PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
February 2015

Welcome Alan H. Heaton, BS (Pharm), Pharm. D., RPh.

Director, Pharmacy Benefits

Dr. Heaton is currently Director, Pharmacy Benefits at PreferredOne. Previously, Dr. Heaton was the Director of Pharmacy Management for UCare, Pharmacy Director for BlueCross BlueShield of Minnesota, and Vice President, Clinical Marketing and Research at Prime Therapeutics.

He has been a coordinator or an investigator for numerous clinical trials involving cardiovascular therapies and interventions. He has been the primary investigator for over 100 integrated database studies with numerous, subsequent, presentations and publications.

Besides his clinical and managerial responsibilities, Dr. Heaton is a Clinical Assistant Professor at the College of Pharmacy, University of Minnesota in Minneapolis, where he lectures on various disease states and relationship to drug therapy. He is an Adjunct Clinical Instructor at the School of Public Health, also at the University.

Dr. Heaton earned a Bachelor of Science in Pharmacy in 1973 and a Doctor of Pharmacy in 1975 from the University of Minnesota College of Pharmacy. From 1975 to 1993, Dr. Heaton was Clinical Specialist of Critical Care and Manager, Pharmacy for United and Children's Hospitals, Inc. in St. Paul, Minnesota.

He is a member of many professional associations including the International Society of Pharmacoeconomics and Outcomes Research, the Academy of Managed Care Pharmacy, the American Society of Health-System Pharmacists, and many local and state Pharmacy Associations. He currently chairs the Minnesota Department of Human Services Drug Formulary Committee. He also chairs the MN chapter of the American Lung Association COPD Coalition. He serves on the editorial boards of several professional journals as well.

He was recently named as one of the "Top 100 Influential Health Care Leaders" by Minnesota Physicians.

Improved Awareness and Clinical Practice Result from *Choosing Wisely*® Minnesota Efforts

The American Board of Internal Medicine Foundation's (ABIMF) *Choosing Wisely*® Campaign is designed to foster conver-sations between clinicians and patients over tests and procedures that specialty medical groups have indicated are unnecessary, overused or at times even harmful.

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In This Issue:

PreferredOne
6105 Golden Hills Dr.
Golden Valley, MN 55416

Phone: 763-847-4000
800-451-9597
Fax: 763-847-4010

CLAIM ADDRESSES:

PreferredOne Insurance Corporation (PIC)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

PreferredOne PPO
PO Box 1527
Minneapolis, MN 55440-1527

Phone: 763-847-4400
800-451-9597
Fax: 763-847-4010

PreferredOne Community Health Plan (PCHP)
PO Box 59052
Minneapolis, MN 55459-0052

Phone: 763-847-4488
800-379-7727
Fax: 763-847-4010

PreferredOne Administrative Services (PAS)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

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In the fall of 2013, three Minnesota groups - the Institute for Clinical Systems Improvement (ICSI), the Minnesota Medical Association (MMA) and the Minnesota Health Action Group - launched the *Choosing Wisely*® Minnesota campaign. As one of the three local grantees, ICSI conducted a pre-campaign survey of its stakeholders to assess their baseline awareness of the campaign, and knowledge and use of tests and procedures national medical societies say should be reduced or avoided. The *Choosing Wisely*® Minnesota campaign used various media to enhance awareness of these evidence-based recommendations, including grantee websites, newsletters, local health trade publications, webinars, consumer press, radio and television public service announcements, social media, and conferences. A post-campaign survey conducted by ICSI last fall indicated:

- Overall awareness of *Choosing Wisely*® increased by 11 percent.
- Sixty-one percent of respondents reported that aware-ness of *Choosing Wisely*® influenced their decision to order a test or procedure.
- More providers now consider costs before ordering or recommending a test.
- Fewer providers say they now order an unnecessary test or procedure, even in the face of patient demand.

Survey details, as well as useful information on how providers, patients and employers can access the free Campaign materials and other helpful websites, can easily be found at https://www.icsi.org/health_initiatives/choosing_wisely_minnesota/. These materials include information sheets and exam room posters that providers can co-brand with their medical group's logo and use with patients as part of shared decision making discussions. The MMA also has useful links and information at http://www.mnmed.org/Advocacy/Choosing-Wisely.

