PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
October 2012

New Link Available to Providers on Secured Site

As discussed at the Provider Forum in September, some PreferredOne clients are requiring tiered and limited network products for their employees. These networks can vary slightly by employer who often require access to a specific provider. We have standardized our networks and processes to have consistency, but occasionally a large employer will require a change. These unique networks make being a provider of service to a PreferredOne member sometimes tricky. To address this issue for providers PreferredOne has developed a way for you to view each person's network with just their ID card and Internet access.

It is very easy to now access your patient's network by simply logging onto our website. The patient's name and/or ID number is required to access this information.

- Under the Subscriber/Dependent Eligibility screen you will find a link of the name of the patient's network(s).
- Click on the link and you will be able to search for your clinic. Sometimes the patient may have more than one network depending on their benefit structure. If there are questions regarding benefits, contact our customer service department.

This link is very specific to this one member. Be sure to verify your network status under each specific patient. If you have questions please contact your provider relations representative.

Sensory Integration

John Frederick, MD, CMO

PreferredOne regularly receives requests for prior authorization of sensory integration services. Each benefit plan that PreferredOne administers may have some variation in which sensory integration services are covered under the employer's benefit plan, but the vast majority have very limited coverage. The most common benefit is that a limited number of visits are covered and only for feeding disorders.

We deny prior authorization requests based on the employer plan benefit language. Denials do not address the issue of medical necessity or whether sensory integration is a proven and effective therapy. Appeals of these denials will not change the coverage determinations and may give the member false hope of getting the services approved. When a provider receives a denial letter for these non-covered services they should understand that pressing the medical necessity, patient need for the services, and value of the services will not change the outcome.

When sensory integration services are a covered benefit for feeding disorders, please include documentation of the medically necessary indication, specific goal setting directed at the feeding disorder, and periodic measurement of progress toward the goals. Please call me at 763-847-3051 if you have further questions.

In This Issue:

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POA Indicator

Just a helpful reminder that **the POA, or "Present On Admission" Indicator is required on all Tribal Member Claims involving inpatient admissions,** as these claims are priced based on Medicare.

For further information regarding POA Indicators,

*Please reference the PreferredOne payment policy **Present on Admission Indicator**, reference number **003** (effective 1-1-2009) per the Office Procedures Manual available online at www.PreferredOne.com.

For the Official Medicare POA Guidelines, please visit www.cdc.gov/nchs/icd/icd9cm.htm

2013 Fee Schedule Update

Additional changes to the 2013 fee schedules were communicated at the PreferredOne Provider Forum in September. The presentation is available on our secure website.

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, 2013. 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 will be based on the 2012 CMS Medicare physician transitional RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register June 2012. New codes for 2013 will be based on the 2013 CMS Medicare physician transitional RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2012. 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. The lab methodology as a % of CMS will remain the same for all products. PreferredOne will maintain the current default values for codes that do not have an established rate.

The 2013 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) and will be taking multiple procedure reduction for additional non-surgical codes as communicated at the Provider Forum.

The Convenience Care Fee schedules will also be updated January 1, 2013.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder that new codes for 2013 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 Bulletin."

New ASA codes for Anesthesia services will be updated with the 2013 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2013.

Hospital Services/UB04 Fee Schedules

The 2013 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 30 as published in the final rule Federal Register to be effective October 2012. Ambulatory Surgery Center (ASC) methodology has been sunsetted effective 12/31/2012. Contact your provider contractor if you have not yet converted!

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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 2013 rates, PreferredOne will use the 2012 APC grouper and edits and weights as of October 2012. 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 2012 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 RVUs.
- Office visit codes (i.e., 908xx, 99xxx code range) are set to reimburse at the practice expense RVUs.
- 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 2013 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, and Skilled Nursing Facility updates will take place April 1, 2013.

