Provider NEWS

DeanHealthPlan
A member of SSM Health

Spring 2020
A newsletter for Dean Health Plan providers

New Decade, New Portal

Modern Portal has more account set-up options, streamlined submissions and Provider Resources

Dean Health Plan has debuted an upgraded Provider Portal, allowing users to complete key tasks with fewer clicks and dropdowns.

Not only does the new Portal have a new look, the upgrades make it much simpler to use.

“We are pleased to offer providers new options and streamlined features in the new Portal,” said Katie Luther, Director of Dean Health Plan Provider Network Administration.

“Many of the upgrades are a result of suggestions we have received from providers using the current Portal. Eligibility and claims status inquiries, for example, have fewer fields to complete to minimize the administrative effort.”

Streamlined submission is just one innovation of the new Portal. Portal account registration opened to providers in March and it offers options that weren’t possible with the previous technology.

Users can now customize their account set-up in a way that makes sense for their organization. *continued on pg 2*

Check out our short video linked from the portal on deancare.com.

This Issue

New Decade, New Portal... (continued)

For example, one account can be established with multiple Tax IDs and NPIs or they can be split out into multiple accounts. Third-party billers can also be added to Portal accounts.

"While registration is intuitive, we encourage providers to join a webinar and consider the options before setting up an account so they can take full advantage of these options," said Luther.

Registration also includes an opt-in feature to receive electronic communications from the health plan such as electronic versions of the quarterly *Provider News* and notifications about changed or new policies. A Provider Resources page with convenient links to provider resources rounds out the new Portal upgrades.

For more information on the new Portal and registration, including webinar information and easy-to-read graphics of account set-up options, refer to the Dean Health Plan Provider Portals Account Login page at **deancare.com** or contact your Provider Network Consultant.

Accounts in the new Portal must be established no later than May 31, 2020. Providers are encouraged to create accounts as soon as possible and start establishing their business history in the new Portal. Limited access to the legacy Portal will be available to view historical information.

Once registration is successfully completed, providers can begin using the new Portal for their day-to-day business.

Additional features are planned for later this year. Contact your Provider Network Consultant if you have suggestions for future enhancements.

"We really want to deliver an enhanced provider experience with less administrative time and more time to provide care," said Luther. "We are confident that the new Portal will be one way we will achieve that this year."

Health and Physical Form to be Submitted with all Behavioral Health Authorizations

Effective December 15, 2019, providers must include clinical information supporting the need for Behavioral Health authorizations to Dean Health Plan. This includes a copy of the patient's Health and Physical form, rationale for the requested service(s), as well as timely information regarding transitions of care and discharge planning, including detailed follow up arrangements. Our goal is to ensure that follow-up care is in place before the patient is discharged, which will ensure that we are providing the care that our patients need.

More Help Available

Another way to better address complex patient needs is to refer them to our Care Management Department. Dean Health Plan offers free, voluntary telephone care management services for members with complex behavioral health needs.

There are several referral options available:

- Providers can refer through the new EPIC referral order for behavioral health case management using the referral order "DHP BH Case Management."
- Call the Care Management Department at **800-279-1301, ext. 4132** or **608-827-4132**.
- Members may self-refer via **deancare.com** or by calling the Customer Care Center number listed on their benefits card.

Dean Health Plan *Provider News*
David Fields, 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 Services

Elizabeth Fleig, Supervisor, Provider Network Services

Honore Manning, Provider Communications Specialist, Provider Network Services

Mission of *Provider News*

Dean Health Plan publishes *Provider News* to facilitate good communication between Dean Health Plan and our network of contracted providers. Regular features for this publication include updates to or creation of medical policies by the Utilization Management Committee during the previous quarter.

Moreover, each issue contains information that is valuable to a Dean Health Plan network provider. This is consistent with the goals of *Provider News*:

- Educate the Dean Health Plan provider network regarding new or changed guidelines that affect the care of our members.
- Introduce new services that benefit our members and affect our provider network.
- Create an extension of the Provider Manual to share information that is needed by the Dean Health Plan provider network.

If you have any questions or suggestions on how to improve *Provider News*, or if someone in your organization is not on our mailing list, please contact your assigned Provider Network Consultant.

