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

2012 Fee Schedule Update

Changes to the 2012 fee schedules were communicated at the PreferredOne Provider Forum in September. The presentation is available on our secure website under Providers/Information/2011 Provider Forum Q & A.

Professional Services

PreferredOne's Physician, Mental Health and Allied Health Fee Schedules are complete and will become effective for dates of service beginning January 1, 2012. These changes are expected to be an increase in overall reimbursement. As with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

Physician fee schedules are based on the 2011 CMS Medicare physician transitional RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register May 2011 for July updates. New codes for 2012 are based on the 2012 CMS Medicare physician transitional RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2011. Other new non-RVU based codes will be added according to PreferredOne methodology.

Various fees for services without an assigned CMS RVU have been updated accordingly. New codes that are not RVU-based will also be added. Examples of these services include labs, supplies/durable medical equipment, injectable drugs, immunizations and oral surgery services. Some of these changes were presented at the September Provider Forum. Also as communicated at the PreferredOne Provider Forum the lab methodology as a % of CMS will be increased for all products. PreferredOne will maintain the current default values for codes that do not have an established rate.

The 2012 Physician fee schedules will continue to apply site of service differential for RVU –based services performed in a facility setting (Place of Service 21-25 are considered facility).

The Convenience Care Fee schedules will also be updated January 1, 2012.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. New codes for 2012 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the "PreferredOne Provider Newsletter".

New ASA codes for Anesthesia services will be updated with the 2012 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2012.

Page 2...

In This Issue:

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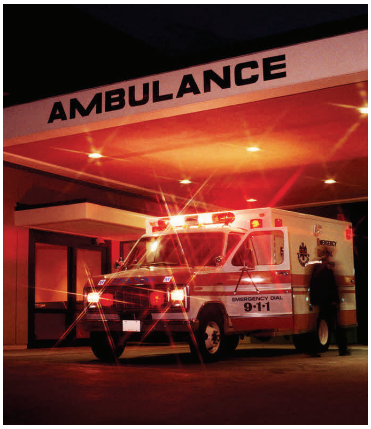
Hospital Services/UB04 Fee Schedules



The 2012 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 29 as published in the final rule Federal Register to be effective October 2011. Ambulatory Surgery Center (ASC) code groupings have been updated for 2012 according to Centers for Medicare and Medicaid Services (CMS). For those codes not assigned a grouper by CMS, PreferredOne will assign them to appropriate groupers as outlined in the policy.

For those on Ambulatory Payment Classifications (APC), we are using Optum (formerly Ingenix) hospital-based grouper that will be one year lag. For example, for 2012 rates, PreferredOne will use the 2011 APC grouper and edits and weights as of October 2011. New codes and APCs will be added according to the Pricing and Payment Policies P-11 "Reimbursement for Free Standing ASC and Hospital Outpatient Ambulatory Centers on APC Methodology".

The Facility (UB04) CPT fee schedule will consist of all physician CPT/HCPC code ranges and will be based on the 2011 CMS Medicare transitional physician RVU file, without the geographic practice index applied and without the work adjust applied. The global rules for the facility CPT fee schedule are as follows:

- The surgical codes (10000 – 69999 and selected HCPCS codes including, but not limited to G codes and Category III codes) are set to reimburse at the practice and malpractice RVU's.
- Office visit codes (i.e. 908xx, 99xxx code range) are set to reimburse at the practice expense RVU's.
- Therapy codes are set at the Allied Health Practitioner rates.
- For those codes that the Federal Register has published a technical component (TC) rate. This rate will be set as the base rate.
- All other remaining codes are set to reimburse at the professional services established methodology.

Reminder that new codes for 2012 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the "PreferredOne Provider Newsletter".

Off-Cycle Fee Schedule Updates

Other provider types such as DME, Dental, Home Health, Skilled Nursing Facility updates will take place April 1, 2012.

