PreferredOne

UPDATE

A Newsletter for PreferredOne Providers

February 2005

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February

2005 Update

I'd like to start this first 2005 newsletter by announcing some leadership changes in the medical management area of PreferredOne. Tammy Bentz, Director of Medical Management has left PreferredOne to move to West Palm Beach with her spouse and his new job. We wish her well but are worried that she may not tan well. Deb Doyle has been selected to assume the position of director of Medical Management. Joni Riley has assumed the position of Director of Quality and Medical Policy. I am confident that Deb and Joni will function well in their new positions.

PreferredOne has seen successful selling Consumer Focused products to employers. These include cost-tiered provider products and high deductible products such as HSA's and HRA's that encourage the member to be involved in the cost decisions around their care. Since many of the member's cost concerns will be brought to the provider, P1 will be making the provider cost information that is available to members also available to providers on the secure P1 Provider Website. This should occur by March 2005.

One of the key network initiatives for 2005 will be to work with providers to find areas of opportunity for Pay for Performance. If we can mutually determine with provider groups improved practices that contribute to medical cost containment for PCHP, we would potentially agree to contract with the providers to share the savings. If you would like to discuss an opportunity, please send me an e-mail to explain your idea at: john.frederick@preferredone.com . Opportunities may be in the areas of increased generic prescribing, use of lower cost facilities, or many other areas.

During 2005 PreferredOne will... *Pg 2*

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also initiate many efforts to try to deal with the escalating cost of specialty pharmaceuticals. These initiatives will involve drugs delivered in the provider office and picked up at retail pharmacies. Many of the provider groups will be effected by this and we will try to communicate as well as possible with the providers on this issue.

Medical Records Reimbursement

As indicated in the PreferredOne Provider Agreement, to perform its utilization and quality management, claims payment and other administrative duties, PreferredOne will have access to medical records.

The provider shall bear the cost of copying and submitting records to PreferredOne in the following instances:

- The provider elects to submit medical records in substantiation of an appeal.
- PreferredOne request medical records to determine medical necessity on retrospective claims that were not prior authorized.
- The provider submits a claim adjustment or a new claim with changes in which case medical records are required to support the changes.
- PreferredOne requests operative reports or medical records to substantiate billing.

If PreferredOne requests medical records based on a complaint/quality issue, then PreferredOne will bear the cost of copying and obtaining the records. PreferredOne will indicate which portions of the medical record it requires and will not accept responsibility for copying or sending any other portions of the record beyond what is requested.

PreferredOne reimbursement for records shall be at the local community standard and according to State Law. Updated policy is attached. Attachment A

Risk Allowance

For 2005 risk allowance we will be using the Episode of Treatment Grouping (ETG) software, as well as unit price. If ETG reports are available, the efficiency score from the report will be used to calculate the risk return. However, if for whatever reason, the ETG report is not available, we will use unit price to determine the risk allowance return. Remember, overall risk allowance return or retention is still based on PCHP's Board of Directors determination. If the board should decide to return all or a portion of the risk allowance it would then be distributed based on the criteria above.

PreferredOne Establishes Partnership with Assurant

As previously communicated, PreferredOne is partnering with selected carriers to assist in market areas where PreferredOne does not have a presence. We have chosen Assurant Health, (formerly known as Fortis), as our small group partner. This will round out our ability to sell and market products with all employers from small, mid-size to large employers.

This new relationship will be effective 5/1/05. Assurant will have access and privilege to all the arrangements under the PreferredOne Administrative services/PreferredOne Community Health Plan contracts. In order to track claims more efficiently, please send your claims to:

PreferredOne Administrative Services
PO Box 1512
Minneapolis, MN 55440-1512

You will begin to see ID cards that say "Assurant Health" with the PreferredOne Administrative Services logo with the PO Box listed above. Please make sure to update your system for this new PO Box claims address.

Network Management Updates

State Farm Effective 12/13/04

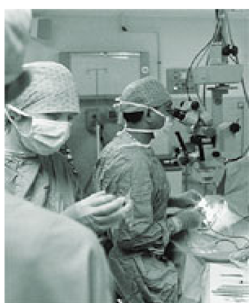
Effective 12/13/04, State Farm has re-contracted for access to the PreferredOne PPO network. State Farm currently has about 2,000 individual policyholders.

Mutual of Omaha/Rural Mail Carriers

Rural Mail Carriers with Mutual of Omaha access the PreferredOne PPO for both active and retiree medical claims.

All claims for the Rural Mail Carriers (includes both active and retired), Group G0001846, must be submitted to PreferredOne.