New and Updated Pricing and Payment Policies

The following new and updated Pricing and Payment Policies are attached and were presented at the September Provider Forum:

- Retirement H-9 "Reimbursement for Free Standing ASC & Hospital OP ASC"
- Updated #11 "Reimbursement for Free Standing ASC and Hospital Ambulatory Centers on APC Methodology" (Exhibit A)
- Updated P-17 "Reimbursement for Multiple Procedures"
- New Pricing & Payment Policy # 12 "Pain Bock with General Anesthesia" (Exhibit B)

Pain Blocks with General Anesthesia

When multiple pain blocks are administered during a surgical preparation, general anesthesia, or in the recovery room they will be treated similar to the "multiple procedure" rules of 50% payment for the secondary procedure. The first line would be for the general anesthesia using ASA.

Codes and the appropriate modifier AA, QK, QX, etc. and will be paid the lesser of billed charges or 100% of the ASA fee schedule. The second line would be for the pain block using CPT codes in the 64400-64455 range with the appropriate modifier. Only one unit of service should be billed for the 64400-64455 code as this service is not based on time units. The first pain block-line item will pay the lesser of billed charges or 100% of the CPT fee schedule. Any additional line items billed for pain block-services will be reduced to 50% payment.

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Focus Areas Presented at the Provider Forum

For incorrect billing (see the presentation online for additional information):

- Clinics billing a place of service = 11 when there is a corresponding UB facility claim. Providers who bill from a facility-based clinic that bills room charges on a UB will be expected to bill with place of service 22 or the claim will be recouped as a provider billing error.
- Surgeries/Procedures performed on the same date of service should be submitted on one claim.
- Professional claims where both a global code and a -26 or –TC modified code billed on the same date of service for same member and service. The provider claim billing the global code will be recouped.
- Reminder that if a free-standing clinic is changing to be a hospital-based clinic, please notify your contract manager or director at PreferredOne to ensure correct system setup. This move will be done on a budget neutral basis.

Coding Update

Billing Unlisted Codes

- Unlisted codes do not describe a specific procedure or service so it is necessary to submit supporting documentation when filing the claim or the claim will be denied.
- Unlisted surgical codes: The submitted attachments should include a written description of the unlisted code. Often submitting only the operative or imaging report is not sufficient
- Unlisted drugs or biologics: Provide the name of the drug, NDC#, and dosing information.
- DME: Provide the name of the item and any other relevant information.

Billing Prolonged Services

When billing prolonged services it must be clearly documented in the record that the provider furnished face to-face time with the patient. Documentation must also include the start and end times of the visit. When the E&M code level is selected based on time, you may report only prolonged services with the highest E&M code level in that family of codes.

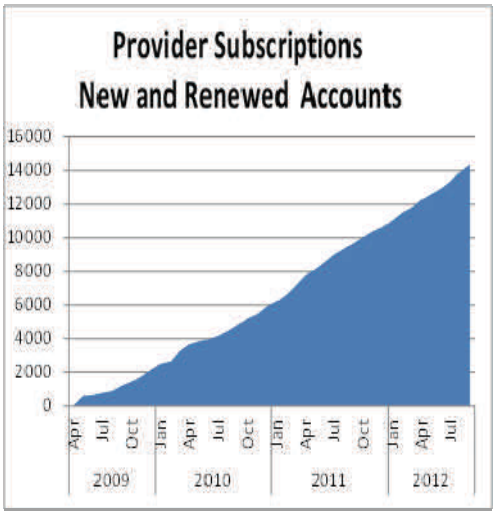
Billing Laboratory Services

- To prevent duplicate denials, it is often better to report lab tests with units when appropriate. Also reminder that the 91 modifier is the modifier for repeat lab testing not 76.
- Policy H-9 will be retired on 12-1-12 (Exhibit C)
- Policy H-17 has been updated (Exhibit D)

Billing Surgical Procedures

PreferredOne follows Minnesota AUC guidelines for surgical procedures. "Report one unit for all services without a measure in the description." Providers are required to report surgical procedures which do not contain a unit of measure with one unit on a single line. For example, if multiple lesions are excised the code should not be reported with units but on single lines with one unit with the appropriate modifier such as 59.

