PreferredOne®

UPDATE A Newsletter for PreferredOne Providers & Practitioners

October 2014

PreferredOne Welcomes New CMO

PHOTO BY KATHRYN FORSS

Dr. Howard Epstein joined PreferredOne as our Chief Medical Officer on September 15. He will lead PreferredOne's efforts in developing new medical management and patient engagement programs that respond to the ever changing needs of our individual policyholders, employers, and government purchasers. More importantly, he brings his reputation as a consensus builder and collaborator with health care systems in creating new working relationships between health plans and care delivery systems.

In his previous role as chief health systems officer at the Institute for Clinical Systems Improvement (ICSI), he led healthcare affordability improvement efforts. He also led clinical initiatives such as the RARE Campaign to reduce avoidable hospital readmissions, the *Choosing Wisely Minnesota®* Campaign to reduce inappropriate use of tests, procedures and treatments, as well as a broad community effort to appropriately manage acute pain and use of opioid pain pills contributing to the growing epidemic of overdoses, heroin addiction, death and crime in our communities.

Prior to ICSI, Epstein served as Medical Director of Quality and Health Management at BlueCross BlueShield of Minnesota where he provided clinical oversight for the medical management of two million commercial members, and was directly accountable for health plan quality and accreditation. He also worked with multiple care delivery systems in helping to design BCBSMN's Aligned Incentives Program and Total Cost of Care contracting models.

Epstein began his clinical and teaching practice at Regions Hospital & HealthPartners Medical Group where he helped found both the hospital medicine and palliative care programs. He received his undergraduate and Doctor of Medicine degrees from Washington University in St. Louis and completed his residency in Internal Medicine at the University of Minnesota Hospitals and Clinics where he holds a faculty appointment as Adjunct Assistant Professor of Medicine. He currently serves on the Board of Directors of the Society of Hospital Medicine and the Washington University Alumni Board of Governors, and is an active leader in the Greater Twin Cities United Way.

Dr. Epstein will become only the third Chief Medical Officer in PreferredOne's 30-year history. Dr. Ken Dedeker served as the founding Chief Medical Officer for our first 15 years and Dr. John Frederick served the second 15 years, retiring this past July. "We are truly fortunate to have Dr. Epstein bring his expertise to our team," said Marcus Merz, CEO, PreferredOne. His experience with multiple care delivery systems, community collaboration and developing care design models will be invaluable as we continue to navigate the changing needs of our members and partners. We look forward to a long and productive working relationship."

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2015 Fee Schedule Update

Additional changes to the 2015 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, 2015. 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 2014 CMS Medicare physician RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register April 2014. New codes for 2015 will be based on the 2015 CMS Medicare physician RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2014. Other new non-RVU based codes will be added according to PreferredOne methodology. The fee schedules for other provider types (such as allied, PhD, Masters, and BA) will also be updated.

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 2015 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, 2015. New codes were added to this fee schedule and a reminder that any code not on the fee schedule will not be reimbursed.

New ASA codes for Anesthesia services will be updated with the 2015 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2015.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder that new codes for 2015 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."

Hospital Services/UB07/Outpatient Fee Schedules

The 2015 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 32 as published in the final rule Federal Register to be effective October 2014.

For those on Ambulatory Payment Classifications (APC), we are using Optum hospital-based grouper that will be one year lag. For example, for 2015 rates, PreferredOne will use the 2014 APC grouper and edits and weights as of October 2014.

The Facility (UB04) CPT fee schedule will consist of all physician CPT/HCPC code ranges and will be based on the 2014 CMS Medicare 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 2015 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, 2015.

New and Updated Pricing and Payment Policies

The following new and updated Pricing and Payment Policies were presented at the September Provider Forum and are attached. (Exhibits A-F):

H-1Observation Bed Status – update to remove references to payment

H-8 Transfer from Acute Facility to another Acute Facility – updated to account for new discharge status codes for planned readmissions will also be exempt when the transfer is to rehab/long term care, substance abuse/mental health with a planned readmission.

H-7 Readmission within 5 days – updated to account for new discharge status codes for planned readmissions will be exempt when the readmission was planned.

P-33 Reimbursement for Maternity/Obstetrical Services

New Pricing and Payment Policy #17 – Hospital, Ambulatory Surgery Center, and Provider Reimbursement for Replaced Devices

New Pricing and Payment Policy #18 – Modifier Payment Reductions

Frequently Asked Questions Presented at the Provider Forum

There were answers to recently asked questions that were shared with the group. See presentation handouts on our website.

