PreferredOne®
UPDATE A Newsletter for PreferredOne Providers & Practitioners
October 2015

Pricing Update

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ICD-10 PreferredOne End-to-End Testing & PreferredOne Readiness

PreferredOne has successfully completed ICD-10 testing of systems. PreferredOne selected a few Clearinghouses and five providers with varying types of service to participate in ICD-10 end-to-end testing. Overall, participants were able to successfully submit ICD-10 test claims and have them processed through PreferredOne claim systems. In addition, the providers received Remittance Advices (RAs) successfully. An acceptance rate of 99.6% was achieved. 11% of the claims were rejected due to invalid submission of ICD-10 code. Inpatient, Outpatient, Surgery Center and Physician claims were tested. Testing demonstrated that PreferredOne systems are ready to accept ICD-10 claims and able to adjudicate and return claims directly or through a Clearinghouse to meet the upcoming deadline.

ICD-10 Crossover Claims

This summer CMS released a MedLearn Matters bulletin SE1408 to clarify language under "Claims that Span the ICD-10 Implementation Date. Please note that PreferredOne is following CMS guidelines when claims span the ICD-10 implementation date for institutional, professional and supplier claims. For example, patient may be admitted inpatient September 29, 2015 and discharged after October 1, 2015. Another example may be patient is in the ER or in Observation on September 30, 2015 and does not leave until October 1, 2015. The general rule is that inpatient claims should be coded according to discharge date. All outpatient and physician claims should be split, based on date of service. So for example, if physician provides E/M inpatient professional services September 29, 2015 – October 2, 2015, the claims should be split where ICD-9 codes are used for September 29-30 dates of service, and a second claim should be submitted where ICD-10 codes are used for October 1-2 dates of service.

ICD-10 DRG Grouper Version 33 and Vaginal Delivery DRGS 774/775 and Acute Rehab DRGS 945/946

PreferredOne is aware that the new DRG ICD-10 grouper Version 33 has some changes for DRGs 774 and 775 (Vaginal deliveries with and without CC/MCC). The Inpatient Prospective Payment System (IPPS) final rule did make some changes to the Version 33 grouper, but not all of the suggested changes were made were suggested. This results in some of the admissions that normally fall into DRGs 774 and 775 grouping to DRGs associated with all MDCS related to OR procedures in the 981 – 989 code range.

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CLAIM ADDRESSES:

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PO Box 59212
Minneapolis, MN 55459-0212

Phone: 763-847-4477
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PO Box 1527
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800-451-9597
Fax: 763-847-4010

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

Phone: 763-847-4488
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Fax: 763-847-4010

PreferredOne Administrative Services (PAS)
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In order to minimize benefit and payment disruption, claims with a DRG in the range of 981 – 989 that also have an ICD-10 diagnosis code(s) or Delivery Procedure as listed in the DRG code book under DRGs 774 and 775 principal or secondary diagnosis or delivery procedure on the claim will be considered a vaginal delivery. Admissions that meet the criteria of a vaginal delivery will be paid at the MS DRG 775 rate. (Exhibit A)

PreferredOne wants to remind providers about the ICD-10 MS DRG version 33 grouper changes for MS DRGs 945 & 946 (Rehabilitation with and without CC/MCC). According to CMS website FAQ response, ICD-10 does not contain specific codes for encounters for rehabilitation such as ICD-9 codes V57.89 (Care involving other specified rehabilitation procedure) and V57.9 (Care involving unspecified rehabilitation procedure). In order to be assigned to ICD -0 MS DRG 945 or 946, one of two ways as described in the CMS Definitions Manual:

- The admission has a principal diagnosis code Z44.8 (Encounter for fitting and adjustment of other external prosthetic devices) or Z44.9 (Encounter for fitting and adjustment of unspecified external prosthetic device) – both of these codes are included in the list of principal diagnosis codes assigned to MDC 23.
- The encounter has a MDC 23 principal diagnosis code AND one of the rehabilitation procedure codes listed under MS DRGs 945 and 946.

