PreferredOne

UPDATE

A NEWSLETTER FOR PREFERREDONE PROVIDERS

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6105 Golden Hills Drive
Golden Valley, MN 55416
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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
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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

Provider Update Available Online

by Donna Larson, Director Provider Operations

The Provider Update is issued three times a year for administrative and clinical PreferredOne participating organizations. This newsletter communicates general information including policies, procedures, and other updates to the Office Procedures Manual. Both current and previous Provider Updates are available on our web-site, **www.prerredone.com**.

Many organizations are able to access the newsletter on line and no longer receive a hard copy via the US Mail. The benefit of online access is more people in the organization have access. It also helps to reduce printing and mailing costs. We strongly encourage your organization to use this electronic exchange to access our provider newsletter.

If your organization has internet capabilities that include Acrobat Reader and you would like to receive an e-mail notification of the newsletter, please contact us at our web-site by clicking on "Contact Us." Please provide your name, clinic name, tax ID, and e-mail address. Be sure to put "Attention: Provider Relations" in the comment box and indicate you would like to receive the Provider Update notification through the Internet. Thanks for your support in our effort to provide a more efficient communication while eliminating paper.

Provider Claim Errors for UnitedHealthcare (UHC)

by Donna Larson, Director Provider Operations

We are continuing to see a high volume of UHC claims sent to PreferredOne in error. As previously communicated, UHC enrollees no longer have access to the PreferredOne PPO network for in-network benefits. PreferredOne will continue to process claims with dates of service prior to 5/1/03, however no action is taken on claims received with dates of service 5/1/03 or later. Before resubmitting any UHC claims that remain unpaid, be sure to confirm that you have the correct network recipient name and address in your billing system.

*The PreferredOne Provider Update is available at **www.preferredone.com**.

June 2003

In this Issue:

Requests for Medical Records

by Donna Larson, Director Provider Operations

As part of its quality, utilization, and operational management programs, PreferredOne occasionally requests copies of patient medical records. HIPAA allows a provider of medical services to share information with a health plan for treatment, payment and certain health plan operation purposes without a specific authorization from the patient.

Recently, we have begun to experience resistance from providers or copy vendors in cases where we are requesting member/patient information. We have been asked to obtain patient authorization before the clinic will release the records. HIPAA regulations allow health plans to obtain records without an authorization. Non-release of records will result in non-payment of a claim.

HIPAA regulations provide for the following disclosures of patient information without their specific consent or authorization;

Payment
45 CFR §164.506(c)(3) states that *"a covered entity may disclose protected health information to another covered entity or a health care provider for the payment activities of the entity that receives the information."* §164.501 goes on to clarify that payment activities that do not require an authorization from the individual include, *"Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services."*

Health Care Operations
45 CFR §164.506(c)(4) states that *"a covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information …and the disclosure is:*

(i) For a purpose listed in paragraph (1) or (2) of the definition of health care operations; or

(ii) For the purpose of health care fraud and abuse detection or compliance."

Purposes defined in paragraph 1 and 2 of the HIPAA definition of health care operations include:

- Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines
- Population-based activities relating to improving health or reducing health care costs
- Protocol development
- Case management and care coordination
- Contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment
- Reviewing the competence or qualifications of health care professionals
- Evaluating practitioner and provider performance
- Health plan performance
- Conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers
- Training of non-health care professionals
- Accreditation, certification, licensing, or credentialing activities

PreferredOne is committed to treating member and patient information with the utmost care. Thank you for your cooperation in providing us with the information necessary to effectively serve our members and your patients.

Secured Web Site

by Dan Van Orsow, Manager Provider Relations

PreferredOne continues to enhance the Secured Provider Web Site. New features include: **PCHP/PAS Reports**, **Forms** and the **Office Procedures Manual.**

The **PCHP/PAS Reports** section gives a clinic the ability to create a claims information report by patient for a specified date range by either date processed or date of service. The report includes claim status, paid amount, paid date, check number and check amount.

The **Forms** section provides you with the various forms that PreferredOne utilizes to obtain information from providers, including the Minnesota Uniform Credentialing Application.

