PreferredOne

UPDATE

A NEWSLETTER FOR PREFERREDONE PROVIDERS

PreferredOne
6105 Golden Hills Drive
Golden Valley, MN 55416
Phone: 763-847-4000
800-451-9597
Fax: 763-847-4010

CLAIMS ADDRESSES:

PreferredOne PPO
P.O. Box 1527
Minneapolis, MN 55440-1527
Phone: 763-847-4400
800-451-9597
Fax: 763-847-4010

PreferredOne Community Health Plan (PCHP)
P.O. Box 59052
Minneapolis, MN 55459-0052
Phone: 763-847-4488
800-379-7727
Fax: 763-847-4010

PreferredOne Administrative Services (PAS)
P.O. Box 59212
Minneapolis, MN 55459-0212
Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

PREFERREDONE WEBSITE:

www.preferredone.com

The PreferredOne Insurance Carrier – TPA Payer Relationships Listing is available on the Secured Site, or you may call PreferredOne at 800-451-9597 or 763-847-4000. Ask to be transferred to Network Management to request a paper copy.

NETWORK MANAGEMENT UPDATES

UnitedHealthcare (UHC) Enrollees to Term with PreferredOne 5/1/03

by Donna Larson, Director Provider Operations

PreferredOne and UnitedHealthcare have reached an agreement that effective 5/1/03, UHC enrollees will no longer have access to the PreferredOne PPO network for in-network benefits. ID cards that have PreferredOne on them should be considered out of date.

PreferredOne will continue to process electronic and paper claims with dates of service prior to 5/1/03. Customer Service will also be available to assist you if you have any questions on claims prior to 5/1/03.

No action will be taken on claims received with dates of service 5/1/03 or later and questions must be directed to UHC.

HIPAA Update

Privacy

by Lori Nelson, Vice President Network Management

For purposes of complying with our provider agreement and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and its Privacy Rules, Code of Federal Regulations Part 45, Sections 160 and 164, providers may share member information for treatment, payment and health care operation functions with PreferredOne. Some sharing of information for operational purposes require what is called a Business Associate Agreement (BAA) as defined at 45 CFR §160.103. The Privacy Rules, however, allow providers and PreferredOne to share information for treatment and payment purposes without entering into a BAA. BAAs are necessary only if you provide other services to PreferredOne, such as case management or peer review. Thus, PreferredOne does not believe a Business Associate addendum to our agreement needs to be completed at this point in time. However, as a "HIPAA Covered Entity" it is your responsibility to understand and comply with the HIPAA Privacy Rules. As a health care provider you are obligated to develop and implement procedures and practices to safeguard access and handling of Protected Health Information (PHI).

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HIPPA Updates Continued from Page 1

The compliance deadline for the Privacy Rules is April 14, 2003. For further information regarding HIPAA and your obligations there under, please contact your legal counsel.

Transactions and Code Sets

by Ed Stroot, Manager Electronic Commerce

PreferrredOne is progressing towards a compliance date of October 16, 2003, with the mandated transactions, code sets, and identifiers require by HIPAA. To achieve this goal, PreferredOne is participating in the Minnesota HIPAA Collaborative. The Collaborative consists of Minnesota health plans and providers. Founding members are:

Allina Hospitals and Clinics
Blue Cross and Blue Shield of Minnesota
Fairview Health Services
HealthPartners
Mayo Foundation
Medica
Park Nicollet Health Services
PreferredOne
Government Participant: MN Department of Health Services

The Minnesota HIPAA Collaborative is focused on developing collaborative work products and recommended practices for achieving HIPAA compliance. These work products will be shared with the healthcare community through a public website and communications program. These work products will include:

- Companion guides with collaborative member rules and edits for the transactions. **Note: these companion guides will detail what PreferredOne's rules and data requirements are for each transaction.**
- Recommended methods and practices for security, connectivity, and testing.
- Schedules showing when Collaborative members will be ready for testing.
- A free tool for testing your compliance with the mandated transactions.

For more information about PreferredOne's HIPAA compliance efforts and the Minnesota HIPAA Collaborative, please access the following website:

http://www.mnhipaacollab.org/

We encourage you to visit the Minnesota HIPAA Collaborative website for compliance information about PreferredOne, and the other collaborative members.

Credentialing

by Kathy Grigsby, Credentialing Supervisor

New Recredentialing Cycle

At the last Credentialing Committee meeting, the committee voted to change from a 2 year recredentialing cycle to a 3-year cycle. Although hospitals must still comply with the 2 year cycle that JACHO requires, URAC and NCQA have changed their requirements to 3 years which is now becoming community standard. PreferredOne began this transition in January.

