmission of claims data, resulting in fewer rejections and more streamlined claims adjudication. Dean Health Plan accepts the 837 Health Care Claim: Professional (837P) and Institutional (837I) transactions. To submit claims electronically, please complete an EDI setup form; if you utilize a clearinghouse or billing service, have them reach out to us.

## ***Claim Acknowledgment (277CA)***

Electronic claim acknowledgment files are a response to the electronic claim submission (837) files we receive. Each claim is identified individually as to whether it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

## ***Health Care Claim Status Request and Response (276/277)***

Electronic claim status requests allow inquiry and response to quickly know the status of a claim that has been accepted for adjudication. Dean Health Plan supports this transaction in either real-time or batch. The provider should wait a minimum of 30 days after claim submission to send a claim status response to allow for the known payment processing time. To engage in EDI transmission, please complete an EDI setup form; if you use a clearinghouse or billing service, have them reach out to us to arrange transmission.

## ***Health Care Claim Payment/Remittance Advice (835) and Electronic Funds Transfer (EFT)***

### ***For Payer ID 39113***

Dean Health Plan contracts with Change Healthcare as our clearinghouse for the exchange of both electronic remittance advices (ERA) and electronic funds transfers (EFT), as well as paper explanation of payments (EOP) information and checks. Providers are encouraged to sign up for EFT payments from our HIPAA Transactions web page. EFTs allow the health plan to directly deposit payments into your organization's designated bank account for a more efficient delivery of payments. EFT payments are secure, eliminates paper, and are not affected by possible delays in mail delivery for faster receipt of payments. Once EFT is established, providers may then sign up to receive electronic 835 Health Care Claim Payment/Advice (835) transactions from Dean Health Plan through Change Healthcare ePayment Services at 866-506-2830 or online at [ChangeHealthcare.com/Support/Custom-Resources/Enrollment-Services](https://ChangeHealthcare.com/Support/Custom-Resources/Enrollment-Services).

### ***For Payer ID 41822***

Dean Health Plan contracts with Instamed to manage payment services (i.e, remittance advice, Explanation of Payments (EOP), electronic funds transfer (EFT) and paper checks. Providers can visit [Instamed.com/eraeft](https://Instamed.com/eraeft) to register.



***EDI Help Desk***

If you have questions related to EDI setup, data content, or other EDI issues, please contact our EDI team directly at [edi@deancare.com](mailto:edi@deancare.com).

# CLAIMS, TIMELY FILING, AND ADJUSTMENTS

## Claims Submission

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

- Dean Health Plan requires providers to use the 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, etc.). Using the correct member numbers on the claims submitted to Dean Health Plan will help us ensure correct claim payment.
- Dean Health Plan requires contracted 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. For more information, refer to the [Timely Filing Guidelines](#) section.
- Dean Health Plan requires that all services billed be appropriately documented in the patient's medical records. If the services billed are not documented in the patient's medical record, they will not be considered reimbursable by Dean Health Plan.
- All claims for services regarding work-related injuries or illness should be submitted to the worker's compensation carrier. If the worker's compensation carrier denies claims, you may submit the claim along with the denial for consideration by Dean Health Plan. **All 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 Dean Health Plan for processing. We will pursue recovery of those expenses from the at-fault party and/or their liability insurer. **All prior authorization guidelines apply in this situation.** You must submit the claim(s) in a timely manner as outlined in the timely filing guidelines.
- While Dean Health Plan will accept paper or electronically submitted claims, it's recommended to submit [electronically](#) to expedite processing and reduce claim rejections. All claims submitted, regardless of submission method, must comply with the applicable national billing rules as well as the published Companion Guides. Only the latest published versions of the claim forms will be accepted for processing. If necessary, providers can mail claims to Dean Health Plan, PO Box 56099, Madison, WI 53705 for payer ID 39113. For payer ID 41822 claims can be mailed to Medica – Dean, PO Box 211404, Eagan, MN 55121.
- Coordination of Benefit (COB) claims must be received along with the primary payer's explanation of payment within the timely filing limit outlined in your agreement with Dean Health Plan, beginning with the date noted on the primary payer's explanation of benefits. COB claims may also be submitted via electronic data interchange (EDI) on the 837 claims transaction. When submitting COB claims electronically, please include the prior payer's payment information in the relevant segments.
- Check the status of a claim through the Provider Portal Claim Status application or through the HIPAA-compliant 276/277 Health Care Claim Status Request and Response transaction.
- When a physician or a clinic becomes a "Contracted Provider," they agree to accept payment made by Dean Health Plan 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.

**Failure to submit all required information could result in claim denials.**

# Acknowledgment of Submitted Claims

Dean Health Plan offers acknowledgment of electronic claim submissions through the following:

- [277 Claims Acknowledgement \(277CA\) transaction](#)
- [Confirmation Reports Portal \\*only available for claims submitted under payer ID 39113](#)

## 277 CA

Providers can sign up from the [HIPAA Transactions page](#) to receive 277CA responses for each electronic 837 claim file submitted to the Health Plan. In the 277CA, each claim is identified individually as to whether it was accepted for processing or was rejected. Reasons for rejections are also supplied in the response.

## Confirmation Reports Portal – only for payer ID 39113

The Confirmation Reports Portal is an option to providers who sign up to receive 277CA responses under payer ID 39113. Confirmation reports show all claims successfully accepted for processing as well as all claims that were rejected and not accepted for processing. Confirmation reports are available within 48 hours of when Dean Health Plan receives a claim. This includes claims submitted electronically or on paper.

Providers must contact their Provider Network Consultant to sign up for the Confirmation Reports Portal. A link to the Confirmation Reports Portal can be found on the Account Login page at [Deancare.com/Account-Login-Page#Providers](#).

Providers should review each received Confirmation Reports Portal report, examples shown below, to confirm that all of their submitted claims were successfully accepted by Dean Health Plan and to resolve the rejected claims. The rejected claims portion of the report will include error codes to explain the specific reason a claim was not accepted. Based on the error codes provided, please resubmit the claims with the necessary changes. **Providers are required to make corrections and resubmit the claim within the allotted time frame agreed upon in the contract beginning with the date of receipt.**

The following shows examples of the Confirmation Reports Portal for accepted and rejected claims:

### Accepted

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	DOB
			10/20/2016	1	164.00	12/01/2016		M	

### Rejected

MEMBER NAME	MEMBER #	PAT ACCT #	FIRST DATE OF SERVICE	TOTAL SERVICE LINES	TOTAL BILLED	RECEIVED DATE	CLAIM NUMBER	SOURCE	REJECT REASON	DOB
			11/10/2016	4	1034.00	12/01/2016		M	Member not on file.	

For electronic claims submission, a [999 acknowledgement transaction](#) will be used to indicate whether your transaction sets (ST/SE) passed SNIP types 1 and 2 compliance. Please work directly with your clearinghouse or EDI team to validate claim transaction acceptance. In cases of rejected 999s, please use the content of the transaction to understand the errors and resubmit the entire transaction.

For information about electronic claims enrollment and responses, go to the [HIPAA transaction page](#).

## Correcting Claims

Dean Health Plan recognizes that it is sometimes necessary to submit a corrected claim (e.g., changes or corrections needed to codes, dates of service, etc.) due to error.

Steps for submitting a corrected claim:

1. Create a new claim with the corrected claim detail(s).
2. Include all lines billed on the original claim on the corrected claim.
3. Include the Claim Frequency Code ('7' for replacement claims) and the Payer Claim Control Number (original claim ID).
4. When replacing/deleting original procedure code, send the original billed code in the 2300 loop.
5. Add a note in the NTE segment (Box 17) about what has been changed from the original claim.
6. Submit the corrected claim using the same submission method of the original claim.

If a provider disagrees with the denial determination the claim can be appealed. Please see the [Provider Appeals](#) section of the manual for further details.

The scenarios in the following tables explain specifically which information is required.

### Scenario #1: Corrected Claims - Not Requiring Supporting Documentation

	General Rule	837P & 837I	CMS-1500	CMS-1450
<i>Claim Frequency Code</i>	Must include one of the following: <ul style="list-style-type: none"> <li>• '7' - Replacement</li> <li>• '8' - Void</li> </ul> <i>Note: Corrected claims submitted with a '1' will be denied as duplicates.</i>	Loop 2300: CLM05-3	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill  <i>Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.</i>
<i>Payer Claim Control Number</i>	Must include the original Dean Health Plan claim number associated with the correction.  <i>Note: Corrected claims without a Dean Health Plan formatted original claim ID will be rejected.</i>	Loop 2300: REF*F8	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

### Scenario #2: Corrected Claims – Requiring Supporting Documentation

Supporting documentation may still be required for certain claim-edit denials related to code bundling, new patient visits, global surgery, diagnosis, unlisted codes, etc. Submitters must only submit claims requiring supporting documentation via the CMS-1450 or CMS-1500 form, using version 02/12. No electronic processing of these claims is currently supported. While Dean Health Plan can accept the PWK segment on a 837 transaction, we cannot guarantee it is being used in claims processing.

In addition, submitters must complete a Code Review Request Form along with any additional required supporting documentation. In order to abide by HIPPA guidelines, only documentation pertinent to the correction should be submitted.

	General Rule	CMS-1500	CMS-1450
<i>Claim Frequency Code</i>	Must include one of the following: <ul style="list-style-type: none"> <li>• '7' - Replacement</li> <li>• '8' - Void</li> </ul> <i>Note: Corrected claims submitted with a '1' will be denied as duplicates.</i>	Box 22 – Resubmission Code and/or Original Reference Number	Box 4 – Type of Bill  <i>Note: For Institutional claims, this represents the third digit of the Type of Bill being submitted.</i>
<i>Payer Claim Control Number</i>	Must include the original Dean Health Plan claim number associated with the correction.  <i>Note: Corrected claims without a Dean Health Plan formatted original claim ID will be rejected.</i>	Box 22 – Resubmission Code and/or Original Reference Number	Box 64 – Document Control Number

## Timely Filing Guidelines for Initial Submission

The initial submission of a claim is subject to the timely filing guidelines outlined in your agreement with Dean Health Plan.

**If a claim is rejected for improper submission, resubmission must be completed by the provider within the filing limit outlined in your agreement with Dean Health Plan.**

When applicable, retain 277CA files or confirmation reports from Dean Health Plan 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 Dean Health Plan 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 a temporary waiver of the timely filing limit must be made **in advance** due to system conversions or other short-term circumstances. Such requests may be made, in writing, to your assigned Provider Network Consultant.
- If the provider had difficulty obtaining Dean Health Plan coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the Dean Health Plan 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 normally been 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 the timely filing limit, beginning with the date of delivery. 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 Dean Health Plan within the filing limit outlined in your provider agreement. The first day of the filing limit for resubmissions/corrections begins with the date upon which Dean Health Plan notifies the provider that a claim has failed processing or was denied. You will find this date on the Explanation of Payment (EOP) or your 835 Health Care Claim Payment/Advice (835).

## ***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 has 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 Dean Health Plan 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 for Dean Health Plan to consider additional payment.
- Medical Assistance HealthCheck claims are exempt from the timely filing limit.
- Newborn claims must be received no later than 14 months from the date of birth.

## **Explanation of Payment**

Dean Health Plan produces Explanation of Payments (EOP) information on a weekly basis. Providers are encouraged to receive remittance information electronically free of charge through the [Dean Health Plan Provider Portal](#) Claim Payments application for payer ID 39113, or our [Health Care Claim Payment/Remittance Advice \(835\) transaction](#). For Payer ID 41822 providers can review EOPs through [Instamed](#).

## **PAYMENT ADJUSTMENTS**

When either Dean Health Plan 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 Dean Health Plan. Upon the discovery of any such overpayments, Dean Health Plan may alternatively offset such overpayments against any amounts otherwise due or thereafter becoming due from Dean Health Plan as in the terms of your provider agreement.

The offset adjustments are made to the provider's claims in Dean Health Plan's claims processing system. These adjustments will appear on the EOP following the processing of a provider's claims. Adjustments will be on the 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 appear on 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.

# CLAIMS CODING PROCESS

## Claims Coding

Dean Health Plan is committed to processing claims in a consistent, timely, and accurate manner. To support this ongoing effort, claims processing logic is maintained to support the application of correct coding principles and HIPAA code-set standards. These payment policies are derived from recommendations from a variety of clinical and coding sources including, but not limited to:

- American Medical Association (AMA) correct coding principals
- Centers for Medicare and Medicaid (CMS) medical and coding policies including local and regional Coverage Determinations
- Nationally recognized academy and society guidelines
- Manufacturer's package inserts (FDA approved indications) for injectable drug and biologic agents

## Code Review Request

If, after review, a provider believes their claim is coded correctly and that the charge was denied in error, they have the option to request a coding review via the Health Plan's Claim Review process.

To submit electronically:

- Complete the Claim Review Request form available in the Claim Appeals application of our Provider Portal at [providerauth.deancare.com](http://providerauth.deancare.com).
- Include a brief but detailed statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

To submit via paper:

- Complete the Claim Review Request form available in our [Document Library](#).
- Include a brief statement indicating why the decision should be overturned along with relevant supporting documentation (operative reports, medical records, etc.).

Please call the Customer Care Center at the phone number on the member ID card with questions.

# PROVIDER CLAIM APPEALS

## PROVIDER APPEALS PROCESS

If Dean Health Plan 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.

Appeal requests must be submitted in writing to be considered by an appropriate representative of Dean Health Plan and should be submitted using the Claim Appeals Application in the Dean Health Plan Provider Portal for efficiency. This instruction applies to appeals filed both for claims submitted under payer ID 39113 and payer ID 41822, as the application in the health plan provider portal will apply to both. Decisions are communicated in writing to the requesting provider specifying the reason(s) for the decision and advising the provider of their subsequent appeal rights should they be dissatisfied with the decision made by the Dean Health Plan representative.

The results of the final review shall be considered final and binding upon Dean Health Plan and provider.

## TIMELY FILING APPEALS

If a claim is specifically denied for timely filing, the provider may appeal the timely filing denial. The provider must submit additional documentation to support that their claim was filed according to timely filing guidelines and/or exception guidelines in order for it to be reviewed by Provider Network Services.

The Provider Network Consultant will communicate the decision in writing to the requesting provider, specifying the reason(s) for the decision and advising the provider of their right to discuss the decision. The Provider Network Consultant 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 Provider Network Services shall be considered final and binding upon Dean Health Plan and the provider.

