Provider NEWS

DeanHealthPlan
A member of SSM Health

Winter 2019
A newsletter for Dean Health Plan providers

High Quality Care Reigns at Dean Health Plan

Thank you for your dedication to our members

The skill, dedication and persistence of our provider network is paying off in enviable care quality ratings.

This fall, Dean Health Plan earned exceptional ratings for both its Medicare Advantage plans and our Commercial HMO product.

"**When it comes to high quality care, Dean Health Plan is 100% committed,**" said David Fields, President of Dean Health Plan. "We're doing very well now but we're already taking action to further improve care for our members."

4.5 Star Rating for Medicare Advantage

Medicare Advantage plans received a 4.5 out of 5 stars for 2020 from the Centers for Medicare & Medicaid Services (CMS) as part of its annual assessment of all Medicare Advantage plans.

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

CMS rated 401 Medicare Advantage contracts in the U.S. this year, and less than one-quarter of plans earned 4.5 stars or better. The average star rating for Medicare Advantage plans across the country was 4.16.

In Wisconsin, Dean Health Plan was one of 10 plans receiving a 4.5 stars or higher. We are working diligently to achieve 5 stars for 2021.

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High Quality Care Reigns...(continued)

4.5 Rating for Dean Health Plan's HMO Plan

Our HMO plan is also performing at a high level. For National Committee for Quality Assurance's (NCQA) Private Health Insurance Plan Ratings for 2019–2020, Dean Health Plan received a rating of 4.5 out of 5 for its private (commercial) product. This makes us one of the highest-rated health insurance plans in the nation for our commercial product.

Only three other Wisconsin health plans received a 4.5, and no Wisconsin plan received higher. Fewer than 10% of the 438 private health plans received a 4.5 or 5 rating nationally.

An overall rating is publicly reported along with subcategory scores. Performance is measured across these three subcategories: Consumer Education, Rates for Clinical Measures and NCQA Accreditation Standards Score.

Congratulations to our network providers for achieving such a high level of excellence on behalf of those we serve. ⊕

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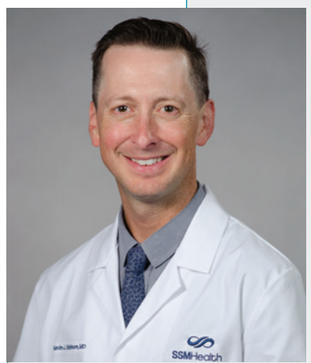
Dr. Kevin Eichhorn Named CMO

Kevin Eichhorn, MD, has accepted the position of Chief Medical Officer (CMO) for Dean Health Plan and WellFirst Health Plan. Dr. Eichhorn has served as Interim CMO since March 29, 2019.

"I have been a Dean Health Plan member myself for 15 years," said Dr. Eichhorn. "I am very grateful for the wonderful care that my provider colleagues bring to my family and all other Dean Health Plan members every day. My job as Health Plan CMO is **to ensure that our members continue to enjoy access to high quality services** and for our network providers to have a great experience, as well."

Dr. Eichhorn has been with Dean Health Plan since 2016 and with Dean Medical Group since 2004. As CMO, Dr. Eichhorn will be accountable for the organization's quality assurance, medical decision making and medical policy development. He will also be tasked with:

- Developing and leading strategies that make health care more affordable and help our members live healthier lives.
- Partnering with leaders and providers within our Integrated Delivery Network (IDN) to achieve meaningful and measurable improvements in clinical quality/outcomes, clinical efficiency, appropriate utilization, total cost of care, quality ratings and member and provider satisfaction.



Dr. Kevin Eichhorn, CMO for Dean Health Plan and WellFirst Health Plan

Dr. Eichhorn completed his medical degree and residency in Internal Medicine/Pediatrics from Indiana University's School of Medicine. After graduating, he joined Dean Medical Group as a hospitalist, and in 2009 became its Division Chief of Hospital Medicine.

He is Board Certified in Internal Medicine with a focus on Hospital Medicine. ⊕

Follow-up Care Critical for Kids on ADHD Medications

Pediatrician advises scheduling before they leave the office

Dr. Julia Dewey, Pediatrician, Fort Healthcare

Julia Dewey, MD, is a high performer when it comes to timely patient follow-up appointments after prescribing ADHD (Attention Deficit Hyperactivity Disorder) medication.

"Scheduling when it's fresh in parents' minds and our mind, that helps make it happen," says Dr. Dewey, a Fort Healthcare pediatrician, regarding successful follow-up appointments with these young patients.