Data Change Request Forms

PreferredOne, in collaboration with Blue Cross and Blue Shield of Minnesota, UCare Minnesota, Medica, and HealthPartners has developed and now accepts the new Minnesota Uniform Practitioner Data Change Request Form and the additional Site Location Addendum for updating practitioner-specific demographic information.

It is now possible for clinic personnel who submit practitioner demographic changes to complete the forms once and then submit copies of them to the four health plans mentioned above. The forms are available on the Web site for the Minnesota Association of Medical Staff Services (MAMSS) at **www.mamss-mn.org**, under "MN Forms/Applications" and will soon be available on the PreferredOne website.

Please remember a copy of the malpractice insurance certificate must be provided with the above form to PreferredOne when adding a credentialed provider to a new clinic.

Data Change Request Forms and copies of malpractice insurance can be faxed to PreferredOne at 763-847-4010. This form does not include clinic closings or additions, site or billing address and phone number changes, name and Federal Tax Identification Number changes. These changes should continue to be sent in writing to your Provider Relations Representative.

PreferredOne PPO Claims Follow-up Procedures

by Dan Van Orsow, Manager Provider Relations

For outstanding claim issues, PreferredOne requires Provider follow-up with our PPO payers. We suggest this be done within 45 days of submission. Here are steps to take when checking claim status.

1. Verify claim receipt at PreferredOne. This can be accomplished in two ways:

   A. Go to PreferredOne's Secure Website at **www.preferredone.com** and then to Providers to check claim status and review the following information:

   - Claim receipt date at PreferredOne
     - Itemized contractual repriced amounts
     - Date claim was processed and sent to the payer
     - Payer address and phone number

   *If currently not connected to the PreferredOne's Secure Website go to **www.preferredone.com**, Providers and then to Register and complete the information requested.

   B. If Internet access is not available, the above information can be obtained through our PPO Customer Service at (763) 847-4400 or (800) 451-9597.

2. If the claim has been received at PreferredOne, contact the payer to check claim status. If claim has not been received at PreferredOne, verify on either our secured website or at PreferredOne Customer Service if the group number is valid. If the group number is valid, resubmit the claim to PreferredOne. If not, contact patient for updated information.

3. If the payer shows receipt of the claim, verify claim processing date, payment amount, and request a copy of the EOB if needed. If claim and/or repricing have not been received,

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PreferredOne PPO Claims Follow-up Procedures Continued from Page 2

obtain fax number from payer. The PreferrdOne repricing information can be printed from our secured website or call PreferredOne Customer Service for forwarding of repricing to the payer.

4. If you receive an EOB from the payer that contains an incorrect payment according to the PreferredOne repricing, fax the repricing sheet to the payer.
5. If the claim is repriced appropriately and you have additional questions regarding reimbursement relating to coding, benefits or denial of services, an appeal in writing should be sent to the payer. If the concern is not addressed to your satisfaction, submit an appeal to PreferredOne in writing to your Provider Relations Representative.
6. If you are submitting the claim for the third time within 90 days of the original submission, contact the payer for claim status or the patient for updated insurance information.
7. If you have not received a remittance advice after 90 days from the payer's receipt of your claim, it is acceptable to bill the member.

Please contact your Provider Relations Representative if you have any questions or difficulties throughout this process.

Secured Web Site

by Dan Van Orsow, Manager Provider Relations

If you have Internet access and are interested in member, claims, referral and payer information pertaining to your clinic or facility, you can register for PreferredOne's Secured Web Site. Go to **www.preferredone.com** and click on Access Your Online Account, Providers and Register. Within 5 business days, you will receive a Log in ID and password for online secured access.

Listed below is the information available on our secured web site:

- **PCHP / PAS Products**
  - Member Eligibility
  - Claims Inquiry
  - Referral Inquiry
  - Referral Submission
  - PCC Roster
- **PPO Products**
  - Member Information
  - Claims Inquiry
  - PPO Group/Payer Lookup
  - PPO Payer Listing
  - PPO Reports
- **Information**
  - Medical Policy
  - Coding Hot Topics
  - Provider Newsletter

If you have any questions about our Secured Web Site, please contact your Provider Relations Representative.

Coding Update

by Elaine McLinden, Manager Coding

Telemedicine Policy:

For telemedicine services provided by an interactive telecommunication system, please see the new policy (Exhibit A) included in this newsletter. Approved originating facility sites as described in the policy are rural hospitals, critical access hospitals, rural health clinics, and federally qualified health centers.