## PROVIDER PORTAL APPEALS

Claims that have been processed with a finalized status (denied-paid) can be appealed online through the Dean Health Plan Provider Portal or via paper submission. In-network providers are encouraged to submit claim appeals electronically through the Claim Appeals application of the Provider Portal.

### *Claim Appeal Types*

- **COB**  
This appeal type is used to request reconsideration of a coordination of benefits (COB) denial. The primary payer's explanation of payment (EOP) is required, if it was not submitted with the original claim.
- **Additional Payment**  
This appeal type is used to request reconsideration of a Dean Health Plan payment. Include both the amount originally paid as well as the expected payment amount. A brief statement explaining why the original payment is incorrect is also required.
- **Recoup**  
This appeal type is used to request a recoupment or refund. Include both the amount originally billed as well as the recoupment/refund amount. The reason for the recoupment/refund is also required.
- **Timely Filing**  
This appeal type would be used to request reconsideration of a timely-filing denial. Providers are required 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. Documentation to support the timely filing appeal request is required.



- **Code Review Request**  
This appeal type is used to request reconsideration of a coding-related claims-denial. Denials may include frequency/maximum units, code bundling, inappropriate modifier, global surgery, and diagnosis. A brief statement explaining why the claim edit should be overturned and corresponding supporting documentation is required.
- **Authorization Appeal**  
This type is used to request reconsideration of a failure-to-prior-authorize denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.
- **Medical Necessity**  
This type is used to request reconsideration of a medical-necessity denial. A brief statement explaining why the denial should be overturned and corresponding supporting documentation is required.
- **Unlisted Codes**  
This type is used to request reconsideration of an unlisted code denial. A description of the unlisted procedure, a brief statement explaining why the unlisted code denial should be overturned, and supporting documentation is required.

# UTILIZATION MANAGEMENT

Failure to follow **Dean Health Plan's** Utilization Management guidelines may result in claim payment denials or reimbursement of a claim at a lesser benefit. Because Dean Health Plan has multiple products and benefits, some Dean Health Plan benefit plans may require authorization for some services, while others may not. As such, the guidelines contained in this section are general and should be confirmed. Verify a member's benefits via the Eligibility functionality available on the Provider Portal at [deancare.com/providerportal](https://deancare.com/providerportal), confirm the authorization requirements as noted in the member's certificate of benefit, and consult the [Dean Health Plan Medical Policies](#).

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

Dean Health Plan staff is available to members and providers seeking information through the Customer Care Center at the phone number listed on the member's ID card from 8:00 A.M. to 5:00 P.M. (CST) Monday through Friday, except for recognized national holidays (e.g., Labor Day, Memorial Day, Christmas Day, etc.) The Customer Care Center is the first contact for general inquiries, but callers with questions regarding specific utilization management matters that cannot be addressed by the Customer Care Center are directed to Utilization Management staff by the Customer Care Center.

Utilization Management staff is available via voice message outside the standard business hours and will contact the requester within one business day of receipt of the voice message, provided the voice message contains the requester's return contact information.

Members may access Dean Health Plan via a toll-free number to the Customer Care Call Center or via a toll-free number to the Utilization Management Department. Utilization Management staff identifies themselves by name, title, and the organization when receiving or initiating calls to providers regarding Utilization Management issues.

Access to TTY/TDD services are available to members via the Telecommunications Relay Service (TRS) number of 711 which is communicated via any correspondence provided to the member from the Utilization Management Department. Translation services are also available to members and providers through a collaborative process between the Customer Care Center and the Utilization Management Department.

## **AUTHORIZATIONS**

A prior authorization is a written request submitted to the health plan by an in-network primary care provider or in-network specialist requesting authorization approval of a specific service(s) with another in-network provider or, in some cases, an out-of-network provider. An approved prior authorization is required when a service is indicated in a Dean Health Plan Medical Policy as requiring prior authorization, when a rendering provider is out-of-network, or the service is an elective inpatient admission. As you review the information below, please note that while the health plan transitions business platforms, submission methods for authorization review may change according to payer ID and provider portal status. Please be sure to review the Provider Communications [page](#) for the most up-to-date submission methods for payer ID 41822.

### ***High-Quality, Cost-Effective Care Through Authorization***

Dean Health Plan's goal is to provide high quality, cost-effective care, at the right time and in the right setting for members. 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 member benefit coverage. The health plan achieves this through our contracts with in-network providers and our Utilization Management Program by monitoring authorizations and through ongoing evaluation.

The scope of UM activities includes, but is not limited to, the following major categories:

- Authorization management through prior authorization, concurrent review, retrospective review, and evaluation/discharge planning

- Monitoring quality of care through clinical indicators and service satisfaction obtained from provider and member surveys
- Quality assurance monitoring and 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 Committee

Refer to the [Dean Health Plan Medical Management](#) page for services requiring prior authorization and their specific requirements. Authorizations should be sought to correspond with the appropriate timeline of care:

### ***Prior Authorization***

A request submitted by a provider for approval of services before they are rendered. This authorization type is sometimes referred to as an initial authorization request or pre-service authorization request.

### ***Concurrent Authorization***

Authorizations submitted by a provider for a member who is receiving ongoing care. Concurrent authorizations are generally related to members who are inpatient in a hospital or skilled nursing facility (SNF) and are actively receiving services at the time the authorization request is made.

### ***Post-Service Authorization***

Post Service authorizations are authorizations that are submitted after a member’s care has been received or completed. Post-service authorizations are only considered for coverage in limited and specific circumstances given that authorization policy is based on a provider obtaining written authorization approval **prior** to services being rendered.

## **AUTHORIZATION INFORMATION AND RESOURCES**

### ***Formal Approval***

Prior authorization approval is written, documented approval from the health plan’s Utilization Management Department, or in some cases for certain services from one of the health plan’s authorization vendors. A verbal or written request for services does not constitute an approved prior authorization. A prior authorization request does not guarantee payment of services received.

### ***Online Authorization Resources***

Providers can access the health plan’s authorization requirements in specific medical policies and in the Dean Health Plan Master Services List (MSL), both accessible from the [Dean Health Plan Medical Management](#) page. If a service is not found in a medical policy or listed in the MSL, providers are encouraged to also refer to the Dean Health Plan Non-covered Medical Procedures and Services list, also accessible from the Dean Health Plan Medical Management page, to verify the service is not on that list.

### ***In-Network Providers***

For most products, only Dean Health Plan in-network providers can submit authorization requests to the health plan. An in-network provider is one that is contracted with Dean Health Plan to provide services and is listed in our provider directory. An out-of-network provider is either not contracted with Dean Health Plan or is contracted differently than an in-network provider. Out-of-network providers are not listed in our provider directory. The health plan has no liability or responsibility for services provided by out-of-network providers without a contract with Dean Health Plan.

In-network providers are responsible for completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically necessary. The in-network provider who submitted the authorization request is also responsible for ensuring the approved prior authorization is in place prior to services being rendered.

### ***Member Benefit Considerations for Authorizations***

Approved authorizations indicate only that the service(s) are considered medically necessary. If a member’s benefits have been exhausted or the requested service is not a covered benefit under the member’s plan, the claim for the service will

deny. The same is true if a member has a change in enrollment status and becomes ineligible for the service. In this case, the claim will deny, indicating that the member is not eligible for coverage.

## **SUBMITTING PRIOR AUTHORIZATION REQUESTS**

Prior authorization requests should be submitted as soon as the determination is made to recommend or schedule a service. This facilitates determinations being made and communicated in advance of the member's scheduled date of service. Please note that processes for authorization submission may differ for members in plan types under payer ID 39113 and those under payer ID 41822. For payer ID 39113, please continue to submit authorizations via the Dean Health Plan provider portal whenever possible.

If an authorization request is processed and denied, a written denial for the requested services will always be provided to the member that includes the reason for the denial or redirection and appeal information. The provider who submitted the authorization request and the servicing providers are also notified of the denial or redirection via the Provider Portal, or in writing if access to the Provider Portal is not available to the provider(s). The member and the provider make the final decision regarding whether the member will receive any services, despite a denial from the health plan.

Authorizations can be submitted through the health plan provider portal for payer ID 39113, and through the Availity Essentials provider portal for members under payer ID 41822. Interim processes, as necessary, will be announced and detailed on the Provider Communications [page](#).

### ***Electronic Authorization Submission for Payer ID 39113***

Providers with Provider Portal access are strongly encouraged to submit authorization requests electronically through the Provider Portal. Authorization requests for most services can be submitted through the secure [Dean Health Provider Portal](#) Authorization Submission application. Our secure Provider Portal is a 24/7 direct line between your organization and our self-service applications to exchange electronic transactions. Additionally, the health plan sends an electronic response to authorization requests that come through the Provider Portal. Refer to the Dean Health Plan Provider Registration User Guide on the [Account Login](#) page for complete instructions on how to create an account.

In the case of an unexpected outage, a paper request form may be faxed or email in for review, found on the Medical Management [Page](#) under Prior Authorization Forms and then General, which applies to both inpatient and outpatient service requests. Please be sure to fill out the form in its entirety, attach supporting documentation, and provide a dedicated contact for return messaging or follow-up. Faxed forms can be sent to 608-252-0830, or email at [IFBHealthManagement@Medica.com](mailto:IFBHealthManagement@Medica.com). Emailed requests will receive an acknowledgement auto-response.

The Dean Health Plan provider portal will indicate determination (approved/denied) and a letter will be sent to the member. If the request was submitted on the paper form, determinations will be sent to the provider via fax.

### ***Electronic Authorization Submission for Payer ID 41822***

As the health plan transitions business platforms, Availity Essentials will be the primary portal for all plan types that fall under payer ID 41822. In early 2024, this transitions begins with IFB (Individual and Family business/ACA) plans. When available, please submit authorizations electronically through that application.

In the case of unexpected delays or outages, a paper request form may be faxed or email in for review, found on the Medical Management Page under Prior Authorization Forms and then General, which applies to both inpatient and outpatient service requests. Please be sure to fill out the form in its entirety, attach supporting documentation, and provide a dedicated contact name and contact method for return messaging or follow-up. Faxed forms can be sent to

608-252-0830, or email at [IFBHealthManagement@Medica.com](mailto:IFBHealthManagement@Medica.com). Emailed requests will receive an acknowledgement auto-response.

Additional methods may be available to support electronic submission. Please review the Provider Communications web [page](#) for up-to-date instructions for options available to you for our members in plan types that fall under payer ID 41822. Regardless of submission, authorization determinations (approved/denied) will be sent to the provider via fax when submitted for members in plan types under 41822. All authorization determinations are mailed to the member.

**Paper Form Submission Guidelines**

- Providers must follow the guidelines below when submitting a paper authorization request form Submit the request using the applicable Prior Authorization Request Forms accessible from the Dean Health Plan Medical Management page at [DeanCare.com/Providers/Medical-Management](http://DeanCare.com/Providers/Medical-Management).
- Authorization request forms should be mailed or faxed on the date the request has been completed to ensure timely processing of the authorization request.
- Complete **all** fields on the form in their entirety, otherwise the Utilization Management Department will return it to the submitting physician for completion.
- When an authorization is requested for the services of an out-of-network provider, include as much information as possible regarding why the request is being submitted and a list of in-network providers who the member has already seen. The Utilization Management Department will review these authorization requests to ensure that medically necessary care has been requested and that the services requested are not available with in-network providers. *Note:* Only services that are NOT provided within the Dean Health Plan provider network are considered for approval with a non-contracted provider.
- Fax paper authorization requests to 608 252-0830 or mail to:

Dean Health Plan  
ATTN: Utilization Management  
PO Box 56099  
Madison, WI 53705

**Use of Other Entities for Authorization Services**

Dean Health Plan contracts with other entities for the review and prior authorization of certain services. In these cases, prior authorization requests should be submitted to the contracted vendor, not Dean Health Plan, as shown in the table below.

Service	Whom to Submit	How to Submit
Pharmacy Benefit Drug Authorizations	Navitus/Navi-Gate	Authorization forms and submission through the Navitus Prescriber Portal at <a href="http://Prescribers.Navitus.com">Prescribers.Navitus.com</a> or via fax information on the form.
Medical Benefit Drug Authorizations	Dean Health Plan	Authorization forms are available through the Navitus Prescriber Portal at <a href="http://Prescribers.Navitus.com">Prescribers.Navitus.com</a> , but should be submitted to Dean Health Plan via the <a href="#">Health Plan Provider Portal</a> or via fax, mail, or phone information on the form.
Medical Injectables <i>* For benefit classifications and submission information, see our <a href="#">Medical Injectables List</a>.</i>	Dean Health Plan (for Medical Benefit medications) or Navitus/Navi-Gate (for Pharmacy Benefit medications)	Authorization forms are available through the Navitus Prescriber Portal at <a href="http://Prescribers.Navitus.com">Prescribers.Navitus.com</a> .  Submit Medical Benefit medications through the portal that corresponds with your member’s plan type (beginning with IFB in 2024) and payer ID, or via fax, mail, or phone information on the form.  Submit Pharmacy Benefit medications through the <a href="#">Navitus Prescriber Portal</a> or via fax information on the form.

<p>Services/Procedures requiring authorization per Dean Health Plan Medical Policies</p> <p><i>* See our Master Service List to know if authorization is required and where and how to submit authorizations.</i></p>	<p>Dean Health Plan</p>	<p>For Payer ID 39113 providers can submit authorization request through the For Payer ID 41822 providers can submit authorizations with the Prevea360 Health Plan Provider Portal by using the tab specific to payer ID 41822 or via the authorization form available on the Medical Management page. At a later date Payer ID 41822 authorization can be submitted via the Availity Essentials provider portal. Please use the Provider Communications page for communications on interim processes and for notification of when authorization submission will transition.</p>
<p>Radiology Prior Authorizations</p> <p><i>* For more information, see our <a href="#">Radiology Prior Authorization web page</a>.</i></p>	<p>NIA Magellan</p>	<p><a href="#">RadMD Portal</a></p>
<p>Musculoskeletal Authorizations (MSK) (inpatient hip and knee and inpatient and outpatient shoulder and spine surgeries)</p> <p><i>* For more information, go to our <a href="#">Musculoskeletal (MSK) Program web page</a>.</i></p>	<p>NIA Magellan</p>	<p><a href="#">RadMD Portal</a></p>

## SUPPORTING DOCUMENTATION

Providers must submit all relevant documentation along with the authorization request submission in order for the Utilization Management Department to review and make a determination on the request. For payer ID 39113, providers can electronically attach supporting documentation when submitting their authorization requests through the Provider Portal. For payer ID 41822, supporting documentation can be emailed to [ifbhealthmanagement@medica.com](mailto:ifbhealthmanagement@medica.com) or faxed to 608-252-0830 regardless of submission type.