Dr. Dewey knows of what she speaks, as she scores highly on HEDIS (Healthcare Effectiveness Data and Information Set) measures for ADHD:

- Get the patient back within 30 days for a follow-up visit
- Have two follow-up visits after that within 9 months

"If we tell them to call a week later, they might forget," says Dr. Dewey. That's why she and her office staff are careful to schedule the appointments before they leave the office. If patients don't make an appointment then, her office follows up after the doctor reviews her notes on the patient.

Why it's important

With ADHD, it may well be the first time these families are managing medications that inevitably change over time for the child. They may not be used to coming back to the clinic so often.

"We must figure out what medication and what dose is going to be best," explains Dr. Dewey. "We settle on something eventually, but kids change, they grow, so it needs to be adjusted."

Other circumstances may change, too, including insurance coverage of particular medications. For all of these reasons, patients with ADHD need to be seen regularly.

Creating clear expectations for the family, says Dr. Dewey, is important in achieving good follow-up care. When they understand why it's important to return for follow-up visits, they will be more likely to do so.

And that, she says, gives providers the best opportunity to manage the condition. ⊕

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Q&A: Packers and Pediatrics

The team doctor for the Green Bay Packers made a play to encourage a neighborhood boy to pursue medicine and as far as that kid was concerned, he won the Super Bowl. For Green Bay native Daniel Beardmore, having that mentoring relationship as a child paved the way for his quest to attend medical school to pursue his dream of also becoming a team doctor. As we learn in this conversation, things didn't work out exactly as Beardmore planned.

Dr. Daniel Beardmore, MD, SSM Health Dean Medical Group – Janesville East

When I was younger, I was a pretty good student and gravitated toward the sciences, so becoming a doctor made sense. Then I got the opportunity to meet the Packers' team doctor (Patrick McKenzie, MD). I grew up down the street from him in Green Bay, I went to school with all of his kids, and his sister was my 5th grade teacher. I knew the family really well. On Sundays after church, we would walk and talk. In high school, I shadowed him a couple of times and that's when my interest really matured. And that's when I thought, "I want to be the Packers' next team doctor. I'm going to fix Brett Favre's ankle."

Q: What was this doctor like?

DB: He was really great. He had me shadow him in the OR and at his clinic a couple of times during high school, before I went off to undergrad. One of the things I'll always remember from many of the talks we had, "You might think this is what you want to do, Dan, but you're a people person. You like to talk to people. Half of my day is spent with patients under anesthesia in the OR. This might not be for you." Eventually, I interviewed for ortho and peds, and ended up getting the peds job in patient care.

Q: Is sports part of your practice?

DB: Yes. For a little while in residency, I considered a sports fellowship. I decided not to go with it. I've really tried word of mouth to get the sports patients or the high school athletes, who are some of my favorite patients to take care of.

Q: What is it about sports that you find so attractive?

DB: For one, I loved the experience of being on a team and playing a sport. Sports can provide so many life lessons. In high school, my football coach probably taught me as much as any of my teachers did, things about teamwork, dedication, hard work, sacrifice — all that stuff. And people who participate in sports are learning and maintaining healthy practices — they're active, they're exercising, they're eating right.

Q: Had it not been for Dr. McKenzie, your friend and neighbor, is there a chance you might have done something else in your professional life?

DB: I always was going to try to get into med school. And sports specifically, as a kid, playing varsity sports in high school and pick-up sports in college, I probably would have done some of those things. But I don't know if it would have worked out so nicely, that's for sure, without that early mentorship. He's still the team doctor with a busy practice in Green Bay.

Q: Do you think Dr. McKenzie is pleased that you became a pediatrician?

DB: I know he is because every step of the way I have updated him, letting him know how I'm doing as a way to thank him for his early influence. He has been really, really, proud.

Q: Do you plan to take somebody under your wing some day?

DB: I love teaching, so I reached out to some places and I regularly have third years from MCW [Medical College of Wisconsin]. They come out and do a couple days with me on their Peds rotation. And earlier this summer, I spent a whole month with a third year who is thinking about peds, so that was really enjoyable. I hope to keep teaching as long as I practice.

Dr. Daniel Beardmore practices at SSM Health Dean Medical Group – Janesville East.

Follow-Up Care for Patients with Substance Use Concerns

Improving HEDIS IET Performance

Millions of Americans have a substance use disorder and about half of the people with a substance use disorder also experience serious mental illness, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Providers play a critical role in ensuring patients with substance use concerns receive timely follow-up care.

