DEAN ADVANTAGE MANUAL
# TABLE OF CONTENTS

- WHAT IS DEAN ADVANTAGE? ........................................................... 2
- SUMMARY OF EXCLUSIONS ............................................................. 3
- AUTOMATIC ASSIGNMENT OF PRIMARY CARE PRACTITIONER .......... 5
- AFTER HOURS CARE FOR PCPS ....................................................... 5
- UPDATED PROVIDER INFORMATION .............................................. 6
- DEAN HEALTH PLAN REGULATORY COMPLIANCE DEPARTMENT .......... 6
- DEAN ADVANTAGE SERVICE AREA .............................................. 6
- DEAN ADVANTAGE CONTACTS .................................................... 7
- PRACTITIONER REIMBURSEMENT .................................................. 7
- DEAN ADVANTAGE PRIOR AUTHORIZATION SERVICE LIST .............. 7
- PRIOR AUTHORIZATION PROCESS ............................................... 8
- PRIOR AUTHORIZATION REQUIREMENTS ...................................... 8
- PRIOR AUTHORIZATION SUBMISSIONS ......................................... 8
- PRIOR AUTHORIZATION PRIORITIES AND TURNAROUND TIME .......... 9
- HOSPITAL ADMISSIONS ............................................................... 9
- MEDICAL INJECTABLES ............................................................... 10
- MEMBER GRIEVANCE AND APPEAL PROCEDURES ...................... 10

Changes are periodically made to the information in this manual. This manual was last updated 12/2017.
WHAT IS DEAN ADVANTAGE?

Dean Advantage is Dean Health Plan’s Medicare Advantage product. Medicare Advantage is a Medicare-approved HMO product (this is a Medicare Replacement product). It is available to eligible Medicare beneficiaries residing in seven counties located in south central Wisconsin. In general, the benefits for Medicare Advantage are the same benefits they have under original Medicare, when provided in accordance with Dean Health Plan’s policies and procedures; Dean Health Plan may also offer value-added benefits for members.

The purpose of this manual is to serve as a resource for policies and procedures that affect Medicare Advantage members and its providers. All information listed in this manual applies, unless noted otherwise. If you have any questions relating to this information, or are unable to find the information you need, please contact Dean Health Plan Member Services at (877) 232-7566 or refer to deancare.com. Information presented in this manual is unique to the plan.

Dean Advantage ID Card Sample

![Sample ID Card](image)

Dean Advantage Benefit Overview

Dean Health Plan has five Dean Advantage Plans:

- Dean Advantage Essential (HMO)
- Dean Advantage Assurance (HMO)
- Dean Advantage Balance (HMO)
- Dean Advantage Confidence (HMO-POS)
- Dean Advantage Gold Complete (HMO)

Please refer to the following link for the overview of benefits: deancare.com/Medicare/

SUMMARY OF EXCLUSIONS

<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services considered not reasonable and necessary, according to the standards of Original Medicare</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Experimental medical and surgical procedures, equipment and medications.</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Services not covered by Medicare</strong></td>
<td><strong>Not covered under any condition</strong></td>
<td><strong>Covered only under specific conditions</strong></td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------</td>
<td>------------------------------------------</td>
</tr>
</tbody>
</table>
| Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community. | | May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.  
(See Chapter 3, Section 5 for more information on clinical research studies.) |
| Private room in a hospital. | √ | Covered only when medically necessary. |
| Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television. | | |
| Full-time nursing care in your home. | √ | |
| *Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. | | |
| Homemaker services include basic household assistance, including light housekeeping or light meal preparation. | √ | |
| Fees charged for care by your immediate relatives or members of your household | √ | |
| Cosmetic surgery or procedures | | • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.  
• Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance. |
| Routine dental care, such as cleanings, fillings or dentures. | √ | |
| Non-routine dental care. | | √  
Dental care required to treat illness or injury may be covered as inpatient or outpatient care. |
<p>| Routine foot care | | √ |</p>
<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedic shoes</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</td>
</tr>
<tr>
<td>Supportive devices for the feet</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Orthopedic or therapeutic shoes for people with diabetic foot disease.</td>
</tr>
<tr>
<td>Routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Our plan pays up to a certain dollar amount (varies by plan) every 2 years for eyeglasses, frames, lenses, and contact lenses. Our plan also covers one routine eye exam every year.</td>
</tr>
<tr>
<td>Reversal of sterilization procedures and or non-prescription contraceptive supplies.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Infertility testing and treatment or any sexual enhancement services</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Acupuncture</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Naturopath services (uses natural or alternative treatments).</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Non-emergency services provided to veterans in Veterans Affairs (VA) facilities</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