Non-Covered Services Reminder

Certain services are not covered. Providers may render these services to members if a member is interested in paying out-of-pocket. Prepare to share information with members about noncovered services, including:

- Establishing a usual and customary charge or retail rate for the total cost of the service that can be shared with the member before rendering the service.
- Ensuring members are aware in advance that the service is a non-covered service and therefore the member will be responsible for payment.
- Informing members that their payment for the cost of the service will not count toward their maximum out-of-pocket.

Organizations should not collect payment from members in advance. We recommend that providers submit a claim after rendering services and receive the appropriate denials before billing members.

For more information, please contact our Customer Care Center at **800-279-1301**.

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Follow-up After Mental Illness Hospitalization Leads to Lower Readmission Rates

Checking in on patients who were recently hospitalized for mental health conditions pays off in multiple ways. Proper follow-up care is associated with lower rates of readmissions and a greater likelihood that gains made during hospitalization are retained. Because hospitalization may stabilize patients with acute behavioral conditions, timely and appropriate continued care is needed to maintain and extend improvement outside of the hospital.

Patients (age 6 and older) should see an outpatient psychiatric or behavioral health specialist within 7 days after a hospital discharge for mental illness, but no later than 30 days after discharge. (Follow-up can be a telepsych visit.)

HEDIS (Healthcare Effectiveness Data and Information Set) monitors the percent of patient discharges who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days and 30 days. (Joint Commission and CMS also monitor follow-up after hospitalizations.)

Schedule the patient's after-care appointment prior to discharge. If there is an obstacle to setting up an appointment within 7 days from discharge, you can refer to Dean Medical Group telepsych to see if there is an available appointment. This option is currently only available to Dean Health Plan members. You may also call **608-252-8226** and request to speak with the Triage Coordinator.

Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtain accurate current contact information, coordinate with Dean Health Plan's Customer Care Center or visit **deancare.com/find-a-doctor** for help finding a provider).

Tips for provider and staff to improve follow-up engagement rates:

Inpatient Providers:

- Discharge planning should begin at the time of admission and continue throughout the inpatient stay.
- Schedule the patient's after-care appointment prior to discharge. If there is an obstacle to setting up an appointment within 7 days from discharge, please call the Dean Health Plan behavioral health utilization management team to discuss.
- Attempt to alleviate barriers to attending appointments prior to discharge (i.e., obtain accurate current contact information, coordinate with Dean Health Plan).
- Ensure the member's discharge paperwork is sent to the outpatient provider and to Dean Health Plan within 24 hours.
- Invite care coordinators to meet members so that aftercare planning can occur.

Outpatient Providers:

- Be flexible when scheduling appointments for patients who are being discharged from acute care. Schedule the appointment within seven days of discharge.
- Review medications with patients to ensure they understand the purpose, appropriate frequency and method of administration.
- Submit claims in a timely manner.

Please note: Outpatient visits conducted on the same day of discharge from an inpatient hospitalization unit are no longer reportable as part of the quality measure. Scheduling follow-up appointments between the first and seventh day *after* hospital discharge ensures meaningful, effective engagement.

Remember, when providers recommend follow-up care, most patients comply. Remind your patients that there is no stigma for having a mental health diagnosis and that consistent follow-up care ensures their treatment progress.

Provider Network Consultants are Here to Help

Provider Network Consultants (PNCs) are a team of specialized individuals who are often the first interaction a provider has when contracting with the health plan. Each PNC is designated to specific areas throughout the state. These designations allow PNCs to focus on their assigned areas and, in some cases, on their area of provider specialty, to effectively help providers.

We value our relationships with providers and have established PNCs to better serve you. In fact, every in-network provider has an assigned PNC. While **deancare.com**, self-service resources and the Customer Care Center are always a provider's first sources of information, a PNC's relationship with a provider starts early in the contracting process and continues long after.

PNCs are particularly skilled at guiding providers through contracting and orientation education. Moreover, a PNC's primary focus is in guidance and education.

They also provide:

- Ongoing education on new policies and procedures to their in-network providers.
- Stay informed of changes important to a provider's claims adjudication.
- Assist with complex billing and claims processing questions.

