Hennepin Health

Provider Manual

JANUARY 2017

Section 1: Introduction to Hennepin Health

Hennepin Health provides health care coverage to Hennepin County residents who are enrolled in a Minnesota health care program. Hennepin Health is a nonprofit, state-certified health maintenance organization that contracts with the Minnesota Department of Human Services.

Utilization and Incentives

Hennepin Health does not specifically reward practitioners and other individuals for issuing denials of coverage. Financial incentives for physicians or any utilization management decision makers do not encourage decisions that result in underutilization. Utilization management decision making is based only on appropriateness of care and service and the existence of coverage.

Section 2: Enrollment

Members may go to any clinic within the Hennepin Health network for covered services without a referral. Members will receive an identification (ID) card that must be presented to receive services. ID cards will state the care type: Hennepin Health-PMAP, Hennepin Health-MinnesotaCare or Hennepin Health-SNBC.

Product Overview

Hennepin Health offers three products for residents of Hennepin County.

Hennepin Health-PMAP

Hennepin Health-PMAP is a plan that offers medical, behavioral, health and social services to Hennepin County residents. To be eligible for Hennepin Health, members must live in Hennepin County, be between the ages of 0 and 64, not have any dependent children and be eligible for Medical Assistance (Medicaid).

Hennepin Health-MinnesotaCare

Hennepin Health-MinnesotaCare is a managed care program that covers health care for people who do not have access to affordable health care coverage. Some s may be required to pay a premium to the State. Hennepin Health-MinnesotaCare offers medical, behavioral, health and social services to Hennepin County residents. To be eligible for Hennepin Health, you must live in Hennepin County, be between the ages of 0 and 64, not have any dependent children and be eligible for Medical Assistance (Medicaid).

Hennepin Health-PMAP and Hennepin Health-MinnesotaCare are provided in partnership with NorthPoint Health & Wellness Center, the Hennepin County Human Services and Public Health Department, and Hennepin County Medical Center.

Hennepin Health-SNBC

Hennepin Health-SNBC is a Special Needs Basic Care (SNBC) plan for Hennepin County residents living with disabilities. To be eligible for Hennepin Health-SNBC, you must live in Hennepin County, be between the ages of 18 and 64, be eligible for Medicaid and be certified disabled (by a State Medical Review Team or through Social Security Disability Insurance).

Every Hennepin Health-SNBC is assigned a care guide who assesses the member's needs, provides him/her with care coordination services and serves as his/her sole point of contact.

Eligibility

Contracted providers may access information through the Provider Portal, which allows contracted providers access to current eligibility, authorizations and claims information. Providers may also access information via MN-ITS. If you are a non-contracted provider, or if you need to speak directly with someone regarding eligibility, call 612-596-1036.

Section 3: Marketing and Outreach

Providers must contact Hennepin Health prior to the distribution of marketing materials that reference Hennepin Health products, as outlined in your contract with Hennepin Health. In addition, materials must meet state and federal requirements. Any marketing materials you would like to distribute must be submitted to Hennepin Health for approval by the Minnesota Department of Human Services (DHS). Approval can take up to 45 days.

Permitted provider marketing activities include:

- Co-sponsoring events such as an open house or a health fair with Hennepin Health
- Explaining the operations of an HMO
- Distributing approved brochures and display posters at doctors' offices and clinics to inform patients that the provider is a part of the Hennepin Health network provided that all plans contracted with the provider have an equal opportunity to be represented (collateral materials must be approved by Hennepin Health, per above)
- Distributing health education materials in provider offices

Prohibited provider marketing activities include:

- Quoting or comparing benefits to patients
- Providing any false or misleading information, including asserting that a patient must enroll in a specific product in order to obtain or maintain covered benefits
- Stating that a particular product is endorsed by the State
- Inducing a patient to enroll in a particular product with the use of rewards, favor or compensation
- Steering patients toward a limited number of health plans/products
- Providing printed information to patients that compares the benefits of health plans/products with which they contract without prior approval (such materials must have the concurrence of all health plans involved and be approved by DHS)
- Mailing product information to patients without the express consent of Hennepin Health
- Discriminating when providing any permitted marketing

Section 4: Services

Rights

- Members will be treated with respect, dignity and consideration for privacy.
- Members shall not be discriminated against based on race, gender, age, religion, sexual preference, national origin, genetic information or health status.
- Members may receive information provided in a format that works for them (translated, Braille, large print or other alternate formats).
- Members' medical information will be kept private according to law.
- Members may choose where to get family planning services; infertility diagnoses; sexually transmitted disease testing and treatment services; and AIDS and HIV testing services. Members

may know their treatment and treatment options, and participate in decisions regarding their health care.

- Members may request advance directives such as a living will or power of attorney for health care and get written instructions on health care directives.
- Members may register a formal appeal or grievance with Hennepin Health if they have concerns or problems related to their health care coverage or file with the Minnesota Department of Health (MDH).
- Members may request information about Hennepin Health, Hennepin Health products, providers, physician incentives, drug coverage and health care costs.
- Members may request information about how Hennepin Health pays providers.
- Members may request survey results if one is required because of Hennepin Health's physician incentive plan, as well as any external quality review study results via the State.
- Members may refuse treatment and receive information about what could happen if they refuse treatment. Members may refuse care from specific providers.
- Members may request and receive a copy of their medical records. They also may ask to have records corrected in the event an error occurs.
- Members will receive a notice if Hennepin Health denies, reduces or stops a service or payment for a service.
- Members may request a State Fair Hearing with MDH before or during the grievance or appeal process.
- Members may request a copy of their Handbook (formerly known as the Evidence of Coverage) at least once a year.
- Members may make recommendations about Hennepin Health's rights and responsibilities policies.

Access to Care Rights

- Members have the right to receive emergency and urgent care without authorization from Hennepin Health.
- Members have the right to access primary care within 30 minutes or 30 miles of their residence and hospital services within 60 minutes or 60 miles of their residence. If network providers are not available within this distance, a service authorization will be approved for receiving care outside of the service area upon notifying Hennepin Health.
- Members have the right to continuity of care, which includes ongoing primary, specialty and maintenance care. Maintenance care includes renal dialysis services provided to s temporarily outside of the Hennepin Health service area.
- Members have the right to receive health care 24 hours a day, seven days a week.
- Members have the right to direct access to mammography screening and influenza vaccinations.
- Female members have the right to direct access to a network of women’s health specialists for routine and preventive services.
- Members have the right to receive a clear explanation of covered nursing home and home care services.
- Member have the right to information about Hennepin Health, Hennepin Health's provider network and covered services.
- Members have the right to choose where they will receive family planning services.
- Members have the right to get a second opinion for medical, mental health and chemical dependency services.

Health Care Rights

- Members do not need a referral from a primary care provider to receive services from a specialist within the Hennepin Health service area.

- Members have the right to age-specific vaccinations without a copay.
- Members have the right to receive an initial health assessment within 90 days of becoming a member.
- Members have the right to receive health care that is delivered in a culturally competent manner.
- Members have the right to be informed of health conditions that require follow up and training in self-care, as appropriate.
- Members have the right to be free of restraints or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Members have the right to make decisions about their health care.

Notification Rights

- Members must be notified by Hennepin Health within 30 days of termination of a contracted provider. Federal Code requires that a health plan notify s when their primary care provider is terminated for any reason. Members should receive notification 30 calendar days before the date termination becomes effective.

Programs

Hennepin Health offers programs geared toward supporting the overall health and well-being of its members.

Wellness Wednesdays

Hennepin Health s are invited to participate in a monthly health education presentation held in the walk-in service center at Hennepin Health. Topics range from substance use disorder to dental benefits to community resources. Wellness Wednesdays take place the fourth Wednesday of every month.

YMCA ship

Hennepin Health-SNBC members have the option of using any YMCA within the Twin Cities metro area where they can benefit from access to group classes and a variety of exercise equipment. Members also receive one personal training consultation. To get started, Hennepin Health-SNBC s need to present their Hennepin Health-SNBC ID card at any metro YMCA during regular business hours.

Interpreter Services

Language access services are necessary for Hennepin Health s to communicate with health care providers, and to receive safe and timely care. Interpreter services are a covered benefit for Hennepin Health members.

Types of interpreter services include:

- Face to face
- Telephonic interpreting
- Sign language

Service authorizations are not required for interpreter services. Providers should contact a Hennepin Health-contracted interpreter service agency to arrange for an interpreter, and the interpreter service agency in turn will bill Hennepin Health for rendered services.

The 2008 State of Minnesota Legislature passed the Interpreter Services Quality Initiative. Minn. Stat. §144.058, which requires the Commissioner of Health to establish a voluntary statewide roster of spoken language health care interpreters. The purpose of the roster is to address health care access concerns for Minnesotans, particularly in rural areas.

Transportation

Transportation services include transport to and from health services that are covered due to a medical and/or psychological condition or disability. Members and providers must call Hennepin Health Member Services three days prior to an appointment to schedule a common carrier (taxi) or special transportation unless it is an urgent same-day appointment or emergency situation.

For bus and metro transit:

- Members may be issued a 31-day bus pass if they have four or more medical/dental appointments within a 31-day period. If the member has less than four medical/dental appointments, they will be issued single bus passes.
- All appointments must be verified prior to authorizing bus passes (bus passes are issued in advance of appointments).
- If s are unable to take a bus or public transit (e.g., the light rail), physicians must fill out a Certification of Need for Exemption from Public Transportation Form and send it in for review.
- Taxi rides will not be given to a member with a 31-day pass unless the member has to undergo sedation or an emergency situation arises.

For taxis:

- All taxi services require a service authorization.
- All medical appointments must be verified prior to authorizing taxi transportation.
- Members and providers must call Hennepin Health Member Services three days prior to an appointment to schedule a ride, unless it is an urgent same-day appointment or emergency situation.

For special transportation:

- All special transportation services require a service authorization.
- All medical appointments must be verified prior to authorizing taxi transportation.
- At the request of a provider, Hennepin Health will authorize monthly rides (as an exception) for members receiving ongoing treatment such as dialysis.
- Members and providers must call Hennepin Health Member Services three days prior to an appointment to schedule a ride, unless it is an urgent same-day appointment or emergency situation.

For basic life support (BLS):

- Non-emergency BLS transportation services requires a service authorization.
- No authorization is required for an emergency ambulance.

For advanced life support (ALS):

- Emergency ALS transportation services do not require an authorization (this includes ambulatory services and air transportation).

- Non-emergency ALS services require a service authorization.

Grievances and Appeals

Grievances and appeals are highly regulated by federal and state agencies. Each health plan contracting with DHS is required to have a grievance system in place that includes a grievance process, an appeals process and access to the State Fair Hearing system. The Grievance System includes the handling and processing of any member Quality of Care (QOC) Complaints.

Hennepin Health's contract with DHS requires a provider be informed of Hennepin Health's grievance system within 60 days after the execution of a contract with Hennepin Health.

Definitions

- Action: 1) The denial or limited authorization of a requested service, including the type or level of service; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of the health plan to act within the timeframes defined in DHS Contract Article 8; or, 6) for a resident of a rural area with only one health plan, the denial of an member's request to exercise his or her right to obtain services outside the network.
- Appeal: An oral or written request from the member, or the provider acting on behalf of the member with the member's written consent, to the health plan for review of an action
- Expedited Appeal: A request from an attending health care professional, an member or their representative, that a health plan reconsider its decision to wholly or partially deny authorization for services as soon as possible but no later than 72 hours after receiving the request because the member's life, health, or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a decision. The request is made prior to or during an ongoing service.
- Expedited Grievance: Any grievance that requires expedited handling if applying the standard grievance/appeal period could seriously jeopardize life, health or ability to regain maximum function.
- Grievance: An expression of dissatisfaction about any matter other than an Action, including but not limited to the quality of care or services provided or failure to respect the member's rights.
- Grievance System: The overall system that includes grievances and appeals handled at the health plan, and access to the State Fair Hearing process.
- Health Care Professional: A physician, optometrist, chiropractor, psychologist, dentist, advanced dental therapist, dental therapist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed independent clinical social worker, and registered respiratory therapy technician.
- Medical Necessity: A health service, pursuant to Minnesota Rules, Part 9505.0175, subpart 25, that is: 1) consistent with the 's diagnosis or condition; 2) recognized as the prevailing standard or current practice by the Provider's peer group; and 3) is rendered:
    - In response to a life threatening condition or pain
    - To treat an injury, illness or infection;
    - To treat a condition that could result in physical or mental disability;
    - To care for the mother and child through the maternity period;
    - To achieve a level of physical or mental function consistent with prevailing community standard for diagnosis or condition, or
    - As a preventive health service defined under Minnesota Rules, Part 9505.0355.
- Notice of Action: Notice of Action includes a Denial, Termination, or Reduction of Service Notice (DTR) or other Action as defined in 42 CFR 438.400(b).

- State Fair Hearing: A hearing files according to an member's written request with the State pursuant to MN Statutes 256.045, related to:
    - The delivery of health services by or enrollment in the Managed Care Organization (MCO);
    - Denial, either wholly or in part) of a claim or service by the MCO;
    - Failure by the MCO to make an initial determination in 30 days; or
    - Any other Action.

Members, a member's authorized representative or a member's practitioner/provider (with or without written consent as it pertains to the request type) may file a grievance or an appeal with Hennepin Health, orally or in writing. Relatives, friends, and/or attorneys, etc. may be an authorized representative for the member, but a signed patient authorization for release information form must be presented. Hennepin Health must include as parties to an appeal the member, his/her representative or the legal representative of a deceased member's estate. The member's practitioner may appeal a utilization review decision without the written signed consent of the member in accordance with 62M.06. Practitioners/ providers can appeal a claim denial; however, practitioners/ providers are not allowed to bill members in accordance with MN Rule 9505.0225.

These requests need to be filed within 90 days of a matter for a grievance, or within 90 days of the DTR Notice, or for any other action taken by the MCO as defined in 42 CFR 438.400(b), for an appeal. Hennepin Health gives s any reasonable assistance in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability during the grievance and appeal processes.

Members who wish to file a grievance or an appeal directly with Hennepin Health may call the Member Services phone number listed on the back of the Hennepin Health ID card for further assistance.

Note: Information pertaining to sexually transmitted diseases, family planning and mental/chemical health may be limited to Health Insurance Protection & Portability Act (HIPPA) laws.