Providers can even learn how to eliminate unnecessary health care costs and improve patient outcomes while earning **FREE CME and ABIM MOC patient safety and medical knowledge points** through the American College of Physicians' (ACP) Online High Value Care Cases at https://hvc.acponline.org/physres_cases.html.

The current list of campaign materials for *Choosing Wisely*®, with downloadable PDFs for each, can be found at http://consumerhealthchoices.org/campaigns/choosing-wisely/.

Pricing and Payment

Updated Payment Policies

Reminder that PreferredOne will apply the lesser of the contracted rate or payment policy rate when calculating final reimbursement rate.

Clarification of Readmission Policy and Leave of Absence – Coding Reimbursement Policy H-7 "Readmission within 5 days" has been updated to clarify the difference between planned readmission and leaves of absence. PreferredOne follows CMS guidelines for leave of absences. Please see attached updated policy. (Exhibit A)

Clarification of Facility Multiple Surgery Reduction – Pricing & Payment policy P #14 "Reimbursement Facility Multiple Surgeries Performed on the Same Date of Service" has been updated to clarify the facility billing for APC providers. In order to follow APC grouper editing, bilateral services should be billed on one line with -50 modifier. Please see attached updated policy. (Exhibit B)

Payment for 2015 Fee Schedule Update for New Codes that are Cross-walked

As previously communicated in the October provider bulletin and provider forum, all 2015 new codes will be added to the fee schedules using the appropriate methodology. This year there were several new codes not recognized by CMS so no RVU was established that impacts professional services. However, additional new codes for the same service were also created that are recognized by CMS. In those instances, the payment was cross-walked to be the same as the code that is recognized by CMS. For some of the new lab codes without a national lab price, CMS also recommended a cross-walk to existing code rates, which PreferredOne also used. For Outpatient services, the APC grouper has established weights for the G codes and the lab codes that are payable will also be cross-walked per the table on the next page.

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HCPCS	DESCRIPTION	Crosswalk RVU or Rate
44384	Small bowel endoscopy with stent placement	G6018
44401	Colonoscopy with ablation	G6019
44402	Colonoscopy w/stent placement	G6020
45346	Sigmoidoscopy w/ablation	G6022
45347	Sigmoidoscopy w/placement of stent	G6023
45388	Colonoscopy w/ablation	G6024
45389	Colonoscopy w/stent placement	G6025
77385	IMRT; simple	G6015
77386	IMRT; complex	G6015
77387	Guidance for localization of target volume for delivery of radiation treatment delivery	G6001 + G6002
80163	Digoxin; free	80162
80165	Valproic acid; free	80164
83006	Growth stimulation expressed gene 2	82777
87505	Infectious agent detection; Gastrointestinal pathogen; 3-5 targets	87631
87506	Infectious agent detection; gastrointestinal pathogen; 6-11 targets	87632
87507	Infectious agent detection; Gastrointestinal pathogen; 12-25 targets	87633
87623	HPV, low risk types	87621
87624	HPV; high risk types	87621
87625	HPV, types 16 and 18 only, includes type 45, if performed	87621
87806	HIV-1 antigen(s), with HIV-1 and HIV-2 antigodies	87389
G0464	Colorectal cancer screening; stool-based DNA and fecal occult hemoglobin	81315+81275+82274
G6017	Intrafraction track motion	G6001 + G6002

Coding Update

2015 CPT® and HCPCS Codes Highlights

Evaluation and Management (E/M)

Renaming of the Complex Chronic Care Coordination Services section to "Care Management Services" with creation of a new code, 99490, for services not deemed as complex. Revision of existing codes 99487 and 99489 for reporting of a complex service. PreferredOne® will be following Medicare for codes 99487 and 99489 – bundled service.

A new category was added to the E/M section for "Advanced Care Planning", codes 99497 and 99498. These codes will be bundled into all services.

Surgery Section - Musculoskeletal System

Codes 20600, 20605, and 20610 (arthrocentesis, aspiration and/or injection…joint or bursa…(by size) were revised to include the terms "*without* ultrasound guidance".

Codes 20604, 20606, and 20611 (arthrocentesis, aspiration and/or injection…joint or bursa…(by size) were created to include the terms "*with* ultrasound guidance". Any ultrasound code reported with any of these 6 codes will be denied as provider liability.

