PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
February 2011

No More Paper Remittance Advices for Minnesota Providers

Effective April 2011, PreferredOne will no longer be printing and mailing remittance advices to Minnesota providers. PreferredOne encourages providers to view your remittance advices electronically by logging onto www.PreferredOne.com or contacting your clearinghouse.

If you have any questions, please contact your Provider Relations Representative.

Happenings at PreferredOne

John Frederick, CMO

PreferredOne has finished the year 2010 on an upswing. We have some new large employer accounts and have exceeded our target for the year for enrollment. Thank you for your support.

Due to the increasing cost of oncology chemotherapy, PreferredOne has started doing prior authorization for the off-label use of oncology drugs such as Avastin. We will be referencing the NCCN guidelines for appropriate indications for the drugs. I would appreciate any comments or suggestions on how to implement this without disrupting patient care.

The Minnesota Credentialing Collaborative is gaining momentum. As you are aware, PreferredOne requires that initial applications for provider credentialing be submitted through the MCC. The MCC is a collaborative effort of the Minnesota Medical Association, the Minnesota Hospital Association, and the Minnesota Council of HealthPlans.

PreferredOne Community Health Plan (PCHP) has again been NCQA accredited in 2010 in the highest health plan category of Excellent. In the *U.S. News and World Report* survey PreferredOne PCHP was ranked #109 health plan in the nation. These recognitions give us significant credibility in the market and allow us compete for a higher market share.

In closing, I would also like to recognize the leadership team for the Integrated Healthcare Services Department. Jason Woods, Director of Integrated HealthCare Services and Julie Sullivan, Director of Chronic Illness Management join Heather Clark, Director of Quality Management, Kris Jackson, Director of Pharmacy Services, and Donna Larson, Director of Credentialing.

In This Issue:

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Coding Update

New Modifier 33 for Preventive Services Is Not Required

The AMA has developed new modifier 33 that may be used by providers to indicate a Preventive Service was performed when appended to CPT or HCPCS codes.

PreferredOne does not require this modifier. Our system is set up by the CPT/ HCPCS code and submitted diagnosis code to adjudicate claims based on the member's benefit. These benefits include services in the Patient Protection and Affordable Care Act when appropriate and may have medical management yearly limits.

Claims will be accepted with this modifier but will not be used in the adjudication process (Exhibit A).

Account Management Update

Radiology Process Change

Effective December 1, 2010, **American Republic Insurance Company**, **World Insurance Company**, and the administered business for **American Family Mutual Insurance Company**, are implementing a diagnostic imaging ordering program for the following types of procedures: CT, CTA, MRI, MRA, PET and cardiac nuclear medicine.

Effective December 1, 2010, all requests for the tests listed above will go through HealthHelp, and the program RadConsult. Please contact HealthHelp using one of the following to obtain quality reference numbers for high-technology imaging procedures:

Phone: 877-685-5254

Fax: 877-685-5256

Website: www.HealthHelp.com/AmericanRepublicWorld

This process applies to the following PreferredOne PPO clients ONLY**: American Republic Insurance Company, World Insurance Company**, and administered business for **American Family Mutual Insurance Company**.

If you have questions regarding this program, or would like additional information, please contact HealthHelp at 800-405-4817 ext 1725.

Assurant Health Launches new Provider Portal

Instant claim activity and eligibility information is now at your fingertips — 24 hours a day, seven days a week. The new Web site — www.AssurantProviders.com — is simple to use and will make your job easier! As the first point-of-contact for many providers, you can access this website to offer even better service, giving answers to questions immediately! Go to www.AssurantProviders.com for:

- Patient eligibility
- Claims tracking and submission
- EOB and Remittance information
- Payment details

There is no software to install and no set-up or monthly fees.

The Principal to Exit Health Market

The Principal has made the decision to exit the health insurance business by winding down the operation within the next 36 months, subject to applicable requirements of federal and state law. **You do not need to make any immediate changes as a result of this announcement.** In fact, it will be business as usual throughout the transition period. Principal is committed to providing the same level of service and attention throughout the transition period.

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.

The Behavioral Health, Chiropractic, Medical/Surgical, and Pharmacy and Therapeutics Quality Management Subcommittees approve new criteria sets for use in their respective areas of Integrated Healthcare Services. Quality Management Subcommittee approval is not required when there has been a decision to retire PreferredOne criterion or when Medical Polices are created or revised; approval by the Chief Medical Officer is required. Notification of these actions is brought to the Quality Management Subcommittees as informational only.

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

-No new or retired Behavioral health criteria sets or policies

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

-No new Chiropractic criteria sets or policies

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

-No new or retired Medical-Surgical criteria sets

-No new Medical-Surgical policies were created

- One Medical-Surgical policy was retired:
    - MP/R004Physical, Occupation, or Speech Therapy: Outpatient Setting

-No additions or deletions to the Investigational/Unproven Comparative Effectiveness List

Remember to check the Precertification/Prior Authorization List posted on the website.

The list can be found with the other Medical Policy Documents on the PreferredOne internet home page, under the Health Resources drop down menu. The list will be fluid, as we see opportunities for impact; driven by changes in standard of care, etc. Please check the list regularly for revisions. See the Pharmacy section of the Newsletter for Pharmacy policy and criteria information.

The attached documents include the latest Chiropractic, Medical and Pharmacy Policy and Criteria indices (Exhibits B-F). Please add these documents 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 on line at Heather.Hartwig-Caulley@PreferredOne.com.

Pharmacy Update

Biologics for Inflammatory Conditions (Rheumatoid Conditions, Crohns Disease, Plaque Psoriasis) – Effective April 2011

PreferredOne has a longstanding prior authorization requirement for these medications. Ensuring their use is medically necessary while also requiring a trial of injectables medications before infusible medications. Additionally, we have allowed a bypass of this prior authorization process for contracted providers specializing in rheumatology, gastroenterology, or dermatology.

Beginning April 2011, the program will be modified. We will continue to assess medical necessity and require a trial of injectable medications before infusible medications. We will also apply FDA approved dosing guidelines to initial/induction, subsequent, and flare treatments for Enbrel and Humira. In order to achieve our goal of optimal dosing for our members, across all disease states, we will remove the specialty bypass for rheumatologists, gastroenterologists, and dermatologists.

Targeted provider and member information about these changes will be available by March 1, 2011.

PreferredOne Community Health Plan (PCHP) and PreferredOne Insurance Company (PIC) Benefit Changes Effective For Employer Groups Renewing On or After January 1, 2011

Upon an employer group's renewal with PCHP or PIC, the following drug classes will no longer be covered under the benefit:

- Non-Sedating Antihistamines (NSAs)
- Non-steroidal Anti-Inflammatory drugs (NSAIDs)
- H2-antagonists (H2As)
- Proton Pump Inhibitors (PPIs)
- Erectile dysfunction medications, regardless of prior authorization

Pharmacy Policy and Criteria

Since the last newsletter, the Pharmacy and Therapeutics Subcommittee has been informed of the following:

- Two new Pharmacy criteria were developed
    - PC/A006 Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) Medications Step Therapy
    - PC/R003 Topical Retinoid Medications Step Therapy

-No Pharmacy criteria were retired

-No new Pharmacy Policies were created or retired.

-No additions or deletions to the Pharmacy Investigational/Unproven Comparative Effectiveness List

Online Medication Request Forms

Providers and office staff can now submit medication request forms to PreferredOne online at www.PreferredOne.com. Click On: For Providers > Pharmacy Resources > Pharmacy Medication Request Form – Online Submission. *Page 5...*

...Cont'd from page 4

Advantages of Online Submission:

- 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 turn around 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.

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.

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

Clinical Practice Guidelines

PreferredOne 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, it has chosen to adopt several of them and monitor their performance within our network (Exhibit G). The guidelines that PreferredOne has adopted are clinical guidelines for Coronary Artery Disease, Asthma, Major Depression in Adults, and Diagnosis and Management of ADHD. The performance of these guidelines by our network practitioners will be monitored using HEDIS measurement data.

All of the ICSI guidelines that we have adopted can be found on ICSI's website at www.icsi.org.

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:

- 2011 PreferredOne QM Program Description, Executive Summary
- 2010 Year-End QM Program Evaluation, Executive Summary

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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 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 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 e-mail Arpita.Dumra@PreferredOne.com. (Exhibit H)

MN Community Measurement – The D5

MN Community Measurement is a community-based nonprofit organization dedicated to improving the quality of health care in Minnesota and surrounding border communities. Its work centers on collecting health care performance data on clinics and publicly reporting the results. The goal of this effort is to provide objective information for consumers to use in making health care decisions. Physicians are already using this information to improve the care they are delivering. This information is also used by health policy makers, employers, and others who are concerned with the quality and costs of health care.

The D5 was created to make it easier for people with diabetes and their health care providers to work together to set and achieve goals to better manage the disease. The D5 goals are based on clinical guidelines developed by the Institute for Clinical Systems Improvement. The same goals are promoted by the American Diabetes Association. The five goals are:

- Your blood pressure is less than 140/90
- Your bad cholesterol, LDL, is less than 100
- Your blood sugar, A1c, is less than 8%
- You are tobacco-free
- You take an aspirin as appropriate (age 40 and older)

For more information regarding MN Community Measurement and its D5 program please visit www.thed5.org.

Reimbursement Requests for Medical Records

Frequently PreferredOne requests medical records from our network providers for the purposes of collecting HEDIS measurements and quality improvement activities. According to contracts that are held with providers the request of these records by PreferredOne does not require reimbursement to the provider. If you have any questions or concerns related to this issue, please talk to your PreferredOne Provider Relations Representative.

Member Rights & Responsibilities

PrereferredOne's Member Rights and Responsibilities statement is attached (Exhibit I). PreferredOne believes observance of these rights will contribute to high quality patient care and appropriate utilization. It is expected that they will be supported by our providers as an integral part of the health care process for our members.

Exhibit A

PreferredOne®

Department of Origin: Coding and Payment Policy	**Approved by:** Coding PolicyCommittee	**Date approved:** 1/1/2011
Department(s) Affected: Coding, Claims, Network Management	**Effective Date:** 1/1/2011	
Policy Description: Reporting Administration of Vaccines and Toxoids	**Retired Date for archived/retired documents:** **P-6, 09/28/1995**	
Reference #: NM019	**Page:** 1 of 1	

PRODUCT APPLICATION:

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

PURPOSE: **To recommend appropriate reporting for the Administration of Immunizations and Toxoids**

POLICY: **PreferredOne requires providers to follow the most up-to-date CPT guidelines for the Administration of Immunizations and Toxoids**

PROCEDURE:

1. PreferredOne requires specific documentation in the records to substantiate why face- to face counseling was necessary and personally performed by the physician or qualified health care professional for ages birth through 18 years of age. Hand outs of routine information e.g., forms, and notations in the medical record that counseling was performed does not support CPT 90460, and 90461. RN's, LPN's, and Medical assistants do not meet the guidelines of qualified health care providers. Qualified Health care providers who render face to face counseling must be an MD, DO, Certified Nurse Midwife, PAC, or NP.

2. When counseling is required for the first immunization/components, (90460) PreferredOne expects that follow up scheduled doses should generally not require repeated counseling services. Records should reflect the need for recurrent face to face counseling for immunizations.

3. When Medical Necessity for counseling is not supported, PreferredOne expects that providers will submit the administration codes without counseling CPT 90471- 90474.

4. Use the units box to indicate the total number of vaccines administered. It is not recommended to use a separate line for each administration.

5. Always identify the vaccine product. The vaccine product must be submitted using appropriate CPT codes 90476-90748 in addition to administration codes.

6. When a vaccine is supplied free of charge to the provider, (State Supplied Vaccine) modifier SL may be appended to the vaccine code and a nominal charge such as 1 cent be reported.

7. Under no circumstances should vaccines containing multiple antigens for the same disease ever be reported with multiple administration units, e.g. Prevnar-13. Prevnar 13 vaccine only prevents diseases caused by one organism, pneumococcus and is ineligible for multiple administration codes.

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
007	Acute and Chronic Pain
009	Recordkeeping and Documentation Standards
010	CPT Code 97140
011	Infant Care - Chiropractic
012	Measureable Progressive Improvement - Chiropractic

Revised 02/04/09

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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)
F022	Orthopaedic/Musculoskeletal	Cervical Disc Arthroplasty (Artificial Cervical Disc)
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation Neck and Back *Revised*
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
G010	Skin and Integumentary	Lipoma Removal
H003	Gastrointestinal/Nutritional	Bariatric Surgery *Revised*
L010	Diagnostic	Breast or Ovarian Cancer, Hereditary -BRCA1 and BRCA2 Genes and BRCAnalysis Rearrangement Testing (BART)
M001	BH/Substance Related Disorders	Mental Health Disorders: 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	Pervasive Developmental Disorders in Children: Evaluation and Treatment *Revised*
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 *Revised*
N004	Rehabilitation	Speech Therapy: Outpatient *Revised*
N005	Rehabilitation	Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers
N006	Rehabilitation	Acupuncture *Revised*
T002	Transplant	Kidney/Pancreas Transplantation
T003	Transplant	Heart Transplantation

Revised 12/10/08

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Medical Policy Table of Contents
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Reference #	Description
A003	Amino Acid Based Elemental Formula (AABF) *New*
C001	Court Ordered Mental Health 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
C011	Court Ordered Substance Related Disorder Services
D002	Diabetes Mellitus Supplies Coverage
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies *Revised*
D005	Dietary Formulas, Electrolyte Substances, or Food Products for PKU or Other Inborn Errors of Metabolism *New*
D007	Handicapped Dependent Eligibility
D008	Dressing Supplies
G001	Genetic Testing
G002	Gender Reassignment *New*
H005	Home Health Care (HHC)
H006	Hearing Devices
I001	Investigational/Experimental Services
I002	Infertility Treatment
I003	Routine Preventive Immunizations
I004	Mental Health Disorders: Intensive Residential Treatment Services (IRTS)
I005	Intensity Modulated Radiation Therapy (IMRT) Coverage Considerations *Revised*
N002	Nutritional Counseling
P008	Medical Policy Document Management and Application
P009	Preventive Screening Tests *Revised*
P010	Narrow-band UVB Phototherapy (non-laser) for Psoriasis
R002	Reconstructive Surgery
R003	Acute Rehabilitation Facilities
S008	Scar Revision *Revised*
S011	Skilled Nursing Facilities *Revised*
S012	Substance Related Disorders Coverage Considerations
T002	Transition of Care - Continuity of Care *Revised*
T004	Therapeutic Pass
W001	Physician Directed Weight Loss Programs

Revised 02/09/09

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Pharmacy Criteria Table of Contents

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Reference #	Description
A002	Oral Antifungal Therapy: Lamisil & Sporanox
A003	Combination Beta2-Agonist Inhalers *Revised*
A004	Antihistamines Step Therapy
A005	Antidepressants Step Therapy
A007	Angiotensin II Receptor Antagonist/Blocker (ARB) Step Therapy
A008	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) Medications Step Therapy *New*
B003	Botulinum Toxin
B004	Biologics for Rheumatoid Arthritis/Psoriatic Arthritis & JRA
B005	Biologics for Plaque Psoriasis: Amevive, Enbrel , Humira, Remicade, & Stelara
B006	Biologics for Inflammatory Bowel Diseases: Humira, Remicade, & Tysabri
B009	Bisphosphonates Step Therapy
C002	Cyclooxygenase-2 (COX-2) Inhibitors (Celebrex)
C003	Topical Corticosteroids Step Therapy *Revised*
D003	Diabetic Drugs Step Therapy
E001	Erectile Dysfunction Medications
F001	Fenofibrate Step Therapy *Revised*
G001	Growth Hormone Therapy
H001	HMG - CoA Reductase Inhibitor
I001	Topical Immunomodulators Step Therapy: Elidel & Protopic
I002	Immune Globulin Therapy (IVIG) *Revised*
L002	Leukotriene Pathway Inhibitors Step Therapy
L003	Lyrica Step Therapy
M001	Multiple Sclerosis Drugs: Avonex, Betaseron, Copaxone, Extavia, Novantrone, Rebif, Tysabri
N002	Nasal Steroids Step Therapy
O001	Overactive Bladder Medication Step Therapy
P001	Proton Pump Inhibitor (PPI) Step Therapy
R003	Topical Retinoid Medications Step Therapy *New*
S003	Sedative Hypnotics Step Therapy
T002	Tramadol Step Therapy *Revised*
W001	Weight Loss Medications

Revised 11/19/08

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Pharmacy Policies Table of Contents

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Reference #	Description
B001	Backdating of Prior Authorizations
C001	Coordination of Benefits
C002	Cost Benefit Program *Revised*
F001	Formulary and Co-Pay Overrides
N001	Pharmacy Benefit Manager Formulary Exceptions/Additions
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist
Q001	Quantity Limits per Prescription per Copayment
S001	Step Therapy

Revised 11/19/08

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Exhibit G

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/14/10
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/14/10	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/9/09	
Reference #: QM/C003	**Page:** 1 of 2	

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.

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

PROCEDURE:

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

A. Coronary Artery Disease, Stable
B. Asthma, Diagnosis and Outpatient Management of
C. Major Depression in Adults in Primary Care
D. Diagnosis and Management of ADHD

II. Distribution and Update of Guidelines

A. 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.
B. 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.
C. On an annual basis, practitioners are notified that all guidelines are available at *www.icsi.org*

III. Performance Measurement - baseline assessment for the initial adoption of the guidelines was conducted in fall of 2007, first network assessment report available in June 2008. Annual assessment to be conducted on an ongoing basis. 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:

A. Coronary Artery Disease
1. 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 130/80 mmHg
• LDL-C less than 100 mg/dl

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/14/10
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/14/10	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/9/09	
Reference #: QM/C003	**Page:** 2 of 2	

- Daily aspirin use
- Documented tobacco-free status

2. Cholesterol management after acute cardiovascular event (HEDIS technical specifications)

B. Asthma, Diagnosis and Outpatient Management of
1. Percentage of patients with persistent asthma who are on inhaled corticosteroid medication (HEDIS technical specifications)
2. Asthma action plan developed (PreferredOne Chronic Illness Management outcome measure)

C. Major Depression in Adults in Primary Care
1. Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks) (HEDIS technical specifications)
2. Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months) (HEDIS technical specifications)

D. Diagnosis and Management of ADHD Initiation Phase
1. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase (HEDIS technical specifications)
2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended (HEDIS technical specifications)

IV. PreferredOne has utilized the ICSI's practice guidelines as the clinical basis for its chronic illness management programs for CAD and Asthma 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

DOCUMENT HISTORY:

Created Date: 1/24/06
Reviewed Date:
Revised Date: 4/10/08, 7/10/08, 7/9/09, 7/14/10

Exhibit H

PreferredOne
Written Quality Complaint Report

Requirement: MN Rules 4685.1110 and 4685.1700-1900 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 written 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_____ 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

PreferredOne Member Rights & Responsibilities

As a PreferredOne member, you have the following rights and responsibilities:

1. A **right** to receive information about PreferredOne, its services, its participating providers and your member rights and responsibilities.

2. A **right** to be treated with respect and recognition of your dignity and right to privacy.

3. A **right** to available and accessible services, including emergency services, 24 hours a day, 7 days a week.

4. 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.

5. A **right** to participate with providers in making decisions about your health care.

6. A **right** to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

7. A **right** to refuse treatment recommended by PreferredOne participating providers.

8. A **right** to privacy of medical, dental and financial records maintained by PreferredOne and its participating providers in accordance with existing law.

9. A **right** to voice complaints and/or appeals about PreferredOne policies and procedures or care provided by participating providers.

10. 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 651.201.5100 or 1.800.657.3916 and request information.

11. A **right** to make recommendations regarding PreferredOne's member rights and responsibilities policies.

12. A **responsibility** to supply information (to the extent possible) that PreferredOne participating providers need in order to provide care.

13. A **responsibility** to supply information (to the extent possible) that PreferredOne requires for health plan processes such as enrollment, claims payment and benefit management.

14. A **responsibility** to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

15. A **responsibility** to follow plans and instructions for care that you have agreed on with your participating providers.