Summer 2023
A newsletter for Dean Health Plan providers

Changes Coming for Claims and Resources- What You Need to Know

Our planned innovations with our partner Medica continue to take shape! While full details are still pending, in this article we share the latest information with our other partners- our valued providers.

Through an SSM Health agreement in 2021, Dean Health Plan and Medica became partners. Both health plans are leveraging the partnership to align best practices and jointly pursue enhanced tools and technology, strengthening their ability to provide high quality support for providers and members amid an ever-evolving health care environment.

New Claims Processing System for Individual and Family Plans

For dates of service on and after January 1, 2024, we are moving to a new, innovative system to process claims for Dean Health Plan Individual and Family plans (both on and off-Marketplace products). We are excited to introduce this next-generation processing system, through HealthRules®, later this year for increased accuracy and efficiency in claims adjudication.

The current claims processing system and processes will continue to be in place for all other products. Opening the new claims processing system to only Individual and Family plan claims initially will allow providers the opportunity to become familiar with the new technology on a smaller scale, as well as benefit from the dedicated resources as they become acclimated to the new system.

Planned changes for Individual and Family plan claims in the new processing system:

- A new payer ID will be assigned for electronic Individual and Family plan claims: Payer ID 41822 – Medica/Dean Health Plan/Prevea360.
- A new mailing address for paper Individual and Family plan claims: Medica – Dean, P.O. Box 211404, Eagan, MN, 55121.
- Payments for Individual and Family plan claims will come through a different bank.

Continued on page 2

This Issue

- Provider Experience Survey Results- What We Learned From You 2
- Good Health Care Claims Habits, Featuring Taxonomy Codes 3
- Prior Authorization Changes for Continuous Glucose Monitoring Systems 4
- Reporting Procedures for Suspected Fraud, Waste, and Abuse Have Changed 5
- Update to Credentialing/ Recredentialing Document Submission Requirements 5
- Promoting Medication Adherence to Patients 7
- Medicare Advantage Corner 8
- Chlamydia Screening Rates Continue to Drop 9
- Medical Policy Updates 10
- Pharmacy and Therapeutics Updates 12

- Explanation of Payments (EOPs) and electronic remittance advice (835s) for Individual and Family plans will be organized differently than today.

What to Expect Next

We know creating new accounts can take time. Look for more information from us soon on EDI and bank account set ups. Also, we will share full details on the new claims system and offer training opportunities later this year.

New Member ID Cards

We will debut a new 2024 member ID card for Individual and Family plans, with a different look than those for other products. Group numbers and member IDs also will be changing for these members. The new cards will feature additional information to help providers navigate a member's benefit plan, so remind your patients to bring their member ID card with them to their appointments.

What to Expect Next

We think this may be best served as a visual. Look for sample member ID card images from us later this year, as well as information about new group numbers and member IDs.

Dedicated Customer Care Support

We will be adding new, dedicated provider and member customer care phone numbers with expanded hours for Individual and Family product-specific assistance and support.

What to Expect Next

Our planned quick reference later this year will guide you to quickly know which resources to contact regarding your questions.

Stay Informed

This edition's cover story reflects our commitment from earlier this year to keep you informed about our partnership with Medica. It is important to us that we share information as it becomes available, and there is more to come! See our Medica-related communications on the Provider Communications page. The page is updated for new communications as they are released.

Provider Experience Survey Results- What We Learned From You

Thank you to providers and support teams for participating in our 2022 Provider Experience Survey!

Last fall, we asked in-network providers to share feedback about their experiences with Dean Health Plan. As we seek to improve processes, hearing from providers and support teams plays a significant role in how we approach and achieve improvements. Here's a recap of some of the survey results.

You like your Provider Network Consultants.

For the 65% of respondents who indicated that they do work directly with a Provider Network Consultant (PNC), they rated those interactions as highly satisfactory or satisfactory. For continued improvement, we have enhanced our PNC staffing to include more dedicated specialties and split out coverage territories to better address specific provider needs. See our updated Provider Network Consultants listing on the bottom of the Providers page.

We need to tell you more about our self-service tools.

While not all resources are relevant to all roles, we learned that providers don't always know where to find online resources and are missing out on important tools to help them interact with the Health Plan. Let us help with that now! We have added the Dean Health Plan Resource Quick Reference, from the Provider Onboarding Book, to the end of this newsletter for easy reference. The Quick Reference contains short descriptions and direct links to a wealth of self-service resources. In the future, we will be sure to direct to online resources, as applicable.

