

Care System Connection

News for providers participating in the Patient Choice programs

April 2007

Patient Choice Publishes 2007 Hospital Guide and Facility Pricing Catalog

Increasingly, individuals are assuming more responsibility for the cost of their care. As a result, price information is an increasingly important consideration in their decision-making.

The *Hospital Guide and Pricing Catalog* is one way Patient Choice is putting more information about care costs into the hands of consumers. It is made available to individuals who participate in plans that offer the Patient Choice Insights network and helps them better understand the cost and quality differences that exist among health care facilities. The resource contains a variety of information including a listing of quality resources, details about hospital patient safety and an innovative Pricing Catalog that includes pricing information for selected services at several facilities in the Twin Cities and surrounding areas.

Appendectomy – Inpatient Service	
<i>The surgical removal of the appendix.</i>	
Provider	Price Range
Hospital A	\$5,000 – \$6,250
Hospital B	\$6,000 – \$7,000
Hospital C	\$5,500 – \$12,250
Hospital D	\$5,750 – \$13,000
Hospital E	\$10,750 – \$28,750

Cost Range:

Low Cost	Medium Cost	High Cost
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The latest version of the *Patient Choice Insights Hospital Guide and Pricing Catalog* is available on the Patient Choice Web site at <http://www.patientchoicehealthcare.com/consumers/insights.html> as well as on the Medica Web site at <http://www.medica.com/C4/PatientChoiceInsights/default.aspx>.

► Network Information

Patient Choice Ready to Accept NPI Numbers

Although the May 23, 2007, compliance date for readiness to use national provider identifier (NPI) numbers has been extended by the Centers for Medicare and Medicaid Services (CMS), Patient Choice a product of Medica and Medica strongly encourage providers to continue submitting their NPI information, if they haven't yet done so. The May 23 date had been the Health Insurance Portability and Accountability Act of 1996 (HIPAA) deadline for NPI-readiness. *More information is included below about submitting NPI information to Medica.*

Patient Choice can accept NPI information from our network providers in electronic file or CD. NPI information should be submitted in an Excel file format. Providers who plan to send the information electronically should work with their organization's Information Technology contact to ensure that the files are sent using a secure transmission process. If providers prefer, they can contact Patient Choice at 952-992-1700 to discuss options for submitting information in a secure manner.

Providers who prefer to submit their NPI information via a CD can mail it to:

Patient Choice
 NPI Processing
 Mail Route CP217
 PO Box 1287
 Minneapolis, MN 55440-1287

Patient Choice Ready to Accept NPI Numbers (continued from page 1)

NPI-readiness Timeframes for Patient Choice Administrators

Medica:

Providers who participate in the Patient Choice Insights by Medica product and have established NPI numbers will be able to submit their NPI for secure electronic transactions online in May 2007. Providers will be notified of the effective date through a Provider Alert e-mail. Providers will also be able to begin submitting their NPI *on all claims* — electronic or paper — by May 23, 2007, and a notification about this capability will also be sent by Provider Alert.

To receive Provider Alerts, providers may add their e-mails at this Web page:

<http://provider.medica.com/C3/ProviderCollegeEmailUpdates/default.aspx>.

If providers have questions regarding Medica's readiness for the NPI initiative or they would like to discuss enumeration strategies, they should contact David Andersen at 952-992-2038 or Paige Hinz at 952-992-2988.

Fiserv Health:

Providers who want to send their NPI information to Fiserv Health in an electronic format via a secure transaction should submit a request to Edi_business_analysts@wausaubenefits.com

Providers who prefer to submit NPI information via CD or paper can mail their information to:

Fiserv Health
Attn: Provider Services MS6290
PO Box 8046
Wausau, WI 54402-8046

More information about Fiserv Health's readiness for the NPI initiative, is available on the Fiserv Health Web site at <https://provider.fiservhealthservices.com/portal>.

CBSA:

CBSA can accept NPI information. Providers can submit their NPI to us via regular mail or Email.

USPS Mail:

CBSA Performax
Attn: Provider Relations / NPI
400 Highway 169 South, Suite 800
Minneapolis, MN 55426-1141

Email:

NPI information can be emailed to NPI@CBSAInc.com Please include "NPI for your name" in the Subject.
Examples: NPI for John Smith, or NPI for Springfield Memorial Hospital.

Recognizing and Rewarding Quality Care

We all know that poor quality is costly — in terms of dollars and, more importantly, in patient care. Patient Choice understands that creating the right incentives promotes continuous quality improvement within the health care system. That's why each year the organization conducts a tiering process in which highlights provider performance by grouping them into three tiers.

