

PreferredOne®

UPDATE *A Newsletter for PreferredOne Providers & Practitioners*

October 2008

2009 Fee Schedule Update

Additional changes to the 2009 fee schedules were communicated at the PreferredOne Provider Forum that was held in September. The presentation is available on our secure website.

Professional Services

PreferredOne's Physician, Mental Health, and Allied Health Fee Schedules are complete and will become effective for dates of service beginning January 1, 2009. These changes are expected to be an increase in overall reimbursement. As with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

Physician fee schedules will be based on the 2008 CMS Medicare physician transitional RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register November 2007. New codes for 2009 will be based on the 2009 CMS Medicare physician transitional RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2008.

Various fees for services without an assigned CMS RVU have been updated accordingly. New codes that are not RVU-based will also be added. Examples of these services include labs, supplies/durable medical equipment, injectable drugs, immunizations and oral surgery services. PreferredOne will maintain the current default values for codes that do not have an established rate.

The 2009 Physician fee schedules will continue to apply site of service differential for services in the CPT surgical code range and additional HCPCS surgical codes performed in a facility setting (Place of Service 21-25).

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder that new codes for 2009 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the "PreferredOne Provider Bulletin."

New ASA codes for Anesthesia services will be updated with the 2009 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2009.

Hospital Services/UB04 Fee Schedules

The 2009 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 26 as published in the final rule Federal Register to be effective October 2008. Ambulatory Surgery Center (ASC) code groupings have been updated for 2009 according to Centers for Medicare and Medicaid Services (CMS). For those codes not assigned a grouper by CMS, PreferredOne will assign them to appropriate groupers as outlined in the policy. *Page 2...*

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Network Management

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The Facility (UB04) CPT fee schedule will consist of all physician CPT/HCPC code ranges and will be based on the 2008 CMS Medicare transitional physician RVU file, without the geographic practice index applied and without the work adjust applied. The global rules for the facility CPT fee schedule are as follows:

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

Reminder that new codes for 2009 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the “PreferredOne Provider Newsletter.”

Off-Cycle Fee Schedule Updates

Other provider types such as DME, Dental, and Home Health updates will take place April 1, 2009.

New Pricing and Payment Policies

See the attached pricing and payment policies going into effect 1/1/2009 for Present on Admission, Late Charges/Corrected Claims, Revenue Codes that Require HCPCS codes, Timely Filing and Adverse Events (**Exhibits A-E**). These were presented at the PreferredOne Provider meeting in September. Also attached are the updated policies: Coding and Reimbursement Policy H-8 “Transfer from an Acute Facility to another Acute Facility” that went into effect 1/1/2008 and Coding and Reimbursement Policy H-7 “Readmission within 5 Days”. (**Exhibits F-G**)

Claims Processing Correction -50 modifier on non-surgical codes

With the change in bilateral to billing modifier 50 and 1 unit of service to one line April 1, 2008, the systems were updated to ensure correct payment for multiple surgeries. A review of system setup discovered some HCPCS/CPT codes for non-surgical procedures were also taking a multiple surgery discount when it should not have been. The system was corrected on July 3, 2008 and claims will be automatically reprocessed to receive the full payment. HCPCS/CPT codes affected are the following: 73562-50, 73630-50, 92135-50, 92225-50, 92235-50, 95934-50.

We will continue to review claims setup routinely to ensure correct payment and will notify providers of any system changes that affect the majority of our providers.

Coding Update

Important Information About Administrative Simplification

Did you know that due to a 2007 Minnesota state law, providers and payers are required to standardize electronic billing transactions? This legislation calls for the AUC to work with the Minnesota Department of Health to streamline three major components of the billing process.

- Eligibility (implementation deadline 1/15/09)
- Claims (implementation deadline 7/15/09)
- Payment and remittance advice (implementation deadline 12/15/09 *Page 3...*)

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The 2007 law was widely supported by the health care billing community, which felt that a single set of billing codes for electronic transactions would simplify the billing system.

An overarching principal of this work is that each Minnesota payer and provider will be required to make changes to their current procedures, policies, and/or systems in some way as a result of the work of the AUC and Medical Code Tag.

Multiple committees and technical advisory groups and strategic steering committees meet regularly to assist in this endeavor.

Please visit www.health.state.mn.us/auc to learn more about the completed activities and continued activities of the different groups. There are effective dates for payers and providers to make the changes.

This information is critical to you as a provider of services. Companion Guides and Best Practices documents have already been published for the following:

- Eligibility Inquiry & Response (effective date January 15, 2009)
- Health Care Claims (effective date July 15, 2009)
- Professional (837P)
- Institutional (837I)
- Dental (837D)
- Pharmacy Claim and Pharmacy Claim Reversal (NCPDP 5.1)
- Remittance Advice (effective December 15, 2009)

The Data Definition TAG has been working on items such as type of bill, late charges, adjustment, timely filing, COB and attachments.

The Medical Code Tag has been working on each chapter of the CMS Medicare Manual and the results of each chapter review are in the 837I (institutional companion guide) and the 837P (professional companion guide). When the group purchasers agreed that Medicare is the preferred coding method, a notation is in the guide stating "follow Medicare."

When the group did not agree with Medicare, (either Medicare was silent on the service, or Medicare may not cover the service) the TAG decided on ONE way to code for services for commercial business in MN. Specific areas in the guide speak to the method decided by the TAG. As an example, EPSDT, maternity, pediatrics, chiropractic, units of service, bilateral services, and home health visits have specific final rules.

Each group is also working on Best Practices. This is not a rule and is the recommended method for claim submission. You will find information on Best Practices when you visit the web site listed above.

Attention Home Health Agencies



PreferredOne prepared early, and as a contracted PreferredOne Home Health Agency you should have received a letter and notification to begin using the new codes for services after April 1, 2008.

After much discussion, (Medicare G codes and Prospective Payment Method vs S codes, T codes) the tag agreed upon the following (you can find this information in the companion guides at the web site for the AUC):

For Medicare – follow Medicare rules (e.g., G codes for Medicare prospective payment system) *Page 4...*

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For all other payers, report the following:

- Use UB04- 837I (institutional) with appropriate Revenue Codes 041X-044X and 055X – 060X
- Skilled nurse encounter visit (per diem) (up to 2 hours) RN T1030
- Skilled nurse encounter visit (per diem) (up to 2 hours) LPN T1031

Report extended **continuous** services **beyond** the encounter by adding the 15 minute code.

- RN services up to 15 minutes (per 15 minutes) T1002
- RN complex up to 15 minutes (per 15 minutes) T1002 TG
- LPN services up to 15 minutes (per 15 minutes) T1003
- LPN complex services up to 15 minutes (per 15 minutes) T1003TG

As an example, a health plan that has prior authorized 6 hours of RN care would be reported as: T1030 1 unit (this includes services up to the first 2 hours of the day + T1002 16 units (4 units X 4 more hours).

- Home Health Aide Visit/Per Visit T1021
- Home Health Aide Extended (Up to 15 Minutes) T1004
- Physical Therapy Visit S9131
- Occupational Therapy S9129
- Respiratory Therapy Evaluation S5180
- Respiratory Therapy Visit S5181
- Speech Visit S9128
- MSW Visit S9127
- Dietician visit S9465

Personal Care is reported on 837P (Professional Claim).

- Home Health Aide up to 15 minutes (Per 15 Minutes) T1004
- PCA (Per 15 Minutes) T1019
- PCA Shared 1:1 T1019 TT
- RN PCA Supervision T1019 UA

Home Infusion -

Home Infusion nursing & services are reported on 837P using per diem “S” codes as appropriate for therapy provided.

- Nurse Visit Home Infusion, per visit, up to 2 hours 99601
- Each additional hour 99602

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Binaural Hearing Aids

Beginning with January 1, 2009 dates of service, PreferredOne will require 1 unit, (1 unit of 2) when billing for bilateral hearing aids. We have increased our fee schedule to be compliant with administrative simplification due July 2009.

Modifiers for APC Billing

Hospitals are encouraged to report all appropriate Medicare APC modifiers to PreferredOne. For administrative simplification do not change your method of reporting services when modifiers are required for CCI edits. PreferredOne will accept all APC modifiers on UB04 (837I) claims.

Sensory Integration for Eating Disorder Services 1/1/2009

CPT code 97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one to one) patient contact by the provider, each 15 minutes.

This is the most appropriate code to use when submitting services for sensory eating disorders. The use of this code does not guarantee payment of the service. Reimbursement is dependent upon member benefits and medical necessity. Clinical information will be required for review.

Medical Policy Update



Medical Policies are available on the PreferredOne website to members and to providers without prior registration. The website address is www.PreferredOne.com. Click on Health Resources and choose Medical Policy from the menu.

PreferredOne purchased Milliman Care Guidelines to help in making medical necessity determinations. Milliman is a national vendor for care guidelines. Our on-going evaluation of the guidelines continues. If PreferredOne has criteria we decide if we will continue to follow PreferredOne criteria or adopt Milliman Care guidelines. **Milliman Guidelines cannot be posted on our website, however, copies of individual guidelines are available upon request.** As always, benefits need to be available before a medical necessity determination can be made.

Since our last newsletter, the Medical/Surgical Quality Management Committee has approved the following:

New Policies and Criteria -

Criteria and Medical Policies are developed to provide guidelines for making medical necessity determinations

- MC/F022 Cervical Disc Arthroplasty (**Exhibit H**)
- MC/G009 Laser Surgery for Psoriasis (**Exhibit I**)
- MP/H006 Hearing Devices provides guidelines for use of auditory devices. (**Exhibit J**)

Milliman Criteria modified and adopted for use at PreferredOne -

These criteria are not available to attach to this newsletter. They will be posted on the PreferredOne internet website by 10/1/08.

- MC/F021 Bone Growth Stimulators
- MC/F023 Intrathecal Pump Implantation *Page 6...*

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- MC/L009 Intensity Modulated Radiation Therapy (IMRT)

Updated Criteria -

- MC/L004 Coronary Computed Tomography (CT) Angiography was modified to include adding a bypass for PreferredOne Designated Centers and added additional indications for use of this procedure. (Exhibit K)
- MC/F019 Back and Neck Surgery removed listing of PreferredOne designated programs. These can be found on the internet. (Exhibit L)
- MC/G008 Hyperhidrosis Surgery. Deleted review for iontophoresis due to infrequent use for this diagnosis. Botulinum toxin was removed as it has become the standard of care. (Exhibit M)
- PC/B003 Botulinum Toxin. Clarifications to initial use indications. (Exhibit N)
- MC/L003 3D Interpretation of Imaging. Deleted indication for mammography from criteria because digital mammography is a covered expense. However, 3D interpretation of breast MRIs is not covered. (Exhibit O)
- MC/C008 Strabismus Repair. Added definition of congenital strabismus and deleted requirement that strabismus be due to recent trauma or disease. (Exhibit P)

Nine PreferredOne Criteria or Medical Policies were retired. Six were replaced with a Medical Policy or a Milliman Guideline -

- MC/G006 Gynecomastia Procedures: Retired and replaced by Milliman Guideline A-0273.
- MC/N001 Acute Inpatient Rehabilitation: Retired and replaced by Medical Policy MP/R003. (Exhibit Q)
- MC/N002 Skilled Nursing Facilities: Retired and replaced by Medical Policy MP/S011. (Exhibit R)
- MC/T001 Bone Marrow/Stem Cell Transplantation: Retired and replaced with Milliman Guideline A-0376.
- MC/A006 Ventricular Assist Device (VAD): Retired and replaced by Milliman Guideline A-0477.
- MC/C001 Rhinoplasty: Retired and replaced by Milliman Guideline A-0184.
- MC/L007 Mobile Cardiac Telemetry (CardioNet): Retired due to low utilization of this technology and all requests for use have been found to be medically appropriate.
- MC/LOO5 Virtual Colonoscopy: Retired.
- MP/S010 Stereotactic Radiosurgery (Cyberknife/Gamma Knife): Retired.

Deletions to the Investigational List -

- Computer-Assisted Navigation for Appendicular Skeletal Orthopedic Procedures: This technology is no longer considered investigational; however, PreferredOne has decided that no additional payment will be made for utilization of this technology.
- Autogenous Bone Marrow Injection into Allografts of Spinal Fusions

Additions to Investigational List -

- Annular Repair
- Cryoablation of Renal Tumors
- Percutaneous Discectomy

Medical Management

Pharmacy Department Update



Pharmacy Policies and Criteria are available on the PreferredOne website to members and to providers without prior registration. The website address is www.PreferredOne.com. Click on Health Resources in the upper left-hand corner and choose the Medical Policy Menu.