Designated Centers for Bariatric Surgery



PreferredOne has recently negotiated with contracted health care facilities to serve members undergoing bariatric surgery. The Bariatric Surgery Designated Centers are the University of Minnesota, Fairview Southdale and Sioux Valley Hospital of Sioux Falls, SD. We are also working to potentially add one more site in St. Paul.

As PAS and PCHP groups renew coverage with PreferredOne, if there is coverage for bariatric surgery, the benefit will be provided only if the services are performed at one of the designated centers.

Bariatric Surgery requires prior authorization. Employer group benefits will be communicated to the clinics during the prior authorization or benefit confirmation inquiry. If you have any questions about this, contact PreferredOne customer service at (PCHP) 1-800-379-7727 / 763-847-4488 or (PAS) 1-800-997-1750 / 763-847-4477.

Coding Update

Preservative Free Tetanus Diphtheria Vaccine

The code 90714 was released by the AMA for use no earlier than July 05, using it prior to July would not be HIPPA compliant. Report the vaccinations using the unlisted immunization code 90749 with a description of the vaccine e.g. preservative free tetanus diphtheria vaccine. When the vaccine is supplied via the free vaccine for the children's program, you may submit 90749 with modifier SL, include the description, an .01 cent charge for the free vaccine, and your administration code.

Immunizations For Children Under 8 Years

The new codes for administration with counseling for children under the ages of 8 are being accepted. Please note the following:

- For each immunization, there should only be one administration code. Some providers are reporting 2 administration codes for each immunization, which is incorrect.
- The four new codes, include the act of giving the immunization as well as the counseling by the physician
- Only one "first" administration service is to be billed during a single patient encounter.

If you administer one injectable vaccine with counseling, and one intranasal vaccine without counseling, you would submit: 90465 Administration & Counseling, plus 90474 for each additional intranasal (90473 first adm/oral not appropriate). *...Pg 4*

Network Management Updates

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New Codes

With Counseling Under Age 8:

90465 First injection with counseling

90466 Each injection additional per day/counseling

90467 First administration intranasal/oral counseling

90468 Each additional adm per day/counseling

Without Counseling Any Age:

90471 Adm no counseling - one vaccine

90472 Each add/adm - no counseling

90473 Intranasal or oral/one - no counseling

90474 Each additional - no counseling

Unlisted Surgical Codes

We receive many electronic claims containing unlisted surgical codes. These claims cannot be processed without information about the procedure so that the member's benefits can be applied. To shorten the claims cycle on unlisted codes, please submit operative reports with the first submission of the claim. Claims without operative reports will be denied. The EOB remark will state that additional information is needed. Once the information is received we will begin our review of your claim.

S0820: Corneal Topography

When submitting claims for corneal topography, use S0820 instead of an unlisted code. Services performed in preparation of cosmetic eye surgery are not covered.

99000: Handling Charges and Reference Labs

A reference lab cannot report handling charges. A handling charge is already paid to the clinic to prepare a specimen for the outside lab. PreferredOne allows one veni puncture for blood and one handling charge for non-blood specimens per encounter.

Bilateral Procedures

PreferredOne requires two lines for bilateral procedures. One line without modifier 50 and the second line with modifier 50.

Updated Polices

Attached to this newsletter are updated policies for outpatient surgery centers. Attachment B1-B4

2005 Coding Grid

Helpful information about new 2005 coding issues have been combined in a grid and are attached to this newsletter. Attachment C

Coding Depression In Primary Care

PreferredOne, other health plan representatives, and member organizations were involved in a project with ICSI regarding primary care providers and billing issues for mental health services.

Principles and policies of a general nature were discussed and the following points were identified in an effort to assist primary care providers who treat depression.

- All health plans reimburse for patients treated for depression in the primary care sector. The use of a diagnosis code of depression does not lead to a rejection of that claim for reimbursement.
- Primary care providers should report E/M codes 99201- 99215. These are new or established patient evaluation and management services and are the basic codes to be used to report these services.

When counseling and/or coordination of care dominate more than 50% of the visit, then time may be considered the key factor when assigning a particular level of E & M Services. The total face to face time spent with the patient must be documented in the record when selecting a level of service based on "time". ...Pg 5

Network Management Updates

...Cont'd from page 4

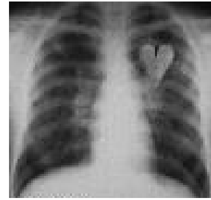
While health plans differ, if patients have a mental health benefit limit as part of their coverage, the use of the psychiatric codes 908xx by a primary care physician, rather than an E&M code, may be applied to that mental health benefit limit, rather than their medical benefit. This could impact their ability to be seen in consultation by a behavioral health provider if the need arose.

