PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
October 2013

2014 Fee Schedule Update

Additional changes to the 2014 fee schedules were communicated at the PreferredOne Provider Forum in September. The presentation is available on our secure website.

Professional Services

PreferredOne's Physician, Mental Health and Allied Health Fee Schedules are complete and will become effective for dates of service beginning January 1, 2014. These changes are expected to be an increase in overall reimbursement. As with prior updates, the effect on physician reimbursement will vary by specialty and the mix of services provided.

Physician fee schedules will be based on the 2013 CMS Medicare physician RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register May 2013. New codes for 2014 will be based on the 2014 CMS Medicare physician RVU file without geographic practice index applied and without the work adjuster applied, as published in the Federal Register November 2013. Other new non-RVU-based codes will be added according to PreferredOne methodology. The fee schedules for other provider types (such as allied, PhD, Masters and BA) will also be updated. Note that effective April 1, 2014, Doctor of Optometry will be moving to the allied fee schedule.

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. Some of these changes were presented at the September Provider Forum. The lab methodology as a percent of CMS will remain the same for all products. PreferredOne will maintain the current default values for codes that do not have an established rate.

The 2014 Physician fee schedules will continue to apply site of service differential for RVU–based services performed in a facility setting (Place of Service 21-25 are considered facility).

The Convenience Care Fee schedules will also be updated January 1, 2014. New codes were added to this fee schedule and reminder that any code not on the fee schedule will not be reimbursed.

New ASA codes for Anesthesia services will be updated with the 2014 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2014.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder that new codes for 2014 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the "PreferredOne Provider Update."

In This Issue:

PreferredOne
6105 Golden Hills Dr.
Golden Valley, MN 55416

Phone: 763-847-4000
800-451-9597
Fax: 763-847-4010

CLAIM ADDRESSES:

PreferredOne Insurance Corporation (PIC)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

PreferredOne PPO
PO Box 1527
Minneapolis, MN 55440-1527

Phone: 763-847-4400
800-451-9597
Fax: 763-847-4010

PreferredOne Community Health Plan (PCHP)
PO Box 59052
Minneapolis, MN 55459-0052

Phone: 763-847-4488
800-379-7727
Fax: 763-847-4010

PreferredOne Administrative Services (PAS)
PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
800-997-1750
Fax: 763-847-4010

Hospital Services/UB07/Outpatient Fee Schedules

The 2014 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 31 as published in the final rule Federal Register to be effective October 2013.

For those on Ambulatory Payment Classifications (APC), we are using Optum hospital-based grouper that will be one year lag. For example, for 2014 rates, PreferredOne will use the 2013 APC grouper and edits and weights as of October 2013.

The Facility (UB04) CPT fee schedule will consist of all physician CPT/HCPC code ranges and will be based on the 2013 CMS Medicare transitional physician RVU file, without the geographic practice index applied and without the work adjust applied. The global rules for the facility CPT fee schedule are as follows:

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

Reminder that new codes for 2014 will be added to all fee schedules using the above listed methodology. PreferredOne reserves the right to analyze and adjust individual rates throughout the year to reflect current market conditions. Any changes will be communicated via the "PreferredOne Provider Update."

Off-Cycle Fee Schedule Updates

Other provider types such as DME, Dental, Home Health, Skilled Nursing Facility updates will take place April 1, 2014. Note that the dental fee schedules will be increasing the percent of the Premier Fee Schedule as communicated at the Provider Forum. Also, reminder that CMS deleted type of bill 33x effective October 1, 2013, for home health providers. Both Part A and Part B home health care providers should bill with type of bill 32x.