New category of "Percutaneous Vertebroplasty and Vertebral Augmentation", codes 22510 – 22515. These codes include all imaging guidance procedures utilized during the performance of the service. *Cont'd to page 4...*

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Surgery Section - Cardiovascular System

Creation of 4 new codes, 33270 – 33273 for subcutaneously implanted defibrillator (S-ICD). Associated new codes for the programming, interrogation, and electrophysiologic evaluations are found in the "Medicine Section", codes 93260, 93261, and 93644.

New category of "Extracorporeal Membrane Oxygenation (ECMO) or Extracorporeal Life Support (ECLS)" due to the evolution of the service. There were 25 new codes created (33946 – 33989) with the percutaneous peripheral insertion codes and all of the repositioning codes incorporating fluoroscopic guidance, if used. The daily management codes (33948 – 33949) cannot be reported on the same day as initiation (33946 – 33947).

Surgery Section - Gastroenterology System

New subsections of "Endoscopy, Small Intestine" and "Endoscopy, Stomal". This subsection has 8 new and several revised codes for colonoscopy via stoma. The 8 new stomal codes include moderate sedation. The unlisted procedure code 44799 now is specific to small intestine.

Colon and Rectum Section under "Endoscopy" - there is a Colonoscopy Decision Tree algorithm in the manual. The unlisted procedure code 45399 is now specific to colon.

High resolution anoscopy procedures have 2 new codes, 46601 and 46607. These were previously reported with the now deleted Category III codes 0226T and 0227T.

Surgery Section - Nervous System

"Injection, Drainage, or Aspiration" subsection had 4 new codes (62302 – 62305) created for reporting of lumbar injection of contrast, radiological supervision and interpretation and image guidance for myelography. These codes cannot be reported with the existing myelography codes (72240 – 72270).

Code 62284 was revised to refer to lumbar injections only.

Under the "Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic" subsection, new codes 64486 – 64489 were created for reporting of Transversus Abdominis Plane (TAP) blocks and rectus sheath blocks. These codes include imaging guidance.

Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) Section

Diagnostic Ultrasound – Chest - New codes 76641 – 76642 created for breast ultrasounds. These codes are to be reported once per breast per session.

Breast Mammography – New codes for digital breast tomosynthesis, 77061 – 77063 created for diagnostic versus screening services. These codes are not to be reported with the 3D rendering codes 76376 – 76377.

Radiation Oncology – "Medical Radiation Physics, dosimetry, Treatment Devices, and Special Services" subsection and the "Radiation Treatment Delivery" subsection have multiple new codes and revisions to reflect industry standard practice by combining several codes into one, i.e., basic dosimetry calculations are now included in the new codes and cannot be separately reported. The entire radiation treatment section has new introductory guidelines, with emphasis on "All treatment delivery codes are reported once per treatment session." The treatment delivery codes are for the technical services only and the treatment management codes are for the professional services only. Definition terms of "simple", "intermediate", and "complex" are now incorporated. The CMS created "G" codes (G6001 – G6017) may reported.

Pathology and Laboratory

A number of significant changes were made for reporting of the drug testing procedures, in order to alleviate ambiguity. There are now 3 subsections – a) Therapeutic Drug Assay, b) Drug Assay, and c) Chemistry. Codes 80100 – 80104 have been deleted and replaced with 80300 – 80304. The "Introductory Guidelines" in the CPT® manual explain the intent for these codes. There were 59 new definitive drug testing codes (80320 – 80377) created and arranged by drug classes.

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The "Introductory Guidelines" in the CPT® manual further explain correct reporting. PreferredOne will closely monitor the utilization of these codes.

Medicine Section

Vaccines, Toxoids – new code 90621 (*Meningococcal recombinant lipoprotein vaccine, serogroup B, 3 dose schedule, for intramuscular use*), trade name is Trumenba® was FDA approved on 10/29/14 and will be **effective 2/1/15**. Age restriction range is 10 – 25 year olds only. This code is not in the 2015 CPT® manual.

Neurostimulators, Analysis-Programming – revision of code 95972, which now states – up to one hour – in order to allow the service to be reported for less than a full hour of analysis.