The **Office Procedures Manual** is now available online for referencing PreferredOne policies and procedures, customer service telephone numbers, plan comparison matrix and our standard provider agreement.

The **Reminder: PPO Products Member Information** contains member information based solely on claims received data. PreferredOne does not receive individual member eligibility from our Payers. Our Payers are required to supply us with employer group information. A member is enrolled when a claim is received with a valid PreferredOne group number. For current member eligibility, please reference the members ID card or contact the Payer directly.

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

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Secured Web Site Continued from Page 2

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

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

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

Credentialing

by Kathy Grigsby, Credentialing Supervisor

New CVO

PreferredOne is contracted with Aperture, a national credentials verification organization (CVO), to handle all credentialing services for our network providers. This change is a result of business acquisitions by Ingenix Health Intelligence of which both Aperture and GeoAccess are subsidiaries. What this means to you is that you will now receive recredenitaling requests from Aperture rather than GeoAccess. You may also receive phone calls from Aperture regarding missing or more information needed for initial credentialing verifications.

Credentialing Policies added to Office Procedures Manual

PreferredOne has added 2 additional Credentialing Policies to the PreferredOne Office Procedures Manual.

1. The *Provider Sanctions, Disciplinary Actions, and Termination of Healthcare Practitioners* policy defines the process by which PreferredOne may place sanctions, deny participation status, or take other disciplinary actions on healthcare practitioners who are contracted with or wish to contract with PreferredOne and who render or wish to render medical care to PreferredOne members.
2. The *Appeal for Non-clinical Contractual Disputes* policy provides participating practitioners an appeal procedure for contractual disputes that are not clinically based. (The *Fair Hearing Policy* for clinical issues has always been part of the Office Procedures Manual.)

These policies, Attachments A and B, should be added to the PreferredOne Policies and Procedures Manual. The manual is on line at **www.preferredone.com**.

Home Health and Infusion Coding Changes

by Joni Frederick, Contracting Manager

Home health and infusion providers may be aware of the AMA's decision to eliminate existing home infusion codes effective July 1, 2003. The change means that beginning July 1, nursing care will utilize codes that are separate from per diems.

The AMA has approved a new CPT code, 99601, for a 2-hour nursing visit for infusion or parenteral drug administration. Also approved was CPT code 99602, used for each subsequent hour following the first two hours of a single visit.

Per diem rates will only include administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment to deliver care in a 24-hour period since drugs and nursing visits will now be coded separately,

Nursing visits for home health services such as wound care, dressing changes, and lab draws that do not include administration of infusion or parenteral drug therapies, must use either codes S9123 (RN) or S9124 (LPN). Conversely, claims for nursing visits that are for infusion or parenteral drug administration must use CPT code 99601.

PreferredOne will accept claims for services using either the current or the new coding structure starting July 1, 2003. However, providers must not use both on the same claim. Beginning October 1, 2003 only claims with the new coding structure will be eligible for reimbursement.

Claims for home health and infusion services must use the UB-92 claim form. Although PreferredOne is assessing the feasibility of processing home health claims on HCFA-1500 forms, current claims payment systems can not accommodate use of the HCFA form for these services. Therefore, home health and infusion service claims that are on an HCFA-1500 will be returned to the provider to resubmit using an UB-92 claim form.

All home health and infusion services require prior authorization. For authorization and member benefit information, please contact us 763-847-4000 or toll-free at 800-940-5049.

PreferredOne Office Procedures Manuals contain detailed information and billing instructions for the current and new coding structures. Providers may access the document at **www.preferredone.com**. For questions or additional information, please contact your provider relations representative or contract representative.

Coding

by Elaine McLinden, Manager Coding

Eye Exam Diagnoses Code Change Requests

We occasionally receive requests to change a diagnosis code for a previously submitted routine eye exam claim. If employer groups have exclusions for routine eye exams, the reimbursement to the provider becomes member responsibility. It is not appropriate to change a diagnosis code based on a claim determination.