Provider Portal usage is high.

Providers agreed that the Dean Health Plan Provider Portal supports their business and work tasks, many citing that they rely on the portal most for benefits & eligibility information. Some providers noted opportunities for enhancements such as, adding more information regarding claims status and more options to save data. As we partner with Medica for new innovations and technologies, portal capabilities are being evaluated.

You shared your "go-to" resources and experiences with Pharmacy and Utilization Management procedures.

Providers indicated that they go to the Document Library, Master Service List (MSL), and Confirmation Reports most often when using online resources.

The majority of providers indicated that their experience with the Health Plan's Utilization Management Program was positive. Additionally, providers indicated that the medical benefit pharmacy prior authorization process was efficient. One respondent shared, "My whole job is prior authorizations, Dean Health Plan is the easiest system to work with."

Let's do it again!

The 2023 Provider Experience Survey is now available! Please provide your feedback by July 14 so that we can better support you.

Why does Dean Health Plan conduct surveys? Get the facts behind Dean Health Plan Provider Surveys. ⊕

Good Health Care Claims Habits, Featuring Taxonomy Codes

As Dean Health Plan prepares for a new claims processing platform in 2024, it's a great time to feature good claims practices for taxonomy codes.

Taxonomy codes are unique, 10-character alphanumeric codes that identify a provider's type, classification, and area of specialty. While providers are required to select one taxonomy code as their primary code when applying for a National Provider Identifier (NPI) through National Plan & Provider Enumeration System (NPPES), it is common for providers to have more than one taxonomy code to reflect the services they are able to provide.

As a good standard of practice, providers are encouraged to use valid, appropriate taxonomy codes on Dean Health Plan claims to accurately identify the specialty they were acting as when they delivered the service being billed to allow more accurate claims processing.

The Centers for Medicare and Medicaid Services (CMS) updates and publishes the Health Care Provider Taxonomy Code Set twice a year on the CMS website. ⊕

Good Claims Habits- *In case you missed it.*

Good standard claims practices entail submitting claims that accurately represent a patient's service(s) and interaction with their providers. Check out these articles from previous newsletters:

Good Health Care Claims Habits, Featuring "Service Facility Location", page 2, Fall 2022.

Stay on Top of Claims through the 277 Claims Acknowledgement, page 2, Winter 2022.

Reminder: Include Supporting Documentation with Authorization Requests

Avoid determination delays and authorization denials.

Providers are reminded to include all relevant clinical documentation supporting medical necessity with prior authorization requests at time of submission. It can make all the difference for prompt determinations and timely services for your patients.

Dean Health Plan's expectations regarding prior authorization and supporting documentation submissions are detailed in the "Submitting Prior Authorization Requests" and "Supporting Documentation" sections in the Dean Health Plan Provider Manual.

We strive to make the process clear. See the Provider Portal User Guide, available in the secure portal, for a quick step-by-step process on how to attach supporting documentation using the secure Dean Health Plan Provider Portal Authorization Submission application.

Prior Authorization Changes for Continuous Glucose Monitoring Systems

Effective April 1, 2023, prior authorization is no longer required for continuous glucose monitoring systems when a member is actively using insulin covered under their pharmacy drug benefit or medical drug benefit, for all products except Medicare Advantage.*

- For members who have an existing prescription for any type of insulin, the Health Plan no longer requires a prior authorization for FreeStyle Libre 2 or 3 or Dexcom G6 or G7.
- For members who do not have an existing prescription for insulin, providers will need to complete an Exception to Coverage Request form and send to Navitus for review.
- Determinations are based on the following patient reasons:
  - Problematic hypoglycemia issue
  - Occupations with public safety implications (regardless of insulin use)
  - Unable to test via fingerstick due to physical or cognitive limitation
  - Post bariatric hypoglycemia
  - High degree of suspicion of Somogyi effect or Dawn phenomenon
  - Young children
  - Pregnancy

  Members who obtain their continuous glucose monitoring (CGM) systems through a medical supplies facility that bills the Health Plan, will continue to go through the same process; however, claims will be reviewed to ensure appropriateness of use.

  Members must use their existing product for more than 1 year before they can switch to another product.

* Read about the new CGM systems coverage criteria for Dean Advantage members.

Reporting Procedures for Suspected Fraud, Waste, and Abuse Have Changed

Dean Health Plan and Medica have aligned their fraud, waste, and abuse reporting procedures for a streamlined process. As part of this alignment, the procedures for reporting suspected fraud, waste, and abuse have changed.

Dean Health Plan providers now can report suspected fraud, waste, and abuse in one of two ways:

- By calling our new 24/7 Integrity Line at 866-595-8495. (Callers can remain anonymous.)
- By submitting the online Medica Special Investigations Unit Referral Form.

Dean Health Plan continues to conduct business with the highest ethical standards, and our compliance program supports this. Dean Health Plan providers are required to promptly report any good faith belief of suspected or known fraud, waste, or abuse. For additional information on our reporting policy, visit the Medica Compliance and Fraud, Waste, and Abuse web page. ⊕

Update to Credentialing/Recredentialing Document Submission Requirements

A must-read for administrators who complete provider applications!

The National Committee for Quality Assurance (NCQA) clarified its 2023 standards regarding malpractice/liability insurance coverage documents submitted with provider credentialing and recredentialing applications. To ensure compliance with NCQA, effective July 1, 2023, every provider application submitted to Dean Health Plan will continue to require the Certificate of Liability Insurance. In addition, if the provider's name is not identified on the Certificate of Liability, a separate roster of all providers covered under the current policy will be required.

In case you missed it - Get the facts about provider recredentialing, page 5, Spring 2023 . ⊕

BadgerCare Plus Eligibility Renewals Have Restarted

The Wisconsin Department of Health Services (DHS) Medicaid program has reinstated eligibility re-determinations for members enrolled in a Wisconsin Medicaid program, which includes Dean Health Plan BadgerCare Plus members. In mid-March 2023, DHS notified members by mail and text, letting them know which month their renewal will be due. DHS is providing a 45-day advanced notice of eligibility renewal prior to the member's termination date. Members will continue to receive coverage until their renewal date. Dean Health Plan is also providing notification to its BadgerCare Plus members.

DHS resumed their standard processing of renewal letters on May 15, 2023, with the first termination date of June 30, 2023. The renewal process for all members will be completed by May 2024.

If your patients are enrolled in BadgerCare Plus, please emphasize that they need to ensure their address and contact information with Wisconsin DHS is up to date so they can receive renewal notices. BadgerCare Plus members can update their information through the ACCESS website, the MyAccess app, or call or visit their county consortia to update their contact information.

See Dean Health Plan's Wisconsin Department of Health Services Medicaid Redetermination FAQ for more information. Providers can also visit Wisconsin's COVID-19 Unwinding Resources for Providers web page for more information on how to support their Medicaid patients. ⊕

Health Equity and Dean Health Plan

Health equity means that every person has the opportunity to be as healthy as possible. Dean Health Plan recognizes that addressing health inequities and promoting cultural awareness are key for delivering a diverse and inclusive experience for members. In support of this, we invite providers and their support teams to visit our Cultural Awareness & Health Equity web page featuring the Cultural Awareness Training Series and free telephonic Language Line for language assistance/interpreter services.

Cultural Awareness Training Series

Viewers can watch modules at their convenience and refer back as often as they wish. Each module reflects timely topics and patient populations in Wisconsin.

- Module 1: Introduction to Cultural Competency and Humility
- Module 2: Introduction to Refugee Communities
- Module 3: Introduction to LGBT Populations
- Module 4: Organizational Cultural Competence

Each module lists clear learning objectives. Viewers can watch modules at their convenience and refer back as often as they wish.

Language Line Bridges Provider and Patient Communications

To address diverse language needs and enable important communications between providers and patients, Dean Health Plan offers a free, telephonic Language Line for language assistance/interpreter services. This service is available 24/7 to in-network providers who need to interact with Dean Health Plan members who have limited English language proficiency. Dean Health Plan providers may request language assistance by calling **844-526-1386**. ⊕

Let's learn from each other!

Is your practice doing something innovative to provide an inclusive experience for your patients? We would like to hear about it! Please contact your Provider Network Consultant to start the conversation. We may be able to feature it in a future edition of the Dean Health Plan News and inspire others.

Freedom from Smoking

Tobacco use is a powerful addiction. It may seem impossible to kick the habit, but thousands quit every year and your patients can too. Once they make the decision to quit, Dean Health Plan can help them along the path to success.

As part of member health benefits, we offer a virtual tobacco program called Freedom from Smoking. This small group program includes eight one-hour sessions led by a certified Freedom-from-Smoking facilitator. The program features a step-by-step plan for helping all tobacco users quit, whether they use cigarettes, smokeless e-cigarettes or vaping.

Each session is designed to help tobacco users understand their triggers and urges. These sessions also help participants develop coping strategies to stay committed to quitting. This engaging program uses a variety of evidence-based techniques to personalize and address individual needs along with the benefits of support from the group. Medications and nicotine replacement therapy are also available at no cost for plan members.

Providers can refer any patient to the Freedom from Smoking program. Freedom from Smoking is open to anyone 18 years and older, regardless of insurance. ⊕

Promoting Medication Adherence to Patients

Data show that up to 57% of patients with chronic disease may not be taking their prescribed medications or are taking medications differently than prescribed.[1] This leads to poor clinical outcomes for patients and an estimated $500 billion in healthcare costs.[2] With better medication adherence, comes better patient outcomes and lower overall healthcare costs.

Poor medication adherence can be attributed to four "barrier" categories: cost, knowledge and understanding of medications and disease state, access, and forgetting to take medication.

Consider making medication adherence a topic of conversation between you and your patients. Below are some topics providers can discuss with their patients to help remove barriers to medication adherence.

When Cost is a Barrier	When Knowledge/Understanding is a Barrier
• Consider prescribing lower cost alternatives and generics, when appropriate • If a branded drug is required, recommend manufacturer assistance programs and copay cards	• Counsel using plain language • Use the "teach-back" method to ensure patient understanding *Don't forget Dean Health Plan offers a Language Line to help bridge provider and patient communications!*
When Access is a Barrier	**When Forgetting Medication is a Barrier**
• Recommend mail order pharmacy (Costco is Dean Health Plan's mail order pharmacy.) • Suggest a prescription delivery service • Sync medication fills	• Suggest setting an alarm or downloading a phone app as a reminder • Suggest getting a pill box organizer • Recommend they mark their calendar

Sources:

1. Osterberg L, Blaschke T. Adherence to medication. *N Engl J Med*. 2005;353(5):487-497. doi:10.1056/NEJMra050100

2. Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. *Ann Pharmacother.* 2018;52(9):829-837. doi:10.1177/1060028018765159

Provider Network Consultants

While online self-service resources and the Customer Care Center are your first sources of information, Provider Network Consultants (PNCs) are health plan personnel who assist with more in-depth inquiries, when necessary. (And, always, contact your PNC to report changes or updates to your demographic information.)

Contact information for PNCs is listed at the bottom of the Dean Health Plan Providers page. Please contact the PNC listed for your specialty. If your specialty does not have a designated PNC, contact the PNC listed for your county.

Medicare Advantage Corner

Welcome to the Medicare Advantage Corner! This section of the newsletter highlights information and timely topics regarding our Medicare Advantage plans with Part D coverage.

This newsletter edition features new continuous glucose monitoring (CGM) systems coverage criteria for Dean Advantage members.

New Centers for Medicare & Medicaid Services CGM Coverage Criteria

Effective April 16, 2023, the Centers for Medicare & Medicaid Services (CMS) updated their CGM coverage criteria. To be eligible for coverage of a CGM and related supplies, Medicare beneficiaries must meet all, points 1-5, of the following initial coverage criteria:

1. The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and
2. The beneficiary's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription; and
3. The continuous glucose monitor is prescribed in accordance with its U.S. Food and Drug Administration (FDA) indications for use; and
4. The beneficiary for whom a continuous glucose monitor is being prescribed, to improve glycemic control, meets at least one of the criteria below:

A. The beneficiary is insulin-treated

B. The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following (see the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section of the LCD-related Policy Article (A52464))

Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan

A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia; and

5. Within six months prior to ordering the continuous glucose monitor, the treating practitioner has an in-person or Medicare-approved telehealth visit with the beneficiary to evaluate their diabetes control and determine that the aforementioned criteria in points 1-4 are met.

Summary of CGM Systems Functionality

CGM systems are made up of a disposable sensor, a transmitter, and a receiver device. The sensor is inserted subcutaneously every 7-14 days and measures the glucose concentration in the interstitial fluid. The transmitter attaches to the sensor and wirelessly transmits the readings to a receiver and, depending on the product, the transmitter and sensor can be separate components or combined into a single component. The receiver which displays the glucose readings can be a stand-alone device, display on an insulin pump, or an application on a patient's smartphone.

CGMs display historical and real-time glucose data to alert patients if their levels are currently or predicted to be high or low, and benefit anyone diagnosed with a diabetic condition. CGMs can be classified as either real-time continuous glucose monitor (rtCGM) or intermittently scanned continuous glucose monitor (isCGM), also known as "flash" glucose monitoring.

- The FreeStyle Libre 3, Dexcom G6 and G7, and

Medtronic Guardian Connect are considered rtCGMs as they measure and store glucose levels continuously with no user prompting required.

- The FreeStyle Libre 2 is a CGM as it measures glucose levels continuously, but requires a scan of the receiver device to obtain current and historical glucose data.

Each of the CGM systems, except for Medtronic's Guardian Connect, are able to guide therapeutic decision-making and do not require calibration with fingerstick blood glucose monitoring (FBGM). Guardian Connect requires calibration via FBGM and readings must be confirmed via FBGM prior to being used to guide therapeutic decisions. ⊕

Chlamydia Screening Rates Continue to Drop

According to the Centers for Disease Control and Prevention (CDC), chlamydia is the most commonly reported notifiable disease in the United States, yet under 50 percent of sexually active young women are screened annually for chlamydia.* Untreated chlamydia infections can lead to complications such as infertility and pelvic inflammatory disease, among others. Although testing and treatment are effective, patients may feel ashamed to get checked.

Healthcare Effectiveness Data and Information Set (HEDIS) performance data measures the percentage of women 16-24 years of age who were identified as sexually active with one or more chlamydia screenings during the measurement year. (Sexually active patients are identified by a pregnancy test or diagnosis, gynecological care [PAP], or prescription for a contraceptive.)

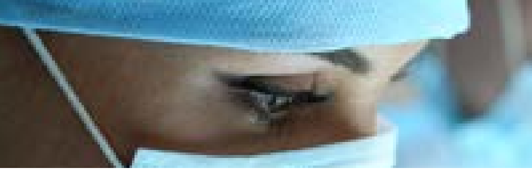
Screening rates for women 16 to 24 years old have decreased among our membership over the last few years. While some of this may be due to pandemic related barriers such as hesitancy to come in for an office visit and supply chain shortages, it is a good time to look at how to improve screening rates.

Adopting these best practices can help prevent undetected cases of chlamydia:

- Include chlamydia screening as part of routine clinical preventive care and establish routine clinic processes and systems to systematically screen sexually active clients at least once a year based on age and sex, or risk.
- Conversations surrounding sexual health can be uncomfortable for both the provider and patient. Use normalizing and "opt-out" language to explain chlamydia screening. "Opt-out" testing is similar to universal screening, where providers set a practice protocol to screen all sexually active women 24 years old and younger and sexually active women 25 years and older at an increased risk, instead of asking them to "opt in." Patients can always opt out by choice.
- Offer multiple screening options including self-collected vaginal swabs in addition to urine samples and provider collected swabs.

We appreciate the shared commitment and partnership with providers to ensure that Dean Health Plan members are taking advantage of free preventive services that will protect the future of their health.

* Source: Family Planning National Training Center American Sexual Health Association ⊕



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 published alongside our quarterly newsletter. The Medical Policy Committee meetings take place monthly. As always, we appreciate the expertise by medical and surgical specialists during the technology assessment of medical procedures and treatments.

To view all of Dean Health Plan's medical policies, visit deancare.com. From the home page, hover over **For Providers** located on the top, right of the screen and click **Medical Management**. Under Dean Health Plan Policies, click **Medical Policies**. 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.

The medical policy updates in this document are published alongside our quarterly newsletters on the Dean Health Plan Provider news page at deancare.com/providers/news. Please call the Customer Care Center at 800-279-1301 if you have questions about accessing our newsletters.

General Information

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

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

For radiology, physical medicine (PT/OT) 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

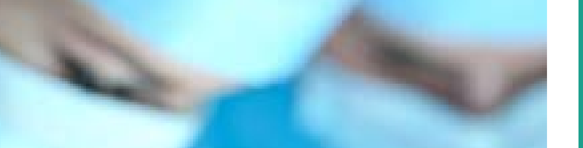
Providers can contact NIA by phone at 866-307-9729 Monday-Friday from 7 a.m. to 7 p.m. CST or by email at RadMDSupport@MagellanHealth.com. View details about the physical medicine prior authorization program.

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.