Central Nervous System Assessments/Tests (eg., Neuro-Cognitive, Mental Status, Speech Testing) – revision of 96110 for reporting of development level only and creation of new code 96127 for brief emotional/behavioral assessment, i.e., depression inventory, ADD/ADHD scale, Vanderbilt), using a standardized instrument. Code 96127 is only a practice expense code as it is usually administered by clinic staff and completed by the parent/guardian/ caregiver. The interpretation by the clinician is to be reported with an E/M code and in most instances will be inherent to the clinic visit or preventive exam being rendered same date of service.

Other Services and Procedures – New code 99188 for topical fluoride varnish application will be bundled into all E/M services.

Modifiers – X {EPSU} – appropriate use is still being defined by the Centers for Medicare and Medicaid Services (CMS) and correct reporting is subject to change. These modifiers will be accepted.

HCPCS Codes

G0472 (Hepatitis C antibody screening) has been assigned an age restriction of 45 – 65 years old, per CMS.

Miscellaneous Coding Guidance

Bilateral Services - reminder to report on one line with the 50 modifier and 1 unit per MN Administrative Uniformity Committee's (AUC's) Coding Companion Guides accessed at http://www.health.state.mn.us/auc/guides.htm and the CMS *Internet-Only Manual* (Publication 100-04 *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 40.7.B. and Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 20.6.2.

Shoulder surgeries - PreferredOne® follows the National Correct Coding Initiative's (NCCI's) directive of - All shoulder joint procedures, i.e., arthroscopic or open, that are bundled per the NCCI edits, even if a 59 modifier is allowed, will be bundled into the primary surgical procedure when performed on the same shoulder joint. The reporting of the 59 modifier will be allowed if the contralateral shoulder joint is also operated on in the same surgical session.

Durable Medical Equipment (DMS) Ventilator Replacement Supplies – when the ventilator (HCPCS codes E0450, E0460, E0461, E0463, E0464, E0470, E0471, E0472) is rented, the vendor assumes responsibility and liability for duplicates, maintenance, servicing, replacement and supplies necessary for the safety and operation of the item (e.g. breathing circuit, filters, PEEP valve, sterile water, tubing, heated wire circuit, water trap, water chamber, etc.).

Member's Rights and Responsibilities

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

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
    - MC/M020 Autism Spectrum Disorders in Children: Non-Intensive Treatment
    - MC/M024 Autism Spectrum Disorders Early Intensive Behavioral and Developmental Therapy
- Retired Criteria: None
- New Policy: None
- Revised Policy: None
- Retired Policy: None

Chiropractic

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

Medical/Surgical

- New Criteria: None
- Revised Criteria:
    - MC/D001 Microprocessor-Controlled Prostheses for the Lower Limb

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  - MC/G004 Breast Reconstruction
  - MC/G007 Prophylactic Mastectomy and Oophorectomy
  - MC/H003 Bariatric Surgery
  - MC/L009 Intensity Modulated Radiation Therapy (IMRT)
  - MC/T002 Kidney Transplantation, Simultaneous Pancreas-Kidney Transplantation, Simultaneous Cadaver-Donor Pancreas and Living-Donor Kidney Transplantation
  - MC/T005 Lung Transplantation
  - MC/T007 Pancreas Transplantation, Pancreas After Kidney (PAK) Transplantation, Autologous Islet Cell
- Retired Criteria: None
- New Policy: None
- Revised Policy
  - MP/D004 DME
  - MP/G001 Genetic Testing for Heritable Conditions
  - MP/C002 Cosmetic Treatments
  - MP/L001 Laboratory Tests
- Retired Policy: None

Addition to the Investigational/Experimental/Unproven Comparative Effectiveness List

- Nasal/sinus endoscopy dilation of maxillary or sphenoid sinus ostium (eg, balloon dilation), transnasal or via canine for chronic sinusitis. This is also known as balloon sinuplasty

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. 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 D-H) 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 Update

Pharmacy and Therapeutics QM Subcommittee

- New Criteria: None
- Revised Criteria
  - PC/B014 Benign Prostatic Hypertrophy Medications Step Therapy
  - PC/H002 Hepatitis C Medications
  - PC/I002 Immune Globulin Therapy (IgG, IVIg, SCIg)
  - PC/P002 Phosphodiesterase 5 Inhibitor Medications
  - PC/R004 Rituxan Prior Authorization
- Retired Criteria: None
- New Policy: None
- Revised Policy: None
- Retired Policy: None

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.