When an error has occurred, the provider must submit a new HCFA with the correct diagnosis and a statement as to why the initial claim was coded incorrectly. Remember, only one diagnosis code should be entered in box 24E as the primary reason for the visit.

Modifier 50 Bilateral

PreferredOne requires two lines for bilateral procedures. The first service should be submitted without modifier, and the second line submitted with a 50 modifier.

Line one, will pay 100% of the fee schedule and line two will pay 50% of the fee schedule.

DME Delivery and Set Up Fees

PreferredOne considers these services to be included in the reimbursement for the item. No additional line item payments will be made for delivery or set up services.

MEDICAL MANAGEMENT UPDATES

Medical Management

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

The PreferredOne Pharmacy and Therapeutics (P&T) committee has supported the recommendation of the PreferredOne medical management staff on the implementation of Step Therapy and Quantity Limits programs to try to slow the escalating costs of pharmacy benefits. The committee also felt that these programs would have a positive impact on the overall quality of care.

Step Therapy is a program that encourages physicians to follow established guidelines of care by starting with conservative therapies and progressing to more aggressive therapies as the patient's needs dictate. The first choice for these guidelines will be the ICSI local guidelines, but they may not always be available. The plan will start these programs with some of the new drugs coming to the market rather than disrupting patients that are already on the therapies. The drugs currently involved in the Step Therapy program are Singular and Zetia.

The Quantity Limits program will address patient situations where certain drugs are being used in higher doses than approved by the FDA, or higher doses than recommended in best practice guidelines. The drugs presently involved in the Quantity Limits program are the anti-migraine agents and the PPI's.

The impact on physicians with these programs is that it may be necessary to document the medical reason for certain patients using these drugs outside of the accepted best practice guidelines. We realize that physicians already have enough of these "hassles" but we will try to make these programs as "hassle-free" as possible. We are currently making changes in our operations to try to minimize the hassle-factor. The practicing physicians and pharmacists on the P&T committee definitely understand these concerns and will work with us to try to "keep it simple." The P&T committee will review all of the drugs involved in the Step Therapy and Quantity Limits programs. I would be open to requests from network physicians wishing to be involved with the P&T committee.

On other issues—medical management is now under the full impact of the new U.S. Dept. of Labor (DOL) regs and HIPAA. Again we are working to try to "keep it simple" so bear with us.

The Community Measurement Project that the Minnesota Health Plans cooperated on last year will be expanded beyond the Diabetes Pilot to a number of other HEDIS quality measurements this year. This will allow broader feedback to provider groups. The efforts last year seemed to be well received. Because of the impact on medical groups, the Community Measurement Project is broadening physician input through the development of a Medical Advisory Board. Groups that were involved in the project last year received an invitation to participate on the Advisory Board. If you are interested in being involved get in touch with me at 763-847-3051 or **john.frederick@preferredone.com**.

In closing, I would remind you that PreferredOne is, and will continue to be, a provider-owned organization. To make that work we need to have involvement by those physicians who are the owners. If you have special skills or interests that you would like to bring to the table, please contact me.

Have a great summer!!!

John Frederick, MD, Chief Medical Officer

PreferredOne Physician Associates (PPA) Share Value Increase

by Dr. Ken Dedeker, Vice President/Medical Director-Medical Administration

Physician (M.D., D.O.) providers contracted with PreferredOne and practicing 50% or more time in one or more PreferredOne contracted clinics, hospitals, or surgical centers in the 10 county metropolitan are required to make a one time purchase of a PPA share. PPA shareholders have input into the PreferredOne Management Corporation via the Board of Directors. The following board seats are available to PPA shareholders: PreferredOne PPO, PreferredOne Community Health Plan, and the PreferredOne Management Corporation Board. PPA shares may be purchased individually by the physician or by their clinic/cooperation and held in their behalf.

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PPA Share Value Increase Continued from Page 4

At the board meeting on May 1, 2003, the Directors of PPA set the share price at $850.00 effective immediately. This is the price to be used for purchase and/or redemption of shares until March 2004 at which time the share price will be re-evaluated and set for the following 12 months.