New and Updated Pricing and Payment Policies

The following are new and updated Pricing and Payment Policies are attached (Exhibits A, B, C, & D) and were presented at the September Provider Forum:

- New: P-10 "Transfer from an Acute Hospital to a Skilled Nursing Facility on the Same Day"
- New: P-11 "Reimbursement for Free Standing ASC and Hospital Outpatient Ambulatory Centers on APC Methodology"
- Updated P-16 "Fee Schedule Updates" (to incorporate APC methodology)
- Updated P-1 "Timely Filing"

A Gems Cross Walk For Providers

Where To Begin The Transition to ICD-10CM

PreferredOne is starting to prepare for changes to ICD-10 for October 1,2013. Here is an inside look at our first steps to mapping diagnosis codes for physician claims and what we discovered in our first project. We hope the following tip will be insightful and help you prepare your clinic for changes.

ICD-9 has about 14,000 codes and ICD-10 includes approximately 69,000 codes.

The General Equivalence Mappings (GEMS) were created by multiple entities, the National Center for Health Statistics (NCHS), the Centers for Medicare & Medicaid Services (CMS), AHIMA, the American Hospital Association, and 3M Health Information Systems. They were developed as a way to convert ICD-9 to ICD-10. One will find much more information on the CMS web site regarding the different types of GEMS files (cross walk, flat files) than we can explain in this article.

We ordered the entire DRAFT version of ICD-10 CM. Our certified coding staff attended intensive training. Having the complete DRAFT version of ICD-10 for reference made the process much easier. It was necessary to have both the ICD-9 and ICD-10 manuals open for review during the entire process.

We began by running a report for the entire 2010 claims year by provider specialty and by the top 15 primary diagnosis codes submitted on the claims. We found that many providers were using the most non specific/ unspecified code (even though ICD-9 included more specific codes). It is understandable that an unspecified code would be appropriate in some circumstances, however it appears that many different provider types chose those codes over more specific ones.

PreferredOne started with the CMS GEMS look up. (see end of article for link). It was easier to go from ICD-9 to ICD-10 rather than ICD-10 to ICD-9. The reason is that ICD-10 codes are so specific, there may not be many 1 for 1 matches when going from ICD-10 to ICD-9. Since the purpose of ICD-10 is to be more specific, this simple GEMS cross walk was **not** sufficient to accomplish this task. Using the ICD-10 manual is an absolute must to find all of the possible diagnoses codes now available to further describe an illness/problem.

Once the GEMS cross walk returned the ICD-10 code category, we discovered pretty early in the process that it required us to look in the DRAFT version of the ICD-10 manual and compare the returned code to other additional codes in that range for detailed coding. There were almost always a significant amount of choices for more specificity. Don't forget to use the alphabetical diagnosis look up in the front of the manual. Upon finding the code, it is best to turn to that code in the chapter and review all other codes, coding guidelines, exclusions, and inclusion notes, before deciding on the most specific codes to use.. Read the official guidelines in the front of the book and refer to them often. Options now include, coding for initial, subsequent, or sequela encounter, right, left, bilateral, and even alpha xx characters within the code to serve as place holders for future codes.

Here is one example of missing an opportunity for specificity:

ICD-9 174.9 Malignant Neoplasm breast, (female) unspecified **This was the primary diagnosis submitted most often for claims submitted in 2010 for several provider types**

Available for coding in ICD-9 but not submitted:

Malignant Neoplasm of Female Breast

- 174.0 Nipple & areola
- 174.1 Central Portion
- 174.2 Upper-inner Quadrant
- 174.3 Lower inner quadrant

Page 4…

...Cont'd from page 3

- 174.5Lower- outer quadrant
- 174.6 Axillary Tail
- 174.8 Other specified sites of female breast
- **174.9 Breast, (female), unspecified (code most often submitted)**

When entering 174.9 (**unspecified**) in the GEMS ICD-9 to ICD-10 look up, one is directed to only one code:

- C50.919: malignant neoplasm of **unspecified site** of **unspecified female breast**

Do not end the search here as all of the following would have been missed, including the new options for male breast cancer by site within some the female code ranges.