Adverse Determination – To Speak to a Physician Reviewer

PreferredOne Integrated Healthcare Services Department attempts to process all reviews in the most efficient manner. We look to our participating practitioners to supply us with the information required to complete a review in a timely fashion. We then hold ourselves to the timeframes and processes dictated by the circumstances of the case and our regulatory bodies.

Practitioners may, at any time, request to speak with a peer reviewer at PreferredOne regarding the outcome of a review by calling 763-847-4488, option 2 and the Intake Department will facilitate this request. You or your staff may also make this request of the nurse reviewer with whom you have been communicating about the case and she/he will facilitate this call. If, at any time, we do not meet your expectations and you would like to issue a formal complaint regarding the review process, criteria or any other component of the review, you may do so by calling or writing to our Customer Service Department.

Phone number: (763) 847-4488, Option 3.

(800) 379-7727, Option 3

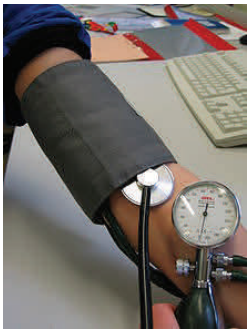
Address: PreferredOne, Grievance Department

6105 Golden Hills Dr.

Golden Valley, MN 55416

Quality Management Update

Blood Pressure Readings for Controlling High Blood Pressure



In 2015 PreferredOne will once again be focusing on an initiative to control high blood pressure among our members diagnosed with hypertension. Controlling blood pressure is a HEDIS measurement specified by NCQA and is also reported by Minnesota Community Measurement. We value this project and deem it as important to our members because hypertension is the most treatable form of cardiovascular disease and medication compliance is a significant factor that contributes to the overall success of treatment. PreferredOne will be providing medication adherence education to members diagnosed with hypertension. As part of this initiative in 2015 we are asking for provider's assistance by conducting a secondary reading of your patient's blood pressure if it is high following the initial reading and ensuring that the patient's medical records reflects both of the measurements taken.

HEDIS Medical Record Review

As a reminder, PreferredOne's HEDIS Medical Record Review Vendor will be contacting clinics in the coming weeks to coordinate medical record review for PreferredOne members seen at your clinics. As a contracted provider you are obligated to allow PreferredOne and its vendor to conduct this review. HEDIS measures are nationally used by all accredited health plans and PreferredOne also has an obligation to the Minnesota Department of Health to collect HEDIS data on an annual basis. Medical record review is an important component of the HEDIS compliance audit. It ensures that medical record reviews performed by our vendor meet audit standards for sound processes and that abstracted medical data are accurate. We would appreciate your cooperation with collecting medical record review information at your clinic site(s). We appreciate your clinic's assistance in making this a smooth process.

Medical Record Documentation Policy

Please see attachment (Exhibit I) for our Medical Record Documentation Policy.

Serving a Culturally and Linguistically Diverse Membership

Cultural and linguistic competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by their patients/consumers to the health care encounter. Cultural and linguistically appropriate services lead to improved outcomes, efficiency, and satisfaction.

Culture Care Connection is an online learning and resource center, developed by Stratis Health, aimed at supporting health care providers, staff, and administrators in their ongoing efforts to provide culturally-competent care in Minnesota.

For more information regarding Stratis Health's resource center, click on the following link: http://www.culturecareconnection.org/.

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 1/1/2015**	
POLICY DESCRIPTION:	Readmission within 5 Days		
EFFECTIVE DATE:	1/1/2014		
PAGE:	1 of 2	**REPLACES POLICY DATED: 7/30/2014, 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:

MS-DRGs: 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. The appropriate discharge status code should be used indicating the planned readmission. Valid planned readmission discharge status codes include 81 – 94. An example of a planned readmission is the scenario for a specific chemotherapy treatment plan that requires several hospital admissions over a period of time.

