

**2010 – 2011 KARMANOS****DMC Care SPD Amendments / Summary of Material Modifications:**

- 1) Power Operated Wheelchair
- 2) Immunization Update
- 3) Immunization Addition
- 4) Skilled Nursing Facility Benefit
- 5) Hospice Care
- 6) 2011 Prior Authorization List (Exhibit A)
- 7) Bariatric Surgery (Exhibit B)
- 8) Skilled Nursing Facility & DME – Power Operated Wheelchair
- 9) Hospice Benefit
- 10) Podiatry Benefit
- 11) Sterilization
- 12) Infertility
- 13) 2011 Benefit Summary Grid Co-pay Changes
- 14) Benefit Maximums
- 15) Behavioral Health and Substance Abuse (BHSA)
- 16) BHSA Benefit Summary Grid
- 17) Prescription Drug Plan

1. **Page 4, 2010 Medical Benefit Summary Major Changes**

(Addition of 2011; Update to Power Operated Wheelchairs or Vehicles limitation)

**Should read:** 2010 – 2011 Medical Benefit Summary Major Changes

**Should read:** Power Operated Wheelchairs or Vehicles  
 •One (1) every 5 years – Prior Auth Required

2. **Page 10, Section 2 – Immunizations**

(Update HPV Vaccine)

**Should read:**

<b>9 – 26 Years/Female and Male:</b>
--------------------------------------

3. **Page 10, Section 2 – Immunizations**

(Addition of Herpes Zoster Vaccine)

**Should read:**

<b>60 Years or Older:</b>
---------------------------

•Herpes Zoster Vaccine
------------------------

4. **Page 10, Section 2, Skilled Nursing Facility, Sidebar**

(Delete the words per lifetime and insert the word annually)

**Should read:** SNF benefits are limited to 365 days annually. The 365 day limit will be reduced 2 days...

5. **Page 12, Section 2, Hospice Care, last sentence of paragraph.**

(Remove the word lifetime and insert the word annual)

**Should read:** Benefits are subject to an annual maximum of \$10,000.

6. **Pages 14 – 16, Section 2, 2010 Prior Authorization Requirements**  
(Change year to 2011 and reference 2011 Prior Authorization Requirements)

**Should read:** 2011 Prior Authorization Requirements

**See:** EXHIBIT A – 2011 DMC Care Prior Authorization Requirements

7. **Page 18, Section 2, Bariatric Surgery (continued), Qualifying Medical Criteria**  
(Delete Qualifying Medical Criteria 1 – 9)  
(Insert Bariatric Surgery Candidate Clinical Assessment Screening Checklist)

**Should read:** Bariatric Surgery Candidate Clinical Assessment Screening Checklist

**See:** EXHIBIT B – Bariatric Surgery Candidate Clinical Assessment Screening Checklist

8. **Page 20, Section 2, Exclusions and Limitations – Skilled Nursing Facility (SNF), 1<sup>st</sup> sentence**  
(Delete the words per lifetime; insert the word annually)

**Should read:** Benefits are limited to 365 days annually.

9. **Page 20, Section 2, Exclusions and Limitations – Hospice**  
**Page 20, Section 2, Exclusions and Limitations – Durable Medical Equipment, Power Operated**  
(Delete the word lifetime and insert the word annually. WC: delete the word lifetime: insert every 5 years)

**Should read:** Benefits are subject to a maximum of \$10,000 annually and require prior authorization.

Power Operated Wheelchairs or vehicles are limited to one every 5 years (prior auth required)

10. **Page 21, Section 2, Exclusions and Limitations – Podiatry, 1<sup>st</sup> bullet**  
(Addition of the word routine)

**Should read:** •Routine treatment for corns, calluses, or toenails is not covered unless you are...

11. **Page 22, Section 2, Exclusions and Limitations – Sterilization**  
(Title change and sentence addition)

**Should read:** **Sterilization and Sterilization Reversal**

Elective Sterilization using Vasclip® is not a covered benefit.

Surgical reversal of a previous Sterilization is not a benefit.