How quality is incorporated into the tiering process varies depending upon the type of services provided. It's a process built on a pioneering approach that was developed in collaboration with employers and providers more than a decade ago — a process that recognizes and rewards quality care. And while we continue to work with stakeholders to improve and refine the process, below are some examples of how quality metrics are currently factored into provider tier placement.

Care Systems/Primary Care Clinics:

Each spring Care Systems have an opportunity to earn “quality credits” toward their tier placement by demonstrating their adherence to best-practice quality standards. To participate, Care Systems submit information about their care process capabilities and clinical outcomes for diabetes, coronary artery disease, asthma and preventive services.

Care Systems that submit applications are scored on their clinical performance in each of the areas mentioned above and earn a corresponding quality credit. The credit can be applied during the bid process to help Care Systems that perform well obtain a lower (or better) tier placement. This information is also applied to the primary care clinics that participate in the Patient Choice Insights program.

Care Systems also earn credit when their affiliated clinics are recognized by Bridges to Excellence (BTE), a national employer-led pay-for-performance program. The Minnesota BTE effort currently recognizes providers that deliver optimal care to their patients with diabetes.

Results of the Care Systems’ clinical performance as well as a listing of the clinics that earned BTE rewards are published in our member materials. To view a copy of the 2007 results, visit the Patient Choice Web site at:

<http://www.patientchoicesignature.com/aboutpcs/consumersurvey.html>.



Specialty Services:

Each year, the “specialty” providers that are contracted with the Patient Choice Insights program have an opportunity to earn quality credits by submitting information about their quality and service practices. The credits can help them improve their tier placement.

During the summer months, eligible specialty clinics, that are not part of a multi-specialty clinic, are asked to provide information about their quality improvement activities, clinical guideline implementation and compliance, technical capabilities, Web tools and more.

The information submitted is analyzed and scored. Depending on their performance, the practice can earn a corresponding quality credit. Those that perform well can earn a better tier placement.

Hospitals:

For hospitals that participate in the Patient Choice Insights network, one of the quality metrics that is incorporated into the annual tiering process includes their performance on the Leapfrog Group’s Hospital Quality and Safety Survey. The Leapfrog Group is a nonprofit organization focused on reducing errors in hospitals. The group surveys hospitals on four practices (or leaps) that it recommends hospitals should have in place including computer physician order entry, evidence-based hospital referral, intensive care unit physician staffing and National Quality Forum Safe Practices.

Another quality measure that has been factored into a hospital’s tier placement is their participation in the Institute for Healthcare Improvement’s (IHI) *100,000 Lives Campaign*, which helps hospitals implement changes in care to improve care and prevent avoidable deaths. Recently expanded, this initiative is now known as the *5 Million Lives Campaign* and will be incorporated into the tiering process going forward. This enhanced version focuses on twelve “care changes”—up from six in the original campaign. A list of the twelve ‘care changes’ is available on the IHI Web site at www.ihl.org/IHI/Programs/Campaign.

During the summer, Patient Choice will survey network hospitals about their status in the campaign. Depending on a hospital’s level of participation, combined with its performance on the Leapfrog Group survey, the facility may be eligible to receive quality credits that can be used to improve its tier placement.

Listing of Bariatric Centers of Excellence Now Online

“Centers of Excellence” is a quality-focused initiative that relies on evidence-based care to help ensure that members get safe, quality care related to certain procedures. The bariatric initiative identifies those providers with a demonstrated record of favorable outcomes for bariatric care, including surgery for morbid obesity.

Member Benefits

For Patient Choice members, out-of-pocket expenses for bariatric services will vary depending on their coverage document. For Patient Choice members with programs that are administered by CBSA and Fiserv Health, this information is being provided for use in their decision-making process about where to obtain bariatric services. At this point, member benefits are not dependent upon the use of a Centers of Excellence provider.

For Patient Choice Insights by Medica members, bariatric surgery continues to require prior authorization. If a Patient Choice Insights by Medica member sees a non-Centers of Excellence provider for bariatric surgery services, claims will be denied.

Medica prefers that its members be directed to bariatric care surgeons/facilities that meet ASBS national standards for excellence and safety. If providers have patients who are Medica members seeking bariatric services from a non-approved surgeon or facility, they should be aware of Medica's program and consult the approved list as necessary.