- If an authorization request is submitted with insufficient information, the Utilization Management Department adheres to the following process to obtain missing documentation. A phone call is made to the provider office to request the additional information. Dean Health Plan Utilization Management will advise of:
  - Member name and DOB
  - Specific authorization request that is missing information
  - Specific information which is required
  - Fax number and name of individual that the information should be made attention to
- If the requested information is **not** provided within the initially requested 2 business days, Utilization Management will contact the provider office again within 1 business day and advise of the following:
  - This is the second request for additional information
  - Date of the original request for information
  - Member name and DOB
  - Specific authorization request that is missing information
  - Specific information which is required
  - Fax number and name of individual that the information should be made attention to
- The provider will be advised that if the information is not received within the second new time frame, the authorization will be submitted to the Medical Director for review based on the information that is available on the first business day after the second requested time frame has ended.
- Authorization and any available information will be directed to the Medical Director for review no later than the first business day following receipt of the information or expiration of the second provided time frame.
- If the authorization is denied a **new** authorization request with new objective medical documentation must be submitted for consideration of the services. The required information **cannot** be provided via the [peer-to-peer process](#) for the authorization denial.
- Resubmission of an authorization request **must** contain **new** objective medical documentation for it to be considered. New authorizations should not be submitted simply to re-open the peer-to-peer process.
- Authorizations without new objective medical documentation will be cancelled back to the provider if entered through the Provider Portal or will not be entered if submitted on paper and the requesting physician's office will be contacted to advise why the authorization is not being processed.

### ***Tips for Submitting Prior Authorization Requests***

- For efficiency, consider these tips when submitting a prior authorization request to Dean Health Plan. All of the tips below may not be relevant for your submission method. Please recall that submissions for members in plan types under payer ID 39113, beginning with IFB/ACA plans in 2024, should continue to be submitted through the Dean Health Plan provider portal. Submit your prior authorization requests through the Dean Health Plan Provider Portal whenever possible.
- Use the provider information that populates from the portal when possible.
  - If the provider information is not found in the portal and must be entered manually, Referring Providers should enter the address for the Servicing Provider only once and in the Addr 1 field. While there is an Addr 2 field, a second address is not required nor should the address from the Addr 1 field be entered again into that field. Always provide a contact name and phone number with the request in the Additional Information field in the portal or on the fax cover sheet.
- Note what is specifically being requested in the Additional Information field in the portal or on the fax cover

sheet. For example: “Left L4 SNRB, please see notes from office visit on August 31, 2019.”

- Include all relevant clinical documentation at the time of submission to prevent delays in the determination review.
- Include dates of office visits, previous procedures, etc. if relevant to the request; note any specific dates in the EMR and/or on the paper documentation that support the request. Refer to the Dean Health Plan document library to review Health Plan Medical Policies. These documents outline the criteria being reviewed and will help to identify what documentation to submit along with the request.
- Indicate if this is a member request or a physician request. As examples:
  - “Request is for John Doe to continue services with ABC Transplant Services through December 31, 2021. Has current authorization to ABC Transplant through December 31, 2020. Kidney transplant on 6/15/2018. Please contact Mary Jones at 888-888-8888 for any questions related to this request. This is a physician request.”
  - “Request is for Jane Doe to see Dr. Jones at XYZ Clinic Cardiology. This is a member request. Please see XYZ Cardiology note dated 12/1/2020 for additional information. Please contact Mary Jones at 888-888-8888 for any questions related to this request.”
  - “Request is for endovenous laser ablation (EVLT) of both right and left greater saphenous veins. See Vascular Surgery note dated 12/1/2020 and ultrasound report dated 11/15/2020 for additional information. Please contact Mary Jones at 888-888-8888 for any questions related to this request.”

## CANCELLED PRIOR AUTHORIZATION REQUESTS

Not all services require prior authorization approval. If an authorization request is submitted when prior authorization is not required, the request is reviewed and a “Cancelled” determination status will be applied. Dean Health Plan offers a variety of resources to help providers determine when prior authorization is required and where to submit the request:

- Check the [Master Service List \(MSL\)](#). In addition to listing policies and services that do require authorization, the MSL also lists a number of services that do not require prior authorization, denoted in purple-colored sections.
- Check the [Document Library](#) to search for specific policies.
- Check the [Medical Injectables List](#) for commonly prescribed drugs and whether prior authorization is required.

Check the [Non-covered Services List](#) if you can’t find the service



# AUTHORIZATION STATUSES AND PRIORITY DEFINITIONS

## Authorization Priority

In compliance with NCQA requirements and state law, Dean Health Plan adheres to specific time frames for authorization determinations.

The authorization status refers to the urgency with which the authorization requires processing. This is a required field for authorization entry. There are six authorization statuses; two are specific to inpatient authorizations and four are specific to outpatient authorizations.

INPATIENT AUTHORIZATION STATUSES	OUTPATIENT AUTHORIZATION STATUSES
<ul style="list-style-type: none"> <li>Urgent Admission</li> <li>Elective Admission</li> </ul>	<ul style="list-style-type: none"> <li>Pre-service Non-Urgent</li> <li>Post service</li> <li>Pre-service Medically Urgent (Refer to the definition of pre-service medically urgent in the table below.)</li> <li>Pre-service Administratively Urgent *(Not available for payer ID 41822)</li> </ul>

## Authorization Priority Definitions

AUTHORIZATION STATUS	TIMEFRAME	DEFINITION	STATUS TYPE
Pre-service non urgent	Determination and notification within 15 calendar days of receipt.	This status is used for outpatient requests.	Outpatient
Urgent admission	Notification within 24 hours of request receipt of determination or need for additional documentation. Notification will not exceed 72 hours of request receipt.	This status is used for inpatient or admission to a facility when the member is admitted from either the emergency room, an observation status, or a physician office.	Inpatient
Elective Admission	Provider notification at least 7 calendar days prior to scheduled elective admission. Determination within 15 calendar days of receipt.	This status is used for elective inpatient admissions to a Hospital or Skilled Nursing Facility.	Inpatient
Post-Service	Determination and notification within 30 calendar days of receipt (unless additional information is required for determination).	This status is used for requests that are received after the member's services have already been received. Most post-service requests will not be accepted. Exceptions will only be considered that initiate over a weekend or holiday.	Outpatient
Pre-Service Medically Urgent	Determination and notification within 72 hours of receipt.	This status is used for requests when the delay of service could jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without this care or treatment.	Outpatient
Pre-Service Administratively Urgent *(not available for payer ID 41822)	Determination and notification as prompt as possible with a goal of within 7 calendar days but may be up to 15 calendar days.	This status is used for requests that do not meet the definition of Medically Urgent, but are deemed to be time-sensitive by one or more of the affected parties due to appointments scheduled within the 15 calendar day determination and notification time frame.	Outpatient

## PEER-TO-PEER REVIEW PROCESS

The peer-to-peer review process offers the requesting provider an opportunity to discuss the denial determination of an authorization request with a Dean Health Plan Medical Director. It is NOT considered a provider authorization appeal. The peer-to-peer review process is intended to give the requesting physician an opportunity to discuss the denial determination when they believe that the submitted documentation supported an approval determination. A request for a peer-to-peer review can be initiated by calling the UM department at the phone number listed in the denial notification. This information is also included in the denial determination notice.

The peer-to-peer review process should not be used as a means for the provision of additional information that should have been provided with the initial authorization request. All applicable medical documentation should be provided or available to Dean Health Plan UM when an authorization is originally submitted for review and/or a determination is in progress. If additional objective medical information is obtained following the denial determination, a new authorization request must be submitted with that additional information. New authorization requests submitted without additional objective medical information will not be accepted.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten calendar day window has elapsed include filing a formal provider appeal, directing the member to the appeals and grievance process outlined in their letter, member benefit certificate, or by contacting the Dean Health Plan Customer Care Center at the phone number listed on the member's ID card.

## AUTHORIZATION APPEALS

Dean Health Plan providers can appeal medical necessity denial determinations through the health plan's [appeals](#) process for authorizations. We strongly recommend that providers complete the [peer-to-peer review process](#) before submitting a provider authorization appeal as resolution may be reached with a verbal discussion between the physician provider and a Dean Health Plan Medical Director through that process.

Dean Health Plan 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 Customer Care Center is responsible for the research and resolution of the grievance.

## PRIOR AUTHORIZATION GUIDELINES

Because Dean Health Plan has multiple products and benefits, some Dean Health Plan benefit plans may require authorization for some services, while others may not. As such, the overview guidelines contained in this section are general and should not be construed as a description of coverage for members. Verify a member's benefits via the Eligibility functionality available on the Provider Portal at [DeanCare.com/ProviderPortal](#) for payer ID 39113, and Availity Essentials for payer ID 41822. Confirm the authorization requirements in the member's Certificate of Coverage, and consult the [Dean Health Plan Medical Policies](#).

Furthermore, some of the Dean Health Plan clinical guidelines used by the Health Services Division (such as the MCG Care Guidelines) are accessible to the provider upon request. Contact the Customer Care Center at the phone number located on the member's ID card to request clinical guidelines.

### ***HMO/EPO Authorization Guidelines***

Dean Health Plan requires members who are enrolled in HMO and EPO benefit plans choose a primary care provider/clinic. The primary care provider acts as a "gatekeeper" to ensure members receive appropriate, high-quality care in a cost-effective manner. Primary care practitioners (and sometimes plan specialists) should assist members by completing and submitting an authorization request for an out-of-network provider when they believe that the request is medically necessary. Dean Health Plan in-network providers are responsible for submitting authorization requests and ensuring that

an approved prior authorization is in place prior to rendering services.

### ***POS Authorization Guidelines***

Dean Health Plan members enrolled in a POS benefit plan are not required to use in-network providers but may have lower out-of-pocket costs by using an in-network provider. Because POS members have the choice to use in-network or out-of-network providers, prior authorization for non-contracted services is not necessary unless required by the Dean Health Plan Medical Policy. They have the option to use in-network or out-of-network providers but may receive a different level of benefits based on the rendering provider's status within the indicated network. POS members may be subject to a prior authorization penalty if the authorization is not obtained prior to receipt of medically necessary services.

If a member seeks services from a non-contracted provider, the member is responsible for prior authorization requirements and may be subject to penalty or denial of services if prior authorization is not obtained before the services are received. Members who are obtaining their own prior authorization should contact the Customer Care Center at the phone number listed on the member's ID card for assistance.

### ***POS In-Network Benefit Exception Policy***

If medically necessary services are not available within Dean Health Plan's provider network, services with out-of-network providers will be considered for coverage at the in-plan benefit level **only if**:

- A Dean Health Plan in-network provider has submitted an authorization request on the member's behalf, indicating that they are requesting services at the in-plan benefit level because they are not available in-network.
- and**
- The request has been reviewed and approved for in-plan benefits by the Dean Health Plan Utilization Management Department **prior** to the delivery of the services.

Authorization requests will be cancelled if all the following criteria are met:

- For out-of-network providers for services that do not require an authorization.
- The request does not indicate that the prior authorization request is being made specifically for in-plan benefits.

Authorization requests will be denied to out-of-network providers requesting in-plan benefits when the services are available with in-network providers. The denial will indicate that the in-plan benefit level of payment has been denied and the in-network provider who can deliver the requested service.

### ***PPO Authorization Guidelines***

Dean Health Plan members enrolled in a PPO benefit plan are not required to use in-network providers but may have lower out-of-pocket costs by using an in-network provider. Members enrolled in PPO plans have access to nationwide networks of providers. Because PPO members have the choice to utilize in-network or out-of-network providers, prior authorizations for out-of-network services are not necessary unless required by the Dean Health Plan Medical Policy. Dean Health Plan Utilization Management does not authorize services for these members for in-network or out-of-network benefit levels of payment. Claims for services will be processed based on the rendering provider's affiliation or lack of affiliation with the PPO network in which the member is enrolled.

### ***Medicare Select and DeanCare Gold Authorization Guidelines***

For Medicare supplemental plans, prior authorization is not required for outpatient services provided by an in-network provider for services covered by Medicare. Because a primary care provider acts as the "gatekeeper" to ensure members receive appropriate and high-quality care, providers are encouraged to discuss any specialty care that their patients may be receiving, even when a prior authorization is not required.

In-network hospitals are not required to notify Dean Health Plan and authorize inpatient admissions when Medicare is the primary insurance.

These are the specific situations in which a prior authorization is required:

- An authorization is required if a member participates in a Dean Care Gold or Medicare Select plan and is seeking care from **out-of-network** providers.
- Prior authorization is required for all **elective** admissions to out-of-network facilities.
- DeanCare Gold members are required to utilize DeanCare Gold providers and have an approved prior authorization from the health plan when receiving services from providers outside of the Dean Care Gold network.

Members who have Medicare as primary insurance and a Dean Health Plan commercial or self-funded plan (**not** a supplement plan or **not** DeanCare Gold plan) as secondary coverage through an employer (or former employer) are required to follow all the current authorization guidelines required for HMO/POS members.

In the event a member has a Dean Health Plan policy that is secondary to Medicare (through an employer or former employer), authorizations are subject to the retiree plan benefits and HMO guidelines. Refer to the Medicare DeanCare Gold Provider Manual available in the [Dean Health Plan document library](#) for additional details regarding this process.

### ***BadgerCare Plus Authorization Guidelines***

Dean BadgerCare Plus policies use Forward Health authorization policies for guidelines specific to coverage of services requested by Dean BadgerCare Plus providers and members. If the ForwardHealth Portal authorization process does not address or provide medical necessity or coverage criteria for services requiring prior authorization, Utilization Management staff will then refer to Dean Health Plan Medical Policies and/or have the request reviewed by a Dean Health Plan Medical Director. Refer to the BadgerCare Plus Provider Manual available in the [Dean Health Plan document library](#) for additional details regarding this process.