New and Updated Pricing and Payment Policies

The following new and updated Pricing and Payment Policies are attached and were presented at the September Provider Forum:

- Updated Coding Policy #P-16 "Fee Schedule Updates" (to account for the change to APC methodology and added clarification around adding of new codes that are FDA approved or if CMS establishes new codes for existing codes) (effective January 1, 2013) (Exhibit A)
- New Pricing & Payment Policy #14 "Reimbursement Facility Multiple Surgeries Performed on the Same Date of Service" (effective January 1, 2013) (Exhibit B)
- New Pricing & Payment Policy #15 "Reimbursement Facility Inpatient Less than 48 Hours" (effective January 1, 2014) PLEASE NOTE UPDATE – There has been an update since the September Provider Forum. The update is that the policy applies to the DRGs that have a GLOS > 4.0 days rather than 2.0 as presented at the September provider forum. (Exhibit C)
- New Pricing & Payment Policy #16 "Multiple Imaging Performed on the Same Date of Service" (effective April 1, 2014) (Exhibit D)

Focus Areas Presented at the Provider Forum for potentially incorrect billing/coding for Mental Health Services (see the presentation online for additional information):

- Psychotherapy with E/M – in 2013 these codes were replaced with new ones and providers are to bill the E/M separately. The E/M should meet the criteria using key components and not time.

Page 3...

Cont'd from page 2…

If a provider looks to be an outlier, we may request medical records to review that the documentation meets the guidelines for the E/M that was billed.

- New add-on code 90785 Interactive complexity – this is a new add-on code for certain psychiatric services. Interactive complexity is commonly present during visits by children and adolescents but may apply to visits by adults. Please review the coding criteria for when to bill these that was presented at the provider forum. If a provider looks to be an outlier, we may request medical records to review that the documentation meets the guidelines for billing this service.

ICD-10 Update – IT'S COMING!

PreferredOne is on track to be ICD-10 compliant by the October 1, 2014 deadline. We have been participating with the Minnesota Collaborative, which is comprised of health plans & providers, and whose objective is to achieve compliance with the law on its effective date and to focus on key shared issues and opportunities. Systems reporting and policies are also in the process of being updated. Look to our provider website under 'ICD-10" updates to be rolled out in October 2013 that has a lot of resources, timelines, checklists, answers to frequently asked questions, presentations as well as the latest news PreferredOne will communicate to our providers such as testing results and other news! The ICD-10 update presented at the September Provider Forum will also be available.

Wausau/UMR Claims Submission

All in network providers should be submitting Wausau/UMR claims directly to PreferredOne. PreferredOne will re-price the claim and send it to Wausau/UMR for payment. Please contact your provider relations representative if you have questions.

Medical Policy Update

Medical Policy documents are available on the PreferredOne website to members and to providers without prior registration. The website address is www.PreferredOne.com. Click on Benefits and Tools and choose Medical Policy, Pre-certification and Prior Authorization.

The Behavioral Health, Chiropractic, Medical/Surgical, and Pharmacy and Therapeutics Quality Management Subcommittees approve new criteria sets and clinical policy bulletins for use in their respective areas of Integrated Healthcare Services. Quality Management Subcommittee approval is not required when there has been a decision to retire a PreferredOne criterion or when medical polices are created or revised; approval by the Chief Medical Officer is required. The Quality Management Subcommittees are informed of these decisions.

Since the last newsletter, the quality management subcommittees have approved or been informed of the following new or retired criteria and policies, and revisions to the investigational list.

Medical/Surgical Criteria

- New Criteria: None
- Criterion with major revision:
    - MC/F024 Radiofrequency Ablation Neck and Back - Due to the significant cost difference across outpatient settings, PreferredOne will cover this procedure when it is performed in an outpatient hospital setting only when the patient is considered at high risk for complications.
- Retired Criteria: None

Page 4…

Cont'd from page 3...

- New Policy: None
- Retired Policy: None

Pharmacy Criteria

- New Criteria: None
- Retired Criteria
  - PC/T004 Triptans Step Therapy
- New Policy
  - PP/C003 Compounded Drug Products
- Retired Policy: None

Revisions to the Investigational/Experimental/Unproven Comparative Effectiveness List: None

PreferredOne has created topic specific prior authorization forms to assist providers in the submission of complete clinical information. These Provider Forms can be found on the PreferredOne website under Providers.

Remember to periodically check the Pre-certification/Prior Authorization List posted on the PreferredOne website. The list will be fluid, as we see opportunities for impact driven by, but not limited to, new FDA-approved devices, medications, technologies, or changes in standard of care.