MEDICAL POLICY

by Joni Riley, Medical Policy Specialist

Medical Policies are now available on the PreferredOne web site to members and to providers without prior registration. The web-site address is **www.preferredone.com**. Click on Health Resources in the upper left hand corner and choose the Medical Policy menu item.

The latest indexes and documents are attached indicating new and revised Medical Policy documents. These policies have been approved at appropriate PreferredOne Quality Management Subcommittee meetings including the March & May meetings of the Medical/Surgical Quality Management Subcommittee, February & May meetings of the Mental Health/Substance Related Disorders Quality Management Subcommittee, and February meeting of the Pharmacy & Therapeutics Quality Management Subcommittee.

Please add the attached Medical Policy indexes (Exhibit C and D) to the Utilization Management section of your Office Procedures Manual and always refer to the on-line policies for the most current versions.

Newly approved documents include criterion for Botulinum Toxin and Extracorporeal Shockwave Therapy for Plantar Faciitis. Both procedures require prior authorization.

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 **jriley@preferredone.com**.

Pharmacy

by Kristine Jackson, Director Pharmacy Benefits

Use of Generic Drugs

The consistent use of generic products can provide substantial savings for your patients and/or their employers, without compromising patient care. Please consider the use of therapeutically equivalent generic medications, which are expected to produce the same clinical effects and possess the same safety profiles as the brand-name drugs, and provide cost savings to patients and/or their health plans.

As a physician, you can educate your patients on the safety and value that generic medications provide. The following information supports the use of generic products.

Abstract

The use of generic drugs in the United States is increasing. The U.S. Food and Drug Administration reviews applications for the marketing of generic drugs. Manufacturers must ensure that generic drugs show bioequivalence to the brand-name products. The cost of generic drugs may be considerably lower than the cost of equivalent brand-name products. Generic drugs are cost-effective alternatives for your patients and/or their employers.

Introduction

The use of generic drugs is on the rise in the United States. In 1984, these products accounted for only 19 percent of prescription drugs dispensed, as measured in total units such as tablets or capsules. By 1996, approximately 43 percent of the prescription drugs sold in the United States were generic drugs. This percentage has remained steady into the year 2000. A number of reasons account for the increase in generic drug use, including availability of additional generic drugs and active promotion of generic substitution by pharmacists, government health programs, and private health insurance plans. This article discusses some of the U.S. Food and Drug Administration (FDA) requirements for generic drugs and highlights the potential cost savings associated with their use.

FDA Requirements

To gain FDA approval, a generic drug must contain the same active ingredients as the brand-name product; be identical in strength, dosage form, and route of administration; demonstrate bioequivalence to the brand-name product; and have the same indications, dosing recommendations, and other labeling information (unless protected by patent or exclusivity). Generic drugs must also meet the same batch-to-batch requirements for identity, strength, purity, and quality, and be manufactured under the same strict standards of the FDA good manufacturing practice regulations required for brand-name products. Generic drugs may differ from the brand-name product in certain characteristics, including shape, release mechanisms, and excipients such as colors, flavors, and preservatives.

Bioequivalence means that the active ingredient is absorbed at the same rate and to the same extent for the generic drug as for the innovator drug. Bioequivalence to the brand-name product must be established before the FDA will determine that a generic product is therapeutically equivalent to the brand-name product. The concept of therapeutic equivalence, as defined by the FDA, applies only to drug products containing the same active ingredient(s) and does not encompass a comparison of different therapeutic agents used for the same condition. The bioequivalency requirements used by the FDA to establish therapeutic equivalence between a generic and a brand-name product are the same requirements that brand-name products must meet when manufacturers wish to support a new formulation or dosage form for their own approved product.

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Pharmacy Continued from Page 5

The FDA publishes *Approved Drug Products with Therapeutic Equivalence Evaluations* (the "Orange Book"), which identifies all drug products that have been approved for marketing, as well as each multi-source drug's therapeutic equivalence evaluation code. An online version of the "Orange Book," which is updated monthly, is available at **http://www.fda.gov/cder/ob**. Products given a rating of "A" are considered to be therapeutically equivalent to other pharmaceutically equivalent drug products. According to the FDA, products classified as therapeutically equivalent can be expected to have the same clinical effects and safety profile.