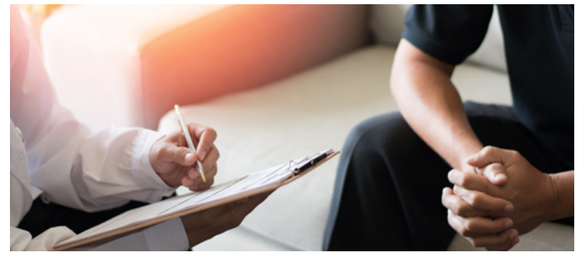
Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET) is monitored by the National Committee for Quality Assurance (NCQA) using the Healthcare Effectiveness Data and Information Set (HEDIS). The goal for the IET HEDIS measure is to ensure all adults and adolescents, ages 13 and older, have at least three follow-up visits following a new episode of alcohol and other drug abuse or dependence. Two phases are reported:

A. One initiation visit within 14 days of the original diagnosis. This can be an inpatient admission, outpatient visit, intensive outpatient visit or partial hospitalization.

B. Two or more additional services for engagement of alcohol and other drug abuse treatment within 34 days of the initiation visit.

Screen for it If you have concerns about a patient's substance use, incorporate an evidence-based screening tool. The National Institutes of Health (NIH) (**drugabuse.gov**) offers a comprehensive guide and links to evidence-based screening and assessment tools you can use with your patients from adolescence to adulthood.

Follow up When diagnosing alcohol or other drug dependence, arrange follow-up visits before the patient leaves the office. Follow-up visits do not need to be with a behavioral health or substance abuse specialist. Evidence suggests that addressing substance use and physical health together improves both physical health and substance use conditions. SAMHSA (**samhsa.gov**) offers resources on supporting substance abuse in partnership with primary care.



Follow-up tips

- Every time a patient receives a new primary or secondary diagnosis indicating abuse of alcohol or other drugs, schedule a follow-up visit within 14 days.
- During the second visit, schedule two additional visits and/or schedule the patient to see a substance abuse treatment specialist within the next 34 days.
- Following a hospital discharge for a patient with an alcohol or other drug dependence diagnosis, schedule two additional visits within 34 days.
- Involve others who are supportive of the patient to increase participation in treatment.
- Listen for and work with existing motivation in patients.
- Attempt to alleviate barriers to appointments prior to discharge.
- Obtain accurate and current patient contact information.

Document it If substance abuse is identified, be sure to document it and code it accurately on any claims submitted. Code remission accurately when it is appropriate as well.

Educate It's important to educate patients on the effects of substance abuse. Research also shows that treatment works in approximately 66% of patients with substance use disorders and is associated with reversal of neuronal damage in recovering users.

Refer Dean Health Plan's Behavioral Health Case Management program provides free, phone-based patient education and resource coordination to members who have Psychiatric/Substance Abuse Disorders and could benefit from additional supports.

For provider referrals, call **608-827-4132**

Residential Treatment Covered for BadgerCare Next Year

Effective February 1, 2020, Wisconsin's Department of Health Services will implement significant changes for BadgerCare, including new residential treatment coverage.

Wisconsin Medicaid will cover residential treatment for all Medicaid enrollees, including BadgerCare members with limits determined by medical necessity. This changes residential treatment from a limited benefit with stays limited to 15 days at certain facilities. The State is removing many restrictions on residential treatment for substance use disorder.

Other changes coming

In addition to changes to residential coverage, there are other changes taking effect on February 1, 2020, for BadgerCare Childless Adults.

- The State is adding eligibility requirements for childless adults whose income is between 50% and 100% of the federal poverty level. There will be an $8 monthly household premium. Members can reduce the premium to $4 per month if they complete a health risk assessment screening and exhibit healthy behaviors.
- There will be emergency room (ER) copays for non-emergency care.
- Childless adults must complete 80 hours of organized activities, such as working, volunteering, training, or be enrolled as a half-time student. They must report this information to the State, unless exempt from this requirement. Forty-eight consecutive months of non-activity will result in a six-month disenrollment period.

For more information on these changes, refer to the ForwardHealth Updates page at **forwardhealth.wi.gov**.

Billing Issues Discovered for Medicare-Medicaid Patients

The Centers for Medicare and Medicaid Services (CMS) is asking insurance plans to further remind providers that they may not collect cost sharing from Qualified Medicare Beneficiaries (QMBs).

For those Dean Health Plan members who are dual-eligible for both Medicare and Medicaid, federal law prohibits the billing of QMBs. This program helps pay for Part A premiums, Part B premiums and deductibles, coinsurance and copays.

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 these QMBs.

If you have any questions about these requirements, please contact your Provider Network Consultant.

Simple Copays, Smart Plans

New Smart Plans help members gauge costs

Transparency and convenience in health care are important for your patients. Dean Health Plan's new Smart Plans, effective January 1, 2020, provide upfront cost transparency. We removed deductibles and coinsurance, so patients know exactly what their medical visits and services will cost them.

