



Referrals/Prior Authorizations/Pre-Certification

The importance of understanding the difference between DHI/DHP's products is necessary to insure proper referral/prior authorization/pre-certification guidelines are followed. **Failure to understand or follow these guidelines will result in claim payment denials or reduction of benefits.** Some products require a referral and/or prior authorization, while others may only require prior authorization or pre-certification.

What is a referral?

Referral - A DHI/DHP form that is completed in full and signed by a Primary Care Practitioner (PCP) and requests approval of outpatient treatment for an HMO member by an adjunctive and/or non-plan provider of healthcare. The completed form is submitted to the DHI/DHP Utilization Management for determination of approval. **The referral must be approved prior to the member obtaining services.** A verbal or written request for services **does not** constitute a referral.

What is Prior Authorization?

Prior Authorization - Written approval from the DHI/DHP Utilization Management prior to the member receiving services. *(This applies to HMO and POS members for services that require prior authorization.)* The authorization will state the type and extent of the treatment or benefit authorized. Failure to complete the required prior authorization may result in a denial of a claim (HMO) or reimbursement of a claim as a lesser benefit. A verbal or written request for services **does not** constitute prior authorization.

What is Pre-Certification?

Pre-Certification - Approval of an admission to a facility and/or the approval of a specified number of days for a facility confinement prior to the services being rendered. *(This applies to POS.)* Pre-Certification does not guarantee coverage and/or payment. Failure to obtain pre-certification, when required, may result in a denial of a claim (HMO) or reimbursement of a claim as a lesser benefit.

How can I verify that a referral/prior authorization/pre-certification has been processed by DHP?

- You will receive a copy of the referral that will indicate if it was denied, approved, or if the member has been redirected to another provider.
- Contact our Customer Service Department for status of the referral/prior authorization/pre-certification.

Approved requests do not authorize payment of non-covered or exhausted benefits.



What is a Plan Provider?

Plan Provider - A provider that has a signed Provider Agreement with Dean Health Systems to provide one or more services and is listed in the most current edition of the **Provider Directory**. (The Provider Directory is accurate at the time of printing.) This includes, but is not limited to, physicians, surgeons, optometrists, chiropractors, podiatrists, and pharmacies.

<http://www.deancare.com/healthplan/Providers/index.asp?V=4>

What is an Adjunctive Provider?

Adjunctive Provider - A provider that has a signed Letter of Agreement with Dean Health Systems to provide one or more services at a specific location only. This is limited to specialty care.

What is a Non-Plan Provider?

Non-Plan Provider - A provider that does not have a signed Provider Agreement with Dean Health Systems and is not listed in the most current edition of the Provider Directory. (The Provider Directory is accurate at the time of printing.) The Health Plan has no liability or responsibility for the quality of care provided by a non-plan provider. Only services that are not available within the DHP provider network are considered for approval with non-plan providers. If you have a question regarding a provider's participation within the DHP network, contact our Customer Service Department.



DHI/DHP HMO Referral & Prior Authorization Guidelines

As an HMO, DHI/DHP requires that members choose a PCP or primary clinic. The PCP acts as a “gatekeeper” to ensure members receive appropriate, high quality care in a cost effective manner. **Primary care practitioners should assist members with completing a referral to an adjunctive or non-plan provider. The provider of service is responsible for prior authorizing services when necessary.**

Dean Health Plan no longer requires referral requests to the following locations and physicians:

- All Plan-to-Plan clinic referrals
- Dean Medical Center locations
- Clinics in association with Dean Medical Center (SMDV-St. Marys Dean Ventures)
- Dean Medical Center/SMDV physicians performing services at outreach locations
- Plan mental health clinics and plan physical, occupational and speech therapy facilities
- Plan Alcohol and Other Drug Abuse (AODA) clinics and/or facilities

Prior authorization may still be required due to a medical policy for a specific service or due to fee schedule limitation.

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

- All services provided by a non-plan provider require a referral or prior authorization. An approved referral (one that has been processed by a Utilization Management Department prior to care being provided) constitutes prior authorization. **These requests are only considered for services that cannot be provided within the DHI/DHP network of providers.** It is recommended that an appointment to a non-plan provider is not made until prior authorization has been obtained.
- *All services provided by a non-plan or out of network mental health provider will still require a referral request and/or prior authorization. Please contact DHP’s Customer Service Department at (800) 279-1301, if you have any questions.
- Dean Health Plan encourages communication between the PCP and the member regarding mental health services. If the PCP determines mental health services are medically necessary and is not certain which mental health practitioner is most clinically appropriate, the PCP may contact Dean Medical Center (DMC) Psychiatry Department at (608) 252-8226 during normal business hours for assistance in determining the practitioner or office site that will best meet their patient’s needs.
- Magnetic Resonance Imaging (MRI) is required to be performed at an approved **plan facility**.

For services that require prior authorization, refer to additional guidelines within this section. They are as follows:



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- Cardiac Nuclear ETT
 - Durable Medical Equipment (DME)
 - Drugs
 - General Surgery
 - Home Health Services
 - Hospice Services
 - Hospital Admissions
 - Occupational Therapy
 - Back Pain Invasive Procedures
 - Oral Surgery
 - PET Scans
 - Physical Therapy
 - Podiatry
 - Respiratory Therapy
 - Skilled Nursing Facility/Swing Bed
 - Speech Therapy
 - Transplants

For specific criteria in regard to prior authorizing services, you may also reference:
www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

This policy applies to initial and interim referrals.

If a physician determines the need for a referral at the time of service, but neglects to complete the Referral Request, a referral will be authorized, given that all referral guidelines have been met. Physician and office errors must be indicated on the Referral Request.

Medicare Supplemental Plan Referral/Prior Authorization Guidelines

Dean Health Plan has reduced the referral and prior authorization requirements for members enrolled in our Medicare supplemental plans.

Written referrals and prior authorization will no longer be required for outpatient services provided by a plan provider for services covered by Medicare. Because a PCP acts as the “gatekeeper” to ensure members receive appropriate, high quality care, we encourage you to discuss any specialty care that your patients may be receiving, even when a referral is not required. In addition, plan hospitals are no longer required to authorize inpatient admissions covered by Medicare.

Members on our Medicare supplemental plans are identified by a Dean Care ID Card with a group number in the 20000 range or a Dean Care Gold ID Card with a group number **C2300D (Shared Value)**, **C2200 (Enhanced with catastrophic drug coverage)**, **C2200D (Enhanced without catastrophic drug coverage)** or **C1200 (Basic)**.

Members who have Medicare as primary insurance and DHP as secondary insurance through an employer (or former employer) will continue to follow our current referral guidelines for HMO members. Please refer to the HMO Referral/Prior Authorization guideline chart.

****In the event a member has a DHI/DHP policy that is secondary to Medicare (through an employer or former employer), therapies are subject to the retiree plan benefits and HMO guidelines.**



- A written referral will continue to be required if DHP members on one of our Medicare supplemental plans seeks care from **non-plan** providers.
- Prior authorization will continue to be required for all **non-plan** admissions.
- Dean Care Gold members are required to utilize Dean Care Gold providers and will continue to require a written referral or prior authorization prior to obtaining services from providers outside of the Dean Care Gold network.

If you have questions regarding our referral requirements for our Medicare supplemental plans, please contact our Customer Service Department at (800) 356-7344 or (608) 836-1400.

Dean Health Insurance, Inc (DHI)/Dean Health Plan (DHP) Point of Service (POS) Prior Authorization/PreCertification Guidelines

Members of DHI/DHP who are enrolled in the POS Plan are not required to select a PCP or clinic. They have the option to use plan and non-plan providers, but may receive a different level of benefits based on what type of provider they obtain services from. Because these members have the option to use plan or non-plan providers, referrals are not required. However, some services require prior authorization or pre-certification. Services that require prior authorization or pre-certification from the provider of care are outlined in this section

The information applies to services rendered by a plan provider. If a member seeks services from a non-plan provider, the member is responsible for prior authorization and pre-certification.**

Contact our Utilization Management Dept. if a service requires prior authorization or pre-certification. A Referral Specialist will assist you with your request.

**When a member is required to obtain prior authorization or pre-certification, they should contact the DHI/DHP Utilization Management Department to obtain instructions on how to prior authorize or pre-certify their care, unless a separate guideline exists in this section.



POS Exception Policy

Members who have the POS plan are required to prior authorize some services as stated on their Schedule of Benefits and are liable for 50 percent up to \$500 of the covered charges if authorization is not obtained. DHI/DHP gives notification on the Explanation of Payment to the member and the provider if a benefit reduction occurs.

