PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
February 2014

ICD-10 Update

PreferredOne continues to work on the ICD-10 transition to meet the October 1, 2014 deadline later this year. The testing strategy involves a two-phase approach. The first testing phase is the financial analysis to remain revenue neutral throughout this process. This involves providers coding claims directly from the medical chart using ICD-9 and ICD-10 procedure and diagnosis codes for selected scenarios.

The second testing phase is an end to end system testing to make sure the claims with ICD-10 will be accepted either directly or via clearinghouse into our claims processing system, adjudicated appropriately and returned to the provider successfully. The testing of clearinghouses needs to be initiated by the provider since PreferredOne works with a variety of them and they are limited in what they are able to do.

Both revenue-neutral and end-to-end testing involve significant resources by both the health plan and providers. As a result, in both testing approaches, PreferredOne will work with selected providers to work through the testing. The end-to-end testing results will be posted on the PreferredOne website in the ICD-10 designated area and are expected to be complete by this summer. If providers are interested in either of these testing phases, submit your request online in the ICD-10 specific area located in the Provider section. Selected providers will be contacted directly.

Be sure to visit the site to see any updates and information about PreferredOne's ICD-10 activities. Here is the website address to the ICD-10 page: https://www.preferredone.com/providers/icd10_update.aspx

Important News About New 2014 HCPCS Codes

As previously communicated at the 2013 September Provider Forum and in the October Provider Newsletter, 2014 new codes will be added to fee schedules effective January 1, 2014 according to the methodology outlined in the P-16 "Fee Schedule Updates" policy.

The October 2013 closing of the federal government during congressional budget talks has delayed the release of the HCPCS Level II code set for 2014. The estimated time that PreferredOne will receive the new HCPCS codes is mid-January 2014. Any new 2014 HCPCS codes will be add to the fee schedules at that time per the policy. The new 2014 CPT codes have already been added to the fee schedules.

In This Issue:

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PreferredOne Community Health Plan (PCHP)
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PreferredOne Administrative Services (PAS)
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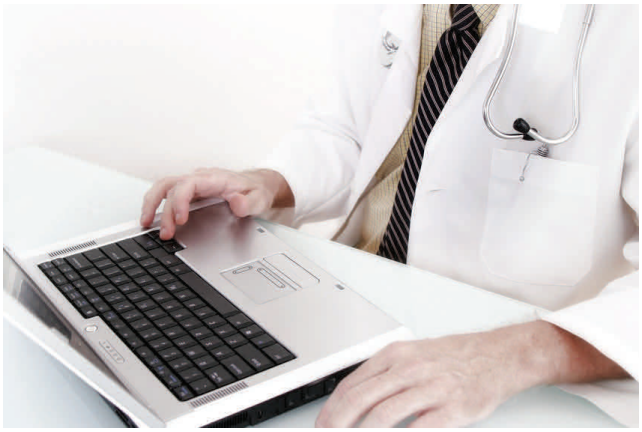
New HCPCS Level Code G0463

CMS published the 2014 OPPS and ASC PS final rule Nov. 27. CMS has elected to collapse hospital clinic E/M services to a single level for Medicare payment in 2014, stating "we believe that the spectrum of hospital resources provided during an outpatient hospital clinic visit is appropriately captured and reflected in the single-level payment for clinic visits. We also believe that a single visit code is consistent with a prospective payment system, where payment is based on an average estimated relative cost for the service, although the cost of individual cases may be more or less costly than the average." Beginning with January 1, 2014 hospital clinic E/M visits, PreferredOne will accept either the new HCPCS level G0463 Hospital outpatient clinic visit for assessment and management of a patient OR the existing 99201 – 99215 E/M level visits. The G0463 code has been assigned to a new APC 0634.

Coding Update

Multiple Procedures When Reporting the Exact Same CPT ® Code on the Same Date of Service



Surgical procedures: Recommended modifier is 59 (Distinct Procedural Service) Do not bill surgical procedures with units if there is not a unit of measure in the description. For example multiple lesion removals using the same code should be billed on single lines with 1 unit and appropriate modifiers.

Radiological procedures: Recommended modifier is 76 (Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional).

Laboratory services: Recommended modifier is 91 (Repeat Clinical Diagnostic Laboratory Test). Laboratory services may also be billed with units.

Unlisted Codes

Recently claims and supporting documentation have been submitted containing unlisted CPT® code(s) for which a separate, payable procedure cannot be identified. When this occurs, the unlisted CPT® code will be denied.

To best facilitate payment for an unlisted CPT® code, please include in the claim's narrative section what specific procedure is being done.

If the service is a surgery, an operative report is required. Sending only the operative note is often not sufficient to determine what the unlisted code is being used for. Providers should include a written letter or explanation that indicates what the unlisted service consisted of.

