Provider NEWS

DeanHealthPlan
A member of SSM Health

Winter 2020
A newsletter for Dean Health Plan providers

SSM Health Transforming Medicine Via Project Vibrance

Q & A with Michael DeGere, DPM, MBA


Michael DeGere, DPM, MBA

Value-based care is an increasingly visible priority in high-quality patient treatment. And for good reason, says Michael DeGere, DPM, MBA, because it has the potential to be transformational in medicine. Dr. DeGere is Regional Vice President – Population Health for SSM Health Wisconsin. He's among those at the company leading the charge to transform SSM Health from a volume-based care model to one based on improved outcomes for the larger patient population.

"All providers deal in the population health space in one way or the other," said Dr. DeGere. "When we really focus on individual need, that works well. How do we do this on a larger scale as an organization?"

That's what Project Vibrance is all about. We asked Dr. DeGere for some context.

What's in it for providers?

The things we're trying to accomplish are not different from what providers want for their patients already—the right care, timely, effective coordination, accessible and affordable care for patients. The best care not just for acute care but for a lifetime. The way that this resonates the most is if it's harmonious with what providers want to focus on. If it feels dissimilar or divergent, it will be difficult.

Historically, most provider reimbursements are formed upon volume and not value of service. Telemedicine, for example, has been available for a long time. Many organizations have not chosen telemedicine as an offering because it wasn't reimbursed by CMS. As most insurance carriers use CMS' Medicare fee schedule as the basis for all their product offerings, the lack of CMS-based coverage for most types

continued on pg 2

This Issue

Dean Value Contract Pays Off for Patients and Providers

Dean Health Plan's provider network reimbursement model is different than that used by other insurance companies.

Beginning in 2011, Dean Health Plan began implementing its Dean Value Contract (DVC). It's a value-based provider pay-for-performance model. We have moved to this structure with in-network hospitals, select medical groups and certain hospital-based specialty care providers. Our DVC model links provider reimbursement increases to performance metrics for quality of patient care outcomes, patient/member satisfaction and effectiveness of care.

These metrics are part of each contract involving hospitals and physicians within our health plan. Provider performance is shared via regular quarterly provider scorecards in "face-to-face" review meetings. Supplemental reporting, designed to support provider performance improvements, are also shared within each of these discussions to ensure provider and health plan alignment on key opportunities for DVC metrics improvement.

Since the inception of our DVC pay-for-performance model, our health plan has seen significant improvements in participating providers' quality, patient satisfaction and efficiency measures.

SSM Health Transforming Medicine ... (continued)

of telemedicine resulted in only limited telemedicine services being offered by providers. Here comes COVID, and it's not just encouraged but reimbursed. Barrier removed! The financial alignment is part of this. If you can save a patient money with fewer copays and fewer people hospitalized, that's nice for insurance companies, too.

What's the reaction to Project Vibrance thus far?

Our SSM Health providers are still learning about it. Most of the elements to date have been in the configuration phase. There is nothing rolled out in a functional way yet but it's coming soon. What are we doing well now? Our partner, NAVVIS, is providing care management coordination—optimizing the way we provide care. Risk adjustment is important. It documents the complexity of the patients we're taking care of. It has reimbursement implications because it gives credit and support for managing a given population.

Why is Project Vibrance needed?

The cost of health care is wildly out of control in this country largely because of the way health care is delivered and the way it has been historically reimbursed. High-volume delivery of service is more reactive than preventive. Value-based agreements deliver on key things—quality at a certain level and cost at a certain level. Control costs by avoiding the need for health care. Virtually every medical group sees Medicare patients. It's a unifying group everybody can relate to. The goal is to get healthy and stay healthy. It's very expensive to see a provider over and over. Yet, under most other health plans' reimbursement models, the more services providers render, the more they get paid. More health care equals more cost but not more health. Are there certain things in conflict with that today? Imagine if we needed acute care less often.

How much does technology play into the transformation to value-based care?

NAVVIS has a tool called Coreo. Information is aggregated there. What does our diabetes practice look like? When is outreach due? What are the next steps? Our outreach may not be the kind of outreach the patient prefers. Our goal is to improve health, considering each patient's preferences.

When we look at a population health model, the County Health Rankings model is one I like a lot. When considering factors that affect health outcomes, the amount of weight given to clinical care is just 20%. By comparison, social and economic factors receive 40% weight, health behaviors 30%, and physical environment 10%. We can't do it all. But there are ways to apply analytics to our situation. If my barrier is getting to an appointment in the first place, we need to ask the question, what can we do? Will this plan work for you?

As a result of this continuing higher-performance, the Health Plan is now introducing a total cost of care (TCOC) incentive model for certain DVC physician groups, which furthers the continuum of value-based payments to a risk-sharing model. Dean Health Plan's TCOC incentive model is based upon a nationally-approved model and continues to reward providers' higher quality of care and increased patient satisfaction while managing costs within an established corridor.

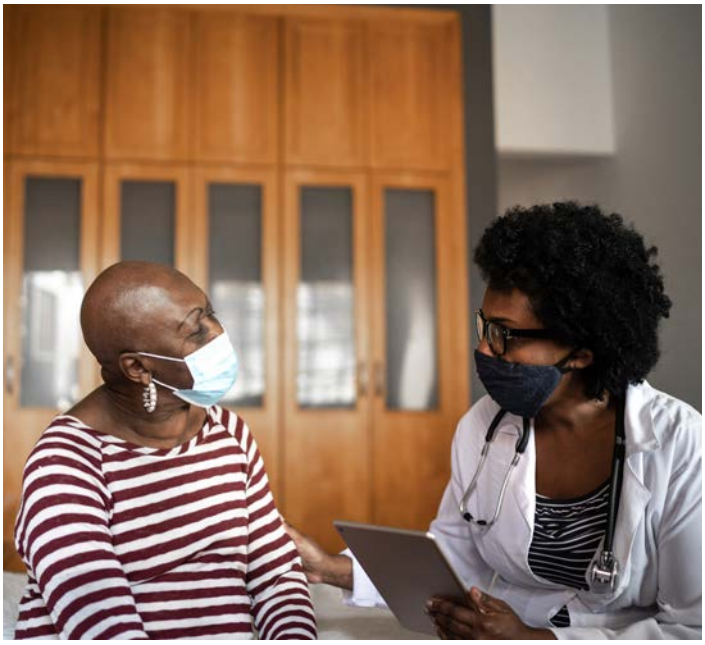
SSM Health Transforming Medicine ... (continued)

You have a front row seat in medicine. How confident are you that we can turn this huge, complex ship around?