The FDA Review Process

Generic drugs are reviewed and approved by the Office of Generic Drugs at the FDA before they are cleared for marketing. To assist in bringing quality generic products to market, the FDA developed an abbreviated new drug application (ANDA) process for the review of generic versions of brand-name drugs that have already been approved as safe and effective. The ANDA contains information on the product formulation, manufacturing and quality control practices, labeling, and a demonstration of bioequivalence to the brand-name drug. Manufacturers of generic drugs are not required to perform duplicative and costly clinical testing on active ingredients or finished dosage forms already found to be safe and effective.

Pricing

The pricing of generic drugs is variable, and is driven, in part, by competition. In general, prices of generic drugs tend to fall as the number of manufacturers rises. In a study done by the Congressional Budget Office, the 1994 average retail prescription price for generic drugs was less than half the price of brand-name drugs for which generic drugs were available.

Pharmacy benefit managers (PBMs) and managed care organizations (MCOs) use several methods for determining reimbursement to pharmacies for the purchase of generic drugs. MCOs, PBMs, and the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) commonly control reimbursement for generic drugs by using Maximum Allowable Cost (MAC). Reimbursement to pharmacies for products on the MAC list, whether generic or brand, is set at a fixed price. Prices of generic drugs on the MAC list are substantially lower than the corresponding average wholesale price (AWP) of brand-name drugs; this price difference may exceed 90 percent for certain generic drugs. Members may have an increased out-of pocket cost if they receive a brand-name drug when a generic is available. MAC pricing of products is an important tool that encourages the dispensing of generic drugs and helps to control costs.

Conclusion

The FDA requirements for manufacturing and quality control are the same for brand-name and generic products. According to the FDA, therapeutically equivalent generic products can be substituted for brand-name products with the expectation that the generic agent will produce the same clinical effect and possess the same safety profile as the prescribed brand-name product.

References are available upon request.

Quality

by Debra Doyle, Director Quality Improvement

PreferredOne Community Health Plan (PCHP) conducts a Health Plan Employer Data and Information Set (HEDIS®) audit annually for selected effectiveness of care and utilization indicators for the State of Minnesota. Chlamydia screening is one of the clinical indicators we have reported for the past three years.

The Minnesota Department of Health reported a significant increase in the number of diagnosed sexually transmitted diseases in 2002 including chlamydia infections. JAMA (Dec. 2002) reported in, "The Effect of a Clinical Practice Improvement Intervention on Chlamydia Screening Among Adolescent Girls," indicated, "Chlamydia is the most commonly reported STD in the USA with 3 million to 4 million cases occurring annually." Up to 15 percent of young women are estimated to have the disease. Untreated chlamydia can lead to pelvic inflammatory disease, infertility, ectopic pregnancy and other serious health problems, including an increased risk of HIV infections. The vast majority of tubal infertility cases are caused by untreated chlamydia infections. These complications can be prevented with appropriate treatment. Despite this information, the screening rate for eligible PCHP members is significantly below the regional mean, which ranges between 34% and 36%. The PCHP screening rates for eligible women ages 16-21 have decreased from 25% to 20% since 2000. The rates for ages 21-26 remained static at 18% and the total rate for all ages has remained static at 19%.

The AHRQ U.S. Preventative Services Task Force, the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists are just are few of the organizations that recommend annual screening for chlamydia for all sexually active women 25 and younger or those who are at high risk of infection. We are encouraging all PreferredOne physicians to follow these recommendations. This and other information can be found online on the AHRQ web site at **www.ahrq.gov** or National Guideline Clearinghouse web site at **www.guideline.gov**.

EXHIBITS

Exhibit A
Provider Sanctions, Disciplinary Actions, and Termination of Healthcare Practitioners Policy

Exhibit B
Appeal for Non-clinical Contractual Disputes Policy

Exhibit C
Medical Policy Table of Contents

Exhibit D
Criteria Table of Contents

Provider Sanctions, Disciplinary Actions, and Termination of Healthcare Practitioners

POLICY:

1. Either PreferredOne or the healthcare provider may voluntarily terminate participation status by providing written notice to the other party within the time period specified in their participation agreement.