"Get Started" Pre-Population for MDs, DOs, PAs, and ODs—Minnesota Credentialing Collaborative



Over the past two years, the Minnesota Credentialing Collaborative (MCC) has continued a steady rate of growth. More than 9,000 providers have ApplySmart records and those providers have submitted more than 26,000 application to Minnesota-based health plans and hospitals. Providers and clinic administrators are benefiting from the MCC online credentialing process which eliminates redundant data entry, assures the application submitted is complete and legible, and stores all images and supplemental data in one place.

The MCC continues to seek ways to simplify the credentialing application submission process. We're pleased to announce that PreferredOne will provide access to a **'starter set of data'** to reduce the data entry time for its providers who want to establish an ApplySmart record. This starter set of data is available to MDs, DO, PAs, and ODs who have previously been credentialed or re-credentialed by PreferredOne. This does not apply to PreferredOne delegated providers.

Accessing the PreferredOne starter set will be of greatest value for small to medium sized clinics (10-50 providers). Often smaller clinics do not have access to sophisticated database tools. Small to mid-sized clinics will not only benefit from the timesaving aspects of storing and submitting electronic applications, but can also use ApplySmart to manage their data, store images, and flag expirables (flagging expiration dates such as board certifications, licenses, malpractice certificates, etc.). Once established, your ApplySmart record can be used to submit to all Minnesota-based health plans and hospitals.

We encourage larger clinics (>50 providers) to contact us to explore opportunities to upload data directly from their in-house data base.

If you have an interest in knowing more about the MCC, the continual improvements and enhancements to the system, or have an interest in exploring whether your providers would benefit from accessing the PreferredOne starter data set, contact the MCC at:

Minnesota Credentialing Collaborative
2550 University Avenue West
St. Paul, MN 55114
651-789-0113
Website: www.mncred.org
Email: mcc@mncred.org

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 TheraQuality Management Subcommittees approve new criteria sets and clinical policy bulletins 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 a PreferredOne criterion or when Medical Polices are created or revised; approval by the Chief Medical Officer is required. Notification of these actions is taken to the Quality Management Subcommittees as informational only.

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Since the last newsletter, the quality management subcommittees have approved or been informed of the following new or retired criteria and policies, and additions to the investigational list.

Medical/Surgical – New Criteria

- MC/I007 Cryoablation/ Cryosurgery for Hepatic, Prostate and Renal Oncology Indications
- MC/K001 IVAB for Lyme Disease
- MC/L012 Oncotype DX Breast Cancer Assay
- MC/T001 Bone Marrow/Stem Cell Transplantation
- MC/T004 Liver Transplantation
- MC/T005 Lung and Lobar Transplant

Chiropractic – new Clinical Policy Bulletin:

CP/015 Advanced Imaging

Deletion from the Investigational/Experimental/Unproven Comparative Effectiveness List:

Exhaled Nitric Oxide Testing for Management of Asthma has been removed and is now covered for use as a biomarker in the assessment of inflammatory airway diseases.

PreferredOne has developed an Orthognathic Surgery Prior Authorization form to be used in conjunction with the Orthognathic Surgery criteria set. This form can be found on the PreferredOne website under the Provider/Provider Forms and the Health Resources/Medical Policy and Pre-certification/Prior Authorization List menus. Please submit the completed form along with your prior authorization request for orthognathic surgeries. If you do not submit a form with your request, PreferredOne will send a blank form to you.

Remember to check the Pre-certification/Prior Authorization List posted on the PreferredOne website. The list can be found with the other Medical Policy documents on the PreferredOne internet home page, under the Health Resources, Medical Policy and Pre-certification/Prior Authorization List menu. The list will be fluid, as we see opportunities for impact; driven by, but not limited to, newly FDA-approved devices and medications, technologies, or changes in standard of care. Please check the list regularly for revisions.