Since our last newsletter, the Pharmacy and Therapeutics Quality Management Committee has approved the following:

Pharmacy Policies -

- PP/C002 Cost Benefit Programs: Additional drugs added to this program
- PP/002 Dosing Optimizing Program: Lipitor half tab requirement removed from policy
- PP/P002 Pharmacy Programs for ClearScripts: Drug lists updated
- PP/Q001 Quantity Limits per Prescription per Copayment: New drugs/quantity limits added

Pharmacy Criteria -

- PC/B008 Beta-Blocker Step Therapy: Drug lists updated.
- PC/C002 Cyclooxygenase-2 (COX-2) Inhibitors: Drug tables updated. Added exception for patients with documented history of GI bleed from duodenal or gastric ulcer.
- PC/C003 Topical Corticosteroid Step Therapy: Drug tables updated.
- PC/L002 Leukotriene Pathway Inhibitor Step Therapy: Drug tables updated.
- PC/L003 Lyrica Step Therapy: Expanded FDA approved indications included. Drug tables updated.
- PC/O001 Overactive Bladder Medication Step Therapy: Drug tables updated.
- PC/P001 Proton Pump Inhibitor (PPI) Step Therapy: Drug tables updated. Added exception for patients with difficulty swallowing.
- PC/S002 Selective Serotonin Reuptake Inhibitors (SSRI) Step Therapy for Adults: Drug tables updated
- PC/S003 Sedative Hypnotics Step Therapy: Drug tables updated. Added exceptions allowing Sonata for a specific indication.
- PC/X001 Xolair (omalizumab): Criteria retired.

2009 PreferredOne Formulary

PreferredOne utilizes the ExpressScripts National Preferred formulary for its members who have ExpressScripts as their Pharmacy Benefit Manager (PBM). This formulary undergoes a complete review annually with all changes taking effect in January of each year. Attached is the 2009 ExpressScripts formulary (**Exhibit S**) as well as a list of the medications that are changing formulary status (formulary to nonformulary and nonformulary to formulary) as of January 1, 2009. (**Exhibit T**)

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.

Medical Management

PreferredOne Health & Wellness Update

PreferredOne members have access to discounted wellness programs and a free personal health risk assessment by going to www.PreferredOne.com. Please encourage your PreferredOne members to take advantage of these programs. After logging in, members can select the “Health Resources” link and take advantage of:

- Weight Watchers.com - receive \$10.00 off the online 3 month program
- 2ndWind Exercise Equipment - receive discounts on exercise equipment
- Corporate Fitness Products - receive a 10% discount on items such as yoga mats, hand weights, exercise DVDs and much more

PreferredOne Health Assessment

The PreferredOne Health Assessment is a free onetime comprehensive health risk assessment designed to give our members an evaluation of their current health status. The PreferredOne Health Assessment is a self scored appraisal with immediate feedback via a private/secure Web link and creates a baseline from which you can make life-style modifications to help you live a healthier lifestyle.

Quality Management Update

2008 Medical Record Documentation Assessment

PreferredOne requires member medical records to be maintained in a manner that is detailed, current and complete to promote safe and effective care, and stored in a manner that is organized and secure to maintain the confidentiality of the member’s health history and allow access. Attached you will find the current Quality Management policy for medical record documentation guidelines (**Exhibit U**). Both the Minnesota Department of Health (MDH) and the National Committee for Quality Assurance (NCQA) require health plans to assess and measure compliance with developed medical record documentation guidelines. Compliance with the attached standards was recently assessed in the spring of 2008 in conjunction with HEDIS medical record data abstraction. Analysis of this year's results revealed several opportunities for improvement among our network practitioners. The following are areas where needed improvement by clinics was documented:

- Personal biographical data (includes all - name, address, DOB, sex, telephone number)
- Current immunization record maintained
- Evidence of Continuity and Coordination of Care documentation between primary care practitioner and consultants

Please review these guidelines and your clinic operations to ensure your medical record keeping system is compliant.

Update on HEDIS Technical Specifications

NCQA has introduced several new measures that PreferredOne will be collecting data on in conjunction with our 2009 Healthcare Effectiveness Data Information Set (HEDIS) chart abstraction process. 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. The new measures for 2009 include:

- **Adult Body Mass Index (BMI) Assessment**
This measure examines the percentage of members 18-74 years of age who had an outpatient office visit and had their BMI documented.

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- **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**
This measure examines the percentage of members 2-17 years of age who had an outpatient office visit and who had evidence of BMI percentile assessment, counseling for nutrition and counseling for physical activity.

PreferredOne will be examining medical records for documentation to support these measures in early 2009. If you have questions about these measures you may visit NCQA's website at www.ncqa.org or contact us at quality@preferredone.com.

If You Do Not Accept New Patients...

PreferredOne is asking all physicians to submit information regarding acceptance of new patients. If you are a clinic site who has a provider that is **not accepting new patients** you can go to www.PreferredOne.com, select "For Providers", login, select "Your Clinic Provider Maintenance" and edit the "Accepting New Patients" information.

If you are unable to access the provider secure website, you may email notification to PreferredOne at quality@preferredone.com. We ask that you include your contact information, clinic(s) name, address, provider name and NPI number of those no longer accepting new patients.

Provider Directories will be updated with this information.

PreferredOne

DEPARTMENT:	Pricing and Payment	APPROVED DATE:	9/11/2008
POLICY DESCRIPTION:	Present on Admission Indicator		
EFFECTIVE DATE:	01/01/2009		
PAGE:	1 of 1	REPLACES POLICY DATED:	
REFERENCE NUMBER:	003	RETIRED DATE:	

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

PURPOSE: To capture the present on admission indicator on the claim for purposes of correctly grouping the diagnoses into the proper DRG.

POLICY: For discharges occurring on or after January 1, 2009, hospitals are required to submit the present on admission indicator for principal diagnosis and other diagnoses codes reported on claim forms UB-04 and 837 Institutional

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

DEFINITIONS: Present on Admission (POA) is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.

PROCEDURE:

1. The POA should be submitted on principal diagnosis and other diagnoses codes reported on claim forms UB-04 and 837 Institutional.
2. The POA Indicator Options and Definitions are as follows:
 - Y – Diagnosis was present at time of inpatient admission
 - N – Diagnosis was not present at time of inpatient admission
 - U – Documentation insufficient to determine if the condition was present at the time of inpatient admission.
 - W – Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission

DEPARTMENT:	Pricing and Payment	APPROVED DATE:	9/11/2008
POLICY DESCRIPTION:	Present on Admission Indicator		
EFFECTIVE DATE:	01/01/2009		
PAGE:	2 of 2	REPLACES POLICY DATED:	
REFERENCE NUMBER:	003	RETIRED DATE:	

- 1 – Unreported/Not used. Exempt from POA reporting.
3. Claims that are submitted for payment that do not contain proper reporting of the POA indicator will be returned to the provider.
 4. The codes that are listed as exempt from Diagnosis Present on Admission Requirement in the ICD-9-CM Official guidelines for Coding and Reporting effective October 1, 2007 are exempt from this requirement.

Other References:

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 9/11/2008
POLICY DESCRIPTION:	Late Charges\Corrected Claims	
EFFECTIVE DATE:	01/01/2009	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER: 002		RETIRED DATE:

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

PURPOSE: To ensure timeliness of the claims adjudication process and to decrease adjustments, manual intervention, incorrect payment and rework.

POLICY: PreferredOne will not accept any billings that include only late charges.

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

DEFINITIONS: A late charge refers to those charges that are submitting after the original admit-through-discharge claim. A late charge is defined as those charges omitted from the original billing.

PROCEDURE:

1. To assure correct adjudication and payment of services, PreferredOne requires all related services to be submitted on a single facility claim (UB-04 or 837I).
2. A late charge must be billed as a corrected claim. A corrected claim is required using the type of bill XX7 to indicated that it is a corrected claim. Late charges billed in any other format will be denied back to the provider.
3. All corrected claims must be received in our office within 60 days of remittance date of the original claim.

PreferredOne

DEPARTMENT:	Pricing and Payment	APPROVED DATE: 9/11/2008
POLICY DESCRIPTION:	Revenue Codes Requiring CPT/HCPCS	
EFFECTIVE DATE:	01/01/2009	
PAGE:	1 of 1	REPLACES POLICY DATED:
REFERENCE NUMBER:	004	RETIRED DATE:

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

PURPOSE: To capture HCPCS/CPT codes for all outpatient services when the revenue code requires a HCPCS/CPT according to Centers of Medicare & Medicaid guidelines.

POLICY: PreferredOne requires a HCPCS/CPT to be submitted with the revenue code for claims submitted on a UB04 or 837 Institutional for outpatient services

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:

- The following revenue codes will require a HCPCS/CPT code for all outpatient services submitted on a UB04 or 837 Institutional claim form.

261	43x	722	812
274	44x	723	813
30x	45x	724	814
31x	46x	729	90x
32x	47x	73x	91x
33x	48x	74x	92x
34x	51x	75x	940
35x	53x	760	941
36x	54x	761	943
38x	61x	769	949
39x	623	77x	95x
40x	634	78x	
41x	635	79x	
42x	636	811	

DEPARTMENT:	Pricing and Payment	APPROVED DATE: 9/11/2008
POLICY DESCRIPTION:	Revenue Codes Requiring CPT/HCPCS	
EFFECTIVE DATE:	01/01/2009	
PAGE:	2 of 2	REPLACES POLICY DATED:
REFERENCE NUMBER:	004	RETIRED DATE:

2. Claims without the required HCPCS/CPT will be returned to the provider.

Other References:

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE:	9/11/2008
POLICY DESCRIPTION:	Timely Filing		
EFFECTIVE DATE:	01/01/2009		
PAGE:	1 of 1	REPLACES POLICY DATED:	
REFERENCE NUMBER:	001	RETIRED DATE:	

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

PURPOSE: To ensure timeliness of the claims adjudication process.

POLICY: All claims must be received by PreferredOne with 120 days of the covered service or discharge date whichever is later or within 60 days of the date of the primary payor's explanation of benefits.

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

DEFINITIONS: Timely filing is the time limit placed on the provider to submit a claim to PreferredOne for the adjudication of the claim based on the member benefit.

PROCEDURE:

1. All claims must be received by PreferredOne within 120 days of the covered service or discharge date whichever is later. Any claim received after 120 days of the covered service or discharge date will be denied.
2. All secondary claims must be received by PreferredOne with 60 days of the date of the primary payor's explanation of benefits. Any claims received after 60 days of the date of the primary payor's explaining of benefits will be denied.
3. All appeals from a denial for timely filing must be received by PreferredOne within 60 days of the date of the initial denial. Any appeal received after 60 days of the date of the initial denial will not be processed and the original denial will become final.
4. In no event will PreferredOne be obligated to pay claims submitted more than 365 days after the date of service or discharge date.

PreferredOne®

Department of Origin: Network Management	Approved by: Vice President of Network Management	Date approved:
Department(s) Affected: Network Management	Effective Date: August 1, 2008	
Policy Description: Adverse Health Care Events	Replaces Effective Policy Dated:	
Reference #: NM019	Page:	1 of 2

PRODUCT APPLICATION:

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

PURPOSE:

The intent of this policy is to inform facilities of PreferredOne's policy on Adverse Health Care Events and the process for which to inform PreferredOne of an Adverse Health Care Event. This policy is in accordance with the Minnesota Adverse Health Care Events Reporting Act of 2003.

POLICY:

Facility will not seek reimbursement from PreferredOne, its affiliates or any PreferredOne member for services associated with an Adverse Health Care Event. Facility must inform PreferredOne, in writing, of any Adverse Health Care Event as it pertains to a PreferredOne member. Please see the attached Case Review form.

PROCEDURE:

Facility Responsibility

1. Facility must maintain policies and procedures on the reporting of Adverse Health Care Events. These policies and procedures must comply with the Minnesota Adverse Health Care Events Reporting Act of 2003.
2. Facility will notify PreferredOne using the Case Review form of any Adverse Health Care Event that pertains to any PreferredOne member.
3. Facility will not seek reimbursement from PreferredOne, its affiliates, or any PreferredOne member for services associated with an Adverse Health Care Event.

PreferredOne Responsibility

1. PreferredOne will review all Case Review forms received from facility and make case specific determinations on liability as it relates to PreferredOne, its affiliates or members.
2. In the event PreferredOne, its affiliates or members have reimbursed facility for an Adverse Health Care Event, PreferredOne will initiate a formal case review. Facility will return any monies to the appropriate parties.
3. All case information will be held confidential and in accordance with Minnesota Statute.

REFERENCES:

Minnesota Law defines an Adverse Health Care Events as the following:
See the Minnesota Statute for the full text description of each individual event.

Surgical Event

1. Surgery performed on the wrong body part
2. Surgery performed on the wrong patient.
3. The wrong surgical procedure performed on a patient.
4. Foreign objects left in a patient after surgery.
5. Death during or immediately after surgery of a normal, healthy patient.

Environmental Events

6. An electric shock
7. A burn incurred while being cared for in a facility
8. A fall while being cared for in a facility
9. The use of or lack of restraints or bedrails while being cared for in a facility.
10. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.

PreferredOne®

Department of Origin: Network Management	Approved by: Vice President of Network Management	Date approved:
Department(s) Affected: Network Management	Effective Date: August 1, 2008	
Policy Description: Adverse Health Care Events	Replaces Effective Policy Dated:	
Reference #: NM019	Page:	2 of 2

Patient Protection Events

11. An infant discharged to the wrong person.
12. Patient death or serious disability associated with patient disappearance.
13. Patient suicide or attempted suicide resulting in serious disability.

Care Management Events

14. Patient death or serious disability associated with a medication error
15. Patient death or serious disability associated with a reaction due to incompatible blood or blood products.
16. Patient death or serious disability associated with labor or delivery in a low-risk pregnancy.
17. Patient death or serious disability directly related to hypoglycemia (low blood sugar)
18. Patient death or serious disability in newborn infants during the first 28 days of life.
19. Patient death or serious disability due to spinal manipulative therapy.
20. Stage 3 or 4 ulcers (very serious pressure sores) acquired after admission to a facility.

Product or Device Events

21. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics.
22. Patient death or serious disability associated with the use or malfunction of a device in patient care.
23. Patient death or serious disability associated with an intravascular air embolism.

Criminal Events

24. An instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
25. Abduction of a patient of any age.
26. Sexual assault on a patient within or on the grounds of a facility.
27. Death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

ATTACHMENTS:

Case Review form.

DOCUMENT HISTORY:

Created Date: 5/15/2008
Reviewed Date:
Revised Date:

PreferredOne®

Adverse Health Event Case Review

MEMBER NAME: _____ MEMBER NUMBER: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: F M (circle)

Date of AHE Occurrence: _____ Date Reported: _____

Reported By: _____ Phone Number: _____

Facility Name (location of AHE)	Facility Type (hospital, clinic, surgery center)

SUMMARY OF EVENT:

Please indicate which type of AHE occurred (see attached)

<input type="checkbox"/> Surgical	<input type="checkbox"/> Care Management	<input type="checkbox"/> Number	Description _____
<input type="checkbox"/> Product or Device	<input type="checkbox"/> Environmental		_____
<input type="checkbox"/> Patient Protection	<input type="checkbox"/> Criminal		_____

Please send report under confidential cover to:

PreferredOne
Attn:
6105 Golden Hills Drive
Golden Valley, MN 55416
(fax)

Surgical Events

- (1) surgery performed on a wrong body part that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
- (2) surgery performed on the wrong patient;
- (3) the wrong surgical procedure performed on a patient that is not consistent with the documented informed consent for that patient. Reportable events under this clause do not include situations requiring prompt action that occur in the course of surgery or situations whose urgency precludes obtaining informed consent;
- (4) retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained; and
- (5) death during or immediately after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or Device Events

- (6) patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the facility when the contamination is the result of generally detectable contaminants in drugs, devices, or biologics regardless of the source of the contamination or the product;
- (7) patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. "Device" includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators; and
- (8) patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient Protection Events

- (9) an infant discharged to the wrong person;
- (10) patient death or serious disability associated with patient disappearance, excluding events involving adults who have decision-making capacity; and
- (11) patient suicide or attempted suicide resulting in serious disability while being cared for in a facility due to patient actions after admission to the facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the facility.

Care management events

- (12) patient death or serious disability associated with a medication error, including, but not limited to, errors involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose;
- (13) patient death or serious disability associated with a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products;
- (14) maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy;
- (15) patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a facility;
- (16) death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. "Hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter;
- (17) stage 3 or 4 ulcers acquired after admission to a facility, excluding progression from stage 2 to stage 3 if stage 2 was recognized upon admission;
- (18) patient death or serious disability due to spinal manipulative therapy; and
- (19) artificial insemination with the wrong donor sperm or wrong egg.

Environmental Events

- (20) patient death or serious disability associated with an electric shock while being cared for in a facility, excluding events involving planned treatments such as electric countershock;
- (21) any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;
- (22) patient death or serious disability associated with a burn incurred from any source while being cared for in a facility;
- (23) patient death or serious disability associated with a fall while being cared for in a facility; and
- (24) patient death or serious disability associated with the use or lack of restraints or bedrails while being cared for in a facility.

Criminal Events

- (25) any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;
- (26) abduction of a patient of any age;
- (27) sexual assault on a patient within or on the grounds of a facility; and
- (28) death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

PreferredOne

DEPARTMENT:	Coding Reimbursement	APPROVED DATE:	8/1/2008, 10/1/2007
POLICY DESCRIPTION:	Transfer from Acute Facility to another Acute Facility		
EFFECTIVE DATE:	1/1/08		
PAGE:	1 of 1	REPLACES POLICY DATED:	
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 lesser 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)
 - 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)

DEPARTMENT: Coding Reimbursement **APPROVED DATE:** 8/1/2008, 10/1/2007

POLICY DESCRIPTION: Transfer from Acute Facility to another Acute Facility

EFFECTIVE DATE: 1/1/08

PAGE: 2 of 1

REFERENCE NUMBER: H - 8

REPLACES POLICY DATED:

RETIRED DATE:

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

PreferredOne

DEPARTMENT:	Coding Reimbursement	APPROVED DATE:	9/22/2008, 10/1/2007
POLICY DESCRIPTION:	Readmission within 5 Days		
EFFECTIVE DATE:	1/1/08		
PAGE:	1 of 1	REPLACES POLICY DATED:	
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. The following DRGs are excluded from this policy:

DRG Version 24: 370 – 375, 385-391, 462

MS-DRG Version 25: 765 - 768, 774 - 775, 789 – 795, 945, 946

DEFINITIONS:

REFERENCES: Contract Definition of Enrollee

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Cervical Disc Arthroplasty (Artificial Cervical Disc)	Replaces Effective Policy Dated: N/A	
Reference #: MC/F022	Page:	1 of 3

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Spinal Instability:

According to the American Academy of Orthopaedic Surgeons, instability is defined as an abnormal response to applied loads, characterized by movement in the motion segment beyond normal constraints. A motion segment is the smallest functional spinal unit exhibiting the generic biomechanical characteristics of the spine. It consists of two adjacent vertebrae, an intervertebral disc, various ligaments and apophyseal joints. Stability to the motion segment is provided by the ligaments, facet joints and intervertebral discs which restrict its range of movements.

BACKGROUND:

This criteria set is based on expert consensus opinion and/or available reliable evidence.

Artificial cervical intervertebral disc must be FDA approved for the spinal level of intended use.

GUIDELINES:

One of the following I or II:

- I. Surgery will be performed by a PreferredOne designated surgeon
- II. Surgery not performed by a PreferredOne designated surgeon – one of the following A or B and none of C:

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Cervical Disc Arthroplasty (Artificial Cervical Disc)	Replaces Effective Policy Dated: N/A	
Reference #: MC/F022	Page: 2 of 3	

- A. Acute onset of pain with neurological changes or chronic pain with acute neurological changes - all of the following 1 – 4:
1. Patient is over 18 years of age; and
 2. Imaging studies document all of the following a – g; and
 - a. Single level cervical degenerative disc disease
 - b. Primarily anterior or disc related pathology is identified
 - c. Radiculopathy and/or myelopathy correlates with imaged degenerative changes
 - d. Disc height is preserved
 - e. No significant facet arthritis evident on imaging
 - f. No previous surgery at involved level
 - g. Normal motion at diseased level is preserved and there is no instability
 3. Documentation of functional impairment; and
 4. Documentation that surgeon has been trained and certified by Medtronic for the Prestige artificial disc or similar training by the manufacturer for other types of FDA approved discs.
- B. Chronic pain – both A and B:
1. Patient has completed a comprehensive rehabilitation program at a PreferredOne designated facility or a facility determined by PreferredOne to be equivalent with no resolution of symptoms; and
 2. Patient meets all guidelines outlined under acute pain above
- C. Contradictions to surgery – none of the following 1 - 8:
1. Any cervical spinal condition other than symptomatic cervical disc disease requiring surgical treatment at the involved level (i.e. significant cervical kyphosis, spondylolisthesis, severe segmental ankylosis, significant facet disease at the involved disc level, combined significant anterior-posterior disease, combination of anterior and posterior disease)
 2. Multi-level disease
 3. Documented cervical disc instability
 4. Previous surgical intervention at the involved level
 5. Spinal metastases or tumor
 6. Previous diagnosis of osteopenia, osteomalacia or osteoporosis
 7. Presence of infection
 8. Allergy to stainless steel

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Cervical Disc Arthroplasty (Artificial Cervical Disc)	Replaces Effective Policy Dated: N/A	
Reference #: MC/F022	Page:	3 of 3

RELATED CRITERIA/POLICIES:

Medical Management Process Manual MI007 Use of Medical Policy and Criteria
 Medical Criteria MC/F019 Back and Neck Surgery
 Medical Policy MP/C009 Medical Step Therapy

REFERENCES:

1. Mummaneni PV, Burkus JK, Haid RW, Traynelis VC, Zdeblick TA. Clinical and radiographic analysis of cervical disc arthroplasty compared with allograft fusion: a randomized controlled clinical trial. J Neurosurg Spine 2007 Mar;6(3):198-209.
2. Nabhan A, Ahlhelm F, Shariat K et al. The ProDisc-C prosthesis: clinical and radiological experience 1 year after surgery. Spine. 2007 Aug 15;32(18):1935-41.
3. Peng-Fei S, Yu-Hua J. Cervical disc prosthesis replacement and interbody fusion – a comparative study. Int Orthop. 2008 Feb;32(1):103-6.
4. Pickett GE, Sekhon LH, Sears WR, Duggal N. Complications with cervical arthroplasty. J Neurosurg Spine. 2006 Feb;4(2):98-105.
5. Rabin D, Pickett GE, Bisnaire L, Duggal N. The kinematics of anterior cervical discectomy and fusion versus artificial c cervical disc: a pilot study. Neurosurgery. 2007 Sep;61(3 Suppl):100-4.
6. Sasso RC, Smucker JD, Hacker RJ, Heller JG. Artificial disc versus fusion: a prospective, randomized study with 2-year follow-up on 99 patients. Spine. 2007 Dec 15;32(26):2933-40.
7. Sears WR, Sekhon LH, Duggal N, Williamson OD. Segmental malalignment with the Bryan Cervical Disc prosthesis – does it occur? J Spinal disord Tech. 2007 Feb;20(1):1-6.
8. Tortolani PJ, Cunningham BW, Eng M, McAfee PC, Holsapple GA, Adams KA. Prevalence of heterotopic ossification following total disc replacement. A prospective, randomized study of two hundred and seventy-six patients. J Bone Joint Surg Am. 2007 Jan;89(1):82-8.

DOCUMENT HISTORY:

Created Date: 09/23/08
Reviewed Date:
Revised Date:

PreferredOne®

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Laser Treatment for Psoriasis	Replaces Effective Policy Dated: N/A	
Reference #: MC/G009	Page:	1 of 2

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

BACKGROUND:

This criteria set is based on expert consensus opinion and/or available reliable evidence.

GUIDELINES:

Treatment of psoriasis with Excimer or pulsed dye laser one of the following I – III and not IV

- I. Initial course of therapy (a course of therapy may consists of up to 13 treatments) – both of the following A and B:
 - A. Documentation of mild to moderate localized plaque psoriasis affecting 10% or less of their body surface area; and
 - B. Failure to respond to three or more months of topical medications and phototherapy:
- II. Requests for second and third course of therapy in a year – documentation of reduction in Psoriasis Area and Severity Index (PASI) score or other objective response measurement.
- III. Requests for more than three courses of therapy in a year – case review
- IV. Patient is not on a biologic for the treatment of psoriasis (Enbrel, Humira, Amevive, Raptiva, or Remicade)

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Laser Treatment for Psoriasis	Replaces Effective Policy Dated: N/A	
Reference #: MC/G009	Page: 2 of 2	

RELATED CRITERIA/POLICIES:

Medical Management Process Manual MI007 Use of Medical Policy and Criteria
 Medical Policy MP/C009 Medical Step Therapy


REFERENCES:

1. Erceg A, Bovenschen HJ, vande Kerkhof PC, Seyger MM. Efficacy of the pulsed dye laser in the treatment of localized recalcitrant plaque psoriasis: a comparative study. Br J Dermatol. 2006 Jul;155(1):110-4.
2. de Leeuw J, Tank B, Bjerring PJ, Koetsveld S, Neumann M. Concomitant treatment of psoriasis of the hands and feet with pulsed dye laser and topical calcipotriol, salicylic acid, or both: a prospective open study in 41 patients. J Am Acad Dermatol. 2006 Feb;54(2):266-71.
3. Ilknur T, Akarsu S, Aktan S, Ozkan S. Comparison of the effects of pulsed dye laser, pulsed dye laser and salicylic acid, and clobetasole propionate and salicylic acid on psoriatic plaques. Dermatol Surg. 2006 Jan;32(1):49-55.
4. Pahlajani N, Katz BJ, Lozano AM, Murphy F, Gottlieb A. Comparison of the efficacy and safety of the 308 nm excimer laser for the treatment of localized psoriasis in adults and in children: a pilot study. Pediatr Dermatol. 2005 Mar-Apr;22(2):161-5.
5. Passeron T, Ortonne JP. Use of the 308-nm excimer laser for psoriasis and vitiligo. Clin Dermatol. 2006 Jan-Feb;24(1):33-42.
6. Taibjee SM, Cheung ST, Laube S, Lanigan SW. Controlled study of excimer and pulsed dye lasers in the treatment of psoriasis. Br J Dermatol. 2005 Nov;153(5):960-6.
7. Zakarian K, Nguyen A, Letsinger J, Koo J. Excimer laser for psoriasis: a review of theories regarding enhanced efficacy over traditional UVB phototherapy. J Drugs Dermatol. 2007 Aug;6(8):794-8.

DOCUMENT HISTORY:

Created Date: 09/23/08
Reviewed Date:
Revised Date:

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Department of Origin: Medical Management	Approved by: Chief Medical Officer 	Date Approved: 03/31/08
Department(s) Affected: Medical Management	Effective Date: 03/31/08	
Medical Policy Document: Hearing Devices	Replaces Effective Policy Dated: N/A	
Reference #: MP/H006	Page:	1 of 4

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This policy applies to PAS enrollees only when the employer group has elected to provide benefits for the service/procedure/device. Check benefits in SPD/COC. If benefits not specifically addressed in the SPD/COC verify with the appropriate account manager the availability of benefits.

The policy applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this policy is to provide coverage guidelines for auditory devices.

DEFINITIONS:

Auditory Brainstem Implants:

ABI is the first device specifically designed to bypass the cochlea and the auditory nerve to transmit sound directly to the brainstem. The ABI is placed directly on the nerve center (cochlear nucleus).

Cochlear Implants:


A Cochlear implant is a surgically implanted electronic device that provides a sense of sound to a person who is profoundly deaf or severely hard of hearing. The cochlear implant is often referred to as a bionic ear. Unlike hearing aids, the cochlear implant does not amplify sound, but works by directly stimulating any functioning auditory nerves inside the cochlea with electrical impulses. External components of the cochlear implant include a microphone, speech processor and transmitter which also allows an individual to adjust the sound for quality and amplification. Since a cochlear implant directly stimulates the auditory nerve it is not considered a hearing aid.

Healthcare Service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Hearing Aid:

Hearing aids can be generally subdivided into air conduction hearing aids and bone conduction hearing aids. Air conduction hearing aids require the use of ear molds. External bone conduction hearing aids function by transmitting sound waves through the bone to the ossicles of the middle ear. According to Centers for Medicare and Medicaid Services (CMS), any device that does not directly stimulate the auditory nerve is a hearing aid.

Department of Origin: Medical Management	Approved by: Chief Medical Officer 	Date Approved: 03/31/08
Department(s) Affected: Medical Management	Effective Date: 03/31/08	
Medical Policy Document: Hearing Devices	Replaces Effective Policy Dated: N/A	
Reference #: MP/H006	Page:	2 of 4

Semi-implantable Bone Anchored Hearing Aid (BAHA):

A hearing aid allowing sound conduction via vibrations through the skull instead of air-conduction as seen in a standard hearing aid. The devices have an implant that is surgically implanted into the mastoid bone of the skull. The sound processor vibrates the implant which in turn vibrates the temporal bone. The vibration is then transmitted through other bones to the cochlea of the opposite ear where it creates the sensation of sound. The BAHA does not directly stimulate the auditory nerve thus it is considered a hearing aid.

Semi-implantable Middle Ear Hearing Aid (Vibrant Soundbridge):

Consists of two components, an internally implanted Floating Mass Transducer (FMT) and an externally worn Audio Processor (AP). The AP picks up sound from the environment and transmits that sound across the skin to the implanted receiver. The implanted receiver converts the signal and transmits it to the FMT, which is a transducer that directly vibrates the ossicles by mimicking the natural motion of the ossicular chain, sending an enhanced signal to the fluid-filled inner ear (cochlea). The ossicular motion creates movement in the cochlea stimulating the hair cells, which in turn provide stimuli to the auditory nerve, which are then interpreted by the brain as sound. Unlike the cochlear implant, the Vibrant Soundbridge is not a prosthetic replacement for the ear; rather, the Vibrant Soundbridge acts as a hearing aid in amplifying sounds

BACKGROUND:

Minnesota State mandate (62Q.675) requires coverage of hearing aids for members who are 18 years of age and younger for hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid in each ear every three years. No special deductible, coinsurance, co-payment, or other limitation on the coverage under this section that is not generally applicable to other coverage under the plan may be imposed.

The Branemark Bone-Anchored Hearing Aid (BAHA) system was FDA approved in 1995 for adult patients with malformations of the external ear, chronically draining ear, a pure tone threshold hearing loss of greater than or equal to 45 decibels, and/or inability to use an air conduction hearing aid. The FDA approval was extended in 1999 to include children five years of age and older. In 2002 the BAHA was approved for single-sided deafness due to sensorineural deafness. Use of bilateral bone-anchored hearing aids has not been reported to increase the ability to determine the direction of a sound source due to the cross-hearing of bone conducted sound.


POLICY:

PCHP/applicable PAS Plan Administrator will cover medically necessary, physician prescribed hearing devices subject to the guidelines listed below if eligible under the applicable COC/SPD benefit summary. Questions regarding eligibility and/or prior authorization requirements should be directed to the Customer Service department. The appropriate telephone number is listed on the back the enrollee's insurance card.


GUIDELINES:

One of the following I - IV:

- I. Hearing Aids (unilateral or bilateral)
 - A. Air conduction hearing aids (i.e. in the ear canal, completely in the canal, behind the ear, on the body hearing aid, contralateral routing of sound)
 - 1. Benefits must be available for hearing aids

Department of Origin: Medical Management	Approved by: Chief Medical Officer 	Date Approved: 03/31/08
Department(s) Affected: Medical Management	Effective Date: 03/31/08	
Medical Policy Document: Hearing Devices	Replaces Effective Policy Dated: N/A	
Reference #: MP/H006	Page: 3 of 4	

2. Standard hearing aids will be covered per benefit limits for hearing loss that is not correctable by other covered procedures. Coverage is limited to one hearing aid in each ear every three years.
- B. Bone conduction devices
1. Benefits must be available for hearing aids
 2. Use of a conventional air conduction device is precluded by a medical condition (e.g. microtic ears, small ear canals)
- II. Implantable Hearing Aids (unilateral or bilateral bone-anchored hearing aid or semi-implantable middle ear hearing aid)
- A. Benefits must be available for hearing aids
- B. Device is being used in accordance with its FDA approval guidelines
- C. Documentation is required indicating failure of a trial of a standard air conduction hearing aid, or one of the following reasons why member would not be a candidate for standard air conduction hearing aid 1 – 4:
1. Congenital malformation of the ear that can not be repaired; or
 2. Tumors of the ear canal that can not be excised; or
 3. Otosclerosis in patients that can not undergo stapedectomy; or
 4. Allergic reaction to plastic where air-conduction hearing aid would not be tolerated.
- III. Cochlear Implants (unilateral or bilateral)
- A. Benefits must be available for cochlear implant
- B. Must meet medical necessity criteria outlined by Milliman Care Guidelines: [Cochlear Implant ACG: A-0177\(AC\)](#)

Department of Origin: Medical Management	Approved by: Chief Medical Officer 	Date Approved: 03/31/08
Department(s) Affected: Medical Management	Effective Date: 03/31/08	
Medical Policy Document: Hearing Devices	Replaces Effective Policy Dated: N/A	
Reference #: MP/H006	Page: 4 of 4	

RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)

Medical Policy [MP/C009 Medical Step Therapy](#)

Milliman Care Guidelines: [Cochlear Implant ACG:A-0177\(AC\)](#)

Milliman Care Guidelines: [Auditory Brainstem Implants ACG:A-0410\(AC\)](#)

REFERENCES:

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 11/27/07
Department(s) Affected: Medical Management	Effective Date: 11/27/07	
Medical Criteria Document: Coronary Computed Tomography (CT) Angiography	Replaces Effective Policy Dated: 11/28/06	
Reference #: MC/L004	Page:	1 of 4

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

Chest Pain Syndrome:

Any constellation of symptoms that the physician feels may represent a complaint consistent with obstructive coronary artery disease (CAD). Examples of such symptoms include, but are not exclusive to: chest pain, chest tightness, burning, dyspnea, shoulder pain, and jaw pain.

Computed Tomography Angiography (CTA):

Non invasive images the coronary arteries as an alternative to standard coronary angiograms in detecting and monitoring the status of coronary artery disease. Both electron-beam computed tomography (EBCT) and helical computed tomography, including multislice CT (MSCT) can be used.

Coronary Heart Disease (CHD) Risk:

- * Low Risk is defined by the age-specific risk level that is below average. In general, low risk will correlate with a 10-year absolute CHD risk less than 10%
- * Moderate/Intermediate risk is defined by the age-specific risk level that is average or above average. In general, moderate risk will correlate with a 10-year absolute CHD risk between 10% and 20%.
- * High risk is defined as the presence of diabetes mellitus or the 10-year absolute CHD risk of greater than 20%.

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

BACKGROUND:

This criteria set is based on expert consensus opinion and/or available reliable evidence.

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 11/27/07
Department(s) Affected: Medical Management	Effective Date: 11/27/07	
Medical Criteria Document: Coronary Computed Tomography (CT) Angiography	Replaces Effective Policy Dated: 11/28/06	
Reference #: MC/L004	Page: 2 of 4	

Electron-beam CT (EBCT) uses a gun instead of a standard X-ray tube that allows high speed scanning. Helical or Spiral CT scanning rotates a standard X-ray tube around a patient producing images gathered in a continuous spiral rather than individual slices. Multidetector or Multislice (MDCT, MSCT) uses CT machines equipped with an array of multiple X-ray detectors that simultaneously image multiple sections at a rapid speed. Currently MSCT/MDCT can have 4, 8, 16, 32, or 64 detectors. The higher number of detectors the thinner the slices and the quicker the images can be obtained. The facility providing the service must use equipment and personnel that meet minimum standards of capability for the intended application.

Table 1: Pre-Test Probability of CAD by Age, Gender, and Symptoms*

Age (yrs)	Gender	Typical/Definite Angina Pectoris*	Atypical/Probable Angina Pectoris*	Non-Anginal Chest Pain*	Asymptomatic
30-39	Men	Intermediate	Intermediate	Low	Very Low
	Women	Intermediate	Very Low	Very Low	Very Low
40-49	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Low	Very Low	Very Low
50-59	Men	High	Intermediate	Intermediate	Low
	Women	Intermediate	Intermediate	Low	Very Low
60-69	Men	High	Intermediate	Intermediate	Low
	Women	High	Intermediate	Intermediate	Low

ACC/AHA 2002 Guideline Update for Exercise Testing

*Angina Symptoms: As defined by the ACC/AHA 2002 Guideline Update on Exercise Testing:

- Typical Angina (Definite): 1) Substernal chest pain or discomfort that is 2) provoked by exertion or emotional stress and 3) is relieved by rest and/or nitroglycerin.
- Atypical Anginal (Probable): Chest pain or discomfort that lacks one of the characteristics of definite or typical angina.
- Non-Anginal chest Pain: Chest pain or discomfort that meets one or none of the typical anginal characteristics.

GUIDELINES:

Coronary CT angiography is considered medically necessary for the following indications:

- I. Detection or coronary artery disease (CAD) – one of the following A - C:
 - A. Evaluation of *chest pain syndrome* – 1 and either 2 or 3:
 1. Intermediate pre-test probability (Table 1) of CAD
 2. ECG uninterpretable or unable to exercise
 3. Uninterpretable or equivocal stress test (exercise, perfusion, or stress echo)
 - B. Evaluation of suspected coronary artery anomalies

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 11/27/07
Department(s) Affected: Medical Management	Effective Date: 11/27/07	
Medical Criteria Document: Coronary Computed Tomography (CT) Angiography	Replaces Effective Policy Dated: 11/28/06	
Reference #: MC/L004	Page:	3 of 4

- C. Evaluation of acute chest pain: both of the following 1 & 2:
 - 1. Intermediate pre-test probability of CAD (Table 1)
 - 2. No ECG changes and serial enzymes negative
- II. Evaluation of structure and function – one of the following A - D:
 - A. Assessment of complex congenital heart disease including anomalies of coronary circulation, great vessels, and cardiac chambers and valves
 - B. Evaluation of coronary arteries in patients with new onset of heart failure to assess etiology
 - C. Evaluation of suspected aortic dissection or thoracic aortic aneurysm
 - D. Evaluation of suspected pulmonary embolism

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 11/27/07
Department(s) Affected: Medical Management	Effective Date: 11/27/07	
Medical Criteria Document: Coronary Computed Tomography (CT) Angiography	Replaces Effective Policy Dated: 11/28/06	
Reference #: MC/L004	Page:	4 of 4

RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)
 Medical Policy [MP/C009 Coverage Determination Guidelines](#)

REFERENCES:

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Back and Neck Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/F019	Page:	1 of 3

PRODUCT APPLICATION:

- PreferredOne Community Health Plan (PCHP)
 PreferredOne Administrative Services, Inc. (PAS)
Currently applies only to Fairview Employee Groups
 PreferredOne (PPO)
 PreferredOne Insurance Company (PIC)

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This criteria set applies only to PAS enrollees when the employer group has adopted the applicable step therapy management program(s).

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary and to ensure that services are rendered in the most cost-efficient setting or methodology appropriate for the condition based on medical standards and accepted practice parameters of the community.

DEFINITIONS:

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Spinal Instability:

According to the American Academy of Orthopaedic Surgeons, instability is defined as an abnormal response to applied loads, characterized by movement in the motion segment beyond normal constraints. A motion segment is the smallest functional spinal unit exhibiting the generic biomechanical characteristics of the spine. It consists of two adjacent vertebrae, an intervertebral disc, various ligaments and apophyseal joints. Stability to the motion segment is provided by the ligaments, facet joints and intervertebral discs which restrict its range of movements.

Spondylosis:

Spinal degeneration and deformity of a joint(s) of two or more vertebrae that commonly occurs with aging

Spondylolisthesis:

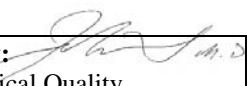
Forward alignment of one vertebra on the one below it.

BACKGROUND:

This criteria set is based on expert consensus opinion and/or available reliable evidence.

Certain enrollee's may be required to follow a Medical Step Therapy program (see Medical policy MP/C009 Medical Step Therapy) for certain *healthcare services*.

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Department of Origin: Medical Management	Approved by:  Medical-Surgical Quality Management Subcommittee	Date approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Back and Neck Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/F019	Page:	2 of 3

GUIDELINES:

Surgery may be approved for either of the following I or II:

- I. Imaging shows a defect (e.g. fracture, *spondylosis*, *spondylolisthesis*, spinal canal narrowing, disc herniation) that is consistent with acute or progressive neurological deficit or *spinal instability* (e.g. numbness, weakness, gait disturbance, change in bowel or bladder control) that is correctable by surgery

Note: Requests for spinal surgery to treat *spinal instability* in the absence of neurological deficit must be reviewed by a physician

- II. Pain has been present for more than 6 weeks and patient has completed a PreferredOne designated formal multidisciplinary rehabilitation program for the treatment of their neck and/or back pain:

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Back and Neck Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/F019	Page:	3 of 3

RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)
 Medical Policy [MP/C009 Coverage Determination Guidelines](#)

REFERENCES:

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Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Hyperhidrosis Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/G008	Page:	1 of 3

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

DSM-IV:

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

Gustatory Sweating (Frey Syndrome):

Gustatory Sweating is an autonomic disorder characterized by excessive sweating of the forehead, upper lip, perioral region, scalp, or sternum subsequent to gustatory stimuli. The auriculotemporal syndrome features facial flushing or sweating limited to the distribution of the auriculotemporal nerve and may develop after trauma to the parotid gland, or in association with parotid neoplasms or following their surgical removal. The use of botulinum toxin has been demonstrated as an effective treatment of primary and secondary gustatory hyperhidrosis.

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Hyperhidrosis:

Hyperhidrosis is a relatively uncommon condition of exaggerated perspiration due to excessive secretion of the exocrine sweat glands in amounts greater than required for physiologic needs of thermoregulation and electrolyte alteration. It consists of primary hyperhidrosis and secondary hyperhidrosis.

Iontophoresis (Drionic Device):

Iontophoresis is the use of electrical current to introduce various ions through the skin for the treatment of palmar, plantar or axillary hyperhidrosis. Iontophoresis is generally not used for Gustatory Sweating (Frey Syndrome) and is not required as conservative management for consideration of treatment with botulinum toxin or surgery for this diagnosis.

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Hyperhidrosis Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/G008	Page: 2 of 3	

Primary Hyperhidrosis (idiopathic or essential hyperhidrosis):

Primary Hyperhidrosis is caused by an overactive sympathetic nervous system. A variety of interventions are available including topical therapy with aluminum chloride, pharmacotherapy including botulinum toxin, iontophoresis, and transthoracic sympathectomy.

Secondary Hyperhidrosis:

Secondary Hyperhidrosis is caused by a variety of drugs or underlying disease conditions. Treatment focuses on the underlying cause if possible.

BACKGROUND:

This criteria set is based on expert professional practice guidelines.

Surgical treatments include open thoracic sympathectomy, thoracoscopic sympathectomy, endoscopic sympathectomy, video assisted thoracic sympathectomy (VATS) and surgical removal of axillary glands.

Requests for treatment of secondary hyperhidrosis, and other types of primary hyperhidrosis besides palmar and axillary require case review.

GUIDELINES:

Surgical treatment of palmar and axillary *primary hyperhidrosis* with both of the following I and II:

- I. A functional defect - must have A, B or C:
 - A. A chronic medical complication or condition is present such as skin maceration with secondary bacterial infections, fungal or candidal conditions, dermatitis, or other skin disease.
 - B. Must have significant interference with activities of daily living or disruption of vocational life.
 - C. *Hyperhidrosis* causing a psychological condition – must have 1 and 2
 1. A medically diagnosed *DSM-IV* Axis I condition causing significant dysfunction
 2. Documentation the patient has not responded, is intolerant to, or a poor candidate for other appropriate treatments for *DSM-IV* Axis I condition
- II. Exhausted conservative treatment options – both of the following A & B:
 - A. Topical agents (e.g. aluminum chloride or other extra strength antiperspirants are ineffective or result in a rash)
 - B. Failure of or inability to tolerate botulinum toxin

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Criteria Document: Hyperhidrosis Surgery	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/G008	Page:	3 of 3

RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)

Medical Policy [MP/C009 Coverage Determination Guidelines](#)

Medical Policy [MP/C002 Cosmetic Procedures](#)

REFERENCES:

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Department of Origin: Pharmacy	Approved by: Medical Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Coding, Claims, Customer Service, Medical Management, Medical Policy	Effective Date: 09/23/08	
Pharmacy Policy Description: Botulinum Toxin	Replaces Effective Policy Dated: 04/23/08	
Reference #: PC/B003	Page:	1 of 6

PRODUCT APPLICATION:

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

PURPOSE:

The intent of the Botulinum Toxin criteria set is to ensure, if benefits are available, that the intended use is medically necessary and prescribed after conservative treatment has failed.

DEFINITIONS:

Achalasia:

A failure of the muscles between the esophagus and the stomach (cardiac sphincter) to open thus preventing food from passing through into the stomach. The condition is also known as cardiospasm.

Neurogenic Overactive Bladder:

Neurogenic bladder is the loss of normal bladder function caused by damage to part of the nervous system. The damage can cause the bladder to be underactive, in which it is unable to contract and unable to empty completely, or it can be overactive, in which it contracts too quickly or frequently.

Alternate names for over activity of the bladder: Detrusor Hyperreflexia, Detrusor Instability, Overactive Bladder, Spasmodic Bladder, Unstable Bladder.

BACKGROUND:

This criteria set is based on U.S. Food and Drug Administration (FDA) approved indications, expert consensus opinion and/or available reliable evidence.

Botulinum toxin is produced by the anaerobic organism clostridia botulinum. There are several distinct serotypes designated as type A, B, C-1, D, E, F and G. They are injected intramuscularly to reduce muscle tone and interfere with release of acetylcholine from nerve endings. The FDA has approved Myobloc (botulinum toxin type B, Elan Pharmaceuticals) for the treatment of cervical dystonia (spasmodic torticollis) in adult patients with severe abnormal head position and neck pain. The FDA has also approved Botox (botulinum toxin type A, Allergan, Inc) for the treatment of cervical dystonia in adult patients with severe abnormal head position and neck pain, with the additional approved indications of treatment of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or facial nerve disorders in patients greater than 12 years old. However Botox has been used "off-label" for a wide variety of disorders characterized by spasticity or dystonia.

Botulinum toxin injections are commonly required every 2-6 months depending on response, with an average approximating 90 days, but exact frequency is dependent on multiple patient variables.

The use of botulinum toxin is indicated only when it is determined to be medically necessary for the treatment of a medical condition, and the use of botulinum toxin has been shown to be effective for that condition. Botulinum toxin is not considered medically necessary for cosmetic uses (e.g. improvement of wrinkles).

Department of Origin: Pharmacy	Approved by: Medical Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Coding, Claims, Customer Service, Medical Management, Medical Policy	Effective Date: 09/23/08	
Pharmacy Policy Description: Botulinum Toxin	Replaces Effective Policy Dated: 04/23/08	
Reference #: PC/B003	Page:	2 of 6

Additional botulinum toxin injections after the second dose require prior authorization every six months for pain syndromes and yearly for all other indications. Documentation of significant improvement in the disability will be required for continued use.

Medical Necessity Criteria:

I. Indications that are considered acceptable medical practice and require prior authorization:

Note: Two injections will be initially authorized if patient circumstances satisfy initial use criteria.

A. Initial Use Indications:

1. Alternative therapy for refractive and chronic debilitating pain syndromes require a or b, and will be reviewed by a physician:
 - a. For headache syndromes:

Letter of medical necessity from a neurologist or headache specialist recommending the use of Botox that includes all of the following:

 - (1) intractable migraine headache (with or without aura) occurring 8 or more days a month or chronic daily headache defined as patients experiencing more than 15 days of headache per month
 - (2) documentation that headaches cause 2-3 days of inability to perform ADLs a month
 - (3) documented attempts at formal behavioral or physical therapy treatment
 - (4) patient has failed trials of at least three preventative pharmacological migraine therapies unless documented to be contraindicated (e.g. Beta blockers, calcium channel blockers, anticonvulsants, anti-depressants) after titration to maximally tolerated doses
 - b. For all other pain syndromes:

Letter of medical necessity from a chronic pain specialist physician that includes all of the following:

 - (1) diagnosis
 - (2) known medical treatment in the last 12 months
 - (3) evidence of impairment to activities of daily living
 - (4) clear evidence from submitted documentation that the pain/symptoms are persistent and disabling and the patient has not responded, is intolerant to, or a poor candidate for other conventional forms of medical therapy.

Note: Documentation of functional impairment to activities of daily living secondary to chronic pain syndrome (e.g., missed school or work days) may be required from the patient if not evident in the requesting letter of medical necessity or available in the medical record.
2. Gastrointestinal disorders – one of the following:
 - a. Chronic anal fissure and documentation demonstrates the patient has not responded to or is intolerant to conservative therapeutic measures
 - b. Achalasia which has failed dilation therapy or surgical myotomy or in patients who are poor surgical candidates

Department of Origin: Pharmacy	Approved by: Medical Surgical Quality Management Subcommittee	Date Approved: 09/23/08
Department(s) Affected: Coding, Claims, Customer Service, Medical Management, Medical Policy	Effective Date: 09/23/08	
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3. Ptyalism (excessive salivation) secondary to other medical conditions that is disabling (e.g., cerebral palsy etc.) and the patient has not responded, is intolerant to, or a poor candidate for to other medical therapy.
4. Neurogenic overactive bladder (e.g. spinal cord injury, multiple sclerosis etc) unresponsive to anticholinergics.
5. Any other condition or indication not specifically addressed in this criteria set needs to be researched by the medical policy specialist and sent for physician review. New off label indications will be added to this criteria set as determined per the Investigational/unproven review process. (see Medical Policy MP/I001 Investigational/Experimental Services or Unproven Comparative Effectiveness of Services)

B. Continued use:
Additional botulinum toxin injections after the second dose require prior authorization every six months for pain syndromes and yearly for all other indications. Must have at least one of the following documented improvements with Botox use:

1. Decrease in medication use
2. Decrease in emergency room visits
3. Decrease in missed days at work
4. Decreased pain frequency and severity
5. Increased activities

II. Indications that are considered acceptable medical practice and do not require prior authorization:

- A. Strabismus and other disorders of binocular eye movements
- B. Idiopathic torsion dystonia
- C. Symptomatic torsion dystonia
- D. Fragments of torsion dystonia:
 1. Blepharospasm
 2. Orofacial dyskinesia
 3. Spasmodic torticollis
 4. Organic writers cramp

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5. Other fragments of torsion dystonia
- E. Other disorders of the central nervous system:
1. Muscle spasms due to demyelinating diseases (e.g. multiple sclerosis, neuromyelitis optica, Schilder's disease)
 2. Spastic hemiplegia
 3. Hereditary spastic paraplegia
 4. Infantile cerebral palsy
 5. Facial nerve disorders (e.g. hemifacial spasm)
- F. Spasmodic dysphonia (laryngeal spasm)
- G. Cervical dystonia
- H. Hyperhidrosis
- III. Exclusions: Cosmetic Indications (e.g. facial wrinkles or any dermatological condition) (see Medical Policy MP/C002 Cosmetic Procedures)

Department of Origin: Pharmacy	Approved by: Medical Surgical Quality Management Subcommittee	Date Approved: 09/23/08
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Coverage is subject to the terms of an enrollee's pharmacy benefit plan and formulary. To the extent there is any inconsistency between this criteria set/policy and the terms of an enrollee's pharmacy benefit plan and /or formulary, the enrollee's pharmacy benefit plan and formulary govern.

This criteria set applies only to PAS enrollees when the employer group has adopted the applicable drug trend management program(s).

RELATED CRITERIA/POLICIES:

- Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)
- Medical Criteria [MC/G008 Hyperhidrosis](#)
- Medical Policy [MP/C002 Cosmetic Procedures](#)
- Medical Policy [MP/C009 Medical Step Therapy](#)
- Medical Policy [MP/I001 Investigational/Experimental Services or Unproven Comparative Effectiveness of Services](#)

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Pharmacy Policy Description: Botulinum Toxin	Replaces Effective Policy Dated: 04/23/08	
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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 06/24/08
Department(s) Affected: Claims, Coding, Customer Service, Medical Management	Effective Date: 06/24/08	
Medical Policy Document: 3D Interpretation of Imaging	Replaces Effective Policy Dated: 09/25/07	
Reference #: MC/L003	Page:	1 of 3

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This criteria set applies to PAS enrollees only when the employer group has elected to provide benefits for the service/procedure/device. Check benefits or verify with the appropriate account manager the availability of benefits when not specifically addressed in the plan document.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Three-dimensional reconstruction (3D):

Reconstruction of the 2D information on computed tomography (CT), magnetic resonance imaging (MRI), Positron emission tomography (PET), ultrasounds or other imaging studies can build a three-dimensional image of the body area being studied using the primary study and computer software programs.

BACKGROUND:


This criteria set is based on expert professional practice guidelines.

CT angiography is the preferred method of evaluating pulmonary emboli over 3D interpretation of imaging.

Positron Emission Tomography (PET) or multislice/multidirectional computed tomography (MSCT/MDCT) is the preferred method of diagnosing, staging and re-staging for cancer.

Note: This criteria set addresses the 3D rendering and interpretation of the imaging study, not the actual MRI, CT, PET, ultrasound or other imaging study.

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Medical Policy Document: 3D Interpretation of Imaging	Replaces Effective Policy Dated: 09/25/07	
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GUIDELINES:

3D interpretation of imaging is considered medically necessary for one of the following I or II:

- I. Assessment of multiple trauma
- II. Evaluation of complex fractures (i.e. pelvic fractures, scapula fractures, vertebral fractures), this does not include the initial screening for the fracture.

Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date Approved: 06/24/08
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Medical Policy Document: 3D Interpretation of Imaging	Replaces Effective Policy Dated: 09/25/07	
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RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)

Medical Policy [MP/C009 Medical Step Therapy](#)

Medical Policy: [MP/S006 Screening Tests for Normal Risk Populations](#)

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Department of Origin: Medical Management	Approved by: Medical-Surgical Quality Management Subcommittee	Date approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Strabismus Repair (Adult)	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/C008	Page:	1 of 3

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This Criteria Set applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this criteria set is to ensure services are medically necessary.

DEFINITIONS:

Amblyopia:

Reduced visual acuity because of defective central visual processing. It is a functional disorder of visual development that is caused by an optical, physical or ocular alignment defect during childhood.

Binocularity:

Simultaneous movement of both eyes in the same (version) and opposite (vergence) directions, resulting in both eyes contributing simultaneously to visual function.

Congenital Strabismus:

Appears in infancy and is presumably due to defects present at birth.

Diopters:

The unit of deviation gage between eyes

Diplopia:

Double vision, which is eliminated by covering either eye

Esotropia:

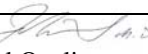
Crossed eyes

Exotropia:

Eye turns outward

Healthcare service:

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Department of Origin: Medical Management	Approved by:  Medical-Surgical Quality Management Subcommittee	Date approved: 09/23/08
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Medical Criteria Document: Strabismus Repair (Adult)	Replaces Effective Policy Dated: 05/22/07	
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A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure
Strabismus:
Misaligned eyes

BACKGROUND:

This criteria set is based on expert professional practice guidelines.

Pediatric strabismus repair (under age 18) is considered medically necessary.

Functional vision improvement is usually not expected with congenital strabismus repair since vision has usually been suppressed in the affected eye.

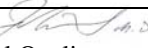
Congenital strabismus repair is not covered for adults age 18 and over when functional vision improvement is not expected (see MP/C002 Cosmetic Treatments).

GUIDELINES

Surgery for repair of adult strabismus (18 years of age or older) —All of the following I – IV:

- I. Formal letter from surgeon documenting medical necessity of procedure and age of onset of strabismus.
- II. Documentation that functional vision is present in both eyes
- III. Documentation that restoration of alignment will result in a functional improvement
- IV. Documentation of failure of conservative treatment (e.g. glasses, prisms, patching, eye muscle exercises, or Botulinum Toxin Type A) after a minimum of a three (3) month trial

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Department of Origin: Medical Management	Approved by:  Medical-Surgical Quality Management Subcommittee	Date approved: 09/23/08
Department(s) Affected: Medical Management	Effective Date: 09/23/08	
Medical Criteria Document: Strabismus Repair (Adult)	Replaces Effective Policy Dated: 05/22/07	
Reference #: MC/C008	Page:	3 of 3

RELATED CRITERIA/POLICIES:

Medical Management Process Manual MI007 Use of Medical Policy and Criteria
 Medical Policy MP/C009 Coverage Determination Guidelines
 Medical Policy MP/C002 Cosmetic Procedures

REFERENCES:

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Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date Approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Policy Document: Acute Rehabilitation Facilities	Replaces Effective Policy Dated: N/A	
Reference #: MP/R003	Page: 1 of 3	

PRODUCT APPLICATION:

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

Please refer to the enrollee's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the enrollee's benefit plan or certificate of coverage, the terms of the enrollee's benefit plan document will govern.

Benefits must be available for *healthcare services*. *Healthcare services* must be ordered by a physician, physician assistant, or nurse practitioner. *Healthcare services* must be medically necessary, applicable conservative treatments must have been tried, and the most cost-effective alternative must be requested for coverage consideration.

This policy applies to PAS enrollees only when the employer group has elected to provide benefits for the service/procedure/device. Check benefits in SPD/COC. If benefits not specifically addressed in the SPD/COC verify with the appropriate account manager the availability of benefits.

The policy applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this policy is to provide coverage guidelines for acute inpatient rehabilitation services.

DEFINITIONS:

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

BACKGROUND:

Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as high of function as possible.

Transfers to a lower level of care for continued rehabilitation after an acute care admission require prior authorization. See Medical Policy, [MP/T005 Transfers from an Acute Care Facility to a Lower Level of Care for Rehabilitation](#).

POLICY:

Coverage of acute rehabilitation facility admissions are subject to the benefits, limitations, and exclusions in the enrollee's benefit plan and must meet the following guidelines.

GUIDELINES:

All of the following I - VII:

- I. Services must be ordered by a physician; and

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Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date Approved: 06/24/08
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Medical Policy Document: Acute Rehabilitation Facilities	Replaces Effective Policy Dated: N/A	
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- II. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than a less intense facility such as a skilled nursing, or on an outpatient basis; and
- III. Patients must need a rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. The rehabilitation team must be coordinated by a physician specially trained and experienced in rehabilitative care, and include a RN providing 24 hour nursing care, and one or more therapists working in a coordinated fashion to achieve maximum results. Psychologists and social workers may also be involved in the rehabilitation team; and
- IV. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and
- V. The program must provide, at least three (3) hours of therapy a day for at least five days a week beginning within at least the first 48 hours of admission; and
- VI. The program will provide an admission evaluation of the patient with objective descriptions of functional status and provisional long and short-term goals including an estimated time frame for completion of goals identified at the time of transfer; and
- VII. Team conferences must be held with a regularity of at least every two weeks to assess the individuals progress or the problems impeding progress, and alter or develop new goals as needed.

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Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date Approved: 06/24/08
Department(s) Affected: Medical Management	Effective Date: 06/24/08	
Medical Policy Document: Acute Rehabilitation Facilities	Replaces Effective Policy Dated: N/A	
Reference #: MP/R003	Page:	3 of 3

RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)

Medical Policy [MP/C009 Medical Step Therapy](#)

Medical Policy [MP/T005 Transfers from an Acute Care Facility to a Lower Level of Care for Rehabilitation](#)

REFERENCES:

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Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date Approved: 06/24/08
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Medical Policy Document: Skilled Nursing Facilities	Replaces Effective Policy Dated: N/A	
Reference #: MP/S011	Page:	1 of 5

PRODUCT APPLICATION:

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

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The policy applies to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

PURPOSE:

The intent of this policy is to provide coverage guidelines for skilled nursing facilities (SNF).

DEFINITIONS:

Custodial Care

Services to assist in activities of daily living and personal care that do not seek to cure or do not need to be provided or directed by a skilled medical professional, such as assistance in walking, bathing and feeding.

Maintenance Care:

Services provided where there is a lack of documented significant progress in functional status over a reasonable period of time.

Habilitative Therapy

Therapy provided to develop initial functional levels of movement, strength, activities of daily living, or speech.

Healthcare service:

A medical or behavioral pharmaceutical, device, technology, treatment, supply, or procedure

Rehabilitative Therapy

Therapy provided to restore functional levels of movement, strength, daily activity, or speech after a sickness or injury.

Skilled Care

Nursing or rehabilitation services requiring the skills of professional medical personnel to provide care or to assess the patient's changing condition. Long term dependence on respiratory support equipment does not in and of itself define a need for skilled care. See Attachment A for Medicare examples of skilled care.

Department of Origin: Medical Management	Approved by: Chief Medical Officer	Date Approved: 06/24/08
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Medical Policy Document: Skilled Nursing Facilities	Replaces Effective Policy Dated: N/A	
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Swing-bed⁵

In order to address the shortage of skilled nursing beds in the rural setting, Medicare has allowed hospitals with fewer than 50 beds to “swing” their beds between acute hospital care and skilled level of care on an as needed basis. When a hospital is providing extended care services, it will be treated as a skilled nursing facility.

BACKGROUND:

Habilitative and *rehabilitative* therapy are usually eligible for coverage if medically necessary. Maintenance and custodial care are typically excluded in the plan document. Refer to enrollee’s benefit plan.

Transfers to a lower level of care for continued rehabilitation after an acute care admission require prior authorization and a four-day qualifying stay in the acute facility, not including the discharge day. See Medical Policy [MP/T005 Transfers from an Acute Care Facility to a Lower Level of Care for Rehabilitation](#).

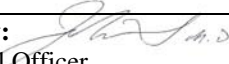
POLICY:

Coverage of skilled nursing facility admissions are subject to the benefits, limitations, and exclusions in the enrollee's benefit plan and meet the following guidelines.

GUIDELINES:

Must have all of the following I - VIII:

- I. Services must be ordered by a physician; and
- II. Services require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses or, respiratory, physical, occupational, or speech therapists; and
- III. Services can only be provided on an inpatient basis in a SNF considering economy and efficiency and not a daily skilled home care visit or outpatient clinic visit; and
- IV. Services are reasonable and necessary for the treatment of a patient’s illness or injury; and
- V. Services are reasonable in terms of duration and quantity; and
- VI. Services must be provided at least 5 days a week; and
- VII. A treatment plan must be developed that includes measurable goals, projected time frames for meeting goals, and discharge plans; and
- VIII. Regular multidisciplinary care conferences must be held with continuing oversight of the patient’s care by the ordering physician.

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RELATED CRITERIA/POLICIES:

Medical Management Process Manual [MI007 Use of Medical Policy and Criteria](#)
 Medical Policy [MP/C009 Medical Step Therapy](#)
 Medical Policy [MP/T005 Transfers from an Acute Care Facility to a Lower Level of Care for Rehabilitation](#)

REFERENCES:

1. American Occupational Therapy Association. Uniform terminology-third addition: application to practice. American Journal of Occupational Therapy. 1994; 48: 1055-1059
2. American Physical Therapy Association. (1999). Guide to Physical Therapist Practice. Alexandria, VA: Author
3. Carr, DD. Case Management for the subacute patient in a skilled nursing facility. Nurse Case Management 2000; 5(2): 83-92.
4. Skilled Nursing Facility Manual, Chapter 2-Coverage of Services. May 3,2003
5. Centers for Medicare and Medicaid Services. SNF Prospective Payment System. Swing Bed Providers Summary. September 16, 2004. Available: http://www.cms.hhs.gov/SNFPPS/03_SwingBed.asp April 15, 2008.

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ATTACHMENT A

The following examples (not inclusive) are from the CMS Skilled Facility Manual examples of skilled and non-skilled care. Available <http://www.cms.hhs.gov/manuals/downloads/bp102c08.pdf> April 15, 2008.

Centers for Medicare & Medicaid Services
 Medicare Benefit Policy Manual
 Chapter 8 – Coverage of Extended Care (SNF) services Under Hospital Insurance

Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services:

1. **30.2.3.1 Management and Evaluation of a Patient Care Plan (Rev.1, 10-01-03)**
 The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective environment. The sum total of unskilled services would only add up to the need for skilled management and evaluation when the condition of the beneficiary is such that there is an expectation that a change in condition is likely without that intervention. .
2. **30.2.3.2 Observation and Assessment of Patient's Condition (Rev. 1, 10-01-03)**
 Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stabilized
3. **30.2.3.3 Teaching and Training Activities (Rev. 1, 10-01-03)**
 Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services.
 Some examples are:
 - Teaching self-administration of injectable medications or a complex range of medications
 - Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions
 - Teaching self-administration of medical gases to a patient
 - Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation
 - Teaching patients how to care for a recent colostomy or ileostomy
 - Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings
 - Teaching patients how to care for and maintain central venous lines, such as Hickman catheters
 - Teaching patients the use and care of braces, splints and orthotics, and any associated skin care
 - Teaching patients the proper care of any specialized dressings or skin treatments
4. **30.3 Direct Skilled Nursing Services to Patients (Rev. 1, 10-01-03)**
 Some examples of direct skilled nursing services are:
 - Intravenous or intramuscular injections and intravenous feeding;
 - Enteral feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day;
 - Naso-pharyngeal and tracheotomy aspiration

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- Insertion, sterile irrigation, and replacement of suprapubic catheters;
- Application of dressings involving prescription and medications and aseptic techniques;
- Treatment of decubitus ulcers, of a severity rated at Stage 3 or worse, or a widespread skin disorder;
- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to evaluate the patient's progress adequately;
- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;
- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and
- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

5. 30.5 Nonskilled Supportive or Personal Care Services c

The following services are not skilled services unless rendered under circumstances detailed in §§30.2:

- Administration of routine oral medications, eye drops, and ointments (the fact that a patient cannot be relied upon to take such medications themselves or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service)
- General maintenance care of colostomy and ileostomy
- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying containers and cleaning them, and clamping tubing)
- Changes of dressings for noninfected postoperative or chronic conditions
- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems
- Routine care of the incontinent patient, including use of diapers and protective sheets
 - General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or needs adjustment of traction)
- Routine care in connection with braces and similar devices
- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack
- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy)
- Assistance in dressing, eating, and going to the toilet
- Periodic turning and positioning in bed; and
- General supervision of exercises which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.)



2009 Express Scripts National Preferred Formulary

A

ABILIFY (excluding Discmelt & solution)
acarbose
acebutolol
acetaminophen w/codeine
acetazolamide
ACTIVELLA*
ACTONEL, with calcium
ACTOPLUS MET
ACTOS
ACULAR, LS, PF *
acyclovir
ADDERALL XR*
ADVAIR DISKUS, HFA
ADVICOR
AGGRENOX
albuterol
alendronate sodium
ALLEGRA-D*
ALPHAGAN P*
amantadine
AMBIEN CR*
aminophylline
amitriptyline
amlodipine besylate
amox tr/potassium clavulanate
amoxicillin
amphetamine salt combo
anagrelide
ANALPRAM-HC
ANDRODERM
ANDROGEL
antipyrine w/benzocaine
apri
aranelle
ARANESP [INJ]
ARICEPT, ODT
ASACOL
ASCENSIA AUTODISC, BREEZE/2
ASCENSIA BRIO METER
ASCENSIA CONTOUR SYSTEM
ASCENSIA ELITE/XL
ASTELIN
atenolol, -chlorthalidone
atropine sulfate
AUGMENTIN XR
AVELOX
aviane
AVINZA
AXID solution only
azathioprine
azithromycin
AZOR

B

balsalazide disodium
balziva
benazepril, /hctz
BENZAFLIN
benzonatate
benzoyl peroxide

betamethasone dp, valerate
BETASERON [INJ]
bisoprolol fumarate/hctz
BONIVA TAB
brimonidine tartrate
bupropion, sr
butalbital/apap/caffeine
BYETTA [INJ]

C

calcipotriene
calcitriol
camila
CANASA
captopril, /hctz
CARAC
carbamazepine
cardiopa-levodopa, er
CARDIZEM LA*
carisoprodol
carvedilol
cefaclor, er
cefadroxil
cefdinir
cefepodoxime
cefprozil
cefuroxime
CELEBREX
CELLCEPT*
cephalexin
cesia
CETROTIDE [INJ]
chlorzoxazone
cholestyramine
choline mag trisalicylate
chorionic gonadotropin [INJ]
ciclopirox
cilostazol
cimetidine
CIPRODEX*
ciprofloxacin, er
citalopram
clarithromycin, er
CLIMARA PRO
clidinium-
chlordiazepoxide
clindamycin phosphate
clobetasol propionate
clomiphene citrate
clotrimazole troche
clozapine
colestipol
COMBIPATCH
COMBIVENT
CONCERTA*
COPAXONE [INJ]
COREG CR
COSOPT*
COZAAR
CREON
CRESTOR
CRINONE
cryselle
cyclobenzaprine hcl
cyclosporine, modified
CYMBALTA [SNRI]

D

desmopressin acetate
desonide
desoximetasone
dexmethylphenidate
dextroamphetamine sulfate
diclofenac sodium
dicyclomine hcl
DIFFERIN
diflunisal
diltiazem, extended release
DIOVAN, HCT
diphenhydramine
dipyridamole
divalproex sodium
doxepin hcl
DUAC
DUETACT
DYNACIRC CR*

E

econazole
EDEX [INJ]
EFFEXOR XR [SNRI]
ELIDEL
ENABLEX
enalapril, hctz
ENBREL [INJ]
enpresse
enulose
EPIPEN, JR [INJ]
errin
erythromycin
erythromycin/benzoyl perox.
ESTRADERM
estradiol, tds
ESTRATEST, H.S.
estropipate
etidronate disodium
etodolac
EUFLEXA [INJ]
EVAMIST
EXELON
EXFORGE

F

famciclovir
famotidine
felodipine er
fenofibrate
fentanyl citrate
fexofenadine
FINACEA
finasteride
FLOMAX
FLOVENT DISKUS, HFA
fluconazole
fluocinonide
fluorouracil
fluoxetine hcl
fluphenazine
flurazepam
fluticasone nasal spray
fluvoxamine maleate

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: The symbol * next to a drug signifies that it is subject to nonformulary status when a generic is available throughout the year. Not all the drugs listed are covered by all prescription-drug benefit programs; check your benefit materials for the specific drugs covered and the copayments for your prescription-drug benefit program. For specific questions about your coverage, please call the phone number printed on your ID card.

folic acid
FOLLISTIM AQ [INJ]
FOLTIX
FORADIL
FORTEO [INJ]
fortical
fosinopril, /hctz

G

gabapentin
GANIRELIX ACETATE [INJ]
gemfibrozil
GENOTROPIN [INJ]
gentamicin sulfate
glimepiride
glipizide, er, xl
glipizide/metformin
GLUCAGEN [INJ]
glyburide, micronized
glyburide/metformin
GONAL-F, RFF [INJ]
granisetron
guaifenesin w/pseudoephedrine

H

HALFLYTELY, -BISACODYL
haloperidol
HECTOROL
HUMALOG [INJ]
HUMIRA [INJ]
HUMULIN [INJ]
hydrochlorothiazide
hydrocodone w/guaifenesin
hydrocodone/acetaminophen
hydrocortisone
hydromorphone
hydroxyurea
hyoscynamine sulfate
HYZAAR

I

ibuprofen
imipramine
indomethacin
INTAL inh
ipratropium bromide
ipratropium-albuterol
isosorbide mononitrate
isotretinoin
itraconazole

J

JANUMET
JANUVIA
jolessa
jolvette
junel, fe

K

kariva
kelnor
KEPPRA*

ketoconazole

L

labetalol hcl
lactulose
lamotrigine
LANTUS, SOLOSTAR [INJ]
leena
leflunomide
lessina
LETAIRIS
leucovorin
leuprolide acetate [INJ]
LEVAQUIN
LEVEMIR, FLEXPEN [INJ]
LEVITRA
levora
levothyroxine sodium
levoxyl
LEXAPRO
LIALDA
LIDODERM
LIPITOR
lisinopril, /hctz
LOTEMAX
LOTREL*
lovastatin
LOVAZA
LOVENOX*
low-ogestrel
LUMIGAN
lutera
LYRICA

M

meclizine hcl
medroxyprogesterone acetate
megestrol
meloxicam
MENEST
MENOPUR [INJ]
mercaptopurine
MERIDIA
METANX
metaproterenol
metformin, er
methocarbamol
methotrexate
methylphenidate hcl
methylprednisolone
metoclopramide hcl
metolazone
metoprolol, hctz
METROGEL
metronidazole
microgestin, fe
mirtazapine, soltab
moexipril/hctz
mometasone
mononessa
morphine sulfate
MUSE

N

nabumetone
nadolol

NAMENDA
naproxen
NASACORT AQ
NASONEX
necon
neomycin/polymyxin/dexamethasone
neomycin/polymyxin/hc
NEXIUM
NIASPAN
nifedipine er
nisoldipine
nitrofurantoin
nitroglycerin
nitroglucal spray
nizatidine
nora-be
nortrel
NOVAREL [INJ]
NOVOFINE
NOVOLIN [INJ]
NOVOLOG [INJ]
NUTROPIN, AQ [INJ]
nystatin

O

ofloxacin
ogestrel
omeprazole
ondansetron
ONETOUCH II, BASIC, PROFILE
ONETOUCH FASTTAKE
ONETOUCH INDUO
ONETOUCH SURESTEP
ONETOUCH ULTRA,-2,-SMART
ONETOUCH ULTRAMINI
OPANA ER
orphenadrine citrate
ORTHO TRI-CYCLEN LO*
oxcarbazepine
oxybutynin, er
oxycodone w/acetaminophen
OXYCONTIN
OXYTROL

P

paroxetine
PATADAY
PATANOL
peg 3350/electrolyte
PEGASYS [INJ]
penicillin v potassium
PERFORMIST
perphenazine
phenentermine hcl
phenytoin sodium, extended
pilocarpine hcl
pindolol
PLAVIX
polymyxin b sul/trimethoprim
portia
PRAMOSONE

(continued)

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PRANDIN*
pravastatin
PRECISION SURE DOSE
PRECISION XTRA
prednisolone
prednisolone acetate
prednisone
PREMARIN
PREMPHASE
PREMPRO
PREVACID NAPRAPAC*
previfem
PREVPAC
PROAIR HFA
PROAIR HFA
PROCHIEVE
prochlorperazine
PROCRIT [INJ]
promethazine
promethazine w/codeine
promethazine w/dm
PROMETRIUM
propranolol hcl, w/hctz
PROTOPIC*
PROVENTIL HFA
pseudoeophedrine
w/chlorpheniramine
PULMICORT, -FLEXHALER

terbinafine hcl
terbutaline sulfate
TEV-TROPIN [INJ]
theophylline,
anhydrous, er
thioridazine hcl
thyroid
tilia fe
timolol maleate
tobramycin sulfate
TOPAMAX*
TRACLEER
trandolapril
trazodone hcl
tretinoin
triamcinolone acetonide
triazolam
TRICOR
tri-legest fe
trimethobenzamide
trimethoprim
trinessa
tri-previfem
tri-sprintec
trivora
TRUSOPT*
TUSSIONEX
TWINJECT [INJ]

Q

quasense
quinapril
quinaretic
QVAR

U

ULTRASE, -MT
UROXATRAL
URSO, FORTE
ursodiol

R

ramipril
RANEXA
ranitidine
REBIF [INJ]
reclipsen
RENAGEL
RENVELA
ribasphere
ribavirin
risperidone
ropinirole

V

VAGIFEM
VALTRESX*
velivet
venlafaxine
VENTOLIN HFA
verapamil hcl
VESICARE
VIGAMOX
VIVELLE-DOT
VOLTAREN GEL

S

salsalate
selenium sulfide
SEREVENT DISKUS
SEROQUEL, XR
sertraline
SIMCOR
simvastatin
SINGLAIR
SKELAXIN*
sodium sulfacetamide/
sulfur
solia
SPIRIVA
sprintec
sronyx
STARLIX
STRATTERA
STRIANT
SULAR
sulfacetamide sodium
sulfasalazine
SYMBICORT
SYMBYAX
SYMLIN, SYMLINPEN [INJ]

W

warfarin
WELCHOL

X

XALATAN
XENICAL*
XOPENEX neb solution
XYZAL

Y

YASMIN*
YAZ

Z

zaleplon
zenchent
ZETIA
zolpidem tartrate
ZOMIG, ZMT
zonisamide
zovia
ZYLET
ZYMAR*
ZYPREXA
(excluding Zydys)

Examples of Nonformulary Medications With Selected Formulary Alternatives

The following is a list of some nonformulary brand-name medications with examples of selected alternatives that are on the formulary.

Column 1 lists examples of nonformulary medications.
Column 2 lists some alternatives that can be prescribed.

Thank you for your compliance.

Nonformulary	Formulary Alternative	Nonformulary	Formulary Alternative
ACCOLATE	Singular	FROVA	Zomig/ZMT
ACCU-CHEK meters/strips	Ascensia, OneTouch	GEODON	risperidone, Abilify (regular tabs), Seroquel/XR, Zyprexa (non-Zydis)
ACIPHEX	omeprazole, Nexium	HUMATROPE	Genotropin, Nutropin/AQ, Tev-Tropin
AEROBID, M	Flovent Diskus/HFA, Pulmicort/Flexhaler, Qvar	HYALGAN	supartz, Euflexxa
ALAMAST	Pataday, Patanol	IMITREX Nasal	Zomig Nasal
ALOCRIAL	Pataday, Patanol	INVEGA	risperidone, Abilify (regular tabs), Seroquel/XR, Zyprexa (non-Zydis)
ALORA	Generic patches, Estraderm, Vivelle-Dot	IOPIDINE	brimonidine tartrate, Alphagan P*, Cosopt*, Trusopt*
ALREX	Generic steroids	LESCOL, XL	lovastatin, pravastatin, simvastatin, Crestor, Lipitor
ALTOPREV	lovastatin, pravastatin, simvastatin, Crestor, Lipitor	LIPOFEN	fenofibrate, Tricor
AMERGE	Zomig/ZMT	LUNESTA	zolpidem tartrate, Ambien CR*
ANGELIQ	Activella*, Prempro/Premphase	MAXAIR AUTOHALER	Proair HFA, Proventil HFA, Ventolin HFA
ANTARA	fenofibrate, Tricor	MAXALT, MLT	Zomig/ZMT
ANZEMET	granisetron, ondansetron	MENOSTAR	Generic patches, Estraderm, Vivelle-Dot
APIDRA	Humalog, Novolog	METADATE CD	methylphenidate, Concerta*
ASMANEX	Flovent Diskus/HFA, Pulmicort/Flexhaler, Qvar	MICARDIS	Cozaar, Diovan
ATACAND	Cozaar, Diovan	MICARDIS HCT	Diovan HCT, Hyzaar
ATACAND HCT	Diovan HCT, Hyzaar	NEVANAC	diclofenac sodium, Acular/LS/PF*
ATRALIN	tretinoin, Differin	NORDITROPIN	Genotropin, Nutropin/AQ, Tev-Tropin
AVALIDE	Diovan HCT, Hyzaar	NOROXIN	ciprofloxacin/er, ofloxacin, Avelox, Levaquin
AVANDAMET	Actoplus Met	NUVARING	Ortho Tri-Cyclen Lo*, Yasmin*, Yaz
AVANDARYL	Duetact	OMNARIS	flunisolide, fluticasone, Nasacort AQ, Nasonex
AVANDIA	Actos	OMNITROPE	Genotropin, Nutropin/AQ, Tev-Tropin
AVAPRO	Cozaar, Diovan	OPTIVAR	Pataday, Patanol
AVITA	tretinoin, Differin	ORTHO EVRA	Ortho Tri-Cyclen Lo*, Yasmin*, Yaz
AVODART	finasteride, Flomax, Uroxatral	ORTHOVISC	supartz, Euflexxa
AXERT	Zomig/ZMT	OVIDREL	chorionic gonadotropin, Novarel
AZASITE	ciprofloxacin, ofloxacin, Vigamox, Zymar*	PATANASE	Astelín
AZELEX	tretinoin, Differin, Finacea	PEG-INTRON, REDIPEN	Pegasy
AZMACORT	Flovent Diskus/HFA, Pulmicort/Flexhaler, Qvar	PRECISION QID, PCX	Ascensia, OneTouch
AZOPT	brimonidine tartrate, Alphagan P*, Cosopt*, Trusopt*	PREFEST	Activella*, Prempro/Premphase
BECONASE AQ	flunisolide, fluticasone, Nasacort AQ, Nasonex	PREVACID	omeprazole, Nexium
BENICAR	Cozaar, Diovan	PRISTIQ	Cymbalta, Effexor XR
BENICAR HCT	Diovan HCT, Hyzaar	PROZAC WEEKLY	fluoxetine (daily), citalopram, paroxetine, sertraline, Lexapro
BRAVELLE	Follistim AQ, Gonal-F/RFF	QUIXIN	ciprofloxacin, ofloxacin, Vigamox, Zymar*
BROVANA	Perforomist	RELENZA	Tamiflu
CARDENE SR	amlodipine, felodipine er, nifedipine er, Dynacirc CR*, Sular	RELPAK	Zomig/ZMT
CEDAX	amox tr/potassium clavulanate, cefdinir, Augmentin XR	RETIN-A, MICRO	tretinoin, Differin
CENESTIN	estradiol, Menest, Premarin	RHINOCORT AQUA	flunisolide, fluticasone, Nasacort AQ, Nasonex
CIALIS	Levitra	RITALIN LA	methylphenidate, Concerta*
CIPRO HC	ofloxacin, Ciprodex*	SAIZEN	Genotropin, Nutropin/AQ, Tev-Tropin
CLARINEX	feofenadine, Xyzal	SANCTURA, XR	oxybutynin/er, Enablex, Vesicare
DETROL, LA	oxybutynin/er, Enablex, Vesicare	SOF-TACT	Ascensia, OneTouch
DIPENTUM	balsalazide disodium, Asacol, Pentasa	SPECTRACEF	amox tr/potassium clavulanate, cefdinir, Augmentin XR
DIVIGEL	Generic patches, Evamist	SYNTHROID	levothyroxine sodium, levoxy
ELESTAT	Pataday, Patanol	SYNVISC	supartz, Euflexxa
ELESTRIN	Generic patches, Evamist	TESTIM	Androderm, Androgel
ENJUVA	estradiol, Menest, Premarin	TEVETEN	Cozaar, Diovan
EPOGEN	Aranesp, Procrit	TEVETEN HCT	Diovan HCT, Hyzaar
ESTRASORB	Generic patches, Evamist	TOBRADEX	Zylet
ESTROGEL	Generic patches, Evamist	TRAVATAN, Z	Lumigan, Xalatan
FACTIVE	ciprofloxacin, ofloxacin, Avelox, Levaquin	TRIGLIDE	fenofibrate, Tricor
FemHRT	Activella*, Prempro/Premphase	VERAMYST	flunisolide, fluticasone, Nasacort AQ, Nasonex
FEMTRACE	estradiol, Menest, Premarin	VIAGRA	Levitra
FENOGLIDE	fenofibrate, Tricor	VYTORIN	simvastatin, Crestor, Lipitor
FERTINEX	Follistim AQ, Gonal-F/RFF	VYVANSE	methylphenidate, Concerta*
FML FORTE	Generic steroids, Lotemax	XIBROM	diclofenac sodium, Acular/LS/PF*
FOCALIN, XR	dexmethylphenidate, methylphenidate, Concerta*	XOPENEX HFA	Proair HFA, Proventil HFA, Ventolin HFA
FOSRENOL	Renagel, Renvela	ZEGERID	omeprazole, Nexium
FREESTYLE	Ascensia, OneTouch		

KEY

The symbol [INJ] next to a drug name indicates that the drug is available in injectable form only.

The symbol [SNRI] stands for Serotonin-Norepinephrine Reuptake Inhibitor.

For the member: Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.

For the physician: Please prescribe preferred products and allow generic substitutions when medically appropriate. Thank you.

Brand-name drugs are listed in CAPITAL letters.

Generic drugs are listed in lower case letters.

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2009 THROUGH DECEMBER 31, 2009. THIS LIST IS SUBJECT TO CHANGE.

You can get more information and updates to this document at our web site at www.express-scripts.com.



2009 ESI National Preferred formulary

Additions 2009:

Drug
ACULAR LS, PF
BONIVA TAB
COREG CR
ESTRADERM
LANTUS CARTRIDGE, SOLOSTAR
NITROLINGUAL SPRAY
OPANA ER
STRIANT
TEV-TROPIN
VOLTAREN GEL
XYZAL

CPC Deletions 2009:

Drug Name	Alternative
ALORA	GENERIC PATCHES,ESTRADERM,VIVELLE-DOT
AVANDAMET	ACTOPLUS MET
AVANDARYL	DUETACT
AVANDIA	ACTOS
BRAVELLE	FOLLISTIM AQ, GONAL-F/RFF
BROVANA	PERFOROMIST
FOSAMAX SOLUTION	alendronate tablet
FOSAMAX PLUS D	alendronate tablet plus vitamin D
HUMATROPE	TEV-TROPIN,GENOTROPIN,NUTROPIN/AQ
IMITREX NASAL	ZOMIG NASAL
PREVACID	omeprazole, NEXIUM
VYTORIN	simvastatin, CRESTOR, LIPITOR
XOPENEX HFA	PROAIR HFA,PROVENTIL HFA,VENTOLIN HFA



Multi Source Brand Deletions 2009:

Drug Name	Alternative
ALTACE CAPSULE	ramipril
ANTIZOL	fomepizole 1 gm/ml vial
CAMPTOSAR	irinotecan
CEFTIN SUSPENSION	cefuroxime suspension
CEREBYX	fosphenytoin 50 mg pe/ml vial
CIPRO I.V. 200 MG/100 ML D5W	ciprofloxacin 200 mg/100 ml
CIPRO I.V. 400 MG/200 ML D5W	ciprofloxacin 400 mg/200 ml
CLEOCIN VAGINAL OVULE	clindamycin 2% vaginal cream
DANTRIUM 20 MG VIAL	dantrolene sodium 20 mg vial
DELESTROGEN 10 MG/ML VIAL	estradiol valerate 10 mg/ml vial
DELESTROGEN 40 MG/ML VIAL	estradiol valerate 40 mg/ml vial
DIANEAL WITH 2.5% DEXTROSE	delflex with 2.5% dextrose
DILAUDID 4 MG/ML AMPULE	hydromorphone hcl 4 mg/ml ampule
DOVONEX SOLUTION	calcipotriene solution
EFUDEX 5% CREAM	fluorouracil cream
EFUDEX OCCLUSION PACK	fluorouracil cream
ETHYOL	amifostine 500 mg vial
FLOLAN	epoprostenol sodium
IFEX 3 GM VIAL	ifosfamide 3 gm vial
IMITREX TABLET, INJECTION *	sumatriptan
MAXIPIME 1 GM VIAL	cefepime hcl 1 gm vial
PANLOR DC	trexix capsule
PARNATE	tranylcypromine sulfate
PRECOSE	acarbose
REQUIP, STARTER KIT	ropinirole
SOLU-MEDROL 500 MG VIAL	methylprednisolone 500 mg vial
TOPROL XL	metoprolol succ er
UNIPHYL	theophylline er
UTIRA-C	urogesic-blue
VOLTAREN 0.1% EYE DROPS	diclofenac sodium eye drops

* IMITREX TABS AND INJECTION ARE SCHEDULED TO HAVE GENERICS BY 01-01-2009.

Other Deletions 2009:

Drug Name	Alternative
chloroxylenol-pramoxine hcl	zoline hc, otirx ear drops
methscopolamine bromide	propantheline bromide

PreferredOne®

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 10/11/07
Department(s) Affected: Quality Management, Network Management	Effective Date: 10/11/07	
Procedure Description: Medical Record Documentation Guidelines	Replaces Effective Procedure Dated: 10/26/06	
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 (Core Elements are identified by an asterisk *):
 1. Patient specific demographic data (address, home or work telephone numbers, date of birth and sex)
 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
 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®

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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
8. An immunization record/history
9. Working diagnoses are consistent with findings*
10. 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 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
- B. Organizations not meeting 80 percent of the above record keeping requirements 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:

- 2007 NCQA MCO Standards and Guidelines, QI 14 Standards for Medical Record Documentation
- Minnesota State Statue 4685.1110, Subp. 13

DOCUMENT HISTORY:

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