**AUTOMATIC ASSIGNMENT OF PRIMARY CARE PRACTITIONER**

If a Dean Advantage member does not designate a Primary Care Practitioner (PCP), Dean Health Plan will contact the member to select a PCP. If member is unable to select a PCP, Dean Health Plan will automatically assign one based upon the Member’s residence. In these situations, Dean Health Plan will send a letter to the member informing them of the PCP assigned. If the member has additional questions, the member can contact Member Services.

**AFTER HOURS CARE FOR PCPS**

Primary Care Practices are responsible for providing 24 hour/ 7 days per week coverage for urgent or emergent care. Members must be instructed to call 911 or go directly to the emergency room in the case of a true emergency. Answering services or machines must instruct members on how to reach an on call practitioner.
UPDATED PROVIDER INFORMATION

It is critical that Dean Health Plan has your current and correct provider information, including your address, phone number, hours of operation, panel status, specialties, and language-fluency capabilities. Please notify us 30 days in advance of any of changes. Please contact your Provider Network Consultant (deancare.com/providers) to get access to future e-blasts and future e-mail notifications from Dean Health Plan. On a quarterly basis you will receive a friendly reminder via email to update Dean Health Plan on any changes for your open/closed panel status and/or any provider demographic changes you may have.

DEAN HEALTH PLAN REGULATORY COMPLIANCE DEPARTMENT

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

DEAN ADVANTAGE SERVICE AREA

The following counties are included in the Dean Advantage service area:
DEAN ADVANTAGE CONTACTS

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

| MEMBER SERVICES | |
| Member Services Department | (608) 828-1978  | (877) 232-7566 |
| Monday – Friday 8:00 am to 8:00 pm | |

| CLAIMS |
| EDI Team | dhpedi@deancare.com |
| Paper Claims: All Dean Advantage paper claims should be mailed to: | Dean Advantage – Claims PO Box 853937 Richardson, TX 75085-3937 |
| Electronic Payor ID: | 39113 |

| DRUG PRIOR AUTHORIZATIONS AND EXCEPTION REQUESTS |
| Drug Prior Authorizations (Navitus Customer Care) | (866) 270-3877 | (855) 668-8552 |

| DEAN ADVANTAGE WEBSITE |
| Dean Advantage Website | deancare.com/medicare |

| PROVIDER NETWORK CONSULTANTS |
| Provider Network Consultants | See deancare.com/providers to find your Provider Network Consultant |

PRACTITIONER REIMBURSEMENT

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

Providers should bill Dean Health Plan for all Medicare Advantage Covered Services, except Hospice Services. Members may elect to receive Hospice Services while they are enrolled in Dean Health Plan’s Dean Advantage Plan. However, if a member receives Hospice Services while enrolled in Dean Health Plan’s Dean Advantage Plan, Provider should bill CMS for those services. Dean Health Plan is not responsible for payment of claims for Hospice Services for Dean Health Plan Members.

DEAN ADVANTAGE PRIOR AUTHORIZATION SERVICE LIST

The list of services that require prior authorization is located at deancare.com/app/files/public/8480/DeanAdvPriorAuthServiceList.pdf. If you do not find the information you need, please contact Dean Advantage Member Services.
PRIOR AUTHORIZATION PROCESS

Dean Advantage members will choose a primary care practitioner (PCP) or clinic site from which to obtain routine and ongoing care. The PCP acts as a “gatekeeper” to ensure members receive appropriate, high quality care in a cost effective manner.

Primary care practitioners and in some cases plan specialists should assist members by completing an authorization to a non-plan provider when the plan provider feels that the request is medically necessary. The plan provider of service is responsible for prior authorizing services when necessary.

Dean Advantage members have the right to go directly to the health plan to request a prior authorization. We strongly encourage our members to work with their PCP when requesting authorizations, but in the event that the member does come to the health plan, the PCP and servicing provider will receive a copy of the determination letter.

PRIOR AUTHORIZATION REQUIREMENTS

The list of specific services requiring prior authorization can be found at: deancare.com/providers/medical-management/dean-advantage/

You will notice that this list is very similar to the Dean Health Plan Master Service List for our Commercial members. The key differences to note are listed below.

The following services do not require prior authorization, but may be compared to Medicare coverage requirements at claims payment.

- Botox injections
- ESIs
- Intrathecal Pumps

The following services will still require prior authorization, but a specific list of codes requiring prior authorization based off of Medicare coverage guidelines is now available.

- DME – Not all DME items over $500 will require prior authorization. The prior authorization list contains the codes of what will now require prior authorization. Outpatient Surgery – Similar to DME, only specific outpatient surgeries will require prior authorization). The comprehensive list of codes requiring prior authorization is available on the prior authorization list.

All prior authorization requests will be reviewed according to the Medicare Coverage Guidelines, established by the centers for Medicare & Medicaid Services (CMS). According to the guidelines, all medical care, services, supplies and equipment must be medically necessary. The Medicare Coverage Guidelines are available online at medicare.gov/coverage/your-medicare-coverage.html

MCG Criteria (formerly Milliman Care Guidelines) and Dean Health Plan Medical Policies will be used in situations where Medicare Coverage Guidelines do not exist for the service requiring prior authorization. If you require a copy of a specific Dean Health Plan medical policy or MCG Criteria you can contact Dean Advantage Member Services.

PRIOR AUTHORIZATION SUBMISSIONS

ELECTRONIC

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

If you are not a Dean Health Plan Provider Portal enabled office for prior authorization submission, you must complete and submit the Dean Advantage Prior Authorization Form ([deancare.com/app/files/public/8673/DeanAdv_PriorAuthForm_fillable.pdf](deancare.com/app/files/public/8673/DeanAdv_PriorAuthForm_fillable.pdf)) and fax to the Dean Health Plan Utilization Management Department at (608) 252-0840. Please see Paper/Fax process below for more information.

**PAPER/FAX**

There is a single Prior Authorization request form for all Dean Advantage prior authorization requests that need to be submitted on paper. Please follow the guidelines below for submission:

- The Prior Authorization Request Form can be found on the Dean Advantage Medical Management page at: [deancare.com/providers/patient-care/medical-management/dean-advantage/](deancare.com/providers/patient-care/medical-management/dean-advantage/)
- Prior authorization forms should be faxed the date the request has been completed to ensure timely processing of the request.
- When submitting the form to Dean Health Plan, please complete ALL fields on the top part of the form in their entirety. If all of the required fields on the Prior Authorization Request Form are not completed, the Dean Health Plan Utilization Management Department will return it to the referring physician for completion.
- Prior authorization requests must be faxed to (608) 252-0840.

**PRIOR AUTHORIZATION PRIORITIES AND TURNAROUND TIME**

Dean Health Plan will follow CMS mandated priorities and turnaround times for prior authorizations. The priority of your prior authorization request must be indicated during the submission process.

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

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

**HOSPITAL ADMISSIONS**

Prior Authorization for planned hospital admissions is required and is reviewed for medical necessity and appropriateness of site. If the hospital admission meets the Medicare definition of emergency, prior authorization is not necessary upon admit or at the time of admission. However, the plan does ask for timely notification of the admission so that discharge planning and post-discharge support can be provided.
MEDICAL INJECTABLES

Certain Medical Injectable drugs covered under the member’s medical benefit require prior authorization. Medical Injectables that require prior authorization are listed on the Dean Advantage Prior Authorization Service List (deancare.com/providers/medical-management/dean-advantage).

These prior authorization requests will be reviewed by Dean Health Plan. Please follow the guidelines below for submission:

- Prior authorization forms for Medical Injectables are available on the Dean Advantage Medical Management page (deancare.com/providers/patient-care/medical-management/dean-advantage/). You must use the prior authorization forms from the Dean Advantage Medical Management site, not the Navitus site (as medical injectibles authorization go to Dean Health Plan, not Navitus).
- Prior authorization requests forms can be submitted via the Provider Portal or via fax.
- Completed prior authorization request forms should be faxed to (608) 252-0840.
- Providers and members will receive authorization determination letters via mail only if submitted by fax. If electronically submitted providers will receive authorization determination via the Provider Portal.

MEMBER GRIEVANCE AND APPEAL PROCEDURES

Members have the right to file complaints and concerns with Dean Health Plan using the number on their ID card.