ICD-10 Update

It's still coming! PreferredOne is on track to be ICD-10 compliant by the October 1, 2015 deadline, despite the delay. Reminder to look to our provider website under 'ICD-10" updates corner. We will be testing with clearinghouses at the end of 2014.

Coding Update September 2014

Bilateral Services

Per the AUC, Modifier 50 should be used only on surgical services that can be performed bilaterally and are not already defined as a bilateral service. When appropriate, report the service appended with the 50 modifier on one line with one unit.

New Patient Preventive Visit with an Illness Visit at the Same Time

Per the AUC, in instances when a new patient receives preventive care and an illness-related E/M service at the same visit, an established patient E/M service should be used to report a separately identifiable problem-oriented E/M code in addition to a new patient preventive medicine service HCPCS code on the same date. Append the 25 modifier to problem-oriented E/M code. Please also refer to coding policy P-32.

Lab Modifiers

Per the AUC, Modifiers 76 or 91 are to be used for repeat services subsequent to the original service. The number of units reported is the number of services performed as defined in the code description. The 59 modifier should be used if necessary for CCI edits.

Facility Billing for Facilities Subject to Multiple Surgery Reduction

As communicated by network management, procedures that are subject to multiple surgery reduction should be billed with an appropriate dollar amount and not $0/$0.0. Claims that are billed incorrectly will be denied.

Billing Based On Time

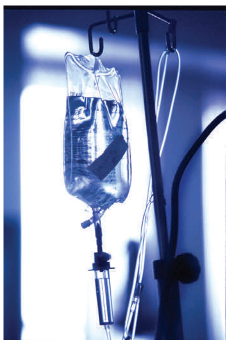
When billing based upon "time", there needs to be documentation of the total time spent and how much time was spent on counseling/coordination of care. PreferredOne follows CMS regarding billing based on time. Below is an example of correct documentation for billing based on time:

A total of XX minutes were spent face-to-face with the patient during this encounter and over half of that time was spent on counseling and coordination of care.

Drugs of Abuse Testing

There will be extensive changes to the codes for drug screening in 2015. Updates will be further communicated at a later date.

Medical Policy Update



Medical Policy documents are available on the PreferredOne website to members and to providers without prior registration. The website address is PreferredOne.com. Click on Benefits and Tools and choose Medical Policy, Pre-certification and Prior Authorization.

The Behavioral Health, Chiropractic, Medical/Surgical, and Pharmacy and Therapeutics Quality 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. The Quality Management Subcommittees are informed of these decisions.

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

Behavioral Health

- New Criteria: None
- Revised Criteria: None
- Retired Criteria: None
- New Policy: None
- Retired Policy: None

Chiropractic

- New Criteria: None
- Revised Criteria: None
- Retired Criteria: None
- New Policy: None
- Retired Policy: None

Medical/Surgical

New Criteria:

- MC/B003 Orthodontic Services
- MC/L016 Lung Cancer Screening by Computed Tomography

Revised Criteria:

- MC/L010 Genetic Testing for Hereditary Cancer Syndromes
- MC/T001 Bone Marrow/Stem Cell Transplantation

Retired Criteria:

- MC/F022 Intervertebral Prosthesis

New Policy:

- MP/M001 Molecular Testing for Tumor/Neoplasm Biomarkers
- MP/P013 Pharmacogenetic/Pharmacogenomic Testing and Serological Testing for Inflammatory Conditions

Retired Policy: None

Additions to the Investigational/Experimental/Unproven Comparative Effectiveness List

- Transcutaneous Electrical Nerve Stimulation for Preventive Treatment of Migraines
- High-Frequency Pulsed Electromagnetic Stimulation
- Lung Cancer Screening by Imaging other than Low-dose Computed Tomography

The American Academy of Pediatrics has published a revised policy statement, Updated Guidance Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection (RSV). PreferredOne will not require prior authorization for Synagis (palivizumab) this RSV season but does expect that providers will incorporate the newest guideline into their clinical practice.

Remember to check the 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. The list will be fluid, as we see opportunities for impact driven by, but not limited to, new FDA-approved devices, 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 G-K) 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

Pharmacy Policy Update

Medications for Risk Reduction of Primary Breast Cancer in Women

Effective October 1, 2014, PreferredOne will be implementing a Prior Authorization (PA) requirement on the medications to prevent breast cancer (tamoxifen and raloxifene). This change will take place for all non-grandfathered fully insured and self-funded employer groups upon their renewal with PreferredOne. This change in coverage is due to a recommendation by the U.S. Preventive Services Task Force (USPSTF) stating that drugs for the prevention of breast cancer should be covered as preventative. The ACA rules say state that the drugs must be covered without cost sharing subject to reasonable medical management.