- The use of 90862 code (covering pharmacologic management of depression) may be appropriate, but an E&M code of 99213 is almost identical in scope and coverage and would provide reimbursement when the visit is related to prescription management.
- Psychiatric codes (908xx) are more suited for psychiatric professionals and suggest a level of care and documentation that is not common to most primary care providers.
- There is no impact on reimbursement based on the use of a specific ICD-9 diagnosis code for depression. Any diagnosis code can be submitted and should be more specific than common code 311 depressive disorder not elsewhere classified.
- If organizations are using the specific codes for major depression (296.2x, 296.3x, the fifth digit, which describes the status of care of improvement is necessary. If the fifth digit is excluded, the claim may be rejected as an invalid diagnosis code.

PreferredOne recognizes the importance of the primary care physician in recognizing and treating depression. PreferredOne also recommends that all patients should have the opportunity to be referred for psychotherapy to further the response to depression treatment and to provide more illness management skills.

Medical Management Updates

Institute for Clinical Systems Improvement (ICSI) Update



Listed below are the ICSI guidelines and technology assessment reports newly available or recently updated on the ICSI web site (www.ICSI.org).

Health Care Guidelines:

- Cervical cancer screening
- Breast cancer treatment
- Adult low back pain
- Preventive services for adults
- Preventive services for children and adolescents
- Intrapartum Fetal Heart Rate Management
- Menopause and Hormonal Therapy: Collaborative Decision-Making and Management
- Prevention, Diagnosis and Treatment of Failure to Progress in Obstetrical Labor
- Vaginal Birth After Cesarean
- Diagnosis and Treatment of Adult Degenerative Joint Disease (DJD) of the Knee
- Domestic Violence
- Management of Type 2 Diabetes Mellitus
- Prevention and Management of Obesity (Mature Adolescents and Adults)
- Diagnosis and Treatment of Headache
- Atrial Fibrillation
- Cardiac Stress Test Supplement
- Diagnosis and Treatment of Chest Pain and Acute coronary Syndrome (ACS)

Technology Assessment Reports:

- Extracorporeal Shock Wave Therapy for Plantar Fasciitis
- Computed Tomographic Colonography for Detection of Colorectal Polyps and Neoplasms

Medical Management Updates

Medical Policy Update

New in the medical-surgical area is the addition of the following to the investigational list effective January 25, 2005:

- Auditory Integration Therapy
- Down Syndrome/Trisomy 18 First Trimester Testing
- Endoscopic GERD Treatments (Bard Endo EndoCinch Suturing System (suturing), Stretta System (radio frequency), and Enteryx (implantation of polymers)
- Pain Management Devices (H-Wave Electrical Stimulation, BioniCare (Pulsed Electrical Stimulation)
- Protonics Neuromuscular Repositioning System
- Tamoxifen for gynecomastia

These services are not eligible for coverage because there is inadequate evidence of the safety and effectiveness and/or diagnostic value in the published peer reviewed literature on these treatment and diagnostic methods.

The latest Medical, Chiropractic and Pharmacy Policy and Criteria indexes are attached (Attachment D/E) and indicate new and revised Medical Policy documents approved at recent meetings of the PreferredOne Medical/Surgical Quality Management Subcommittee, Behavioral Health Quality Management Subcommittee, and Pharmacy & Therapeutics Quality Management Subcommittee.

Please add the attached indexes to the Utilization Management section of your Office Procedures Manual and always refer to the online policies for the most current version.

Medical Policies are available on the PreferredOne web site to members and to providers without prior registration. PreferredOne reserves the right to amend medical policies without notice to health care providers or members. If members or providers have questions about a policy, they should feel free to contact PreferredOne. The web-site address is for accessing medical policies on line is http://www.PreferredOne.com. Click on Health Resources in the upper left hand corner and choose the Medical Policy menu item. If you wish to have paper copies of medical policies or you have questions feel free to contact the Medical Policy department at (763)-847-3527.

Pharmacy

Specialty Medication Program

Effective October 1, 2004, PreferredOne partnered with CuraScript to provide specialty medications to our members as part of their retail pharmacy benefit.

CuraScript is the nation's leading specialty pharmacy company providing oral and injectable/infusable medications to patients with chronic illnesses requiring complex, high-cost treatment. At CuraScript, quality care and outstanding customer service are top priorities. CuraScript understands the complexity of these specialty drugs; therefore, each patient receives personalized care management required for successful outcomes and confidence in treatment.

