PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
October 2009

Novel H1N1

John Frederick, MD, CMO

PreferredOne has been involved with multiple discussions with the Minnesota Department of Health, the CDC, the Minnesota Council of Health Plans, and America's Health Insurance Plans regarding H1N1 preparation. PreferredOne is committed to supporting the recommendations of MDH and the CDC regarding the vaccine and other treatments related to a potential H1N1 epidemic. If a pandemic does occur, it will not be a case of business as usual for anyone in healthcare industry. PreferredOne will do its part to support the provider efforts. Provider communication will be available through the PreferredOne website.

A concerning issue that surfaced during the spring of 2009 H1N1 outbreak was that the majority of the prescriptions for Tamiflu and Relenza were for physicians and their family members. In most cases the prescribing was done by the physician in the family. In a potential pandemic where shortages are likely, PreferredOne is obligated to make sure that the antivirals are prescribed according to the CDC and MDH recommendations. For those provider groups and hospitals with medical plans administered by PreferredOne, there is benefit language that excludes from coverage prescriptions written by a family member. Please be responsible to the needs of the community in these potentially critical times ahead.

Health Care Reform

As our legislators at both the Federal and State levels come together to redesign the healthcare industry, there is one thing we should all agree on. Minnesota is far ahead of the rest of the country in dealing with many of the basic issues. Our quality is consistently higher than the rest of the country. Our costs are consistently lower than the rest of the country. We have fewer uninsureds. We have not, though, gotten a lot of reward for doing the right thing. I would hope that our combined efforts around quality, cost, and access get recognized and rewarded.

Integrated Care Management

The Medical Management Department at PreferredOne is being renamed the Integrated Care Management Department. This is more than symbolic in that we are making huge efforts to integrate the functions of the department so we can get information to you to help you manage your patients. *Page 2…*

In This Issue:

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In the past disease management services have been contracted out to national vendors. We are transitioning the provision of these services to be provided by PreferredOne staff. While we will continue to work with Accordant to manage many of the rare and intense diseases, we will no longer use contracted vendors providing the services for diabetes, heart disease, CHF, asthma, COPD, back pain, and depression. We feel the focus for these diseases should be to support the members in following the provider's care plan and encouraging medication compliance. In 2010 you will begin receiving reports on your patients and our members regarding their adherence with your treatment plan. When you review these reports, I would like to get your feedback at 763-847-3051 or John.Frederick@PreferredOne.com. More information will be given over the coming months.

2010 Fee Schedule Update

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, 2010. There is 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 2009 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 2008. New codes for 2010 will be based on the 2010 CMS Medicare physician transitional RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2009. Other new non-RVU based codes will be added according to PreferredOne methodology.

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 2010 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. Beginning January 1, 2010, the site of service differential will apply to all RVU-based CPT and HCPCS codes (Place of Service 21-25 are considered facility). Please refer to the Pricing and Payment Policy #6 that replaces P12 (Exhibit A). Another new Pricing and Payment Policy #7 is attached (Exhibit B) as well as an update to an existing Coding policy H-7 (Exhibit C). These were presented at the September Provider Forum.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder of new codes for 2010 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 Update."

New ASA codes for anesthesia services will be updated with the 2010 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2010. The convenience care Fee Schedules have also been updated with some changes to rates as well as adding additional services.

Hospital Services/UB04 Fee Schedules

The 2010 calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 27 as published in the final rule Federal Register to be effective October 2009.

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Ambulatory Surgery Center (ASC) code groupings have been updated for 2010 according to Centers for Medicare and Medicaid Services (CMS). Those codes not assigned a grouper by CMS, will be assigned by PreferredOne to appropriate groupers as outlined in the policy.

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 adjuster 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: The new codes for 2010 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 Update."

Off-Cycle Fee Schedule Updates

Other provider types such as DME, Dental, Home Health, and Skilled Nursing Facility updates will take place April 1, 2010.

Coding Update

H1N1

There are two new G codes for Medicare, and CPT has released CPT 90470 for administration of H1N1.

PreferredOne will accept either the Medicare codes or CPT codes for H1N1. Keep the reporting of the H1N1 vaccine and administration to one set of codes (either all Medicare or all CPT).

Medicare:

- G9142 –influenza A (H1N1) vaccine (fee schedule set to $0 as this is a free vaccine).
- G9141 –Influenza A (H1N1) administration of vaccine, includes physician counseling. This is a reimbursable service based on the member's benefits.

CPT:

- 90663 influenza vaccine-pandemic formulation H1N1 (fee schedule set to $0 as this is a free vaccine).
- 90470 CPT just announced for administration of H1N1. This is a reimbursable service based on the members benefit. *Page 4…*

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Modifier SL indicating a state supplied vaccine is not necessary for either 90663 or G9142.

Please see the AMA Fact Sheet attachment for more information regarding the H1N1 vaccine (Exhibit D).

Knee Arthroscopies and Debridement/Shaving of Articular Cartilage (29877)

PreferredOne follows Medicare CCI correct coding. When billing knee arthroscopies and CPT 29877, the lesser procedure is bundled into the major procedure. If, however, providers submit G0289 arthroscopy, knee, surgical for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment, G0289 will be allowed when reported.

Reporting Units for Lesion Removal

In order to help reduce numerous corrected claims, we would like to remind providers of the units rule regarding surgical procedures.

If the CPT definition includes "per" or "each" in the description, only then is it appropriate to use more than "one" unit in the unit box for multiple removal/excisions. Many of the codes in the lesion section **do not contain the words "per or each."**

As an example, CPT code 11400 does not contain the word per or each. The code description states "excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arm, or legs; excised diameter 0.5 cm or less." If more than one lesion is excised, the proper submission would be **separate** lines rather than 2 units in the units box.

- 11400 (for 1st 0.5 cm lesion)
- 11400 59 (for 2nd 0.5 cm lesion)

The AUC Medical Code Tag will begin additional discussions of "units" and publish an updated Best Practice to assist providers in these complicated issues. There appears to be confusion on how to submit services when the description of the code is per diem, per, each, as well as when the code has no definition of units. Lab and pathology services likely will be included in the discussion.

S codes for home infusion have per diem in the description. This means that the code can only be billed once per day. The to and from date for services must be a span of dates. Multiple units are not accepted for a single date for per diem services.

The current best practices for reporting only the dispensing date as the to and from date for pharmaceuticals, should have indicated that this was for NCPDP (pharmacy claims) and was not intended for 837 P instructions.

We know that providers and payers are working diligently on becoming more uniform in the submission of claims. Great strides have been made thus far, and we anticipate that many more questions and issues will be resolved in the coming months.

Limited Developmental Testing (96110)

When a limited developmental screening test is performed during the comprehensive preventative exam, it is considered part of the comprehensive exam. Consequently, there is no separate payment for CPT 96110 when performed for screening during this visit. Adding modifier 59 to the code **does not** change the bundling of this service.