My confidence lies in the fact that we must. Our current system is not sustainable. It's something we have to do. The imperative lies in the way health care will be reimbursed in the future. It's whether we change or not. Some providers may be farther along in the evolution in risk adjustment today. This is the purpose of the whole project. Why did I go into medicine? How do we transform care? Transformational change is better for patients, care teams and the organization.

Remind Patients about Mask-Wearing Importance

A clinician's advice goes a long way. Let's do our best to help minimize the spread of COVID-19 and the flu by reminding patients to wear a mask and to do so properly.



"Please consider making a quick mention regarding the importance of masking during an office visit," said Kevin Eichhorn, MD, Chief Medical Officer for Dean Health Plan. "Your advice can make an important impression on patients and help reduce the spread of infection in our communities."

Dr. Eichhorn recommends colleagues pass along CDC recommendations regarding effective and safe mask use:

- Wash your hands before putting on your mask
- Put it over your nose and mouth and secure it under your chin
- Don't touch your eyes, nose and mouth when removing the mask
- Wash your hands immediately afterwards

Masks and physical distancing, along with flu shots, are our most effective weapons against these dangerous viruses. But so are our own clinical efforts to encourage patients to do the right things to protect themselves and others.

Confronting the Decline of Colonoscopies to Screen for Cancer

Dean Health Plan has seen a one-third decline in colonoscopies in 2020, compared to 2019. To address this problem, many health care organizations are turning to alternative screenings options.

Several studies on the US National Library of Medicine National Institutes of Health's website show that offering patients choices is an effective way of encouraging them to get screened for colorectal cancer.

Importantly, all Dean Health Plan member benefit plans offer 100% coverage for preventive colorectal cancer screenings. Polyp removal during an initial colonoscopy falls under preventive screening coverage. Cologuard, gFOBT and FIT tests are also covered as preventive screenings.

Please discuss covered, non-invasive screening options with patients and explain that they may not be as accurate as a colonoscopy. It may be helpful to include key points about each type of screening.

- A description of the test, how often it is recommended and patient preparation.
- If a non-invasive screening shows a positive, or suspicious result, a follow-up colonoscopy will be recommended.

If patients have questions about their benefits, they can call the Customer Care Center number listed on their member ID card.

Dean's Medicare Advantage Earns High Quality Rating

Thank you for your dedication to our members

Our enviable provider network continues to pay dividends for our members and for our organization, thanks to the skill, dedication and commitment of our providers. Dean Medicare Advantage plans earned a 4.5 out of 5 stars for 2021 from the Centers for Medicare & Medicaid Services (CMS) as part of its annual assessment of all Medicare Advantage plans. The ratings came out in fall.

"Quality improvement will always be number 1 at Dean Health Plan," said Les McPhearson, President of Dean Health Plan, "so it's gratifying to see your consistent level of achievement confirmed by CMS, as we continue our quest to reach the 5-star peak."

Dean Health Plan already received an exceptional 5 out of 5 stars for our Medicare Cost product.

A Star Rating of 4.5 and 5 stars demonstrate a shared commitment across care delivery and the health plan to providing high-quality care and service to our members and patients.

CMS rated 400 Medicare Advantage contracts in the U.S. this year, and only 21% of plans earned 4.5 stars or better. The average star rating for Medicare Advantage plans across the country was 4.06. In Wisconsin, we were one of six plans receiving 4.5 stars or higher and we are working diligently to achieve 5 stars for 2022.

CMS' Star Ratings methodology includes a total of 44 quality and performance measures. Dean Health Plan earned 5 out of 5 stars on half of our rated measures (i.e., 20 out of 40), including health care quality and several clinical care measures.

Star rating reflects everyone's contribution

Achieving 4.5 Stars requires consistent effort and commitment from all areas of the Health Plan and our colleagues in care delivery. It is more difficult than ever to keep up a high rating in the face of changing benchmarks for excellence each year. National health plan performance continues to improve, which pushes the bar higher. Consumer expectations continue to rise, which in turn, drives organizations to deliver more.

Individuals will have access to the Star Rating for Medicare Advantage plans during the enrollment process. Earning a 4.5-Star Rating is critical for our success as a Medicare Advantage plan.