# MEDICAL MANAGEMENT

The following pages contain an overview of some common services designated by the outpatient- “OUTPATIENT/AMBULATORY CARE SERVICES” or inpatient- “HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS” nature of the service. These descriptions are intended to provide only an overview of when a provider should seek authorization through Dean Health Plan and the guidelines by which to do so. This information should not be used as a description of specific coverage for members. When reviewing this section, please also refer to the online Dean Health Plan medical management information and other resources, listed below, to navigate the health plan policies, requirements, and member coverage.

## **Access**

- [Dean Health Plan Medical Management](#) web page by following these step-by-step instructions:
  1. Go to the Dean Health Plan home page at [DeanCare.com](#).
  2. Hover over **For Providers** located on the top-right of the screen.
  3. Click **Medical Management** Home showing under the Medical Management option.

## **Resources and Requirements**

- Once on the [Dean Health Plan Medical Management](#) page, access the following:
  - **Medical Prior Authorization Service List**, also referred to as the Master Service List (MSL), lists medical policies with links, prior authorization requirements, and applicable coverage limitations, as well as information for some services that do not require authorization. When authorization is required, submission method information about where and how to submit authorizations is also listed.
  - **Medical Injectables List** This is a list of drugs that are covered under the medical benefit.
  - **Non-Covered Services** This is a list of medical procedures and services that are not covered by the health plan.
  - **Medical and Drug Policies** Dean Health Plan policies are reviewed at least annually and updated based on technology assessment resources and in-network provider feedback.
  - **Prior Authorization web pages** detailing certain services, including, but not limited to:
    - [Radiology](#) — Dean Health Plan contracts with NIA Magellan for authorization of high-end radiology services. Authorization requests for high-end radiology should be submitted through the NIA Magellan portal linked from our [Account Login page](#).
    - [Musculoskeletal \(MSK\) Care Management Program](#) — Dean Health Plan contracts with Magellan Healthcare for review and authorization of non-emergent MSK, including inpatient hip and knee and inpatient and outpatient shoulder and spine surgeries. Authorization requests for MSK services should be submitted through the NIA Magellan portal linked from our [Account Login page](#).
    - Provider Communications webpage – Keep up-to-date on processes in place to support members in plans under payer 41822.
  - **Prior authorization forms** for certain services to be used by those providers without the ability to submit authorization requests electronically through the Dean Health Plan Provider Portal.
  - **Member benefit plan information** Access online member health plan benefit information, including certificate of coverage, member policy, or certificate at [memberbenefits.deancare.com](#) by entering the full member ID or group number. (*Note: You must use Google Chrome to access this page.*)
  - **Customer Care Center** Call the number on the member ID card with questions about policies, authorization requirements, member coverage, or the maximum number of visits in a member’s certificate.

# OUTPATIENT/AMBULATORY CARE SERVICES

## AUTISM SERVICES

Dean Health Plan covers services in accordance with the Wisconsin Autism Mandate.

For successful claim adjudication, the primary diagnosis must be a recognized autism diagnosis for the rendered service to be eligible for coverage without a prior authorization. If the service is for a primary diagnosis other than a recognized autism diagnosis, the service is subject to prior authorization requirements.

## BEHAVIORAL HEALTH AND SUBSTANCE ABUSE – OUTPATIENT

Dean Health Plan provides coverage of mental health and substance abuse treatment for those members whose benefit package includes mental health/substance abuse services with an approval authorization from the health plan. For providers without [Portal access](#), authorization requests may be faxed to 608-252-0830. All services must be medically necessary.

### ***Outpatient Behavioral Health and Substance Abuse***

Some outpatient services require prior authorization to determine medical necessity. These include but may not be limited to:

- Outpatient care with an out-of-network provider, including group, family, and individual therapy unless the member has a PPO or POS plan.

See Dean Health Plan’s Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers. These brief training slides, available from the [Behavioral Health Prior Authorization web page](#), highlight behavioral health medical policies and prior authorization information.

## OUTPATIENT SURGERY/OUTPATIENT PROCEDURE

### ***Definitions of Surgical Day Care Services And Ambulatory Surgery Center (ASC)***

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

*Note:* members who do not have an acute medical need which meets inpatient medical necessity criteria guidelines **cannot** be admitted as an inpatient status either prior to or following 23 hours of post procedural care.

SDC/SDCON procedures that are converted to an inpatient admission due to an unforeseen complication and meet inpatient criteria guidelines are considered urgent/emergent and require authorization as outlined in the Urgent/Emergent Inpatient Admission section of this manual.

- **Ambulatory/Minor Surgery Service (ASC)** are surgical services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.
- **Outpatient Surgery/Outpatient Procedures** are services that usually do not require general anesthesia or extended recovery room time and the member is expected to be discharged home that same day.

Some outpatient procedures require authorization prior to the services according to Dean Health Plan Medical Policy. If the service requires an authorization, providers are responsible for obtaining an approved authorization **prior** to the services being received.

Providers with Provider Portal access to authorizations **must** submit the required information through the Provider Portal. All providers without Provider Portal authorization access have two options to provide the required admitting information:

- Fax the required information to 608-252-0830
- Phone the required information to 800-356-7344

The applicable medical policy for the service being requested should be reviewed prior to submission of an authorization. Refer to the Medical Policies on the Medical Management page accessible from the Dean Health Plan website at [DeanCare.com](http://DeanCare.com).

## EMERGENT AND URGENT CARE SERVICES

### *Emergent/Emergency Care*

An emergency medical condition is one brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or part
- Inadequately controlled pain
- With respect to a pregnant woman who is having contractions:
  - Inadequate time to complete a safe transfer to another hospital before delivery, or
  - A transfer to another hospital may pose a threat to the health or safety of the woman or unborn child

**Emergency services are covered services given by any qualified provider, and are services needed to evaluate or stabilize an emergency medical condition. A prior authorization is not required for emergency services.**

### *Emergency Care from Dean Health Plan Providers*

Most of the time, members will get emergency care from a Dean Health Plan in-network provider. If members are unable to reach an in-network provider, they should go to the nearest medical facility to receive care.

### *Emergency Care from Out-of-Network Providers*

If your patient must go to an out-of-network provider for emergency care, call the Customer Care Center at the phone number listed on the member's ID card as soon as possible after they have received care to notify us of where they received emergency care. A prior authorization is not required for emergency care services. Applicable emergency room copayments apply whenever emergency services are received at an emergency room.

Non-emergent/non-urgent follow up care with an out-of-network provider is not covered unless this care is prior-authorized by the Dean Health Plan Utilization Management Department or unless use of an out-of-network provider is allowed under the member's benefit plan.

### *Urgent Care*

Urgent care is care that is needed sooner than a regular physician's office visit (i.e., broken bones, sprains, minor cuts and burns, drug reactions, and non-severe bleeding). A prior authorization is not required for services in an urgent care setting.

### *Urgent Care from In-Network Providers*

If the member is in the Dean Health Plan in-network service area and has a sudden illness or injury that is not a medical emergency, the member should call their primary care provider. Dean Health Plan expects that members receive urgent



care from in-network providers. In most cases, Dean Health Plan will not pay for urgently needed care that a member receives from an out-of-network provider while the member is in the Dean Health Plan in-network service area.

### ***Urgent Care from Out-of-Network Providers***

**Authorization is not required for services provided in an urgent care center.** If the member is outside of the service area, the member should call their primary care provider or the 24-hour nurse advice line to see if their condition needs immediate attention. Urgent care should be received at the nearest appropriate medical facility unless the member can safely return to the in-network service area to be seen by their primary care provider.

There are no available benefits for follow-up care with an out-of-network provider unless such care is necessary to prevent further health risks. **Such care must be prior authorized through the Dean Health Plan Utilization Management Department** unless the use of an out-of-network provider is allowed under the member's benefit plan.

The aforementioned guidelines do not apply to members enrolled in Dean Health Plan PPO or POS plans as they are not required to use in-network providers.

## **NEW TECHNOLOGIES**

Procedures not commonly accepted as a standard of care within the health profession are not a covered benefit of the member's plan. New technology services are reviewed by the Dean Health Plan Health Services Division for medical appropriateness and efficacy by the Dean Health Plan Medical Directors. Updated information about new technology assessments, when determined, is published in editions of the monthly [Dean Health Plan Provider News](#).

## **CHIROPRACTIC CARE**

Dean Health Plan provides coverage for chiropractic care when provided by an in-network provider with the exception of long-term and maintenance therapy. (Dean Health Plan Point of Service members are not required to use in-network providers.) For emergent/urgent chiropractic care by an out-of-network provider, refer to emergent and urgent care services in this section. A prior authorization request from a member's primary care provider is not required in order to see an in-network chiropractor. If you need further assistance in understanding chiropractic benefits, contact the Dean Health Plan Customer Care Center at 800-279-1301 and the phone number on the back of the member ID card for members in IFB plan types using payer ID 41822

### ***Therapy Types***

- **Active Therapy** — regular care with an established patient to resolve a particular ailment. An AT modifier is required for Active Therapy and must be in the first modifier position.
- **Long-Term Therapy** — therapy extending beyond two months that is determined, by our Medical Affairs Division, to be primarily maintenance therapy.
- **Maintenance Therapy** — ongoing therapy delivered after the acute phase of an accident or illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes "maintenance therapy" is made by the health plan after reviewing an individual's case history or treatment plan submitted by a health care provider.

The determination of what constitutes "maintenance/long-term therapy" is made by the chiropractor. Dean Health Plan will review the case history or treatment plan of the patient if a questionable situation would arise. When a member reaches long-term/maintenance therapy, providers can give them a copy of the "Chiropractic Handout for Dean Health Plan Members" on the next page of this manual. This is designed to give members a brief description of benefits that are not available for long-term/maintenance therapy.



## CAPITATION FOR CHIROPRACTIC SERVICES

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

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

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

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

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

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

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

### ***Reimbursement for Medicare Select***

The chiropractor should submit claims for services provided to Medicare Select Members directly to the Medicare Part B fiscal intermediary. Reimbursement for Medicare Select claims is as follows:

#### **Copayments, deductibles, & coinsurance:**

- Provider will receive payment directly from the Medicare B fiscal intermediary for Medicare-covered services.
- Dean Health Plan will reimburse the provider for all applicable copayments, deductibles, and coinsurance as specified on the Explanation of Benefits form the Medicare Part B fiscal intermediary.

#### **Non-Medicare Covered Services (i.e., supplemental benefits)**

- Dean Health Plan shall reimburse providers for covered services which are not Medicare-covered services (i.e., services that are supplemental benefits under the Medicare Select Product) at the Medicare par prevailing rate.

Covered Services for which there is no Medicare par prevailing rate shall be paid at Dean Health Plan's maximum allowable rate.

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

### ***Example of How Distribution of Monthly Capitation is Calculated***

Refer to Explanation of Chiropractic Capitation Allocation example. Total Allocation of Capitation Revenue for the entire chiropractic network:

Member months (Commercial Member Months Year to Date (YTD))

x Commercial Member Months at the Per Member Per Month (PMPM) rate  
= Gross Chiropractic Capitation Pool (CCP)

- Out-of-network urgent/emergent care (within service area)  
= Net Capitated Revenue before Withhold

- 10% Withhold  
= Net Capitation Revenue YTD

+ Supplies YTD  
= YTD Allocation for entire chiropractic network

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

Actual + Accrued chiropractic unique patients YTD  
÷ Actual + Accrued total unique Dean Health Plan Chiropractic patients YTD  
= % of Unique Patients

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

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

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

Key	
+	plus
x	multiply
-	minus
÷	divided
=	equals

# Explanation of Chiropractic Capitation

## Explanation of Chiropractic Capitation Allocation

CONFIDENTIAL BUSINESS INFORMATION

Dean Health Plan, Inc.

### Allocation of Capitation Revenue

Period Ending January 01, 2006 - September 30, 2006

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

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

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

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

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

	(29)	(30)	(31)	(32)	(33)	(34)	(35)	(36)	(37)
	Accrued	Accrued %	Prior Pymts	Prior Pymts	Prior Pymts	Current YTD	Current YTD	Current YTD	Monthly
(28)	Pat. YTD	Pat YTD	Sup \$'s	Cap \$'s	Med Select	Sup \$'s	Cap \$'s	Med Select	Payment
January YTD	38	2.18%	\$0.00	\$0.00	\$0.00	\$0.00	\$7,148.61	\$0.00	\$7,148.61
February YTD	76	2.18%	\$0.00	\$7,148.61	\$0.00	\$0.00	\$14,150.05	\$0.00	\$7,001.44
March YTD	113	2.18%	\$0.00	\$14,150.05	\$0.00	\$52.58	\$21,163.42	\$0.00	\$7,065.95
April YTD	272	2.63%	\$52.58	\$21,163.42	\$0.00	\$107.83	\$33,900.11	\$0.00	\$12,791.94
May YTD	343	2.88%	\$107.83	\$33,900.11	\$0.00	\$107.83	\$46,395.97	\$0.00	\$12,495.86
June YTD	381	2.87%	\$107.83	\$46,395.97	\$0.00	\$107.83	\$55,650.11	\$0.00	\$9,254.14
July YTD	405	2.74%	\$107.83	\$55,650.11	\$0.00	\$107.83	\$62,030.88	\$0.00	\$6,380.77

August YTD	415	2.60%	\$107.83	\$62,030.88	\$0.00	\$107.83	\$67,445.65	\$0.00	\$5,414.77
<b>September YTD</b>	<b>437</b>	<b>2.55.%</b>	<b>\$107.83</b>		<b>\$0.00</b>	<b>\$66.45</b>	<b>\$74,401.95</b>	<b>\$0.00</b>	<b>\$6,914.92</b>
September YTD \$67,445.65									
October YTD									
November YTD									
December YTD									

**Allocation Key**

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

**Explanation of Chiropractic Payment**

Dean Health Plan, Inc. CONFIDENTIAL BUSINESS INFORMATION

Payment for: *Dean Health Plan Sample Chiropractic Office*

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

**Explanation of Chiropractic Payment Key**

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

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

**Chiropractic Supplies Paid Key**

- 43. Billing Chiropractor
- 44. Service Date
- 45. Patient Name
- 46. Member Number
- 47. Service Code
- 48. Supply Description
- 49. Number of Units
- 50. Dollar Amount Claimed
- 51. Copay Amount
- 52. Total Amount Paid for Supplies

## CHIROPRACTIC HANDOUT FOR DEAN HEALTH PLAN MEMBERS

Dean Health Plan covers chiropractic services when they are provided by a Dean Health Plan in-network provider to a Dean Health Plan member with applicable coverage. As a Dean Health Plan member, we encourage you to refer to your benefit certificate to determine your coverage and see if you are required to pay an office copayment each time you visit your chiropractor. Also, check your benefit certificate to see if items supplied by your chiropractor are covered under your member benefit.

