Provider NEWS

DeanHealthPlan
A member of SSM Health

Fall 2020
A newsletter for Dean Health Plan providers

Flu Shot "More Important than Ever," Says Infectious Disease Expert

Prevention efforts are critical as we enter flu season under the massive cloud of an ongoing pandemic.

On the positive side, infectious disease specialist James Levin, MD, of SSM Health Dean Medical Group-Madison, is optimistic that all of our increased precautions because of COVID-19 may lead to a more manageable flu season so long as we have strong flu vaccination rates.

James Levin, MD

"I am less concerned about getting influenza this year than I have ever been. We know masking works for COVID-19 because we've flattened the curve," said Dr. Levin. "It's also going to decrease the probability of spreading influenza."

Continuing to strongly recommend flu shots remains important, though, as all prevention efforts must be emphasized.

"Getting an influenza shot this year is probably more important than ever simply because you certainly don't want to get both illnesses simultaneously or separately," said Dr. Levin, who noted it's theoretically possible to get both COVID-19 and influenza.

"That's not been seen or shown in the literature yet but it's something that makes me scratch my head a little bit. The probability of that happening is probably low but I don't think it's zero."

The other issue regarding the two diseases is that they present with similar symptoms and will require testing to define which is which, hopefully with one swab.

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This Issue

Flu Shot ... (continued)

"Do you have influenza or COVID-19? It's going to lead to a lot of confusion and worry by some patients," predicts Dr. Levin. "That's why it's important to get a shot to protect yourself from at least one of these viruses."

The message he recommends colleagues continually reinforce to patients is: "The same thing you are doing to protect yourself from COVID-19 is exactly the same thing you do to protect yourself from influenza." Wear your mask, socially distance and wash your hands regularly, but also get the flu shot.

What about clinician risk?

Although both diseases are in play now, Dr. Levin is not overly concerned about the threat to physicians and other care providers, even though he was personally concerned initially about contracting COVID-19. Masking in the hospital quickly became common and few clinicians became infected.

"I'm very confident that personal protective equipment is keeping us safe," said Dr. Levin. "I'm not concerned about transmission within the hospital and clinic setting for these respiratory infections."

COVID-19 Updates from the Health Plan

In response to the coronavirus (COVID-19) pandemic, Dean Health Plan has established interim COVID-19 policies to support our members and providers. We continue to monitor the situation and evaluate these interim policies to determine timing for reinstating standard policies, where appropriate. Providers frequently ask about the health plan's expanded telemedicine coverage which we are continuing to cover at the time of this publication. As decisions are made, we will communicate them in our COVID-19 provider communications and update our COVID-19 provider information web page.

Providers who chose to "Opt in for Electronic Communications" during their 2020 Provider Portal registration will receive COVID-19 provider communications via email. Communications are also published to our website. For current COVID-19 health plan information, refer to our COVID-19 provider information web page link located at the top of all pages on **deancare.com**.

Automated Approval for Epidural Steroid Injection or Selective Nerve Root Block

Dean Health Plan is pleased to announce our first venture into automated authorization approval. Effective on and after January 1, 2021, automated authorization approval will be available to in-network providers who submit a prior authorization request through the Provider Portal for an epidural steroid injection (ESI) or selective nerve root block (SNRB). Prior authorization requests for an ESI and/or SNRB that meet the health plan's medical policy criteria will receive an approval notification generated within seconds of submitting the request.

This initial 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 automated authorization for ESIs and SNRBs will influence potential future automated authorization approval for other services and procedures.

We are not removing the authorization requirement for ESIs and SNRBs. Refer to the Epidural Steroid Injection (ESI) and Selective Nerve Root Block (SNRB) Medical Policy document, MP9362, available in **our document library at deancare.com**. This policy accurately reflects the medical policy criteria applicable to automated authorizations for ESI and SNRB.

The automated authorization functionality will be available for authorization submissions through the Provider Portal only. If you are not submitting your authorizations through the Portal, we strongly encourage you to do so. **To register for a Provider Portal account, click here**. You may also view the Complete Registration User Guide on how to register for the Provider Portal.