Medicare Advantage Benefits in 2021

Familiarize yourself with all the exciting benefits available to Dean Advantage members in 2021. These benefits include:

- **Transportation benefit through the Lyft program.** Members can call our Customer Care Center at 877-232-7566 to request a ride to an upcoming appointment.
- **Preferred pharmacies and insulin savings.** Members will save money on copays when they fill their prescriptions at a preferred pharmacy such as SSM Health, CVS, Walmart and Hy-Vee pharmacies.
- **In-home and virtual support and companionship through Papa.** Screened and trained Papa Pals assist members with meal prep, house chores, technology lessons, companionship and other senior services. Members can call Papa at 888-840-1609.
- **Post-inpatient meals through Mom's Meals** for members who are discharged from the hospital or skilled nursing facility. Mom's Meals works with members for dietary needs, preferences, and delivery details.
- **Comprehensive and preventive dental benefits through Delta Dental**. Our plans have no deductible and a simple copay structure. Members can use their Dean Advantage member ID card to access care at their dentist's office.
- **Quarterly allowance for over-the-counter supplies** like bandages and pain relievers purchased online, over the phone, or at participating stores including Walgreens, CVS, Kroger and Walmart.
- **Gym and fitness benefit through the Silver & Fit program**. All plans provide free gym memberships to in-network gyms, fitness centers and YMCAs. If members prefer to exercise at home, they can have at-home fitness kits mailed to them. Members can register at silverandfit.com.
- **Living Healthy Rewards Program** rewards members for completing healthy activities. Members can sign up for Living Healthy Rewards at deancare.com/login.
- **Hearing benefit**. All of our plans include a $0 hearing exam and a $750 hearing aid allowance.
- **Vision benefit**. All of our plans include a $0 vision exam and a $200 eyewear allowance.
- **Nurse Advice Line** available 24 hours a day, 365 days a year. Members can call if they aren't sure if they need to see a doctor or have a question.
- **Virtual Visits & Telehealth.** From the comfort of their home, members can get a diagnosis, a treatment plan and even a prescription, if needed. Members can start a virtual visit at deancare.com/virtualvisit.
- **Worldwide Travel.** For emergent and urgent coverage outside of the US and its territories.

Refer to the Dean Health Plan Medicare Advantage 2021 additional benefits web page for more details on all the benefits available to members in the upcoming year.

Medicare Part B Step Therapy Program

In 2021, our Medicare Part B medication coverage for Dean Advantage members will institute a new program called Medicare Part B Step Therapy program. Our program highlights preferred drug strategies with physician-administered Part B therapies in a way that lowers costs and improves the quality of care for our Medicare Advantage members.

Step therapy is a type of prior authorization that requires preferred therapies to be used prior to other non-preferred therapies if appropriate. This change will not affect members who are active utilizers of non-preferred Part B step-therapy medications prior to 2021 but it will affect all new starts of non-preferred therapies for 2021. Members already on non-preferred therapies within the last 365 days can remain on their established treatment plan.

An approved authorization from Dean Health Plan is required prior to the administration of a non-preferred medication. Once a prior authorization is submitted, the plan will complete a 365-day lookback period to determine if the drug therapy constitutes a new start of therapy. Furthermore, we utilize this lookback period for new members who switch plans to avoid disrupting ongoing therapies. Members and physicians can request coverage determinations and can appeal any decisions under timeframes used in CMS-regulated Part D programs with Part B step-therapy edits.

The following table lists preferred drug(s) versus non-preferred drug(s). Preferred drugs are required to be tried first for treatment before a non-preferred drug is used.

Preferred drug(s)	Non-Preferred drug(s)
Drug A	Drug B
Herzuma, Trazimera, Kanjinti, Ogivri	Herceptin
Mvasi, Zirabev	Avastin
Truxima, Ruxience	Rituxan
Renflexis	Inflectra, Avsola, Remicade
Ziextenzo, Fulphila, Udenyca	Neulasta
Nivestym, Zarxio	Neupogen/Granix
Oral bisphosphonate trial - Part D Medication (alendronate, ibandronate, or risedronate)	Prolia (for a diagnosis of osteoporosis with high risk of fractures)
Synvisc-One or Monovisc	Durolane, Glesyn-3, Supartz FX, Synvisc, Euflexxa, Gel-one, Genvisc 850, Hyalgan, Hymovis, Sodium Hyaluronate, TriLuron, TriVisc, Visco-3
Zario, Nivestym	Leukine
fulvestrant	Faslodex
Retacrit	Procrit, epogen

Part D and Part B Vaccinations for Medicare Members

Medicare members must get Part D vaccinations with their Part D carrier. Examples of vaccines that are covered for Medicare members as a Part D (drug benefit) when received in a pharmacy setting include:

- Hepatitis A
- Shingles
- Tetanus Diphtheria (Td)
- Tetanus Diphtheria Pertussis (Tdap)

If a Medicare member receives a Part D vaccination in a clinic setting, we will deny the claim to show member responsibility to pay. It is the expectation that providers will advise members that it is their responsibility to pay for Part D vaccinations administered in a clinic setting.

Members who receive Part D vaccinations in a physician's office will pay the entire cost of the vaccine and its administration. Members can then ask for reimbursement for their share of the cost.

Examples of vaccines covered for Medicare members as a Part B benefit include:

- Hepatitis B – in the clinic
- Influenza (flu) – in the clinic or the pharmacy
- Pneumonia – in the clinic
- Tetanus – when given in the clinic due to injury ⊕

Preventive Cancer Screenings Continue to Decline: Here's What Our Members Say

Over the past few years, Dean Health Plan has seen a decline in preventive cancer screening rates. We surveyed our Medicare Advantage Part D and ACA Marketplace members who are either due or past due for a breast or colorectal cancer screening and asked them why they are not getting screened for cancer.

Survey results revealed these top 5 reasons:

- Fear of the cost and follow-up care if something is found
- Decided to not be screened after talking with their provider
- Cancelled or rescheduled their screening due to COVID-19
- Fearful of the procedure or pain
- Fearful of the results

Tips to help ease concerns about screening:

- Preventive screenings are covered by member insurance and any follow-up care costs can be evaluated after obtaining the results.
- If a screening is not being recommended, clearly communicate why.
- If patients are uncomfortable coming to the clinic, discuss the availability of other covered options (e.g., Cologuard, gFOBT and FIT tests).
- Use shared decision making around other available screening options.
- Reassure patients that fear and anxiety are normal, and that most cancers can be treated if found early.