Staying informed is a two-way relationship. Providers should advise their PNC of any changes to their demographic information, practitioners, office or practice locations, and services/specialties.

The Dean Health Plan PNC team information is at **deancare.com/providers** at the bottom of the page.

Keeping the Provider Perspective

Kim Butenhoff,
Dean Health Plan Provider Network Consultant

After working with Dean Health Plan on the provider side of things, Kim Butenhoff joined Dean Health Plan as a Provider Network Consultant (PNC) last summer. Having 15 years of experience working in health care, Kim said it felt like a natural progression. "The provider experience is still very fresh for me," said Kim. "Knowing the ins and outs really helps me to see situations from a provider's perspective. When I say to a provider 'I have been in your shoes,' I really mean it."

In her short time as a PNC, Kim is already working directly with providers to help them understand policies that affect their claims and tackling complex claim questions. "I really like to dig and problem solve to get to the root of an issue," said Kim. She also uses her health care experience to explain issues in a way that is understandable and meaningful.

Kim is looking forward to continuing her work with providers in 2020 and getting to know them even better.

"I think that is my favorite part," Kim says. "I get to keep my 'provider hat' on and guide providers for a positive experience for them and our members."

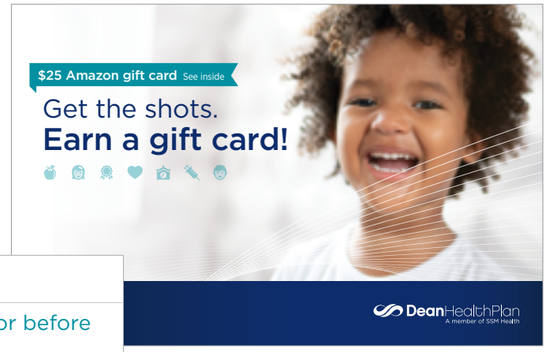
Kim works with providers in Columbia, Dodge, and Fond du Lac counties. Get to know your PNC. Find him or her at **deancare.com/providers**.

Gift Card Vaccination Incentive for BadgerCare Plus 2-Year Olds

Get your shots, earn a $25 Amazon gift card! Not a bad deal.

Those eligible are Dean Health Plan BadgerCare Plus members born between May 1, 2018 and December 31, 2018.

Members' children must complete all of the following recommended vaccines on or before their 2nd birthday to receive the incentive:



RECOMMENDED VACCINES*	DOSE
Diphtheria & Tetanus (DTaP)	4 separate doses on or before child's 2nd birthday.
Inactivated Polio Vaccine (IPV)	3 separate doses on or before child's 2nd birthday.
Measles, Mumps & Rubella (MMR)	At least 1 dose after 1st birthday, but before 2nd birthday.
Haemophilus Influenza Type B (HiB)	At least 3 separate doses on or before child's 2nd birthday.
Hepatitis B (HepB)	At least 3 separate doses on or before child's 2nd birthday.
Varicella Zoster Vaccine (VZV)	At least 1 dose on or before child's 2nd birthday.
Pneumococcal Conjugate Vaccine (PCV)	At least 4 separate doses on or before child's 2nd birthday.

These vaccines reflect the requirements for the Childhood Immunization Status (CIS) Combo 3 measure that is monitored by the National Committee for Quality Assurance (NCQA) using the Healthcare Effectiveness Data and Information Set (HEDIS). The CIS Combo 3 measure is also part of the Wisconsin Department of Health Services (DHS) Medicaid Quality Program, as one of the eight measures DHS has put primary emphasis on for 2020.

If members have questions, please direct them to call the Customer Care Center at **800-279-1301**. For more information, email **stefanie.schulz@deancare.com**.

Blood Lead Screening Recommended for All BadgerCare Members by Age 2

Lead screening is recommended for Medicaid-eligible individuals, according to Bright Futures/American Academy of Pediatrics.

The State of Wisconsin Medicaid agency continues to monitor our performance at providing this recommended screening to their members. Please ensure Medicaid-eligible pediatric patients have at least one capillary lead level before their second birthday.

Residential Treatment for Substance Abuse Postponed, Copays Waived

The Medicaid program has postponed residential treatment for substance use disorder so it can perform further work with residential treatment providers to ensure successful implementation of this new benefit. Originally, this was scheduled to begin in February. Medicaid/BadgerCare enrollees do not have residential treatment as a covered benefit. As of press time, there was no specific timetable for implementing the benefit.

