PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
February 2010

PreferredOne Disease Management

John Frederick, MD, CMO

In the last PreferredOne Update, I noted that we would be integrating the disease management member services previously provided by LifeMasters with the medical management services provided by PreferredOne's in-house programs. These services will be provided to members with asthma, COPD, CHF, coronary artery disease, and diabetes. The PreferredOne program is now up and running. It will take about 12 months to fully transition all of the LifeMasters members into the PreferredOne integrated program. During this time, providers may receive communications from PreferredOne or LifeMasters, depending on the member's employer group, regarding their patients. We appreciate your patience during this transition.

As employer groups are transitioned to PreferredOne's disease management program, providers will receive more targeted and valuable information from PreferredOne for these members. Care opportunities for the members will be identified by a sophisticated claims analysis process. Members who have not been adherent with optimal care for their disease, as defined by ICSI, will be contacted by PreferredOne nurse managers and encouraged to work with their providers to optimize their outcomes. The patient's identified primary care physician for the targeted disease will receive information which may include that the member has not been in for appropriate labs or medical care. You may also be notified that a member has not been fully adherent with their prescribed medications or other components of your treatment plan. Occasionally your office may receive an urgent notification by phone regarding significant issues noted by our nurse managers during their interaction with the member. Our intent is to try to support your efforts in optimizing the care for our members, and we would like to do this in the way most convenient for you. We have created a link on our website for you to inform us whether you prefer to receive these notifications by email, by fax, or by mail. Please go to www.preferredone.com. On the home page, click on For Providers in the side menu bar. When in the Login page (you do not need to login or register), click on the link that says Disease Management Notification and complete the requested information and submit. Also, you may contact Judy Branstad, RN, by phone at 763-847-3071 or by email at Judy.branstad@PreferredOne.com to communicate your preference of notification.

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PreferredOne Insurance Corporation (PIC)
PO Box 59212
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Phone: 763-847-4477
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PreferredOne PPO
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PreferredOne Administrative Services (PAS)
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Pricing & Payment Update

Place of Service (POS) Codes

Center for Medicare and Medicaid Services (CMS) has created a new place of service code for Walk-in Retail Health Clinic (17) - "A walk-in retail health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services." The code now appears in the POS database which is located at: www.cms.hhs.gov/PlaceofServiceCodes/Downloads/POSdatabase102609.pdf.

PreferredOne now accepts this POS 17. Please note this Place-of-Service should only be used by contracted convenience care clinics. Claims may be returned to providers who use this place of service but are not contracted with PreferredOne as convenience care. Members who have a convenience care benefit will receive their highest level benefit only when seen at contracted convenience care clinics.

Provider Appeals and Timely Filing

Provider appeals will be accepted within 60 days but no more than 180 days after the original remittance date. The Timely Filing policy was updated with a grammatical change, effective January 1, 2010. See the attached updated policies effective January 1, 2010. (Exhibits A & B)

Coding Update

Consultations

PreferredOne will continue to follow existing CPT guidelines for consultation services. Providers should continue to submit consultation services when provided. Consultation codes are still valid national HIPAA compliant CPT codes. Even though Medicare will no longer allow consultation codes for Medicare recipients, we expect our commercial business providers to continue to report these services.

The recommendation of the AUC (Administrative Uniformity Committee) is that group purchasers will continue to accept consultative service codes as defined by CPT for non-Medicare business. When members have PreferredOne as primary insurance, and Medicare as secondary, providers may follow Medicare guidelines.

Lipomas Requiring Prior Authorization (PA)

Any lipoma excisions being done at an inpatient or outpatient facility require a PA for medical necessity. This does not include office excisions.

PPO Update

Eligibility Verification

Please keep in mind that member eligibility should always be confirmed with the insurance company or plan administrator for PreferredOne PPO Network Access members. PreferredOne does not maintain positive enrollment for all our payer partners, and therefore the PreferredOne website should not be used to verify eligibility or enrollment status. Please contact the member's insurance company or plan administrator as listed on the member's ID card for eligibility and benefit verification.

