PreferredOne UPDATE

A NEWSLETTER FOR PREFERREDONE PROVIDERS OCTOBER 2003

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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.

Dear Providers,

As the year 2003 comes to a close, I will summarize the important issues at PreferredOne this year.

The best news is, PreferredOne has come to an agreement with its owners on a stock redemption agreement for Fairview. This has involved a lengthy discussion amongst the owners of PreferredOne. The outcome is PreferredOne has bought back one-third of the shares owned by Fairview for cash. This transaction required super majority approval of the PreferredOne (PAS) board. The ownership and governance will now reflect a 50% ownership by Fairview and 25% ownership each by North Memorial and PreferredOne Physician Associates (PPA). I extend a thank you to all of the PPA members and others who have contributed time and effort to this agreement.

Diabetes care has been an emphasis for improved clinical outcomes. The health plans in Minnesota are getting ready to report to the clinics on the second round of Community Measurement results. As you may remember the pilot results last year showed about 7.7% of the diabetics in the involved clinics were "optimally" managed. This means that all of the eight clinical diabetic outcomes measured were within the expected range. This second year of data will allow clinics to see how they have improved over the year.

I would encourage you to have your poorly controlled Type II diabetics consider enrolling in the ACCORD/NIH study that has five participating centers in the area. Another article in this newsletter gives more information on this study.

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The new ICSI community initiative for 2004 will be to support the diagnosis and treatment of depression in primary care. Employers are asking for better ways of dealing with this high impact disease. I would ask the clinics participating in ICSI to be involved in the initiative.

PreferredOne is working with employers and their agents to develop a tiered network product. In this type of plan a patient would have a greater financial responsibility at a high cost provider than at a more efficient provider. There is more information on this product that you should review elsewhere in this newsletter.

Dr. John Frederick

Vice President/Chief Medical Officer

Network Management Updates

2004 Fee Schedules

Professional Services

by Paul Moreno, Director of Provider Analysis and Reporting

PreferredOne's Physician Fee Schedules are complete and will become effective for dates of service beginning January 1st 2004. The PreferredOne PCHP and PAS overall professional services budget will increase by 2%. Although the PPO will follow the same methodology and RVU update, the overall professional services budget will decrease by 2%.

Physician fee schedules will be based on the *2003 Resource Based Relative Value Scale* (RBRVS). Non-Medicare relative value units will be based on 2003 Relative Value Studies Inc.'s Complete RBRVS. Immunizations, HCPC and a few additional CPT codes will be adjusted to reflect local market values. In addition, PreferredOne will manually adjust the top utilized lab codes to reflect a fee in excess of Medicare rates.

The 2004 Physician fee schedules will continue to use the RBRVS Site of Service differential for the surgical code range (10000 – 69999). This will not require any changes in billing practices from providers. The practice site will be determined by the value in box 24B on the HCFA1500 form.

PreferredOne will maintain the current default values. In addition, PreferredOne Administrative Services will continue their practice of not bundling for multi-channel labs unless it applies to an existing panel.

As with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations.

Furthermore, PreferredOne is currently exploring different alternatives for handling future risk allowance return allocations.

Off Cycle Fee Schedule Updates

On July 1st 2004, the fee schedules will be amended to include new codes and adjustments will be made to accommodate major definitional changes. In addition, PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions.

New ASA codes for Anesthesia services will be updated with the 2003 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by March 1, 2004.

Hospital Services- UB92 Fee Schedules

by Gunnar Nelson, Director of Network Pricing

The 2004 Calendar year DRG schedule will be based on the CMS DRG grouper Version 21, released October 2003. Please note that for calendar year 2003, PreferredOne requires DRG grouper version 20.

Ambulatory Surgery Center (ASC) code groupings will be updated to include any changes made by Medicare in 2003. Any surgical CPT codes not included in the Medicare ASC grouper will be reviewed and added to the appropriate category.

ICD9 based fee schedule will remain constant.