Telemedicine

PreferredOne updated the Telemedicine policy with additional G codes for inpatient consultations. The new policy is attached (Exhibit E).

Credentialing in Minnesota Has Gotten Simpler!

For the first time, providers in Minnesota can submit their credentialing applications electronically through an organization called the Minnesota Credentialing Collaborative (MCC). The MCC is owned by the Minnesota Medical Association, Minnesota Hospital Association, and the Minnesota Council of Health Plans and is endorsed by MMGMA.

If it is time for your providers to be credentialed with their hospitals and/or health plans, you can now use this community-based service to electronically submit your credentialing applications.

One of the best things about electronic credentialing is that after you enter your data, your information is stored and can be used again and again for the credentialing process.

Other benefits include:

- Eliminating repetition - The data you enter into the program is stored in a website so you can use it in future applications. This means you can avoid the hassle of filling out a separate credentialing form for each health plan and hospital.
- Reducing errors - The system checks some data to assure accuracy.
- Securing data - Data is stored in a secure database controlled by the provider who can delegate access and updating functions to clinic staff.
- Saving time - Drop-down lists make it easy for you to complete the form.
- Submission Flexibility - You have the ability, right now, to submit your data electronically to all health plans and some hospitals. For those hospitals and health plans moving toward electronic acceptance, your credentialing application can be downloaded as a paper form and either faxed or mailed.

If you have not enrolled, start now by visiting www.mncred.org or contact Tracey Torgersen, Manger Credentialing Programs at the MCC at Tracey@mncred.org or 612-360-9793.

Case Management Services

What is Case Management?

Case management is a collaborative process among the Case Manager (an RN or Social Worker), the plan member, the member's family, and health care providers. The goal of case management is to help members in navigating through the complex medical system. The Case Manager will assist in preventing gaps in care with the goal of achieving optimum health care outcomes in an efficient and cost-effective manner. This service is **not** intended to take the place of the attending providers or to interfere with care.

Core Services

- Serve as a resource to members
- Provide both verbal and written education regarding a disease condition
- Coordinate care
- Serve as a liaison between the health plan, member and providers

Eligibility and Access

All members of the health plan experiencing complex health needs are eligible for case management. A Case Manager may call a member based on information that has been received at PreferredOne, or members *Page 6...*

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may call and request a case manager. There is no cost for this service and it is strictly optional.

Health care provider referrals and member self referrals are accepted by contacting PreferredOne and requesting to speak with a case manager. The telephone number for the Case Management department is **763-847-4477, option 2.**

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 as an additional tool to support the Medical Management staff in making medical necessity determinations. Milliman is a national vendor for care guidelines. Our on-going evaluation of the guidelines continues. If both Milliman and PreferredOne have criteria for the same healthcare service, we compare the two criteria sets to assess if we will continue to the follow PreferredOne criteria or adopt Milliman Care guidelines. If we chose to adopt a Milliman Care Guideline, the PreferredOne criteria set is retired.

The Behavioral Health, Chiropractic, Medical/Surgical and Pharmacy and Therapeutics Quality Management Subcommittees approve new criteria sets for use in their respective areas of Medical Management. Quality Management Subcommittee approval is not required when there has been a decision to adopt Milliman Care Guidelines, to retire PreferredOne criteria sets, or when new Medical Polices are created; approval by the Chief Medical Officer is required. Notification of decisions to retire or the development of new Medical Policies is brought to the Quality Management Subcommittees as informational only.

Milliman Guidelines cannot be posted on our website; however, copies of individual guidelines are available upon request.

Since the last newsletter, the Behavioral Health Quality Management Subcommittee has approved or been informed of the following:

No new Behavioral health criteria sets.

No Behavioral criteria sets were retired.

No new Behavioral health policies.

No Behavioral health policies were retired.

Since the last newsletter, the Chiropractic Quality Management Subcommittee has approved or been informed of the following:

No new Chiropractic criteria sets.

No Chiropractic criteria sets were retired.

No new Chiropractic policies.

No Chiropractic policies were retired. *Page 7...*

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Since the last newsletter, the Medical/Surgical Quality Management Subcommittee has approved or been informed the following:

No new Medical/Surgical criteria sets.

Two (2) Medical/Surgical criteria sets were retired:

- 3-D Interpretation of Imaging: Prior authorization is no longer required; appropriate payment is managed through claims edits and processing.
- Intestinal Transplant: Low utilization of criteria. All medical necessity determinations are sent for physician review.

One (1) new Medical-Surgical related medical policy:

- Intensive Modulated Radiation Therapy (IMRT).

No Medical/Surgical related medical policies were retired.

No additions to the Investigational/Unproven Comparative Effectiveness List.

No deletions from the Investigational/Unproven Comparative Effectiveness List.

Since the last newsletter, the Pharmacy and Therapeutics Quality Management Subcommittee approved or been informed the following:

No new Pharmacy criteria sets.

- One (1) Pharmacy criteria sets were retired:
- Tekturna: Due to low volume and low impact, prior authorization is no longer required

No new Pharmacy related medical policies.

No Pharmacy related medical policies were retired.

One (1) addition to the Investigational/Unproven Comparative Effectiveness List:

- Bio-identical Compounded Hormones

No deletions from the Investigational/Unproven Comparative Effectiveness List.

The attached documents include the latest Chiropractic, Medical, and Pharmacy Policy and Criteria indexes (Exhibits F-I). Please add these documents to the Utilization Management section of your Office Procedures Manual. For the most current version of the policy and criteria documents, please access the Medical Policy option on the PreferredOne website.

If you wish to have paper copies of these documents, or you have questions, please contact the Medical Policy department telephonically at 763-847-3386 or on line at: Heather.Hartwig-Caulley@PreferredOne.com

Institute for Clinical Systems Improvement (ICSI)

The new and recently revised ICSI health care guidelines, order sets, and protocols listed below are available at www.icsi.org.

Health Care Guidelines

July 2009

- Stroke, Ischemic, Diagnosis and Initial Treatment of

June 2009

None

May 2009

- Antithrombotic Therapy Supplement
- Chronic Disease, Primary Prevention of
- Coronary Artery Disease, Stable
- Depression, Major, in Adults in Primary Care
- Diabetes Mellitus in Adults, Type 2; Diagnosis and Management of
- Labor, Management of

Order Sets and Protocols

July 2009

- Stroke for Patient not Receiving tPA, Ischemic; Admission for
- Stroke for Patients Receiving tPA, Ischemic; Admission for
- Ventilator-Associated Pneumonia, Prevention of

June 2009

None

May 2009

- Insulin Management, Subcutaneous
- Labor, Admission for Routine
- Rapid Response Team

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.

