PreferredOne®
UPDATE *A Newsletter for PreferredOne Providers & Practitioners*
JULY 2007

Advanced Imaging & Spine Surgery

John Frederick, MD, Chief Medical Officer

I would like to update PreferredOne providers on three issues that will have an impact on their practices.

The first issue is that of "High Tech Diagnostic Imaging" (HTDI). As you are aware, this issue is getting a lot of attention both locally and nationally. It is one of the fastest growth areas in medical spending with PreferredOne experiencing a trend of over 10% per year over the last four years. There is also evidence that many of the scans may be inappropriately ordered. This could mean that the tests are either not necessary or that a different type of scan would be more valuable for the patient's situation.

Two major efforts are happening in our community. The first is at ICSI where discussions between plans and providers have identified the need for a Decision Support Tool (DST) at the time of ordering HTDI. This will allow the ordering physician to confirm that they indeed are ordering the appropriate test for the patient's situation. A number of provider groups are piloting this DST in their offices, usually as part of an electronic record application. This solution holds promise but will be difficult to apply to all physicians, especially those who practice in smaller groups or are not using electronic medical records. PreferredOne is involved in these discussions.

The second effort is to try to manage the utilization by way of a Radiology Benefit Manager (RBM) similar to the systems used to manage pharmacy utilization. Other plans in the state are using this approach. PreferredOne has not hired a RBM, but has, instead chosen to identify HTDI preferred providers. These preferred imaging facilities will meet quality criteria for their machines, technicians, and radiologic interpretation. They will also agree to apply appropriateness criteria to the imaging they provide, so the ordering physician does not need to invest in the DST. From a patient's perspective, changes will be simplified so that a consumer can determine their best HTDI "value." We hope to roll this out, but in late summer.

The second area of impact for your practices is that PreferredOne is piloting a program that would require patients undergoing spine surgery for a chronic condition to go through treatment by a comprehensive back rehab program prior to surgery. Clinical evidence supports that use of these types of programs can avoid spine surgeries or at least better condition the patient so their surgical outcome is improved. At this time a limited number of members are involved in this program, but it will expand to most of PreferredOne members by Jan. 1, 2008. I would ask you to consider one of our identified Chronic Back Rehab Programs for your patients before sending them for surgical evaluation. *Page 2...*

In This Issue:

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Other programs will be added as the participation of PreferredOne members grows. The following clinics offer Chronic Back Rehab programs:

- Fairview Pain and Palliative Care Center at 612-273-5400
- Fairview Sports Medicine and IAM at 612-672-7100
- Physicians Neck and Back Clinic at 866-333-PNBC
- LIFEBACK at 800-378-8186

The last area of impact on your practice involves legislation presently being considered by the U.S. Congress. At present most biotech specialty pharmaceuticals have an indefinite period of exclusivity for their products due to federal rules and regulations. This means that the FDA has no process in place to approve generics for these biopharmaceuticals. The impact is that these very important drugs will never have competitive generics to bring the cost down so that they are more affordable. The legislation being considered by Congress would establish a definitive process for the FDA to approve generics for these drugs without hindering the development of new biopharmaceuticals to advance the treatment of other serious diseases. More information is available at www.therightprescription.org. These are interesting times in which we live (and work)!!!

PreferredOne Update Paper Copies to be Discontinued

Beginning in October 2007, PreferredOne plans to modify the distribution of the PreferredOne Update provider publication. Rather than mailing out paper copies each month, the newsletters are posted on the PreferredOne secured website.

There are two ways to view the PreferredOne Update. Those providers who **do not** yet have login information can visit the PreferredOne secured website at www.PreferredOne.com and in the menu bar on the homepage, click on "For Providers." Now you are in the Login Registration page. Click on "Provider Newsletters" to view current and past publications. If you would like to receive email notifications when new publications are posted, you will need to click on the "Submit your email to receive email notifications" link and submit your email address.

Those providers who **do** have login information can log onto the PreferredOne website and view all publications under, "Information," "Provider Newsletter." If you do not already receive email notifications when new publications are posted but would like to, just click on the "Change Email & Newsletter Settings" link in the publication page, update your email address and check the box. If you no longer want to receive these notifications, simply uncheck the box at any time.

We encourage you to register for login information and once you're registered, you can easily access an abundance of information on the PreferredOne secured website. Just to list a few of the available resources, you can check claim status, subscriber/dependant information, medication authorization, referral inquiry and submission, submit NPI information, download forms and much, much more! To register, please visit www.PreferredOne.com, click on "For Providers," in the menu bar. Once you are in the Login Registration page, click "Register" and fill in the requested information and submit. You will receive your login information within a few business days. PreferredOne continues to enhance the PreferredOne website. Providers and clinics have indicated to us that our site is very user friendly and provides invaluable information.

A letter/form will be mailed shortly to providers who are currently receiving paper copies of the PreferredOne Update. You will be asked to indicate on the letter/form your Internet availability/secured site status and to return the form to PreferredOne. We are requesting this information from you to help us to better update our records and to ensure that the PreferredOne Update is available to all of our providers. Thank you in advance for your response!

Timely Filing

As the payor, PreferredOne's Timely Filing Policy requires providers to submit claims for Covered Services within 120 days from the date the Covered Services are provided, or within 60 days from the date of the primary payor's explanation of benefits. Claims submitted after these timelines will result in denial of payment. These charges become provider responsibility, which means the member cannot be billed.

Appeals will be considered if they are received within 60 days from the date of the initial denial. Supporting documentation of previous billing or other causes for late submission must be included in the appeal.

Claims are reconsidered for payment for the following reasons:

- Documentation of previous billing
- Coordination of Benefits (COB)
- Long-term hospital stays
- Inaccurate Payor information provided by member

PreferredOne Community Health Plan (PCHP) and PreferredOne Administrative Services (PAS) appeals with supporting documentation may be sent to:

PreferredOne Administrative Services, Inc.
Attention: Provider Relations
6105 Golden Hills Drive
Golden Valley, MN 55416

A Remittance Advise will be sent to the provider indicating the results of the appeal.

In no event will claims submitted more than 365 days after the date the charges were incurred be considered for payment. Unless the member failed to provide accurate or current insurance information, the member cannot be billed for the charges.

Timely filing denials through PreferredOne PPO may be appealed with supporting documentation through the appropriate payor.

Coding Update

Consultations

Beginning May 1, 2007, PreferredOne will allow office-based consultations by the participating Nurse Practitioners, Physician Assistants- Certified, Certified Midwives, and Certified Nurse Specialists.

The following criteria will apply:

- Request for advice/opinion for a specific problem by an appropriate source
- Evaluation by the consulting physician, NP, PA-C Midwife, CNS
- Advice/opinion for a specific problem is given
- Documentation of the request, reason, and outcome in both the requesting and consulting physicians' medical records

Referrals from one specialty practice to another may not be a consultation, but rather a new patient referral. This is especially true if the requesting provider is not intending to treat the patient for the referred condition. The intention is to have the patient receive care and treatment from the specialist. *Page 4...*

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Pre-Operative Clearance

Consultations are not appropriate when:

- The sole purpose is to fulfill mandatory preoperative or pre-admission history and physical or as a substitute for the surgeon's preoperative evaluation. Example, a child is having T &A and requires a pre-op physical from his pediatrician.
- A patient is already under the care of a primary physician/internist and a clearance for surgery is needed (the patient is an established patient and is already receiving care for medical issues from his primary care provider).

Consultations are appropriate when:

- There is a medical necessity related to the evaluation and management of a **specific problem and it is clearly documented.** The requesting physician must document how the consultant's opinion will be used in the management of the patient. As an example, an orthopedic surgeon has a patient who states he sometimes has shortness of breath and the surgeon requests a consultation from an internist to evaluate this problem.

Transfer of Care vs. Consultation

A transfer of care (new patient visit or established patient visit) occurs when a physician or qualified provider requests that another physician take over the responsibility for managing the patient's complete care for the condition and does not expect to continue treating or caring for the patient for that condition. The requesting physician or qualified NPP is not asking for an opinion or advice so that he or she can personally continue to treat this patient.

Medical Management Update

Medical Policy

Medical Policies are available on the PreferredOne website to members and to providers without prior registration. The website address is http://www.PreferredOne.com. Click on Health Resources in the upper left-hand corner and choose the Medical Policy Menu option.