If the admission does not have a principal diagnosis code from the MDC 23 list but does have a procedure code from the list included under the Rehabilitation Procedures for MS DRGs 945 and 946, the admission will not be assigned to MS DRGs 945 or 946. The case will instead be assigned to a MS DRG within the MDC where the principal diagnosis code is found.

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, 2016. 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 2015 CMS Medicare physician RVU file without geographic practice index (GPCI) applied and without the work adjuster applied, as published in the Federal Register May 2015. New codes for 2016 will be based on the 2016 CMS Medicare physician RVU file without geographic practice index applied and without the work adjuster applied as published in the Federal Register November 2015. 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.

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. The lab methodology as a % 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 2016 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, 2016. New codes were added to this fee schedule and a reminder that any code not on the fee schedule will not be reimbursed.

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New ASA codes for Anesthesia services will be updated with the 2016 release of Relative Value Guide by the American Society of Anesthesiologists. This update will take place by January 1, 2016.

Requests for a market basket fee schedule may be made in writing to PreferredOne Provider Relations. Reminder that new codes for 2016 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 Newsletter."

Hospital Services/UB07/Outpatient Fee Schedules

The 2016 Calendar year DRG schedule will be based on the CMS MS-DRG Grouper Version 33 as published in the final rule Federal Register to be effective October 2015. Reminder that this grouper version was put into place October 1, 2015 in order to be ICD-10 compliant.

For those on Ambulatory Payment Classifications (APC), we are using Optum hospital-based grouper that will be a one year lag. For example, for 2016 rates PreferredOne will use the 2015 APC grouper and edits and weights as of October 2015.

The Facility (UB04) CPT fee schedule will consist of all physician CPT/HCPC code ranges and will be based on the 2015 CMS Medicare 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 RVU's
- Office visit codes (i.e. 908xx, 99xxx code range) are set to reimburse at the practice expense RVU's
- 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 2016 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 Bulletin".

Off-Cycle Fee Schedule Updates

Other provider types such as DME, Home Health, Skilled Nursing Facility updates will take place April 1, 2016.

New and Updated Pricing and Payment Policies

The following are new and updated Pricing and Payment Policies are attached:

Pricing & Payment #018 - Modifier Payment Reductions has been updated to reflect the change in modifier 22 reimbursement. (Exhibit B)

Pricing & Payment #006 - Site of Service Payment has been updated to reflect the newly added place of service 19 "Off Campus-Outpatient Hospital" to be considered as facility and will take the site of service differential. (Exhibit C)

New Pricing & Payment Policy #20 Same Day Labs Billed by multiple Providers – a new policy has been added to address when multiple providers bill the same lab service for the same member on the same date of service. PreferredOne is being billed multiple times for the same service for the same member from different providers. These claims are from the clinic and the reference lab for the same test on the same patient. PreferredOne will reimburse for only one service. (Exhibit D)

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Coding Update

Evaluation and Management (E/M) Services

Consistent and complete documentation in the medical record is an essential component of quality patient care and a required component of provider agreements. All services must be supported by accurate documentation for appropriate benefit application.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

Billing Provider Direction for Obtaining Supporting Documentation

It is the billing provider's responsibility to obtain supporting documentation from a referring provider's office or from a facility as the billing provider's charges are at risk ("Medicare Program Integrity Manual" (Pub.100-08), Chapter 3, Section 3.2.3.3).

Reference Lab Billing

PreferredOne® Health Plans will adjudicate the Reference Lab's claim and deny the ordering provider's claim as duplication of services when lab tests are sent to a reference lab, regardless if the ordering provider's claim that has the 90 modifier (Reference (Outside) Laboratory) appended to the lab CPT® code(s) or not. It is recommended the ordering provider's claim have the 90 modifier appended per correct coding rules and guidelines.

Medical Management 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 policies 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 investigative list.