PreferredOne members who are currently utilizing the following pharmacies in order to obtain their specialty medications may continue to do so:

- Fairview Specialty Pharmacy...*Pg 7*
- Chronimed Pharmacy

Following are additional details about the CuraScript specialty program:

- Only those drugs listed on the CuraScript Drug List are part of this program at this time. This drug list is available on the PreferredOne physician secure website.
- Drugs provided by physician offices or home health agencies are not subject to this program at this time. ...*Pg 7*

Medical Management Updates

...Cont'd from page 6

- Members can obtain one fill of their specialty medication at a retail pharmacy before being required to transition to CuraScript.
- In order to begin using CuraScript, the provider or the member must complete the Patient Enrollment Form. This form is available on the PreferredOne physician secure website.
- Provider questions regarding this program may be directed to CuraScript at 877-283-2829.

Step Therapy Program

Effective February 15, 2005, PreferredOne will implement two new Step Therapy programs. Step Therapy is a program that encourages physicians to follow established guidelines of care starting with conservative therapies and progressing to more aggressive therapies, as the patient's needs dictate. The drug classes/drugs currently involved in the Step Therapy program include, but are not limited to the following:

- Zetia - - **New effective 2/15/05**
- Leukotriene Pathway Inhibitors - - **New effective 2/15/05**
- Proton Pump Inhibitors (omeprazole, Aciphex, Nexium, Prevacid, Protonix)
- COX-II Inhibitors (Bexta, Celebrex)
- Brand Name NSAIDs (Arthrotec, Ponstel, Mobic)

The step therapy criteria are located on the PreferredOne physician secure website. The website address is www.preferredone.com. The criteria are located under Information, Medical Policy, Pharmacy Criteria.

Quantity Level Limits

The Quantity Level Limit program addresses situations where certain drugs are being dispensed in higher doses or quantities than approved by the FDA or higher than recommended in best practice guidelines. The drug classes/drugs currently involved in the Quantity Level Limit program includes, but is not limited to the following:

- Antiemetics (Anzemet, Kytril, Zofran) - - **New effective 3/15/05**
- Proton Pump Inhibitors (omeprazole, Nexium, Prevacid, Aciphex, Protonix)
- Anti-Migraine Agents (Amerge, Axert, Imitrex, Maxalt/MLT, Zomig/ZMT)
- Sedative-Hypnotic Drugs (Ambien, Sonata, Lunesta)

The quantity level limit criteria and drug specific limits are located on the PreferredOne physician secure website. The website address is www.preferredone.com. The criteria are located under Information, Medical Policy, Pharmacy Policy.

Over the Counter Drug Coverage

Effective January 1, 2005, PreferredOne implemented plan coverage for most enrollees for the following over the counter (OTC) medications in up to a 93-day supply for the lowest member copayment:

- Prilosec OTC
- Claritin product line (all available dosage forms, strengths, and generic versions)

In order for these OTC medications to be covered under the member's pharmacy benefit, the provider must issue a prescription for the item, which must be presented to a retail pharmacy to be processed and filled.

Attachment A

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	**04/19/05**
POLICY DESCRIPTION:	Medical Records		
EFFECTIVE DATE:	02/01/05		
PAGE:	1	**REPLACES POLICY DATED:**	01/13/98
REFERENCE NUMBER:	NM/P024	**RETIRED DATE:**	

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

PURPOSE: The purpose of this policy is to define the circumstance under which the Provider, the PPO Payer and PreferredOne are each responsible for bearing the cost of providing a copy of the medical record.

POLICY: Guidelines regarding the reimbursement of medical record requests.

PROCEDURE:

I. Regular Review Purposes

The Provider shall bear the cost of copying and submitting medical records to PreferredOne in the following instances:

A. The Provider elects to submit medical records in substantiation of an appeal.

B. PreferredOne or payer requests medical records to determine medical necessity on retrospective claims that were not prior authorized.

C. The Provider submits a claim adjustment or a new claim with changes in which case medical records are required to support the changes.

D. PreferredOne or payer requests operative reports or medical records to substantiate billing.

II. Quality/Complaint Issues

A. If PreferredOne requests the medical record based on a complaint/quality issue, then PreferredOne will bear the cost of copying and obtaining such record. PreferredOne will indicate which portions of the medical record it requires and will not accept responsibility for copying or sending any other portions of the record beyond that which is requested.

B. Should Payer request medical records, then the payer is responsible for the copying and sending costs of the portion of the medical record which it requests.