There are four new criteria sets in the medical/surgical area. MC/F016 Allogenic and Autologous Grafts of the Knee was developed to provide guidelines of when various grafts to the knee are medically necessary. MC/F019 Back and Neck Surgery was developed to encourage a trial of a formal multidisciplinary approved rehabilitation program before back or neck surgery. MC/L007 Mobile Cardiac Telemetry was developed to provide guidelines when the technology is considered to be medically appropriate. Finally, MC/N005 Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers was developed to provide guidelines of when various treatments are considered medically necessary. As always, cases that do not meet the guidelines of criteria will be referred for physician review (Exhibits A, B, C, & D).

Five criteria sets were retired: MC/A007 Lung Volume Reduction, MC/C009 Cochlear Implant, MC/E008 Uterine Artery Embolization, and MC/F014 Percutaneous Vertebroplasty and Kyphoplasty and MC/L003 3D Interpretation of Imaging. Criteria sets and policies are retired when there is low utilization of the service/technology, when new legislation provides guidelines for the service or technology, or benefits outline when the service or technology will be covered. Retired criteria and policies will remain available on the internal web page for reference but will not be updated annually.

One new medical policy was developed: MP/I003 Preventative Immunization outlines covered immunizations (Exhibit E). Three policies were retired MP/F006 FluMist Influenza Vaccine, MP/P004 Private Room and MP/P007 Preparatory Preoperative Blood Donation. *Page 5...*

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The Medical/Surgical Quality Management Subcommittee addressed the following investigational list items:

Effective May 22, 2007

Additions to List:

- Magnetoencephalography (MEG) Scan for Mapping of Seizure Focus
- Osteochondral Autograft (OATS)

Deleted from List:

- Pulsed Dye Laser Treatment of Rosacea

The Behavioral Health Quality Management Subcommittee approved one new criteria set: MC/M021 Vagus Nerve Stimulation for Treatment Resistant Depression and Treatment Resistant Bipolar Depression (Exhibit F). This criteria set outlines when this treatment would be considered medically necessary.

New in the pharmacy area are two criteria sets: PC/A004 Antihistamines Step Therapy and PC/S003 Sedative Hypnotics Step Therapy (Exhibits G & H). Two criteria sets, PC/D001 Diabetic Adjunct Agents and PC/N001 Branded Nonsteroidal Anti-inflammatory Drugs were retired.

The Pharmacy and Therapeutics Quality Management Subcommittee added the following item to the investigational list effective April 18, 2007:

- Avastin for all ocular indications except macular degeneration

The latest Medical and Pharmacy Policy and Criteria indexes indicating new and revised documents approved at recent meetings of the PreferredOne Quality Management subcommittees are attached. Please add the attached documents (Exhibits I, J, & K) to the Utilization Management section of your Office Procedures Manual and always refer to the on-line policies for the most current version.

If you wish to have paper copies or you have questions, feel free to contact the medical policy department at (763) 847-3386 or on line at pkreber@preferredone.com.

Institute for Clinical Systems Improvement (ICSI)

Health Care Guidelines

- Diagnosis and Treatment of Headache
- Palliative Care
- Chronic Obstructive Pulmonary Disease
- Diagnosis and Treatment of Respiratory Illness in Children and Adults
- Assessment and Management of Chronic Pain
- Atrial Fibrillation
- Diagnosis and Initial Treatment of Ischemic Stroke
- Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School Age Children and Adolescents *Page 6...*

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- Diagnosis and Treatment of Adult Degenerative Joint Disease (DJD)/Osteoarthritis (OA) of the Knee
- Management of Labor

Pharmacy Update

Pharmacy Website Update

Providers without login access to the PreferredOne website can now view pharmacy benefit information that impacts PreferredOne members.

The PreferredOne Pharmacy department has added a new link to the PreferredOne web page for providers. Within the "Pharmacy Resources - Drug Formulary" box you can access the following information:

- **2007 Express Scripts National Preferred Formulary** - *(This information applies to only those members with Express Scripts as their Pharmacy Benefit Manager)*
- **Medication Request Forms –** Contains *updated* Infertility and Erectile Dysfunction Medication Request Forms.
- **Pharmacy Policy & Criteria**
- **Guide for providers interested in learning about our on-line Medication Request Form**

Providers are able to request paper copies of this information by contacting the pharmacy department from the email link at the top of the pharmacy information page on the website. That address is pharmacy@preferredone.com.

Pharmacy Information Available Upon Request

A paper copy of any pharmacy information that is posted on the PreferredOne Provider website is available upon request by contacting the Pharmacy Department online at pharmacy@preferredone.com.

2007 PreferredOne Formulary

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.

Please note that the following medications are also on the 2007 PreferredOne formulary:

- Geodon
- Lipitor
- Xalatan

Disease Management & Wellness Update

Programs Update

Employer interest and enrollment in the PreferredOne Disease Management Programs continues to grow.

The Accordant Program is for the management of:

- Rheumatoid Arthritis
- Parkinson's Disease
- Hemophilia
- Dermatomyositis
- Myasthenia Gravis
- Cystic Fibrosis
- CIPD
- Scleroderma
- Multiple Sclerosis
- Lupus
- Gaucher Disease
- ALS
- Sickle Cell Disease
- Crohn's Disease
- Polymyositis

As of April 2007, 403 PreferredOne members are participating in the program. The largest enrollment is in Rheumatoid Arthritis, Multiple Sclerosis and Crohn's Disease. The following PreferredOne employer groups have made the Accordant program available to their PreferredOne members:

- State of Minnesota
- Fairview Health Services
- UCare Minnesota
- Treasure Island Resort and Casino
- Fairview Red Wing Hospital
- North Memorial Hospital
- Arctic Cat
- Personnel Decisions Inc.
- Davis Family Holdings
- Smyth Companies
- Short Elliot Hendrickson

All PreferredOne Community Health Plan members are eligible to participate in the Accordant program.

The LifeMasters Disease Management program has been in place since October 2006. Currently 689 PreferredOne members are enrolled and being managed for the following conditions:

- Diabetes
- CHF
- CAD
- COPD
- Asthma

PreferredOne will be working with **Advantage Health** to implement and design **Wellness Programs** for our members. Advantage Health offers a diverse list of programs and the flexibility needed to implement them. Please watch for updates on this new partnership. (Advantage Health is located in Bloomington, Minnesota. www.advantagehealth.com)

Quality Management Update

Minnesota Immunization Information Connection (MIIC)

The Minnesota Immunization Information Connection (MIIC) is a network of regional immunization services—health care providers, public health agencies, health plans, and schools working together to prevent disease and improve immunization levels. These services combine high quality immunization delivery with public health assessment and outreach to help ensure that children and adults are protected against vaccine-preventable diseases.

These regional services use a confidential, computerized information system that contains shared immunization records. This information system - also known as an immunization registry - provides clinics, schools, and parents with secure, accurate, and up-to-date immunization data, no matter where the shots were given. MIIC users can generate reminder cards when shots are coming due or are past due and they greatly simplify the work of schools in enforcing the school immunization law.

What are the Benefits of MIIC?

- Consolidates immunizations a person has received into a single record, no matter where they received the shots.
- Provides an accurate, official copy of a child's immunization history for day care, school, camp enrollment, or for personal records.
- Helps ensure a child's immunizations are up to date.
- Provides reminders when an immunization is due.
- Provides recalls when an immunization has been missed.
- Helps ensure timely immunization for children whose families move or switch health care providers.
- Prevents unnecessary (duplicative) immunization.

(Information from the Minnesota Department of Health)

We are encouraging all health care practitioners to participate in MICC and submit immunization information to the registry to support our efforts in ensuring our members are getting the immunizations they need. For more information, or to become a member of MICC, please visit www.health.state.mn.us/divs/idepc/immunize/registry/index.html.

Quality Management (QM) Program

The mission of the QM Program is to identify and act on opportunities that improve the quality, safety, and value of care provided to PreferredOne members both independently and/or collaboratively with contracted practitioners and community efforts, and also improve service provided to PreferredOne members and other customers.

PreferredOne's member and physician websites have been updated to offer the following program documents:

- 2007 PreferredOne QM Program Description, Executive Summary
- 2006 Year-End QM Program Evaluation, Executive Summary

To access these documents, log into the Provider site and then click on the Quality Management Program link under the Information heading.

If you would like to request a paper copy of either of these documents, please contact Heather Clark at 763-847-3562 or e-mail us at quality@preferredone.com.

Affirmative Statement

PreferredOne does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization. Utilization management decision making is based only on the appropriateness of care and service and existence of coverage.