Grievances

Hennepin Health does not require a grievance be filed in writing as a condition of taking action on a grievance. All grievances meeting the filing requirements are investigated by the Grievances and Appeals Coordinator with a decision on a grievance being made by an individual not involved in any previous level of review or decision-making. Any grievances regarding the denial of an expedited resolution of an appeal or one that involves clinical issues, the individual making the decision must be a health care professional with appropriate clinical expertise in treating the member's condition or disease. The determination will be made in accordance with the expedited appeal timeframe.

Hennepin Health sends an acknowledgement letter to the member and/or the practitioner/ provider acting on the member's behalf within 10 days of receiving a written grievance. This may also include the grievance outcome if a decision has been made within 10 days. Except for QOC grievances, the findings or outcome and actions related to the grievance are communicated to the member. The oral grievance outcome may be communicated verbally or in writing within 10 calendar days from the receipt of the grievance. If the disposition, as determined by the member, is partially or wholly adverse to the member, or the oral grievance is not resolved to the member's satisfaction, Hennepin Health must offer to the member that the grievance may be submitted in writing. Hennepin Health must also offer to provide the member with any assistance needed to submit a written grievance, including an offer to complete the grievance form, and promptly mail the completed form to the member for his/her

signature pursuance to MN Statutes 62Q.69, subd. 2. Hennepin Health must notify the member in writing of the disposition for all grievances filed in writing.

At the time of informing the member of the disposition either orally or in writing, Hennepin Health must notify the member the results of the investigation, Hennepin Health's actions related to the grievances and options for further review and assistance through the DHS Managed Care Ombudsman and/or review by MDH.

Hennepin Health may extend the timeframe for resolution of a grievance by an additional 14 days if the member or the practitioner/ provider requests the extension or if Hennepin Health justifies that an extension is in the member's best interest. Hennepin Health provides written notice to the member of the reason for the decision to extend the timeframe if Hennepin Health determines that an extension is necessary. Hennepin Health issues a notice of disposition no later than the date the extension expires.

Appeals

The member may request an appeal either through Hennepin Health's appeal process or by requesting a State Fair Hearing (SFH) with DHS. The member is not required to exhaust Hennepin Health's appeal process before requesting a SFH; the member can choose file an appeal with Hennepin Health and request a SFH at the same time. If the appeal is filed orally, Hennepin Health must assist the member or the practitioner/ provider filing on behalf of the member, in completing a written signed appeal. Once the oral appeal is reduced to writing by Hennepin Health, and pending the member's signature, Hennepin Health must resolve the appeal in favor of the member, regardless of receipt of a signature; or, if not signed appeal is received within thirty (30) days, Hennepin Health may resolve the appeal as if a signed appeal were received.

An expedited appeal request will be accepted when an initial DTR determination is made prior to or during an on-going service, and if the attending health care professional believes that the determination warrants an expedited appeal. A member's request for an expedited appeal, without physician support, will be reviewed to determine if it meets the expedited criteria. If Hennepin Health denies a request for an expedited appeal, Hennepin Health will transfer the denied request to the standard appeal process, preserving the first date of the expedited appeal. Hennepin Health will notify the member of that decision orally within twenty-four (24) hours of the request and follow up with a written notice within two (2) days.

If member files an appeal with Hennepin Health before the date of the action proposed on the DTR and requests continuation of benefits within the time allowed, Hennepin Health may not reduce or terminate the service until 10 days after a written decision is issued to that appeal unless: a) the member withdraws the appeal; or b) if the member requested a SFH with a continuation of benefits, until the SFH decision is reached. The continuation of benefits is not required if the practitioner/ provider who orders the service is not a participating practitioner/ provider with Hennepin Health or authorized non-participating practitioner/ provider.

The member, authorized representative or the attending health care professional may provide additional information regarding the appeal in person, by telephone or in writing. For expedited appeal resolutions the member is informed of the limited time available to present evidence in support of the appeal. The member, and his/her representative are provided an opportunity, before and during the appeals process, to examine the member's case file including medical records and any other documents and records considered during the appeal process. The member may request and receive copies of all documents relevant to the appeal free of charge, upon request.

Hennepin Health ensures that individual making the decision was not involved in any previous level of review or decision-making. An expedited appeal is resolved as expeditiously as the member's health condition warrants, but no later than 72 hours after receiving the request. The member and the attending health care professional will be notified of its determination by telephone. The standard appeal will be resolved as expeditiously as the member's health condition warrants, not to exceed 30 calendar days after the receipt of the appeal. The member is informed in writing of the appeal decision. For any appeal involving a UM decision, the attending health care professional will be informed of the appeal decision. If the resolution is adverse to the member, the member will be informed of their right to request a SFH. Hennepin Health may take an extension of up to 14 additional days for both an expedited and standard appeal to make the decision if the member requests the extension or if Hennepin Health justifies that an extension is in the member's best interest. For an expedited appeal, Hennepin Health will provide an oral notice to the member of the reason for the decision to extend the timeframe. For a standard appeal, Hennepin Health will provide a written notice to the member of the reason for the decision to extend the timeframe. For any appeal involving a UM decision, the attending health care professional will also be informed of the extension orally for an expedited appeal and written for a standard appeal. Hennepin Health will resolve and communicate the decision no later than the date the extension expires.

State Fair Hearings

State Fair Hearing Human Services Judges may review any action by the health as defined I 42 CFR 438.400(b) and section 2.3. The parties to the State Fair Hearing include the health plan, the member, his/her representative, or the legal representative of the deceased member's estate.

The member or the provider acting on behalf of the member, with the member's written consent, must request a SFH within 30 days of the DTR notice or written action by Hennepin Health or within 90 days if the shows a good reason for not submitting the request within the 30 day time limit as pursuant to MN Statute 256.045.

If an member makes a written request for a State Fair Hearing with the State, and requests continuation of benefits within the time allowed before the date of a proposed action in either Hennepin Health's DTR notice or written appeal decision, Hennepin Health may not reduce or terminate the service until a written decision is issued by the State in the State Fair Hearing or the member withdraws the request for the State Fair Hearing. In the case of a reduction or termination of ongoing services, services must be continued, pending outcome of all appeal hearings if: (1) there is an existing order for services by the treating and participating provider; or (2) the treating and participating provider orders discontinuation of services and another participating provider orders the service, but only if the provider is authorized by his/her contract with Hennepin Health to order such services.

Prior to the scheduled hearing date, Hennepin Health reviews the appeal information received, and if necessary, initiates a subsequent review process to review new information, or reopens the case to correct any errors identified with the original denial determination. If no additional action is needed, Hennepin Health completes the State Agency Appeals Summary form and submits this form, along with all necessary documentation, at least three days before the scheduled hearing.

During the State Fair Hearing, Hennepin Health representatives present testimony and defend the determination that was made. Following the hearing, a recommendation is made by the DHS Human Services Judge, with the final order decided by the Commissioner of Human Services. Hennepin Health will comply with the Commissioner's final order promptly and as expeditiously as the member's health condition requires.

Hennepin Health
400 South Fourth Street, Suite 201
Minneapolis, Minnesota 55415
Appeals and Grievances Coordinator: 612-596-9914

Minnesota Department of Human Services
Ombudsman for Public Managed Health Care Programs
P.O. Box 64249
St. Paul, Minnesota 55164-0249
651-431-2660 (toll-free: 1-800-657-3729)

Minnesota Department of Health
Health Policy and Systems Compliance Division
Managed Care Systems
P.O. Box 64882
St. Paul, MN 55164-0882
651-201-5100 (toll-free: 1-800-657-3916)

Minnesota Department of Human Services
Appeals Office
P.O. Box 64941
St. Paul, Minnesota 55164-0941
651-431-2660 (toll-free: 1-800-657-3729)
Fax: 651-431-7523

Continuity of Care for New Members
To ensure s' continuity of care is not compromised, Hennepin Health allows new members to continue receiving medical services from their current provider for a predetermined time frame. Hennepin Health will review a request for continued care from an out-of-plan provider and will grant the request to receive services through the current provider unless the member does not meet the following criteria:

- A life-threatening mental or physical illness
- A pregnancy beyond the first trimester

Hennepin Health will allow members to continue seeing their provider for the established time frames:

- 120 days if the is engaged in a current course of treatment
- The rest of the 's life if a physician certifies that he/she has an expected lifetime of 180 days or less

Hennepin Health will provide transitional services when:

- The has a service authorization from another Managed Care Organization or the State (at the time of enrollment)
- A transfer of care is clinically appropriate

Note: In both instances, Hennepin Health will review the member's case and make a determination.

Section 5: Clinic Services

Clinic services are provided in a clinic setting by a licensed, qualified health care professional.

Covered services

- Physician services
- Preventive health services
- Family planning services
- Early periodic screening, diagnosis and treatment services, also known as Child and Teen Checkups
- Dental services
- Prenatal care services

Provider network

- Members may see any specialist in Minnesota licensed by the State or any contracted specialist outside of Minnesota.
- Members must receive preventive and prenatal services within the Hennepin Health network unless they are given a service authorization for out-of-network care.

Child and adolescent services

Child and Teen Checkups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, a required service under Title XIX of the Social Security Act. C&TC is a comprehensive child health program offered to children and teens (newborn through the age of 20) enrolled in Medical Assistance (MA) or MinnesotaCare. The purpose of the program is to reduce the impact of childhood health problems by identifying, diagnosing, and treating health problems early.

C&TC medical services

- Anticipatory guidance (health education)
- Physical growth and measurement
- Health history (includes mental health, nutrition and chemical use)
- Developmental health
- Mental health
- Physical examination
- Immunizations and review
- Newborn metabolic screening
- Laboratory tests (includes blood, lead and hemoglobin/hematocrit)
- Other tests as indicated
- Vision screening
- Hearing screening
- Dental checkups (verbal referral)

Periodic table

The Minnesota Department of Human Services established and maintains a schedule of age-related screening standards (C&TC Screening Periodicity). Refer to the C&TC screening periodicity schedule for more detailed information.

C&TC referral coding information

A referral for C&TC reporting purposes indicates that the child needs to be seen again for further assessment, diagnosis or treatment of a problem or concern that was identified during the C&TC screening. The referral can be made to the screening provider or another provider.

To be recognized as a C&TC claim and paid with the MHCP C&TC payment methodology, all C&TC claim lines must list the most appropriate HIPAA compliant referral code. Be sure to use only one C&TC referral code per claim and the same referral code on all lines of the claim.

Chiropractic services
Chiropractic services are medically necessary therapies provided by a licensed chiropractor that employ manipulation and specific adjustment of body structures such as the spinal column.

Covered services
- Medically necessary manual manipulations of the spine for the treatment of incomplete or partial dislocations and X-rays
- Initial exam to diagnose subluxation of the spine
- 24 routine treatments per calendar year
- Spinal X-rays when needed to diagnose subluxation

Exclusions and limitations
- Adjustments other than manipulations for subluxation and therapy (e.g., vitamins, medical supplies, equipment and lab)
- Any Evaluation & Management (E&M) exams after the initial exam
- Maintenance therapy
- Any X-rays exceeding the initial X-ray to diagnose subluxation

Service authorization
- A service authorization is required for more than 24 spinal manipulations per year.
- The chiropractor is required to provide written documentation to Hennepin Health's Medical Administration Department.

Provider network
Eligible Hennepin Health s have open access to licensed chiropractic services within the State of Minnesota.

Vision services/eye care
An eye exam entails an evaluation of vision and vision problems, as well as prescriptions for eyeglasses. Eye wear is defined as vision aids prescribed by an optometrist or ophthalmologist.

Service authorization
Service authorizations are not required for vision services, eye exam and eye wear.

Covered services
- Glasses: One pair every two years (Medicaid-covered frames and lenses only)
- Lenses: One pair every two years (Medicaid-covered lenses only); replacement of lost, stolen or damaged lenses covered
- Frames: One pair every two years (Medicaid-covered frames only); replacement of lost, stolen or damaged frames covered
- Contacts: Covered only for s who have a diagnosis of aphakia keratoconus and aniseikonia (bandage lenses; Medicaid-covered lenses only)

Provider network

- Routine eye exam and eye wear (through Hennepin Health-contracted providers)
- Specialty vision services (through any licensed providers who are practicing within the State of Minnesota who accepts Medicaid members)

Hearing services

Hearing services include hearing devices used to treat hearing loss that impacts a member's daily activities, or requires special assistance or intervention.

Covered services

- Batteries
- Ear impressions
- Ear molds, including open-dome style ear molds (not disposable) replaced approximately every three months
- Hearing aids (Medicaid covered hearing aids at Medicaid rates; includes maintenance and repairs)
- Parts and accessories
- Programming/reprogramming
- Re-casing, remakes and shell modifications
- Replacing battery doors and microphone protectors

Service authorizations

- Required for hearing aid
- For repairs, must use manufacturer's warranty until expired. Repairs are reimbursed up to the value of replacement.
- Limit up to two replacements in a five year period
- Not required for an annual exam

Section 6: Specialty Services

Surgery Services

Surgery services are surgical procedures performed by a surgeon, physician, or dentist to treat a disease or condition.

Service locations

- Office clinics
- Inpatient/outpatient hospital
- Ambulatory surgical center

Provider network

Hennepin Health-contracted providers that are licensed and credentialed within the State of Minnesota

Service authorization

- Gastric bypass surgery
- Breast reduction surgery
- Any surgery that could be considered cosmetic or experimental
- Uvulopalatopharyngoplasty (UPPP) and laser assisted uvulopalatoplasty (LAUP) throat surgeries
- Transplants (excluding kidney)
- Circumcisions

Note: This is not an all-inclusive list.

Exclusions and limitations

- Cosmetic surgery is not covered unless it is related to a congenital defect, previous procedures, or trauma.
- Sex re-assignment surgery is not covered.
- Circumcision is not a covered service unless deemed medically necessary by Hennepin Health's Medical Administration Department.
- Reconstructive surgery is a covered benefit when such services is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part.
- Reconstructive breast surgery is provided if the mastectomy is medically necessary as determined by the attending physician.

Contact for service authorization

Contact Hennepin Health's Medical Administration Department via phone at 612-596-1504 or fax at 612-677-6222.

Home health care services

Authorization: The process for obtaining approval for select covered medical services. For services requiring authorization, a medical review is completed to ensure medical necessity prior to the delivery of care or payment of service. An authorization number will be issued upon approval.

Home: A place of residence, including assisted-living facilities, group homes, and personal care homes. An adult daycare facility is not considered a patient's home unless the service provided requires medical equipment that is too cumbersome to bring into a patient's home.

Home Care: A range of medical care and support services provided in a patient's home. Services range from providing assistance with daily activities to a level of care similar to that provided in a hospital.

Covered services

- Skilled nursing visits
- Home health aide visits
- Private duty nursing services
- Rehabilitation services (physical, occupational, speech and respiratory therapy)
- Personal care attendant services (refer to chapter 6)

Authorization requirements

It is the provider's responsibility to obtain a prior service authorization from Hennepin Health before delivering health care services that require prior authorization.

Services requiring authorization

- Private duty nursing services
- Skilled nursing visits exceeding 54/year
- Home health aide visits

Provider responsibilities

- Verifying insurance monthly
- Obtaining authorization when required
- Submitting the CMS 485 form, home health certification and plan of care for medical review signed by the ordering provider
- Sending a discharge summary at the completion of home care services

Retrospective authorization
Hennepin Health's retrospective authorization requirements are outlined in chapter 6.

Exclusions and limitations
- Services must be provided by a Hennepin Health-contracted provider.
- Personal care attendant services for Hennepin Health-SNBC members (all groups are covered by the Minnesota Department of Human Services)

Durable medical equipment (DME) and medical supplies
Durable medical equipment (DME) is defined as equipment that:
- Is generally only useful to a person with a medical condition
- Is appropriate for use in the home
- Can withstand repeated use

Prosthetics are devices that:
- Replace all or part of a limb
- Replace all or part of the function of a permanently inoperative or malfunctioning limb
- Must be ordered and/or prescribed by a physician

Orthotics are designed and fitted to support or correct musculoskeletal deformities and/or abnormalities of the human body.

Non-durable medical supplies:
- Are disposable in nature
- Cannot withstand repeated use by more than one individual
- Are primarily and customarily used to service a medical purpose

Covered services
- Prosthetics and orthotics
- DME (including, but not limited to wheelchairs, hospital beds, walker, crutches, breast pumps and hearing aids)
- Oxygen and oxygen equipment, C-PAP and Bi-PAP
- Supplies necessary to treat a medical condition (including, but not limited to adult diapers, bandages, dressings, gauze and equipment batteries)
- Medical equipment repairs (including hearing aids)
- Medically necessary foot wear
- Adult diapers and incontinence products

Note: This is not an all-inclusive listing.

Authorization
Authorization is the process for obtaining approval for select covered medical services. For services requiring authorization, a medical review is completed to ensure medical necessity prior to the delivery of care or payment of service. An authorization number will be issued upon approval. It is the

responsibility of the provider to obtain an authorization from Hennepin Health prior to delivering DME that requires an authorization.

Authorization requirements

- Bone growth stimulators (authorization is required after three months rental)
- Cranial Electrotherapy Stimulator (authorization is required after three months rental)
- Suction pump (authorization is required after three months rental)
- Repairs of DME exceeding $1,000
- DME greater than $5,000 billed amount
- Prosthetics greater than $5,000 billed amount
- Orthotics greater than $5,000 billed amount
- Medical supplies greater than $3,000 billed amount
- Wheelchairs greater than $5000 billed amount
- Rental of a hospital-grade breast pump (no authorization needed for the purchase of an electric breast pump)

Note: This is not an all-inclusive listing.

Exclusions and limitations

- DME, medical supplies, orthotics and prosthetics must be provided by a Hennepin Health-contracted provider.
- Breast pumps can be purchased once every three years.
- Wigs are covered for the diagnosis of alopecia areata only.
- Bed-wetting alarms are not a covered item.
- Rent for most durable medical equipment is covered up to 13 months, or to the purchase price of the equipment. After 13 months of rental or when the purchase price is reached, the item is the recipient's property.
- All purchased equipment must be new upon delivery to the recipient. Equipment that is intended to rent until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase, must be replaced with new equipment.

Provider responsibilities

- Verifying the member's eligibility (monthly)
- Obtaining authorization when required
- Completing a service authorization form (PDF)

Retrospective authorization

Hennepin Health's retrospective authorization requirements are outlined in chapter 6. Hennepin Health covers medical supplies and equipment subject to thresholds, authorization, and other requirements. Additional restrictions apply to supply and equipment coverage for Hennepin Health members residing in long-term care facilities.

Authorizations - rentals and repair

For rental authorization extensions that do not have a threshold, you will need to provide the following documentation:

- Updated medical necessity information
- Anticipated length of time for continued service

For rental authorization extensions that do have a threshold, you will need to provide the following documentation:

- The member's agreement or denial to purchase the equipment (and if applicable, notification of a member's lack of response, in which case, the authorization will be extended to 13 months)

For authorization requests pertaining to the repair of equipment owned by a member, you will need to provide the following documentation:

- Medical information regarding length of time the member will need the equipment

Resources

- Hennepin Health Provider Services: 1-800-647-0550 612-596-1036
- Hennepin Health Medical Administration Department fax: 612-677-6222 or phone 612-593-1504

Nursing home admissions
Nursing services provided in a non-acute facility as an alternative to hospital confinement

Covered services
For Hennepin Health members, Hennepin Health covers ancillary charges for nursing home care; room and board charges are covered by the State of Minnesota.

For Hennepin Health-SNBC members, Hennepin Health covers 100 days of nursing home charges, including stays at both skilled-nursing and nursing facilities. A service authorization is required for all Hennepin Health-SNBC members' admission. Nursing home staff will submit a PMAP communication form to Hennepin Health when a Hennepin Health-SNBC member is admitted to the nursing home, the RUG rate/class changes or the is discharged from the nursing home.

NOTE: MinnesotaCare does not provide coverage for nursing home benefits.

Service authorization
A service authorization is required for both skilled-nursing and nursing facility charges.
- Providers are required to notify Hennepin Health within one business day of the admission.
- An initial PAS form (completed by the Senior Linkage Line) needs to be submitted to Hennepin Health for long-term care admission.

Rehabilitation therapies
Therapy services and education to enable sick or disabled individuals to participate in daily activities. Rehabilitative and therapeutic services include the following: restorative, specialized maintenance, and rehabilitative nursing services.

Service authorization
The process for obtaining approval for selected medical covered medical services. For services requiring authorization, medical review is done to assure medical necessity prior to the delivery of care or payment of service. An authorization number will be issued upon approval.

Covered services

Rehabilitative therapies covered services are defined as, but not limited to the following:

- Occupational therapy
- Physical therapy
- Speech-language pathology service
- Orthotic procedures (L-codes)
- Respiratory services

Service authorization requirements
No service authorization is required for contracted providers

Service authorization
Hennepin Health will collaborate with providers to coordinate clinical care and services to ensure quality, cost-effective, appropriate health care. Service authorization requirements are subject to change based on, but not limited to, state~~,~~ or federal changes (by directive or legislation). Service authorizations apply to:

- Hennepin Health-SNBC
- Hennepin Health-PMAP and Hennepin Health-MinnesotaCare

Standard authorization determination
Hennepin Health will process completed requests for service within 10 business days of receipt. Hennepin Health will request further information, if necessary, and will approve or deny the request within 10 business days of receiving new information.

Expedited service authorization determination
In order to be considered for an expedited service authorization determination, fax required information to 612-677-6222.

Physicians must state, orally by calling 1-800-647-0550 or 612-596-1036, or in writing, that the standard time to make a determination could jeopardize a member's life, health or ability to regain maximum function. (The physician need not be appointed as a member's authorized representative in order to make the request).

Hennepin Health will respond to requests to expedite an authorization as follows:

- If a physician believes that waiting for a decision under the standard timeframe could jeopardize a member's life, health, or ability to regain maximum function, Hennepin Health will automatically expedite the request.
- Hennepin Health will resolve each request as promptly as is practical, but no later than 72 hours after receiving it.
- If a service has already been provided, expedited service authorization will not be given.

If criteria for expedited service authorization are not met:

- Hennepin Health will process the authorization request within the standard service authorization time frame.
- Members will be notified by phone of the decision to deny a request for an expedited determination.
- A written notification will be delivered to s within 72 hours of a decision.
- The notice will inform s of the right to resubmit a request for an expedited determination.

- The notice will provide instructions about the expedited grievance and time frames.

Retrospective service authorization determination
For a retrospective service authorization on a denied or non-submitted claim, fax information to 612-677-6222. Hennepin Health will conduct retrospective reviews if the request is received within 180 days from the date of service.

Provider responsibility
Submit required information for retrospective authorization or payment may be denied.

Processing of a retrospective review
Hennepin Health will issue a determination for retrospective service authorization within 30 days of receipt of request.

Disclosure of review criteria/reviewer credentials
Upon request, Hennepin Health will provide members, physicians and/or providers criteria used to determine the medical necessity, appropriateness, and efficacy of a procedure or service. Hennepin Health will identify the data and professional treatment guidelines or other basis for the decision. The qualifications of the reviewers, including any license, certification, or specialty designation, will be made available upon request.

Continuity-transitional services
Hennepin Health will follow contractual requirements with the State of Minnesota.
Hennepin Health will provide, upon request, authorization to receive covered health care services for up to 120 days if the member is engaged in current course of treatment for one or more of the following conditions:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy beyond the first trimester
- A physical or mental disability defined as an inability to engage in one or more major life activities provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase

Hennepin Health provides transitional services for members new on the health plan. If a member enters into Hennepin Health with authorization for services from another managed care organization or the state, Hennepin Health reviews the case for continued coverage of these services from an out-of-plan provider. Hennepin Health may require the member to receive the services by a Hennepin Health Provider if such a transfer of care would not create undue hardship for the member and is clinically appropriate. If Hennepin Health determines the member should continue to receive their care from an out-of-plan provider, authorization is provided for up to 120 days of service during which time the member shall be transitioned to a Hennepin Health provider.

Continuity of member care is also addressed day to day with the utilization review process. When a request for medical review is received, a review of recent requests is done to assure coordination of the member's care.

Forms/instructions
Find service authorization request forms in the provider resources section at www.hennepinhealth.org, or call 1-800-647-0550.

Fax completed service authorization request forms with medical documentation to support the medical need of the request ~~at~~ to 612-677-6222.

Billing instructions
When billing for covered services which require a service authorization, include the service authorization number on all claims.

For more billing information, see the claims submissions chapter.

OB/GYN and reproductive services
Obstetric, gynecologic, and reproductive services are services and procedures that are performed by a provider to promote health and prevent disease in women.

Service locations
- Office clinics
- Inpatient/outpatient hospital
- Ambulatory surgical center

Covered Services
- Annual preventative health exam
- Prenatal, delivery, and postpartum care*
- Childbirth classes
- Hospital services for newborns*
- HIV counseling and testing for pregnant women – **open access service**
- Treatment for HIV-positive pregnant women
- Treatment for newborns of HIV-positive mothers
- Testing and treatment of sexually transmitted diseases (STDs) – **open access services**
- Pregnancy-related services received in connection with an abortion *(does not include abortion-related services)*
- Doula services* by a certified doula registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers including services of certified nurse midwives and licensed traditional midwives.

Note:
You have "direct access" to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that your qualified health care provider says are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get the direct access services, you must go to a provider in the Plan network. For services labeled as **open access**, you can go to any qualified health care provider, clinic, hospital, pharmacy or family planning agency licensed in Minnesota and registered with the Department of Human Services (DHS).

Exclusions and limitations
Abortion: This service is not covered under the Plan. It may be covered by the state. Call the Minnesota Health Care Programs Helpdesk at 651-431-2670 or 1-800-657-3739 (toll free) for coverage information.
Artificial ways to become pregnant (artificial insemination, including in-vitro fertilization and related services; fertility drugs and related services)
- Reversal of voluntary sterilization
- Planned Home births

Services requiring authorization
It is the provider's responsibility to obtain a prior service authorization before delivering health care services to Hennepin Health members.

- Doula services require an authorization for greater than 7 sessions, one of which must be labor and delivery.

Hospice care services
Members must be certified by a physician as terminally ill (life expectancy of six months or less) and elect the hospice program. Terminally ill is used to describe a disease that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within a short period of time.

Hospice covered services

- Doctor, nurse and professional services
- Medical social service
- Medical equipment and supplies
- Physical, occupational and speech therapies
- Short-term inpatient care including respite care
- Counseling including dietary counseling
- Home health aide and homemaker services
- Outpatient drugs for symptom management and pain relief

Services requiring authorization
Hospice services do not require an authorization.

Section 7: Behavioral Health Services

Mental health
Mental illnesses are medical conditions that disrupt a person's thinking, mood, and feelings. Mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, post-traumatic stress disorder and borderline personality disorder. Mental illnesses can affect persons of any age, race, religion, or income.

Covered services

- Consultation about care between primary care doctor and psychiatrist
- The diagnosis and treatment of mental disorders
- Medication management.
- Diagnostic assessment
- Psychological and neuropsychological assessment and testing
- Cognitive remediation training
- Emergency room crisis services
- Explanation of findings.
- Inpatient hospital stay
- Partial hospitalization
- Day treatment
- Intensive Residential Treatment Services (IRTS)
- Assertive Community Treatment Services (ACT)

- Mental Health Targeted Case Management (MH-TCM)
- Mental health services provided over interactive television
- Individual, group and family therapy, including biofeedback

Covered services - adult

- Adult Mental Health Rehabilitative Services (ARMHS)
- Adult mental health crisis services
- DBT (Dialectical Behavioral Treatment)

Certified peer specialist level I or level II who are employed in agencies that provide mental health rehabilitation services. The agency must be approved to provide certified peer specialist services. These mental health rehabilitation services include ACT, IRTS, ARMHS, and crisis stabilization services.

Physician mental health services include:

- Health and behavior assessment/intervention
- Inpatient visits
- Psychiatric consultations to primary care providers
- Physician consultation, evaluation and management

Covered services - children

- Children's mental health screening, children's therapeutic services and supports (CTSS must be certified by DHS to provide CTSS) and children's mental health crises response services
- Mental health treatment services for emotionally disturbed children in licensed treatment foster care
- Therapeutic support of foster care for children up to age 21 with Serious Emotional Disturbance (SED)
- Family community support services for children up to age 21 with SED
- Home-based mental health services for children up to age 21 with SED
- Rule 5 children's residential treatment services

Authorization

Authorization is the process for obtaining approval for selected medical covered medical services including some behavioral health services. For services requiring authorization, medical review is done to assure medical necessity prior to the delivery of care or payment of service. An authorization number will be issued upon approval.

It is the responsibility of the provider to obtain an authorization from Hennepin Health prior to delivering the services that requires authorization.

Authorization requirements

- Inpatient admits less than 24 hours in length or greater than 10 days require medical review
- Psychological and neuropsychological testing greater than 8 units per calendar year
- Medication management exceeding weekly
- Diagnostic assessment and interactive diagnostic assessment exceeding 2 sessions in a calendar year
- Children's residential treatment (Rule 5)

Notification required

Notification of admission to the above treatment programs facilitates the health plan care coordination staff to provide optimal transitional care support for s who are receiving these intensive services. Timely notification of admission and discharge is contract requirement and an expectation for all providers of these mental health services.

- IRTS (Intensive Residential Treatment Services)
- Mental Health Targeted Case Management (MH-TCM)
- ACT services (Assertive Community Treatment)
- Inpatient hospitalization greater than 24 hours and less than 10 days
- Chemical dependency treatment

Exclusions and limitations

If Hennepin Health decides mental health services are not needed, a member may request a second opinion. For the second opinion, Hennepin Health will allow a member to go to any qualified licensed mental health professional. Hennepin Health must consider the second opinion, but Hennepin Health has the right to disagree and not provide services. The member has the right to appeal Hennepin Health's decision.

Hennepin Health will not do a separate medical necessity review of court-ordered mental health services. The behavioral care evaluation must be performed by a licensed psychiatrist or a doctoral level licensed psychologist, and include a diagnosis and individual treatment plan for care in the most appropriate, least restrictive environment, refer to Minnesota Statutes, 62Q.535. The member needs to use Hennepin Health providers for his or her court-ordered mental health assessment.

Room and board for IRTS and Rule 5 Children's Residential Treatment is not covered by Hennepin Health. Room and board is available through the member's county of residence and Hennepin Health coordinates this service with the county.

Provider responsibilities

- Verifying insurance monthly
- Obtaining authorization when required
- Notification of admission/discharge to IRTS, MH_TCM, ACT, Chemical Dependency Treatment and inpatient hospitalization under 24 hours and over 10 days

Retrospective authorization

Hennepin Health Retrospective Authorization requirements are outlined in Chapter 6.

Chemical dependency

Chemical dependency is dependence on alcohol or an illegal drug or a medication. Chemical dependency means not being able to control drug or alcohol use and continued use of the addictive substance despite the harm it causes. Drug addiction can cause serious, long-term consequences, including problems with physical and mental health, relationships, employment and the law. Dependence or addiction can cause an intense craving for the substance. Addiction to drugs or alcohol is chronic and progressive, and is a treatable illness.

Note: Hennepin Health will reimburse for only those chemical dependency (CD) services that are identified through a chemical dependency assessment (Rule 25) provided in the member's county of residence.

Covered benefits:

- Assessment and diagnosis

- Inpatient, outpatient and residential treatment (includes room and board) for CD treatment
- Methadone treatment
- Detoxification is not covered unless medically necessary for medical treatment

Service authorization
Hennepin County Human Services and Public Health department, Chemical Health Unit approves all Rule 25 Assessments and completes the Client Placement Authorization form (CPA) with the exception of the 5 agencies contracted with HSPHD to perform the Rule 25 Assessment. These agencies are: African American Family Services, CLUES, Crysalis, Create-Workhouse in Plymouth and Indian Health Board. Please refer to Hennepin Health's Chemical Health Frequently Asked Questions for further details.

The CPA form is required for Hennepin Health to authorize payment of Chemical Health services. The CPA must be completed accurately and be legible.

If an extension for chemical dependency treatment is necessary the provider needs to communicate with the original Rule 25 Assessor as indicated in the Client Placement Authorization (CPA).

Fax notification that client has been admitted to treatment and upon discharge from treatment to Hennepin Health Medical Administration 612-677-6222.
- Rule 25 assessments are required for all Chemical Dependency services.
- Fax the Client Placement Authorization (CPA) Form, Assessment and Placement Summary Form via secure fax to Hennepin Health at 612-321-3781.
- Fax medical information to secure fax 612-677-6222.

Who to contact
Member Services for all Hennepin Health plan options: 1-612-596-1036.

Exclusions and limitations
A qualified assessor will decide what level of chemical health services the member needs.
- A member may obtain a second assessment if he or she does not agree with the first one. Requests for second assessments must be received by Hennepin Health within 5 working days of completion of the original assessment or before the client enters treatment, whichever occurs first.
- Hennepin Health will give the a second assessment by a different qualified assessor including those who are not contracted with Hennepin Health within 5 working days of receipt of the request for a second assessment.
- Members have the right to appeal both assessments.
- Detoxification is not covered unless medically necessary for medical treatment

Hospital Services

Inpatient
Inpatient service is defined as a stay in a hospital or treatment center in which the Hennepin Health member receives room, board, and professional services.

Covered services
- Room and board
- Diagnostic procedures
- Surgery

- Drugs
- Medical supplies
- Therapy services
- Professional services

Authorization of inpatient admissions

Authorization is the process for obtaining approval for selected medical and surgical procedures, and inpatient services that require utilization review or medical necessity review prior to the delivery of care or payment of service. An authorization number will be issued upon approval.

It is the responsibility of the treating provider to obtain an authorization from Hennepin Health prior to performing the following services:

- Bariatric procedures
- Any procedure that may be considered cosmetic or reconstructive including, but not limited to:
    - Panniculectomy
    - Scar excisions/revisions
    - Suction lipectomy
    - Septoplast, rhinoseptoplasty
- Maxillofacial surgery or uvulopalatopharyngoplasty
- Oral surgery
- Transplants
- Experimental, investigative and new technology
- Any hospital stay more than 10 days
- Any hospital stay less than 24 hours

Notification requirements

Hennepin Health requires a hospital inpatient notification in lieu of a service authorization for specific hospital inpatient services. Providers will be required to notify Hennepin Health within one business day of the member's admission. Hennepin Health may be notified by means of the hospital's face sheet, or daily admission/ discharge report.

The notification requirements are as follows:

- Hennepin Health name and number, date of birth (DOB) , social security number, hospital medical record number
- Admission date and time
- Hospital service type
- Level of care
- Admission source
- Diagnosis
- Attending physician
- Discharge status
- Discharge disposition

The completed documentation shall be faxed to Hennepin Health, Medical Administration Department at 612-677-6222 or Call 612-596-1504

Exclusions and limitations

- Coverage excludes a private room, unless ordered by a physician for a medical reason.
- In-room phones and amenities, such as a television, are not covered.
- Covered drugs and biologicals must be consistent with United States Pharmacopeias or the American Dental Association Guide to Dental Therapeutics and approved by the FDA as safe and

effective. Drugs and biologicals that have not received final FDA approval are not covered unless CMS instructs otherwise. Off-label use is permitted.
- Services received subsequent to a non-covered inpatient stay
- Cosmetic surgery, sexual reassignment, non-covered organ transplants, non-covered organ implants (e.g., bladder stimulator), reversal of intestinal bypass, and treatment of a surgical site infection of a non-covered procedure.

Provider responsibilities
- For selected scheduled inpatient admission, a service authorization is required before admission. Request an extension (concurrent review) of a previously obtained authorization before the end date of the initial authorization.
- Notify Hennepin Health of members who have complex discharge needs
- Notify Hennepin Health of the need for care coordination. For asthma, diabetes, or heart disease management, speak to a disease case manager.

Inpatient authorization for acute mental health admission
- Completed Hennepin Health service authorization form (PDF)
- Diagnosis
- Date of admission
- Expected disposition of after admission
- Clinical information to support admission (ER notes, H&P, test results, etc.). For mental health admissions, include Axis I through V
- Plan of care to support intensity of service

Psychiatric hospital admissions
- Complete Hennepin Health Inpatient service authorization form.
- Notify Hennepin Health of all inpatient admissions and information must include;
- Diagnosis
- Date of admission
- Expected disposition of after admission
- Behavioral and functional limitations presented at admission, i.e., specific Axis I through V
- Physician statement for expectations for a member's improvement or diagnosis
- Active individual treatment or diagnostic plan

Inpatient admission for chemical dependency or substance abuse treatment
- Complete a rule 25 assessment
- Copy of the assessment or summary of findings, past history related to the condition, including previous treatments needs to be sent to Hennepin Health along with a Client Placement basement (PSA) form.
- Treatment plan

Concurrent review
On expected date of discharge, provide:
- Current mental health and functional limitations for mental health stays or current physical status for medical inpatient stays
- Current treatment plan or orders and date of change to psychotropic medication, if applicable

Retrospective authorization
Hennepin Health Retrospective Authorization requirements are outlined in Chapter 6.

Section 8: Outpatient Services

Outpatient services are those services provided at a hospital or outpatient facility that are not at an inpatient level of care. These services may also be available at a member's clinic or health care facility.

Covered services

- Urgent care
- Surgery
- Test and X-rays
- Dialysis
- Emergency room services for a medical emergency
- Post-stabilization care

Service authorization

A service authorization is not required for outpatient services.

Exclusions and limitations

- Coverage excludes a private room, unless ordered by a physician.
- In-room phone and amenities, such as a TV, are not covered.

Emergency room service for restricted recipients

The State of Minnesota Restricted Recipient Program (MRRP) is a program for Minnesota Health Care Program (MHCP) members who have abused or misused these publicly subsidized health care programs. This program requires restricted recipient s to receive services from only designated contracted Hennepin Health providers who are a primary care provider, a clinic, a hospital, and a pharmacy.

Hennepin Health follows all federal and state requirements for payment of emergency room claims. Upon initial receipt of a claim, Hennepin Health utilizes the Utah list of authorized diagnoses for emergency department reimbursement ("Utah List") and will automatically authorize payment without requiring further review for any ER claim found on therein. For claims not found on the Utah List, Hennepin Health considers the presenting symptoms, time of day and day of the week as well as the "prudent lay person" standard before a determination is reached.

For all members in the MRRP, Hennepin Health will not pay for services from a non designated hospital unless the condition appears on the Utah List or if the member had no other options available. This includes a review of time of day, day of the week, presenting symptoms and prudent lay person view of the illness or injury. Hennepin Health has attempted to contact all s on the MRRP with this information at the time of the restriction at the last known address used by the member. A restriction will last for 24 months of eligibility pursuant to DHS rules and the restricted status moves with the should they leave one plan and join a different plan or fee-for-service. Restrictions can be reinstated if the issue or behavior persists and at that time an additional 36 months will be added on. All rules related to MRRP are posted on the DHS website (PDF).

Section 9: Pharmacy

Hennepin Health contracts with Navitus Health Solutions (Navitus) to provide pharmacy services for Hennepin Health members. Navitus services are designed to deliver the most effective and appropriate medicines with the greatest cost savings. They consider convenience a high priority, by offering Hennepin Health members the choice of getting their medicines at one of their 63,000 or more participating local retail pharmacies.

Hennepin Health members' pharmacy benefits include:

- Prescription drugs included in the Hennepin Health formulary
- Medicaid covered drugs for certain products
- Over-the-counter drugs when prescribed or included in the Hennepin Health Medicaid formulary, or approved as a formulary exception

Non-Formulary Drugs
Non-formulary drugs are drugs that are not included in the Hennepin Health formulary. These drugs may be available to Hennepin Health members as medical exceptions or non-formulary requests. To receive non-formulary drugs, members must obtain a prior authorization from Hennepin Health's pharmacy department.

To request a non-formulary drug, complete the Minnesota Uniform Formulary Exception Form (available on www.hennepinhealth.org) and submit it to Hennepin Health by secure fax at 612-677-6222 or encrypted email at HH.Pharmacy.PA@hennepin.us.

For questions regarding coverage and formulary exceptions, call Navitus Health Solutions Services 24/7 at 1-855-673-6504.

Antipsychotic Drugs
Hennepin Health will provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the formulary, as long as the prescribing provider indicates to the dispensing pharmacist (orally or in writing) that the prescription must be dispensed as communicated; certifies in writing to Hennepin Health that the provider has considered all equivalent drugs in the formulary; and has determined that the prescribed drug will best treat the 's condition.

Hennepin Health is not required to provide coverage for a drug if the drug was removed from the formulary for safety reasons. Hennepin Health will not impose a special deductible, copayment, coinsurance or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary. Hennepin Health will not require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the member's condition. Non-formulary drugs are subject to periodic review and modification by Hennepin Health for addition to the formulary.

Section 10: Clinical Practice Guidelines

Hennepin Health adopts and disseminates clinical practice guidelines relevant to our members for the provision of preventive, acute or chronic medical services and behavioral healthcare services. These clinical practice guidelines help practitioners and members make decisions about appropriate health for specific clinical circumstances and behavioral healthcare services. Practice guidelines are based on valid, reliable clinical evidence. The practice guidelines may be adopted from recognized sources such as Institute for Clinical Systems Integration (ICSI) or through input of board-certified practitioners from appropriate specialties. At a minimum, the practice guidelines are reviewed and updated at least every two years or more frequently if national guidelines change within the two-year period. Hennepin Health evaluates the practice guidelines and monitors their applicability and use by contracted practitioners.

The Quality Management Committee (QMC) reviews the practice guidelines to assure:

- Hennepin Health population's needs are being met
- Guidelines remain valid and reliable
- Consensus-based
- Periodically updated

Hennepin Health's Quality Management Department will disseminate guidelines to the contracted primary care/medical home providers at least every two years or upon any revisions being made.

Guidelines are embedded in the decision algorithms used by the Hennepin Health Medical Administration area and are applied to utilization management decisions, member education, coverage or services and any other area for which the guidelines are applicable.
The audit of practitioner compliance with the practice guidelines in an addendum to the quality work plan and details:

- Hennepin Health implementation of practice guidelines
- Outline of the guideline, source, dates and revisions
- Audit results
- Improvement or corrective strategies that will be initiated, if appropriate
- Relevant measures, addenda, or information to the above.

To request a copy of the Hennepin Health clinical practice guidelines, contact Provider Services at 612-596-1036.

HEDIS Data Collection
The purpose of HEDIS is data collection, validation and reporting using the HEDIS technical specification from NCQA. HEDIS data is also used to meet the Minnesota Community Measurement requirements and may also be used to measure compliance with practice guideline standards. The annual HEDIS data collection is audited by an outside NCQA accredited agency, to assure accuracy and to meet the data collection and reporting needs of Hennepin Health, DHS and MDH.

Quality of Care Grievance
Hennepin Health uses the National Association of Healthcare Quality (NAHQ) definition, which states that quality of care is the provision of health care services that are based on the best available knowledge and practice in a manner that is safe and results in satisfied patients (members). Quality care is accessible, effective, safe, accountable and fair. The quality of care definition has been extended to include quality of service grievances as well.

Hennepin Health quality management staff evaluates all member appeals and grievances to determine if there are any components that may be a quality of care grievance. A quality of care grievance is investigated and, if necessary, corrective actions are taken in accordance with Hennepin Health's quality program.

Medical Utilization
The Hennepin Health appeal policy offers a mechanism for attending health care professionals to request an appeal for certain health plan decisions. This policy ensures that concerns are properly

investigated and responded to in a timely manner. All attending health care professionals shall follow the established appeal procedures when filing an appeal or expedited appeal.

Attending health care professionals providing care within the scope of the professional's practice and with primary responsibility for the care provided to a member. Attending health care professionals include physicians, chiropractors, dentists, mental health professionals (as defined in Minnesota Statute section 245.462, subdivision 18, or 235.4871, subdivision 27), podiatrists and advanced practice nurses.

Medical Utilization Appeal

A medical utilization review appeal is an appeal to review Hennepin Health's initial decision not to certify a health care service.

Hennepin Health a will accept appeals for medical utilization review decisions either orally/telephone or in writing. Hennepin Health may request that copies of part or all of the medical record and a written statement from the attending health care professional be submitted with the appeal. Hennepin Health will not take any punitive action against an attending health care provider who supports a member's appeal.

A Medical utilization appeal must be filed within 90 days of the action to be considered. Hennepin Health will send a written acknowledgement within 10 days of receiving the appeal and may combine it with Hennepin Health's notice of resolution if a decision is made within the 10 days. Hennepin Health shall notify the attending health care professional within 30 days of Hennepin Health's determination in writing.

If Hennepin Health cannot make a determination within 30 days due to circumstances outside Hennepin Health control, an additional 14 days may be used to notify the attending health care professional of its determination. Hennepin Health will inform the attending health care professional, in advance, of the extension and the reasons for the extension.

The documentation required by Hennepin Health to review an appeal may include copies of part or all of the medical record and a written statement from the attending health care professional.

Prior to upholding the initial determination not to certify for clinical reasons, Hennepin Health will conduct a review of the documentation by a physician of Hennepin Health's choice. This physician will be in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion, who is reasonably available to review the case and who did not make the initial determination not to certify. Hennepin Health will provide the following information to the attending health care professional when the decision is to not certify the requested services:

- A complete summary of the review findings
- Qualifications of the reviewers, including any license, certification or specialty designation
- The relationship between the member's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision

Expedited Medical Utilization Appeal

A medical utilization review expedited appeal is an urgent appeal pertaining to a life-threatening health condition of a member or to a health condition of a member that could be serious jeopardized without a quick response.

Expedited medical utilization appeal is used for cases in which an attending health care professional determines the appeal time-frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Hennepin Health will not take any punitive action against an attending health care provider who requests an expedited appeal resolution.

When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, Hennepin Health offers the member and the attending health care professional an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, Hennepin Health ensures reasonable access to its consulting physician or health care provider.

Hennepin Health will follow the procedures and notify the member and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the member's medical condition requires, but no later than 72 hours after receiving the request for medical utilization expedited attending health care professional appeal.

If the determination not to certify is not reversed through the expedited appeal, Hennepin Health will include in its oral and written notification the member's right to request a State Fair Hearing for resolution. A written copy of the State's Notice of Rights will be provided to the member and the attending health care professional with the written determination as soon as practical.

Section 11: Claims

Hennepin Health has programming and procedures in place for identifying payers who may be primary to Hennepin Health as far as payment obligations (coordination of benefits or COB). All possible attempts will be made to protect the plan's resources. Hennepin Health will make all efforts to keep to a minimum the impact of the COB process on the member, including timely processing of their claims.

There are several types of potential COB:

- Private health insurance
- Accident related (home or auto)
- Injury (tort)
- Medicare Part A, B, C and/or D or Medicare Advantage Plan

Coordination of Benefits

Medicare is a federally financed Health care program of hospital insurance (Part A) and supplemental medical insurance (Part B) for people age 65 and older, and people under the age of 65 with certain disabilities.

Medicaid is a joint federal and state Health care program that helps pay medical costs for individuals with limited income and resources. The State of Minnesota Department of Human Services (DHS) oversees this program known as Minnesota Health Care Programs (MCHP).
Medicare and Private Health insurance is always the primary payer to Hennepin Health Plan. Accident and injury insurance is always primary payer to Hennepin Health, specific to the injury claimed. Providers should always bill the primary insurance prior to billing Hennepin Health.

A provider or authorized staff should verify the member's medical coverage by asking to see the Hennepin Health member card. The group number listed on the member card designates the Hennepin Health member's coverage and benefit set.

Minnesota Health Care Program eligibility is based on monthly criteria. Therefore, it is important to verify the Hennepin Health member's eligibility at the beginning of each month:

- Hennepin Health-SNBC group numbers are 8280, 8290, 8380, and 8390
- Hennepin Health-PMAP group numbers are 9080, 9090, 9280, 9290, 9390, 9380, 9480, 9490, 9980, and 9990
- Hennepin Health-Minnesota Care group numbers are 7000, 7100, 7200, 7800, 7900

Coordination of benefits means**:**

- Sharing eligibility data with other payers
- Coordinate the payment process between insurance carriers to ensure claims are paid correctly by the primary payer (pays first)
- Transmission of paid claims to supplemental insurers for secondary payers' payment
- Ensuring that the amount paid by payers in dual coverage situations does not exceed 100% of the total claim
- Ensuring to avoid duplicate payments

The goal of coordination of benefits is:

- To identify available health benefits for the member
- To coordinate the payment process
- To prevent payment errors of health care benefits.

To speak with a Hennepin Health representative who can assist you with questions about benefits or claims, call Provider Services at 612-596-1036.

Provider Claims Appeal
All providers have the option to file a claims appeal, which is a second review of the claim adjustment and/or reconsideration request.

A claims appeal can only be filed after receiving a denial on a submitted claim adjustment/reconsideration request. An appeal filed prior to the denial of a claim adjustment/reconsideration request will be returned to the provider. All appeals must be filed within 90 days from the date of the claim adjustment/reconsideration request was denied.

To submit an appeal:

- Complete the Hennepin Health Provider Appeal Form (www.hennepinhealth.org) and include documentation relating to the reason for the appeal
- Submit the form and supporting documentation to Hennepin Health via fax or mail

Hennepin Health will review the appeal and make a determination within 60 days of the receipt.

General Billing Requirements

Providers are responsible to follow basic claims submission rules:

- Submit claims only after the Hennepin Health covered service has been provided
- Dates of service must reflect the date when the service was provided
- Bill only one calendar month of service per claim
- Bill the provider's usual and customary charge
- All claims require a valid diagnosis (ICD-10)
- As part of the 2011 Minnesota Legislative session, all claims for supplies or services that are based on an order or referral must include the ordering or referring provider's National Provider Identifier (NPI) (MN Statute section 256B.03, subd. 5). The ordering or referring provider must also be enrolled in MHCP. Claims submitted without this information will deny as "referring/ordering provider is not registered with MHCP."
- If attending, rendering, or referring providers are present in the claim transaction, the NPI or Unique Minnesota Provider Identifier (UMPI) must be present in order for Hennepin Health to pay the claim. If not present, the claim will be rejected back to the provider.

Prompt Payment and Timely Filing Requirements
A clean claim:

- Does not have defects or impropriety, including any lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim
- Includes appropriate and accurate provider and biller information both on the claim and on file at Hennepin Health
- Includes a valid standardized code set (ICD-10, CPT, HCPCS, revenue codes, etc)
- Includes diagnosis coding that is not discrepant with the service provided
- Includes valid authorization codes when required
- Is submitted without attachment(s)

Complex claims include:

- Replacement claims
- Medicare crossover claims
- Third-party liability claims
- Claims with information in notes or comment fields
- Claims with attachments
- Claims submitted with duplicate information to previously submitted claims

Complex claims will be paid or denied within 60 days.

Prompt Payment
If Hennepin Health does not pay a clean claim within the period provided in the policy, it will pay interest on the claim for the period beginning on the day after the required payment date. The rate of interest to be paid is 1.5 percent per month or any part of a month per Minnesota State Statute 62Q.75. Hennepin Health will itemize the interest payment from other payments being made for services provided on the provider "remittance advice" document (see example of a remittance advice below).

Hennepin Health is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices. Failure to provide

any of the information noted above on how to submit a claim may result in Hennepin Health considering the claim "complex" for processing, and it will not be eligible for interest payment due to delayed processing.

Timely Filing Requirement
Contracted providers must submit claims within 180 days from the date of service, or admit date for inpatient claims, unless otherwise specified in their contract. Non-contracted providers must submit claims within one year from the date of service, or admit date for inpatient claims, unless otherwise specified.

The only exception is when Hennepin Health is the secondary payer, the member's claim and primary payer's Explanation of Benefits (EOB) shall be submitted within 180 days of the primary payer's determination.

Duplicate Payment
Any claim submitted by a physician or provider for the same service provided to a particular individual on a specified date of service that was included in a previously submitted claim; this does not include corrected claims, will be denied for payment.

Standard Duplicate Rules
The transaction processing system is configured with standard duplicate claim rules. Based on the following criteria, the system generates warning messages that a possible or definite duplicate claims exists based on the following:

- Claim is submitted with overlapping dates
- The exact charge amount was submitted on a previous claim
- The type of service matches on a previous claim
- The revenue code matches on previous claims
- The same provider submits a claims with some or all of the above criteria

Transaction processing system is configured with Definite Duplicate Claim rules if all of the following match a previous claim:

- Exact date of service
- Exact charge amount
- Exact type of service
- Exact place of service
- Exact procedure code
- Exact Provider Identifier

Duplicate claims review and recovery:

- All duplicate submissions will be reviewed
- All duplicate payments will be recovered and claims reconciled as they are identified

Duplicate claims training and monitoring:

- Claim examiner will be trained annually to identify duplicate claim submissions

- Random claim audits will be performed annually to identify possible duplicate payments

Interest Payment
Hennepin Health must pay or deny clean claims within 30 days after the date of receipt. Hennepin Health has 30 calendar days from receipt of a clean claim to process the claim and make a determination of payment or denial. If Hennepin Health does not pay a clean claim within the period provided in the policy; it must pay interest on the claim beginning on the day after the required payment date. Hennepin Health must itemize the interest payment from other payments being made for services.

Hennepin Health Claims Department continually monitors claims payment for compliance on interest payments.

Claims payment and electronic remittance advice (ERA)

Claims payment
Automated Clearinghouse (ACH) funds transfer
- Claim payments are made on a weekly basis.
- Automated Clearinghouse (ACH) payments with accompanying electronic remittance advice documents shall be the preferred payment methodology, unless otherwise specified.
- If you do not choose to receive ACH payments you will receive a Hennepin County physical check, (Hennepin Health is a Department within Hennepin County) along with the accompanying electronic remittance advice.
- If the address on the check and/or the remittance does not match, is incorrect, or needs to be updated, immediately contact Hennepin Health Member Services at 1-800-647-0550.

You must sign up to receive ACH payments by completing a Hennepin County ACH funds transfer request form (DOC).

Electronic Remittance Advice (ERA)
Minnesota State Statutes requires all health care transactions to be conducted electronically. These transactions include electronically transmitting provider's remittance advice.
Effective January 1, 2011, Hennepin Health discontinued distributing paper copies of the remittance advice. Providers are required to contact one of the Hennepin Health contracted Electronic Remittance Advice Clearinghouses to set-up systems in order to begin receiving electronic remittance advices.

Hennepin Health requires the following information to set-up your electronic remittance advice:
- Name of your Electronic Clearinghouse
- The agency’s NPI or UMPI number, and TIN number
- An agency contact person & phone number

The current Hennepin Health contracted clearinghouses for electronic remittance advice are:

Availity
http://www.availity.com
800-282-4548

ClaimLynx
http://www.claimlynx.com
952-593-LYNX (5969)

Change Healthcare
http://www.emdeon.com/support/support.php
877-271-0054

Infotech Global, Inc. (IGI)
aka MN E-Connect
http://www.mneconnect.com
877-444-7194

RelayHealth
http://www.relayhealth.com
800-778-6711

Electronic data interchange (EDI)
In accordance with Minnesota State Statue, 62J.536, Hennepin Health requires the receipt of electronic institutional (837I) and professional claims (837P).

Providers are required to adhere to State of Minnesota Uniform Companion guide requirements and the Administrative Uniformity Committee (AUC) Best Practices for claims submission. These documents are available on the AUC website. Hennepin Health requires all claims to be submitted via an electronic institutional (837I) and professional (837P) EDI compliant transactions with no exceptions.

Additional information
If you are unable to send electronic institutional and professional claims and/or electronic replacement/cancel claims, Hennepin Health, along with several other large Minnesota group purchasers, have secured the services of Infotech Global, Inc. (IGI) to provide free Web-based services for provider data entry of AUC compliant claims.

Availity is ***not*** a direct submitter of 837 (claims) transactions to Hennepin Health. Providers using Availity as their claims submission clearinghouse can contact Availity directly if you would like to know how these are routed to Hennepin Health.

Electronic Data Interchange (EDI) numbers
Hennepin Health has contracted with several EDI clearinghouses that specialize in claim data exchange (eligibility, professional and institutional claims, and remittance advice):

Clearinghouse Name	837p	837i	835	Eligibility
Availity www.availity.com 800-282-4548			x	
ClaimLynx www.claimlynx.com 952-593-5969	x	x	x	
Change Healthcarewww.emdeon.com 877-271-0054	x	x	x	

Infotech Global, Inc. (IGI) aka MN E-Connect www.mneconnect.com 877-444-7194	x	x	x	
Office Ally www.officealley.com 866-575-4120	x	x	x	
RelayHealth **http://www.relayhealth.com** **800-778-6711**	x	x	x	

Electronic attachments

For claims requiring attachments, Hennepin Health follows best practices set forth by the AUC:

- Create a unique attachment control number containing 50 characters or less
- Enter the number either in segment PWK02 in Loop 2300 of the 837 or in the appropriate field if entering via a direct data entry method such as MN–ITS Interactive or Orbit
- Download and complete the uniform cover sheet (be sure to fill out the patient's information exactly as you did on the claim); complete the property and casualty (P&C) claim number field only if the services are related to a P&C claim
- Fax the attachments to 612-321-3781 using this cover sheet (send a separate uniform cover sheet and attachment control number with each attachment to ensure a proper match to the submitted claim)

Ambulatory surgery center facility billing requirements

Ambulatory surgery center facility claim submission requirements

Free standing ASC

- The appropriate bill form is electronic claim submission 837P.
- The appropriate place of service code is 24.
- Item 32 or electronic equivalent must be completed properly.
- Item 32a or electronic equivalent enter National Provider Identification Number (NPI).
- Do not populate the operating physician's NPI or Medicare provider number in item 24J or electronic equivalent.
- ASC providers are not required to submit an operative report by fax or by mail when multiple surgery procedures are done within the same operative session. Providers should keep the operative report on file and have it available upon request.
-

Additional tips

- The billed procedure must be on the approved ASC facility fee list.
- On or after January 1, 2008, the procedure code will not require the SG modifier.
- On or after January 1, 2008, the 50 modifier is not valid when billing for bilateral procedures performed within an ASC setting.
- The TC modifier must be submitted when billing diagnostic procedures (when applicable) to indicate the technical component was performed.
- Effective January 1, 2009, the ordering/referring physician must be reported on claims for diagnostic services.
- Professional charges should never be billed on facility bill.

PCA claim submission requirements
PCA agencies are required to enroll individual PCAs with the Minnesota Department of Human Services (DHS) to obtain an UMPI (unique Minnesota provider identifier) and affiliate the individual PCA with their agency pay to provider ID.

The PCA agency is required to bill the individual's PCA UMPI on the claim to report the PCA as the person who provided the services to the Hennepin Health members. Providers are to bill only one PCA per claim, but they are allowed to bill more than one claim per month. Claims billed with multiple PCA's or multiple months will be returned to the agency. Date spans are not valid for this type of service. Claims submitted with a PCA who is not affiliated with pay to provider ID of the home Health agency will be denied, "PCA not affiliated with Hennepin Health agency."

Nursing home facility claim submission
Hennepin Health requires all nursing home facility claims to be submitted with an associated Prepaid Medical Assistance Program (PMAP) form. The nursing home facility PMAP nursing form shall be completed in its entirety:

- Name and number
- Dates of service
- Reason code
- Reason code for bed hold days
- Case mix rate
- Qualified Medicare stay
- Medicare days to be paid since initial admission
- Total days since initial admission
- Remaining number of days liable to Health plan

The claim information submitted shall match the information on the PMAP form. Claims submitted without the required information on the associated PMAP form will be denied.

Out-of-network claim submission requirements

Claim submission requirements for non-contracted providers practicing within the State of Minnesota
Hennepin Health members can receive services from out-of-network providers in specific instances. Contact Hennepin Health Provider Services at 1-800-647-0550 to inquire if the services you provide to a Hennepin Health member may be covered without a contract.

Provider information requirements
Hennepin Health requires specific provider information prior to process an out-of-network provider's claim. This information must be in Hennepin Health Claim Processing System to submit a claim.

- Completion of the non-contracted provider information form (PIF)
- A current W-9 form or a substitute W-9 form
- Completed PIF and W-9 form are to be faxed to 612-632-8830.

Forms are available on the Hennepin Health website: www.HennepinHealth.org, under Provider Resource Section/Forms

Remember to indicate your electronic clearinghouse for claim submission and receipt of a remittance advice on the PIF.

Claim submission requirements

- Claims shall be submitted on the appropriate form for type of service provided.
- Claims shall be submitted electronically.
- Claims shall be submitted timely within one year from the date of service.
- Bill only one month of services per claim when billing multiple dates of service.

Out-of-area claim submission requirements

Hennepin Health members can receive services from out-of-area providers in specific instances. Contact Hennepin Health Provider Services at 1-800-647-0550 to inquire if services you provide to a Hennepin Health member may be covered without a contract.

Provider information requirements

Hennepin Health requires specific provider information prior to processing an out-of-the-state provider's claim.

- Completion of a Hennepin Health Provider Information Form (PIF)
- A current W-9 form or a substitute W-9 form
- Completed PIF and W-9 form are to be faxed to 612-632-8830.
- Forms available on Hennepin Health website: www.HennepinHealth.org, under Provider Resource Section/Forms

Claim submission requirements

Out-of-Area providers practicing outside the State of Minnesota are require to submit claims electronically; Refer to Information on electronic claim submissions in this manual for instruction. Further assistance is available by calling: Hennepin Health Provider Services at 1-800-647-0550.

Health Care Home (HCH) claims submissions

- Current contract with Hennepin Health to participate in its' products and networks
- Meet all certification criteria as required by the State of Minnesota
- Meet all applicable documentation requirements as required by the State of Minnesota
- Have a standardized method of determining whether the complexity of an individual's medical condition(s) makes them eligible to participate in a HCH
- Inform the member about participation in a HCH
- Document in the members medical record their acceptance to participate in a HCH, and the agreed upon start date for participation to begin
- Establish the member's complexity tier and willingness to participate in care coordination
- Reevaluate the member's complexity tier annually, or more often if warranted by a change in the patient's medical condition(s)
- Provide Hennepin Health on a monthly basis a roster of all members who have agreed to participate in an HCH, along with the start date for participation
- Provide Hennepin Health on a monthly basis a roster of all members who have terminated their participation in an HCH, along with the termination date for participation
- Submit clean claims electronically, following all required claim submission criteria, billing on the 837P format, utilizing the HCPC codes and applicable modifier as outlined below
- Recipients must have an E/M visit with the care coordination provider within the last 12 months from the care coordination procedure code date of service to be eligible for reimbursement. The appropriate E/M procedure code can occur on a different date of service and be billed separately from the care coordination.

Coding

HCPCS	Description	Billable units	Billing criteria
S0280	Medical home program, comprehensive care coordination and planning, initial plan	1	Allowed once per twelve month period. Services exceeding these criteria will be denied using M90 remark code, which will state "Benefit Maximum for this time period or occurrence has been reached."
S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan	1 unit per month	Allowed to be billed once per month, per member. Services exceeding these criteria will be denied using M86 remark code which will state "Service denied because payment already made for a same/similar procedure within set time frame."

Modifiers

When appropriate, modifiers that designate the complexity tier and special circumstances attributed to an individual must also be appended to the HCPCs codes. If both the complexity level and special circumstances are relevant to an individual, all applicable modifiers must be appended to the HCPCs code.

Tier	Complexity level and special circumstances	Modifier
1	Basis	U1
2	Intermediate	TF
3	Extended	U2
4	Complex	TG
5	Primary language non-English	U3
6	Active mental Health condition	U4

Payment qualifiers

Hennepin Health will administer payment for HCM services as outlined below:

- The member is enrolled and eligible for coverage through Hennepin Health.
- The product the member participates in includes benefits for HCH services.
- The provider of service is a contracted provider with Hennepin Health, and meets all certification criteria as required by the state of Minnesota.
- The claim submitted meets the definition of a clean claim.
- Hennepin Health will not contract separately for HCM services. Instead, certified providers contracted with Hennepin Health will receive payment at your then-current contracted rate of reimbursement.
- Members may actively participate in more than one HCH, but as required Hennepin Health will pay for a single HCH service per member, per month. Given that it is not feasible for Hennepin Health to identify which HCH is the real HCH, Hennepin Health will pay the first claim that is received each month. Additional claims will be not be paid.
- S0280 (Medical home program, comprehensive care coordination and planning, initial plan) will be allowed once per provider contract. When this code is billed more than once per twelve months by a provider for a member, the claim will be denied with M90 remark code.
- S0281 (Medical home program, comprehensive care coordination and planning, maintenance of plan) will be allowed once per member, per month for subsequent months. When this code is billed more than once per month, it will be denied with M86 remark code.

Case management coding guidelines

SNBC case management coding guidelines
Hennepin Health-SNBC providers submit claims with the coding listed in the grid below: If a diagnosis is not determined on date of service, please submit R69 on the claim.

The Supervising clinician is billed as treatment provider.

Service	Code	Amount	Billing frequency
Health risk assessment	S0250	$0.01	Unlimited
Care guide care coordination telephonic encounters	G9004	$0.01	Unlimited
Care guide care coordination face-face encounters	G9003	$0.01	Unlimited
Mental Health targeted case management	T2023	Negotiated rated	1x monthly
Per member per month charge	G9002	Negotiated rate	1x monthly

Section 12: Provider rights and responsibilities

Provider rights

- Contracted providers have the right to offer input in the development of Hennepin Health medical policy, quality assurance programs and medical management procedures.
- Contracted providers have the right to receive written notice 60 days before Hennepin Health terminates its contract with that provider, if termination is not for cause.
- Providers have the right to not be discriminated against when considered for Hennepin Health network participation.
- Providers have the right to written notification of Hennepin Health's decision to deny, suspend or terminate the providers' participation in its contracted network.

General responsibilities
As providers, you are expected to verify member eligibility and coverage.

- Hennepin Health member eligibility information is available through McKesson Payer Connectivity Services™ (PCS). To access the PCS portal, you or your organization must be registered with PCS. To register, contact PCS Support Services at 877-411-7271 or PCSupport@mckesson.com. Provide services consistent with professional standards of care.
- Inform members of follow-up health care and offer training in self-care or other measures to promote their own health.
- Obtain a thorough patient history to avoid duplication of services.
- Help arrange or coordinate other covered services (X-rays, laboratory tests, therapies, DME, etc.); Contact HH Customer Service at 612-596-1036 for more information.
- Provide care in collaboration with members or authorized representatives.
- Notify Hennepin Health of members whose care will be transitioned to another provider due to the member's refusal to follow the clinic and health plan guidelines; to notify Hennepin Health of this decision, providers shall call Hennepin Health Customer Service at 612-596-1036.
- Notify Hennepin Health of complex discharge plans; call Hennepin Health Customer Service at 612-596-1036 and ask to speak to a medical services coordinator.
- Notify Hennepin Health when care coordination is required; call Hennepin Health Customer Service and ask to speak to a disease management case manager for asthma, diabetes, or chronic obstructive pulmonary disease (COPD).

- Providers must be licensed by the state to provide services to any plan members.
- Provide health care to members in a culturally competent manner.
- Document prominently an advance directive (living will, health care power of attorney) in members' medical records.
- Comply with the U.S. Civil Rights Act, Americans with Disabilities Act, Rehabilitation Act of 1973, Age Discrimination Act and applicable federal and state funds laws

*See specific chapters for additional provider responsibilities based on service provided.

Advance directives

The Patient Self-Determination Act (PSDA) is a federal law passed by Congress in 1990 which requires providers to inform all adult patients about their rights to accept or refuse medical or surgical treatment and the right to execute an "advance directive." An "advance directive" is a written instruction such as a living will or durable power of attorney for health care recognized under state law relating to the provision of health care when the individual is incapacitated.

PSDA provider requirements

- Give written information to all adults receiving services of their rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and to formulate advance directives.
- Provide the written information to an individual upon each admission to a medical facility and each time an individual comes under the care of a home health agency, personal care provider, or hospice.
- Maintain written policies and procedures concerning advance directives for all adults receiving care or services and inform the individual, in writing, of these policies. The policies must include a clear and precise explanation of any objection a provider or provider's agent may have, on the basis of conscience, to honoring an individual's advance directive.
- Document in the patient's medical record whether or not an individual has executed an advance directive.
- Inform individuals that they may file a complaint with the department concerning a provider's non-compliance with advance directive requirements.
- Not discriminate against an individual based on whether he or she has executed an advance directive.
- Ensure compliance with requirements of state law regarding advance directives.
- Provide staff and community education on advance directives. This education must minimally include what an advance directive is, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives.

Provider accessibility and availability

Definitions

- Emergency: Medically necessary care which is necessary to preserve life, prevent serious impairment to bodily functions, organs or parts or prevent placing the physical or mental health of the member in serious jeopardy.
- Urgent: Acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of a member.
- Routine, non-urgent: Medical services that are not urgent in nature, i.e., preventative services, well-visits.

Physician appointment guidelines require access 24 hours per day, seven days a week. Hennepin Health monitors access and wait times for scheduling appointments with its contracted primary care, outpatient mental health, and outpatient specialty physicians to determine adherence to these appointment guidelines.

Appointment guidelines

- Emergency - immediate access if on-site or call 911.
- Urgent or acute - same day access or within 24 hours.
- Non-urgent or non-acute - within 1 week.
- Routine: physicals or health maintenance exams - 3 to 4 weeks

Appointment access survey

- Hennepin Health calls providers to survey appointment availability for both urgent and routine visits. Hennepin Health primary care, outpatient specialty care physician clinics and outpatient mental health clinics will be surveyed on a quarterly basis.
- Access survey results are shared with Hennepin Health's contracting, medical administration, and quality management departments who address provider corrective action needs, to communicate these needs to providers, and to document follow-up corrective action.

Provider termination - continuity of care

Hennepin Health will provide a mechanism to ensure that an adequate provider network is available to s and to ensure that that continuity of care for s is not compromised.

Termination for cause: If the contract termination was for cause, Hennepin Health will notify all members being treated by that provider and/or practitioner with the change and transfer members to participating providers and/or practitioner in a timely manner so that health care services remain available and accessible to the affected .

Termination not for cause: If the contract termination was not for cause and the contract was terminated by Hennepin Health, Hennepin Health will provide the terminated provider and all members being treated by that provider with notification of the s' rights for continuity of care with the terminated provider.

Notification

Hennepin Health will review provider/patient history within six months or remaining current calendar year to identify affected members and will inform affected members regarding the provider termination (for cause) at least 30 days prior to the termination effective date or as soon as possible.

Hennepin Health will review provider/patient history within six months or remaining current calendar year to identify affected members and will inform affected s via letter regarding the provider termination (not for cause) at least 30 days prior to the termination effective date or as soon as possible.

The member will receive instructions on the procedures by which members will be transferred to another provider and/or practitioner. Under "not for cause" terminations, members with special medical needs, special risks, or other special circumstances that require the member to have a longer transition period will be notified of the change; however, the member will have the option to continue services with the provider/practitioner based on Hennepin Health's open access for specialty care.

Authorization for continued specialty care
Service authorizations are not needed for accessing specialty physician care from any Minnesota licensed provider or Hennepin Health contracted provider in good standing. Should services fall outside of this situation, Hennepin Health's medical administration team will provide authorization to receive covered services through the member's current provider for the following conditions, provided the provider/practitioner remains in good standing:

- For up to 120 days if the member is engaged in a current course of treatment for one or more of the following conditions:
    - (i) an acute condition;
    - (ii) a life-threatening mental or physical illness;
    - (iii) pregnancy beyond the first trimester of pregnancy;
    - (iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one year, or can be expected to result in death; or
    - (v) a disabling or chronic condition that is in an acute phase; OR
- For the rest of the member's life if a physician certifies that the member has an expected lifetime of 180 days or less.
- Is receiving culturally appropriate services and Hennepin Health does not have a provider in its provider network with special expertise in the delivery of those culturally appropriate services within the time and distance requirements of Minnesota Statutes section 62D.124, subdivision 1.
- Does not speak English and Hennepin Health does not have a provider in its provider network who can communicate with the member, either directly or through an interpreter.

Transportation

- For new health plan members, Hennepin Health will honor prior public transportation exemptions and/or STS certifications for a period of one year from the initial member's enrollment effective date with Hennepin Health. The members will need to provide a copy of the certification and/or exemption forms prior to scheduling any rides.
- New health plans members with established transportation services at the time of initial enrollment and receiving such services through non-contracted providers will be allowed to continue receiving services from the non-contracted provider for 30 days. After 30 days, Hennepin Health will transition transportation services to a contracted transportation provider.
- The need for continuing utilizing a non contracted provider for a period longer than 30 days will need to be brought to the attention of Hennepin Health at a minimum of 14 days prior to the expiration of the initial 30 days grace period.
- A prior service authorization is required for non-contracted providers before services are rendered.

Limitations
This policy only applies if the member's health care provider agrees to:

- Accept as payment in full the lesser of Hennepin Health's reimbursement rate for in-network providers for the same or similar service or the 's health care provider's regular fee for that service;
- Adhere to Hennepin Health's service authorization requirements;
- Maintains Medicaid billing privileges; and
- Provide Hennepin Health with all necessary medical information related to the care provided to the member.

Nothing in this policy requires HH to provide coverage for a health care service or treatment that is not covered under the member's health plan.

State and federal agency notification
Hennepin Health shall send written notification of contract termination to the provider. This shall be in accordance with contract terms, standard business practices and time frames.
In the case of "for cause" primary care clinics, notification of provider and practitioner terminations shall be made to the following agencies:

- Minnesota Department of Human Services (DHS), for state public program contracts
- Minnesota Department of Health, for all contracts

Provider network - continuity of care
HH will guarantee an adequate provider network is available to members so their continuity of care is not compromised.

Continuity of care is available to newly enrolled members.

Provider non-interference
Hennepin Health members, especially those with a lack of understanding of the U.S. healthcare system, those with poor English skills and those with low literacy, are often unable to effectively communicate their needs and advocate for themselves. Hennepin Health allows and encourages providers to advise and advocate for their Hennepin Health patients.

Health care providers are well positioned to assist these s to obtain the services that they need. Hennepin Health shall not prohibit providers from doing any of the following:

- Giving s information about medical care, their health status, and treatment options (including those that may be self-administered) so that a member is fully informed of all options, benefits and risks.
- Explaining the benefits, risks and consequences of treatment or no treatment.
- Allowing members the opportunity to refuse treatment or express preferences about future treatment decisions.

Section 13: Credentialing

Continued participation by these providers is dependent upon the provider meeting routine monitoring and recredentialing requirements at least every three years.

Providers subject to credentialing include:

Medical practitioners

- Medical doctors.
- Oral surgeons.
- Chiropractors.
- Dentists.
- Doctors of osteopathy.
- Doctors of podiatric medicine.
- Doctors of optometry.
- Acupuncturists.
- Nurse practitioners.
- Clinical nurse specialists.
- Physician assistants.
- Certified nurse midwives.

- Certified traditional midwives.
- Other medical practitioners.

Behavioral healthcare practitioners

- Psychiatrists and other physicians.
- Addiction medicine specialists.
- Doctoral or master's-level psychologists.
- Master's-level clinical social workers.
- Master's-level clinical nurse specialists or psychiatric nurse practitioners.
- Licensed marriage and family practitioners.
- Mental health rehabilitative professionals (ARMHS only)*
- License psychological practitioners (LPP).
- Psychotherapists.
- Substance abuse counselors
- Other behavioral healthcare specialists.

Additional types of practitioners

- Pharmacists (PharmD and RPh) performing face to face medication therapy management
- Physical therapists[1]
- Occupational therapists[1]
- Speech language pathologists[1]
- Audiologists[1]

1. Mental health practitioners must work under the clinical supervision of a mental health professional.
2. A mental health professional must hold a current and valid national certification as a certified rehabilitation counselor or certified psychosocial rehabilitation practitioner.

Credentialing by Hennepin Health is not required for those providers under contract with a hospital and who practices exclusively within the inpatient hospital setting. Examples include pathologists, anesthesiologists, hospitalists, and emergency room physicians. All hospitals, home health agencies, skilled nursing facilities, nursing homes, free standing ambulatory surgical centers, ("organizational providers") inpatient, residential and ambulatory mental health or substance abuse services are subject to organizational provider credentialing.

Medical record review

A significant role of quality improvement and credentialing is to monitor the quality, safety, and accessibility of patient care in the practitioner office. Medical record standards are established to promote efficient and effective treatment by facilitating communication, coordination and continuity of care.

Hennepin Health has a process to ensure that practitioners meet its medical record and office site standards. Clinical settings using a nationally recognized electronic health record (e.g. Epic) are deemed to meet Hennepin Health requirements for medical records.

Credentialing practitioners

HH has a process to credential practitioners to assure that these providers meet HH's standard for participation.

The criteria include state licensure, accreditations, absence of outstanding state or federal sanctions, and an absence of current Hennepin Health concerns. Verification of this information ensures that decisions are based on the most accurate, current information available to Hennepin Health.

Practitioners who need to be credentialed

- Practitioners who have an independent relationship with the organization
- Anesthesiologists independent with pain-management practice
- Clinicians who are hospital based and who also have private practices
- Practitioners who see s outside the inpatient hospital setting or in outside free-standing, ambulatory facilities
- Practitioners who are hospital based, but who see Hennepin Health members as a result of their independent relationship with Hennepin Health
- Dentists who provide care under the organization's medical benefits
- Endodontists
- Oral surgeons
- Periodontists
- Non-physician practitioners who have an independent relationship with the organization, and who provide care under the organization's medical benefits

Types of practitioner files reviewed

- Medical doctors (MD)
- Dentists (DDS/DMD)
- Chiropractors (DC)
- Nurse midwives
- Nurse practitioners
- Optometrists
- Osteopaths (DO)
- Physician assistants
- Podiatrists (DPM)
- Speech and language pathologists

Behavioral health practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists who are sate certified or licensed
- Master's-level clinical social workers who are state certified or licensed
- Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- Other behavioral healthcare specialists, who are licensed, certified or registered by the state to practice independently

Adult Rehabilitative Mental Health Services (ARMHS)

This is unique to Minnesota

- Licensed psychologists
- Licensed psychological practitioner (LPP)
- Licensed marriage and family practitioners
- Mental Health Rehabilitative Professionals (ARMHS only)

Providers who do not need to be credentialed

Practitioners who practice exclusively within the inpatient setting and who provide care for organization s only as a result of members being directed to the hospital or another inpatient setting.

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency room physicians
- Hospitalists
- Occupational therapists
- Physical therapists
- Telemedicine consultants
- Local tenens

Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of s being directed to the facility.

- Mammography centers
- Urgent-care centers
- Contracted surgicenters
- Ambulatory behavioral healthcare facilities (e.g., psychiatric and addiction disorder clinics)
- Dentists who provide primary dental care only under a dental plan or rider
- Pharmacists who work for a pharmacy benefits management (PBM) organization to which the organization delegates utilization management (UM) functions
- Covering practitioners (e.g. locum tenens)
- Practitioners who do not provide care for s in a treatment setting (e.g., board-certified consultants)

Delegated entities

To ensure that delegated entities have the capacity to deliver and maintain standard performance for those activities that would normally be performed by Hennepin Health. It is expected that all delegated activities will be performed at the minimally accepted levels as required by Hennepin Health and in accordance with standards set forth by the Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA) and other state or federal regulatory bodies.

Organizational credentialing

Hennepin Health has a process to credential contracted facilities including hospitals, home health agencies, skilled nursing facilities, nursing homes, free standing ambulatory surgical centers, and behavioral health and chemical health provider organizations.

Hennepin Health has a process to credential contracted facilities at the time of contracting (initial credentialing) and at least every three years (36 months) to assure that these organizational providers meet HH's standards for participation.

Types of organizations to be credentialed and re-credentialed

- Hospitals
- Home health agencies (no PCA services)
- Ambulatory surgical center (free-standing only)
- Nursing homes/skilled nursing facilities
- Outpatient mental health or chemical dependency center
- Inpatient mental health or chemical dependency center
- Residential treatment center for mental health or chemical dependency

Hennepin Health will conduct assessments of facilities including hospitals, home health agencies, skilled nursing facilities, nursing homes, contracted free-standing surgical centers, contracted behavioral health and chemical provider organizations, regardless of the number of members treated at the facilities. HH is not required to credential organizational providers that operate only as a 12-step program.

Behavioral health care providers include the following contracted entities:

- Psychiatric hospitals and clinics
- Addiction disorder facilities
- Residential treatment centers for psychiatric and addiction disorder. (NCAA CR11C)

Hennepin Health requires that all providers remain in compliance with the following criteria, (MN Rules, part 4685.1110, subpart 11)

- Confirmation provider is in good standing with state and federal regulatory bodies
- Verification of licensure, accreditation, and current liability insurance
- Documentation that provider complaints are taken in to consideration
- Conducts an on-site quality assessment if the provider is not accredited
- Documentation of the previous credentialing committee date to determine the re-credentialing time line

Section 14: Fraud and Abuse

Anti-fraud policy

Hennepin Health supports and maintains provisions for the prevention, detection, and correction of waste, fraud, abuse, and improper payments related to all benefits of our plans. Hennepin Health is committed to work collaboratively with the Centers for Medicare & Medicaid Services (CMS), Minnesota Department of Human Services (DHS) and other appropriate regulating bodies to comply with all applicable federal and state standards related to fraud and abuse.

Definitions

- Abuse: a pattern of practice inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to Hennepin Health or in reimbursement for services not medically necessary, or that fail to meet the professionally recognized standards for health services.
- Fraud: acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes.
- Claim: for purposes of the False Claims Act (FCA), a claim includes any request or demand for money that is submitted to the U.S. government or its contractors, such as an HMO contracting with CMS to provide Medicare or Medicaid benefits.

Healthcare fraud

As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended to include a prohibition against committing any scheme to defraud health care program or making any false or fraudulent representations. It is a crime to knowingly and willfully execute, or attempt to execute a scheme or artifice to defraud any healthcare benefit program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any health care benefit program. The healthcare fraud offenses created by HIPPA are found at 18 USC §1347. Penalties include a fine and imprisonment up to 10 years.

Legal requirements

Hennepin Health will follow all federal and state laws regarding the detection, correction and prevention of fraud, waste and abuse. Hennepin Health:

- Has developed and follows a compliance plan
- Has developed and follows a fraud, waste and abuse plan
- Reports annually to the Minnesota Department of Human Services
- Refers suspected fraud, waste and abuse to appropriate state and federal agencies

Health service records

Health services records are any electronically stored data and written documentation of the nature, extent and medical necessity of a health service provided to a Hennepin Health member by a provider and billed to Hennepin Health.

Health services records must be developed and maintained as a condition of contracting with Hennepin Health. Each occurrence of a health service must be completely, promptly, accurately and legibly documented in the member's health record. Hennepin Health funds that are paid for services not documented in the health record are subject to monetary recovery.

Health records must contain the following information when applicable. Any additional requirements for a particular provider are contained in the provider contract.

- The member's name must be on each page of the member's record.
- Each entry in the health services record must contain:
    - The date on which the entry is made
    - The date or dates on which the health service is provided
    - The length of time spent with the member, if the amount paid for the service depends on time spent
    - The signature and title of the person from whom the member received the service
    - Reportage of the member's progress or response to treatment, and changes in the treatment or diagnosis
    - When applicable, the countersignature of the vendor or the supervisor, and
    - Documentation of supervision of the supervisor
- The record also must state:
    - The member's case history and health condition as determined by the provider's examination or assessment
    - The results of all diagnostic tests and examinations, and
    - The diagnosis resulting from the examination.
- In addition, the record must contain reports of consultations that are ordered for the member, as well as the member's plan of care, individual treatment plan, or individual program plan.
- The record of laboratory or X-ray service must document the provider's order for services.
- Upon discharge, the record must contain a discharge summary--including the status relative to goal achievement, prognosis and further treatment conditions.

Protection of health services record information

For any medical records or other health care and enrollment information maintained with respect to members, the provider must establish procedures to do the following:

- Abide by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The provider must safeguard the privacy of any information that identifies a particular and implement procedures that specify:
    - For what purpose the information will be used within the organization; and
    - To whom and for what purposes it will disclose the information outside the organization
- Ensure that medical information is released only in accordance with applicable federal or state law or pursuant to court orders or subpoenas.

- Maintain medical records and information in an accurate and timely manner.
- Ensure timely access by members to the records and information that pertain to them.
- Obtain a member's written consent before releasing information not required to be released by law.

Record-keeping requirement
Financial records, including written and electronically stored data, of a provider who receives payment for member services must contain:

- Payroll ledgers, canceled checks, bank deposit slips and any other accounting records prepared by or for the provider
- Contracts for services or supplies relating to the provider's costs and billings to Hennepin Health for members' health services
- Evidence of the provider's charges to Hennepin Health members consistent with the Minnesota Government Data Practices Act
- Evidence of claims for reimbursement, payments, settlements or denials resulting from claims submitted by program, for example Hennepin Health and other third-party payers as well as Medicare and Medicaid
- The provider's appointment books for patient appointments and the provider's schedules for patient supervision, if applicable
- Billing transmittal forms
- Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider's organization or practice, as defined in the Code of Federal Regulations, title 42, part 455, sections 101 and 102
- Employee records for those persons currently, or within the previous five years, employed by the provider, which, under Minnesota Government Data Practices Act would be consider public data for public employee, e.g., employee name, salary, qualifications, position description, job title and dates of employment. Employee records also should include the current home address of the employee or the last known address of any former employee.