5. Please note that planned readmissions are ***different*** than a Leave of Absence (LOA). Hospitals may place a patient on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. In order to bill for LOA, submit one bill for covered days and days of leave when the patient is ultimately discharged. Report the leave days as non-covered, and report the beginning and ending dates of the leave with Occurrence Span Code 74. To account for the LOA Non-covered

days in the billed accommodation days/units, show non-covered days/units under Revenue Code 018X (Leave of Absence) with zero charges. Hospitals may not use the LOA billing when the second admission is unexpected. Examples include, but are not limited to:

- Situations where surgery could not be scheduled immediately
- Specific surgical team was not available
- When further treatment is indicated following diagnostic tests but cannot begin immediately.

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

Exhibit B

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE:** 1/1/2015	
POLICY DESCRIPTION:	Reimbursement Facility Multiple Surgeries Performed on the Same Date of Service		
EFFECTIVE DATE:	1/1/2013		
PAGE:	1 of 1	**REPLACES POLICY DATED: 12/1/2012**	
REFERENCE NUMBER:	P#14	**RETIRED DATE:**	

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

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

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. 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 contracted rate. 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.

2. 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.

3. The appropriate revenue codes that are considered a procedures for this policy are including, but not limited to 36x, 49x, 75x and 790.

4. Facilities on APC methodology follow the APC editing for multiple procedures. (For example, bilateral services should be billed on one line with a -50 modifier).

DEFINITIONS:

REFERENCES: Pricing & Payment Policy #11 Reimbursement For Free-Standing ASC & Hospital Outpatient to APC Methodology

Exhibit C

PreferredOne Member Rights & Responsibilities

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

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

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

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

4. A **right** to be informed of your health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.

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

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

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

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

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

10. A **right** to file a complaint with PCHP and the Commissioner of Health and to initiate a legal proceeding when experiencing a problem with PCHP or its participating providers. For information, contact the Minnesota Department of Health at 651.201.5100 or 1.800.657.3916 and request information.

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

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

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

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

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

Exhibit D

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 E

Medical Policies

Reference #	Description
A001	Elective Abortion
A003	Amino Acid Based Elemental Formula (AABF)
A004	Acupuncture
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 *Revised*
C009	Coverage Determination Guidelines
C011	Court Ordered Substance Related Disorder Services
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies *Revised*
D005	Dietary Formulas, Electrolyte Substances, or Food Products for PKU or Other Inborn Errors of Metabolism
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*
P010	UVB Phototherapy (non-laser) for Skin Disorders *Revised*
P011	Prenatal Testing
P013	Pharmacogenetic/Pharmacogenomic Testing and Serological Testing for Inflammatory Conditions *New*
R002	Reconstructive Surgery
S008	Scar Revision *Revised*
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

Medical Criteria

Reference #	Category	Description
A006	Cardiac/Thoracic	Ventricular Assist Devices (VAD)
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
B003	Dental and Oral Maxillofacial	Orthodontic Services
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea
D001	Durable Medical Equipment	Microprocessor-Controlled Prostheses for the Lower Limb *Revised*
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back
G001	Skin and Integumentary	Eyelid and Brow Surgery (Blepharoplasty & Ptosis Repair)
G002	Medical/ Surgical	Breast Reduction Surgery
G003	Skin and Integumentary	Excision Redundant Tissue
G004	Medical/ Surgical	Breast Reconstruction *Revised*
G007	Medical/ Surgical	Prophylactic Mastectomy and Oophorectomy *Revised*
G008	Skin and Integumentary	Hyperhidrosis Surgery
G010	Skin and Integumentary	Lipoma Removal
G011	Medical/ Surgical	Hyperbaric Oxygen Therapy
H003	Gastrointestinal/Nutritional	Bariatric Surgery *Revised*
I007	Oncology	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	Surgical/ Medical	IVAB for Lyme Disease
K002	Surgical/ Medical	Bronchial Thermoplasty
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
L009	Diagnostic	Intensity Modulated Radiation Therapy (IMRT) *Revised*
L010	Diagnostic	Genetic Testing for Hereditary Cancer Syndromes
L011	Durable Medical Equipment	Insulin Infusion Pump
L012	Diagnostic	Oncotype DX Breast Cancer Assay
L014	Diagnostic	Laboratory Testing for Detection of Heart Transplant Rejection
L015	Diagnostic	Comparative Genomic Hybridization (CGH, aCGH)
L016	Diagnostic	Lung Cancer Screening by Computed Tomography *New*
M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment/Intensive Outpatient Program (IOP)
M005	BH/Substance Related Disorders	Eating Disorders: Level of Care Criteria
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)

Exhibit G

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
C001	Coordination of Benefits
C002	Cost Benefit Program *Revised*
C003	Compounded Drug Products
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 *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 *Revised*
B015	Breast Cancer Risk Reduction Medications Step Therapy
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
E001	Erectile Dysfunction Medications - Non-PDE-5 Inhibitor Medications
H002	Hepatitis C Medications *Revised*
I002	Immune Globulin Therapy (IgG, IVIg, SCIg) *Revised*
L003	Gabapentin/Lyrica Medications Step Therapy
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy
O001	Overactive Bladder Medication Step Therapy
P001	Proton Pump Inhibitor (PPI) Step Therapy
P002	Phosphodiasterase-5 Inhibitor Medications *Revised*
R003	Topical Retinoid Medications Step Therapy
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

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/9/09
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/9/09	
Procedure Description: Medical Record Documentation Guidelines	**Replaces Effective Procedure Dated:** 10/09/08	
Reference #: QM/M001	**Page:** 1 of 2	

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

BACKGROUND:
PreferredOne requires medical records to be maintained in a manner that is complete, current, detailed and organized, and permit effective and confidential patient care and quality review.

The medical record for each PreferredOne member, whether paper or electronic, should be an organized, consistent record that accurately communicates information required to render timely, comprehensive medical care.

PROCEDURE:

PreferredOne member health records must be maintained according to all of the following:

I. The medical record must include all the following:

A. For paper records, all pages must contain patient identifier (name or ID#)

B. All record entries must:

1. Be dated; and

2. Must be legible

C. All medical record documentation must include:

1. Patient specific demographic data (address, telephone number(s) and date of birth)

2. A completed problem list that indicates significant illnesses and medical conditions for patient seen three or more times in one year

3. A medication list if applicable, or a note of no medications

4. Medication allergies and other allergies with adverse reactions prominently noted in the record, or documentation of no known allergies (NKA) or no history of adverse reaction appropriately noted

5. Past medical history is identified and includes a review of serious accidents, surgical procedures and illnesses if the patient has been seen three or more times (for children and adolescents, 18 years and younger, past medical history relates to prenatal care, birth, operations and childhood illnesses)

6. Current or history of "use" or "non-use" of cigarettes, alcohol and other habitual substances is present when age appropriate

PreferredOne®

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/9/09
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/9/09	
Procedure Description: Medical Record Documentation Guidelines	**Replaces Effective Procedure Dated:** 10/09/08	
Reference #: QM/M001	**Page:** 2 of 2	

7. Continuity and coordination of care between the primary care practitioner and consultants as evidenced by consultant's written report or notation of verbal follow-up in the record's notes if consultations are ordered for the member (if applicable)

8. An immunization record/history

9. Evidence that treatment plans are consistent with diagnoses and notes indicating the specific time for return/follow-up in weeks, months, or "as needed" if the member requires follow-up care or return visits

II. Medical records must be stored in a manner that allows easy retrieval and in a secure area that is inaccessible to unauthorized individuals.

III. Clinic has written policies for:

A. Documented standards for an organized medical record keeping system

B. Confidentiality, release of information and advanced directives

C. Chart availability including between practice sites (if applicable)

D. Reviewing test/lab results and communicating results to patient.

IV. Compliance with medical record organization and documentation requirement policies will be monitored as follows:

A. Chart audits will occur in coordination with HEDIS data collection on a yearly basis. A maximum of 10 charts per clinic will be reviewed for documentation completeness.

B. Clinics surveyed that do not meet an overall rate of 80 percent of the above record keeping requirements (based on the total number of charts reviewed) will be notified of their deficiencies and a corrective action plan will be requested from the clinic addressing how they will conform to the above guidelines with follow-up measurement performed the following year.

REFERENCES:

- 2009 NCQA Standards and Guidelines for the Accreditation of Health Plans, QI 12 Standards for Medical Record Documentation
- Minnesota State Statue 4685.1110, Subp. 13

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