Administrative Uniformity Committee (AUC) Compliance Issues

PreferredOne PPO works with nearly 120 different insurance companies and plan administrators. Only a handful of these are located in Minnesota and are therefore not required to comply with AUC Best Practice requirements as it relates to submission of electronic claims and COB/EOB data in the electronic form. PreferredOne is working with our clients to ensure they are aware of this new Minnesota requirement and will help develop a process to ensure that claims flow smoothly and correctly from PreferredOne to our payer clients. Please contact your PreferredOne Provider Representative if you have specific questions. More information will be made available in the next newsletter update.

American Family Members

American Family has a fairly large block of individual insurance members that use the PreferredOne PPO Network. If American Family patients come through your clinic/hospital, please submit claims directly to PreferredOne and not to American Family. We have been having issues lately with claims going to them directly, and in the process of getting them to PreferredOne for pricing, important data (i.e. NPI numbers, etc) can be lost in the transfer. Submitting American Family member claims directly to PreferredOne will help ensure smooth processing and a faster turnaround time.

Guardian and Electronic Funds Transfers (EFT) Payments

Guardian will begin offering the ability for providers to receive EFT payments. Stay tuned for further information in upcoming editions of the PreferredOne Update.

Pharmacy Update

Online Medication Request Forms

Providers and office staff can now submit medication request forms to PreferredOne online at www.PreferredOne.com and by clicking on For Providers > Pharmacy Resources > Pharmacy Medication Request Form – Online Submission.

Advantages of Online Submission are:

- Offices can track the status of requests from the minute they are submitted to PreferredOne
- Reduces the number of requests received that are incomplete, which reduces the overall turnaround time needed to complete a review
- Reduces legibility/handwriting errors
- Office staff no longer need to be registered with the PreferredOne website in order to use the online form
- Eliminates lost or misplaced submitted forms

In the near future, we will no longer accept the paper medication request forms and you will be required to use our online form submission process.

If you have any questions about the online medication request form, please contact the Pharmacy Department at Pharmacy@PreferredOne.com.

Minnesota Uniform Formulary Exception Form

The following link is to the Minnesota Uniform Formulary Exception Form:
http://www.health.state.mn.us/asa/formularyexcep.pdf

This form is intended for use by health care providers to request exceptions from group purchasers (payers) formularies. Please refer to this form for additional instructions. The online form is the best way to submit requests to PreferredOne; however, we will continue to accept faxes at 763-847-4014.

Pharmacy Information Available Upon Request

A paper copy of pharmacy information that is posted on the PreferredOne Provider website is available upon request by contacting the Pharmacy Department at Pharmacy@PreferredOne.com. Please specify what information you would like to receive and provide a mailing address or fax number.

Medical Policy Update

Medical Policy documents 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 have 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 set 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 brought 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.

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

No new Behavioral Health criteria sets.

No Behavioral Health criteria sets were retired.

No new Behavioral Health policies.

No Behavioral Health policies were retired.

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

No new Chiropractic criteria sets.

No Chiropractic criteria sets were retired.

No new Chiropractic policies.

No Chiropractic policies were retired.

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...Cont'd from page 4

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

One (1) new Medical/Surgical criteria set:

- Radiofrequency Ablation Neck and Back

Three (3) Medical/Surgical criteria sets were retired:

- Intrathecal Pump Implantation: retired due to low utilization and low impact
- CT Angiography: retired due to low impact
- Otoplasty: no need for specific criterion; medically necessary indications are not unique and are already addressed in Reconstructive Surgery policy

No new Medical/Surgical related medical policies.

No Medical/Surgical related medical policies were retired.

One (1) addition to the Investigational/Unproven Comparative Effectiveness List:

- Peripheral Nerve Field Stimulation for Back Pain

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:

No new Pharmacy criteria sets.

No Pharmacy criteria sets were retired.

No new Pharmacy related medical policies.

One (1) Pharmacy related medical policies was retired:

- Dosing Optimization Program

No additions to the Investigational/Unproven Comparative Effectiveness List.

No deletions from the Investigational/Unproven Comparative Effectiveness List.