See the Pharmacy section of the Newsletter for Pharmacy policy and criteria information.

The attached documents (Exhibits E-I) include the latest Chiropractic, Medical (includes Behavioral) 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 Update

Pharmacy – New Criteria: None

Pharmacy – Retired Criteria

- PC/C003 Topical Corticosteroids Step Therapy
- PC/D003 Diabetic Medications
- PC/G001 Growth Hormone Therapy

Pharmacy – New Policies: None

Pharmacy – Retired Policies: None

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 J). 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 practitioners 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.

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, the member's family and health care providers. The goal of case management is to help members in navigating 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

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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 receive.

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

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 regimens.
- 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. *Page 9...*

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There are several benefits when your patients participate in these PreferredOne programs:

- Program participants learn how to better follow and adhere to treatment plans.
- 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.

Exhibit A

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE:** 1/1/2012	
POLICY DESCRIPTION:	Reimbursement for Free Standing Ambulatory Surgery Centers and Hospital Outpatient Ambulatory Centers on APC Methodology		
Surgery Centers			
EFFECTIVE DATE:	6/1/2009		
PAGE:	1 of 2	**REPLACES POLICY DATED: 6/1/2009,09/01/2011**	
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. The APC Grouper and weights will be updated on an annual basis. Once the updates have been loaded into production, claims will be processed according the conversion factor and weights that are in effect using the new grouper based on process date not date of service due to system limitations.

7. Refer to the APC Manual

DEFINITIONS:

REFERENCES: See APC Manual

Exhibit B

PreferredOne

DEPARTMENT:	Pricing and Payment	**APPROVED DATE: 5/1/2012**	
POLICY DESCRIPTION:	Pain Block with General Anesthesia		
EFFECTIVE DATE:	**5/1/2012**		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	012	**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: The intent of this policy is to inform providers of PreferredOne's policy on billing and payment of pain blocks associated with general anesthesia.

POLICY: When multiple pain blocks are administered during a surgical preparation, general anesthesia, or in the recovery room they will be treated similar to the "multiple procedure" rules of 50% payment for the secondary procedure.

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 first line would be for the general anesthesia using ASA codes and the appropriate modifier AA, QK, QX, etc, and will be allow the lessor of billed charges or 100% of the ASA fee schedule.

2. The second line would be for the pain block using CPT codes in the 64400 – 64455 range with the appropriate modifier.

3. Only one unit of service should be billed for the 64400 – 64455 code as this service is not based on time units.

4. The first pain block line item will allow the lessor of billed charges or 100% of the CPT fee schedule.

5. Any additional line items billed for pain block services will be reduced to 50% allowable.

REFERENCES:

Exhibit C

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:** 6/1/2009,10/01/2007	
POLICY DESCRIPTION:	Reimbursement for Free Standing Ambulatory Surgery Centers and Hospital Outpatient Ambulatory Surgery Centers		
EFFECTIVE DATE:	1/1/08		
PAGE:	1 of 3	**REPLACES POLICY DATED: 4/1/06, 11/01/04**	
REFERENCE NUMBER:	H – 9 (P-10)	**RETIRED DATE 12-31-2012**	

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

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

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

PROCEDURE:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Other coding and system edits may apply

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

Exhibit D

PreferredOne

DEPARTMENT: Coding Reimbursement	**APPROVED DATE:**
POLICY DESCRIPTION: Reimbursement for Multiple Procedures	
EFFECTIVE DATE: 02/04/97	
PAGE: 1of 2	**REPLACES POLICY DATED:**
REFERENCE NUMBER: P-17	**RETIRED DATE:**

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

PURPOSE: Multiple procedures by the same professional provider in the same setting on the same date of service may be subject to multiple procedure reduction for the secondary and subsequent procedures.

POLICY: PreferredOne will adjudicate multiple procedures performed by the same physician on the same day according to the following schedule:

- Primary Procedure 100%
- Secondary and Additional Procedures 50%

CPT codes designated as exempt from the multiple procedure reduction such as add on codes will not be subject to the multiple procedure reduction.

PROCEDURE:

1. Avoid unbundling by applying the multiple procedures policy only if there is no single inclusive code available.

2. List multiple procedures according to value, with the primary procedure reflecting the greatest value – total RVU. Modifier 51 is for informational use only and does not affect claims processing of the codes eligible for multiple surgery reduction.

3. Do not apply the 50% reductions on the secondary and additional procedures. Let reductions be made as part of the claims adjudication process.

4. Do not report CPT codes which are designated as add-on codes with a –51 modifier.

- Add-on codes are commonly carried out in addition to the primary procedure performed.
- Add-on codes would never be reported separately as stand-alone codes or as primary procedures.
- Add-on codes are identified with descriptive phrases such as “each additional” or “list separately in addition to primary procedure.”

REVIEWED/UPDATED: 12/13/06, 09/01/2012

DEFINITIONS:

REFERENCES:

Exhibit E

Chiropractic Policies

Reference #	Description
001	Use of Hot and Cold Packs
002	Plain Films Within the first 30 days of Care
003	Passive Treatment
004	Experimental, Investigational, or Unproven Services
006	Active Care: Active Procedures
007	Acute and Chronic Pain
009	Recordkeeping and Documentation Standards
010	CPT Code 97140
011	Infant Care - Chiropractic
012	Measureable Progressive Improvement - Chiropractic
013	Chiropractic Manipulative Therapy Recommendation
014	Treatment Plan Documentation
015	Advanced Imaging *New*

Exhibit F

Medical Policies

Reference #	Description
A003	Amino Acid Based Elemental Formula (AABF)
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
C011	Court Ordered Substance Related Disorder Services *Revised*
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies
D005	Dietary Formulas, Electrolyte Substances, or Food Products for PKU or Other Inborn Errors of Metabolism
D007	Handicapped Dependent Eligibility
D008	Dressing Supplies
D009	Dental Services, Hospitalization, and Anesthesia for Dental Services Covered Under the Medical Benefit *New*
G001	Genetic Testing
G002	Gender Reassignment
H005	Home Health Care (HHC)
H006	Hearing Devices
I001	Investigational/Experimental Services
I002	Infertility Treatment
I003	Routine Preventive Immunizations
L001	Laboratory Tests
N002	Nutritional Counseling
P008	Medical Policy Document Management and Application
P009	Preventive Screening Tests
P010	Narrow-band UVB Phototherapy (non-laser) for Psoriasis
P011	Prenatal Testing
R002	Reconstructive Surgery
R003	Acute Rehabilitation Facilities
S008	Scar Revision
S011	Skilled Nursing Facilities
T002	Transition of Care - Continuity of Care
T004	Therapeutic Pass
W001	Physician Directed Weight Loss Programs