Behavioral Health

- New Criteria: None
- Revised Criteria: None
- Retired Criteria: None
- New Policy: None
- Revised Policy: None
- Retired Policy: None

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Chiropractic

- New Criteria: None
- Revised Criteria: None
- Retired Criteria: None
- New Policy: None
- Revised Policy: None
- Retired Policy: None

Medical/Surgical

- New Criteria: None
- Revised Criteria:
    - MC/A006 Ventricular Assist Devices
    - MC/F021 Bone Growth Stimulators
    - MC/G008 Hyperhidrosis Surgery
    - MC/I007 Cryoablation/Cryosurgery for Oncology Indications
    - MC/L010 Genetic Testing for Hereditary Cancer Syndromes
    - MC/L011 Insulin Infusion Pump
    - MC/L012 Gene Expression Profiling
    - MC/T004 Liver Transplantation
- Retired Criteria: None
- New Policy:
    - MP/D010 Urine Drug Testing in Substance Abuse Treatment and Chronic Pain Settings
- Revised Policy:
    - MP/A001 Elective Termination of Early Pregnancy
    - MP/G002 Gender Reassignment
    - MP/N002 Nutritional Counseling
    - MP/P013 Pharmacogenetic Testing and Serological Testing for Inflammatory Conditions
    - MP/V001 Vision Care, Pediatric
- Retired Policy: None

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Investigative List

- Additions:
    - Amniotic membrane allograft for all indications except corneal grafting
    - Endoluminal cryoablation for the treatment of symptomatic varicose veins
    - Measurement of antibodies to infliximab
    - Methylenetetrahydrofolate reductase (MTHFR) genotyping for determining therapeutic response to antifolate chemotherapy and for guiding antidepressant therapy
    - Proton beam radiation therapy for prostate cancer
    - Sacroiliac joint fusion or pinning for low back pain due to sacroiliac joint syndrome, mechanical low back pain, degenerative sacroiliac joint, and radicular pain syndromes
    - Steroid-eluting nasal stents or spacers for chronic sinusitis without polyposis
- Deletions:
    - Intrafraction localization and tracking during delivery of radiation therapy
- Revisions:
    - Allow cytochrome P450 genotyping to determine drug metabolizer status for the CYP2D6 variants used for eliglustat (Cerdelga) in persons with Gaucher disease type 1, and CYP2D6 variants used for tetrabenazine (Xenazine) doses greater than 50mg per day

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

- No changes

Remember to check the 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.

See the Pharmacy section of the Newsletter for Pharmacy policy and criteria information.

The attached documents (Exhibits E-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.

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*

Pharmacy

Pharmacy and Therapeutics QM Subcommittee

- New Criteria: None
- Revised Criteria

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- PC/B003 Botulinum Toxin
- PC/H002 Hepatitis C Virus Medications
- PC/H001 HMG Co-A Reductase Inhibitors
- PC/M001 MS Medications
- PC/N002 Nasal Corticosteroids Step Therapy
- PC/R004 Rituxan Prior Authorization
- PC/V001 Vascular Endothelial Growth Factor Antagonists for Intravitreal use
- PC/W001 Weight Loss Medications

- Retired Criteria:
  - PC/L003 Gabapentin/Lyrica Step Therapy
  - PC/S003 Sedative/Hypnotics Step Therapy
- New Policy: None
- Revised Policy:
  - PP/C001 Coordination of Pharmacy Benefits
  - PP/C002 Cost Benefit Program
- Retired Policy: None

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, ADHD/ADD, Prenatal - Routine Care, Preventive Services for Children and Adolescents, and Preventive Services for Adults. The performance of these guidelines by our network practitioners is monitored utilizing HEDIS and Minnesota Community 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.