Quality Management Update

2009 Medical Record Documentation Assessment

PreferredOne requires members' 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 J). 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 will be assessed in the Fall of 2009. Please review these guidelines and your clinic operations to ensure your medical record keeping system is compliant.

Do You Have a Doctor Who is Not Accepting New Patients?

PreferredOne is requesting all physicians to submit information regarding acceptance of new patients. If you are a clinic site that has a physician who is **not accepting new patients**, you can go to www.PreferredOne.com. Select For Providers, login, select Your Clinic Providers, and edit the Accepting New Patients information for your provider. Our provider directories will be updated with this information.

If you are unable to access the provider-secured website, please send an alert to PreferredOne by electronic mail to Quality@PreferredOne.com**.** We ask that you please include your clinic(s) site name and address, the practitioner(s) name, and NPI number of those no longer accepting new patients and the contact information for the individual sending us the notification in case we have questions

Update on HEDIS Technical Specifications

NCQA has introduced several new measures for which PreferredOne will be collecting data in conjunction with our 2010 Healthcare Effectiveness Data Information Set (HEDIS) chart abstraction process. HEDIS measures are used nationally 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 2010 include:

- Immunizations for Adolescents
- Aspirin Use and Discussion

PreferredOne will be examining medical records for documentation to support these measures in early 2010. If you have questions about these measures, you may visit NCQA's website at www.ncqa.org or contact us at Quality@PreferredOne.com

Pharmacy Update

Online Medication Request Forms

Providers and office staff can now submit medication request forms to PreferredOne online at www.PreferredOne.com. **Click On:** For Providers > Pharmacy Resources > Pharmacy Medication Request Form – Online Submission.

Advantages of Online Submission:

- Offices can track the status of requests from the minute they are submitted to PreferredOne
- Reduces the number of incomplete requests, which reduces the overall turnaround time needed to complete a review
- Reduces legibility/handwriting errors
- Office staff no longer needs to be registered with the PreferredOne website in order to use the online form
- Eliminates lost or misplaced submitted forms

In the near future, we will no longer accept the paper medication request forms, and you will be required to use our online form submission process.

If you have any questions about the online medication request form, please contact the Pharmacy Department at Pharmacy@PreferredOne.com.

2010 PreferredOne Formulary

PreferredOne utilizes the Express Scripts National Preferred formulary for its members who have Express Scripts as their Pharmacy Benefit Manager (PBM). This formulary undergoes a complete review annually with all changes taking effect on January 1 of each year. Attached is the 2010 Express Scripts formulary (Exhibit K) as well as a list of the medications that are changing formulary status (formulary to nonformulary and nonformulary to formulary) as of January 1, 2010 (Exhibit L).

Exhibit A

PreferredOne

DEPARTMENT:	Pricing and Payment	**APPROVED DATE: 9/1/2009**	
POLICY DESCRIPTION:	Site-of-Service Payment		
EFFECTIVE DATE:	**1/1/2010**		
PAGE:	1 of 2	**REPLACES POLICY DATED:**	P-12 of 1/1/2002
REFERENCE NUMBER:	006	**RETIRED DATE:**	

SCOPE: Network Management, Customer Service Department for PreferredOne, PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc, Medical Management, Claim Department for PreferredOne Community Health Plan, PreferredOne Administrative Services, PPO claims, Model Office, and PreferredOne Participating Providers

PURPOSE: Site of service payments for professionals

POLICY: Beginning with services with a **date of service 1/1/2010,** PreferredOne will adjudicate professional claims based on place of service (site of service differential office versus facility) as published in the Federal Register.

PROCEDURE:

1. When services are rendered in an office setting, the practice expense RVUs maybe higher in an office setting, whereas the practitioner solely bears the costs of the necessary staff, supplies and equipment. When a provider renders the service in a facility setting such as designated below, the facility practice expense is no longer part of the physician clinic and becomes part of the facility billing.

    - inpatient hospital
    - outpatient hospital-based facilities including clinics and emergency rooms
    - outpatient free-standing facilities
    - accredited surgical suites within a physician's office
    - comprehensive outpatient rehabilitation facilities
    - comprehensive inpatient rehabilitation facilities
    - inpatient psychiatric facilities

2. The non-facility practice expense (office) will be based on the Federal Register data of the previous year in which the service occurs. As an example, the practice expense for a service rendered in 2009, will be based on data from the 2008 Federal Register, unless the CPT/HCPCS code is new for that year and then the current year RVU will be used.

3. A place of service must be on the HCFA 1500. A place of service 21 – 25 indicates that the facility RVU will be used. Otherwise the non-facility RVU will be used.

4. PreferredOne will conduct periodic audits for compliance.

DEFINITIONS:

REFERENCES:

Exhibit B

PreferredOne

DEPARTMENT:	Pricing and Payment	**APPROVED DATE: 9/1/2009**	
POLICY DESCRIPTION:	RVU Status Indicators for Professional Services		
EFFECTIVE DATE:	**1/1/2010**		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	007	**RETIRED DATE:**	

SCOPE: Network Management, Customer Service Department for PreferredOne, PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc, Medical Management, Claim Department for PreferredOne Community Health Plan, PreferredOne Administrative Services, PPO claims, Model Office, and PreferredOne Participating Providers

PURPOSE: Identify services that are not separately payable as defined by Centers of Medicare and Medicaid (CMS)

DEFINITIONS: Per CMS, Status Code of B **=** Bundled Code. Payment for covered services are always bundled into payment for other services not specified. (An example is a telephone call from a hospital nurse regarding care of a patient).

POLICY: PreferredOne will not allow separate payment for codes that are assigned the RVU Status "B" as published in the Federal Register for Physician Services.

PROCEDURE:

1) Any code submitted that has a status code of B assigned will not be separately payable and will be provider liability.

2) Any code with a status code of B that has an RVU value assigned or PreferredOne deems to be an exception, will be exempt from the policy.

3) If this policy conflicts with any language in the Summary Plan Description (SPD) or Certificate of Coverage (COC), the SPD/COC will supersede this policy.

4) See list below of codes that applies to this policy. This list will be reviewed on a periodic basis by PreferredOne.

