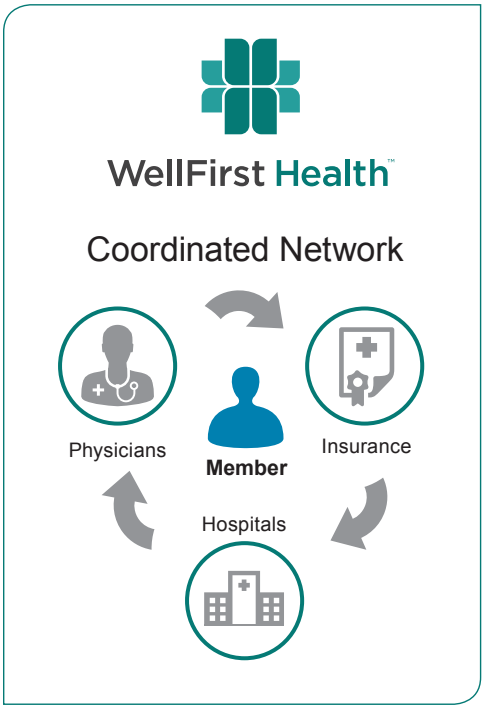
Provider NEWS

DeanHealthPlan
A member of SSM Health

Fall 2019
A newsletter for Dean Health Plan providers

WellFirst Health™: New ASO Plan Administrator for SSM Health Employees

Dean Health Plan Provides Foundation for WellFirst Health



We are pleased to introduce WellFirst Health to our Dean Administration Services Only (ASO) Network providers. SSM Health is launching WellFirst Health, inspired by Dean Health Plan's comprehensive approach to member care.

Effective January 1, 2020, WellFirst Health will be the third party administrator of the SSM Health Employee Health Plan for employees in Illinois, Missouri, Oklahoma and Wisconsin. In Wisconsin, WellFirst Health will leverage the Dean Health Plan ASO Network.

Dean ASO Network providers will be able to continue to deliver exceptional health care services to SSM Health employees and their families in 2020. We estimate that over 50,000 SSM Health employees and dependents across four states will be enrolled in the SSM Health Employee Health Plan in 2020. Within that population, approximately 15,000 members will be Wisconsin-based from Dean Health Plan, Agnesian HealthCare, SSM Health hospitals and clinics, and Monroe Clinic. (continued on page 2)

This Issue

Dean Health Plan Provides Foundation for WellFirst Health (continued)

WellFirst Health is modeled after Dean Health Plan's successful integrated approach to health care – a coordinated network consisting of medical providers, care sites, and health plan to support members and encourage individuals to seek their health care locally. While WellFirst Health broadens the integrated care model to other states, Dean ASO Network providers and members will continue to benefit from an emphasis on high quality, local care.

Dean Health Plan's strong partnership with local providers who deliver exceptional health care to members paved the way for the development of WellFirst Health. Dean Health Plan serves more than 400,000 members in Wisconsin and member enrollment continues to increase every year. Last year, the Congregation of Sisters of St. Agnes officially transitioned sponsorship of Agnesian HealthCare, Monroe Clinic, and its affiliates to SSM Health, deepening the connection Dean Health Plan has with members and providers throughout southern and central Wisconsin.

In 2019, Prevea360 Health Plan (underwritten by Dean Health Plan) expanded in six western Wisconsin counties in addition to the existing 11 eastern Wisconsin counties. Since July 2018, member enrollment across Prevea360 Health Plan has increased by approximately 17%.

While WellFirst Health will be the administrator of the SSM Health Employee Health Plan, in many instances, providers will continue to work with Dean Health Plan resources in the same way they do currently. ⊕

Editor's note: *See page 3, "Dean ASO Network Providers: Navigating WellFirst Health," to learn more about what will (and will not) be changing in day-to-day processes.*

Dean Health Plan *Provider News*

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Dean ASO Network Providers: Navigating WellFirst Health

Wondering what to expect when WellFirst Health begins administering SSM Health's Employee Health Plan on January 1, 2020? In many instances Dean Administration Services Only (ASO) Network providers will continue working with us as they currently do. There will be some changes to day-to-day processes with the addition of WellFirst Health. The following checklist provides an overview of what is (and what is not) changing in 2020.

Are the current Dean Health Plan Member ID numbers and cards for employee enrollees changing?

☑ Yes ☐ No

SSM Health employees who are enrolled in the SSM Health Employee Health Plan will be issued new Member ID numbers and cards with the WellFirst Health and SSM Health logos. A preview of the new card will be available this fall.