Patients who have questions about insurance coverage can contact the Customer Care Center at the number listed on their member ID card. ⊕

2021 Medicare Advantage Benefit Addresses Cost Concerns

Dean Health Plan continues to evaluate how we can enhance our benefit offerings to remove any perceived preventive cost barriers for our members. Starting in 2021, we are enhancing benefits for our Medicare Advantage members, including: $0 mammogram and $0 screening colonoscopy (including when screening becomes diagnostic due to biopsy or removal of a growth, as well as after a positive at-home screening kit).

Provider-Patient Communication Can Improve Satisfaction and Health Outcomes

Dean Health Plan wants to accurately reflect the high-quality care and service you provide to our members. To be successful in marketing services to consumers, including services provided by our in-network providers, we need to perform well on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and Health Outcomes Survey (HOS) surveys. These two, 68-question surveys are mailed annually to Dean Health Plan members.

The CAHPS survey assesses the communication skills of providers and the ease of access to health care services. **Questions include:**

- In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?
- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, when your personal doctor ordered a blood test, X-ray or other test for you, how often did you get those results as soon as you needed them?

The HOS survey assesses the ability of Medicare Advantage organizations to maintain or improve the physical and mental health of its members overtime. **Questions include:**

- Compared to one year ago, how would you rate your physical health in general now?
- Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed, or irritable) in general now?
- In the past 12 months, did you talk with a doctor or other health provider about your level of exercise or physical activity?
- Many people experience leaking of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?

Essentially, these surveys ask Dean Health Plan members to self-report on their access to health care and received services as well as their physical and mental health. This also measures how well patients retain information from conversations with their provider.

Termination of Doctor/Patient Relationship

Practitioners sometimes feel it is necessary to terminate a relationship with a patient. Dean Health Plan has an established policy for this, as part of our contract with providers while assuring continuity of care for the member.

A practitioner may terminate such care only for good cause, as determined by Dean Health Plan. Information regarding this process can be found in the Provider Manual. See **deancare.com/providers**.

Improve Survey Outcomes

A personal discussion can go a long way toward improving survey results. Discuss the following topics at least once per year during a Medicare physical or annual wellness visit (AWV):

Improving or maintaining physical health

- Talk about patients' perceptions of their own physical health.
- Applaud patients' physical health when possible and encourage them to stay positive.

Improving or maintaining mental health

- Ask about your patients' mental health, and refer to behavioral health supports and services, if appropriate.
- Simple recommendations such as increased social activity, exercise, and healthy eating can have a big impact on a patient's sense of emotional well-being.

Monitoring physical activity

- Discuss exercise and advise to start, increase, or maintain their physical activity level during the year.
- Strengthen recommendations by being specific. For example, suggest walking at a local park so patients have a specific, actionable idea.

Improving bladder control

- Ask patients if they are having a urine leakage problem and offer potential treatment(s) for the problem.
- When recommending Kegel exercises or other non-pharmacologic remedies, emphasize that you are providing treatment so patients will take your recommendations seriously.
- Discuss available treatment options no matter the frequency or severity of the bladder control problem.

Reducing the risk of falling

- Focus on fall-risk intervention to patients who had a fall or have problems with balance.
- If appropriate, refer to exercise/physical therapy programs aimed at improving balance, gait, and strength, withdrawing or minimizing psycho-active medications, management of orthostatic hypotension, or management of foot problems.
- Remind patients that installing handrails or using a cane can prevent falls.

Evaluation and Management (E/M) CPT Code Revisions

Effective January 1, 2021, Dean Health Plan will adopt the new rules developed by the American Medical Association (AMA) and approved by the Centers for Medicare and Medicaid Services (CMS) for coding the office and outpatient E/M visit code set (CPT codes 99201 through 99215). Under this new framework, patient history and physical exam will no longer be used to select the level of code for the office and/or outpatient E/M visits. Instead, the level of E/M may be determined by either Medical Decision Making (MDM) or Total Time.

These changes are designed to reduce administrative burden by simplifying the code-selection criteria, making them more clinically relevant and creating consistency across payors.

More information can be found on **cms.gov**. The AMA has provided additional training modules at **ama-assn.org/practice-management/cpt/cpt-evaluation-and-management**.

Modifier 25 Prepayment Review

Effective January 1, 2021, Dean Health Plan will begin pre-payment claim reviews of evaluation and management (E/M) codes submitted with modifier 25 to determine if the circumstances support the modifier use. Clinical documentation will not be required at the time of claim submission. Providers may appeal decisions to not provide additional reimbursement for the E/M service through our standard-appeal processes.

Use of modifier 25 indicates a "significant, separately identifiable E&M service by the same physician on the same day of the procedure or other therapeutic service."

In general, E/M services provided on the day of a procedure are considered part of the work of the procedure, and are not reimbursed separately. Similarly, an insignificant or trivial problem addressed during a preventive visit should not be reported separately, unless additional work, as a result, is required.

In either scenario, when the documentation supports work above and beyond what the physician would normally provide, and when the visit can stand alone as a medically necessary billable service, it may be appropriate to report the E/M service separately with a 25 modifier appended.

Autism Dx Indicator Process Ending in 2021

To reduce administrative burden, effective January 1, 2021, Dean Health Plan will no longer require autism treatment providers to contact the Health Plan and ensure an autism diagnosis indicator is placed on a member's file.

With this change, in 2021 providers can render and bill autism treatment services that are medically necessary per the state mandate without a prior authorization if the primary diagnosis on the claim is a recognized autism diagnosis. For successful claim adjudication, the primary diagnosis for the rendered service 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.

The "Autism Services" section in the Dean Health Plan Provider Manual is updated to reflect this change for 2021.