HCPCS codes H, T, S:

These services are primarily for government programs for Medical Assistance. Claims received will be denied, asking for resubmission with appropriate CPT codes and/ or revenue codes specific to your contract for mental health/substance abuse/chemical dependency.

S codes for injectable drugs will be accepted.

Most other "S" codes will be denied, with an EOB message to resubmit using CPT codes. Many of the S codes are duplicates of CPT codes. The only exception to the S codes, are the Home Health/Home Infusion Codes which are discussed below.

Home Health/ Home Infusion:

Due to HIPPA requirements to eliminate local or internal codes, PreferredOne has developed a new Home Health/Home Infusion Fee Schedule. If you are a contracted provider for these unique services, you have already received instructions and a copy of the limited CPT/ HCPCS codes that are included in the new schedule. Please note that not all of the codes listed in CPT/ or HCPCS for Home Health/ Home Infusion services are eligible for submission. A limited number of HCPCS - S codes and CPT codes were selected for these contracts. Beginning April 1, 2003 you must use the codes on the new schedule. Until April 1, you may use either the new codes, or the PreferredOne codes on the old schedule.

Updated Lab Policies P-5, P-8:

We have updated our lab test/ and venipuncture handling policies (Exhibits B & C) with current CPT codes. PreferredOne continues to recommend 1 venipuncture for a patient encounter regardless of the number of blood specimens drawn, and one handling fee for a non blood specimen regardless of the number of specimens referred to an outside Lab. As an example, if a patient had a pap smear and a general health panel, the provider may submit CPT 99000 for the handling of pap smear, and 36415 for the venipuncture. Modifier –90 must be added to any tests that are sent to a reference lab.

PreferredOne does not recommend reimbursement for capillary or finger sticks CPT 36416, and considers this a bundled service.

Pediatrix- new immunization CPT 90723:

The code has been entered into our system and providers may bill for this service.

Health & Behavior Assessment/Intervention CPT 96150- 96155:

These services can be billed by the following mental health providers; psychologists, advanced practice nurses, and clinical social workers. Services should be submitted on a HCFA with the name and PreferredOne provider number of the mental health

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*The PreferredOne Provider Update is now available on the secured site at **www.preferredone.com**.

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professional rendering the service. The January 2002 issue of the CPT Assistant published by the AMA clarified that MD, pediatricians, and psychiatrists were ineligible to report these services. MD's pediatricians and psychiatrist's can report E/M codes for education /and counseling of medical conditions.

The mental health provider should report the patient's medical diagnosis for the service. PreferredOne continues to review these services on a case by case basis, and may request supporting documentation from time to time.

Changes for submission of "units" for Mental Health on HCFA 1500 for DOS beginning 01/01/03:

As discussed in earlier newsletters, when the Current Procedural Terminology Manual (CPT) is silent on time for a particular service, the service is considered an event with a 1 unit maximum. Providers are no longer able to submit multiple units of time. The relative value units have been adjusted for this change.

The codes identified are:

90801, 90802, 90846, 90847, 90849, 90853, 90857, 90885, 90887.

If a diagnostic interview is performed over two days, submit the day the interview began as the DOS and use 1 in the units box. This is considered a one time event even though part of the interview began on one day and concluded on another.

Therapy on recurring days:

As an example, group therapy, or family therapy performed on successive days should be submitted as separate line items as follows:

01/03/03	90853	(group therapy)	1 unit
01/04/03	90853	(group therapy)	1 unit

Changes in Units for Speech for DOS 01/01/03:

The descriptions for speech therapy services are also silent on time. CPT considers this to be an "event" and therefore units of time are not appropriate. The relative values units have been adjusted for this change.

Global OB Package:

PreferredOne currently follows CPT guidelines with regard to the initial visit being part of the global OB package. While state programs may separately reimburse for prenatal education (H1000 – H1005) PreferredOne does not separately reimburse for these services. They are included within the global OB package, or one of the antepartum packages when the patient does not continue with clinic for the entire pregnancy.

NEW PRODUCT INFORMATION

Consumer Advantage?

by Eugene Sako, Manager Product Development

PreferredOne is pleased to announce the launch of its *Consumer Advantage?* program. Marked by the January 1st effective date of four employer groups (Lakeland Engineering, Stevens Community Medical Center, Amcon Block & Precast, and Hoffco Inc.), the program is available to both fully insured and self-insured business.