The Hospital (UB92) CPT schedule will be based on the 2003 Complete RBRVS relative value scale. The schedule will consist of the current code ranges: lab, radiology, therapy, minor (non ASC) surgical codes, office visits, immunizations and supplies.

Reimbursement for the hospital CPT schedule will be at the physician rates with the following exceptions:

- Global radiology codes are set to the technical component only
- Therapy codes are set at allied health rates
- Minor surgical procedures and office visit codes are set to the RBRVS practice expense value

The codes will be updated throughout the year to match current terminology.

ICD9 Procedures Codes on Outpatient Claims

By Gunnar Nelson, Director of Network Pricing

Hospitals that are currently submitting ICD-9 procedure codes on outpatient UB 92 claims will need to continue to do so until further notice.

We understand that HIPPA requires a plan to phase out Outpatient ICD-9 procedure codes and we are implementing such a plan. If your hospital contract has an ICD-9 procedure fee schedule, we will be contacting you in the near future to present an updated payment methodology.

There are no plans to change inpatient ICD-9 procedure code requirements, as these are not impacted by HIPPA coding requirements.

Therefore, to ensure timely and accurate processing of your claims, please continue to submit ICD-9 procedure codes in accordance with the contract terms on all UB92 claim forms.

If you have any questions, please contact your provider representative.

PPA Update

by Donna Larson, Director Provider Operations

The subscription form for PreferredOne Physician Associates (PPA) shares is now on our Secured Site under "Forms" at www.PreferredOne.com. As you are aware, MDs and DOs practicing 50% or more of their time in a clinic in the Twin Cities Metropolitan area are required to purchase a PPA share. The current value of a share is $850.00. The share is purchased at the time of Initial Credentialing. In order to better facilitate this transaction, it is very helpful for you to indicate on the application if the provider is practicing less than 50% and the requirement does not apply.

Through PreferredOne's buy back of shares from Fairview Hospital System, PPA is now a 25% owner of PreferredOne. We continue to be the only major health plan in Minnesota owned in part by physicians. PreferredOne is committed to continue it's partnership with physicians who are the primary source for the evaluation, monitoring, and improvement of the quality (appropriateness, effectiveness, and efficiency) of the PreferredOne system.

Tiered Plan Program Introduced

by Lori Nelson Vice President of Network Management

PreferredOne is pleased to announce an expansion of our current benefit designs to include a tiered program which will be available by second quarter 2004 for both fully and self insured PreferredOne Community Health Plan and PreferredOne Administrative Services clients.

One of the new benefit designs offered under the tiered program will be for MEDICAL PROVIDER GROUPS ONLY. An advisory team made up of clinic administrators and benefits managers, brokers from Johnson McCann Benefits and representatives from PreferredOne have been meeting this year to develop this product. At this point we are calling the product "Healthcare Providers Medical Plan," but we are researching name alternatives.

This tiered benefit design was initially developed for those clients located in the twin cities metropolitan area. The program will allow consumer choice through an open access, point of service delivery method that will allow consumers to easily move between and within tiers. The initial benefit design will create a simple way for consumers to navigate through the healthcare system. It will consist of a two tier design which will offer employers flexibility in benefit options while providing the consumer with comparative data so they can make informed choices about accessing a tier 1 or tier 2 provider. The tiers will have significant differences in enrollee responsibility. As in other tiered benefit design products, access to the tier 1 providers will be more beneficial financially to the enrollee than access to the tier 2 providers. This may be a good benefit design for clinic to consider purchasing for your own employees.

Continued...

Tiered Continued…

The provider tiers are based on a provider's cost level with PreferredOne. However, cost was not the sole determinant of the tier. The tier placement also included an adjustment for a clinic's episode treatment grouping efficiency score. Please check the PreferredOne secure website under Tiered Program to view the tier for your clinic and/or hospital. If your clinic is in tier 2 and would like to reduce your tier assignment, please contact your contracting representative by November 21, 2003. If you do not know who that is please feel free to contact PreferredOne's customer service at 763-847-4477.

Coding

By Elaine McLinden Manager of Coding/Payment

ICD9 Diagnosis Codes Added:

The October 2003 release of new ICD9 diagnosis codes and new DRG's have been added to our system.

Flu Immunizations Added:

New Code, 90655	Preservative free, ages 6-35 months.
New Code 90656	Preservative free, 3+ years
New Code 90698	DtaP – Hib- IPV
New Code 90715	TdaP
New Code 90734	Menigococcal conjugate

Intranasal Influenza Vaccine:
CPT code 90660 for intranasal flu vaccine is considered not medically necessary and will not be reimbursed. Please see the PreferredOne medical policy in this issue.

Bilateral Surgical Procedures:
Procedures indicated in CPT as a bilateral and appropriate for modifier 50, must be reported on two lines for proper reimbursement .

The first line will reimburse at 100% of the fee schedule, and the second line will reimburse at 50% of the fee schedule for surgical procedures.
Example:

19318…
19318-50 – Reduction mammoplasty 1 unit

We do not add codes with modifier 50 into our system unless they appear in CPT with this designation. The claim will suspend in the system looking for a match for the CPT and 50 modifier causing un-necessary delays.

When the same procedure is performed on different sides of the body (but is not indicated in CPT as a bilateral procedure), you should submit with RT and LT modifiers.
Example:

29824-LT
29824-RT

Coding Continued...

Assistant Surgeon Services:
Each provider must bill for his/her own services under his/her name and identification number. The primary surgeon may not bill for his/her assistant surgeon under the surgeon's name.

Please refer to PreferredOne's Assistant Surgeon Policy P1, which states Nurse Practitioners, RNFA's and PA-C's who are acting as an assistant surgeon must bill those services under their own provider number, not under the surgeon's.

The reason for this requirement is that a provider cannot be both a surgeon and an assistant at the same time. Only the lesser service is paid. The surgeon services are typically denied, causing significant appeals.

If your Nurse Practitioner, RNFA or PA-C does not have his or her own provider number, contact your network management representative.

Modifier 25 for E/M services only:
Modifier 25 – Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service should be added as necessary to evaluation and management services only.

When modifier 25 is submitted on surgical procedures, your claim is suspended in the system looking for a CPT modifier match causing unnecessary delays for payment.

Units for Surgery Procedures:
Codes designated in CPT as "add on codes" are the only surgical procedures that can be submitted with multiple units in box 24 G.

Example: CPT 11101 4 units

- Biopsy, each separate additional lesion: If 4 additional biopsies are performed then 4 would be appropriate in the units box.

Units for surgery not appropriate:

Example: CPT 11400 4 units

- Excision of lesion 0.5 cms. If 4 lesions are excised, it would not be appropriate to use 4 units in box 24G.

Correct Example:

11400	1 unit
11400 59	1 unit
11400 59	1 unit
11400 59	1 unit

Unlisted Codes:
In order to process services with an unlisted code, we must have a description of the service, or an operative report if the service is for a surgery. Without this documentation, the claim is unable to be processed and will be returned to the provider.

Corneal Topography Computed CT Ultrafast:
We have added the following "S" codes to the system to reduce manual review of unlisted codes. If you have been submitting unlisted codes for corneal topography or computed CT ultrafast you may now use the following "S" codes.
Corneal topography should not be billed when it is performed in preparation for cosmetic Lasik eye surgery.

- S0820 - Computerized corneal topography, unilateral/ use in place of 92499
- S8092 - Electron beam computed tomography (also known as ultrafast CT) / use in place of 76499

Mental Health Services
H & T codes - New Revenue Codes:
Several changes have taken place over the past months with the publication of state agency services with "H" & "T" codes, and the release of new revenue codes for reporting intensive outpatient psychiatric, chemical dependency and behavioral health day treatment. Do not change your current system programming for PreferredOne at this time.

- Your current contracts have specific instructions for billing for these services and will remain in effect at this time.
- If you are a HCFA contracted provider, you may have been instructed to use the unlisted mental health code with specific modifiers for day treatment. Please continue to use those codes and modifiers. Do not use H2012.
- If you are a UB92 contracted provider, continue using the revenue codes listed in your contract. As an example, revenue codes 0945, 0940, 0912, 0913, and 0915 are still valid and have not been deleted on a national basis. Submitting the new "H" & "T" codes, or the new revenue codes will cause your claim to be returned.

Other "H"& "T" Codes Specific for State Agencies.
PreferredOne does not accept most "H" & "T" codes as these services describe special Medical Assistance only services that are not included in our contracts. Claims will be denied or returned. If there is a corresponding CPT code, then the service should be submitted using CPT codes.

Our denial letter can be used to submit the services to Medical Assistance.

Home Health/ Home IV Services:
If you are a home health or home IV provider you should have received a new billing schedule within the past few months. New schedules were prepared to eliminate any local home grown codes.

Only a limited number of CPT and HCPCS codes are included for reimbursement. If you have not been contacted by PreferredOne about home health or home IV billing, call your network management representative.

Preventative Medicine and level 99214 illness:
In order to report both the preventative medicine and illness visit, there must be sufficient documentation to complete the comprehensive well exam and sufficient documentation to support a significant separately identifiable illness visit. As an ongoing project, PreferredOne has reviewed the documentation for level 99214 under these circumstances. In nearly all the reviews, we have found insufficient evidence of the necessary key components for a level 99214 visit in addition to the comprehensive preventative medicine visit.

Please make certain that the illness level of service that is reported is well documented in the medical chart.

Electronic Commerce Updates

HIPAA Operating Guidelines and Contingency Plan

by Ed Stroot, Manager Electronic Commerce

PreferredOne is committed to ensuring that there will be no interruption in claims submission, processing and payment as a result of HIPAA compliance. Consistent with the recent guidance from CMS, PreferredOne has adopted a contingency plan to address provider and trading partner concerns about claims processing.
PreferredOne is ready to accept and process HIPAA-compliant claims for both physician and hospital submitters. We have tested, or are currently testing the new format with all of our clearinghouse connections and hope to eventually migrate all submitters to the HIPAA-compliant format.

We will continue to accept and process the existing claim formats beyond the October 16, 2003 deadline for HIPPA compliance. Clearinghouses will be able to submit current formats, HIPAA-compliant 837's, or both formats. We have not determined a date when we will no longer accept the current formats, but it will not be earlier than December 31, 2003.
We will continue to accept paper claim formats for physician, hospital and dental claims, but we strongly encourage you to submit these claims electronically.

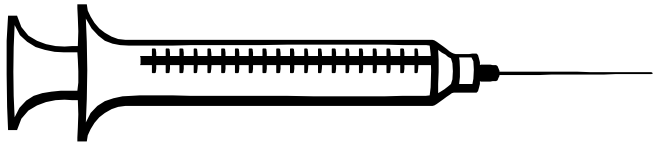
We will be relaxing our HIPAA-compliance checking and front-end data edits on October 16, 2003 to ensure that claims are not unnecessarily rejected. We will be monitoring claims data for error conditions, and we reserve the right to add edits to ensure that submitted claims have the required/necessary information.
Should you experience any problems with your claim submissions, on or after October 16, 2003, we ask that you contact PreferredOne, Electronic Commerce before submitting the claims

PreferredOne Electronic Commerce:
763.847.4400 or 800.451.9597

Synagis

Synagis season began October 1st and will continue through April 30, 2004.

All in-home Synagis visits provided by a Home Health Agency should be pre-authorized with Care Management prior to the visit. Synagis provided in a physician's office does not require prior authorization.



Medical Management Updates

Medical Policy Update

Joni Riley, Medical Policy Specialist

Medical Policies are now available on the PreferredOne web site to members and to providers without prior registration. The website address is https://www.PreferredOne.com. Click on Health Resources in the upper left hand corner and choose the Medical Policy menu item.
The latest indexes, Exhibits A, B & C, are attached indicating new and revised Medical Policy documents. These policies have been approved at appropriate PreferredOne Quality Management Subcommittee meetings including the July and September meetings of the Medical/Surgical Quality Management Subcommittee, August meeting of the Mental Health/Substance Related Disorders Quality Management Subcommittee, and May and August meetings of the Pharmacy & Therapeutics Quality Management Subcommittee. Newly approved documents include medical policies addressing the nasal-spray influenza vaccine (FluMist) and the Wireless Capsule Endoscopy.
PreferredOne has been asked to consider coverage of the He2™ High-Risk HPV Test by the Digene Company as a result of their recent FDA approval. The decision has been made to cover HPV testing for routine screening in addition to cervical cytology testing alone every three years in women over age 30, and more frequently for non-screening situations. This decision is based on the *2002 American Cancer Society Guideline for the Early Detection of Cervical Neoplasia and Cancer.*

Please add the attached Medical Policy indexes (Exhibits A,B,C) 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 jriley@preferredone.com.

Pharmacy

by Kristine Jackson, Director Pharmacy Benefits

PreferredOne utilizes the Express-Scripts National Preferred Formulary for its members that have Express-Scripts as their Pharmacy Benefit Manager (PBM). This formulary undergoes a complete review annually with all changes taking effect in January of each year. Attached please find the 2004 National Preferred Formulary for physicians (listed by therapeutic class) and for patients (listed alphabetically). PreferredOne will be notifying in writing all members negatively affected (i.e. increase in co-payment, drug no longer covered) by the formulary changes. Our members may be contacting you to discuss formulary alternatives. Please work with these members where clinically appropriate to utilize the formulary medications.

Effective January 1, 2004, PreferredOne will also be implementing additional Step Therapy programs and prescription quantity limitations. More information on these programs will be provided in the February Provider Update newsletter.

Quality

by Debra Doyle, Director Quality Improvement

PreferredOne annually conducts the Consumer Assessment of Health Plan Satisfaction (CAHPS®) survey of PCHP and PAS members. Participants are randomly selected from eligible subscribers. The purpose of the survey is to provide feedback to PreferredOne on how members feel about their health care and the services provided to them.

We are pleased that members' satisfaction rating of their personal doctor or nurse is significantly above the national average at 81% for PCHP and 79% for PAS members. The national benchmark is 75% satisfied.

Members are also asked to rate Providers Communication. There was a significant decrease in how members rated provider communication—from 94% satisfied in 2001 to 89% satisfied in 2002. Provider communication is a composite of the four questions. Members are asked to rate providers using the categories "always", "usually", "sometimes" or "never." The final score is the percentage of the respondents who answered "always" or "usually."

1) How often did doctors or other healthcare providers listen carefully to you?
2) How often did doctors or other healthcare providers explain things in a way you could understand?
3) How often did doctors or other health care providers show respect for what you had to say?
4) How often did doctors or other healthcare providers spend enough time with you?

While these results are not clinic-specific, we thought this feedback might be of value to you because you are in the best position to evaluate and address this perception.

If you have any questions regarding the survey please contact:

Debra Doyle
Director of Quality Improvement
deb.doyle@preferredone.com
763-847-3228

Exhibits

Exhibit A
Medical policy
Exhibit B
Criteria Table of Contents
Exhibit C
MAPS Registration Form

Type 2 Diabetes Study Seeks Participants

Action to Control Cardiovascular Risk in Diabetes
ACCORD

The Berman Center for Outcomes and Clinical Research is the coordinating center for the Minnesota/Iowa Clinical Center Network, part of an exciting NIH sponsored international study. The study is called ACCORD, Action to Control Cardiovascular Risk in Diabetes. The study is looking at ways reduce the risk of cardiovascular disease in adults with Type 2 Diabetes. Your assistance in identifying possible study candidates would be greatly appreciated.

The overall goal of the ACCORD study is to test three complementary medical treatment strategies for type 2 diabetes to enhance the options for reducing the high rate of major cardiovascular morbidity and mortality in this disease. The study is designed to test the effect on major cardiovascular events of intensive blood sugar control, of fibrate treatment to increase HDL-cholesterol and lower triglycerides (in the context of good LDL-cholesterol and glycemia control), and of greater blood pressure control (in the context of good glycemia control).

ACCORD participants will be provided with individualized study medications for glycemic control, and either blood pressure or cholesterol medication at no cost. Regular follow up for glycemic control and either cholesterol or blood pressure treatment will occur as part of the study.

The ACCORD patient eligibility criteria are:

- **Type 2 Diabetes**
- **Age 55-79**
- **If age 40-54, must have had previous heart attack, stroke or serious blood vessel problems.**
- **HbA1c 7.5 to 11**

You and your patient would be advised as to which arm of the study the patient is enrolled in as well as regular progress reports. ACCORD investigators will not be assuming medical care for your patient outside of the research treatment.

The Berman Center has informational brochures, posters and recruitment letters available to help you provide ACCORD information to your patients. To request materials or for more information about ACCORD please call **Brenda Kirpach, Study Coordinator, CCN Manager, 612-341-7922.** Prospective study participants may contact: **The Berman Center recruitment line at 612-341-7918.**

Exhibit A - Medical Policy Table of Contents

Click on description link to view the PDF

Criteria #	Description
A001	**Elective Abortion**
A002	**Mifepristone/RU486**
A003	**Acupuncture**
C001	**Court Ordered Mental Health & Substance Related Disorders Services**
C002	**Cosmetic Surgery**
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**
D004	**Durable Medical Equipment, Non-Durable/Supplies, Support Devices and Prosthetics**
D005	**Dental-Hospitalization & Anesthesia**
D007	**Disability Determinations: Proof of Incapacity Requirements**
D008	**Dressing Supplies**
E001	**Ambulance Transportation**
E002	**Emergency Care**
E004	**Enteral Nutrition Therapy**
E005	**EROS Device (Vacuum Therapy for Treatment of Female Sexual Dysfunction**
F001	**Formulary Drug Exceptions**
F003	**Half Tab Program**
F004	**Coordinatioin of Pharmacy Benefits**
F005	**Off-label Drug Use for Cancer Treatment**
F006	**FluMist Influenza Vaccine** ***New***
G001	**Genetic Testing**
H001	**Home Health Aid Services**
H002	**Home Uterine Monitoring (Remote)**
H003	**Home Prothrombin Time Testing Devices**
I001	**Investigational/Experimental**
I002	**Infertility Diagnosis and Treatment (Female and Male)**
I004	**Immunizations**
M001	**Medical Necessity**
M003	**In-Patient Maternity Length of Stay and Postdelivery Care**
M004	**Maintenance Care**
N001	**Non-Plan Services**
N002	**Nutritional Counseling**
O001	**OB/GYN Direct Access**
P001	**Phenylketonuria Formula**
P003	**Port-Wine Stain**
P004	**Private Room**

P006	**Enrollees with Mental Health Disorders not Receiving Active Psychiatric Treatment (Inpatient)**
P007	**Preparatory/Preoperative Blood Donation**
R002	**Reconstructive Surgery**
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** ***Revised***
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**
W001	**Wireless Capsule Endoscopy** ***New***

Revised 9/23/03

Back

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

Exhibit B - Criteria Table of Contents

Click on description link to view the PDF

Criteria #	Category	Description
A005	Cardiac/Thoracic	**Transmyocardial Revascularization (TMR)**
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	**Nasal Reconstructive Surgery**
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	Orthopaedic/Musculoskeletal	**Fusion - Lumbar and Lumbosacral**
F006	Orthopaedic/Musculoskeletal	**Fusion - Cervical or Thoracic**
F013	Orthopaedic/Musculoskeletal	**IDET (Intradiscal Electrothermal Treatment)**
F014	Orthopaedic/Musculoskeletal	**Percutaneous Vertebroplasty & Kyphoplasty**
F015	Orthopaedic/Musculoskeletal	**Extracorporeal Shockwave Therapy (ESWT) for Plantar Fasciitis**
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**
	MH/Substance Related	

M005	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**
P002	Pharmacy	**Growth Hormone Therapy-Pediatrics (<18 yrs. old)**
P003	Pharmacy	**Growth Hormone Therapy-Adult**
P004	Pharmacy	**Weight Loss Medications**
P005	Pharmacy	**Viagra**
P006	Pharmacy	**Botulinum Toxin**
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**

Revised 9/23/03

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Medical Policy

---- Quick Links ----

** Note: All medical policies documents are in PDF format (Requires **Adobe Acrobat Reader**).*

- **Criteria**
- **Durable Medical Equipment and Supplies (PDF)** ***Revised 09/23/03***
- **Institute for Clinical Systems Improvement**
- **Investigational List (PDF)** ***Revised 09/23/03***
- **Medical Policies**
- **Orthotic List (PDF)**
- **Prosthetic List (PDF)**

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The Minnesota Alliance for Patient Safety (MAPS)

Impact of Low Health Literacy:
Practical Strategies for Providers to Improve Communication

Thurs., Nov. 6, 2003
8 a.m. – 10 a.m.
Registration and Continental Breakfast 7:30 – 8 a.m.

Content

There are a number of influential state and national organizations that are emphasizing the importance of patient/family participation in health care planning and delivery. At this session, you will learn how improved communication can increase patient safety by engaging patients and their families.

The education session will focus on why health literacy is a crucial factor in 21st century medicine, the scope of health literacy and the barrier it presents for patients to become actively involved in their care. Participants will be able to identify principles and key strategies to enhance health literacy.

~MAPS is a public-private partnership, which includes more than 50 Minnesota health care organizations working together to improve patient safety practices in the delivery of health care~

Presenters

- Joanne Disch, PhD, RN, Director, Densford International Center for Nursing Leadership
- Gloria Lewis, Director, Office of Minority and Multicultural Health, Minnesota Department of Health
- Steve Rush, Manager, Continuous Improvement and Measurement, American Academy of Neurology

Target audience

This program is targeted to health care professionals, organizations and associations that have an interest in health literacy and want to learn more about the barrier it presents for patients to become actively involved in their care and strategies to overcome the barriers.

Schedule

7:30 a.m.	Registration and Continental Breakfast
8 a.m.	Welcome and Introductions, Joanne Disch, PhD, RN
8:15 a.m.	Health Literacy in Minnesota, Gloria Lewis
8:40 a.m.	Gaining Skills to Enhance Health Literacy, Steve Rush
9:40 a.m.	Audience Response
9:50 a.m.	Identify Next Steps
10 a.m.	Adjourn

-over-

Fee

$30 registration fee, includes breakfast and materials

Program site

Minneapolis Marriott Southwest (see map, end of this document)
5801 Opus Parkway, Minnetonka, Minnesota

MAPS Impact of Low Health Literacy:
Practical Strategies for Providers to Improve Communications
Nov. 6, 2003
Minneapolis Marriot Southwest
Minnetonka, Minn.

Name _____

Title _____

Facility Name _____

Address _____

City _____ State _____ Zip _____

Please note any questions you would like the speakers to address:

Payment Method (please indicate payment method)

☐ Please charge to credit card ☐ Master Card ☐ Visa

Name on card _____ Exp. Date _____

Card Number _____

☐ Check enclosed. **Please make checks payable to the Minnesota Hospital Association.**

You may register to this program in any of the following ways:

Mail this completed form and check to:

Minnesota Hospital Association
2550 University Ave. W., Suite 350 S.
St. Paul, MN 55114-1900.

Fax this form to (651) 659-1477.

Online: www.mnhospitals.org
Click here for the registration form.

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