DEPARTMENT:	Coding Reimbursement	APPROVED DATE:	04/19/05
POLICY DESCRIPTION:	Medical Records		
EFFECTIVE DATE:	02/01/05		
PAGE:	2	REPLACES POLICY DATED:	01/13/98
REFERENCE NUMBER:	NM/P024	RETIRED DATE:	

III. Reimbursable Cost

A. Reimbursement for all records shall be at the local community standard and according to State Law, should any apply.

DEFINITIONS:

REFERENCES:

Attachment B1

PreferredOne

DEPARTMENT: Network Management APPROVED: 11/1/04
POLICY DESCRIPTION: Assistant Surgeon, Physician Extenders working as assistant surgeons, Co-Surgeon, Team Surgeon
EFFECTIVE DATE: 1/1/05

REFERENCE NUMBER: P-1 REPLACES POLICY DATED: 4/28/97

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

PURPOSE: To provide guidelines for submission of claims for Assistant Surgeons ,co-surgeons, team surgeons, and Physician Extenders working as Assistant Surgeons, according to practice parameters, CPT-4 guidelines, PreferredOne's requirements, and Medicare guidelines.

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 Service, Inc. (PAS administers, are eligible to receive all benefits mandated 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. It is the policy of PreferredOne that payment for an assistant surgeon, co- surgeon, or team surgeon will only be allowed on procedures as identified by Medicare as requiring these designations.

2. For those procedures designed as not requiring an assistant surgeon and where only an assistant (surgical tech or scrub nurse) may be necessary, no additional payment will be made.

3. Modifier 80, 81, or 82 must be appended for the assistant surgeon charges

4. Modifier 62 (two surgeons) must be appended by both surgeons when working together as primary surgeons performing distinct part (s) of a procedure. Each surgeon should report his work by appending modifier 62 to the procedure (s). The same CPT codes

must be submitted by both surgeons with modifier 62. Separate operative reports must be dictated defining each surgeon's distinct part of the procedure. Reimbursement is based on 62.5% of the allowable fee schedule.

5. Surgical teams should report modifier 66 on CPT codes for highly complex procedures, requiring the concomitant services of several physicians often of different specialties as designated by Medicare. Separate operative reports must be dictated defining each surgeon's distinct part of the procedure.

6. PreferredOne defines physician extenders acting as assistant surgeons to include: physician assistants (PA), nurse practitioners (NP), certified registered nurse first assistants (CRNFA,) clinical nurse specialists (CNS), certified nurse midwives (CNM), and certified registered nurse anesthetists (CRNA.)

7. Physician extenders must be credentialed by PreferredOne and report their services with their own provider number on a separate HCFA-1500 form. Services reported on the same claim with the surgeon will result in denial of all or a portion of the claim.

8. Physician extenders acting as assistant surgeons for approved procedures, will be paid at 80% of the allowable assistant surgeon's fee.

Attachment B2

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	
POLICY DESCRIPTION:	Reimbursement for Free-standing Ambulatory Surgery Centers		
EFFECTIVE DATE:	12/21/95		
PAGE:	1 of 2	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	P-10	**RETIRED DATE:**	

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

PURPOSE: To provide guidelines for reimbursement for Free-standing Ambulatory Surgery Centers

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 mandated by the state of Minnesota. Please call the customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

Procedure:

1. Accreditation by an approved accrediting body is mandatory for ambulatory surgery centers capable of providing a number of surgical procedures.

2. Ambulatory surgery centers must submit claims with their PreferredOne facility provider number.

3. Only CPT codes in the surgical range 10000 - 69999, and designated by Medicare as approved procedures for ASC's will be considered for reimbursement. Reimbursement is based on PreferredOne's standard reimbursement methodology, which utilizes Medicare designated groupers.

4. When multiple procedures are performed on the same date of service, select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of PreferredOne's facility fee schedule. Subsequent allowable procedures will be reimbursed at the following rate: : 50% for the second procedure 25% for the third procedure and $0 for any additional surgical procedures.

5. PreferredOne requires multiple procedures and bilateral procedures to be submitted on separate lines e.g. bilateral knee arthroscopy:

   29870 LT on one line and 29870 RT on the second line, or 29870 on one line and 29870-50 on the second line.

6. Intraocular lenses, IOL, are included in the payment groups.

7. All other services, equipment, and supplies are considered part of the reimbursement for the surgical procedure.

Attachment B3

PreferredOne

DEPARTMENT:	Network Management	**APPROVED DATE:**	11/25/04
POLICY DESCRIPTION:	Reimbursement for Hospital Outpatient Ambulatory Surgery		
EFFECTIVE DATE:	1/1/05		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	12/21/95
REFERENCE NUMBER:	P-11	**RETIRED DATE:**	

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

PURPOSE: To provide guidelines for reimbursement for Hospital Outpatient Ambulatory Surgery

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 mandated by the state of Minnesota. Please call the customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

Procedure:

1. PreferredOne will recommend reimbursement for hospital outpatient ambulatory surgery based on PreferredOne standard reimbursement methodology which utilizes Medicare designed groupers for CPT codes 10000- 69999.