No Copays

A covered benefit BadgerCare members enjoy now is the elimination of copays. Copays are being waived for all Medicaid/BadgerCare enrollees, including for non-emergency ER use by childless adults. Federal rule prohibits imposing cost-sharing above 5% of a person's income. There is no mechanism currently to measure the copay amount against a household income limit of 5%.

Wisconsin Medicaid anticipates re-establishing copays on fee-for-service enrollees beginning in July. There is no definitive timeline for adding copays for Medicaid/BadgerCare managed care enrollees.

Personalized Help for Patients with Complex Care Needs

When patients have complex, acute or chronic health conditions, multiple emergency department visits or are frequently hospitalized, Case Management helps them get the care they need.

Nurses and social workers work with providers to best meet the patient's needs while also supporting high-quality, cost-effective care.

Care Management Team:

- Navigate access to services within a complex health care system.
- Provide education on member's condition and how to access resources to best manage your health.
- Support and guide members in setting achievable goals as they work toward improving quality of life and overall health and well-being.
- Help members to understand their individual health care plan including how to maximize benefits.
- Connect with services and community resources necessary for members to self-manage their health care needs.
- Serve as an advocate to help members achieve optimal physical and mental health.

Now, more than ever, medicine needs a team approach and Care Management is here to assist. Patients notice the difference and appreciate it.

"My case manager was accessible and communicated with me in a way that helped me understand differing opinions from doctors, prevent ED visits, and improve my declining health status. Case Management staff were outstanding!"

To refer a Dean Health Plan patient into the program, call **800-356-7344, ext. 4132**.

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Spring 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, 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 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.

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

Radiology:
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 radiology prior authorization program on the medical management page on **deancare.com**.

Physical Medicine:
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 physical medicine prior authorization program on **deancare.com**.

Musculoskeletal
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 musculoskeletal prior authorization program on **deancare.com**.

Genetic Testing MP9012

Testing is covered if test results provide a direct medical benefit or guides reproductive decision-making. Prenatal testing is covered without a prior authorization. Multi-gene testing panels may be considered medically necessary if category 1, 2A or 2 B National Comprehensive Cancer Network (NCCN) level of evidence guidelines are met.

Breast Pumps, Hospital Grade MP9092

BadgerCare Plus members may purchase one manual breast pump or one personal-use electric breast pump per birth.

New Medical Policies

Whole Exome and Whole Genome Sequencing MP9548

Effective December 1, 2019, whole exome sequencing (WES) requires prior authorization and is considered medically necessary for a phenotypically-affected individual less than age 21. Whole exome sequencing testing for heritable disorders of a non-Dean Health Plan relative is considered medically necessary for an affected child's mother and/or father if criteria is met. Whole genome sequencing is considered experimental and investigational and therefore not medically necessary.

Total Knee Arthroplasty (Unilateral) Level of Care MP9550

Effective June 1, 2020, Utilization Management will retrospectively review medical necessity for the site of care for elective, unilateral knee arthroplasty. Patients that meet select criteria MP9550 will be reviewed for inpatient vs. outpatient level of care. This retrospective review will determine the appropriate place of service.

Shingrix (RZV), Non-Routine Use MP9549

Effective December 1, 2019, non-routine administration of Shingrix for members age 18-49 requires prior authorization. For adults under age 50 who are a hemopoietic stem-cell transplant (HSCT) recipient, re-vaccination is considered medically necessary if 24 months have passed since the HSCT. Members under age 50 who are on high dose immunosuppressive therapy are not eligible for this vaccination. BadgerCare Plus does not cover non-routine use of Shingrix. Effective May 1, 2020, prior authorization requests should be submitted to Navitus.

Effective January 1, 2020

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

Genetic testing for high-risk breast cancer genes may be indicated when an individual is from a family with a known deleterious BRCA1/BRCA2 mutation. The policy was updated to align with NCCN Guidelines for testing criteria for high-penetrance breast and/or ovarian cancer susceptibility genes.