With a Smart Plan, when members stay in-network, preventive care is covered at 100% and copays are limited by an out-of-pocket maximum. When members reach their out-of-pocket maximum within the plan year, they don't pay anything else for in-network services for the rest of that plan year. No deductibles. No coinsurance. No confusion.

There are seven categories of copays that are limited by an out-of-pocket maximum. All services have been put into one of the seven categories. Smart Plans follow current policies, the services just have been categorized and assigned the copay amount. Preventive care falls into $0 copay category and includes X-rays, labs, annual physicals, virtual visits and more.

For more information, visit **deancare.com/smartplans**.

Keep Current with License and Credentials

With a new year fast approaching, resolve to avoid unexpected claims impacts by keeping your professional licensure and credentialed status with Dean Health Plan current.

In the case of both lapse of license or lapse in credentialed status, providers are not to continue to see Dean Health Plan members until renewal is verified. To get additional information on these requirements, please reach out to your Provider Network Consultant.

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Winter 2019 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 referral does not guarantee authorization of the referral or the services. After a referral request has been reviewed in the Health Services Division, a notification is sent to the requesting provider and member. Note that prior authorization through the Dean Health Plan Health Services Division may be required for some treatments or procedures.

For all other Dean Health Plan members (HMO, MA, and POS/PPO) please contact National Imaging Associates (NIA). Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program on **deancare.com** by searching "radiology prior authorization."

Epidural Steroid Injection and Selective Nerve Root Block MP9362

The procedure does not require prior authorization for BadgerCare Plus members.

New Medical Policies

Effective September 1, 2019

Percutaneous Interspinous Spacer System ISS (VertiFlex®) MP9544

Requires prior authorization and is considered medically necessary for members with a diagnosis of moderate (or greater) degenerative lumbar stenosis with or without Grade 1 spondylolisthesis.

Effective October 1, 2019

Bone, Cartilage and Ligament Graft Substitutes MP9454

New medical policy indicating products which are considered medically necessary or experimental and investigational. Criteria for the following (not an all-inclusive list): bone graft materials/substitutes, recombinant bone morphogenetic Protein rhBMP-2; rhBMP-7; ligament or meniscus reconstruction; and bone filler and/or articular cartilage. Prior authorization is not required.

Robotic Assisted Surgery MP9546

Robotic surgical systems are considered integral to the primary procedure and not a separate service. Robotic assisted surgery is considered medically necessary for laparoscopic prostatectomy.

Medical Policy Changes

Effective September 1, 2019

Laboratory Testing MP9539

The following are considered experimental and investigational and therefore not medically necessary: autoimmune biomarker for rheumatoid arthritis (e.g., Vectra DA). The following profiles or panels are considered experimental and investigational and therefore not medically necessary: NutrEval, ION Profile amino acid panel, Cardio ION Profile, GI Effects Profile, Organix Dysbiosis and CV Health Plus Genomics (e.g., Genova Labs).

Hospice Services MP9299

Certification is required when the member has a terminal illness with a life expectancy of 12 months or less (was previously 6 months or less).

Effective October 1, 2019

Continuous Glucose Monitoring (CGM) MP9091

The medical policy for CGM was updated to align with the Navitus prior authorization form. The criteria for short-term continuous glucose monitoring for members with Type 1 or 2 diabetes was removed.

Engineered Products for Wound Healing MP9287

FloGraft is considered experimental and investigational, and therefore not medically necessary.

Non-Covered Durable Medical Equipment MP9347

Items which are available over the counter, and/or considered to be for comfort, convenience and/or personal hygiene are not medically necessary unless specifically indicated in the member's certificate or summary plan description (SPD) including but not limited to the following: cold therapy units (e.g., Game Ready or Cryo Cuff) and high-frequency TENS stimulation (e.g., Quell Wearable Pain Relief).

Corneal Cross Linking MP9470

Corneal cross-linking is not medically necessary for ectasia when performed concurrently with refractive eye surgery procedures (e.g., LASIK).

Effective November 1, 2019

Intermittent Pneumatic Compression Devices MP9119

The use of intermittent pneumatic compression devices for venous leg ulcers is appropriate when other compression interventions have failed. For immobile patients, compression devices are considered medically necessary for the prevention of deep venous thrombosis.

Vagus Nerve Stimulation MP9232

Prior authorization is not required for the revision or replacement of a cranial nerve (e.g., vagus nerve) neurostimulator electrode array and pulse generator.

