PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
June 2009

PreferredOne Comprehensive Chronic Back Pain Therapy Programs

John Frederick, MD, Chief Medical Officer

In the last Provider Newsletter I discussed the implementation of patient involvement in Comprehensive Chronic Back Pain Therapy Programs to promote better "Back Health." I received very enthusiastic response from a number of therapists who treat chronic back issues. I have had further discussion with a number of individuals. I would like to lay out the criteria for being listed as a PreferredOne Chronic Back Therapy Program. The chronic back therapy programs must:

1. Present a written definition of their program components including the frequency of care and length of therapy to be expected.
2. Define an outcome measure, such as the Oswestry Score, that can be used to measure outcomes, follow therapy progress, and allow comparative effectiveness of the designated back programs.
3. Define the treatment team and their roles including any physician involvement.
4. Present a written summary of the program aimed at members that includes contact information, location, and other information to be used by PreferredOne care managers to introduce the program to members.
5. Have an interest in developing "package pricing" allowing members to have an expectation of their financial responsibility upon entering the program.

We are now ready to accept applications from any prospective Comprehensive Chronic Back Therapy Programs. The benefit to the programs is that the PreferredOne care managers will direct members to the designated programs. The benefit to the members is expected to be the ability to lead a healthier more active life. Please call me at 763-847-3051 with any questions. To submit applications, programs should mail the above information to me at John.Frederick@PreferredOne.com or:

PreferredOne
Attn: John Frederick, MD
6105 Golden Hills Drive,
Golden Valley, MN 55416

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PreferredOne
6105 Golden Hills Dr.
Golden Valley, MN 55416

Phone: 763-847-4000
800-451-9597
Fax: 763-847-4010

CLAIM ADDRESSES:

PreferredOne Insurance Corporation (PIC)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

PreferredOne PPO
PO Box 1527
Minneapolis, MN 55440-1527

Phone: 763-847-4400
800-451-9597
Fax: 763-847-4010

PreferredOne Community Health Plan (PCHP)
PO Box 59052
Minneapolis, MN 55459-0052

Phone: 763-847-4488
800-379-7727
Fax: 763-847-4010

PreferredOne Administrative Services (PAS)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

PreferredOne Obesity Management Programs

John Frederick, MD

PreferredOne is now piloting a program to help members better manage obesity. This is an issue that leads to severe chronic medical problems as well as having a significant impact on a member's ability to lead an active healthy life. A major issue with obesity that frequently it is not formally addressed when the member is in the office. If it is discussed, it frequently is not coded. If it is not coded it is difficult for plans to support members in addressing their weight issues. Components of the PreferredOne program will be to encourage providers who care for children to measure and plot the BMI as part of the child's care. The ACP and others have encouraged providers to follow this measure and react appropriately to outliers. PreferredOne will also identify programs that have had success with supporting adult and children in their weight loss efforts, facilitating employers in setting up worksite efforts, and involving PreferredOne care managers in discussions with members. There will be more information to follow on this effort.

You Are Invited to the Fall '09 PreferredOne Provider Forum

We are pleased to invite PreferredOne Providers to visit us here at PreferredOne for a Provider Forum and continental breakfast on **Tuesday, September 15, 2009.** Sign-in from 7-7:30 a.m./Program from 7:30-8:30 a.m**.** This is a great opportunity for you to hear the PreferredOne updates, learn about our membership, get the first look at new policies, and give input on upcoming issues. This Forum will keep you current and up to date with all that is happening at PreferredOne in this ever changing healthcare industry.

We will have a special Q & A session to hear your feedback and answer any questions you might have for us. To RSVP, please visit www.PreferredOne.com, click on "For Providers" in the side menu bar on the home page. Once in the Login/Registration page, click on "2009 PreferredOne Provider Forum RSVP" and submit your email address by September 1, 2009 or simply click HERE to be taken directly to the page. We hope to see you here!

EDI Update

PreferredOne Compliance with Minnesota E3 Electronic Claim Requirements

PreferredOne will be complying with the Minnesota E3 Electronic Claim Requirements, effective July 15, 2009.

Claims Submission

MN providers are required to submit all of their claims electronically beginning July 15, 2009. PreferredOne, along with other MN health plans, has contracted with Infotech Global, Inc. (IGI) to offer providers a tool to easily meet the state's July 15 electronic claims submission deadline. Providers may register now at www.mnEconnect.com to use the tool, which is offered at no cost to providers to submit claims.

We also have numerous clearinghouse connections that providers may utilize for their claim submissions. Please visit our provider internet portal for more information: https://secure.preferredone.com/providerapps/edi.asp *Page 3...*

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Medical Code Sets

MN providers are required to submit claims codes as instructed by CMS or Appendix A of Minnesota's Uniform Claims Guide (professional, institutional or dental). Note: This requirement does not guarantee payment. Please refer to PreferredOne's payment policy for further information and/or instructions.

Claims Attachments

PreferredOne will be complying with the AUC Best Practice for Claims Attachments. Claims submitted with attachments must indicate that an attachment will be sent via other method (preferably fax per the AUC Best Practice), or by mail. The fax number for attachments is 763-847-4010. If sending attachments via mail, please refer to the mailing address on the patient's ID card.

Replacement/Void Claims

PreferredOne will be complying with the AUC Best Practice for Replacement/Void Claims. A replacement/void claim must include the PreferredOne claim number, or the claim will be denied.

Electronic COB Claims

PreferredOne will be complying with the previous payer payment information (COB) requirements in the Minnesota Uniform Claims Guide (professional, institutional or dental).

Submission of Appeals

PreferredOne will be complying with the AUC Best Practice for Submission of Appeals. Appeals should be faxed to your Provider Relations Representative. If you are unsure who that is please fax your appeal to 763-847-4851.

Additional Information

For further information about PreferredOne's EDI capabilities, please refer to our provider internet portal https://secure.preferredone.com/providerapps/edi.asp, or contact your network provider representative.

For additional information about Minnesota's E3 Electronic Claim Requirements, please refer to the MN Administrative Uniformity Committee website http://www.health.state.mn.us/auc/index.html.

Updated Policy

Updated Policy H-9 "Reimbursement for Free Standing Ambulatory Surgery Centers and Hospital Outpatient Ambulatory Surgery Centers." Please read the attached updated policy (Exhibit A) regarding the change in the C series of HCPCS codes with an APC status indicator of "N." Effective with dates of services 6/1/09 and after, this specific term of the policy will no longer be applied.

Provider Appeal Policy

Provider appeals will be accepted within 60 days of the original remittance date. See the attached (Exhibit B) pricing and payment policy going into effect August 1, 2009.

Now available on the PreferredOne website is a claim adjustment request form for PCHP/PAS/PIC. This form is to be used only after payment has been made by PreferredOne and an adjustment is needed to a claim but it is within 60 days of the original remittance date.

Case Management Services

What is Case Management

Case management is a collaborative process among a PreferredOne employed Case Manger (an RN or Social Worker), the plan member, and the member's family, and health care providers. The goal of case management is to help members in navigating through the complex medical system. The Case Manager will assist in preventing gaps in care with the goal of achieving optimum health care outcomes in an efficient and cost-effective manner. This service is **not** intended to take the place of the attending providers or to interfere with care.

Core Services

- Serve as a resource to members
- Provide both verbal and written education regarding a disease condition
- Coordinate care
- Serve as a liaison between the health plan, member, and providers

Eligibility and Access

All members of the health plan experiencing complex health needs are eligible for case management. A Case Manager may contact a member based on information that has been received at PreferredOne, or members may call and request a Case Manager. There is no cost for this service and it is strictly optional.

Health care provider referrals and member self referrals are accepted by contacting PreferredOne and requesting to speak with a Case Manager. Please call 763-847-4477, option 2**.** This information can also be found on the PreferredOne website at www.PreferredOne.com.

Medical Policy Update

Medical Policies are available on the PreferredOne website to members and to providers without prior registration. The website address is www.PreferredOne.com. Click on Health Resources and choose Medical Policy from the menu.

PreferredOne purchased Milliman Care Guidelines as an additional tool to support the Medical Management staff in making medical necessity determinations. Milliman is a national vendor for care guidelines. Our on-going evaluation of the guidelines continues. If both Milliman and PreferredOne has criteria for the same healthcare service, we compare the two criteria sets to assess if we will continue to the follow PreferredOne criteria or adopt Milliman Care guidelines. If we chose to adopt a Milliman Care Guideline, the PreferredOne criteria is retired.

The Behavioral Health, Chiropractic, Medical/Surgical and Pharmacy and, Therapeutics Quality Management Subcommittees approve new criteria sets for use in their respective areas of medical management. Quality Management Subcommittee approval is not required when there has been a decision to adopt Milliman Care Guidelines, to retire PreferredOne criteria sets, or when new Medical Polices are created; approval by the Chief Medical Officer is required. Notification of decisions to retire or the development of new Medical Policies is provided to the quality management subcommittees as informational only.

Milliman Guidelines cannot be posted on our website; however, copies of individual guidelines are available upon request.

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Since the last newsletter, the Behavioral Health Quality Management Subcommittee has approved or been informed of the following:

- No new PreferredOne criteria sets
- Two new Behavioral related medical policies:
    - Intensive Residential Treatment Service (IRTS)
    - Substance Related Disorders Coverage Considerations

Since the last newsletter, the Chiropractic Quality Management Subcommittee has approved or been informed of the following:

- No new PreferredOne criteria sets
- No new Chiropractic related medical policies

Since the last newsletter, the Medical-Surgical Quality Management Subcommittee has approved or been informed of the following:

- No new PreferredOne criteria sets
- Three new Medical-Surgical related medical policies:
    - Physical, Occupational and Speech Therapy: Outpatient Setting
    - Demonstration of Provider Clinical Competence
    - Narrow-band UVB Phototherapy (non-laser) for Psoriasis

Three (3) additions to the M/S Investigational/Unproven Comparative Effectiveness List:

- Exatest
- Hyaluronic Acid injections into any joint other than the knee
- 4-Channel Pneumocardiogram Home Monitoring for Evaluation of Sleep Apnea in Children

No deletions from the Investigational/Unproven Comparative Effectiveness List.