A4262	Temporary tear duct plug
A4263	Permanent tear duct plug
A4270	Disposable endoscope sheath
A4300	Cath impl vasc access portal
A4550	Surgical trays

G0269	Occlusive device in vein art
Q3031	Collagen skin test
R0076	Transport portable EKG
22841	Insert spine fixation device
91123	Irrigate fecal impaction
92531	Spontaneous nystagmus study
92532	Positional nystagmus test
92533	Caloric vestibular test
92534	Optokinetic nystagmus test
92605	Eval for nonspeech device rx
92606	Non-speech device service
97602	Wound(s) care non-selective
99001	Specimen handling
99002	Device handling
99024	Postop follow-up visit
99070	Special supplies
99071	Patient education materials
99080	Special reports or forms
99090	Computer data analysis
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99288	Direct advanced life support
36416	Capillary blood draw
99050	Medical services after hrs
99051	Med serv, eve/wkend/holiday
99053	Med serv 10pm-8am, 24 hr fac
99056	Med service out of office
99058	Office emergency care
99060	Out of office emerg med serv

REFERENCES:

Exhibit C

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE: 9/1/2009, 9/22/2008, 10/1/2007**
POLICY DESCRIPTION:	Readmission within 5 Days	
EFFECTIVE DATE:	1/1/2010	
PAGE:	1 of 1	**REPLACES POLICY DATED:**
REFERENCE NUMBER:	H - 7	**RETIRED DATE:**

01

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

PURPOSE: To provide guidelines for reimbursement for Readmissions to the same Hospital within 5 days.

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

PROCEDURE:

1. If more than one admission occurs for a given Enrollee with a related diagnosis or same Major Diagnostic Category (MDC) as determined by PreferredOne within a 5 day period, Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

2. If the readmission is a different MDC, but is related to the initial admission as a result of post-op infection (MS DRG 856 – 863), Hospital shall be financially responsible for facility charges for Services rendered to the Enrollee for the readmission.

3. The following DRGs are excluded from this policy:

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

Exhibit D

AMA Fact Sheet On Reporting For H1N1

(Please note that the information on this sheet is subject to change and should be referenced for further updates)

In response to concerns related to the need for national vaccination efforts for H1N1 and to assist health plans with their commitment to cover the cost for vaccine administration, the CPT® Editorial Panel acted upon this urgent matter with the establishment of a new vaccine administration code, 90470, specific to the 2009 H1N1 virus, and revision of existing code 90663 to report either the intranasal or intramuscular formulations of the H1N1 virus. The American Medical Association (AMA) expedited the publication of the new and revised codes to the AMA website on Monday, September 28, 2009 for these codes to become immediately effective on that date.

The use of Current Procedural Terminology (CPT) codes 90470 and 90663 will help to efficiently report and track immunization administration services related to the H1N1 vaccine throughout the health care system, and will streamline reporting and the reimbursement procedure for physicians and health care providers who are expected to administer nearly 200 million doses of the H1N1 vaccine in the United States.

The codes are as follows:

90470—H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

90663—Influenza virus vaccine, pandemic formulation, H1N1

Please note that code 90470 and the revision of code 90663 will *not* be published in the 2010 CPT codebook. These changes were made after publication of the book.

Q: How do I report administration of the H1N1 virus vaccine?

To report the administration of 2009 H1N1 influenza type A monovalent vaccine, providers should report CPT code 90663 (Influenza virus vaccine, pandemic formulation, H1N1) in conjunction with the immunization administration code 90470 (H1N1 immunization administration (intramuscular, intranasal), including counseling when performed). In the charge field on the claim form, code 90663 for the 2009 H1N1 vaccine product should be billed either for zero dollars, since the vaccine is provided free of charge by the federal government or for $.01 depending upon the billing recommendations provided by the individual payers. Providers will be paid for 2009 H1N1 vaccine administration.

Q: How do I report provision of a seasonal flu virus vaccine product?

There are a number of vaccine codes that should be reported for provision of the seasonal flu vaccine.

90655	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90658	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use
90660	Influenza virus vaccine, live, for intranasal use

90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

90662 Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use

Q: How do I report administration of the seasonal flu virus vaccine when provided at the same patient encounter as the initial H1N1 vaccine administration?

In the event that a seasonal flu vaccination is administered in addition to the H1N1 vaccination at the same visit, it is necessary that code 90470 should be reported for the initial administration service for the H1N1 vaccine product, and either code 90466, 90468, 90472, or 90474 for the additional administration service. Since these codes are add-on codes, modifier 51 does not apply to these services and should not be reported with these codes.

The H1N1 vaccine administration code should not be reported in addition to the initial service vaccine administration codes 90465, 90467, 90471, and 90473 because these changes were made after the publication of the 2010 CPT codebook and therefore the add on vaccine administration codes have not been updated to include 90470. To reiterate, these changes were made after the publication of the 2010 CPT codebook. Therefore, the instructional notes following the add-on vaccine administration codes have not been updated to include 90470 in the list of primary procedures. However, appropriate reporting of multiple vaccine administrations is to report one initial administration code and the appropriate add-on administration code(s) 90466, 90468, 90472, or 90474 for the additional administration(s). Be sure to check with your payer or visit the AMA H1N1 Web site for a listing of payer billing requirements:

http://www.ama-assn.org/ama/pub/h1n1/vaccination-information.shtml

For face-to-face physician counseling of the patient and family during the pediatric administration of a vaccine, the following codes are reported according to the route of administration ***in addition to the initial service code 90470:***

+90466 Immunization administration **younger than 8 years** of age (includes percutaneous, intradermal, subcutaneous, or intramuscular injections) when the physician counsels the patient/family; each additional **injection** (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

+90468 Immunization administration **under age 8 years** (includes **intranasal or oral** routes of administration) when the physician counsels the patient/family; each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

For immunization administration of any vaccine that is not accompanied by face-to-face physician counseling to the patient/family, without limit on the age of the patient, the following codes are reported according to the route of administration ***in addition to code 90470:***

+90472 Immunization administration (includes **percutaneous, intradermal, subcutaneous, or intramuscular** injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

+90474 Immunization administration by **intranasal or oral route**; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

The following table summarizes and compares the data included in each of the additional vaccine administration codes listed above:

Code	Admin Route	Physician Face-to-Face Counseling	Pediatric Only
90466	Sub-Q/IM	Yes	Yes
90468	Oral/Intranasal	Yes	Yes
90472	Sub-Q/IM	No	No
90474	Oral/Intranasal	No	No

Q: How do I report administration of the H1N1 vaccine on the same date as a routine visit (Evaluation and Management)?

In the event that the H1N1 vaccination is administered at the same time as a scheduled visit, code 90470 should be reported for the initial administration service for the H1N1 product, along with code 90663 for the product and the appropriate level of Evaluation and Management (E/M) service based upon the services provided. Modifier 25 is reported with the E/M service to indicate that the significant, separately identifiable E/M service was provided on the same date as the vaccine administration service. It would NOT be appropriate to additionally report an E/M code for the counseling provided for administration of a vaccine.

To meet the needs of the Centers for Disease Control (CDC) safety monitoring programs, and to identify the specific vaccine product administered, the AMA suggests listing the 11-digit National Drug Code (NDC) assigned by the U.S. Drug and Food Administration **http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm)** on the claim form in addition to 90663 *Influenza virus vaccine, pandemic formulation, H1N1* (*see National Uniform Claim Committee NUCC™ 1500 Claim Form Instruction Manual, pgs. 43-45 http://www.nucc.org/images/stories/PDF/claim_form_manual_v5-0_7-09.pdf*.

