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HealthPartners Contacts

Corporate Address

HealthPartners
(Insert Department / Mail Stop here)
8170 33rd Avenue / PO Box 1309
Minneapolis, MN 55440-1309

Claims Address

HealthPartners Claims
PO Box 1289
Minneapolis, MN 55440-1289

Provider Portal Login

Providers can locate eligibility and benefits, claim status and referral inquiry, contracted medical providers, medical and administrative policies and much more. If your facility does not yet have access, register now.

Log into the Provider Portal (www.HealthPartners.com/Provider)

Member Services

Contact with questions about benefits, eligibility and medical policies. Hours 7 a.m. – 6 p.m., Central time.

Commercial Plans

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-5000 TTY: 952-883-5127	800-883-2177 TTY: 888-850-4762	952-967-7192	21104G	NA

Senior Plans

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-7979 TTY: 952-883-6060	800-233-9645 TTY: 800-443-0156	952-883-7666	21103R	NA

Public Programs

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-967-7998 TTY: 952-883-6060	866-885-8880 TTY: 800-443-0156	952-883-7666	21103R	NA

Claims

Contact with questions relating to claims payment, why an authorization was requested or needed and general coding questions *(not how to bill).*

Commercial Plans

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-967-6633	866-429-1474	651-265-1230	25510F	Contact Us: Claims Inquiries CCSEProviderInquiry@Healthpartners.com

Senior and Public Programs Plans

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-7699	888-663-6464	952-853-8746	21103R	RVSCProviderInquiry@HealthPartners.com RVSCProviderInquiry@HPEXCHG.HealthPartners.com

Dental Plans

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
651-265-1000	800-642-1323	651-265-1001	21113A	Contact Us: Claims Inquiries

Network Management

Contact with questions about your medical contract, reimbursement or escalated service issues. To find your contracting representative's name and contact information click on the appropriate provider type web link or call the number below. Do not provide this information to members.

Phone #	Toll Free #	Fax #	Mail Stop	Web link to contract representative's contact information
PSNM (Professional Services Network Mgmnt) 952-883-5589 HRNM (Hospital & Regional Network Mgmnt) 952-883-5604	888-638-6648	952-853-8848 952-853-8848	21108J 21108P	Specialty Provider Contracts Primary Care Provider & Hospital Contracts Ancillary Provider Contracts (to include Treatment Centers, Skilled Nursing Facilities and Surgery Centers)

Credentialing

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-5755	866-630-0188	952-853-8702	21107Q	Web: Credentialing Email: Credentialing@HealthPartners.com

Medical Management

Use the link below to view HealthPartners Medical and Durable Medical Equipment coverage criteria:
https://www.healthpartners.com/public/coverage-criteria/

Finding Care outside the service area

Contact Member Services by plan type: Commercial Plans, Senior Plans or Public Programs
(Please see Member Services listing on prior page)

Area	Phone #	Toll Free #	Fax #	Mail Stop
General Medical Management Line	952-883-7888	877-499-7888	952-853-8713	21108T
Medical Policy, Prior Authorization for Procedures, Habilitative (Hab), Home Care, Hospice, Rehabilitation (Rehab), Skilled Nursing Facility (SNF), Personal Care Attendant (PCA) and Durable Medical Equipment (DME)	952-883-5724	888-467-0774	Procedures: 952-853-8713 Home Care, Hospice, Rehab, SNF, PCA: 952-853.8712 DME, Hab: 952-853-8714	21108T Medicalpolicy@HealthPartners.com
Disease and Case Management Services/HealthPartners Connect	952-883-5469	800-871-9243	952-853-8745	21106H
Inpatient Case Management	952-883-6277	800-255-1886 X36277	952-853-8748	21106H
Authorized Care Outside Service Area (Contact a Nurse Navigator)	952-883-5000	800-883-2177		

Behavioral Health

Area	Phone #	Toll Free #	Fax #	Mail Stop
Prior authorization for behavioral health services	952-883-7501	866-669-3856	952-853-8830	21103M
Personalized Assistance Line (PAL) – can help find providers in the HP behavioral health network. This number is also available to members.	952-883-5811	888-638-8787		211046

Quality Measurement and Improvement

Contact with questions about quality improvement, Clinical Indicators, HEDIS, medical practice guidelines, site surveys, complaint reporting or at risk registry program.

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-5777	NA	952-883-6150	21108X	Quality and Measurement Contact: Quality

You can access 2013 quality and cost assessment information online at:

https://www.healthpartners.com/files/42635.pdf

Pharmacy Administration

Contact with questions about formulary exceptions or equivalents.

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-5813	800-492-7259	952-853-8700 888-883-5434	21111B	Formulary Information

Provider E-Commerce

Contact with questions about on-line tools, electronic connectivity for claims submission and electronic remittances or access to HealthPartners Secured Provider Home Page.

Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
952-883-7505 x 1 password reset x 2 Web assistance x 3 EDI assistance	855-699-6694	952-853-8708	21108C	Secured Online Systems Register Now! Electronic Transactions (EDI)!

Dental Administration & Contracting

Contact with questions about dental contract, reimbursement or escalated service issues.

Area	Phone #	Toll Free #	Fax #	Mail Stop	Web or Email Link
Dental Contracting	952-883-5168	877-839-8199	952-883-5160	21113A	Email Dental Provider Contracting, Reimbursement and Network questions Web Contact Provider Relations
Dental Provider Relations and Network Questions	952-883-7511 or 952-883-6140	NA	952-883-5160	21113A	Email Dental Provider Network Questions Web Contact Provider Relations

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HealthPartners Inc (HPI) Administrative Program

HealthPartners contracted medical and dental providers, facilities and vendors are required to follow the HealthPartners Inc (HPI) Administrative Program. The most current copy of the HPI Administrative Program is available online at www.healthpartners.com/hpiadministrativeprogram . A written copy can be obtained by contacting 883-638-6648.

Administrative policies:

1. Access to Care & Services
2. Accessibility to Utilization Mgmt Staff
3. Affirmative Statement Regarding Incentives
4. Anesthesia Payment Methodology
5. CIGNA/HealthPartners Alliance
6. Claim Submission Requirements for Drug Codes (formerly J Code Submission on Claims)
7. Clinical Practice Guidelines
8. Complaint Reporting
9. Continuity of Care Due to Employer Change in Health Plans
10. Continuity of Care Following Termination of a Provider
11. Coordination of Care, Provider Responsibility
12. Credentialing Notifications
13. Diagnostic Imaging Provider Notification Program
14. Disease Management
15. Do Not Use Abbreviations & Error-prone Abbreviations
16. Enrollee Rights - HealthPartners Care
17. GA Modifier on Claim Submissions
18. Hospital Admission Notification Process
19. Imaging Accreditation
20. Intensive Obesity Counseling
21. Interpreter Services
22. Medicaid Enhanced Payment for Primary Care Practitioners
23. Medical Records Standards
24. Medicare Responsibilities for Providers and HealthPartners
25. Medication Therapy Management (MTM) Provider Coordination of Care Policy
26. Medication Therapy Management (MTM) Provider Participation Criteria
27. Member Appeals Process for Medicare Products - Primary Care
28. Member Appeals Process for Medicare Products - Specialty
29. Member Appeals Process for Public Programs
30. Member Bill of Rights & Responsibilities for Medicaid Products
31. Member Bill of Rights for Network Services

32. Member Rights and Responsibilities
33. Member Rights and Responsibilities for Medicare Products
34. Minnesota Care Tax
35. Never Events
36. Oncology Care Program Standards
37. Patient-Provider Communication
38. Pediatric Vision – HP Eyewear Collection
39. Personal Care Assistance & Elderly Waiver Provider Requirements
40. Pharmaceutical Sampling
41. Physician Incentive Plan (PIP) Data and Surveys
42. Practitioner Office Site Quality
43. Preventing, Detecting & Reporting Fraud, Waste & Abuse
44. Prior Authorization Review Process
45. Prior Authorization Review Process for Medicare & Medicaid Products
46. Privacy Practices for Contracted Network Providers
47. Provider-Initiated Clinic Reassignment of Member
48. Provider Portal Electronic Data Access
49. Quality Case Reviews
50. Quality Measurement
51. Quality Monitoring of Organizational Providers
52. Referral Management: Provider Recommendation for Further Services
53. Self-administered Drugs Requiring Claim Submission on the Pharmacy Benefit
54. Prior Authorization for Low Back Pain
55. Standing Referral Process
56. Telemedicine Services
57. Transition of Care When Benefits End
58. Transplant Coordination of Care Management
59. Utilization Management Criteria Access
60. Workers Compensation Certified Managed Care Plan

Get Connected

Go to healthpartners.com/provider and click on ***Register your facility***. It's that easy!

Go to www.healthpartners.com/provider to create your HealthPartners provider portal account*.

HealthPartners Provider Portal:

Is a free, HIPAA compliant Web site that helps you:

- Estimate claims using the ***Claims Estimator*** application.
- Check a claims status using the ***Claim Status Inquiry*** application. A two year claims history is available.
- Determine a member's benefits, eligibility, co-payments and deductibles using the ***Eligibility Inquiry*** application.
- Search a member's formulary (prescription drugs covered by a particular drug benefit plan) using the ***Formulary By Member*** application.
- Request prior authorization for medical, pharmacy and DME services using the ***Prior Auth Request*** application.
- Check and make changes to clinic, hospital, care network and individual practitioner information marketed to HealthPartners members on healthpartners.com using the ***Provider Data Profiles*** application.
- Review, revise, track, enter and answer medical and/or dental referrals using ***the Referral Maintenance*** application (primary care clinics only).
- View medical and/or dental referral information, as well as prior authorizations using the ***Referral/Auth Inquiry*** application.

Why you should get connected:

HealthPartners no longer mails remittance advices. Review HealthPartners' electronic connection options at healthpartners.com/eservices.

Other online resources include:

- Patient education resources to support your patients between visits and Centers of Excellence resources.
- Quality improvement tools that provide provider performance on clinical measures.
- Fast Facts newsletters to keep you up-to-date on provider network operations.
- Provider forms for claim adjustment, appeal and attachment submissions
- Registries

**Every individual accessing the provider portal must have their own, separate account.*
The first person to register is the site delegate and manages accounts on behalf of each facility.

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Credentialing Information

Index:

What is Credentialing?

Credentialing is the process of assessing and validating the qualifications of a licensed independent practitioner to provide patient care.

Before you begin the credentialing process, you must be a HealthPartners contracted provider or working under a contracted provider.

If you are interested in providing contracted medical or dental services for HealthPartners members, please contact us at Provider Contracting.

If you are a behavioral health provider (Mental Health and Chemical Health) interested in contracting with HealthPartners, please complete the Behavioral Health Application.

How do I get credentialed with HealthPartners?

When a practitioner type that HealthPartners credentials joins a HealthPartners contracted clinic, the practitioner or clinic must complete a credentialing application.

ApplySmart™ system

HealthPartners is now using the Minnesota Credentialing Collaborative's (MCC) ApplySmart™ system. As of July 1, 2013 all Minnesota-based medical clinics are required to use ApplySmart™ for submission of initial credentialing applications.

Practitioners or clinics can join the MCC and use this web-based credentialing application for submission of the credentialing application to HealthPartners. **Join Now** at mncred.org.

If you or your clinic are already a member of the MCC and have an ApplySmart™ account, log into ApplySmart™ to submit your credentialing application to HealthPartners.

Clinics in WI, ND, SD, IA, and NE may use ApplySmart™ or continue to submit paper applications by fax or email. Medical practitioners or clinics complete the Minnesota Uniform Credentialing Application and fax or send by secure email to Credentialing@HealthPartners.com.

Dental providers or clinics complete the Initial Dental Credentialing Application and fax it to 952-883-5160 or email it to Dental Contracting

Practitioners may not see HealthPartners members and will not appear in directories or in any Member Service resources until the credentialing process is completed and the application is approved.

How long does the credentialing process take?

The process can vary depending on completeness of the application, whether additional information needs to be obtained from the practitioner, and whether the practitioner meets all HealthPartners credentialing criteria. It is recommended that an application be submitted at least 90 days prior to employment date.

Practitioners will receive written notification once their application has been approved. Practitioners or clinics may also contact the HealthPartners Credentialing Service Bureau at credentialing@healthpartners.com to check the status of an application.

What to do if I am currently credentialed with HealthPartners and am joining a new clinic?

A practitioner who is currently credentialed with HealthPartners and is just changing clinic sites needs to notify HealthPartners.

Medical practitioners can fax (952-853-8703) or email the Minnesota Uniform Practitioner Change Form with the Site Location Addendum page, if applicable to Provider Data Support.

Dental providers complete the Dental Contracted Provider Change Notice and fax (952-883-5160) or email to Dental Contracting.

How do I know if I am currently credentialed with HealthPartners?
Please contact HealthPartners Credentialing Service Bureau at credentialing@healthpartners.com .

What paperwork should be completed for non-credentialed practitioner types?
When a non-credentialed practitioner type joins a HealthPartners contracted clinic or is already enrolled in the HealthPartners provider network or just changes clinic sites, notify HealthPartners using the Minnesota Uniform Practitioner Change Form (with the Site Location Addendum if applicable) and fax or email to Provider Data Support. Newly enrolled practitioners (except Interpreters) must submit a NPI to be enrolled with HealthPartners.

How can I review information about practitioners working in my clinic?
Contracted providers can manage clinic and practitioner information on-line through the HealthPartners Provider Portal. This application offers practitioner information related to specialties, clinics, and personal profiles. To gain access to this time-saving tool contact your site administrator or call Provider E Commerce at 952-883-7505 or click on Contact Web Support for assistance.

Behavioral Health Practitioners
HealthPartners requests all behavioral health practitioners to identify age populations or services or verifiable expertise they provide. This information will help us better serve you and our members. Omission of this data will result in an inability to recommend you as provider for members requesting or needing specific behavioral health services. To gain access to this convenient on-line tool, contact your site administrator or click on Contact Web Support for assistance.

Do I need to inform HealthPartners if I leave my clinic?
It is very important that HealthPartners be notified when a practitioner leaves a contracted clinic.

Medical practitioners complete the Minnesota Uniform Practitioner Change Form and fax or e-mail to Provider Data Support .

Dental providers complete the Dental Contracted Provider Change Notice and fax or email to Dental Contracting.

It is recommended to use secured, encrypted email service to send private and protected information via email.

Submission Information for Medical Practitioners Credentialed by HealthPartners

Minnesota based clinics apply online through Mncred.org

Clinics in WI, ND, SD, IA, and NE:

Fax: (952) 853-8702 or email:Credentialing@HealthPartners.com.
HealthPartners Credentialing Service Bureau
Mailstop 21107Q
P.O. Box 1309
Minneapolis, MN 55440-1309
Phone (952) 883-5755

Submission Information for Non-Credentialed Practitioners

Fax: 952-853-8703 or e-mail: ProviderData@HealthPartners.com

Submission Information for Dental Practitioners

Fax: 952-883-5160 or email: DentalContracting@HealthPartners.com
HealthPartners Dental Contracting
Mailstop 21113A
PO Box 1309
Minneapolis, MN 55440-1309

Who HealthPartners Credentials

Practitioner Types Credentialed by HealthPartners - Note: This list is subject to change

Practitioner Type/Title	Practitioner Type/Title Explanation
APRN	Advanced Practice Registered Nurse (all Nurse Practitioner types except CRNA)
CCDC II	Certified Chemical Dependency Counselor II (SD only)
CCDC III	Certified Chemical Dependency Counselor III (SD only)
CICSW	Certified Independent Clinical Social Worker (WI only)
CMFT	Certified Marriage and Family Therapist (Nebraska Only)
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
CNS	Clinical Nurse Specialist
CPC	Certified Professional Counselor (ND/SD/WI only)
CSW-PIP	Clinical Social Worker in Private Independent Practice (SD only)
DC	Doctor of Chiropractic
DDS	Dentist
DMD	Dentist
DO	Doctor of Osteopathy
DPM	Doctor of Podiatric Medicine
IntCS, CSAC	Intermediate Clinical Supervisor, Clinical Substance Abuse Counselor (WI only)
IndCS, CSAC	Independent Clinical Supervisor, Clinical Substance Abuse Counselor (WI only)
LAC	Licensed Addiction Counselor (ND only)
LADC	Licensed Alcohol and Drug Counselor
LCSW	Licensed Clinical Social Worker (WI only)
LICSW	Licensed Independent Clinical Social Worker
LISW	Licensed Independent Social Worker (IA only)
LMFT	Licensed Marriage and Family Therapist
LP	Licensed Psychologist
LPC	Licensed Professional Counselor
LPC-MH	Licensed Professional Counselor Mental Health (SD only)
LPCC	Licensed Professional Clinical Counselor
LTM	Licensed Traditional Midwife (MN only)
MBBCH	Bachelor of Medicine and Bachelor of Surgery
MBBS	Bachelor of Medicine and Bachelor of Surgery
MD	Physician
OD	Doctor of Optometry
PA-C	Physician Assistant

Non-Credentialed Practitioners - Note: This list is subject to change
The practitioners that HealthPartners does not credential but who should be enrolled via a MN Practitioner Change Form in order for claims to pay are:

Acupuncturists
Anesthesiologists (unless practicing pain management in a clinic setting)
Audiologists
Certified Genetic Counselors
Certified Registered Nurse Anesthetists
Certified Registered Nurse First Assistants
Critical Care Medicine

Non-Credentialed Practitioners (continued)

Critical Care Surgery
Pediatric Critical Care
ER Practitioners (unless also practicing in a clinic setting)
Interpreters
Medication Therapy Management Pharmacists
Neonatologists (unless also practicing in a clinic setting)
Nutritionists
Occupational Therapists
Pathologists
Physical Therapists
Radiologists (except Radiation Oncologists)
Registered Dieticians
Speech Pathologists

Practitioners Filling In Temporarily (Locum Tenens Practitioners) – Policy is subject to change

This is discussed in the HealthPartners Credentialing Plan

The Credentialing Plan

The HealthPartners Credentialing Plan describes the HealthPartners Credentialing Program. The purpose of the Credentialing Program is to support the systematic approach to credentialing within HealthPartners. Specific objectives of the Plan include:

- Setting forth the criteria to be used in assessing the qualifications of applicants seeking initial or on-going association with HealthPartners.
- Establishing the processes for verification and evaluation of a practitioner's credentials.
- Establishing the processes for action if a practitioner's credentials do not meet the established minimum criteria.

Practitioner Rights

Under HealthPartners Credentialing Plan, practitioners applying for initial participation or on-going participation have the following rights:

1. The right to review the information submitted in support of their credentialing applications.

   Practitioners may call the HealthPartners Credentialing Service Bureau at (952) 883-5755 to arrange for a time to review their credentialing file. Practitioners are not allowed to review references or recommendations or other information that is peer review protected or otherwise protected by state or federal law.

2. The right to correct erroneous information submitted by other sources.

   During the review process, credentialing staff will make note of any substantial discrepancies between the information reported by the practitioner and information obtained through the credentialing process. If a substantial discrepancy is identified, the practitioner is notified in writing of the discrepancy. The practitioner is given the opportunity to submit in writing, within 10 days, any corrections of erroneous information obtained from other sources or explanations for such discrepancies.

3. The right to be informed, upon request, of the status of their credentialing or recredentialing application.

   Practitioners may call the HealthPartners Credentialing Service Bureau at (952) 883-5755 and ask for ask for the status of their credentialing application.

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HealthPartners CIGNA Alliance

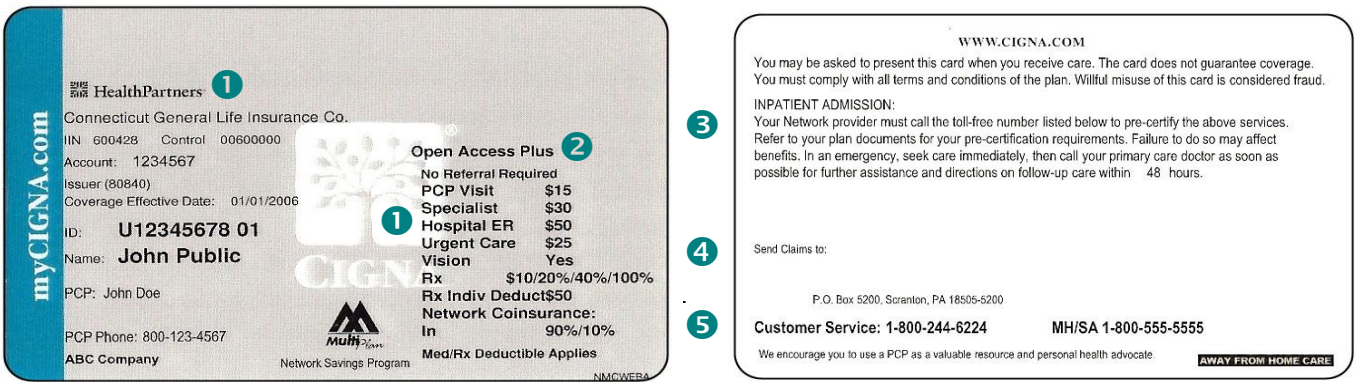
CIGNA/HealthPartners Strategic Alliance
Quick Reference Guide

To better serve our members, HealthPartners, Inc. and CIGNA have formed a strategic alliance making a national network available to **HealthPartners and CIGNA** employer groups and individual customers. The focus of this alliance is providing access to quality care and improving health through a comprehensive network.

What you should know:

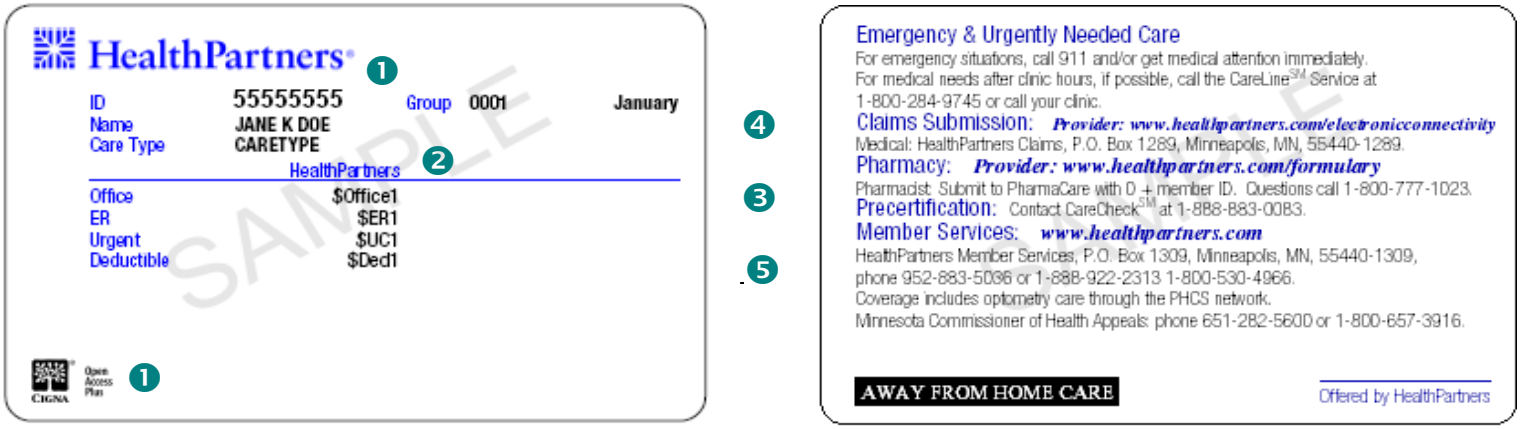
- The alliance national network is comprised of the CIGNA Open Access Plus provider network and the HealthPartners provider network.
- HealthPartners service area is Minnesota, North Dakota, Western Wisconsin and South Dakota.
- CIGNA membership (including Behavioral Health) within the HealthPartners service area will utilize the HealthPartners provider network (except in South Dakota).
- HealthPartners membership (including Behavioral Health and Transplant networks) will utilize the CIGNA **Open Access Plus** provider network in areas outside the Minnesota, North Dakota, Western Wisconsin and South Dakota service area.
- **The key distinguishing factor in determining if the member is accessing the alliance national network as a CIGNA member or HealthPartners member is the member ID card.**

Sample ID card - CIGNA Plan Administration (Claims are submitted to CIGNA address on back of card)



❶ CIGNA/HealthPartners logos ❷ Product Information ❸ Precertification Info ❹ Paper Claims address ❺ Customer Service Contact Numbers

Sample ID card–HealthPartners Plan Administration (Claims are submitted to HealthPartners address on back of card)



***These ID card samples are examples.

http://www.cignaforhcp.com

IF YOU WANT TO:	***USE THIS SERVICE FOR CIGNA RELATED INQUIRIES***	***USE THIS SERVICE FOR HEALTHPARTNERS RELATED INQUIRIES***
Perform the following online transactions: • Verify patient eligibility and coverage • Check the status of a claim • Request precertification for services (CIGNA only) • View claim coding policies and payment guidelines Review Administrative Information including: • Medical coverage positions • Pharmacy formulary • Update address information • Quality and Quality Improvement Programs • Clinical Guidelines • Utilization Management Including: Financial Incentives Criteria Contact a Medical Director • Member Rights and Responsibilities and Complaint processes and procedures • Confidentiality Privacy	http://www.cignaforhcp.com/	http://www.healthpartners.com/provider/
Perform the following electronic transactions: • Verify patient eligibility and coverage • Inquire about patient coverage and covered services • Check the status of a claim • Request precertification for services (CIGNA only) • Submit claims electronically • Receive electronic remittance advice	CIGNA Managed Care and PPO Payer ID: 62308 CIGNA Medicare Advantage PFFS Payer ID: 86033 Post-N-Track http://www.post-n-track.com/ 1.860.257.2030 Existing Clearinghouse or contact Emdeon http://www.emdeon.com/ 1.877.469.3263	HealthPartners has multiple options for electronic claims submission-Visit www.HealthPartners.com/Provider and click "Explore Electronic Transactions (EDI)"
Perform the following through telephonic transactions: • Learn about electronic services • Verify patient eligibility and coverage • Check the status of a claim • Request precertification/prior authorization services • Check credentialing status • Request an exception to the prescription drug list	1.800.88CIGNA(882.4462)	1.800.883.2177

IF YOU WANT TO:	***USE THIS SERVICE FOR CIGNA RELATED INQUIRIES***	***USE THIS SERVICE FOR HEALTHPARTNERS RELATED INQUIRIES***
Contact Provider Services or for general inquiries	1.800.88CIGNA(882.4462)	1.800.444.4558
Submit a payment appeal	Cigna National Appeals PO Box 188011 Chattanooga, TN 37422 1.800.88Cigna Fax:1.877.815.4827	1.800.444.4558
Submit a clinical appeal	Refer to contact information on the authorization/denial letter	Refer to the contact information received on the authorization/denial letter
Transplants	1.800.668.9682	1.799.773.2177

Specialty Pharmacy

Specialty pharmacy is a continued area of focus at HealthPartners as the industry continues to see significant cost increases for specialty medications. Although only a small number of prescriptions drive that cost, specialty medications are the fastest growing segment of the pharmaceutical industry.

Coverage
All drugs are reviewed by the HealthPartners Pharmacy and Therapeutics (P&T) Committee. This committee promotes the appropriate use of high quality and cost-effective pharmaceuticals for HealthPartners members. Self-administered medications are reviewed for formulary status and all medications are reviewed for coverage criteria. Prior to P&T review and coverage determination, all drugs require review for medical necessity and approval to ensure payment.