The attached documents include the latest Chiropractic, Medical and Pharmacy Policy and Criteria indexes. Please add these documents to the Utilization Management section of your Office Procedures Manual (Exhibits C-G). 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 by telephone at (763) 847-3386 or email at 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

November 2009:

- ACS: Chest Pain and Acute Coronary Syndrome, Diagnosis and Treatment of
- Lipid Management in Adults
- Pain, Chronic; Assessment and Management of
- Palliative Care
- Venous Thromboembolism Prophylaxis

October 2009:

- Preventive Services for Adults
- Preventive Services for Children and Adolescents

September 2009:

- Prenatal Care, Routine

Order Sets and Protocols

November 2009:

- ACS: Acute Coronary Syndrome, Admission to CCU for
- Palliative Care
- Retained Foreign Objects During Vaginal Deliveries, Prevention of Unintentionally (Protocol)
- Venous Thromboembolism Prophylaxis

October 2009:

None

September 2009:

- Perioperative Protocol
- Safe Site Invasive Procedure – Non-Operating Room Protocol
- Surgical Site Infection Prevention in Adults, Antibiotic Prophylaxis for Order Set
- Surgical Site Infection Prevention in Children, Antibiotic Prophylaxis for Order Set

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 under-utilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

Quality Management Update

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:

- 2010 PreferredOne QM Program Description, Executive Summary
- 2009 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.

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's 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. If you'd 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 e-mail Arpita.Dumra@PreferredOne.com. (Exhibit H)

Update on HEDIS Technical Specifications

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. Two of the new measures in 2009 were related to BMI assessment in adults and BMI assessment and counseling for children. At this time PreferredOne is not collecting this information from medical records, but will be required to do so in the future. *Page 8...*

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These measures are hybrid measures, which means, they can be collected both from administrative data and chart information. By using appropriate CPT Category II codes when submitting claims, having to collect this information from your clinic records will be reduced.

The following two BMI measures should be coded as follows:

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 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**

PreferredOne may begin examining medical records for documentation to support these measures in 2011 so we encourage practitioners to begin using the above coding specifications now to reduce the burden of onsite chart review. If you have questions about these measures you may visit NCQA's website at www.ncqa.org or contact us at Quality@PreferredOne.com.

Basic Medical Weight Loss Techniques

According to The **U.S. Centers for Disease Control and Prevention (CDC)** approximately two-thirds of U.S. adults and one-fifth of U.S. children are obese or overweight. Reversing the U.S. obesity trend requires comprehensive and coordinated efforts that include changes to policy as well as environmental changes that support and promote healthy lifestyle choices for U.S. citizens.

We believe the first step in the effort begins with primary care physicians and pediatricians conducting BMI assessments and providing counseling to their patients and/or parents of obese children during annual preventative care office visits.

PreferredOne recognizes that while physicians may be in an ideal position to diagnose obesity, they may not have the knowledge of how educate and treat obese patients. The American Society of Bariatric Physicians is providing a one-day CME on Basic Medical Weight Loss Techniques on March 6, 2010. We have attached a registration form for your convenience (Exhibit I).

Task Force: Screen Kids, Obesity Treatment Works!

There is a growing body of knowledge and community focus on childhood obesity. Obesity is a serious health concern for children and adolescents. 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 aged 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.

Recently, the U.S. Preventive Services Task Force has come out with recommendations that state school-aged youngsters and teens should be screened for obesity and sent to intensive behavior treatment if they need to lose weight.

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. Locally, ICSI's Obesity Prevention and Management guideline outlines similar recommendations for adolescents and adults.

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. If you are a provider group or clinic that offers specialized obesity treatment and management programs for children and adolescents we would like to hear about them and work with you to encourage our members to enroll in your programs. Please contact Chief Medical Officer, Dr. John Frederick at 763-847-3051 or John.Frederick@PreferredOne.com. 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

Clinical Practice Guidelines

PreferredOne is a sponsor of the Institute for Clinical Systems Improvement (ICSI) and promotes clinical practice guidelines to increase the knowledge of both our members and contracted providers about best practices for safe, effective, and appropriate care. Although PreferredOne endorses all of ICSI's guidelines, we have chosen to adopt several of them and monitor their performance within our network (Exhibit J). Additionally, to address behavioral health conditions, we have adopted two treatment guidelines developed by Behavioral Healthcare Providers (BHP). The guidelines that PreferredOne has adopted include ICSI's clinical guidelines for Coronary Artery Disease and Asthma and BHP's clinical guidelines for Depression and ADHD. The performance of these guidelines by our network practitioners will be monitored using HEDIS measurement data, PreferredOne's disease management vendor's data, and BHP's annual evaluation.

Member Rights and Responsibilities Statement to Participating Practitioners

PreferredOne presents this Member Rights & Responsibilities with the expectation that observance of these rights will contribute to high quality patient care and appropriate utilization for the patient, the providers, and PreferredOne. PreferredOne further presents these rights in the expectation that they will be supported by our providers on behalf of our members and an integral part of the health care process. It is believed that PreferredOne has a responsibility to our members. It is in recognition of these beliefs that these rights are affirmed.

- A **right** to receive information about PCHP, its services, its participating providers and your member rights and responsibilities.
- A **right** to be treated with respect and recognition of your dignity.
- A **right** to available and accessible services, including emergency services, 24 hours a day, 7 days a week.
- A **right** to be informed of your health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.
- A **right** to participate with providers in making decisions about your health care.
- A **right** to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- A **right** to refuse treatment recommended by PCHP participating providers.
- A **right** to privacy of medical, dental and financial records maintained by PCHP and its participating providers in accordance with existing law.
- A **right** to voice complaints and/or appeals about PCHP policies and procedures or care provided by participating providers.
- A **right** to file a complaint with PCHP and the Commissioner of Health and to initiate a legal proceeding when experiencing a problem with PCHP or its participating providers. For information, contact the Minnesota Department of Health at 651.282.5600 or 1.800.657.3916 and request information.
- A **right** to make recommendations regarding PCHP's member rights and responsibilities policies.
- A **responsibility** to supply information (to the extent possible) that PreferredOne participating providers need in order to provide care.
- A **responsibility** to supply information (to the extent possible) that PreferredOne requires for health plan processes such as enrollment, claims payment and benefit management. *Page 11...*

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- A **responsibility** to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- A **responsibility** to follow plans and instructions for care that you have agreed on with your participating providers.

All of these activities must be conducted with a concern for the patient and recognition of his dignity as a human being.

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 1/1/2010
POLICY DESCRIPTION:	Provider Appeals	
EFFECTIVE DATE:	01/01/2010	
PAGE:	1 of 1	REPLACES POLICY DATED: 8/1/2009
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 180 days of the original remittance date.

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

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 9/11/2008
POLICY DESCRIPTION:	Timely Filing	
EFFECTIVE DATE:	01/01/2009	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER:	001	RETIRED DATE:

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

PURPOSE: To ensure timeliness of the claims adjudication process.

POLICY: All claims must be received by PreferredOne with 120 days of the covered service or discharge date whichever is later or within 60 days of the date of the primary payor's explanation of benefits.

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: Timely filing is the time limit placed on the provider to submit a claim to PreferredOne for the adjudication of the claim based on the member benefit.

PROCEDURE:

1. All claims must be received by PreferredOne within 120 days of the covered service or discharge date whichever is later. Any claim received after 120 days of the covered service or discharge date will be denied.
2. All secondary claims must be received by PreferredOne within 60 days of the date of the primary payor's explanation of benefits. Any claims received after 60 days of the date of the primary payor's explanting of benefits will be denied.
3. All appeals from a denial for timely filing must be received by PreferredOne within 60 days of the date of the initial denial. Any appeal received after 60 days of the date of the initial denial will not be processed and the original denial will become final.
4. In no event will PreferredOne be obligated to pay claims submitted more than 365 days after the date of service or discharge date.

Exhibit C

LOGIN ID:

PASSWORD:

SIGN ON

Medical Policy

Chiropractic Policies Table of Contents
Click on description link to view the PDF

Reference #	Description
001	Use of Hot and Cold Packs
002	Plain films within the first 30 days of care
003	Passive Treatment Therapies beyond 6 weeks
004	Experimental, investigational, or Unproven Services
006	Active Care – Therapeutic Exercise
007	Acute and Chronic Pain
008	Multiple Passive Therapies
009	Recordkeeping and Documentation Standards
010	CPT Code 97140

Revised 02/04/09

Quick Links:
Chiropractic Policies
Medical Criteria
Medical Policies
Pharmacy Criteria
Pharmacy Policies

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Exhibit D

LOGIN ID:

PASSWORD:

SIGN ON

Medical Policy

Medical Policies Table of Contents
Click on description link to view the PDF

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
D002	Diabetes Mellitus Supplies Coverage
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies
D007	Handicapped Dependent Eligibility
D008	Dressing Supplies *Revised*
E004	Nutrition Therapy
G001	Genetic Testing
H005	Home Health Care (HHC)
H006	Hearing Devices
I001	Investigational/Experimental Services *Revised*
I002	Infertility Treatment
I003	Preventative Immunizations
I004	Intensive Residential Treatment Services (IRTS)
I005	Intensity Modulated Radiation Therapy (IMRT) Coverage Considerations
N002	Nutritional Counseling

P008	**Medical Policy Document Management and Application**
P009	**Preventative Screening Tests**
P010	**Narrow-band UVB Phototherapy (non-laser) for Psoriasis**
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** ***Revised***
T002	**Continuity of Care**
T004	**Therapeutic Overnight Pass**
W001	**Physician Directed Weight Loss Programs**

Revised *02/09/09*

Quick Links:

Chiropractic Policies
Medical Criteria
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Pharmacy Criteria
Pharmacy Policies

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Exhibit E

LOGIN ID:

PASSWORD:

SIGN ON

Medical Policy

Pharmacy Policies Table of Contents
Click on description link to view the PDF

Reference #	Description
B001	Backdating of Prior Authorizations *New*
C001	Coordination of Benefits
C002	Cost Benefit Program *Revised*
F001	Formulary and Co-Pay Drug Overrides
N001	National Formulary Exceptions
O001	Off-Label Drug Use *Revised*
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

Revised 11/19/08

Quick Links:
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Medical Policy

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)
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulator *Revised*
F022	Orthopaedic/Musculoskeletal	Cervical Disc Arthroplasty (Artificial Cervical Disc)
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation Neck and Back *New*
G001	Skin and Integumentary	Eyelid and Brow Surgery (Blepharoplasty & Ptosis Repair)
G002	Skin and Integumentary	Breast Reduction Surgery
G003	Skin and Integumentary	Excision Redundant Tissue
G004	Skin and Integumentary	Breast Reconstruction
G008	Skin and Integumentary	Hyperhidrosis Surgery
G009	Skin and Integumentary	Laser Treatment for Psoriasis
H003	Gastrointestinal/Nutritional	Bariatric Surgery
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**
M009	BH/Substance Related 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/Vagal 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**

Revised *12/10/08*

Quick Links:
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Exhibit G

LOGIN ID:
PASSWORD:
SIGN ON

Medical Policy

Pharmacy Criteria Table of Contents
Click on description link to view the PDF

Reference #	Description
A001	ACE Inhibitor Step Therapy
A002	Oral Antifungal Therapy: Lamisil & Sporanox
A003	Combination Beta2-Agonist Inhalers *Revised*
A004	Antihistamines Step Therapy
A006	Antiviral Therapy: Zovirax (acyclovir), Famvir (famciclovir) & Valtrex (valacyclovir)
A007	Angiotensin II Receptor Antagonist/Blocker (ARB) Step Therapy
B003	Botulinum Toxin
B004	Biologics for Rheumatoid Arthritis/Psoriatic Arthritis & JRA
B005	Biologics for Plaque Psoriasis: Amevive, Enbrel , Humira, Remicade, & Stelara *Revised*
B006	Biologics for Inflammatory Bowel Diseases: Humira (adalimumab), Remicade (infliximab) & Tysabri (natalizumab)
B008	Beta-Blocker Step Therapy
B009	Bisphosphonates Step Therapy *Revised*
C002	Cyclooxygenase-2 (COX-2) Inhibitors (Celebrex)
C003	Topical Corticosteroids Step Therapy
D002	Dihydropyridine Calcium Channel Blocker (DHP CCB) Step Therapy
D003	Diabetic Drugs Step Therapy
E001	Erectile Dysfunction Medications *Revised*
F001	Fenofibrate Step Therapy *New*

G001	**Growth Hormone Therapy**
H001	**HMG - CoA Reductase Inhibitor** ***Revised***
I001	**Topical Immunomodulators Step Therapy: Elidel & Protopic**
I002	**Immune Globulin Intravenous Therapy (IGIV) or Intravenous Immune Globulin Therapy (IVIG)** ***Revised***
K001	**Kuvan (sapropterin dihydrochloride) for PKU**
L002	**Leukotriene Pathway Inhibitors Step Therapy**
L003	**Lyrica Step Therapy**
N002	**Nasal Steroids Step Therapy**
O001	**Overactive Bladder Medication Step Therapy**
P001	**Proton Pump Inhibitor (PPI) Step Therapy**
S002	**Selective Serotonin Reuptake Inhibitors (SSRIs) Step Therapy**
S003	**Sedative Hypnotics Step Therapy**
S004	**Antidepressant Step Therapy for Adults - non SSRI**
T002	**Tramadol Step Therapy** ***New***
W001	**Weight Loss Medications**

Revised *11/19/08*

Quick Links:

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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*.

Exhibit I

Basic Medical Weight Loss Techniques

Course Overview

Evaluation of the Obese Patient
What is different about a workup of an obese/overweight patient? Learn about the critical lab data needed to determine the right course of action for these patients.

Obesity and Co-Morbid Conditions
Identify and manage metabolic disorders including type 2 diabetes, metabolic syndrome, depression and other conditions that impair weight loss.

Dietary Treatment
A discussion of current thoughts on nutrition and the dietetic exchange system. Includes a review of pyramid systems and their flaws, fad diets and why they usually fail, reputable formula diets, and vitamin and mineral supplements.

Pharmacotherapy for the Obese Patient
Discussion of the pharmacology of currently available and emerging medications. Includes a review of drug interactions including Xenical, Ephedra and Metformin.

Behavioral Basics
A comprehensive weight loss program includes behavior modification. What techniques are most successful and how are they implemented?

Starting a Practice: The Business of Bariatric Medicine
What are the essentials in starting a bariatric practice? Obtain information on office and practice development, staff training, patient recruitment, commonly asked questions, and other essentials of a bariatric practice.

Course Information

Where:
January 23: San Francisco Marriott Marquis
55 Fourth Street, San Francisco, CA 94103
Phone: 415.896.1600 • www.marriott.com
CODE: ASBP Workshop

March 6: Minneapolis Airport Marriott
2020 American Blvd. East, Bloomington, MN 55425
Phone: 952.854.7441 • www.marriott.com
CODE: ASBP Workshop

Time:
7:30 - 8:15 am ....Registration & continental breakfast
8:15 am - 4:30 pm ....Course including lunch

CME:
The ASBP designates this educational activity for a maximum of 7 *AMA PRA Category 1 Credits™*. This activity has been reviewed and is acceptable for up to 7 Prescribed credits by the American Academy of Family Physicians. This program has been approved for 7 hours of AOA Category 2-A.

Fee:
$ 189.00.......................... Register by January 20 or March 3
$ 199.00...................... Register January 20-23 or March 3-6
Second person from same office registers for $159.00.
Note: A $50 cancellation fee will be charged if notice is received prior to the Tuesday before the course. No refunds thereafter, and no refunds for no-shows.

Faculty - Two of the following at each program:
Erin Snyder, MD, FAAFP - ASBP Board of Trustees
Mary Vernon, MD, FAAFP, CMD, FASBP - ASBP Past Chairman of the Board
David Bryman, DO - ABBM Board of Directors
Larry Richardson, MD, FASBP - ASBP President

Registration Form

Course: ❒ **San Francisco - January 23, 2010** ❒ **Minneapolis - March 6, 2010**

Registration Options: *Each attendee must complete a separate form.*
1. Online: Visit www.asbp.org.
2. Mail: Complete form and return with payment to: ASBP, 2821 S. Parker Road, Ste. 625, Aurora, CO 80014.
3. Phone/Fax: Complete form; call 303.770.2526 with credit card, or fax to 303.779.4834.

Registrant's name: ....

Designation (to appear on name badge): ....

Address: .... City, State, Zip: ....

Phone: .... Email: ....

Payment Information

❒ Check enclosed (make payable to ASBP) OR charge my: ❒ Visa ❒ MasterCard ❒ Am. Express ❒ Discover

Card Number: .... Expiration Date: ....

Signature: ....