2. When multiple procedures are performed on the same date of service, select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of the PreferredOne's facility fee schedule. Subsequent allowable procedures will be reimbursed at the following rate: 50% for the second procedure, 25% for the third procedure and $0 for any additional surgical procedures.

3. PreferredOne requires multiple procedures and bilateral procedures to be submitted on separate lines e.g. bilateral arthroscopy

   29870 LT on one line and 29870 RT on the second line, or 29870 on one line and 29870-50 on the second line.

4. Intraocular lenses, IOL, are included in the payment groups.

5. All other services, equipment, and supplies are considered part of the reimbursement for the surgical procedure.

Attachment B4

PreferredOne

DEPARTMENT:	Network Management	APPROVED DATE:	11/1/04
POLICY DESCRIPTION:	Services Provided by Unlicensed Staff		
EFFECTIVE DATE:	1/1/05		
PAGE:	1 of 1	REPLACES POLICY DATED:	11/05/98
REFERENCE NUMBER:	P-31	RETIRED DATE:	

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

PURPOSE: To provide guidelines for services rendered by either unlicensed staff or staff providing services outside of the scope of their practice and being billed through a participating provider.

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 Service, Inc. (PAS) administers, are eligible to receive all benefits mandated by the state of Minnesota. Please call the customer service telephone number on the back of the enrollee's insurance card with coverage inquiries.

Procedure:

1. PreferredOne will not reimburse or recommend for reimbursement, any services or supplies ordered or rendered by providers or para-professionals unlicensed by the appropriate state regulatory agency. These denied services will be the provider's liability

2. PreferredOne will not reimburse or recommend for reimbursement, services or supplies that are ordered or rendered by providers or para -professionals outside of the scope of their practice. These denied services will be the provider's liability.

Attachment C

January 05 New CPT Services	New Codes	Accepted/ additional information
Acupuncture codes	97810, 97811, 97813, 97814	Most plans have an exclusion for accupuncture. Only paid if plan allows accupuncture. PPO re-priced and sent to payer.
Administration of immunizations, when counseling about the immunization	90465, 90466, 90467, 90468	Yes - accepted . Only 1 "first" administrtion code for an encounter. See Jan/Feb 05 newsletter
Conscious sedation by non anesthesia MD's	use existing 99141 for conscious sedation	We are not currently allowing other providers to bill anesthesia codes when they give sedation for procedures. Example, ER Dr. is asked to give sedation in ER while orthopedic Dr. sets a fracture. The ER Dr. should use conscious sedation code 99141, & not anesthesia codes. The anesthesia code by non Anesthesiologist will cause rejection in the system. Even though CPT says the Dr. giving sedation should use anesthesia codes, we do not agree..
Bariatric Surgery, weight reduction by laparoscopy	43644, 43645	All bariatric surgery requires prior authorization for PCHP/PAS. Per plan language, may require surgery to be performed at PreferredOne specially designated centers of excellence . Additional information TBA.
Conscious Sedation. P1 will follow CPT guidelines in that some procedures already include conscious sedation and should not be billed separately. There is a list of procedures in CPT in which conscious sedation is part of the procedure.	Codes identified with (target symbol circle with dot)	We will follow CPT for the types of surgeries that include conscious sedation and should not be billed separately. Conscious sedations must be medically necessary.
G codes for I.V. administration	G0345 -G0360	Yes, either G codes or CPT for IV administration do not mix CPT & G codes codes. **No payment for G codes for demonstrati**on project (see below).
G codes for Medicare Demonstration project to assess nausea, energy, pain	G0921- G0932	Not payable. Medicare is allowing payment, but this is for their demo project, not reimbursed by P1.
Internet on line evaluaton E mail from physican to patient	0074T	Provider responsibility
Medicare 1 time Preventative physicals for fist time recipients	G0344- physical, G0366 EKG TC & 26	Will accept when Medicare is Primary and P1 is secondary. These are for Medicare patients, do not use for other patients for preventative exams.
Tetanus diptheria **injection preservative free new 05**	Two issues: 1. new preservative free solution (use unlisted 90747 until AMA releases the code July 05-CPT 90714) 2. Reimbursement will be higher (AWP) than 90718 which is for the solution **with** the preservatives.	Yes, accept unlisted immunization until new CPT is released.
Varicose vein surgery (usually in the office, but may be OP hospital) by Laser - , or by Radiofrequency) See comments last column	36475 , 36476 for radiofrequency and 36478 and 36479 for laser surgery	PCHP/PAS Requires prior auth for **all** vein surgery including radiofrequency varicose vein surgery. Laser surgery is considered investigational and is not a covered benefit. For PPO we will re price and send to payer. The codes 36475, 36476, 36478, 36479 do not have a TC/ 26 split. The code is inclusive of all equipment and other necessary procedures. (do not bill other procedures such as 37204, 75894, 36011, 76942, 93970) these and other codes are part of this procedure)
Modifiers:		
Genetic testing - new modifiers (located in back of CPT book) . Can submit the modifiers Modifiers may be helpful in determining what is being tested. Not always covered. For diagnosis on the claim use for the reason for ordering the test, not the diagnoses after test results.	See back of CPT book Apppendix I	We will accept., The modifiers will not change pricing, and many benefit packages exclude genetic testing. For PCHP/pas each claim will be individually reviewed. For PPO will re-price and send on to payers

Other new modifiers		
AE registered dietician (helpful - accept)		Helpful on claim when submitting incident to. Distinguishes services by MD and registered dietician
AF specialty physician - not required		
AG primary physician - not required		
AK - non participating physician - not required		
AR - physician scarcity area- not needed no additional reimbursement		
SY- contact with high risk population - not required		
Performance Measures	Appendix H in CPT	Informational only, no reimbursement for these procedures
For Coronary Artery Disease	1000F - 4009F	Informational only, no reimbursement for these procedures
For Prenatal- Postpartum Care	0500F - 0503F	Informational only, no reimbursement for these procedures

Attachment D

Medical Policy Table of Contents

Click on description link to view the PDF

Criteria #	Description
A001	**Elective Abortion** ***Revised***
A002	**Mifepristone/RU486**
A003	**Acupuncture**
C001	**Court Ordered Mental Health & Substance Related Disorders Services**
C002	**Cosmetic Surgery** ***Revised***
C008	**Oncology Clinical Trials Covered/Non-covered Services**
D002	**Diabetic Supplies** ***Revised***
D004	**Durable Medical Equipment, Supplies, Orthotics and Prosthetics**
D007	**Disability Determinations: Proof of Incapacity Requirements** ***Revised***
D008	**Dressing Supplies**
E004	**Enteral Nutrition Therapy** ***Revised***
E005	**EROS Device (Vacuum Therapy for Treatment of Female Sexual Dysfunction**
G001	**Genetic Testing** ***Revised***
H001	**Home Health Aid Services**
H004	**Healthcares Services with Demonstrated Lack of Therapeutic Benefit**
H005	**Home Health Care** ***New***
I001	**Investigational/Experimental** ***Revised***
I002	**Infertility Treatment** ***Revised***
N002	**Nutritional Counseling** ***Revised***
P004	**Private Room**
P007	**Preparatory/Preoperative Blood Donation**
R002	**Reconstructive Surgery** ***Revised***
S006	**Screening Tests** ***Revised***
S007	**Sensory Integration (SI)**
S008	**Scar Revision** ***Revised New***
T002	**Transition/Continuity of Care** ***Revised***
T004	**Therapeutic Overnight Pass**
T005	**Transfers to a Lower Level of Care for Rehabilitation from an Acute Care Facility**

Revised 01/27/05

Attachment E

Medical criteria accessible through this site serve as a guide for evaluating the medical necessity of services. They are intended to promote objectivity and consistency in the medical necessity decision-making process and are necessarily general in approach. They do not constitute or serve as a substitute for the exercise of independent medical judgment in enrollee specific matters and do not constitute or serve as a substitute for medical treatment or advice. Therefore, medical discretion must be exercised in their application. Benefits are available to enrollees only for covered services specified in the enrollee's benefit plan document. Please call the Customer Service telephone number listed on the back of the enrollee's identification card for the applicable pre-certification or prior authorization requirements of the enrollee's plan. The criteria apply to PPO enrollees only when the employer group has contracted with PreferredOne for Medical Management services.