List Updates

The list of designated Centers of Excellence is subject to change based on the ongoing approval process for the program. Through an application process, surgeons and hospitals are required to meet certain qualifications in order to achieve an approved certification status for the bariatric program. More information about the Centers of Excellence program, including details about the application process and program criteria is available on the SRC Web site at www.surgicalreview.org.

Free, Accredited Educational Courses Aimed at Reducing Racial and Ethnic Disparities in Health Care Available Online

According to the United States Bureau of the Census, within 50 years, nearly half of the nation's population will be from cultures other than White, non-Hispanic—dramatically increasing needs to provide medical services to patients of diverse cultures or languages.

As the U.S. population becomes increasingly diverse, it is critical for health care professionals to be aware that cultural differences can affect patient care. The U.S. Department of Health and Human Services' Office of Minority Health has developed a Web site that offers the latest resources and tools to promote cultural competency in health care. The Web site, located at www.thinkculturalhealth.org, includes online self-directed courses designed to help health care professionals promote respectful, understandable and effective care to an increasingly diverse patient population.

Currently, the site includes two educational programs. One, "A Physician's Practical Guide to Culturally Competent Care," which is targeted to physicians, nurses, nurse practitioners and pharmacists. The other program, "Culturally Competent Nursing Care: A Cornerstone of Caring," is specifically designed for nurses.

The online courses are free and accredited for continuing education credit. Physicians can earn up to nine free Continuing Medical Education (CME) credits. Nurses can earn nine Continuing Nursing Education (CNE) credits or nine contact hours.

In addition, providers who participate in the Patient Choice Insights network have the opportunity to obtain Medica's health literacy and cultural competency program; a train the trainer kit, "Walking in their Shoes – Enhancing Authentic Practitioner-Patient Communication." The program is designed to improve communication skills across cultures and across all levels of health literacy in support of improved medication compliance, patient safety and patient satisfaction.

Target audiences for the training program include clinic employees, hospital employees, and other health care workers who have direct contact with patients. This program is built for easy customization, specific to the provider organization and available to plan providers free of charge. For more information about the Walking in their Shoes kit or to obtain a copy of it, please contact Sue Metoxen, director of Compliance and Product Administration, via e-mail at sue.metoxen@medica.com.

► Administrative Information - Medica

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Note: The following articles have been reprinted from recent issues of Medica's Connections newsletter. The content has been modified for those providers who participate in the Patient Choice Insights by Medica product.
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Medica High-Tech Imaging Program Begins

For certain high-tech, outpatient diagnostic imaging services, Medica now requires ordering providers to complete a notification with consultation process beginning with March 1, 2007 dates of service. It applies to most Medica members including Patient Choice Insights by Medica members.

The consultation process is completed by contacting HealthHelp, Medica's strategic partner. Prior to performing the ordered services, performing providers should verify that a reference number has been issued for the requested study. Medica will require providers to complete the notification with consultation process and obtain a Medica reference number prior to services being performed. The program does not apply to doctors ordering scans in the emergency room or for inpatient hospitalizations.

Physicians ordering the imaging service will continue to make final decisions on appropriate care for their patients. Medica will pay for a claim — depending on member coverage — when there has been a consultation completed, even if providers order a scan that is not recommended by HealthHelp. It's the completion of the consultation that is required, not the outcome of that consultation.

Program updates and clarifications

- Pay-for-performance incentive determined. Medica has added a pay-for-performance incentive tied to the new High-Tech Imaging Program. For each completed consultation, Medica will pay \$2.50 to eligible ordering provider groups (at federal tax ID level) in order to help offset administrative expenses related to the new program requirement.
- Ordering providers can now use Medica's secure Web page for online consultation requests. This is available on www.medica.com "Provider Resources" under "Electronic Transactions" (at [https://www.medica.com /C16/ CommonRegLogin/default.aspx?ReturnUrl=https%3a%2f%2fprovider.medica.com%2fC6%2fElectronic Transactions%2fdefault.aspx&Lmsg=](https://www.medica.com/C16/CommonRegLogin/default.aspx?ReturnUrl=https%3a%2f%2fprovider.medica.com%2fC6%2fElectronic%20Transactions%2fdefault.aspx&Lmsg=)).

More Information

Providers who have questions or need further information about Medica's High-Tech Imaging Program may:

- refer to more details online at www.medica.com in the "Tools and Forms" section under "Claims Tools and Forms." <http://provider.medica.com/C13/ClaimsToolsForms/default.aspx>
- call Medica's Provider Service Center at 1-800-458-5512.