Since the last newsletter, the Pharmacy and Therapeutics Quality Management Subcommittee has approved or been informed the following:

- One (1) new PreferredOne pharmacy criteria set:
    - Diabetic Medication Step Therapy

No new Pharmacy related medical policies.

Three (3) additions to the Pharmacy Investigational/Unproven Comparative Effectiveness List:

- Avastin for all Ocular Indications except Neovascular (wet) Age-Related Macular Degeneration (AMD) and Retinal Vein Occlusion

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- Lucentis for all Ocular Indications except Neovascular (wet) Age-Related Macular Degeneration (AMD) and Retinal Vein Occlusion

No deletions from the Pharmacy Investigational/Unproven Comparative Effectiveness List.

The attached documents include the latest Medical and Pharmacy Policy and Criteria indexes. Please add these documents (Exhibits C, D, E, & F) to the Utilization Management section of your Office Procedures Manual. For the most current version of the policy and criteria documents, please access the Medical Policy option on the PreferredOne website.

If you wish to have paper copies of these documents, or you have questions, please contact the Medical Policy Department telephonically at (763) 847-3386 or email Heather.Hartwig-Caulley@PreferredOne.com

Institute for Clinical Systems Improvement (ICSI)

The new and recently revised ICSI health care guidelines, order sets, and protocols listed below are available at www.icsi.org

Health Care Guidelines

April 2009: None

March 2009:

- Headache, Diagnosis and Treatment
- Venous Thromboembolism Diagnosis and Treatment

February 2009:

- Chronic Obstructive Pulmonary Disease (COPD), Diagnosis and Management

Health Care Order Sets and Protocols

April 2009: None

March 2009: None

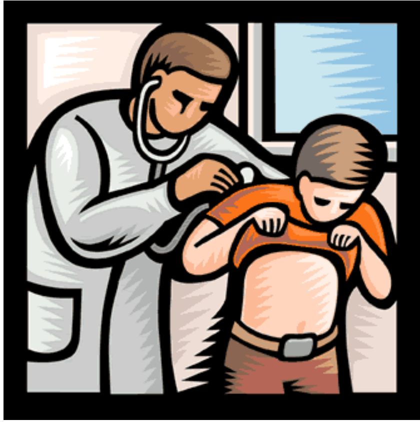
February 2009: None

Quality Management Update

Affirmative Statement about Incentives

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.

Childhood Obesity and the Primary Care Practitioner's Role in Assessment, Identification and Treatment



There is a growing body of knowledge and community focus on childhood obesity. Obesity is a serious health concern for children and adolescents. Data from NHANES surveys (1976–1980 and 2003–2006) show that the prevalence of obesity has increased: for children aged 2–5 years, prevalence increased from 5.0% to 12.4%; for those aged 6–11 years, prevalence increased from 6.5% to 17.0%; and for those aged 12–19 years, prevalence increased from 5.0% to 17.6%.

Obese children and adolescents are more likely to become obese as adults. For example, one study found that approximately 80% of children who were overweight at age 10–15 years were obese adults at age 25 years.[1] Another study found that 25% of obese adults were overweight as children.[2] The latter study also found that if overweight begins before 8 years of age, obesity in adulthood is likely to be more severe.

So what role do primary care providers play in assessing children for obesity risk and improving early identification of elevated BMI, medical risks, and unhealthy eating and physical activity habits?

In *Pediatrics* (2007; 120; S164-S192) author Sarah Barlow and an Expert Committee address several key recommendations for providers which include:

- Annual screening and addressing of weight management and lifestyle for all patients (utilizing BMI-for-age percentile charts)
- All children between 2-18 years, who are at a healthy weight, should be informed of prevention methods:
    - Limit consumption of sugar-sweetened beverages
    - Encourage diets with recommended quantities of fruits and vegetables
    - Limiting television and other screen time to no more than two hours per day
    - Removing television and computers from children's primary sleeping areas
    - Eating breakfast daily
    - Limiting eating at restaurants, particularly fast food restaurants
    - Encouraging family meals
    - Limiting portion sizes
- Staged treatment of oversight involving caregiver participation and consideration for age, BMI, comorbidities, and parental weight status

In summary, primary care providers should universally assess children for obesity risk to improve early identification of elevated BMI, medical risks, and unhealthy eating and physical activity habits. Providers can provide obesity prevention messages for most children and suggest weight control interventions for those with excess weight.

The National Committee on Quality Assurance (NCQA) has supported these recommendations in their development and implementation of a measure focusing on childhood obesity diagnosis and weight management counseling (physical activity and nutrition) in 2009. In 2010 PreferredOne will begin collecting information from clinics sites to support this measure (in addition to an adult weight assessment measure). Locally, ICSI's Obesity Prevention and Management guideline outlines similar recommendations for adolescents and adults.

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Childhood obesity is a complex condition that need to be addressed on many levels and PreferredOne is committed to addressing this issue from both an individual health perspective and as a health care community encouraging our network practitioners to assess and counsel their patients so we can improve the health of our youngest members.

For more information regarding the recommendations regarding the prevention, assessment and treatment of child and adolescent and obesity, please see: *Pediatrics* 2007: 120; S164-S192.

1. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. *N Engl J Med* 1997; 37(13):869–873.

2. Freedman DS, Khan LK, Dietz WH, Srinivasan SR, Berenson GS. Relationship of childhood overweight to coronary heart disease risk factors in adulthood: The Bogalusa Heart Study. *Pediatrics* 2001;108:712–718.

HEDIS Chart Abstraction & Coding

Each spring PreferredOne conducts site visits or requests medical records from our provider network to fulfill our obligation of collecting annual healthcare effectiveness data information sets (HEDIS) that support our regulatory and accreditation requirements. HEDIS measures are nationally used by all accredited health plans and PreferredOne also has an obligation to the Minnesota Department of Health to collect HEDIS data on an annual basis.

What you may not realize is that the burden of collecting this information from your records could be lessened if practitioners were to use appropriate CPT Category II codes when submitting the HCFA billing statements. There are several hybrid HEDIS measures that can be collected both from administrative data and chart information. Submitting these codes on your billing statements would allow PreferredOne to collect this information administratively and in turn reduce the number of charts we need to review from your medical offices for chart review. Below is a list of the measures and their supporting CPT Category II codes in which we are seeking practitioner sites to submit on the HCFA to assist us in obtaining the required data to support our HEDIS efforts. These measures include:

- Adult Body Mass Index (BMI) Assessment:

This measure examines the percentage of members 18-74 years of age who had an outpatient office visit and has had their BMI documented.

ICD-9-CM Diagnosis	HCPCS
V85.0-V85.5	G8417-G8420

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:

This measure examines the percentage of members 2-17 years of age who had an outpatient office visit and who had evidence of BMI percentile assessment, counseling for nutrition and counseling for physical activity.

Description	CPT	ICD-9-CM Diagnosis	ICD-9-CM Procedure	HCPCS
BMI Percentile		V85.5		
Counseling for nutrition	97802-97804	V65.3		S9470, S9452, S9449, G0270-G0271
Counseling for physical activity		V65.41	93.11, 93.13, 93.19, 93.31	S9451, H2032

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- Comprehensive Diabetes Care (CDC):

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c good control (<7.0%)
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Blood pressure control (<130/80 mm Hg)
- Blood pressure control (<140/90 mm Hg)

Codes to Identify HbA1c Screening & Results

CPT Category II
3044F, 3045F, 3046F, 3047F

Codes to Identify Eye Exams

CPT Category II
2022F, 2024F, 2026F, 3072F

Codes to Identify LDL-C Screening & Results

CPT Category II
3048F, 3049F, 3050F

Codes to Identify Nephropathy Screening Tests

CPT Category II
3060F, 3061F

Codes to Identify Evidence of Nephropathy

Description	CPT Category II
Urine macro-albumin test	3062F
Evidence of treatment for nephropathy	3066F
ACE inhibitor/ARB therapy	4009F

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Codes to Identify Systolic and Diastolic BP Levels <130/80

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <130/80 mm Hg)	3074F	3078F
Not numerator compliant (BP ≥130/80 mm Hg)	3075F, 3077F	3079F, 3080F

Codes to Identify Systolic and Diastolic BP Levels <140/90

Description	CPT Category II	
	Systolic	Diastolic
Numerator compliant (BP <140/90 mm Hg)	3074F, 3075F, 3076F	3078F, 3079F
Not numerator compliant (BP ≥140/90 mm Hg)	3077F	3080F

- Cholesterol Management for Patients With Cardiovascular Conditions (CMC):

The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA) from January 1–November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to measurement year, who had each of the following during the measurement year.

  - LDL-C screening
  - LDL-C control (<100 mg/dL)

Codes to Identify LDL-C Screening

CPT	CPT Category II
80061, 83700, 83701, 83704, 83721	3048F, 3049F, 3050F

- Prenatal and Postpartum Care (PPC):

The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

  - Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
  - Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

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CPT	CPT Category II	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure
57170, 58300, 59400, 59410, 59430, 59510, 59515, 59610, 59614, 59618, 59622, 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175	0503F	G0101, G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091	V24.1, V24.2, V25.1, V72.3, V76.2	89.26, 91.46

PreferredOne will continue to examine medical records and claims data for documentation to support these measures in 2010 so we encourage practitioners to begin using the above coding specifications now to reduce the burden of chart review that will need to be performed at your clinic in the following year. If you have questions about these measures, you may visit NCQA's website at www.ncqa.org or contact us at Quality@PreferredOne.com. It should also be noted that PreferredOne accepts all level 2 codes and encourages use for all of them as they support other measures not specifically addressed in this article.

We appreciate your cooperation during the HEDIS data collection season and would appreciate any feedback you have regarding this process. Comments or questions can be sent to Quality@PreferredOne.com.

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 website will be updated in the near future to offer the following program documents:

- 2009 PreferredOne QM Program Description, Executive Summary
- 2008 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.