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Preventive Health Services for Children and Adolescents

The ICSI Preventive Health Services for Children and Adolescents guideline provides the basis for measurement and monitoring of several relevant clinical indicators. The measures that are assessed for adherence to the clinical guideline include the spectrum of childhood immunizations (using HEDIS technical specifications) and Chlamydia screening for adolescents (using HEDIS technical specifications). Utilizing 2014 claims data PreferredOne evaluated adherence to this set of guidelines through our HEDIS data collection process. The results were as follows:

Preventive Health Measures for Children & Adolescents	2014
Four DTaP/DT	87.90%
Three IPV	91.94%
One MMR	87.10%
Three Hib	91.13%
Three Hepatitis B	87.90%
One VAR, or documented chicken pox disease	84.68%
Four pneumococcal	86.29%
Two Hepatitis A	74.19%
Rotavirus Two doses of the two-dose vaccine; or one dose of the two-dose and two doses of the three-dose vaccine; or three doses of the three-dose vaccine	80.65%
Two influenza	80.65%
Chlamydia Screening	43.96%

PreferredOne strongly encourages our provider network clinic systems to send their immunization information to the Minnesota Immunization Information Connection (MIIC). MICC data is utilized to support our HEDIS data collection process and may reduce the burden of chart review at your clinic. To learn more about MICC and how you can participate please visit: http://www.health.state.mn.us/divs/idepc/immunize/registry/basics.html#providers.

Continuity & Coordination of Care

Continuity and coordination of care is important to PreferredOne. If your clinic is terminating its 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, 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.

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Core Services

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

Eligibility & 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
- Chronic Obstructive Pulmonary Disease
- Asthma
- Depression
- Multiple Sclerosis
- Rheumatoid Arthritis
- Ulcerative Colitis
- Crohn's Disease

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TDS:

- Low Back Pain
- Health 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 & 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 or Social Worker
- 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
- 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 tThe PreferredOne CIM or TDS Programs:

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

Monday-Friday 7:00am to 7:00pm 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 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 who are no longer accepting new patients and the contact information for the individual sending us the notification in case we have questions.

Quality Complaint Reporting For Primary Care Clinics

MN Rules 4685.1110 and 4685.1900 require health plans to collect and analyze quality of care (QOC) complaints, including those that originate at the clinic level.

A QOC complaint is any matter relating to the care rendered to the member by the physician or physician's staff in a clinic setting. Examples of QOC include, but are not limited, to the following:

- Adverse reaction/effect
- Ordering unnecessary tests
- Incorrect diagnosis
- Perceived incompetence of the physician or staff
- Incorrect medication prescribed
- Untimely follow-up on test results

QOC complaints directed to the clinic are to be investigated and resolved by the clinic whenever possible. PreferredOne's requires clinics to submit quarterly reports to our Quality Management Department as specified in the provider administrative manual. We have attached the form for your reference. If you would like to have the file electronically, please e-mail *Quality@PreferredOne.com*. If you have any questions or concerns please contact Arpita Dumra at 800-940-5049, ext. 3564 or e-mail *Arpita.Dumra@PreferredOne.com*. (Exhibit K)

Exhibit A

PreferredOne

DEPARTMENT:	Pricing and Payment	APPROVED DATE:	9/1/2015
POLICY DESCRIPTION:	Maternity Vaginal Delivery		
EFFECTIVE DATE:	**10/1/2015**		
PAGE:	1 of 1	REPLACES POLICY DATED:	
REFERENCE NUMBER:	019	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: Clarify Payments for Maternity Vaginal Delivery with implementation of ICD-10 DRG Grouper

POLICY: Beginning with services with a **date of service 10/1/2015,** PreferredOne will review MS DRGs 981 – 989 and if the admission is a vaginal delivery, will pay according to the 774/775 MS DRG rate.

PROCEDURE:

1. For V33 CMS DRG Grouper and beyond, some of the admissions for vaginal delivery group to other DRGs in the associated with all MDCs related to OR procedures in the 981 – 989 MS DRG code range.

2. Claims with a DRG in the range of 981 – 989 that have an ICD-10 diagnosis code(s) or Delivery Procedure as listed in the DRG code book under DRGs 774 and 775 principal or secondary diagnosis or delivery procedure on the claim will be considered a vaginal delivery.