Emergency and Community Health Outreach

ECHO (Emergency and Community Health Outreach) is a collaborative that includes public health and safety agencies across Minnesota, ethnic advisory organizations and non-profit groups. It is spearheaded by Saint Paul-Ramsey County Public Health, Hennepin County Public Health Protection, the Minnesota Department of Health and other agencies charged with public health emergency preparedness.

ECHO provides health and safety information in multiple languages by fax, phone, on television and on the web during emergency and non-emergency times to people with limited English language skills. ECHO was created to address the concern that new systems were needed to help all Minnesotans stay safe and healthy as hundreds of thousands of immigrants and refugees from vastly different cultures and climates make this state thier home.

New residents need information on specific health and safety issues that occur here, and methods were needed to reach limited-English speakers in a statewide emergency such as the outbreak of a highly contagious disease like SARS, or a man-made attack such as a bomb explosion.

ECHO benefits all Minnesotans because when a serious disease outbreak happens, no one can be fully protected unless everyone is first fully informed. In an emergency, the goal of ECHO is to make sure that no Minnesotans are left out because of barriers of language or culture.

PreferredOne is a collaborative member of the ECHO initiative. For more information on ECHO please visit www.echominnesota.org.

Account Management Update

Sioux Valley Health Plan Is Now Sanford Health Plan

As approved by the Health Plan Board of Directors on March 13, 2007, Sanford Health Plan is now the new legal name for the entity formerly known as Sioux Valley Health Plan. This name change is a result of a system-wide renaming convention that is taking plan in conjunction with the transformation of Sanford Health. Sanford Health Plan remains a wholly owned subsidiary of Sanford Health.

The transition from Sioux Valley to Sanford will continue to take place over the next 6 to 12 months. Please look for changes on member ID cards.

American Family Requesting Notification

American Family is requesting notification for the following: All inpatient hospital admissions (a) within 2 business days after an emergency admission (b) within 10 days before any planned admission.

All outpatient surgical procedures within 10 days. All Hospice, Home Health Care Services, Physical Therapy and Chiropractic services. Call toll free at 800-333-6886 ext. 33090.

Unicare AIM Initiative

UniCare has partnered with American Imaging Management, Inc. (AIM) to enhance their existing diagnostic imaging review program. Beginning June 4, 2007, this enhancement will include AIM's Radiology Quality Initiative (RQI) for elective, outpatient high-tech imaging services scheduled at a hospital outpatient department, freestanding radiology facility, or physician's office on or after June 18, 2007. Please review the important information below with regard to UniCare members.

Beginning June 4 For Services Scheduled on June 18 and Later

Providers who order services should obtain an RQI number **prior to scheduling** the outpatient diagnostic, non-emergency services listed below:

- CT/CTA scans
- MRI/MRA scans
- Nuclear cardiology studies
- PET scans

The RQI number will serve the same purpose as the authorization number currently provided through UniCare's review program. An ordering provider can obtain an RQI number by calling the Customer Service telephone number on the member's ID card. As an alternative, providers can link to AIM by clicking on Radiology Preauthorization at www.unicare.com or at accesspoint.unicare.com. The AIM website allows providers to enter relevant information online and in most cases obtain immediate RQI numbers.

The RQI process must be initiated by the ordering provider.

Providers who perform imaging exams (physician offices, hospitals, and freestanding imaging centers) should confirm that RQI numbers were issued by linking to AIM from www.unicare.com or accesspoint.unicare.com. The Radiology Preauthorization link on that site will display a list of all current RQI numbers pertinent to each facility. Performing providers may also obtain the RQI number status by calling the Customer Service telephone number on the member's ID card and following the prompts for radiology preauthorization. Please note that providers who perform exams based upon the orders written by the prescribing physician will not be able to initiate the RQI process.

The issuance of an RQI number is not a benefit decision and is not a guarantee of payment or a determination regarding the appropriateness of the service or treatment. The final decision regarding treatment or services is up to the patient and the physician. Payment of any claim or services or treatment is subject to the member's active enrollment, benefit limitations and exclusions, and other applicable terms of the member's certificate of coverage at the time the services are provided.

Payors Merge to Become Meritain Health

North American Health Plans Inc. (NAHP) and its affiliates-North American Administrators (NAA), DBL/North American, BSI/North American, North American Benefits Network (NABN), E-V Benefits, Nyhart, and Century Westport North American---have a new name: Meritain Health. You have probably already seen ID cards with the new name and logo. Please update your systems accordingly to reflect any name/address changes per the member ID card.

Exhibit A

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Allogenic and Autologus Grafts (Chondrocyte, Osteochondrocyte, Anterior Cruciate Ligament and Meniscus Grafts) of the Knee	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/F016	**Page:** 1 of 4	

PRODUCT APPLICATION:
☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☒ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:
The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:
Allograft:
Tissue that is implanted into a patient that is foreign to that patient.

Autologus:
Involving one individual as both donor and recipient.

Chondrocyte:
A cartilage cell.

Osteochondral:
Relating to or composed of bone and cartilage

BACKGROUND:
This criteria set is based on expert consensus opinion and/or available reliable evidence.

Patients who are candidates for grafts should be otherwise healthy, active, adult patients who are able to participate in an extensive rehabilitative period.

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Reference #: MC/F016	**Page:** 2 of 4	

GUIDELINES:
Either of the following I or II:

I. Autologus Grafts of the Knee – either of the following A or B:

A. Autologus chondrocyte implantation (ACI) also known as autologus chondrocyte transplantation (ACT) of the patellofemoral joint (petella lesions or trochlear groove lesions) – all of the following 1 – 9:

Note: Autologus chondrocyte implantation of any other location requires physician review.

1. Patient is between 15 and 45 years of age

2. Disabling pain and/or knee locking related to a full thickness medial or lateral femoral condyle lesion

3. Lesion size is between 1.5 – 10 centimeters squared

4. Presence of stable ligaments

5. Presence of intact meniscus

6. No evidence of malalignment

7. No evidence of degenerative arthritis

8. Failure of conservative therapy consisting of at least 2 months of physical therapy

9. Failure of other traditional surgical interventions (i.e. microfracture, drilling, abrasion, osteochondral autograft)

B. Osteochondral Autografting (OATS or Mosaicplasty) – considered investigational (see Investigational List)

II. Allografts of the Knee- any of the following A - C:

A. Anterior Cruciate Ligament (ACL) – one of the following 1 – 3:

1. ACL deficiency and patient is not a candidate for an autogenous graft – either of the following a or b:
   a. Individuals whose own tissues have been compromised by previous surgery or injury
   b. Contra-indications are present for use of patient's own tissue such as collagen disease or generalized ligament laxity

2. History of knee pathology such as chronic patellar tendonitis and hamstring injury

3. Multi-ligament reconstruction is being performed.

B. Osteochondral – must have one of the following 1 – 4:

1. Treatment of an isolated defect, or traumatic injury that is full thickness depth (grade 3 – 4) in the weight-bearing surface of the medical or lateral femoral condyle with all of the following a-d):
   a. Symptomatic after adequate trial of appropriate conservative medical and surgical treatments
   b. Absence of inflammatory joint disease, extensive osteoarthritis, or uncorrected joint instability or malalignment
   c. Lesion size within the knee is greater than or equal to 2 centimeters squared; and
   d. Presence of stable ligaments and adequate meniscus

2. Non-repairable stage 3 or 4 osteochondritis dissecans.

3. Avascular necrosis lesions of the femoral condyle.

4. Not a candidate for other more traditional procedures due to size, shape, or location of the lesion, or have failed previous procedures.

C. Meniscus Transplantation - all of the following 1 – 5:

1. Pre-operative studies (MRI or previous arthroscopy) reveal absence or near absence of the meniscus

2. Minimal or absent degenerative changes

3. Knee must be stable (i.e. intact or reconstructed ACL)

4. No malalignment present

5. Symptoms remain (e.g. pain, swelling, etc.) after failed trial of conservative medical treatment

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Reference #: MC/F016	**Page:** 4 of 4	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy

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DOCUMENT HISTORY:

Created Date: 05/22/07
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Exhibit B

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Back and Neck Surgery	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/F019	**Page:** 1 of 3	

PRODUCT APPLICATION:

☐ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
Currently applies only to Fairview Employee Groups
☐ PreferredOne (PPO)
☐ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This criteria set applies only to PAS enrollees when the employer group has adopted the applicable step therapy management program(s).