Minnesota Community Measurement - Release of the 2008 Health Care Quality Report

Minnesota Community Measurement (MNCM) is collaboration among health plans and provider groups designed to improve the quality of medical care in Minnesota. MNCM's mission is to accelerate the improvement of health by publicly reporting health care information. MNCM has three goals:

- Reporting the results of health care quality improvement efforts in a fair and reliable way to medical groups, regulators, purchasers and consumers.
- Providing resources to providers and consumers to improve care.
- Increasing the efficiencies of health care reporting in order to use our health care dollars wisely.

PreferredOne is one of seven founding health plan members of MNCM. The state medical association, medical groups, consumers, businesses and health plans are all represented on the organization's board of directors. Data is supplied by participating health plans on an annual basis for use in developing their annual Health Care Quality Report.

MNCM released their 2008 Health Care Quality Report on their website during the first quarter of 2009. The 2008 Health Care Quality report features comparative provider group performance on preventive care screening and chronic disease care. One of the primary objectives of this report is to provide information to support provider group quality improvement. Provider groups will find this report useful to improve health care systems for better patient care. Sharing results with the public provides recognition for provider groups that are doing a good job now and motivates other groups to work harder. The report will allow provider groups to track their progress from year-to-year and to set and measure goals for future health care initiatives. The MNCM website also provides consumers with information regarding their role as active participants in their own care. Visit the MNCM website site to view the 2008 annual report at www.mnhealthscores.org.

MNCM has also launched new tools to promote patient awareness of diabetes treatment goals. In an effort to better engage patients in high quality diabetes care, a new way to describe the five treatment goals of optimal diabetes care was launched: The D5. Now a new set of communication tools is available to help clinicians, educators, health plans and employers educate patients about these treatment standards for diabetes. Electronic files for many of the communications tools are available free of charge at www.theD5.org/catalog. From this site, users can download printer-ready PDF files of posters, flyers, notebooks, appointment reminder cards, scorecards, and D5 logo files for use on promotional products such as pedometers or water bottles. These files can be used "as is" or customized to include your organization's logo and other information.

The D5 is based on clinical guidelines developed by the Institute for Clinical Systems Improvement. While other factors are important in managing diabetes, the D5 treatment goals are most critical for preventing the dangerous cardiovascular complications associated with the disease. MNCM publicly reports the quality of a clinic's diabetes care based on the number of diabetes patients who meet all five of these goals.

Do you have a doctor who is not accepting new patients?

PreferredOne is requesting all physicians to submit information regarding acceptance of new patients. If you are a clinic site who has a physician that is **not accepting new patients** you can go to www.PreferredOne.com, select For Providers, login, select Your Clinic Providers and edit the Accepting New Patients information for your provider. Our provider directories will be updated with this information.

If you are unable to access the provider secure website please send an alert to PreferredOne by electronic mail to Quality@PreferredOne.com. We ask that you include your clinic(s) site name and address, the practitioner(s) name and NPI number for those no longer accepting new patients and the contact information for the individual sending us the notification in case we have questions.

Institute for Clinical Systems Improvement (ICSI)

ICSI supports and promotes the use of evidence-based health care in all of its scientific documents and advances improvement in patient safety and efficiency.

ICSI's clinical guidelines, order sets, protocols and more are available in their internet site. Please visit the ICSI Web site at www.icsi.org/ and click on Guidelines and More.

Quality Complaint Reporting for Primary Care Clinics

MN Rules 4685.1110 and 4685.1900 require health plans to collect and analyze quality of care (QOC) complaints, including those that originate at the clinic level.

A QOC complaint is any matter relating to the care rendered to the member by the physician or physician's staff in a clinic setting. Examples of QOC include, but are not limited, to the following:

- Adverse reaction/effect
- Ordering unnecessary tests
- Incorrect diagnosis
- Perceived incompetence of the physician or staff
- Incorrect medication prescribed
- Untimely follow-up on test results

QOC complaints directed to the clinic are to be investigated and resolved by the clinic whenever possible. PreferredOne requires clinics to submit quarterly reports to our Quality Management Department as specified in the provider administrative manual. We have attached the form for your reference (Exhibit G). If you would like to have the file electronically please e-mail Quality@PreferredOne.com. If you have any questions or concerns please contact Arpita Dumra at 800-940-5049, ext. 3564, or by email Arpita.Dumra@PreferredOne.com.

Pharmacy Update

Online Medication Request Forms

Coming Soon! Within the next few months, providers will be able to submit Medication Request Forms online. Look for more details on this change in a future edition of this newsletter. In the mean time, if you have any questions about this change, please contact the Pharmacy Department at Pharmacy@PreferredOne.com.

Pharmacy Information on the PreferredOne Provider Webpage

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. *Page 14...*

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Within the "Pharmacy Resources - Drug Formulary" box you can access the following information:

- 2009 Express Scripts National Preferred Formulary - (This information applies only to those members with Express Scripts as their Pharmacy Benefit Manager)
- Medication Request Forms – Contains updated Medication Request Forms.
- Pharmacy Policy & Criteria

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.

Exhibit A

PreferredOne

DEPARTMENT: Coding Reimbursement	APPROVED DATE: 6/1/2009,10/01/2007
POLICY DESCRIPTION: Reimbursement for Free Standing Ambulatory Surgery Centers and Hospital Outpatient Ambulatory Surgery Centers	
EFFECTIVE DATE: 1/1/08	
PAGE: 1 of 3	REPLACES POLICY DATED: 4/1/06, 11/01/04
REFERENCE NUMBER: H – 9 (P-10)	RETIRED DATE

SCOPE: Claims, Coding, Customer Service, Medical Management, Finance, Network Management

PURPOSE: To provide guidelines for reimbursement and information on pricing methodology for Ambulatory Surgery Centers (ASC) (hospital-based and/or free-standing).

COVERAGE: Coverage is subject to the terms of an enrollee's benefit plan. To the extent there is any inconsistency between this policy and the terms of an enrollee's benefit plan, the terms of the enrollee's benefit plan documents will always control. Enrollees in PreferredOne Community Health Plan (PCHP) and some non-ERISA group health plans that PreferredOne Administrative Services, Inc, (PAS) administers are eligible to receive all benefits mandate by the state of Minnesota. Please call customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

PROCEDURE:

1. For free-standing Ambulatory Surgery Centers, accreditation by Centers for Medicare and Medicaid (CMS) is mandatory for ambulatory surgery centers capable of providing a number of surgical procedures. They must also submit claims with their PreferredOne facility number.

2. Claims should be submitted on the UB-04 Claim form

3. The CPT codes in the surgical range 10000 – 69999 and select surgical HCPCS codes will be considered for reimbursement.

4. The appropriate Revenue Codes need to be billed with the CPT surgical range listed in # 3 above are billed together in order to price according to the ASC fee schedule. The appropriate revenue codes are 36x, 49x, 75x and 790.

5. PreferredOne's standard reimbursement methodology for ASC, which is based on the groupers as designated by Center of Medicare and Medicaid Services (CMS), will be utilized to determine payment rate. Effective January 1, 2007 there will be the following exception. The new code changes that are published in November CPT and HCPCS that are to be effective for the following year will also be added to the fee schedule using the current year CMS groupers.

6. When there is no CMS grouper assigned, the CPT/HCPCS code pricing methodology defaults according to the following categories below. A Medical and Pricing Policy committee consisting of Executive Medical Director, Coding Manager and Director Pricing will review these categories on an annual basis.

   a. Procedures that are minor and should be performed in a clinic setting as defined by CMS are not separately payable when submitted on the same date of service as a valid ASC procedure. If submitted as the only service, reimbursement will not be ASC pricing groupers 01 - 00, but will be based according to the terms of the contract for ancillary pricing (CPT fee schedule or default %).

   b. Procedures that CMS deem as required to be performed as inpatient only will be assigned to an appropriate grouper as recommended by Medical and Pricing Policy Committee.

   c. Procedures that are not assigned by CMS, but have the APC status indicator of B, E, N or M are not separately payable when submitted on the same date of service as a valid ASC procedure. If submitted as the only service, reimbursement will not be ASC pricing, but will be based according to the terms of the contract for ancillary pricing (CPT fee schedule or default %).

   d. Other procedures not meeting the criteria listed 6a-6c will be assigned to a ASC grouper by the Medical and Pricing Policy committee.

7. The Ambulatory Surgery Center list of CPT/HCPCS codes will be reviewed annually and will be updated on January 1st of each calendar year. The update includes review of changes, deletions and additions in CPT, HCPCS, grouper assignment by CMS and PreferredOne Medical and Pricing Policy Committee.

8. Any changes to the ASC list will be communicated via the PreferredOne Provider Bulletin.

9. When multiple procedures are performed on the same date of service, PreferredOne will select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of PreferredOne's ASC fee schedule. Subsequent allowable procedures will be reimbursed at the following rate: 50% for the second procedure, 25% for the third procedure and $0 for any additional surgical procedures.

10. PreferredOne requires multiple procedures and bilateral procedures billed on the UB-04 claim form to be submitted on separate lines e.g. bilateral knee arthroscopy:

    a. 29870 LT on one line and 29870 RT on the second line, or 29870 on one line and 29870-50 on the second line.

11. Intraocular lenses (IOL) are included in the surgical grouper payments.

12. All other services, equipment, and supplies are considered part of the reimbursement for the surgical procedure

13. The C series of HCPCS codes with an APC status indicator of "N" are included in the surgical grouper payment and not separately payable. Centers for Medicare and Medicaid Services (CMS) defines the status indicator of "N" as items and services packaged into payment for other services (effective 1/1/2008 – 5/31/2009 only).

14. Inpatient Health Services Following Scheduled Outpatient Surgical Procedure Payment for Hospital Outpatient Ambulatory Surgery Centers - Admission of an Enrollee to hospital as an inpatient within 24 hours of rendering of Scheduled Outpatient Surgical Procedure shall be reimbursed at the appropriate inpatient payment. Such payment shall be considered payment in full for all Health Services rendered to Enrollee for the entire of the Admission, including the scheduled outpatient surgical procedure. Charges for such scheduled outpatient surgical procedure shall not be separately billed by Hospital, but shall be included in the inpatient Admission charges.

15. Other coding and system edits may apply

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

Exhibit B

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 3/17/2009
POLICY DESCRIPTION:	Provider Appeals	
EFFECTIVE DATE:	08/01/2009	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER:	005	RETIRED DATE:

SCOPE: Claims, Coding, Customer Service, Pricing, Network Management

PURPOSE: To inform Providers of PreferredOne's appeal process.

POLICY: All appeals must be submitted and received by PreferredOne within 60 days of the date of the original remittance.

COVERAGE: Coverage is subject to the terms of an enrollee's benefit plan. To the extent there is any inconsistency between this policy and the terms of an enrollee's benefit plan, the terms of the enrollee's benefit plan documents will always control. Enrollees in PreferredOne Community Health Plan (PCHP) and some non-ERISA group health plans that PreferredOne Administrative Services, Inc, (PAS) administers are eligible to receive all benefits mandate by the state of Minnesota. Please call customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

DEFINITIONS: An appeal is a written request for review.

PROCEDURE:

1. The Provider should submit a written appeal along with any supporting documentation to their Provider Relations Representative.

2. The Provider Relations Representative will present the issue and all materials to the appropriate committee for review and determination.

3. Once a determination is made the Provider Relations Representative will contact the Provider directly.

4. In no event will PreferredOne be obligated to review appeals submitted after 60 days of the original remittance date.

Other References:
Pricing & Payment Policy\Late Charges\Corrected Claims Ref#002

Exhibit C

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

Click on description link to view the PDF

Reference #	Category	Description
B002	Dental and Oral Maxillofacial	**Orthognathic Surgery**
C008	Eye, Ear, Nose, and Throat	**Strabismus Repair (Adult)**
C010	Eye, Ear, Nose, and Throat	**Otoplasty**
F017	Orthopaedic/Musculoskeletal	**Hip Resurfacing**
F020	Orthopaedic/Musculoskeletal	**X Stop**
F021	Orthopaedic/Musculoskeletal	**Bone Growth Stimulator**
F022	Orthopaedic/Musculoskeletal	**Cervical Disc Arthroplasty (Artificial Cervical Disc)**
F023	Orthopaedic/Musculoskeletal	**Intrathecal Pump Implantation**
G001	Skin and Integumentary	**Eyelid Surgery (Blepharoplasty & Ptosis Repair)**
G002	Skin and Integumentary	**Breast Reduction Surgery**
G003	Skin and Integumentary	**Panniculectomy/Abdominoplasty**
G004	Skin and Integumentary	**Breast Reconstruction**
G008	Skin and Integumentary	**Hyperhidrosis Treatment**
G009	Skin and Integumentary	**Laser Treatment for Psoriasis**
H003	Gastrointestinal/Nutritional	**Bariatric Surgery**
L003	Diagnostic	**3D Interpretation Imaging (MRIs and CTs)**
L004	Diagnostic	**Coronary Computed Tomography (CT) Angiography**
L008	Diagnostic	**Continuous Glucose Monitoring Systems for Long Term Use**
M001	BH/Substance Related Disorders	**Mental Health Disorders: Inpatient Treatment**
M002	BH/Substance Related Disorders	**Electroconvulsive Treatment (ECT): Inpatient Treatment**
M004	BH/Substance Related Disorders	**Mental Health Disorders: Day Treatment Program**
M006	BH/Substance Related Disorders	**Mental Health Disorders: Partial Hospital Program (PHP)**
M007	BH/Substance Related Disorders	**Mental Health Disorders: Residential Treatment**
M008	BH/Substance Related Disorders	**Psychotherapy: Outpatient Treatment**
	BH/Substance Related	

M009	Disorders	**Chronic Pain: Outpatient Program**
M019	BH/Substance Related Disorders	**Pathological Gambling: Outpatient Treatment**
M020	BH/Substance Related Disorders	**Autism Spectrum Disorders Treatment**
M021	BH/Substance Related Disorders	**Vagus Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression**
N003	Rehabilitation	**Occupational and Physical Therapy: Outpatient Setting**
N004	Rehabilitation	**Speech Therapy: Outpatient**
N005	Rehabilitation	**Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers**
N006	Rehabilitation	**Acupuncture**
T002	Transplant	**Kidney/Pancreas Transplantation**
T006	Transplant	**Intestinal Transplant**

Revised 12/10/08

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Exhibit D

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Reference #	Description
C001	Court Ordered Mental Health & Substance Related Disorders Services
C002	Cosmetic Treatments
C003	Criteria Management and Application
C008	Oncology Clinical Trials, Covered / Non-covered Services
C009	Coverage Determination Guidelines
C010	Demonstration of Provider Clinical Competence *Revised*
D002	Diabetes Mellitus Supplies Coverage
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies
D007	Handicapped Dependent Eligibility
D008	Dressing Supplies
E004	Nutrition Therapy
G001	Genetic Testing *Revised*
H005	Home Health Care (HHC)
H006	Hearing Devices *Revised*
I001	Investigational/Experimental Services
I002	Infertility Treatment
I003	Preventative Immunizations
I004	Intensive Residential Treatment Services (IRTS) *New*
I005	Intensity Modulated Radiation Therapy (IMRT) Coverage Considerations *New*
N002	Nutritional Counseling
P008	Medical Policy Document Management and Application
P009	Preventative Screening Tests
P010	Narrow-band UVB Phototherapy (non-laser) for Psoriasis *New*
R002	Reconstructive Surgery
R003	Acute Rehabilitation Facilities
R004	Physical, Occupational or Speech Therapy; Outpatient Setting
S008	Scar Revision
S011	Skilled Nursing Facilities
S012	Substance Related Disorders Coverage Considerations *New*
T002	Continuity of Care
T004	Therapeutic Overnight Pass
W001	Physician Directed Weight Loss Programs