Medical Criteria Table of Contents

Click on description link to view the PDF

Criteria #	Category	Description
A006	Cardiac/Thoracic	**Ventricular Assist Devices (VAD)**
A007	Cardiac/Thoracic	**Lung Volume Reduction** ***Revised***
B002	Dental and Oral Maxillofacial	**Orthognathic Surgery** ***Revised***
C001	Eye, Ear, Nose, and Throat	**Nasal Reconstructive Surgery**
C007	Eye, Ear, Nose, and Throat	**Uvulopalatopharyngoplasty (UPPP)** ***Revised***
C008	Eye, Ear, Nose, and Throat	**Strabismus Repair (Adult and pediatric)** ***Revised***
C009	Eye, Ear, Nose, and Throat	**Cochlear Implant**
C010	Eye, Ear, Nose, and Throat	**Otoplasty** ***New***
E008	Obstetrical and Gynecological	**Uterine Artery Embolization (UAE)**
F014	Orthopaedic/Musculoskeletal	**Percutaneous Vertebroplasty & Kyphoplasty**
G001	Skin and Integumentary	**Eyelid Surgery (Blepharoplasty & Ptosis Repair** ***Revised***
G002	Skin and Integumentary	**Reduction Mammoplasty** ***Revised***
G003	Skin and Integumentary	**Panniculectomy/Abdominoplasty** ***Revised***
G004	Skin and Integumentary	**Breast Reconstruction**
G006	Skin and Integumentary	**Gynecomastia Procedures** ***Revised***
G007	Skin and Integumentary	**Prophylactic Mastectomy**
G008	Skin and Integumentary	**Hyperhidrosis Treatment** ***Revised***
H003	Gastrointestinal/Nutritional	**Bariatric Surgery**
J001	Vascular	**Treatment of Varicose Veins** ***Revised***
L001	Diagnostic	**Positron Emission Tomography (PET) Scan** ***Revised***
L002	Diagnostic	**Electron Beam Computed Tomography (EBCT)/Ultrafast Computed Tomography (UFCT)** ***Revised***
M001	MH/Substance Related Disorders	**Inpatient Treatment for Mental Disorders**
M002	MH/Substance Related Disorders	**Electroconvulsive Treatment (ECT): Inpatient Treatment**

M004	MH/Substance Related Disorders	**Day Treatment Program-Mental Health Disorder** ***Revised***
M005	MH/Substance Related Disorders	**Eating Disorders-Level of Care Criteria**
M006	MH/Substance Related Disorders	**Partial Hospitalization Program (PHP)-Mental Health Disorder**
M007	MH/Substance Related Disorders	**Residential Treatment** ***Revised***
M008	MH/Substance Related Disorders	**Outpatient Psychotherapy** ***Revised***
M009	MH/Substance Related Disorders	**Outpatient Chronic Pain Program Criteria**
M010	MH/Substance Related Disorders	**Substance Related Disorders: Inpatient Primary Treatment**
M014	MH/Substance Related Disorders	**Detoxification: Inpatient Treatment**
M019	MH/Substance Related Disorders	**Pathological Gambling Outpatient Treatment** ***Revised***
M020	MH/Substance Related Disorders	**Autism Spectrum Disorders Treatment** ***Revised***
N001	Rehabilitation	**Acute Inpatient Rehabilitation**
N002	Rehabilitation	**Skilled Nursing Facilities** ***Revised***
N003	Rehabilitation	**Outpatient Occupational, Physical and Speech Therapy**
T001	Transplant	**Bone Marrow Transplantation/Stem Cell Harvest (Autologous and Fetal Cord Blood)** ***Revised***
T002	Transplant	**Kidney/Pancreas Transplantation** ***Revised***
T003	Transplant	**Heart Transplantation**
T004	Transplant	**Liver Transplantation** ***Revised***
T005	Transplant	**Lung Transplantation**
T006	Transplant	**Intestinal Transplant** ***Revised***

Attachment F

PreferredOne Physician (PPA) Email Address Request

PreferredOne Physician Associates (PPA) own a 25% interest in PreferredOne Administrative Services (PAS) and its wholly owned subsidiary PreferredOne Insurance Company (PIC). PPA shareholders have input into PAS and serve as members on various PreferredOne boards. PPA shareholders are typically providers who practice in the Twin Cites Metropolitan area, but all interested physicians are welcome to participate.

From time to time, PreferredOne Medical Directors Dr. Ken Dedeker and Dr. John Frederick have PPA information they would like to communicate to the clinics in a timely manner. In order to achieve this, we need the assistance of the clinics whose providers are PPA members.

PreferredOne is asking you to provide us with the name and e-mail address of the lead physician at your clinic by filling out the from below. If your clinic has a website address, we would like that information as well. You can also fax, e-mail, or mail this information to:

FAX: **763-847-4010**
Attn: Alisa Hajicek

MAIL: **PreferredOne**
Attn: Alisa Hajicek
6105 Golden Hills Drive
Golden Valley MN 55416

E-MAIL: Alisa.Hajicek@PreferredOne.com

Clinic Name________________________________

Clinic Address________________________________

Clinic Phone________________________________

Lead Physician________________________________

Specialty________________________________

Physician Email________________________________

Clinic Website________________________________