- C50.011 Malignant neoplasm of nipple and areola, right female breast
- C50.012 Malignant neoplasm of nipple and areola, left female breast
- C50.019 Malignant neoplasm of nipple and areola, unspecified female breast

- C50.021 Malignant neoplasm of nipple and areola, right male breast
- C50.022 Malignant lesion of nipple and areola, left male breast
- C50.029 Malignant neoplasm of nipple and areola, unspecified male breast

- C50.111 Malignant neoplasm of central portion of right female breast
- C05.112 Malignant neoplasm of central portion of left female breast
- C50.119 Malignant neoplasm of central portion of unspecified female breast

- C50.12 Malignant neoplasm of central portion of right male breast
- C50.112 Malignant neoplasm of central portion of left male breast
- C50.129 Malignant neoplasm of central portion of unspecified male breast

More possible codes continue for axillary tail of breast, overlapping sites, upper-inner quadrant, lower inner quadrant, upper outer quadrant, etc.

Tip number one, look up each code that is suggested in the cross walk. Check that section of the ICD-10 manual and review all of the possible codes.

PreferredOne has included the link (below) for the GEMS cross walk, but remember to read and research all the information on the CMS Web site for ICD-10, and how the cross walks were developed and how to use them. In order for ICD-10 to be successful, it is necessary to be as specific as possible. A little extra time in setting up your internal coding guides for October 2013 will ensure better data collection. http://www.aapc.com/ICD-10/codes/index.aspx

"Transitioning to ICD-10 Codesets – The Clock is Ticking…End the Year with a Plan"

Minnesota ICD-10 Collaborative is pleased to present a 90-minute free webinar on the business and technical impacts of ICD-10 and the importance of getting started with implementation planning

Wednesday, November 8th, from 9-10:30am cst

Presentation Topics

Minnesota Collaboration "A Success Story" presented by Alan Abramson, Sr. VP and Chief Information Office for HealthPartners, Inc.

Hear how Minnesota successfully implemented HIPAA mandated transactions and codesets, NPI and other standards using a collaborative approach for planning, testing and implementing across the provider and payer community. Now, hear how the same approach is being used to achieve compliance by supporting the Minnesota healthcare industry through the ICD-10 conversion.

Advanced Issues in ICD-10 Compliance presented by Jim Daly, Director of IT Risk & Compliance for BlueCross BlueShield of South Carolina.

ICD-10 is being called the largest HIPAA mandate yet. But many providers are unaware of how much change it will bring to claims management. Listen as our presenter covers the key business issues that have significant IT impacts. Impacts include "non-HIPAA" entities such as Providers, payers, vendors, employers, members/patients, business associates/trading partners, agents, workers' compensation, state agencies, schools, transplant/disease registries, etc.

Getting Started "a provider focus" presented by provider members of the collaborative

October 1, 2013 is two years away but there are things you can get started on now. Whether you are part of a large or small care delivery service provider, our presenters will cover some practical tools and tips for getting started with inventory and assessment to identify your business and technical impacts such as changes to forms, policies, processes, training as well as software/vendor readiness.

Q/A with a post-presentation panel discussion

This will be an opportunity for you to ask questions fielded by a panel of subject matter experts who will share their input, ideas and "best practice" approach to ICD-10 implementation.

To register for this free webinar, please follow the link below:

https://chartersolutions.webex.com/chartersolutions/onstage/g.php?d=665531553&t=a&EA=mnicd10%40chartersolutions.com&ET=0dfba16e64a6cb91b7c26806a54e01fd&ETR=68f6da22e2d24504a1c8a3c6262064c7&RT=MiM3&p

The mission of the ICD-10 Collaborative is to bring together a consortium of providers and payers to identify and evaluate opportunities to minimize the disruption in health care billing, reporting, and related processes for a variety of stake-holders in the healthcare industry in connection with the ICD-10 conversion.

Coding Update

Duplicate Laboratory Tests to be Recouped

When performing an internal review, PreferredOne has discovered the same lab services are being reported by two different providers for the same patient, same date of service.

As an example, a provider in the office billed labs and venipuncture on the CMS 1500, a hospital/ and or an outside lab also billed for those same tests, same patient, same day.

After many telephone calls to the different providers, it appears that there is confusion between the entities as to who should be reporting the services. We urge the office providers to clearly indicate to the performing laboratory who should be reporting the services to the payer. PreferredOne will be recouping the duplicate payments. *Page 6...*

...Cont'd from page 5

Reimbursement for Maternity/Obstetrical Services Policy

Changes have been made to the OB Policy which include clarification that the initial visit for the Comprehensive examination is paid one time, outside of the global package.

Policy states that prolonged services during labor (hospital or home) are part of the global package and not separately reimbursed. Revised policy is attached to this newsletter (Exhibit E).

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:

Three new Behavioral Health criteria sets -

- MC/M005 Eating Disorders: Level of Care Criteria
- MC/M010 Substance Related Disorders: Inpatient Primary Treatment
- MC/M014 Detoxification and Addiction Stabilization: Inpatient Treatment

No retired Behavioral Health criteria sets

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 of the following:

Five new Medical/Surgical criteria sets -

- MC/C007 Surgical Treatment for Obstructive Sleep Apnea in Adults
- MC/F021 Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic
- MC/L008 Continuous Glucose Monitoring Systems for Long-Term Use
- MC/L011 Insulin Infusion Pump
- MC/T003 Heart Transplant

No new Medical/Surgical policies were created

Page 7...

...Cont'd from page 6

The following are additions to the Investigational/Experimental/Unproven Comparative Effectiveness List -

- Alternative/Holistic Laboratory Testing: Micronutrient Testing in absence of specific symptoms related to malnourishment
- Alternative /Holistic Laboratory Testing: NutrEval in absence of specific symptoms related to malnourishment
- Automated Point-of-Care Nerve Conduction Studies
- Breath test for diagnosing heart transplant rejection (Heartsbreath)
- Implanted Estrogen or Testosterone Hormone Pellets for Symptoms of Menopause
- Lyme Disease testing by the following methods:
  - Borrelia burgdorferi antibody index testing
  - Borrelia culture
  - C6 peptide ELISA assay (using recombinant VIsE1 or peptide antigens of Borrelia burgdorferi)
  - CD57+ lymphocyte counts
  - IgA screen (IFA)
  - Lyme Dot Blot Assay for antigen
  - Plymerase chain reaction for identification or quantification of Lyme disease (B. burgdorferi)
  - Provocative testing (testing for B. burgdorferi after antibiotic provocation)
  - Serum borreliacidal assay
  - Spirochetal DNA or RNA
  - T-cell proliferation response assay
  - 31kDa Epitope Test for IgM
  - Urine antigen assay
- Occipital nerve stimulation for headaches
- Obstructive Sleep Apnea (OSA) Treatments:
  - Adjustable tongue-advancement device (e.g. Advance system)
  - Cardiac (Atrial) Pacing
  - Cautery-Assisted Palatal Stiffening Operation (CAPSO)
  - Flexible Positive Airway Pressure (pressure-relief C-PAP [C-Flex, Respironics])
  - Injection Snoreplasty
  - The Provent Sleep Apnea Therapy
  - Tongue Based Suspension (e.g. Repose System)
  - Transpalatal Advancement Pharyngoplasty (TAP)
- Pulsed radiofrequency ablation
- Vitamin/Mineral infusion - intravenous nutrient therapy (Myer's Cocktail)
- Water-cooled radiofrequency ablation

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. *Page 8...*

...Cont'd from page 7

The attached documents (Exhibits F, G, H, I, & J) include the latest Chiropractic, Medical and Pharmacy Policy and Criteria indices. 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

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.

Pharmacy Policy and Criteria Update

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

One new Pharmacy criteria was developed -

- PC/V001 Vascular Endothelial Growth Factor Antagonists for Intravitreal Use (Avastin, Lucentis, and Macugen)

The following three Pharmacy criteria were previously incorporated into other Biologics criteria. These have now been placed into their own, disease specific, criteria.

- PC/B011 Biologics for Psoriatic Arthritis
- PC/B012 Biologics for Ankylosing Spondylitis
- PC/B013 Biologics for Ulcerative Colitis

No Pharmacy criteria were retired

No Pharmacy Policies were created or retired

Revised entry for Avastin on the Pharmacy Investigational/Experimental/Unproven Comparative Effectiveness List in conjunction with the development of the new criteria.

Quality Management Update

Clinical Practice Guidelines

PreferredOne supports the Institute for Clinical Systems Improvement's (ICSI) mission 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, it has chosen to adopt several of them and monitor their performance within our network (Exhibit K). The guidelines that PreferredOne's Quality Management Committee has adopted include ICSI's clinical guidelines for Coronary Artery Disease, Asthma, Depression and ADHD/ADD. The performance of these guidelines by our network practitioner's will be monitored using HEDIS measurement data.

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

...Cont'd from page 8

Continuity & Coordination of Care

Continuity and coordination of care is important to PreferredOne. If your clinic is terminating your contract with PreferredOne please notify your PreferredOne provider representative immediately. According to the Minnesota Department of Health statute 62Q.56 subdivision 1: the health plan must inform the affected enrollees about termination at least 30 days before the termination is effective, if the health plan company has received at least 120 days' prior notice. If you need further information please contact your network representative at PreferredOne regarding this statute.

Case Management Referral

What is Case Management?

Case management is a collaborative process among the Case Manager (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 call out to 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. The telephone number for the case management department is (763) 847-4477, option 2.

Programs from PreferredOne at No Cost to Your Patients

PreferredOne has implemented Chronic Illness Management and Treatment Decision Support programs available to your patients who live with chronic conditions. Your patients will still have the same level of benefits, access to any ancillary services and access to your referral network. They will also continue to see their practitioner(s) and receive the same services that they currently provide them.

The Chronic Illness Management (CIM) and Treatment Decision Support (TDS) Programs focus on the following conditions:

CIM:

- Diabetes
- Coronary Heart Disease
- Heart Failure
- Chronic Obstructive Pulmonary Disease
- Asthma

Page 10...

...Cont'd from page 8

TDS:

- Low Back Pain
- Health Mom and Baby

The goals of these programs are to:

- Promote self-management of chronic conditions
- Improve adherence to treatment plans
- Improve adherence to medication regimes
- Reduce or delay disease progression and complications
- Reduce hospitalizations and emergency room visits
- Improve quality of life

Benefits to You and Your Practice

These PreferredOne programs are designed to collaborate with a practitioner's recommended treatment plans. With the help of a nurse health coach, patients are educated telephonically about their chronic conditions and taught how to track important signs and symptoms specific to their condition. There are several benefits when your patients participate in these PreferredOne programs:

- Program participants learn how to better follow and adhere to treatment plan
- Program participants learn how to maximize their office visits
- If clinically concerning warning signs are discovered through the program, practitioners are notified, if clinically appropriate, via a faxed *Health Alert*
- Program participants receive ongoing support and motivation to make the necessary lifestyle changes practitioners have recommended to them

Benefits to Patients:

- Access to a PreferredOne Registered Nurse
- Information about managing their health condition
- Education and tools to track their health condition
- Equipment, as needed, for participation in the program
- Access to Healthwise®, an online health library at www.PreferredOne.com

Program Participants learn to:

- Track important signs and symptoms to detect changes in their health status early enough to avoid complications and possible hospitalizations
- Make better food choices
- Start an exercise program
- Regularly take their medications
- Avoid situations that might make their condition worse

To make a Referral to the PreferredOne CIM or TDS programs:

Contact PreferredOne toll free at 1-800-940-5049 Ext. 3456.

Monday-Friday 7:00am to 7:00pm CST.

DEPARTMENT:	Pricing and Payment	**APPROVED DATE: 9/1/2011**	
POLICY DESCRIPTION:	Transfer from an Acute Hospital to a SNF on the same day		
EFFECTIVE DATE:	**1/1/2012**		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	010	**RETIRED DATE:**	

SCOPE: Network Management, Customer Service Department for PreferredOne, PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc, Medical Management, Claim Department for PreferredOne Community Health Plan, PreferredOne Administrative Services, and PreferredOne Participating Providers

PURPOSE: To provide guidelines for reimbursement when an enrollee is transferred early from an acute care facility and admitted to a skilled Nursing facility on the same day.

POLICY: PreferredOne will reduce payment to the discharging acute care hospital if the patient is discharged more than 1 day sooner than the geometric length of stay of that DRG as listed in the CMS DRG weight file.

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 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. The Acute Care Hospital claim (UB04) will have a Patient Status (FL 17) of 03 which is a transfer to a Skilled Nursing Facility.

2. This policy applies if the assigned DRG for that inpatient discharge is one of Medicare deemed Post Acute DRG's or one of the Special Pay DRG's(click here for listing)

3. Transferring facilities under the Post Acute DRG's are paid a per diem rate. Hospitals receive twice the per diem rate for the first day and a per diem rate for each additional day up to the full MS-DRG rate. Transferring facilities under the Special Pay DRG's are paid half the full MS-DRG payment plus one and a half per diem rate for subsequent days up to the full MS-DRG rate.