2. PreferredOne may deny participation status or terminate a healthcare provider without reconsideration and right to appeal under the *Appeal and Fair Hearing Policy and Procedure for Clinically Based Disputes* if the proposed adverse action is based upon non-clinical issues. Non-clinical bases for an adverse action may arise if the provider:

    a. Fails to purchase or maintain malpractice insurance policies with the required amount of insurance established by PreferredOne, or;
    b. Is disqualified from practice or has any license, registration, certification, accreditation, or authorization required to perform any duties there under suspended, revoked, or otherwise terminated, or;
    c. Is no longer a member in good standing of the medical, dental, or professional staff of any hospital of which the healthcare provider was a member during his or her agreement with PreferredOne, unless otherwise agreed to by PreferredOne, or;
    d. Is convicted of a felony or;
    e. Breaches the provider's contract with PreferredOne, and such breach is not related to the clinical competence of the provider as determined by PreferredOne.

    Any contractual disputes that are not clinically based will be handled in a manner consistent with the Appeal Policy and Procedure for Non-Clinical Contractual Disputes.

3. PreferredOne may place sanctions, or take disciplinary actions it deems necessary and appropriate, on those participating or applying healthcare providers who fail to abide by PreferredOne administrative, billing, documentation, coding, or community quality of care standards. Sanctions and/or disciplinary actions may include (1) requirement that a healthcare provider participate in a specific program of remedial education, (2) suspension or (3) denial or termination of the healthcare provider's participation status and a return of monies.

4. Upon termination, by either party for any reason, whether for cause or not for cause, both PreferredOne and the healthcare provider shall continue to be bound by the terms of the participation agreement in determining and enforcing their respective rights and in resolving all claims and disputes occurring before the termination date.

PROCEDURE:

1. PreferredOne may review those healthcare providers whose practice patterns and/or conduct may adversely affect the welfare or health of PreferredOne members, or those who fail to fulfill PreferredOne participating provider criteria. Any action(s) taken by PreferredOne will be documented in the healthcare provider's Credentialing File. In the event that any correspondence is sent to the healthcare provider, detailing PreferredOne's concerns and request for information, compliance, etc., such correspondence will be sent via certified mail. The Return Receipt, copies of any correspondence, and all other pertinent documentation will be kept in the healthcare provider's Credentialing File.

2. A determination or recommendation of no action, denying, sanctioning, disciplining, suspending, or terminating a healthcare provider may be made upon each review. PreferredOne will notify the appropriate authoritative agencies according to PreferredOne obligations under law (e.g. the National Practitioner Data Bank, Federation of State Medical Boards, the appropriate state licensing agency, etc.) when a healthcare provider's participation has been denied, reduced, sanctioned, suspended, disciplined, or terminated by PreferredOne for reasons relating to professional competence or conduct.

3. When any action which is adverse to a healthcare provider is proposed by PreferredOne, which relates to for cause termination due to the professional conduct or competence of the healthcare provider, the healthcare provider shall not be offered more than one reconsideration and one appeal with respect to the same subject matter, as per the Appeal and Fair Hearing Policy and Procedure for Clinically Based Disputes. The competence of the provider includes without limitation identified practice patterns or individual acts, which could adversely affect the patient or payer.

4. PreferredOne will give notice to the healthcare provider of an adverse recommendation or action. The notice will include the following:

    a. The reasons for the adverse recommendation or action, and;
    b. If applicable, that the healthcare provider has the right to request reconsideration and/or appeal pursuant to the appropriate appeal policy and procedure.

5. The appropriate PreferredOne entity shall take such action as may be necessary or appropriate to implement its final decision.

6. All correspondence regarding a request for reconsideration or appeal will be sent to the healthcare provider via certified mail. Copies of such correspondence, pertinent documentation, and the Return Receipt will be considered confidential and will be kept in the healthcare provider's Credentialing File.