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary and to ensure that services are rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community.

DEFINITIONS:

Spondylosis:
Spinal degeneration and deformity of a joint(s) of two or more vertebrae that commonly occurs with aging

Spondylolisthesis:
Forward alignment of one vertebrae on the one below it.

BACKGROUND:

This criteria set is based on expert consensus opinion and/or available reliable evidence.

Certain enrollee's may be required to follow a Medical Step Therapy program (see Medical policy MP/C009 Medical Step Therapy) for certain *healthcare services*.

GUIDELINES:

Surgery may be approved for either of the following I or II:

I. Imaging shows a defect (e.g. fracture, *spondylosis*, *spondylolisthesis*, spinal canal narrowing, disc herniation) that is consistent with acute or progressive neurological deficit or instability **(**e.g. numbness, weakness, gait disturbance, change in bowel or bladder control) that is correctable by surgery

Note: Requests for spinal surgery to treat spinal instability in the absence of neurological deficit must be reviewed by a physician

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Back and Neck Surgery	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/F019	**Page:** 2 of 3	

II. Pain has been present for more than 6 weeks and patient has completed an approved formal multidisciplinary rehabilitation program for the treatment of their neck and/or back pain - approved programs include, but are not limited to:

A. Fairview's Pain and Palliative Care Center

B. Fairview Sports Medicine/IAM (Institute of Athletic Medicine)

C. Physicians Neck and Back Clinic

D. LIFEBACK Program

Note: Fairview enrollees will be eligible for higher benefits when using a Fairview provider (i.e. Fairview's Pain and Palliative Care Center or Fairview Sports Medicine/IAM)

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Back and Neck Surgery	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/F019	**Page:** 3 of 3	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy

REFERENCES:

1. Greitemann B, Dibbelt S, Buschel C. Multidisciplinary orthopedic rehabilitation program in patients with chronic back pain and need for changing job situation – long-term effects of a multimodal, multidisciplinary program with activation and job development. Z Orthop Ihre Grenzgeb. 2006 May-Jun;144(3):255-66.
2. Institute for Clinical Systems Improvement. ICSI Health Care Guideline: Adult Low Back Pain. Twelfth Edition
   September 2006.
3. Joines JD. Chronic low back pain: progress in therapy. Curr Pain Headache Rep. 2006 Dec;10(6):421-5.
4. Smith SD. When the pain won't go away. Minnesota Medicine. January 2006;20-21.

DOCUMENT HISTORY:

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Exhibit C

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Mobile Cardiac Telemetry (CardioNet)	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/L007	**Page:** 1 of 3	

PRODUCT APPLICATION:
☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☒ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:
The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:
Cardiac Event Monitor/External Ambulatory Loop Monitor:
Event monitors are small devices that are used by patients over a longer period (weeks to months, typically one month). Two sticky patches (electrodes) on the chest connect two wires to the event recorder. The monitor is always on but will only store the patient's rhythm when the patient or caregiver pushes the button. Most monitors will save the rhythm for several seconds of rhythm before the button is even pushed. The rhythm is also saved for a period after the button is pushed. A few specialized monitors are used only after the patient has symptoms. The intent is for most event monitors to be worn as much as possible every day to increase the chances of recording the patient's rhythm when he/she has symptoms.

Holter Monitor:
The Holter monitor, invented by Dr. Norman Holter, is a device that records the heart rhythm continuously for 24 hours. This means that it records each and every heart beat over that time. Sticky patches (electrodes) on the chest are connected to wires from the Holter monitor. The monitor is carried with the patient for the recording period. The heart rhythm is recorded onto a cassette tape or flash card technology and then processed at a heart center. From this recording, a wide variety of information can be obtained including heart rates during day and night, abnormal heart beats, and recording of rhythm during any symptoms during the recording. A diary comes with the Holter for the patient or caregiver to write down the time and type of symptoms so the rhythm can be reviewed.

BACKGROUND:
This criteria set is based on expert consensus opinion and/or available reliable evidence.

Device should not be used for more than 21 days to detect infrequent arrhythmias.

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Mobile Cardiac Telemetry (CardioNet)	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/L007	**Page:** 2 of 3	

GUIDELINES:
Mobile cardiac telemetry is considered medically necessary when an FDA approved device is used for one of the following I - III:

I. Documentation by their physician indicates that the patient has been determined to be at high risk of cardiac arrhythmia despite being asymptomatic.

II. Diagnostic alternative to a cardiac event monitor for enrollees with infrequent arrhythmias (occur less frequently than once every 48 hours) who have documented difficulty triggering an event monitor (e.g. children, elderly patients, disabled patients, or patients with syncope).

III. Patient is symptomatic or is documented to be at high risk for cardiac arrhythmia after at least one other outpatient recording modality (e.g. Holter or cardiac event monitor) has been deemed non-diagnostic.

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Mobile Cardiac Telemetry (CardioNet)	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/L007	**Page:** 3 of 3	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy

REFERENCES:

1. Joshi AD, Kowey PR, Prystowsky EN et al. First experience with a Mobile Cardiac Outpatient Telemetry (MCOT) system for the diagnosis and management of cardiac arrhythmia. Am J Cardiol. 2005 Apr 1;95(7):878-81.
2. Saarel EV, Stefanelli CB, Fischbach PS, Serwer GA, Rosenthal A, Dick M 2nd. Transtelaphonic electrocardiographic monitors for evaluation of children and adolescents with suspected arrhythmias. Pediatrics 2004 Feb; 113(2):248-51.
3. Vasamreddy CR, Dalal D, Dong J et al. Symptomatic and asymptomatic atrial fibrillation in patients undergoing radiofrequency catheter ablation. J Cardiovasc Electrophysiol. 2006 Feb;17(2):134-9.

DOCUMENT HISTORY:

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Exhibit D

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/N005	**Page:** 1 of 4	

PRODUCT APPLICATION:
☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☒ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:
The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:
Cervical Dystonia:
Also known as spasmotic tortocollis. Involuntary contraction of neck muscles in any direction. The movements may be sustained or jerky. Sustained contractions cause abnormal posture of the head and neck, while periodic spasms produce jerky head movements.

Plagiocephaly:
Any condition characterized by a persistent flatten spot on the back or side of the head. Plagiocephay can be directly related to torticollis as the tightness on one side causes the infant to turn their head position to the unaffected side, sheering forces cause a flatness on that side, pushing the face and ear forward.

Torticollis (wry neck, wryneck):
Torticollis is a contracture/tightness of one sternocleidomastoid muscle. Torticollis in infancy is generally related to positioning in utero, difficult delivery, multiple gestations, fetal positioning low in the pelvis in the last trimester or rarely, birth trauma causing true muscular torticollis/fibrosis of sternocleidomastoid muscle.
The contracture/muscle tightness causes: 1.) The head to rotate so that the face is turned to the opposite side of tightness and 2.) the head to tilt toward the side of tightness so that the ear is closer to the shoulder on the side of tightness.

BACKGROUND:
This criteria set is based on expert consensus opinion and/or available reliable evidence.

Physical therapy, is usually effective in treating most cases, especially if instituted in the first two months of life. Botox has recently been shown to be an effective intermediate method of treatment for more resistant cases of torticollis in older children and adults, but is not used extensively in infants. Surgery may also be an option.

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/N005	**Page:** 2 of 4	

GUIDELINES:
Either of the following:

I. Torticollis – any of the following:

A. Physical Therapy – One of the following

1. One to three visits for teaching of passive stretching exercises to be done at home, and repositioning techniques can be approved initially, then re-evaluation will be done.

2. If no progress is documented in restriction of range of motion of neck following the initial 3 physical therapy visits an additional 3 visits may be recommended

3. Continuation of therapy beyond six (6) visits:
   a. Documentation of degree of restriction in neck range of motion is required
   b. Documentation of goals and detailed plan for involving parents/caregivers in home treatment plan (see Medical Criteria MC/N003 Occupational and Physical Therapy: Outpatient Setting)

C. Bracing/restraint use: for older infants/toddlers with refractory torticollis or those children that resist stretching exercises

D. Botox Injections (see Pharmacy Criteria PC/B003 Botulinum Toxin) following failure of home physical therapy

E. Surgical Correction for release or lengthening of sternocleidomastoid muscle if conservative treatment are not successful by 12 months of age

II. Positional Plagiocephaly – one of the following A or B:

A. Related to torticollis – either of the following 1 or 2

1. Physical therapy program
   a. An initial six (6) visits may be recommended for teaching of passive stretching exercises to be done at home, and repositioning techniques
   b. Continuation of therapy beyond six (6) visits:
      1.) Documentation of degree of restriction in neck range of motion is required
      2.) Documentation of goals and detailed plan for involving parents/caregivers in home treatment plan (see Medical Criteria MC/N003 Occupational and Physical Therapy: Outpatient Setting)

2. Cranial Orthosis
   a. Documentation of moderate to severe deformational plagiocephaly
   c. Infant is 4-18 months of age
   d. Failure of physical therapy program with 6-8 weeks of repositioning therapy

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/N005	**Page:** 3 of 4	

B. Not related to torticollis – any of the following 1 – 3:

1. Physical Therapy - One to three visits can be approved initially for teaching of passive stretching exercises, and repositioning techniques to be done at home, then re-evaluation will be done if further treatments are needed.

2. Cranial Orthosis
   a. Documentation of moderate to severe deformational plagiocephaly
   b. Infant is 4-18 months of age

3. Neurosurgical Intervention – for rare cases that have failed all available conservative treatment

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Department of Origin: Medical Management	**Approved by:** Medical-Surgical Quality Management Subcommittee	**Date approved:** 05/22/07
Department(s) Affected: Medical Management	**Effective Date:** 05/22/07	
Medical Criteria Document: Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/N005	**Page:** 4 of 4	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy
Medical Criteria MC/N003 Occupational and Physical Therapy
Pharmacy Criteria PC/B003 Botulinum Toxin

REFERENCES:

1. Celayir AC. Congenital muscular torticollis: early and intensive treatment is critical. A prospective study. de Chalain TM, Park S. Torticollis associated with positional plagiocephaly: a growing epidemic. J Craniofac Surg. 2005 May;16(3):411-8.
2. Do TT. Congenital muscular torticollis: current concepts and review of treatment. Curr Opin Pediatr. 2006 Feb;18(1):26-9.
3. Institute for Clinical Systems Improvement. Technology Assessment Reports: Cranial Orthoses for Deformational Plagiocephaly. TA #082; released 3/2004.
4. Joyce MB, deChalain TM. Treatment of recalcitrant idiopathic muscular torticollis in infants with botulinum toxin type a. J Craniofac Surg. 2005 Mar;16(2):321-7.
5. Oleszek JL, Chang N, Apkon SD, Wilson PE. Botulinum toxin type a in the treatment of children with congenital muscular torticollis. Am J Phys Med Rehabil. 2005 Oct;84(10):813-6.
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Exhibit E

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Chief Medical Officer	**Date approved:** 02/21/07
Department(s) Affected: Coding, Claims, Customer Service, Medical Management	**Effective Date:** 02/21/07	
Medical Policy Document: Preventative Immunizations	**Replaces Effective Policy Dated:** N/A	
Reference #: MP/I003	**Page:** 1 of 5	

PRODUCT APPLICATION:

- ☒ PreferredOne Community Health Plan (PCHP)
- ☒ PreferredOne Administrative Services, Inc. (PAS)
- ☐ PreferredOne (PPO)
- ☒ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This policy applies to PAS enrollees only when the employer group has elected to provide benefits for the service/procedure/device. Check benefits in SPD/COC. If benefits not specifically addressed in the SPD/COC verify with the appropriate account manager the availability of benefits.

PURPOSE:

The intent of this policy is to provide guidelines as to when routine preventative immunizations are covered.

DEFINITIONS:

DTaP:
A vaccine given to children to immunize them against diphtheria, tetanus and pertussis. Immunization can fade over time and periodic boosters are needed. (DTP) is an older version of DTaP and is no longer available in the United States).

Hib:
Haemophilus influenzae b Conjugate Vaccines

Inactivated Polio Vaccine (IVP):
An injection with inactivated or killed poliovirus.

Tdap:
First vaccine for adolescents and adults to protect against diphtheria, tetanus and pertussis.

Td:
Tetanus and diphtheria vaccine that has been used for many years as a booster for adolescents and adults. It does not contain pertussis vaccine.

POLICY:

Immunizations are a covered benefit if they are considered community standard based on the recommendations released by the Centers for Disease Control. For immunizations not addressed in this policy, or details on immunizations addressed by this policy please check the Centers for Disease Control's web site for their recommendation (http://www.cdc.gov/node.do/id/0900f3ec8000e2f3).

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Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date approved: 02/21/07
Department(s) Affected: Coding, Claims, Customer Service, Medical Management	Effective Date: 02/21/07	
Medical Policy Document: Preventative Immunizations	Replaces Effective Policy Dated: N/A	
Reference #: MP/I003	Page: 2 of 5	

GUIDELINES:

Table 1:
Routine Preventative Immunization Schedule for Infants, Children and Adolescents

Vaccine	Birth	1mo	2mo	4mo	6mo	12mo	15mo	18mo	24mo	4-6 Years	11-12 Years	15-18 Years
1. DTaP			X	X	X	X				X	Tdap	
2. IPV			X	X	X					X		
3. MMR (MMRV)	Combined measles, mumps, rubella and varicella vaccine (MMRV) is preferred for children 12 months through 12 years of age over separate injection of equivalent component vaccines.					X				X		
4. Varicella						X				X		
5. Pneumococcal (PCV7)			X	X	X	X						
6. Hib			X	X	X	X						
7. Rotavirus			X	X	X							
8. Hep B Schedule 1	X	X			X							
9. Hep B Schedule 2		X		X	X							
10. Influenza (FluMist allowed for ages 5 – 18)						X (6-59 months, annual – tiv)					X annual	X annual
11. Hep A							X					
12. Meningococcal											X	
13. Human Papilloma Virus											X (3-dose series)	X (catch up if not done at age 11 – 12 (3-dose series)

Table from Institute for Clinical Systems Improvement. Immunization Update. January 2007.

Table 2:
Special Uses Immunization Schedule for Infants, Children and Adolescents

Vaccine	6mo	12mo	2 Years	3 Years	4-6 Years	13-18 Years
4. Varicella			For children without evidence of immunity initiate and/or complete a 2-dose series of varicella vaccine. Minimum interval for 2nd dose is 3 months for children 12 months to 12 years and 28 days for children 13 years or older.			
5. Pneumococcal	There are two pneumococcal vaccines available: the 7 valent conjugated polysaccharide vaccine (PCV7) and the 23 valent polysaccharide vaccine (PPV23). PCV7 is intended for use in children age 6 weeks to 5 years; PPV23 is intended for use in age 2 years and older. Certain chronic conditions will place a child in a high-priority category for immunization.					
10. Influenza	X Annually (FluMist allowed for children age 5 – 18)					
11. Hep A		Vaccine is recommended for all children at 1-2 years of age with catch –up until school entry. For older children the risk-based strategy should continue. Hep A vaccine is recommended for all people 1 year of age or older living in an endemic area. Hep A is recommended for persons at increased risk including: • Persons traveling to or working in countries that have high or intermediate endemicity of infection • Men who have sex with men • Illegal drug users • Military personnel • Persons who have occupational risk for infection Special considerations for: • Persons with clotting disorders • Persons with chronic liver disease				
12. Meningococcal						X (15 years)
13. Human Papilloma Virus (HPV)						X (Catch up if appropriate)
14. Palivizumab (Synagis)	Considered medically necessary for high risk infants and children 24 months and under. (Prior authorization or administration of vaccine by a PreferredOne recommended vendor may be required)					

Table from Institute for Clinical Systems Improvement. Immunization Update. January 2007.

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Department of Origin: Medical Management	**Approved by:** Chief Medical Officer	**Date approved:** 02/21/07
Department(s) Affected: Coding, Claims, Customer Service, Medical Management	**Effective Date:** 02/21/07	
Medical Policy Document: Preventative Immunizations	**Replaces Effective Policy Dated:** N/A	
Reference #: MP/I003	**Page:** 4 of 5	

Table 3:
Adult Immunization Schedule – routine and High-Risk

Vaccine	19-26 Years	27-39 Years	40-64 Years	65 Years & Older
1. Td/Tdap	Tdap if previously not immunized, TD booster every 10 years			Td booster
2. IPV	Immunize if not previously immunized			
3. MMR	Persons born during or after 1957 should have 1-dose measles; a second dose may be required in special circumstances for adults who were: • Recently exposed to measles or in an outbreak setting • Previously vaccinated with killed measles vaccine • Vaccinated with an unknown vaccine during 1963-1967 • Are students in post secondary educational institutions • Work in healthcare facilities • Plan to travel internationally			
4. Varicella	For all adults who do not have evidence of immunity to varicella give two doses of varicella vaccine with at least 28 days between the first and second doses. Special consideration for varicella vaccination should be given to: • Those who have close contact with persons at high-risk for severe disease (health care workers and family contacts of immunocompromised persons). • Are at high =-risk for exposure or transmission to others (such as teachers of young children, child care employees, residents and staff members of institutional settings, including correctional institutions, college students, military personnel, adolescents and adults living in households with children, nonpregnant women of childbearing age, and international travelers) • Nonimmune family members living with a non-immune, pregnant or immune deficiency person should be immunized to lessen the risk of wild virus varicella in the immune deficient person • Children who are less than 18 that have conditions requiring treatment with chronic salicylates should be given the immunization to lessen their risk of Reye's Syndrome from wild varicella infections • While the currently formulated vaccine is not licensed for post-exposure prophylaxis, evidence supports its effectiveness in the first 3 days after exposure and its use would confer little risk			
5. Pneumococcal (PPV23)	Immunize high-risk groups once. Re-immunize those at risk of losing immunity once after five years.			Immunized at 65 if not done previously. Re-immunize once if 1st received more than five years ago and before age 65 or an appropriate immunocompromising condition is present
8. Hep B	Universal immunization		Immunize those at high risk	
10. Influenza	Annually between Oct – March (FluMist allowed for age 18 – 49)			
11. Hep A	Immunize those in risk groups			
12. Meningococcal	Immunize those in risk groups			
13. Human Paploma Virus (HPV)	X (catch up if not done as child, 3 dose series)			
14. Herpes Zoster/Shingles			Immunize at age 60 and older	

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Department of Origin: Medical Management	**Approved by:** Chief Medical Officer	**Date approved:** 02/21/07
Department(s) Affected: Coding, Claims, Customer Service, Medical Management	**Effective Date:** 02/21/07	
Medical Policy Document: Preventative Immunizations	**Replaces Effective Policy Dated:** N/A	
Reference #: MP/I003	**Page:** 5 of 5	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy

REFERENCES:
Institute for Clinical Systems Improvement. Health Care Guideline: Immunizations. Eleventh Edition June 2006.

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Exhibit F

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Behavioral Health Quality Management Subcommittee	**Date approved:** 05/08/07
Department(s) Affected: Medical Management	**Effective Date:** 05/08/07	
Medical Criteria Document: Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/M021	**Page:** 1 of 3	

PRODUCT APPLICATION:
☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☒ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:
The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:
DSM:
The most current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Health disorders.

BACKGROUND:
This criteria set is based on expert professional practice guidelines.

All requests for VNS requires prior authorization.

All requests for VNS require physician review.

GUIDELINES:
Must meet all of the following I - XI:

I. Patient is 18 years of age or older.

II. Patient has the primary DSM Axis I diagnosis of treatment resistant depression or treatment resistant bipolar disorder.

III. Patient is currently experiencing a major depressive episode.

IV. Requests for VNS must be submitted by a board certified psychiatrist.

V. Patient must have obtained a second opinion by a board certified psychiatrist who is knowledgeable about VNS and who concurs with the recommendation of VNS.

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Behavioral Health Quality Management Subcommittee	**Date approved:** 05/08/07
Department(s) Affected: Medical Management	**Effective Date:** 05/08/07	
Medical Criteria Document: Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/M021	**Page:** 2 of 3	

VI. Failure to respond to treatment with at least four (4) pharmacologic treatments of adequate dosage and duration of treatment including at least one tricyclic and one MAOI unless contraindications exist.

VII. Failure of two trials of augmentation of antidepressant treatment with agents such as Lithium, Lamictal, Thyroid Hormone, or combination antidepressant care.

VIII. Failure of an acute ECT series and maintenance ECT within the last 2 years, or it is determined that the patient is unable to do ECT, or it is unsafe for the patient.

IX. Patient has a history of hospitalization for depression or bipolar depression with insufficient clinical benefit.

X. Patient has a history of intensive outpatient program failure and outpatient psychotherapy failure.

XI. Implantation and treatment is being requested by the University of Minnesota Medical Center, Department of Psychiatry (when services are requested outside of Minnesota providers will be evaluated on a case by case basis by PreferredOne to determine if they have done a high volume of procedures and if outcome data from the procedure will be available).

PreferredOne®

Department of Origin: Medical Management	**Approved by:** Behavioral Health Quality Management Subcommittee	**Date approved:** 05/08/07
Department(s) Affected: Medical Management	**Effective Date:** 05/08/07	
Medical Criteria Document: Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression	**Replaces Effective Policy Dated:** N/A	
Reference #: MC/M021	**Page:** 3 of 3	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy

REFERENCES:

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2. HAYES ALERT. Critical Developments in Health Technology Assessment. Pivital Trial Data on NVS for Depression Published. Volume Viii, Number 10, October 2005.
3. George MS, Rush AJ, Marangell LB et al. A one-year comparison of vagus nerve stimulation with treatment as usual for treatment-resistant depression. Biol Psyciatry 2005;58:364-373.
4. Kosel M, Schlaepfer TE. Beyond the treatment of epilepsy: new applications of vagus nerve stimulation in psychiatry. CNS Spectrums July 2003;8(7):515-521.
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DOCUMENT HISTORY:

Created Date: 05/08/07
Reviewed Date:
Revised Date:

Exhibit G

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Antihistamines Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/A004	**Page:** 1 of 4	

PRODUCT APPLICATION:
- ☒ PreferredOne Community Health Plan (PCHP)
- ☒ PreferredOne Administrative Services, Inc. (PAS)
- ☐ PreferredOne (PPO)
- ☒ PreferredOne Insurance Company (PIC)

Coverage is subject to the terms of an enrollee's pharmacy benefit plan and formulary. To the extent there is any inconsistency between this criteria set/policy and the terms of an enrollee's pharmacy benefit plan and /or formulary, the enrollee's pharmacy benefit plan and formulary govern.

This criteria set applies only to PAS enrollees when the employer group has adopted the applicable drug trend management program(s).

PURPOSE:
The intent of this criteria set is to encourage the use of generic antihistamine/antihistamine-decongestant combinations prior to the use of brand name antihistamine/antihistamine-decongestant combinations.

DEFINITIONS:
Step Therapy:
Step therapy requires the use of the more cost-effective drug when there is no literature to support the therapeutic benefit of one drug over another. The first step in a step therapy process, utilizing the most cost-effective drug is called the first-line therapy. If first-line therapies are ineffective for a person, the next required step known as "second-line therapies" are tried, then "third-line therapies" etc. as required.

Automated Step Therapy:
Step therapy programs are generally automated within the pharmacy claims adjudication system. The pharmacy claims system reviews the patient's medication history prior to dispensing at the pharmacy. If the automated requirements are met, the pharmacy claim will automatically process through the claims processing system.

BACKGROUND:
This criteria set is based on U.S. Food and Drug Administration (FDA) approved indications, expert consensus opinion and/or available reliable evidence.

When requesting a drug other than a first line drug in step therapy, the ordering physician must supply additional clinical information documenting why the specific medication is required for the patient, or published professional literature supporting the increased therapeutic benefit or safety of the second, third (etc.) line drug.

Approval of a drug for step therapy does not ensure full coverage of the drug. Other pharmacy programs may be in place affecting supply and payment of the medication such as but not limited to formulary and copay guidelines (see Pharmacy Policy PP/F001 Formulary and Copay Drug Overrides) and quantity limits (see Pharmacy Policy PP/Q001 Quantity Limits per Prescription per Copayment).

PreferredOne®

Department of Origin: Pharmacy	Approved by: Pharmacy and Therapeutics Quality Management Subcommittee	Date approved: 04/18/07
Department(s) Affected: Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Antihistamines Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/A004	**Page:** 2 of 4	

Table 1:
Drugs Affected:

Generic Name	Generics available	Brand Name
loratadine tablets	Y	Claritin Alavert
loratadine rapidly disintegrating tablets	Y	Claritin Reditabs Alavert
loratadine syrup	Y	Claritin
cetirizine tablets, chewable tablets, and syrup	N	Zyrtec
fexofenadine capsules and tablets	Y	Allegra
desloratadine tablets and syrup	N	Clarinex Clarinex Reditabs
cetirizine/pseudoephedrine extended-release tablets	N	Zyrtec-D 12 Hour
desloratadine/pseudoephidrine extended-release tablets	N	Clarinex-D 12 Hour Clarinex-D 24 Hour
fexofenadine/pseudoephedrine extended-release tablets	N	Allegra-D 12 Hour Allegra-D 24 Hour
loratadine/pseudoephedrine extended-release tablets	Y	Claritin-D 12 Hour Alavert Allergy-Sinus Tab Claritin-D 24 Hour

These agents are characterized as causing very few central nervous system (CNS) side effects and they are less sedating and cause less impairment compared with first-generation antihistamines (e.g. diphenhydramine, chlorphenamine, hydroxyzine, triprolidine). Cetirizine, however, has demonstrated mixed results in studies with some reporting a similar incidence of CNS effects as placebo and others noting significant deterioration in psychomotor tests and cognitive abilities.

