PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
February 2016

Pricing Update

Duplicate Billing Reminder

Reminder that professional claims where a global code is billed and another claim is submitted with a corresponding -26 professional component only or –TC technical component claim billed for the same member and the same date of service is considered incorrect billing. Correct coding indicates that for the service provided to the member, where the professional and technical components are provided by separate entities that the appropriate -26 professional component only or –TC technical component only be used. PreferredOne continues to see incorrect billing where both the global code and the modified code are billed for the same member, same date of service and same CPT/HCPCS code. The providers submitting these claims may be the same or different entities. The claim submitted by the provider billing the global code will be denied for incorrect billing. The provider will have to submit a correct claim with the appropriate modifier.

Multiple Imaging Performed on the Same Date of Service

Reminder of the Pricing and Payment Policy #16 Multiple Imaging Performed on the Same Date of Service apply to the codes listed in the policy when performed on the same patient by the same group practice or facility during the same sessions. Imaging procedures subject to the multiple imaging reduction, when billed to the same member on the same date of service by the same group practice or facility should be billed on one claim. Separately billed claims will be denied for incorrect billing. The provider will have to submit a correct claim with all of the services listed on one claim.

Please also note an updated Pricing and Payment policy, P15 Reimbursement Facility Less than 48 Hours. (Exhibit A)

Coding Update

2016 CPT® and HCPCS Codes Highlights

CPT® Codes

The American Medical Association (AMA) CPT® Editorial Panel continues to combine procedure and diagnostic service codes that are consistently reported together 75% of the time or more. Multiple CPT® codes were created for 2016 for this reason. This mostly affects ultrasound, fluoroscopy, contrast material, etc., so please read the new code description in order to avoid unnecessary claim denials.

69209 – *Removal impacted cerumen using irrigation/lavage, unilateral* – will be bundled with all E/M codes (eg., 99201 – 99215, 99381 – 99397, (not inclusive list)), when reported on the same date of service with the same or related diagnosis (eg., otalgia, itching, hearing loss).

There were multiple code additions and revisions to "Molecular Pathology Procedures, Tiers 1 and 2" and "Genomic Sequencing Procedures and Other Molecular Multianalyte Assays", further clarifying specific testing methods. REMINDER – PreferredOne requires prior authorization for these codes.

In This Issue:

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New codes were created for "Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision" -

- 99415 - Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
- 99416 - Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service).

1. These codes will be monitored and documentation may be requested.
2. As stated in the CPT® Manual, less than 45 minutes of continuous **face-to-face time** between the clinical staff and the patient is not a reportable service.
3. If the patient is being monitored for toxic medication reaction post injection or infusion, the clinical staff will need to document exact times they were face-to-face with the patient. Those times, even though not continuous, may be added up in order to determine if code 99415 is reportable.
4. Providers may consider these codes when clinical staff spend additional time providing disease process education above and beyond what the physician or mid-level provider rendered.
5. These codes are NOT to be reported for preventive counseling as there are specific established codes for that service.
6. These codes are NOT to be reported for medication management services as there are specific codes for that service when performed by a PharmD.
7. These codes are NOT to be reported with chemotherapy services.

Effective 1/1/2015, CPT® codes for "Advanced Care Planning" were created with PreferredOne® bundling these codes into all services (see February, 2015 Provider Update Bulletin, page 3). Beginning 1/1/2016, PreferredOne will allow these codes as a covered service using the guidance documented in the CPT® Manual Introductory Notes. Codes are –

- 99497 – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate;
- 99498 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.

HCPCS Codes

The majority of the HCPCS code changes were in the "Quality Measures" section, G8935 – G9677 range. This includes newly created, revised, and deleted codes.

There are multiple recycled/reinstated codes. Affected codes will have a circle in front of the code in the HCPCS Manual. Below are some examples, this is not an all-inclusive list.

Code	New Description	Previous Description
E1012	Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each	Integrated Seating System, Planar, For Pediatric Wheelchair - deleted 12/31/07
G0297	Low dose CT scan (LDCT) for lung cancer screening (NOTE: prior authorization is required)	Insertion of single chamber pacing cardioverter defibrillator pulse generator - deleted 12/31/2007

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The "Drug Testing" section has completely changed. Codes G6030 – G6058 have been deleted and replaced with codes G0477 – G0483 indicating the number of drug class(es) being tested. PreferredOne® does accept these codes.