The attached documents (Exhibits E, F, G, H, & I) include the latest Chiropractic, Medical (includes Behavioral) and Pharmacy Policy and Criteria indices. Please add these documents to the Utilization Management section of your Office Procedures Manual.

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.

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

Clinical Practice Guidelines

PreferredOne supports the Institute for Clinical Systems Improvement's (ICSI) mission and promotes clinical practice guidelines to increase the knowledge of both our members and contracted providers about best practices for safe, effective and appropriate care. Although PreferredOne endorses all of ICSI's guidelines, it has chosen to adopt several of them and monitor their performance within our network (Exhibit J). The guidelines that PreferredOne's Quality Management Committee has adopted include ICSI's clinical guidelines for Coronary Artery Disease, Asthma, Depression, and ADHD/ADD. The performance of these guidelines by our network practitioners will be monitored using HEDIS measurement data.

The most recent version of the ICSI guidelines that we have adopted can be found on ICSI's website at *www.icsi.org*.

Continuity & Coordination of Care

Continuity and coordination of care is important to PreferredOne. If your clinic is terminating your contract with PreferredOne, please notify your PreferredOne provider representative immediately. According to the Minnesota Department of Health statute 62Q.56 subdivision 1: the health plan must inform the affected enrollees about termination at least 30 days before the termination is effective, if the health plan company has received at least 120 days' prior notice. If you need further information please contact your network representative at PreferredOne regarding this statute.

Case Management Referral

What is Case Management?

Case management is a collaborative process among the Case Manager (an RN or Social Worker), the plan member, and 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 out to a member based on information that has been received at PreferredOne or members 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.**

Programs from PreferredOne at No Cost to Your Patients

PreferredOne has implemented Chronic Illness Management and Treatment Decision Support programs available to your patients who live with chronic conditions. Your patients will still have the same level of benefits, access to any ancillary services, and access to your referral network. They will also continue to see their practitioner(s) and receive the same services that they currently provide them.

The Chronic Illness Management (CIM) and Treatment Decision Support (TDS) Programs focus on the following conditions:

CIM

- Diabetes
- Coronary Heart Disease
- Heart Failure

Page 6...

Cont'd from page 5...

- Chronic Obstructive Pulmonary Disease
- Asthma

TDS

- Low Back Pain
- Healthy Mom and Baby

The Goals of These Programs Are to:

- Promote self-management of chronic conditions
- Improve adherence to treatment plans
- Improve adherence to medication regimes
- Reduce or delay disease progression and complications
- Reduce hospitalizations and emergency room visits
- Improve quality of life

Benefits to You and Your Practice

These PreferredOne programs are designed to collaborate with a practitioner's recommended treatment plans. With the help of a nurse health coach, patients are educated telephonically about their chronic conditions and taught how to track important signs and symptoms specific to their condition. There are several benefits when your patients participate in these PreferredOne programs:

- Program participants learn how to better follow and adhere to treatment plan
- Program participants learn how to maximize their office visits
- If clinically concerning warning signs are discovered through the program, practitioners are notified, if clinically appropriate, via a faxed *Health Alert*
- Program participants receive ongoing support and motivation to make the necessary lifestyle changes practitioners have recommended to them

Benefits to Patients

- Access to a PreferredOne Registered Nurse
- Information about managing their health condition
- Education and tools to track their health condition
- Equipment, as needed, for participation in the program
- Access to Healthwise®, an online health library at www.PreferredOne.com

Program Participants Learn to:

- Track important signs and symptoms to detect changes in their health status early enough to avoid complications and possible hospitalizations

Page 7...

Cont'd from page 6...

- Make better food choices
- Start an exercise program
- Regularly take their medications
- Avoid situations that might make their condition worse

To make a Referral to the PreferredOne CIM or TDS Programs:

Contact PreferredOne toll free at 1-800-940-5049, Ext. 3456.

Monday-Friday 7:00 a.m. to 7:00 p.m. CST.

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

Exhibit A

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	
POLICY DESCRIPTION:	Fee Schedule Updates		
EFFECTIVE DATE:	**1/1/2013**		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	**1/1/2008,04/01/06,**
07/01/05, 7/1/2011			
REFERENCE NUMBER:	P-16	**RETIRED DATE:**	

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

PURPOSE: To give provider information on the effective dates of the provider fee schedule updates.

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. All fee schedules will be reviewed and updated annually. The fee schedule update includes but is not limited to a review of changes, deletions, and additions in CPT, HCPCS, DRG, American Society of Anesthesiology and ASC Groupers, and APCs.

2. The provider and hospital CPT fee schedules are updated on January 1st of each calendar year. The codes that are assigned an RVU as defined by Centers of Medicare (CMS) are updated to use a one year lag, non-GPCI adjusted total RVU as published in the Federal Register. Effective January 1, 2007 there will be the following exception. The new code changes that are published in November CPT and HCPCS that are to be effective for the following year will also be added to the fee schedule using the current year CMS RVU's.

   Example: The fee schedule that is effective January 1, 2006 – December 31, 2006 will use the CMS RVU from 2005. The new CPT and HCPCS codes published in November 2005 to be effective January 1, 2006 will use the 2006 CMS non-GPCI RVU as published in the Federal Register and be added to the fee schedule effective January 1, 2006 – December 31, 2006.

3. The non-RVU code pricing will also be reviewed and updated to be effective January 1st of each calendar year.

- For drugs & immunizations, new codes will be added using PreferredOne standard methodology when FDA approves, if applicable, and RJ establishes pricing. If the new code is replacing or is another option for an existing code, the new code will be added at either the RJ established pricing or the existing code rate. The effective date will be based on either when RJ pricing is newly established or when the code became effective.
- For labs, new codes will be added using PreferredOne standard methodology when FDA approves, if applicable, and CMS establishes pricing. If the new code is replacing or is another option for an existing code, the new code will be added at either the CMS established pricing or the existing code rate. The effective date will be based on either when CMS pricing is newly established or when the code became effective.

4. The hospital DRG schedules will use the current version as published in the October Federal Register that is to be effective January of the following year.

5. For the providers on APC methodology, PreferredOne uses a one year lag in the Optum Hospital based grouper and weights (ex. for 2012 we will use the 2011 grouper and the Oct 2011 weights). However, new codes will be added according to the following:
   - If the new code is assigned a new APC we will add it to the current APC weight and rate file at the NEW APC WEIGHT.
   - If the new code is assigned to an existing APC it will be added and will follow the existing APC weight and rate.
   - If a new code is assigned to a status indicator that points to a fee schedule, the code will be added to that fee schedule according to the fee schedule methodology.

   - The APC Grouper and weights will be updated on an annual basis. Once the updates have been loaded into production, claims will be processed according the conversion factor and weights that are in effect using the new grouper based on process date not date of service due to system limitations.

   The provider and hospital CPT fee schedules are updated on January 1st of each calendar year. The codes that are assigned an RVU as defined by Centers of Medicare (CMS) are updated to use a one year lag, non-GPCI adjusted total RVU as published in the Federal Register. Effective January 1, 2007 there will be the following exception. The new code changes that are published in November CPT and HCPCS that are to be

effective for the following year will also be added to the fee schedule using the current year CMS RVU's.

- For drugs & immunizations, new codes will be added using PreferredOne standard methodology when FDA approves, if applicable, and RJ establishes pricing. If the new code is replacing or is another option for an existing code, the new code will be added at either the RJ established pricing or the existing code rate. The effective date will be based on either when RJ pricing is newly established or when the code became effective.
- For labs, new codes will be added using PreferredOne standard methodology when FDA approves, if applicable, and CMS establishes pricing. If the new code is replacing or is another option for an existing code, the new code will be added at either the CMS established pricing or the existing code rate. The effective date will be based on either when CMS pricing is newly established or when the code became effective.

6. Fee schedules for DME, Home Health, Home IV, and Dental are updated on April 1st of each year.

7. Anesthesia fee schedules are updated annually on January 1st of each year according to the current year Relative Value Guide published by the American Society of Anesthesiologists in November of the preceding year.