12. **Page 22, Section 2, Exclusions and Limitations – Infertility, last sentence in paragraph**  
(Delete last sentence; add excluded procedure as last sentence in paragraph)

**Should read:** Thawing of cryo-preserved embryo is not a covered benefit.

## 13. Page 23, Section 2, Benefit Summary Grid

(Remove the word deductible under Emergency Care and Urgent Care)

(Update Emergency Care, Urgent Care, Office Visits (Well Child, Annual Physical, GYN, Specialist, Podiatric, Pre/Post Natal) Co-pays)

(Addition of International Benefits)

**Should read:**

DMC Care 2011	DMC Care Basic Network	Out of Basic Network
<b>Hospital outpatient/Outpatient Facilities</b>		
Emergency Care (EC)	\$55 EC co-pay waived if admitted	\$155 EC co-pay waived if admitted
Urgent Care	\$15	\$30
<b>Physician Services</b>		
Office Visit Co-Pay	\$15	No Change
Well Child Office Visit (Infant to 2 years)	\$15	No Change
Annual Physical Adults & Children >2 yrs	\$15	No Change
GYN Office Visit	\$15	No Change
Specialist Office Visit	\$15	No Change
Podiatric Office Visit	\$15	No Change
Pre/Post Natal Office Visit	\$15	No Change
<b>International Benefits</b>	Emergency Services Only	

14. Page 24, Section 2, Benefit Maximums, 1<sup>st</sup>, 4<sup>th</sup>, 5<sup>th</sup> bullets

(Delete the word lifetime or per lifetime; add the word annual or annually)

(Insert Voluntary Interruption of Pregnancy (VIP) as 8<sup>th</sup> bullet)

**Should read:** 1<sup>st</sup> Bullet: •Total Annual Benefit Maximum (Mental Health included) \$2,000,000

4<sup>th</sup> Bullet: •Skilled Nursing Facility Maximum: 365 days annually, reduced by 2 days...

5<sup>th</sup> Bullet: •Hospice Annual Benefit Maximum: \$10,000

8<sup>th</sup> Bullet: •VIP Maximum: One procedure per lifetime; additional procedures require prior auth

15. Page 25, Section 3, Behavioral Health & Substance Abuse, 2<sup>nd</sup> Sidebar

(Delete the word Lifetime and insert the word Annual)

**Should read:** Mental health included in Annual Maximum Benefits of \$2,000,000.

## 16. Page 25, Section 3, Behavioral Health &amp; Substance Abuse

(Update Office Visit Co-pay)

(Under Residential Treatment (Behavioral Health only) delete the word Lifetime and insert the word Annual)

**Should read:**

BHSA Benefit 2010 – 2011	DMC / Value Options In-Network	Value Options Out of Network
Office Visits	\$15 Co-pay per visit	No Change
Residential Treatment (Behavioral Health only)	365 Day Annual Limitation – Reduced by 2 Days for Each Day of Acute Hospitalization	

## 17. Pages 28, Section 4 – Prescription Drugs, 2010-2011 Prescription Drug Plan, DMC “On Site,” Navitus Network Pharmacies and Pharmacies Outside the Navitus Network

(Co-pay changes for Generic Drugs, Formulary Brand Name and Non-Formulary Brand Name)

**Should Read: DMC “On-Site” Pharmacies****Generic Drugs**

\$7 co-pay per prescription

**Formulary Brand Name**

\$20 co-pay per prescription

**Non-Formulary Brand Name**

\$30 co-pay per prescription

**Navitus Network Pharmacies****Generic Drugs**

\$17 co-pay per prescription

**Formulary Brand Name**

30% co-pay per prescription with \$35 minimum, \$50 maximum

**Non-Formulary Brand Name**

40% co-pay per prescription with \$60 minimum, \$100 maximum

**Pharmacies Outside the Navitus Network****Generic Drugs**

\$17 co-pay per prescription

**Formulary Brand Name**

No Change

**Non-Formulary Brand Name**

No Change

**Attachments (2):****Exhibit A** – DMC Care 2011 Prior Authorizations Requirements**Exhibit B** – Bariatric Surgery Candidate Clinical Assessment Screening ChecklistSection 7 Amendments to the 2010 – 2011 Summary Plan Description for the DMC Medical and Prescription Plan booklet will be available online at: [www.dmc-care.org](http://www.dmc-care.org).