7. This policy will be reviewed annually and revised as necessary.

Appeal for Non-clinical Contractual Disputes

POLICY: PreferredOne will adhere to the non-clinical dispute resolution appeal procedures described in this policy and procedure when handling any participating practitioner appeals from contract disputes that are not clinically based. If PreferredOne is proposing to take any adverse action against a practitioner's participation status for clinical reasons, then the Appeal and Fair Hearing policy shall apply instead of the procedures outlined below.

PROCEDURE:

If PreferredOne determines that a participating practitioner has breached the parties' agreement for reasons that are not clinically based and PreferredOne decides to take adverse action against the practitioner's participation status, PreferredOne will give the practitioner written notice setting forth the nature of the breach and its proposed resolution to the problem, which may be termination of the parties' agreement. If the proposed resolution is termination of the parties' agreement, PreferredOne's notice will also include the procedures for requesting an appeal of the action.

The participating practitioner is entitled to appeal PreferredOne's determination, by sending PreferredOne a written request for appeal within 15 days of the practitioner's receipt of the notice of breach from PreferredOne. The practitioner's appeal request must include the reasons the practitioner believes s/he is not in breach of the parties' agreement. The appeal request should include an explanation of the practitioner's position, any supporting documentation the practitioner wants PreferredOne to consider in handling the appeal and a response to the proposed solution.

Where an appeal is requested, a senior level manager of PreferredOne who has authority to settle the dispute and who was not involved in making the initial determination to take the adverse action will review the matter, including any information the practitioner has submitted.

Within 15 days of PreferredOne's receipt of the appeal request, PreferredOne will send the practitioner written notice of its appeal decision, which may include notice of termination.

If the practitioner remains dissatisfied with the resolution of the dispute, the practitioner may pursue arbitration as set forth in the parties' agreement.

Exhibit C

Medical Policy

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Click on description link to view the PDF

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C003	**Cleft Lip/Cleft Palate**
C004	**Children's Health Supervision Services**
C005	**Communication Services for Ventilator-Dependent Members (In-Patient)**
C008	**Oncology Clinical Trials Covered/Non-covered Services**
D001	**Diagnostic Procedures for Cancer**
D002	**Diabetic Supplies**
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E005	**EROS Device (Vacuum Therapy for Treatment of Female Sexual Dysfunction**
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F004	**Coordinatioin of Pharmacy Benefits**
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P006	**Enrollees with Mental Health Disorders not Receiving Active Psychiatric Treatment (Inpatient)**
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R004	**Referrals-Standing Referrals to Specialty Care**
S001	**Scalp Hair Prostheses**
S002	**Second Opinion Related to Substance Related Disorders and Mental Health Services**
S005	**School Based Therapy**
S006	**Screening Tests**
S007	**Sensory Integration (SI)**
T001	**Temporal Mandibular Disorder (TMD) Temporal Mandibular Joint (TMJ) Disorder Caraniomandibula Disorder**
T002	**Transition/Continuity of Care**
T003	**Transplantation-Bone Marrow/Organ**
T004	**Therapeutic Overnight Pass**
V001	**Vision Therapy**

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Exhibit D

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Please note: The following apply to PPO members only when the employer group has contracted with PreferredOne for utilization management services.

Criteria Table of Contents

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Criteria #	Category	Description
A005	Cardiac/Thoracic	**Transmyocardial Revascularization (TMR)** ***Revised***
A006	Cardiac/Thoracic	**Ventricular Assist Devices (VAD)**
B001	Dental and Oral Maxillofacial	**Temporomandibular Joint Surgical Procedures**
B002	Dental and Oral Maxillofacial	**Orthognathic Surgery**
C001	Eye, Ear, Nose, and Throat	**Rhinoplasty**
C002	Eye, Ear, Nose, and Throat	**Septoplasty**
C007	Eye, Ear, Nose, and Throat	**Uvulopalatopharyngoplasty (UPPP)**
C008	Eye, Ear, Nose, and Throat	**Strabismus Repair (Adult and pediatric)**
C009	Eye, Ear, Nose, and Throat	**Cochlear Implant**
D001	Eye, Ear, Nose, and Throat	**Outpatient Occupational, Physical and Speech Therapy**
E007	Obstetrical and Gynecological	**Tocolysis (ICD99.29)/Terbutaline Pump**
E008	Obstetrical and Gynecological	**Uterine Artery Embolization (UAE)**
F005	Orthopadic/Musculoskeletal	**Fusion - Lumbar and Lumbosacral**
F006	Orthopadic/Musculoskeletal	**Fusion - Cervical or Thoracic**
F013	Orthopadic/Musculoskeletal	**IDET (Intradiscal Electrothermal Treatment)**
F014	Orthopadic/Musculoskeletal	**Percutaneous Vertebroplasty & Kyphoplasty**
F015	Orthopadic/Musculoskeletal	**Extracorporeal Shockwave Therapy (ESWT) for Plantar Fasciitis** ***New***
G001	Skin and Integumentary	**Eyelid Surgery (Blepharoplasty & Ptosis Repair**
G002	Skin and Integumentary	**Reduction Mammoplasty**
G003	Skin and Integumentary	**Panniculectomy (Abdominoplasty Dermolipectomy)**
G004	Skin and Integumentary	**Breast Reconstruction**
G006	Skin and Integumentary	**Gynecomastia Procedures**
G007	Skin and Integumentary	**Prophylactic Mastectomy**
G008	Skin and Integumentary	**Hyperhidrosis Treatment**
H002	Gastrointestinal/Nutritional	**Repair of Ventral "Hernia" (without fascial defects) - Diastasi Recti/Abdominal Wall Relaxation**
H003	Gastrointestinal/Nutritional	**Bariatric Surgery**
I007	Urological	**Cryosurgery Ablation of the Prostate**
I008	Urological	**Implantable Sacral Nerve Stimulator**
J001	Vascular	**Treatment of Varicose Veins**
L001	Diagnostic	**Positron Emission Tomography (PET) Scan**
L002	Diagnostic	**Electron Beam Computed Tomography (EBCT)/Ultrafast Computed Tomography (UFCT)**
M001	MH/Substance Related Disorders	**Inpatient Treatment for Mental Disorders**

M002	MH/Substance Related Disorders	**Electroconvulsive Therapy (ECT)**
M004	MH/Substance Related Disorders	**Day Treatment Program-Mental Health Disorder**
M005	MH/Substance Related Disorders	**Eating Disorders-Inpatient Treatment**
M006	MH/Substance Related Disorders	**Partial Hospitalization Program (PHP)-Mental Health Disorder**
M007	MH/Substance Related Disorders	**Residential Treatment**
M008	MH/Substance Related Disorders	**Outpatient Psychotherapy**
M009	MH/Substance Related Disorders	**Outpatient Chronic Pain Program Criteria**
M010	MH/Substance Related Disorders	**Substance Related Disorders: Inpatient Primary Treatment**
M011	MH/Substance Related Disorders	**Outpatient SRD Primary Treatment Criteria/Guidelines**
M014	MH/Substance Related Disorders	**Admission for Adult/Adolescent Inpatient Detoxification**
M019	MH/Substance Related Disorders	**Pathological Gambling Outpatient Treatment**
N001	Rehabilitation	**Acute Inpatient Rehabilitation**
N002	Rehabilitation	**Skilled Nursing Facilities**
O002	Pharmacy	**Growth Hormone Therapy-Pediatrics (<18 yrs. old)**
O003	Pharmacy	**Growth Hormone Therapy-Adult**
O004	Pharmacy	**Weight Loss Medications**
O005	Pharmacy	**Viagra**
O006	Pharmacy	**Botulinum Toxin** ***New***
T001	Transplant	**Bone Marrow Transplantation/Stem Cell Harvest (Autologous and Fetal Cord Blood)**
T002	Transplant	**Kidney Transplantation**
T003	Transplant	**Heart Transplantation**
T004	Transplant	**Liver Transplantation**
T005	Transplant	**Lung Transplantation**

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