GUIDELINES:
Step Therapy Requirements – One of the following I - III:

I. The patient has been started and stabilized on one of the second line antihistamines (Table 3) during the previous 130 days (i.e. grandfathering).

II. The patient has not responded to, is intolerant to, or a poor candidate for a first line agent (Table 2), then a second line agent (Table 3) will be approved.

III. Zyrtec or Clarinex can be approved for children less than 2 years of age.

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Antihistamines Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/A004	**Page:** 3 of 4	

Table 2:
PreferredOne First Line Step Therapy Drugs*

FIRST LINE ANTIHISTAMINES
fexofenadine
OTC loratadine
OTC loratadine/psedoephedrine

* Listing of drugs in table above does not ensure coverage. Please check members prescription benefit.

Table 3:
PreferredOne Second Line Step Therapy Drugs*

SECOND LINE ANTIHISTAMINES
Clarinex
Clarinex-D 12 Hour
Clarinex-D 24 Hour
Zyrtec
Zyrtec-D 12 Hour
Allegra
Allegra-D

* Listing of drugs in table above does not ensure coverage. Please check members prescription benefit.

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Antihistamines Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/A004	**Page:** 4 of 4	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Medical Policy MP/C009 Medical Step Therapy
Pharmacy Policy PP/S001 Step Therapy

REFERENCES:

1. Bhattacharyya N, Kepnes LJ. Associations between fatigue and medication use in chronic rhinosinusitis. Ear Nose Throat J. 2006 Aug;85(8):510, 512, 514-5.
2. Davies MJ, Fisher LH, Chegini S, Craig TJ. A practical approach to allergic rhinitis and sleep disturbance management. Allergy Asthma Proc. 2006 May-Jun;27(3):224-30.
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Exhibit H

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Medical Management and Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Sedative Hypnotics Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/S003	**Page:** 1 of 4	

PRODUCT APPLICATION:

☒ PreferredOne Community Health Plan (PCHP)
☒ PreferredOne Administrative Services, Inc. (PAS)
☐ PreferredOne (PPO)
☒ PreferredOne Insurance Company (PIC)

Coverage is subject to the terms of an enrollee's pharmacy benefit plan and formulary. To the extent there is any inconsistency between this criteria set/policy and the terms of an enrollee's pharmacy benefit plan and /or formulary, the enrollee's pharmacy benefit plan and formulary govern.

This criteria set applies only to PAS enrollees when the employer group has adopted the applicable drug trend management program(s).

PURPOSE:

The intent of criteria is to encourage the use of first line sedative hypnotics (Table 2) prior to the use of second line sedative hypnotics (Table 3).

DEFINITIONS:

Step Therapy:

Step therapy requires the use of the more cost-effective drug when there is no literature to support the therapeutic benefit of one drug over another. The first step in a step therapy process, utilizing the most cost-effective drug is called the first-line therapy. If first-line therapies are ineffective for a person, the next required step known as "second-line therapies" are tried, then "third-line therapies" etc. as required.

Automated Step Therapy:

Step therapy programs are generally automated within the pharmacy claims adjudication system. The pharmacy claims system reviews the patient's medication history prior to dispensing at the pharmacy. If the automated requirements are met, the pharmacy claim will automatically process through the claims processing system.

BACKGROUND:

This criteria set is based on U.S. Food and Drug Administration (FDA) approved indications, expert consensus opinion and/or available reliable evidence.

When requesting a drug other than a first line drug in step therapy, the ordering physician must supply additional clinical information documenting why the specific medication is required for the patient, or published professional literature supporting the increased therapeutic benefit or safety of the second, third (etc.) line drug.

Approval of a drug for step therapy does not ensure full coverage of the drug. Other pharmacy programs may be in place affecting supply and payment of the medication such as but not limited to formulary and copay guidelines (see Pharmacy Policy PP/F001 Formulary and Copay Drug Overrides) and quantity limits (see Pharmacy Policy PP/Q001 Quantity Limits per Prescription per Copayment).

PreferredOne®

Department of Origin: Pharmacy	Approved by: Pharmacy and Therapeutics Quality Management Subcommittee	Date approved: 04/18/07
Department(s) Affected: Medical Management and Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Sedative Hypnotics Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/S003	**Page:** 2 of 4	

Table 1:
Drugs Affected

Generic Name	Generics available	Brand Name
estazolam	Y	ProSom
eszopiclone tablets	N	Lunesta
flurazepam	Y	Dalmane
quazepam	N	Doral
ramelteon tablets	N	Rozerem
temazepam	Y	Restoril
trazodone	Y	Desyrel
triazolam	Y	Halcion
zaleplon capsules	N	Sonata
zolpidem tablets	Y	Ambien
zolpidem extended-release tablets	N	Ambien CR

POLICY:
Certain enrollee's may be required to follow a Step Therapy program for certain drug classes.

GUIDELINES:
Step Therapy Requirements – one of the following I-IV:

I. The patient has been started and stabilized on one of the second line sedative hypnotics (Table 3) during the previous 130 days (i.e. grandfathering).

II. For patients age 60 and under who have not responded to, are intolerant to, or a poor candidate for two first line drugs (Table 2), then a second line agent (Table 3) will be approved.

III. For patients over age 60 who have not responded to, are intolerant to, or a poor candidate for Ambien (Table 2), then a second line agent (Table 3) will be approved.

III. Exceptions – either of the following A or B:

A. Sonata may be allowed if the patient is in a situation of possible forced-awakening at which time the patient would be expected to engage in activity in which cognitive or motor impairment would not be acceptable (e.g., on-call work, military operations, etc.).

B. If the patient requires concomitant use of an agent that has a noted potential drug-drug interaction with Ambien or a higher potential to interact with Ambien compared to the other agents in this category, then a trial of Ambien is not required and a second line agent may be approved.

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Medical Management and Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Sedative Hypnotics Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/S003	**Page:** 3 of 4	

Table 2:
PreferredOne First Line Step Therapy Drugs*

FIRST LINE SEDATIVE HYPNOTICS
Ambien®
estazolam
flurazepam
Rozerem™
temazepam
trazodone
triazolam

Revised 02/26/07

*Listing of drugs in table above does not ensure coverage. Please check member's prescription benefit.

Table 3**:**
PreferredOne Second Line Step Therapy Drugs*

SECOND LINE SEDATIVE HYPNOTICS
Ambien™ CR
Doral®
Lunesta™
Sonata®

Revised 02/26/07

*Listing of drugs in table above does not ensure coverage. Please check member's prescription benefit.