Lumicera Specialty Pharmacy

As announced this fall, Lumicera Specialty Pharmacy is our preferred specialty pharmacy. It 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**
310 Integrity Rd. Madison, WI 53717
lumicera.com

Care Management Lends a Hand

We offer free programs to support your Dean Health Plan-insured patients. Whether it's a new mom who would benefit from breastfeeding support or an elderly patient in need of an advance care planning conversation and document completion, the Care Management team is here to help.

"Sometimes we're the only adults they talk to during the day," said Alexandria Hellenbrand, a program outreach specialist on the OB Care Management Team, of new mothers she cares for. "We call to ask how they are doing in the course of the pregnancy or afterwards." Hellenbrand and her team offer resources and advice on lactation and other pregnancy-related matters.

Through telephone outreach, our specially trained nurse case managers, social workers and support staff can help your patients navigate insurance, find community resources, or set goals to improve self-management of their chronic condition.

Visit **deancare.com/wellness/care-management** to view our programs and resources. You can also refer patients to Care Management by calling **800-356-7344, ext. 4132**.

Provider Network Consultant Embraces Working with Providers


Sydney Sipos

Working as an analyst in the Network Solutions Department helped prepare Sydney Sipos for her current role as a Senior Provider Network Consultant (PNC), a role she has enjoyed for almost two years.

"I had a lot of hands-on experience with pulling analytics and compiling reports, which helps me tremendously in my current role helping providers and supporting the PNC team," Sydney said.

As a Senior PNC, Sydney mentors other PNCs and develops procedural documentation so the team has resources to fully support providers. Her goal is for providers to have positive and consistent experiences with their PNCs.

Sydney is the PNC assigned to Waukesha County providers as well as autism treatment providers in the Dean Health Plan network across the state. She acknowledges that prior to this role, she had little knowledge surrounding autism, especially the levels of treatment and different state mandates regarding treatment but has worked to become proficient in these topics.

"It's been a privilege to work with autism treatment providers and learn more about the services they provide our members," said Sydney. "I've been amazingly lucky with the providers I work frequently with, as they are always willing to explain more about the services they offer. Learning the ins and outs of autism treatment has taught me how far diagnosing and treating autism has come in just a few decades."

Sydney recognizes that autism treatment providers and their patients have been particularly affected during the COVID-19 public health emergency. She is pleased to have been a part of the health plan's response to ensure that members can still receive their regular treatments via telemedicine.

She looks forward to her continued work with providers. "Helping providers understand the resources available to them is always a highlight – seeing that "aha!" moment where providers realize the resources they can utilize to better access information is very rewarding," Sydney said.

Winter 2020 Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by Dean Health Plan's Medical Policy Committee, are shown below. The Medical Policy Committee meetings take place monthly. We appreciate contributions by specialists during the technology assessment of medical procedures and treatments.

To view all of Dean Health Plan's medical policies, visit **deancare.com**, ▶**For Providers,** and then ▶**Medical Management** ▶**Search Dean Health Plan's Medical Policies**. **Deancare.com** is updated as the medical policies become effective. For questions regarding any medical policy or if you would like copies of a complete medical policy, please contact our Customer Care Center at **800-279-1301**.

All other Dean Health Plan clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at **800-356-7344, ext. 4012**.

General Information

Coverage of any medical intervention discussed in a Dean Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note that prior authorization through the Dean Health Plan Health Services Division is required for some treatments or procedures.

Prior authorization requirements for Self-funded plans (ASO) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

For radiology, physical medicine and musculoskeletal surgery prior authorizations, please contact National Imaging Associates (NIA)/Magellan.

Radiology:

Providers may contact NIA by phone at **866-307-9729**, Monday-Friday from 7 am to 7 pm CST or via **RadMDSupport@MagellanHealth.com**. View details about the **radiology prior authorization program** on **deancare.com**.

Physical Medicine:

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 am to 7 pm CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the **physical medicine prior authorization program** on **deancare.com**.

Musculoskeletal

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 am to 7 pm CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the **musculoskeletal prior authorization program** on **deancare.com**.

General Information

- Prior authorization is required for adult and pediatric tilt in space manual wheelchairs.
- Effective September 1, 2020, prior authorization is not required for Cardiac Monitoring Device (ZioPatch).
- Foot prosthesis with a user-adjustable heel height feature is considered not medically necessary.

Technology Assessments

Medically necessary:

- Magnetic expansion control (MAGEC) procedure
- Hypoglossal nerve stimulation for obstructive sleep apnea (e.g. Inspire)
- Dry needling (effective January 1, 2021)
- Orthoptics for convergence insufficiency (effective January 1, 2021)

Experimental and investigational, and therefore are not medically necessary:

- Interferential current stimulation (e.g., Sanexa)
- Intravascular lithotripsy
- Iontophoretic drug delivery except for hyperhidrosis
- Irreversible electroporation
- NuShield placental allograft

- Pharmacogenetic screening in the general population
- Transdermal glomerular filtration rate measurement
- Voiding prosthesis for impaired detrusor contractility

New Medical Policies

Effective October 1, 2020

Vertos Minimally Invasive Lumbar Decompression (MILD) MP9551

The Vertos MILD procedure is considered medically necessary when the member has failed at least six (6) weeks of conservative treatment. A CT or MRI demonstrates lumbar spinal stenosis secondary to ligamentum flavum hypertrophy. Neurogenic claudication secondary to lumbar spinal stenosis is documented. Prior authorization is required.

Revised Medical Policies

Effective September 1, 2020

Bone Growth (Osteogenesis) Stimulator MP9076

The use of a stimulator is considered experimental and investigational, and therefore not medically necessary for the following: iliac apophysitis, stress fracture, talar dome lesion following osteochondral autograft and fractures with post-reduction displacement of more than 50%. Prior authorization is required.