Examples of covered supplies include:

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

Examples of non-covered supplies include orthopedic pillows, cushions, and other convenience items.

Services not covered for chiropractic care:

- Long-term and/or maintenance therapy
- Chiropractic care (non-urgent/emergent) provided by an out-of-network chiropractor (unless you are enrolled in a Dean Health Plan Point of Service (POS) or Preferred Provider Organization (PPO) health plan).

Dean Health Plan provides coverage for chiropractic care with an in-network provider with the exception of long-term and maintenance therapy, as described below. If you are enrolled in a Dean Health Plan Point of Service health plan, you are not required to use in-network providers.

- **Long-Term Therapy** – means therapy extending beyond two months which is determined, by the Dean Health Plan Health, to be 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 their 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 Dean Health Plan after reviewing the case history or treatment plan. Services are **not covered** if you seek chiropractic care with a provider who is out of the Dean Health Plan network, unless it is urgent or emergent.

We are here to help! If you need assistance in understanding chiropractic benefits or have questions, please call the Dean Health Plan Customer Care Center at the number on the member ID card.

# HOSPITAL ADMISSIONS AND CONCURRENT REVIEW PROCESS

## BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES– INPATIENT

Dean Health Plan manages behavioral health services for all members who have behavioral health benefits. For providers without [Portal access](#), authorization requests may be faxed to 608-252-0840. All services must be medically necessary.

### ***Inpatient Behavioral Health and Substance Abuse***

- For urgent/emergent inpatient hospital admissions, a prior authorization is not required. However, the admitting facility must notify Dean Health Plan of the admission within 48 hours or whenever it is medically feasible (whichever is longer).
- Prior authorization is required for all elective or non-emergency inpatient and residential treatment center stays *before* admission.

## URGENT/EMERGENT INPATIENT ADMISSION NOTIFICATION

In-network hospitals are responsible for notifying the Dean Health Plan Utilization Management Department within 48-hours or whenever it is medically feasible (whichever is longer) of an urgent/emergent inpatient admission. A member may require emergent/urgent inpatient admission to an acute hospital from any of the following settings:

- Home
- Doctor's office
- Emergency room
- Observation bed
- Surgical day care (SDC) unit
- Transfer from another facility (*including neonatal intensive care unit admission from another facility*)

Hospital observation admissions **do not require authorization** by Dean Health Plan. They are considered an extension of the emergency care that the member received while in the emergency room.

### ***Notifying the Health Plan of an Emergent Inpatient Admission***

For payer ID 39113 we encourage providers to establish a [Dean Health Plan Provider Portal account](#) and submit their emergent inpatient authorization requests through our secure Provider Portal. Member eligibility can also be confirmed in the health plan's Provider Portal through the Eligibility application.

If not working through the health plan's Provider Portal, the process for notification and submitting authorization requests for emergent inpatient admissions by phone varies depending on whether the request is made during standard business hours or outside of standard business hours. Standard business hours for the Utilization Management Department are Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding federal holidays.

Providers should be prepared to provide all the following information when submitting an authorization request:

- Member name (*middle initial if available*)
- Member date of birth (DOB)
- Member ID number
- Admission date (*must be the actual date the member was admitted to inpatient status*)
- Admitting/attending physician name and phone number
- Facility name and phone number

- Admitting diagnosis
- Type of admission: ER, direct admit, day of surgery

Hospital inpatient admissions require authorization from Dean Health Plan whenever a member is admitted from an emergency room. In urgent and emergency situations, Dean Health Plan must be notified of any inpatient admissions resulting from emergency room services within 48 hours or when it is medically necessary (whichever is longer).

All hospitals without Provider Portal access have two options to notify Dean Health Plan of the inpatient admission:

- Fax the required admitting information to 608-252-0830
- Phone the required admitting information to 800-356-7344

Urgent/emergent inpatient admissions with the exception of labor and delivery will be reviewed by Dean Health Plan Utilization Management to confirm that the inpatient level of care is medically necessary. The medical necessity criteria utilized by Dean Health Plan Utilization Management is nationally recognized and evidence based.

### ***Concurrent Review***

Urgent/Emergent inpatient admissions that meet medical necessity requirements will be approved for the date of admission only, pending concurrent review and ongoing medical necessity determinations for facilities that do not have a Diagnosis Related Group (DRG) contract with Dean Health Plan. Hospital facilities that do not have a DRG contract with Dean Health Plan are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Concurrent review information is required to be provided to the Dean Health Plan Utilization Management department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Dean Health Plan are not required to provide concurrent review to the Dean Health Plan Utilization Management Department, however they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the inpatient admission and discharge dates provided by the DRG hospital facility.

## **ELECTIVE INPATIENT ADMISSION AUTHORIZATION**

**Note: This section is specific to non-urgent/emergent conditions ONLY.**

The hospital or servicing provider is responsible for notifying Dean Health Plan as soon as the procedure is scheduled or **at least five to seven days prior** to the planned inpatient admission date.

Elective Admissions are defined as non-urgent/emergent inpatient services that are planned and are able to safely be scheduled at a future date and are not being admitted from one of the settings indicated in the "Urgent/Emergent Admission Notification" section above. Notification of elective inpatient admission by the servicing hospital or specialist provider is required **a minimum of five to seven days prior** to the scheduled admission date.

Elective inpatient services that were scheduled but were not prior authorized in the indicated minimum time frame are not considered an urgent/emergent service. Providers who fail to follow the indicated prior authorization requirements for Elective Admissions may be responsible for services denied as not medically necessary.

### ***Provider Portal Authorization Submissions for Inpatient Admission Authorization under payer ID 39113***

Only **one** authorization will be processed for the requested inpatient elective admission. If submitted via the Provider Portal, the determination will be viewable only to the submitting hospital or specialty provider. It is the responsibility of the submitting hospital or specialty provider to communicate the determination to the non-submitting provider. The Provider Portal and resources can be accessed from the [Account Login](#) page.

### ***Elective Inpatient Prior Authorization Requirements***

The following information is required for prior authorization of an elective admission:



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

For payer ID 39113, providers with Provider Portal access to the authorization applications must submit the required information through the Provider Portal. All providers without Provider Portal authorization access have two options to provide the required information indicated above:

- Fax the required information to 608-252-0830
- Phone the required information to 800-356-7344
- For payer ID 41822, providers with access to Availity Essentials should submit electronically via this multi-payer tool. If interim processes are in place, select instructions for your preferred submission method found on our Communications [Page](#), found on the Dean Health Plan provider home page.

### **Concurrent Review**

Elective inpatient admissions that meet medical necessity requirements will be approved for the date of admission only. Hospital facilities that do not have a DRG contract with Dean Health Plan are required to provide ongoing, concurrent review information for determination of the continued medical necessity of the member's stay. Concurrent review information is required to be provided to the Dean Health Plan Utilization Management department from the facility's Utilization Management Department.

Facilities that have a DRG contract with Dean Health Plan are not required to provide concurrent review to the Dean Health Plan Utilization Management Department, however they are required to provide the date of the member's discharge from the facility. Authorization dates of service will be based on the admission and discharge dates provided by the DRG hospital facility.

If the elective date of admission is rescheduled or cancelled, please notify the Dean Health Plan Utilization Management Department at 800-356-7344, ext. 4455.

## **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.

- Dean Health Plan POS or PPO members are not required to use a Dean Health Plan participating provider.
- POS members may elect to use out-of-network providers with reimbursement at the out-of-network benefit level.

For critical medical, surgical, perinatology and adult psychiatric conditions, please contact an in-network hospital facility prior to transferring a member to ensure the service is available. If services are available with an in-network hospital facility, and the member is deemed medically stable by the attending physician, Dean Health Plan HMO members are required to be transferred to an in-network facility. Dean Health Plan POS members are required to be transferred to an in-network facility once deemed medically stable by the attending and accepting providers to continue receiving in-plan benefit levels.

When transfer to an out-of-network facility is determined to be appropriate for emergency and/or specialty care that is unavailable in-network, the admission is authorized. However, Dean Health Plan must be notified within 24 hours or the next business day of the transfer as well as of the medically necessary reason. For all non-emergent transfers to out-of-

network facilities, prior authorization is required to be obtained from Utilization Management before transfer to the out-of-network facility occurs. If a Dean Health Plan HMO member is emergently admitted to an out-of-network facility, the member may be required to transfer to an in-network inpatient facility once they are medically stable. If you have any questions about transferring one of your patients, contact Customer Care Center at the phone number listed on the member's ID card.

## OBSERVATION STAYS

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

An observation stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member to determine if they may require an inpatient stay or follow-up care in another setting. An observation stay should not exceed 48 hours.

Examples considered appropriate for observation stay include, but are not limited to:

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

Providers are NOT required to notify or receive authorization for an observation stay in a facility. Reimbursement for observation stays is limited to a maximum of 48 hours. Observation stays that are converted to an inpatient admission are considered urgent/emergent and require authorization as outlined in the [Urgent/Emergent Inpatient Admission Notification section](#).

## PROGRAM OBJECTIVES AND EVALUATION

The purpose of the 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. The UM objectives include, but are not limited to the following:

- Comply with State and Federal regulations, as well as National Committee for Quality Assurance (NCQA) standards
- Monitor potentially avoidable admissions and address identified areas of concern
- Focus inpatient or outpatient review activities on opportunity areas as determined by various data sources
- 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), emergency room utilization, inpatient utilization, laboratory utilization, and physician practice utilization
- Assess provider and member satisfaction with UM activities and address areas of dissatisfaction, when appropriate
- Integrate UM with Disease and Case Management as appropriate when identified during UM activities
- Monitor and analyze variations in the delivery of care in the network for which evidence-based standards of appropriate care exist, and consider opportunities to improve quality of care and reduce medical costs
- Implement or maintain policies and procedures in accordance with regulatory and accreditation requirements
- Develop or adopt UM criteria and guidelines that are consistent with generally accepted standards and are based on sound clinical evidence
- Implement and maintain a process to review emerging medical technology and new uses for existing medical technology to determine both safety and effectiveness
- Maintain a process to ensure that relevant information is collected to review medical necessity for coverage
- Employ qualified health professionals to assess the clinical information used to support UM decisions
- Maintain a process in which UM decisions are made in a timely manner and to ensure that members and providers are notified of determinations in accordance with federal and state requirements as well as accreditation standards
- Provide access to staff for members and providers seeking information about the UM process and the authorization of care and prompt turnaround of decisions by qualified health reviewers
- Implement and maintain processes for objective and systematic monitoring, evaluation, and improvement of UM processes and services
- Implement and maintain processes, policies, and procedures to assist in monitoring the quality of UM decisions. These mechanisms include, but are not limited to, inter-rater reliability and manageability, case audits, and the identification of potential adverse events

The UM Department annually evaluates the UM Program and submits their UM Program Evaluation to the UM Committee for review and approval. The evaluation includes a review of the UM Program using member complaints, 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.

## STATEMENT OF CONFIDENTIALITY

Dean Health Plan 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 Dean Health Plan 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 requests 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 Dean Health Plan where that employment may be construed as a conflict of interest.

# PHARMACY

## PHARMACY MANAGEMENT

Dean Health Plan provides a comprehensive drug benefit for those members in a plan with prescription drug coverage. Member ID cards identify those members with a drug benefit.

A pharmacy benefit drug is a medication covered and paid for under the pharmacy benefit, oftentimes self-administered by the member. A medical benefit drug is defined as a medication that is covered and paid for under the medical benefit, oftentimes administered to the member by another healthcare professional.

Pharmacy Management includes but is not limited to:

- Formulary Tiering
- Prior Authorization and Step Therapy Requirements
- Quantity Limits
- Specialist Restrictions
- Mandatory Specialty Pharmacy
- Mandatory Generic Substitution

Dean Health Plan provides pharmacy information, including medical benefit drug policies, pharmacy benefit drug policies, formulary coverage, a listing of prior authorized drugs, and pharmacy program information for providers on the Dean Health Plan website at [DeanCare.com/Providers/Pharmacy](https://deancare.com/Providers/Pharmacy). Medical benefit drug prior authorization forms and policies can be accessed via the [Medical Injectable List](#) or links from deancare.com. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms that can be accessed through the Navitus Prescriber Portal at [Prescribers.Navitus.com](https://Prescribers.Navitus.com).

Dean Health Plan notifies clinics of new pharmacy information through provider notifications including:

- The monthly [Dean Health Plan Provider News](#) – a newsletter specifically for Dean Health Plan providers
- Policy update provider notifications – issued monthly to communicate medical benefit drug policy updates, in addition to certain medical policy updates and Health Plan initiatives, outside of the monthly newsletter

## DRUG PRIOR AUTHORIZATION PROCESS

### ***Pharmacy Benefit Drug Prior Authorization***

Dean Health Plan contracts with Navitus to manage pharmacy benefit drug prior authorizations. Information about the prior authorization process for pharmacy benefit drugs is available at [Navitus.com](https://Navitus.com). From this website, providers can go to the Prescribers Section, choose more information for prescribers, then refer to the prior authorization area. Providers can view instructions on how to submit a prior authorization and log into the Navitus Prescriber Portal at [Prescribers.Navitus.com](https://Prescribers.Navitus.com) to access the prior authorization forms. Pharmacy benefit drug prior authorization criteria are listed on the prior authorization forms. Please note that the listed fax and phone numbers on the forms for submission and Customer Care can vary.

### ***Medical Benefit Drug Prior Authorization***

Dean Health Plan manages medical benefit drug prior authorization requests with support from Magellan Rx for oncology and oncology-related drugs. Medical benefit drug prior authorization policies and forms can be accessed from the [Medical Injectable List](#). Oncology and oncology-related medical benefit drug policy documents can be accessed from the “View Medical Oncology Drugs List” link on the Dean Health Plan Document Library web page.