PreferredOne®

Department of Origin: Pharmacy	**Approved by:** Pharmacy and Therapeutics Quality Management Subcommittee	**Date approved:** 04/18/07
Department(s) Affected: Medical Management and Pharmacy	**Effective Date:** 04/18/07	
Pharmacy Criteria Document: Sedative Hypnotics Step Therapy	**Replaces Effective Policy Dated:** N/A	
Reference #: PC/S003	**Page:** 4 of 4	

RELATED CRITERIA/POLICIES:
Medical Management Process Manual MI007 Use of Medical Policy and Criteria
Pharmacy Policy PP/C002 Cost Benefit Program
Pharmacy Policy PP/Q001 Quantity Limits
Pharmacy Policy PP/S001 Step Therapy

REFERENCES:

1. Express Scripts Step Therapy Policy: Sedative Hypnotics. 05/17/06.
2. Dundar Y, Boland A, Strobl J et al. Newer hypnotic drugs for the short-term management of insomnia: a systematic review and economic evaluation. Health Technol assess. 2004 Jun;8(24):iii-x, 1-125.
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5. McCall WV. Diagnosis and management of insomnia in older people. J Am Geriatr Soc. 2005 Jul;53(7 Suppl):S272-7.
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Exhibit I

Medical Policy Table of Contents

Reference #	Description
C001	Court Ordered Mental Health & Substance Related Disorders Services *Revised*
C002	Cosmetic Procedures *Revised*
C003	Criteria Management and Application
C008	Oncology Clinical Trials, Covered / Non-covered Services
C009	Medical Step Therapy
D002	Diabetic Supplies *Revised*
D004	Durable Medical Equipment, Supplies, Orthotics and Prosthetics *Revised*
D007	Disability Determinations: Proof of Incapacity Requirements
D008	Dressing Supplies *Revised*
E004	Nutrition Therapy
G001	Genetic Testing
H003	Home Prothrombin Time Testing Devices *Revised*
H004	Healthcares Services with Demonstrated Lack of Therapeutic Benefit *Revised*
H005	Home Health Care (HHC) *Revised*
I001	Investigational/Experimental (Formerly MM/B010)
I002	Infertility Treatment *Revised*
I003	Preventative Immunizations *New*
N002	Nutritional Counseling *Revised*
P008	Medical Policy Document Management and Application
R002	Reconstructive Surgery *Revised*
S006	Screening Tests for Normal Risk Populations *Revised*
S008	Scar Revision *Revised*
S009	Screening Tests for Patient Specific Situations (High Risk) *Revised*
S010	Stereotactic Radiosurgery (Cyberknife, Gamma Knife, Linear Accelerator) *Revised*
T002	Transition of Care for Continuity and Safety
T004	Therapeutic Overnight Pass *Revised*
T005	Transfers from an Acute Care Facility to a Lower Level of Care for Rehabilitation *Revised*
W001	Physician Directed Weight Loss Programs *Revised*

Revised 04/23/07

Exhibit J

Medical criteria accessible through this site serve as a guide for evaluating the medical necessity of services. They are intended to promote objectivity and consistency in the medical necessity decision-making process and are necessarily general in approach. They do not constitute or serve as a substitute for the exercise of independent medical judgment in enrollee specific matters and do not constitute or serve as a substitute for medical treatment or advice. Therefore, medical discretion must be exercised in their application. Benefits are available to enrollees only for covered services specified in the enrollee's benefit plan document. Please call the Customer Service telephone number listed on the back of the enrollee's identification card for the applicable pre-certification or prior authorization requirements of the enrollee's plan. The criteria apply to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

Medical Criteria Table of Contents

L002	Diagnostic	**Coronary Artery Calcium Scoring Without Contrast**
L004	Diagnostic	**Coronary Computed Tomography (CT) Angiography**
L005	Diagnostic	**Virtual Colonoscopy**
L006	Diagnostic	**Wireless Capsule Endoscopy**
L007	Diagnostic	**Mobile Cardiac Telemetry (CardioNet)** ***New***
M001	BH/Substance Related Disorders	**Mental Health Disorders: Inpatient Treatment** ***Revised***
M002	BH/Substance Related Disorders	**Electroconvulsive Treatment (ECT): Inpatient Treatment** ***Revised***
M004	BH/Substance Related Disorders	**Mental Health Disorders: Day Treatment Program** ***Revised***
M005	BH/Substance Related Disorders	**Eating Disorders-Level of Care Criteria**
M006	BH/Substance Related Disorders	**Mental Health Disorders: Partial Hospital Program (PHP)**
M007	BH/Substance Related Disorders	**Residential Treatment: Mental Health/Substance Related Disorders** ***Revised***
M008	BH/Substance Related Disorders	**Psychotherapy: Outpatient Treatment** ***Revised***
M009	BH/Substance Related Disorders	**Chronic Pain: Outpatient Program** ***Revised***
M010	BH/Substance Related Disorders	**Substance Related Disorders: Inpatient Primary Treatment**
M014	BH/Substance Related Disorders	**Detoxification: Inpatient Treatment**
M019	BH/Substance Related Disorders	**Pathological Gambling: Outpatient Treatment** ***Revised***
M020	BH/Substance Related Disorders	**Autism Spectrum Disorders Treatment** ***Revised***
M021	BH/Substance Related Disorders	**Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression** ***New***
N001	Rehabilitation	**Acute Inpatient Rehabilitation** ***Revised***
N002	Rehabilitation	**Skilled Nursing Facilities**
N003	Rehabilitation	**Occupational and Physical Therapy: Outpatient Setting**
N004	Rehabilitation	**Speech Therapy: Outpatient**
N005	Rehabilitation	**Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers** ***New***
T001	Transplant	**Bone Marrow / Stem Cell Transplantation** ***Revised***

T002	Transplant	**Kidney / Pancreas Transplantation** ***Revised***
T003	Transplant	**Heart Transplantation**
T004	Transplant	**Liver Transplantation** ***Revised***
T005	Transplant	**Lung Transplantation**
T006	Transplant	**Intestinal Transplant** ***Revised***

Revised 05/22/07

Exhibit K

Pharmacy Criteria Table of Contents

Reference #	Category	Description
A001	Pharmacy	**ACE Inhibitors Step Therapy** *Revised*
A002	Pharmacy	**Oral Antifungal Treatment**
A003	Pharmacy	**Advair Step Therapy**
A004	Pharmacy	**Antihistamines Step Therapy** *New*
B003	Pharmacy	**Botulinum Toxin** *Revised*
B004	Pharmacy	**Drugs for Rheumatoid Arthritis** *Revised*
B005	Pharmacy	**Biologics for Psoriasis: Amevive (alefacept) Enbrel (etanercept), Humira (adalimumab) and Raptiva (efalizumab)** *Revised*
B006	Pharmacy	**Biologics (Remicade) for Crohn's Disease and Ulcerative Colitis** *Revised*
B007	Pharmacy	**Biologics (Enbrel & Remicade) for Ankylosing Spondylitis** *Revised*
C002	Pharmacy	**Cyclooxygenase-2 (COX-2) Inhibitors (Celebrex)** *Revised*
C003	Pharmacy	**Topical Corticosteroids Step Therapy**
D002	Pharmacy	**Dihydropyridine Calcium Channel Blocker (DHP CCB) Step Therapy** *Revised*
G001	Pharmacy	**Growth Hormone Therapy**
H001	Pharmacy	**HMG - CoA Reductase Inhibitor**
I001	Pharmacy	**Topical Immunomodulators** *Revised*
L002	Pharmacy	**Leukotriene Pathway Inhibitors Step Therapy**
L003	Pharmacy	**Lyrica Step Therapy**
N002	Pharmacy	**Nasal Steroids Step Therapy**
P001	Pharmacy	**Proton Pump Inhibitor (PPI) Step Therapy** *Revised*
R002	Pharmacy	**RSV Prohylaxis - American Academy of Peds**
S002	Pharmacy	**Selective Serotonin Reuptake Inhibitors (SSRIs) Step Therapy** *Revised*
S003	Pharmacy	**Sedative Hypnotics Step Therapy** *New*
W001	Pharmacy	**Weight Loss Medications**
X001	Pharmacy	**Xolair (omalizumab)**

Revised 04/18/07

Exhibit L

PreferredOne

DEPARTMENT: Coding Reimbursement	APPROVED DATE:
POLICY DESCRIPTION: Outpatient Facility Fees	REVIEWED/UPDATED: 6/15/07
EFFECTIVE DATE: 4/21/98	
PAGE: 1 of 1	REPLACES POLICY DATED: 12/31/96
REFERENCE NUMBER: H - 2	RETIRED DATE:

SCOPE: Network Management, Claims, Customer Service, Sales and Finance

PURPOSE: Reimbursement of facility fees for a clinic room is a duplication of payments already made to physicians billing for professional services. The practice of allowing additional reimbursement for clinic room charges is inequitable to the majority of providers who incur facility overhead.

POLICY: PreferredOne will deny facility fees submitted for clinic room charges.

PROCEDURE:

1. Do not bill facility fees for a clinic room when the services rendered are normally reimbursable through physician professional fees. These clinic room charges include but are not limited to:

   - Revenue codes 510 –521, 523, 529, 760, 761, 769, billed on a UB-92 and
   - CPT codes are as 99199, unlisted service, billed on a HCFA 1500

   Any method of billing for clinic type room charges/facility fees under these circumstances is inappropriate such as but not limited to revenue code 914 and 530.

2. Facilities are encouraged to negotiate with physician providers regarding reimbursement for facility usage.

DEFINITIONS:

REFERENCES: