PreferredOne

UPDATE

A NEWSLETTER FOR PREFERREDONE PROVIDERS

July 2002

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NETWORK MANAGEMENT UPDATES

Credentialing Update

by Donna Larson, Director Provider Operations

Process Change for Provider ID Numbers:
PreferredOne has historically issued provisional provider numbers upon receipt of a complete credentialing application with no potential quality concerns (all answers to the disclosure questions were “No,” etc.). The provisional provider number was issued pending the completion of the credentialing process and subsequent approval of the application by the PreferredOne Credentialing Committee and Board. The provisional number then became the permanent provider number unless PreferredOne notified you otherwise due to a quality concern.

In order to meet the standards of our accrediting organization (URAC), PreferredOne is no longer able to issue provider numbers upon receipt of the credentialing application. Beginning August 1, 2002, all provisional provider numbers will be issued **upon completion of the primary and/or secondary source verification by PreferredOne’s Credential Verification Organization (CVO).** This verification is typically completed 60-90 days *after receipt of the completed credentialing application.* Similar to the current process, the provisional provider number will become the permanent provider number unless PreferredOne notifies you otherwise.

What does this change mean to you as a provider?

1. PreferredOne has always encouraged the submission of completed credentialing applications prior to a practitioner start date with a practice. Because we must now complete the CVO verification (which typically takes 60-90 days from receipt date of a complete application) *prior to issuing a provider number*, **it is critical for credentialing applications to be submitted as soon as possible**. Similar to today, the clinic will need to hold claims pending receipt of the provider number.

2. While PreferredOne will continue to issue a provisional provider number (retroactive to the provider’s start date) for complete applications received no later than 30 days after the practitioner start date,

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*The PreferredOne Provider Update is now available on the secured site at **https://secure.preferredone.com**.

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it is important to note that the provisional number becomes the permanent provider number only after the completion of the entire credentialing process. The completion of the entire credentialing process, including approval by the PreferredOne credentialing committee and board, may take up to an additional 60 days from the CVO verification.

Any complete applications received greater than 30 days after the provider start date will be limited to a backdated effective date of 30 days prior to the receipt date of the application. PreferredOne will be unable to accept appeals for timely filing claims denials for these practitioners.

3. Practitioners who are effective with a clinic prior to final acceptance of the credentialing application may choose to render services to PreferredOne enrollees. If services are rendered to our enrollees and the application does not pass the entire credentialing process, the clinic will not be able to bill either PreferredOne or the enrollees for services provided. This means that the clinic will be liable for all services rendered by any practitioner that does not meet the PreferredOne credentialing standards.

4. In order to comply with URAC requirements, practitioners will not be added to PreferredOne's directory (either paper or online copy on our web-site) until after final approval by the PreferredOne credentialing committee and board.

Delegated Entity Requirements:
The above changes do not apply to entities with delegated credentialing agreements with PreferredOne. As always for delegated entities, it is important that all practitioner additions, terminations, and changes be communicated to PreferredOne as soon as possible. This will ensure that our database is both current and accurate for claims processing and payment, and provider directory printing. Practitioner profiles for recredentialing must include the following:

- Health Care Practitioner's name and degree
- Date of birth
- Social Security Number
- Current medical license number(s) and expiration date(s)
- Drug Enforcement Registration Number (DEA) and expiration date
- Specialty(ies), Board Certification(s) status
- Practicing specialty (if practitioner has multiple specialties)
- Practice site location(s) and address(es)
- Date recredentialing process was completed
- Hospital affiliation(s)
- Malpractice carrier information including name of insurance carrier and dates and amount of coverage

Uniform Credentialing Application:
Credential One requires all applications to be completed on the Minnesota Uniform Credentialing Application form.

An electronic version of the Minnesota Uniform Credentialing Application is available on the Credential One website. There are two versions of the application on the website. One version is simply a PDF file that can be printed and manually filled in. The second version is a field editable PDF form. This version will allow the clinic and/or practitioner to type information directly into the form. The form can then be saved for later retrieval and editing.

To access either version, navigate to **www.idsconnect.com** and click on the "Downloads" link on the gray bar at the top of the page. Click on "Minnesota Uniform Credentialing Application." Please note, Adobe Acrobat is needed to use the order to use the field editable application; a link to download the Acrobat Reader is further down the IDS/CredentialOne downloads page.

Fair Hearing Policy:
If the PreferredOne Credentialing Committee receives information which it believes warrants discipline or termination of a practitioner's participation or denial of a practitioner's request for participation in the network relating to the practitioner's professional competence or conduct, it will offer the practitioner an opportunity to request reconsideration of the Credentialing Committee's recommendation and an opportunity to appeal an adverse recommendation.

Attached to this newsletter is the revised Fair Hearing Policy (Exhibit A). This policy provides practitioners with a fair hearing opportunity before PreferredOne takes final adverse action against a practitioner's participation status based upon clinical issues. Please update your Provider Manual to replace the old version with this new version.

Please call your Provider Relations Representative if you have any questions. If you do not know who your representative is please feel free to contact customer service at 763-847-4000 or 800-451-9597.

Clinics with Facility-Based Designation

by Donna Larson, Director Provider Operations

PreferredOne is in the process of identifying clinics with facility-based designation. Facility-based designation is used for integrated delivery systems in order to accommodate the appropriate accounting and allocation of costs for situations where more than one service is performed within the same facility. Clinics with this facility-based designation generally subject our enrollees to increased financial liability. With the market movement towards higher deductible/coinsurance benefit plans, we believe it is important to notify our enrollees that they may be subject to additional out of pocket expense when accessing a facility-based clinic. The reason for this is that charges from an outpatient hospital place of service will be applied to the enrollee's outpatient hospital benefits rather than a clinic visit benefit. Initially we will use our claims data to try to identify clinics that may have this designation. Starting in 2003, facility-based clinics will be flagged in provider directories, both web-site and paper, with a disclaimer alerting enrollees that services may be paid against hospital outpatient benefits.

CareTeam Open Access for OB/GYN

by Donna Larson, Director Provider Operations

Effective January 1, 2003, enrollees under a PreferredOne CareTeam plan requiring a clinic selection will have open access to any OB/GYN provider in the network. This means that a enrollee may self refer to any OB/GYN specialist within the network regardless of the care team or clinic in which have enrolled. Currently all employer groups accessing the CareTeam model are self-insured. All of these self insured employers have designed their benefit set such that employees have open access to OB/GYN providers. This change makes the directory consistent with how the benefit design is administered. Your Provider Relations Representative may be contacting you if further administrative follow-up is required as it pertains to your CareTeam Introduction Page in the Care Team Directory.

PreferredOne Physician Associates, P.A. (PPA)

by Donna Larson, Director, Provider Operations

PreferredOne Physician Associates, P.A. (PPA) is a for-profit corporation that owns 20 percent of PreferredOne. PreferredOne is the only major health plan in Minnesota that is owned in part, by physicians.

All MDs and DOs practicing 50% or more of their time in a clinic in the Twin Cities Metropolitan area are required to purchase a PPA share. **Effective March 7, 2002, the PPA share has changed to $800.** This price is used for both the purchase (to be accompanied with all new applications) and redemption of shares.

Secured Web Site Update

by Dan Van Orsow, Supervisor, Provider Relations

PreferredOne continues to enhance our Secured Provider Web Site. New features include: **Access Your Online Account** through **www.preferredone.com**, **Referral Inquiry** and **PCC Rosters**.

By logging on to **www.preferredone.com** and clicking on **Access Your Online Account** and Providers, you will have access to the Secured Web Site.

Referral Inquiry allows providers to view all referrals created to other providers and referrals from other providers. To access this information, click on Referral Inquiry and enter the enrollee's ID/Social Security Number or the enrollee's name.

PCC Rosters identify enrolleess that have chosen your clinic and the employer name. Use the following steps to produce the rosters:

- Under PCHP/PAS Products choose PCC Roster
- Choose the Primary Care Clinic
- Click on Get Roster

Listed below is additional information available on the secured web site.

- **PCHP / PAS Products**
  - Member Eligibility
  - Claims Inquiry
  - Referral Inquiry
  - Referral Submission
  - PCC Roster
- **PPO Products**
  - Member Information
  - Claims Inquiry
  - PPO Group/Payer Lookup
  - PPO Payer Listing
  - PPO Reports
- **Information**
  - Medical Policy
  - Coding Hot Topics
  - Provider Newsletter

If you do not have access to our Secured Web Site, go to **www.preferredone.com** and click on Access Your Online Account, Providers and Register.

CODING UPDATE

by Elaine McLinden, Manager Coding

Minnesota Local XV Modifier Replaced for State Vaccine:
As of July 1, 2003 there is a national modifier to identify vaccine that is supplied by the state free of charge to providers. The Minnesota local XV modifier that has been in use will be replaced with **SL.** The immunization codes have been loaded into our system with this modifier. We will still accept the old modifier for several more months until practitioners have been able to update their systems. The immunization code appended with modifier SL will be the reimbursement for the administration. Do not report the codes 90471 (administration single vaccine) or 90472 (each additional immunization) as an additional line item unless non state received vaccines were given at the same visit.

J7315 Hyalgan 20 mg – deleted code
J7316 Hyalgan 5 mg – new January 2002
Q3030 Sodium Hyaluronate per 20 to 25 mg – new September 30, 2002 for Medicare

The code for Hyalgan 20 mg was deleted for 2002. It was replaced with J7316 Hyalgan with a description of 5 mg. When using J7316 for 5 mg you will have to report the number of 5 mg units injected. If the practitioner injected 20 mgs, report 4 in the units box. The appropriate pricing is in our system based on a 5 mg unit dose. Even though Medicare will no longer accept J7316 after September 30, you may continue to use this code for PreferredOne until the end of the year.

Our fee schedule was updated on July 1, 2002 to include the 5 mg Hyalgan. The fee schedule will not be updated again until January and therefore does not include AWP pricing for Medicare's newest code Q3030. We suggest you continue to submit J7316.

Place of Service 20 For Urgent Care:
Beginning August 1, 2002 you may begin submitting HCFA 1500's with place of service 20 for services rendered in an urgent care.

"S" Codes:
PreferredOne will only accept the "S" codes related to drugs S0009 – S0191. Other "S" codes will be denied with the EOB message to resubmit with appropriate CPT codes.

Coding Hot Topics on the Web:
PreferredOne has begun a Coding Hot Topics section on our secured web site. We will make every attempt to keep this updated with new information that may be of interest.

Unlisted Codes:
PreferredOne Community Health Plan and PAS must have a description of the unlisted code in order to process claims. If the description is not on the claim, the claim will be denied with the EOB message to submit a description of service/item.

Preventative Medicine Visits and Illness Visits:
PreferredOne follows CPT guidelines regarding the reporting of both an illness visit and a preventative medicine visit on the same day. Most often, the documentation does not substantiate the level of service being billed for the illness exam. This service must be a significant separately identifiable service. We will continue to reduce the illness service as appropriate per the documentation.

*The PreferredOne Provider Update is now available on the secured site at **https://secure.preferredone.com**.

MEDICAL MANAGEMENT UPDATE

by Dr. John Frederick, Vice President/Chief Medical Officer

Over the last few months PreferredOne has brought additional physicians in to do medical case reviews. Our intention is to get more practicing physicians involved with the process and to broaden our expertise. The following physicians are working at PreferredOne on a part time basis; Mark Berg (IM and ER), Michael Goertz (IM and Preventative Med.), Rick Simmons (FP), and Kent Svee (IM). They join Kevin Crosston (Surgery), Ken Dedeker (IM), John Simon (Psychiatry), and myself (FP) as PreferredOne's in house medical case reviewers. I would like to take this opportunity to ask for any feedback on the case review process. We're always looking to improve.

The Community Measurement Project for Diabetes continues to move forward. PreferredOne is working with Blue Cross Blue Shield, HealthPartners, Medica, Metropolitan Health Plan and Ucare to integrate the existing data gathering and processing so that it is less intrusive on clinics but also will provide clinics with data on their care of Diabetic patients. Practitioner representatives have also been involved in the design of the project. The data on 60 patients in each of 50 different medical groups will be gathered, analyzed and reported back to the medical group. If the Diabetic measurements go well over the next couple of years (coincident with the ICSI Diabetes Community Initiative), the project members hope to expand to additional quality measures in years to come.

Please e-mail me at **john.frederick@preferredone.com** or call at 763-847-3051 or 800-451-9597 if you have any questions or comments on the above issues.

MEDICAL POLICY UPDATE

by Joni Riley, Medical Policy Specialist

Considerable controversy continues to exist regarding the efficacy of remote home uterine monitoring. Large randomized trials have demonstrated the use of a home uterine monitor is not associated with a decrease in the incidence of preterm birth. This analysis is supported by policy statements made by the American College of Obstetricians and Gynecologists, the U.S. Preventative Services Taskforce, and the Agency for Health Care Policy and Research. Because of this, effective August 12, 2002, non-stress tests are a covered benefit only when provided within a comprehensive pre-term labor management home care program. *Remote home uterine as a stand-alone service or billing is not eligible for coverage*. The medical policy (Exhibit B) is attached for your review.

Medical Policies continue to be available on the PreferredOne secured web-site. The web-site address is **https://secure.preferredone.com**. Medical policy indexes (Exhibit C) are also attached indicating new and revised policies approved by recent meetings of PreferredOne's Medical/Surgical, Mental/Substance Related Disorder, and Pharmacy and Therapeutics Quality Management Subcommittees. Add the index dated 6/1/02 to the Utilization Management section of your Office Procedures Manual.

If you wish to have paper copies of policies or you have questions feel free to contact me at 763-847-3238 or on line at **jriley@preferredone.com**.

UTILIZATION MANAGEMENT/ CASE MANAGEMENT POLICY UPDATE

by Linda Chapeau, VP Medical Management

Department of Labor Claim Regulation

The Department of Labor has issued changes to the claims procedure regulation that employer group health plans are required to follow. They define a claim as a request for plan benefits made by a claimant in accordance with the plan's reasonable procedure for filing benefit claims. Health care claims are now divided into pre-service health care claims and post-service health care claims. If a request of a claim is denied, the new regulation gives shorter time frames for the plan to respond to an appeal and longer time for the member to request an appeal. The member may also bypass the plan's appeal policies and directly file an ERISA lawsuit. The regulation does not apply to contractual disputes between a health care provider and an insurer or managed care organization, provided that the health care provider has no recourse against a claimant for amounts not paid by the plan.

The new claims procedure regulation applies to health benefit claims filed on or after the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003. PreferredOne will assume following the new regulations on July 1, 2002. New appeal and complaint polices were developed and are available. You may request a copy of the Appeals Policy or Complaint Policy from PreferredOne by calling Customer Service at 800-451-9597 or 763-847-4000.

QUALITY IMPROVEMENT UPDATE

by Deb Doyle, Director Quality Improvement

HIPAA Privacy and Security

PreferredOne's HIPAA Privacy Committee has finalized PreferredOne's Privacy Principles. The Privacy Officer and Security Officer have been designated, and they are working together with the Privacy Committee to ensure PreferredOne is compliant with the privacy regulations by the deadline. We are currently amending all business associate agreements so they will be compliant with the HIPAA Privacy Rules. A gap analysis will also be conducted over the next few months to identify policies and procedures that need to be written or modified for compliance with the privacy rules by the April 14, 2003 deadline.

PreferredOne will be applying for the compliance extension to the Transaction and Code Sets regulations. We are currently implementing a HIPAA-compliant version of our adjudication software, and we will begin testing the mandated transactions prior to April 16, 2003.

Internal security processes and procedures are also being analyzed for compliance with the proposed Security regulations. Some of the proposed requirements have already been implemented, and we are working with our external auditors to identify systems and procedures that need to be upgraded.

If you have any questions regarding PreferredOne's efforts to become compliant with the HIPAA Privacy and Security regulations, please feel free to contact Debra Doyle, Privacy Officer at 763-847-3228 or **deb.doyle@preferredone.com** or Ed Stroot, Transaction and Code Set Project Manager at 763-3847-3323 or **ed.stroot@preferredone.com**.

URAC Approval
by Deb Doyle, Director Quality Improvement

PreferredOne is pleased to announce that URAC/American Accreditation HealthCare Commission has approved our two year application for full re-accreditation for PreferredOne PPO, Health Network, Credentialing, and Utilization Management. PreferredOne has been accredited by URAC since 1993. The URAC accreditation process involves a lengthy written application as well as a three-day onsite review. URAC is a non-profit organization founded in 1990 to establish standards for the managed care industry. URAC has accredited over 300 organizations doing business in all 50 states.

Health Plans Work Together to Improve Data Collection and Reporting by Deb Doyle, Director Quality Improvement

Minnesota's health plans are launching an effort to collect health care data, analyze it and report combined results to medical groups. The collaboration is called the Community Measurement Project, and a pilot effort measuring diabetes care is currently being developed.

The project focuses on priorities that are important in Minnesota including improving diabetes care, improving data collection and reporting, and providing medical groups meaningful information on how they compare to others. At the same time, it's necessary to maintain the ability to report performance at the health plan level. Over time, the health plans expect this effort will cut down on chart pulls and auditing visits to medical groups. However, for now, health plans must continue to conduct their own chart reviews on other measures.

"By working together, the health plans can get better information on quality of care, support improvements in care, and at the same time reduce the costs and administrative burden on clinics and health plans," said Michael Scandrett, executive director of the Minnesota Council of Health Plans. "Because most medical groups contract with several health plans, they will see a reduction in the number of quality researchers in to conduct reviews."

"This is a logical evolution of health plans' efforts to improve quality," said Gail Amundson, M.D., FACP, of HealthPartners, chair of the project steering committee. "We recognize the significant efforts of medical groups and continue to take pride in our own individual health plan accomplishments in quality improvement, but we know that both our own work and the community will benefit from better collaboration."

The health plans involved in the pilot include Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne and UCare Minnesota. Aspen Medical Group and Northwest Family Physicians Medical Group represent medical groups. The Minnesota Council of Health Plans is coordinating the overall project. NCQA is involved because this initiative has the potential to enhance the impact of HEDIS reports produced by health plans.

What specific diabetes measures will be reviewed in the pilot phase? Institute for Clinical Systems Improvement (ICSI) selected diabetes care improvement as the first ICSI-wide area of focus. The Community Measurement Project is supporting this effort by selecting care for people with diabetes for its pilot project. The 2001 measure reported is the percentage of patients who have all of the following:

- HbA1c at or below 8.0
- LDL cholesterol below 130
- Blood pressure below 130/85
- Tobacco-free status confirmed
- Aspirin use if over age 40

What results from the pilot will be reported and to whom? Results will be reported to medical groups at the summarized level of each medical group. Note that results will not be reported at the level of an individual physicians or clinic sites. In addition, overall Minnesota numbers (not medical group specific) will be reported publicly for the pilot. In future years of the Community Measurement Project, medical group-specific results will be shared publicly.

If you have additional questions regarding, this project please contact John Frederick, CMO at 763-847-3051 or **john.frederick@preferredone.com** or Debra Doyle, Director of Quality Improvement at 763-847-3228 or **deb.doyle@preferredone.com**.

DISEASE MANAGEMENT UPDATE
by Mary Jo Kingston, Director Disease Management

At present PreferredOne has three disease management initiatives up and running. Our first program, PreferredOne AccordantCare, was implemented July 1, 2001. The program appears to be very successful as indicated by the fact that we have experienced no voluntary terminations. In fact, we have received requests from physicians and patients to enroll patients belonging to plans not yet having access to the program. This program is for patients with any of 14 complex, chronic diseases such as hemophilia, lupus, multiple sclerosis, rheumatoid arthritis, ALS, etc. The program, which is administered by Accordant Health Services of Greensboro, N.C., uses multiple venues (internet, telephone, written materials) to educate and support patients in remaining compliant with the treatment plan recommended by the physician. It assists them in preparing for office visits with their provider and answering questions between visits. The goal is to bolster patient knowledge and control of their disease in order to minimize exacerbations, slow progression if possible, and improve quality of life.

PreferredOne CareEnhance Diabetes Management Program is a joint venture of McKesson Health Solutions and PreferredOne. Patient enrollment began in February of 2002 and at present we have 22% of eligible diabetics enrolled, with enrollment growing. The emphasis of the CareEnhance specially trained nurses is to increase patient knowledge of the disease process and slow progression as much as possible. Nurses are available 24 hours a day, 7 days a week to answer questions about diabetes or any other health issue. An audio library on a variety of diverse health conditions is also available. The CareEnhance nurses are following the guidelines published by ICSI (Institute for Clinical Systems Improvement).

In April PreferredOne began a Migraine initiative aimed at reducing emergency room and urgent care visits for patients suffering from migraines and other severe headaches. From a claims analysis, a list of patients was generated who had at least two emergent/urgent care facility visits within the previous

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12 month period. These patients were sent a letter explaining the project along with a brochure published by the American Medical Association on Migraines and other headaches. It explains the different types of headaches, causes, triggers, treatment – both therapeutic and prophylactic, and included a diary/log for the patient to better understand the headache patterns.

Patients with 5 or more emergent/urgent facility visits in the previous 12 months period for headaches/migraines were detailed along with pharmaceutical records for the primary provider as a means of identifying and informing the primary provider of the patient's utilization pattern. The goal is to better control the headaches, reduce the pain and disruption involved in going to emergency/urgent care, and improve the quality of life generally for these patients.

In coordination with the PreferredOne Quality Committee, new initiatives are being selected and designed for implementation early next year. Suggestions from our providers are always welcome. Providers can call 800-451-9597 or 763-847-4000 or email us at **www.preferredone.com**.

The PreferredOne Insurance Carrier – TPA Payer Relationships Listing is available on the Secured Site, or you may call PreferredOne at 800-451-9597 or 763-847-4000. Ask to be transferred to Network Management to request a paper copy.

Exhibits

Exhibit A	Appeal and Fair Hearing Policy and Procedure for Clinically Based Disputes
Exhibit B	Remote Home Uterine Activity Monitoring (HUAM) Medical Management
Exhibit C	Medical Policy Index