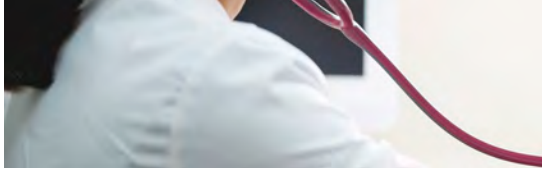
SSM Health Merges with Lumicera Specialty Pharmacy

Effective on October 1, 2020, SSM Health Specialty Pharmacy will be merging with Lumicera Health Services Pharmacy. This unified service will provide a single specialty pharmacy program for all health plan members and SSM Health patients. With this initiative, existing specialty prescriptions filled at the 1313 Fish Hatchery Rd. location will be transitioned to the new location at **Lumicera Health Services Pharmacy, 310 Integrity Dr., Madison WI 53717**.

Members with prescriptions affected by this change will receive a communication in September with new contact information to refill prescriptions. Existing prescriptions with refills will be sent to Lumicera in order to reflect the updated pharmacy location and information.

If members are out of refills after their September order, the specialty pharmacist will request a new order. Send new specialty prescriptions electronically to **Lumicera Health Services Pharmacy, 310 Integrity Dr., Madison WI 53717**.

Members will continue to receive the high-quality care, follow up calls and refill reminders under this new collaboration.



Screening for Perinatal Mood and Anxiety Disorders Often Overlooked

Mental health disorders among pregnant women are all too common but with improved and more frequent screening, we have a better opportunity to intervene before the conditions worsen.

It is estimated that 15%-21% of pregnant women experience moderate to severe symptoms of depression or anxiety and approximately 21% of women experience major or minor depression following childbirth. Low-income women and teens suffer rates up to three times as high.

Perinatal mental health disorders, such as prenatal and postpartum depression, anxiety and emotional stress are clinically defined, treatable, and amenable to support, education and intervention.

Although there is increasing awareness of the rates of perinatal mental health disorders and the potential negative impact on mothers, their babies and their families, perinatal mental health is far too often undiagnosed, under-treated or not treated at all.

Because the burden of perinatal depression and other mental health distress is so high, and it is often overlooked, national standard-of-care recommendations now include screening for mental health during the pregnancy and postpartum period using evidence-based tools such as the Edinburgh Postnatal Depression Screen (EPDS) or Patient Health Questionnaire (PHQ-9).

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

Reminder for providers

There are two new HEDIS measures for depression screening and follow-up during and after pregnancy.

Prenatal Depression Screening and Follow-up:
The proportion of deliveries in which members were screened for clinical depression while pregnant and, if positive, received follow-up care.

- Depression screening
- Follow-up on positive screen: women who received follow-up care within 30 days of screening positive for depression.

Postpartum Depression Screening and 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.

- Depression screening
- Follow-up on positive screen: women who received follow-up care within 30 days of screening positive for depression.

When to Screen

Screening for perinatal mood and anxiety disorders is a responsibility of both the mom and baby's provider care teams. Postpartum Support International recommends providers screen patients during the following timeframes:

- First prenatal visit
- At least once in second trimester
- At least once in third trimester
- Six-week postpartum obstetrical visit (or at first postpartum visit)
- Repeated screening at 6 and/or 12 months in OB and primary care settings
- 3, 9, and 12-month pediatric visits
- 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

provides 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.

Strong Beginnings

Dean Health Plan’s Strong Beginnings offers the support mothers need to have a healthy pregnancy and baby.

Our team of OB and Behavioral Health nurse case managers, social workers and program outreach specialists can help women navigate the health care system, locate community resources and services, and coordinate care to ensure their and their child’s individual needs are met to achieve an optimal health outcome. Our certified lactation counselors can provide support moms need to be successful with breastfeeding and pumping.

Providers can call our Care Management Provider Referral Line at **800-356-7344, Ext. 4132**. Members can receive more information or self-refer by calling Strong Beginnings at **608-830-5908** or by visiting **deancare.com**.

Improve Depression Treatment in Primary Care Setting

Major Depressive Disorder (MDD) is one of the most common mental health illnesses seen in the primary care setting. Although treating depression can be difficult for primary care physicians, effective depression treatment in the primary care setting is crucial because so many patients are only treated for depression by their primary doctor. Below are recommendations for following established best practice protocols for treating depression.

Clinical Recommendations

- Implement universal depression screening for patients age 12 and older. Screening must be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Patients with MDD are at increased risk for suicidal ideation, suicide attempts and suicide completion. Therefore, systems must also include assessment of suicidality and triage protocols.
- The Patient Health Questionnaire-2 (PHQ-2) is accepted as an initial screening instrument for depression in all age groups. If depression is identified by the PHQ-2, completion of the PHQ-9 or a clinical interview is recommended.
- When screening is positive for possible depression, the diagnosis should be confirmed using criteria from the Diagnostic and Statistical Manual of Mental Disorders, 5th ed.
- Refer to psychiatry if bipolar disorder, schizoaffective disorder, schizophrenia or schizophreniform disorder is suspected.
- Use the PHQ-9 as a way to monitor progress when starting antidepressants.
- Explain the importance of remaining on antidepressant medications for at least six months for the most benefit.
- Discuss the benefits of counseling in combination with antidepressant medications and make referral, as appropriate.
- Collaborate with Dean Health Plan nurse case managers to work with patients whose depression is unstable and would benefit from additional education and resource coordination.
- Good follow-up practices are critical for patients with depression; check in with patients regularly to make sure they are filling their prescriptions and/or making appointments with counselors.

Dean Health Plan can help!

Dean Health Plan provides free phone education and resource coordination for members with complex, unstable behavioral health needs. To refer one of your patients, call the Care Management Department at **800-635-9233, ext. 4132** or **608-827-4132**.

Help Patients Better Understand Antibiotics

Antibiotic resistance is one of the most serious public health problems in the United States and threatens to return us to the time when simple infections were often fatal, according to the Centers for Disease Control (CDC).

Patient expectations are often a challenge to manage, especially when meeting those expectations has been recognized as a significant factor in patient satisfaction.

Patients have a specific agenda when visiting their providers, which usually reflects concerns and problems they want addressed during the consultation; it might also include a desire for specific services such as a prescription for an antibiotic. Interestingly though, most patients' expectations are focused on the health care provider's ability to show interest by listening to patients' concerns and discussing their problems and doubts.

We suggest having a detailed discussion on the risks and benefits of antibiotic use for patients who desire antibiotics. For most patients, the risks associated with antibiotic use outweigh the benefits. Discussion can also help align patient and provider expectations. A systematic review found that a physician's perception of patient desire for antibiotics was strongly associated with antibiotic prescription, more so than actual patient desire.

Here are some tips for aligning expectations when the patient presents with a viral infection such as:

- Upper respiratory tract infections
- Influenza
- Acute bronchitis
- Some ear infections
- Some sinus infections
- Viral gastroenteritis
- Coronavirus (COVID-19)

Make sure to mention that antibiotics for their viral infection:

- Won't cure the infection
- Won't keep other people from getting sick
- Won't help them feel better any quicker
- May cause unnecessary and harmful side effects, including most commonly; gastrointestinal tract upsets, and most significantly, allergic reaction
- Will alter their microbiome (which could impair immune function) and carries the risk of inducing antibiotic-resistant organisms both in the individual patient and in the community
- Comes at increased financial cost

Despite all this being common knowledge to most providers, inappropriate antibiotic prescription is widespread. For example, studies cited by UpToDate indicate that 50% - 90% of patients with acute bronchitis who seek care are given antibiotics, making acute bronchitis one of the most common reasons for antibiotic overuse. Multiple high-quality trials and meta-analyses have shown that antibiotics do not provide substantial benefit or enhance likelihood of cure in patients with acute bronchitis. Avoidance of antibiotic prescribing in acute bronchitis is also one the American Board of Internal Medicine's *Choosing Wisely* initiatives.

Where possible, take the time to listen and gauge your patients' expectations, address their concerns, including options for symptomatic treatment, and explain your rationale for avoiding antibiotics in viral infections. Ultimately, a reduction in antibiotic overuse will be in everyone's best interest.

Screening Best Hope for Reducing Retinopathy in Diabetes Patients

Diabetes increases a patient's risk for conditions such as glaucoma and cataracts, but the primary concern is the development of diabetic retinopathy. Optimizing glycemic control reduces the risk or slows the progression of diabetic retinopathy. Optimizing blood pressure and serum lipid control to reduce the risk or slow the progression of diabetic retinopathy is also recommended.

Screening for diabetic eye disease is important because most patients who develop retinopathy have no symptoms until the very late stages (by which time it may be too late for effective treatment).

To best care for your patients, the American Diabetes Association recommends that those with diabetes be screened or monitored for diabetic retinopathy:

- Patients with type 1 diabetes, an initial comprehensive examination by an ophthalmologist or optometrist is recommended within the first five years after diagnosis.
- Patients with type 2 diabetes, an initial comprehensive examination by an ophthalmologist or optometrist is recommended shortly after the diagnosis of diabetes is made.
- The frequency of follow-up examinations should be individualized, with more frequent follow-up in patients who have abnormal findings or if retinopathy is progressing.
- Patients with preexisting type 1 or type 2 diabetes who plan on becoming pregnant, should have an eye exam before pregnancy or within the first trimester and should be monitored every trimester and for 1 year postpartum as indicated by the degree of retinopathy.

Tips for improving screening rates:

- If not established yet, create a workflow within your clinic for patient referrals to an optometrist and/or ophthalmologist for this screening and assign a staff member to monitor that this referral is occurring at the appropriate intervals.
- Create an outreach strategy for patients who are overdue on this screening.
- Establish a procedure to ensure the optometrist or ophthalmologist performing the exam is sending the findings of patients' exams back to the referring provider with concrete recommendations as to the clinically appropriate follow-up interval.

Programs that use retinal photography (with remote reading or use of a validated assessment tool) to improve access to diabetic retinopathy screening can be appropriate screening strategies for diabetic retinopathy. When previous exams have been normal, subsequent examinations can be done with these retinal photographs. If you are using such a program for your diabetic patients' eye screening, please ensure there is a pathway for timely referral for a comprehensive eye examination when clinically indicated.

Dean Health Plan offers the Living Healthy Plus Program to assist and support members in managing their chronic Type 1 and 2 diabetes. See the article in this issue [page 15] about our enhanced functionality to track member visits for the Living Healthy Plus Program.

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, CMS and other regulatory and accreditation entities require us to keep provider information current.

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

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.

Partnering with BetterDoctor to ensure provider demographic data accuracy

To remain compliant with requirements regarding provider data accuracy in our Provider Directory, we have contracted with Quest Analytics through its provider management platform, BetterDoctor.

BetterDoctor will contact our providers on a quarterly basis by one of the following communication methods: fax, mail, email and/or telephone. Providers will work directly with BetterDoctor to attest to the accuracy of their provider demographic data.

Don't wait for the BetterDoctor attestations to update your information! Providers are still required to communicate any changes to their Provider Network Consultant promptly.

Understanding a Drug Formulary

Understanding a member's drug formulary coverage can be complex, especially at the point of prescribing. From the Dean Health Plan Member Benefit Information web page at **app.deancare.com/sites/memberbenefits**, providers can access the drug formulary for a specific member by entering the member's Group or Member ID. Use Ctrl+F to search the PDF formulary document by drug or drug class to view coverage status.

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, is available on **deancare.com**.

Fall 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**, ▶**Search Dean Health Plan's Medical Policies**. Our website 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 may contact NIA by phone at **866-307-9729**, Monday-Friday from 7 a.m. to 7 p.m. CST or via **RadMDSupport@MagellanHealth.com**. View details about the **radiology prior authorization program**.

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**.

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**.

General Information

Prior Authorization Updates

Prior authorization has been removed from the following medical policies. Self-funded plans Administrative Services Only (ASO) may require prior authorization. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's insurance card for specific prior authorization requirements.

Effective June 1, 2020

- Corneal Cross-Linking MP9470

Effective August 1, 2020

- Shoes and Shoe Modifications MP9016

Revised Medical Policies

Effective June 1, 2020

Total Ankle Arthroplasty (TKA) MP9363

Total ankle arthroplasty is restricted to orthopedic surgeons or podiatry. Prior authorization is required.

Sacroiliac (SI) Joint Injections and Radiofrequency Ablation (RFA) MP9466

Radiofrequency ablation of the SI joint is non-covered.

Genetic Testing for Reproductive Carrier Screening and Prenatal Care MP9477

Universal carrier screening (e.g. QHerit, Inheritest Comprehensive Panel, Inheritest Society-Guided) panels are considered not medically necessary.

Genetic Testing for Somatic Tumor Markers MP9486

Oncotype DX and EndoPredict are considered medically necessary. myChoice CDx is considered experimental and investigational, and therefore is not medically necessary.

Speech Generating Devices (SGD) MP9523

One software program in the member's primary language is considered medically necessary. Prior authorization is required. Computers (e.g., desktop and laptop), pagers, personal digital assistants, smart phones, and tablet devices (e.g., Galaxy, iPads, Kindle) are not covered.

Effective July 1, 2020

Biofeedback MP9163

Pelvic floor training may be medically necessary for the treatment of chronic pelvic pain, myofascial pelvic floor dysfunction or urinary incontinence after radical prostatectomy. Prior authorization is required.

Non-Covered Services MP9415

Vestibular autorotation, ocular vestibular evoked myogenic potential (oVEMP), cervical vestibular evoked myogenic potential (cVEMP) or unilateral centrifugation are considered experimental and investigational, and therefore are not covered for vestibular disorders or any other indication.

Genetic Testing for Somatic Tumor Markers MP9486

Progensa PCA3 assay, 4Kscore, Prostate Health Index (PHI) and ConfirmMDx are considered medically necessary. Liquid biopsy tests such as CancerIntercept, GeneStrat, FoundationOne Liquid are considered experimental and investigational, and therefore are not medically necessary for any indication.

Effective August 1, 2020

Transcranial Magnetic Stimulation (rTMS) MP9526

rTMS is considered medically necessary for members age 18 and older who have a confirmed diagnosis of major depressive disorder (MDD), single or recurrent episode, who meet all of the following criteria. Pharmacologic treatment within the last five (5) years did not provide a clinically significant response. Four (4) trials of psychopharmacologic agents, of therapeutic dose and duration, were ineffective. At least two (2) evidence-based augmentation therapies were included in the trial. Prior authorization is required.

Effective December 1, 2020

Non-Covered Services MP9415

Signal-averaged electrocardiography (SAECG) is considered experimental and investigational, and therefore is not medically necessary.

Facet Injections and Radiofrequency Ablation (RFA) MP9448

Cervical, thoracic and lumbar RFA requires prior authorization. Occipital nerve RFA is considered medically necessary for refractory trigeminal neuralgia or occipital neuralgia/headache. Genicular nerve RFA is considered medically necessary for treatment of severe osteoarthritis for which conservative care has not provided significant relief. Occipital and genicular nerve RFA require prior authorization. Peripheral nerve destruction using radiofrequency ablation is considered experimental and investigational, and therefore is not medically necessary for foot/heel pain or lower extremity pain resulting from: complex regional pain syndrome, peripheral nerve entrapment/compression, or peripheral neuropathy. Prior authorization is required.

Technology Assessments

The following treatments, procedures, or services are considered experimental and investigational, and therefore are medically necessary:

- NuShield placental allograft
- Intravascular lithotripsy
- Irreversible electroporation

The following treatments, procedures, or services were determined to be medically necessary:

- Eye movement desensitization and reprocessing (EMDR) for treating post-traumatic stress disorder ⊕

Fall 2020 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. 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. We encourage all prescribers review the current policies.

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).

New Drug Policies

ADAKVEO (crizanlizumab-tmca) MB2003

Effective July 1, 2020, ADAKVEO, which is used to treat sickle cell disease, will require a prior authorization. It is restricted to hematologists or sickle cell disease specialists.

SARCLISA (isatuximab-irfc) MB2004

Effective July 1, 2020, SARCLISA, which is used to treat multiple myeloma, will require a prior authorization. It is restricted to oncology prescribers.

TEPEZZA (teprotumumab-trbw) MB2005

Effective July 1, 2020, TEPEZZA, which is used to treat Graves' Disease, will require a prior authorization. It is restricted to ophthalmologist, ophthalmic or ocuplastic surgeon prescribers.

Changes To Drug Policy

ALIMTA (pemetrexed for injection) MB1837

Effective September 1, 2020, removed indications for Epithelial ovarian cancer and Thymomas or thymic carcinoma. Added indication to include diagnosis of NCCN category 1, 2a, or 2b for off-label uses or FDA indications. Prior authorization is required and is restricted to oncology prescribers.

ANDEXXA (andexanet alfa) MB1843

Effective August 1, 2020, updated HCPCS code to J7169. No prior authorization is required.

Antihemophilia Factors and Clotting Factors MB1802

Effective July 1, 2020, added Espercot and Sevenfact products. Prior authorization is required and is restricted to hematology prescribers.

Bevacizumab Products MB9431

Effective October 1, 2020, MVASI and ZIRABEV will be the preferred bevacizumab products. New indication of unresectable metastatic hepatocellular carcinoma added for AVASTIN only. Prior authorization is not required but is restricted to oncology prescribers.

CYRAMZA (ramucirumab) MB1918

Effective August 1, 2020, updated criteria for metastatic non-small cell lung cancer to include the requirement of use in combination with erlotinib for members with metastatic NSCLC whose tumors have EGFR exon 19 deletions or exon 21 substitutions. Prior authorization is required and is restricted to oncology prescribers.

DARZALEX (daratumumab) MB1832

Effective July 1, 2020, added DARZALEX FASPRO (daratumumab and hyaluronidase-fihi) for the treatment of multiple myeloma. Prior authorization is required and is restricted to oncology prescribers.

EPOETIN ALFA- EPOGEN, PROCRIT (epoetin alfa) and RETACRIT (epoetin alfa-epbx) PA9715

Effective July 1, 2020, updated HCPCS code for EPOGEN and PROCRIT to Q4081. Prior authorization is required and is restricted to oncology, infectious disease, hematology or nephrology prescribers.

GIVLAARI (givosiran) MB2001

Effective August 1, 2020, updated HCPCS code to J0223. Prior authorization is required and is restricted to a hematologist or specialist with expertise in diagnosis and management of acute hepatic porphyria.

Immune Globulin MB9423

Effective August 1, /2020, added Xembify to current criteria. Prior authorization is required.

Infliximab Infusions MB9231

Effective July 1, 2020, added biosimilar AVSOLA to current criteria. Prior authorization is required and is restricted to dermatology, rheumatology, or gastroenterology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective September 1, 2020, added new indications for cutaneous squamous cell carcinoma and tumor mutation burden-high cancer. Prior authorization is required and is restricted to oncology prescribers.

LUPRON-ELIGARD (leuprolide) MB1942

Effective August 1, 2020, updated policy to list FENSOLVI as a non-covered product. Prior authorization is not required for LUPRON or ELIGARD and must be prescribed by an oncology, urology, OBGYN, internal medicine, family medicine, or pediatrics prescribers.

OPDIVO (nivolumab) MB1844

Effective July 1, 2020, added new indication for small cell lung cancer. Updated criteria for metastatic non-small cell lung cancer. Prior authorization is required and is restricted to oncology prescribers.

Effective September 1, 2020, added indication for esophageal squamous cell carcinoma. Prior authorization is required and is restricted to oncology prescribers.

ORENCIA (abatacept) IV MB9457

Effective September 1, 2020, updated criteria allowing coverage after only one step through medication. Prior authorization is required and is restricted to rheumatology prescribers.

Pegfilgrastim Products MB1808

Effective August 1, 2020, added biosimilar ZIEXTENZO to current criteria. Prior authorization is required and is restricted to hematology and oncology prescribers.

Effective September 1, 2020, remove prior authorization requirement for Fulphila, Udenyca, and Ziextenzo. Prior authorization IS required for Neulasta and Neulasta OnPro. Restricted to hematology and oncology prescribers.

Rituximab Products MB9847

Effective October 1, 2020, TRUXIMA and RUXIENCE will be the preferred rituximab products. Updated HCPCS code for RUXIENCE to Q5119. Prior authorization is required and is restricted to rheumatology, transplant, hematology, neurology, dermatology, ENT or oncology prescribers.

SINUVA (mometasone furoate) MB1833

Effective August 1, 2020, updated HCPCS code to include C9122. Prior authorization is required and is restricted to an ENT specialist.

TECENTRIQ (atezolizumab) MB1817

Effective August 1, 2020, added new indication of Hepatocellular Carcinoma and updated criteria for non-small cell lung cancer. Prior authorization is required and is restricted to oncology prescribers.

Trastuzumab Products MB1805

Effective October 1, 2020, HERZUMA, TRAZIMERA, OGIVRI, and KANJINTI will be the preferred trastuzumab products. Prior authorization is required and is restricted to oncology prescribers.

YERVOY (ipilimumab) MB9945

Effective July 1, 2020, added indication of non-small cell lung cancer. Prior authorization is required and is restricted to oncology or dermatology prescribers.

ZOLGENSMA (onasemnogene abeparvovec-xioi)

Effective August 1, 2020, updated HCPCS code to J3399. Prior authorization is required and is restricted to a neurologist with expertise in the diagnosis of spinal muscular atrophy (SMA).

Retired Policies

Effective September 1, 2020 OZURDEX (dexamethasone intravitreal implant) MB9877

Effective September 1, 2020 ILUVIEN (fluocinolone acetonide intravitreal implant) MB9918

Effective September 1, 2020 XIALFEX (collagenase clostridium histolyticum) MB1846

Effective September 1, 2020 ALPHA 1-ANTITRYPSIN INHIBITOR MB9446

Making a Difference in Provider Network Consultant Role

Four years in Dean Health Plan's Customer Care Center prepared Dawn Kinishi for her current role as a Provider Network Consultant (PNC). "Customer service was an excellent training ground," Dawn said. "The fast pace, multi-tasking and problem solving prepared me for the work I am doing now directly with providers."

Joining the Provider Network Services team last summer, Dawn is the PNC assigned to in-network behavioral health providers across the state. This assignment has proven to be a good fit as she likes people, keeping busy and holds the behavioral health specialty in high esteem. She is directly involved in ensuring that the health plan's behavioral health network of providers is robust to serve members—an important need further heightened by the COVID-19 pandemic. "The effects of the public health emergency to health care will affect all of us for years to come," Dawn said. "Behavioral health care is needed more than ever."

Dawn notes the health plan's expanded interim coverage of telemedicine services, put in place in March, was crucial to further provide access to services for members. "We all had to move quickly to put a plan in place, while working within CMS guidelines and direction."

She looks forward to her continued work with providers in her PNC role, including her involvement with behavioral health. "Our culture is better than it was 5 or 10 years ago, but I am hopeful for a day when people can freely discuss, stigma-free, their behavioral health diagnosis the way we discuss a muscle strain or other physical diagnosis," Dawn said.

CMS Publishes New Risk Adjustment Guidance for Telehealth and Telephone Services During COVID-19 Pandemic

On August 3, 2020, the Centers for Medicare & Medicaid Services (CMS) released updated guidance addressing the treatment of certain telehealth services under the Affordable Care Act (ACA) risk adjustment program. The guidance—released in the form of an updated frequently asked questions (FAQ) document—specifically clarifies which telehealth services (including telephone services) are valid for data submissions under the risk adjustment program. Additionally, CMS updated its guidance on telehealth services during the pandemic.

In response to the COVID-19 pandemic and the increased need to expand the use of telehealth and virtual care, CMS' guidance designates nine e-visit codes, new for calendar year 2020, as valid for 2020 benefit year risk adjustment data submissions, subject to applicable state law requirements. Providers should document and code all acute and chronic diagnosis codes during the allowable telehealth and virtual services. These services and diagnosis codes will be validated through risk adjustment data validation in the same manner as risk adjustment diagnosis codes provided via in-person services are validated. CMS also intends to reconsider these codes' inclusion for future benefit years, as may be appropriate (e.g., if the COVID-19 pandemic continues into the 2021 benefit year).

CMS has also given additional consideration to the treatment of telephone-only services in the ACA and Medicare risk adjustment program and the guidance announces that additional codes will be valid for 2020 benefit year data submissions for the risk adjustment program. CMS will designate diagnosis codes from telephone-only service CPT codes (98966-98968, 99441-99443) as valid for risk adjustment diagnosis filtering purposes in risk adjustment data submissions for the 2020 benefit year, subject to applicable state law requirements.

View CMS's ACA guidance.

View the Medicare Advantage guidance.

Dean Medicare Advantage Plans for 2021

Dean Health Plan is adding market-leading benefits to the 2021 Medicare Advantage plans that will offer expanded value to seniors, including: transportation to medical appointments, insulin savings for patients with diabetes, in-home and virtual support and companionship and comprehensive dental benefits through Delta Dental. All Dean Advantage plans will also help members address challenges around COVID-19 and social isolation by offering dedicated companionship and transportation options, as well as support with technology and connectivity so that members will have convenient access to their health care providers in-person or virtually.

Additionally, Dean Health Plan will offer a new Medicare Advantage-only plan — Dean Advantage Harmony. The Dean Advantage Harmony plan does not offer Part D Prescription Drug coverage. This is an excellent plan choice for those who already have prescription drug coverage through Wisconsin's Senior Care Prescription Drug Assistance Program, TRICARE for Life, the VA or an employer health plan.

Member enrollment for the 2021 Medicare Advantage Plans will be open from October 15 through December 7, 2020. The Medicare Advantage Provider Manual and Dean Advantage Medical Management web page will be updated for 2021 plan offerings this fall.

Enhanced Functionality to Count Member Visits for Living Healthy Plus Program

It's now easier to track how well diabetes patients are managing their disease. Enhanced functionality now calculates how many diabetes management visits a member enrolled in a Dean Health Plan Large Group commercial product has used under the Living Healthy Plus Program.

Dean Health Plan offers the Living Healthy Plus program to assist and support members in their management of their chronic Type 1 and 2 diabetes. Eligible members are allowed four diabetes management visits per year at $0 copay. The functionality allows a provider to view, in the Provider Portal or the native 271 Eligibility & Benefit Response transaction, where a member is in their four-visit allotment and assess when to appropriately charge a copay. In the Provider Portal, providers can use the '+' symbol to display the descriptive message.

In the 271 transaction, providers can view the number of total visits and remaining visits eligible for the $0 copay in the HSD segment (Health Care Services Delivery) with a message detailing the copays in the MSG segment (Message Text).

For additional information about the Living Health Plus program, refer to the Living Healthy Plus page on the Dean Health Plan at **deancare.com/wellness/health-and-wellness/living-healthy-plus**.

This issue is our first digital-only publication of Dean Health Plan *Provider News*

We are pleased to offer providers a faster distribution for health plan news. Each quarter, we will send an email notifying you when *Provider News* is published on **deancare.com/providers/news**. Providers who chose to "Opt In for Electronic Communications" during their 2020 Provider Portal registration will automatically receive this email. Providers who opted not to receive electronic communications during registration or do not have access to a Portal account but would like to receive an email when *Provider News* is published, may contact Provider Network Services at **DHP.ProviderNewsletter@deancare.com** to be added to the distribution list.

Get Rid Of Paper Checks – Go Electronic!

Is your organization still receiving paper checks from the health plan? If the answer is yes, go electronic by signing up for electronic funds transfer (EFT). It's easy! We contract with Change Healthcare for EFT. EFTs allow the health plan to directly deposit payments into your organization's designated bank account for a more efficient delivery of payments. EFT payments are secure, eliminates paper and are not affected by possible delays in mail delivery for faster receipt of payments. Sign up with Change Healthcare ePayment Services at **changehealthcare.com** or by calling **866-506-2830**.

Dean Health Plan *Provider News*

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Billing Issues Discovered for Medicare-Medicaid Patients

Per the Centers for Medicare and Medicaid Services (CMS), providers may not collect cost sharing from Qualified Medicare Beneficiaries (QMBs).

For Dean Health Plan members who are dual-eligible for both Medicare and Medicaid, federal law prohibits the billing of QMBs.

The QMB program ensures beneficiaries with limited income and assets have meaningful access to Medicare benefits. For QMBs, Medicaid covers the Medicare Part A and Part B premiums and the deductibles, coinsurance and copays for which a Medicare beneficiary is normally liable. While providers may be reimbursed at the lesser of the Medicaid or Medicare rates, providers are prohibited from balance billing or collecting any cost sharing from QMBs.

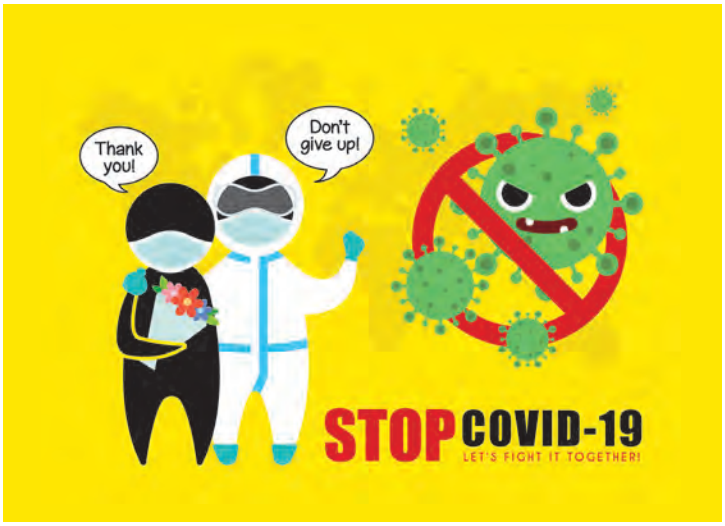
If you have questions about these requirements, please contact your Dean Health Plan Provider Network Consultant.

Shared Decision-Making Aid Tool

Dean Health Plan offers free online educational programs that all our in-network providers can use to further educate their patients. Emmi® is a series of evidence-based online programs that walk patients through important information about a health topic, condition or procedure. In-network providers can sign up for an account through Dean Health Plan and then send interactive educational content directly to their patients via email.

Members enrolled in any Dean Health Plan product are eligible to access Emmi. By clicking the link in the email sent by their provider, members will be prompted to create a login to access the content. Each program runs from 15 to 30 minutes. Members can watch at their convenience and refer back as often as they wish.

To sign up for a provider account, contact Emmi customer support by calling **866-294-3664** or via **support@my-emmi.com**.



Fall 2020

☑ Yes! Sign me up!

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• Phone	• Email

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 web page.

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