If the service is a diagnostic/laboratory test, clinical notes should be included describing the patient's diagnoses, the test performed, and the results of the test.

If the item is a DME item, the name of the item, a description, the manufacturer, product number, and a copy of the invoice should be included.

If the service is a drug (e.g., J3490), the name, NDC number of the drug, and dosage information should be listed on the claim

If the service is a compounded drug, the provider should bill with the unlisted code J3490 on a single line with one unit. The provider should also include the invoice.

Mental Health Benefits

Please be aware that due to the Mental Health Parity law there is no longer a limit on mental health visits. If you are searching online for mental health benefits please look under the medical office visits benefits or the hospital visit benefits. Our system has been updated to reflect this.

Member Rights & Responsibilities

PreferredOne presents this Member Rights & Responsibilities with the expectation that observance of these rights will contribute to high quality patient care and appropriate utilization for the patient, the providers, and PreferredOne. PreferredOne further presents these rights in the expectation that they will be supported by our providers on behalf of our members and as an integral part of the health care process. It is believed that PreferredOne has a responsibility to our members. It is in recognition of these beliefs that these rights are affirmed (Exhibit A).

Medical & Pharmacy Policy Update

Medical Policy documents are available on the PreferredOne website to members and to providers without prior registration. The website address is 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.

Behavioral Health Criteria

- New Criteria: None
- Criterion with Major Revision:
    - MC/M020 Autism Spectrum Disorders in Children: Non-Intensive Treatment - title change to reflect DSM V language and to differentiate from Early Intensive Treatments
- Retired Criterion:
    - MC/M009 Chronic Pain: Outpatient Program
- New Policy:
    - Autism Spectrum Disorders in Children: Assessment and Evaluation
- Retired Policy: None

Chiropractic Criteria

- New Criteria: None
- Criteria with Major Revisions: None
- Retired Criteria: None
- New Policy: None
- Retired Policy: None

Medical/Surgical Criteria

- New Criteria: None
- Criteria with Major Revisions: None
- Retired Criterion:
    - MC/N006 Acupuncture
- New Policy: None
- Retired Policy: None

Revision(s) to the Investigational/Experimental/Unproven Comparative Effectiveness List: None

Remember to check the Pre-certification/Prior Authorization List posted on the PreferredOne website. The list can be found with the other Medical Policy documents on the PreferredOne internet home page. 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. Please check the list regularly for revisions.

The attached documents (Exhibits B-F) 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.

With the continued roll-out of the Affordable Care Act provisions and local Exchange products, new policies and criteria will continue to be developed and posted.

For the most current version of the policy and criteria documents, please access the Medical Policy area 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.

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.

Adverse Determination – To Speak to a Physician Reviewer

PreferredOne Integrated Healthcare Services Department attempts to process all reviews in the most efficient manner. We look to our participating practitioners to supply us with the information required to complete a review in a timely fashion. We then hold ourselves to the timeframes and processes dictated by the circumstances of the case and our regulatory bodies.

Practitioners may, at any time, request to speak with a peer reviewer at PreferredOne regarding the outcome of a review by calling 763-847-4488, option 2 and the Intake Department will facilitate this request. You or your staff may also make this request of the nurse reviewer with whom you have been communicating about the case and she/he will facilitate this call. If, at any time, we do not meet your expectations and you would like to issue a formal complaint regarding the review process, criteria or any other component of the review, you may do so by calling or writing to our Customer Service Department.

PreferredOne
Attn: Grievance Department
6105 Golden Hills Dr.
Golden Valley, MN 55416

(763) 847-4488, Option 3.
(800) 379-7727, Option 3

Quality Management Update

Blood Pressure Readings for Controlling High Blood Pressure

In 2014 PreferredOne will once again be focusing on an initiative to control high blood pressure among our members diagnosed with hypertension. Controlling blood pressure is a HEDIS measurement specified by NCQA and is also reported by Minnesota Community Measurement. We value this project and deem it as important to our members because hypertension is the most treatable form of cardiovascular disease and medication compliance is a significant factor that contributes to the overall success of treatment. PreferredOne will be providing medication adherence education to members diagnosed with hypertension. As part of this initiative in 2014 we are asking for provider's assistance by conducting a secondary reading of your patient's blood pressure if it is high following the initial reading and ensuring that the patient's medical records reflects both of the measurements taken.

HEDIS Medical Record Review

As a reminder, PreferredOne's HEDIS Medical Record Review Vendor will be contacting clinics in the coming weeks to coordinate medical record review for PreferredOne members seen at your clinics. As a contracted provider you are obligated to allow PreferredOne and its vendor to conduct this review. HEDIS measures are nationally used by all accredited health plans and PreferredOne also has an obligation to the Minnesota Department of Health to collect HEDIS data on an annual basis. Medical record review is an important component of the HEDIS compliance audit. It ensures that medical record reviews performed by our vendor meet audit standards for sound processes and that abstracted medical data are accurate. We would appreciate your cooperation with collecting medical record review information at your clinic site(s). We appreciate your clinic's assistance in making this a smooth process.