Genetic Testing for Somatic Tumor Markers MP9486

OncotypeDX Breast Recurrence Score is considered medically necessary. Oncotype DX Breast DCIS Score is considered experimental and investigational, and therefore not medically necessary.

Percutaneous Mitral Valve MP9500

MitraClip is considered medically necessary for the following indications: For patients with grade 3+ or 4+ symptomatic degenerative mitral regurgitation. When used with maximally tolerated guideline-directed medical therapy, for the treatment of symptomatic, moderate to severe secondary or severe secondary mitral regurgitation grade 3+ or 4+.

Echocardiogram and Stress Echocardiography MP9513

In response to provider feedback, indications for stress echocardiography were added to the echocardiogram policy, including the following: Stress Echocardiography is considered medically necessary for ANY of the following, when the patient is able to exercise and in the appropriate clinical scenario (not an all-inclusive list):

- Acute chest pain in the appropriate clinical scenario when ALL of the following criteria are met:
  - Cardiac risk factors present
  - ECG non-diagnostic
  - Negative or minimally elevated cardiac biomarkers
  - No ongoing chest pain
  - Chest pain in members suspected of angina when exercise treadmill testing alone would be unreliable or inconclusive
- Arrhythmia in need of evaluation, such as sustained or non-sustained ventricular tachycardia, or in new-onset atrial or supraventricular arrhythmia when the member is at moderate or high risk of coronary artery disease
- Need for testing in the course of cardiac rehabilitation
- Congenital heart disease
- Coronary artery disease in the appropriate clinical scenario, when exercise treadmill testing alone would be unreliable
- Cardiac evaluation of diabetic members in the appropriate clinical scenario
- Cardiomyopathy in members with heart failure, ventricular dysfunction or cardiomyopathy
- Preoperative cardiovascular evaluation in the appropriate clinical scenario
- Syncope when exercise treadmill testing alone would be unreliable or inconclusive
- Valvular heart disease evaluation is required and clinically appropriate

The use of Stress Echocardiography is considered not medically necessary and therefore not a covered service when the criteria for transthoracic echocardiography has not been met, or when performed for other indications, including but not limited to the following:

- Unspecified chest pain, in the absence of a condition or finding which would indicate potential structural heart disease
- Nonrheumatic mitral valve insufficiency
- Patient ductus arteriosus

Providers are encouraged to read this revised policy in its entirety.

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Winter 2019 Medical Policy Updates (continued)

Prior Authorization Updates

Prior authorization was removed from the following medical policy:

- Effective September 1, 2019, Intrathecal Pump Implantation trials and permanent placements do not require prior authorization.

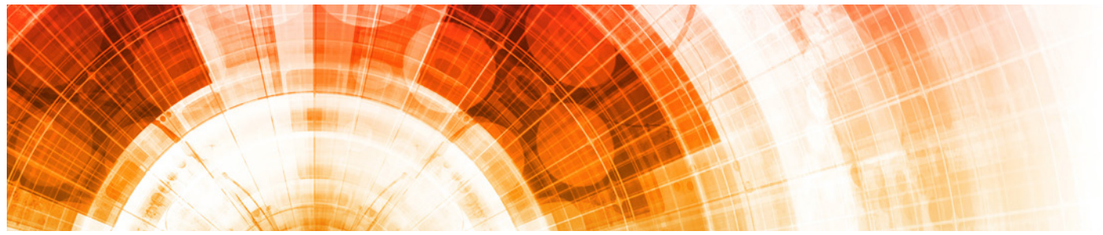
Retired Medical Policies

- Effective September 1, 2019, Coronary Computed Tomography Angiography (CCTA). Prior authorization and clinical indications are managed by NIA.
- Effective October 1, 2019, Measurement of Serum Levels and Antibodies: infliximab and HUMIRA (adalimumab) MP9464 was retired. Prior authorization is not required.
- Effective November 1, 2019, Lung Volume Reduction Surgery was retired. Prior authorization is not required.

Technology Assessments

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

- Age-related macular degeneration home monitoring (ForseeHome AMD)
- Anorectal fistula repair with xenograft plug
- Artificial pancreas (closed loop insulin delivery system)
- Aspire Assist gastric emptying system
- Avance nerve allograft
- Avise MTX, Avise CTD, Avise Anti-Carp
- Cartiva synthetic cartilage implant
- Intense physical therapy suite (Suit Therapy)
- Maestro rechargeable system for weight loss
- Magnetic expansion spinal control system (MAGEC System)
- ReWalk robotic lower body exoskeleton
- Sinus tarsi implant (subtalar implant)
- Wireless hand rehabilitation system (NESS H200) ⊕



Continuous Glucose Monitoring

Continuous glucose monitors (CGMs), such as Freestyle Libre and Dexcom, are now available to Dean Health Plan members as a pharmacy benefit and as a medical benefit.

The monitors, which require a prior authorization, are a Tier 3 benefit on the pharmacy benefit. By adding them to the pharmacy benefit, members enjoy:

- Similar out-of-pocket costs
- Reduced lag time between ordering and delivery
- The option to pick up prescriptions directly at the pharmacy

In addition, providers complete less paperwork and have their patients start using the monitoring devices sooner.

This benefit, however, does not apply to our MAPD population. ⊕

Winter 2019 Pharmacy and Therapeutics / Drug Policy / Formulary Change Updates

Starting January 1, 2020, we will mail a monthly letter to providers highlighting any changes that require a 90-day notification. The effective date of any changes will be clearly stated in each letter. In addition to the letters, we will continue to publish changes in *Provider News*.

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:** The written highlights below may reflect all changes to the policies. We encourage all prescribers to review the current policies.

Dean Health Plan must prior authorize all drugs with written Dean policies 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).

New Drug Policies

EVENITY (romosozumab-aqqg) MB1939

Effective October 1, 2019, EVENITY, which is used to treat osteoporosis in postmenopausal patients at high risk for fracture, will require a prior authorization. It is restricted to endocrinology or rheumatology prescribers.

ZOLGENSMA (onasemnogene abeparvovic-xioi) MB1941

Effective October 1, 2019, ZOLGENSMA, which is used to treat spinal muscular atrophy, will require a prior authorization. It must be prescribed by a neurologist with expertise in the diagnosis of spinal muscular atrophy.

Changes to Drug Policy

Trastuzumab Products MB1805

Effective October 1, 2019, added biosimilars ONTRUZANT (Q5112), HERZUMA (Q5113), and OGIVRI (Q5114). Updated code for KANJINTI to Q5117. Prior authorization is required and is restricted to oncology prescribers.

ONPATTRO (patisiran) MB1838

Effective October 1, 2019, updated code to J0222. Prior authorization is required and is restricted to oncology, hematology or neurology prescribers.

LIBTAYO (cemiplimab) MB1901

Effective October 1, 2019, updated code to J9119. Prior authorization is required and is restricted to oncology prescribers.

ULTOMIRIS (ravulizimab) MB1902

Effective October 1, 2019, updated code to J1303. Prior authorization is required and is restricted to hematology, oncology or immunology prescribers.

LUMOXITI (moxetumomab) MB1920

Effective October 1, 2019, updated code to J9313. Prior authorization is required and is restricted to oncology prescribers.

ELZONRIS (tagraxofusp-erzs) MB1905

Effective October 1, 2019, updated code to J9269. Prior authorization is required and is restricted to oncology or hematology prescribers.

Bevacizumab Products MB9431

Effective October 1, 2019, added new biosimilar ZIRABEV (Q5118). Prior authorization is required and is restricted to oncology prescribers.

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Winter 2019 Pharmacy and Therapeutics (continued)

SYNAGIS (palivizumab) M9221

Effective October 1, 2019, updated policy for the typical RSV season for Wisconsin, Illinois, Missouri and Oklahoma. Prior authorization is required and must be prescribed by a NICU physician, neonatologist, or pediatric specialist (including family practice, general pediatrics, pediatric pulmonology and pediatric cardiology).

Antihemophilia Factors and Clotting Factors MB1802

Effective November 1, 2019, we removed the reference link to the Hemlibra policy, which was retired October 1, 2019. Prior authorization is required and is restricted to hematology prescribers.

DARZALEX (daratumumab) MB1832

Effective November 1, 2019, added indication for multiple myeloma when used in combination with bortezomib, thalidomide and dexamethasone; and member is eligible for autologous stem cell transplant; or when used in combination with lenalidomide and dexamethasone; and member is ineligible for autologous stem cell transplant. Also added dosing schedules for both of the above. Prior authorization is required and is restricted to oncology prescribers.

Botulinum Toxin MB9020

Effective November 1, 2019, updated criteria for BOTOX to include headache frequency occurring 15 of more days per month for 3 or more months and migraine frequency occurring 8 or more days per month. Prior authorization is required.

Rituximab Products MB9847

Effective November 1, 2019, added biosimilar TRUXIMA (Q5115) which is used to treat CD20-Positive, B-cell, non-Hodgkins lymphoma (NHL) and CD20-Positive Chronic Lymphocytic Leukemia (CLL) in combination with fludarabine and cyclophosphamide or bendamustine. Prior authorization is required and is restricted to oncology prescribers.