Summer 2023 Medical Policy Updates

The Summer 2023 Medical Policy Updates are published alongside this newsletter on our Dean Health Plan Provider news web page at deancare.com/providers news. Please call the Customer Care Center at 800-279-1301 if you have questions about accessing the updates.



Notification Necessary for Provider Demographic Changes

Please don't forget to update NPPES information too!

Dean Health Plan is committed to ensuring that our provider directories are accurate and current for the members who rely on this information to find in-network providers for their care. Additionally, Centers for Medicare & Medicaid Services (CMS) and other regulatory and accreditation entities require us to have and maintain current information in our provider directories.

To help accomplish this, providers must notify their designated Dean Health Plan Provider Network Consultant of any updates to their information on-file with us as soon as they are aware of the change.

On a quarterly basis, outreach is provided by our vendor BetterDoctor requesting providers to validate that their information on-file with us is current and accurate. Information regarding a provider's ability to provide services via telehealth are part of these attestations. Providers should not wait for these reminders to update their information with the Health Plan.

As our provider directories accommodate additional information for our in-network providers and additional requirements in the future, please review your directory information regularly at deancare.com/find-a-doctor to verify it reflects current and accurate information for you and your organization. Report any updates for the following to your Provider Network Consultant:

- Ability to accept new patients
- Practice location address
- Location phone number
- Provider specialty
- Languages spoken by provider
- 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 office staff
- Provider website URL

Providers are also encouraged to review and update their National Plan and Provider Enumeration System (NPPES) information when they have changes. NPPES provides information such as name, specialty, address, and telephone number for virtually every provider in the country in a machine-readable format. NPPES data serves as an important resource to improve provider directory reliability and accuracy. ⊕

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 is in the Dean Health Plan Provider Manual under the section titled "Termination of Patient/ Practitioner Relationship Policy and Procedure." ⊕

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 published alongside our quarterly newsletter. Drug policies are applicable to all Dean Health Plan products, unless directly specified within the policy. 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 with documented Dean Health Plan policies must be prior authorized, 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, hover over **For Providers** located on the top, right of the screen and click **Pharmacy Services**. Under Current Drug Policies, click **See Library**.

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, hover over **For Providers** located on the top, right of the screen and click **Pharmacy Services**. Under Covered Drugs/Formulary, click **See Drug Formularies**. Select appropriate plan type and then benefit plan to open formulary document.

Please note that the name of the drug (either brand or generic name) must be spelled completely and correctly when using the search bar.

Summer 2023 Updates

The Summer 2023 Pharmacy and Therapeutic Updates are published on the Dean Health Plan Provider News web page at deancare.com/providers/news. Please call the Customer Care Center at **800-279-1301** if you have questions about accessing the updates.

Dean Health Plan Resource Quick Reference

Resource / Direct Link	Description	Path to Access
Automated Authorization	Automated authorization (Auto Auth) is available to in-network providers who submit a prior authorization request through the Provider Portal only. Prior authorization requests that meet the health plan's medical policy criteria or MCG Dean Health Plan guideline will receive an approval notification generated within seconds of submitting the request.	Click the **Automated Authorization** link located under Information & forms at deancare.com/providers/medical-management
Confirmation Reports Portal	Separate from the Provider Portal. Confirmation reports shows whether claims, submitted electronically or on paper, were accepted or rejected for processing. Confirmation reports are available within 48 hours of when the health plan receives a claim. Once users sign up, this is the only method they will receive as acknowledgement of claim acceptance.	Click the **Go to Portals** link located under Provider portals at deancare.com/providers
Document Library	Online document repository that allows users to search for manuals, policies, forms and other documents by using dropdowns for keyword, policy number, audience and/or category.	Click the **Document Library** link located under Helpful Links at deancare.com/providers
Electronic Funds Transfers (EFT)	Receive electronic payments from the health plan through Change Healthcare ePayment Services.	Sign up by calling **866-506-2830** or online at changehealthcare.com/support/customer-resources/enrollment-services
HIPAA Transactions Alternative to EDI Claim Submission	Exchange HIPAA-compliant electronic transactions with the health plan, including an alternative EDI claim submission option.	Click the Learn more about EDI link located Click the **HIPAA Transactions** link located under **Helpful Links** at deancare.com/providers For EDI claim submission alternative, click the **Smart Data Stream Clearinghouse Portal** link at deancare.com/providers/hipaa-transactions
Medical and Drug Policies Medicare Advantage Policy Guidelines	Reviewed at least annually and based on technology assessment resources and feedback from in-network providers. Material changes to our policies are communicated in the Dean Health Plan Provider News or through special mailings or email distributions to those who have opted in to receive electronic communications from the health plan.	Click the Medical policies or Drug policies link under **Helpful Links** at deancare.com/providers For Medicare Advantage, click the **Medicare Management** link under Dean Advantage at deancare.com/providers/medical-management
Medical Injectables List	A reference of drugs covered under the medical benefit.	Click the **Medical Injectables** link at deancare.com/providers/medical-management For Medicare Advantage, the Medical Injectables that require prior authorization are listed within the Dean Health Plan Medicare Advantage Plans Prior Authorization List, listed in the row directly below.
Medical Prior Authorization Service List Dean Health Plan Medicare Advantage Plans Prior Authorization List	Also referred to as the Master Service List, it is divided by products and lists medical service codes that require prior authorization. It also links to medical policies that require prior authorization and/or have coverage limitations.	Click the **Medical Prior Authorization Services** list link located under Prior Authorization Services on the Dean Health Plan Medical Management web page at deancare.com/providers/medical-management For **Medicare Advantage**, click the Dean Health Plan Medicare Advantage Plans Prior Authorization List link at deancare.com/medicare/medicare-member-center/dean-advantage-member-center/pharmacy-benefits/medical-management
Member Summary of Benefits and Coverage	Documentation related to member health plan benefits, including certificate of coverage, member policy or certificate and member handbook, including exclusions.	Using **Google Chrome**, go to memberbenefits.deancare.com

Resource / Direct Link	Description	Path to Access
Navitus/Navi-Gate Portal	Dean Health Plan contracts with Navitus/Navi-Gate for the authorization of pharmacy benefit drug authorizations.	Click the Go to portals link located under Provider portals at deancare.com/providers
NIA Magellan Healthcare RadMD Portal	Dean Health Plan contracts with NIA Magellan Healthcare for the authorization of physical and occupational therapy, radiology and musculoskeletal services. Providers must submit authorization requests for these services directly to NIA Magellan Healthcare through their RadMD Portal.	Click the Go to portals link located under Provider portals at deancare.com/providers
Non-Covered Services	List of medical procedures and services that are not covered by the health plan.	Click the **Non-covered Services** link located under Authorization and coverage at deancare.com/providers/medical-management
Opt In/Opt Out for Electronic Communications	Available during the Provider Portal registration process. Select Opt In to receive direct email communications from the health plan. After registration and account setup, available through Provider Selection option under the Settings dropdown located at the top of the Provider Portal home page, select **Account Settings**. Click **Save Changes** once completed.	Click the **Go to Portals** link located under Provider portals at deancare.com/providers
Pharmacy Information	Includes medical benefit drug policies, formulary coverage, and a listing of prior authorized drugs.	Click the **See Pharmacy Services** link located under Pharmacy services at deancare.com/providers
Provider Communications	Links to a variety of past and current provider notifications for on-demand retrieval of information. Includes communications to in-network providers about changes to health plan procedures, policies and benefits, and larger initiatives.	Click the **Communications Library** link located under Helpful Links at deancare.com/providers
Provider Directory	Titled as **Find A Doctor** on deancare.com Interactive, up-to-date listing of in-network providers and locations contracted with the health plan that is publicly accessible to members and providers.	Click the **Find A Doctor** link located at deancare.com
Provider Manuals	Provider resource for health plan policies and procedures intended to serve as supplemental information to a provider's contract.	Click the **Go to Manuals** link located under Manuals at deancare.com/providers
Provider News	Quarterly newsletter with health care interest stories, provider and health plan highlights, and updated medical and drug policies.	Click the **See News** link located under Provider News at deancare.com/providers
Provider Portal	Secure Provider Portal accessible 24/7 as a direct line between your organization and the health plan's self-service applications to exchange electronic transactions and share current health care information and health plan resources.	Using Google Chrome, click the **Go to Portals** link located under Provider portals at deancare.com/providers
Provider Portal Registration Guide	Details the registration process to create individual and organization Provider Portal accounts.	Click the **Go to Portals** link located under Provider portals at deancare.com/providers
Provider Portal User Guide	Details how to use the self-service applications available in the Portal once a Provider Portal account is created.	Available to registered users in the secure Provider Portal once a Portal account is established.