Attached are the PA criteria that will be used to determine if the medication is being used for the prevention of breast cancer versus for the treatment of breast cancer. The criteria also have an embedded step therapy requirement of tamoxifen before raloxifene. If it is determined that the medication is being used for the treatment of breast cancer, the request will be approved, when appropriate and medically necessary, but the member will be required to pay the applicable benefit level for the medication. In this scenario the medication will not be covered as preventive without cost share.

Attached is the Medication Request Form that must be used when submitting a request for one of these medications to PreferredOne (Exhibit L).

If you have any questions about this coverage change, please contact the PreferredOne Pharmacy Department at Pharmacy@PreferredOne.com.

Pharmacy Information on the PreferredOne Provider Web Page

Providers without login access to the PreferredOne website can now view pharmacy benefit information that impacts PreferredOne members. The PreferredOne Pharmacy department has added a new link to the PreferredOne web page for providers. Within the "Pharmacy Resources" box you can access the following information:

- Drug Formulary - (This information applies only to those members with ClearScript as their Pharmacy Benefit Manager)
- Specialty Drug List
- Medication Request Form – Online Submission
- Minnesota Uniform Formulary Exception Form
- Medical Policy – Pharmacy Policy, Pharmacy Criteria

Pharmacy Information Available Upon Request

A paper copy of any pharmacy information that is posted on the PreferredOne Provider website is available upon request by contacting the Pharmacy Department online at Pharmacy@PreferredOne.com.

Online Medication Request Form

Providers and office staff can now submit medication request forms to PreferredOne online at PreferredOne.com

Click On:

For Providers > Pharmacy Resources > Pharmacy Medication Request Form – Online Submission

Advantages of Online Submission:

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

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

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

Affirmative Statement About Incentives

PreferredOne does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for utilization management decision-makers do not encourage decisions that result in under -utilization. Utilization management decision making is based only on appropriateness of care and service and existence of coverage.

Quality Management Update

Clinical Practice Guidelines

PreferredOne 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 M). 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 ICSI.org.

Continuity & Coordination of Care

Continuity and coordination of care are important to PreferredOne. If your clinic is terminating its 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 to promote compliance with provider treatment plan
- 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 that are 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 are currently receiving.

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
- Depression
- Multiple Sclerosis
- Rheumatoid Arthritis
- Ulcerative Colitis
- Crohn’s Disease

TDS:

- Low Back Pain
- Healthy 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 or Social Worker
- 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 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.

Do You Have a Doctor Who is not Accepting New Patients?

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

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

Quality Complaint Reporting for Primary Care Clinics

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

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

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

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

Serving a Culturally and Linguistically Diverse Membership

PreferredOne is consistently making efforts to address serving our culturally and linguistically diverse membership. We will provide information and tools to staff and network practitioners to support culturally appropriate information and facilitate effective communication. Language line service availability is communicated to members on an annual basis.

PreferredOne®

Department of Origin: Coding Reimbursement	Approved by:	Date approved:
Department(s) Affected:	**Effective Date:** 08/25/95 Review Date 09/01/14	
Policy Description: Observation Bed Satus	**Replaces Effective Policy Dated:**	
Reference #: H-1	**Page:** 1 of 2	

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

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

PURPOSE: For observation bed status which is considered any outpatient stay up to 24 hours that is clinically indicated/medically necessary.

POLICY: Observation bed status will be considered any outpatient stay up to 24 hours that is clinically indicated/medically necessary:

a. to determine false/true labor
b. following treatment in the emergency room setting (the expected observation time that usually follows an emergency treatment, will be considered part of the treatment and will not be used to begin observation bed status)
c. following an operative procedure done in the outpatient setting and after return from recovery room (the expected time that usually follows recovery room time, will be considered part of the surgery and will not be used to begin observation bed status)
d. to observe a mental health or substance related disorder patient

PROCEDURE:

1. The 24 hour period begins when the above indications are met. For ambulatory surgical care procedures, observation bed coverage would be restricted to situations where a patient exhibits an inordinate reaction to the surgical procedure, such as difficulty in awakening from anesthesia, a drug reaction or other post-surgical complication which requires monitoring, or treatment beyond that customary provided in the recovery room.

2. Use the revenue code 762 for observation bed status.

3. Observation bed charges should be billed in units; one unit equals one hour. Units billed for observation bed status can not exceed an equal proportionate amount of charges for a daily inpatient bed charge. Consequently, a charge for 24 hours of observation bed status will not exceed the standard daily bed charge (not including ancillary charges).

Exhibit B

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 7/31/2014**
POLICY DESCRIPTION:	Readmission within 5 Days	
EFFECTIVE DATE:	1/1/2014	
PAGE:	1 of 1	**REPLACES POLICY DATED: 1/1/2014, 9/1/2009, 9/22/2008, 10/1/2007**
REFERENCE NUMBER:	H - 7	**RETIRED DATE:**

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

PURPOSE: To provide guidelines for reimbursement for Readmissions to the same Hospital within 5 days.

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. If more than one admission occurs for a given Enrollee with a related diagnosis or same Major Diagnostic Category (MDC) as determined by PreferredOne within a 5 day period, Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

2. If the readmission is a different MDC, but is related to the initial admission as a result of post-op infection (MS DRG 856 – 863), Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

3. The following DRGs are excluded from this policy:

DRG Version 24: 370 – 375, 385-391, 462 (Note: for dates of service prior to 1/1/2008)
MS-DRG Version 25: 765 - 768, 774 - 775, 789 – 795, 945, 946 (Note for date of service after 1/1/2008)

4. Also excluded from this policy are planned readmissions to acute care hospitals.

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

Exhibit C

PreferredOne

DEPARTMENT:	Coding Reimbursement	APPROVED DATE:	1/1/2014, 11/4/2009, 8/1/2008, 10/1/2007
POLICY DESCRIPTION:	Transfer from Acute Facility to another Acute Facility		
EFFECTIVE DATE:	1/1/08		
PAGE:	1 of 2	REPLACES POLICY DATED:	11/4/2009
REFERENCE NUMBER:	H - 8	RETIRED DATE:	

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

PURPOSE: To provide guidelines for reimbursement when an enrollee is transferred from one Acute Facility to another Acute Facility

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. **Transfers within the same hospital system**. In the event an enrollee is transferred from an acute facility to another acute facility as part of a continuous course of treatment and is part of the same hospital system, the reimbursement will be considered one admission. All eligible facility charges will be considered. The final discharging facility will receive payment based on the discharge admission payment category.

2. **Transfers to another hospital system**. In the event an enrollee is transferred from an acute facility to another acute facility as part of a continuous course of treatment and is not part of the same hospital system, the reimbursement to the originating facility will be paid the lessor of the ungroupable payment rate specified in the contract or the discharge admission payment category. The reimbursement to the receiving facility will receive payment based on the discharge admission payment category.

3. The following list does not apply:

   - A transfer from acute facility to rehab or long term care facilities or a transfer from a rehab or longer term care facilities to an acute facility (including but not limited to discharge status of 03, 06, 61, 62, 63, 83, 86, 89, 90, 91 OR MS DRG 945, 946)

   - A transfer from acute facility to Substance Abuse/Mental Health or a transfer from a Substance Abuse/Mental health to an acute facility (including but not limited discharge status of 04, 65, 84, 93)

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

Exhibit D

PreferredOne

DEPARTMENT:	Coding Reimbursement	APPROVED DATE: 10-10-06
POLICY DESCRIPTION:	Reimbursement for Maternity/Obstetrical Services	
EFFECTIVE DATE:	10-10-06	REVIEW DATE; 9-30-2014
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. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

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

8. 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 and one home visit for the infant when the mother is discharged early. (please see HIS Home Health policy also)

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:

Exhibit E

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 9/1/2014
POLICY DESCRIPTION:	Modifier Payment Reductions	
EFFECTIVE DATE:	1/1/2015	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER:	P#18	RETIRED DATE:

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

PURPOSE: To provide guidelines for reimbursement when modifiers that affect payment are attached to CPT/HCPCS

POLICY: PreferredOne will increase or reduce payment to the provider or facility when certain modifiers are attached to the CPT/HCPCS.

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. Modifiers should be attached to CPT/HCPCS when appropriate.
2. See specific coding policies for when to apply the modifier appropriately.
3. The following reimbursement will be applied when these modifiers are attached to CPT/HCPCS:

Modifier	Description	Percent of Allowable
22	Increased procedureal Services	125%
26	Professional Component, only if no RVU assigned or concept does not apply	40%
50	Bilateral Procedure	150%
52	Reduced Services (apc has 52 and 73 at same rate)	50%
53	Discontinued Procedure	50%
54	Surgical Care Only	80%
55	Postoperative Management Only	20%
56	Preoperative Management Only	10%
62	Two Surgeons	62.5%
66	Surgical Team	62.5%

73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the administration of Anesthesia	50%
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after administration of Anesthesia	75%
80	Assistant Surgeon	16%
81	Minimum Assistant Surgeon	16%
82	Assistant Surgeon (when qualified resident surgeon not available)	16%
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	16%
SL	State Supplied Vaccine	0%
BO	Orally administered nutrition, not by feeding tube	0%
TC	Technical component, only if no RVU assigned or concept does not apply	60%
FB	Item provided without cost to provider, supplier or practitioner, or full credit received fro replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	See Pricing & Payment Policy #17
FC	Partial credit received for replaced device	See Pricing & Payment Policy #17
GZ	Item or service expected to be denied as not reasonable or necessary	0%
PA	Surgical or other invasive procedure on wrong body part	0%
PB	Surgical or other invasive procedure on wrong patient	0%
PC	Wrong surgery or other invasive procedure on patient	0%

DEFINITIONS:

REFERENCES:

Exhibit F

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 9/1/2014
POLICY DESCRIPTION:	Modifier Payment Reductions	
EFFECTIVE DATE:	1/1/2015	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER:	P#18	RETIRED DATE:

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

PURPOSE: To provide guidelines for reimbursement when modifiers that affect payment are attached to CPT/HCPCS

POLICY: PreferredOne will increase or reduce payment to the provider or facility when certain modifiers are attached to the CPT/HCPCS.

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. Modifiers should be attached to CPT/HCPCS when appropriate.
2. See specific coding policies for when to apply the modifier appropriately.
3. The following reimbursement will be applied when these modifiers are attached to CPT/HCPCS:

Modifier	Description	Percent of Allowable
22	Increased procedureal Services	125%
26	Professional Component, only if no RVU assigned or concept does not apply	40%
50	Bilateral Procedure	150%
52	Reduced Services (apc has 52 and 73 at same rate)	50%
53	Discontinued Procedure	50%
54	Surgical Care Only	80%
55	Postoperative Management Only	20%
56	Preoperative Management Only	10%
62	Two Surgeons	62.5%
66	Surgical Team	62.5%

73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the administration of Anesthesia	50%
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after administration of Anesthesia	75%
80	Assistant Surgeon	16%
81	Minimum Assistant Surgeon	16%
82	Assistant Surgeon (when qualified resident surgeon not available)	16%
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	16%
SL	State Supplied Vaccine	0%
BO	Orally administered nutrition, not by feeding tube	0%
TC	Technical component, only if no RVU assigned or concept does not apply	60%
FB	Item provided without cost to provider, supplier or practitioner, or full credit received fro replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	See Pricing & Payment Policy #17
FC	Partial credit received for replaced device	See Pricing & Payment Policy #17
GZ	Item or service expected to be denied as not reasonable or necessary	0%
PA	Surgical or other invasive procedure on wrong body part	0%
PB	Surgical or other invasive procedure on wrong patient	0%
PC	Wrong surgery or other invasive procedure on patient	0%

DEFINITIONS:

REFERENCES:

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
C001	Coordination of Benefits
C002	Cost Benefit Program
C003	Compounded Drug Products
F001	Formulary and Co-Pay Overrides
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist *Revised*
Q001	Express Scripts Quantity Limits
Q002	ClearScript Quantity Limits *Revised*
R001	Review of New FDA-Approved Drugs and Clinical Indications *Revised*
S001	Step Therapy
T001	Tobacco Cessation Medications *New*