Medical Record Documentation Policy

Please see (Exhibits G-H) for our Medical Record Documentation policy and Reimbursement for Medical Record Requests policy.

Exhibit A

PreferredOne Member Rights & Responsibilities

As a PreferredOne member, you have the following rights and responsibilities:

1. A **right** to receive information about PreferredOne, its services, its participating providers and your member rights and responsibilities.

2. A **right** to be treated with respect and recognition of your dignity and right to privacy.

3. A **right** to available and accessible services, including emergency services, 24 hours a day, 7 days a week.

4. A **right** to be informed of your health problems and to receive information regarding treatment alternatives and risks that are sufficient to assure informed choice.

5. A **right** to participate with providers in making decisions about your health care.

6. A **right** to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.

7. A **right** to refuse treatment recommended by PreferredOne participating providers.

8. A **right** to privacy of medical, dental and financial records maintained by PreferredOne and its participating providers in accordance with existing law.

9. A **right** to voice complaints and/or appeals about PreferredOne policies and procedures or care provided by participating providers.

10. A **right** to file a complaint with PCHP and the Commissioner of Health and to initiate a legal proceeding when experiencing a problem with PCHP or its participating providers. For information, contact the Minnesota Department of Health at 651.201.5100 or 1.800.657.3916 and request information.

11. A **right** to make recommendations regarding PreferredOne's member rights and responsibilities policies.

12. A **responsibility** to supply information (to the extent possible) that PreferredOne participating providers need in order to provide care.

13. A **responsibility** to supply information (to the extent possible) that PreferredOne requires for health plan processes such as enrollment, claims payment and benefit management.

14. A **responsibility** to understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

15. A **responsibility** to follow plans and instructions for care that you have agreed on with your participating providers.

Exhibit B

Chiropractic Policies

Reference #	Description
002	Plain Film X-rays
003	Passive Treatment
004	Experimental, Unproven, or Investigational Services
006	Active Procedures in Physical Medicine
007	Acute and Chronic Pain Administration Policy
011	Infant Care Policy - Chiropractic
012	Measurable Progressive Improvement - Chiropractic
013	Chiropractic Manipulative Therapy Documentation
014	Plan of Care
015	Advanced Imaging

Exhibit C

Medical Policy

Reference #	Description
A001	Elective Abortion ***New***
A003	Amino Acid Based Elemental Formula (AABF) ***Revised***
A004	Acupuncture ***New***
C001	Court Ordered Mental Health Services
C002	Cosmetic Treatments ***Revised***
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 for Heritable Conditions ***Revised***
G002	Gender Reassignment
H006	Hearing Devices
H007	Hospice Care
H008	FDA-Approved Humanitarian Use Devices (HUD) ***New***
I001	Investigational/Experimental Services
I002	Infertility Treatment ***Revised***
I003	Routine Preventive Immunizations
L001	Laboratory Tests ***Revised***
N002	Nutritional Counseling ***Revised***
O001	Orthodontic Services ***New***
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***
V001	Vision Care, Pediatric ***New***
W001	Physician Directed Weight Loss Programs

Exhibit D

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
F022	Orthopaedic/Musculoskeletal	Intervertebral Disc Prosthesis
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back
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
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) ***Revised***
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 ***Revised***
M010	BH/Substance Related Disorders	Substance Related Disorders: Inpatient Primary Treatment
M014	BH/Substance Related Disorders	Detoxification: Inpatient Treatment
M020	BH/Substance Related Disorders	Autism Spectrum 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
N007	Rehabilitation	Home Health Care
T001	Transplant	Bone Marrow / Stem Cell Transplantation
T002	Transplant	Kidney, SPK, SPLK Transplant
T003	Transplant	Heart Transplant
T004	Transplant	Liver Transplantation
T005	Transplant	Lung Transplantation
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplant ***Revised***

Exhibit E

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 F

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

Exhibit G

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 H

PreferredOne

DEPARTMENT:	Coding Reimbursement	**APPROVED DATE:**	04/19/05
POLICY DESCRIPTION:	Medical Records		
EFFECTIVE DATE:	03/15/2013		
PAGE:	1	**REPLACES POLICY DATED:**	01/13/98, 02/01/2005
REFERENCE NUMBER:	NM/P024	**RETIRED DATE:**	

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

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

POLICY: Guidelines regarding the reimbursement of medical record requests.

PROCEDURE:

I. Regular Review Purposes

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

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

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

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

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

E. HEDIS medical record review

II. Quality/Complaint Issues

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

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

III. Reimbursable Cost

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

DEFINITIONS:

REFERENCES: