



Provider Manual – September 2023

Summary of content changes

Date	Change detail	Section	Type of content changes		
			Update	New	Deletion
9/1/2023	Updated authorization list text	Section 6.1	X		
6/13/2023	Updated authorization grid	Section 6.1	X		
4/18/2023	New authorization grid and updates to DME exclusions and limitations	Sections 6.1 and 8.3	X		
4/15/2022	General updates made throughout all chapters of the provider manual	All sections	X		
11/19/2020	Clarified reimbursement policy on appointments for multiple members at the same location.	Section 4.6	X		
12/27/19	Information for FQHC's on sending MinnesotaCare claims to Hennepin Health	Section 15.2	X		
12/03/19	New information for pharmacies on cash payment for medication	Section 13.3		X	

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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.

Section 1.1 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.

Section 2.1 Product Overview

Hennepin Health offers three products for residents of Hennepin County.

Hennepin Health – PMAP

Hennepin Health-PMAP is a managed care 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, and be eligible for Medical Assistance (Medicaid).

Hennepin Health – MinnesotaCare

Hennepin Health-MinnesotaCare is a managed care program that offers medical, behavioral health, dental, and care coordination for Hennepin County Residents who exceed the income requirements for PMAP and who do not have access to other affordable health care coverage. Some members maybe required to pay a premium to the State. To be eligible for Hennepin Health-MinnesotaCare, you must live in Hennepin County and be eligible for MinnesotaCare.

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 member is assigned a Care Guide who assesses the member's needs, provides care coordination services, and serves as a point of contact for the health plan.

Section 2.2 Eligibility

Providers may access information via [MN-ITS](#). If you need to speak directly with someone regarding eligibility, call Provider Services at 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.

Section 3.1 Provider Marketing Activities

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

Section 4.1 Member 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 healthcare 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
- Hennepin Health members/authorized representatives and medical practitioners appealing UM decisions must first file an appeal with Hennepin Health
- Members may file a grievance at any time. Previously any grievances needed to be filed with Hennepin Health within 90 days of the occurrence
- 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

Section 4.2 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 members 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 from an in-network provider.
- 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 substance use disorder services.

Section 4.3 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 a health assessment.
- 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.

Section 4.4 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 members when their primary care provider

is terminated for any reason. Members should receive notification 30 calendar days before the date termination becomes effective.

Section 4.5 Hennepin Health Programs

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

YMCA of the North Membership

Hennepin Health-SNBC members have the option of using any YMCA within the Twin Cities metroarea 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 members need to present their Hennepin Health-SNBC ID card at any metro YMCA during regular business hours.

Hennepin Health offers a health club membership credit to MinnesotaCare members who belong to the YMCA of the North. Members who visit the YMCA six times in the month receive a \$30.00 credit to their account. With the credit, MinnesotaCare members can save up to 40% off the monthly membership fee.

Section 4.6 Interpreter Services

Language access services are necessary for Hennepin Health members to communicate with healthcare 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

Interpreter services will be reimbursed only by Hennepin Health for covered services provided in the settings listed below:

- Medical Clinic
- Urgent Care
- Dental Clinic
- Pharmacy
- Outpatient Hospital
- Emergency Department
- Ambulatory Surgical Center
- Home Care
- Dialysis Facility

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

Hennepin Health contracted interpreter agencies:

- All in One Translation - (952) 435-0799
- Arch Language Network, Inc. - (651) 789-7897
- A-Z Friendly Languages - (763) 566-4312
- Global Language Connections- (612) 249-6100
- Kim Tong Translation Services - (651) 252-3200
- Language Line Services, Inc. - (888) 259-5761
- Middle English Interpreting - (612) 747-2813
- Surad Interpreting & Translation - (612) 872-8059
- University Language Center - (952) 224-5600

Hennepin Health reimburses face-to-face interpreting for the actual time services were provided with a 4 unit minimum for each appointment. This time should include the beginning to the end of communication with the member, provider, and interpreter.

The following is Hennepin Health's reimbursement guidelines for interpreter services billing:

- 1 unit equals 15 minutes. To be reimbursed for 1 unit, the interpreter must provide 8 or more minutes' worth of interpreter services.
- If interpreter services do not total up to 8 minutes, no units should be billed.
- Interpreters that have multiple members at the same location on the same date of service as well as a single member that has multiple appointments on the same date of service are not allowed with a 4 unit minimum for each appointment. When such scheduling occurs, the interpreter will be reimbursed as follows:
 - The initial member appointment for that date of service will be reimbursed at one-hour/4 units minimum, or the actual time interpreter services were provided, whichever is greater.
 - The subsequent appointments scheduled after the initial appointment on the same date of service must be at least 1.5 hours between the end of the last appointment and the initial start time of the following appointment to be reimbursed at the one-hour minimum or the actual time the interpreter services were provided, whichever is greater. The time in between appointment(s) that occur less than 1.5 hours shall be reimbursed for the actual time the interpreter services were provided.

Section 4.7 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 a provider has a patient who may be in need for transportation services other than public transportation, please contact Member Services at 612-596-1036.
- 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 for immediate care that is non-life threatening, or to the nearest emergency room, please call 911 for life threatening situations.

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 for immediate care that is non-life threatening, or to the nearest emergency room, please call 911 for life-threatening situations.

For basic life support (BLS):

- Non-emergency BLS transportation services require 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.

Section 5: Grievances and Appeals

Grievances and appeals are highly regulated by federal and state agencies. Hennepin Health has a Grievance System in place that includes a grievance/complaint process, an appeals process and access to the State Fair Hearing (a.k.a. StateAppeal) system. The Grievance System also includes the handling and processing of any member Quality of Care (QOC) and Quality of Service (QOS) Grievance.

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

Section 5.1 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 contracts; 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 Hennepin Health for review of an Action. An Attending Health Care Professional may Appeal a utilization management decision without the member's written consent.

Attending Health Care Professional: the health care professional 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 section [245.462, subdivision 18](#), or [245.4871, subdivision 27](#); podiatrists; and advanced practice nurses.

Expedited Appeal: A request from an attending health care professional, a member or their authorized 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. An Attending Health Care Professional's request to have an Appeal reviewed as an Expedited Appeal is always granted by Hennepin Health.

Grievance (also known as a complaint): 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/complaints and appeals handled by Hennepin Health and access to the State appeal process.

Medical Necessity: A health service, pursuant to Minnesota Rules, [Part 9505.0175](#), subpart 25, that is: 1) consistent with the member'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 for a mother and child through the maternity period
- to achieve a level of physical or mental function consistent with prevailing community standards or diagnosis or condition
- as a preventive health service defined under Minnesota Rules, Part 9505.0355

Notice of Action: Notice of Action includes a denial, termination, or reduction (DTR) of service notice or other Action as defined in [42 CFR 438.400\(b\)](#).

Quality of care (QOC)/ Quality of Service (QOS) Grievance: An expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. QOC grievance/ complaint may include the following, to the extent that they affect clinical quality of health care services rendered: access, provider and staff competence; clinical appropriateness of care, communications, behavior; facility and environmental considerations; and other factors that could impact the quality of health care services. QOS grievance examples are inappropriate behavior or rudeness. A QOC/QOS Grievance may include only a QOC or QOS issue or it may include both a QOC and QOS issue.

State Appeal: a hearing filed according to a member's written request with the State pursuant to Minnesota Statutes §256.045, related to: 1) the delivery of health services or participation in Hennepin Health; 2) denial (full or partial) of a claim or service by Hennepin Health; 3) failure to make an initial determination in thirty (30) calendar days; or 4) any other action.

A member, their authorized representative or a provider wishing to act on behalf of the member, with the member's written consent may file a Grievance or an Appeal with Hennepin Health, orally or in writing. When needed, a member may provide written consent by completing a release of information form. Hennepin Health must include as parties to an Appeal the member, their authorized representative or the legal representative of a deceased member's estate. The member's Attending Health Care Professional may appeal a utilization review decision without the written signed consent of the member. Practitioners/providers can appeal a claim denial; however, practitioners/providers are not allowed to bill members in accordance with [MN Rule 9505.0225](#).

Grievances may be filed at any time. An Appeal to review a Notice of Action must be filed with 60 days of the DTR notice or other Action taken by Hennepin Health. More time may be allowed if the member has a good reason for missing the deadline. Hennepin Health gives members 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/TDD 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 health/substance use disorder services may be limited to Health Insurance Portability & Accountability Act (HIPAA) laws.

Section 5.2 Grievances

Grievances may be filed orally or in writing. All Grievances are investigated by the Appeal and Grievance (A&G) Coordinator with a decision on a grievance being made by an individual not involved in any previous level of review or decision-making. If a Grievance is 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 Grievance 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 is 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. Hennepin Health must notify the member in writing of the disposition for all Grievances filed in writing.

The Grievance disposition provided to the member, either orally or in writing, will include the results of the investigation, Hennepin Health's actions related to the Grievances and member's options for further review and assistance through the DHS [Managed Care Ombudsman](#) and/or review by the Minnesota Department of Health (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.

Quality of Care Grievance

Grievances are handled by the Quality Management (QM) department. QOC and QOS issues are investigated based on their unique merits and may include medical record review, site visits, interviews or other investigation techniques as appropriate. When warranted following an investigation, corrective actions are taken in accordance with Hennepin Health's Quality Program.

All peer reviews conducted during the review of QOC concerns are considered confidential information of a review organization in accordance with Minnesota Statutes Sections 145.61 - 145.67, and the Health Care Quality Improvement Act of 1986. Upon receipt of a QOC Grievance the Complainant is sent an acknowledgement letter that the issue will be reviewed by the QM department, but that as a result of confidential, peer review issues the results of the investigation cannot be shared. Upon receipt of a QOS Grievance the complainant receives an acknowledgement letter and, in most cases, will receive the results of the investigation.

Substantiated QOC/QOS issues are communicated to the Credentialing department on a quarterly basis. The Credentialing department records the information within the provider's credentialing file and follows the Credentialing department's internal process for review and determination.

Section 5.3 Appeals

Hennepin Health provides only one level of Appeal for members. Multiple reviews by different personnel within Hennepin Health are not construed as multiple levels of Appeals. Hennepin Health members/authorized representatives and Attending Health Care Professionals appealing utilization management (UM) decisions must first file an appeal with Hennepin Health. 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 Appeals are properly processed and responded to in a timely manner. All Attending Health Care Professionals shall follow the established Appeal procedures when filing an Appeal.

A medical necessity Appeal is an Appeal to review Hennepin Health's initial decision not to certify a health care service. For a medical necessity Appeal request, 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 never take punitive action against an Attending Health Care Professional who supports a member's appeal.

An Appeal can be filed orally or in writing. If a member wishes to file an Appeal in writing, Hennepin Health will assist the member, or the provider filing on behalf of the member, in completing a written Appeal.

If a member files an Appeal with Hennepin Health and requests continuation of benefits within the time allowed, Hennepin Health will not reduce or terminate the service until 10 days after a written decision is issued to that Appeal unless the member withdraws the Appeal. Providers may not request continuation of benefits. "Within the time allowed" means the request is made on or before the date that is 10 days after Hennepin Health sends the DTR, or the effective date of reduction or denial of services on the DTR, whichever is later. The time period of the original authorization must not have expired. In the case of a reduction or termination of ongoing services, services must be continued pending the outcome of the Appeal if there is an order for services by an authorized provider.

The member 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 is 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 any individual(s) making the Appeal decision was not involved in any previous level of review or decision-making and is not a subordinate of the person making the previous decision. Standard Appeals are 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 Appeals involving a UM decision, the Attending Health Care Professional is informed of the Appeal decision. If the Appeal resolution is adverse to the member, the member is informed of their right to request a State Appeal.

Hennepin Health may take an extension of up to fourteen additional days for a 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. Hennepin Health will make reasonable efforts to provide prompt oral notice and provide written notice within two (2) calendar days to the member of the reason for the decision to extend the timeframe if Hennepin Health determines that an extension is necessary. For an Appeal involving a UM decision, the Attending Health Care Professional is informed of the extension in writing for a standard Appeal. Hennepin Health will resolve and communicate the Appeal decision no later than the date the extension expires.

If Hennepin Health is deciding an Appeal regarding a denial of a service based on: 1) lack of Medical Necessity; 2) a Grievance regarding denial of an expedited resolution of an Appeal; or 3) a Grievance or appeal that involves clinical issues, Hennepin Health will ensure that the individual making the decision is a board-certified physician of 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 take into account all comments, documents, records and other information submitted by the member without regard to whether the information was submitted or

considered in the initial action.

Hennepin Health will provide the following information to the member and 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

Hennepin Health will provide a written letter of resolution for Appeals which will include:

- The results of the resolution process and date it was completed;
- The member's right to request a State Appeal if the resolution was adverse to the member, and how to do so; and,
- The member's right to continuation of benefits and potential liability for the cost of continued benefits if the State Appeal decision upholds Hennepin Health's decision. Hennepin Health will include with the letter a copy of the State's notice "Your Appeal Rights".

In the event Hennepin Health fails to adhere to the notice and timing requirements of an appeal, the member is deemed to have exhausted the Appeals process and may proceed to a State Appeal.

Expedited Appeals

An Appeal is processed as an Expedited Appeal when the member's life, health, or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a standard Appeal decision. An Expedited Appeal is always granted when the member's Attending Health Care Professional determines the standard Appeal timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. An expedited Appeal request may be accepted when an initial DTR determination is made prior to or during an on-going service. 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.

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 filing date of the Expedited Appeal request. 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.

Hennepin Health may take an extension of up to 14 additional days for an Expedited 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. If Hennepin Health determines that an extension is necessary, Hennepin Health will make reasonable efforts to provide prompt oral notice and provide written notice to the member and the Attending Health Care Professional, as applicable, within two calendar days stating the reason for the decision to extend the timeframe. Hennepin Health will resolve and communicate the decision no later than the date the extension expires.

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. Hennepin Health also sends a written notification of the resolution to the member and the Attending Health Care Professional.

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 Appeal. A written copy of the State's notice "Your Appeal Rights" is provided to the member and the Attending Health Care Professional, if the appeal involved utilization management decisions, with the written determination as soon as practical.

Section 5.4 State Appeals

State Human Services Judges may review any Action by Hennepin Health. The parties to the State Appeals include Hennepin Health, the member, his/her authorized representative, or the legal representative of a deceased member's estate.

The member or a provider acting on behalf of the member, with the member's written consent, may request a State Appeal after exhaustion of Hennepin Health's Appeals process, but the request must be made within 120 days of the Hennepin Health Appeal decision.

If a member makes a written request for a State Appeal, and requests continuation of benefits within the time allowed, Hennepin Health may not reduce or terminate the service until the State issues a written decision in the State Appeal, or the member withdraws the request for the State Appeal. "Within the time allowed" means the request is made on or before the date that is 10 days after Hennepin Health sends its notice of resolution of the Appeal. In the case of a reduction or termination of ongoing services, services must be continued pending outcome of all Appeal or State Appeal if there is an order for services by an authorized provider.

Once the State Appeal's final administration action is received, Hennepin Health complies with the decision in the State Appeal promptly and as expeditiously as the member's health

condition requires.

If the member disagrees with the State Appeal decision, the member may consider seeking legal counsel to identify further legal recourse. The member can choose the following options:

- (a) The member can request that the State Appeals Office reconsider the decision. The member's request must state the reasons why the decision should be reconsidered. The request may include legal arguments and may include proposed additional evidence supporting the request; however, if submitting additional evidence, it must be explained why it was not provided at the time of the hearing. The request must be submitted in writing within 30 days of the date of the decision and include the document number. Requests must be sent to: Appeals Office Minnesota Department of Human Service. P.O. Box 64941, St. Paul, MN 55164-0941. Requests may also be faxed to: 651-431-7523. Copies must also be submitted to Hennepin Health.
- (b) The member can start an appeal in district court. This is a separate legal proceeding that must occur within 30 days of the date of the decision. The process is started by serving a written copy of the notice of appeal upon the Commissioner and any other adverse party of record and filing the original notice and proof of service with the court administrator of the county district court. The law that describes this process is in Minnesota Statute §256.045, subdivision 7.

Section 5.5 Continuity of Care for New Members

To ensure members 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-network provider and may grant the request to receive services through the current provider when the member meets following criteria:

- The member is engaged in a current course of treatment for
 - An acute condition
 - A life-threatening mental or physical illness
 - A pregnancy beyond the first trimester
 - A physical or mental disability defined as an inability to engage in one or more major life activities
 - A disabling or chronic condition that is in an acute phase
 - culturally appropriate services and Hennepin Health does not have an in-network provider with expertise in the applicable culture of that member
- The member does not speak English and Hennepin Health does not have an in-network provider who can communicate with the member

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

- 120 days if the member is engaged in a current course of treatment

- The rest of the member's life if a physician certifies that he/she has an expected lifetime of 180 days or less

Hennepin Health will provide transitional services:

- If the member has a service authorization from another Managed Care Organization or the State (at the time of enrollment)
- If a transfer of care is clinically appropriate
- In the event of an in-network contract termination

In all instances, Hennepin Health will review the request and make a determination. The provider will be notified by phone and both the member and provider are notified in writing of the determination.

Section 6: 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
- Hennepin Health-MinnesotaCare

Service Authorization Process

The process for obtaining approval for selected covered medical or 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.

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, to assist with the determination. If Hennepin Health is unable to obtain all necessary information to make a determination within 10 business days, the provider request may be denied for lack of information.

Expedited Service Authorization Determination

To be considered for an expedited service authorization determination, fax required information to 612-677-6222 and mark the request as “urgent”.

Physicians must state in writing that the standard time to make a determination could jeopardize a member’s life, health or ability to regain maximum function.

Hennepin Health will respond to expedited service authorization requests 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 proceed with an expedited review.
- Hennepin Health will resolve each request as promptly as the member’s health requires, but no later than 72 hours after receipt.
- If a service has already been provided, the request will not be processed as expedited.
- If an adverse determination is made for an expedited service authorization request: Members and providers will be notified by phone of the decision to deny a request for an expedited determination.
- A written notification will be mailed to members and providers within 72 hours of receipt of

the expedited request.

- The notice will inform members of the right to appeal including the process to submit an expedited appeal request.

Retrospective Service Authorization Determination

When services have been provided prior to requesting authorization, Hennepin Health will review services on a retrospective basis. Providers should fax a retrospective authorization request to 612-677-6222. Hennepin Health will review post-service requests within 30 calendar days from receipt.

When services requiring an authorization have been provided and a claim submitted to Hennepin Health without authorization, the provider may receive a claim denial. In that case, the provider should submit a claim reconsideration form to the Hennepin Health Provider Services department at 612-321-3786. The claim reconsideration will be reviewed by Hennepin Health within 45 days from receipt.

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 of Care/Transition of Care

Hennepin Health provides, upon request, authorization to receive covered health care services from a non-contracted provider for up to 120 days from the member's eligibility with Hennepin Health if the member is engaged in a 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 also provides transitional services for members new to the health plan. If a member becomes eligible with Hennepin Health and the prior managed care organization or the State authorized services, Hennepin Health will honor the previous MCO's authorization. If previously approved services are being provided by a non-contracted practitioner, Hennepin Health may require the member to transition services to a Hennepin Health

contracted provider at the end of the authorization period.

If Hennepin Health determines the member should continue to receive their care from a non-contracted provider, authorization is provided for a timeframe determined appropriate to prevent unnecessary gaps in treatment.

Service Authorization Forms/instructions

Service authorization forms can be found on the Hennepin Health website on the [Provider Forms](#) page. Providers may also call customer service at 1-800-647-0550 or 612-596-1036 for assistance. Hennepin Health has multiple authorization request forms tailored to specific types of requests. Authorization forms include:

- Service Authorization form: providers should submit this form when requesting authorization for services identified on Hennepin Health's prior authorization list
- Continuity of Care form: non-contracted providers should submit this form when requesting authorization for continued out-of-network services for members who are newly eligible with Hennepin Health
- Partner Provider Out-of-Network Referral form: Hennepin Healthcare providers should submit this request form when referring members to non-contracted providers

Fax completed service authorization forms with relevant medical documentation to support the medical need of the request 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 Section 15.

Section 6.1 Authorization Requirements List

Services that require authorization from, or notification to, Hennepin Health are listed on Hennepin Health's website on the [Prior Authorization page](#).

Please note the following important information regarding Authorization requests:

- All out of network services require authorization, EXCEPT emergency/urgently needed care, post-stabilization care and family planning services.
- All services are subject to member eligibility and benefit coverage.
- Hennepin Health review timelines for non-urgent pre-service or concurrent authorization requests is 10 business days.
- If Medicare is the primary coverage, please submit claims to Medicare first for all Medicare- eligible or covered services or equipment. Medicare coverage can be confirmed by checking the Minnesota DHS MN-ITS site.
- Hennepin Health reserves the right to review and verify medical necessity for all services.

- For services that require authorization, failing to obtain the authorization in advance may result in a denied claim.
- If you have a denied claim, please reach out to Hennepin Health's Provider Service team for questions or information at 612-596-1036.

Section 7: Clinic Services

Clinic services that are provided in a clinic setting by a licensed, qualified health care professional include:

- 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

Members must receive preventive and prenatal services within the Hennepin Health network unless they are given a service authorization for out-of-network care.

Section 7.1 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 includes:

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

Periodicity Schedule

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.

Section 7.2 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. Additional treatments require an authorization from Hennepin Health.
- 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 Requirements

- A service authorization is required for more than 24 spinal manipulations per year.
- The chiropractor is required to provide updated progress notes along with the request for additional treatments to Hennepin Health's Medical Administration Department.

Section 7.3 Vision Services/Eye Care

An eye exam entails an evaluation of vision and vision problems, as well as prescriptions for eyeglasses. Eyewear is defined as vision aids prescribed by an optometrist or ophthalmologist.

Service Authorization Requirements

Prior authorization is required for contact lenses when members do not have a Medicaid covered diagnosis (listed below under the Covered Services section).

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 members who have a diagnosis of aphakia, keratoconus, aniseikonia or bandage lenses. Only Medicaid covered lenses are allowed

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 and who accept Medicaid members)

Section 7.4 Hearing Services

Hearing services include hearing devices used to treat hearing loss that affects 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)
- FM Systems
- Parts and accessories
- Programming/reprogramming
- Re-casing, remakes and shell modifications
- Replacing battery doors and microphone protectors
- Conformity evaluations

Service Authorization Requirements

- For repairs greater than \$1,000, providers must use manufacturer's warranty until expired. Repairs are reimbursed up to the value of replacement

Section 8: Specialty Services

Section 8.1 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

Service Authorization Requirements

- Gastric bypass surgery (includes revisions or replacements):
 - Biliopancreatic diversion with duodenal switch
 - Laparoscopic adjustable gastric binding
 - Rou-en-Y gastric bypass
 - Sleeve gastrectomy
- Any surgery, procedures or treatment that could be considered reconstructive, cosmetic, experimental, or investigational:
 - Blepharoplasty
 - CardioMEMS heart failure system
 - Chemical peel
 - Cryotherapy
 - Facelift
 - Lipectomy
 - Otoplasty
 - Rhinoplasty
 - Scar revision
 - Subcutaneous injection of collagen
 - Tattooing
 - TMD/TMJ procedures
 - Uvulopalatopharyngoplasty (UPPP) and laser assisted uvulopalatoplasty (LAUP) throat surgeries
- Transplants, except kidney and corneal
- Circumcision

- Gender Confirmation Surgery
- Insertion of penile prosthesis
- Neurostimulator implantation:
 - Cranial nerve stimulator
 - Peripheral nerve stimulator
 - Spinal cord stimulator
- Radiofrequency Ablation
- Vein procedures:
 - Endovascular ablation
 - Sclerotherapy

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.
- Reconstructive surgery is a covered benefit when such service 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.

Service Authorization Contact Information

For questions related to service authorization requirements, contact Hennepin Health's Provider Services Department via phone at 612-596-11036, option 2. To submit a service authorization request to Hennepin Health's Utilization Management team, fax the appropriate Hennepin Health request form along with relevant medical records to 612-677-6222.

Section 8.2 Home Health Care Services

Definitions

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 assistance with daily activities to more complex services involving nursing assessment and intervention.

Covered Services

- Skilled nursing visits
- Home health aide visits
- Rehabilitation services (physical, occupational, speech and respiratory therapy)

Service Authorization Requirements

- Home health aide visits
- Skilled nursing visits exceeding 54 per year for Hennepin Health-SNBC members
- Visits exceeding nine (9) per year for Hennepin Health-PMAP and Hennepin Health-MNCare members
- Home infusion therapy (includes medication, supplies, and skilled nursing visits)

Provider Responsibilities

- Verifying insurance monthly
- Obtaining authorization when required
- Submit a completed home health certification and plan of care signed by the prescribing physician, physician's assistant, or nurse practitioner
- Submit a signed physician order (if the home health certification and plan of care is not signed by the prescribing physician, physician's assistant, or nurse practitioner)
- Sending a discharge summary at the completion of home care services

Exclusions and Limitations

- Services must be provided by a Hennepin Health-contracted provider.
- Personal care attendant services for all Hennepin Health members are now covered by the Minnesota Department of Human Services (DHS). Claims are submitted to DHS.

Section 8.3 Durable Medical Equipment and Medical Supplies

Definitions

Durable Medical Equipment (DME) is equipment that:

- Is generally only useful to a person with a medical condition
- Is appropriate for use in the home
- Can withstand repeated use
- Must be ordered and/or prescribed by a physician, physician's assistant, or nurse practitioner

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, physician's assistant, or nurse practitioner

Orthotics are devices designed and fitted to support or correct musculoskeletal deformities and/or abnormalities of the human body. These services must also be ordered and/or prescribed by a physician, physician's assistant, or nurse practitioner.

Non-durable Medical Supplies includes supplies that:

- 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, and breast pumps)
- Oxygen and oxygen equipment, C-PAP and Bi-PAP
- Supplies necessary to treat a medical condition (including, but not limited to bandages, dressings, gauze and equipment batteries)
- Medical equipment repairs (including hearing aids)
- Medically necessary footwear
- Adult diapers and incontinence products
 - Note: This is not an all-inclusive listing

Service Authorization Requirements for Equipment

- Bone growth stimulators
- Unlisted DME codes exceeding \$250
- 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 \$5,000 billed amount
 - Note: This is not an all-inclusive listing

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.

Service Authorization Requirements for Rentals and Repairs

Equipment authorized for rental will cap at 13 months, at which time the equipment will be considered purchased and will be considered the member's property.

Providers requesting authorization for repairs of member-owned equipment will need to provide the following documentation:

- Information regarding length of time the member will need the equipment
- Warranty information to document the repairs are not covered under the manufacturer's warranty or that the warranty has expired
- Information confirming repair charges do not exceed the cost of purchasing new equipment

Exclusions and Limitations

- DME, medical supplies, orthotics and prosthetics must be provided by a Hennepin Health contracted provider
- Wigs are covered for people with hair loss due to any medical condition

Refer to the DHS provider manual for a list of non-covered DME, medical supplies, orthotics and prosthetics.

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 member's property.

All purchased equipment must be new upon delivery to the member. 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.

Section 8.4 Nursing Facility Care 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 [Nursing Facility \(NF\) Communication Form](#) to Hennepin Health when a Hennepin Health-SNBC member is admitted to the nursing home, the RUG rate/class changes or the member is discharged from the nursing home.

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

Service Authorization Requirements

- service authorization is required for both skilled-nursing and nursing facility charges
- providers are required to notify Hennepin Health within one (1) business day of the admission

- an initial PAS form (completed by the [Senior Linkage Line](#)) needs to be submitted to HennepinHealth for long-term care admission

Section 8.5 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.

Covered Services

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

- Occupational therapy
- Physical therapy
- Speech-language pathology services
- Respiratory therapy services

Service Authorization Requirements

No service authorization is required for contracted providers.

Section 8.6 Obstetrics, Gynecology, 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 service**

- 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: Members have “direct access” to OB-GYN providers for the following services: annual preventive health exam, including follow-up exams that a qualified health care provider determines are necessary; maternity care; evaluation and treatment for gynecologic conditions or emergencies. To get direct access services, a member must go to a provider in the Plan network. For services labeled as **open access**, a member 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).

Service Authorization Requirements

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 seven (7) sessions.

Exclusions and Limitations

- Elective 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

Section 8.7 Medications Administered in an Office Setting

Services include injectable medications administered in the setting of a provider office. These medications are described using J-codes and are payable by Hennepin Health under the medical benefit. These services are not payable under the pharmacy benefit. See the Hennepin Health prior authorization list for specific medications requiring authorization.

Provider Network

Hennepin Health members enrolled in either a PMAP or MNCare group plan are required to access these services from a Hennepin Health contracted provider. Members enrolled in an SNBC group plan may access these services from any provider registered with the Minnesota Department of Human Services.

Section 8.8 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.

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

Service Authorization Requirements

Hospice services do not require authorization.

Section 9: Behavioral Health Services

Section 9.1 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

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

Adult Specific Covered Services

- Adult Mental Health Rehabilitative Services (ARMHS)
- Adult mental health crisis services

- DBT (Dialectical Behavioral Treatment)

Child Specific Covered Services

- 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
- Services to children residing in a psychiatric residential treatment facility (PRTF)
- Early intensive developmental and behavioral intervention (EIDBI)

Authorization Requirements

- Inpatient admits of more than 10 days require medical review
- Psychological and neuropsychological testing greater than eight (8) units per calendar year
- Diagnostic assessment and interactive diagnostic assessment exceeding two (2) sessions in a calendar year
- Children's residential treatment (Rule 5)
- Adult day treatment after 115 hours of services per calendar year
- Children’s day treatment after 150 hours of services per calendar year
- Children’s Therapeutic Services and Supports (CTSS) after 200 hours of services per calendar year
- Psychiatric Residential Treatment Facility (PRTF)
- Intensive Residential Treatment Services (IRTS) after 90 days

Notification Requirements

Notification of admission to the above treatment programs facilitates the health plan care coordination staff to provide optimal transitional care support for members 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.

The following services require notification to Hennepin Health:

- 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

- Substance use disorder treatment
- Acute Psychiatric admission

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. Hennepin Health must be given a copy of the court order and the behavioral care evaluation, 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.

Section 9.2 Substance Use Disorder

Substance Use Disorder (also known as Chemical Dependency) is dependence on alcohol, an illegal drug or a medication. A Substance Use Disorder (SUD) occurs when the recurrent use of alcohol and/or other drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Addiction to drugs or alcohol is chronic and progressive and is a treatable illness.