NUCALA (mepolizumab) MB9914

Effective November 1, 2019, updated age for eosinophilic asthma indication to 6 years or older. Prior authorization is required and is restricted to pulmonology, allergy and immunology prescribers.

CRYSVITA (burosumab) MB1831

Effective November 1, 2019, updated age for X-linked hypophosphatemia to 6 months or older. Prior authorization is required and must be prescribed by an endocrinologist or specialist experienced in treatment of metabolic bone disorders.

SINUVA (mometasone furoate) MB1833

Effective November 1, 2019, updated code to J7401. Prior authorization is required and is restricted to ENT prescribers.

LARTRUVO (olaratumab) MB9956

Effective November 1, 2019, added criteria for soft-tissue sarcoma stating after 8 cycles are completed of Lartruvo, continue as dingle agent until disease progression or unacceptable toxicity. Prior authorization is required and is restricted to oncology prescribers.

KEYTRUDA (pembrolizumab) MB1812

Effective November 1, 2019, added indication of edometrial carcinoma. Prior authorization is required and is restricted to oncology prescribers.

Effective December 1, 2019, added indication for anal cancer, metastatic squamous cell. Prior authorization is required and is restricted to oncology prescribers.

TECENTRIQ (atezolizumab) MB1817

Effective November 1, 2019, updated criteria for the urothelial carcinoma indication to include use in patients who tumor express PD-L1 as determined by an FDA-approved test are not eligible for cisplatin containing chemotherapy, have disease progression during or following platinum containing chemotherapy, or have disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum containing chemotherapy. Prior authorization is required and is restricted to oncology prescribers.

OPDIVO (nivolumab) MB1844

Effective November 1, 2019, criteria changes for the following indications: Unresectable or Metastatic Melanoma, Merkel Cell Carcinoma, Non-Small Cell Lung Cancer and Classical Hodgkin Lymphoma. Added indication for Microsatellite Instability-High or mismatch Repair Deficient Metastatic Colorectal Cancer. Prior authorization is required and is restricted to oncology prescribers.

BENLYSTA (belimumab) IV MB1820

Effective December 1, 2019, added criteria that member must be age 5 or older. Prior authorization is required and is restricted to rheumatology or dermatology prescribers.

ANDEXXA (andexanet alfa) MB1843

Effective December 1, 2019, updated code to include C9041. Prior authorization is not required.

Digital Know-how Fosters Collaboration

Jon Zillman, Senior Provider Network Consultant

Jon Zillman understands the power of technology and the ability to build provider relationships. As a Senior Provider Network Consultant, Zillman has the experience and skills necessary to further enhance the provider experience. In fact, he serves as Dean Health Plan's resident expert on the Provider Portal.

"Working with the Portal has given me the opportunity to collaborate with coworkers all across Dean Health Plan to problem-solve for the providers," says Zillman. "I've really enjoyed facing new issues, discovering resources and being able to apply answers to everyday self-service challenges."

Zillman works with providers in Jefferson, Rock and Walworth counties. Whether answering questions about the Provider Portal, chiropractic reimbursement or aiding providers through escalated claims issues, his collaborative attitude helps resolve questions because he takes the time necessary to understand the specifics of the issue.

"Creating a calm environment when a provider is stressed is really important to issue resolution," Zillman explains. "**I make establishing rapport with providers a priority** to not only solve a problem, but to grow long-term relationships."

Get to know your Provider Network Consultant at **deancare.com/providers**.

Quit for Life® - Tobacco Cessation

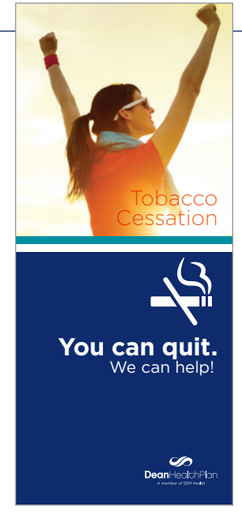
The New Year is a popular time for resolutions, including the intentions to quit using tobacco. Dean Health Plan is here to help with our tobacco cessation program, Quit for Life®.* With 25 years of experience employing a mixture of medication and phone-based coaching, Quit for Life® is designed to help members quit their tobacco use and overcome physical, psychological and behavioral addictions.

The Quit for Life® Program is free to members, 18 years and older, and includes access to a highly trained Quit Coach®, print and online resources, email messages and optional text messages. As part of their specific "quit plan," the member may also receive 12 weeks of Nicotine Replacement Therapy (NRT) (patch or gum) delivered directly to their home. To help our members along their path to success, Dean Health Plan provides coverage of prescription NRT medications at a $0 copay.

Enrollment in the Quit for Life® Program is easy and can be done by calling **866-QUIT4LIFE** or online at **deancare.com/quitforlife**.

As a health care provider, we ask you to encourage your patients who use any type of tobacco product (cigarette, cigar, pipe, chew, or e-cigs) to take advantage of the Quit for Life® Program and gain the knowledge, skills and behavioral strategies to help them quit for life.

If you have questions about the Quit For Life® Program or tobacco cessation prescription coverage, visit **deancare.com/quitforlife** or contact your Provider Network Consultant.



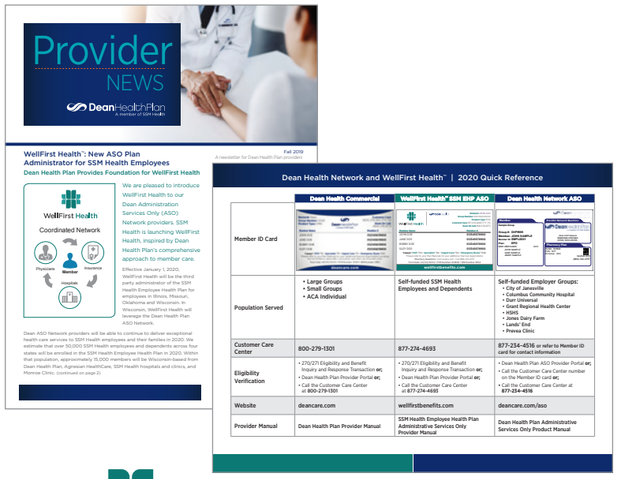
** Quit for Life is not offered to Medicare and Medicaid members as other smoking cessation programs are available to those populations.*

DeanHealthPlan
A member of SSM Health

Starting the New Year with WellFirst Health™

Effective January 1, 2020, WellFirst Health will be the third-party administrator of the SSM Health Employee Health Plan. If you are an in-network Dean Administrative Services Only (ASO) provider who will be serving SSM Health employees enrolled in the WellFirst Health SSM Health Employee Health Plan in 2020, this exciting change includes you.

Make sure you and your organization are ready to successfully navigate the SSM Health Employee Health Plan in 2020. In addition to the WellFirst Health articles in the 2019 Fall edition of *Provider News*, WellFirst Health information was mailed in October to providers that included Frequently Asked Questions about WellFirst Health and a Dean Health Network and WellFirst Health 2020 Quick Reference. This information is also available online from the "WellFirst Health Information for Dean ASO Network Providers" link under Helpful Links on the Dean Health Plan Providers page at **deancare.com/providers**.



WellFirst Health™

Notification Necessary for Provider Demographic Changes

Dean Health Plan is committed to ensuring accurate provider information is displayed within our provider directories. As a health plan, we are required to keep provider information up-to-date by Centers for Medicare & Medicaid Services 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 it lists the most current information for your organization.

CMS Medicare Advantage – General Compliance and Fraud, Waste and Abuse Annual Attestation

Dean Health Plan is required by Centers for Medicare & Medicaid Services to ensure its First Tier, Downstream and Related Entities (FDRs) complete compliance and fraud, waste and abuse (FWA) training within 90 days of hire/contracting and annually thereafter.

FDRs must ensure that all applicable employees complete the required FWA training, and submit a signed attestation annually in order to remain in compliance with Dean Health Plan.

Providers contracted with Dean Health Plan for Dean Medicaid, Dean Gold or Dean Medicare Advantage (MAPD) were mailed an attestation form in November. Providers must return their completed and signed attestation to Dean Health Plan in order to maintain compliance.

Termination of Doctor/Patient Relationship

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

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

DeanHealthPlan
A member of SSM Health

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.

- **Kimberly Butenhoff**
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  Columbia, Dodge and Fond du Lac counties
- **Jerusha Durrani**
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  608-827-4106
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  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**
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  608-827-4081
  800-356-7344 ext. 4081
  Adams, Crawford, Grant, Green Lake, Marquette and Richland counties, and APM
- **Michelle Madison**
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  608-827-4246
  800-356-7344 ext. 4246
  University of Wisconsin Hospital & Medical Clinics, University of Wisconsin Medical Foundation, WI Fertility Institute, Sauk, Green and Juneau counties
- **Sydney Sipos**
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  608-827-4144
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  Autism Providers, Waukesha County
- **Available Consultant**
  DHP.PNCInquiry@deancare.com
  Dubuque, Iowa, Lafayette and Vernon counties
- **Jon Zillman**
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  608-827-4059
  800-356-7344 ext. 4059
  Dane County Chiropractic, Jefferson, Rock and Walworth counties

Visit
deancare.com

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

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