Medical Policy Changes

Effective December 1, 2019

Bone Anchored Hearing Aid (BAHA) MP9018

Cortical bone thickness of 3 mm or more is no longer a required criterion.

Manual or Power Operated Wheelchairs (PWC) MP9111

Group 1 through 5 power operated wheelchair criteria was revised.

Sleep Studies: Unattended Sleep Studies and Attended Nocturnal Polysomnography MP9132

Co-morbid medical conditions and co-morbid sleep disorder examples were added to the policy. A repeat supervised sleep study requires prior authorization and may be considered medically necessary when the member has a change in medical condition to determine device settings or treatment effectiveness.

Treatment of Obstructive Sleep Apnea (OSA) MP9239

The following positive airway pressure devices require prior authorization: continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP) or bilevel positive airway pressure (BiPAP).

Bariatric Surgery MP9319

Prior authorization is required for a biliopancreatic bypass procedure with or without a duodenal switch.

Clinical Trials MP9447

A written protocol, which describes a scientifically sound study, is required for members of the State of Wisconsin. Prior to participant enrollment, the trial must have been approved by an Institutional Review Board (IRB).

Genetic Testing for Polyposis MP9482

Testing for serrated polyposis syndrome (e.g., hyperplastic polyposis) requires prior authorization.

Genetic Testing for Multiple Endocrine Neoplasia Syndrome, Type 1 and Type 2 MP9483

Gene testing is considered medically necessary when there is a pregnancy at risk prenatal diagnosis.

Genetic Testing for Cowden Syndrome MP9488

Major and minor clinical diagnostic testing criteria were updated to align with NCCN guidelines.

Genetic Testing for Birt-Hogg Dubé Syndrome MP9527

Testing may be indicated by a combination of skin lesions, pulmonary cysts, renal carcinomas or hybrid oncocytic tumor manifestations presenting in the patient or family members.

Transcatheter Aortic Valve Implantation (TAVI)

Prior authorization was removed.

Spring 2020 Medical Policy Updates (continued)

Effective January 1, 2020

Plastic and Reconstructive Surgery MP9022

Prior authorization is required for an otoplasty to improve hearing when the ears are absent or deformed due to trauma, surgery, disease or a congenital defect. Otoplasty to correct prominent, protruding, lop, cupped or constricted ears is considered not medically necessary.

Genetic Testing for Hereditary Cardiac Disease MP9472

Testing for arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVC) is considered medically necessary when a diagnosis is unable to be confirmed by other means. QT syndrome or catecholaminergic polymorphic ventricular tachycardia testing criteria was added to the policy.

Genetic Testing for Reproductive Carrier Screening MP9679

Twin zygosity testing is considered experimental and investigational and therefore not medically necessary.

Genetic Testing for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) MP9487

Testing is considered medically necessary for members with a personal history of colorectal or endometrial cancer.

Genetic Testing for Neurological Disorders MP9497

Friedreich Ataxia and Myotonic Dystrophy gene testing is considered medically necessary when the individual to be tested has a family history and is asymptomatic. Testing of an asymptomatic individual (age 18 and older) who has a family history of Amyotrophic Lateral Sclerosis, is considered medically necessary when the proband individual is deceased or unavailable for testing.

Myocardial Imaging, Positron Emission Tomography (PET)

Effective February 1, 2020, prior authorization requests for outpatient myocardial imaging, positron emission tomography (PET), metabolic evaluation studies (CPT codes 78429 to 78434) will be processed by Magellan Healthcare.

Technology Assessments

The following treatments, procedures, or services are considered experimental and investigational, and therefore not medically necessary:

- Aquablation therapy prostate (AquaBeam robotic system)
- AngelMed Guardian System implantable intracardiac ischemia monitor
- Bioidentical hormone testing
- Breast thermography for breast cancer screening
- Colaris (Myriad Genetics) cancer risk
- PancraGEN

The following treatments, procedures, or services were determined to be medically necessary. Prior authorization is not required:

- Absorbable perirectal spacer (SpaceOAR hydrogel)
- Fractional Flow Reserve (FFCRct)
- Elastography for distinguishing hepatitis cirrhosis is a covered indication ⊕

Member Rights and Responsibilities

To promote effective health care, Dean Health Plan clearly states its expectations for the rights and responsibilities of its members to foster cooperation among members, practitioners and Dean Health Plan.