Many new "J" codes have been created, several of them replacing deleted "C" codes. Please refer to the HCPCS Manual for those.

The code for Mirena, J7302, has been deleted and replaced with two new codes which are delineated by year duration —

- J7297 – Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration (Liletta)
- J7298 - Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration (Mirena)

A code for a biosimilar drug has been created that requires a new modifier to be appended each time it is reported. Please reference CMS Transmittal 1542, CR9284, dated Sep 4, 2015 for specific information.

- Q5101 – Injection, filgrastim (G-CSF), biosimilar, 1 microgram
- ZA - Novartis/Sandoz

Additional Coding Information

PreferredOne® has updated their policy for "Unlisted Procedure Codes", which is attached at the end of this newsletter. Please review as there will be claim impact.

Please also see updates to Policies H7 Readmission within 5 Days and H8 Transfer from Acute Facility to another Acute Facility and a new Coding Policy P40 Unlisted Procedure Codes. (Exhibits B, C, & D)

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. (Exhibits E & F)

Credentialing Update

Confirmation Letters of Added Providers Will No Longer Be Sent - Register to Receive Email Notification When Providers are Added

Beginning March 1, 2016, PreferredOne will no longer send letters via US Postal Service to notify that an individual practitioner has been added in our systems. You may register on the PreferredOne provider portal to receive an email notification of providers added. Log in at PreferredOne.com, select Your Clinic Provider Maintenance, then select "Register for email notification when providers are added." You may also view the last 10 weeks of provider additions using the secured site even if you do not wish to register for notification.

You may use this same application to submit term dates to PreferredOne as well as notify us of "Accepting New Patients" and "Directory Display" changes. Watch for new features to be added during 2016.

Tobacco Cessation - Help Connect your Patients to Quitline Support

We know tobacco use is the leading cause of preventable death and disease. But beyond telling patients they should quit, what more can you do? You can do more by referring them to quitline support, where they can speak to a trained cessation counselor.

With Minnesota's different insurance programs and quitline numbers, it can be hard to ensure patients are directed to the right place. That's where the Call it Quits Referral Program can help. The Call it Quits Referral Program enables health care providers to use a single form and fax number to refer patient who use tobacco to quitline support. All Minnesotan residents – whether covered by a health plan or not – have access to free support to quit.

Call it quits℠ Referral Program

This program makes quitting easier for your patients as well. Rather than navigating our complex health system, a referral through Call it Quits Referral Program means your patient will receive a call directly from their quitline. It's a proactive approach to receiving the help that they need.

The referral program is free for both the clinic and patients, and you can easily monitor your patient enrollments using our online data reporting website.

Register your clinic or site today! Visit www.health.mn.gov/callitquits to learn more.

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 investigative list.

Behavioral Health

- New Criteria: None
- Revised Criteria: None
- 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

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Medical/Surgical

- New Criteria: None
- Revised Criteria
    - MC/D001 Microprocessor-Controlled Prostheses for the Lower Limb
    - MC/G004 Breast Reconstruction
    - MC/G007 Prophylactic Mastectomy/Oophorectomy
    - MC/H003 Bariatric Surgery
    - MC/L009 Intensity Modulated Radiation Therapy
    - MC/N003 Occupational and Physical Therapy: Outpatient Setting
    - MC/N004 Speech Therapy: Outpatient Setting
    - MC/T002 Kidney Transplant
    - MC/T007 Pancreas Transplant
- Retired Criteria: None
- New Policy: MP/F007 Free-standing Birth Centers
- Revised Policy:
    - MP/C002 Cosmetic Treatments
    - MP/S008 Scar Revision
- Retired Policy: None

Investigative List

- Additions: Genotyping of ADRA2A, COMT, DRD2, HLA-B*1502 (except for persons of Asian ancestry before initiating treatment with carbamazepine [Tegretol]), HTR2A, HTR2C, OPRM1, SLC6A4, and UGT2B15