Consumer Advantage? is PreferredOne's defined contribution - consumer directed benefit program. *Consumer Advantage?* is built entirely within PreferredOne's administrative services and combines the employer's existing level of benefit coverage (deductible medical plan), with consumer involvement (individually tracked consumer account used to pay for deductible claims). Unlike competing products, which typically broaden the benefit to the individual, *Consumer Advantage?* supports the employer's current medical plan benefits along with a corresponding provider network. *Consumer Advantage?* doesn't promote the increased liability of expanded services, e.g., LASIK, cosmetic surgery, aromatherapy, etc.

Consumer Advantage? promotes easy entry for both employers and their employees as they embark down the path of consumer directed healthcare. All claims are processed by PreferredOne beginning with medical benefit claim processing and followed by the individual's consumer account processing. The purpose is to allow deductible claims to be reprocessed for payment by available funds in the individuals consumer account.

For providers, this means that *Consumer Advantage?* member claims are subject to normal provider billing procedures (to PreferredOne), with the potential for a claim remittance first for the medical benefit, followed by the same claim remitting from the consumer account. By properly entering both, results will reflect either payment in full or a remaining member responsibility. If a claim is initially processed and the deductible is met, plan benefits will apply and no further processing occurs.

PreferredOne offers the *Consumer Advantage?* program as an additional option for our current and prospective clients as they seek viable options for the successful sponsorship of the employee health benefit.

MEDICAL MANAGEMENT UPDATES

2002 in Review

by Dr. John Frederick, Vice President/Chief Medical Officer

2002 was another successful year for PreferredOne. Although the PPO product line has continued it's expected decline in enrollment due to market changes and the economy, the PreferredOne Community Health Plan (PCHP) and PreferrredOne Administrative Services (PAS) products have grown beyond expectations. The bottom line financial expectations were exceeded. The budget for 2003 has been approved by the Board of Directors and aggressive goals have been set for enrollment and profitability. Despite the fact that United Healthcare has decided to move it's membership from PreferredOne to Medica's Laborcare product effective May 1, 2003, we have achieved nearly half of our enrollment goals with January new groups.

Medical Management accomplishments in 2002 include URAC accreditation, US Dept. of Labor regulation implementation, transition to the Express Scripts national formulary, HIPAA implementation, updating of the case review training program for PPA physicians, and heavy involvement with the Diabetic Community Measurement project

PreferredOne is on schedule to be HIPAA compliant by the April 14, 2003 deadline for Privacy Rules. We expect that most privacy issues relating to providers will fall under the Treatment, Payment, and Operations (TPO) provisions which allows the use of Protected Health Information (PHI) without an authorization from the individual.

Thank you for your continued support and participation. We look forward to a successful 2003.

PreferredOne Medical Management Review Process Changes by Tammy Bentz, Director of Medical Management

PreferredOne's Medical Management review process has changed in response to the U.S. Department of Labor claim regulations issued on 11/21/00 and effective no later than 1/1/2003. It is anticipated that each state will evaluate their utilization review legislation in light of making it more similar, if not the same, to the Department of Labor Claim regulations. URAC (Utilization Review Accreditation Commission), a national certification agency for utilization review organizations, is currently re-evaluating it's standards in light of the new Department of Labor Claim regulations. PreferredOne has had URAC utilization review accreditation since 1992. PreferredOne, in alliance with the American Association of Health Plans, is in dialogue with URAC as they evaluate bringing their standards in alignment with the DOL regulations. Our revised policies follow federal and state requirements.

Under the Department of Labor Claims regulations, pre-certification (pre-service), concurrent and post-service (retrospective) reviews may now be considered claims subject to the DOL claims regulations. Dependent on the medical circumstances and timing of the review request, urgent types of reviews must be completed as soon as possible but no longer than 24 – 72 hours, non-urgent review requests 15 days, and post-service reviews 30 days. Extensions to these timelines are available in specific situations. Under the new regulations, plans can require 1 or 2 appeal levels for each claims process: pre-service, concurrent, and post-service. Timelines are attached to each appeal option. The plan fiduciary is required to make the final (and sometime the only) appeal determination. PreferredOne is the fiduciary for PCHP and select PAS plans. We will assist the fiduciary to complete appeals, when asked, by helping find the appropriate review specialty and issuing a letter on behalf of and at the direction of the fiduciary.

There are also several other key differences in the Department of Labor Claim regulations that differ from URAC and state regulatory language. Time (hours and days) is measured in actual time and days, not business hours and business days. Requests can no longer be pended indefinitely for lack of information, they must be denied within defined timeframes. The regulations shift the responsibility for initiating prospective and concurrent utilization review to the member or their authorized representative. PreferredOne considers the provider to be the authorized representative unless the member directs us otherwise.