3. Admissions that meet the criteria of a vaginal delivery above will be paid at the MS DRG 775 rate.

DEFINITIONS:

REFERENCES:

Exhibit B

PreferredOne

DEPARTMENT:	Pricing & Payment	APPROVED DATE: 9/1/2015
POLICY DESCRIPTION:	Modifier Payment Reductions	
EFFECTIVE DATE:	1/1/2016	
PAGE:	1 of 1	REPLACES POLICY DATED: 9/1/2014
REFERENCE NUMBER:	P#18	RETIRED DATE:

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

PURPOSE: To provide guidelines for reimbursement when modifiers that affect payment are attached to CPT/HCPCS

POLICY: PreferredOne will increase or reduce payment to the provider or facility when certain modifiers are attached to the CPT/HCPCS.

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. Modifiers should be attached to CPT/HCPCS when appropriate.
2. See specific coding policies for when to apply the modifier appropriately.
3. The following reimbursement will be applied when these modifiers are attached to CPT/HCPCS:

Modifier	Description	Percent of Allowable
22	Increased procedural Services	120%
26	Professional Component, only if no RVU assigned or concept does not apply	40%
50	Bilateral Procedure	150%
52	Reduced Services (apc has 52 and 73 at same rate)	50%
53	Discontinued Procedure	50%
54	Surgical Care Only	80%
55	Postoperative Management Only	20%
56	Preoperative Management Only	10%
62	Two Surgeons	62.5%
66	Surgical Team	62.5%

73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the administration of Anesthesia	50%
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after administration of Anesthesia	75%
80	Assistant Surgeon	16%
81	Minimum Assistant Surgeon	16%
82	Assistant Surgeon (when qualified resident surgeon not available)	16%
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	16%
SL	State Supplied Vaccine	0%
BO	Orally administered nutrition, not by feeding tube	0%
TC	Technical component, only if no RVU assigned or concept does not apply	60%
FB	Item provided without cost to provider, supplier or practitioner, or full credit received fro replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	See Pricing & Payment Policy #17
FC	Partial credit received for replaced device	See Pricing & Payment Policy #17
GZ	Item or service expected to be denied as not reasonable or necessary	0%
PA	Surgical or other invasive procedure on wrong body part	0%
PB	Surgical or other invasive procedure on wrong patient	0%
PC	Wrong surgery or other invasive procedure on patient	0%

DEFINITIONS:

REFERENCES:

Exhibit C

PreferredOne

DEPARTMENT:	Pricing and Payment	APPROVED DATE:	9/1/2015
POLICY DESCRIPTION:	Site-of-Service Payment		
EFFECTIVE DATE:	**1/1/2016**		
PAGE:	1 of 2	REPLACES POLICY DATED:	9/1/2009
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 2015, will be based on data from the 2014 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. Effective 1/1/2016 CMS added a new place of service 19, defined as “Off Campus-Outpatient Hospital: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.” Place of service 19 will use the facility RVU and take the site of service differential beginning with 1/1/2016 dates of service.

4. PreferredOne will conduct periodic audits for compliance.

DEFINITIONS:

REFERENCES:

Exhibit D

PreferredOne

DEPARTMENT:	Pricing and Payment	APPROVED DATE:	10/1/2015
POLICY DESCRIPTION:	Same Day Labs Billed by multiple Providers		
EFFECTIVE DATE:	**1/1/2016**		
PAGE:	1 of 1	REPLACES POLICY DATED:	
REFERENCE NUMBER:	020	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: Clarify Payments for same day labs billed by multiple providers

POLICY: Beginning with services with a **date of service 1/1/2016,** PreferredOne will reimburse one claim for the same lab service for the same member and the same date of service.

PROCEDURE:

1. When the same lab service cpt/hcpcs code(s) is billed for the same member and same date of service by multiple providers, PreferredOne will only reimburse one claim.

2. If the both the reference lab and clinic bill, the reference lab claim will be reimbursed and the clinic bill will be denied to provider liability.

3. If two clinics bill, the first claim received will be reimbursed and the second claim will be denied to provider liability.