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

- No changes

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 Update

Pharmacy and Therapeutics QM Subcommittee

- New Criteria
  - PC/D005 Diabetic Medications – Clinical Progression of Therapy
  - PC/O002 Ophthalmic Anti-allergy Medications Step Therapy
  - PC/P001 PCSK9 Inhibitor Medications
- Revised Criteria
  - PC/B014 Benign Prostatic Hypertrophy Medications Step Therapy
  - PC/E001 Erectile Dysfunction Medications – Non-PDE5 I
  - PC/G001 Growth Hormone Medications Step Therapy
  - PC/H001 HMG Co-A Reductase Inhibitor Medications Step Therapy
  - PC/H002 Hepatitis C Virus Medications
  - PC/I002 Immune Globulin Therapy
  - PC/P002 Phosphodiesterase 5 Inhibitor Medications
  - PC/R003 Topical retinoid Medications Step Therapy
- Retired Criteria: None
- New Policy: None
- Revised Policy
  - PP/B001 Backdating of Pharmacy Authorizations
  - PP/C001 Coordination of Pharmacy Benefits
  - PP/F001 Formulary Overrides
  - PP/P001 Bypass of Prior Authorizations Ordered by a Contracted Specialist
- 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.

Quality Management Update

Blood Pressure Readings for Controlling High Blood Pressure

In 2016 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 2016 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 L) 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/.

Coordination of Care

Coordination of care among providers is a vital aspect of good treatment planning to ensure appropriate diagnosis, treatment and referral. PreferredOne would like to take this opportunity to stress the importance of communicating with your patients' other health care practitioners. This includes primary care physicians and medical specialists, as well as behavioral health practitioners. While we realize in this age of electronic medical records, many records are available to other practitioners in the same care system, currently across systems there is not this coordination of information about your patients.

Coordination of care is especially important for patients with high utilization of general medical services and those referred to a behavioral health specialist by another health care practitioner. PreferredOne urges all of its practitioners to obtain the appropriate permission from these patients to coordinate care between behavioral health and other health care practitioners at the time treatment begins.

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We encourage all health care practitioners to:

1. Discuss with the patient the importance of communicating with other treating practitioners.
2. Obtain a signed release from the patient and file a copy in the medical record.
3. Document in the medical record if the patient refuses to sign a release.
4. Document in the medical record if you request a consultation.
5. If you make a referral, transmit necessary information; and if you are furnishing a referral, report appropriate information back to the referring practitioner.
6. Document evidence of clinical feedback (i.e., consultation report) that includes, but is not limited to:
    - Diagnosis
    - Treatment plan
    - Referrals
    - Psychopharmacological medication (as applicable)

We appreciate your efforts to provide coordinated care among our membership population and ensuring your patients and their entire medical team is informed about patients' medical treatment plans and outcomes.

Exhibit A

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE: 1/1/2016,** 09/1/2013	
POLICY DESCRIPTION:	Reimbursement Facility Inpatient Less than 48 Hours		
EFFECTIVE DATE:	1/1/2016		
PAGE:	1 of 1	**REPLACES POLICY DATED: 1/1/2014**	
REFERENCE NUMBER:	P#15	**RETIRED DATE:**	

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

PURPOSE: To provide guidelines for reimbursement when an enrollee is admitted as an Inpatient to an acute care facility (TOB 11X) where the length of stay is less than 48 hours.

POLICY: PreferredOne will reduce payment to the acute care hospital if the patient is discharged less than 48 hours after admission and is one of the DRG's that CMS has listed as having a Geometric Length of Stay (GLOS) greater than 4.0 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. The Inpatient Hospital claim (UB04) must have a length of stay less than 48 hours.

2. This policy applies only to the applicable current year version DRG's with a GLOS greater than 4.0. For example, 2015 based on V32 DRG list or 2016 based on V33 DRG).

3. This policy excludes Mental Health, Chemical Dependency, eating disorders, Maternity, Newborn and Rehab claims.

4. These claims will process at the lesser of providers DRG payment or 60% of charges.

DEFINITIONS:

REFERENCES:

Exhibit B

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 10/1/2015**	
POLICY DESCRIPTION:	Readmission within 5 Days		
EFFECTIVE DATE:	10/1/2015		
PAGE:	1 of 2	**REPLACES POLICY DATED: 10/1/2015,7/30/2014, 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); effective 10/1/2015: 98x when diagnosis or procedure code indicates a delivery, and DRGs with revenue codes 128 and 118.

4. The following list does not apply:

- A transfer from acute facility to rehab or long term care facilities/swing beds or a transfer from a rehab or longer term care facilities/swing beds to an acute facility (including but not limited to discharge status of 03, 06, 61, 62, 63)

- 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)

5. 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 – 95. 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.