# DMC Care - 2011 Prior-Authorization Requirements

# Exhibit A

You must call 877-501-0958 for pre-authorization before you or any of your covered dependents receive the following medical services marked with an X:

<b>INPATIENT CARE (All inpatient admissions require notification prior to admission)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
All Elective In-Patient Hospital Admissions	X	X	X	X
Emergency / Urgent Admissions	X	X	X	X
Obstetrical (OB) Admissions (exceeding 48 hrs LOS for vaginal delivery & 96 hours for C-Section delivery) <sup>1</sup> (NEW)	X	X	X	X
All Rehab Admissions (prior to admission)	X	X	X	X
All Skilled Nursing Facility Admissions (prior to admission)	X	X	X	X
All Sub-Acute Admissions (prior to admission)	X	X	X	X
<b>OUTPATIENT DIAGNOSTIC PROCEDURES</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
CT Scan (any anatomic location)	Not Required	X	X	X
MRI/MRA (any anatomic location)	X	X	X	X
PET Scan	Not Required	X	X	X
CTA (Computed Tomographic Angiography) (Non- Cardiac)	Not Required	X	X	X
CTA/CCTA(Computed Coronary Tomography Angiography) <sup>2</sup>	X	X	X	X
Capsule Endoscopy	X	X	X	X
Cardiac Event Monitors (Real-time continuous) (NEW)	X	X	X	X
Following services provided in a doctor's office will not be covered: MRI/MRA, CT Scan, PET Scan, CTA, CCTA,	Not Covered	Not Covered	Not Covered	Not Covered
<b>SURGICAL PROCEDURES</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Sclerotherapy/Ligation of Varicose Veins (All Treatments/Surgery)	X	X	X	X
Breast Repair and/or Reconstruction (Related to non-cancer diagnosis or history)	X	X	X	X
Breast Reduction -Mammoplasty	X	X	X	X
Uterine Artery Embolization	Not Required	X	X	X
Bariatric Surgery	X	Not Covered	Not Covered	Not Covered
Cochlear Implants (Age Restrictions, Coverage: DMC Care Plus Only)	X	Not Covered	Not Covered	Not Covered
All Spinal (Back)	X	X	X	X
Any Cosmetic Procedure- (Performed at a Facility) (See list per SPD Manual. Does not include mole removal, skin lesion removal or skin tag removal)	X	X	X	X
Transplants (Organ, Bone Marrow & Corneal) & Related Services <sup>3</sup>	X	X	X	X
Keloids (Surgery) (NEW)	X	X	X	X
<b>REHABILITATION THERAPY</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Physical Therapy, Occupational Therapy or Speech Therapy (17 years of age and under)	X	X	X	X
Physical Therapy, Occupational Therapy or Speech Therapy (Extension Beyond 30 visits-regardless of age)	X	X	X	X
Cardiac and Pulmonary Rehabilitation Services	X	X	Not Covered	Not Covered
<b>HOME HEALTH CARE</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hospice (Inpatient/Home)	X	X	X	X
Home Care (Skilled Nurse, Social Worker, Home Health Aide, Other)	X	X	X	X
Physical Therapy/Occupational Therapy/Speech Therapy	X	X	X	X
Infusion Therapy	X	X	X	X
<b>OTHER</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hemodialysis / Home Dialysis/ CAPD (Continuous Ambulatory Peritoneal Dialysis) (REVISED)	X	X	X	X
Infusion Therapy (Covered only for Facility Based or Infusion Center) Exception: chemotherapy for cancer related care	X	X	X	Not Covered
Botulinum Toxin (Botox/Myobloc) (Physician Office)	X	X	X	X
Hyperbaric Oxygen Therapy	X	X	X	X
Unique Services/Procedures (Including Not Available at any DMC Facility)	X	X	X	X
Donor Transplant Related Services	X	Not Covered	Not Covered	Not Covered
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>