To view these rights and responsibilities, visit deancare.com/member-rights. ⊕

Policy Change Increases Access to Substance Use Treatment

Suboxone and Narcan have gone from a Tier 2 drug to a Tier 1 drug with quantity limits removed. The tier change will reduce copays for our members and help increase access to substance use treatment.

Drugs used for addiction and overdose reversal do not require a prior authorization. ⊕

Spring 2020 Pharmacy and Therapeutics / Drug Policy / Formulary Change Updates

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 pre-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 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).

Note: On January 1, 2020, we began sending a monthly letter to providers highlighting any changes that require a 90-day notification. The effective date of any changes is clearly stated in each monthly letter. In addition to the monthly letters, we will continue to communicate these changes here in *Provider News*, published quarterly.

New Drug Policies

BAVENCIO (avelumab) MB1936

Effective January 1, 2020, BAVENCIO, which is used to treat metastatic merkel cell carcinoma, urothelial carcinoma and renal cell carcinoma, will require a prior authorization. It is restricted to oncology prescribers.

NULOJIX (belatacept) MB1937

Effective April 1, 2020, NULOJIX, which is used for prophylaxis of organ rejection in kidney transplant patients, will require a prior authorization. It is restricted to renal transplant or immunosuppressive therapy specialists.

ADCETRIS (brentuximab vedotin) MB1945

Effective April 1, 2020, ADCETRIS, which is used to treat Classical Hodgkins Lymphoma, Systemic anaplastic large cell lymphoma, primary cutaneous anaplastic large cell lymphoma or CD30 expressing mycosis fungoides, and CD30 expressing peripheral T-cell lymphomas, will require a prior authorization. Dose for ADCETRIS must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. It is restricted to oncology or hematology prescribers.

POLIVY (polatuzumab vedotin-piiq) MB1938

Effective January 1, 2020, POLIVY, which is used to treat diffuse large B-cell lymphoma, will require a prior authorization. It is restricted to oncology prescribers.

ZULRESSO (brexanolone) MB1939

Effective January 1, 2020, ZULRESSO, which is used to treat moderate to severe postpartum depression, will require a prior authorization. It is restricted to a psychiatrist or an obstetrician-gynecologist.

BEOVU (brolucizumab-dbll) MB1944

Effective January 1, 2020, BEOVU, which is used to treat Neovascular (Wet) Age-related Macular Degeneration, will not require a prior authorization. Providers should review the criteria for use, as claims audits can be performed to ensure appropriate utilization, even without a prior authorization requirement. Correct HCPCS code for BEOVU is J0179.

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Spring 2020 Pharmacy and Therapeutics (continued)

Changes to Drug Policy

NUCALA (mepolizumab) MB9914

Effective January 1, 2020, added criteria for eosinophilic granulomatosis with polyangiitis including baseline blood eosinophil count greater than 1,000 cells/µL or baseline blood eosinophil count greater than 10% of the total leukocyte count, trial of oral corticosteroid therapy was ineffective, contraindicated, or not tolerated, and trial of one of the following was ineffective, contraindicated, or not tolerated: Azathioprine, Cyclophosphamide, Leflunomide, or Methotrexate.

Updated criteria for eosinophilic asthma to include only the following: Age 6 years or older; and documented baseline blood eosinophil concentration of ≥ 150 cell/mm^3; and within the last year, member has greater than or equal to 2 asthma exacerbations requiring treatment with systemic corticosteroids, emergency department visits, or hospitalization despite adherent utilization of medium or high dose inhaled corticosteroids in combination with a long-acting beta agonist and either a leukotriene receptor antagonist or tiotropium; and prescriber attests to ALL of the following: member adherence to controller medications; and member is a non-smoker or is adherent to an attempt at smoking cessation; and member will not be using in combination with omalizumab, dupilumab, or other interleukin-5 agents.

Prior authorization is required and is restricted to pulmonology, immunology, or allergy prescribers for Eosinophilic Asthma and pulmonology, immunology, allergy, or rheumatology prescribers for Eosinophilic granulomatosis with polyangiitis.

OPDIVO (nivolumab) MB1844

Effective January 1, 2020, removed indications for Merkel Cell Carcinoma, Resected Advanced Melanoma, Non-Small Cell Lung Cancer, Small Cell Lung Cancer, and Mesothelioma. Updated criteria for Unresectable or Metastatic Melanoma, Metastatic Non-Small Cell Lung Cancer, Metastatic Colorectal Cancer, and Classical Hodgkin Lymphoma. Prior authorization is required and is restricted to oncology prescribers.

Infliximab Infusions MB9231

Effective February 1, 2020, updated criteria for moderate to severe hidradenitis suppurativa to include only the following: prescribed by a dermatology specialist; and total abscesses or inflammatory nodule count of ≥ 3; and patient has documented tried and failed at least one oral antibiotic. Added indication for diagnosis of NCCN category 1, 2a, or 2b for off-label uses or FDA indications. Prior authorization is required.

YERVOY (ipilimumab) MB9945

Effective February 1, 2020, dose for YERVOY must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology or dermatology prescribers.

Rituximab Products MB9847

Effective February 1, 2020, dose for RITUXAN and TRUXIMA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

ABRAXANE (paclitaxel albumin-bound) MB1801

Effective February 1, 2020, dose for ABRAXANE must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

Trastuzumab Products MB1805

Effective February 1, 2020, dose for Trastuzumab products must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

VECTIBIX (panitumumab) MB1810

Effective February 1, 2020, dose for VECTIBIX must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

DARZALEX (daratumumab) MB1832

Effective February 1, 2020, dose for DARZALEX must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

ALIMTA (pemetrexed for injection) MB1837

Effective February 1, 2020, dose for ALIMTA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Prior authorization is required and is restricted to oncology prescribers.

CYRAMZA (ramucirumab) MB1918

Effective February 1, 2020, dose for CYRAMZA must be rounded down to the nearest vial size if calculated dose is within 10% of the nearest vial size. If an eligible dose is not rounded down, clinical rationale is required. Criteria added that if first infusion is tolerated, subsequent infusions may be administered over 30 minutes. Prior authorization is required and is restricted to oncology prescribers.

ARANESP (darbepoetin alpha) MB9799

Effective February 1, 2020, included statement that dosing amount and intervals are required to stay within FDA approved limitations. Prior authorization is required and is restricted to oncology, infectious disease, hematology, or nephrology prescribers.

Effective March 1, 2020, removed requirement of a trial and failure or intolerance to Procrit or Epogen. Prior authorization is required and is restricted to oncology, infectious disease, hematology, or nephrology prescribers.

Botulinum Toxin MB9020

Effective March 1, 2020, removed requirement that there is no infection at the proposed injection site. Prior authorization is required, and prescriber restrictions are listed separately under each botulinum toxin product in the policy.

Antihemophilia Factors and Clotting Factors MB1802

Effective March 1, 2020, updated policy to include FDA approved indication for Wilate when member has hemophilia A. Prior authorization is required and is restricted to hematology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective March 1, 2020, added new indication for bladder cancer, non-muscle invasive with carcinoma in situ with or without papillary tumors. Prior authorization is required and is restricted to urology or oncology prescribers.

SPRAVATO (esketamine) MB1921

Effective March 1, 2020, updated HCPCS codes to G2082 and G2083. Prior authorization is required and is restricted to psychiatrist or psychiatric nurse practitioner prescribers.

Rituximab Products MB9847

Effective March 1, 2020, updated age requirement for Granulomatosis with Polyangiitis and Microscopic Polyangiitis from 18 years of age or older to 2 years of age or older. Prior authorization is required and is restricted to rheumatology prescribers.

STELARA (ustekinumab) IV MB9891

Effective March 1, 2020, updated criteria to include only the following: Documented diagnosis of moderate to severe Crohn's disease or ulcerative colitis; AND Symptoms have remained active despite failure of, or intolerance to, treatment with: 6-mercaptopurine, azathioprine, methotrexate or corticosteroids. Prior authorization is required and is restricted to gastroenterology prescribers.

Retired Policies

CIMZIA (certolizumab pegol) PA9875

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Pre-Payment Review of Unbundling Modifiers

Effective July 1, 2020, Dean Health Plan will manually review claims submitted with certain modifiers on a pre-payment basis to determine if the modifier has been appended appropriately.

Using nationally-sourced guidelines, Professional Coders - including RNs - will use a combination of the submitted claim information and the patient's related-claim history, to determine if the circumstances warrant the use of a modifier that typically prevents the bundling of services, such as 25, 59, 79 and 24.

The guidelines for the correct use of overriding modifiers are well documented in Current Procedural Terminology (CPT) manuals and Coding with Modifiers manual both published by the American Medical Association (AMA); and by the Centers for Medicare and Medicaid Services (CMS) in the Correct Coding Initiatives (CCI) manual and the CMS claims processing manuals. The correct use of these modifiers may encompass the appending to services that do not require a modifier to allow separate reimbursement. For example, we frequently see modifier 59 appended to code combinations that are not considered Procedure-to-Procedure (PTP) edits under CCI.

This review is designed to not only promote accurate claims payment for the provider, but to ensure appropriate out-of-pocket amounts are assigned to our members.

Unspecified ICD-10 CM Codes

The ICD-10-CM code assigned to each procedure, service or item should reflect the diagnosis or reason for the visit as documented in the medical record. If the procedure code reflects what was performed, the diagnosis code (ICD-10-CM) indicates the why.

Accurate and specific diagnosis coding may not only impact whether the claim is paid or denied, but also what benefit is assigned. For example, a cholesterol test reported with Z13.220 - Encounter for screening for lipoid disorders – may be paid in full under the member's preventive benefit. However, a cholesterol test performed to monitor a patient's high cholesterol would no longer be a screening service and member out-of-pocket would apply.

In order to ensure appropriate reimbursement of the Women's Contraceptive benefit, the following unspecified ICD-10-CM codes will no longer be reimbursed effective 07/01/2020. Instead, the more specific code will be required.

- Z30.019 – Encounter for initial prescription of contraceptives, unspecified
- Z30.40 – Encounter for surveillance of contraceptives, unspecified
- Z30.9 – Encounter for contraceptive management, unspecified

While these denials may be appealed with supporting documentation, reporting accurate and specific diagnosis codes will help to ensure your claim is paid correctly the first time.

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.

Requesting Utilization Management Criteria

Dean Health Plan's prior authorization requirements, medical policies and the current medication formulary are all available for online viewing at **deancare.com**. The printed formulary is also available upon request. For a printed copy, contact Dean Health Plan at **800-279-1301** and we will either mail it or fax it to you.

Dean Health Plan also licenses MCG Guidelines, which are nationally recognized, evidenced-based guidelines for medical necessity determinations. The specific MCG Guideline used in making a denial determination is available upon request by contacting Dean Health Plan at **800-279-1301**.

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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.

- **Kim Butenhoff**
  kimberly.butenhoff@deancare.com
  608-828-2939
  800-356-7344 ext. 2939
  Columbia, Dodge and Fond du Lac counties
- **Dawn Kinishi**
  dawn.kinishi@deancare.com
  608-828-6367
  800-356-7344 ext. 6367
  Dane County
  SSM Health: St. Clare Hospital - Baraboo, St. Clare Meadows Care Center, St. Mary's Hospital - Madison and Janesville and St. Mary's Care Center
- **Lydia Flack**
  lydia.flack@deancare.com
  608-827-4081
  800-356-7344 ext. 4081
  Adams, Crawford, Grant, Green Lake, Marquette and Richland counties, and APM
- **Michelle Madison**
  michelle.madison@deancare.com
  608-827-4246
  800-356-7344 ext. 4246
  University of Wisconsin Hospital & Medical Clinics, University of Wisconsin Medical Foundation, WI Fertility Institute, Green, Juneau and Sauk counties
- **Sydney Sipos**
  sydney.sipos@deancare.com
  608-827-4144
  800-356-7344 ext. 4144
  Autism Providers and Waukesha County
- **Available Consultant**
  DHP.PNCInquiry@deancare.com
  Dubuque, Iowa, Lafayette and Vernon counties
- **Jon Zillman**
  jon.zillman@deancare.com
  608-827-4059
  800-356-7344 ext. 4059
  Chiropractor Providers, Jefferson, Rock and Walworth counties

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