6. 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 C

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	**1/1/2016, 1/1/2014, 11/4/2009, 8/1/2008, 10/1/2007**
POLICY DESCRIPTION:	Transfer from Acute Facility to another Acute Facility		
EFFECTIVE DATE:	1/1/16		
PAGE:	1 of 2	**REPLACES POLICY DATED:**	**1/1/2014, 11/4/2009, 8/1/2008, 10/1/2007**
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, or revenue codes 128 and 118)

- 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

PreferredOne®

Department of Origin: Coding Reimbursement	**Approved by:**	**Date approved:** 1-1-2016
Department(s) Affected: Coding, Claims, Network Management	**Effective Date:** 1-1-2016	
Policy Description: Unlisted Procedure Codes	**Replaces Effective Policy Dated:**	
Reference #: P-40	**Page:** 1 of 2	

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

PURPOSE:

To provide billing guidelines for unlisted and unspecified procedure codes

POLICY:

The purpose of this policy is to address the appropriate reporting of unlisted Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes. The policy also identifies the additional information needed to complete a review.
The CPT and HCPCS manuals provide unlisted procedure codes for healthcare providers to report services for which there is no specific code descriptor available

PROCEDURE:

Unlisted and unspecified procedure codes do not describe a specific procedure or service therefore it is necessary to submit supporting documentation when filing a claim.

It is the responsibility of the provider to ensure all information required to process unlisted procedure codes or Not Otherwise Classified (NOC) codes (codes that usually end in 99) is included with the CMS-1500/837P form, electronic media claim (EMC), UB-04/837I or ADA/837D form at the time the claim is submitted.

Pertinent information should include:
• A clear description of the nature, extent, and need for the procedure or service.
• Whether the procedure was performed independent from other services provided, or if it was performed at the same surgical site or through the same surgical opening.
• Any extenuating circumstances which may have complicated the service or procedure.
• Time, effort, and equipment necessary to provide the service.

To expedite claim processing and payment, the provider is required to submit the necessary information in Item 19 as documented in the CMS-1500/837P claim form instructions or the electronic equivalent or if necessary include an attachment.

PreferredOne®

Department of Origin: Coding Reimbursement	Approved by:	Date approved: 1-1-2016
Department(s) Affected: Coding, Claims, Network Management	**Effective Date:** 1-1-2016	
Policy Description: Unlisted Procedure Codes	**Replaces Effective Policy Dated:**	
Reference #: P-40	**Page:** 2 of 2	

When submitting attachments (e.g., operative report, procedure report, invoices) to support the unlisted code billed the provider should identify the unlisted procedure with a written description, underlining or marking the billed service on the submitted attachments. Highlighters should not be used as this obliterates the text and is not visible after the document is photocopied or scanned. Submitting only the operative note often does not adequately support the use of a unlisted code.

Laboratory and pathology unlisted procedures require the submission of a complete description and the laboratory or pathology report.

Unclassified drug billing requires the submission of the 11 digit National Drug Code (NDC), drug name and dosage in the correct format and location on the claim form.

Multiple units will not be allowed for any unlisted code. Only one (1) unit may be submitted.

Claims submitted with unlisted procedure codes and without the required narrative information and/or supporting documentation will be denied.

DOCUMENT HISTORY:

Created Date: 1-1-2016
Reviewed Date:
Revised Date:

PreferredOne®
COMMUNITY HEALTH PLAN

Members Rights & Responsibilities

As a PreferredOne Community Health Plan 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.
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 its participating providers.
10. A **right** to file a complaint with PreferredOne and the Commissioner of Insurance and to initial at legal proceeding when experiencing a problem with PreferredOne or its participating providers. For information, contact the Minnesota Department of Commerce 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, and providing access to care.
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 providers.

PreferredOne
INSURANCE COMPANY

Members Rights & Responsibilities

As a PreferredOne Insurance Company 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.

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 its participating providers.

10. A **right** to file a complaint with PreferredOne and the Commissioner of Insurance and to initial at legal proceeding when experiencing a problem with PreferredOne or its participating providers. For information, contact the Minnesota Department of Commerce 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, and providing access to care.

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 providers.

Exhibit G

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

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
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	Radiation Therapy	Intensity Modulated Radiation Therapy (IMRT)
L010	Diagnostic	Genetic Testing for Hereditary Cancer Syndromes
L011	Durable Medical Equipment	Insulin Infusion Pump
L012	Diagnostic	Gene Expression Profiling
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

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)
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	BH/SubstanceRelated Disorders	Mental Health Disorders: Residential Crisis Stabilization Services (CSS)
M023	BH/SubstanceRelated 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)
M025	BH/Substance Related Disorders	Transcranial Magnetic Stimulation *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 Transplantation
T002	Transplant	Kidney, SPK, SPLK Transplantation
T003	Transplant	Heart Transplantation
T004	Transplant	Liver Transplantation
T005	Transplant	Lung Transplantation
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplantation *Revised*

Exhibit I

Medical Policies

Reference #	Description
A001	Elective Abortion *Revised*
A003	Amino Acid Based Elemental Formula (AABF)
A004	Acupuncture
A005	Autism Spectrum Disorders in Children: Assessment and Evaluation
C001	Court Ordered Mental Health Services
C002	Cosmetic Treatments *Revised*
C003	Criteria Management Development, Application, and Oversight
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
D008	Dressing Supplies
D009	Dental Services, Hospitalization, and Anesthesia for Dental Services Covered Under the Medical Benefit *Revised*
D010	Urine Drug Testing in Substance Abuse Treatment and Chronic Pain Management Settings *New*
F007	Free-Standing Birth Centers *New*
G001	Genetic Testing for Heritable Conditions
G002	Gender Reassignment *Revised*
H006	Hearing Devices
H007	Hospice Care
H008	FDA-Approved Humanitarian Use Devices (HUD)
I001	Investigative Services
I002	Infertility Treatment
I003	Routine Preventive Immunizations *Revised*
L001	Laboratory Tests *Revised*
M001	Molecular Testing for Tumor/Neoplasm Biomarkers *Revised*
N002	Nutritional Counseling *Revised*
P008	Medical Policy Document Management and Application
P010	UVB Phototherapy (non-laser) for Skin Disorders
P011	Prenatal Testing
P013	Pharmacogenetic/Pharmacogenomic Testing and Serological Testing for Inflammatory Conditions *Revised*
R002	Reconstructive Surgery *Revised*

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

Pharmacy Criteria

Reference #	Description
A003	Combination Beta-2 Agonist/Corticosteroid Inhalers Step Therapy *Revised*
A005	Antidepressant Medications Step Therapy
B003	Botulinum Toxin *Revised*
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
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
D003	Diabetic Medications Step Therapy
E001	Erectile Dysfunction Medications - Non-PDE-5 Inhibitor Medications
G001	Growth Hormone Medications Step Therapy
H001	HMG - CoA Reductase Inhibitor Medications Step Therapy *Revised*
H002	Hepatitis C Medications *Revised*
I002	Immune Globulin Therapy
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy *Revised*
O001	Overactive Bladder Medications Step Therapy
P001	Proton Pump Inhibitor (PPI) Medications Step Therapy
P002	Phosphodiasterase-5 Inhibitor Medications
P003	PCSK9 Inhibitor Medications *New*
R003	Topical Retinoid Medications Step Therapy
R004	Rituxan Prior Authorization (Non-Oncology) *Revised*
V001	Vascular Endothelial Growth Factor Antagonists for Intravitreal Use *Revised*
W001	Weight Loss Medications *Revised*

Exhibit K

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
B002	Biosimilar Products
C001	Coordination of Benefits *Revised*
C002	Cost Benefit Program *Revised*
C003	Compounded Drug Products
F001	Formulary Exceptions *Revised*
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist *Revised*
Q003	Quantity Limits *New*
R001	Review of New FDA-Approved Drugs and Clinical Indications
S001	Step Therapy
T001	Tobacco Cessation Medications *Revised*

Exhibit L

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Chief Medical Officer	**Date approved:** 10/8/15
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 10/8/15	
Procedure Description: Medical Record Documentation Guidelines	**Replaces Effective Procedure Dated:** 10/11/13	
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: Chief Medical Officer	Date approved: 10/8/15
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 10/8/15	
Procedure Description: Medical Record Documentation Guidelines	**Replaces Effective Procedure Dated:** 10/11/13	
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 on an annual basis for a sample of practitioner clinics who we have no knowledge of them utilizing an electronic medical record system. A maximum of 10 charts per clinic will be reviewed on a select number of documentation standards for completeness.

B. Clinics surveyed that do not meet an overall rate of at least 80 percent on the standards that are 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:

- Minnesota State Statue 4685.1110, Subp. 13

DOCUMENT HISTORY:

Created Date: 5/22/06
Reviewed Date:
Revised Date: 10/26/06, 10/11/07, 10/9/08, 7/9/09, 10/11/13, 10/8/15