8. Hospice fee schedules are updated annually on October 1st of each year according to the Centers of Medicare and Medicaid Services Fee Schedule.

9. Additional updates to the fee schedules may occur when warranted by special circumstances.

10. All updates will be communicated via the PreferredOne Provider Bulletins

11. All fee schedule updates involve a consensus process between coding, pricing and contracting.

Exhibit B

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE:**	12/1/2012
POLICY DESCRIPTION:	Reimbursement Facility Multiple Surgeries Performed on the Same Date of Service		
EFFECTIVE DATE:	1/1/2013		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	P#14	**RETIRED DATE:**	

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

PURPOSE: Multiple procedures by the same facility in the same setting on the same date of service may be subject to multiple procedure reduction for the secondary and subsequent procedures.

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. When multiple procedures are performed on the same date of service, PreferredOne will select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of PreferredOne's contracted rate. 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.

2. PreferredOne requires multiple procedures and bilateral procedures billed on the UB-04 claim form to be submitted on separate lines e.g. bilateral knee arthroscopy:

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

3. The appropriate revenue codes that are considered a procedures for this policy are including, but not limited to 36x, 49x, 75x and 790.

4. Facilities on APC methodology follow the APC editing for multiple procedures.

DEFINITIONS:

REFERENCES: Pricing & Payment Policy #11 Reimbursement For Free-Standing ASC & Hospital Outpatient to APC Methodology

Exhibit C

PreferredOne

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

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

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

POLICY: PreferredOne will reduce payment to the acute care hospital if the patient is discharged less than 48 hours after admission and is one of the DRG's that CMS has listed as having a GLOS greater than 4.0 days.

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

PROCEDURE:

1. The Inpatient Hospital claim (UB04) must have a length of stay less than 48 hours.
2. This policy applies only to the DRG's with a GLOS greater than 4.0.
3. This policy excludes Mental Health, Chemical Dependency, eating disorders, Maternity, Newborn and Rehab claims.
4. These claims will process at the lesser of providers DRG payment or 60% of charges.

DEFINITIONS:

REFERENCES:

Exhibit D

PreferredOne

DEPARTMENT:	Pricing & Payment	**APPROVED DATE:**	09/1/2013
POLICY DESCRIPTION:	Multiple Imaging Performed on the Same Date of Service		
EFFECTIVE DATE:	4/1/2014		
PAGE:	1 of 1	**REPLACES POLICY DATED:**	
REFERENCE NUMBER:	P#16	**RETIRED DATE:**	

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

PURPOSE: To provide guidelines for reimbursement when multiple imaging is performed on the same member, same date of service by the same group practice or facility.

POLICY: Multiple imaging selected services performed at the same group practice or facility, the same date of service and same patient may be subject to multiple procedure reduction for the secondary and subsequent procedures.

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

PROCEDURE:

1. The imaging services that qualify for multiple imaging reduction are identified in the CMS RVU file with a Multiple procedure indicator = 4 or Revenue Code ranges 35x and 61x or CMS defined radiology composite APCs.

2. This applies to group practices billing on CMS HCFA 1500 claim form, regardless of place of service and facilities billing on CMS UB claim form.

3. Multiple imaging reductions apply to these codes when performed on the same patient by the same group practice or facility during the same session.

4. A single imaging procedure subject to the multiple imaging reduction concepts is submitted with multiple units. For example, code 70450 is submitted with 2 units. A multiple imaging reduction would apply to the second unit.

5. Exceptions to the multiple imaging reduction:

    a. When modifier -26 for the professional component only is billed

b. When modifier -59 to indicate the procedure was done on the same day but not during the same session

6. When multiple procedures are performed on the same date of service, PreferredOne will select the procedure classified in the highest payment group for the primary procedure. This procedure will be reimbursed at 100% of PreferredOne's contracted rate. Subsequent imaging procedures will be reimbursed as follows: If the group practice bills globally the subsequent imaging procedures will be reimbursed at 75% of the allowed rate. If the group practice or facility bills TC technical component, the subsequent imaging procedures will be reimbursed at 50% of the allowed rate, or for APC methodology, grouped to the appropriate composite APC.

DEFINITIONS:

REFERENCES: CMS Transmittal 1104 Change Request 7747 August 2, 2012

MedLearn Matters # MM7747

Exhibit E

Chiropractic Policies

Reference #	Description
001	Use of Hot and Cold Packs
002	Plain Films Within the first 30 days of Care ***Revised***
003	Passive Treatment
004	Experimental, Investigational, or Unproven Services ***Revised***
006	Active Care: Active Procedures
007	Acute and Chronic Pain
009	Recordkeeping and Documentation Standards
010	CPT Code 97140 ***Revised***
011	Infant Care - Chiropractic
012	Measureable Progressive Improvement - Chiropractic
013	Chiropractic Manipulative Therapy Recommendation
014	Treatment Plan Documentation
015	Advanced Imaging ***New***

Exhibit F

Medical Criteria

Reference #	Category	Description
A006	Cardiac/Thoracic	Ventricular Assist Devices (VAD)
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea
D001	DME	Microprocessor-Controlled Prostheses for the Lower Limb
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic ***Revised***
F022	Orthopaedic/Musculoskeletal	Intervertebral Disc Prosthesis
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back ***Revised***
G001	Skin and Integumentary	Eyelid and Brow Surgery (Blepharoplasty & Ptosis Repair)
G002	Skin and Integumentary	Breast Reduction Surgery ***Revised***
G003	Skin and Integumentary	Excision Redundant Tissue
G004	Skin and Integumentary	Breast Reconstruction
G007	Skin and Integumentary	Prophylactic Mastectomy and Oophorectomy
G008	Skin and Integumentary	Hyperhidrosis Surgery
G010	Skin and Integumentary	Lipoma Removal
G011	Skin and Integumentary	Hyperbaric Oxygen Therapy
H003	Gastrointestinal/Nutritional	Bariatric Surgery
I007	Neurology	Cryoablation/Cryosurgery for Hepatic, Prostate, and Renal Oncology Indications
I008	Neurological	Sacral Nerve Stimulation
I009	Neurological	Deep Brain Stimulation
I010	Neurological	Spinal Cord/Dorsal Column Stimulation
K001	General Surgical/Medical	IVAB for Lyme Disease
K002	General surgical/ medical	Bronchial Thermoplasty
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
L009	Diagnostic	Intensity Modulated Radiation Therapy (IMRT)
L010	Diagnostic	Genetic Testing for Hereditary Breast or Ovarian Cancer Syndromes (BRCA1/BRCA2, BART, PTEN, TP53)
L011		Insulin Infusion Pump
L012	Diagnostic/Radiology	Oncotype DX Breast Cancer Assay

M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment Program
M005	BH/Substance Related Disorders	Eating Disorders-Level of Care Criteria ***Revised***
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)
M007	BH/Substance Related Disorders	Mental Health Disorders: Residential Treatment
M010	BH/Substance Related Disorders	Substance Related Disorders: Inpatient Primary Treatment
M014	BH/Substance Related Disorders	Detoxification: Inpatient Treatment
M020	BH/Substance Related Disorders	Pervasive Developmental Disorders in Children: Evaluation and Treatment
M022	MH/Substance Related Disorders	Mental Health Disorders: Residential Crisis Stabilization Services (CSS)
M023	MH/Substance Related Disorders	Mental Health Disorders : Intensive Residential Treatment Services (IRTS)
N002	Rehabilitation	Inpatient Skilled Services (Skilled Nursing Facility and Acute Inpatient Rehabilitation)
N003	Rehabilitation	Occupational and Physical Therapy: Outpatient Setting
N004	Rehabilitation	Speech Therapy: Outpatient
N005	Rehabilitation	Torticollis and Positional Plagiocephaly Treatment for Infants/Toddlers
N006	Rehabilitation	Acupuncture
N007	Rehabilitation	Home Health Care
T001	Transplant	Bone Marrow / Stem Cell Transplantation ***Revised***
T002	Transplant	Kidney, SPK, SPLK Transplant ***Revised***
T003	Transplant	Heart Transplant ***Revised***
T004	Transplant	Liver Transplantation ***Revised***
T005	Transplant	Lung Transplantation ***Revised***
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplant ***Revised***