PreferredOne's review staff will advise you when we are operating under tight review timelines and the goal is to avoid issuing a denial. Please note that in some situations, the member will only be eligible for one appeal which may have to be done by the plan fiduciary which may not be PreferredOne. It is in everyone's best interest to avoid using that appeal to resolve insufficient information issues.

Also, for plans subject to ERISA regulations there are additional mandatory information requirements that must be provided;

- A statement that copies of all medical records, guidelines, and criteria considered in reviewing the request are available upon request and free of charge.
- A statement that the identity of all case (peer) reviewers consulted during the determination (even if their advice was not relied upon in making the determination) is available upon request and free of charge.
  NOTE: Providing the name of the practice or the telephone number of the case reviewer is not required.

Please feel free to contact us if you have any questions or concerns as we change our processes to comply with the Department of Labor Claims regulations. I can be reached at 1-800-940-5049, extension 3232 or at (763) 847-3232 or at **tammy.bentz@preferredone.com**. You may also call DiAnn Smith, Manager of Medical Management, at (800) 940-5049, extension 3224 or at (763) 847-3224 or at **diann.smith@preferredone.com.**

MEDICAL POLICY UPDATES

Medical Policy
by Joni Riley, Medical Policy Specialist

Medical Policies continue to be available on the PreferredOne secured web-site. The web-site address is **www.preferredone.com**. Work continues to allow providers and members access without registration and should be completed in February. The latest Medical Policy index is attached indicating new and revised policies approved at recent meetings of PreferredOne's Quality Management Subcommittees. Upcoming meetings of the Medical/Surgical, Mental Health/ Substance-Related Disorders, and Pharmacy & Therapeutics Quality Management Subcommittees will result in additional new and revised policies. Please add the attached Medical Policy index (Exhibit D) dated 11/2002 to the Utilization Management section of your Office Procedures Manual and always refer to the on-line policies for the most current versions.

If you wish to have paper copies of policies or you have questions feel free to contact me at (763)-847-3238 or on line at **joni.riley@preferredone.com**.

Medication Request Form
by Kristine Jackson, Director Pharmacy Benefits

Medication Request Form: This form (Exhibit E) should be used by physicians to request Prior Authorized medications, nonformulary medications, and copay overrides on behalf of their members. The member's benefit design and plan set up may drive which medications can be reviewed and/or overridden. A review turn around time of 48 hours is requested and incomplete forms will be returned.

*The PreferredOne Provider Update is now available on the secured site at **www.preferredone.com**.

Upcoming Workshop Series

Building for Excellence
An interactive series of workshops to support care improvement initiatives

The *Building for Excellence Advisory Group,* which is made up of eleven health plans and quality organizations in Minnesota, including PreferredOne, invites health care professionals from clinics and hospitals to attend an upcoming three-part series of workshops aimed at providing:

- A model for supporting improvement initiatives in clinics and hospitals
- Ideas for integrating improvement into the daily work and culture of your facility
- Guidance in identifying and implementing principles of measurement, change management and patient-focused care

Session One – April

Workshop I: A Blueprint for Quality Culture and Leadership

Participation in this workshop will enable learners to:

- Describe the basic elements of quality improvement
- Discuss the model for improvement
- Explain how leaders enable change
- Recognize and evaluate successes in similar environments
- Assess progress of individual project implementations
- Assess barriers to quality improvement in individual healthcare settings
- Identify resources for supporting projects

Session Two - July

Workshop II: The Foundation: Data and Measurement

Participation in this workshop will enable learners to:

- Describe key measurement principles
- Identify measurement tools for individual projects
- Use data to formulate a compelling story for improving processes
- Discuss progress on data tracking and organizing for projects in process
- Evaluate success stories in light of measurement principles

Session Three – October

Workshop III: Erecting a Framework for Change Management and Patient Focused Care

Participation in this workshop will enable learners to:

- Relate patient-focused care concepts to individual operations
- Identify principles of change management
- Assess progress on individual projects
- Evaluate successes of real-life example projects
- Recognize the availability of tools in support of change management and patient-focused care

For a copy of the brochure or information on how to register, see the Stratis Health web site at: **www.stratishealth.org**, or contact Chere Wood at 952-853-8558 or **mnpro.cwood@sdps.org**.

Exhibits

Exhibit A	*Telemedicine Policy*
Exhibit B	*Coding Laboratory Test*
Exhibit C	*Venipuncture and Specimen Handling*
Exhibit D	*Medical Policy Index*
Exhibit E	*Medication Request Form*
Exhibit F	*2003 Express Scripts National Preferred Formulary*

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