Exhibit E

PreferredOne

DEPARTMENT: Coding Reimbursement	**APPROVED DATE:**
POLICY DESCRIPTION: Telemedicine	
EFFECTIVE DATE: 6-24-04	
PAGE: 1 of 2	**REPLACES POLICY DATED:**
REFERENCE NUMBER: P-30	**RETIRED DATE:**
	Updated 8/14/09

SCOPE: Account Management, Coding, Customer Service, Legal, Medical Management, Finance, Claims, Underwriting, Network Management

PURPOSE: To provide coverage guidelines for services related to telemedicine.

POLICY: PreferredOne will recommend reimbursement for telemedicine services only when provided by an interactive telecommunications system. Interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the patient. The patient must be present and participating in the telehealth visit.

PreferredOne will recommend reimbursement for both the originating site (where the patient is located) and the distant practitioner performing the consultation or office visit.

The service should be reasonable and necessary, medically appropriate, and provided within the accepted standards of medical practice.

Providers must be licensed to provide the services for which they are billing, and all services are subject to post payment or pre payment verification.

Originating Site:

The originating site is considered a rural hospital, critical access hospital, rural health clinic, or federally qualified health center (reported with code Q3014)

Types of Service:

Services are limited to:

- New or established office or outpatient visits (CPT codes 99201-99215)
- Consultations (99241- 99255)
- Follow up inpatient consults (G0406,G0407, G0408)
- Individual psychotherapy (CPT 90804 – 90809)
- Diagnostic Interview (CPT 90801)
- Pharmacology management (90862)
- Neurobehavioral status exam (CPT 96116)

- Individual Medical Nutritional Therapy: (G0270, 97802, 97803)
- End State Renal Disease (CPT 90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961.

Clinical psychologists, and clinical social workers cannot bill for psychotherapy services that include E/M services or pharmacology management services (90805, 90807, 90809, 90862)

Telemedicine for Home Health Services are <u>not</u> covered

Practitioners:

- Physician
- Nurse Practitioner
- Physician Assistant
- Nurse Midwife
- Clinical Nurse Specialist
- Clinical psychologist
- Clinical social worker
- Registered Dieticians

PROCEDURE:

For reporting the originating site services:

1. When using the 837 I: Report revenue code 780 (telemedicine) with Q3014. Other revenue codes such as 510, 450, 360 could result in denial of the claim. Use HCPCS code Q3014 (telehealth originating site).

2. For originating site using CMS 837P Use HCPCS code Q3014

For reporting distant providers services:

1. Distant providers would use the E/M code for the services they provided, appended with modifier GT (via interactive telecommunications systems). Chart documentation would be exactly the same as if the patient presented for face-to face- hands on encounter.

2. Distant surgeons should not bill for post operative follow up telemedicine services if provided within the global surgical package.

3. Only the E/M services listed above will be considered for telemedicine reimbursement.

4. It is expected that both industry standard and CPT coding guidelines will be followed.

REVIEWED/UPDATED: 08/14/09

Exhibit F

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Big on Essential Services

Health Benefit Options and Services

Medical Policy

Chiropractic Policies Table of Contents
Click on description link to view the PDF

Reference #	Description
001	Use of Hot and Cold Packs
002	Plain films within the first 30 days of care
003	Passive Treatment Therapies beyond 6 weeks
004	Experimental, investigational, or Unproven Services
006	Active Care – Therapeutic Exercise
007	Acute and Chronic Pain
008	Multiple Passive Therapies
009	Recordkeeping and Documentation Standards
010	CPT Code 97140

Revised *02/04/09*

Quick Links:

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Medical Criteria
Medical Policies
Pharmacy Criteria
Pharmacy Policies

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Exhibit G

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Big on Essential Services

Health Benefit Options and Services

Medical Policy

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

Reference #	Category	Description
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
C008	Eye, Ear, Nose, and Throat	Strabismus Repair (Adult)
C010	Eye, Ear, Nose, and Throat	Otoplasty
F017	Orthopaedic/Musculoskeletal	Hip Resurfacing
F020	Orthopaedic/Musculoskeletal	X Stop
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulator
F022	Orthopaedic/Musculoskeletal	Cervical Disc Arthroplasty (Artificial Cervical Disc)
G001	Skin and Integumentary	Eyelid and Brow Surgery (Blepharoplasty & Ptosis Repair)
G002	Skin and Integumentary	Breast Reduction Surgery
G003	Skin and Integumentary	Excision Redundant Tissue
G004	Skin and Integumentary	Breast Reconstruction
G008	Skin and Integumentary	Hyperhidrosis Surgery
G009	Skin and Integumentary	Laser Treatment for Psoriasis
H003	Gastrointestinal/Nutritional	Bariatric Surgery
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M002	BH/Substance Related Disorders	Electroconvulsive Treatment (ECT): Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment Program
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)
M007	BH/Substance Related Disorders	Mental Health Disorders: Residential Treatment

M008	BH/Substance Related Disorders	**Psychotherapy: Outpatient Treatment**
M009	BH/Substance Related Disorders	**Chronic Pain: Outpatient Program**
M019	BH/Substance Related Disorders	**Pathological Gambling: Outpatient Treatment**
M020	BH/Substance Related Disorders	**Autism Spectrum Disorders Treatment**
M021	BH/Substance Related Disorders	**Vagus/Vagal Nerve Stimulation (VNS) for Treatment Resistant Depression and Treatment Resistant Bipolar Depression**
N003	Rehabilitation	**Occupational and Physical Therapy: Outpatient Setting**
N004	Rehabilitation	**Speech Therapy: Outpatient**
N005	Rehabilitation	**Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers**
N006	Rehabilitation	**Acupuncture**
T002	Transplant	**Kidney/Pancreas Transplantation**

Revised *12/10/08*

Quick Links:
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Pharmacy Policies

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Exhibit H

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Health Benefit Options and Services

Medical Policy

Medical Policies Table of Contents
Click on description link to view the PDF

Reference #	Description
C001	Court Ordered Mental Health & Substance Related Disorders Services
C002	Cosmetic Treatments
C003	Criteria Management and Application
C008	Oncology Clinical Trials, Covered / Non-covered Services
C009	Coverage Determination Guidelines
C010	Demonstration of Provider Clinical Competence
D002	Diabetes Mellitus Supplies Coverage
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies
D007	Handicapped Dependent Eligibility
D008	Dressing Supplies
E004	Nutrition Therapy
G001	Genetic Testing
H005	Home Health Care (HHC)
H006	Hearing Devices
I001	Investigational/Experimental Services
I002	Infertility Treatment
I003	Preventative Immunizations
I004	Intensive Residential Treatment Services (IRTS)
I005	Intensity Modulated Radiation Therapy (IMRT) Coverage Considerations
N002	Nutritional Counseling
P008	Medical Policy Document Management and Application

P009	**Preventative Screening Tests**
P010	**Narrow-band UVB Phototherapy (non-laser) for Psoriasis**
R002	**Reconstructive Surgery**
R003	**Acute Rehabilitation Facilities**
R004	**Physical, Occupational or Speech Therapy; Outpatient Setting**
S008	**Scar Revision**
S011	**Skilled Nursing Facilities**
S012	**Substance Related Disorders Coverage Considerations**
T002	**Continuity of Care**
T004	**Therapeutic Overnight Pass**
W001	**Physician Directed Weight Loss Programs**

Revised *02/09/09*

Quick Links:
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Exhibit I

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Health Benefit Options and Services

Medical Policy

Pharmacy Policies Table of Contents
Click on description link to view the PDF

Reference #	Description
C001	Coordination of Benefits
C002	Cost Benefit Program
F001	Formulary and Co-Pay Drug Overrides
N001	National Formulary Exceptions
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist
P002	Pharmacy Programs for ClearScript
Q001	Quantity Limits per Prescription per Copayment *Revised*
S001	Step Therapy

Revised *11/19/08*

Quick Links:
Chiropractic Policies
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Exhibit J

PreferredOne®

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

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

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

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

PROCEDURE:

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

I. The medical record must include all the following:

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

B. All record entries must:

1. Be dated; and

2. Must be legible

C. All medical record documentation must include:

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

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

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

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

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

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

PreferredOne®

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

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

8. An immunization record/history

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

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

III. Clinic has written policies for:

A. Documented standards for an organized medical record keeping system

B. Confidentiality, release of information and advanced directives

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

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

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

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

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

REFERENCES:

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

DOCUMENT HISTORY:

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

Exhibit K

EXPRESS SCRIPTS®

2010 Express Scripts National Preferred Formulary

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.

A

ABILIFY (excluding Discmelt & solution)
acarbose
ACCU-CHEK MULTICLIX lancets
acebutolol
acetaminophen w/codeine
acetazolamide
ACTONEL with calcium
ACTOPLUS MET
ACTOS
ACULAR, LS*
acyclovir
ADVAIR DISKUS, HFA
ADVICOR
AGGRENOX
albuterol
alendronate sodium
ALPHAGAN P*
ALTABAX
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
ARIMIDEX*
ARIXTRA [INJ]
ASACOL, HD
ASCENSIA AUTODISC, BREEZE/2
ASCENSIA CONTOUR SYSTEM
ASCENSIA ELITE
ASTELIN*
ASTEPRO
atenolol, -chlorthalidone
atropine sulfate
AUGMENTIN XR
AVANDAMET
AVANDARYL
AVANDIA
AVELOX
aviane
AVODART
AXID solution only
AZASITE
azathioprine
AZILECT
azithromycin
AZOR

B

balsalazide disodium
balziva
benazepril, /hctz
BENZACLIN (excluding carekit)*
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
carbamazepine, xr
carbidopa-levodopa, er
CARDIZEM LA*
carisoprodol
carvedilol
cefaclor, er
cefadroxil
cefdinir
cefpodoxime
cefprozil
cefuroxime
CELEBREX
CELLCEPT oral susp*
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
CONCERTA*
COPAXONE [INJ]
COREG CR*
COZAAR*
CREON
CRESTOR
CRINONE
cryselle
cyclobenzaprine hcl
cyclosporine, modified
CYMBALTA

D

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

E

econazole
EFFEXOR XR*
ELIDEL
eliphos
ENABLEX
enalapril, hctz
ENBREL [INJ]
enpresse
enulose
EPIPEN, JR [INJ]
errin
erythromycin
erythromycin/benzoyl perox.
ESTRADERM
estradiol, tds
estropipate
etidronate disodium
etodolac
EUFLEXXA [INJ]
EVAMIST
EXELON
EXFORGE, HCT

F

famciclovir
famotidine
felodipine er
fenofibrate
fentanyl citrate
fexofenadine
FINACEA, PLUS
finasteride
FLECTOR
FLOMAX*
FLOVENT DISKUS, HFA
fluconazole
fluocinonide
fluorouracil
fluoxetine hcl
fluphenazine
flurazepam
fluticasone nasal spray
fluvoxamine maleate
folic acid
FORADIL
FORTEO [INJ]
fortical
fosinopril, /hctz
FOSRENOL

G

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

H

HALFLYTELY, -BISACODYL
haloperidol
HUMALOG [INJ]
HUMATROPE [INJ]
HUMIRA [INJ]
HUMULIN [INJ]
hydrochlorothiazide
hydrocodone/acetaminophen
hydrocortisone
hydromorphone
hydroxyurea
hyoscyamine sulfate
HYZAAR*

I

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

J

JANUMET
JANUVIA
jolessa
jolivette
junel, fe

K

kariva
kelnor
KEPPRA XR
ketoconazole

L

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

M

MAXALT, MLT
meclizine hcl
medroxyprogesterone acetate
megestrol
meloxicam
MENEST
mercaptopurine
MERIDIA
METANX
metaproterenol
metformin, er
methocarbamol
methotrexate
methylphenidate hcl
methylprednisolone
metoclopramide hcl
metolazone
metoprolol, hctz
METROGEL
metronidazole
microgestin, fe
MIRAPEX*
mirtazapine, soltab
moexipril/hctz
mometasone
mononessa
morphine sulfate
MOVIPREP
MUSE
mycophenolate mofetil

N

nabumetone
nadolol
NAMENDA
naproxen
NASACORT AQ
NASONEX
nateglinide
necon
NEEVO
neomycin/polymyxin/dexamethasone
neomycin/polymyxin/hc
NEVANAC
NEXIUM
NIASPAN
nifedipine er
nisoldipine
nitrofurantoin macrocrystal
nitroglycerin
NITROLINGUAL SPRAY
nizatidine
nora-be
nortrel
NOVOFINE
NOVOLIN [INJ]
NOVOLOG [INJ]
NUTROPIN, AQ [INJ]
nystatin

O

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

P

paroxetine
PATADAY
PATANOL
peg 3350/electrolyte
PEGASYS [INJ]
PEG-INTRON, REDIPEN [INJ]
penicillin v potassium
PERFOROMIST
perphenazine
phentermine hcl
phenytoin sodium, extended
pilocarpine hcl
pindolol
PLAVIX
polymyxin b sul/trimethoprim
portia
PRAMOSONE
PRANDIMET
PRANDIN*
pravastatin
PRECISION SURE DOSE
PRECISION XTRA

(continued)

THIS DOCUMENT LIST IS EFFECTIVE JANUARY 1, 2010 THROUGH DECEMBER 31, 2010. THIS LIST IS SUBJECT TO CHANGE.
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prednisolone
prednisolone acetate
prednisone
PREMARIN
PREMPHASE
PREMPRO
PRENATE ELITE
previfem
PRISTIQ
PROAIR HFA
PROCHIEVE
prochlorperazine
PROCRIT [INJ]
promethazine
promethazine w/codeine
promethazine w/dm
PROMETRIUM
propranolol hcl, w/hctz
PROTOPIC*
pseudoephedrine w/chlorpheniramine
PULMICORT FLEXHALER
PYLERA

Q

quasense
quinapril
quinaretic
QVAR

R

ramipril
RANEXA
ranitidine
REBIF [INJ]
reclipsen
RELENZA
RENAGEL
RENVELA
reprexain
REQUIP XL
RESTASIS
ribasphere
ribavirin
risperidone, odt
ropinirole
RYTHMOL SR

S

salsalate
selenium sulfide
SEREVENT DISKUS
SEROQUEL, XR
sertraline
SIMCOR
simvastatin
SINGULAIR
SKELAXIN*
sodium sulfacetamide/sulfur
SOFT TOUCH lancets
SOFTCLIX lancets
solia
SOMATULINE DEPOT [INJ]
SPIRIVA
sprintec
sronyx
STRATTERA
STRIANT
SULAR
sulfacetamide sodium
sulfasalazine
sumatriptan tab, inj
SYMBICORT
SYMBYAX
SYMLIN, SYMLINPEN [INJ]

T

TAMIFLU
tamoxifen
TAZORAC
TEKTURNA, HCT
temazepam
terbinafine hcl
terbutaline sulfate
theophylline, anhydrous, er
thioridazine hcl
thyroid
tilia fe
timolol maleate
tobramycin sulfate
topiramate
TRACLEER
trandolapril
trazodone hcl
tretinoin
TREXIMET
triamcinolone acetonide
triazolam
tri-legest fe
TRILIPIX
trimethobenzamide
trimethoprim
trinessa
tri-previfem
tri-sprintec
trivora
TUSSICAPS
TUSSIONEX
TWINJECT [INJ]

U

ULTRASE, -MT
UROXATRAL
ursodiol

V

VAGIFEM
VALTREX*
VECTICAL
velivet
venlafaxine (immediate release)
VENTOLIN HFA
VERAMYST
verapamil hcl
veripred
VESICARE
VIAGRA
VIGAMOX
VIMPAT
VIVELLE-DOT
VOLTAREN GEL
VYVANSE

W

warfarin
WELCHOL

X

XALATAN
XOPENEX neb solution
XYZAL

Y

YAZ

Z

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

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	Singulair	FREESTYLE	Ascensia, OneTouch
ACCU-CHEK meters/strips	Ascensia, OneTouch	FROVA	sumatriptan tab, Maxalt/MLT, Zomig/ZMT
ACIPHEX	omeprazole, Nexium	GELNIQUE	oxybutynin er, Oxytrol
ADDERALL XR	dextroamphetamine-amphetamine	GEODON	risperidone, Abilify (regular tabs), Seroquel/XR, Zyprexa (non-Zydis)
AEROBID, M	Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar	HYALGAN	Euflexxa
		IMITREX Nasal	Zomig Nasal
ALAMAST	Pataday, Patanol	INVEGA	risperidone, Abilify (regular tabs), Seroquel/XR, Zyprexa (non-Zydis)
ALOCRIL	Pataday, Patanol		
ALOMIDE	Pataday, Patanol	IQUIX	ciprofloxacin, Vigamox, Zymar*
ALORA	Generic patches, Estraderm, Vivelle-Dot	KADIAN	morphine sulfate er
ALTOPREV	lovastatin, pravastatin, simvastatin, Crestor, Lipitor	KAPIDEX	omeprazole, Nexium
		LESCOL, XL	lovastatin, pravastatin, simvastatin, Crestor, Lipitor
ALVESCO	Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar	LEVITRA	Viagra
AMERGE	sumatriptan tab, Maxalt/MLT, Zomig/ZMT	LIPOFEN	fenofibrate, Trilipix
ANGELIQ	Prempro/Premphase	LUNESTA	zolpidem tartrate, Ambien CR*
ANTARA	fenofibrate, Trilipix	MAXAIR AUTOHALER	ProAir HFA, Ventolin HFA
APIDRA	Humalog, Novolog	MENOSTAR	Generic patches, Estraderm, Vivelle-Dot
APRISO	balsalazide, Asacol/HD, Lialda	METADATE CD	dextroamphetamine-amphetamine, methylphenidate, Concerta*, Vyvanse
ASMANEX	Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar	MICARDIS	Cozaar*, Diovan
		MICARDIS HCT	Diovan HCT, Hyzaar*
ATACAND	Cozaar*, Diovan	NORDITROPIN	Genotropin, Humatrope, Nutropin/AQ
ATACAND HCT	Diovan HCT, Hyzaar*	NOROXIN	ciprofloxacin/er, ofloxacin, Avelox, Levaquin
ATRALIN	tretinoin, Differin*		
AVALIDE	Diovan HCT, Hyzaar*	NUVARING	Ortho Tri-Cyclen Lo, Yaz
AVAPRO	Cozaar*, Diovan	OMNARIS	flunisolide, fluticasone, Nasacort AQ, Nasonex, Veramyst
AVINZA	morphine sulfate er		
AVITA	tretinoin, Differin*	OMNITROPE	Genotropin, Humatrope, Nutropin/AQ
AXERT	sumatriptan tab, Maxalt/MLT, Zomig/ZMT	OPTIVAR	Pataday, Patanol
AZMACORT	Flovent Diskus/HFA, Pulmicort Flexhaler, Qvar	ORTHO EVRA	Ortho Tri-Cyclen Lo, Yaz
		ORTHOVISC	Euflexxa
AZOPT	brimonidine tartrate, dorzolamide, Alphagan P*	PATANASE	Astelin*, Astepro
		PRECISION PCX, QID	Ascensia, OneTouch
BECONASE AQ	flunisolide, fluticasone, Nasacort AQ, Nasonex, Veramyst	PREFEST	Prempro/Premphase
		PREVACID	omeprazole, Nexium
BENICAR	Cozaar*, Diovan	PREVPAC	Pylera
BENICAR HCT	Diovan HCT, Hyzaar*	PROVENTIL HFA	ProAir HFA, Ventolin HFA
BESIVANCE	ciprofloxacin, Vigamox, Zymar*	PROZAC WEEKLY	fluoxetine (daily), citalopram, paroxetine, sertraline, Lexapro
BRAVELLE	Gonal-F/RFF		
BROVANA	Perforomist	QUIXIN	ciprofloxacin, Vigamox, Zymar*
CARDENE SR	amlodipine, felodipine er, nifedipine er, Dynacirc CR*, Sular	RAPAFLO	doxazosin, Flomax*, Uroxatral
		RELPAX	sumatriptan tab, Maxalt/MLT, Zomig/ZMT
CEDAX	amox tr/potassium clavulanate, cefdinir, Augmentin XR	RETIN-A MICRO	tretinoin, Differin*
		RHINOCORT AQUA	flunisolide, fluticasone, Nasacort AQ, Nasonex, Veramyst
CENESTIN	estradiol, Menest, Premarin		
CETRAXAL	Ciprodex	RITALIN LA	dextroamphetamine-amphetamine, methylphenidate, Concerta*, Vyvanse
CIALIS	Viagra		
CIMZIA	Enbrel, Humira	SAIZEN	Genotropin, Humatrope, Nutropin/AQ
CIPRO HC	Ciprodex	SANCTURA, XR	oxybutynin/er, Enablex, Vesicare
CLARINEX	fexofenadine, Xyzal	SIMPONI	Enbrel, Humira
DETROL, LA	oxybutynin/er, Enablex, Vesicare	SOF-TACT	Ascensia, OneTouch
DIVIGEL	Generic patches, Evamist	SPECTRACEF	amox tr/potassium clavulanate, cefdinir, Augmentin XR
DUREZOL	Generic steroids, Lotemax		
EDEX	Caverject, Muse	STARLIX	nateglinide
EDLUAR	zolpidem tartrate, Ambien CR*	SUMATRIPTAN Nasal	Zomig Nasal
ELESTAT	Pataday, Patanol	SUPARTZ	Euflexxa
ELESTRIN	Generic patches, Evamist	SYNTHROID	levothyroxine sodium, levoxyl
EMADINE	Pataday, Patanol	SYNVISC, ONE	Euflexxa
ENJUVIA	estradiol, Menest, Premarin	TESTIM	Androderm, Androgel
EPOGEN	Aranesp, Procrit	TEVETEN	Cozaar*, Diovan
ESTRASORB	Generic patches, Evamist	TEVETEN HCT	Diovan HCT, Hyzaar*
ESTROGEL	Generic patches, Evamist	TEV-TROPIN	Genotropin, Humatrope, Nutropin/AQ
FACTIVE	ciprofloxacin/er, ofloxacin, Avelox, Levaquin	TOVIAZ	oxybutynin/er, Enablex, Vesicare
		TRAVATAN, Z	Lumigan, Xalatan
FemHRT	Prempro/Premphase	TRICOR	fenofibrate, Trilipix
FEMTRACE	estradiol, Menest, Premarin	TRIGLIDE	fenofibrate, Trilipix
FENOGLIDE	fenofibrate, Trilipix	VENLAFAXINE ER	Cymbalta, Effexor XR*, Pristiq
FERTINEX	Gonal-F/RFF	VYTORIN	simvastatin, Crestor, Lipitor
FML FORTE	Generic steroids, Lotemax	XIBROM	diclofenac sodium, Acular/LS*, Nevanac
FOCALIN, XR	dexmethylphenidate, dextroamphetamine-amphetamine, Concerta*, Vyvanse	XOPENEX HFA	ProAir HFA, Ventolin HFA
		ZEGERID	omeprazole, Nexium
FOLLISTIM AQ	Gonal-F/RFF		

KEY
The symbol [INJ] next to a drug name indicates that the drug is available in injectable form only.
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, 2010 THROUGH DECEMBER 31, 2010. 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.

Exhibit L

2010 Express Scripts National Preferred formulary

Additions 2010:

Drug
AVANDAMET
AVANDARYL
AVANDIA
AZILECT
FOSRENOL
HUMATROPE
MOVIPREP
NEEVO
NEVANAC
OSMOPREP
PEGINTRON, REDIPEN
PRENATE ELITE
PYLERA
REQUIP XL
RYTHMOL SR
VIAGRA

Deletions 2010:

Drug Name	2010 Formulary Alternative
ACTIVELLA	estradiol-norethindrone acetate
ALLEGRA-D	generic antihistamine plus decongestant
ALOMIDE	Generic,PATANOL,PATADAY
AVINZA	morphine sulfate er
EDEX	CAVERJECT,MUSE
EMADINE	Generic,PATANOL,PATADAY
FOLLISTIM AQ	GONAL-F/RFF
FOLTX	folamin, folbic
LEVITRA	VIAGRA
OCL	peg 3350/electrolyte soln
PANCREASE MT	CREON, ULTRASE/MT, VIOKASE
PREVACID NAPRAPAC	naproxen + omeprazole
PREVPAC	PYLERA
PROVENTIL HFA	PROAIR HFA, VENTOLIN HFA
SUPARTZ	EUFLEXXA
TEV-TROPIN	GENOTROPIN,HUMATROPE,NUTROPIN/AQ
TRICOR	fenofibrate,TRILIPIX
VENLAFAXINE HCL ER	CYMBALTA, EFFEXOR XR, PRISTIQ
XENICAL	OTC ALLI*

**OTC may be excluded from coverage by benefit design*

Multi Source Brand Deletions 2010:

Drug Name	2010 Formulary Alternative
ADENOCARD	adenosine
ADENOSCAN	adenosine
AUGMENTIN	amox tr/potassium clavulanate
BENTYL	dicyclomine hcl
BUPRENEX	buprenorphine hcl
CARDENE I.V.	nicardipine hcl
CASODEX	bicalutamide
COGENTIN	benztropine mesylate
CYTOMEL	liothyronine
DEMEROL	meperidine hcl/pf
DEPAKOTE, ER, SPRINKLE	divalproex
DIALYVITE	b-plex tablet
DIAMOX SEQUELS	acetazolamide
ELOXATIN	oxaliplatin
GENTAMICIN SULFATE IN NS	gentamicin in saline, iso-osm
ILOPAN INJECTION	dexpanthenol
INFUMORPH	morphine sulfate/pf
INTRALIPID	fat emulsions
KEPPRA	levetiracetam
LANOXIN	digoxin
LIPOSYN II	fat emulsions
NALLPEN	nafcillin sodium
NALLPEN-ISO-OSMOTIC DEXTROSE	nafcillin sodium/d2.4w
NEO-SYNEPHRINE	phenylephrine hcl
PLAN B	next choice 0.75 mg tablet
PROGRAF	tacrolimus anhydrous
PULMICORT RESPULES	budesonide
RU-TUSS DM	pseudo cough liquid
STARLIX	nateglinide
TEGRETOL XR	carbamazepine
TETRAVISC	tetracaine hcl
TOPROL XL	metoprolol succinate
TORADOL	ketorolac tromethamine
URSO, FORTE	ursodiol
VIDEX EC	didanosine
XYLOCAINE IV FOR CARDIAC	lidocaine hcl/pf
YASMIN 28	ocella
ZERIT	stavudine

Other Deletions 2010:

Drug Name	2010 Formulary Alternative
chlorpropamide	glimepiride,glipizide,glyburide