## PEER-TO-PEER REVIEW PROCESS

Providers are encouraged to take advantage of the peer-to-peer review process before submitting a prior authorization appeal. The [peer-to-peer review process](#) offers the requesting provider an opportunity to discuss the denial determination of a pharmacy authorization request with a Dean Health Plan Medical Director.

The opportunity for a peer-to-peer review is available for up to ten calendar days after the denial determination has been made. Alternatives to consider if the ten-calendar day window has elapsed include filing a formal provider appeal, directing the member to the appeals and grievance process outlined in their letter, member benefit certificate, or by contacting the Dean Health Plan Customer Care Center at the number on the member ID card.

## AUTHORIZATION APPEALS

Dean Health Plan providers can appeal medical and pharmacy benefit drug denial determinations, including denials for oncology and oncology-related drugs. We recommend that providers complete the [peer-to-peer review process](#) before submitting a provider authorization appeal as resolution may be reached with a verbal discussion.

**Prior authorization appeals must be submitted to Dean Health Plan, regardless of the entity that processed the prior authorization request.** To submit an appeal for an authorization request that was submitted to Dean Health Plan or Navitus, providers may submit a letter of necessity by fax to 608-252-0812 or by paper mail to: Dean Health Plan, Route CP595, PO Box 9310, Minneapolis MN 55440-9310.

When submitting an appeal, review the denial reason and provide supporting documentation for the request (e.g., medical records, medication history, medical journals, etc.). If more information becomes available after the authorization request was initially denied, the authorization request may be submitted again to be reconsidered. Ultimately, the prescriber or member has the opportunity to pursue the grievance process for any drug prior authorization request that is redirected to other covered drugs or denied.

## DRUG FORMULARIES

Dean Health Plan has developed pharmacy benefit drug formularies specific to our benefit plans to help providers choose the appropriate drugs based on their member's needs, coverage plan, and cost of each drug. Our drug formularies are published on the Dean Health Plan website at [DeanCare.com/Members/Pharmacy-Benefits/Member-Drug-Formulary](https://www.deancare.com/Members/Pharmacy-Benefits/Member-Drug-Formulary). If you are unsure which drug formulary applies to a member, go our online member health plan benefit information at [MemberBenefits.DeanCare.com](https://www.deancare.com/MemberBenefits).

Formularies are available as Adobe PDFs. Users can scroll through the list or type in "Ctrl + F" to bring up the search bar to type in the name of the drug. All formularies contain the Drug Name, Special Code, Tier level, and Category the drug is listed under.

*Note:* The State of Wisconsin Group Health Insurance Program (for members enrolled in the Wisconsin Department of Employee Trust Funds [ETF] plan), Medica SSM Employee Health Plan and the Medica Employee Health Plan has its own unique formulary and drug prior authorization process. Refer to the Navitus website at [Navitus.com](https://www.navitus.com) or call Navitus Customer Service at using the phone number on the member's ID card for formulary and benefit information for this member population.

## PREVENTIVE DRUG LIST

Dean Health Plan publishes a Preventive Drug List of covered drugs to assist providers in choosing the right drugs for their patient's needs. This resource details certain preventive medications that are available at \$0 to members. For the up-to-date list of \$0 preventive drugs, refer to the Preventive Drug List available from the Pharmacy Services for Health Care Providers page on the [Dean Health Plan Pharmacy benefits for Members web page](#).

## SPECIALTY PHARMACY

Dean Health Plan uses Lumicera Health Services for specialty pharmacy services. Lumicera is experienced in managing specialty medications and coordinating personalized support for members impacted by chronic illnesses and complex diseases. Lumicera offers free delivery, same day service, medication consultations, and refill reminders. Refer to our [Specialty Pharmacy Program web page](#) for more information about Lumicera and available support for members.

Contact information for Lumicera:

- Phone: 855-847-3554
- Fax: 855-847-3558
- Address: 310 Integrity Rd. Madison, WI 53717
- Website: [lumicera.com](http://lumicera.com)

## MAIL ORDER PHARMACY

Costco is Dean Health Plan's preferred mail order pharmacy. Members do not need to have a Costco membership to use this service. Refer to [the mail order information on our website](#) for more information. For additional information or for member registration, go to [deancare.com/members/pharmacy-benefits/cost-savings](http://deancare.com/members/pharmacy-benefits/cost-savings).

## EXCLUDED OR NONFORMULARY DRUG POLICY

Dean Health Plan has an established policy for handling requests for drugs excluded from the formulary (notated as "NC" on the formulary). Physicians may request consideration for excluded drugs on an exception basis. Exception requests should be submitted using the Exception To Coverage form, which can be found on the Navitus Prescriber Portal. 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 the Medical Policy Committee.**

In the case of denials for exception requests, a denial letter will outline appeal options available to physicians, members, and their representatives. Pharmacy appeals for coverage under a Commercial product are reviewed by Dean Health Plan's Grievance and Appeals Team.

## OTHER PHARMACY INFORMATION

- 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.
- Mail order prescriptions are available through Costco Mail Order Pharmacy at [pharmacy.costco.com](http://pharmacy.costco.com). Members do not need to have a Costco membership to use this service.
- 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.
- Only retail pharmacies with an active Dean Health Plan Pharmacy Agreement may provide outpatient drugs to Dean Health Plan 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 an in-network pharmacy provider.
- When a member has more than one insurance carrier, coordination of benefits for pharmacy claims shall occur. If Dean Health Plan is the member's primary carrier, all pharmacy charges should be submitted according to the Dean Health Plan filing guidelines.

In situations where Dean Health Plan 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 an in-network pharmacy (usually a one-day supply).
- The member should be given a written prescription for the remaining medication needed and instructed to have the prescription filled at an in-network pharmacy.



# CASE MANAGEMENT

## CASE MANAGEMENT PROGRAM DESCRIPTION

Dean Health Plan offers case management to optimize the overall health of our members across their health care continuum by engaging them in population informed programs and services available through the Health Plan, network providers, and community. Core objectives of case management programs are to help members self-manage complex or chronic conditions, promote the primary care provider relationship, connect members with appropriate community resources, and assist in navigation of the health care system including optimum utilization of health coverage and benefits.

Member participation in case management is voluntary, and members may opt out at any time. Please see below for how to refer patients to Case Management.

Dean Health Plan's Case Management team includes nurses, social workers, engagement coordinators, and others who help members learn how to manage their health care needs. Through various outreach methods, the team provides education, support, and resources for members while promoting quality, cost-effective outcomes and working to reduce the burden of illness. A comprehensive assessment of the member's health and wellness needs informs development of an individualized plan of care with member-centric goals. Licensed Case Management staff adhere to NCQA standards for complex case management.

Case Management team members:

- Educate members on how to self-manage their diagnosis.
- Support and guide members in setting achievable goals as they work toward improving their quality of life, overall health, and well-being.
- Help members understand their individual health care plan including how to maximize benefits.
- Connect members with services and community resources necessary to self-manage their health care needs.
- Serve as an advocate to help members achieve their optimal physical and mental health.
- Help members learn how to navigate the complex health care system.
- Assist in guiding members to the best in class location for the type of transplant they need, utilizing Optum-designated transplant centers (Centers of Excellence).
- Support members with breastfeeding and pumping.

Case Management is not able to answer or resolve issues for questions specifically related to:

- Enrollment (e.g., questions about services before becoming a member)
- Billing
- Claims
- Prior authorizations
- Denials
- Grievance and appeals
- Benefit determinations
- Provider availability and scheduling of health care appointments

## CASE MANAGEMENT PROGRAMS

### ***Advanced Illness and Advance Care Planning***

Dean Health Plan's Advanced Illness program provides comprehensive care for members facing life-limiting illness, generally defined as the last twelve months of life. The model is focused on reducing the burden of illness impacting the physical, psycho-social, emotional, spiritual and environmental well-being of our members while supporting and honoring their unique traditions, culture and goals of care.

Advance care planning is the process of thinking about, communicating, and documenting future health care wishes in case of illness, accident, or sudden medical event. Dean Health Plan wants to ensure that members' health care wishes are known and respected. Social workers are available to help any member over age eighteen begin or continue the process of advance care planning.

Advanced Illness nurses and advance care planning social workers help members:

- Explore personal values, beliefs, and meaning of quality of life
- Weigh options for the kind of care and treatment members would or would not want
- Consider who members should appoint to speak on their behalf
- Start the conversation with family, friends, clergy, health care and other providers
- Work to align member goals and coordination of goals with health care team and family
- Complete advance directive documents (Power of Attorney for Health Care and Living Will) to clearly state values and wishes
- Review current advance directive to ensure it continues to reflect the member's wishes

For more information, go to Dean Health Plan's Advanced care planning web page at [DeanCare.com/Wellness/Care-Management/Advance-Care-Planning](https://DeanCare.com/Wellness/Care-Management/Advance-Care-Planning).

### ***Behavioral Health Case Management***

Behavioral health and substance use case management provides an individualized approach for members with mental health and substance use disorders to enable them to manage their health and improve their quality of life. For members with medical and behavioral needs, Dean Health Plan offers an integrated program that supports members with depression, anxiety, stress, and other mood disorders.

A behavioral health case manager can help members to:

- Understand individual health care plans to self-manage health conditions.
- Coordinate care with providers, clinics, and programs to facilitate treatment for mental health or substance use conditions.
- Connect to community-based services and resources to enhance wellness.
- Understand how to use available health care services to receive the right care at the right time in the right place.
- Transition back to home after an inpatient behavioral health or substance use hospitalization.

For more information, go to Dean Health Plan's Behavioral health and substance use web page at [DeanCare.com/Wellness/Care-Management/Behavioral-Health-And-Substance-Use](https://DeanCare.com/Wellness/Care-Management/Behavioral-Health-And-Substance-Use).

### ***Complex Case Management***

Dean Health Plan's complex case management program is a multi-disciplinary approach to the coordination of care and services provided to adult and pediatric members who have a chronic or acute medical condition and who need help navigating the system to facilitate appropriate delivery of care and services.

The complex case management team helps members and caregivers:

- Navigate the complex health care system.
- Understand current acute and chronic medical conditions.
- Manage medications, including how to communicate with providers to get the best results from medications.
- Understand how to use available health care services to receive the right care at the right time in the right place.
- Identify self-care needs, including arranging referrals to therapeutic services and community-based support resources.

For more information, go to Dean Health Plan's Complex case management and care coordination web page at [Dean Health Plan Provider Manual | Revised Jan 2024](#)

## **Pregnancy Program**

Dean Health Plan provides case management services to birthing parents enrolled in our Pregnancy program to promote healthy outcomes for mother and baby. The pregnancy case management team provides outreach, education, and complex case management on continuum through the pregnancy and post-partum period.

The pregnancy case management team supports birthing parents:

- Navigate the complex health care system.
- Coordinate appointments with their provider and specialists, including connecting to transportation resources as needed.
- Assess for stress and markers of depression, integrates with behavioral health care as appropriate.
- Assesses for social determinant of health needs and connects to appropriate community-based support resources.
- Develop a plan for services and supports after the birth of the baby.
- Make healthy changes – like quitting tobacco.
- Connect with local resources and find pregnancy education classes.
- Get support with breastfeeding and pumping.
- Receive support with any health concerns or chronic conditions, including behavioral health and substance use.

For more information, go to the Dean Health Plan’s Pregnancy Program webpage at [DeanCare.com/Wellness/Care-Management/Maternal-and-Child-Health](https://deancare.com/Wellness/Care-Management/Maternal-and-Child-Health)

## ***Transplant Case Management***

Transplants are life changing and complex, not only affecting the member but involving their family as well. Dean Health Plan’s Case Management team offers support before, during, and after the procedure, providing education and coordination of services to ensure members receive the care they need. This includes guiding members to the best-in-class location for the type of transplant they need, utilizing Optum designated transplant centers through the Centers of Excellence (COE) Program.

Transplant case managers complete both utilization management and case management functions to provide members with a seamless relationship and key points of contact with Dean Health Plan.

A transplant case manager and engagement coordinator helps members:

- Understand and manage the complex disease that is leading toward transplantation.
- Coordinate care with providers, clinics, and programs through the transplant process.
- Navigate the evaluation and listing process and help them to maintain transplant readiness while awaiting transplant.
- Navigate and understand health coverage and benefits before, during, and after transplant.
- Ensure appropriate prior authorizations for transplant services are in place.
- Connect with an advance care planning social worker, if desired.

All transplant services except for cornea require prior authorization. For CAR-T services please submit prior authorization requests directly through the pharmacy department using the Medical benefit prior authorization form found here: [DeanCare.com/Providers/Medical-Management](https://deancare.com/Providers/Medical-Management).

For more information, go to the Dean Health Plan Transplant Case Management webpage at [DeanCare.com/Wellness/Care-Management/Transplant-Case-Management](https://deancare.com/Wellness/Care-Management/Transplant-Case-Management).

## **Social Work Resources**

Dean Health Plan by Medica social workers help members to meet their goals and have a good quality of life with a focus on physical, emotional, social, and spiritual well-being.

A social worker helps members:

- Connect with housing, food and employment resources
- Find transportation resources
- Locate resources for caregiver support
- Understand how to access public benefits
- Connect socially through support groups, peer groups, and spiritual communities
- Identify resources to stay safe and report abuse, neglect, harassment and discrimination

For more information, go to Dean Health Plan's Social Work web page at [deancare.com/wellness/care-management/social-work](https://deancare.com/wellness/care-management/social-work)

## **CASE MANAGEMENT REFERRALS**

Members may self-refer to Case Management by calling the Dean Health Plan Customer Care Center at 866-905-7430, or by emailing [caresupport@medica.com](mailto:caresupport@medica.com) or online at [DeanCare.com/CareManagement](https://DeanCare.com/CareManagement).

Providers may refer a member to Case Management via:

- The provider referral line 866-905-7430. Provider should have the following information when calling in a member referral:
  - Provider name/office information
  - Member name
  - Member date of birth
  - Reason for referral, including pertinent diagnosis
- Email to [caresupport@medica.com](mailto:caresupport@medica.com)
- Epic REF294
  - DHP Care Management
  - DHP OB Case Management or
  - DHP BH Case Management
- Guide patients to Health Plan Case Management websites for more info or to self-refer
  - [DeanCare.com/CareManagement](https://DeanCare.com/CareManagement)

In addition, Dean Health Plan Case Management identifies members for case management services through:

- Discharge Planners and nurse navigators
- Pharmacy data
- Claims data
- Hospital discharge data
- Health Assessments
- Internal referrals from other departments
- Dean Health Plan's Utilization Management

## CASE MANAGEMENT OUTREACH PROCESS

Dean Health Plan's Case Management standard hours of operation are 8:00 a.m. to 5:00 p.m. (CST), Monday through Friday excluding nationally recognized holidays.