4. Exceptions will be made if the service was truly performed by two separate providers upon appeal.

DEFINITIONS:

REFERENCES:

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 F

Medical Policies

Reference #	Description
A001	Elective Abortion
A003	Amino Acid Based Elemental Formula (AABF) *Revised*
A004	Acupuncture
A005	Autism Spectrum Disorders in Children: Assessment and Evaluation
C001	Court Ordered Mental Health Services
C002	Cosmetic Treatments
C003	Criteria Management Development, Application, and Oversight
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
D005	Dietary Formulas, Electrolyte Substances, or Food Products for PKU or Other Inborn Errors of Metabolism *Revised*
D007	Disabled Dependent Eligibility *Revised*
D008	Dressing Supplies
D009	Dental Services, Hospitalization, and Anesthesia for Dental Services Covered Under the Medical Benefit
G001	Genetic Testing for Heritable Conditions
G002	Gender Reassignment *Revised*
H006	Hearing Devices
H007	Hospice Care
H008	FDA-Approved Humanitarian Use Devices (HUD)
I001	Investigative Services
I002	Infertility Treatment
I003	Routine Preventive Immunizations *Revised*
L001	Laboratory Tests *Revised*
M001	Molecular Testing for Tumor/Neoplasm Biomarkers *Revised*
N002	Nutritional Counseling *Revised*
P008	Medical Policy Document Management and Application
P010	UVB Phototherapy (non-laser) for Skin Disorders
P011	Prenatal Testing
P013	Pharmacogenetic/Pharmacogenomic Testing and Serological Testing for Inflammatory Conditions *Revised*
R002	Reconstructive Surgery *Revised*
S008	Scar Revision
T002	Transition of Care - Continuity of Care: PCHP *Revised*
T004	Therapeutic Pass *Revised*
T006	PreferredOne Designated Transplant Network Provider *Revised*
T007	Transition of Care - Continuity of Care: PIC and PAS Non-ERISA *New*
V001	Vision Care, Pediatric *Revised*
W001	Physician Directed Weight Loss Programs

Exhibit G

Medical Criteria

Reference #	Category	Description
A006	Cardiac/Thoracic	Ventricular Assist Devices (VAD)
B002	Dental and Oral Maxillofacial	Orthognathic Surgery
B003	Dental and Oral Maxillofacial	Orthodontic Services
C007	Eye, Ear, Nose, and Throat	Surgical Treatment of Obstructive Sleep Apnea
D001	Durable Medical Equipment	Microprocessor-Controlled Prostheses for the Lower Limb
F021	Orthopaedic/Musculoskeletal	Bone Growth Stimulators (Osteogenic): Electrical/Electromagnetic and Ultrasonic
F024	Orthopaedic/Musculoskeletal	Radiofrequency Ablation (Neurotomy, Denervation, Rhizotomy) Neck and Back
G001	Skin and Integumentary	Eyelid and Brow Surgery (Blepharoplasty & Ptosis Repair)
G002	Medical/ Surgical	Breast Reduction Surgery
G003	Skin and Integumentary	Excision Redundant Tissue
G004	Medical/ Surgical	Breast Reconstruction
G007	Medical/ Surgical	Prophylactic Mastectomy and Oophorectomy
G008	Skin and Integumentary	Hyperhidrosis Surgery *Revised*
G010	Skin and Integumentary	Lipoma Removal
G011	Medical/ Surgical	Hyperbaric Oxygen Therapy
H003	Gastrointestinal/Nutritional	Bariatric Surgery
I007	Oncology	Cryoablation/Cryosurgery for Hepatic, Prostate, and Renal Oncology Indications *Revised*
I008	Neurological	Sacral Nerve Stimulation
I009	Neurological	Deep Brain Stimulation
I010	Neurological	Spinal Cord/Dorsal Column Stimulation
K001	Surgical/ Medical	IVAB for Lyme Disease
K002	Surgical/ Medical	Bronchial Thermoplasty
L008	Diagnostic	Continuous Glucose Monitoring Systems for Long Term Use
L009	Radiation Therapy	Intensity Modulated Radiation Therapy (IMRT) *Revised*
L010	Diagnostic	Genetic Testing for Hereditary Cancer Syndromes *Revised*
L011	Durable Medical Equipment	Insulin Infusion Pump *Revised*
L012	Diagnostic	Gene Expression Profiling
L014	Diagnostic	Laboratory Testing for Detection of Heart Transplant Rejection
L015	Diagnostic	Comparative Genomic Hybridization (CGH, aCGH)
L016	Diagnostic	Lung Cancer Screening by Computed Tomography
M001	BH/Substance Related Disorders	Mental Health Disorders: Inpatient Treatment
M004	BH/Substance Related Disorders	Mental Health Disorders: Day Treatment/Intensive Outpatient Program (IOP)
M005	BH/Substance Related Disorders	Eating Disorders: Level of Care Criteria
M006	BH/Substance Related Disorders	Mental Health Disorders: Partial Hospital Program (PHP)