Exhibit G

Medical Criteria

Reference #	Category	Description
A006	Cardiac/Thoracic	Ventricular Assist Devices (VAD)
B002	Dental and Oral Maxillofacial	Orthognathic Surgery *Revised*
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea *Revised*
D001	DME	Lower Limb (Ankles, Feet, Knees, Hips) Prosthesis
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic
F022	Orthopaedic/Musculoskeletal	Cervical Disc Arthroplasty (Artificial Cervical Disc)
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back
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 *Revised*
G004	Skin and Integumentary	Breast Reconstruction
G007	Skin and Integumentary	Prophylactic Mastectomy and Oophorectomy
G008	Skin and Integumentary	Hyperhidrosis Surgery *Revised*
G010	Skin and Integumentary	Lipoma Removal
G011	Skin and Integumentary	Hyperbaric Oxygen Therapy
H003	Gastrointestinal/Nutritional	Bariatric Surgery *Revised*
I007	Neurology	Cryoablation/Cryosurgery for Hepatic, Prostate, and Renal Oncology Indications *New*
I008	Neurological	Sacral Nerve Stimulation
I009	Neurological	Deep Brain Stimulation
I010	Neurological	Spinal Cord/Dorsal Column Stimulation
K001	General Surgical/Medical	IVAB for Lyme Disease *New*
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
L009	Diagnostic	Intensity Modulated Radiation Therapy (IMRT)
L010	Diagnostic	Breast or Ovarian Cancer, Hereditary -BRCA1 and BRCA2 Genes and BRCAnalysis Rearrangement Testing (BART) *Revised*
L011		Insulin Infusion Pump
L012	Diagnostic/Radiology	Oncotype DX Breast Cancer Assay *New*
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
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)
M007	BH/Substance Related Disorders	Mental Health Disorders: Residential 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*
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
N004	Rehabilitation	Speech Therapy: Outpatient
N005	Rehabilitation	Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers *Revised*
N006	Rehabilitation	Acupuncture
T002	Transplant	Kidney, SPK, SPLK Transplant
T003	Transplant	Heart Transplant
T005	Transplant	Lung Transplantation *New*
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplant

Exhibit H

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
C001	Coordination of Benefits
C002	Cost Benefit Program *Revised*
F001	Formulary and Co-Pay Overrides *Revised*
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist
Q001	Express Scripts Quantity Limits *Revised*
Q002	ClearScript Quantity Limits *Revised*
R001	Review of Newly FDA-Approved Drugs and Clinical Indications
S001	Step Therapy

Exhibit I

Pharmacy Criteria

Reference #	Description
A003	Combination Beta-2 Agonist/Corticosteroid Inhalers Step Therapy
A004	Antihistamines Step Therapy
A005	Antidepressants Step Therapy
A008	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) Medications Step Therapy
A009	Alpha Blockers for Benign Prostatic Hypertrophy (BPH) Step Therapy *New*
B003	Botulinum Toxin *Revised*
B004	Biologics for Rheumatoid Arthritis *Revised*
B005	Biologics for Plaque Psoriasis *Revised*
B006	Biologics for Crohn's Disease *Revised*
B009	Osteoporosis Prevention and Treatment Medications
B010	Biologics for Juvenile Rheumatoid Arthritis *Revised*
B011	Biologics for Psoriatic Arthritis *Revised*
B012	Biologics for Ankylosing Spondylitis *Revised*
B013	Biologics for Ulcerative Colitis
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
E001	Erectile Dysfunction Medications
F001	Fenofibrate Step Therapy
H001	HMG - CoA Reductase Inhibitor Step Therapy
I001	Topical Immunomodulators Step Therapy: Elidel & Protopic
I002	Immune Globulin Therapy (IVIG) *Revised*
L002	Leukotriene Pathway Inhibitors Step Therapy
L003	Gabapentin Step Therapy *Revised*
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy *Revised*
O001	Overactive Bladder Medication Step Therapy *Revised*
P001	Proton Pump Inhibitor (PPI) Step Therapy
R003	Topical Retinoid Medications Step Therapy
R004	Rituxan Prior Authorization *Revised*
S003	Sedative Hypnotics Step Therapy
T002	Tramadol Step Therapy
T004	Triptans Step Therapy *New*
V001	Vascular Endothelial Growth Factor Antagonists for Intravitreal Use *Revised*
W001	Weight Loss Medications

Exhibit J

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/12/12
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/12/12	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/14/11	
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 adopted four of the Institute of Clinical Systems Improvement (ICSI) 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

PreferredOne®

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/12/12
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/12/12	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/14/11	
Reference #: QM/C003	**Page:** 2 of 2	

• 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, 7/12/12
Revised Date: 4/10/08, 7/10/08, 7/9/09, 7/14/10