Sleep Studies: Unattended and Attended Nocturnal Polysomnography MP9132

Attended split-night sleep studies are considered medically necessary for the following: Apnea Hypopnea Index (AHI) is greater than 15 in the first two (2) hours of a diagnostic sleep study. Moderate or severe sleep apnea is noted during an in-lab study. Previous study indicated moderate or severe apnea.

Attended full-night titration sleep study are considered medically necessary for the following: CPAP treatment criteria is met. A previous split-night study did not allow for abolishment of the vast majority of obstructive respiratory events. Despite documented compliance, prescribed CPAP/AutoPAP does not control clinical symptoms. The AHI remains persistently high with the use of a PAP device. A non-CPAP alternative was tried.

Prostate Treatment MP9361

Cystourethroscopy with anterior prostate commissurotomy and drug delivery for benign prostatic hyperplasia is considered experimental and investigational, and therefore not medically necessary.

Genetic Testing for Pharmacogenetics MP9479

Pharmacogenetic screening in the general population is considered not medically necessary.

Effective October 1, 2020

Seat-lift Mechanisms and Standing Devices MP9102

A transfer device (e.g., hydraulic, mechanical, or Hoyer) is considered medically necessary when the member would otherwise be bedbound. Prior authorization is required.

Engineered Products for Wound Healing MP9287

Allomax does not require prior authorization for a covered breast reconstruction procedure.

Hearing Aids MP9445

Contralateral routing of sound (CROS) device requires prior authorization.

Effective November 1, 2020

Whole Exome and Whole Genome Sequencing (WES) MP9548

Panel testing in the general population is considered not medically necessary. ⊕

Winter 2020 Pharmacy and Therapeutics/Drug Policy/Formulary Change Update

Highlights of recent drug policy revisions, as well as any new drug policies approved by Dean Health Plan's Medical Policy Committee, are shown below. **Note:** All changes to the policies may not be reflected in the written highlights below. We encourage all prescribers to review the current policies.

All drugs that have written Dean Health Plan policies **must be prior authorized** by sending requests to Navitus unless otherwise noted in the policy. Please note that most drugs listed below and with policies require specialists to prescribe and request authorization.

Policies regarding medical benefit medications may be found on deancare.com. From the home page, drop down from the **I am... screen** to Provider and then Pharmacy Services. Under current Drug policies, click See Library and search.

Criteria for pharmacy benefit medications may be found on the prior authorization form located in the provider portal. Pharmacy benefit changes may be found on **deancare.com**. From the home page, drop down from the **I am... screen to Provider and then Pharmacy Services. Under Covered Drugs/Formulary there is a change notices link below each formulary.**

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar. Medical injectable drugs may also be searched using the appropriate J-code (e.g., J9301 for Gazyva).

New Drug Policies

PADCEV (enfortumab vedoin-ejfv) MB2010

Effective October 1, 2020, PADCEV, which is used to treat refractory or relapsed locally advanced or metastatic urothelial cancer or stage 4 advanced metastatic disease, will require a prior authorization. It is restricted to oncology or hematology prescribers.

TRODELVY (sacituzumab govitecan) MB2009

Effective January 1, 2021, TRODELVY, which is used to treat metastatic triple-negative breast cancer, will require a prior authorization. It is restricted to oncology prescribers.

KADCYLA (ado-trastuzumab emtansine) MB2008

Effective January 1, 2021, KADCYLA, which is used to treat unresectable or metastatic HER2-positive breast cancer and adjuvant treatment of early HER2-positive breast cancer, will require a prior authorization. It is restricted to oncology prescribers.

ENHERTU (fam-trastuzumab deruxtecan-nxki) MB2007

Effective January 1, 2021, ENHERTU, which is used to unresectable or metastatic HER2-positive breast cancer, will require a prior authorization. It is restricted to oncology prescribers.

REBLOZYL (luspatercept-aamt)

Effective January 1, 2021, REBLOZYL, which is used to treat very low- to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T), will require a prior authorization. It is restricted to oncology or hematology prescribers.

Changes to Drug Policy

ZULRESSO (brexanolone) MB1939

Effective October 1, 2020, updated HCPCS code to J1632. Prior authorization is required and is restricted to a psychiatrist or an obstetrician-gynecology prescriber.

TECENTRIQ (atezolizumab) MB1817

Effective October 1, 2020, added indication for Melanoma. Prior authorization is required and is restricted to oncology prescribers.

TEPEZZA (teprotumumab-trbw) MB2005

Effective October 1, 2020, updated HCPCS code to J3241. Prior authorization is required and is restricted to ophthalmology, ophthalmic, or oculoplastic surgeon prescribers.

SARCLISA (isatuximab) MB2004

Effective October 1, 2020, updated HCPCS code to J9227. Prior authorization is required and is restricted to oncology prescribers.

DARZALEX (daratumumab) MB1832

Effective October 1, 2020, updated HCPCS code for Darzalex Faspro to C9062. Prior authorization is required and is restricted to oncology prescribers.

Botulinum Toxin MB9020

Effective November 1, 2020, added disclaimer that the Hyperhidrosis (axillary) indication does not apply to members of the state of Illinois. Prior authorization is required.

CRYSVITA (burosumab) MB1831

Effective November 1, 2020, updated continuation criteria to include, documentation that the member has experienced an increase or normalization of serum phosphorus while on CRYSVITA therapy. Prior authorization is required and is must be prescribed by an endocrinologist or specialist experienced in treatment of metabolic bone disorders.

BAVENCIO (avelumab) MB1936

Effective November 1, 2020, added indication for locally advanced or metastatic urothelial carcinoma that has not progressed with first-line platinum-containing chemotherapy. Prior authorization is required and is restricted to oncology prescribers.