M007	BH/Substance Related Disorders	Mental Health and Substance Related Disorders: Residential Treatment
M010	BH/Substance Related Disorders	Substance Related Disorders: Inpatient Primary Treatment *Revised*
M014	BH/Substance Related Disorders	Detoxification and Addiction Stabilization: Inpatient Treatment
M020	BH/Substance Related Disorders	Autism Spectrum Disorders in Children: Non-Intensive Treatment
M022	BH/SubstanceRelated Disorders	Mental Health Disorders: Residential Crisis Stabilization Services (CSS)
M023	BH/SubstanceRelated Disorders	Mental Health Disorders : Intensive Residential Treatment Services (IRTS) *Revised*
M024	BH/Substance Related Disorders	Autism Spectrum Disorders in Children: Early Intensive Behavioral and Developmental Therapy (EIBDT)
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 Setting
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 Transplantation
T003	Transplant	Heart Transplantation
T004	Transplant	Liver Transplantation
T005	Transplant	Lung Transplantation
T007	Transplant	Pancreas, PAK, and Autologous Islet Cell Transplantation

Exhibit H

Pharmacy Policies

Reference #	Description
B001	Backdating of Prior Authorizations
B002	Biosimilar Products
C001	Coordination of Benefits *Revised*
C002	Cost Benefit Program *Revised*
C003	Compounded Drug Products
F001	Formulary Overrides *Revised*
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
R001	Review of New FDA-Approved Drugs and Clinical Indications
S001	Step Therapy
T001	Tobacco Cessation Medications

Exhibit I

Pharmacy Criteria

Reference #	Description
A003	Combination Beta-2 Agonist/Corticosteroid Inhalers Step Therapy *Revised*
A005	Antidepressant Medications Step Therapy
B003	Botulinum Toxin *Revised*
B004	Biologics for Rheumatoid Arthritis
B005	Biologics for Plaque Psoriasis
B006	Biologics for Crohn's Disease
B009	Bisphosphonates and Osteoporosis Prevention and Treatment Medications
B010	Biologics for Juvenile Idiopathic Arthritis and Juvenile Rheumatoid Arthritis
B011	Biologics for Psoriatic Arthritis
B012	Biologics for Ankylosing Spondylitis
B013	Biologics for Ulcerative Colitis
B014	Benign Prostatic Hypertrophy Medications Step Therapy
B015	Breast Cancer Risk Reduction Medications Step Therapy
C002	Cyclooxygenase-2 (COX-2) Inhibitors Step Therapy (Celebrex)
D003	Diabetic Medications Step Therapy
E001	Erectile Dysfunction Medications - Non-PDE-5 Inhibitor Medications
G001	Growth Hormone Medications Step Therapy
H001	HMG - CoA Reductase Inhibitor Medications Step Therapy *Revised*
H002	Hepatitis C Medications *Revised*
I002	Immune Globulin Therapy
M001	Multiple Sclerosis Medications
N002	Nasal Corticosteroids Step Therapy *Revised*
O001	Overactive Bladder Medications Step Therapy
P001	Proton Pump Inhibitor (PPI) Medications Step Therapy
P002	Phosphodiasterase-5 Inhibitor Medications
R003	Topical Retinoid Medications Step Therapy
R004	Rituxan Prior Authorization (Non-Oncology) *Revised*
V001	Vascular Endothelial Growth Factor Antagonists for Intravitreal Use *Revised*
W001	Weight Loss Medications *Revised*

PreferredOne
Quality Complaint Report

Requirement: MN Rules 4685.1110 and 4685.1900 require the collection and analysis of quality of care complaints including those which originate at the clinic level. Complaints directed to the clinic are to be investigated and resolved by the clinic, whenever possible.