Access to records
Hennepin Health has the right to access to records pursuant to the provider contract and the member's consent signed in accordance with Minnesota Rule 9505.2185. Hennepin Health will give the provider no less than 24 hours before obtaining access to a health service or financial record, unless the provider waives notice.

During the term of the contract with Hennepin Health and for 10 years following termination, the provider shall give Hennepin Health and its authorized agents access to all information and records related to the health services provided according to the contract--to the extent permitted by law and without further authorization by any member.

The provider shall submit copies of the records requested by Hennepin Health within a reasonable amount of time from the date of such request, or sooner if necessary to comply with laws related to the resolution of member complaints or to cooperate with an investigation by Hennepin Health. If the provider fails to comply, Hennepin Health has the right to withhold reimbursement for health services until the provider fully complies and Hennepin Health and/or its authorized agents have reviewed the information and records.

Retention of records

A provider shall retain all health service and financial records related to the health services for which payment was received or billed for at least eleven years after the initial date of billing. Microfilm records satisfy the recordkeeping requirements in the fourth and fifth years after the date of billing.

A provider who no longer contracts with Hennepin Health must retain or make available to Hennepin Health on demand the health services and financial records as required in Minnesota Rules 9505.2190.

If ownership of the provider changes, the transfer or, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to Hennepin Health on demand the health services and financial records related to services generated before the date of the transfer as required under Minnesota Rule 9505.2185.

Record copying
Hennepin Health, at its own expense, may photocopy or otherwise duplicate any health service or financial record related to a health service for which a claim or payment was made by Hennepin Health. Photocopying shall be done on the provider's premise unless removal is specifically permitted by the provider. If a vendor fails to allow Hennepin Health to use the provider's equipment to photocopy or duplicate any health service or financial record on the premises, the provider must furnish copies at the provider's expense within two weeks of the request for copies by Hennepin Health.

Reporting fraud or abuse

Fraud
Fraud is understood to be acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes. Acts which can be defined are fraud are:

- Theft, perjury, forgery and aggravated forgery, Medical Assistance fraud, or financial transaction card fraud
- Making a false statement, claim, or representation to a program where the individual knows or should reasonably know the statement, claim, or representation is false
- Receiving remuneration in return for the provision of health care services in violation of the federal Stark Law or the Anti-kickback Statute

Abuse
Abuse is understood to be a pattern of practice inconsistent with sound fiscal, business, or health service practices, and that result in unnecessary costs to Hennepin Health or in reimbursement for services not medically necessary, or that fail to meet the professionally recognized standards for health services.

- Submitting repeated claims:
    - With missing or incorrect information
    - Using procedure codes that overstate the level or amount of health service provided
    - For health services that are not reimbursable by Hennepin Health
    - For the same health service provided to the same member
    - For health services that do not comply with the requirements defining covered services per Minnesota Rules 9505.0210, or
    - For services not medically necessary
- Failure to develop and maintain health services records
- Failure to use generally accepted accounting principles or other accounting methods that relate entries on a member's health record to corresponding entries on the billing invoice--unless another accounting method or principle is required by federal or state law or rule

- Failure to disclose or make available to Hennepin Health a member's health service records or vendor's financial records
- Repeatedly failing to report duplicate payments from third-party payers for covered services provided to members and billed to Hennepin Health
- Failure to keep financial records
- Repeatedly submitting or causing repeated submission of false information for the purpose of obtaining (prior) authorization, inpatient hospital admission certification, or a second medical opinion
- Knowingly and willfully submitting a false or fraudulent application for provider status
- Soliciting, charging, or receiving payments from Hennepin Health members, in violation of provider agreement with Hennepin Health
- Payment of program funds to a second provider whom the primary provider knows has been suspended or barred from participating in federal health care programs
- Repeatedly billing Hennepin Health for health services after entering into an agreement with third-party payer to accept an amount in full satisfaction of the payer's liability
- Repeatedly failing to comply with the requirements of the contract entered into with Hennepin Health

Reporting fraud and abuse

To report suspected fraud or abuse against Hennepin Health, please contact the Chief Compliance and Privacy Officer, the Hennepin Health Compliance mail box at HH.Compliance@hennepin.us, the Hennepin Health Compliance reporting website at **http://mhp.alertline.com or** the Hennepin Health Fraud Hotline at 1-844-440-3290. Hennepin Health will make every attempt to keep the identity of reporters confidential. Also, reports of suspected fraud or abuse by a provider call the Minnesota Department of Human Services (DHS) SIRS section at 651-431-2650 or 1-800-657-3750.

Investigative process

Hennepin Health reviews closely any report of potential fraud or abuse and investigates each allegation and takes steps as appropriate to correct any violation of regulation, policy or law which could include civil or criminal action.

Hennepin Health conducts routine audits of participating providers to monitor compliance with contractual agreements and administrative policies and procedures. Hennepin Health uses information from a number of sources, including:

- Government agencies
- Third-party payers, including Medicare
- Professional review organizations
- Members and their responsible relatives
- Providers and persons employed by or working under a provider contract
- Professional associations and boards of providers and their peers
- Members' advocacy organizations
- General public

A Hennepin Health investigation may include:

- Examination of health care service and financial records
- Examination of equipment, materials, prescribed drugs, or other items used in providing health service to a member
- Examination of prescriptions written for Hennepin Health members
- Data mining

- Interviews with anyone providing information pertinent to the allegation of fraud or abuse
- Verification of the professional credentials of a provider, the provider's employees and entities under contract with the provider
- Determination of whether health care services provided were medically necessary
- Suspension of claims payment until the investigation is complete

Following completion of the investigation, Hennepin Health will determine whether:
- Providers are in compliance with requirements of their provider agreements and Hennepin Health policies and procedures
- Sufficient evidence exists to support that fraud, theft, or abuse has occurred
- Evidence of fraud, theft, or abuse supports administrative, civil, or criminal action

After completing the determination, Hennepin Health will take one or more of the actions:
- Close the investigation when no further action is warranted
- Impose administrative sanctions
- Seek monetary recovery
- Refer the investigation to the appropriate state regulatory agency
- Refer the investigation to the appropriate local law enforcement officials for review pursuant to Minnesota law

Administrative sanctions that may be imposed include:
- Placing restrictions on the provider
- Referral to the appropriate licensing board
- Suspension or termination of the provider contract
- Suspension or termination of the participation of any person or corporation with whom the provider has any ownership or controlling interest
- Requiring a contract that stipulates specific condition of participation
- Review of the provider's claims before payment
- Suspending payments to the provider

Hennepin Health has the authority to simultaneously seek monetary recovery and administer sanctions.

Hennepin Health will notify the provider in writing of any intent to recover money or impose sanctions.

False claims

False Claims Act

The False Claims Act [42 USC §1396a(a)] establishes liability for any person who knowingly presents, or causes to be presented, false or fraudulent claims to the U.S. government for payment. Health care providers can be prosecuted and/or subject to civil monetary penalties for a wide variety of conduct that leads to the submission of fraudulent claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false claim to be submitted.

Liability

Health care providers and suppliers who violate the False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $11,000 for each false claim submitted. In addition to civil penalty, providers and suppliers can be required to pay three times the amount of damages sustained by the U.S. Government. No proof of specific intent to defraud is required to establish liability under the FCA.

Examples

Examples of health care fraud can include but are not limited to:

- Billing for goods not provided
- Falsifying certificates of medical necessity and billing for services not medically necessary
- Filling separately for services that should be a single service
- Falsifying treatment plans or medical records to maximize payments
- Failing to report overpayments or credit balances
- Duplicate billing
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referral services
- Physician billing for services provided by interns, residents, and fellows in a teaching hospital

Reporting suspected false claim

Hennepin Health takes health care fraud and abuse very seriously. It is our policy to provide information to contractors, agents and all employees about the federal and Minnesota laws related to false claims, remedies available under these provisions and protections under these laws. No contractor, agent or employee will suffer any penalty or retribution for reporting, in good faith, any suspected misconduct or non-compliance.

In May 2008 Minnesota passed health reform legislation that included development of Health Care Homes (HCH). The legislation related to HCH includes payment to certified providers who collaborate with eligible patients and their families to coordinate care on behalf of the patient. Effective July 1, 2010, Department of Human Services (DHS) contracts require that persons with complex and/or chronic medical conditions have access to HCH services through certified providers of service.

Section 15: Care Coordination Services

Health care homes

In May 2008 Minnesota passed health reform legislation that included development of Health Care Homes (HCH). The legislation related to HCH includes payment to certified providers who collaborate with eligible patients and their families to coordinate care on behalf of the patient. Effective July 1, 2010, Department of Human Services (DHS) contracts require that persons with complex and/or chronic medical conditions have access to HCH services through certified providers of service. Health home services are comprehensive and timely high-quality services provided by a health home.

Health care homes:

- Facilitate consistent and ongoing communication among the HCH, the patient and the patient's family, and provide the patient with continuous access to the patient's HCH
- Utilize an electronic, searchable patient registry that enables the HCH to manage health care services, provide appropriate follow-up, and identify gaps in patient care
- Provide care coordination that focuses on the patient and family-centered care
- Provide a care plan for selected patients with a chronic or complex condition, involving the patient and, if appropriate, the patient's family in the care planning process
- Reflect continuous improvement in the quality of the patient's experience, health outcomes, and the cost-effectiveness of services
- Provide comprehensive care management
- Provide care coordination and health promotion
- Includes comprehensive transitional care including appropriate follow-up from inpatient to other settings
- Includes patient and family support, including authorized representatives

- Makes referrals to community and social support services

Interaction with Hennepin Health

As a health plan providing services to Medicaid enrollees, Hennepin Health is required to actively provide case management and oversight for services provided to its members. In specific circumstances (e.g., individuals with significant behavioral health conditions), specific assessments or oversight is required. In order to facilitate these services, avoid duplication of services, share information between providers and the health plan, and mutually meet the needs of the individual, upon Hennepin Health's request, the provider agrees to include a Hennepin Health case manager as part of the HCH care team. When appropriate to meet the individual's needs Hennepin Health reserves the right to require the individual to receive services through a specific HCH. An example of where this may be necessary is for individuals who have been placed in the Restricted Recipient program.

Care coordination requirements

- Inform the individual about participation in a HCH
- Have a standardized method of determining whether the complexity of an individual's medical condition(s) makes them eligible to participate in a HCH
- Document in the individual's medical record their acceptance to participate in a HCH, and the agreed upon start date for participation to begin
- Establish the individual's complexity tier and willingness to participate in care coordination
- Reevaluate the individual's complexity tier annually, or more often if warranted by a change in the patient's medical condition(s)
- Provide Hennepin Health on a monthly basis with a roster of all members who have agreed to participate in a HCH, along with the start date for participation
- Provide Hennepin Health on a monthly basis with a roster of all members who have terminated their participation in a HCH, along with the termination date for participation

Section 16: Subcontractual relationship and delegated entity

Hennepin Health retains the responsibility for performance of all delegated activities. Hennepin Health shall develop and implement review and reporting requirements to ensure that the delegated entity performs all delegated activities and ensure subcontractors have the capacity to deliver and maintain performance standards for those activities delegated through a formal agreement. All delegated activities will be performed as required by Hennepin Health and in accordance with standards set forth by the National Committee for Quality Assurance (NCQA) and other state or federal regulatory bodies.

Physician incentives and disclosures

Hennepin Health will not exceed the specified limits on physician incentives unless special physician-specific review processes are in place. Hennepin Health will disclose physician incentive plans to Minnesota Department of Human Services (DHS), and to members.

Definitions

Culture

The thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups

Cultural competence

A set of congruent behaviors, attitudes and policies that converge in a system, an agency or among professionals to enable effective interactions in a cross-cultural framework

Linguistic competence

The provision of readily available, culturally appropriate oral and written language services to limited-English proficiency (LEP) s through such means as bilingual/bicultural staff, trained medical interpreters and qualified translators

Cultural and linguistic competence

The ability of health care providers and organizations to understand and respond effectively to members' cultural and linguistic needs

Provider requirements

Cultural competence requires organizations and their personnel to:

- Value diversity
- Assess themselves
- Manage the dynamics of difference
- Acquire and institutionalize cultural knowledge
- Adapt to diversity and the cultural contexts of individuals and communities served

Hennepin Health will work with staff, providers and partner agencies to ensure that plan members receive culturally and linguistically competent health care. Hennepin Health makes an effort to recruit and retain providers able to meet the cultural needs of our members.

Provider responsibilities

- Provide culturally and linguistically competent health care services to Hennepin Health plan members
- Ensure that all s, including LEP and vision-impaired s, receive effective communications in the health care setting
- Notify members of their right to language assistance services.
- Ensure that their policies and procedures do not deny s access to health care because of language barriers
- Comply with Title VI of the Civil Rights Act of 1964 and State and Federal regulations concerning health care provider cultural competence

Section 16: Non-discrimination affirmative action

In accordance with Hennepin County's policies against discrimination, providers agrees that they shall not exclude any person from full employment rights nor prohibit participation in or the benefits of any program, service, or activity on the grounds of race, color, creed, religion, age, sex, disability, marital status, sexual orientation, public assistance status, or national origin. No person who is protected by applicable federal or state laws against discrimination shall be subjected to discrimination.

The affirmative action plan must include the following elements:

- EEO policy statement
- Identification of a person responsible for EEO coordination
- Harassment policy statement
- Initial workforce analysis (form CC399) (PDF)
- Identification of the specific steps provider will take to achieve or maintain a diverse workforce and ensure non-discrimination
- List of recruitment sources
- A plan for dissemination of the provider's affirmative action plan and policy

Exemption from the affirmative action plan requirements:

- Contract is for emergency or life safety (threatening) related purchases

- Provider has no facilities and has no more than one product/sales representative operating in Hennepin County
- Provider has an average of thirty (30) or fewer full-time/benefit-earning employees during the twelve (12) months preceding the submission of the bid, request for proposal or execution of contract
- Pursuant to Hennepin County policy, the county administrator or his or her designee granted an exemption

Providers agrees to adhere to Hennepin County's AIDS policy which provides that no employee, applicant, or client shall be subjected to testing, removed from normal and customary status, or deprived of any rights, privileges, or freedoms because of his or her AIDS status except for clearly stated specific and compelling medical and/or public health reasons. Providers shall establish the necessary policies concerning AIDS to assure that county clients in contracted programs and provider's employees in county contracted programs are afforded the same treatment with regard to AIDS as persons directly employed or served by the county.

Paper recycling
Hennepin County encourages the provider to develop and implement an office paper and newsprint recycling program.