Medica to Move Lipitor to Non-Preferred Status

In a continuing effort to make medications more affordable to its members, Medica will remove Lipitor from the Medica preferred drug list (i.e., drug formulary) as of April 1, 2007. This change is intended to encourage the use of clinically effective preferred generic and brand alternatives.

Patient Choice Insights by Medica members currently taking Lipitor will be able to continue with their current prescription through November 30, 2007. This transition period is intended to allow physicians time to discuss medication options with their patients. Whenever possible, Medica encourages patients and physicians to discuss if it's appropriate to use safe, effective and affordable generic drugs.

Medica's formulary will continue to include five cholesterol-lowering medications: three generics — simvastatin, pravastatin and lovastatin — and two brand-name statins, Crestor and Vytorin.

Medica to Move Lipitor to Non-Preferred Status (continued)

Generic statin alternatives are about one-third the cost of Lipitor. The recent availability of powerful generic statins offers an opportunity for substantial health care cost savings — estimated to be about \$7 to \$11 billion nationwide. Medica members who can safely switch to a generic will gain immediate benefit from lower generic copayment amounts, and Medica estimates cost savings for these members could total nearly \$3 million per year.

Beginning December 1, 2007, the transition period will end. Those who remain on Lipitor may need to pay more to continue taking it. Medica's tiered pharmacy benefit and formulary-exception process (for closed formularies) continue to be options that will allow the member to stay on Lipitor with some level of benefit. Requesting a formulary exception may be appropriate if a physician concludes that Lipitor is the best statin for a high-risk patient.

Medication request forms

When requesting a formulary exception, a medication request form (MRF) should be used. This form is available on www.medica.com under "Pharmacy" and then "Medication Request Forms for Formulary Exceptions" (or directly through this Web link: <http://member.medica.com/C15/DrugFormulary/default.aspx>). MRFs may also be obtained by calling MedImpact at 1-800-788-2949. It is important to fill out the form as completely as possible and to cite which medications have been tried and failed. This includes the dosages used and the identified reason for failure (e.g., side effects or lack of efficacy). The more complete the information provided, the quicker the review, with less likelihood of Medica needing to request more information.

Drug formulary

Medica's drug formulary is available:

- online at www.medica.com by selecting "Pharmacy" on the home page (or directly through this Web link: <http://member.medica.com/C15/DrugFormulary/default.aspx>).
- by download from ePocrates® Rx. Providers may visit <http://www.epocrates.com> for downloading details.
- as a printed copy, by calling Medica's Provider Literature Request Line at 952-992-2355 or toll-free at 1-800-458-5512

► Administrative Information – Fiserv Health (formerly Wausau Benefits, Inc.)

Lack of Member-Provided Information Can Suspend Claim Payment

In some instances, Fiserv Health requires additional information from a member in order to process a claim and make provider payment. Examples of member-provided information include updates to other insurance and student status. When this information is missing, a claim can be suspended, delaying payment.

When a claim is suspended for lack of member information, the provider receives a remittance advice document indicating that payment is denied because information is needed from the member. In turn, the member receives an Explanation of Benefits (EOB) indicating that additional information is needed in order to process the claim and directing him/her to several convenient options that can be used to submit it. Once the member information is updated, Fiserv Health works to process claims immediately.

To expedite a claim suspension due to lack of member-provided information, you may want to refer your patient to the Fiserv Health Web site at <https://member.fiservhealthservices.com> or ask them to call 888-291-3774 and provide the information needed to process the claim.

Reconsideration for Denied Anesthesia Claim Codes with Modifier 59

Fiserv Health subscribes to the McKesson claim system edits. Typically, CPT codes for anesthesia services are considered all-inclusive or “global.” When anesthesia claims are submitted with a 59 modifier for additional services, payment for the additional services will automatically be denied.

However, Fiserv will consider payment for services in which the practitioner has demonstrated that the additional specific service meets the quality and efficiency standard of care for payment when billed with the 59 modifier. In instances where additional claim payment is initially denied, practitioners may submit medical record documentation to identify ‘distinct and separate’ services that qualify for payment consideration.

For reconsideration of a claim denial, providers can call Fiserv Health toll-free at 1-877-390-7632. Providers must have the member’s identification number for the claim. A Customer Service representative will provide required information to the caller for reconsideration of the claim. More specific questions will be directed to the supervisors.

Fiserv Health’s Annual Claim System Code Update Process

Each year, Fiserv Health receives claim system updates/notifications/edits from its health care services vendor, McKesson. Fiserv Health then conducts internal clinical reviews to determine which changes it will implement on its claims system.

Those changes with the potential for significant provider/program impact are brought to Patient Choice for advisement. When necessary, Care Systems are also consulted on proposed changes. For major changes, Care Systems/providers are notified prior to implementation.

During the latter part of the second quarter, Fiserv Health implements final changes and completes testing of the claims system.

Fiserv Health Updated ID Cards

Fiserv Health recently updated its logo. The new logo will appear on medical identification cards for 2007. Below are samples of the new cards.


**Patient Choice Insights
Front of card**

	BENEFITS ADMINISTERED BY 
NAME:	
ID:	
EMPLR:	
GROUP:	

**Patient Choice Insights
Back of card**

This card must be presented each time services are requested.	
MAIL ALL FORMS TO: FISERV HEALTH PO BOX 8013 WAUSAU WI 54402-8013 EDI PAYER ID # 39026	CUSTOMER SERVICE 1(877) 390-6008 1(800) 678-PHCS
Notice to Providers, Physicians and Facilities: You are required to call for all inpatient admissions. Notice to Members: You are required to call for all plan required certifications and all admissions.	
For out of area participating PHCS providers when traveling contact PHCS , provider information line or www.phcs.com	
Patient Choice Web Site: Your source for the most up-to-date information www.patientchoicehealthcare.com	

**Patient Choice Care System
Front of card**

	BENEFITS ADMINISTERED BY 
NAME:	
ID:	
EMPLR:	
GROUP:	
OFFICE COPAY:	

**Patient Choice Care System
Back of card**

This card must be presented each time services are requested.	
MAIL ALL FORMS TO: FISERV HEALTH PO BOX 8013 WAUSAU WI 54402-8013 EDI PAYER ID # 39026	CUSTOMER SERVICE 1(877) 390-6008 1(800) 678-PHCS
Notice to Providers, Physicians and Facilities: You are required to call for all inpatient admissions. Notice to Members: You are required to call for any plan required certifications and any admission not directed by your care system physician.	
For out of area participating PHCS providers when traveling contact PHCS , provider information line or www.phcs.com	
Patient Choice Web Site: Your source for the most up-to-date information www.patientchoicehealthcare.com	

► Administrative Information – Corporate Benefits Service of America (CBSA)

CBSA PERFORMAX Acquired by Meritain Health




In December 2006, CBSA PERFORMAX was acquired by Meritain Health, Inc., a provider of services for self-funded health plans. Meritain Health, Inc. is a division of the health care services holding company Prodigy Health Group and is headquartered in Amherst, New York.

The announcement followed the recent merger between CBSA and PERFORMAX last August. The newly combined companies will operate under the Meritain Health name and maintain CBSA PERFORMAX's presence in Baltimore and Minneapolis, as well as its regional sales and service offices. In total, the company now has offices throughout the country, more than 1,350 employees, 1,400 clients and more than a million members nation wide.

For Patient Choice programs that are administered by CBSA, the process for submitting claims and contacting Customer Service will remain the same.

New ID Card

Some participants in the Patient Choice Care System program will continue to use identification cards with the CBSA name and logo for 2007. Going forward, identification cards reflecting the Meritain name and logo will be provided to participants upon renewal. A sample of the new card is below.

	MERITAIN HEALTH		Patient Choice
Member Name: EE Name: JANE DOE ID#: OSTES T0002			
Group #: 08810 Div: A01 Group Name: MERITAIN HEALTH Coverage: Medical EMP/FAM; Vision EMP/FAM			
Clinic # Clinic Name: Care System:			
Patient Customer Service: 877-468-6592 Pharmacist Use Only: 800-235-4357 Powered by Express Scripts		SCRIP WORLD Rx Group: PRX	
Hospital admissions must be Pre-Certified 48 hours prior to admission or 48 hours after an emergency admission. Failure to comply may reduce benefits. Pre-Certification Phone Number: 888-593-6586 952-593-6586			
minuteclinic™	SUBMIT ALL CLAIMS TO: MERITAIN HEALTH P.O. Box 5355 Hopkins MN 55343 Benefit/Claim Customer Service: 888-254-6401 952-593-6401 Electronic claims accepted through: WebMD - #41124		
www.mycbsa.com	Claims Fax Line: 952-593-3714		
NurseLine: 888-229-9301 PIN# 736	When out of your service area call 800-678-7427 for a referral to a participating PHCS provider.		
 Select eyewear and pay discount amount at time of purchase. For Provider listing: 800-342-7188 or www.mycbsa.com	NY-Electing	Printed 02-02-07	