Exhibit J

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/9/09
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/9/09	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/10/08	
Reference #: QM/C003	**Page:** 1 of 3	

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

BACKGROUND:
PreferredOne sponsors the Institute for Clinical Systems Improvement (ICSI) and endorses all of their healthcare guidelines. Clinicians from ICSI member medical organizations survey scientific literature and draft health care guidelines based on the best available evidence. These guidelines are subjected to an intensive review process that involves physicians and other health care professionals from ICSI member organizations before they are made available for general use. More than 50 guidelines for the prevention or treatment of specific health conditions have been developed and are updated annually.

Behavioral Healthcare Providers (BHP), a delegated entity of PreferredOne, has also developed and adopted several behavioral health clinical guidelines that PreferredOne approves in their annual work plan each year.

PreferredOne adopts the guidelines listed below for distribution in the contracted networks and performance measurement.

PROCEDURE:

I. PreferredOne adopts the following guidelines and supports implementation within its provider network:

A. ICSI Guidelines
1. Coronary Artery Disease, Stable
2. Asthma, Diagnosis and Outpatient Management of

B. BHP Guidelines
1. Assessment Guideline for Depression
2. Guideline for ADHD/ADD Assessment and Treatment

II. Distribution and Update of Guidelines

A. ICSI Guidelines
1. PreferredOne's adopted guidelines are distributed via the provider newsletter to the contracted network and posted on the PreferredOne Web site. Adopted guidelines are always available upon request.
2. Guidelines are reviewed approximately every 18 months following publication to reevaluate scientific literature and to incorporate suggestions provided by medical groups who are members of ICSI. The ICSI workgroup revises the guideline to incorporate the improvements needed to ensure the best possible quality of care. When guidelines are revised PreferredOne will send out the updated guideline(s) to all practitioners via the provider newsletter.
3. On an annual basis, practitioners are notified that all guidelines are available at *www.icsi.org*

B. BHP Guidelines
1. BHP distributes their guidelines via their BHP annual newsletter, they include them in a mailing with initial contract, BHP Web site and they are also sent with audit request letters and results (for those who do not meet the standards specified in the guidelines)

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/9/09
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2. Guidelines are reviewed annually by BHP's Quality Improvement Committee in conjunction with the chart audit results.

III. Performance Measurement - baseline assessment conducted in fall of 2007, first network assessment report available in June 2008. Annual assessment to be conducted on an ongoing basis.

A. The ICSI guidelines provide the basis for measurement and monitoring of clinical indicators and quality improvement initiatives. The annual measures that will be used to assess performance for each clinical guideline adopted are as follows:

1. Coronary Artery Disease
   a. Optimal Vascular Care Measure (Minnesota Community Measurement measure)
      This measure examines the percentage of patients, ages 18-75, with coronary artery disease who reached all of the following four treatment goals to reduce cardiovascular risk:
      • Blood pressure less than 140/90 mmHg
      • LDL-C less than 100 mg/dl
      • Daily aspirin use
      • Documented tobacco-free status
   b. Cholesterol management after acute cardiovascular event (HEDIS technical specifications)
2. Asthma, Diagnosis and Outpatient Management of
   a. Percentage of patients with persistent asthma who are on inhaled corticosteroid medication (HEDIS technical specifications)
   b. Peak flow meter use (Disease Management vendor measure)

B. BHP Guidelines

1. Assessment Guideline for Depression
   a. Percent of comprehensive assessments from a sample population of practitioners treating members with depression (BHP Specifications and Measurement)
   b. Evidence of a medical evaluation (BHP Specifications and Measurement)
2. Guideline for ADHD/ADD Assessment and Treatment
   a. Percent of comprehensive assessments based on community criteria and improvement in children and adolescents with this diagnosis (BHP Specifications and Measurement)
   b. Evidence of a medical evaluation (BHP Specifications and Measurement)

IV. PreferredOne's disease management vendor, LifeMasters has adopted the two ICSI's practice guidelines as the clinical basis for its disease management programs and will ensure program materials are consistent with the practice guidelines.

ATTACHMENTS:

ICSI Program Description

REFERENCES:

2009 NCQA Standards and Guidelines for the Accreditation of Health Plans
- QI 9 Clinical Practice Guidelines
- QI 8 Disease Management

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/9/09
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/9/09	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/10/08	
Reference #: QM/C003	**Page:** 3 of 3	

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