Exhibit H

Pharmacy Criteria

Reference #	Description
A003	Combination Beta-2 Agonist/Corticosteroid Inhalers Step Therapy
A005	Antidepressant Medications Step Therapy
B003	Botulinum Toxin
B004	Biologics for Rheumatoid Arthritis
B005	Biologics for Plaque Psoriasis
B006	Biologics for Crohn's Disease
B009	Bisphosphonates and Osteoporosis Prevention and Treatment Medications
B010	Biologics for Juvenile Idiopathic Arthritis and Juvenile Rheumatoid Arthritis
B011	Biologics for Psoriatic Arthritis
B012	Biologics for Ankylosing Spondylitis
B013	Biologics for Ulcerative Colitis
B014	Benign Prostatic Hypertrophy Medications Step Therapy
B015	Breast Cancer Risk Reduction Medications Step Therapy *New*
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
E001	Erectile Dysfunction Medications - Non-PDE-5 Inhibitor Medications
F001	Fenofibrate Medications Step Therapy
H002	Hepatitis C Medications *New*
I002	Immune Globulin Therapy (IgG, IVIg, SCIg)
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy *Revised*
O001	Overactive Bladder Medication Step Therapy *Revised*
P001	Proton Pump Inhibitor (PPI) Step Therapy
P002	Phosphodiasterase-5 Inhibitor Medications *Revised*
R003	Topical Retinoid Medications Step Therapy *Revised*
R004	Rituxan Prior Authorization (Non-Oncology) *Revised*
S003	Sedative Hypnotics Step Therapy
V001	Vascular Endothelial Growth Factor Antagonists for Intravitreal Use
W001	Weight Loss Medications *Revised*

Exhibit I

Medical Policies

Reference #	Description
A001	Elective Abortion
A003	Amino Acid Based Elemental Formula (AABF) *Revised*
A004	Acupuncture *Revised*
A005	Autism Spectrum Disorders in Children: Assessment and Evaluation *New*
C001	Court Ordered Mental Health Services
C002	Cosmetic Treatments *Revised*
C003	Criteria Management Development, Application, and Oversight *Revised*
C008	Oncology Clinical Trials, Covered / Non-covered Services
C009	Coverage Determination Guidelines
C011	Court Ordered Substance Related Disorder Services
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	Disabled Dependent Eligibility
D008	Dressing Supplies
D009	Dental Services, Hospitalization, and Anesthesia for Dental Services Covered Under the Medical Benefit
G001	Genetic Testing for Heritable Conditions *Revised*
G002	Gender Reassignment *Revised*
H006	Hearing Devices
H007	Hospice Care *Revised*
H008	FDA-Approved Humanitarian Use Devices (HUD)
I001	Investigational/Experimental Services
I002	Infertility Treatment
I003	Routine Preventive Immunizations *Revised*
L001	Laboratory Tests
M001	Molecular Testing for Tumor/Neoplasm Biomarkers *New*
N002	Nutritional Counseling
P008	Medical Policy Document Management and Application *Revised*
P009	Preventive Screening Tests for Grandfathered Plans *Revised*
P010	UVB Phototherapy (non-laser) for Skin Disorders *Revised*
P011	Prenatal Testing *Revised*
P013	Pharmacogenetic/Pharmacogenomic Testing and Serological Testing for Inflammatory Conditions *New*
R002	Reconstructive Surgery

S008	Scar Revision
T002	Transition of Care - Continuity of Care: PCHP PAS-ERISA *Revised*
T004	Therapeutic Pass
T006	PreferredOne Designated Transplant Network Provider
T007	Transition of Care - Continuity of Care: PIC and PAS Non-ERISA *New*
V001	Vision Care, Pediatric *Revised*
W001	Physician Directed Weight Loss Programs

Exhibit J

Medical Criteria

Reference #	Category	Description
A006	Cardiac/Thoracic	Ventricular Assist Devices (VAD) [Revised]
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
B003		Orthodontic Services [New]
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea
D001	DME	Microprocessor-Controlled Prostheses for the Lower Limb
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic [Revised]
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
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 [Revised]
H003	Gastrointestinal/Nutritional	Bariatric Surgery
I007	Neurology	Cryoablation/Cryosurgery for Hepatic, Prostate, and Renal Oncology Indications
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
K002	General surgical/ medical	Bronchial Thermoplasty
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use [Revised]
L009	Diagnostic	Intensity Modulated Radiation Therapy (IMRT)
L010	Diagnostic	Genetic Testing for Hereditary Cancer Syndromes [Revised]
L011		Insulin Infusion Pump
L012	Diagnostic/Radiology	Oncotype DX Breast Cancer Assay [Revised]
L014	Diagnostic	Laboratory Testing for Detection of Heart

		Transplant Rejection
L015	Diagnostic	Comparative Genomic Hybridization (CGH, aCGH)
M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment/Intensive Outpatient Program (IOP) *Revised*
M005	BH/Substance Related Disorders	Eating Disorders: Level of Care Criteria *Revised*
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP) *Revised*
M007	BH/Substance Related Disorders	Mental Health and Substance Related Disorders: Residential Treatment
M010	BH/Substance Related Disorders	Substance Related Disorders: Inpatient Primary Treatment
M014	BH/Substance Related Disorders	Detoxification and Addiction Stabilization: Inpatient Treatment
M020	BH/Substance Related Disorders	Autism Spectrum Disorders in Children: Non-Intensive Treatment
M022	MH/Substance Related Disorders	Mental Health Disorders: Residential Crisis Stabilization Services (CSS) *Revised*
M023	MH/Substance Related Disorders	Mental Health Disorders : Intensive Residential Treatment Services (IRTS)
M024	BH/Substance Related Disorders	Autism Spectrum Disorders in Children: Early Intensive Behavioral and Developmental Therapy (EIBDT) *New*
N002	Rehabilitation	Inpatient Skilled Services (Skilled Nursing Facility and Acute Inpatient Rehabilitation)
N003	Rehabilitation	Occupational and Physical Therapy: Outpatient Setting
N004	Rehabilitation	Speech Therapy: Outpatient Setting
N005	Rehabilitation	Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers
N007	Rehabilitation	Home Health Care
T001	Transplant	Bone Marrow / Stem Cell Transplant *Revised*
T002	Transplant	Kidney, SPK, SPLK Transplant
T003	Transplant	Heart Transplant *Revised*
T004	Transplant	Liver Transplant *Revised*
T005	Transplant	Lung Transplant
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplant

Exhibit K

Chiropractic Policies

Reference #	Description
002	Plain Film X-rays
003	Passive Treatment
004	Experimental, Unproven, or Investigational Services
006	Active Procedures in Physical Medicine
007	Acute and Chronic Pain Administration Policy
011	Infant Care Policy - Chiropractic
012	Measurable Progressive Improvement - Chiropractic
013	Chiropractic Manipulative Therapy Documentation
014	Plan of Care
015	Advanced Imaging

Exhibit L

  All fields must be completed. Incomplete and/or Illegible forms will be returned. **Refer to www.preferredone.com under Benefits & Tools/Medical Policy/Pharmacy Criteria**	**Breast Cancer Risk Reduction Medication Step Therapy Medication Request Form** **Attn: Pharmacy Dept. Fax (763.847.4014)** **Allow 72-hour turnaround for all requests.** **Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.** **Page 1**

Member/Provider Information

Member Name:	Provider Name:
Member ID:	Clinic:
Date of Birth:	Clinic Address:
Group Number:	Contact Name/Telephone Number:
Group Name:	Fax Number:

Medication Information

Drug Name:	Strength/Units:

Medications Tried for this diagnosis and when-PLEASE INCLUDE ALL PERTINENT INFORMATION AVAILABLE

Drug Name:	Strength/Units:
Adverse Reaction to or failure of alternative: ☐ Yes ☐ No	If Yes, List reaction or failure:
Drug Name:	Strength/Units:
Adverse Reaction to or failure of alternative: ☐ Yes ☐ No	If Yes, List reaction or failure:

What is woman's lifetime breast cancer risk score as determined by answering the questions on the following website http://www.cancer.gov/bcrisktool/? (if able to provide this answer, please proceed to the last question)…__________%

OR please answer the following questions:

Does woman have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or has member received previous radiation therapy to the chest for the treatment of Hodgkin lymphoma?........................ ☐ Yes ☐ No

Does the woman have a mutation in either the *BRCA1* or *BRCA2* gene, or a diagnosis of a genetic syndrome that may be associated with elevated risk of breast cancer?... ☐ Yes ☐ No ☐ Unknown

What is the woman's age? .... _____________

What was the woman's age at the time of her first menstrual period?…………………………. ☐ 7–11 ☐ 12–13 ☐ >=14 ☐ Unknown

What was the woman's age at the time of her first live birth of a child?.. ☐ None ☐ <20 ☐ 20-24 ☐ 25-29 ☐ >=30 ☐ Unknown

How many of the woman's first-degree relatives – mother, sisters, daughters – have had breast cancer?.............. .....☐ 0 ☐ 1 ☐ >1

  All fields must be completed. Incomplete and/or Illegible forms will be returned. **Refer to www.preferredone.com under Benefits & Tools/Medical Policy/Pharmacy Criteria**	**Breast Cancer Risk Reduction Medication Step Therapy Medication Request Form** **Attn: Pharmacy Dept. Fax (763.847.4014)** **Allow 72-hour turnaround for all requests. Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.** **Page 2**