4. Policy doesn't apply to Outlier or any additional device payments (internal only).

REFERENCES:

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE:** 09/1/2011	
POLICY DESCRIPTION:	Reimbursement for Free Standing Ambulatory Surgery Centers and Hospital Outpatient Ambulatory Centers on APC Methodology		
Surgery Centers			
EFFECTIVE DATE:	6/1/09		
PAGE:	1 of 2	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	011	**RETIRED DATE**	

SCOPE: Network Management, Customer Service Department for PreferredOne, PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc, Medical Management, Claim Department for PreferredOne Community Health Plan, PreferredOne Administrative Services, and PreferredOne Participating Providers

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

POLICY: PreferredOne will be replacing the ASC grouper payment methodology with the APC payment methodology for outpatient hospital's and free standing surgery centers. This policy will outline PreferredOne's Methodology.

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. Services that are reimbursed under APC(billed on UB04):
    a. Emergency Room services
    b. Scheduled outpatient Visits, including Radiology
    c. Same day Surgery visits (Hospital and free standing)

   Services that reimburse under a fee schedule:
    a. Laboratory and Pathology
    b. Physical, Occupational and Speech Therapy
    c. Mammography
    d. Non-Implantable prosthetics, orthotics and DME devices
    e. Various drugs will use RJ 9see status indicator)
    f. Ambulance

Services not reimbursed under the PC methodology:

a. Behavioral health programs
b. Partial hospitalization
c. Home Health Care
d. Skilled Nursing
e. Physician based professionals (billed on HCFA)

2. APC's is a line item reimbursement that utilizes CPT and HCPCS codes to assign payment. Each code is assigned a status indicator which points to how each particular code is paid. Certain status indicators point to a fee schedule payment, APC payment, % of charge or no payment/packaged service.
    a. Payment for a code that points to an APC is calculated by multiplying the relative weight X CF X Units.

3. PreferredOne uses a one year lag in the Optum Hospital based grouper and weights (ex. for 2012 we will use the 2011 grouper and the Oct 2011 weights). However, new codes will be added according to the following:
    a. If the new code is assigned a new APC we will add it to the current APC weight and rate file at the NEW APC WEIGHT.
    b. If the new code is assigned to an existing APC it will be added and will follow the existing APC weight and rate.
    c. If a new code is assigned to a status indicator that points to a fee schedule, the code will be added to that fee schedule according to the fee schedule methodology.

4. APC line items can pay more that line charges. The fee schedule payments will cap at charges. The total payment for a claim will not pay more than total charges.

5. There are OCE and CCI edits embedded in the APC grouper. Each claim will have to pass thru the edits cleanly in order to get paid. If lines are flagged as incorrectly billed the line will not pay or the whole claims will be denied and sent back to provider.

6. Refer to the APC Manual

DEFINITIONS:

REFERENCES: See APC Manual

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	
POLICY DESCRIPTION:	Fee Schedule Updates		
EFFECTIVE DATE:	**7/1/2011**		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	**1/1/2008,04/01/06,** 07/01/05
REFERENCE NUMBER:	P-16	**RETIRED DATE:**	

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

PURPOSE: To give provider information on the effective dates of the provider fee schedule updates.

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. All fee schedules will be reviewed and updated annually. The fee schedule update includes but is not limited to a review of changes, deletions, and additions in CPT, HCPCS, DRG, American Society of Anesthesiology and ASC Groupers, and APCs.

2. The provider and hospital CPT fee schedules are updated on January 1st of each calendar year. The codes that are assigned an RVU as defined by Centers of Medicare (CMS) are updated to use a one year lag, non-GPCI adjusted total RVU as published in the Federal Register. 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 RVU's.

   Example: The fee schedule that is effective January 1, 2006 – December 31, 2006 will use the CMS RVU from 2005. The new CPT and HCPCS codes published in November 2005 to be effective January 1, 2006 will use the 2006 CMS non-GPCI RVU as published in the Federal Register and be added to the fee schedule effective January 1, 2006 – December 31, 2006.

3. The non-RVU code pricing will also be reviewed and updated to be effective January 1st of each calendar year.

4. The hospital DRG schedules will use the current version as published in the October Federal Register that is to be effective January of the following year.

5. PreferredOne's standard reimbursement methodology for ASC is based on the groupers as designated by Center of Medicare and Medicaid Services (CMS) will be utilized. 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. PreferredOne also has APC reimbursement methodology. For the APC providers, the methodology is based on the APC weights and rates as designated by Center of Medicare and Medicaid Services (CMS). The grouper and weights will be one year lag, with the following exception for new codes. For example, for 2012 rates will use the 2011 APC grouper and weights. New codes will be added according to the following: If the new code is listed in the CMS Addendum B crosswalk points the code to a new APC, the code will be added to the current year APC weight and rate. If the new code is listed in the CMS Addendum B crosswalk points the code to points to an existing APC, the code will be added to that existing APC weight and rate.

   The provider and hospital CPT fee schedules are updated on January 1st of each calendar year. The codes that are assigned an RVU as defined by Centers of Medicare (CMS) are updated to use a one year lag, non-GPCI adjusted total RVU as published in the Federal Register. 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 RVU's.

6. Fee schedules for DME, Home Health, Home IV, and Dental are updated on April 1st of each year.

7. Anesthesia fee schedules are updated annually on January 1st of each year according to the current year Relative Value Guide published by the American Society of Anesthesiologists in November of the preceding year.

8. Hospice fee schedules are updated annually on October 1st of each year according to the Centers of Medicare and Medicaid Services Fee Schedule.

9. Additional updates to the fee schedules may occur when warranted by special circumstances.

10. All updates will be communicated via the PreferredOne Provider Bulletins

11. All fee schedule updates involve a consensus process between coding, pricing and contracting.

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DEPARTMENT:	Pricing & Payment	**APPROVED DATE: 9/01/2011**
POLICY DESCRIPTION:	Timely Filing	
EFFECTIVE DATE:	09/01/2011	
PAGE:	1 of 1	**REPLACES POLICY DATED: 1/1/2009**
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 explanation 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 unless a government program recoups their payment resulting in PreferredOne / Employer liability.

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DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 10-10-06**	
POLICY DESCRIPTION:	Reimbursement for Maternity/Obstetrical Services		
EFFECTIVE DATE:	**10-10-06**	**REVIEW DATE;**	
PAGE:	1of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	P-33	**RETIRED DATE:**	

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

PURPOSE: To provide guidelines for submission of claims for Maternity/Obstetrical Services

POLICY: PreferredOne will recommend reimbursement for Maternity/Obstetrical Services when billed using the appropriate global obstetric CPT codes. Coverage is subject to the terms of the enrollee's benefit plan.

PROCEDURE:

1. All genetic testing must be prior authorized. (ex: cystic fibrosis).

2. PreferredOne accepts the global obstetric care codes. (see # 8 for options) The global package may include the antepartum care, delivery services and postpartum care. These are defined as follows:

A. Antepartum care – PreferredOne will separately reimburse for the initial OB visit. The global package includes subsequent history, physical exams, recording of weight, blood pressure, fetal heart tones and routine chemical urinalysis. This includes monthly visits up to 28 weeks and biweekly/weekly visits from 28 weeks to delivery. This should be approximately 13 visits for a routine pregnancy. The global antepartum includes all routine visits. Extra routine visits do not warrant additional E&M visits being billed.

B. Delivery services – includes admission to the hospital, history and physical, management of labor (including induction and augmentation), vaginal delivery (includes episotomy, forceps and delivery of the placenta), or cesarean delivery.

C. Postpartum care – includes routine hospital and routine office visits during the obstetrical global period.

3. Additional visits above and beyond the antepartum package due to complications of pregnancy (ex: hyperemesis, preterm labor, diabetes) may be billed. If the number exceeds 13 visits report using the appropriate E&M codes with the complication of pregnancy diagnosis code. Additional E&M codes should not be billed for routine visits even if there are more than 13 visits during the pregnancy.

4. Multiple Births – Antepartum and postpartum care should be included with only one delivery code. Reimbursement will be made for only a single antepartum and postpartum period regardless of the number of newborns delivered. Additional births should be

billed with the delivery code only. Example: Total global package billing for twins delivered vaginally – Twin A – 59400 and Twin B – 59409.

5. Antepartum/Postpartum Care Only – If the provider provides the antepartum/postpartum care only and does not do the delivery use the appropriate CPT codes. Antepartum – 59425 or 59426. Postpartum – 59430.

6. 5. 22 modifier - If there are unusual circumstances the claim for the global obstetric care or the delivery that is appended with a 22 modifier may be given individual consideration. Additional payment for such care may be made when warranted by the patients medical condition based on the documentation in the patients medical record. All pertinent records should be attached to the claim.

7. Unrelated illness during the pregnancy – Global billing is not intended to cover treatment for conditions totally unrelated to the pregnancy (ex: sinusitis, upper respiratory infection) that occur during the prenatal course. In these situations bill the appropriate E&M code using the unrelated diagnosis as the primary diagnosis. V22.2 may be used as a secondary code.

8. PreferredOne considers the H codes (H1000-H1005) for prenatal at risk assessment to be part of the obstetrical package.

9. Obstetrical Care Coding Options:

A. Global Billing – global billing includes the antepartum care, delivery and postpartum care.

59400	Vaginal Delivery
59510	C-Section
59610	VBAC
59618	C-Section after VBAC

B. Care Only Antepartum

E&M	1-3 visits (ex: patient transfers care elsewhere)
59425	4-6 visits (includes the first three visits)
59426	7+ visits (includes the first six visits)

C. Delivery Only

59409	Vaginal delivery
59514	C-Section
59612	VBAC
59620	C-Section after VBAC

D. Delivery and Postpartum Care Only

59410	Vaginal Delivery
59515	C-Section
59614	VBAC
59622	C-Section after VBAC

E. Postpartum Care only

59430 Postpartum Care

10. PreferredOne does not reimburse separately for visits/prolonged services during labor provided in the home, birthing center or hospital. This is considered to be part of the global package.

11. PreferredOne will reimburse for one home visit for the mother (99501) and one home visit for the infant (99502) when the mother is discharged within 24 hours of delivery.

12. PreferredOne does not reimburse separately for multiple routine home visits after delivery. This is considered to be part of the global package.

DEFINITIONS:

REFERENCES:

Medical Criteria Table of Contents

Reference #	Category	Description
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic ***New***
F022	Orthopaedic/Musculoskeletal	Cervical Disc Arthroplasty (Artificial Cervical Disc)
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) 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
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
L010	Diagnostic	Breast or Ovarian Cancer, Hereditary -BRCA1 and BRCA2 Genes and BRCAnalysis Rearrangement Testing (BART)
L011		Insulin Infusion Pump
M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment Program
M005	BH/Substance Related Disorders	Eating Disorders-Level of Care Criteria ***Revised***
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)
M007	BH/Substance Related Disorders	Mental Health Disorders: Residential Treatment ***Revised***
M008	BH/Substance Related Disorders	Psychotherapy: Outpatient Treatment
M009	BH/Substance Related Disorders	Chronic Pain: Outpatient Program
M010	BH/Substance Related Disorders	Substance Related Disorders: Inpatient Primary Treatment ***Revised***
M014	BH/Substance Related Disorders	Detoxification: Inpatient Treatment ***Revised***
M019	BH/Substance Related Disorders	Pathological Gambling: Outpatient Treatment
M020	BH/Substance Related Disorders	Pervasive Developmental Disorders in Children: Evaluation and Treatment
M022	MH/Substance Related Disorders	Mental Health Disorders: Residential Crisis Stabilization Services (CSS)
M023	MH/Substance Related Disorders	Mental Health Disorders : Intensive Residential Treatment Services (IRTS)
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
T002	Transplant	Kidney/Pancreas Transplantation
T003	Transplant	Heart Transplant ***New***

Medical Policy Table of Contents

Pharmacy Criteria Table of Contents

Pharmacy Policies Table of Contents

Chiropractic Policies Table of Contents

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Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/14/11
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/14/11	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/14/10	
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

- 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:
20011 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: 7/14/11
Revised Date: 4/10/08, 7/10/08, 7/9/09, 7/14/10, 7/14/11