ENTYVIO (vedolizumab) MB9453

Effective November 1, 2020, removed age requirement of 18 years or older. Prior authorization is required and is restricted to gastroenterology prescribers.

KYMRIAH (tisagenlecleucel) MB1822

Effective November 1, 2020, moved 'Member has had prior stem cell transplantation that has disease progression 6 months post stem cell infusion' to be included in 1.1.3 instead of its own step. Prior authorization is required and is restricted to oncology prescribers.

ONPATTRO (patisiran) MB1838

Effective November 1, 2020, removed age requirement of 18 years or older. Prior authorization is required and is restricted to oncology, hematology, or neurology prescribers.

ORENCIA (abatacept) IV Formulation MB9457

Effective November 1, 2020, updated continuation criteria to include efficacy documented in the medical record indicating stabilization or improvement in disease activity and absence of treatment limiting toxicity. Prior authorization is required and is restricted to rheumatology prescribers.

Pegfilgrastim and biosimilars MB1808

Effective February 1, 2021, removed Udenyca for preferred products. No prior authorization is required for the preferred products (Fulphila and Ziextenzo) but products must be prescribed by a hematologist or oncologist.

Immune Globulin MB9423

Effective November 1, 2020, added indications of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome. These two indications only apply to members of the state of Illinois and prior authorization is required.

Pertuzumab Products (formerly PERJETA) MB9438

Effective February 1, 2021, added PHESGO as a preferred product. Prior authorization is required and is restricted to oncology or hematology prescribers.

Rituximab Products MB9847

Effective November 1, 2020, removed age requirement for the rheumatoid arthritis indication and added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

Trastuzumab Products MB1805

Effective February 1, 2021, added PHESGO as a preferred product. Prior authorization is required and is restricted to oncology or hematology prescribers.

Bevacizumab Products MB9431

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

LARTRUVO (olaratumab) MB9956

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

POLIVY (polatuzumab vedotin-piiq) MB1938

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

VECTIBIX (panitumumab) MB1810

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

EMPLICITI (elotuzumab) MB1906

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology or hematology prescribers.

IMFINZI (durvalumab) MB1828

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

ONCASPAR (pegasargase) MB1903

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology or hematology prescribers.

Bendamustine Products MB1917

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology or hematology prescribers.

VELCADE (bortezomib) MB1922

Effective November 1, 2020, added requirement that the dose must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. Prior authorization is not required but is restricted to oncology prescribers.

Antihemophilia Factors and Clotting Factors MB1802

Effective December 1, 2020, removed all investigational and not medically necessary references. If an indication is not listed in the policy, it is considered investigational and not medically necessary. Prior authorization is required.

Infliximab Infusions MB9231

Effective December 1, 2020, added indication for refractory pulmonary sarcoidosis. Prior authorization is required and is restricted to dermatology, rheumatology, or gastroenterology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective December 1, 2020, added indication for primary mediastinal large b-cell lymphoma (PMBCL). Prior authorization is required and is restricted to oncology prescribers.

NUCALA (mepolizumab) MB9914

Effective December 1, 2020, added indication for hypereosinophilic syndrome (HES). Prior authorization is required and is restricted to hematology, pulmonology, or immunology prescribers.

SIMPONI ARIA (golimumab) MB9874

Effective December 1, 2020, added indications for polyarticular juvenile idiopathic arthritis and pediatric psoriatic arthritis for member 2 years of age or older. Prior authorization is required and is restricted to rheumatology prescribers.

Retired Policies

Effective December 1, 2020, PIROXICAM CAPSULES PA9936

Effective December 1, 2020, VALSARTAN PA1943

Did you receive a 2021 Plan and Benefit Changes notification?

To keep Dean Health Plan in-network providers informed of changes that will affect their patients, we annually compile an informational packet summarizing plan and benefit changes for the upcoming year. This year's notification for 2021 was distributed to providers on October 30, 2020. Please contact your Provider Network Consultant if you have any questions. To find your designated Provider Network Consultant, go to deancare.com/providers and scroll to the bottom of the web page.

Finding Member Benefit Information

Providers can access documentation related to a member's Dean Health Plan benefits, including certificate of coverage, member policy or certificate and the member handbook, at **memberbenefits.deancare.com**. From this web page, providers can enter the Group Number or Member ID to retrieve information for a particular member. Providers are encouraged to check their entered information to ensure that accurate information for the member is returned.

Providers can access the Member Summary Plan Description (SPD) for SSM Health's Employee Health Plan Administrative Services Only (ASO) plan members at **memberbenefits.wellfirstbenefits.com**.

How to find a Prior Authorization form

Prior authorization forms for medications under the *medical benefit* for Dean Health Plan commercial plans and medications under the *pharmacy benefit* for Dean Health Plan commercial and Dean Advantage plans can be obtained from the Navitus Prescriber Portal. Access the Prescriber Portal from the Dean Health Plan website at **deancare.com** by following the steps below:

1. Select '**I am a**...'
2. Select **Provider**
3. Select **Pharmacy Services**
4. On the left side of the page under Prior Authorization, click **Prescribers**
5. Enter your **NPI number and state**
6. Select **Prior Authorization** on the right-hand side of the Prescriber Portal
7. Select **Dean Health Plan for Navitus Client**

Prior authorization forms will populate. You may also use the search field to search for a specific prior authorization form.

Prior authorization requests for medications under the *medical benefit* for Dean Advantage plans must be submitted to Dean Health Plan (not Navitus) through the Provider Portal Authorization Submission application.

Provider Portal Enhancement Allows Users to Update Their Information

A new feature of the Dean Health Plan Provider Portal allows users to update their contact information at any time, not just during their initial account setup. Users can update their email address, name, and phone number in their Account Settings, as well as select "Opt-In for Electronic Communications" if they initially selected "Opt-Out" during their registration.

By selecting the "Opt-In" option, Portal users will receive direct and expedited provider email communications from Dean Health Plan. Communications include emails to providers when the *Provider News* is published on **deancare.com** and occasional notifications about changed or new policies, for example. Opt-In will not replace all paper communications.

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

Legacy Provider Portal Will No Longer Be Available in 2021

Dean Health Plan will retire its legacy Provider Portal at the end of this year. We extended the transition period to the new Provider Portal, knowing providers are dealing with the public health emergency. Those who have not yet made the transition to the new Provider Portal, should do so immediately and start taking advantage of the upgraded applications and new features for a more modern user experience.

To assist providers in transitioning to the new Provider Portal, please refer to our self-service resources on the **Account Login web** page, including a short video introduction to key features, easy-to-read account setup options and recommendations, and Registration User Guide.

Please contact your Provider Network Consultant if you have questions.

Free Virtual Tobacco Cessation Group

Dean Health Plan is offering The American Lung Association's Freedom from Smoking program as a free virtual tobacco cessation group. This group is led by a certified Freedom from Smoking facilitator to help tobacco users develop coping skills and quit their tobacco use. The seven-week program features a step-by-step plan to support users of any type of nicotine, including cigarettes, smokeless, e-cigarette, pipe, cigar, and vaping products. The program uses evidence-based techniques to personalize and address individual needs, along with the benefits of support from the group.

Providers can refer any patient to the program as it is not limited to Dean Health Plan members. Our members are eligible to receive medications and nicotine-replacement therapy at no cost. For more information, visit **deancare.com/quitnow**.

2021 sessions are scheduled as follows:

- Tuesdays, starting on January 19 through March 2 at 5 pm-6 pm
- Tuesdays, starting on May 4 through June 15 at Noon-1 pm
- Tuesdays, starting on July 27 through September 7 at 12:30 pm - 1:30 pm
- Tuesdays, starting on September 28 through November 9, 11:30 am -12:30 pm

Interested participants can contact **dhp.health@deancare.com** or call **866-896-4602** to register.

Dean Health Plan *Provider News*
Les McPhearson, President

Loretta Lorenzen Vice President, Network Management and Contracting

Editorial Staff
Scott Culver Manager, Communications
scott.culver@deancare.com

Steve Busalacchi Editor
stephen.busalacchi@deancare.com

Content Reviewers
Loretta Lorenzen Vice President, Network Management and Contracting

Cara Peterson, Quality and Accreditation Lead

Katherine Luther, Director, Provider Network Administration

Elizabeth Fleig, Supervisor, Provider Network Services

Honore Manning, Provider Communications Specialist, Provider Network Services

©2020 Dean Health Plan
1277 Deming Way • Madison, WI 53717

Automated Approval for Epidural Steroid Injection or Selective Nerve Root Block

To support providers as they begin using the new automated authorization functionality through the Provider Portal for epidural steroid injection (ESI) or selective nerve root block (SNRB) authorization requests, we have created an **Automated Authorization web page**. Access the page from the Medical Management page by clicking the Automated Authorization link. Resources available from the page include Frequently Asked Questions, ESI and SNRB checklists, links to relevant medical policy, and an Automated Authorization Guide.

If you are not submitting your authorizations through the Provider Portal, we strongly encourage you to do so. Refer to the Complete Registration User Guide on the **Account Login** page for information on how to register for a Provider Portal account.

Earlier this year, we announced the automated authorization functionality to in-network providers, effective January 1, 2021. This first venture into the automated authorization process is our response to provider feedback to make the authorization process more user-friendly and efficient for both providers and members alike. The success of the automated authorization for ESIs and SNRBs will influence potential future automated authorization approval for other services and procedures. ⊕

Notification Necessary for Provider Demographic Changes

Dean Health Plan is committed to ensuring accurate provider information is displayed within its provider directories. As a health plan, we are required to keep provider information up to date by CMS and other regulatory and accreditation entities.

To ensure we have the most current, accurate provider information available for our members, we require providers to notify their designated Provider Network Consultant as soon as staff are aware of any of the following changes:

- Ability to accept new patients
- Practicing address
- Phone number
- Provider terminations
- Other changes that affect publicly posted provider accessibility and demographics information. This includes, but is not limited to:
  - Practice location's handicap accessibility status
  - Hospital affiliation
  - Provider specialty
  - Languages spoken by provider
  - Provider website URL

Dean Health Plan is committed to ensuring that we present accurate provider information. Communication between the health plan and providers will assist in maintaining excellent quality of care and customer service to our members and patients.

Please review the current listing of practitioners and locations included in the online provider directory at **deancare.com/find-a-doctor** to ensure we are posting the most current information. ⊕

Winter 2020

Yes! Sign me up!

Would you like to receive an email when the *Provider News* is published on **deancare.com?** Please contact Provider Network Services at **DHP.ProviderNewsletter@deancare.com** to be added to our email distribution list.

• Facility Name	• Full Name
• Address	• City, State, Zip
• Phone	• Email

©2020 Dean Health Plan, Inc. • 517291_R06_2005

Visit
deancare.com/providers

To view your **Provider Network Consultant** and view updated territory contact information.

Provider Network Consultants

While online self-service resources and the Customer Care Center are your first sources of information, Provider Network Consultants (PNCs) are here to support our in-network providers with more in-depth inquiries. To find your assigned PNC, go to **deancare.com/providers** and scroll to the bottom of the page.

DeanHealthPlan
A member of SSM Health

Dean Health Plan, Inc.
1277 Deming Way
Madison, WI 53717

Customer Care Center
800-279-1301
Monday–Thursday
7:30 am – 5 pm
Friday
8 am – 4:30 pm

Visit
deancare.com