Revised 02/09/09

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Exhibit E

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Reference #	Category	Description
A001	Pharmacy	**ACE Inhibitor Step Therapy** ***Revised***
A002	Pharmacy	**Oral Antifungal Therapy: Lamisil & Sporanox** ***Revised***
A003	Pharmacy	**Combination Beta2-Agonist Inhalers**
A004	Pharmacy	**Antihistamines Step Therapy**
A006	Pharmacy	**Antiviral Therapy: Zovirax (acyclovir), Famvir (famciclovir) & Valtrex (valacyclovir)**
A007	Pharmacy	**Angiotensin II Receptor Antagonist/Blocker (ARB) Step Therapy** ***Revised***
B003	Pharmacy	**Botulinum Toxin**
B004	Pharmacy	**Biologics for Rheumatoid Arthritis/Psoriatic Arthritis & JRA** ***Revised***
B005	Pharmacy	**Biologics for Plaque Psoriasis: Amevive (alefacept), Enbrel (etanercept), Humira (adalimumab) & Remicade (infliximab)** ***Revised***
B006	Pharmacy	**Biologics for Inflammatory Bowel Diseases: Humira (adalimumab), Remicade (infliximab) & Tysabri (natalizumab)** ***Revised***
B008	Pharmacy	**Beta-Blocker Step Therapy** ***Revised***
B009	Pharmacy	**Bisphophonates Step Therapy**
C002	Pharmacy	**Cyclooxygenase-2 (COX-2) Inhibitors (Celebrex)**
C003	Pharmacy	**Topical Corticosteroids Step Therapy**
D002	Pharmacy	**Dihydropyridine Calcium Channel Blocker (DHP CCB) Step Therapy** ***Revised***
D003	Pharmacy	**Diabetic Drugs Step Therapy** ***Revised***
E001	Pharmacy	**Erectile Dysfunction Medications** ***Revised***
G001	Pharmacy	**Growth Hormone Therapy** ***Revised***
H001	Pharmacy	**HMG - CoA Reductase Inhibitor**
I001	Pharmacy	**Topical Immunomodulators Step Therapy: Elidel & Protopic** ***Revised***
I002	Pharmacy	**Immune Globulin Intravenous Therapy (IGIV) or Intravenous Immune Globulin Therapy (IVIG)**
K001	Pharmacy	**Kuvan (sapropterin dihydrochloride) for PKU**
L002	Pharmacy	**Leukotriene Pathway Inhibitors Step Therapy**
L003	Pharmacy	**Lyrica Step Therapy**
N002	Pharmacy	**Nasal Steroids Step Therapy**
O001	Pharmacy	**Overactive Bladder Medication Step Therapy**
P001	Pharmacy	**Proton Pump Inhibitor (PPI) Step Therapy** ***Revised***
S002	Pharmacy	**Selective Serotonin Reuptake Inhibitors (SSRIs) Step Therapy**
S003	Pharmacy	**Sedative Hypnotics Step Therapy**
S004	Pharmacy	**Antidepressant Step Therapy for Adults - non SSRI** ***Revised***
T001	Pharmacy	**Tekturna Step Therapy**
W001	Pharmacy	**Weight Loss Medications**

Revised 11/19/08

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Reference #	Description
C001	**Coordination of Benefits**
C002	**Cost Benefit Program**
D002	**Dosing Optimization Programs**
F001	**Formulary and Co-Pay Drug Overrides**
N001	**National Formulary Exceptions**
O001	**Off-Label Drug Use**
P001	**Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist**
P002	**Pharmacy Programs for ClearScript**
Q001	**Quantity Limits per Prescription per Copayment** ***Revised***
S001	**Step Therapy**

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Exhibit G

PreferredOne
Quality Complaint Report

Requirement: MN Rules 4685.1110 and 4685.1900 require the collection and analysis of quality of care complaints including those which originate at the clinic level. Complaints directed to the clinic are to be investigated and resolved by the clinic, whenever possible.

Definition: Quality complaints are defined as concerns regarding access, communication, behavior, coordination of care, technical competence, appropriateness of service and facility/environment concerns.

Frequency: The clinics must report to PreferredOne on a quarterly basis during January, April, July and October for the preceding three months. Please keep a copy in your files.

Clinic______________________________ Location____________________
Completed by_______________________ Phone #____________________

Reporting Period: Jan-March April-June July-Sept Oct-Dec Current Date_________________________

Date Received	Occurrence Date	Written (W) Verbal (V)	Member Name	Date of Birth	Issue	Date and Summary of Resolution

Send report to Quality Management Department, PreferredOne, 6105 Golden Hills Drive, Golden Valley, MN 55416 or FAX 763-847-4010 or E-mail *quality@preferredone.com*.