Is the customer care telephone number changing?

☑ Yes ☐ No

The customer care number for the SSM Health Employee Health Plan will be 877-274-4693.

Are Provider Portal credentials changing?

☐ Yes ☑ No

Providers will use their Dean Health Plan Provider Portal, accessible from the link **deancare.com/providerportal**, for the SSM Health Employee Health Plan using their Dean Health Plan-issued credentials.

Are the methods for verifying member eligibility changing?

☐ Yes ☑ No

Providers will verify member eligibility using the 270/271 Eligibility and Benefit Inquiry, the Dean Health Plan Provider Portal, or by calling the customer care telephone number on the back of the Member ID card.

Are the requirements under the medical policies changing?

☐ Yes ☑ No

Wisconsin medical policies are not changing due to WellFirst Health. Medical policies are published on the Medical Management web page accessible from **deancare.com** or **wellfirstbenefits.com**. While WellFirst Health will use the same current policies, the policies are branded for each website respectively.

Are the methods for authorization submissions changing?

☐ Yes ☑ No

Providers will submit authorization requests through the Dean Health Plan Provider Portal or through Authorization Partner Portals such as Navitus/Navi-Gate and NIA Magellan.

Are the methods for claim submission changing?

☐ Yes ☑ No

Providers will submit claims as they do currently through 837 Health Care Claim transactions, Online Direct Data Entry Form, or on paper claim forms. Dean Health Plan's Payer ID will remain 39113.

Are the methods for checking claim status changing?

☐ Yes ☑ No

Providers will check claim status using the 276/277 Health Care Claim Status Request and Response transaction, through their Dean Health Plan Provider Portal, or by calling the Customer Care Center.

Is more information available?

☑ Yes! ☐ No

We will mail more information about WellFirst Health to providers later this fall. We encourage providers to visit the WellFirst Health website at **wellfirstbenefits.com** and to check it regularly for updated information and more content, as it is available. ⊕

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New HEDIS Measures for Depression Screening and Follow-Up During and After Pregnancy

Performance measures that take effect in 2020 will shine a brighter light on depression during and after pregnancy. There are two new Healthcare Effectiveness Data and Information Set (HEDIS) measures around prenatal and postpartum depression screenings and follow-up:

- **Prenatal Depression Screening & Follow-Up** – The proportion of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.
    1. Depression screening
    2. Follow-up on positive screen: women who received follow-up care within 30 days of screening positive for depression.
- **Postpartum Depression Screening & Follow-up** – The percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care.
    1. Depression screening
    2. Follow-Up on positive screen: women who received follow-up care within 30 days of screening positive for depression.

Prenatal and postpartum formal, scored depression screenings are covered benefits under Dean Health Plan.

USPSTF Grade B Recommendation

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

Why screen for depression?

An estimated 10-20% of women who recently gave birth experience post-partum depression (PPD) and these numbers are much higher in at-risk communities. Up to 48% of new mothers in low-income households experience PPD and 40-60% of adolescent mothers in low-income households experience it. Yet only about 15% of these higher-risk women seek treatment for PPD.

The national standard of care recommendations now includes screening for mental health during the pregnancy and postpartum period.

When to screen

The American College of Obstetricians and Gynecologists (ACOG) recommends patients are screened at least once during the prenatal period for depression and anxiety symptoms using a standardized, validated tool. ACOG also recommends that a full assessment of mood and emotional well-being using a standardized, validated tool, is completed during the postpartum visit for each patient.

If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit.

Women with current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts warrant particularly close monitoring, evaluation, and assessment. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to behavioral health care providers offers maximum benefit. Systems should be in place to ensure follow-up for diagnosis and treatment.

Prenatally

- Ideally once per trimester, but at least once prenatally.
- When there is a concern by the patient or the patient's family about the patient's ability to function.
- When there is a subsequent pregnancy before 12 months postnatal, at least once per trimester.

Postpartum

- Between 2-4 weeks postpartum.
- Between 8-12 weeks postpartum.
- Between 9-12 months postpartum.

Rescreen at any time there is a concern by the patient or patient's family about the patient's ability to function.

Talking to your patients after screening

Even if a patient completes a screening tool with no troubling responses, talking to your patient after screening allows providers an opportunity to begin discussion about how she is doing emotionally. Asking the patient questions like; "How are you handling the transition to motherhood?" or "Are you enjoying the baby?" can normalize the screening process. Follow-up questions will create an environment where the patient may be more comfortable disclosing to you what she is experiencing. The patient may be embarrassed of her feelings or afraid of the consequence if she tells you how she's feeling. Create an environment of openness and trust with your pregnant or postpartum patient.

Evaluating Mood Symptoms

	Onset	Duration	Signs/Symptoms	Treatment
Baby Blues: Common and temporary, often occurring in the immediate postpartum period.	Typically in the first week following delivery.	No more than 2 weeks.	Tearfulness, excessive worrying, mood swings, irritability, difficulties sleeping, and changes in appetite.	Will likely resolve naturally without formal intervention. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.
Perinatal Depression: An episode of major depression occurring in the context of pregnancy and/or the postpartum period.	During pregnancy or up to 1 year postpartum.	May persist until treated.	Depressed mood, loss of interest in all/most activities, changes in appetite, changes in sleep habits, excessive guilt and/or worry, impaired concentration, recurrent thoughts of death or suicidal ideation.	Therapy medications. Encourage participation in support groups, asking for help when needed, and healthy self-care practices.
Bipolar Disorder: A mood disorder consisting of both depressive symptoms as well as mania.	Prior to pregnancy, during pregnancy, or in the postpartum period (often precipitated by disturbed sleep).	Persists until treated.	May present with depressive symptoms, as previously delineated. Mania characterized by a decreased need for sleep, risk-taking behaviors (e.g., gambling, promiscuity), euphoria or irritability, increased goal directed activity, grandiosity.	Medications, therapy. Inpatient hospitalization may be indicated if symptoms are severe and associated with psychosis. Encourage participation in support groups, asking for help when needed, and healthy self-care practices (most importantly sleep hygiene).
Psychosis: A psychiatric emergency consisting of notable changes in mental status, typically associated with severe mood symptoms.	Sudden with rapid deterioration. Most commonly occurs within 2-12 weeks of delivery, often on days 1-3 postpartum.	Persists until treated.	Symptoms are severe and include depression, mania, or a mixed mood episode. Prominent symptoms include delusions, hallucinations, and/or confusion.	Inpatient hospitalization is usually indicated in these cases.

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Follow-Up Care for Children Prescribed ADHD Medication

With the new school year upon us, more children and families will come to our clinics with questions about Attention Deficit/Hyperactivity Disorder (ADHD). October is ADHD Awareness Month. ADHD is one of the most commonly diagnosed and extensively studied childhood behavioral health disorders.

The National Committee for Quality Assurance (NCQA) monitors ADHD follow-up care using the Healthcare Effectiveness Data and Information Set (HEDIS*) measures. The goal is to ensure children ages 6-12 have at least three follow-up visits within a 10-month period when they are newly prescribed ADHD medication or returning to a prescription after a break of four or more months. The first of these visits needs to be within 30 days of dispensing the first ADHD medication. Two phases are reported:

- 1 Visit within 30 days (Initiation Phase)
  - Must be a face-to-face visit between prescriber and patient
- 2 additional visits in the following 9 months (Continuation and Maintenance Phase)

Improve follow-up visit compliance:

- If you prescribe ADHD medication, consider limiting the first prescription to a 30-day supply.
- Consider not refilling unless follow-up appointments are kept.
- Schedule follow-up appointment(s) before the patient leaves the office.
- Discuss the importance of follow-up appointments with the parent/guardian.
- Educate the parent or guardian that the child must be seen within 30 days of starting the medication to evaluate if the medication is working as expected and assess any adverse effects.
- Verify the parent or guardian understands the aforementioned requirements and keeps the appointment for refill prescriptions.

Tips for talking with patients about safe ADHD medication use:

- Educate families on the expected response to the medication, known side effects, and potential adverse effects.
- Advise parents to lock all medications in a safe place and to have a responsible adult directly monitor administration, whenever possible.
- Advise families and patients to never share the medication, or any medications, with others.
- Provide education on taking medication as prescribed, including what to do if a dose is missed and when to call the provider.

ADHD Medications Description	Prescription
CNS Stimulants	• Amphetamine-dextroamphetamine • Dexmethylphenidate • Dextroamphetamine • Lisdexamfetamine • Methamphetamine • Methylphenidate
Alpha-2 Receptor Agonists	• Clonidine • Guanfacine
Miscellaneous ADHD Medications	• Atomoxetine

Discuss the signs and symptoms of stimulant misuse, including under and over use:

- Lack of expected therapeutic response, especially after achieving a target dose and clinical stability.
- Unexpected increased arousal, irritability, decreased appetite, sleep changes, hyperactivity, or behavioral changes.
- School reports of new or unexpected behavioral and/or academic performance concerns.
- Running out of medications early; unexplained new possessions or access to spending money.
- Monitor patterns of "lost" medications and early refill requests by parents of children on stimulant medications as diversion does occur within the patient home as well. ⊕

**HEDIS is a registered trademark of the NCQA.*

Q&A: Service Excellence Director on Advisory Council's role in Patient Experience

If we're committed to patient-centered care, we need to consult with those who know the topic best: patients! That's the idea behind SSM Health Dean Medical Group's Patient and Family Advisory Council, which meets 10 times per year. "I always walk away with at least one or two nuggets," says Martha Hughes, Service Excellence Director for Dean Medical Group.

Martha Hughes, Service Excellence Director for Dean Medical Group

Q: Who is on the Council?

MH: The Council is a group of patients recommended by their clinic or location who could provide feedback to the organization about the patient experience. They are 15-20 diverse individuals—single, married, by gender, ethnicity, age, etc. It's hearing the voice of the patient when we're trying to implement something new or different and making sure we are customer focused and providing great services.

Q: How would you characterize the type of advice you get from the Council?

MH: Practical. I would also tell you it is sometimes challenging because what they want to see as a consumer probably is not what we are thinking of. So for instance, tell me to go to a website—look for palliative care. Why can't you provide the main link on the front page so I don't have to search for it? It's practical and real. A lot of them will compare their health care experience to other consumer experience, so if we can get this kind of service here, why can't we get it in the health care world?

Q: Is it fair to say that? Isn't health care quite different than other kinds of industries?

MH: It's completely fair. If we are truly a patient-centered organization, we better be keeping up with what the market demands of us or else we lose that loyalty. What's best for patients and their families? It's a trend across health care, so you have the voice of the patient.

Q: What drives the discussion?

MH: Sometimes we'll get a request from one of the members of the Council or we know that a service line is coming up. Sometimes we have departments that say, We just need an extra set of eyes on this. Each meeting is separate, though there may be some issues that carry over. Each meeting is really unto itself.

Q: Any suggestions for providers, or is there a theme regarding providers that comes up?

MH: They say that providers should listen to what patients are *not* saying. Are they avoiding a subject? Try to approach it differently. When referring or not referring patients, be careful how you talk about colleagues. Realize what you're saying to your patients. They are listening.

Q: Do members of the Council feel providers are doing a good job?

MH: They say how they love their providers. They consider providers the captains of their ship and they are incredibly loyal to them. It's overwhelmingly positive. But they want to see it better. ⊕

Q: Do things actually change because of what they recommend?

MH: Absolutely. Those things that they recommend or suggest are done. It's not lip service. A doctor just came to the Council to ask what they knew about palliative care. What does it mean? What do they not know? What should be included in the brochure? I'm always amazed at the thoughtful insight they bring to the table.

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Formulary Management Procedures

The Dean Health Plan drug formulary is reviewed every month. With the approval of newer generic entities, changes and updates are made on a regular basis. In addition to updating the formulary status of covered drugs, formulary restrictions are also modified as necessary. Here is an update of restrictions and limitations associated with the drug formulary:

Closed formulary. Dean Health Plan employs a closed formulary. If a drug is not listed on the drug formulary, the product is not covered by the member's pharmacy benefit. If the member chooses a product not on the formulary, the member is responsible for 100% of the cost of the drug.

Mandatory Generic Substitution. If a drug is available in a generic version, Dean Health Plan may require the use of the generic version. If the generic version of the drug is mandated and the patient chooses to receive the brand, the patient is responsible for the highest tier branded copay plus the ingredient cost difference between the brand and generic versions. If the patient's physician requests the branded version, the patient is only responsible for the highest tier branded copay.

Prior Authorization. When a drug is prior authorized, the physician must receive approval prior to prescribing the drug. The list of prior authorized drugs and the request forms are available on **deancare.com**.

Step Therapy. Step edits are often used within a therapeutic class to require generic or preferred drug use prior to a non-preferred drug. When a step edit is in place, the patient must have trialed therapy with a preferred drug(s) prior to receiving approval for the non-preferred drugs. Step edits are completed point-of-service at the pharmacy, and there are no prior authorization requirements.

Specialist Restrictions. Specialist restrictions limit the prescribing of a drug to a unique specialty. These decisions are based on the indications and uses for the specific drug.

Quantity Level Limits. Quantity level limits restrict the supply of drug product that may be dispensed either per prescription or per a specific amount of time.

Specialty Pharmacy. If a drug is available or mandated to be dispensed by a specialty pharmacy, the specialty pharmacy designation will be applied.

A complete listing of the all Dean Health Plan pharmacy resources, including the drug formulary, can be found on the Pharmacy services for health care providers page at **deancare.com**.

Pharmacy Benefit Drug Policies

Effective September 1, 2019, pharmacy benefit drug policies are no longer posted on deancare.com. Prior Authorization (PA) criteria is listed on the PA form, which can be accessed through the Navitus Prescriber Portal, **prescribers.navitus.com**. This change will ensure that the most up-to-date and accurate information is available in one location. Medical benefit drug policies will remain posted on **deancare.com**, and their PA forms will continue to be posted on the Navitus Prescriber Portal.

Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights

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. All prescribers are encouraged 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 noted 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 **› Up to Date Drug Policies**, click **› See Library** and search. Criteria for pharmacy benefit medications may be found on the associated prior authorization form located in the provider portal.

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

Bendamustine Hydrochloride Products—TREANDA, BENDEKA, BELRAPZO MB1917

Effective September 1, 2019, bendamustine products, which are used to treat Chronic Lymphocytic Leukemia (CLL) and Indolent B-cell Non-Hodgkin Lymphoma (NHL), will require a prior authorization. They are restricted to oncology and hematology prescribers.

CYRAMZA (ramucirumab) MB1918

Effective September 1, 2019, CYRAMZA, which is used to treat Colorectal Cancer, Non-Small Cell Lung Cancer, Gastric Cancer, and Hepatocellular Carcinoma, will require a prior authorization. It is restricted to oncology prescribers.

ERWINAZE (asparaginase erwinia chrysanthemi) MB1919

Effective September 1, 2019, ERWINAZE, which is used to treat Acute Lumphoblastic Leukemia, will require a prior authorization. It is restricted to oncology and hematology prescribers.

LUMOXITI (moxetumomab pasudotox) MB1920

Effective July 1, 2019, LUMOXITI, which is used to treat Refractory Hairy Cell Leukemia (HCL), will require a prior authorization. It is restricted to oncology prescribers.

SPRAVATO (esketamine) MB1921

Effective July 1, 2019, SPRAVATO, which is used to treat treatment-resistant depression (TRD), will require a prior authorization. It is restricted to psychiatrist or psychiatric nurse practitioner prescribers.

VELCADE (bortezomib) MB1922

Effective September 1, 2019, VELCADE, which is used to treat Adult T-Cell Leukemia/Lymphoma, Mantle Cell Lymphoma, Multicentic Castelman disease, Multiple Myeloma, Primary cutaneous CD30+ T-Cell Lymphoproliferative Disorders, Systemic light chain amyloidosis, and Waldenström's macroglobulinemia/ Lymphoplasmacytic lymphoma, will require a prior authorization. It is restricted to oncology prescribers.

ARIKAYCE (amikacin liposomal inhalation)

Effective July 1, 2019, ARIKAYCE, which is used to treat Mycobacterium avium complex lung disease, will require a prior authorization. It is restricted to infectious disease or pulmonology prescribers.

COPIKTRA (duvelisib)

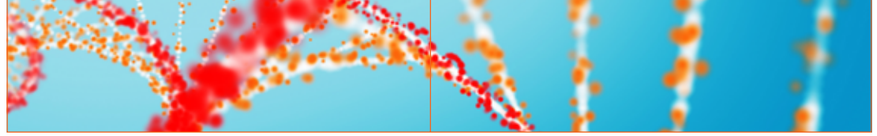
Effective July 1, 2019, COPIKTRA, which is used to treat Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma, and Follicular Lymphoma, will require a prior authorization. It is restricted to oncology or hematology prescribers.

EPIDIOLEX (cannabidiol)

Effective July 1, 2019, EPIDIOLEX, which is used to treat Lennox-Gastaut Syndrome or Dravet Syndrome, will require a prior authorization. It is restricted to neurology prescribers.

GALAFOLD (migalastat)

Effective July 1, 2019, GALAFOLD, which is used to treat Fabry disease, will require a prior authorization. It is restricted to a medical geneticist or other prescriber specialized in the treatment of Fabry disease.



Pharmacy and Therapeutics / Drug Policy / Formulary Change Update Highlights (continued)

QBREXZA (glycopyrronium)

Effective July 1, 2019, QBREXZA, which is used to treat primary axillary hyperhidrosis, will require a prior authorization. It is restricted to dermatology prescribers.

SKYRIZI (risankizumab)

Effective July 1, 2019, SKYRIZI, which is used to treat Plaque Psoriasis, will require a prior authorization. It is restricted to dermatology prescribers.

TALZENNA (talazoparib)

Effective July 1, 2019, TALZENNA, which is used to treat locally advanced or metastatic breast cancer, will require a prior authorization. It is restricted to oncology prescribers.

VIZIMPRO (dacomitinib)

Effective July 1, 2019, VIZIMPRO, which is used to treat Metastatic Non-small cell lung cancer, will require a prior authorization. It is restricted to oncology prescribers.

Changes to Drug Policy

ABRAXANE (paclitaxel albumin-bound) MB1801

Effective July 1, 2019, criteria updated to include diagnosis of NCCN category 1, 2a, or 2b ('recommended') for off label uses of FDA indications. Prior authorization is required and is restricted to oncology prescribers.

OCREVUS (ocrelizumab) MB9941

Effective July 1, 2019, added exception to infusion limits (splitting the every 6 month infusion into two separate infusions of 300mg two weeks apart) during the maintenance phase made be made in cases with documented severe infusion reactions. Prior authorization is required and is restricted to neurology prescribers.

Antihemophilia Factors and Clotting Factors MB1802

Effective August 1, 2019, added Jivi (J7208). Prior authorization is required and is restricted to hematology prescribers.

Botulinum Toxin MB9020

Effective August 1, 2019, added criteria for BOTOX to include no concurrent use of a calcitonin gene-related peptide (CGRP) inhibitor (e.g., Aimovig, Emgality, Ajovy). Also, removed sweat production of 50mg per axilla requirement under the Hyperhidrosis indication for DYSPORT. Prior authorization is required.

RITUXIMAB Products

Effective August 1, 2019, added biosimilar TRUXIMA (Q5115) and added indication for Dermatomyositis or Polymyositis. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

LEMTRADA (alemtuzumab) MB9468

Effective August 1, 2019, updated initial and continuation approval duration to 12 months. Prior authorization is required and is restricted to neurology prescribers and administered at a facility certified for LEMTRADA infusions.

Trastuzumab Products MB1805

Effective September 1, 2019, added biosimilar KANJINTI (J9999). Prior authorization is required and is restricted to oncology prescribers.

PROLIA, XGEVA (denosumab) MB9409

Effective September 1, 2019, extended the initial and renewal approval durations to 2 years. Prior authorization is required and is restricted to oncology, rheumatology, internal medicine, family medicine, orthopedic surgery or endocrinology prescribers.

ULTOMIRIS (ravulizumab) MB1902

Effective September 1, 2019, updated HCPCS codes to J3590 and C9052. Prior authorization is required and is restricted to hematology, oncology or immunology prescribers.

TECENTRIQ (atezolizumab) MB1817

Effective September 1, 2019, added indications for Small Cell Lung Cancer and Triple-Negative Breast Cancer along with dosing information. Prior authorization is required and is restricted to oncology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective September 1, 2019, added indications for Esophageal Cancer, Small Cell Lung Cancer and Renal Cell Carcinoma. Prior authorization is required and is restricted to oncology prescribers.

Medical Policy Update

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, go to **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 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 or drug) policy is subject to the limitations and exclusions outlined in the member's benefit certificate or policy and to applicable state and/or federal laws. A verbal request for a referral does not guarantee authorization of the referral or the services. After a referral request has been reviewed in the Health Services Division, a notification is sent to the requesting provider and member. Note that prior authorization through the Dean Health Plan Health Services Division may be required for some treatments or procedures.

Please note, some of the imaging policies may apply to Dean Health Plan's self-funded ASO groups only. For all other Dean Health Plan members (HMO, MA, and POS/PPO) please contact National Imaging Associates (NIA). Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program on **deancare.com/providers/patient-care**.

Bone Anchored Hearing Aid MP9018

Prior authorization is required for initial insertion and replacement for members five (5) years of age and older.

Hyperhidrosis Treatment MP9224

Home or office iontophoresis requires prior authorization and must be a covered benefit of the member's plan.

Lumbar Discography MP9427

Cervical and thoracic discography are considered experimental and investigational, and therefore not medically necessary.

Measurement of Serum Levels and Antibodies: infliximab and HUMIRA (adalimumab) MP9464

Testing must be ordered by a board certified gastroenterologist and prior authorization is required.

Neuropsychological Testing MP9493

The initial evaluation visit does not require prior authorization.

Medical Policy Changes

Effective June 1, 2019

Wheelchairs: Manual or Power Operated and Power Operated Vehicles/Scooters MP9111

A lightweight wheelchair may be medically necessary if the member cannot self-propel in a standard wheelchair. Effective July 1, 2019, criteria was added for heavy duty and high strength lightweight wheelchairs.

Bariatric Surgery MP9319

A psychosocial evaluation is no longer required to determine the member's appropriateness for surgery.

Risk Reducing (Prophylactic) Mastectomy MP9449

Woman with atypical hyperplasia of lobular or ductal origin and/or lobular carcinoma in situ, confirmed on biopsy with dense fibronodular breasts are considered a medically necessary indication for the procedure.

Genetic Testing for Reproductive Carrier Screening and Prenatal Care MP9477

Prior authorization is not required for prenatal cell-free DNA testing (e.g., MaterniT21) for a condition associated with an abnormal fetal ultrasound or fetal demise/stillbirth.

Genetic Testing for Somatic Tumor Markers MP9486

Prostate cancer molecular tumor testing such as Oncotype DX, Genomic Prostate Score (GPS) assay, Decipher prostate cancer gene-expression classifier, and Prolaris are considered medically necessary tests. Melanoma (cutaneous) gene expression profiling (e.g., DecisionDx-Melanoma) is considered experimental and investigational, and therefore not medically necessary.

Medical Policy Update (continued)

Genetic Testing for Chromosomal Microarray Analysis (CMA) MP9491

CMA testing does not require prior authorization and may be indicated by the absence of a clinically recognizable single gene disorder or syndrome.

Effective June 1, 2019

Transport of Members (Ambulance) MP9137

Any ground, water or air ambulance transportation for member convenience or other non-clinical reasons is not a covered benefit.

Biofeedback MP9163

Biofeedback is considered experimental and investigational, and therefore not medically necessary, for overactive bladder syndrome and urinary incontinence after prostatectomy.

Genetic Testing for Breast and/or Epithelial Ovarian Cancer Susceptibility MP9478

Genetic testing for high-risk breast cancer genes (e.g., CDHA, PALB2, PTEN, STK11 genes) individually or as a panel require prior authorization.

Genetic Testing for Pharmacogenetics MP9479

Prior authorization is not required for discrete targeted genetic tests for cancer related drug therapy.

Effective August 1, 2019

Phototherapy for Skin Conditions, Including Home Ultraviolet Light MP9057

Phototherapy treatment for morphea (localized sclerodoma) is considered medically necessary.

Lymphedema Compression Devices MP9119

Home use of pneumatic compression devices, with calibrated gradient pressure pumps, are considered medically necessary for the treatment of chest, trunk, and/or abdomen lymphedema.

Blepharoplasty or Blepharoptosis (Eyelid Surgery) MP9214

Lower lid blepharoplasty requires prior authorization. The procedure is considered medically necessary to relieve excessive lower lid bulk, only if proper positioning of prescription eyeglasses is precluded and is secondary to conditions indicated in the policy.

Intensity Modulated Radiation Therapy (IMRT) MP9426

IMRT is considered medically necessary for soft tissue sarcoma, hepatocellular carcinoma and non-small cell lung cancer. IMRT does not require prior authorization.

Refractive and Therapeutic Keratoplasty MP9461

Criteria for epikeratoplasty and penetrating keratoplasty procedures were added.

Treatment of Obstructive Sleep Apnea (OSA) MP9239

Surgical treatment requires CPAP and oral appliance trial failure.

Dynamic Splinting and Static Progressive Stretch Devices MP9289

Home dynamic splinting devices for home use require prior authorization. Indications were added for static progressive stretch devices.

Prior Authorization Updates

If a medical policy does not refer to a specific genetic test, prior authorization is required. MCG Care Guidelines may be used to determine medical necessity. Criteria is available from DHP Utilization Management department upon request. The following genetic policies were retired as of June 1, 2019:

- Genetic Testing for Hearing Loss and Usher Syndrome MP9481
- Genetic Testing for Peutz-Jeghers Syndrome MP9480
- Genetic Testing for Li-Fraumeni Syndrome MP9485
- Genetic Testing for Von Hippel-Lindau Syndrome MP9501
- Genetic Testing for Thoracic Aortic Aneurysm and Nonsyndromic Aortic Dissection MP9503
- Genetic Testing for Huntington Disease MP9490

Retired Medical Policies

- Effective June 1, 2019, requests for collagenase injections for Dupuytren's Contracture should be submitted to Navitus.
- Effective July 1, 2019, MCG Care Guidelines criteria will be used to determine medically necessity for transcatheter aortic valve implantation.
- Effective August 1, 2019, Fecal Bacteriotherapy MP9441.

Technology Assessments

The following treatments, procedures, or services are considered medically necessary:

- Amyotrophic Lateral Sclerosis (ALS) gene testing
- Computer aided detection (CAD) related to breast imaging
- Transluminal peripheral atherectomy ⊕

Dean Health Plan Senior Select Enrollments End

Dean Health Plan will no longer offer the Dean Health Plan Senior Select product, effective December 31, 2019. Although Dean Health Plan will not be offering this product to new enrollees, the product will continue to be supported by Dean Health Plan and individuals who currently have this coverage can retain it, if they choose. Nothing will change with provider contracts at this time. Reach out to your Provider Network Consultant with any questions. ⊕

Changes to Medicare Reimbursement for Skilled Nursing Facilities

The Centers for Medicare and Medicaid Services (CMS) will change Skilled Nursing Facility reimbursement from the Resource Utilization Groups (RUGS) system to the Patient Driven Payment Model (PDPM) effective October 1, 2019. Dean Health Plan will follow CMS guidelines and PDPM for all claims submitted for Medicare Advantage members with dates of service on and after October 1, 2019. ⊕

DeanHealthPlan
A member of SSM Health

Best Practice Guidelines Updated

Updated clinical practice guidelines help ensure high quality preventive care and care management. These guidelines include new information about treatments, medications, and technology that reflect best practices. Search "clinical practice guidelines" on **deancare.com** to review the specifics.

Information is available regarding the diagnosis and treatment of asthma, standards of medical care in diabetes, and management of heart failure, among other topics. Dean Health Plan adopts and develops clinical practice guidelines from national organizations and/or in cooperation with specialty organizations and collaborative groups.

These clinical practice guidelines are separate and independent from coverage criteria, which vary by product and may differ from these guidelines. In order to determine whether a treatment or service is covered, review the plan document and coverage criteria.

Continuous Glucose Monitoring

As of September 1, 2019, continuous glucose monitors (CGMs), such as Freestyle Libre and Dexcom are available to Dean Health Plan members as a pharmacy benefit. CGMs are a Tier 3 benefit.

Adding CGMs to the pharmacy benefit results in several advantages:

- Members will have similar out-of-pocket costs.
- The lag time between ordering and delivery will be reduced as members will be able to pick them up directly at the pharmacy.
- Patients start using the monitoring devices sooner because providers have less paperwork.

An approved prior authorization is required. Authorization requests for the medical benefit are to be submitted to the durable medical equipment provider. Authorization requests for the pharmacy benefit are to be submitted through Navitus.

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.

Pharmacy and Therapeutics Committee Recruitment

Dean Health Plan Pharmacy Services is looking for prescribers who would be interested in joining our Pharmacy and Therapeutics (P&T) Committee. Prescribers across the network are welcome to join!

The purpose of this committee is to evaluate the available evidence-based safety and efficacy of drugs and make recommendations on coverage and prior authorization criteria. It serves as an advisory body to the Dean Health Plan Medical Policy Committee.

The Committee meets quarterly for two hours and committee members receive a stipend for each meeting they attend. Committee members are able to call into the committee meeting if they are not able to join in-person.

If interested, please contact Dean Health Plan Pharmacy Services via email at **DHP.PharmacyServices@deancare.com**

UM Statement of Policy

Dean Health Plan's utilization management decisions are based solely on the appropriateness of care and services, as well as the existence of coverage. We do not reward practitioners or other individuals making utilization management decisions for issuing denials of coverage for care. Dean Health Plan also does not provide financial incentives for utilization management decision makers that encourage decisions that result in underutilization. You may request a copy of the Utilization Management Statement of Policy by contacting the Customer Care Center at **800-279-1301 (TTY/TDD users dial 711)**.

Be one of the first to know!

Yes! Sign me up!

Would you like to receive an email when the *Provider News* is published on the Dean Health Plan website? 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

Visit
deancare.com/providers

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

Provider Network Consultants

Get to know your Provider Network Consultant. Find him or her at deancare.com/providers.

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

Visit deancare.com