Exhibit G

Medical Policies

Reference #	Description
A001	Elective Abortion ***New***
A003	Amino Acid Based Elemental Formula (AABF)
C001	Court Ordered Mental Health Services
C002	Cosmetic Treatments
C003	Criteria Management and Application ***Revised***
C008	Oncology Clinical Trials, Covered / Non-covered Services
C009	Coverage Determination Guidelines
C011	Court Ordered Substance Related Disorder Services
D004	Durable Medical Equipment, Orthotics, Prosthetics and Supplies ***Revised***
D005	Dietary Formulas, Electrolyte Substances, or Food Products for PKU or Other Inborn Errors of Metabolism
D007	Disabled Dependent Eligibility
D008	Dressing Supplies
D009	Dental Services, Hospitalization, and Anesthesia for Dental Services Covered Under the Medical Benefit
G001	Genetic Testing ***Revised***
G002	Gender Reassignment
H006	Hearing Devices
H007	Hospice Care
I001	Investigational/Experimental Services
I002	Infertility Treatment ***Revised***
I003	Routine Preventive Immunizations
L001	Laboratory Tests ***Revised***
N002	Nutritional Counseling ***Revised***
P008	Medical Policy Document Management and Application
P009	Preventive Screening Tests for Grandfathered Plans
P010	Narrow-band UVB Phototherapy (non-laser) for Psoriasis
P011	Prenatal Testing ***Revised***
R002	Reconstructive Surgery
S008	Scar Revision
T002	Transition of Care - Continuity of Care
T004	Therapeutic Pass
T006	PreferredOne Designated Transplant Network Provider ***New***
W001	Physician Directed Weight Loss Programs

Exhibit H

Pharmacy Criteria

Reference #	Description
A003	Combination Beta-2 Agonist/Corticosteroid Inhalers Step Therapy
A005	Antidepressants Step Therapy
A008	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) Medications Step Therapy
B003	Botulinum Toxin ***Revised***
B004	Biologics for Rheumatoid Arthritis ***Revised***
B005	Biologics for Plaque Psoriasis
B006	Biologics for Crohn's Disease
B009	Osteoporosis Prevention and Treatment Medications
B010	Biologics for Juvenile Rheumatoid Arthritis ***Revised***
B011	Biologics for Psoriatic Arthritis
B012	Biologics for Ankylosing Spondylitis
B013	Biologics for Ulcerative Colitis
B014	Benign Prostatic Hypertrophy Medications Step Therapy
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
E001	Erectile Dysfunction Medications - Non-PDE-5 Inhibitor Medications
F001	Fenofibrate Step Therapy ***Revised***
I001	Topical Immunomodulators Step Therapy: Elidel & Protopic
I002	Immune Globulin Therapy (IVIG)
L003	Gabapentin Step Therapy ***Revised***
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy ***Revised***
O001	Overactive Bladder Medication Step Therapy ***Revised***
P001	Proton Pump Inhibitor (PPI) Step Therapy
P002	Phosphodiasterase-5 Inhibitor Medications ***Revised***
R003	Topical Retinoid Medications Step Therapy
R004	Rituxan Prior Authorization ***Revised***
S003	Sedative Hypnotics Step Therapy
T002	Tramadol Step Therapy
V001	Vascular Endothelial Growth Factor Antagonists for Intravitreal Use ***Revised***
W001	Weight Loss Medications ***Revised***

Exhibit I

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
C001	Coordination of Benefits
C002	Cost Benefit Program ***Revised***
C003	Compounded Drug Products ***New***
F001	Formulary and Co-Pay Overrides
O001	Off-Label Drug Use
P001	Bypass of Prior Authorization of a Medication Ordered by a Contracted Specialist ***Revised***
Q001	Express Scripts Quantity Limits
Q002	ClearScript Quantity Limits ***Revised***
R001	Review of New FDA-Approved Drugs and Clinical Indications
S001	Step Therapy

Exhibit J

PreferredOne®

Department of Origin: Quality Management	**Approved by:** Quality Management Committee	**Date approved:** 7/11/13
Department(s) Affected: Quality Management, Network Management	**Effective Date:** 7/11/13	
Procedure Description: Clinical Practice Guidelines	**Replaces Effective Procedure Dated:** 7/12/12	
Reference #: QM/C003	**Page:** 1 of 2	

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

BACKGROUND:
PreferredOne adopts Institute of Clinical Systems Improvement (ICSI) clinical practice guidelines. Clinicians from ICSI member medical organizations survey scientific literature and draft health care guidelines based on the best available evidence. These guidelines are subjected to an intensive review process that involves physicians and other health care professionals from ICSI member organizations before they are made available for general use. More than 50 guidelines for the prevention or treatment of specific health conditions have been developed and are updated annually.

PreferredOne adopts the guidelines listed below for distribution in the contracted networks and performance measurement.

PROCEDURE:

I. PreferredOne adopts the following ICSI guidelines and supports implementation within its provider network:

A. Coronary Artery Disease, Stable
B. Asthma, Diagnosis and Outpatient Management of
C. Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
D. Major Depression in Adults in Primary Care
E. Diagnosis and Management of ADHD

II. Distribution and Update of Guidelines

A. PreferredOne's adopted guidelines are distributed via the provider newsletter to the contracted network and posted on the PreferredOne Web site. Adopted guidelines are always available upon request.
B. Guidelines are reviewed approximately every 18 months following publication to reevaluate scientific literature and to incorporate suggestions provided by medical groups who are members of ICSI. The ICSI workgroup revises the guideline to incorporate the improvements needed to ensure the best possible quality of care. When guidelines are revised PreferredOne will send out the updated guideline(s) to all practitioners via the provider newsletter.
C. On an annual basis, practitioners are notified that all guidelines are available at *www.icsi.org*

III. Performance Measurement - baseline assessment for the initial adoption of the guidelines was conducted in fall of 2007, first network assessment report available in June 2008. Annual assessment to be conducted on an ongoing basis. The ICSI guidelines provide the basis for measurement and monitoring of clinical indicators and quality improvement initiatives. The annual measures that will be used to assess performance for each clinical guideline adopted are as follows:

A. Coronary Artery Disease
1. Optimal Vascular Care Measure (Minnesota Community Measurement measure)
This measure examines the percentage of patients, ages 18-75, with coronary artery disease who reached all of the following four treatment goals to reduce cardiovascular risk:
• Blood pressure less than 140/90 mmHg

- LDL-C less than 100 mg/dl
- Daily aspirin use
- Documented tobacco-free status

2. Cholesterol management after acute cardiovascular event (HEDIS technical specifications)

B. Asthma, Diagnosis and Outpatient Management of
1. Percentage of patients with persistent asthma who are on inhaled corticosteroid medication (HEDIS technical specifications)
2. Asthma action plan developed (PreferredOne Chronic Illness Management outcome measure)

C. Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
The percentage of members 18-75 years of age with diabetes who had each of the following:
1. HbA1c control (<8.0%)
2. BP control (<140/90 mm Hg)

D. Major Depression in Adults in Primary Care
1. Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks) (HEDIS technical specifications)
2. Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months) (HEDIS technical specifications)

E. Diagnosis and Management of ADHD Initiation Phase
1. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase (HEDIS technical specifications)
2. Continuation and Maintenance (C&M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended (HEDIS technical specifications)

IV. PreferredOne has utilized the ICSI's practice guidelines as the clinical basis for its chronic illness management programs for CAD, Diabetes and Asthma and will ensure program materials are consistent with the practice guidelines.

REFERENCES:

- NCQA Standards and Guidelines for the Accreditation of Health Plans
- QI 9 Clinical Practice Guidelines
- QI 8 Disease Management

DOCUMENT HISTORY:

***Created Date**: 1/24/06*
***Reviewed Date:** 7/14/11, 7/12/12*
***Revised Date:** 4/10/08, 7/10/08, 7/9/09, 7/14/10 , 7/11/13*