Has the woman ever had a breast biopsy? .... ☐ Yes ☐ No ☐ Unknown

- How many breast biopsies (positive or negative) has the woman had?.. ☐ 1 ☐ >1
- Has the woman had at least one breast biopsy with atypical hyperplasia? .... ☐ Yes ☐ No ☐ Unknown

What is the woman's race/ethnicity? ....
☐ White ☐ African American ☐ Hispanic ☐ Asian American ☐ American Indian or Alaskan Native ☐ Unknown

- If Asian American, what is the sub race/ethnicity?..
☐ Chinese ☐ Japanese ☐ Filipino ☐ Hawaiian ☐ Other Pacific Islander ☐ Other Asian American

Prior history of venous thromboembolism (VTE) such as but not limited to deep vein thrombosis, pulmonary emboli, CVA, TIA, or retinal vein thrombosis .... ☐ Yes ☐ No ☐ Unknown

Exhibit M

PreferredOne®

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/10/14
Department(s) Affected: Quality Management, Network Management	Effective Date: 7/10/14	
Procedure Description: Clinical Practice Guidelines	Replaces Effective Procedure Dated: 7/11/13	
Reference #: QM/C003	Page: 1 of 3	

PRODUCT APPLICATION:

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

BACKGROUND:

PreferredOne adopts Institute of Clinical Systems Improvement (ICSI) clinical practice 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. Asthma, Diagnosis and Outpatient Management of
B. Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
C. Major Depression in Adults in Primary Care
D. Diagnosis and Management of ADHD
E. Preventive Health
- Prenatal Care, Routine
- Preventive Services for Children and Adolescents
- Preventive Services for Adults

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:

B. Asthma, Diagnosis and Outpatient Management of

1. Percentage of patients with persistent asthma who are on inhaled corticosteroid medication (HEDIS technical specifications)
   2. Optimal Asthma Care Measure (Minnesota Community Measurement Measure)This measure examines the percentage of patients, ages 5-50, with persistent asthma who have reached the following three targets to control their asthma:

   - Evidence of well-controlled asthma
   - Not at risk for elevated exacerbation as evidenced by patient-reported emergency department visits and hospitalizations
   - Patient has been educated about his or her asthma and self- management of the condition and has received a written asthma management plan

C. Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
   The percentage of members 18-75 years of age with diabetes who had each of the following:
   1. HbA1c control (<8.0%) (HEDIS technical specifications)
   2. BP control (<140/90 mm Hg) (HEDIS technical specifications)

D. 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)

E. 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)

F. Preventive Health
   1. Preventive Services for Children and Adolescents
      a. Percentage of patients who by their second birthday have the following immunization status (HEDIS technical specifications):
         • Four DTaP/DT
         • Three IPV
         • One MMR
         • Three Hib
         • Three hepatitis B
         • One VAR, or documented chicken pox disease
         • Four pneumococcal
         • Two hepatitis A
         • Rotavirus:
         - Two doses of the two-dose vaccine, or

- One dose of the two-dose and two doses of the three-dose vaccine, or
- Three doses of the three-dose vaccine
• Two influenza

b. Percentage of sexually active women age 16-24 years of age who had at least one test for chlamydia during the measurement year (HEDIS technical specifications).

2. Preventive Services for Adults

a. Breast Cancer Screening. The percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the previous two years (HEDIS technical specifications).

b. Colorectal Cancer Screening. The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer (HEDIS technical specifications).

One or more screenings for colorectal cancer. Any of the following meet criteria:
- Fecal occult blood test (FOBT Value Set) during the measurement year. For administrative data, assume the required number of samples were returned regardless of FOBT type.
- Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set) during the measurement year or the four years prior to the measurement year.
- Colonoscopy (Colonoscopy Value Set) during the measurement year or the nine years prior to the measurement year.

IV. PreferredOne has utilized the ICSI's practice guidelines as the clinical basis for its chronic illness management programs for Diabetes and Asthma and will ensure program materials are consistent with the practice guidelines.

REFERENCES:

- 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, 7/10/14
Revised Date:	4/10/08, 7/10/08, 7/9/09, 7/14/10 , 7/11/13, 7/10/14

PreferredOne
Written Quality Complaint Report

Requirement: MN Rules 4685.1110 and 4685.1700-1900 require the collection and analysis of quality of care complaints including those which originate at the clinic level. Complaints directed to the clinic are to be investigated and resolved by the clinic, whenever possible.

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

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

Clinic_______________________________ Completed by______________________ Phone #__________________

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

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

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