If the member disagrees with the determination or has additional information to be submitted, they are encouraged to submit this information to the DHI/DHP Medical Affairs Division for review.

Upon review the following may take place:

- If prior authorization was required for a service with a plan provider, DHP may allow a **ONE TIME** exception and pay the services as if prior authorization was obtained.
- If prior authorization or pre-certification was needed to a non-plan facility or a non-plan provider, DHP **WILL NOT** make an exception.
- If pre-certification was required to a plan facility, DHP may pay the claim as a **ONE TIME** exception.

No reduction in Mental Health/AODA benefits apply to this exception.

EXCEPTION: Prescription drugs and DME supplies are NOT covered if prior authorization has not been obtained.

Cardiac Rehabilitation Authorization Guidelines

HMO and Point of Service

Cardiac Rehabilitation (Phase II) services are considered medically appropriate for up to 18 visits during a 12-month period when:

- Provided by an approved plan facility
- Patient has other cardiac conditions requiring supervised progressive exercise or rehabilitation to ensure patient safety.

In addition, Cardiac Rehabilitation (Phase II) services are covered when prescribed by a **cardiac rehabilitation specialist or physician within 90 days of the date** a patient has been diagnosed with, or undergone a procedure for, any of the following:

- Myocardial Infarction,
- Cardiac Transplantation,
- Coronary Artery Bypass Grafting,



- New diagnosis of Arterial Sclerotic Heart Disease (ASHD) with Angina Pectoris,
- New diagnosis of Cardiomyopathy, or
- New diagnosis of Congestive Heart Failure.

The 18 visit program is designed to provide the following services:

- One evaluation visit, including:
 - ✓ Preparation and review of patient records,
 - ✓ Comprehensive patient history,
 - ✓ Individual treatment plan including those elements described above,
 - ✓ Monitored exercise (blood pressure and electrocardiogram-(EKG)), and
 - ✓ One-on-one patient/therapist ratio with usual time spent about 90 minutes.
- The next five visits include:
 - ✓ Individual exercise sessions with EKG and blood pressure monitoring,
 - ✓ Continued implementation of individual's treatment program including exercise prescription, and
 - ✓ One-on-one therapist to patient session usually lasting 90 minutes each.
- The final twelve visits include:
 - ✓ Group supervised activities (education and exercise),
 - ✓ Electrocardiogram and blood pressure monitored exercise sessions (EKG may be optional depending on patient risk), and

After completing the Cardiac Rehabilitation program, patients should be encouraged to continue their risk reduction efforts and exercise independently thereafter.

Some patients may wish to continue their exercise efforts within the cardiac rehabilitation program. However, these additional visits would not be a covered benefit unless specific criteria is met.

If additional cardiac rehabilitation services are needed, please refer to MP9079 at www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Continued Inpatient Hospital Stay

Plan hospitals are required to contact DHP upon admission of DHP members to receive an initial authorization of their stay. Physicians supervising the care of hospitalized patients should assume that continuing inpatient care is approved unless the DHP Utilization Management (UM) Department contacts you indicating otherwise. Should this occur, we may request additional clinical information which supports that member's need to stay. If a continued stay is not approved, you may request information regarding alternative care available to the member to assist you in expediting a timely discharge.

If you have any questions regarding this information or any UM processes, please contact the Director of Utilization Management at (608) 827-4169.



Home Health Authorization Guidelines

HMO and POS Policies

Home healthcare services must be ordered by a physician through a plan home health provider and must be prior authorized. Obtaining prior authorization is the responsibility of the home healthcare provider, and if not obtained, coverage will be denied leaving the provider financially liable for any services rendered.

Once the physician has ordered home healthcare services, the home healthcare provider will fax DHI/DHP Utilization Management Coordinator (UMC) a form that request the following required information: When requesting prior authorization, the Home Health provider needs to contact the DHP Customer Service Department to verify benefits. The Home Health provider will then be transferred to the Utilization Management Coordinator, who will then acquire the following information:

- Provider Contact Information:
 - ✓ Date sent to Dean Health Plan
 - ✓ Contact name
 - ✓ Phone and Fax Number
 - ✓ Provider Name and assigned DHP Provider number
- Patient Information:
 - ✓ Patient Name
 - ✓ Member Number
 - ✓ Date of Birth
 - ✓ Benefit Year
 - ✓ If they are a Wisconsin Educational Association (WEA) Point of Service Member
 - ✓ Diagnosis (ICD-9) – list all applicable diagnosis'
 - ✓ Referring physician
 - ✓ Referring physician's main clinic site
 - ✓ Address, City, St., & Zip
 - ✓ Start date of Care

Once the form is completed and faxed by the home healthcare provider to DHP, a UMC will be designated to receive the form. The UMC will verify the member has coverage with DHP. The authorization will then be approved with the start date of service given by the provider and a stop date of the end of the member's benefit year. **It is essential the provider gives the correct start date for accurate claim payment.**

The DHP UMC will fax back to the home healthcare provider the approved authorization with the UMC signature and the original faxed notification form with the dates of the authorization entered.



Home healthcare providers will manage the care and benefit following DHP contract language regarding medical necessity. No phone calls from providers are necessary to authorize visits. However, the home healthcare providers are encouraged to contact the DHP UMC with questions or to request assistance with a member's situation.

The home healthcare provider will be required to contact DHP UMC if a member uses 20 or more visits so the UMC can offer assistance, as needed. This contact is not to approve additional visits, it is to confer about the member's current needs.

If you have any questions on prior authorizing home healthcare, contact our Customer Service Department at (800) 279-1301.

Durable Medical Equipment (DME) and Supplies

All DME and supply items must be obtained through a plan DHP DME provider. Dean Health Plan will not be responsible for any items not obtained through a plan provider. It is the responsibility of the DME supplier to prior authorize services.

Epidural Steroid Injection (ESI) Medical Policy has been Discontinued.

Refer to the New Policy named Back Pain Invasive Procedures for the prior authorization guidelines.

Dean Health Plan prior authorization guidelines can be found under the Back Pain Invasive Procedures at: www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp



Positron Emission Tomography (PET) Scans Authorization Guidelines

HMO & POS

The newest type of radiographic technique that is being utilized to diagnose members is PET scans. Currently, there is a growing application of PET scans being used to study and diagnose cancer, cardiac applications, lung disease, and in the studies for neurologic application.

Dean Health Insurance/Dean Health Plan has developed the following guidelines in an effort to provide utilization management for PET scans. Dean Health Plan requires **ALL** PET scans to be prior authorized through the Medical Affairs Division.

The following are basic guidelines for the types of PET scans that are covered if prior authorization has been obtained by the plan provider ordering the scan.

- A PET scan to evaluate whether or not an invasive procedure is necessary are considered medically appropriate for staging:
 - ✓ Thyroid Cancer
 - ✓ Esophageal Cancer
 - ✓ Head & Neck Cancer
 - ✓ Breast Cancer
 - ✓ Cervical Cancer
 - ✓ Colorectal carcinomas
 - ✓ Malignant lymphoma
 - ✓ Melanoma
 - ✓ Lung Cancer
- A PET scan for cardiac applications is considered medically appropriate when:
 - ✓ Evaluation of Coronary Artery Disease following an inconclusive SPECT scan (i.e., the results of the SPECT are equivocal, technical unable to interpret, or discordant with a member's other clinical data).
 - ✓ Assessment of myocardial viability prior to revascularization, either as:
 - *A primary or initial diagnostic study, or
 - *Following an inconclusive SPECT scan or nuclear ETT
- A PET scan is considered medically appropriate to determine the likelihood of malignancy in solitary pulmonary nodules after detection by another method (usually Computed Tomography (CT) scan) and when used to plan future management and treatment for the patient.
 - ✓ A PET scan should not be used if a biopsy is planned regardless of the results.
- A PET scan is considered medically appropriate for the initial staging of pathologically diagnosed non-small cell lung carcinoma after a CT scan and pathology report document the presence of a cancer.
- A PET scan is considered medically appropriate for localization of seizure foci in subjects with intractable epilepsy if there is a reasonable chance of avoiding deep electrode study and requires:



- ✓ Prior authorization through the Medical Affairs Division with:
 - Medical Director review, and
 - A consultation with an appropriate plan Neurologist.

For members enrolled in DHP Medicare supplemental plan, DHP pays when Medicare also covers the benefit.

Dean Health Plan does not consider the following PET scans medically appropriate. Therefore, they are not a covered benefit:

- Whole body PET scans for cancer screenings.
- Using a PET scan for detection or follow-up of ovarian cancer.
- Use of a PET scan for determining the progress of a lung tumor during treatment.

Contact the Customer Service Department with any additional questions in regard to the coverage of PET scans.

For additional guidelines related to the diagnosing, staging, and restaging of specific cancer related diagnoses, reference the medical policies at:

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchresults.asp?txtMedSearch=pet

Cardiac Nuclear Exercise Tolerance Tests (ETT) Authorization Guidelines

HMO & POS Policies

Dean Health Plan requires prior authorization for **ALL outpatient** nuclear ETTs.

The prior authorization process for an outpatient nuclear ETT requires the ordering physician to complete and return a "Prior Authorization Check Sheet." The check sheet has five (5) "yes/no" questions, which will help DHP to determine if a patient's condition would favor choosing a nuclear ETT over a regular ETT. Most patients without documented coronary artery disease needing an ETT should start with a regular (non-imaging) ETT, rather than a nuclear ETT.

The criteria for approval of a nuclear ETT are as follows:

- Has the patient had a previous MI or previous cardiac catheterization showing coronary artery disease?
- Has the patient had a prior abnormal ECG response to exercise during an ETT?
- Is the patient unable to exercise but still needs an ETT?
- Does the patient also need assessment of left ventricular function (assumes a cardiac echo has not recently been done)?
- Does the resting ECG have any of the following abnormalities:
 - ✓ Electronically paced rhythm



- ✓ Significant Q waves (at least 0.4 mm wide)
- ✓ Left bundle branch block (complete or incomplete)
- ✓ Left ventricular hypertrophy
- ✓ Resting ST depression greater than 1mm
- ✓ ST depression and patient on digoxin

The ordering physician should submit the completed check sheet to DHP for approval. This information can be faxed or mailed.

Please note that the facility performing the nuclear ETT has the final responsibility to ensure that prior authorization has been granted. Otherwise, DHP may deny or recoup payment for outpatient nuclear ETTs performed without prior authorization.

Please contact our Customer Service Department for any questions regarding this process or to obtain a "Prior Authorization Check Sheet."

To access the most up-to-date medical policy regarding the prior authorization requirements for Nuclear ETTs go to

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Therapies (Occupational, Physical, Respiratory, and Speech)

Prior Authorization Guidelines HMO Policies Only

Dean Health Plan's goal is to provide high quality, cost effective care for its members. One method of controlling the increasing cost of medical care is to manage services through monitoring the therapy services provided to our members.

When a member requires therapy services, the plan therapy provider should follow the prior authorization process outlined below. If requests are made to a **nonplan therapy provider**, prior authorization must be approved prior to services being rendered.

Primary care practitioners are still required to prior authorize ultrasonic treatment performed in their office.



Physical, Speech, & Occupational Therapy Services

The Therapy Provider's responsibilities are to:

- The patient's physician will assess the need for physical, speech, or occupational therapy and write a prescription for an evaluation and treatment to a plan DHP therapy provider.
- **ALL plan physical, occupational, and speech therapy visits require prior authorization by the plan therapist. Visits are limited to medically necessary treatment.**
- The therapist will conduct the initial evaluation and be required to complete a written referral request form. The therapist will send the written referral request form to DHP to include the patient's diagnosis and estimated plan of care for DHP approval. **Following the completion of the evaluation, the request for therapy should be immediately faxed to DHP for processing. Requests received later than seven (7) days of being written will be considered late and denied.**
- Dean Health Plan will approve the requests for covered services and note any limitations regarding non-covered services or limited benefits (e.g.; developmental delay). A copy of the approved request will be sent to the therapist, ordering physician, and DHP member.
- If, at any time, the therapist begins to treat the member for a new condition or provides more than one type of therapy (within the same therapy session); A new referral request form must be submitted to DHP for approval.
- Requests for additional medically necessary therapy visits require submission of a written treatment plan.
- Contact our Customer Service Department at (800) 279-1301 or (608) 828-1301, with any additional questions.

Care is terminated when services are no longer medically necessary. Please also note that keeping the treating physician apprised of the member's progress is strongly recommended to ensure the best coordination of care for the member.

Charges for services that have not been prior authorized by the provider of service are not billable to DHI/DHP or the member.



Physical, Occupational, & Speech Therapy Prior Authorization Guidelines

POS Policies

The therapy provider is responsible for prior authorizing care (this includes the initial evaluation, even if this is the only visit a member has).

To access the most up-to-date medical policies regarding the prior authorization requirements for physical, speech, and occupational therapy go to

www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp.

Respiratory Therapy

HMO & POS Policies

Policies do not require a referral and/or prior authorization/pre-certification.

Non-Covered Therapy Services

- Vocational Rehabilitation including work hardening programs.
- Long-term and maintenance therapy. Examples of long-term/maintenance conditions include, but are not limited to:
 - ✓ Autism and learning disabilities
 - ✓ Attention deficit
 - ✓ Hyperactivity disorder
 - ✓ Sensory defensiveness
 - ✓ Auditory defensiveness
 - ✓ Mental retardation

LIMITED BENEFIT FOR DEVELOPMENTAL DELAY

- Hearing therapy for communication delay, therapy for perceptual disorders, mental retardation and related conditions, and other long-term special therapy.
- Recreational and educational therapy or physical fitness and exercise programs.
- Biofeedback, except as provided by PT for treatment of headaches, and spastic tortocollis.
- Services to enhance athletic training or performance.



Miscellaneous Prior Authorization Guidelines

Cosmetic Surgeries

HMO and POS Policies

Prior authorization is required for any surgical procedure that maybe considered cosmetic. A letter of medical necessity must be submitted to the DHI/DHP Medical Affairs Division for review prior to scheduling the procedure (please refer to the *Health Plan Overview* section for phone number and fax number).

New Technologies

HMO & POS Policies

For any new technology or procedure not commonly accepted as standard care within the health profession, a letter describing the procedure or technology and the appropriateness of utilizing such techniques, must be submitted to the DHI/DHP Medical Affairs Division for review prior to scheduling the procedure.

Hospice

HMO & POS Policies

All hospice services are prior authorized on a case by case basis subject to the policy limitations outlined in the Member's Certificate. Prior authorization can be requested by contacting the DHI/DHP Medical Affairs Division at (608) 827-4024 or (800) 356-7344 ext. 4177 to review your case.

Pulmonary Rehabilitation

HMO & POS Policies

Phase I and II Pulmonary Rehabilitation is medically appropriate when:

- The rehabilitation is prescribed by the patient's physician and is provided at an approved facility

The program incorporates teaching and exercises with a goal for patients to resume home, recreational, and occupational activities, along with education to encourage lifestyle changes, thus preventing future hospitalizations.

Pulmonary Rehabilitation for other diseases such as pulmonary vascular disease and lung resections may be covered if the patient has any of the following:



- Chronic and restrictive lung disease
- Pulmonary vascular disease
- Lung resections

Treatment is limited to 16 visits along with the following ancillary services:

- Initial assessment (allowed to medically assess the patient prior to entering the program)
- 16 oximetries
- 4 blood gases

For additional information, please refer to MP9077 at www.deancare.com/healthplan_apps/MedPolicySearch/medsearchpolicy.asp

Transplants

HMO

The provider is required to prior authorize all services, including transplant work ups, by contacting our Medical Affairs Division.

POS

The member is required to prior authorize all services, including transplant work ups, by contacting our Medical Affairs Division.

Audiology Services

HMO

A referral request from the member's PCP is needed (only when services are provided in a clinic setting). Prior authorization is not required.

POS

Prior authorization is not required for audiology services.



Surgery

HMO

In general, HMO policies do not require prior authorization for surgeries or hospital services. Exceptions to this include cosmetic surgery or pre-op stays. Referral requirements may exist for outpatient physician services.

POS

The member is responsible for prior authorization and pre-certification of surgeries performed outside of a physician's office.

Diagnostic Tests

HMO

Health Maintenance Organization policies do not require a referral or prior authorization for diagnostic tests. Refer to MRA and Breast Imaging policies for specific guidelines.

POS

Prior authorization is needed for certain diagnostic tests (refer to MRI policy for specific guidelines). Most routine tests do not require subsequent authorization, however, examples that would require prior authorization include a biopsy and lesions scraping since these fall under the surgery classification. When unsure if a procedure will require prior authorization, you may call our Customer Service Department.

Referral Requests

Electronic Referral Submissions

If you are a DHP NaviNet™ enabled office, all referral request submissions are sent to DHP electronically via the secured Internet site <https://navinet.navimedix.com>. You will receive the response to your request electronically via DHP's NaviNet™. The member and referred to physician will receive DHP's response to the request via written correspondence.

If you are not a DHP NaviNet™ enabled office, then you must complete and submit the Referral Request Form and fax to Health Services at (608) 827- 4300.



Paper Referral/Prior Authorization Request Submissions

Once you have determined that you will need to complete a Written Referral Request Form, follow the guidelines below:

- Referral/prior authorization request forms should be mailed or faxed the date the request has been completed to insure timely processing of the referral request.
- When submitting the form to DHP, please complete **ALL** fields on the top part of the form in their entirety. **If all of the required fields on the Referral Request Form are not completed, the DHP Utilization Management Coordinator will return it to the referring physician for completion.**
- Referral/prior authorization requests must be signed by a physician, not a physician assistant or nurse practitioner.
- When a referral/prior authorization is requested to an **adjunctive or non-plan** provider the instruction sheet will assist providers in completing the single page referral form correctly. A **Utilization Management Coordinator** will review the referral to ensure appropriate care had been requested. Any changes or rejections will be communicated to the referring physician, consultant, and the member.

All copies of these referrals must be mailed to:

Dean Health Insurance, Inc./Dean Health Plan
Attn: Utilization Management
P.O. Box 56099
Madison, WI 53705

Only services that are not provided within the DHP provider network are considered for approval with a non-plan network provider.



REQUEST FOR REFERRAL INFORMATION

Tear off “member” information section below and give to member at the time the request for referral to a non network provider is completed

Physician/Office

This “Request For Referral” form is to be used when referring a member for medically necessary services away from their Primary Site/Provider. Please follow the steps outlined below to help avoid delays:

- ✓ This form **must be completed in full**. Attach or document all necessary information that will assist in making a determination.
- ✓ Referrals for 12 month duration are allowed for medically necessary services except physical, occupational, and speech therapy, and certain mental health services.
- ✓ Send the completed form to Dean Health Insurance, Inc./Dean Health Plan at the address listed on the bottom of the form. Requests **must be received in our office within seven (7) days of being written** to avoid possible claim denial(s), and meet our member’s processing expectations. Requests received later than seven (7) days will be considered late.
- ✓ Backdated requests **must indicate whether it is office or member error**. Backdated requests to non-network providers are not allowed.

Member Error Criteria

- Covered benefit.
- Services were provided by a network provider.
- You agree the request is medically appropriate.

Office Error Criteria

- Covered Benefit
- Services were with a network provider
- Member was referred by you, however paperwork was not submitted.
- ✓ Referral Requests to non-network providers are considered only when requested services are not provided within our plan provider network. All requests for services with non network providers require prior authorization and must be approved in writing by Dean Health Insurance, Inc./Dean Health Plan prior to the member receiving services. Call Dean Health Insurance, Inc./Dean Health Plan Customer Services if you need to determine the participation status of the physician/facility.
- ✓ **Requests for urgently needed services with a non-network provider can be faxed to (608) 836-6516 for review.**
- ✓ All necessary labs, X-rays or other diagnostic testing needed either prior to or after the visit should be performed within the plan network. **Results should be sent with member. If the consultant(s) needs to order tests to complete the evaluation, they will be informed of the need to contact the Utilization Management to obtain approval before providing these services.**
- ✓ Requests for 2nd opinion are approved with network providers. **Request for 2nd opinion with non-network providers will be considered for approval if the services are not available within the network. If approved, approval will be for one (1) visit, for physician services only.**

Dear Dean Health Plan/Premier member:

You have been referred to a healthcare practitioner outside of your primary care site.

For a Dean Health Plan Practitioner - you receive services for covered benefits without prior approval from Dean Health Plan.

For a non Dean Health Plan Practitioner - You MUST OBTAIN WRITTEN APPROVAL from Dean Health Insurance, Inc./Dean Health Plan **before you receive services to receive coverage for this requested referral. We will mail a copy of your processed request within one (1) working day following our receipt of all necessary information needed to reach a decision.** If more than five (5) working days have passed since your referral was written, you may contact our Customer Service Department at (800) 279-1301 between the hours of 7:30 AM to 5:00 PM, Monday through Thursday, Fridays between 8:00 AM to 4:30 PM regarding the status of your referral. For TDD assistance, call 608-827-4086.