Durable Medical Equipment (DME) - (Single purchase items with costs/purchase price greater than \$1,000) (REVISED WORDING)	X	X	X	X
All DME Rentals including but not limited to C-PAP, BiPAP, Oxygen, Insulin Pumps, Ventilators, Wound Vacuums	X	X	X	X
Prosthetics and Orthotics (including braces) over \$1,000 per item (REVISED WORDING)	X	X	X	X
Vagus Nerve Stimulator, Bone Growth Stimulator, Sacral Nerve Stimulator, Neuromuscular Electrical Stimulator, Spinal Stimulator, Electrical Stimulators (NEW)	X	X	X	X
Continuous Glucose Monitoring Devices (NEW)	X	X	Not Covered	Not Covered
Enteral Formula	X	X	X	X
Communication Devices	X	X	X	X
<b>GENETIC TESTING</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Oncotype DX Breast Cancer Assay (Breast Cancer only)	X	X	X	Not Covered
Breast Cancer: BRCA 1 & BRCA 2 Genetic Testing	X	X	X	X
Genetic Testing (All Types)	X	X	X	X

**Please note:** Authorization of a service/procedure does not eliminate the member's responsibility for co-pays, deductibles or coinsurance. Authorization of a service DOES NOT guarantee payment.

\* = Tier 2, 3, & 4 services will result in higher out of pocket costs for the member (co-pays & co-insurance)

REVIEW LIMITATIONS/EXCLUSIONS FOR CERTAIN SERVICES AS DETAILED IN THE DMC CARE SUMMARY DESCRIPTION PLAN (SPD) BOOKLET FOR 2010-2011

**AUTHORIZATION EXCEPTIONS:**

<sup>1</sup> Authorization is required for OB deliveries that exceed the standard admission timelines: 48 hours for Vaginal & 96 hours for C-Section

<sup>2</sup> Coronary CTA must be ordered by a Cardiologist

<sup>3</sup> Tier 2, 3, & 4 Transplant services managed per DMC Care Transplant Network

**Mental Health/Behavioral Health Services – CALL VALUEOPTIONS (877-362-2472) prior to starting treatment or services for mental health, behavioral health or substance abuse needs.**

**NOTE:** This list may be updated throughout the year. Please check the HYPERLINK <http://www.dmc-care.org> website or call 1-800-543-0161 for the most current listing.

DMC CARE BARIATRIC SURGERY CANDIDATE CLINICAL ASSESSMENT  
SCREENING CHECK LIST

EXHIBIT B

Date of Request: \_\_\_\_\_

DMC Care Karmanos

Member Name: \_\_\_\_\_

Member ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Physician/Surgeon: \_\_\_\_\_

The DMC Care Bariatric Surgery benefit requires that specific qualifying medical criteria must be met to support the medical necessity for the surgical procedure. Documentation must be submitted to DMC Care Medical Management for review and formal authorization by the plan's Medical Director before the surgery can be done.

DMC Care Medical Management Contact Information: Phone: 1-877-501-0958 Fax: 313-745-0930

1. BMI \_\_\_\_\_

2. Co-morbidities (Check all that apply):

Cardiovascular Disease

Type 2 Diabetes

Hypertension

Coronary Artery Disease

Pulmonary Hypertension

Sleep Apnea

3. Active participation **within the last two years** in a weight loss program for a **minimum of 6 consecutive months** under the supervision of a physician or registered dietitian (See below for required documentation):

a. Weight Management Program:

Weight Watchers  Jenny Craig  Medical Weight Loss

Other: \_\_\_\_\_

b. Dates of Participation: From: \_\_\_\_\_ To: \_\_\_\_\_

c. Name of Physician/Dietitian: \_\_\_\_\_

4. Monthly records for a period of **at least 6 consecutive months** documenting participation in a weight management program that meets **ALL** of the following criteria:

Weight measurements done

Compliance with dietary regimen attempted

Compliance with exercise regimen attempted

Behavioral modification

5. Evaluation within the last 12 months which includes **ALL** of the following:

Evaluation by bariatric surgeon recommending surgery

Medical clearance from a physician other than bariatric surgeon

Clearance for bariatric surgery by a mental health provider: psychological evaluation

Nutritional evaluation by a physician or registered dietitian

Letter from primary care doctor

6. Medical documentation supports that Member does not have **ANY** of the following conditions that would exclude them from the benefit

- Active substance abuse
- Non-compliance with previous medical care
- Terminal disease
- Pregnancy
- Severe psychopathology