Definition: Quality complaints are defined as concerns regarding access, communication, behavior, coordination of care, technical competence, appropriateness of service and facility/environment concerns.

Frequency: The clinics must report to PreferredOne on a quarterly basis during January, April, July and October for the preceding three months. Please keep a copy in your files.

Clinic________________________________ Location_____________________
Completed by________________________ Phone #_____________________

Reporting Period: Jan-March April-June July-Sept Oct-Dec Current Date__________________________

Date Received	Occurrence Date	Written (W) Verbal (V)	Member Name	Date of Birth	Issue	Date and Summary of Resolution

Send report to Quality Management Department, PreferredOne, 6105 Golden Hills Drive, Golden Valley, MN 55416 or FAX 763-847-4010 or E-mail *quality@preferredone.com*.

PreferredOne®

Department of Origin: Quality Management	Approved by: Quality Management Committee	Date approved: 7/10/15
Department(s) Affected: Quality Management, Network Management	Effective Date: 7/10/15	
Procedure Description: Clinical Practice Guidelines	Replaces Effective Procedure Dated: 7/10/14	
Reference #: QM/C003	Page: 1 of 3	

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. Asthma, Diagnosis and Outpatient Management of
B. Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
C. Major Depression in Adults in Primary Care
D. Diagnosis and Management of ADHD
E. Preventive Health
- Prenatal Care, Routine
- Preventive Services for Children and Adolescents
- Preventive Services for Adults

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. Asthma, Diagnosis and Outpatient Management of

1. Percentage of patients with persistent asthma who are on inhaled corticosteroid medication (HEDIS technical specifications)
2. Optimal Asthma Care Measure (Minnesota Community Measurement Measure) This measure examines the percentage of patients, ages 5-50, with persistent asthma who have reached the following three targets to control their asthma:
   - Evidence of well-controlled asthma
   - Not at risk for elevated exacerbation as evidenced by patient-reported emergency department visits and hospitalizations
   - Patient has been educated about his or her asthma and self- management of the condition and has received a written asthma management plan

B. 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%) (HEDIS technical specifications)
2. BP control (<140/90 mm Hg) (HEDIS technical specifications)

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)

F. Preventive Health

1. Preventive Services for Children and Adolescents
   a. Percentage of patients who by their second birthday have the following immunization status (HEDIS technical specifications):
      - Four DTaP/DT
      - Three IPV
      - One MMR
      - Three Hib
      - Three hepatitis B
      - One VAR, or documented chicken pox disease
      - Four pneumococcal
      - Two hepatitis A
      - Rotavirus:
      - Two doses of the two-dose vaccine, or
      - One dose of the two-dose and two doses of the three-dose vaccine, or

- Three doses of the three-dose vaccine
- Two influenza

b. Percentage of sexually active women age 16-24 years of age who had at least one test for chlamydia during the measurement year (HEDIS technical specifications).

2. Preventive Services for Adults

a. Breast Cancer Screening. The percentage of women 50–74 years of age who had at least one mammogram to screen for breast cancer in the previous two years (HEDIS technical specifications).

b. Colorectal Cancer Screening. The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer (HEDIS technical specifications).

One or more screenings for colorectal cancer. Any of the following meet criteria:

- Fecal occult blood test during the measurement year.
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year.
- Colonoscopy during the measurement year or the nine years prior to the measurement year.

IV. PreferredOne has utilized the ICSI's practice guidelines as the clinical basis for its chronic illness management programs for 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, 7/10/14, 7/10/15
Revised Date:	4/10/08, 7/10/08, 7/9/09, 7/14/10 , 7/11/13, 7/10/14