The Minnesota Department of Human Services (DHS) has been working with individuals, providers, counties and stakeholders to update the substance use disorder (SUD) treatment system. During the 2017 Minnesota legislative session, significant components of the proposed SUD Reform plan were passed. The SUD reform plan supports the transformation of Minnesota's SUD treatment systems from acute episodic care to a longitudinal chronic disease model. Through these changes, management of treatment and care for individuals with a SUD diagnosis is similar to how treatment and care are managed for individuals with other chronic health conditions.

Definitions

Comprehensive Assessment: A Comprehensive Assessment will replace the Rule 25 Chemical Health Assessment to authorize a level of treatment placement. A Comprehensive Assessment of a substance use disorder must be administered face-to-face by an alcohol

and drug counselor as follows: a) within three (3) calendar days after service initiation for a residential program; or b) during the initial session for all other programs. The assessment must include a wide range of information about the client's needs that relate to substance use and personal strengths that support recovery. Assessments are comprehensive and include demographics, prior attempts at treatment and substance abuse history. If an opioid use disorder is identified, there are additional requirements that need to be followed. For a complete list of required elements see 2018 Minnesota Statutes [245G.05 Sub. 1 and 2](#). Comprehensive assessments will be the only way to receive services after July 1, 2022 as the Rule 25 Assessments will be discontinued.

Direct Access: Allows an individual to go directly to a provider for a Comprehensive Assessment to authorize a level of treatment placement. Individuals are able to select the service provider of their choice with the level of care approved.

Peer Recovery Support Services: Peers are individuals with lived experience of a SUD willing to share their personal recovery experience and engage with individuals to offer reassurance, reduce fears, answer questions, support motivation and convey hope. Peers must complete training, certification and continuing education identified by DHS. Peer recovery services can be provided before, during and after SUD treatment to help individuals connect with resources that support recovery. For more information on Peers and their scope of practice, educational and training requirements visit the Substance Use Disorder Reform page on the [DHS website](#).

Rule 25 Assessment: The chemical health assessment named for the original Minnesota Rule 25. A Rule 25 Assessment must be performed by a qualified Rule 25 Assessor. The Rule 25 Assessor gathers information about the individual using a Rule 25 Assessment form which determines whether the individual needs treatment and if so, what type will be the most beneficial. Under the Rule 25 system, the county or tribe is the placing authority and Managed Care Organizations are the payer. Rule 25 Assessments will be discontinued after July 1, 2022.

Treatment Coordination: Treatment Coordination is a service involving the deliberate, collaborative planning of SUD services with the client and other professionals involved in the client's care. The staff credentials required for providing treatment coordination are aligned with current requirements for Rule 25 Assessments. Legislation identifies SUD programs, withdrawal management programs and counties as eligible vendors of this benefit. For more information on Treatment Coordination including billing, scope of practice, educational and training requirements visit the Substance Use Disorder Reform page on the [DHS website](#).

Covered Services

- Assessment and diagnosis
- Inpatient, outpatient and residential treatment (includes room and board) for SUD treatment
- Methadone treatment
- Detoxification is covered by Hennepin Health when deemed medically necessary

New SUD Reform Covered Services

- Comprehensive Assessment: Comprehensive Assessment and Rule 25 Assessments are used to authorize a level of treatment placement. Hennepin Health members can access treatment through either a Comprehensive Assessment or Rule 25 until July 2020 when Rule 25 will sunset.
- The Comprehensive Assessment must be administered face-to-face by an alcohol and drug counselor as follows: a) within three (3) calendar days after service initiation for a residential treatment program; or b) during the initial session for all other programs. The contents of the assessment must follow Minnesota Statute 245G.05 Sub. 1 and 2.
- Treatment Coordination
- Peer Recovery Support Services

Service Authorization

The [Addiction and Recovery Services Unit](#) of Hennepin County Behavioral Health approves all Rule 25 placement requests with the exception of the three agencies contracted with Hennepin County Behavioral Health to perform the Rule 25 Assessments. These agencies are:

- CLUES
- Crysalis
- Create Workhouse in Plymouth

The CPA form is required for Hennepin Health to authorize payment of SUD treatment services for those using the Rule 25 Assessment to access care. The CPA must be completed accurately and be legible. If an extension for substance use disorder treatment is necessary, the provider needs to communicate with the original Rule 25 Assessor as indicated on the CPA.

Notification

Hennepin Health does not require prior authorization for SUD treatment. Hennepin Health does require notification when treatment has started and upon discharge.

The provider must fax notification to Hennepin Health Medical Administration at 612-677-6222 upon admission of the Hennepin Health member and upon discharge from treatment.

Fax the Client Placement Authorization (CPA) Form, and Assessment and Placement Summary Form via secure fax to Hennepin Health at 612-321-3781. Fax medical information to the secure fax at 612-677-6222.

Section 10: Inpatient Hospital Services

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

Covered Services

- Room and board
- Diagnostic procedures
- Surgery
- Drugs
- Medical supplies
- Therapy services
- Professional services

Service Authorization Requirements for Planned Acute Inpatient Admissions

It is the responsibility of the treating provider to obtain an authorization from Hennepin Health prior to admitting a member to an inpatient hospital for 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
 - Septoplasty
 - Rhinoseptoplasty
- Maxillofacial surgery or uvulopalatopharyngoplasty
- Oral surgery
- Transplants
- Experimental or investigative, including new technology

Notification Requirements for Medical and Psychiatric Inpatient Admissions

Hennepin Health requires inpatient facilities notify us within 24 hours of a member admission for hospital inpatient services. Hennepin Health may be notified by means of the hospital's face sheet, or daily admission/discharge reports. The notification requirements are as follows:

- Hennepin Health member name and number, date of birth (DOB), social security number, hospital medical record number
- Admission date and time
- Hospital service type (medical or psychiatric)
- Level of care

- Admission source
- Diagnosis
- Attending physician with physician NPI #
- Discharge status (at member discharge)
- Discharge disposition (at member discharge)

The Hennepin Health Inpatient Notification form must be faxed to the Utilization Management Department at 612-288-2878..

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. Off-label use may be permitted.
- Cosmetic surgery, 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 scheduled inpatient admissions to a non-contracted facility, a service authorization is required prior to the admission date
- Request an extension (concurrent review) of the initial length of stay authorization prior to the last day authorized. Include information regarding discharge planning.
- Notify Hennepin Health of members who have complex discharge needs
- Notify Hennepin Health of the need for care coordination

Inpatient Admission for Substance Use Disorder Treatment Services

- See [Section 8.2](#) for details on Substance Use Disorder inpatient requirements

Section 11: 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
- Diagnostic tests and X-rays
- Dialysis
- Emergency room services for a medical emergency
- Post-stabilization care

Service Authorization Requirements

A service authorization may be required for specific outpatient services (e.g., specific surgical procedures, out-of-network services). Please refer to Hennepin Health's prior authorization list for services requiring authorization in an outpatient setting.

Section 12: Restricted Recipient Program

Section 12.1 Program Details

The Minnesota [Restricted Recipient Program](#) (MRRP) is a program, operated under the direction of the Minnesota Department of Human Services (DHS) that identifies Minnesota Health Care Program (MHCP) recipients who may be abusing or misusing health care services. Hennepin Health follows the standards for this program as set forth in Minnesota Rules.

When a MHCP recipient is identified and determined to qualify for the MRRP, they are considered a 'Restricted Recipient' and must receive health services from one (1) designated primary care provider, one (1) pharmacy, one (1) hospital, or other designated health services provider. Restricted Recipients are limited to receiving services only from these designated health care providers for at least 24 months during their eligibility for Minnesota Health Care Programs (MHCP). If specialty care is needed the Restricted Recipient must obtain a referral from the designated primary care provider. The referral must be faxed to the Restricted Recipient Program at Hennepin Health in order for the claim to be paid. Restricted Recipients may not pay out-of-pocket to obtain services from a non-designated provider who is the same provider type as one of their designated providers.

Universal rules established among all Managed Health Care Programs ensures the restriction follows individuals regardless of which health plan is managing care. Restricted Recipients who change health plans or change to Minnesota Health Care Programs (MHCP) fee-for-service will remain under restriction with the new MHCP plan. The restriction remains in place until the Restricted Recipient has satisfied the time period of the restriction. Restricted Recipients do not lose eligibility for MHCP due to placement in the MRRP.

Eligible Providers

Hennepin Health Network Providers:

- Primary Care Physician
- Primary Care Clinic
- Hospital
- Pharmacy

Restricted Recipients can be seen without a referral at any of their designated providers including their primary care provider and clinic, hospital and pharmacy.

The MRRP applies to all MHCP recipients including Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC) members.

Authorization Requirements

Any provider seen outside of a Restricted Recipient's designated providers requires a referral from the Restricted Recipient's primary care provider. All referrals must be in writing and sent to HennepinHealth. Restricted Recipients cannot self-refer to non-designated providers. Referrals must be received by Hennepin Health within 90 (ninety) days to be considered. The 90 days starts when the member has been seen. **Hennepin Health cannot accept referral requests that are more than 90 days.**

Non-Designated Provider Referrals for the Restricted Recipient Program

In 2022 there has been a change in the referral process to non-designated providers for the Restricted Recipient program. Referrals to a non-designated provider that are received greater than 90 days from the date of service will not be reimbursed.

If a member wants to see a non-designated provider, they must get a referral from their Restricted Recipient provider (designated provider). If the referral is received from the designated provider less than 90 days from the date of service, we will enter an authorization in the care management system. The non-designated provider claim will be paid.

If the claim is received before the designated provider referral is submitted to Hennepin Health, it will be denied, and a DTR issued. Once the designated provider referral is received and an authorization entered, the claim will be reprocessed and paid if the referral is received by Hennepin Health less than 90 days from the date of service with the non-designated provider.

For referrals that come in after 90 days from the date of service no approval or denial is entered. The referral will be documented in the members case, calls will be made to both the designated provider and the non-designated provider informing them that the non-designated provider service will not be paid as the referral did not meet the 90-day cut off.

Section 12.2 Restricted Recipient Program Referral Guidelines

<p style="text-align: center;">Referrals Required from Designated Primary Care Provider (PCP)</p> <p><i>The designated PCP must submit a referral before a restricted recipient receives services from a provider that is not one of the members' designated providers for all of the services listed in this column.</i></p> <p><i>All restricted members will have a designated:</i></p> <ul style="list-style-type: none"> ▪ Primary Care Provider (PCP) ▪ Clinic ▪ Hospital ▪ Pharmacy <p>Note: If care is needed by a specialist or other provider outside of the primary care clinic, the designated PCP may authorize a Restricted Program Referral.</p>	<p style="text-align: center;">No Referrals from Designated Primary Care Provider (PCP)</p> <p>Restricted recipients may directly access the services listed in the column below without needing a Restricted Recipient Referral.</p>
<ul style="list-style-type: none"> • All Specialty care services, including services provided by oral surgeons • Hospital services not provided in the designated hospital • <i>Note: Only one referral necessary for all services during an inpatient stay.</i> • Emergency department services provided by a non-designated hospital • Behavioral health services provided by a psychiatrist, clinical nurse specialists, or any mental health provider ordering medications • Vision care provided by an ophthalmologist • Dental prescriptions including services rendered by oral surgeons • Suboxone prescriber • Pain clinic providers, including anesthesiologists • Urgent care 	<ul style="list-style-type: none"> • Partners of the designated primary care provider at the same clinic/practice location when the PCP is not available. • Medicare Covered services for enrollees covered by Medicare • Emergency services at the designated hospital • Long term care facilities • Annual routine eye exam by optometrist • Audiologist and hearing aides • Behavioral Health therapists, counselors or psychologist • Routine dental services EXCLUDING prescriptions • Methadone clinic • PCA and Assessment for PCA services • PT/OT, speech therapy, respiratory therapy • Home care services • Radiology, imaging services (X-ray, CT, MRI, ultrasound, etc) • DME and Supplies • Laboratory services • Chiropractor • Dietician

- Note: if a member meets restriction criteria and has Medicare, Hennepin Health will restrict by limiting transportation to designated providers only

Section 13: 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. Navitus considers 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

Section 13.1 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](#) and submit it to Hennepin Health by secure fax at 612-6776222 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.

Section 13.2 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 member'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 13.3 Cash Payment for Medications

Hennepin Health will inform pharmacies and providers of members' right to pay cash for medications under certain circumstances. The list below describes the circumstances under which this is

allowed. It is the pharmacist's and prescriber's responsibilities to document the event, using the form required by the Department of Human Services ([Advance Member Notice of Noncovered Prescription \(DHS-3641\)](#) (PDF)). Hennepin Health does not require pharmacies or providers to submit the [DHS-3641](#) form, but the form must be kept on file and be made available to Hennepin Health or the Department of Human Services upon request.

A pharmacy may accept cash payment for a noncovered prescription drug if **all** the following apply:

- The member is not enrolled in the restricted member program
- The pharmacist has reviewed all available covered alternatives with the member
- The pharmacy obtains an [Advance Member Notice of Noncovered Prescription \(DHS-3641\)](#)(PDF)
- The prescription is not for a controlled substance (other than weight loss medications that are not part of the Hennepin Health benefit, such as phentermine)
- The prescription is not for gabapentin

A pharmacy may accept cash payment for a controlled substance or gabapentin only if the pharmacy has received an [Advance Member Notice of Noncovered Prescription \(DHS-3641\)](#) (PDF) signed by the prescriber and all criteria has been met for a member who is not enrolled in the restricted member program. Hennepin Health will not authorize a pharmacy to accept cash if the medication requires prior authorization or is subject to a quantity limit and the prescriber has not attempted to obtain the prior authorization or authorization to exceed the quantity limit. Hennepin Health will authorize cash payment if the pharmacy and member complete their sections of the DHS-3641 and the prescriber confirms the following:

- Covered alternatives are not viable options for the member
- The prescriber is aware he/she is seeking authorization for the pharmacy to charge the member for the medication
- The prescriber is aware the last time the medication was filled for the member, if applicable
- The prescriber attests that allowing the member to purchase the medication is medically necessary

The prescriber must sign DHS-3641, send the completed form to the pharmacy and retain a copy of the completed form in the member's medical record. The pharmacy must retain a copy of the completed form as documentation of approval from Hennepin Health to accept cash payment on the date of service. The completed DHS-3641 is authorization from Hennepin Health to accept cash payment on the date of service; you do not need to submit a copy to Hennepin Health unless requested. The prescriber or pharmacy does not need to call Hennepin Health for additional authorization.

In situations where Hennepin Health or PBM staff have concerns about the practices of a provider or pharmacy, or when possible abuse of the health care system by a member is suspected, Hennepin Health may ask for copies of the [DHS-3641](#) form(s) from pharmacists or clinics to determine if the process to allow for cash payments is functioning appropriately.

Section 14: Quality and 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. The clinical practice guidelines support sound decision-making by health care professionals and members, improve health care outcomes, and meet state and federal regulations.

Hennepin Health adopts medical and behavioral health/substance use clinical guidelines to assist health care professionals in recommended interventions for certain conditions. Hennepin Health strongly encourages the use of the adopted medical and behavioral health/substance use clinical guidelines but do not require they be used. The clinical practice guidelines are not a replacement for the advice or clinical expertise of the physician or other health care professionals or providers. The guidelines are to be used as a tool to support decision-making and identify areas of clinical improvement.

Hennepin Health, through the Clinical Quality Outcomes Committee (CQOC) adopts medical and behavioral health/substance use clinical practice guidelines from nationally or locally recognized sources. Practice guidelines are based on valid, reliable clinical evidence. At a minimum, the practice guidelines are reviewed and updated at least every two years or more frequently if the guidelines change within the two-year period. The adopted clinical practice guidelines are disseminated to the primary care, behavioral health/substance use and/or medical home providers through the Provider Manual 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 the utilization management decisions, member education, coverage or services and any other area for which the guidelines are applicable.

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

The Hennepin Health clinical practice guidelines are divided into two sections: Medical and Behavioral Health/Substance Use. The format includes the primary and secondary (if applicable) source(s) with a direct link to online content, modifications (if needed) of the guidelines for the Hennepin Health population characteristics, rationale for the modifications and any additional references if available.

Medical

Medical

Hennepin Health adopted five medical clinical practice guidelines. Individual guidelines can be accessed on the Hennepin Health website at <https://hennepinhealth.org/providers/manual>.

- Preventive Services for Adults
Primary Source(s): Agency for Healthcare Research and Quality (AHRQ) for the United

States Preventive Services Task Force (USPSTF): 2014

The *Guide to Clinical Preventive Services 2014* includes both new and updated recommendations released from 2004-2014 in a brief, easily usable format meant for use at the point of patient care. The most up-to-date version of the recommendations, as well as the complete USPSTF recommendation statements, are available along with their supporting scientific evidence at _

[The Guide to Clinical Preventive Services 2014 \(ahrq.gov\)](http://www.ahrq.gov)
[American Academy of Family Physicians: 2017](http://www.aafp.org)

- Preventive Services for Children/Adolescents
Primary Source(s): Agency for Healthcare Research and Quality (AHRQ) for the United States Preventive Services Task Force (USPSTF): Section 3
American Academy of Pediatrics (AAP) Bright Futures and Bright Futures Periodic Schedule
Minnesota Department of Health Child and Teen Checkup
- Diabetes Type 1 and 2: Diagnosis and Management
Primary Source(s): Minnesota Community Measurement D5
American Diabetes Association
- Prenatal/Postpartum Care
Primary Source(s): American College of Obstetricians and Gynecologists
United States Preventive Services Task Force
- Pain Management: Non-Opioid Treatment Options and Opioid Management
Primary Source(s): Center for Disease Control

Behavioral Health/Substance Use Disorder

Hennepin Health adopted three behavioral health and two substance use clinical practice guidelines. Individual guidelines can be accessed on the Hennepin Health website at <https://hennepinhealth.org/providers/manual>.

- Attention Deficit Hyperactivity Disorder (ADHD) – Children/Adolescents
Primary Source(s): American Academy of Pediatrics
American Academy of Child and Adolescent Psychiatry
- Treatment of Patients, Adults and Children with Major Depressive Disorders
Primary Source(s):
American Psychiatric Association
- Treatment of Patients with Schizophrenia
Primary Source(s): American Psychiatric Association

- Treatment of Patients with Substance Use Disorders (SUD)
Primary Source(s): American Society of Addiction Medicine
American Psychiatric Association
- Treatment of Patients with Alcohol Dependence
Primary Source(s): American Psychiatric Association
American Psychiatric Association

HEDIS Data Collection

The purpose of HEDIS is data collection, validation and reporting using the HEDIS technical specification from the National Committee for Quality Assurance (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.

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.

The Hennepin Health Prepaid Medical Assistance Program/MinnesotaCare and Special Needs BasicCare Contracts require Hennepin Health to conduct a medical record audit annually ensuring that the provider has documented in the member's medical record whether or not an individual has executed an advance directive.

Hennepin Health's Medical Record Standards

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

When examining the medical records associated with our members, Hennepin Health uses the following questionnaire during the review.

- Is the record secured from public access during and after office hours?
- Do all pages contain patient ID?
- Is there biographical/personal data?
- Are all entries signed/initialed and/or has a unique electronic identifier or initials?
- Are all entries dated?
- Is the record legible?
- Is there a completed problem list?
- Is the use of tobacco, alcohol, and substances documented?
- Is the purpose of the visit stated?
- Does the encounter include subjective and objective information related to complaints?
- Are current medications and supplements noted in the medical record?
- Is a diagnosis present for each encounter?
- Is there a follow-up plan for each encounter?
- Is there evidence of a system review and/or follow-up on test results?
- Is there documentation of immunizations?
- Is there documentation regarding advanced directives?
- Are allergies/adverse reactions present?
- Is there a medical, psycho-social and family history?
- Is there evidence of use of consultants and referrals documented?
- Is health education documented?
- Is there evidence of counseling regarding high-risk behaviors?
- Is there evidence of screening for mental health status?

- Is there evidence of preventive screening?

Verbal of Written Complaints Received by the Provider

According to MN Rules 4685.1110 and 4685.1900, Providers are required to report verbal and/or written complaints which originate at the provider level to Hennepin Health each quarter. Quality of care and service complaints directed to the medical group are to be investigated and resolved by the medical group. A link to the complaint form found [here](#).

Section 15: 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, and/or D or Medicare Advantage Plan

Section 15.1 Coordination of Benefits

As MN Medicaid Managed Care Organization, Hennepin Health will coordinate benefits to ensure that all other sources of healthcare coverage are billed and paid by the primary insurance carrier, as applicable, before processing claims.

Hennepin Health members may have other health care coverage. If a member has Medicare or other Third-Party Liability (TPL), it is the providers responsibility to bill the insurance and receive payment, to the fullest extent possible, before billing Hennepin Health. Hennepin Health is considered the payer of last resort.

Third party payers include

- Health Insurance coverage
- Accident/injury insurance (Auto, Tort, Workman's Compensation)
- Medicare
- Veteran's Benefits

Verification of Benefits

To verify benefits and other coverage information for a Hennepin Health member please contact the Provider Services team at 612-596-1036. Eligibility and other coverage information may also be obtained through the [MN Department of Human services, MN-ITS](#) application.

Billing TPL Claims

TPL information for Professional (837P) and Outpatient (837I) claims must be entered at the service line to report the payment and/or adjustments specific to each line item. Claims submitted without the TPL information at the line level will be denied.

TPL information for inpatient Hospital claims (837I) must be billed at the claim level for proper adjudication.

Hennepin Health requires TPL adjustment and payment information to be submitted electronically within the claim transaction, not as an attachment.

Providers must follow primary coverage requirements. Hennepin Health will not pay for services that could have been covered by the primary insurer if the applicable plan rules were followed.

Hennepin Health will not reimburse for services covered by, but not billed to Medicare because the provider has chosen to opt out or not enroll in Medicare.

Timely filing for TPL claims is 180 days from the primary payer's adjudication date.

Reporting Other Health Insurance Coverage Termination

Notify Hennepin Health of any health insurance terminations. Information can be faxed to Hennepin Health with a cover letter and the documentation from your office. Submit the verification printout from the primary insurance. Include your contact information and the following member information.

- Member Hennepin Health ID
- Member Name
- Insurance Carrier Name
- Insurance Policy #
- Insurance Termination date

Fax to:

Hennepin Health COB

612-336-1334

Section 15.2 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 valid diagnosis codes (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 for Hennepin Health to pay the claim. If not present, the claim will be rejected back to the provider.
- Federally Qualified Health Centers should submit all claims for Hennepin Health members on MinnesotaCare directly to Hennepin Health.

Void Claims

If a provider has billed a claim to Hennepin Health in error and needs to void that claim transaction, a void claim must be submitted. All data elements of the void claim must match the original claim with the exception of using a value of "8" as the claim frequency code. This void claim transaction will cancel the original claim.

Examples of when a void claim would be used:

- Incorrect payer information
- Claim type should be inpatient instead of outpatient or outpatient instead of inpatient

Replacement Claims

If a provider needs to correct or add an element of data on a claim that has already been billed, a replacement claim must be submitted. Replacement claims may also be referred to as corrected claims. The replacement claim should contain the corrected or additional data along with a value of "7" as the claim frequency code. A replacement claim should not be submitted until the original claim has reached the final adjudication status. Final adjudication status is considered when a claim has been processed and either paid or denied.

Examples of when a replacement claim would be used:

- Missing procedure code
- A change or addition of diagnosis code(s)
- Place of service change

Claim Adjustment / Reconsideration Requests

Hennepin Health has a form to utilize to request a claim adjustment or a claim reconsideration. The [Claim Adjustment/Reconsideration Request Form](#) should only be used in cases where an electronically submitted void or replacement claim has been unsuccessful or is not appropriate. The Claim Adjustment / Reconsideration Request Form should not be used in lieu of submitting a void or replacement claim or to request refunds that the provider considers due.

Examples of when a Claim Adjustment / Reconsideration Request Form should be used:

- The provider believes that a claim was denied in error, or incorrectly paid, due to a special circumstance that needs explanation and is requesting that Hennepin Health reconsider the claim to be paid or for additional payment.

When submitting a Claim Adjustment / Reconsideration Request Form is determined necessary and appropriate, the provider must make sure that all the data provided is complete and accurate.

The claim adjustment/reconsideration request form, along with supporting documents, can be faxed to Hennepin Health at 612-321-3786 or mailed to:

Hennepin Health
Attn: Adjustment Department
300 South Sixth Street MC 604
Minneapolis, MN 55487-0604

Or emailed to: hennepinhealth@hennepin.us

The timely filing for a claim adjustment/reconsideration request form is 180 days from the paid or denied date of the claim.

Section 15.3 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-4](#), [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 the provider's 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.

Section 15.4 Fee Schedules

Unless regulatory requirements dictate otherwise, Hennepin Health will update fee schedules on a quarterly basis. Once updated fee schedules are published by DHS and CMS, Hennepin Health will implement the updated fee schedules within 40 business days. Hennepin Health will only retroactively adjust claims if the fee schedule updates take longer than 40 business days.

Section 15.5 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 claim exists based on the following:

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

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

- Exact date of service
- Exact charge amount
- Exact 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 Monitoring

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

Section 15.6 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.

Section 15.7 Auto Recoveries

When the reversal and correction of a previously reported claim results in a reduction of the claim payment amount, this is categorized as an overpayment. When an overpayment occurs, Hennepin Health will attempt to recover the dollars via an auto recovery process. This means Hennepin Health will recover provider overpayments from future payments and report the recovery amounts through the remittance advice. If the overpayments cannot be recovered as part of the auto recovery process, Hennepin Health will send an invoice to the impacted provider for the remaining balance due.

Auto recoveries are communicated as an adjustment within the Provider Level Adjustment (PLB) segment of the ERA. This is accomplished by adding a Forward Balance (FB) adjustment to the PLB segment. The reference number contains the same number as the trace number used in TRN02 of the current transaction. This reference number should be used by the provider to facilitate tracking. The dollar amount will be the sum of all the reversed claims reported within the same ERA that resulted in overpayments. The monetary amount will be reported as a negative number to eliminate any financial impact and ensure the transactions balance against the payments made. Please remember, adjustments in the PLB segment can either decrease the payment (a positive number) or increase the payment (a negative number).

Example of an auto recovery from the 835 ERA:

- PLB*ABA8789*20001231*FB:1234554*-200~

Section 15.8 Electronic Data Interchange (EDI)

In accordance with Minnesota State Statute, 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.

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.

Section 15.9 Clearinghouses

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

Hennepin Health requires claims be submitted directly or indirectly to one of our contracted clearinghouses. If you do not use one of these clearinghouses contact your clearinghouse for intermediary access.

Clearinghouse Name	837 P	837I	835
Availity www.availity.com 800-282-4548			X
ClaimLynx www.claimlynx.com 952-593-5969	X	X	X
Change Healthcare https://www.changehealthcare.com/ 877-271-0054	X	X	X

Infotech Global, Inc. (IGI) akaMN E-Connect www.mneconnect.healthc.c.com 877-444-7194	X	X	X
Change Healthcare (Formerly Relay Health) Healthcare Claims Management Software Change Healthcare 800-457-1209	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)

Section 15.10 Claims Payment and Electronic Remittance Advice (ERA)

Automated Clearinghouse (ACH) Funds Transfer

You must sign up to receive ACH payments for claims by completing a Hennepin County [Automated Clearinghouse ACH Enrollment Form](#). 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. Automated Clearinghouse (ACH) payments with accompanying electronic remittance advice documents shall be the preferred payment methodology, unless otherwise specified. If the address on the check and/or the remittance does not match, is incorrect, or needs to be updated, immediately contact Hennepin Health Provider Service Team at 1-800-647-0550.

Claim payments are made on a weekly basis.

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.

Hennepin Health does not distribute paper 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

Section 15.11 Adult Mental Health Targeted Case Management Billing Requirements

Claim Format

Claims are to be submitted using the 837P format (electronic equivalent of the CMS 1500).

Coding Specifics

Procedure Code	Modifier	Service Description	Unit
T1017	HE	AMH-TCM face to face encounter	1 unit = 15 minutes
T2023	HE	AMH-TCM fact to face session	1 unit = 1 session (regardless of time)
T2023	HE U4	AMH-TCM telephone or telemedicine videoconference session	1 unit = 1 session (regardless of time)

Limitations

- T1017 HE can be billed once per day but cannot be billed in conjunction with T2023 HE or T2023 HE U4 within the same month. If a claim is received with T2023 HE or T2023 HE U4 in the same month that T1017 HE has been billed, it will be denied for “incidental to another service”.
- Only one session of T2023 HE or T2023 HE U4 is allowed once per month but cannot be billed in conjunction with T1017 HE. The first claim with T2023 HE or T2023 HE U4 will be allowed; any subsequent claims billed within the same month with T2023 HE, T2023 HE U4, or T1017 will be denied for “incidental to another service”.

Section 15.12 Ambulatory Surgery Center Billing Requirements

An Ambulatory Surgery Center (ASC) is a licensed facility that is certified as an outpatient surgical center dedicated to providing medically necessary surgical services that are more intensive than those done in a physician's office but not so intensive that an overnight (or longer) hospital stay is needed.

Claim Submission Requirements

- 837I electronic claim format
- Appropriate CPT code(s)
- Modifiers approved for ASC hospital outpatient
- Procedures that were terminated must be billed with the appropriate modifier
 - Procedures that were terminated after the patient was prepped and taken to the operating room, but before anesthesia was induced, may receive partial ASC payment
 - Procedures that were terminated after the induction of anesthesia, due to medical complications or risk, may receive full ASC payment
- If more than one procedure was performed, use the appropriate modifier(s) for CPT or HCPCS codes for subsequent surgeries
- 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
- The billed procedure must be on the approved ASC facility fee list

Additional Billing Tips

- The following services and supplies are not covered as ASC service nor are they included in the ASC procedure payment. They may be billed separately.
 - Professional services by a Physician, Anesthesiologist, and/or a Certified Registered Nurse Anesthetist
 - Laboratory, x-rays or diagnostic procedures not directly related to the performance of the surgical procedure
 - Ambulance services
 - DME to be used in the patient's home
 - Take home supplies or medications that were not furnished at the time of the surgical procedure
 - Pathology services
 - Secondary dressings

Section 15.13 Case Management Billing Requirements

SNBC 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-to-face encounters	G9003	\$0.01	Unlimited
Mental Health targeted case management	T2023	Negotiated rate	1x monthly
Per member per month charge	G9002	Negotiated rate	1x monthly

Section 15.14 Chiropractic Billing Requirements

Providers are required to supply an appropriate number of subluxation ICD-10-CM diagnosis code(s) to identify the area(s) of subluxation when billing for the following CPT procedure codes:

- 98940 – Chiropractic manipulative treatment; spinal, one to two regions
- 98941 – Chiropractic manipulative treatment; spinal, three to four regions
- 98942 – Chiropractic manipulative treatment; spinal, five regions

Listing all applicable diagnoses will confirm the medical necessity for the treatment provided when using the above referenced CPT codes. If a claim is received that does not contain an appropriate number of diagnosis codes, Hennepin Health will deny that claim with a reason of procedure inconsistent with diagnosis.

Section 15.15 Diagnostic Radiology Billing Requirements Computerized Tomography (CT) Scans

Providers who perform CT scans must designate a CT modifier on claims billed for CT scans performed on scanning equipment that does not meet the National Electrical Manufacturers Association (NEMA) standards. For dates of service on or after January 1, 2018, a 15% payment reduction will apply to claims billed with a CT modifier. Information on NEMA standards for CT equipment can be found on their website.

X-Rays

Providers who perform x-rays must designate an FX modifier for x-rays taken by film (non-digital). For dates of service on or after January 1, 2018, a 20% payment reduction will apply to claims billed with an FX modifier indicating x-ray services taken by film.

Section 15.16 Health Care Homes (HCH) Billing Requirements

- 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 HCPCS 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

Code	Code Description	Billable Units	Billing Criteria
S0280	Medical home program, comprehensive care coordination and planning, initial plan	1	Allowed once per 12-month period. Services exceeding this criteria will be denied. "Benefit maximum for this time period has been reached"
S0281	Medical home program, comprehensive care coordination and planning, maintenance of plan	1	Allowed to be billed once per month, per member. Services exceeding this criteria will be denied "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	Basic	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 HCH 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 HCH 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.
- 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 Concurrent Services
- The following services are considered duplicative of Healthcare Home Services:
 - Behavioral Health Home

Section 15.17 Nursing Facility Billing Requirements

Hennepin Health requires all nursing home facility claims to be submitted with an associated [Nursing Facility \(NF\) Communication Form](#). The Nursing Facility Communication 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 must match the information on the Nursing Facility Communication Form. Claims submitted without the required information on the associated form will be denied.

Section 15.18 Out of Network Billing Requirements

Out of Network Providers within 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 [Provider Information Form for Non-Contracted Providers \(PIF\)](#)
- A current [W-9 form](#)
- Completed PIF and W-9 form are to be faxed to 612-632-8830.

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

Billing 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 Network Providers Outside of Minnesota

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 the [Provider Information Form for Non-Contracted Providers \(PIF\)](#)
- A current [W-9 form](#)
- Completed PIF and W-9 form are to be faxed to 612-632-8830.

Billing Requirements

Out-of-Area providers practicing outside the State of Minnesota are required 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.

Section 16: Provider Rights and Responsibilities

Section 16.1 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.

Section 16.2 Provider Responsibilities

- As providers, you are expected to verify member eligibility and coverage.
 - Hennepin Health member eligibility information is available through Change Healthcare 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 chc_pcssupport@changehealthcare.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 Member Services 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 Member Services at 612-596-1036.
- Notify Hennepin Health of complex discharge plans; call Member Services at 612-596-1036 and ask to speak to a medical services coordinator.
- 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

Section 17: Provider Accessibility and Availability

Section 17.1 Definitions

Emergency: care which is medically 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.

Section 17.2 Appointment Guidelines

- Emergency - immediate access if on-site or call 911.
- Urgent or acute - same day access or within 24 hours.
- Routine: physicals or health maintenance exams - 45 days

Appointment Access Survey

Hennepin Health calls providers to survey appointment availability for both urgent and routine visits. 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.

Section 17.3 Provider Termination - Continuity of Care

Hennepin Health will provide a mechanism to ensure that an adequate provider network is available to members and to ensure that that continuity of care for members 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 member'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 15 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 members 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 Hennepin Health contracted provider. For members newly enrolled with Hennepin Health, the medical administration team will provide authorization to receive covered services through the member's current provider for the following conditions:

- For up to 120 days if the member is engaged in a 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 of pregnancy;
 - 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
 - for the rest of the member's life if a physician certified that the member has an expected lifetime of 180 days or less
- The member 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.

- The member 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 plan 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 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 member's health care provider's regular fee for that service;
- Adhere to Hennepin Health's service authorization requirements;
- Maintain 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 Hennepin Health 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

Section 17.4 Provider Non-Interference

Hennepin Health members, especially those with a lack of understanding of the U.S. healthcaresystem, those with limited English proficiency and those with low literacy, are often unable to effectively communicate their needs and advocate for themselves. Hennepin Health allows and encourages providers to give advice and advocate for their Hennepin Health patients.

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

- Giving members 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 18: Credentialing Program

Section 18.1 Definitions

Administrative Review: Credentialing files that meet a set of criteria unrelated to the Provider's professional performance, which are submitted with affirmative disclosure of misdemeanor convictions or other administrative variances that do not meet the qualifications for Credentialing Committee review. These files are submitted to the Chief Medical Officer (CMO) or Associate Medical Director (AMD) for review and determination.

Appeals Committee: Committee whose purpose is to hear appeals from Providers after the Credentialing Committee has recommended denial, suspension, termination or has recommended or imposed disciplinary action based on professional conduct or competence.

Applicant: A Practitioner or Provider that submitted the required documentation and is seeking to become or continue to be a Credentialed Provider within the Hennepin Health network.

Board Certification: Certification obtained from a nationally recognized board by a Practitioner as proof that a Practitioner has satisfied requirements/standards in their licensed or field of practice.

Chief Medical Officer (CMO): Designated head of medical services, holding an active medical license. The CMO serves as the Chair of the Credentialing Committee, directly responsible for the Hennepin Health Credentialing Program and otherwise serves as a resource to the Hennepin Health Credentialing team.

Clean File: Credentialing files for Providers that have been reviewed by Credentialing staff and approved by the CMO or designee as complete, without variation from Professional or Administrative criteria.

Corrective Action Plan (CAP): A step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: (a) identify cost-effective actions that can be implemented to correct the root cause of errors; (b) develop and implement a plan of action to improve processes or methods so outcomes are more effective and efficient; (c) achieve measurable improvement in high priority areas; and (d) eliminate repeated deficient practices.

Credentialing: The review of qualifications and other relevant information pertaining to a Provider subject to credentialing who seeks to participate as a network Provider, under contract, with Hennepin Health.

Credentialing Committee (CC): Committee responsible for reviewing credentialing and re-credentialing files with appropriate administrative and professional criteria set forth in this Credentialing Program. Reviews and approves changes to the Credentialing Program, including changes to or adoption of credentialing procedures.

Credentialing Program: A written document which contains Hennepin Health's credentialing and re-credentialing requirements, policies and procedures and includes, by reference, the Organization Credentialing Manual and the Credentialing Delegation Manual. This program is submitted to the Hennepin Health CC, no less than yearly, for review and approval.

Delegate: Provider that enters into a Delegated Credentialing Agreement and agrees to manage the Credentialing and Re-credentialing process for designated Practitioners employed and/or contracted with the Delegate in a manner consistent with the Hennepin Health Credentialing Program, Nationally Committee for Quality Assurance (NCQA) Credentialing Standards and Guidelines, statutory and regulatory requirements.

Delegated Credentialing Agreement: A formal process by which Hennepin Health delegates certain credentialing and re-credentialing functions to a specific participating organization (“Delegate”), giving the organization authority to perform Practitioner credentialing on behalf of Hennepin Health consistent with the standards of Hennepin Health’s Credentialing Program, including the Delegated Credentialing Manual.

Ongoing Monitoring: Continual assessment between credentialing cycles using various methods to ensure Providers are compliant with contractual, statutory and regulatory requirements while meeting standards of care.

Organization Credentialing: The review of qualifications and other relevant information pertaining to an organization subject to credentialing who seeks to participate as a network Provider, under a contract, with Hennepin Health in adherence to this Credentialing Program, including the Organization Credentialing Manual.

Organization Provider: Health care facilities that provide health care services, such as hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, and inpatient, residential and ambulatory mental health or substance abuse services.

Practitioner Appeals: Practitioners, participating with Hennepin Health, who appeal a Credentialing Committee or designee decision based on professional conduct or competence.

Practitioner: Individual health care professionals, participating with Hennepin Health as a contracted provider, permitted by law to provide health care services.

Professional Conduct Concerns: A problem or situation that puts a member at risk, fails to meet Quality of Care standards for a Practitioner’s peer group or represents a departure from a Provider’s scope of practice or licensure.

Professional Review: Credentialing files with affirmative disclosure statements related to gross misdemeanor or felony conviction(s), impact to license to practice or related to clinical performance and meet the threshold for review as stated in Section V.I of this document. These files are submitted to the Credentialing Committee for review and determination.

Provider: Practitioner or Organization Provider providing health care services under contract with Hennepin Health that is licensed or otherwise authorized to render services.

Quality of care (QOC)/Quality of services (QOS) Grievance/Complaint: An expressed dissatisfaction regarding health care services resulting in potential or actual harm to a member. QOC grievance/ complaint may include the following, to the extent that they affect clinical quality of health care services rendered: access, provider and staff competence; clinical appropriateness of care, communications, behavior; facility and environmental considerations; and other factors that could impact the quality of health care services. QOS grievance examples are inappropriate behavior or rudeness.

Re-Credentialing: The re-review of qualifications and credentialing criteria for providers every thirty-six (36) months in accordance with the process criteria described herein.

Site Visit: Physical inspection or tour of a location for evaluating the health and safety of the location for Hennepin Health members.

Symplr Payer: The system in which the contracting and credentialing data is stored.

Section 18.2 Introduction

The Hennepin Health Credentialing Program is a comprehensive program that incorporates all aspects of the credentialing process and governance and can be provided upon request. Hennepin Health evaluates and selects which Practitioners and Organization Providers are accepted for participation in Hennepin Health networks. This Credentialing Program outlines the standards, policies, and procedures for the acceptance, discipline, denial and termination of Providers. All Practitioners are held to the standards listed within this Credentialing Program regardless of providing services in an office, hybrid location, or a fully remote setting. Credentialing determinations are guided by an evaluation of Practitioner capability to provide comprehensive, safe, effective, efficient, and quality care to Hennepin Health members, in addition to the assessment of the Practitioner's background, credentials and qualifications. The Credentialing Program is compliant with regulatory requirements and the requirements set forth by the Minnesota Department of Human Services (DHS), the Minnesota Department of Health (MDH), the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA) and other state or federal regulatory bodies.

This Credentialing Program may be changed at any time upon approval by the Hennepin County Board of Commissioners or the Hennepin Health Credentialing Committee. Any change in legal, regulatory or accreditation requirements shall automatically be incorporated into the Credentialing Program and made effective as of the applicable requirement's effective date. Changes shall be effective for all new and existing Providers from the effective date of the change. Hennepin Health will make every effort to communicate all changes at least sixty (60) calendar days in advance of their implementation via provider communication channels including, but not limited to the Hennepin Health Provider Manual.

Hennepin Health retains discretion in accepting, disciplining, denying, or terminating Providers. Hennepin Health may deny or suspend participation of a Provider, terminate a Provider's participation or impose other disciplinary action in accordance with the Provider's written participation agreement, the Hennepin Health Credentialing Program and/or the policies, procedures and processes adopted from time to time by Hennepin Health.

Section 18.3 Policy on Non-Discrimination

Hennepin Health will not discriminate against any Practitioner who is acting within the scope of his or her license under state law with respect to participation, reimbursement or indemnification, solely on the basis of such licensure. Hennepin Health believes that our continued success depends on a positive environment complete with a network of qualified individuals regardless of race, ethnic/national identity, national origin, religion, creed, gender, gender expression, sexual orientation or identification, disability, age, marital status or military status, the types of procedures a Practitioner performs within his or her scope of practice, the types of patients a Practitioner sees, or any other characteristic protected under applicable

local, state and federal laws. Participation criteria as set forth in this Credentialing Program are applied uniformly to all Applicants for initial and continued participation. Hennepin Health shall require the members of the CC to sign, on an annual basis, compliance documents including a Confidentiality and Non-Discrimination Agreement. Prior to the commencement of an Appeals Committee session, all voting members of the Appeals Committee will be required to sign a Confidentiality and Non-Discrimination Agreement.

Hennepin Health ensures non-discrimination in the credentialing process in the following ways:

- a) The Credentialing department is required to process applications based on oldest received date;
- b) A percentage of applications, are peer audited prior to submission to CC or designee;
- c) Quality Management (QM) investigates all complaints/grievances alleging discrimination and reports those findings to the CC;
- d) Hennepin Health does not request, record, or track Practitioner race, ethnic/national identity, religion, national origin, creed, sexual orientation or disability;
- e) Hennepin Health collects Providers' birth dates and languages spoken; however, this information is not presented during the Credentialing or Re-credentialing process;
- f) The Credentialing department is responsible for redacting CC discussion threads relating to the details of a case in the event the case is submitted for external or peer review.

Reports are generated on a monthly basis to determine the age of Credentialing applications, ensuring the oldest applications are processed first. Credentialing management reviews the monthly reports to ensure correct processing by staff.

Section 18.4 Policy on Confidentiality of Data

All committees described in the Credentialing Program, the Hennepin County Board of Commissioners and Credentialing staff supporting Credentialing actions operate as review organizations pursuant to Minnesota Statutes § 145.61 et seq. and professional review bodies pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq. Documents used for the purposes of Credentialing are stored in a secure area of Symplr Payer with access limited to authorized individuals. Credentialing information is not released except to the extent necessary to carry out one or more of the purposes of the review organization as described in Minnesota Statutes § 145.64, or otherwise permitted or required by law. Release of Credentialing information to any external organization or individual may only occur upon approval from Hennepin Health Provider Operations and Compliance management.

Information obtained, created or reported pertaining to, or in support of, Provider Credentialing is secured in Symplr Payer. The Symplr Payer access roles are based on the person/area requiring access to Symplr Payer for the purpose of claims, contracting or credentialing, with credentialing specialists retaining full access to the Provider records within Symplr Payer. Information deemed confidential in nature such as adverse events or disciplinary actions are restricted from view for all non-credentialing personnel. Persons with access to confidential Provider information are required to exercise every reasonable precaution to safeguard the confidential information. Hennepin Health staff are to ensure Provider files and other confidential documents are not accessible by unauthorized persons and conversations involving confidential information are conducted in a manner as to respect the sensitivity of the data and to maintain confidentiality. Hennepin Health staff complete the Hennepin Health privacy training,

compliance training and confidentiality statement at the time of hire and annually thereafter, which includes expectations and guidelines for password generation and protection. Information is maintained electronically for a period of ten years beyond the termination of the Provider's relationship with Hennepin Health

Section 18.5 Credentialing Committee

The Hennepin County Board of Commissioners has formally delegated authority for the Credentialing Program to Hennepin Health's CC. The CC delegates its responsibility for oversight and administration of the Credentialing Program to the Chief Medical Officer (CMO) and/or designee should the CMO be unavailable. The CC has formally delegated review and approval of Clean Files to the CMO and Associate Medical Director (AMD). The CMO, AMD and all voting CC members are credentialed and subject to the requirements set forth in the Hennepin Health Credentialing Program. Ad hoc Committee members are not required to be credentialed by Hennepin Health but will be members of the Hennepin County medical community in good standing, as determined by the Hennepin Health CMO.

The CC is a peer review body with members drawn from Providers participating within the Hennepin Health network. The CC is responsible for reviewing and approving the Credentialing Program, granting authority and/or determining if a Provider's Hennepin Health application for initial or ongoing participation meets the minimum professional criteria established by Hennepin Health including reviewing cases which meet the threshold for review, substantiated Quality of Care/Quality of Service complaints and grievances and Professional Conduct Concerns. The Credentialing Committee may approve, deny, suspend, restrict or terminate a Provider's status with Hennepin Health.

CC voting members must have an active license to practice in the State of Minnesota and be part of Hennepin Health's contracted network. The CC consists of a 4 to 6 practitioners with voting rights, and members of Hennepin Health's Compliance and Credentialing with no voting rights. Members from other areas of Hennepin Health may be requested to attend CC meetings on an ad hoc basis as determined by the subject matter.

A minimum of three voting members are required to attend a CC meeting to qualify as a quorum. Action is taken by majority vote. The CMO votes if there is a tie vote, in order to break the tie. If, during a meeting, a quorum is no longer met, the voting must cease. As applicable, the CC meets on a monthly basis to review files, changes to programs and policy and procedures and more frequently if necessary.

The Committee Chair may temporarily, in writing, add a licensed Practitioner to hear professional credentialing matters that require peer expertise not available from existing CC members. The ad hoc Practitioner must sign the Confidentiality/Non-Disclosure and Delegation of Authority agreements, be a participating practitioner within the Hennepin Health network and agree to comply with the same standards as a CC member.

Credentialing Committee decisions are made during meetings in-person, via a conference call or video conferencing. The CC may request further information from the Applicant, table an application pending the outcome of an investigation of the Practitioner by any authority, organization or institution, or take other action as deemed appropriate and relevant. CC decisions are communicated to the Provider via email within 30 days of Committee decision.

Credentialing Committee members are required to:

1. provide thoughtful consideration of Credentialing information through evaluation of background and qualifications of the initial and renewal applications of current Providers and Applicants;
2. review and provide determination of referrals relating to potential Quality of Care/Quality of Service (QOC/QOS) Grievance/Complaint from QA as outlined in this Program, QM program and Credentialing processes;
3. recommend disciplinary actions against Providers determined to be out of compliance with Hennepin Health contractual requirements in addition to state and federal laws rules and regulations; and
4. review and provide determination of professional issues related to a new or current Provider discovered through the Credentialing, Re-credentialing or Ongoing Monitoring processes, included and not limited to:
 - a. Closed, settled, completed or otherwise adjudicated malpractice within the last five (5) years that do not result in a resolution of dismissed or dismissed with prejudice; and/or
 - b. Open and/or active reprimands, suspension, correction orders or other licensing board actions within the last five (5) years;
 - c. Any criminal history currently being investigated or has resulted in conviction within the last ten (10) years;
 - d. Any previous or current federal or state sanction; and/or
 - e. More than two (2) cases, incidents or adverse events within the past ten (10) years old; and/or
 - f. Drug or Alcohol dependency disorders within the last ten (10) years; and/or
 - g. Cases that do not meet threshold for review but deemed egregious in nature by credentialing staff.

All other cases are delegated to CMO and/or AMD for review and determination, reserving the right to escalate a case to CC for review. Emergent decisions may be made by the CMO or designee, when reasonable information has been submitted indicating Hennepin Health member(s) may be endangered by potentially unsafe, unethical or inappropriate care or treatment. When an emergent decision is made resulting in the suspension, restriction or termination of a Provider, written notification will be sent to the Provider. Within ten (10) business days of a notification for suspension, all pertinent information is gathered for review via an ad hoc CC meeting.

If the CC takes action against an Applicant or Provider, the Applicant or Provider is notified in writing, via Certified Mail, within thirty (30) calendar days following the date of the action. The notification will include a written explanation, summary of reasons for the disciplinary action and a detailed description of the appeal process.

This description includes the following rights:

1. to request a hearing not less than thirty (30) days from the date of appeal, unless a shorter period is mutually agreed to by Provider and Hennepin Health;
2. to be represented by an attorney or other person of Applicant or Provider's choice;
3. to be provided the date, time and place of hearing;
4. to have a record made of the proceedings by a court reporter;
5. to call, examine, and cross-examine witnesses;
6. to present evidence determined to be relevant by the Appeals Committee, regardless of its admissibility in a court of law;

7. to submit a written statement at the close of the hearing; and
8. the fax number, email address and USPS address to submit an appeal

Provider may submit a written request for reconsideration of determination to the CC within thirty (30) calendar days of receiving notification from Hennepin Health. Requests for reconsideration must address the issues identified by the CC including providing additional information and/or supporting documentation. Upon receipt, Hennepin Health will send the Applicant or Provider an acknowledgement communication. Failure to submit a written request for reconsideration within thirty (30) calendar days of receiving notification from Hennepin Health will be deemed a waiver of the Providers' right to appeal. Requests for postponement or extension, or failure to appear at the appeal hearing, without good cause, will be deemed a waiver of the Providers' right to appeal.

Section 18.6 Hennepin Health Appeals Committee

Appeals Committee members are selected by Hennepin Health's Compliance Committee. The Appeals Committee consists of 1 member of the Compliance team serving as chairperson, 2 Hennepin Health participating Practitioners participating of the same healthcare specialty as the subject Practitioner, and up to 4 Hennepin Health participating practitioners.

The Appeals Committee is responsible for:

1. review of all information submitted by the Credentialing staff, CC and Provider (Note: Peer review discussion notes are confidential and may only be disclosed pursuant to Minn. Stat. § 13.04 and Minn. Stat. § 145.64.);
2. maintaining all information and deliberations in strictest confidence;
3. hearing all information present by or on behalf of the Provider during the Appeals Committee meeting;
4. providing fair and prompt resolution to appeals raised by Providers;
5. notifying the Applicant or Provider of the decision; or
6. reporting serious QOC/QOS deficiencies to the appropriate state/national board and act as final authority in Provider participation decisions.

Appeal rights are not offered to Providers with an active federal or state exclusion. Pursuant to Hennepin Health's contract with the Minnesota Department of Human Services (DHS) as well as federal law, Hennepin Health is prohibited from contracting with any individual or entity listed on a federal or state exclusion list.

Appeals rights are offered if the Credentialing Committee:

1. denies an initial Credentialing or Re-credentialing application;
2. approves an application with conditions;
3. alters the condition of Hennepin Health network participation; or
4. notes an applicant or providers has privileges reduced, suspended, termination, or otherwise subject to adverse action based on professional conduct or competence

The Appeals Committee chairperson or designee will facilitate the scheduling and review of the case by the Appeals Committee not less than thirty (30) calendar days of receipt of Provider appeal. Any hearing will occur prior to the effective date of the termination or other disciplinary action,

except in the case of an actual or potential danger to a Hennepin Health member or a disciplinary action limited to less than thirty (30) days. The Appeals Committee chairperson or designee will notify the Provider, in writing, of its intent to review the appeal including date, time and location of the Appeals Committee hearing and other administrative details.

The Appeals Committee shall review all pertinent documentation and any new information relating to the original decision. The Appeals Committee shall make its determination based on the information and evidence produced at the hearing, including the oral testimony of witnesses, summary oral and written statements, all officially noticed matters, and all documentary evidence submitted to the Credentialing Committee and at the hearing. Following the hearing and the receipt of any written statements, the Appeals Committee shall convene to review and determine the case. The Appeals Committee may uphold, reject, or modify the original action. The Appeals Committee's decision shall be by majority vote. The Provider is notified in writing, via Certified Mail, within thirty (30) calendar days following the date of the action, of the Appeals Committee's decision and will include a statement of the basis for the decision. Final determinations shall be binding and not subject to further appeal. Upon completion of the appeals hearing, no further rights to appeal or appear before the Appeals Committee will be extended.

In the event that participation is denied or terminated from the Hennepin Health network, the Provider is ineligible for Credentialing reapplication for two (2) years following the effective date of denial or termination, unless the Appeals Committee, in its sole discretion, deems a shorter period to be appropriate.

Section 18.7 Hennepin Health Credentialing Staff

Hennepin Health Credentialing staff develop and maintain the Hennepin Health Credentialing Program and any other credentialing policies, procedures, work guides and workflows necessary to ensure compliance with federal and state regulations and NCQA Standards and Guidelines for Health Plan Credentialing Standards.

Credentialing staff are responsible for notifying Applicants of the following rights:

1. To review information obtained and used to evaluate a Credentialing application except for references, recommendations and/or peer-review protected information;
2. To access the provider manual at any time via the Hennepin Health website;
3. To receive information regarding Hennepin Health, its services, member rights and responsibilities;
4. To receive the status of their Credentialing or Re-credentialing application via email or phone call, within 3 days of the initial request;
5. To access information, from outside sources such as state licensing boards and malpractice carriers, obtained by Credentialing staff used to evaluate credentialing applications;
6. To access redacted copies or summaries of information (redaction may be required to protect the confidentiality of an individual who provided information to the CC);
7. To be offered ability to correct erroneous, missing, incomplete or discrepant information

An Applicant is notified within 3 business days, via email, of the discovery of an application discrepancy, missing documents or incomplete information. An Applicant is provided 10 business days from notification by Credentialing staff to correct erroneous, missing, incomplete or discrepant information obtained during the Credentialing process that varies substantially

from the information provided by the Provider and to submit a corrected statement and/or supporting documentation via email to hhcredentialing@hennepin.us. Appeal rights are communicated via the Provider Manual and automated email response from the Credentialing inbox.

The foregoing does not require Hennepin Health to alter or delete any information contained in a Credentialing file, nor does it require Hennepin Health to disclose to a Practitioner's references, decisions, or other peer review protected information.

Credentialing staff shall perform credentialing functions including preparing cases for the CMO, AMD and/or Credentialing Committee and Appeals Committee review. All information and documentation obtained by Hennepin Health as part of the Credentialing or Re-credentialing application review process must be collected and verified prior to all Credentialing decisions. The Credentialing staff are responsible for providing a list of Practitioners approved via Clean File review in the previous month.

Credentialing staff are responsible for providing a list of Practitioners approved via Clean File review in the previous month. Credentialing staff are responsible for notifying Providers within 60 days of:

- approval for initial Credentialing
- file review by the CC, Appeals Committee or designee

Credentialing is responsible for ensuring information provided in member materials, including provider directories, is consistent with the information obtained during the Credentialing process. Practitioner qualifications in such member materials will accurately reflect Practitioner's education, training, certification and designated specialty gathered during the Credentialing process. Credentialing is required to process all add, term and change requests within thirty (30) calendar days of receipt. Provider data changes are reflected in the on-line directory immediately following the update to Symplr Payer. The hard copy directory is updated on intervals established by DHS.

Section 18.8 Acceptance of Practitioners

Practitioners must be fully credentialed pursuant to this Credentialing Program prior to providing care to Hennepin Health members, submitting claims, or being listed in any member materials or provider directories as a Provider for a Hennepin Health member.

The following Practitioner types are subject to this Credentialing Program:

- advanced practice registered nurses (APRN) including nurse practitioners, nurse anesthetists, and certified nurse midwives;
- acupuncturists;
- chiropractors (DC);
- doctors of optometry (OD);
- doctors of podiatric medicine (DPM);
- licensed alcohol and drug counselor;
- licensed marriage and family therapist (LMFT);
- licensed professional clinical counselor (LPCC);
- master's-level clinical social workers (LCSW);
- mental health rehabilitative professionals (ARMHS only);

- physician (Medical Doctor, Doctor of Osteopath);
- physician assistants (PA);
- psychiatrists;
- psychologists doctoral or master's-level (Ph.D., Psy.D, Ed.D, MA, MS);
- psychotherapists (Ph.D., Psy.D, Ed.D, MA, MS);
- oral and maxillofacial surgeons

Section 18.9 Criteria for Participation

The criteria for participation in Hennepin Health's network include, but are not limited to, the following:

1. Applicant's application has not previously been denied or participation terminated for cause by Hennepin Health within the preceding 24 months, unless reviewed and approved by CC;
2. Applicant is appropriately licensed or registered to practice in the state(s) where the Applicant will render services to Hennepin Health members;
3. Applicant has completed appropriate post-graduate training, as defined by the appropriate state licensing or registration agency of the Applicant's profession, or as otherwise defined by Hennepin Health,
4. Applicant has sufficient qualifications and training for the practice area for which Applicant seeks participating practitioner status, as determined by Hennepin Health, in its sole discretion;
5. If Applicant's practice requires clinical privileges that allow for hospital admission, Practitioner: (a) maintains such privileges in good standing at a hospital participating with Hennepin Health, (b) provides evidence that Applicant has made satisfactory arrangements for another Hennepin Health participating Practitioner to admit Hennepin Health members, or (c) requests a waiver from this requirement, with an explanation as to why the clinical privileges are not necessary for Applicant's care and treatment of Hennepin Health members;
6. Applicant has a current and valid DEA registration or prescriptive authority unless the practitioner license does not allow prescription of controlled substances and therefore the practitioner does not maintain DEA registration or prescriptive authority;
7. Upon request by Hennepin Health, Applicant has signed a consent or release of information necessary to permit Hennepin Health to monitor compliance with stipulations, orders or CAP's of a state licensing board, accreditation or other health care organization;
8. Applicant has not misrepresented, misstated or omitted a relevant or material fact on the application, disclosure statements or any other documents provided as part of the Credentialing process;
9. Applicant has not engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction;
10. Applicant has not engaged in any unprofessional conduct, including willful or negligent disregard of patient health, safety or welfare, professionally incompetent medical practice, failure to conform to minimal standards of acceptable and prevailing medical practice, or failure to maintain appropriate professional boundaries;
11. Applicant has not engaged in any sexual misconduct, nor in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional or sexual abuse or harassment;
12. Applicant has not engaged in any unethical conduct, including actions likely to deceive, defraud or harm patients, Hennepin Health or the public;
13. Applicant has not personally engaged in or otherwise contributed to the submission of

- claims for payment that were false, negligently incorrect, intentionally duplicated or indicated other abusive billing practices;
14. Applicant has not been sanctioned or excluded by federal, state or local government programs;
 15. Applicant does not have a history of professional liability lawsuits or other incidents, or the application fails to disclose such history, that constitute a pattern and/or indicate a potential QOC/QOS concern;
 16. Applicant has not been involuntarily terminated from professional employment or as hospital medical staff or resigned from professional employment or as hospital medical staff after knowledge of an investigation into Applicant's conduct, or in lieu of disciplinary action;
 17. Applicant has not disclosed an ongoing medical or physical condition likely to adversely affect Applicant's ability to perform the essential functions of Applicant's profession with or without reasonable accommodation;
 18. Applicant has not disclosed an ongoing medical or physical condition that could adversely affect Applicant's ability to practice safely and/or constitute a direct threat to the health and safety of others;
 19. Applicant has not used illegal drugs during the past three (3) years;
 20. Applicant has not engaged in disruptive behavior as specified in Hennepin Health credentialing policies that inhibits the performance of the job responsibilities of Hennepin Health staff; and
 21. Applicant has not engaged in other behavior, whether or not related to Applicant's role as a healthcare professional, which calls into question Applicant's judgment, honesty, character, and/or suitability to provide care to Hennepin Health members.

Section 18.10 Initial Credentialing Process

Hennepin Health follows a defined process and makes all Credentialing decisions using criteria based on Provider's ability to deliver care. Upon receipt of an application, Credentialing staff review the application to ensure it meets the participation criteria set forth in this Credentialing Program. Practitioners must be Credentialed and approved for network participation prior to providing care to members, submitting claims or being listed in any member materials or provider directories. In accordance with Minnesota Statute 62Q.97, within 7 business days of receipt, Credentialing staff will determine if a practitioner application is deemed clean for practitioner credentialing. Practitioner credentialing will be completed within 45 days after receiving a clean application, unless Hennepin Health identifies a substantive quality or safety concern in the course of practitioner credentialing that requires further investigation. If a practitioner file is deemed to be deficient, missing information, or has substantiated concerns, Credentialing staff will inform the practitioner within 3 business days of determining the application is not a clean application. The Practitioner or designee is provided 10 business days to provide the additional information, as requested by Credentialing staff. If the practitioner or designee provides the requested information within 10 business days, Credentialing staff is allowed 30 additional days to investigate any quality or safety concerns and present their findings to the Credentialing Committee. If the Practitioner or designee is non-responsive to the request(s) from Credentialing staff, the practitioner will be notified of the application being closed for lack of response.

A Practitioner will need to undergo initial Credentialing if:

1. Practitioner is new to the Hennepin Health network

2. Practitioner has had a break in network participation greater than 30days
3. Practitioner failed to Re-credential in a timely manner
4. Practitioner is no longer affiliated with a Hennepin Health delegate

Any updates, edits, or modifications to applications and/or attestations must be made, initialed and dated by Practitioner or the Practitioner must resubmit a clean document(s). All Providers shall fully cooperate in providing Credentialing staff with all supporting documents needed to satisfy Credentialing requirements, including primary verification requirements.

Credentialing staff will present Practitioners to the CMO and/or AMD for Clean File and Administrative review and CC for those meeting thresholds for review. The CC shall rescind approval of a Practitioner for participation, in the event Practitioner is not actively practicing at a Hennepin Health contracted facility within 180 calendar days of the CC's decision.

Hennepin Health does not fully credential locum tenens hired to cover Practitioners for less than 90 days. Locum tenens is defined as a Practitioner who is filling in for another Practitioner on a temporary basis and does not have an independent relationship with Hennepin Health. A Minnesota Practitioner change form must be submitted for the locum tenens and primary source verification of license, sanctions and adverse actions must be completed with no adverse results. Locum tenens with adverse results will be required to undergo the full Credentialing process.

Section 18.11 Re-Credentialing Process

The Re-credentialing process shall take place at least every 36 months for Practitioners. Continued participation by a Practitioner is conditioned upon the continued execution of a participation agreement with Hennepin Health and continued compliance with all credentialing, administrative, and contractual requirements. Practitioners must be Re-credentialed and approved by CC or designee by the last day of the month in which they are due to remain in good standing and continue to appear in member materials and provider directories as participating.

Credentialing staff sends an email request to the Provider credentialing contact listed within Symplr Payer, notifying them of the Practitioner(s) re-credentialing due date with Hennepin Health. When necessary, Credentialing staff will include in the email a MN Universal Re-Credentialing application template and checklist of supporting documents, within 3 business days of request. The Practitioner may return the completed application and supporting documents via email, fax, or USPS mail or through the Minnesota Credentialing Collaborative (MCC).

Any needed updates, edits or modifications to applications and/or attestations must be made, initialed and dated by Practitioner or the Practitioner must resubmit a clean document(s). All Practitioners shall fully cooperate in providing Credentialing staff all supporting documents needed to satisfy credentialing requirements, including primary verification requirements.

Credentialing will review all applications and determine completion status. If an application is incomplete, Credentialing will follow the Re- Credentialing follow-up process. Credentialing staff will present Practitioners to the CMO/AMD for Clean File review, CMO for Administrative review and CC for those meeting threshold for review.

Section 18.12 Primary Source Verification

Hennepin Health Credentialing staff shall collect and verify all credentials in accordance with NCQA Credentialing standards by utilizing any of the following sources to verify credentials:

1. the primary source (or its Web site);
2. a contracted agent of the primary source (or its Web site) where Hennepin Health has obtained documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.
3. State Medicaid agency or intermediary;
4. list of Excluded Individuals and Entities maintained by the Office of the Inspector General (OIG);
5. Medicare Exclusion Database;
6. Federal Employee Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General;
7. National Plan and Provider Enumeration System (NPPES);
8. Excluded Parties List System (EPLS) via Systems for Awards Management
9. Drug Enforcement Agency (DEA) agency or copy of DEA certificate or the National Technical Information Services (NTIS) database;
10. American Medical Association (AMA) Physician Masterfile, American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or Physician Master File (DEA only); and
11. Social Security Death Master (SSDM)

Primary source verification is entered into eVIPs. Each user of eVIPs is provided with a unique electronic identifier and password to ensure accurate audit trails, data integrity and security. Information and documentation obtained by Hennepin Health as part of the Credentialing or Re-credentialing process must be collected and verified prior to all Credentialing decisions. Hennepin Health Credentialing staff shall conduct timely verification of Provider's credentials to ensure it is within the prescribed time limit as reflected below. All verifications will include notation of date verified and the identification of the Credentialing staff who completed the verification. Verification time limits are based on the Credentialing Committee determination date, not the date of submission to the Credentialing Committee.

Licensure

Verification Time Limit: 180 calendar days

Licensure verification is required for Credentialing and Re-credentialing. Hennepin Health verifies that Practitioner has a valid and current license to practice at the time of Credentialing decision. Hennepin Health verifies licenses in all states where Practitioner provides care to Hennepin Health members. Licenses are verified directly with the state licensing or certification agencies.

DEA Certificates

Verification Time Limit: 180 calendar days

DEA verification is required for Credentialing and Re-credentialing. Hennepin Health verifies that each Practitioner qualified to write prescriptions holds a valid and current DEA certificate in each state where Practitioner provides care to Hennepin Health members.

Hennepin Health may Credential a Practitioner whose DEA certificate is pending. The Applicant or Practitioner must provide documentation of a Practitioner with a current and active DEA license, who will write prescriptions for Hennepin Health members (when

needed) until the Applicant or Practitioner's DEA certificate is issued. Credentialing staff will present these situations to the CMO or designee for Administrative Review and determination. Credentialing staff will continue to monitor the file, using self-alerts, with the expectation that the Practitioner promptly submit a copy of the valid DEA certificate once received. If a Practitioner has not received a DEA certificate within six (6) months of monitoring start date, the Provider will be contacted for follow-up. If a qualified Practitioner does not prescribe medications or does not hold a valid DEA certificate, then Practitioner must notify Hennepin Health and Hennepin Health will note this in Practitioner's credentialing file.

Education and Training

Verification Time Limit: Prior to the credentialing decision

Education verification is only required during initial Credentialing. Hennepin Health will verify the highest of the three following levels of education and training obtained by each Practitioner as appropriate:

- a) Board Certification
- b) Residency
- c) Graduation from medical or professional school

Hennepin Health will verify education through at least one of the following sources:

- a) The primary source;
- b) The state licensing agency or specialty board, if it performs primary source verification as part of the licensing process;
- c) Sealed transcripts, if Hennepin Health can provide evidence that it inspected the contents of the envelope and confirmed the Practitioner completed and/or graduated from the appropriate training program;
- d) AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report, AOA Physician Masterfile (physician only);
- e) Education Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986 (physician only) or AMA's Fifth Pathway program,; or
- f) FCVS for closed residency programs

Board Certification

Verification Time Limit: 180 calendar days

Board certification verification is required for Credentialing and Re-credentialing, if the Practitioner is board certified. Hennepin Health does not require board certification in order to participate within the Hennepin Health network. Hennepin Health will verify board certification on each Practitioner attesting to holding an active and accredited board certification through one of the following sources:

- a) The primary source;
- b) The state licensing agency or specialty board, if it performs primary source verification as part of the licensing process;
- c) American Board of Medical Specialties (ABMS) or its member boards, or an official ABMS Display Agent, where a dated certificate of primary source authenticity has been provided;
- d) AMA Physician Masterfile;
- e) AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report, AOA

- Physician Masterfile (physician only);
- f) registry that performs primary source verification of board status; or
 - g) *Educational Commission For Foreign Medical Graduates (ECFMG)*

If a practitioner has a “lifetime” certification status and/or no expiration date, the record is given a default expiration date of 36 months from the application processing date.

Work History

Verification Time Limit: 365 calendar days.

Work history is only verified during initial Credentialing. Hennepin Health will obtain a minimum of the most recent five (5) years of work history as a health professional through the Practitioner’s application or curriculum vitae (CV). Work history from the initial date of licensure to the present is used if Practitioner has fewer than five (5) years of work history as a health professional.

The application or CV must include the beginning and ending month and year for each position of employment experience. If the Practitioner has had continuous employment for five (5) years or more with no gap in employment, providing only the year will suffice.

Hennepin Health will document the work history review, including any gaps in employment on the application, CV, checklist or other identified documentation methods. If a gap in employment exceeds six (6) months, Practitioner must clarify the gap verbally or in writing to Credentialing staff who will note the clarification in the Practitioner’s credentialing file. Employment gaps exceeding one (1) year must be clarified by Practitioner in writing.

Malpractice History

Verification Time Limit: 180 calendar days

Malpractice history verification is required for Credentialing and Re-credentialing. Credentialing staff will obtain confirmation of the past five (5) years of history of malpractice settlements from the malpractice carrier or through a query with the NPDB and may include years in residency or fellowship. Credentialing staff is not required to obtain confirmation from the carrier for Practitioners holding a hospital insurance policy during residency or fellowship.

Section 18.13 Sanction Information

Sanction verification is required for Credentialing and Re-credentialing and must be completed within 180 days prior to the Credentialing Committee approval date. Hennepin Health will verify Medicare and Medicaid sanctions, state sanctions, restrictions on licensure, and limitations on scope of practice in all states where Practitioner provides care to Hennepin Health members.

Hennepin Health will verify through one or more of the following sources, depending on Practitioner type, for state sanctions, license restrictions or other adverse events relating to licensure:

1. Minnesota Board of Medical Practice
2. Federation of State Medical Boards (FSMB)
3. Minnesota Board of Chiropractic Examiners
4. Federation of Chiropractic Licensing Boards’ Chiropractic Information Network-Based Action Databank (CIN-BAD)

5. Minnesota Board of Dentistry
6. Minnesota Board of Podiatric Medical Boards
7. Federation of Podiatric Medical Boards
8. Minnesota Board of Behavioral Health and Therapy
9. Minnesota State Board of Nursing
10. Minnesota Board of Marriage and Family Therapy
11. Minnesota Board of Psychology
12. State of Minnesota Board of Social Work

Hennepin Health will query state and federal sanction lists at the time of initial Credentialing and Re-credentialing, including Medicare and Medicaid sanctions. This information may be obtained from any relevant source, including state licensing authorities, other government entities, third-party payers, health care providers and professional liability carriers, including:

1. State Medicaid agency or intermediary;
2. List of Excluded Individuals and Entities maintained by the Office of the Inspector General (OIG);
3. Medicare Exclusion Database
4. Federal Employee Health Benefits Plan (FEHB) Program department record, published by the Office of Personnel Management, Office of the Inspector General;
5. Federation of State Medical Boards (FSMB);
6. NPDB; and
7. Social Security Death Master File (SSDM) via Social Security Administration
8. Medicare/Medicaid Exclusion List (DHS Exclusion)
9. Medicare/Medicaid Provider Enrollment (DHS Provider File)

Any Applicant discovered on the sanction or adverse action report(s) will result in an immediate halting of the initial Credentialing process and denial of the Applicant's applications. If the Provider is currently in Hennepin Health's network, the Provider will be immediately suspended from the network and submitted to the Credentialing Committee for review and determination. The Credentialing Committee's review will include information from the applicable agency and/or written statements from the Provider. If a previously issued Medicare/Medicaid sanction is lifted, the Provider must present a copy of the reinstatement letter as issued by the applicable government and/or state agency to Hennepin Health for further consideration. Any Credentialing or Re-credentialing file involving a previously issued sanction, that has since been lifted, will be submitted to the Credentialing Committee for review.

Section 18.14 Supporting Documentation

Application

Verification Time Limit: Prior to the credentialing decision

Applications are required for Credentialing and Re-credentialing. A Provider is required to complete, in its entirety, one application. The application provides notification to the Provider that the following agencies will be queried and reviewed as part of the application process: a) the NPDB,

b) the relevant state licensing board(s); and c) the Medicare and Medicaid Sanctions and Reinstatement Report. The application also notifies the Provider that a report may be submitted to the appropriate state licensing boards and/or the NPDB in the event the application is denied for professional reasons.

Certificate of Insurance

Verification Time Limit: Prior to the credentialing decision

Certificate of Insurance is required for Credentialing and Re-Credentialing. The certificate of insurance must state the amount of Provider's current malpractice insurance, dates of coverage and be current at the time of Credentialing Committee decision. The minimum coverage limits must be \$1 million per occurrence and \$3 million aggregate. Hennepin Health may accept a copy of the insurance face sheet from the malpractice carrier in lieu of collecting the information in the application. For Providers with federal tort coverage, the Credentialing file will include a copy of the federal tort letter.

Delegation Agreements for Physician Assistants

Verification Time Limit: 180 days

A Delegation agreement between a Physician Assistant and the supervising physician is required for Credentialing and Re-Credentialing. The delegation agreement must meet all requirements of Minn. Stat. § 147A.20 and be included within the credentialing file.

Hospital Admitting Privileges

Verification Time Limit: 180 days

Hospital admitting privileges verification is required for Credentialing and Re-credentialing through validation that all applicable physicians have hospital admitting privileges at a hospital participating with Hennepin Health. If a physician does not have admitting privileges, Practitioner must document that he/she has made appropriate admission arrangements with another Hennepin Health network physician to admit patients and this information must be part of the Credentialing file.

Disclosure

Verification Time Limit: 365 calendar days

Disclosure is required for Credentialing and Re-credentialing. Each Practitioner file will include a checklist or other documentation confirming that the following information was verified by Credentialing staff:

- a) Reasons for inability to perform the essential functions of the position.
- b) Lack of present illegal drug use.
- c) History of loss of license.
- d) History of felony and gross misdemeanor convictions.
- e) History of loss or limitation of privileges or disciplinary actions.
- f) Current malpractice insurance coverage.

Attestation

Verification Time Limit: 365 calendar days

Attestation verification is required for Credentialing and Re-Credentialing which must be current and signed confirming the correctness and completeness of the application and all related documents. Applicant must provide Hennepin Health with:

- An unaltered, signed and dated release granting Hennepin Health permission to review the records of and to contact any licensing entity, medical society, medical school, hospital, clinic, insurance company or other entity, institution or organization that has or may have records concerning the Applicant;
- An unaltered, signed and dated release relieving any person, entity, institution or organization that provides information as part of the application process from liability;

and

- A signed attestation dated within 365 days of the credentialing decision, certifying that the application and all supporting documentation is complete and correct as of the date of submission to Hennepin Health.