- The goal is to outreach to members within two business days of provider or member self-referral.
- Case Management makes three contact attempts (typically two phone calls and a letter) over approximately a two-week timeframe before closing the referral if a member does not respond to the outreach attempts.
- Members must engage with a case management team member and accept referral to additional services/resources before said service can be provided (e.g., case management cannot arrange transportation to appointments without the member's permission).

**Note:** Dean Health Plan's case management team **does not** provide urgent or emergent services.

## LIVING HEALTHY

In partnership with WebMD, Dean Health Plan offers Commercial and Medicaid members over the age of 18 years condition management health coaching for those with one or more of the following conditions; asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure and coronary artery disease (CAD) through its Living Healthy Program.

WebMD Health Coaches provide support online and by phone around three key aspects of condition self-management:

- Medication — education and goal setting around medication adherence for long-term health outcomes.
- Monitoring — help members understand their "health numbers" and healthy ranges, how often to have tests done, and the factors that can influence these key markers of their condition.
- Lifestyle — telephone support from a registered nurse or certified health coach on healthy behaviors, goal setting, development of healthy habits, and optimization of self-care.

For more information, go to the [Dean Health Plan Living Healthy webpage](#).

# MEMBER GRIEVANCE AND APPEALS PROCESS

## 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 Plan 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, Dean Health Plan may contact a provider for more information related to the issue. We require that our practitioners respond promptly to any requests for information from Dean Health Plan. 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, Dean Health Plan gives our practitioners the opportunity to discuss decisions that are based on medical necessity with a Dean Health Plan Medical Director, through our peer-to-peer process. The treating physician will be informed at the time of the denial by the Medical Affairs Division of how to initiate the peer-to-peer process should they want to discuss the decision. It is recommended, when available, to first exhaust the peer-to-peer process prior to pursuing the Grievance and Appeal process.

The procedure for filing a complaint, appeal, or grievance is defined below. This information is also located in the Member Certificates. Your understanding of this process will assist us in resolving member issues in a timely manner.

### ***Complaint***

Dean Health Plan takes all member complaints seriously and is committed to responding to them in an appropriate and timely manner. If a member has a complaint regarding any aspect of care or decision made by you or the health plan, please contact the Customer Care Center using the phone number listed on the member's ID card. We will document and investigate the member complaint and may notify the member of the outcome of the complaint. Complaints regarding the quality of service or quality of care of a physician, clinic, or staff are considered confidential and the outcomes are not shared with members. If the complaint is not resolved to the member's satisfaction, they can file a grievance. Because most concerns can be addressed informally, we encourage either you or the member to contact the Customer Care Center first for discussion before taking any formal action.

### ***Grievance/Appeal***

Any written expression of dissatisfaction will automatically be addressed as a grievance and/or appeal as required by product type and applicable regulations. Dean Health Plan does not require a provider or member use a specific term in order for a review to begin.

A member or their authorized representative can file a grievance/appeal in writing to the following address or fax number:

**Dean Health Plan  
Route CP595  
PO Box 9310  
Minneapolis MN 55440-9310  
Fax 608-252-0812**

Expedited grievances/appeals, or situations that may seriously jeopardize the member's life, health, or the ability to regain maximum functionality may also be submitted by calling the number listed on the member's ID card. In most cases, standard grievances/appeals will be researched and responded to within 30 working calendar days, while expedited grievances/appeals will be resolved and responded to within 72 hours.

Upon receipt of the grievance, Dean Health Plan's Grievance and Appeal Department will acknowledge it within five business days. Our acknowledgment letter will advise the member of their right to:

- Submit additional written comments, documents, or other information regarding their grievance/appeal
- Be assisted or represented by another person of their choice
- Appear before the Grievance and Appeal Committee if they wish to do so, if eligible; 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 a 30 calendar day timeframe 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.

The member or the member's authorized representative have the right to request a copy of documents, free of charge, relevant to the outcome of the grievance by sending a written request to the address listed above.

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

### ***Independent External Review***

A member may be entitled to an independent external review (IER) 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 an experimental treatment. Determinations involving pre-existing conditions and Policy Rescissions are also eligible for IER. A member must exhaust all appeal/grievance options before requesting an independent external review.

However, if we agree with the member that the matter should proceed directly to independent review, or if they need immediate medical treatment and believe that the time period for resolving an internal grievance/appeal will cause a delay that could jeopardize their life or health, they may ask to bypass our internal grievance/appeal process. In these situations, the request will be processed on an expedited basis.

If the member or the member's authorized representative wish to file a request for an independent review, the request must be submitted in writing to the address listed above in the "Grievance/Appeal" subsection, or submitted directly to the IER if specified in the grievance/appeal decision letter, and received within four months of the decision date of the grievance.

Upon receipt of the request, a URAC accredited IER will be assigned to the case through an unbiased random selection process, unless the policy is subject to the Federal IER process in which case Maximus will be the selected IER. The assigned IER will also deliver a notice of the final external review decision in writing to the member or the member's authorized representative and Dean Health Plan within 45 calendar days of their receipt of the request.

A decision made by an IER is binding for both Dean Health Plan and the member with the exception of pre-existing condition exclusions and the rescission of a policy or certificate. The member is not responsible for the costs associated to the IER. The decision is binding on both the insurer (the Plan) and the insured.

Requests for benefits beyond those defined in the benefit package are not eligible for independent external review. Please contact our Customer Care Center for information regarding availability, and the process for initiating the review. Appeals filed on behalf of a Medicare member will be automatically forwarded to Maximus if a final adverse determination is issued.

### ***Urgent Grievance/Appeal***

If the initial grievance/appeal involves the need for urgent care, we will resolve those within 72 hours of receiving the grievance/appeal according to Dean Health Plan's criteria which is based upon the urgent care grievance/appeal provisions of state law. If the grievance/appeal meets criteria for an expedited grievance/appeal, meaning the situation is deemed urgent in nature or the member is receiving ongoing treatment, they are also eligible for an expedited external review concurrent with the internal expedited review of their grievance/appeal. The request may be oral or written.

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

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

**Office of the Commissioner of Insurance  
PO Box 7873  
Madison, WI 53707-7873**

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



# QUALITY IMPROVEMENT

It is the mission of Dean Health Plan to promote members' health by ensuring the right care, at the right place, at the right time, and with the right provider. The Quality Improvement Program provides the overview of how the Health Plan assesses and improves the quality of clinical care and quality of service delivered to its members.

## QUALITY OF SERVICE ISSUES

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

Dean Health Plan categorizes quality of service issues as follows:

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

All issues relating to quality of service provided to Dean Health Plan members are referred to Quality Improvement for investigation. Quality Improvement logs all incoming issues concerning quality of service, noting the date of receipt and the source. Quality Improvement will determine if the individual(s) involved was a Dean Health Plan member at the time of service. If not, the quality of service concern is referred to the practitioner clinic and/or medical facility for investigation and resolution. This referral is documented in Quality Improvement.

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

Quality Improvement will review the following as they pertain to the service issue:

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

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

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

## QUALITY OF CARE ISSUES

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

Grievance and Appeals logs all incoming issues concerning quality of care, noting the date of receipt and the source (member complaints, inpatient and outpatient review, studies, reports, and referrals from providers and practitioners). Grievance and Appeals will also send any required acknowledgement letter within 5 working days of receipt. Grievance and Appeals will then forward all quality of care issues involving a Dean Health Plan member at the time of service to the Health Services Division for investigation. If the individual involved in a quality of care complaint was not a Dean Health Plan member at the time of service, the concern will be sent to the practitioner clinic and/or medical facility for investigation and resolution. .

In investigating the quality of care complaint, the health plan will follow the Dean Health Plan MPRC (Medical Peer Review Committee) Workflow process. An MPRC Case Summary will be prepared for each case investigated. The investigation may include the following information:

- Dean Health Plan complaint and/or grievance documentation.
- Prior authorization information.
- Utilization review information.
- Medical records.
- Any documentation of the issue at appropriate practitioner clinics and medical facilities.
- Any other available information relevant to the issue.
- Results of an External Independent Review if there is a referral for a second level review recommended by a Dean Health Plan Medical Director.

The Chair of the MPRC, the Dean Health Plan Medical Director, or the MPRC Committee may contact the physician under review in writing, via telephone, or electronically to request additional information or clarification. The physician is expected to respond appropriately to the request(s) for additional information. MPRC reviews, observe confidentiality, privilege of information, and immunity from liability to the extent permitted under State and Federal law.

The Chair of the MPRC or Dean Health Plan Medical Director will conduct and complete their investigation of the quality of care complaint within 90 working days of receipt. This 90-day period applies only to the investigation of the Chair of the MPRC or Dean Health Plan Medical Director. If the file is referred to the MPRC Committee for further investigation, that investigation may go beyond the 90-day time period. A summary of the investigation and any actions taken will be documented within MPRC. The Chair of the MPRC, a Dean Health Plan Medical Director and/or Medical Peer Review Committee will determine the appropriate level of severity and disposition of the issue. Levels of Severity include:

- Level 1 – Standard of care.
- Level 2 – Marginal deviation from standard of care – MPRC review required.
- Level 3 – Significant deviation from standard of care – MPRC Committee review required.

Where the MPRC Chair or a Dean Health Plan Medical Director believes a case has the potential to be leveled at a two or above, the case will be referred to the MPRC Committee for review, discussion, and final determinations.

The purpose of the MPRC and its Committee is to function as an advisory board and to provide a review of medical practitioners by peers in the areas of quality of care and effective utilization of services. The outcome of the review process is to educate practitioners on issues identified as requiring improvement and to initiate any applicable remedial or disciplinary actions. Members of the MPRC Committee are medical practitioners from various specialties. The responsibilities of MPRC include:

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

The MPRC will review the quality of care issues referred by the Chair of the MPRC or a Dean Health Plan Medical Director and determine the appropriate corrective actions. Quality Improvement staff will attend the Medical Peer Review Committee meeting to support the presentation of the quality of care issues.

The MPRC will specify the activities, responsible parties, time frame, and reporting requirements for implementing corrective actions which may include a recommendation for an ad hoc recredentialing if deemed appropriate by the MPRC Committee members. MPRC will update the log of quality of care issues, noting the actions taken by the MPRC Committee. Any actions to reduce, suspend, or terminate a Dean Health Plan practitioner will follow the process outlined in Dean Health Plan’s Credentialing Committee’s policies and procedures.

The MPRC Committee will, as appropriate, implement and monitor corrective action plans. The MPRC Committee will document all activities and progress of corrective action plans.

## ACCESSIBILITY OF SERVICES

Dean Health Plan has set standards for member access to services provided by primary care practitioner, behavioral health, and specialty care practitioner clinic locations.

### ***Access to Primary Care***

Dean Health Plan defines the following practitioners as primary care practitioners: Internal Medicine, Family Medicine, General Practice, and Pediatric Medicine. The access standards for primary care practitioner clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 30 days
Urgent care appointments	Within 48 hours
After-hours care	Primary care clinic locations must have information available and accessible to members regarding after-hours care and 24-hour emergency room access

### ***Access to Specialty Care***

Dean Health Plan assesses specialty care accessibility for practitioners identified as high-volume or high-impact. The access standards for specialty care clinic locations are listed in the table below.

APPOINTMENT/CARE ACCESS	ACCESSIBILITY
Regular and routine care appointments	Within 30 days
Urgent care appointments	Within 48 hours

### **Access to Behavioral Health Care**

Dean Health Plan assesses behavioral health care accessibility with any of the following providers: Psychiatrists, Psychologists, Other Therapists (e.g., LPC, LCSW, LMFT, MS), and Alcohol and Other Drug Abuse (AODA) Counselors. The access standards for behavioral health clinic locations are listed in the table below.

<b>APPOINTMENT/CARE ACCESS</b>	<b>ACCESSIBILITY</b>
Non-life threatening emergency	Within 6 hours
Urgent care appointments	Within 48 hours
Initial visit for routine care	Within 10 business days
Follow-up routine care with Prescribers (e.g., psychiatrists)	Within 30 days
Follow-up routine care with non-Prescribers (e.g., psychologists)	Within 20 days

### **Appointment Accessibility Assessment Survey**

Dean Health Plan conducts an annual Appointment Accessibility Assessment of all primary care, behavioral health, and specialty care practitioner clinic locations within the Dean Health Plan network. This is accomplished through a self-assessment appointment access survey sent annually to practitioner clinic locations for completion. The Health Plan compiles and evaluates the results from the survey and presents that information annually to the Quality Improvement Committee (QIC).

## **CLINICAL GUIDELINES**

Dean Health Plan, in cooperation with our providers, is dedicated to continually improving the quality of care for our members. Dean Health Plan has adopted guidelines to help providers make health care decisions for their patients at [DeanCare.com/Providers/Clinical-Guidelines](https://deancare.com/providers/clinical-guidelines). These guidelines are not intended to replace clinical judgment.

## **HEDIS REPORTING REQUIREMENTS**

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

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

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

## RISK ADJUSTMENT

The Risk Adjustment Program was established by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services (HHS) as a requirement of Medicare Advantage Organizations and the Affordable Care Act (ACA). The program requires health plans to submit claims and detailed documentation pertaining to each Medicare Advantage and Commercial ACA member in a specific format for each benefit year. The specific diagnoses of each plan member must be documented in accordance with ICD-10 standards and supported by valid documentation within the patient's medical record **each year**. All current or active diagnoses should be documented by an advanced practitioner or MD/DO that exist at the time of the face-to-face encounter/visit, and require or affect patient care.

Dean Health Plan has created an internal audit process to comply with CMS and HHS requirements of capturing and submitting complete and accurate severity and disease status of their members. We contract with a vendor to identify members for patient medical record review throughout the year. The vendor's medical record review is to support the internal process and ensure that our records properly reflect the clinical condition(s) of our Medicare Advantage and Commercial ACA members.

Annually, Dean Health Plan must comply with the HHS Risk Adjustment Data Validation (RADV) audit of our Commercial ACA members by using an independent auditor. The independent auditor must retrieve and review the medical records for the members identified by HHS for the audit. All in-network providers are expected to cooperate with Dean Health Plan in the accurate and timely collection of data and review of medical records. All providers are expected to provide Dean Health Plan, and those working on behalf of Dean Health Plan with a Business Associate Agreement (BAA), with timely access to medical records, as requested, and allow these entities to print and/or make photocopies, as necessary.

Applicable to providers participating in our Medicaid program only, Dean Health Plan has also created an internal audit process to comply with CMS requirements for their Program Integrity initiative, administered by Forward Health. Dean Health Plan is required to report any information uncovered that may indicate possible fraud, waste, and abuse seen in billing practices to Forward Health, which may result in follow up and additional investigation.

# MEMBER RIGHTS AND RESPONSIBILITIES

Dean Health Plan members deserve the best service and health care possible. Dean Health Plan is committed to maintaining a mutually respectful relationship with its members. Rights and responsibilities foster cooperation among members, practitioners, and Dean Health Plan. Member rights and responsibilities are outlined in this section. Dean Health Plan also publishes member rights and responsibilities for provider and member reference on the Dean Health Plan website at [DeanCare.com/Helpful-Links/Rights-Responsibilities](https://DeanCare.com/Helpful-Links/Rights-Responsibilities).

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

- Be treated with respect and recognition of their dignity and have the right to [privacy](#).
- Receive a listing of Dean Health Plan’s participating practitioners in order to choose a [primary care provider](#).
- [Submit a question, complaint, or grievance to Dean Health Plan](#) about the organization or the services it provides without fear of discrimination or repercussion.
- Receive information on procedures and policies regarding their health care benefits.
- Timely responses to requests regarding their health care plan.
- Request information regarding [Advance Directives](#).
- Participate with practitioners in making decisions about their health care.
- 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 Dean Health Plan concerning their health care benefits. We encourage members to contact Dean Health Plan if they have any questions.
- Present their member ID card to identify themselves as Dean Health Plan members before receiving health care services.
- Notify Dean Health Plan 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 copays or deductibles and/or premiums as outlined in your policy.

# MEMBER PRIVACY POLICY

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

Dean Health Plan is required by law to maintain the privacy of your personal health and financial information (collectively referred to as “nonpublic personal information”) and provide you with written notification of our legal duties and privacy practices concerning that information. This Notice describes how we protect the confidentiality of our members’ (and former members’) nonpublic personal information. It includes brief explanations on how we obtain, use, and protect your nonpublic personal information.

## ***Types of Nonpublic Personal Information Dean Collects About You***

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

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

## ***Choices about Your Health Information***

We will not use or disclose your health information without your written authorization, except as described in this Notice. You generally have the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

In the following cases we never share your information unless you give us written permission:

- Most uses and disclosures of psychotherapy notes.
- Marketing purposes.
- Sale of your information.

If you do give us written authorization to use or disclose your health information for a particular purpose, you may change your mind at any time. You must let us know in writing if you change your mind.

## ***How Dean May Use or Disclose Your Health Information***

We will not disclose your nonpublic personal information unless we are allowed or required by law to do so. The following categories describe the ways that Dean may use and disclose your nonpublic personal information. For each category of uses and disclosures, we will explain what we mean and present some examples. Not every use or disclosure we might make will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

*Note: Some of the uses and disclosures described in this notice may be limited in certain cases by applicable State laws that are more stringent than Federal laws, including disclosures related to mental health and substance abuse, developmental disability, alcohol and other drug abuse (AODA), and HIV testing.*



We are allowed to use and disclose information that falls within one of the following categories:

- **Payment:** we may use and disclose your health information to make and collect payment for treatment and services you receive, such as: determining your eligibility for plan benefits, obtaining premiums, determining your health plan's responsibility for benefits, and collecting payment for your health services.
- **Health Care Operations:** we may use and disclose your health information to support our business activities and improve our coverage and services. However, we are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage. Health care operations include such activities as:
  - Underwriting
  - Premium rating
  - Claims
  - Other functions related to plan coverage
  - Quality assessment and improvement activities
  - Activities designed to improve health and reduce health care cost
  - Case management and care coordination

*Notice: We are part of an Organized Health Care Arrangement (OHCA) with SSM Health and Dean Health System. As part of the OHCA, we may from time to time share your information with other members of the OHCA in order to perform joint health care operations. These uses and disclosures allow the OHCA to run efficiently. For example, we may share your information in order to: improve population health management, conduct quality assessment and improvement activities, conduct or arrange for medical review, legal services, audit services, and fraud and abuse detection programs, business planning and development such as cost management, and business management and general OHCA administrative activities.*

- **Treatment:** we may disclose your health information to a physician or other health care provider that is treating you. We may contact you with information on treatment alternatives and other related functions that may be of interest to you.
- **Distributing Health-related Benefits and Services:** we may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.
- **Disclosure to Plan Sponsors:** if applicable, we may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan. If you have a group health plan, your employer is the plan sponsor.
- **Public Safety:** we can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious and imminent threat to the health or safety of a particular person or the public.
- **Research:** under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.
- **Required by Law:** we will share information about you if laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- **Workers' Compensation, Law Enforcement, and Other Government Requests:** we can use and share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.
- **Legal Actions:** we may disclose your health information in the course of any administrative or judicial proceeding.

### **How Dean Protects 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 oral, written, and electronic nonpublic personal information about you and ensure that only authorized staff and business associates with the need to know have access to it. We maintain safeguards for your nonpublic personal information and review them regularly to protect your privacy.



### ***Your Health Information Rights***

- **Right to Request Restrictions:** you have the right to request restrictions on certain uses and disclosures of your health information.
- **Right to Request Confidential Communications:** you have the right to receive your health information through a reasonable alternative means or at an alternative location.
- **Right to See and Copy:** you have the right to see and copy certain health information about you.
- **Right to Correct Records:** you have a right to request that Dean correct certain health information held by Dean if you think it is incorrect or incomplete.
- **Right to Accounting of Disclosures:** you have the right to receive a list or “accounting of disclosures” of your health.
- **Information made by us in the past six years:** the list will not include disclosures made for purposes of treatment, payment, health care operations, or certain other disclosures (such as those you asked us to make).
- **Right to Copy of Notice:** you have a right to receive a paper copy of this Notice at any time.
- **Right to be notified of a Breach:** you will be notified in the event of a breach of your unsecured protected health information.

### ***Changes to this Notice of Privacy Practices***

Dean Health Plan may change this Notice from time to time and make the new provisions effective for all nonpublic personal information we maintain, including information we created or received before the change. Dean will always comply with the current version of this Notice.

### ***Complaints***

Please submit complaints about this Notice or how we handle your health information, in writing, to our Privacy Officer. Dean will not hold any complaint you submit against you in any way. In addition, if you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services.

If you have questions, complaints, or want to exercise any of your health information rights, call the Customer Care Center at the phone number on the member’s ID card.

**Privacy Officer  
PO Box 56099  
Madison, WI 53705**

# HISTORICAL REVISION LOG

The grid below lists recent past revisions to the manual for historical reference.

Description of Change	Manual Revision Date
<b>Updated:</b> Branding changes to reflect Dean Health Plan partnership with Medica. Updates to WellFirst Health brand as Medica.	October 2023
<b>Added:</b> Customer Care Center phone number and Nurse Advice Line phone number for the Medica Employee Health Plan.	January 2023
<b>Updated:</b> Dean Health Plan’s relationship with Medica.	January 2023
<b>Updated:</b> Provider information components to ensure current and accurate provider information is in the Provider Directory.	January 2023
<b>Added:</b> Medica Employee Health Plan information and overview section.	January 2023
<b>Updated:</b> Sample member ID card image for DeanCare Gold (Cost).	January 2023
<b>Added:</b> Sample member ID card image for the Medica Employee Health Plan.	January 2023
<b>Added:</b> Member eligibility web page information for the Medica Employee Health Plan.	January 2023
<b>Updated:</b> Features the online Dean Health Plan Member Resources Reference Guide for Providers as a one-stop resource for information regarding member programs and services.	January 2023
<b>Updated:</b> Clarified 277 Claim Acknowledgement response and Confirmation Reports Portal information; available tools to help prevent billing gaps and payment delays.	January 2023
<b>Added:</b> Section regarding cancelled prior authorization requests.	January 2023
<b>Updated:</b> Removed physician signature requirement from pre-service medically urgent for outpatient in Authorization Priority Definitions table.	January 2023
<b>Added:</b> Concert Genetics as the Health Plan’s contracted vendor for genetic testing.	January 2023
<b>Updated:</b> Locations to access for medical benefit drug policies and pharmacy benefit drug policies.	January 2023
<b>Updated:</b> Case management information throughout to reflect current program offerings.	January 2023

Description of Change	Manual Revision Date
<b>Added:</b> Telephone number for new Language Assistance Line to this manual's Directory.	June 2022
<b>Added:</b> Health equity section, including information about our new web page.	June 2022
<b>Updated:</b> Commercial and ACA member ID card sample to show deductible amount, deductible/coinsurance maximum amount, and out-of-pocket maximum amount to represent a card for a member who has a different deductible/coinsurance maximum amount from their out-of-pocket maximum amount.	June 2022
<b>Updated:</b> Health Plan's provider communication offerings to include monthly policy update provider notifications and Provider Onboarding Guide.	June 2022
<b>Added:</b> Free language assistance interpreter services for in-network providers interacting with Dean Health Plan members.	June 2022
<b>Added:</b> Information regarding Dean Health Plan's Behavioral Health Provider Annual Training created specifically for in-network Behavioral Health providers.	June 2022
<b>Added:</b> Reminder to also update National Plan and Provider Enumeration System (NPPES) when there are changes to provider information.	April 2022
<b>Added:</b> Organizational provider types required to be credentialed under Centers for Medicare and Medicaid Services (CMS) standards.	April 2022
<b>Added:</b> Steps to correct a claim and more information regarding adjustments.	April 2022
<b>Updated:</b> The Health Plan manages medical benefit drug prior authorizations(formerly managed by Navitus Health Solutions). Forms will continue to be available through the Navitus Prescriber Portal. Navitus will continue to manage pharmacy benefit drug authorizations.	April 2022
<b>Updated:</b> Health Plan's mail order pharmacy is Costco.	April 2022
<b>Updated:</b> Provider types for primary care and behavioral health.	April 2022
<b>Updated:</b> Accessibility of Services for member access to primary care practitioner, behavioral health, and specialty care practitioner clinic locations.	October 2021
<b>Updated:</b> Product descriptions for Dean Preferred Provider Organization (PPO) with new wrap network First Health information.	July 2021

<b>Updated:</b> Dean Advantage service area to include now includes Fond du Lac and Green counties.	July 2021
<b>Clarified:</b> WellFirst Health is the employer-offered health insurance for Dean Health Plan employees and their dependents.	July 2021
<b>Updated:</b> Member ID Card images for Commercial, Focus, PPO, and WellFirst Health SSM Health Employee Health Plan.	July 2021
<b>Updated:</b> Importance of using real-time eligibility resources (270/271 & Provider Portal) when verifying member eligibility.	July 2021
<b>Added:</b> New Provider Communications page as a provider resource.	July 2021
<b>Added:</b> New Advance Care Planning video information, Emmi, Foodsmart, and Wellness Events.	July 2021
<b>Added:</b> Failure to comply with credentialing and recredentialing requirements and timelines.	July 2021
<b>Added:</b> Opportunity to correct errors on provider applications when necessary.	July 2021
<b>Added:</b> Automated authorization available in the Dean Health Plan Provider Portal for some services.	July 2021
<b>Added:</b> Tips for Submitting Prior Authorization Requests.	July 2021
<b>Updated:</b> Musculoskeletal (MSK) Care Management Program summary to reflect that prior authorization is no longer required for outpatient hip and knee.	July 2021
<b>Added:</b> Navigation tips.	March 2021
<b>Added:</b> Information and link to the online Provider Network Application.	March 2021
<b>Added:</b> Health Plan Communications for Providers.	March 2021
<b>Added:</b> New in 2021, Dean Health Plan is offering free virtual tobacco cessation group sessions for members and all of our in-network provider's patients.	March 2021
<b>Updated:</b> Provider Portal features to reflect the new applications and new Opt in for health plan communications available in the new Dean Health Plan Provider Portal introduced in March 2020.	March 2021
<b>Changed:</b> Retitled "Authorization Process" section to "Utilization Management." This section has also been reorganized.	March 2021
<b>Added:</b> Medical Management section replacing certain policy specific sections. It provides guidance on where to find specific medical policies and other medical management resources to ensure access to the most current information.	March 2021
<b>Updated:</b> Dean Health Plan no longer requires autism treatment providers to have an autism diagnosis indicator on a member's file.	March 2021

<b>Changed:</b> Intensive Outpatient Services now require an authorization even when provided in an office or clinic setting.	March 2021
<b>Added:</b> Lumicera Specialty Pharmacy is Dean Health Plan's preferred specialty pharmacy.	March 2021
<b>Added:</b> Necessary approvals for providers to begin providing services to Dean Health Plan members	January 2020
<b>Added:</b> Reporting a replacement practitioner	January 2020
<b>Added:</b> Member-related information and resources for providers	January 2020
<b>Added:</b> WellFirst Health SSM Health Employee Health Plan including distinctions for Dean ASO Network providers and updated information for DeanCare Gold and Dean Health Plan Select	January 2020
<b>Added:</b> Sample of the WellFirst Health SSM Health Employee Health Plan member ID card for Wisconsin	January 2020
<b>Added:</b> Delegation agreement information and credentialing and licensure lapse information	January 2020
<b>Added:</b> Water transportation to Ambulance Services	January 2020
<b>Added:</b> Autism Services section	January 2020
<b>Updated:</b> Musculoskeletal Care Management (MSK) Program revised for the removal of the length of stay authorization requirement (effective for dates of service on and after January 1, 2020)	January 2020
<b>Updated:</b> Physical and occupational therapy authorizations for Initial eight visits and end dated authorizations on December 31 <sup>st</sup> every year	January 2020
<b>Updated:</b> Pharmacy benefit drug policies are no longer posted on deancare.com. Prior Authorization (PA) criteria are listed on the PA form, accessible through the Navitus Prescriber Portal, at prescribers.navitus.com.	January 2020