Professional Liability Claims

Verification Time Limit: 180 calendar days

A complete history of professional liability claims that resulted in settlement or judgement paid on behalf of the Practitioner are required for Credentialing and Re-credentialing. Credentialing staff will request a full history of any such claims at the time of initial Credentialing and/or Re-credentialing. Cases which the Credentialing Committee has previously reviewed and approved, during prior Credentialing cycles, will not be submitted to Credentialing Committee unless a new case results in the application Section 18.10 Acceptance of Organization Providers. In addition to the terms set forth in this Credentialing Program, Organization Providers are reviewed for Credentialing and Re-credentialing purposes in accordance with the Hennepin Health Organization Credentialing Manual. This manual outlines the detailed process for Credentialing and Re-Credentialing these Providers.

Section 18.15 Site Visits

Hennepin Health shall conduct a quality assessment Site Visit if the Organization Provider's location(s) meets the following threshold:

1. The Organization Provider has not had a MDH or DHS site visit within the last 36 months
2. The Organization Provider is not accredited through one of the below listed:
 - a. American Association for Accreditation of Ambulatory Surgery Facilities
 - b. Accreditation Association for Ambulatory Health Care
 - c. American Academy of Sleep Medicine
 - d. Accreditation Commission for Health Care
 - e. Commission on Accreditation of Birth Centers
 - f. Commission on Accreditation of Rehabilitation Facilities
 - g. Continuing Care Accreditation Commission
 - h. Community Health Accreditation Program
 - i. Council on Accreditation
 - j. Healthcare Facilities Accreditation Program
 - k. National Committee for Quality Assurance
 - l. The Joint Commission
 - m. Utilization Review Accreditation Commission
3. A new location is opened under an existing contract where Organization Provider's policies have changed or new services have been added.

Hennepin Health reserves the right to conduct a Site Visit on a facility that meets the threshold for review including sites that have member complaints or those with Professional Conduct Concerns.

Section 18.16 Delegated Credentialing

Providers desiring to enter into a Delegated Credentialing Agreement with Hennepin Health,

to perform Practitioner credentialing on behalf of Hennepin Health, are subject to the process set forth in the Delegated Credentialing Manual. This manual outlines the detailed process for review, acceptance, and monitoring of such delegated Providers and can be provided upon request.

Section 18.17 Ongoing Monitoring and Interventions

Hennepin Health monitors Providers on a monthly basis between Credentialing cycles. Monitoring may include obtaining information from any relevant source, including state licensing authorities, other government entities, third-party payers, health care providers and professional liability carriers. Hennepin Health may take whatever action it deems appropriate based on the information obtained.

Credentialing staff monitors Medicare and Medicaid sanctions, restrictions and limitations imposed on Providers on a monthly basis by obtaining the following reports and comparing against the Providers.

Credentialing staff monitors state disciplinary actions imposed on Providers on a monthly basis. If a licensing board does not publish disciplinary actions on a set schedule, Credentialing staff will check the licensing board monthly, noting when a board did not publish information for that month.

Any Provider discovered on a federal or state sanction list or adverse action report(s) is immediately suspended from the Hennepin Health network and submitted to the CC for review and determination. CC review will include information from the applicable agency and/or written statements from the Provider or designee. Any Provider with a permanent loss of licensure is immediately terminated from the Hennepin Health network with no CC review.

If a previously issued Medicare/Medicaid Sanction is lifted, the affected party may present a copy of the reinstatement letter as issued by the applicable government and/or state agency for consideration for participation in the Hennepin Health Network. Any lifted sanction cases are submitted to CC for review and determination.

QOC/QOS Grievance and Complaint Resolution

Credentialing staff make every effort to resolve complaints against a Provider in an efficient and thorough manner. If the Credentialing team is made aware of a member complaint(s) or grievance(s) against a provider in relation to QOC/QOS, the complaint(s) or grievance(s) and all supporting documentation is escalated to QM for investigation within 1 business day of receipt.

If there are objective findings to substantiate a claim and it involves a reportable offense under the appropriate regulatory agency, the Provider is immediately suspended from the Hennepin Health network. Credentialing staff will submit all findings to the CC or designee for review and determination. On a monthly basis, a report of all Adverse Actions and QOC/QOS complaint(s) or grievance(s) is generated and reviewed by management. Providers who reach the threshold for review, are submitted to the CC for review and determination. Provider retaliation of any kind against a complainant may result in disciplinary actions including and up to termination from the Hennepin Health network.

Corrective Action Plan Monitoring

A CAP may be required from a Provider if a concern is identified in the Credentialing or Re-credentialing process, a pattern of substandard professional performance is identified or there

is a failure to comply with the requirements of the Hennepin Health Credentialing Program. All CAPs are submitted to the CC for review and approval.

Credentialing staff monitor CAP compliance and report status updates to the CC and Compliance department. Monitoring may include Site Visits or Credentialing audits of the Provider. Provider timelines for completion of CAP are determined on a case-by-case basis based on the severity of the non-compliance, with best efforts to provide a minimum of 60 days to address and implement corrective actions which address the CAP.

Hennepin Health reserves the right to monitor the progression of CAP compliance no less frequently than monthly to ensure CAP progress and/or to address complaints or potential noncompliant issues identified through the Credentialing process. Progressive and final results are submitted to the Credentialing Committee for review and determination of CAP closure. When all CAP's are effectively closed, Hennepin Health will provide written confirmation of the CAP closure to the Provider.

CC may deny or suspend a Provider based on the nature or severity of an open CAP. Failure to comply with CAP requirements may result in disciplinary action including to and including termination of a Provider from the Hennepin Health network. Notification of Professional Conduct Concerns that are unrelated to an existing and active CAP will result in initiation of a new investigation.

Section 18.18 Disciplinary Action

If Hennepin Health receives information suggesting that a disciplinary action or Professional Conduct Concern exists with a Provider, Credentialing staff conduct an investigation that includes:

1. contacting the Provider to conduct an initial discussion of the findings;
2. obtaining the Provider's explanation, in writing, of the details regarding the alleged Professional Conduct Concern or disciplinary action including:
 - a) details and nature of the action;
 - b) date(s) of allegation, summary of findings and closure of investigation;
 - c) requirements to satisfy any cases of adverse actions, complaints, grievances or other judgments placed by a licensing board or other official;
 - d) limits on practice, if any;
 - e) nature of a condition that may impact their ability to practice;
 - f) length of time Provider is or was affected by the condition, if applicable; and
3. obtaining court or board documents regarding the action or concern, if applicable

The Credentialing staff will compile all relevant information noted above and will refer the matter to the CC or designee for review and determination. The CC or designee may request case review and involvement from a member of the Compliance department and/or Special Investigations Unit.

The CC or designee, on its own initiative or following a recommendation from Credentialing or the Special Investigation Unit, may request the following:

1. Further information/statements from the Provider
2. Further information/statements from the reporting source

3. Direct the Provider to appear before the Credentialing Committee to discuss issues relevant to the investigation

The CC or designee may determine disciplinary action is appropriate due to the substandard professional performance or failure to comply with participation criteria. Disciplinary action may include but is not limited to:

1. monitoring Provider for a specified period of time to determine if issues have been remediated;
2. written notification to Provider describing the disciplinary action that will be taken if noncompliance with Hennepin Health requirements are not remediated or noncompliance reoccurs;
3. requiring Provider to submit and adhere to a CAP;
4. levying a monetary fine against the Provider;
5. recoupment of overpayments to a Provider as determined by internal and/or external claims audit or review;
6. suspension or termination of Provider's participation status;
7. requiring the Provider to obtain training or use peer consultation in specified type(s) of care;
8. temporarily suspending Provider from the Hennepin Health network;
9. requiring Provider to execute an amendment to a participation agreement or a separate agreement related to the disciplinary action; or
10. termination of Provider's participation status.

Providers shall be informed, via Certified Mail, of the disciplinary action within ten (10) calendar days of when the action is taken. The notification will include a written explanation, summary of reasons for the disciplinary action and a detailed description of the appeal process consistent with the Appeals Notification Process outlined in Section VI.C of this Credentialing Program. If a Provider appeals the Credentialing Committee's decision regarding disciplinary action, the appeal will be submitted to the Appeals Committee for review and handling pursuant to the appeals process set forth in this Credentialing Program.

Professional Conduct Concerns

Providers participating in Hennepin Health's network are expected to conduct business in an ethical, safe, professional, non-discriminatory manner, within the scope of the licensure, their Hennepin Health Agreement, and industry and health care standards.

Hennepin Health shall investigate reports submitted in good faith, investigated by third parties, or discovered by Credentialing staff regarding Provider conduct or business practices that may include, but are not limited to:

1. unethical or unsafe practices (in violation of state/city/county safety codes or regulations);
2. unsanitary conditions or those in violation of applicable OSHA and/or ADA standards;
3. violations of privacy or security of patients' data as required by federal, state or local laws and regulations;
4. evidence of malfunctioning or unmaintained medical equipment;
5. evidence of substance use disorders impacting patient care;
6. discrimination against patients;
7. practicing outside the scope of their license/certification;
8. Conflict with Hennepin Health or industry healthcare standards and requirements; or

9. QOC/QOS complaints or grievances

The CMO reserves the right to determine if an act or practice falls under the definition of a Professional Conduct Concern. The CC or CMO may determine that a Professional Conduct Concern(s) does not currently warrant disciplinary action or termination from participation with Hennepin Health. The CC or CMO, in its sole discretion, determines any ongoing monitoring and the duration required, and has the right to extend, end or reverse the monitoring duration. The CC or CMO may require ongoing monitoring of a Provider until the concern is satisfactorily resolved with the appropriate board or agency. New information and/or findings brought forth during any monitoring period will be submitted to the CC or CMO for review and determination.

CC or CMO shall determine, based on findings, whether and when any actions are reported to the appropriate federal, state or local agencies or authorities, state licensing board, national licensing board or NPDB. Notification to such authorities will take place, via Certified mail, within 10 business days from the CC or CMO determination. If a Provider appeals the CC's decision, the appeal will be submitted to the Appeals Committee for review and handling pursuant to the appeals process set forth in this Credentialing Program.

Administrative Suspension by Credentialing Staff

Credentialing may administratively suspend a Practitioner if a leave of absence exceeds the Practitioner's current 36-month Re-credentialing cycle or if Practitioner fails to complete the Re-credentialing process. Exceptions are made for reasons of Family Medical Leave Act (FMLA) or military leave as appropriate.

Credentialing shall immediately administratively suspend a Provider upon notice that the Provider's license has been revoked or suspended, the Provider has been excluded from participation in any federal, state or local government program, or failure to meet Hennepin Health's minimum malpractice insurance requirements. In such cases, Credentialing staff will submit a narrative of the findings to the CC or designee for review and determination.

Termination by Credentialing Committee

The CC may decide to terminate participation of any Provider meeting the following criteria:

1. Practitioner has failed to continuously meet one or more of the participation criteria set forth in this Credentialing Program; and/or
2. Practitioner engages in uncooperative, unprofessional or abusive behavior towards Hennepin Health members, Hennepin Health staff, or a member of the CC, Appeals Committee or Board of Commissioners.

If the CC disciplines or terminates a Provider from Hennepin Health participation:

1. Provider shall be notified, via email, within 10 business days of decision;
2. Provider shall be provided the effective date of action and summary of basis for decision; and
3. Provider will be offered appeals rights in accordance with this Credentialing Program;

The termination date of Provider's participation shall be determined based on the facts and circumstances surrounding the events that led to the disciplinary action and may be immediate. Provider terminations are eligible for the Appeals process unless the termination is due to an active sanction.

This type of termination does not apply to administrative termination due to credentialing or re-credentialing non-compliance.

Section 18.19 Reporting Requirements

Hennepin Health shall determine whether or when any adverse decision shall be reported to the NPDB, the Minnesota Board of Medical Practice, or any other appropriate licensing agency, based upon the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 401 et seq., Minn. Stat. § 147.111, in accordance with Hennepin Health's Credentialing Program and any other relevant federal and state laws and regulations. Reportable actions include but are limited to the following:

- Acting outside the scope of practice
- Unethical or unprofessional conduct involving sexual contact with a patient or former patient
- Conduct indicating that the person may be medically or physically unable to engage safely in the practice of medicine.

Credentialing Management will report the information in a manner required by the applicable reporting agency, within 10 business days of Hennepin Health's determination to report. The determination shall be made in good faith. Hennepin Health shall notify the affected Practitioner, in writing, in the event such a report is made, and such notification is required.

Section 19: Fraud and Abuse

Section 19.1 Definitions

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

Fraud: any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

Waste: overutilization of services or other misuse of resources that, directly or indirectly, result in unnecessary costs to the health care system, including Hennepin Health.

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.

Section 19.2 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.

Legal Requirements

Hennepin Health follows 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

Section 19.3 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
 - 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 patient 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 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 Requirements

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, including 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 records pursuant to the provider contract and the member's consent signed in accordance with [Minnesota Statute § 256B.27](#). 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 5 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. Failure to comply with a Hennepin Health records request may also result in a referral to the Minnesota Department of Human Services and the Medicaid Fraud Control Unit of the Attorney General's office.

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 5 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 transferor, 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.

Section 19.4 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 as fraud are:

- Theft, perjury, 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 the excessive or improper use of services or practices that are 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. Examples include:

- Submitting repeated claims:
 - With missing or incorrect information
- Using procedure codes that overstate the level or amount of health service provided

- Ordering unnecessarily expensive equipment or tests

Waste

Waste is the overutilization of services or other misuse of resources that, directly or indirectly, result in unnecessary costs to the health care system, including Hennepin Health. Examples include:

- Failure to manage medical inventory appropriately so that a large percentage of supplies expire before use
- Prescribing more medications than are necessary to treat a specific condition

Reporting

To report suspected fraud or abuse against Hennepin Health, please contact Hennepin Health at hh.fwa@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. Suspected fraud or abuse by a provider may also be reported to 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 reviews of participating providers to monitor compliance with contractual agreements and administrative policies and procedures. Hennepin Health uses information from a number of sources, including:

- Third-party payers, including Medicare
- Government agencies
- 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 HennepinHealth 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 following 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.

Section 19.5 False Claims

False Claims Act

The False Claims Act [[31 U.S.C. § 3729](#)] 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 violations include but are not limited to:

- Billing for goods or services not provided
- Billing for services not medically necessary
- Billing separately for services that should be a single service (unbundling)
- 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

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.

Section 20: 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 recipients, 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 21: Sub-contractual 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 any applicable 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.

Section 22: Culturally Competent Care

Section 22.1 Definitions

Culture: the thoughts, communication, 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) members 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.

Section 22.2 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.

Section 22.3 Provider Responsibilities

- Provide culturally and linguistically competent health care services to Hennepin Health plan members
- Ensure that all members, including LEP and vision-impaired members, 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 members 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 23: Non-discrimination Affirmative Action

In accordance with Hennepin County's policies against discrimination, providers agree 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 forty (40) 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 agree 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.

Recycling

Hennepin County encourages providers to have a single-sort recycling program or provide recycling service for at least three types of materials, which may include food waste. Hennepin County also encourages providers to educate employees about the recycling program.