Self-administered drugs
To reduce costs and ensure knowledgeable pharmacy care for these conditions, we have made exclusive arrangements with specialty pharmacy providers for self-administered specialty medications.

Self-administered specialty medications may be dispensed by the following pharmacies:

CVS Caremark Specialty Pharmacy…….Most specialty drugs
HealthPartners Riverside Pharmacy…….. Growth Hormones
Fairview Specialty Pharmacy/Children's Healthcare……..Blood Factor and Cystic Fibrosis Products

Benefits to members
Members can have these medications delivered directly to their homes for no additional charge, have access to a pharmacist 24 hours per day and get monthly refill calls to ensure adherence to the care plan from their provider team.

Other local retail pharmacies (e.g., CVS, Target, etc.) are not able to process these prescriptions for health plan coverage.

Ordering drugs from the specialty pharmacy
Members or providers can start this process. Providers may send referrals or prescriptions directly to the specialty pharmacy or to the manufacturer's HUB or call center. Once the prescription is received, the member will be contacted to arrange for the delivery of the medication. This program applies only to specialty medications and members can continue to obtain all other non-specialty prescription medications through our retail pharmacy network or HealthPartners mail order pharmacy.

Information you may need for your Electronic Health Record system or your internal contact document

	NCPDP	NPI	Address	Phone #	Fax #
CVS Caremark Specialty Pharmacy, LLC	3958898	1043382302	105 Mall Boulevard Monroeville, PA 15146	1-800-368-1624	1-800-441-5809

Professionally administered drugs
This program doesn't apply to drugs administered by professionals in the home or clinic setting.

Self-administered injectable drugs included in the specialty drug lists are generally not eligible for reimbursement through a medical claim. When in-clinic administration is medically necessary, the drug should be sourced through our specialty pharmacy providers and sent to the clinic for administration. Administration costs are eligible for reimbursement through a medical claim.

Please see the Specialty Drug List , the Growth Hormone List , and the Infertility Product List on HealthPartners.com for updated drug lists.

Specialty Drug List

Specialty medicines are usually prescribed by doctors who treat chronic and complex diseases. These medications usually require a higher degree of management, have a high price and are not generally stocked at retail pharmacies.

Call CVS Caremark Specialty Pharmacy at **800-368-1624** for your specialty prescriptions.
Or see your Summary of Benefits and Coverage (SBC) to learn more about your specialty medicine benefits.

PA = prior approval, **ST** = step therapy, **QL** = quantity limit, **NF** = non-formulary (New drugs are **NF PA** until reviewed.) **TD** = Drugs included in the Trial Drug program.

Please see **healthpartners.com** for full coverage criteria.

BLOOD MODIFIERS
ARANESP
EPOGEN (NF)
LEUKINE
NEULASTA
NEUMEGA (NF PA)
NEUPOGEN
PROCRIT
PROMACTA (PA)

CANCER DRUGS (1)
AFINITOR TD
BOSULIF (PA)
CAPRELSA
COMETRIQ (PA)
ERIVEDGE (PA)
GILOTRIF (PA)
GLEEVEC
HYCAMTIN
ICLUSIG (PA)
IMBRUVICA (NF PA)
INLYTA (PA)
JAKAFI (PA)
LYSODREN (NF PA)
MATULANE
MEKINIST (PA)
NEXAVAR TD
POMALYST (PA)
REVLIMID
SPRYCEL TD
STIVARGA (PA)
SUTENT TD
SYLATRON

CANCER DRUGS (1)
TAFINLAR (PA)
TARCEVA TD
TARGRETIN ORAL (NF) **TD**
TASIGNA TD
TEMODAR (NF PA)
temozolomide
THALOMID
tretinoin
TYKERB
VALCHLOR (PA)
VOTRIENT TD
XALKORI (PA)
XELODA
XTANDI (PA)
ZELBORAF (PA)
ZOLINZA (PA)
ZYTIGA (PA-Preferred)

CHRONIC INFLAMMATORY DISEASE
ENBREL (PA)
HUMIRA (PA)
KINERET (PA)
CIMZIA (NF PA)
ORENCIA SC (NF PA)
SIMPONI (NF PA)
STELARA (NF PA)
XELJANZ (NF PA)

CLOTTING DISORDERS(2)
ADVATE
ALPHANATE
ALPHANINE SD
BEBULIN VH
BENEFIX
BIOCLATE
FEIBA VH
HELIXATE FS
HEMOFIL M
HUMATE-P
KOATE DVI
KOGENATE FS
MONOCLATE-P
MONONINE
NOVOSEVEN
NOVOSEVEN RT
PROFILNINE SD
RECOMBINATE
REFACTO
RIXUBIS (NF PA)
SOLOFUSE
WILATE
XYNTHA

CYSTIC FIBROSIS (2)
BETHKIS (NF PA)
CAYSTON
KALYDECO (PA)
PULMOZYME
TOBI (NF PA)
TOBI PODHALER (NF PA)
tobramycin neb solution (PA)

HEPATITIS C
COPEGUS (NF PA)
INCIVEK (PA)
INFERGEN (NF PA)
OLYSIO (NF PA)
PEG-INTRON (PA-Preferred)
PEGASYS (PA)
REBETOL CAPSULE (NF PA)
REBETOL SOLUTION
ribapak (NF PA)
RIBATAB (NF PA)
ribasphere (NF PA)
ribavirin
SOVALDI (NF PA)
VICTRELIS (PA)

HIV
FUZEON
EGRIFTA (NF PA)
SEROSTIM (NF PA)

MULTIPLE SCLEROSIS
AMPYRA (PA)
AUBAGIO (NF PA)
AVONEX (ST)
BETASERON (NF PA)
COPAXONE
EXTAVIA (ST)
GILENYA (PA)
REBIF
TECFIDERA (NF PA)

PULMONARY HYPERTENSION
ADCIRCA (PA)
ADEMPAS (NF PA)
LETAIRIS (PA)
OPSUMIT (NF PA)
REVATIO (NF PA)
sildenafil (PA)
TRACLEER (PA)
TYVASO (PA)
VENTAVIS (PA)

OTHER
ACTIMMUNE (NF PA)
ARCALYST (NF PA)
CARBAGLU (PA)
CYSTARAN (PA)
EXJADE (PA)
FERRIPROX (PA)
FIRAZYR (QL PA)
FORTEO (PA)
GATTEX (NF PA)
HP ACTHAR GEL (PA)
ILARIS (NF PA)
JUXTAPID (PA)
KORLYM (NF PA)
KUVAN (PA)
KYNAMRO (PA)
octreotide
PROCYSBI (NF PA)
RAVICTI (PA)
SABRIL (PA)
SAMSCA (NF PA)
SANDOSTATIN (NF PA)
SANDOSTATIN LAR (NF PA)
SIGNIFOR (PA)
SOMATULINE DEPOT (NF PA)
SOMAVERT (PA)
SUCRAID (PA)
SYPRINE (NF PA)
XENAZINE (PA)
XOLAIR (NF PA)
XYREM (PA)
ZAVESCA
ZORBTIVE (NF PA)

(1)These medicines aren't subject to specialty medication copays-standard benefits apply
(2)These medicines are also available through:

- **Children's Hospitals & Clinics Pharmacy** Minneapolis 612-813-7290 St. Paul **651-220-6963**
- **Fairview Specialty Pharmacy** Clotting Disorders: **612-626-8484** or **866-419-7859**
- **Fairview Specialty Pharmacy** Cystic Fibrosis: **612-672-5260** or **800-595-7140**

*These medicines aren't subject to specialty medication copays—standard benefits apply
Generic medicines are shown in lowercase names (e.g., ribavirin)

Growth Hormone Product List

Coverage for growth hormone products is typically under a separate medical benefit for "Growth Deficiency Therapy" and requires prior approval. Please check your policy or call Member Services to verify your coverage level.

Coverage criteria for "Growth Deficiency Therapy" is located on healthpartners.com in the HealthPartners Insurance Coverage Criteria Policies section.

Growth Hormone is available through HealthPartners Riverside Pharmacy. Please call HealthPartners Riverside Pharmacy at 612-341-5105 or 866-554-6570 to receive your prescriptions for growth hormone.

COVERED	NOT COVERED
OMNITROPE	GENOTROPIN HUMATROPE NORDITROPIN NUTROPIN NUTROPIN AQ SAIZEN TEV-TROPIN

Generic formulations are indicated by lowercase names.

This list can change and doesn't apply to Medicare Part D benefit plans.

Infertility Product List

Coverage for infertility products generally occurs under the "Prescription Drug Services – Drugs for Treatment of Infertility" benefit. **Not all benefit plans have coverage for these drugs.** Please check your policy or call Member Services to verify your coverage level.

Contact Walgreens Specialty Pharmacy infertility pharmacy by telephone at **800-424-9002** or by facsimile at 800-874-9179 to fill your prescriptions for injectable fertility medications.

Prescriptions may also be filled by the 24-hour Walgreens store at 2426 Hennepin Avenue South, Minneapolis, Minnesota. To contact the Hennepin Avenue Walgreens call 612-277-0197

This list can change and doesn't apply to Medicare Part D benefit plans.

COVERED	NOT COVERED
CETROTIDE	BRAVELLE
chorionic gonadotropin (NOVAREL, PREGNYL)	GONAL-F
clomiphene (CLOMID)*	
FOLLISTIM AQ	
GANIRELIX	
leuprolide (LUPRON)*	
LUVERIS	
MENOPUR	
OVIDREL	
REPRONEX	

*Clomiphene (Clomid) and Leuprolide (Lupron) are part of the infertility benefit but may be filled at any network pharmacy.

Generic formulations are indicated by lowercase names. Select brand names for these generics are also provided in lowercase for reference. [e.g., clomiphene (Clomid)]

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Medical & Durable Medical Equipment Coverage Policy Index

HealthPartners Commercial and State Public Programs Coverage Policies and related lists are available online at https://www.healthpartners.com/public/coverage-criteria/. Upon request, a paper version of revised and new policies can be mailed to clinic groups whose staff does not have Internet access.

A link to CMS Medicare national coverage determinations (NCDs) or local coverage determinations (LCDs) is provided on the medical policy web page.

Contact the medical policy department: email medicalpolicy@healthpartners.com or phone 952-883-6333 or 1-800-883-2177.

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HealthPartners Products for Commercial Business

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HealthPartners Primary Clinic & HealthPartners Primary Clinic Choice Plans

How HealthPartners Primary Clinic Plans Work

HealthPartners Primary Clinic Plan members do not have out of network benefits. Members have access to a large network of HealthPartners providers committed to providing high quality care and excellent service.

Members must utilize the primary clinic's panel of specialty providers or obtain a referral from the primary clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.

HealthPartners Primary Clinic Choice Plan members do have out of network benefits and receive the highest level of benefits when care is received from a network provider.

Selecting a clinic

Upon enrollment, HealthPartners members select a primary care clinic in the network. Each covered family member may select a different primary care medical group.

Insurance card identifies a Primary Care Clinic Plan Member

Sample Insurance Card Primary Clinic Choice Plan

FRONT OF MEMBER CARD


Emergency & Urgently Needed Care
Print Date: 07/08
For emergency situations, call 911 and/or get medical attention immediately.
For medical needs after clinic hours, if possible call the CareLine℠ service at 612-339-3663 or 1-800-551-0659 or call your clinic.
Precertification
Contact CareCheck℠ at 952-883-5800 or 1-800-942-4872 for any admission not directed by a network physician.
Claims Submission: Provider: healthpartners.com/electronicconnectivity
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN, 55440-1289.
Pharmacy: Provider: healthpartners.com/formulary
Member Services: healthpartners.com
HealthPartners Member Services, P.O. Box 1309, Minneapolis, MN, 55440-1309, phone 952-883-5000 or 1-800-883-2177. For TTY call 952-883-5127 or 1-888-850-4762.
Minnesota Commissioner of Health Appeals: phone 651-201-5100 or 1-800-657-3916.
Coverage includes optometry care through the PHCS network.
AWAY FROM HOME CARE
Offered by HealthPartners

BACK OF MEMBER CARD

"Offered by HealthPartners" indicates the member is in a fully-insured group.
"Administered By HealthPartners Administrators, Inc." indicates the member is in a self- insured group.

Primary care clinic plans may require referrals for claims payment

Most employer groups choose plans with an open access network which do not require a referral. Some employers, however, choose primary clinic plans which may require referrals.

A few examples of the primary clinic plan product types which may require referrals are:

- **HealthPartners Primary Clinic Copay Options IV SI**
- **Park Nicollet First Plan**
- **HP Tiered Referral - Benefit Level 1, 2, 3 & 4**

Providers are encouraged to check eligibility and contact Member Services to verify if referrals are required. Eligibility may be checked on the Provider Portal at www.HealthPartners.com/provider/. After logging in, select Eligibility from the drop down menu under the heading Applications. Member Services contact information is listed on page 1 of this manual under HealthPartners Contacts.

The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at www.HealthPartners.com/provider. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can also be made by completing a *Provider Recommendation Form* (found in Claims Section of this manual) and faxing or mailing it to the Claims department.

Importance of Primary Care Clinics responding to all RAIs

An RAI is generated when a member receives services outside of their assigned primary clinic's specialty referral network. To process claims, Primary Care Clinics need to respond to these RAI's even if the care was not referred by the Primary Clinic care system. RAI notifications are sent to Primary Care providers via the Provider Portal. There is no indicator on the Provider Portal that an RAI has been sent when you log on so it is important to check your work queues regularly to view and respond to RAI's.

HealthPartners Open Access / HealthPartners Open Access Choice Plans, Distinctions, HealthPartners Open Access Perform Network & Small Group Perform, CareChoices Network, the Park Nicollet and HealthPartners Achieve & Peak Networks and HealthPartners Open Access State of Wisconsin

HealthPartners Open Access , Open Access Choice, and Distinctions Plans

HealthPartners Open Access and **HealthPartners Open Access Choice** plans allow members to access any primary or specialty care provider within the Open Access Network without a referral. Members do not select a primary care clinic.

Members who have a **HealthPartners Open Access Choice** plan can visit an open access network provider or an out-of-network provider. Members receive the highest level of benefits when care is received from a network provider.

Providers in the **Distinctions** open access network are designated to one of the two or three benefit tiers. Member liability will vary on which tier the provider is in.

The Mayo Clinic *primary* care (family medicine, internal medicine, pediatrics) providers are not part of the **Distinctions** network (unless the delivery network indicates **Distinctions *w/Mayo***). The Mayo *specialty* providers are in the **Distinctions** network.

The **Distinctions** plan is also available as a choice product. Members enrolled in the **Distinctions Choice** product have a supplemental benefit tier in addition to their HealthPartners benefits. Members on this plan will receive their HealthPartners benefits when accessing providers within the **Distinctions** network. If they access a provider outside of the Open Access network, they will receive their supplemental benefits.

HealthPartners Open Access Perform and Small Group Perform Networks

- The Open Access Perform Network allows members to visit more than 700,000 network providers and 5,800 network hospitals in the United States as part of HealthPartners strategic alliance with CIGNA HealthCare.

- This network DOES NOT include in-network access to Mayo Health System, Mayo Clinic-Rochester, St. Mary's Hospital, or Rochester Methodist Hospital. The Small Group Perform Network, in addition, excludes Gunderson Lutheran and Sanford-Sioux Falls. Members WILL be able to access these locations using their out-of-network benefits.

- Members do not select a primary care clinic and do not need referrals to see a specialist.

CareChoices Network

The CareChoices network is an open access network where members choose a care system as their main provider of care. When members access their care system for medical care, they receive their best benefit level. Members are also able to access other providers in the network but would pay a higher copay or coinsurance amount.

In addition, a member's monthly premium contribution is determined by the care system they choose. Member premiums are based on the chosen care system's Total Cost Index (TCI). The higher the TCI for the provider, the higher the premium and co-payments/coinsurance are for the member.

Park Nicollet and HealthPartners Achieve & Peak Networks

Achieve is offered to all group markets and **Peak** to the individual market.

- The Park Nicollet and HealthPartners Achieve & Peak Networks are focused networks and not all contracted providers will be in-network.
- Members do not select a primary care clinic and do not need referrals to see a specialist.
- These networks are only marketed in the following counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Morrison, Benton, Stearns, Sherburne, Wright, Meeker, Chisago, McLeod and Washington.

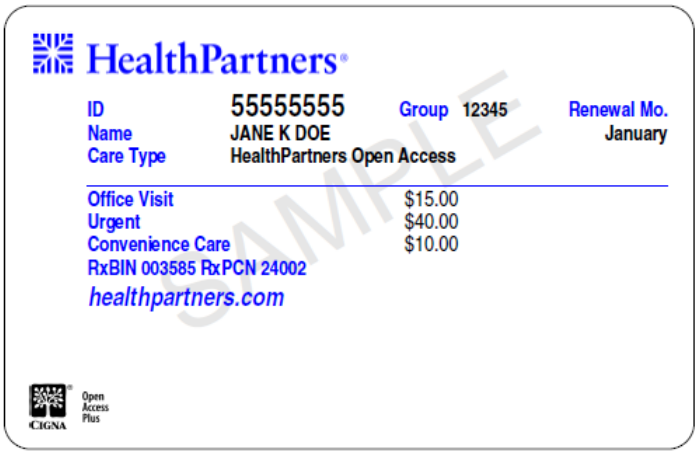
HealthPartners Open Access State of Wisconsin

- The State of Wisconsin has a custom network. This is a focused network and not all contracted providers will be in-network.
- This network is marketed only to employees who live in Pierce, Polk, St. Croix, Burnett and Douglas counties, and to State of WI members living in MN.
- Members do not have out-of-network coverage and have no benefits outside of the network.

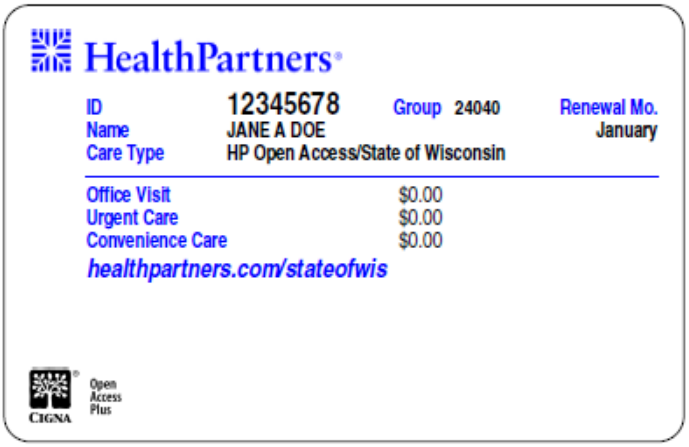
Insurance card identifies an Open Access Plan Member

Sample Insurance Card for Member with Open Access Plan

SAMPLE # 1 FRONT OF CARD



SAMPLE #2 FRONT OF CARD



SAMPLE #3 FRONT OF CARD

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HealthPartners Workers' Compensation Managed Care Plan

HealthPartners Workers' Compensation Managed Care Plan (WCMCP) is certified by the Minnesota Department of Labor and Industry (DOLI).

How the Plan Works

Providers in this network work with HealthPartners Worker's Compensation Managed Care Plan case managers, who are registered nurses, to manage the medical care of injured workers from the point of injury to the time they return to maximum function.

The injured employee is directed to call HealthPartners 24-hour CareLine which will direct the patient to the designated clinic assigned for their associated employer group. If the employee wants to be seen by his/her own family practice physician, Managed Care statutes state the patient must have been treated by this physician at least twice within the last two years. The employee will receive follow-up care from this facility or another participating facility if specialty care is needed.

Member Identification

After identifying that the patient was injured at work, please follow your normal protocol of asking the patient where he/she works. The patient may be accompanied by an assigned qualified rehabilitation consultant (QRC). The QRC may be assigned by the insurer, commissioner or chosen by the patient.

Medical Record Dictation

Due to differences in data privacy between workers' compensation (W/C) and general medical care, two separate dictations should be made when a patient is seen for both a workers' compensation injury/illness and a non-work related condition. The W/C dictation should indicate that this is a workers' compensation injury. If this is the first encounter for the W/C injury/illness, it should document the basis for the work-relatedness.

Report of Work Ability Form

Within 24 hours of each visit, please fax a completed *Report of Work Ability Form* to the HealthPartners Case Management Office at 952-853-8732. Also, please give a copy of the form to the patient. This form is essential for the employer to determine appropriate accommodations that conform to the medical assessment of the patient's safe, functional capabilities. More complete information is available on the DOLI website at www.doli.mn.gov

Claim Submission

Submit all claims with a copy of the medical progress notes to the patient's Workers' Compensation carrier. You may contact the case management office at 952-883-5396 for the correct billing address.

PreCertification/Referrals

Please call the HealthPartners case management office at the number listed below to request a pre-certification or referral. If specialty care is needed, please direct the patient to participating providers listed in the HealthPartners Workers' Compensation Provider Directory. When sending a patient to a provider outside of your clinic, make sure you refer to an appropriate in-network facility. Clearly state to the employee exactly what services are being approved and when to check back with you. If the patient needs a specialist who is not listed in the HealthPartners WCMCP Provider Directory, which can be found at http://www.healthpartners.com/files/41795.pdf, call a HealthPartners case manager for assistance at 952-883-5396.

To schedule an appointment within 24 hours of injury:

24/7 CareLine: 952-883-5484 or 888-544-5484 toll free

For referrals, treatment and other case management questions**: 952-883-5396 or 888-779-3625 toll free or 952-853-8732 fax**

HealthPartners Products for Medicare Eligible Individuals

HealthPartners Products for Medicare Eligible Individuals

I. HEALTHPARTNERS FREEDOM MEDICAL PLANS: BASIC, VITAL, BALANCE & ULTIMATE. HEALTHPARTNERS FREEDOM PLANS WITH MEDICARE PRESCRIPTION DRUG COVERAGE; VITAL W/RX, BALANCE W/RX, ULTIMATE W/RX & ULTIMATE W/ENHANCED RX.

Type of Program: These are Medicare "Cost" plans

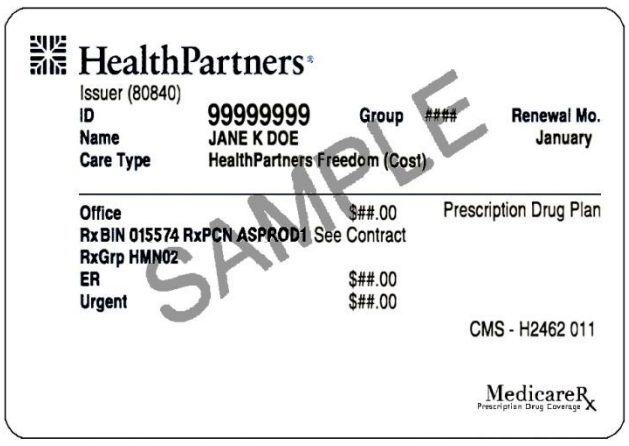
Primary Payer: Medicare is primary for all Medicare Part A services and for Part B Medicare services not received from plan providers. HealthPartners is primary for all Medicare Part B services that are received through the health plan's network.

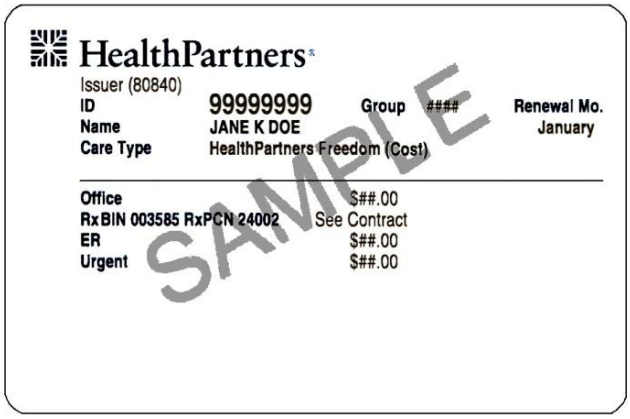
Medicare Status: Medicare is not assigned to HealthPartners

Copays: Basic covers Medicare-covered services only and has 20% coinsurance for most outpatient services. Vital covers office visits with a $15 copay for primary care and a $40 copay for specialists. Balance has a $15 office visit copay. Ultimate has no office visit copay.

Status of Product: Open to new enrollment although plan options with the Part D prescription drug benefit are subject to Medicare enrollment limitations as to when and how often individuals may elect or change Part D coverage.

ID Card: Two versions: one with Medicare RX symbol indicates Part D coverage and one without. Both cards will indicate "HealthPartners Freedom (Cost)" in Care Type field.




HealthPartners
Issuer (80840)
ID 99999999 Group #### Renewal Mo.
Name JANE K DOE January
Care Type HealthPartners Freedom (Cost)
Office $##.00
RxBIN 003585 RxPCN 24002 See Contract
ER $##.00
Urgent $##.00
SAMPLE


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at **952-555-5555.**
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission not directed by a network physician.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Preventive Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services: HealthPartners Member Services, P.O. Box 9463, Minneapolis, MN, 55440-9463, phone **952-883-7979 or 800-233-9645.**
For TTY call 952-883-6060 or 800-443-0156.
Minnesota Commissioner of Health Appeals: phone 651-201-5100 or 800-657-3916.
healthpartners.com Offered by Group Health, Inc.
SAMPLE

II. HEALTHPARTNERS SENIOR HEALTH ADVANTAGE

Type of Program: This is a *Medicare Select* plan.

Primary Payer: Medicare is primary for all Part A and Part B Medicare services.

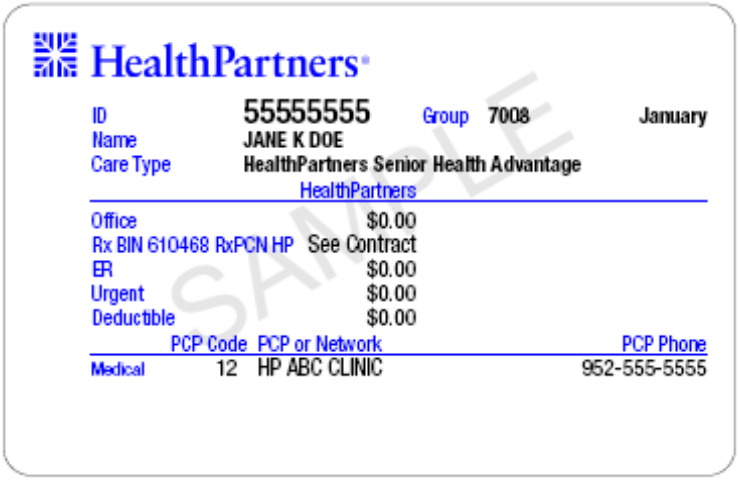
Medicare Status: Medicare is not assigned to HealthPartners

Copays: There is no office visit copayment.

Status of Product: Open to new individual enrollment.

ID Card: Standard HealthPartners member card with "HealthPartners Senior Health Advantage" in Care Type field

Referral Required: This is a primary care clinic based plan. Members must utilize the Primary Clinic's panel of specialty providers or obtain a referral from the Primary Clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.


HealthPartners
ID 55555555 Group 7008 January
Name JANE K DOE
Care Type HealthPartners Senior Health Advantage
HealthPartners
Office $0.00
Rx BIN 610468 RxPCN HP See Contract
ER $0.00
Urgent $0.00
Deductible $0.00
PCP Code PCP or Network PCP Phone
Medical 12 HP ABC CLINIC 952-555-5555
SAMPLE

III. HEALTHPARTNERS MEDICARE SUPPLEMENT PLAN

Type of Program: This is a *Medicare Supplement* plan.

Primary Payer: Medicare is primary for all Part A and Part B Medicare services.

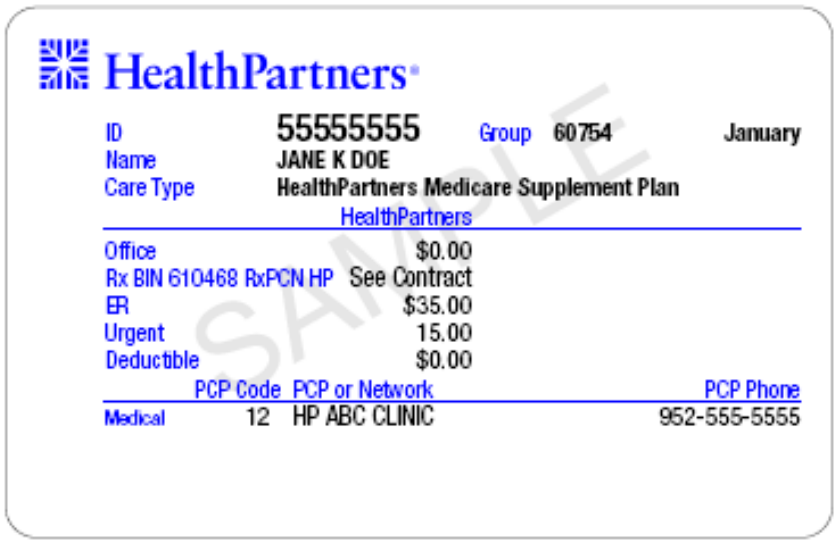
Medicare Status: Medicare is not assigned to HealthPartners

Copays: There is no office visit copayment

Status of Product: Closed to new enrollment

ID Card: Standard HealthPartners member card with "HealthPartners Medicare Supplement Plan" in Care Type field

Referral Required: This is a primary care clinic based plan. Members must utilize the primary clinic's panel of specialty providers or obtain a referral from the primary clinic for care outside of the specialty panel. Not all contracted providers will be considered in network for members with this plan type.



Medicare Part D for Low-Income Medicare beneficiaries

The Medicare prescription drug benefit (also known as Medicare Part D) was effective January 1, 2006.

Medicaid eligible Medicare beneficiaries (dual eligibles) will automatically qualify for low-income assistance through Medicare Part D.

For additional information on Medicare Part D, visit *www.Medicare.gov*.

For more information about low-income subsidy assistance or to request an application, call the Senior LinkAge Line ® at 1-800-333-2433.

For more information on how the new Medicare Part D impacts HealthPartners members in your facility, please visit *www.healthpartners.com*.

What is covered under Medicare Part D?

- Prescription drugs
- Biological products
- Insulin
- Certain Vaccines
- Medical supplies associated with the injection of insulin

For more information regarding this go to:
http://www.cms.hhs.gov/partnerships/downloads/determine.pdf

Where do providers submit claims for HealthPartners Part D Medicare beneficiaries?

Submit claims electronically to our pharmacy benefit management company (PBM), MedImpact. Providers are encouraged to ask pharmacies to submit claims electronically to MedImpact.

If a Part D drug is dispensed in an outpatient setting and it is not possible to submit an electronic claim to MedImpact, please send a paper claim to:

HealthPartners Pharmacy Benefits
Attn: Part D Claims
PO Box 1309
Minneapolis, MN 55440-1309

2014 Medicare Information

The following pages contain important information on our Medicare Products.

There is a fax back verification form for you to complete at the back of this section.

Please complete the form and return it to HealthPartners at this fax number:
952-853-8848

2014 Key Points: HealthPartners Freedom Medicare Products

HealthPartners Freedom is a Medicare Cost plan that is open access. Medicare is the primary payer for Part A (inpatient hospital) services, and HealthPartners is the primary payer for most Part B (outpatient) services.

General Responsibilities of Providers to *HealthPartners Freedom Members*

1. **No Discrimination:** Members will not be discriminated based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

2. **Access to Care:** Covered Services are available 24 hours per day, 7 days per week, when medically necessary. General hours of operation will be convenient to, and not discriminate against, Medicare members.

3. **Inform Members of Follow-Up Care:** Members are informed of specific health care needs that require follow-up care and receive, as appropriate training in self-care and other measures necessary to promote their health.

4. **Involve Members in Treatment**:
   Providers will:
   a) educate members regarding their health needs,
   b) share findings of history and physical examinations,
   c) discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms.

   However, the patient has the right to choose the final course of action among clinically acceptable choices. Members have the right to choose no treatment as an option.

5. **Include Member Input in Treatment Plan:** Members have a right to have input into their treatment plan. If they are unable to fully participate in their treatment decisions, they have the right to be represented by parents, guardians, family members or other conservators, as they choose.

6. **Encourage Members to Participate in Decision Making:** Providers will encourage the member or their representative to participate in decision making regarding his or her health care, including but not limited to; withholding resuscitative services, or forgoing or withdrawing life sustaining treatments.

7. **Confidentiality and Communications:** There will be appropriate and confidential exchange of information among providers in the network. In addition, there will be appropriate communication between primary care and specialty care to assure continuity of care and coordination of services.

8. **Right to Access Medical Records:** Member has a right to access their medical records, per HealthPartners policies.

9. **Advise Members when Service is Not Covered:** Providers shall advise members when a service is not covered and document the discussion of the non-covered service in the medical record.

10. **Appeals, Grievances and Complaints:** Providers will fully cooperate with HealthPartners policies and procedures related to member complaints, grievances, and organization determinations involving benefits, appeals, and expedited appeals.

11. **Respect, Dignity and Privacy:** Providers will ensure that all members are treated with respect, dignity, and are considerate of the enrollee's privacy.

PROVIDER REFERENCE TOOL*

2014 BENEFIT COMPARISON OF MEDICARE VS. HEALTHPARTNERS FREEDOM PLANS

*For greater detail, refer to the Evidence of Coverage for the member's policy.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Doctor & Hospital Choice	Medicare beneficiaries may use any doctor, specialist, or hospital that accepts Medicare.	• This is an open access plan; however, members must use HealthPartners Freedom network providers to receive plan level of coverage (except for emergency & urgently needed care or as provided under the Extended Absence benefit). • Medicare benefits are not "locked-in" giving members option to go outside network but they will receive Medicare coverage only and will be responsible for any Medicare deductibles, coinsurance and all charges not covered by Medicare • The **Extended Absence benefit** provides the plan level of coverage when outside the service area. Members **must** call to activate this benefit prior to leaving the service area or they will have Medicare coverage only.
Premium	$104.90*/month for the Medicare Part B premium *This is the 2014 Part B premium amount and is subject to change in 2015.	Members must continue to pay $104.90*/month for Medicare Part B premium in addition to the plan premium: **Medical plan options:** • $47/month for Basic • $54/month for Vital • $94/month for Balance • $145/month for Ultimate

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Premium (cont'd)		**Plans with Part D prescription drug coverage** • $66.10/month for Vital w/Rx • $117.80/month for Balance w/Rx • $187.70/month for Ultimate w/Rx • $343.30/month for Ultimate w/Enhanced Rx Note: Basic is not eligible for drug coverage. *This is the 2014 Part B premium amount and is subject to change in 2015.
Inpatient Services		
Hospital	Coverage based on 90 day benefit period: • Days 1- 60: $1,216* deductible • Days 61- 90: $304*/day copay • Days 91-150: $608*/day copay for 60 lifetime reserve days • Beyond lifetime reserve days: all costs *This is the 2014 amount and is subject to change in 2015.	• **Basic**: $600 copayment per benefit period for Medicare-covered stays; no coverage for additional non-Medicare covered days. • **Vital:** $300 copayment per benefit period for Medicare-covered stays; unlimited days. • **Balance:** $200 copayment per benefit period for Medicare-covered stays; unlimited days. • **Ultimate:** $100 copayment per benefit period for Medicare-covered stays; unlimited days.
Skilled Nursing Facility	Requires 3-day hospitalization to qualify; Must meet Medicare skilled criteria: • Days 1-20: 100% coverage • Days 21-100: $152.00*/day copayment • Limit of 100 days per benefit period. *This is the 2014 amount and is subject to change in 2015.	Requires 3-day hospitalization to qualify; Must meet Medicare skilled criteria: • **Basic:** 100% coverage days 1-20; $130 copay/day for days 21-100 • **Vital:** 100% coverage days 1-20; $100 copay/day for days 21-100 • **Balance & Ultimate:** 100% coverage up to 100 days

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Home Health Care	• No copayment for medically necessary skilled nursing and rehabilitative care for members who are home bound. • 80% of approved amount for Home IV Therapy.	**All Freedom plans:** • No copayment for Medicare covered home health visits. • 20% of approved amount for Home IV Therapy. • Inhalation drugs and Enteral formula are paid under the members DME benefit and may require PA.
Mental Health		
Inpatient	Same deductible and coinsurance as Hospital above 190-day lifetime limit psychiatric hospital.	• **Basic**: $600 copayment per benefit period for Medicare-covered stays; no coverage for additional non-Medicare covered days. • **Vital:** $300 copayment per benefit period for Medicare-covered stays; unlimited days. • **Balance:** $200 copayment per benefit period for Medicare-covered stays; unlimited days. • **Ultimate:** $100 copayment per benefit period for Medicare-covered stays; unlimited days **All Freedom plans:** 190-day lifetime limit in a Medicare-certified psychiatric hospital**.**
Outpatient	• 35% coinsurance for most outpatient Mental Health services. • 20% coinsurance for Substance Abuse treatment	• **Basic:** 80% coverage per visit • **Vital:** $40 copayment per individual therapy visit; $20 per group therapy visit • **Balance:** $15 copayment per individual therapy visit; $7.50 per group therapy visit • **Ultimate:**100% coverage per visit

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Outpatient Services		
Doctor office visits	• 80% coverage for Medicare approved amounts. • 100% coverage for preventive services including Welcome to Medicare physical exam during first 12 months of new Part B coverage. • One Annual Wellness exam every 12 months, thereafter.	• **Basic:** 80% coverage of Medicare-approved amounts; 100% coverage for the Medicare-covered initial preventive physical exam and annual wellness visits. • **Vital:** $15 copayment for primary care, $40 specialist copayment; no copayment for one routine physical exam each year. • **Balance:** $15 copayment; no copayment for one routine physical exam each year. • **Ultimate:** No copayment; no copayment for one routine physical exam each year.
Immunizations	• 100% coverage & no referral required for flu and pneumonia vaccines • 80% coverage of Medicare approved amount for Hepatitis B vaccine	• 100% coverage for flu, pneumonia, or Hepatitis B vaccine. • No referral needed for pneumonia or flu vaccines
Hearing Exams/ Hearing aids	No coverage for routine exams, 80% coverage of Medicare approved amount for diagnostic hearing exams. No coverage for hearing aids	• **Basic:** No coverage for routine exams; 80% coverage of Medicare approved amount for diagnostic hearing exams. • **Vital:** 100% coverage for routine hearing tests; up to one visit per year; $40 copay for Medicare covered diagnostic hearing exams • **Balance:** 100% coverage for routine hearing tests; up to one visit per year; $15 copay for Medicare covered diagnostic hearing exams • **Ultimate:** 100% coverage for routine hearing tests (up to one visit per year) or Medicare covered diagnostic hearing exams **Hearing Aids – All Plans:** • No coverage

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Vision Services	• 80% coverage of Medicare approved amounts for diagnosis & treatment services. Coverage for one pair of eyeglasses or contact lenses after each cataract surgery. • Routine exams & eyeglasses not covered	**Basic:** • 80% coverage for exams for diagnosis & treatment services • Routine exams not covered **Vital:** • $0-40 copayment for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **Balance:** • $0-15 copayment for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **Ultimate:** • 100% coverage for Medicare-approved diagnosis & treatment services • 100% coverage for routine eye exams up to one visit per year **All Freedom Plans:** • 100% coverage for one pair of eyeglasses or contact lenses after each cataract surgery
Chiropractic Care	80% coverage of Medicare-allowable fees	• **Basic:** 80% coverage for each Medicare-covered visit. • **Vital:** $15 copayment for each Medicare-covered visit. • **Balance:** $15 copayment for each Medicare-covered visit. • **Ultimate:** 100% coverage for Medicare-covered chiropractic services.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Podiatry	• 80% coverage of Medicare approved amounts for medically necessary foot care • Routine foot care not covered	• **Basic:** 80% coverage for each Medicare-covered visit; no coverage for routine visits • **Vital:** $40 copay for each Medicare-covered visit; no coverage for routine visits • **Balance**: $15 copay for each Medicare-covered and routine visit • **Ultimate:** 100% coverage for each Medicare-covered and routine visit
Acupuncture	Not covered	• **Basic:** No coverage • **Vital:** $35 copayment for each visit • **Balance:** $15 copayment for each visit • **Ultimate:** 100% coverage
Outpatient Rehabilitation	80% coverage of Medicare approved amounts	• **Basic:** 80% coverage for each Medicare-covered physical, occupational, and speech therapy visit • **Vital:** $40 copayment for each Medicare-covered physical, occupational, and speech therapy visit • **Balance:** $15 copayment for each Medicare-covered physical, occupational, and speech therapy visit • **Ultimate:** 100% coverage for Medicare-covered physical, occupational, and speech therapy visits
Durable Medical Equipment & Prosthetics	80% coverage of Medicare approved amount	**All Freedom plans:** 80% coverage for each Medicare covered item.
Emergency Care		
Emergency Room visit	80% coverage of doctor and facility charges Usually not covered outside the U.S.	• **Basic:** $100 copayment • **Vital:** $75 copayment • **Balance:** $65 copayment • **Ultimate:** $50 copayment Worldwide emergency coverage for Vital, Balance & Ultimate plans.

BENEFIT CATEGORY	Medicare	HealthPartners Freedom (Medicare Cost)
Dental		
Dental Services	In general, not covered	• **Basic:** Not covered • **Vital:** Not covered • **Balance & Ultimate:** 100% coverage for one oral exam, one cleaning and one set of dental x-rays per year. **Vital, Balance & Ultimate:** Additional optional comprehensive dental coverage is available.
Prescription Drug Coverage		
Prescription Drugs	• 80% for prescription drugs covered under Medicare Part B • Most drugs are not covered.	• 80% for prescription drugs covered under Medicare Part B **Freedom plans with Part D prescription coverage** • **Vital w/Rx:** - Premium (medical & Rx): $66.10/month - Annual deductible: $175 all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $20 nonpreferred generic drug copay; $45 preferred brand drug copay;$95 nonpreferred brand drug copay; 33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs; 2.5% plan pays - Catastrophic Threshold: $4,550

Prescription Drug Coverage		
Prescription Drugs (cont'd)		• **Balance w/Rx:** - Premium(medical & Rx): $117.80/month - Annual deductible: $125 for all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $15 non-preferred generic drug copay; $45 preferred brand drug copay;$95 non-preferred brand drug copay;33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs;2.5% plan pays - Catastrophic Threshold: $4,550 • **Ultimate w/Rx:** - Premium (medical & Rx): $187.70/month - Annual deductible: $175 for all drugs tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $15 non-preferred generic drug copay;$45 preferred brand drug copay; $95 non-preferred brand drug copay; 33% for specialty drugs up to $2,850 - Coverage gap (from $2,850 to $4,550 out of pocket): 72% coinsurance for generics; 50% manufacturer discount on brand drugs; 2.5% plan pays - Catastrophic Threshold: $4,550 • **Ultimate w/Enhanced Rx:** - Premium (medical & Rx): $343.30/month - Annual deductible: $100 for all drug tiers except Tier 5-specialty drugs - Initial coverage: $5 preferred generic drug copay; $12 non-preferred generic drug copay; $40 preferred brand name drug copay; $65 non-preferred brand drug copay; 33% for specialty drugs up to $2,850

Prescription Drug Coverage		
		- Coverage gap: $5 preferred generic drug copay; $12 non-preferred generic drug copay; 40% coinsurance for preferred brand name drug copay; additional manufacturer discount on brand drugs - Catastrophic Threshold: $4,550 Catastrophic copays for all plans: - Generic: $2.55 or 5%, whichever is greater - Brand: $6.35 or 5%, whichever is greater Rx Drug Days Supply: 30 Must use formulary drugs, unless non-formulary drug approved. • Employer groups: Coverage varies by group

HealthPartners' Medicare Product Portfolio
January 2014

	Medicare Cost	Carve-out / PDP	Medicare Select	Medicare Supplement	Medicare Carve-out
aka	1876 Cost, TEFRA Cost (formerly HCPP)		Medigap Medicare PPO	Medigap	
HP Product Name	Freedom (formerly HealthPartners 65+)	National Retiree Group Plan + HealthPartners Prescription Drug Plan	Senior Health Advantage	Medicare Supplement	
CMS Plan #	H2462	S1822			
Underwriting Corporation	Group Health Plan 501(c)3	HealthPartners Inc 501(c)4 (PDP) HPIC (medical)	HealthPartners Inc 501(c)4	HealthPartners Inc 501(c)4	HealthPartners Inc 501(c)4
Regulated by	• CMS • MN Dept of Health • WI OCI	• CMS • MN Dept of Health • WI OCI	MN DoC & MDH	MN DoC	same as commercial
Funding	prepayment from CMS and member premium	prepayment from CMS and group or member premium	member premium	member premium	group and/or member premium
Sold to	individuals and groups	groups	individuals	individuals (closed to new)	groups
Network	HealthPartners open access	None	HealthPartners network	HealthPartners network minus HPMG	same as commercial
Service Area	87 MN counties 8 WI counties	National (50 states;no territories)	24+ counties	21 counties	same as commercial
Enrollment rules	No health history underwriting	No health history underwriting	No underwriting	closed to new sales	same as commercial
Primacy	• MCR prime for Part A • HP prime for Part B • No "lock in" – members may access MCR benefits outside network	• MCR prime for A&B services • HP prime for Part D	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network	• MCR prime for Parts A&B • No "lock in" – members may access MCR benefits outside network
Rx	• Standard • Enhanced	• PDP			

HealthPartners®

Subject Medicare Responsibilities for Providers and HealthPartners	**Attachments** ☐ Yes ☒ No
Key words Medicare Responsibilities for Providers and HealthPartners	**Number** **AM013**
Category Business Practices (BP)	**Effective Date** **November 1, 2003**
Manual HPI Administrative Policies	**Last Review Date** **April 1, 2013**
Issued By Professional Services Network Management and Hospital and Regional Network Management	**Next Review Date** **April 1, 2014**
Applicable ▪ All Primary Care Medical Groups and Providers ▪ All Specialty Care Medical Groups and Providers ▪ All Facilities and Providers	**Origination Date** **November 1, 2003** **Retired Date**
Review Responsibility Bev Vacinek, Rob Sauer, Laurena Lockner, Brenda Thommen, Melanie Teske	**Contact** Bev Vacinek

Products

☐ Fully Insured ☐ Self-Insured ☒ Medicare Cost ☐ Medicaid ☒ MSHO

I.

PURPOSE

To explain the requirements for Providers and HealthPartners in providing care to Medicare Members.

II.

POLICY

This policy outlines the requirements for Providers and HealthPartners in providing care to Medicare Members.

III. **PROCEDURE(S)**

Provider Responsibility:

1. Provider will allow Medicare Members direct access to screening mammography services, influenza vaccinations and routine and preventive services to women's health specialists included in the Medicare network. 42 CFR § 422.100(g)(1); § 422.112(a)(3)

2. Provider will not collect a co-pay or co-insurance from Medicare Members seeking influenza or pneumococcal vaccines. 42 CFR § 422.100(g)(2)

3. Provider will provide all Covered Services to Medicare Members in a manner consistent with professionally recognized standards of health care. 42 CFR § 422.504(a)(3)(iii)

4. Provider shall, and shall cause each Subcontractor to:

   a. Document, in a prominent part of the Medicare Member's current medical record whether or not the Medicare Member has executed an advance directive
   b. Not refuse care or otherwise discriminate against a Medicare Member based on whether or not the Medicare Member has executed an advance directive; and
   c. Comply with Minnesota law regarding advance directives. 42 CFR § 422.128(b)(1)(ii)(e-g)

5. Provider must cooperate with HealthPartners in respect to HealthPartners obligation to disclose to Centers for Medicare and Medicaid Services (CMS) Medicare plan quality and performance indicators, including:

   a. Disenrollment rates for Medicare Members electing to receive benefits through the Medicare Plan for the previous two years; 42 CFR § 422.504(f)(2)(iv)(A)
   b. Information on Medicare Member satisfaction; 42 CFR § 422.504(f)(2)(iv)(B) and
   c. Information on health outcomes. 42 CFR § 422.504(f)(2)(iv)(c)

6. Provider must be knowledgeable of Medicare requirements as communicated in the HealthPartners Participating Provider Agreement, the HPI Administrative Manual, and the Provider Training Manual.

7. Provider will not employ or contract with any providers that are excluded from participation in Medicare for the provision of any of the following:

   a. Health care
   b. Utilization review
   c. Medical social work
   d. Administrative services. 42 CFR § 422.752(a)(8)

8. Provider must certify (based on knowledge, information and belief) that the encounter data and medical records it submits are accurate, complete and truthful. 42 CFR § 422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)

9. Provider will participate and fully cooperate with the activities of any independent quality review and improvement organization appointed by HPI. In addition, Provider will participate and fully cooperate with HPI's medical policies, quality assurance programs, practice guidelines and utilization management programs and will consult with HPI, when requested, regarding these policies, guidelines and programs. 42 CFR § 422.504 (a)(5); 42 CFR § 422.202 (b)

10. Provider will not deny, limit, or condition the coverage or furnishing of benefits to Medicare Members on the basis of any factor that is related to health status, including but not limited to the following:

    a. Medical condition, including mental as well as physical illness.
    b. Claims experience
    c. Receipt of health care
    d. Medical history
    e. Genetic information
    f. Evidence of insurability, including conditions arising out of acts of domestic violence
    g. Disability 42 CFR § 422.110(a)

11. Provider must cooperate with HealthPartners in regards to HealthPartners obligation to provide to CMS all necessary information for:

a. Members and potential Members to make informed decisions regarding their Medicare choices
b. CMS to administer and evaluate the program 42 CFR § 422.64(a); 42 CFR § 422.504(a) (4); 42 CFR § 422.504(f) (2);

12. Provider must cooperate with HealthPartners in regards to HealthPartners obligation to disclose information, in a manner and form required by CMS, to all Medicare Members. 42 CFR § 422.64; § 422.504(a)(4); § 422.504(f)(2)

13. Provider will participate in and fully cooperate with HealthPartners policies and procedures pertaining to member complaints, grievances, organization determinations involving benefits and member liability, appeals and expedited appeals. 42 CFR § 422.562(a)

HealthPartners Responsibility:

1. HealthPartners will not deny, limit, or condition the coverage or furnishing of benefits to Medicare Members on the basis of any factor that is related to health status, including but not limited to the following:

   a. Medical condition, including mental as well as physical illness.
   b. Claims experience
   c. Receipt of health care
   d. Medical history
   e. Genetic information
   f. Evidence of insurability, including conditions arising out of acts of domestic violence or
   g. Disability. 42 CFR § 422.110(a)

2. HealthPartners will make timely and reasonable payment to non-contracted suppliers or providers for services covered by the plan. These services include:

   a. Ambulance services dispatched through 911 or its local equivalent
   b. Emergency and urgently needed services
   c. Maintenance and post-stabilization care services
   d. Renal dialysis services provided while the Medicare Member was temporarily out of the service area.
   e. Services for which coverage has been denied by the health plan and found (upon appeal) to be services the Medicare Member was entitled to have furnished or paid for. 42 CFR § 422.100(b), 422.100(b)(1)(iv)

3. HealthPartners will maintain and monitor a network of appropriate healthcare providers that is supported by written agreements and is sufficient to provide adequate access to covered services and meet the needs of the Medicare population. 42 CFR § 422.112(a)(1)

4. HealthPartners will make mammography, influenza vaccinations and routine and preventive services provided by Women's Health Specialists in the Medicare Network available to Medicare Members without a referral. 42 CFR § 422.100(g)(1); § 422.112(a)(3)

5. HealthPartners may only distribute marketing materials, election forms, or make such materials available to individuals eligible to select a Medicare product upon meeting the requirements as set forth in 42 CFR § 422.2262.

6. HealthPartners must provide to CMS all necessary information required for:

   a. Members and potential Members to make informed decisions regarding their Medicare choices
   b. CMS to administer and evaluate the program. This information includes, but is not limited to:

i. The benefits covered under Medicare plans; 42 CFR § 422.504(f)(2)(i)
ii. The monthly basic and supplemental premium 42 CFR § 422.504(f)(2)(ii)
iii. The service and continuation area, if any, and the enrollment in each plan
iv. 42 CFR § 422.504(f)(2)(iii)
v. Plan quality and performance indicators for the benefits under the plan including:

   a. Disenrollment rates for Medicare enrollees for the previous 2 years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to CMS guidelines;
   b. Information on Medicare Member satisfaction;
   c. Information on health outcomes;
   d. Plan-level appeal data
   e. The recent record regarding compliance of HPI with the CMS requirements;
   f. Other information determined by CMS to be necessary to assist members in making informed choices 42 CFR § 422.111(f)(8); 42 CFR § 422.504(f)(2)(iv)

vi. Information about appeals and their disposition; and 42 CFR § 422.504 (E)(v)
vii. Information about all formal actions, reviews, findings, or similar actions by States, other regulatory agencies or any other certifying or accrediting boards. 42 CFR § 422.504 (E)(vi)
viii. In addition, HPI must also disclose information, in a manner and form required by CMS, to all Members. 42 CFR § 422.64; § 422.504(a)(4); § 422.504(E)(vii)
ix. HealthPartners must establish a formal mechanism to consult with the network providers regarding the medical policy, quality assurance programs and medical management procedures. HealthPartners must ensure that practice and utilization management guidelines:

   a. are based on reasonable medial evidence or a consensus of health care professionals in the particular field
   b. consider the needs of the members
   c. are developed in consultation with network providers and
   d. are reviewed and updated periodically 42 CFR § 422.202 (b)(1)(iv)

x In addition, the guidelines must be communicated to network providers, and as appropriate, to members. Decisions with respect to utilization management, member education, coverage of services and other areas in which the guidelines apply are consistent with the guidelines. 42 CFR § 422.202(b)(2-3)

7. HealthPartners must have an agreement with an independent quality review and improvement organization approved by CMS. In addition, HealthPartners must operate a Quality Assurance and Performance Improvement program. 42 CFR § 422.504(a)(5)

8. HealthPartners does not offer a continuation of enrollment option to Medicare Members when they no longer reside in the service area. 42 CFR § 422.54(b)

9. Requirements of other laws and regulations. The MA organization agrees to comply with:
   a. Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and
   b. HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. 42 CFR § 422.504(h)

10. HealthPartners will not employ or contract with any providers that are excluded from participation in Medicare for the provision of any of the following:
   a. Health care

b. Utilization review
c. Medical social work
d. Administrative services. 42 CFR § 422.752(a)(8)

11. HealthPartners will not impose cost sharing for influenza and pneumococcal vaccinations for Medicare Members. 42 CFR § 422.100(g)(2)

12. HealthPartners must certify (based on knowledge, information and belief) that the encounter data it submits are accurate, complete and truthful. 42 CFR § 422.504(l)(2)

13. HealthPartners must establish and maintain the following in regards to grievances, organization determinations and appeals:
    a. A grievance procedure for addressing issues that do not involve organization determinations
    b. A procedure for making timely organization determinations
    c. Appeal procedures that meet the requirements for issues that involve organization determinations 42 CFR § 422.562(a)(1)

14. HealthPartners must ensure that all Medicare Members receive written information about the grievance and appeal procedures as well as the complaint process available to them under the QIO process. 42 CFR § 422.562(a)(2)

IV. DEFINITIONS N/A

V. COMPLIANCE

Failure to comply with this policy or the procedures may result in disciplinary action, up to and including termination.

VI. ATTACHMENTS N/A

VII. OTHER RESOURCES N/A

CMS: 42 CFR 422
CMS MANAGED CARE MANUAL CHAPTER 4

VIII. APPROVAL(S)

Rita Murtada, Sr. Director
Hospital and Regional Network Management

Charles Abrahamson, Vice President
Network Management and Provider Relations

IX. ENDORSEMENT N/A

Miscellaneous Medicare Information Web Sites

Center for Medicare and Medicaid http://www.cms.hhs.gov

Wisconsin Physician Services

Local Medicare Part B Carrier

http://www.wpsic.com

CMS Manuals and Provider Updates

Overview Manuals

HealthPartners, Inc

http:/www.healthpartners.com.

Medicare Communications

E-mail/Fax Back Verification Form

Please complete this form and e-mail back to
contractedcare@HealthPartners.com
or fax back to 952-853-8848

Clinic/Vendor Name _____

Date Medicare Training took place _____

Method of Training _____
(Ex. Staff meeting, Medicare in-service, distribution of copies of the manual)

Name and title of accountable staff member:

_____

Additional Comments:

Thank you.

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HealthPartners Products for State Public Programs

Minnesota Health Care Programs
HealthPartners Care and
HealthPartners Minnesota Senior Health Options (MSHO) Plan
(HMO SNP)
Provider Reference Guide

HEALTHPARTNERS CARE (HPCARE)

The HealthPartners Care plans provide care to recipients of Prepaid Medical Assistance Programs (PMAP), MinnesotaCare Programs (MNCare), and Minnesota Senior Care Plus (MSC+). These products are Primary Care clinic based and not all contracted providers will be in network for these members. Referrals to specialty providers may be required.

As a health plan, we are allowed to set prior authorization thresholds. Member Services will help you with questions you may have on benefits. The HealthPartners Coverage Policy Manual will be of assistance to primary care clinic staff.

HealthPartners Care Service Area

HealthPartners Care Service Area includes the following counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, McLeod, Meeker, Ramsey, Scott, Sherburne, Stearns, Washington, and Wright. HealthPartners Care MNCare program also participates in McLeod and Meeker counties

Prepaid Medical Assistance Programs (PMAP)

The benefits are based on the Medical Assistance (MA) benefit packages. PMAP covers health care for the following people who have Medical Assistance.

- Children under the age of 21
- Parents and caretakers of a dependent child
- Pregnant women
- Certain low-income adults without a dependent child

MinnesotaCare (MNCare)

There are two levels of coverage under MinnesotaCare—each with distinctive benefits and copays.

Minnesota Senior Care Plus (MSC+)

MSC+ is for members age 65 or older with Prepaid Medical Assistance and fee-for-service Medicare. The benefits are similar to PMAP coverage with the addition of Elderly Waiver Services and Nursing Facility services for those who are assessed as needing those services.

HEALTHPARTNERS MINNESOTA SENIOR HEALTH OPTIONS (MSHO) PLAN

HealthPartners MSHO Plan covers health care and Elderly Waiver services for people who are ages 65 and over, have Medical Assistance, and both Medicare Parts A and B. MSHO integrates primary, acute, and long-term care and Medicaid and Medicare services through managed care for the elderly. MSHO benefits include all Medicare and Medicaid services including home and community based "waiver" services as needed and 180 days of nursing home care for community enrollees. Home and community based services include assisted living, adult day care, home modifications, personal care attendant services, chore services, home delivered meals, and others.

One of the most attractive benefits of the MSHO plan is each member is assigned a Care Coordinator. The Care Coordinator will perform an initial assessment of the member within 30 days of enrollment and annually thereafter. Following the assessment, the Care Coordinator will develop a personalized care plan. The Care Coordinator will follow the member through different settings of care and update the member's care plan to accommodate the members' changing needs.

HealthPartners MSHO Plan Service Area
HealthPartners MSHO Plan's service area includes the following counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright.

Medicare Prescription Drug Coverage (Part D Drug Coverage)
HealthPartners MSHO Plan combines Medicare, Medicaid and Part D prescription drug coverage all in one plan. In addition, HealthPartners MSHO Plan covers some other drug classes and over the counter medications that are not covered by Medicare.

MSHO Supplemental Benefits 2014
The MSHO plan provides comprehensive coverage for all seniors covered by Medicare and Medical Assistance. HealthPartners also offers supplemental benefits to MSHO members. These benefits may change each year.

The MSHO Supplemental Benefits for 2014 are as follows:

Dental
• Second annual visit for cleaning and exam
• Adult fluoride
• Scaling and root planning
• Full mouth debridement
• Periodontal maintenance
• Root canals on molars
• Denture services – tissue conditioning
• Porcelain crowns, up to $2,000
• Bridges, up to $2,000
• Electric toothbrush* and replacement heads
Vision and Hearing Aids
• Second pair of eyeglasses
• Tints and coatings on eyeglasses (up to two pairs)
• Additional hearing aid coverage

Durable Medical Equipment (DME)
• Second pair of orthotics and orthotic shoes
• Light therapy lamp
Health and Wellness
• Silver & Fit Exercise & Healthy Aging Program fitness center membership or home exercise kit for members living in the community
• Transportation to/from supplemental benefit covered services
• Safety/falls kit for members living in the community*
• 10,000 Steps® program with pedometer for members living in the community
• Health education classes
• Foot care visits for non-Elderly Waiver members living in the community
• Personal emergency response system for non-Elderly Waiver members living in the community
• In-home safety devices and installation for non-Elderly Waiver members living in the community, up to $1,000
• Home delivery meals for non-Elderly Waiver members living in the community
*One per lifetime
For more information, contact Member Services.

Product Names with Group Number and Medical Package Codes

State Public Program Members	Group Number	Medical Package Code
MA Kids & Pregnant Women N**o** Copay	4183	HP2
MA Adults with Copay	4183	HPC2
MA Adults No Copays	4183	HPD2
MA Adults Copay Max (0)	4183	HPC4
MA Adult Copay Max (1-6)	4183	HPC4A
MA Adult Copay Max (7-17)	4183	HPC4B
MA Adult Copay Max (18-110)	4183	HPC4C
MA Adults - Medcaid Expansion with copay	4183	HP25
MA Adults - Medicaid Expansion No copay	4183	HP26
MA Adults - Medicaid Expansion Copay Max (0)	4183	HP27
MA Adults - Medicaid Expansion Copay Max (1-6)	4183	HP27A
MA Adults - Medicaid Expansion Copay Max (7-17)	4183	HP27B
MA Adults - Medicaid Expansion Copay Max (18-110)	4183	HP27C
MA Adult <65 FFS Medicare with Copay	4183	HPMC2
MA Adult <65 FFS Medicare No Copay	4183	HPM2
MA Adult <65 FFS Medicare Copay Max (0)	4183	HPMC4
MA Adult <65 FFS Medicare Copay Max (1-6)	4183	HMC4A
MA Adult <65 FFS Medicare Copay Max (7-17)	4183	HMC4B
MA Adult <65 FFS Medicare Copay Max (18-110)	4183	HMC4C
MSC+ NHC (Medicare AB) with Copay	4184	GSP01
MSC+ NHC (Medicare AB) Copays Max (0)	4184	GSP16
MSC+ NHC (Medicare AB) Copays Max (1-6)	4184	GSP26
MSC+ NHC (Medicare AB) Copays Max (7-17)	4184	GSP27
MSC+ NHC (Medicare AB) Copays Max (18-110)	4184	GSP28
MSC+ Institutional (Medicare AB) No copay	4184	GSP03
MSC+ Non-NHC (Medicare AB) with Copay	4184	GSP02
MSC+ Non-NHC (Medicare AB) Copays Max (0)	4184	GSP17
MSC+ Non-NHC (Medicare AB) Copays Max (1-6)	4184	GSP29
MSC+ Non-NHC (Medicare AB) Copays Max (7-17)	4184	GSP30
MSC+ Non-NHC (Medicare AB) Copays Max (18-110)	4184	GSP31
MSC+ NHC (Medicare B no A)	4186	GSP04
MSC+ NHC (Medicare B no A) Copays Max (0)	4186	GSP18
MSC+ NHC (Medicare B no A) Copays Max (1-6)	4186	GSP32
MSC+ NHC (Medicare B no A) Copays Max (7-17)	4186	GSP33
MSC+ NHC (Medicare B no A) Copays Max (18-110)	4186	GSP34
MSC+ Institutional (Medicare B no A) No Copay	4186	GSP06
MSC+ Non-NHC (Medicare B no A) with Copay	4186	GSP05
MSC+ Non-NHC (Medicare B no A) Copays Max (0)	4186	GSP19
MSC+ Non-NHC (Medicare B no A) Copays Max (1-6)	4186	GSP35
MSC+ Non-NHC (Medicare B no A) Copays Max (7-17)	4186	GSP36
MSC+ Non-NHC (Medicare B no A) Copays Max (18-110)	4186	GSP37
MSC+ NHC (Medicare A no B) with Copay	4187	GSP07

State Public Program Members	Group Number	Medical Package Code
MSC+ NHC (Medicare A no B) Copays Max (0)	4187	GSP20
MSC+ NHC (Medicare A no B) Copays Max (1-6)	4187	GSP38
MSC+ NHC (Medicare A no B) Copays Max (7-17)	4187	GSP39
MSC+ NHC (Medicare A no B) Copays Max (18-110)	4187	GSP40
MSC+ Institutional (Medicare A no B) No Copay	4187	GSP09
MSC+ Non-NHC (Medicare A no B) with copay	4187	GSP08
MSC+ Non-NHC (Medicare A no B) Copays Max (0)	4187	GSP21
MSC+ Non-NHC (Medicare A no B) Copays Max (1-6)	4187	GSP41
MSC+ Non-NHC (Medicare A no B) Copays Max (7-17)	4187	GSP42
MSC+ Non-NHC (Medicare A no B) Copays Max (18-110)	4187	GSP43
MSC+ NHC (No Medicare) with Copay	4188	GSP10
MSC+ NHC (No Medicare) Copays Max (0)	4188	GSP22
MSC+ NHC (No Medicare) Copays Max (1-6)	4188	GSP44
MSC+ NHC (No Medicare) Copays Max (7-17)	4188	GSP45
MSC+ NHC (No Medicare) Copays Max (18-110)	4188	GSP46
MSC+ Institutional (No Medicare) No Copay	4188	GSP12
MSC+ Non-NHC (No Medicare) with Copay	4188	GSP11
MSC+ Non-NHC (No Medicare) Copays Max (0)	4188	GSP23
MSC+ Non-NHC (No Medicare) Copays Max (1-6)	4188	GSP47
MSC+ Non-NHC (No Medicare) Copays Max (7-17)	4188	GSP48
MSC+ Non-NHC (No Medicare) Copays Max (18-110)	4188	GSP49
MSHO Community Non-Nursing Home Certifiable	4182	GPM07
MSHO Community Nursing Home Certifiable	4182	GPM08
MSHO Institutional	4182	GPM09
MSHO Community Non-Nursing Home Certifiable With Hospice	4182	GPH07
MSHO Community Nursing Home Certifiable - With Hospice	4182	GPH08
MSHO LIS1 Community Non-Nursing Home Certifiable	4181	GPM82
Minnesota Care Adult (Non-Parents)	4190	HP24
Minnesota Care Adult (Non-Parents) FFP	4190	HP24A
Minnesota Care Adult (Parents)	4190	HP1
Minnesota Care Child	4190	HP8

INFORMATION FOR BOTH HEALTHPARTNERS CARE AND HEALTHPARTNERS MSHO

Spoken Language Interpreter Services

HealthPartners Care members may use the following spoken language interpreter services:

Kim Tong Translation Service
2994 Rice St.
Little Canada, MN 55113
Phone: 651-252-3200
Fax: 651-252-3214
24 Hour Service
Face to face and phone interpretation
Website: http://kttsmn.com/

Itasca Corporation
1560 Livingston Ave
Suite 101
West St. Paul, MN 55118
Phone: 651-457-7400
Fax: 651-457-7700
Website: http://www.itascacorp.biz

The Bridge World Language Center, Inc.
110 2nd St S Ste 213
Waite Park, MN 56387
Phone: 320-259-9239
Fax: 320-654-1698
Website: http://www.bridgelanguage.com

Garden and Associates
4301 Highway 7 Suite 140
St. Louis Park, MN 55416
Phone: 952-920-6160
Fax: 952-922-8150
24 Hour Service
Website: http://www.gardentranslation.com/

The Language Banc
1625 Park Ave
Minneapolis, MN 55404
Phone: 612-588-9410
Fax: 612-588-9420
24 Hour Service
Website: http://www.thelanguagebanc.com/

Arch Language
1885 University Avenue West, Suite 75
Saint Paul, MN 55104
Phone: 651-789-7897
Fax: 651-789-7898
24 Hour Service
Website: http://www.ArchLanguage.com

The Minnesota Language Connection, Inc.
International Court Building
2550 University Ave W. Suite 245-N
Saint Paul, MN 55114
Phone: 651-644-7100
Fax: 651-644-7600
24 Hour Service
Website: www.minnesotalanguageconnection.com

To arrange for these services, please contact your provider and they will submit *a Spoken Language Interpreter Work Order* directly to the interpreter service. If you have questions please contact HealthPartners Member Services 952-967-7998.

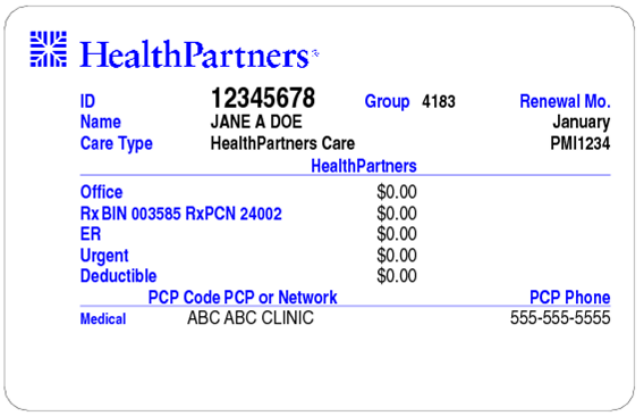
Insurance Card Identifies State Public Program Member

Member Card:

- The member's identification number, name, and PMI number appear at the top of the card.
- Under the member name is "Care Type" which shows the member's product. For MSHO, it reads "HealthPartners - MSHO (HMO SNP)"
- Copays appear in the middle of section of the card.
- The member's clinic number and clinic name appear next to "Medical" and "Dental" on the bottom of the card.


HealthPartners
Issuer (80840)
ID 12345678 Group 4182 Renewal Mo.
Name JANE A DOE January
Care Type HealthPartners MSHO HMO SNP PMI1234
HealthPartners
Office $0.00 Prescription Drug Plan
RxBIN 015574 RxPCN ASPROD1 See Contract
RxGrp MHN99
ER $0.00
Urgent $0.00
PCP Code PCP or Network CMS - H24221234
Medical ABC ABC CLINIC
MS-ID Card GP051061
MedicareRx Prescription Drug Coverage


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at 555-555-5555.
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission at an out-of-network hospital or facility.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services Call HealthPartners Member Services at 952-967-7029 or 888-820-4285 or TTY/TTD (for hearing impaired only): 952-883-6060; 800-443-0156. Or write to P.O. Box 9463, Minneapolis, MN 55440-9463. To schedule a ride to a medical appointment, call RideCare: 952-883-7400 or 888-288-1439.
To file a State Fair Hearing, please send your request to: Appeals Office/Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. Or, fax your request to: 651-431-7523. A State Ombudsman may be able to help you with your problem. They can also help you request a State Fair Hearing. You may call them at 651-431-2660 or toll free at 1-800-657-3729.
healthpartners.com Offered by HealthPartners


HealthPartners
ID 12345678 Group 4183 Renewal Mo.
Name JANE A DOE January
Care Type HealthPartners Care PMI1234
HealthPartners
Office $0.00
Rx BIN 003585 RxPCN 24002 $0.00
ER $0.00
Urgent $0.00
Deductible $0.00
PCP Code PCP or Network PCP Phone
Medical ABC ABC CLINIC 555-555-5555


Emergency & Urgently Needed Care
For emergency situations, call 911 and/or get medical attention immediately.
For medical advice call the CareLine℠ nurse service any time at 612-339-3663 or 800-551-0859 or call your clinic at 555-555-5555.
Hospital Admissions Contact CareCheck℠ at 866-275-8555 for any admission not directed by a network physician.
Claims Submission
Medical: HealthPartners Claims, P.O. Box 1289, Minneapolis, MN 55440-1289
Dental: HealthPartners Dental Claims, P.O. Box 1172, Minneapolis, MN 55440-1172.
Member Services Call HealthPartners Member Services at 952-967-7998; 866-885-8880; or TTY/TTD (for hearing impaired only): 952-883-6060; 800-443-0156. Or write to P.O. Box 9463, Minneapolis, MN 55440-9463. To schedule a ride to a medical appointment, call RideCare: 952-883-7400 or 888-288-1439.
To file a State Fair Hearing, please send your request to: Appeals Office/Department of Human Services, PO Box 64941, St. Paul, MN 55164-0941. Or, fax your request to: 651-431-7523. A State Ombudsman may be able to help you with your problem. They can also help you request a State Fair Hearing. You may call them at 651-431-2660 or toll free at 1-800-657-3729.
healthpartners.com Offered by HealthPartners

Pharmacy / Formulary

The HealthPartners formulary should be used when writing prescriptions. In addition, all classes of drugs on the Medical Assistance formulary are covered. Many over-the-counter drugs are also covered as long as they are prescribed by a plan physician and obtained at a plan pharmacy.

A new preferred drug list was launched for members on HealthPartners Medicaid plans**. HealthPartners Care and MSHO formulary can be accessed on the HealthPartners web site.**

Noncovered Services

A provider may bill HealthPartners Care members for non-covered services only if:

1) The Provider notified the member in writing of the member liability for non-covered services using the State approved waiver form; and,
2) Prior to performance of the service, the provider receives written authorization from the member for the non-covered services

The agreement should include information specific to the date, the estimated cost of the service and the service to be delivered. A provider cannot bill members for missing scheduled appointments.

Public programs products may require referrals for claims payment

All HealthPartners public programs products are primary clinic based and may require referrals. Providers are encouraged to check eligibility and call Member Services to verify if referrals are required. Eligibility may be checked on the Provider Portal at www.healthpartners.com/provider/. After logging in, select "Eligibility" from the drop down menu under the heading Applications.

The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at www.HealthPartners.com/provider. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can also be made by completing a *Provider Recommendation Form* (found in Claims Section of this manual) and faxing or mailing it to the Claims department.

An RAI is generated when a member assigned to a Primary Clinic product receives services outside of the Primary Clinic's specialty referral network. The member may or may not have been directed by the Primary Care Clinic care system; however, it is important for Primary Care providers to respond to these RAI's indicating if the care was referred by the Primary Clinic care system or not. The RAI response is needed so the outstanding claim can be processed appropriately. RAI notifications are sent to Primary Care providers via the Provider Portal. There is no indicator on the portal that an RAI has been sent when you log on so it is important to check your work queues regularly to view and respond to RAI's.

Please note: The current policies and procedures remain in effect and in place regarding prior authorization or Recommendation For Further Services for the HealthPartners Transplant Centers of Excellence, HealthPartners Direct Access Mental Health Network, HealthPartners Referral Mental Health Network, the WLS (Weight Loss Surgery) Designated Network, Low Back Pain or other designated networks remain in effect.

HealthPartners Care members may self-refer to the following providers:

- Mental health/chemical health providers in HealthPartners Behavioral Health network
- HealthPartners plan wide urgent care providers
- HealthPartners plan wide vision providers for routine eye care
- Members may self-refer to any provider for family planning services
- Tribal Health Clinics

Members can learn about the providers in these plan-wide networks in several ways:

- Visit **healthpartners.com** to view a list of providers.

- Review the provider directory that was mailed to them in their enrollment packet.
- Call Member Services to ask about a particular provider.

WHERE TO CALL FOR ASSISTANCE

Please verify member eligibility EVERY month!

Electronic claim transactions for Minnesota Health Care Programs (MHCP) are accepted through MN-ITS *Interactive* or MN-ITS *Batch*. Claims sent through ITS or NSF will no longer be accepted.

Verify recipient eligibility through MN-ITS or by calling EVS at (651) 431-4399 or 1-800-657-3613.

Learn more about MN-ITS and register online at http://mn-its.dhs.state.mn.us.

HealthPartners Member Services:

HealthPartnersCare Main Number:	952-967-7998	or	1-866-885-8880
MSHO Main Number:	952-967-7029	or	1-888-820-4285
Fax:	952-883-7333	or	952-883-7666
TTY:	952-883-6060	or	1-800-443-0156
Spanish:	952-967-7050		
Somali	952-967-7159		
Oromo:	952-967-7160		
Hmong	952-883-7575		

Claims Helpline: 952-883-7699 or 888-663-6464

RideCare (PMAP, MSC+ and MSHO): 952-883-7400 or 888-288-1439
CareLine: 612-339-3663 or 800-551-0859 (Providers Only: 952-883-5883)

Medical Management

- General Medical Management Line: 952-883-7888 or 877-499-7888
- Prior Authorization for Services and Procedures: 952-883-5724 or 888-467-0774
- Outpatient Case Management: 952-883-6983 or 877-499-7888 or Fax 952-883-6664
- Inpatient Case Management: 952-883-6277 or 877-499-7888 or Fax 952-883-6975

The information that follows this page includes the HealthPartners 2012-2014 Minnesota Senior Health Options (MSHO) Model of Care Summary document which describes our MSHO program.

Following the Model of Care Summary document is a training packet that should be reviewed by all providers. MSHO Model of Care training is an annual requirement from the Center for Medicare and Medicaid Services (CMS).

HealthPartners Minnesota Senior Health Options
Model of Care
2012-2014

The Model of Care defines the management, procedures and operational systems that provide access, coordination and structure needed to provide services and care to the MSHO population.

1. Description of the Minnesota Senior Health Options (MSHO) Population

HealthPartners Model of Care Program is designed to serve members of the HealthPartners Minnesota Senior Health Options (MSHO) Program. MSHO is a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) that provides specialized care to seniors age 65 and older who are eligible for both Medical Assistance and Medicare parts A and B. The population served by this program is primarily frail and elderly.

HealthPartners total MSHO enrollment for January 2012 was 2,951. Of the total membership, 1,159 (39%) members are living in the community and have been assessed as Nursing Home Certifiable. An additional 1,113 (37%) Non-Nursing Home Certifiable members also live in the community. The remaining 679 (23%) members reside in an institutional setting. The average age of our MSHO population is 77.

The cultural make up of our MSHO population is rich with diversity. 55% of enrollment identifies their race as White, 27% as Asian or Pacific Islander, 13% as Black or African American, 4% as Hispanic or Latino and 1% Native American or Alaskan Native. 77% of members speak English, 9% speak Vietnamese, 8% speak Hmong, 5% speak Cambodian and 3 % speak Spanish.

2. Measurable Goals

The 2012 MSHO Model of Care Measurable Goals are being finalized and will be added to this document upon approval.

3. Staff Structure and Care Management Roles

Staff that performs administrative functions

- Membership Accounting Department: Process enrollments, verify eligibility, CMS reporting, reconcile capitation payments
- Claims Department: Adjudicate claims, provider customer service, medical and code review, third party recovery, authorization administration, data collection
- Member Rights and Benefits Department: Review and respond to grievances, review and respond to provider complaints, analyze and assess trends
- CareLine Department: Provide medical advice to members 24 hours a day, 365 days a year

- RideCare Department: Arrange transportation to covered services

- Member Services Department: Member and provider customer service, member outreach calls, assist members in navigating health care system, provide member informational materials upon request and monitors call trends and volume

- Marketing Department: Communicate plan information, develop and distribute member materials

- Government Programs Department: Product and contract management, strategic planning, regulatory and compliance programs management, audit and monitoring management, internal business area support, external regulatory purchaser, liaison between the Minnesota Department of Human Services, Centers for Medicare and Medicaid services and internal operations groups, local county and community involvement

- Market Research and Care Innovation & Measurement: Survey beneficiaries and providers, analyze and present results, project implementation, training

- Government Relations: Build relationships with members of state and federal trade associations as well as elected officials; educate officials and advocates in order to advance good public policy that directly or indirectly improves the health of our members, patients and the community.

- Finance Department: Lead, facilitate and consult on the management and utilization of financial resources around processing activities such as general accounting, accounts payable, business office, billing and payroll

Staff that performs clinical functions

- Disease and Case Management Department: Inpatient and complex case management, disease management, care coordination.

- Geriatrics Services Department: Provides primary medical care to members in long-term settings, transitional care centers and assisted living facilities.

- Behavioral Health Department: Assessment of emotional, behavioral and cognitive problems, behavioral health case management; assist members and providers regarding the locations, qualification, specialties and services of providers in the direct access behavioral health network; analyze data for oversight of provider network; behavioral health case management.

Staff that performs administrative and clinical oversight functions

- Dental Department: Provider customer service, authorization administration, data collection and analysis, process and examine claims

- Pharmacy Department: Manages and reviews pharmacotherapy, pharmacy customer service, prior authorization, medication therapy management, drug trending analysis

- Quality Utilization and Improvement Department: Admissions point of contact for hospital, same day surgery, and nursing home services;
  responsible for Utilization Review & management including prior authorization and notification; quality measurement and improvement monitoring and evaluation of clinical services; overseeing and assisting staff on the review process and ensuring that processes are compliant with regulatory statutes and accreditation standards; develop evidence based criteria by reviewing available scientific evidence, current standards of medical practice, and existing coverage positions as defined by state and federal laws, rules and regulations.

- Operational Integrity Department: Validate data within the HealthPartners Data Warehouse (HPDW), develop validation methodologies, consult on validation process for toher areas, facilitate development of common definitions within the HPDW, facilitate communication of development projects between the Administrative Systems and HPDW as well as project management/acceptance testing of regulatory encounter data reporting.

- Health Informatics Department: Improve and facilitate decisions and actions with data; provide analytical, project management, reporting consulting, and information support; design, implement, and report meaningful and actionable metrics; create methodologies that focus on cost of care, quality, efficiency, trend, risk analysis, and predictive modeling.

- Corporate Integrity Department: Provide channels for reporting of potential compliance issues; investigate and conduct thorough review to confirm compliance with company policies, and government regulations and laws; facilitate corrective action; compliance training for staff; develop standards of conduct and organizational policies and procedures; advise and assist in development of audit tools and procedures; review privacy complaints.

- Internal Audit Department: Review the reliability, integrity and utility of information used by management for risk-assessment, decision-making, and performance-monitoring; assess compliance with approved policies, plans, procedures, laws and regulations; ensure that appropriate procedures are in place to safeguard the organizations assets; carry out analyses to develop recommendations for the effective and efficient use of resources; report findings to appropriate management staff

- Law Department: Provide comprehensive legal advice and direction to the management and governance of HealthPartners and its affiliated entities; manage the risk management functions of the organization

- Executive Leadership Team: Analysis of program quality and performance; identify strategic program direction; provide advice and oversight of implementation and overall program integrity.

- HealthPartners & Group Health Plan, Inc. Boards of Directors: The HealthPartners, Inc. and Group Health Plan, Inc. Boards of Directors (the "Board") represent the members' interest in ensuring the accomplishment of the organization's mission to improve the health of our members, patients and the community. The business of the organization is managed under the Board's direction. The Board delegates to the Chief Executive Officer, and through him or her, to other senior management the authority and responsibility for managing the everyday affairs of the organization.

4. Interdisciplinary Care Team (ICT)

Composition of the ICT and how membership is determined.

The Interdisciplinary Care Team (ICT) is made up of the specialists that are appropriate to each member's health care needs and are specialists that the member chooses to work with. The Primary Care Clinic has input and leadership, together with the member, regarding specialists and other health care professionals that may be needed on the ICT at various points during the care of the member. In conjunction with the member, the MSHO Care Coordinator provides input and leadership, regarding other health care professionals who may be part of the ICT at various points during the care of the member.

The MSHO ICT may include any or all of the following:

- Member/appropriate family or caregiver. Family, caregivers, or any other persons are involved per the member's choice, and with member's authorization for providers to speak with such persons.
- MSHO Care Coordinator
- Primary Care Provider
- Appropriate board certified Specialist(s)based on the individual member's Care Plan
- Dental Provider
- Pharmacist
- Palliative Care Team
- Inpatient Care Manager
- Geriatric Nurse Practitioners
- Disease Manager
- Home Health Care Nurses and/or therapists (physical, occupational, speech)
- Customized Living Services Nurses and/ or Social Workers
- Adult Day Service Providers
- Skilled Nursing Facility Nurses and/or Social Workers
- Dietician
- Primary Care Clinic Social Worker/Nurse
- Behavioral Health Case Manager
- Behavioral Health Provider
- Community ARHMS workers (behavioral health in the community setting)
- Medical Director

- Nurse Educators
- Pastoral Specialists
- Health plan utilization review staff (to review prospectively, concurrently and retroactive reviews of care)

Facilitate member participation when feasible.

MSHO member demographics, as well as race, ethnicity, and language are tracked and stored in HealthPartners data base. When contacting MSHO members, the availability of this data allows for the use of interpreters for outreach calls, clinic appointments, home visits, and any other interaction with the member.

MSHO Care Coordinators reach out to MSHO members to initiate contact and work with the members to monitor their progress toward reaching goals through the year. Outreach is typically by telephone but may be via letter in some cases. Similarly, clinics reach out to members to remind them of appointments or the need to schedule an appointment, lab work or procedure.

MSHO Care Coordinators complete initial and annual health risk assessments for MSHO members in person, usually in the member's home. For non-English speaking members, interpreters or Care Coordinators fluent in the member's primary language are present for the home visit to ensure members are able to fully participate in the assessment and planning process. MSHO Care Coordinators may ask for input from other members of the ICT prior to meeting with the member to complete an assessment, and if the member is in agreement, appropriate ICT members may be asked to participate in the member assessment process. Based on the results of the assessment, as well as the member's desires and preferences, the Care Coordinator and member together develop an individualized care plan for the member. As part of the care planning process, members are encouraged to identify health goals that are important to them and that they want to achieve during the coming year. Upon completion of the member's care plan, the member is asked to sign a copy of the care plan indicating agreement with the plan. The member is given a copy of the completed plan.

HealthPartners training for MSHO Care Coordinators results in a patient centered, values-based approach to working with members that helps members identify what is important to them at their current stage of life. MSHO Care Coordinators are trained in Intrinsic Coaching and Motivational Interviewing; they have the knowledge and skills needed to engage members and/or their authorized representatives and help them to identify what is most important to them. Care Coordinators also work with members to help them share responsibility for improving their own health and safety, and improving quality of life perception, independence, and pain management. Care Coordinators are also trained to provide shared decision making support for members challenged with making difficult decisions. When a member identifies a decisional conflict, the Care Coordinator is able to provide personalized decision-making support.

In summary, the MSHO Care Coordinator's work with members includes facilitating member participation in assessment and care planning via face-to-face meetings, phone calls, providing an interpreter as needed, involving the member's primary care physician and other members of the ICT and providing patient support including direct contact with members and/or family members during transitions of care.

ICT operations and communications.

Meetings can be requested by any member of the ICT team, including the member or family/caregiver and MSHO Care Coordinator. The frequency of meetings is at least annually and more frequent as determined by the member's severity and complexity of medical and/or psychosocial concerns and the member's desired frequency for meetings. Meetings may take place in the member's home, primary or specialty care clinic settings, at nursing facilities, Customized Living Facilities, or Adult Day Service Facilities. Care Coordinators are responsible for documentation and retention of records for care coordination meetings as well as distribution and dissemination of appropriate information to appropriate stakeholders. All Physicians, Regions Hospital staff, and all MSHO Care Coordinators have access to the same electronic medical record (EMR) for MSHO members and are able to communicate with ICT staff within the member's EMR through use of the secure messaging feature of HealthPartners EMR. The EMR is the primary mode of communication among HealthPartners providers.

The ICT has the responsibility, together with input from the member and family/caregiver, to assess needs, develop, implement, monitor and update a care plan that is based on member choices and preferences as well as ICT recommendations. Each MSHO member is assigned to a Care Coordinator that coordinates the ICT. Care Coordinators work with members and providers as part of the interdisciplinary care team to assess, plan and deliver care. The member's primary care provider has the principle role of recommending and arranging services required for and agreed upon by the member and facilitating communication and information exchange (using the appropriate communication medium) among the different providers treating the member. Providers may request information from members and other treating providers as necessary to provide care. Transition of care policies exist to address continuity of care for the member when a contract for one of the member's providers is discontinued or a member terminates coverage. The role of the team is:

- Analyze and incorporate the results of the initial and annual health risk assessment into the care plan according to the member's desires and preferences, and conduct annual care coordination meetings.
- For community and some institutionalized members, the Care Coordinators conduct case rounds on a regular basis or as required based on health status.
- For most institutional members, the HealthPartners Geriatric Team conducts case rounds on a regular basis or as required based on health status.
- The Care Coordinator collaborates with the ICT as needed to develop and annually update an individualized care plan for each MSHO member.
- With every clinic visit, the member receives a printed copy of the visit summary as well as a care plan noting any changes to medications or other treatments.
- Manage the medical, cognitive, psychosocial, and functional needs of MSHO members according to the needs and preferences of each member.
- Communication to coordinate the care plans and meetings in the forum or format most appropriate to the member and providers. This may include the EMR, face to face meetings and written correspondence as necessary.

HealthPartners MSHO Care Coordination staff hold two types of complex case rounds. The typical process is where the MSHO Care Coordinator meets first with their supervisors at least monthly to review complex cases. Either the MSHO Care Coordinator or his/her supervisor may identify a member appropriate for complex round discussions. When a member is identified from the first case rounds discussion as being in need of further collaboration, the member's case will be brought to the second complex case rounds which include all MSHO supervisors, several MSHO Care Coordinators, and the Associate Medical Director for the MSHO Care Coordination program. Complex case rounds that include the Medical Director are held every two weeks. The Care Coordinator is responsible to bring current, accurate information to the rounds, including results of discussions with the member's physician, home-care nurse if appropriate, and other ICT team members. The Care Coordinator's supervisor is responsible to ensure the complex case rounds are scheduled, that rooms are reserved and that the Medical Director is given the name and identification number to review the member chart in the EMR. Following complex case rounds, the Medical Director will talk with the member's physician, if applicable, to share recommendations from the complex case rounds. The MSHO Care Coordinator will notify all other members of the ICT as appropriate with any information regarding changes to the member's plan of care.

5. Provider Network with Specialized Expertise and Use of Clinical Practice Guidelines

Specialized expertise in HealthPartners provider network.

HealthPartners provides access to preventive and primary care, dental care, acute and post-acute rehabilitation and long-term care services. These services are provided and coordinated through a fully integrated health care delivery system. This system is primarily composed of HealthPartners Clinics which provide a full-range of geriatric programs, dental clinics as well as hospital services provided at Regions Hospital and other facilities.

HealthPartners Clinics

HealthPartners Medical Group Clinics make up one of the largest medical groups in Minnesota serving approximately 425,000 members primarily in the Twin Cities, St. Cloud, and western Wisconsin markets. HealthPartners Clinics provide access to a full range of primary care, specialty and dental services at 70 HealthPartners clinics. In addition to primary and dental care, there are more than 35 medical and surgical specialties represented by the group. The medical group is staffed by a little over 700 physicians, including approximately 350 family practice and internal medicine physicians who provide services to both adult and geriatric members. The dental group is staffed by 60 dentists and offers specialties in oral surgery, orthodontics, periodontics and prosthodontics. HealthPartners has 23 geriatricians in the HealthPartners Clinics. The geriatric programs within HealthPartners Clinics include nursing home care, post-acute care services, home-based medical care, hospice care and behavioral health services.

Geriatric care teams, comprised of a geriatrician and nurse practitioner, provide ongoing services at over one hundred different nursing home facilities. In addition, there are intensive geriatric care teams that provide services at seven distinct post-acute transitional care sites. Home-based primary medical care is also provided at several assisted living sites by these geriatrician/nurse practitioner teams. Hospice and palliative care services are delivered through a number of HealthPartners Clinic-owned Medicare certified hospice locations. Geriatric psychiatry services are provided within the system for both institutionalized members and outpatient care. There is also a dedicated outpatient geriatric clinic at Regions Hospital and a dementia assessment clinic within the HealthPartners integrated system.

HealthPartners Clinics deliver hospital care primarily through Regions Hospital which is a 427-bed tertiary care facility and a teaching and research hospital located in St. Paul. The hospital provides specialized expertise in a number of acute care areas including: trauma, burns, emergency, surgery, heart, digestive and cancer care. Regions is a Level 1 Adult and Level 1 Pediatric Trauma Center as well as a regional center for behavioral health care. Hospital care is coordinated with outpatient providers through a network of hospitals which actively see members at Regions Hospital as well as both North Memorial and Mercy Hospitals in the Twin Cities.

HealthPartners Dental Group has 20 locations that provide a significant amount of access to this membership. HealthPartners made a major investment in establishing the HealthPartners Dental Group Midway clinic to specifically improve dental access and serve the dental care needs of this membership. By keeping appointment schedules flexible and providing clinic hours conducive to appointment access, the Midway Dental Clinic is uniquely positioned to care for members.

Contracted Clinics and Providers

In addition, throughout the geographic service area, HealthPartners has a network of providers and facilities with specialized clinical expertise pertinent to the MSHO population. These providers have training and experience in managing medically complex and/or chronic conditions and provide diagnostic and treatment services to meet the specialized needs of the targeted population.

Home and Community-Based Services Providers

HealthPartners has a network of Home and Community-Based Service (HCBS) providers, also known as Elderly Waiver Providers. Many of these providers offer non-traditional services that enable members to stay in their home such as homemaker, chore services, meals on wheels, and adult companion services. HealthPartners has direct contracts with many Home and Community-Based Service providers as well as contracts with counties for their HCBS provider network.

Scope of Care

The provider and facility network delivers services that includes, but is not limited to, the following provider types:

- Acute care facility, hospital, medical center
- Laboratory
- Long-term care facility, skilled nursing facility
- Pharmacy
- Radiography facility
- Rehabilitative facility
- Advanced degree social workers
- Board-certified specialists
- Mental health specialists
- Mid-level practitioners (nurse practitioner, physician assistant)
- Registered nurses and other nursing professionals
- Registered pharmacists
- Registered physical, occupational, respiratory and speech therapists

- Other allied health professionals
- Medical specialists pertinent to targeted chronic conditions and identified co-morbid conditions
- Home and community based service providers

Network facilities and providers are actively licensed and competent.

All providers are credentialed in compliance with The National Committee for Quality Assurance (NCQA) guidelines, to ensure they are practicing in fields for which they are appropriately and adequately trained. HealthPartners credentials all providers according to NCQA guidelines. Whenever possible, the Professional Services Network Management department focuses on contracting with board-certified providers.

Providers are re-credentialed on a bi-annual schedule to verify appropriate licensure, insurance and other criteria on a regular basis. HealthPartners investigates quality concerns or issues that arise including exclusion from Medicare.

HealthPartners health care services are supported by a written contractual arrangement. Monitoring of the professional qualifications of practitioners or providers associated with HealthPartners is done through credentialing, contracting and peer review activity. If a concern involving a specific practitioner or provider is identified, appropriate monitoring and/or intervention is initiated. As part of the monitoring process, quality of care issues are monitored and investigated, including cases when a deviation from applicable standards of care is suspected or confirmed. Credentialing is notified of cases involving an adverse outcome and takes appropriate action based on credentialing policies and procedures. When possible in selecting providers, board certified specialists are preferred in the provider network.

Use of clinical practice guidelines

HealthPartners uses reliable and valid measures of quality and resource use to improve the quality and affordability of care provided by network providers. Comparative provider performance results are reported to providers, consumers and purchasers to support improvement and provide consumers with information to help make informed decisions about health care. The annual Clinical Indicators Report features comparative provider performance on clinical measures related to preventive and chronic care, behavioral health, pharmacy, specialty and hospital care.

Collaboration with providers in establishing best practices and defining effective performance measures is essential. All measures are based on evidence-based guidelines established by the Institute for Clinical Systems Improvement (ICSI). The ICSI guidelines provide the basis for the development of improvement initiatives and performance measurement. HealthPartners supports the implementation within its provider network of the ICSI guidelines. The ICSI guidelines facilitate agreement on elements of care that are medically appropriate and result in the best possible outcomes. The use of clinical practice guidelines allows HealthPartners to measure the impact of the guidelines on the outcomes of care and reduce variation in diagnosis and treatment.

Determining services members will receive.

Preventive services are directly available to members. In addition, members can go directly to specialists, with care most often being coordinated by the Primary Care Provider and/or the Care Coordinator. The member, member's authorized representative, medical practitioner, member's Care Coordinator and the ICT are all involved in determining which services the member will receive.

HealthPartners has a dedicated Member Services department that serves the MSHO population. Member Services representatives are knowledgeable about the MSHO product, the benefit set and how to access services. Representatives assist MSHO members when they have questions about coverage for services, how to access services, referral questions and any other product related question. For more complex help in navigating the health care system, Nurse Navigators are available to assist members.

The provider network coordinates with the ICT and the member to deliver specialized services.

The provider network, along with the ICT, work to support the member in the following ways:

- Contact members to remind them of upcoming appointments
- Coordinate care from setting to setting in conjunction with the Care Coordinators
- Provide 24-hour access to a nursing hotline
- Assist with developing and updating individualized care plans
- Conduct home visits for clinical assessment or treatment and safety inspections (including fall prevention) and wellness promotion
- Improve coordination of care through the communication and coordination of the ICT. This includes conducting information exchange and/or meetings/teleconferences with the ICT as needed, track, analyze and communicate as appropriate utilization and transitions of care to assure appropriate use of services
- Assist with conducting disease management services
- Provide clinical consultation
- Provide long-term facility care
- Provide telemedicine and telemonitoring services
- Provide pharmacotherapy consultation and management clinics
- Provide in-patient acute care services
- Provide wound management services
- Provide long-term facility care
- Assess, diagnose, and treat in collaboration with the ICT
- Provide home-based palliative or end-of-life care
- Provide home health services
- Provide hospital-based or urgent care facility-based emergency services

HealthPartners model of care is designed to manage the member's care throughout all stages of their health including the delivery of specialized services and benefits to vulnerable special needs individuals who are frail, disabled or near the end-of-life. Health goals are specific to the member whether to increase function, improve quality of life or improve health status.

Care Coordinators communicate with the primary physician regarding clinical, functional, and psychosocial information. Care Coordinators incorporate the information received from the primary physician and other interdisciplinary care team members into the member care plan. Care Coordinators and the member's physician and other interdisciplinary care team members collaborate to discuss the member's progress toward goals and changes to the plan of care.

The care coordination and member services departments are available to link members to services and to facilitate the sharing of information among providers and the ICT.

HealthPartners assures that providers use evidence-based clinical practice guidelines and nationally recognized protocols.

HealthPartners adopts the Institute for Clinical Systems Improvement (ICSI) guidelines and supports implementation within its provider network.

Guidelines facilitate agreement on elements of care that are medically appropriate and result in the best possible outcomes. The use of clinical practice guidelines allows HealthPartners to measure the impact of the guidelines on the outcomes of care and reduce inter-practitioner variation in diagnosis and treatment. Medical practice guidelines developed by ICSI utilize continuous improvement principles to standardize health care processes, improve member education, improve health care outcomes and reduce the cost of health care.

In order to assure provider use of clinical practice guidelines and nationally recognized protocols HealthPartners:

- Adopts and supports the development of clinical practice guidelines through the activities of ICSI.
- Communicates new and revised guidelines to providers and practitioners, in conjunction with ICSI.
- For new medical groups, the ICSI website and phone number is communicated to practitioners at the time of initial contracting. On a quarterly basis, practitioners are notified regarding new and revised guidelines that are available at www.icsi.org and are provided with ICSI's phone number if they wish to request a hard copy.
- Ensures consistency of utilization management criteria, member education materials and disease management programs with ICSI guidelines.
- Monitors guideline status within groups through annual reports and site survey processes.
- Facilitates implementation through the availability of tools, resources and consultation.
- Assesses effectiveness of guideline implementation through various measures, (e.g., HEDIS, Clinical Indicators). The Clinical Indicators Report features comparative provider performance on measures of clinical quality, patient experience and affordability. The Triple Aim approach improves the health of the population, enhances the patient experience of care and helps make care more affordable.

6. Model of Care Training for Personnel and Provider Network

HealthPartners conducts initial and annual Model of Care training including training strategies and content.

Model of Care training is conducted for employed and contracted personnel who are involved in the MSHO Model of Care including all health plan personnel that work with MSHO. Personnel in this training include but are not limited to staff that provide or manage care management and

administrative personnel that provide or manage pharmacy, dental, government programs product management, sales, member services, enrollment and claims services.

Training is conducted using the following methods:

- Web based training for providers through the HealthPartners Provider Portal
- A Self-Study program using interactive web-based training & document storage system. This training is followed by an interactive training survey for employed and contracted staff.
- Follow-up is conducted to make sure all appropriate staff is trained using reports to identify those who have not completed the annual training. Any staff member that does not complete the training within 30 days of the requirement is reported to their respective leadership for follow-up with the employee.
- Face-to-face department training is available as needed.

Model of Care Training for Providers

- All providers who are contracted or employed by HealthPartners are provided with training.
- Providers in HealthPartners network are linked to HealthPartners electronically via the HealthPartners provider portal. This website is updated continually, includes a training manual, and also has links to additional information for providers.
- Information regarding the Model of Care is available via the provider portal, which is an online site used regularly by provider offices for administration of HealthPartners programs. Within the provider portal, the Model of Care and training document are part of the provider manual. Providers are notified annually of the requirement to complete the Model of Care Training. This notification is sent in the Provider Newsletter sent to all contracted provider offices. A copy of the mailing labels is retained by the Provider Contracting department as evidence. In addition, the Model of Care is discussed in annual contract meetings with large group practices.

The Model of Care training reviews all major components of the Model of Care including:

- Overview of HealthPartners Model of Care Training
- Minnesota Senior Health Options Overview
- Model of Care Definition
- Measurable Goals
- Staff Structure and Roles
- Interdisciplinary Care Team
- Provider Network of Specialized Expertise
- Model of Care Training
- Health Risk Assessment
- Individualized Care Plans
- Communication Network
- Care Management
- Performance & Health Outcome Measurement

HealthPartners assures and documents completion of training by the employed and contracted personnel.

The training for employed and contracted personnel is performed through an electronic training and document storage system that allows tracking of the completed training. The system stores the training data and provides reports that are used for training reminders and tracking training completion.

Personnel responsible for oversight of the model of care training.

HealthPartners Government Programs department works with the Monitoring and Compliance department to monitor the progress of training and verify that all staff completes the training.

Actions HealthPartners takes when the required model of care training has not been completed.

An electronic training and document storage system is used to create reports to identify personnel who have not completed the annual training. During the training time period, reminders go out to staff that have not completed the training. Personnel that do not complete the training are reported to their respective leadership for follow-up training completion.

7. Health Risk Assessment

Health Risk Assessment (HRA) tool used to identify special needs.

HealthPartners uses a comprehensive Health Risk Assessment (HRA) tool required by the State of Minnesota. The assessment addresses medical, social, environmental and mental health factors, including the physical, psychosocial and functional needs of the member. It includes assessment of the following:

- Activities of daily living
- Instrumental activities of daily living
- Falls risk including environmental hazards
- Independent living skills including money management, and use of transportation
- Cognitive orientation which includes administration of the Katzman test for cognition
- Depression
- Social isolation and support
- Prescription and OTC medications
- Chronic and acute conditions through member interview as well as the Care Coordinator's review of claims, the member's electronic medical record, and other utilization records
- Environmental hazards
- Engagement with primary care
- Dental health
- Exploitation and abuse
- Living arrangement and housing status
- Caregiver support if appropriate

- Preventive health immunizations and screenings
- History of inpatient, emergency department, and nursing home admissions
- Impact of incontinence on activities of daily living and access to the community
- Nutritional status
- Access to culturally appropriate services
- Emergency plans and contacts
- End of life planning including advance directives
- Self preservation skills

The initial HRA and reassessments are conducted for each member.

Initial HRA
An initial HRA is completed within 30 calendar days of enrollment and is usually done face-to-face in the member's home.

MSHO introductory letters, including the name and telephone number of the MSHO Care Coordinator, are mailed to all new MSHO members within the first ten days of enrollment. The Care Coordinator contacts the member by telephone to introduce herself/himself, to ensure the member has her/his name and telephone number, to explain the role of MSHO Care Coordination services, and to schedule an initial HRA.
The Care Coordinator brings an interpreter for assessment visits with members when the Care Coordinator does not speak the member's primary language. This personal interaction gives the Care Coordinator firsthand knowledge about functional abilities and the ability to manage in their home environment.

The Care Coordinator is expected to pursue every avenue available to reach the member and complete an initial face-to-face assessment. HealthPartners has developed a document titled "Patient Locator Tips" that outlines multiple ways to try to find a member's correct phone number and/or address. If the Care Coordinator is unable to reach the member after multiple attempts on different days and times of day, the Care Coordinator will send the member an "unable to contact" letter along with a paper copy of the HRA tool. The letter asks the member to complete and return the tool to the Care Coordinator, and to provide the Care Coordinator with a best time of day to reach the member or provide the Care Coordinator another number where the member can be reached. If the member mails in the completed HRA, the Care Coordinator will review their responses and contact the member to discuss the findings. The Care Coordinator will develop a care plan based on the results of the paper HRA form. If the Care Coordinator has been unable to contact the member, and the member has not returned a completed HRA form, the Care Coordinator will continue to attempt to contact the member quarterly for as long as the member is enrolled in MSHO unless the member has asked to have no Care Coordinator involvement.

The results of the initial assessment are used as part of care planning. The member and/or member's authorized representative and the Care Coordinator discuss and agree on goals for the member's care plan. The Care Coordinator implements the care plan by referring to service providers, disease management programs, primary or specialty care, or other resources as defined during the care planning process. The care plan includes:

- Long- and short-term goals, with timeframes for re-evaluation

- Resources to be used
- Barriers to meeting goals or complying with the care coordination plan
- Relocation assistance planning for nursing facility residents returning to a community setting
- Consideration of the member's cultural heritage and written/oral communication needs
- Coordinating the medical needs of the patient with his/her social service needs including coordination with county social services staff and other community resources such as Area Agencies on Aging
- Development and communication of member's self-management plan including any identified risks to health and safety including risks due to the member's refusal of recommended services
- Schedules for follow-up and communication with the member
- Collaboration with the member's health care team, including the Veteran's Administration when applicable
- Planning for continuity of care

The Care Coordinator sends a printed copy of the care plan to the member and to the primary physician.

Follow-up and Reassessments

Follow-up HRAs are performed annually for each member, within twelve months of the member's previous assessment and when the member's condition changes such as after a hospitalization, upon a new diagnosis or decline in functional ability.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member's progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals.

Care Coordinators call members within two days of discharge from a hospital or nursing home setting. They assess the member's health status telephonically by review of hospital records, and from input from other Interdisciplinary Care Team members such as HealthPartners Inpatient Case Managers and discharge planners who were onsite where the member was hospitalized. If such an assessment indicates a significant change in the member's health or functional status, the Care Coordinator will complete a face-to-face assessment with the member for a more comprehensive assessment using all elements of the HRA tool. The Care Coordinator documents their assessment findings in the member's electronic chart.

The Care Coordinators also assess and adjust the goals and the care plan as needed. This includes:

- Reviewing progress towards existing goals
- Developing new goals, including rehabilitation services following an acute event
- Creating new health actions aimed at meeting goals and removing barriers
- Re-evaluating acuity and functional status
- Assessing medications—at least annually; more frequently when warranted by the member's health situation (e.g., after a hospitalization)

- Assisting members in their choice of providers/hospitals, using publicly reported quality data (such as Leapfrog Group for hospital choice)

When the member's care plan is updated, the Care Coordinator sends printed copies of the plan to the member and to the primary physician. The member is provided two copies of their care plan; the first copy is for the member to keep, the second copy is for the member to sign and return to the Care Coordinator.

Personnel who review, analyze and stratify health care needs.

The MSHO Care Coordinator, either a registered nurse or licensed social worker, is the primary person responsible for review, analysis and stratification of the member's health care needs. The Care Coordinator uses information from the HRA, medical records, member and family/caregiver input, utilization reports to the extent records are available and predictive modeling risk scores in the development of a comprehensive care plan. The HRA results are stratified to identify the risks for each member. Care Coordinator assessment may result in a re-stratification of the member. Members with difficulty living in the community may be assessed as needing a nursing facility level of care and Elderly Waiver services to prevent or delay nursing home placement. The Care Coordinator assessment may identify the need for member to move from a nursing facility level of care to a nursing home placement. A member may also be moved from a nursing home resident status to a community setting if the member's condition has improved.

In addition to the results of HRAs, predictive modeling software helps to identify members at risk for hospitalization. Complex and high-risk MSHO members are proactively identified by methods such as predictive modeling or review of multiple inpatient admission reports. Care Coordinators receive multiple inpatient reports monthly for review and analysis, and they are notified of members identified as high risk by predictive modeling. High risk scores as a result of predictive modeling are saved in the member's record in the electronic charting system for easy reporting of members by risk score. Complex and high-risk MSHO members receive a more intense level of Care Coordination activities and are often included in complex case rounds that include the Medical Director, home health care providers, palliative or hospice care service providers and the MSHO Care Coordinator. Case rounds may result in identification of interventions to assist the member to achieve health goals, potential adjustments to medications and treatments. Other members of the Interdisciplinary Care Team are consulted for the review, analysis and stratification of health care needs as needed.

The MSHO Care Coordinator continues to assess the member's risk throughout the year during conversations with the member, through calls to the member following an acute event, and through review of the member's inpatient and emergency department utilization reports.

Communication mechanism HealthPartners institutes to notify the Interdisciplinary Care Team (ICT), provider network, members, etc. about the HRA and stratification results.

Care Coordinators work with providers as part of the ICT to assess, plan and deliver care. Results of the HRA are shared with the ICT. The member's primary care provider has the principle role of recommending and arranging services required for the member and facilitating communication and information exchange among the different providers treating the member. The primary means of communication among members of the ICT is through the member's chart in HealthPartners

electronic medical record (EMR). Physicians, home care providers, hospital staff, specialists, hospice and palliative care staff and MSHO Care Coordinators all have access to the member record in the EMR. Providers can send ICT members secure messages from within the member's electronic record to share information and inform providers that certain notes, assessment or test results are available. Providers may request information from other treating providers as necessary to provide care. HRA results are incorporated into the individual care plan and shared with the Interdisciplinary Care Team, the member and pertinent providers.

The delivery and review of services and benefits are coordinated through communication systems connecting all members of the ICT. Some of these systems include the following:

- Member Services Department for member inquiries regarding benefits, network or any issues or problems, including facilitation of any formal member complaint, appeals and grievances.
- Appeals and grievances are monitored and tracked using a coordinated system as well as monitored for adherence to requirements and timelines for resolution.
- Call-line for provider inquires
- Care Coordination Meetings
- Follow-up on members that are inpatient in hospitals, nursing homes and rehabilitative facilities
- Electronic medical records when available

8. Individualized Care Plan

Personnel that develop the individualized plan of care and member involvement.

Care Coordinators develop the individualized care plan along with the member and any family or caregivers the member chooses to have involved with this process. MSHO Care Coordinators are either RNs or Social Workers. For a subset of institutionalized members, care coordination is handled by Geriatric Nurse Practitioners who complete both health risk assessments and care plans for MSHO members residing in nursing facilities.

The Care Coordinator has the responsibility to assess the member's needs, develop, implement and monitor a care plan for the member. The Care Coordinator works in partnership with the member and/or authorized family members, responsible parties or guardians. The Care Coordinator collaborates with the member in developing, coordinating and, in some instances, providing supports and services identified in the care plan and obtaining consent to the medical treatment or service. Care Coordination is provided at a level of involvement based on the needs and choices made by the member and/or authorized family members or guardian, and as appropriate to implement and monitor the plan of care.

The essential elements incorporated in the care plan.

The following are the essential elements that HealthPartners incorporates in the care plan.

- Results of the Health Risk Assessment (initial and annual)
- Medical history
- Family involvement

- Interdisciplinary team involvement
- Documentation of member involvement in care plan development with consideration given to member preferences, such as:
  - Documentation of member choice of services needed
  - Documentation of member choice of providers
  - Documentation of member choice to receive services in the community or in a skilled nursing facility when appropriate
- Follow-up and monitoring of member goals updated upon change of condition (at least annually with the reassessment of the health risk assessment) and shared with Interdisciplinary Care Team
- Includes goals and objectives, services, benefits and measurable outcomes
- Documentation of all assessed needs being addressed in care plan in the care management system
- Specific services and benefits to be provided, including home and community based services provided to prevent or delay nursing home placement.
- Regularly scheduled and as needed communication with the member and appropriate care giver and providers
- Status of member's preventive care
- Cultural needs such as interpreter or culturally appropriate providers
- Includes risks the member is accepting by refusing services recommended by the Care Coordinator
- Maintenance of health care information systems for appropriate documentation and facilitation as needed to the documented individualized care plan within the HealthPartners care management system
- End of life planning.
  - HealthPartners promotes appropriate end of life planning. Staff is trained regarding who is eligible, how to refer and how to coordinate care with on-going treatment. Care Coordinators also educate members and family members regarding advance directives.
  - HealthPartners is working to enhance in-home care coordination for the frail and seriously ill MSHO members who have chronic and/or serious life-limiting illnesses. MSHO Care Coordinators may partner with palliative care case managers who specialize and are gifted in end of life planning and care.

Personnel who review the care plan and frequency of review and revisions.

All providers involved in the care of the member, the member, necessary and appropriate caregivers and family are regularly updated by the Care Coordinator for the member's individualized care plan. Results of the initial and annual health risk assessments are used in the development of the individualized care plan and it evolves with the member's medical needs and health status. Compliance with HIPAA standards with regard to patient information and privacy laws is maintained in all communications.

A health risk assessment is performed annually and when the member's condition changes. The Care Coordinators implement the care plan by referring to service providers, disease management programs, or other resources as defined during the care planning process.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member's progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals. The Care Coordinator reviews the care plan with the member at a minimum of every six months. The Care Coordinator also communicates the care plan to the primary physician who also reviews the plan. The Care Coordinator co-manages a member's care with interdisciplinary care team members; this includes but is not limited to Social Workers, behavioral health case managers, health educators, inpatient and complex care case managers, disease management staff, MTM staff, the primary care physician and other health care providers.

The care plan is documented and documentation is maintained.

Documentation of MSHO care coordination efforts and a completed care plan is maintained in HealthPartners medical management database system. The documentation includes results of patient assessments, the MSHO care plan, services authorized to prevent or delay long-term care placement and/or hospitalization, notations about patient care transitions, notations about co-management with other partners in care and measurements of progress toward meeting member's safety and health care goals. Care plans are also communicated to the member's primary and specialty physicians as applicable; communication is via the electronic medical record system.

HealthPartners medical management system is a secure, encrypted database that is backed up daily. Records are never expunged. Copies of paper care plans that are signed and returned by the member are kept in a locked file room.

The care plan and revisions are communicated to the member, ICT, HealthPartners, and pertinent network providers.

The Care Coordinator communicates with the member and provider(s) per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition, and does periodic assessments of the member's progress toward achieving health goals, overcoming barriers to care, and meeting treatment goals. The Care Coordinator co-manages a member's care with interdisciplinary care team members including but not limited to Social Workers, behavioral health case managers, health educators, inpatient and complex care case managers, disease management staff, MTM staff, the primary care physician and other health care providers.

The Care Coordinators assess and adjust the goals and the care plan as needed. This includes:

- Reviewing progress towards existing goals
- Developing new goals, including rehabilitation services following an acute event
- Creating new health actions aimed at meeting goals and removing barriers
- Re-evaluating acuity and functional status
- Assessing medications—at least annually; more frequently when warranted by the member's health situation (e.g., after a hospitalization)

- Assisting members in their choice of providers/hospitals, using publicly reported quality data (such as Leapfrog Group for hospital choice)

The Care Coordinators communicate with the primary physician regarding clinical, functional, and psychosocial information. The Care Coordinators incorporate the information received from the primary physician and other interdisciplinary care team members into the member care plan. The Care Coordinators and the member's physician and other interdisciplinary care team members collaborate to discuss the member's progress toward goals and changes to the plan of care.

The MSHO Care Coordinator develops a care plan together with the member and other members of the ICT as appropriate. The MSHO Care Coordinator completes the care plan and sends the member a letter and two copies of the care plan. One copy is for the member to keep, one is for the member to sign and return to the Care Coordinator. Any time a change is made to the member's plan of care, the MSHO Care Coordinator sends the Care Coordinator a copy of their revised care plan so the Care Coordinator and member both have the most recent care plan.

Clinic providers give members a printed visit summary and care plan upon completion of all clinic appointments with MSHO members. The MSHO Care Coordinator views the provider's clinic care plan in HealthPartners electronic medical record system.

9. Communication Network

HealthPartners communication network structure.

Some of the tools used in care management to help ensure good communication about the member's health status:

- Daily admission reports from hospitals
- Admissions reports from SNFs
- Common medical management database/system which provides a means of access to shared electronic health information and documentation of results of care conferences
- Electronic medical records (EMR)
- Interdisciplinary Care Team conferences
- Telephonic care conferences
- Face-to-face meetings between members of the Interdisciplinary Care Team and the member and/or designee for planning or providing of care
- An integrated system. HealthPartners as an integrated health care system composed of care delivery, medical and dental clinics and hospitals allows access to medical information across the system.
- Inpatient case management specialists focused on care management while the member is hospitalized and to assist with transiting member home
- Behavioral health case management specialists focused on care management
- Written care plan that is made available to all members of the Interdisciplinary Care Team and documents personnel responsible for communication
- Geriatric specialists for consultation or care

- Secure e-mails, secure fax machines, and confidential written correspondence to meet HIPPA requirements
- Health education materials and interpreter services
- Electronic meetings for training and communication in coordinating care
- The State's online Medicaid eligibility verification system (MN-ITS), and established forms and communication protocols to assist in communication between HealthPartners and county financial workers
- Reminder calls to members for upcoming appointments as needed
- Grievance and appeals reports
- Newsletters to members
- Department meetings, complex case rounds resulting in communication with the member's physician and Interdisciplinary Care Team and teleconference options if needed.

Other communication tools used by the health plan:

- Web based Provider Portal with information for providers
- Newsletters to members (HPCare Today)
- Provider newsletters that communicate health plan and member information

Communication network that connects the plan, providers, members, public and regulatory agencies.

Through HealthPartners integrated health care system, the Interdisciplinary Care Team is able to communicate between care coordinators, the member's medical and dental providers and hospital staff. The communication network provides consistent and clear information to staff at the health plan, to providers in the MSHO network, to members, to the community and to our Regulatory agencies. Each necessary communication is evaluated using communication protocols to determine who needs the information or needs to take action, the appropriate communication tool, the appropriate documentation and any necessary follow up actions.

When required, the appropriate regulatory agencies are consulted. This may include regulatory guidance or notification of communication that is necessary per contract requirements.

In addition, all required reporting is submitted to regulatory agencies. For example, SNP Structure and Process Measures, HEDIS, encounter reporting, etc.

HealthPartners preserves aspects of communication as evidence of care.

HealthPartners has written procedures describing how communication among stakeholders is documented and maintained as part of the administrative and clinical care records. Documentation includes:

- Meeting minutes and agenda
- Recordings of meetings if necessary
- Transcripts of meetings if necessary
- Web-based database of communications
- Written correspondence as necessary
- HIPPA standards for secure emails, fax machine and other written materials

Personnel with oversight responsibility for monitoring and evaluating communication effectiveness.

HealthPartners works across departments to assure regulatory compliance, monitoring, and consistent and effective communication. Regular meetings are held with personnel having responsibility for oversight in these areas to share feedback and enhance future communications.

Disease and Case Management: The Disease and Case Management department management staff is responsible for the information that is communicated by the MSHO Care Coordinators to members, family members and the health plan regarding Care Coordination functions.

Government Programs Department: The Government Programs department management staff are responsible for the monitoring and oversight of the information that is communicated about the MSHO product to regulatory agencies including the MN Department of Human Services and CMS. In addition, Government Programs sends all member materials and communications to the Regulatory agencies for review and approval.

Marketing Department: The Marketing Department management staff is responsible for the information that is communicated about the MSHO product in member materials and marketing pieces. The Marketing Department works closely with internal partners to evaluate whether materials are meeting the needs of members. Member satisfaction measurement tools (such as CAHPS, HEDIS and NCQA) are used to judge if communication improvements are needed.

HealthPartners uses a member-friendly communication checklist and a 7th grade reading level standard to assist with health literacy.
Examples:

- Based on an analysis of market materials, HealthPartners added additional translated information to documents. As part of an annual process, Marketing evaluates the languages spoken by current MSHO members and potential MSHO members in the plan service area to determine if there is a need to add or adjust the translated languages currently offered.
- Marketing evaluates and improves, when necessary, communications sent to MSHO members throughout the year. Improvements include making the communications as member-friendly as possible. This is an on-going process and is done both proactively and as materials are updated throughout the year.
- HealthPartners conducts an annual audit of the materials that are mailed to prospective MSHO members. This audit ensures that prospective members are receiving the correct enrollment materials.

Government Relations Department: The Government Relations department works at the local, state and national level to advance public policy that directly or indirectly improves the health of our members, patients and the community. The Director of Legislative Affairs in Government Relations provides regulatory information and updates that may impact the MSHO product to the Manager of State Public Programs. The Manager of State Public Programs reviews regulatory guidance and provides feedback to Government Relations.

Member Services Department: The Member Services staff has input on member communications and also receives feedback from members about communications sent out from the health plan and

regulatory agencies. This feedback is shared to correct existing communications and to enhance future communications.

Members Services also utilizes a phone monitoring program to improve effectiveness. When opportunities for improvement are identified, coaching and improvement action plans are implemented.

Sales Department: The Medicare and Individual Sales department staff has input on prospective member communication and work closely with the Government Programs and Marketing Departments to ensure clarity and regulatory compliance in communications. They are responsible for educating and informing potential members about the enrollment process and elements of the HealthPartners Medicare plans to ensure the applicant has the necessary information to make an informed decision prior to enrolling. Sales team calls to members are recorded and randomly monitored by the Supervisor and/or the Manager for accuracy and effectiveness. Sales team inbound call scripts are submitted to CMS for review prior to use. Written materials are also submitted to CMS for review prior to use. Feedback on communications is shared to continuously improve future communications.

10. Care Management for the most Vulnerable Subpopulations

HealthPartners identifies the most vulnerable members.

The most vulnerable MSHO members will receive a more intense level of Care Coordination and additional services. They may have complex health or behavior needs and also be at high risk for hospitalization or emergency department admission.

Complex and high-risk MSHO members are proactively identified by methods such as:

- Predictive algorithm monthly report (based on patterns of care and treatment, non-disease specific) using monthly data files including medical claims, pharmacy claims, hospital admission and discharge data, and authorizations from the UM process
- Other high-risk registries (e.g., high utilizers of emergency room or multiple inpatient admissions)
- Hospital census reports
- Care coordinator and Interdisciplinary Team observations
- Member, family or authorized representative requests
- Physician input and requests
- Initial and annual Health Risk Assessment
- Member Services also identifies our most vulnerable beneficiaries and reports this to the Care Coordinator for specialized follow-up.

Additional services and benefits HealthPartners delivers to the most vulnerable members.

Complex case management is provided for members identified as in need of enhanced care coordination. Care coordination may include the provision of additional services or care coordination for members identified as frail, disabled, with end-stage-renal disease that developed after enrollment, near the end of life (such as hospice and palliative care services) and those having multiple and complex medical conditions.

Care Coordinators assist members with services that help members maintain independent living and program enrollment. This includes but is not limited to helping members with their eligibility paperwork, paying bills, connecting with housing and social services and other essential services that help members.

Elderly waiver services are provided as needed for members living in the community who are assessed as being nursing home certifiable to allow at-risk seniors to remain in their homes as long as possible. Elderly waiver services include:

- Homemaker services
- Respite care services (In Home and Out of Home)
- Adult day services (ADS)
- Adult companion services
- Specialized medical supplies and equipment
- Extended State Plan home health care services, including home health aide and skilled nursing services
- Extended State Plan private duty nursing
- Extended State Plan personal care assistance services
- Family and care giver training and education services
- Home delivered meals
- Residential care services
- Customized living services
- 24-hour customized living
- Adult foster care services
- Environmental accessibility adaptations
- Chore services
- Consumer directed community supports
- Transportation
- Transitional supports services
- Adult day service bath

In addition, HealthPartners is able to offer supplemental benefits that go above and beyond the robust Medicaid and Medicare benefits and services. These supplemental benefits for calendar year 2012 include extra vision benefits, dental benefits and DME benefits.

Palliative care case management services are available for frail and seriously ill MSHO members who have chronic and/or serious life-limiting illnesses. MSHO Care Coordinators partner with palliative care case managers who specialize and are gifted in end of life planning and care. These specialized Care Coordinators meet individually with members to provide:

- Eight visits per year over a two year period by a Registered Nurse, MSW and chaplain (primary follow up occurs with phone contacts)
- Pain and symptom management
- 24 hour nurse available for phone consultation
- Goals of Care and Advance Care Planning including discussions surrounding the Advance Directive and DNR/DNI
- Education on disease process, emotional support and counseling services

- Medical Director oversight and regular team meetings with Palliative Care Team members to review and update the plan of care

11. Performance and Health Outcome Measurement

HealthPartners collects, analyzes and reports Model of Care data.

HealthPartners Health Informatics department collects, analyzes and reports data for the Model of Care evaluation from HealthPartners systems. A report is prepared for the Bi-annual Review Meeting in collaboration with department leadership. The data is reviewed to determine if goals are met and if future actions are needed. Goals may be adjusted during this mid-year review. A Comprehensive Annual Analysis report is also prepared for review by the Government Programs Quality and Utilization Improvement Committee. Action items from these meetings are identified, documented and accountable owners are assigned for follow-up.

Scheduled reviews to evaluate the status of CMS Star Rating performance data are also scheduled at the Medicare QUI Workgroup and QUI Committee. Data is reviewed on a quarterly, bi-annual or annual basis. This includes a review of HEDIS, CAHPS, HOS, PDE data, IRE, CMS audits, CMS phone monitoring, complaint tracking module and call center monitoring data.

A multidisciplinary work group reviews and updates the established CMS Star rating work plan that includes initiatives for improvements. The work plan is brought to the Medicare QUI Workgroup for review and approval. Updates on new and current initiatives are also given at both of these meetings.

Personnel collect, analyze, report, and act on data to evaluate the Model of Care.

The Medicare Quality Improvement Workgroup and Government Programs Quality Improvement Committee are responsible to collect, analyze, report and act on data to evaluate the Model of Care. The required reporting is assigned to each committee and reports are assigned to respective staff. Reporting is done on a regular reporting schedule. The committee reviews the information and determines follow-up actions to manage the Model of Care. HealthPartners Quality Improvement Program for MSHO is based on the Triple Aim to simultaneously improve:

- Health of the MSHO population
- Experience of the MSHO members
- Affordability of health care

HealthPartners has a written Quality Improvement Plan, including policies, procedures and a systematic methodology to conduct an overall quality improvement program with components targeted to our MSHO members. Health information systems and analysts are used in the collection, analysis and integration of valid and reliable data used in the Quality Improvement program. The data that is collected, used and reported is overseen by a department called Operational Integrity to verify reliability, validity, completeness and accuracy of data within the organization. On an annual basis, HealthPartners quality and utilization management activities are evaluated and approved by the Quality Committee of the Board and the Board of Directors. Specific components for review include:

- Quality Improvement Program Description
- Quality Annual Work Plan
- Annual Evaluation

Responsibility to collect, analyze, report and act

Data	Responsibility	Collect	Analyze	Report		Review, Action and Assignment of accountable owners
Demographics, utilization, financial trends	Health Informatics in collaboration with department leadership	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee
Clinical Indicators	Quality and Compliance Manager	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee - other groups
CAHPS & HOS	Manager of Marketing and Research	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee -Operations workgroup - Government Programs
Practitioner Availability Report	Contracting Manager	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee - Contracting Department
Grievance Data	Member Services Manager	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee -Operations workgroup - Other groups as needed
CCIP Data	Disease & Case Management Manager	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee
Quality Improvement Projects	Quality Utilization Improvement Consultant	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee - Multi health plan collaborative group
CMS Stars Quality Report	Government Programs MSHO Manager	X	X	X		-Medicare QUI Workgroup -Government Programs QUI Committee - Operations workgroup -Stars management team

HealthPartners uses the analyzed results of the performance measures to improve the Model of Care.

The quality reporting committees have the responsibility to analyze results of performance measures to improve the Model of Care. If the results are not consistent with the established goals, the information is sent to the Medicare Quality and Utilization Workgroup and others as needed to analyze and to recommend a plan for improvement.

Modifications to the Model of Care are made as needed based on the results of committee review and analysis, as well as observations, trends, and patterns identified in response to current and new state and federal regulatory mandates and/or member feedback. These changes, if required, may include changes in policies and procedures, staffing patterns or personnel, changes in provider or facility network, initiatives and goals and/or changes in system of operation.

The evaluation of the Model of Care is documented and preserved.

Minutes from the Government Programs Medicare Workgroup and the Government Programs QUI Committee contain documentation of the evaluation and any changes made to the Model of Care initiatives and goals. Minutes are reviewed and approved by all committee members and saved electronically. Additionally, the Model of Care document is updated accordingly and the new version is given a revision date. All associated reports to evaluate the Model of Care are stored electronically in the yearly evaluation files.

Oversight responsibility for monitoring and evaluating the Model of Care effectiveness.

Members of the quality committees have oversight responsibility for monitoring and evaluating the Model of Care effectiveness.

The Government Programs QUI Committee is chaired by the HealthPartners Medical Director of Medical Management & Government Programs. Committee members include other Medical Directors, management from Disease and Case Management, Behavior Health Strategy and Operations, Health Plan Quality Utilization Improvement, Government Programs, Pharmacy Services, Medical Policy, Health Informatics, Quality Measurement and Improvement. Other areas are invited as needed.

The Medicare QUI Workgroup is chaired by the Associate Medical Director and the Quality Measurement Improvement Consultant. Committee members include staff from Quality Measurement Improvement, Government Programs, HealthPartners Medical Group Quality consultant, Behavioral Health Manager, Disease and Case Management and Pharmacy. Other key contacts and ad hoc membership include staff from Health Informatics, Medical Policy, Legal, Marketing, Provider Contracting and Geriatric Services.

HealthPartners communicates improvements in the Model of Care to stakeholders.

HealthPartners communicates improvements made to the Model of Care in the following manner:

- Changes are communicated to members of the Government Programs QUI Workgroup and Medicare QUI Committees and documented in the meeting minutes.
- The Model of Care document is updated and training will occur with the Care Coordinators and Interdisciplinary Care Team as needed. Appropriate implementation changes will occur including any changes needed to policies and procedures.
- Training regarding the changes will also be made to all other impacted areas. Appropriate implementation changes will occur including any changes needed to policies and procedures.
- Changes relevant to providers will be communicated along with any implementation action that needs to occur. Provider policies will be updated as needed.
- Changes to the Model of Care will be incorporated into the Model of Care training and materials.
- Additionally, information will be shared with CMS and the Minnesota Department of Human Services as requested.

Minnesota Senior Health Options
2014 Model of Care Training

Minnesota Senior Health Options 2014 Model of Care Training

Welcome to the MSHO 2014 Model of Care Training

- Minnesota Senior Health Options (MSHO) is a Fully Integrated Dual Eligible Special Needs Plan in which Medicaid and Medicare benefits and services are integrated into one benefit package.

  HealthPartners contracts with the Minnesota Department of Human Services (DHS) and Centers for Medicare and Medicaid Services (CMS) for the MSHO program.

- The MSHO Model of Care describes the management, procedures, and operational systems that HealthPartners has in place to provide access to services, coordination of care and the structure needed to best provide services and care for the MSHO population.

MSHO 2014 Model of Care Training

- Model of Care training is required for employed and contracted personnel who work with MSHO patients/product to ensure staff have knowledge of the MSHO population and the Model of Care.

- CMS requires that Model of Care Training be completed annually.

Meet Rosie

Today we would like to introduce you to Rosie.

She is a new HealthPartners MSHO member.

Rosie is going to tell us about her experience as a MSHO member.

MSHO Members

" Hi. My name is Rosie. My daughter helped me sign up with HealthPartners as an MSHO member. A few months ago I met my Care Coordinator."

Tidbit

Who can be an MSHO member?

- Anyone 65 years of age or older
- Who is eligible for Medical Assistance (Medicaid)
- Who has both Medicare Part A and B
- They must also reside in the HealthPartners 12 county metro service area

Care Coordinator

"My Care Coordinator called me up that very first month and asked to meet with me. I was a little nervous about meeting someone new and having them come into my home; so I asked my daughter to be there as well. I really didn't need to worry. My Care Coordinator is very nice. She has helped me so much."

Tidbit

Every MSHO Member has a Care Coordinator.

Health Risk Assessment

"When my Care Coordinator came to my house, she did a Health Risk Assessment. I answered a lot of questions about my health and we talked about how I am getting along at home. I really want to stay in my home; but I need some help."


Care Coordinator

Tidbit

All Health Risk assessments are completed within 30 days of enrollment and within 12 months of the previous assessment as well as any time the member has a change in condition.

The Health Risk Assessment includes physical/medical, psychosocial, cognitive, and functional areas of need.

Individualized Care Plan

"After we completed my Health Risk Assessment, my Care Coordinator included me in the development of my Individualized Care Plan. I was able to choose which services I wanted from the ones I was qualified for and also which providers I preferred."

Tidbit

Members who meet Nursing Facility Level of Care criteria may be eligible for Home and Community Based services such as Meals on Wheels, Chore Service, Customized Living Services, Adult Day Care, Home Making, and Life Line.

Individualized Care Plan

"I qualified to receive meals on wheels and tomorrow someone is coming to mow my lawn. He will even clean the snow off of my driveway this winter. It is called chore service.

My daughter also helps me with many things."

Tidbit

Based on the results of the assessment, provider input and the member's desires; the member and Care Coordinator develop a care plan that incorporates goals to be achieved during the coming year.

The Primary Care Provider recommends needed health care services and facilitates communication and information exchange among the treating providers.

Provider Network

"My care plan is sent to me so I have a copy and it is also shared with my doctors."

"I am really glad that I can continue to go to my same doctors."

Tidbit

HealthPartners MSHO has a select, high quality provider network that includes: HealthPartners Medical Group, Park Nicollet, Fairview Clinics, Osceola Medical Centers, Community Clinics.

The provider network is composed of primary, specialty and dental care providers as well as a full-range of geriatric, hospital, acute and post acute rehabilitation, long-term care services, home and community-based services and other specialty services.

Providers are credentialed according to NCQA guidelines and re-credentialed to verify appropriate licensure, insurance and other criteria.

Network specialists can be directly accessed: most often coordinated by the Primary Care Provider and/or the Care Coordinator.

Interdisciplinary Care Team

Primary Care Provider

"My Care Coordinator also explained that I am part of my Interdisciplinary Care Team. This is a group of caregivers and providers who help me stay as healthy as I can be, so I can live in my home."

Specialist

Tidbit

Interdisciplinary Care Team is composed of:

- Member and/or appropriate family/caregiver
- MSHO Care Coordinator
- Primary Care Provider
- Other providers appropriate to specific health needs (Specialists, Palliative Care Team, Pharmacist, Dentist, etc.)
- Others as needed

Communication

"My Care Coordinator calls me to see how things are going and how my services are working out. I also have goals on my care plan that she asks me about.

A few of my goals for this year are to always use my walker so I don't fall; to always take my medicine; to get a flu shot; and to see my dentist."

Tidbit

The Care Coordinator works in partnership with the member and Interdisciplinary Care Team members to develop, coordinate, and monitor the Individualized Care Plan on an ongoing basis. The Care Coordinator communicates the member's progress toward health goals to the Interdisciplinary Care Team.

HealthPartners uses a variety of tools to ensure good communication between all ICT members regarding a member's health status. Such as use of electronic medical records when available; secure email, fax and other confidential correspondence that meet HIPAA requirements.

Care Management

"My Care Coordinator even talked to me about my diabetes. She told me about the Diabetes Disease Management Program. I am able to have a Disease Management case manager call me to teach me more about how to manage my diabetes."

Tidbit

All MSHO members receive care management services through their Care Coordinator.

HealthPartners identifies complex and high-risk MSHO members through the use of proprietary predictive monthly algorithm reports based on patterns of care and treatment; high-risk registries; physician input and requests; and Health Risk Assessments.

These services include but are not limited to enhanced care coordination, Palliative Care Case Management and other Disease Management Programs.

Behind the Scenes

There are many aspects of the Model of Care that occur behind the scenes:

- –The supporting structure of the Model of Care is composed of employed and contracted staff who perform administrative, clinical and oversight functions. Such as:
  - •Enrollment processing and eligibility verification
  - •Adjudication of claims
  - •Member and provider customer service
  - •Management of contracts with a variety of providers
  - •Regulatory compliance
  - •Professional staff credentialing
  - •Development and evaluation of standards of care
  - •Data collection and analysis of program goals
  - •Assessment of emotional, behavioral and cognitive problems

MOC Measureable Goals

CMS defines several goals for the Model of Care

Examples of CMS defined goals:

- – Improve access to essential services such as medical, mental health, and social services
- – Improve access to affordable care
- – Improve coordination of care through an indentified point of contact
- – Improve seamless transitions of care across healthcare settings, providers, and health services
- – Improve access to preventive health services

MOC Measureable Goals

- HealthPartners has identified measureable goals around each of the MSHO CMS defined goals.
- These goals are utilized to evaluate our ability to provide services to MSHO members.
- Examples of HealthPartners MSHO goals:
  - Improve member health outcomes through efforts to reduce re-hospitalizations within 30 days of previous discharge.
  - Improve access to preventive care by increasing colorectal cancer and mammogram screenings.

Performance & Health Outcome Measurement

- HealthPartners Quality Program is based on the Triple Aim to simultaneously improve:
  - The Health of the MSHO population;
  - The Experience of the MSHO members; and,
  - The Affordability of health care.

Click to add title

"Thank you for talking with me today about MSHO."

Tidbit

Please close the slide presentation and click on the "Take Survey" link at the bottom of the email to complete the post-training quiz.

Thank you for taking HealthPartners 2014 MSHO Model of Care Training

Claims Information

CLAIMS SUBMISSION-GENERAL

HealthPartners contracted providers have language in their contracts stating as a condition of payment that all claims for services must be submitted within a specified period of the date of service. Claims requiring coordination of benefits shall be submitted within sixty (60) days of determining HPI's or its Affiliates obligation to make payment.

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUCC 1500 and NUBC UB04 manual for submission of claims. The Minnesota Companion Guides can be accessed at www.health.state.mn.us/auc. The National Uniform Claim Committee website can be accessed at www.nucc.org. The National Uniform Billing Committee website can be accessed at www.nubc.org.

For information on electronic capabilities visit: www.HealthPartners.com/ElectronicConnectivity.

MNsure Product: Key Plan
Advanced Premium Tax Credit (APTC) Grace Period

Members who receive an *advanced premium tax credit* (**APTC**) to help with their healthcare premiums are eligible for a grace period of up to three months if they have paid the premium for the first month of coverage. These members are the only HealthPartners members eligible to receive a three-month grace period.

For Services Provided During Month One of Grace Period:

- HealthPartners accepts responsibility and processes claims in a timely manner according to the benefits.
- HealthPartners claim payment is not dependent on whether or not the member pays the premium.

For Services Provided During Months Two and Three of Grace Period:

- HealthPartners will pend claims with status code 766: *Services were performed during a Health Insurance Exchange (HIX) premium payment grace period*

If the member pays the full premium due before the end of the third month of non-payment, HealthPartners will process pending claims according to the benefits.

If the member does not pay the full premium due within the required time frame, HealthPartners will deny pending claims and cancel the member retroactively, effective the last day of month one of the grace period. The member is eligible to reenroll at the next open enrollment period.

Non-APTC-eligible members who are responsible for their full premium payment are eligible for a 31-day grace period for nonpayment.

- HealthPartners will pend these grace period claims with status code 734: *Verifying Premium Payment*

To check claims status, providers use a 276/277 electronic data interchange (EDI) transaction or the Claim Status Inquiry application on the HealthPartners Provider Portal.

Questions & Answers

Q1: Would you provide an example of the three-month grace period in action for an APTC-eligible member?

January	February	March	April	May
Plan is effective 01/01/14.	Premium for February is not paid.	Premium for February and March is not paid.	Premium for February-April is not paid.	Premium for February-April is not paid.
Premium has been paid for this month.	Grace period begins – month one.	Grace period continues – month two.	Grace period continues – month three.	No longer in three-month grace period.
Claims received for January service dates are paid.	Claims received for January and February service dates are paid.	Claims received with January and February service dates are paid.	Claims received with January and February service dates are paid.	Claims received with January and February service dates are paid.
		Claims received with March service dates pend with status code 766.	Claims received with March and April service dates pend with status code 766.	Claims with March and April service dates are reprocessed and denied to member liability.
			Grace period ends on last day of April.	Member is retroactively cancelled effective 02/28/14.

Q2: Is there a unique timely filing requirement for submitting HealthPartners claims for APTC-eligible members who stop paying their premium, but are eligible for the three-month grace period?

We look at the service date to determine our liability. For example, let's say an eligible member pays his or her premiums for January and February only. Claims submitted for January, February, and March services will be covered according to the member's benefits *as long as the claim is received within the timely filing limit specified in your contract*.

Q3: Does HealthPartners recoup the money paid for those claims during the first month of premium nonpayment?

No. HealthPartners assumes liability regardless of whether or not the member pays the premium.

Q4: Can providers collect from APTC-eligible members at the time of services if they haven't paid their premium?

How providers manage patient collection is up to them. APTC-eligible members who do not pay the premium in full within three months are financially responsible for paying for their services during the final two months of nonpayment. *Remember:*

- We assume liability and pay participating providers for services provided during the first month according to the member's benefits. These claims are paid in a timely manner.
- If a member eligible for the three-month grace period pays the premium in full before the grace period ends, we process pending claims according to their benefits. Claim payments are sent to participating providers.

Q5: Could an APTC-eligible member receive more than one premium grace period in a calendar year?

Members are eligible for more than one grace period, regardless of whether they are eligible for a 3-month or 31-day grace period. However, if a member reaches the end of the applicable grace period and is terminated for nonpayment of premium, he or she may enroll again with HealthPartners or any other Qualified Health Plan (QHP) *only during an open enrollment period*.

Q6: How do members present proof of premium payment if requested by our medical facility?

Members may create or sign into their secure web account at www.healthpartners.com and print or obtain proof of payment. If members require assistance with their web account, they may call the HealthPartners Web Support Help Desk at 952-853-8888 or 877-726-0203.

Claim Submission Quick Reference Guide

Claim Submission Quick Reference Guide		Mode Of Claim Data Submission			
Submission Reason	**Definition**	**Electronic (ANSI Standard)**	**Fax Line**	**Provider Portal**	**U.S. Mail**
New claim without an attachment	Claim has never been submitted and no supporting documentation is required.	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide.	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN
New claim with an attachment	Claim has never been submitted and supporting documentation is required for adjudication. .	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide.	Submit the attachment with cover sheet (see links below). Attachment Fax Lines: Dental: 651-265-1001 Medical:952-853-8860	Or: Submit through the Online Claim Attachments form.	Or: Mail paper attachment to the appropriate claims address.
		Note: Document Control Number assigned by provider must exactly match as submitted on claim. Each number must be unique to each submission.			
Late claim submission	Claim has never been submitted and is past the timely filing requirement. Attachment could be a copy of claim with original print date, or screen print from billing system demonstrating reason for late submission. Required to support the reason for a late submission.	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. *Document control number must be submitted, as well as method used to submit attachments.*	Submit the attachment with cover sheet (see links below). Attachment Fax Lines: Dental: 651-265-1001 Medical:952-853-8860	Or: Submit through the Online Claim Attachments form.	Or: Send a paper attachment to the appropriate claims address.
		Note: Document Control Number assigned by provider must exactly match as submitted on claim. Each number must be unique to each submission.			

Claim Submission Quick Reference Guide		Mode Of Claim Data Submission			
Submission Reason	**Definition**	**Electronic (ANSI Standard)**	**Fax Line**	**Provider Portal**	**U.S. Mail**
Charges billed in error	Partial or total credit on previously paid claim.	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. *Submit Bill Frequency 8 If partial submit Bill Frequency 7	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN
Item returned	Credit on previously paid claim due to DME return by patient	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. *Submit Bill Frequency 8 If partial submit Bill Frequency 7	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN
Incorrect rendering provider	Correction to rendering provider field	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. *Submit Bill Frequency 7	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN
Corrected coding	Correction to any other codes on a previously submitted claim.	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. *Submit Bill Frequency 7	Submit supporting documentation as an attachment with cover sheet (see links below). Attachment Fax Lines: Dental: 651-265-1001 Medical:952-853-8860	Or: Submit through the Online Claim Attachments form.	Or: Mail paper attachment to the appropriate claims address.

Claim Submission Quick Reference Guide		Mode Of Claim Data Submission			
Submission Reason	**Definition**	**Electronic (ANSI Standard)**	**Fax Line**	**Provider Portal**	**U.S. Mail**
Incorrect member	Correction to member identifiers submitted on previously processed claim.	Electronic submission using ASC X12 837 transactions, MN Companion Guide & HIPAA Implementation Guide. * Submit Bill Frequency 8	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN	Not applicable to providers rendering services in MN
Unlisted Procedure Description	Submission of more detailed description of a previously processed service.	This should be resubmitted electronically in data element SV101-7	Use the Medical/Dental Adjustment Request form and fax to the appropriate fax number (see last page).	Or: Use online Claim Adjustment/Appeal Request form.	Or: Use the Medical/Dental Adjustment Request form and mail to the appropriate address (see last page).
Timely Filing Appeal	Request to reconsider claim denial.	Not applicable	Use the Medical/Dental Appeal Request form and fax to the appropriate fax number (see last page).	Or: Use online Claim Adjustment/Appeal Request form.	Or: Use the Medical/Dental Appeal Request form and mail to the appropriate address (see last page).
			Note: Submit all required supporting documentation with appeal.		
Appeals related to: **Pricing** **Benefits** **Coding Review** **Medical Policy** **Credentialing** **Other**	Request to reconsider claim adjudication related to these areas.	Not applicable	Use the Medical/Dental Appeal Request form and fax to the appropriate fax number (see last page).	Or: Use the online Claim Adjustment/Appeal Request form.	Or: Use the Medical/Dental Appeal Request form and mail to the appropriate address (see last page).
			Note: Submit all required supporting documentation with appeal.		

Claim Submission Quick Reference Guide		Mode Of Claim Data Submission			
Submission Reason	**Definition**	**Electronic (ANSI Standard)**	**Fax Line**	**Provider Portal**	**U.S. Mail**
Previously denied authorization has been approved	Request to reconsider claim as authorization has been approved.	Not applicable	Use the Medical/Dental Adjustment Request form and fax to the appropriate fax number (see last page).	Or: Use online Claim Adjustment/Appeal Request form.	Or: Use the Medical/Dental Adjustment Request form and mail to the appropriate address (see last page).
Other correspondence	General correspondence that doesn't apply to the above reasons.	Not applicable	Fax to the appropriate fax number (see last page).	Or: Use online Claim Correspondence Form	Or: Mail to the appropriate claim address.

Link to the print/fax version of the adjustment form.

Link to the print/fax version of the appeal form.

Link to the medical claim attachment fax cover sheet.

Link to the dental claim attachment fax cover sheet.

Attachments and adjustment/appeal forms can be mailed or faxed based on the member's product. See the following table.

Fully Insured and Self Insured Products	Senior/Medicare Products, State of MN Assistance/Medicare Products, Federal Employee Group	Dental Products
HealthPartners PO Box 1289 Minneapolis, MN 55440-1289 Fax: 651-265-1230	HealthPartners PO Box 9463 Minneapolis, MN 55440-9463 Fax: 952-883-7666	HealthPartners Dental Product PO Box 1172 Minneapolis, MN 55440 Fax: 651-265-1001

BILL TYPE FREQUECY CODES FOR USE IN THE 837 PROFESSIONAL AND 837 DENTAL IMPLEMENTATION GUIDES

The developers of the Professional and Dental Health Care Claim Implementation Guides (837 ASC X12N 837 (004010X098A1 and 004010X097A1)) have indicated that the following UB-92 Bill Type Frequency Codes are acceptable for use in those transactions.

Frequency (3rd Digit)

Code	Description	Definition
1	Admit thru Discharge Claims	This code is to be used for a bill, which is expected to be the only bill to be received for a course of treatment or inpatient confinement. This will include bills representing a total confinement or course of treatment, and bills that represent an entire benefit period of the primary third party payer.
7	Replacement of Prior Claim	This code is to be used when a specific bill has been issued for a specific Provider, Patient, Payer., Insured, and "Statement Covers Period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill
8	Void/Cancel of Prior Claim	This code reflects the elimination in its entirety of a previously submitted bill for a specific Provider, Patient, Payer, Insured and "statement Covers Period." The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.

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Claims Manual

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- **Prompt Payment of Clean Claims**

- **Medical Cost Management**
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How to Submit a Claim to HealthPartners

- Electronic Capabilities
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Subject: Electronic Capabilities

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:
HealthPartners offers many electronic capabilities for our providers.

ADMINISTRATIVE PROCESS:

Minnesota Statute, section 62J.536 requires all health care providers to submit health care claims electronically, including secondary claims, using a standard format effective July 15, 2009.

The law applies to all health care providers that provide services for a fee in Minnesota and who are otherwise eligible for reimbursement under Minnesota Medical Assistance (Medicaid).

Please review the FAQ article on the MDH website for more information regarding applicability of the statute at www.health.state.mn.us/asa/faq62j536.pdf

For additional information, please visit www.healthpartners.com/electronicconnectivity.

The entire law is available online at the Minnesota Department of Health (MDH) web site: www.health.state.mn.us/asa/index.html.

HealthPartners offers electronic capabilities for our providers in the following areas:

- Electronic Claims Submission
- Electronic Remittance Advice
- Electronic Eligibility Inquiry
- Electronic Claims Inquiry
- On-line Member Eligibility and Co-Payment Information
- On-line Claim Status Inquiry
- On-line Referral Entry and Inquiry
- On-line Provider Reference Information

Please contact your provider representative at HealthPartners for more details or visit: www.HealthPartners.com/ElectronicConnectivity.

Subject: CMS 1500/5010 837 Professional Claims Submission

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUCC 1500 manual for submission of claims. The Minnesota Companion Guides can be accessed at www.health.state.mn.us/auc. The National Uniform Claim Committee website can be accessed at www.nucc.org.

Subject: UB04/5010 837 Institutional Claims Submission

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:

HealthPartners follows guidelines outlined in the Minnesota Companion Guides and in the NUBC UB04 manual for submission of claims. The Minnesota Companion Guides can be accessed at www.health.state.mn.us/auc. The National Uniform Billing Committee website can be accessed at www.nubc.org.

Subject: Timely Filing of Claims

Effective: January 2000
Last Updated: April 2003
Reviewed: November 2013

EXPLANATION:

HealthPartners contracted providers must submit claims within the specified period of the date of service as outlined in their provider contract.

ADMINISTRATIVE PROCESS:

HealthPartners contracted providers have language in their contracts that state as a condition of payment, they must submit all claims for services, other than claims pended for coordination of benefits, to HPI or its Affiliate within a specified period of the date of service. Claims requiring coordination of benefits shall be submitted within sixty (60) days of determining HPI's or its Affiliates' obligation to make payment. In HealthPartners' appeal guidelines, a provider has 60 days from the remit date of the original timely filing denial to submit an appeal. If the appeal is received after the 60 days, a letter will be sent to the provider stating the appeal was not accepted.

Subject: COB – Coordination of Benefits

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:

HealthPartners follows guidelines for Coordination of Benefits that are outlined in the Minnesota Companion Guides. The Minnesota Companion Guides can be accessed at www.health.state.mn.us/auc.

Subject: Present on Admission Indicators

Effective: January 1, 2009
Last Updated: November 2008
Reviewed: November 2013

EXPLANATION:
HealthPartners requires acute care hospitals that are contracted under a DRG methodology to submit a Present on Admission (POA) indicator for all claims involving inpatient admissions. This policy is effective with admissions on or after January 1, 2009.

ADMINISTRATIVE PROCESS:
POA values and submission requirements should follow NUBC billing guidelines.

Subject: Remittance Advice and Template, HIPAA Version 5010

Document Added: October 2011
Reviewed: November 2013

See next page for sample remittance.
For more information on HIPAA Remittance codes visit http://www.wpc-edi.com.

(N)

HEALTHPARTNERS (A)
8170 33RD AVE S
PO Box 1289
Minneapolis, MN 554401289
CONTACT: (B)
(952) 967-6633 or 1-866-429-1474
PAYER ID: (C)
SUPPLEMENTAL ID: (BANK) (D)

PAYEE: PROVIDER ORG NAME (E)
ADDRESS 1
ADDRESS 2
CITY, MN 12345-1234
PAYEE TAX ID: (F) 123456789
PAYEE NPI: (G) 1234567890
PAYEE ID (H) V12345678900001

PROD DATE: (I)01312009
CHECK/EFT DT: (J)02012009
CHECK/EFT (K)123456789
PAYMENT: (L)12345678.90
PAYMENT METHOD: (M)(ACH,CHK,NON)

PAT CTRL#: (1)XXXXX CLM #: (2)xxxxxxxx CLM STATUS: (3)1 PAID PRIMARY CLM DT (6)01012009-01012009 CLM CHG: (4) 200.00
PATIENT: (5)DOEABCDEFGH, JOHN S **CLM PAYMENT (7)** 190.00
PATIENT ID: (8)123456789 GRP: (9)12345 CLM FILING IND: (10) BILLING PROVIDER: (29) **PAT RESP:** (11) 0.00 PRV LIAB **(12)** **0.00**
REND PROV ID: (13)1234567890 CLM RECEIVED DT: (14) FACILITY TYPE:(15) FREQ: (16) OTHER LIAB (17) 0.00 PROVIDER TAX(18) **0.00**
MED REC #: (19)1234567890 DRG: (20) DRG WGHT: (21) COV EXP DT: (22) WITHHOLD (23) 0.00 COVERED: **(24)** **200.00**
CORRECTED PATIENT: (25) CORRECTED PATIENT ID: (26)
CORRECTED PRIORITY PAYER(27) OTHER SUBSCRIBER: (28)
CROSSOVER CARRIER: (30) ID: (31)
PMI (32) 123456789 CONTRACT: (33)PLEASE SUBMIT CLAIM TO CIGNA

REMARK CODES: CLM ADJ AMT(GRP CD/CLM ADJ RSN CD):
(34) 35.1(35.2/35.3)

LINE CTRL # (a)	DOS (b)	REV (c)	ADJUDICATED PROD/SVC/MOD (d)	SUBMITTED PROD/SVC/MOD (e)	CHARGE ALLOWED (f) (m) (n)	# (g)	APC (h)	ADJ AMT (GRP CD/CLM ADJ RSN CD) i.1(i.2/i.3)	REMARK CODES (j)	REND PROV ID (k)	PAYMENT (l)
001	01012009-01012009	C		A	100.00	001		-100.00(OA/94)	N19	1234567899	190.00
					200.00			10.00(PR/1)	C0213		
002	01012009-01012009	C		B	100.00	001		100.00(CO/97)			0.00
					0.00						

PROVIDER ADJUSTMENT(S):

PROV ADJ CD: (o)	PROV ADJ ID: (p)	PROV ADJ AMT: (q)
CS	12849081-81852719	S12345678.90

TOTAL PAYMENT AMT (r)S12345678
TOTAL PROVIDER TAX (s)
TOTAL WITHHOLD (t)

(u)
EXPLANATION OF CODE(S):

GRP CD	GROUP CODE DESCRIPTION	ADJ RSN	ADJUSTMENT REASON DESCRIPTION	REMARK CD	REMARK CODE DESCRIPTION
(CO)	provider liability	(125)	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	[C0213]	xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

(v)
Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense.
OR
FOR REMITTANCE KEY INFORMATION GO TO: www.healthpartners.com/provider

HealthPartners Paper Remit Field Descriptions HIPAA Version 5010:

Element	Field name	label	Usage	835 element
A	Payer Name and Address,	none	HealthPartners name, address	N102 where N101 = PR N3, N4
B	Payer contact	CONTACT	HealthPartners name of business contact area and contact phone numbers for local and long distance.	PER where PER01= CX
C	Payer ID	PAYER ID	1 followed by TIN	BPR10 TRN03
D	Supplemental ID	SUPPLEMENTAL ID	Field contains the BANK ID associated to the payment. BANK can be used to identify product line and to reconcile multiple remits to the same vendor.	TRN04
E	Payee Name and Address	PAYEE	Defines the entity to which payment is directed.	N102 where N101 = PE N3, N4
F	Payee Tax ID	PAYEE TAX ID	Federal Tax ID or SSN assigned to payee.	N104 where N103 = FI or REF02 where REF01 = TJ
G	Payee NPI	PAYEE NPI	NPI associated to payee	N104 where N103=XX
H	PAYEE ID	PAYEE ID	Payer assigned ID -- Payee ID assigned by HealthPartners. This provides additional identification information critical to vendor balance that is not accommodated by the NPI. A single NPI may have multiple HPFIN's associated to it..	REF02 where REF01 = PQ
I	Production End Cycle Date	PROD DATE	The last date HealthPartners adjudicated claims appearing on this remittance advice.	DTM02 where DTM01 = 405
J	Check/EFT Date	CHECK/EFT DT	This is the check issue date or in the case of a non payment remittance this is the date the remittance was generated. Required on the top of each page of a multipage remittance.	BPR16
K	Check/EFT trace Number	CHECK/EFT	This is a trace number which is used to re-associate payments and remittances, must be a unique number for this business purpose between the payer and the payee. This is the check number, EFT payment ID or in the case of a non-payment remittance it is a unique ID assigned to the remit.	TRN02
L	Payment Amount	PAYMENT	This is the total amount of payment that corresponds to the remittance advice. The total payment amount for this remit cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the remit cannot be issued for less than zero dollars	BPR02
M	Payment method	PAYMENT METHOD	Defines the way payment is transmitted: Check, EFT or no-payment. Values: CHK, ACH, NON	BRP04
N	Page number		Remittance page number	Na

Element	Field name	label	Usage	835 element
1	Patient Control Number	PAT CTRL #	This is the first 20 bytes of the provider assigned identifier submitted on the claim (CLM01). If an identifier was not submitted the value is defaulted to'0'. This data element is the primary key for posting the remittance information into the provider's database.	CLP01
2	Payer Claim Control number	CLM #	This is the identifier assigned by HealthPartners that identifies the claim submission. For 5010 format this value will be the same on the original, void and the replacement.	CLP07
3	Claim status	CLM STATUS	Claim status code and narrative definition. • Usage of Denied status changed for 5010-it is only used if the patient is not recognized and the claim is not forwarded to another payer. • Status 23 – not our claim, forwarded to additional payer(s) requires usage of crossover carrier • Status 1-3 processed as primary, secondary or tertiary are used regardless of whether any part of the claim was paid.	CLP02
4	Claim Charge Amount	CLM CHG	This is the total submitted charges for the claim. This amount can be positive, zero or negative.	CLP03
5	Patient Name	PATIENT	If claim was submitted in the 5010 837 format then this is the submitted patient name else this is the name that identifies the patient on the claim. Format is last, first middle initial. Field will be in bold. .	NM103,04, 05,07 where NM101 = QC
6	Statement From and To Date	CLAIM DT	This is the service date range that applies to the entire claim.	DTM02 where DTM01 = 232 and 233
7	Claim Payment Amount	CLM PAYMENT	This is the total amount paid on this claim by HealthPartners. This amount can be positive, negative or zero.	CLP04
8	Patient Identifier	PATIENT ID	If claim was submitted in the 5010 837 format then this is the submitted patient ID. Else this is the identifier assigned by HealthPartners that identifies the patient. Field will be in bold.	NM109 where NM101=QC
9	Group or Policy Number	GRP	This is the HealthPartners group number associated to the patient's coverage.	REF02 where REF01 = 1L
10	Claim filing indicator	CLM FILING IND	Coded value, used to identify different product lines within a payer.	CLP06
11	Patient Responsibility Amount	PAT RESP	This is the total patient responsibility amount for this claim. Amounts correspond to adjustments with grouping code of PR..	CLP05
12	Provider liability	PRV LIAB	Total provider liability amount applied to the claim other than the MNTAX or withhold amounts. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals CO (excluding adjustment reason codes 137 and 104). .	na
13	Rendering provider identifier	REND PROV ID	This is the payer assigned ID number or the National Provider Identifier of the provider who performed the service. Required if the rendering provider identifier is different than the payee ID. Element should contain the NPI or the payer assigned ID number for atypical providers. Field contains either NPI or UMPI.	NM109 where NM108=XX Or NM109 where NM108 = PC
14	Claim received date	CLM RECEIVED DT	Date claim was received by HPI	DTM02 where DTM01=050
15	Facility type	FACILITY TYPE	For the 5010 remit format this element is populated on all claim types. Required when the information was received on the original claim. Professional and dental default to POS from first line	CLP08

Element	Field name	label	Usage	835 element
16	Claim Frequency	FREQ	Submitted claim frequency. For 5010 remit format this element is used on all transaction types and is required if submitted on the original claim.	CLP09
17	Other liability	OTHER LIAB	Total other liability amount applied to the claim. The total of claim and line level adjustment amounts where the claim adjustment grouping code equals OA	na
18	PROVIDER TAX	PRV TAX	Total MNTax payment amount applied to the claim. The sum of all claim and line level adjustments associated to adjustment reason codes 137. For this field, the MNTAX payment amount is not reflected as a negative, unless it is a voided claim. If no mntax amount then the value will equal zero	AMT02 where AMT01=T
19	Medical Record Number	MED REC #	This is the provider assigned medical record number that was submitted on the claim.	REF02 where REF01 = EA
20	Diagnosis Related Group Code	DRG	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP11
21	Diagnosis Related Group Weight	DRG WGHT	This element is specific to institutional claims and is present when the adjudication considered the DRG code.	CLP12
22	Coverage expiration date	COV EXP DT	If claim is denied because of the expiration of coverage, this is the date coverage expired.	DTM02 where DTM01=036
23	Withhold	WITHHOLD	Total withhold amount adjusted from the claim. Sum of claim and line level amounts associated to adjustment reason 104 If no withhold amount then the value will equal zero.	na
24	Covered amount	COVERED	This is the amount of charges considered as eligible for coverage This is the sum of the original submitted provider charges that are considered for payment under the benefit provisions of the health plan. This excludes charges considered not covered (i.e. per day television or telephone charges) but includes reductions to payments of covered services (i.e reductions for amounts over fee schedule and patient deductibles**).**	AMT*AU
25	CORRECTED PATIENT NAME	CORRECTED PATIENT	If claim was submitted in the 5010 837 format and the patient info does not match HealthPartners eligibility then this field contains the values that are different. Only the elements that are different are populated not necessarily the full name	NM1*74
26	Corrected patient ID	CORRECTED PATIENT ID	If the claim was submitted in the 5010 837 format and the patient ID does not match HealthPartners eligibility then this field contains the value from HPI eligibility.	NM109
27	Corrected Priority Payer	CORRECTED PRIORITY PAYER	This is the name of the payer that has priority over HealthPartners in making payment. For 5010 remit format, this element is only populated when HealthPartners has identified a payer primary to the HPI coverage and the COB loop was not submitted on claim.	NM103 where NM101 = PR
28	Other subscriber name	OTHER SUBSCRIBER	Populated for 5010 when a priority payer has been identified.	NM103 NM104 Where NM101=GB
29	BILLING PROVIDER:	BILLING PROVIDER:	Subsidiary provider ID, used when payment is made to other than the billing entity. For the 5010 remit format this element is populated when the submitted billing NPI is different than the payee NPI.	TS301

Element	Field name	label	Usage	835 element
30	Crossover carrier name	CROSSOVER CARRIER	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23).	NM103 where NM101=TT
31	Crossover carrier ID	ID	Required when the claim is transferred to another carrier or coverage (CLP02 = 19,20,21 or 23). .	NM109 where NM101=TT
32	Patients Medicaid Identifier	PMI	MEDICAL ASSISTANCE NUMBER	REF 02 where REF01=1W
33	Contract Code	Contract	The contract that was used between the payer and the provider to determine payment. Populate with CIGNA misdirect message when claim should have been submitted under the CIGNA contract or the PMAP program code	REF01 where REF02=CE
34	Remark codes	REMARK CODES	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone or are not associated to a dollar adjustment. Claim can contain up to five claim level remark codes . For Non MN providers field may contain an internal remit remark code. .	MIA/MOA
35.1	Claim adjustment amount	CLM ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per claim. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts must equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS
35.2	Claim Adjustment group code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. OA Other adjustments- avoid using OA except for business situations defined in HIPAA guide. PI Payor Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS
35.3	Claim adjustment reason code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount.	CAS
a)	Line Item control number	LINE CTRL #	Line item identifier submitted by the provider to identify the line or if control number is not submitted than the claim line number	REF02 where REF01 = 6R
b)	Dates of Service	DOS	This is the date range of services for each line. Format is MMDDCCYY-MMDDCCYY.	DTM02
c)	Revenue Code	REV	Element applies to institutional claims only. This is the revenue code submitted on the claim line.	SVC04 or SVC01-2
d)	Adjudicated Product/Service Code/Modifiers	ADJUDICATED PROD/SVC/MOD	This is the adjudicated procedure code and modifiers. Values can be HCPC, or ADA codes.	SVC01
e)	Submitted Product/Service Code/Modifiers	SUBMITTED PROD/SVC/MOD	If the code used for adjudication is different than the submitted value, than the submitted value is contained in this element.	SVC06

Element	Field name	label	Usage	835 element
f)	Line Item Charge or Billed Amount	CHARGE	This is the line item charge/billed amount that was submitted on the line.	SVC02
g)	Units	#	This is the number of paid units of service.	SVC05
h)	APC	APC	Element applies to institutional only. A value is present if adjudication considered the APC.	REF02 where REF01 = APC
i.1	Claim Adjustment Amount	ADJ AMT	This is the adjustment amount associated to the adjustment grouping code and reason code. There can be multiple adjustment amounts per line. The total submitted charges minus the sum of the claim level adjustment amounts and the line level adjustment amounts should equal the Claim payment amount. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	CAS
i.2	Claim Adjustment Grouping Code	GRP CD	This code categorizes the adjustment amount. The values are as follows: CO Contractual Obligations - Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment. OA Other adjustments- avoid using OA except for business situations defined in HIPAA guide. PI Payor Initiated Reductions - Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer. PR Patient Responsibility	CAS
i.3	Claim Adjustment Reason Code	CLM ADJ RSN CD	This code defines the reason for the adjustment amount. Narrative values of codes are available at www.wpc-edi.com	CAS
j)	Remittance Advice Remark Code	REMARK CODE	This is a code used to relay informational messages that cannot be expressed with a claim adjustment reason code alone. If claim line has multiple adjustment reasons the remark code is not in relationship to the adjustment reason across from it but to the line. This is the same relationship as the 835 electronic transaction. If the facility is outside of MN, we will also supply some legacy codes. These legacy remarks primarily define our National Network utilization.	LQ
k)	Rendering provider ID	REND PROV ID	This is the NPI or atypical ID of the rendering provider if the value is different than the claim level	REF
l)	Payment Amount	PAYMENT	This is the payment amount corresponding to the adjudicated service line. The line item billed amount minus the line item adjustment amounts must equal the line item payment amount.	SVC03
m)	Submitted procedure code description	No label	If a description was received on the original service for a not otherwise classified procedure and the adjudicated procedure is different than the submitted value.	SVC06-7
n)	Allowed amount		Allowed amount is the amount the payer deems payable prior to considering patient responsibility	AMT02 where AMT01=B6

Element	Field name	label	Usage	835 element
o)	Provider adjustment reason Code	PROV ADJ CD	This is the reason for the provider adjustments that are not specific to a particular claim or service. Multiple adjustments may apply to the payment. .	PLB0
p)	Provider Adjustment Identifier	PROV ADJ ID	For 5010 remit format the ID will vary by reason code: Adjustment codes are used as defined in the HIPAA guide.	PLB
q)	Provider Adjustment Amount	PROV ADJ AMT	This is the monetary amount of the adjustment. Note: positive adjustment amount decreases payment and a negative adjustment amount increases payment.	PLB
r)	Total payment	TOTAL PAYMENT AMT		NA
s)	Total Provider Tax amount	TOTAL PROVIDER TAX	Total MNTAX payment amount applied to the check for all claims on the remittance.	NA
t)	Total withhold amount	TOTAL WITHHOLD	Total withhold amount adjusted from check for all claims on the remittance. .	NA
u)	Explanation of code(s)	EXPLANATION OF CODE(S)	Narrative description of grouping codes, adjustment codes and remark codes contained in remit.	NA
v)			Current Dental Terminology (c) American Dental Association Claims reviewed using ClaimSense. FOR REMITTANCE KEY INFORMATION GO TO: www.healthpartners.com/provider	

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Commonly Used Forms

Subject: Adjustment Request Form

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:

Claims sent for Adjustment must also be submitted electronically under the new Minnesota Mandates.

HealthPartners follows guidelines for Adjustment Requests outlined in the Minnesota Companion Guides and Best Practices documents. The Minnesota Companion Guides and Best Practices documents can be accessed at www.health.state.mn.us/auc

ADMINISTRATIVE PROCESS:

Adjustment claims must also be submitted electronically under the new Minnesota Mandates.

If additional information is needed to support the submission of an adjusted claim then the NTE segment, PWK segment or Condition Codes should be utilized.

Requests for adjustments without needing a new claim can be submitted through the portal or via the faxable form. These resources can be accessed at http://www.healthpartners.com/ProviderForms for providers.

Subject: Appeal Request Form

Effective: January 2000
Last Updated: August 2009
Reviewed: November 2013

EXPLANATION:

Claims appeals must also be submitted electronically under the new Minnesota Mandates.

HealthPartners follows guidelines for Adjustment Requests outlined in the Minnesota Companion Guides and Best Practices documents. The Minnesota Companion Guides and Best Practices documents can be accessed at www.health.state.mn.us/auc or

ADMINISTRATIVE PROCESS:

Requests for adjustments without needing a new claim can be submitted through the portal or via the faxable form. These resources can be accessed at http://www.healthpartners.com/ProviderForms for providers.

Subject: Prompt Payment of Clean Claims

Effective: January 2000
Last Updated: October 2008
Reviewed: November 2013

EXPLANATION:
"Prompt Payment of Clean Claims" is a Minnesota law effective for claims submitted on or after January 1, 2001. The law requires health plan companies and third party administrators to pay or deny clean claims within 30 calendar days after the date upon which the claim was received. A clean claim is defined in the law as one "that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made." Clean claims that are not paid or denied within the time required are subject to interest.
For the full text of this law, check the Minnesota Legislature's web page at: http://www.leg.state.mn.us/leg/statutes.htm. Click on "Retrieve a Section" and enter 62Q.75.

ADMINISTRATIVE PROCESS:
HealthPartners will determine what claims are eligible for interest under the Prompt Payment of Clean Claims law by using the following criteria:

Received Date: This is the date HealthPartners receives the claim. For electronic claims, this is the date of EDI file receipt in HealthPartners system. For paper claims, this is the date the claim is received in HealthPartners mailroom.

Paid Date: This date is not defined in the law. HealthPartners will calculate using the date of the check plus 3 days for mailing. If you have the postmarked envelope in which the payment was received with a later postmark date, we are willing to accept that as the paid date. If you are consistently experiencing delays beyond the check date plus 3 days, contact your Primary Care Relations and Contracting representative to help resolve the issue.

Clean Claim: For a claim to be a clean claim, it must be completed with all necessary data elements, any referrals need to be received by the plan and all needed COB information must be received by the plan.
HealthPartners will pay interest for late claims payment (as defined by Minnesota Statute 62Q.75) directly to providers for dates of service beginning January 1, 2003. Providers do not have to submit a bill to HealthPartners for the interest. Interest will be paid for claims with dates of service beginning January 1, 2003. The first check will be issued on a quarterly basis.

Subject: Prompt Payment of Clean Claims (cont'd)

Note: HealthPartners will not calculate and pay interest on claims for which the provider is capitated, on payment advances, or on self-insured claims or as otherwise defined in 62Q.75.

Provider Responsibility
In order for HealthPartners to pay claims promptly we require that providers:
Submit claims electronically whenever feasible.
Submit referral authorizations consistently and timely.
Attach primary insurer information or an Explanation of Benefits form whenever applicable.
Submit complete bills with accurate coding and the correct provider number, including NPI.

Medical Cost Management

ClaimCheck Review®

HealthPartners ClaimCheck Review® Edit Categories

Standard Modifier Table Policy

Casting Supplies

Codes For Data Collection and Reporting Only Procedures

Global Obstetric Package

Services Not Billable On A Professional Format

Services Not Separately Reimbursable

Surgery

- Assistant Surgeon Services
- Bilateral Billing Guidelines
- Global Surgical Follow Up Care
- Multiple Surgery
- Surgical Trays

Subject: ClaimCheck®

Effective: January 2000
Last Updated: November 2010
Reviewed: November 2013

EXPLANATION:

HealthPartners uses ClaimCheck®, a coding software system purchased from an external vendor.

ADMINISTRATIVE PROCESS:

Coding logic is applied to physician and professional claims that include Current Procedural Terminology (CPT) codes and Health Care Financing Administration Coding System (HCPCS) codes. ClaimCheck® provides consistent, objective claims review by applying the coding criteria outlined in the AMA's CPT-4 manual to all physician services.

The coding software is updated by the vendor in the first quarter of each year. Any new edits generally occur at the end of the first quarter, on or about April 1st. ClaimCheck is used in the review of professional claims processed for all HealthPartners products.

HealthPartners ClaimCheck® Edit Categories		
EDIT CATEGORY	**DESCRIPTION**	**OUTCOME**
Visit	Professional visits [E & M] billed on the same day as a substantial diagnostic, therapeutic or surgical procedure is performed.	ClaimCheck® automatically denies same day visits when billed with the allowable surgical procedure. Payment is based on the surgical procedure. Claim is routed to Medical Review for review.
Unlisted Procedure	Unlisted services or procedures are defined as those procedures or services performed/rendered by providers but not found in the appropriate edition of CPT or HCPCs for the date of service. Unlisted procedure codes are not to be used when a more descriptive procedure code representing the service provided is available.	Unlisted procedures are questioned and routed to Medical Review for review.
Assistant Surgeon	Surgical procedure in which it is medically necessary to have an assistant assisting the primary surgeon at surgery.	ClaimCheck® automatically denies assistant surgeon charges when the assistant is not medically necessary. ClaimCheck® will question assistant surgeon charges when documentation is needed to support charges. Claim ir routed to Medical Review for review.
CCI-Incidental	Procedure combinations identified in the CMS Column 1/Column 2 edits, formerly the comprehensive/component edits. These are solely based on CMS guidelines.	ClaimCheck® automatically denies CCI-Incidental edits.
CCI-Mutually Exclusive	Procedure combinations identified in the CMS CCI Mutually Exclusive tables. These are solely based on CMS guidelines.	ClaimCheck® automatically denies CCI-Mutually Exclusive edits
Bilateral Duplicate procedures	The procedure code contains the word “bilateral”, the procedure can be performed *only once on a single date of service.*	ClaimCheck® automatically denies bilateral duplicate procedures. Claim is routed to Medical Review for review.
Unilateral/Bilateral Duplicate procedures	The procedure code contains the phrase “unilateral/bilateral”, the procedure can be performed *only once on a single date of service.*	ClaimCheck® automatically denies unilateral/bilateral duplicate procedures. Claim is routed to Medical Review for review.

EDIT CATEGORY	DESCRIPTION	OUTCOME
Duplicate Rebundle/Replacements Duplicate procedures	The procedure code specifies "unilateral" and there is another procedure whose description specifies "bilateral" performance of the same procedure, the unilateral procedure *cannot* be submitted more than once on single date of service.	ClaimCheck® automatically denies duplicate rebundle/replacement duplicate procedures. Claim is routed to Medical Review for review.
Global Duplicate Value procedures	The procedure code is assigned the total number of times per date of service that the procedure may be appropriately submitted. This is reflective of the total number of times it is clinically possible or clinically reasonable to perform a given procedure on a single date of service across all anatomic sites.	ClaimCheck® automatically denies global duplicate value procedures. Claim is routed to Medical Review for review.
Right/Left Duplicate Value procedures	The procedure code is assigned a value which is the maximum number of times per side, per date of service that a procedure may be submitted when modifiers –RT and/or –LT are used. Procedures (that clinically can be performed only once per date of service) are limited globally at "1", but are allowed to be reported with the appropriate –RT or –Lt modifier for the site specific designation.	ClaimCheck® automatically denies right/left duplicate value procedures. Claim is routed to Medical Review for review.
Site specific Duplicate Value procedures	The procedure code is assigned a value which is the maximum number of times per site, per date of service that a procedure may be submitted when site specific modifiers E1-E4, FA-F9, TA-T9, LC, Ld and RC are used.	ClaimCheck® automatically denies site specific duplicate value procedures. Claim is routed to Medical Review for review.
Reporting Only procedures	The procedure code is submitted for data collecting only and reimbursement is not warranted.	ClaimCheck® automatically denies the reporting only procedure.
Incidental Procedures	The procedure is performed at the same time as a more complex primary procedure and is clinically integral to the successful outcome of the primary procedure.	ClaimCheck® automatically denies incidental procedures. Claim is routed to Medical Review for review.
Mutually Exclusive procedures	The edits consist of combinations of procedures that differ in technique or approach but lead to the same outcome. Mutually exclusive edits are developed between procedures based on the following CPT description verbiage: • Limited/Complete • Partial/Total • Single/Multiple • Unilateral/Bilateral • Initial/Subsequent	ClaimCheck® automatically denies mutually exclusive procedures. Claim is routed to Medical Review for review.

	• Simple/Complex • Superficial/Deep • With/Without	

HealthPartners ClaimCheck® Edit Categories		
EDIT CATEGORY	**EDIT CATEGORY**	**EDIT CATEGORY**
Bilateral Procedures	Codes submitted with a 50 modifier.	ClaimCheck® will question the claim and route to a Medical Review analyst to verify what was actually done.
Replacement codes	Reassignment of the appropriate comprehensive CPT code representing those procedures and/or services billed as performed. Reassignment will take place when there is a one-to-one code replacement for an age or gender edit.	ClaimCheck® automatically replaces and assigns the appropriate CPT code. Payment is based on the replaced code.
Inconsistency of Gender to Procedure	CPT codes that are specific to the patient's gender	ClaimCheck® will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the gender of the patient to the procedure being performed.
Inconsistency of Age to Procedure	CPT codes that are specific to a patient's age.	ClaimCheck® will generate a questioned claim that is routed to a Medical Review analyst. Medical review will verify the age of the patient to the procedure being performed.
Relationship of Procedure to place of service	Generally accepted setting where a procedure or service is performed/rendered.	If the place of service submitted is inappropriate with the procedure being performed ClaimCheck® will deny the procedure. Medical Review will verify.
Modifier to procedure edit	Procedure to modifier validity check to determine if a procedure code is valid with a specific procedure.	ClaimCheck® will question the line item and route to a Medical Review for review.
Pre/Post Operative Visit	Evaluation and management services are denied when rendered by the surgeon during the established pre/post operative period.	ClaimCheck® automatically denies pre/post operative visit procedures. Claim is routed to Medical Review analyst for review.
Multiple Surgery	Two or more surgical procedures are performed during one operative session by the same physician. Hierarchy is determined by the highest dollar procedure.	Primary procedure is reimbursed at 100% of the fee schedule or billed amount, whichever is less. Secondary, tertiary, etc., are reimbursed at 50% of the fee schedule or billed amount, whichever is less.

Subject: Standard Modifier Table Policy

Effective: As noted below for modifier
Last Updated: February 2014
Reviewed: February 2014

EXPLANATION:

The following table lists all modifiers on the HealthPartners standard modifier table that affect payment on claims by either increasing or decreasing the allowable amount. Some modifiers are addressed in separate policies, so please review the specific policy for additional information on the identified modifiers below.

Modifier	Modifier Description	Percent of Allowable
22	Increased procedural services	110%
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	80%
50	Bilateral procedure	See Bilateral Billing Guidelines Policy
52	Reduced services	Through 4/30/14 75% Effective 5/1/14 50%
53	Discontinued Procedure	Through 4/30/14 50% Effective 5/1/14 25%
54	Surgical care only	75%
55	Postoperative management only	25%
56	Preoperative management only	10%
62	Two surgeons	62.5%
80	Assistant surgeon	See Assistant Surgery Services Policy
81	Minimum assistant surgeon	See Assistant Surgery Services Policy
82	Assistant surgeon (when qualified resident surgeon not available)	See Assistant Surgery Services Policy
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery	See Assistant Surgery Services Policy

Modifier	Modifier Description	Percent of Allowable
FB	Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)	0%
FC	Partial credit received for replaced device	50%
GZ	Item or service expected to be denied as not reasonable or necessary	0%
PA	Surgical or other invasive procedure on wrong body part	See Never Events Policy
PB	Surgical or other invasive procedure on wrong patient	See Never Events Policy
PC	Wrong surgery or other invasive procedure on patient	See Never Events Policy
PM	Post Mortem	100%

ADMINISTRATIVE PROCESS:

The modifier pricing is automated in the Claims system.

APPLIES TO:

All Commercial Products

EFFECTIVE DATE PER MODIFIER:

22 - 1/1/1995
25 - 1/1/2011
50 - 1/1/2007
52 - 7/1/2006
53 - 1/1/1997
54 - 8/15/2001
55 - 8/15/2001
56 - 1/1/1984
62 - 1/1/1996
80 - 1/1/1995
81 - 1/1/2004
82 - 1/1/1995
AS - 1/1/2004
FB - 1/1/2006
FC - 1/1/2008
GZ - 1/1/2002
PA - 1/1/2011
PB - 1/1/2011
PC - 1/1/2011
PM - 1/1/2014

Subject: Casting Supplies

Effective: January 2000
Last Updated: July 2003
Reviewed: November 2013

EXPLANATION:

Casting supplies will be allowed for reimbursement as separately billable charges for initial fracture care and at the time of cast reapplication. An office visit charge is not reimbursable at the time of reapplication.

ADMINISTRATIVE PROCESS:

HealthPartners has adopted the Medicare Part B guidelines for reimbursement of cast supplies.

Subject: Codes for Data Collection and Reporting Only Procedures

Number: CC/U11
Approved: MCM
Effective: July 2010
Reviewed: November 2013

EXPLANATION:

Codes listed below are intended to facilitate data collection or are for reporting purposes only and are not separately reimbursable.

ADMINISTRATIVE PROCESS:

Deny procedure codes when billed. No review necessary. Claims system is automated.

CODES LIST:

Procedure Codes
90663
0001F – 7025F (CPT Category II)
G8126 – G9140
G9142
S0302

APPLIES TO:

All Providers and Products

Subject: Global Obstetric Package

Number: MCM/O01
Approved: MCM
Effective date: January 1996
Last Updated: July 2004
Reviewed: November 2013

EXPLANATION:

Global OB package includes all services rendered during the entirety of a patient's uncomplicated pregnancy.

Ante-partum care includes:

Subsequent history
Physical/pelvic examinations
Recording of weight and blood pressures
Fetal heart tones
Routine urinalysis
Supplies and materials generally associated with OB care
Educational supplies and services

Uncomplicated delivery includes:

Management of labor
Cesarean delivery
Suction of forceps assist of vaginal delivery, with or without episiotomy
Admission history and physical, hospital visits and discharge
Induction of labor on the same day of delivery
Administration of routine anesthesia by the delivering physician
External and internal fetal monitoring
Fetal contractions stress tests performed on the day of delivery at the hospital

Uncomplicated postpartum care/office visits:

CPT code 59430 should only be used when the physician who performs postpartum care is not the physician who performed the delivery.

Subject: Global Obstetric Package cont'd.

Six weeks for vaginal delivery and eight weeks for C-section.

Service includes:

Pelvic exam
Suture removal
Contraceptive management

Total OB Package

The initial visit is to be billed separately. The OB package includes all ante-partum care (12 prenatal visits), delivery and postpartum care. All routine urinalysis are included. Any other lab work or procedures can be billed separately. Use the initial visit date and the date of delivery as the "to" and "from" dates of service when submitting the global code.

COVERAGE:

Check On Line Benefits for group specific coverage for OB care.

ADMINISTRATIVE PROCESS:

Requests for appeal review should include the adjustment request form. Supporting documentation with a copy of the remittance advice showing the last processed date should be included with the request.

APPLIES TO:

All products / All providers

Subject: Services Not Billable on a Professional Format

Number: CC/U10
Approved: MCM
Effective date: July 2010
Reviewed: November 2013

EXPLANATION:

Codes C1300-C9899 are for dugs, biologicals, and devices that must be used by OPPS hospitals. These codes cannot be billed on a professional format.

ADMINISTRATIVE PROCESS:

Deny codes when billed on a professional format. No review necessary. Claim system is automated.

APPLIES TO:

All Providers and Products

Subject: Services Not Separately Reimbursable

Number: CC/UD8
Approved: MCM
Effective date: July 2010
Reviewed: November 2013

EXPLANATION:

HPI has determined the codes listed below are not separately reimbursable.

ADMINISTRATIVE PROCESS:

Deny procedure codes when billed. No review necessary. Claims system is automated.

Code list:

Procedure Code
90889 94760, 94761 96110 99000, 99001, 99002, 99026, 99027, 99050, 99051, 99053, 99056, 99058, 99060, 99070, 99075, 99078, 99080, 99082, 99090, 99091, 99358, 99359, 99367, 99368 A4550 J2001 Q0091 S0020, S0039, S2055, S2061, S2140, S2150, S3600, S3601, S9088, S9981, S9982

Subject: Services Not Separately Reimbursable cont'd.

COVERAGE EXCEPTIONS:

Code 96110 is allowed for Medicaid members

APPLIES TO:

All Providers and Products:

Subject: Surgery-Assistant Surgeon

Number: MCM/A02
Approved: MCM Steering Committee
Effective date: January 1995
Last Updated: February 2014
Reviewed: February 2014

EXPLANATION:

HealthPartners' definition of Assistant Surgeon includes MD, RNFAs (RN First Assistants), PAs (Physicians Assistant) and NPs (Nurse Practitioners). HealthPartners follows Medicare guidelines regarding necessity of Assistant Surgeon.

Assistant Surgeon professional services are identified by the following procedure modifiers billed with the surgical CPT code.

80 = Assistant Surgeon

81= Minimum Assistant Surgeon

82 = Assistant surgeon (when qualified resident surgeon not available)

AS = Physician Assistant (PA), Nurse Practitioner(NP), or clinical nurse specialist services for assistant at surgery.

The modifier will automate the correct percentage for pricing.

COVERAGE:

HealthPartners will reimburse appropriate Assistant Surgeon services at:

80 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

81 = 16% of the Surgeon's allowed amount

82 = 20% of the Surgeon's allowed amount through 4/30/14
= 16% of the Surgeon's allowed amount effective 5/1/14

AS = 14% of the Surgeon's allowed amount

APPLIES TO:

All providers / All products

Subject: Surgery-Assistant Surgeon cont'd.

ADMINISTRATIVE PROCESS:

Multiple assistant surgeon services will be considered and reviewed for medical necessity.

Claims systems are automated to allow those services which are appropriate.

HealthPartners uses the Medicare Physician Fee Schedule Database (MPFSDB) "Assistant Surgeon Indicator" field as the basis for determining which CPT codes will be allowed for assistant surgeon reimbursement.

To access this database, refer to the CMS Web site at:
cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13A.html?DLPage=1&DLSort=0&DLSortDir=descending

Subject: Bilateral Billing Guidelines

Last Updated: September 2009
Reviewed: November 2013

A “bilateral procedure” is defined as a procedure which can be performed on either the right or left anatomic structure or is unspecific as to anatomic location, but can be performed on an anatomically bilateral structure the use of modifier -50 is valid. There are some exceptions to this rule for codes which may be inherently bilateral or for procedures which may involve paired structures, but are not performed bilaterally.

HealthPartners prefers bilateral procedures to be reported on one line using modifier “50” with a unit of service of one.

However, HealthPartners will allow a CPT4 code with a bilateral indicator assignment of ‘1’ to be billed on two line items, one with modifier RT and the other with LT. Each line must be billed with a single unit of service

ADMINSTRATIVE PROCESS:

Where applicable, HealthPartners would reimburse the lesser of, a) 150% of the fee schedule amount or b) billed charges.

NOTE: Use of modifiers applies to services/procedures performed on the same calendar day.

HealthPartners uses the Medicare Physician Fee Schedule Database (MPFSDB) as the basis for determining which CPT codes can be submitted as “bilateral”.

The “Bilateral Surgery Indicator” (Field 22) in the MPFSDB indicates how the bilateral service must be submitted to Medicare.

To access this database, refer to the CMS Web site at: http://www.cms.gov/apps/physician-fee-schedule/

Bilateral Surgery Indicators and Claim Submission

Bilateral Indicator	Definition	Submission Instructions
0	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50.
1	Reimbursement of 150% for bilateral procedure applies	Submit a bilateral procedure on a single detail line with CPT modifier “50” and a quantity of “1.” OR same CPT4 code on two lines, one with modifier LT the other with RT, each line item containing 1 unit of service.
2	If a CPT4 is not exempt from multiple procedure discounting, then a reduction will occur (100%, 50%, 50% and so on).	It is not appropriate to submit these procedure codes with modifier 50.
3	The usual payment adjustment for bilateral procedures does not apply.	Submit the procedure on a single line with a quantity of 2 or on two separate lines with modifiers RT and LT.
9	Bilateral concept does not apply.	It is not appropriate to submit these procedure codes with modifier 50.

If you have additional questions, please contact your Service Specialist.

APPLIES TO:

All contracted providers billing on 837P or CMS 1500 format / All products

Subject: Global Surgical Follow Up Care

Number: MCM/G01
Approved: MCM Steering Committee
Approved: January 1995
Effective date: January 1995
Reviewed: November 2013

EXPLANATION:

Surgical procedures have a defined "follow up" period. Under this guideline follow up visits performed within the indicated period are considered included as part of the reimbursement for the surgery performed by the same physician/surgeon. HealthPartners follows Medicare surgical follow-up periods.

COVERAGE:

Those visits billed within the follow up period will be denied.

ADMINISTRATIVE PROCESS:

ClaimCheck®/Historical Auditing will deny those visits billed within the global period defined by CPT code. This policy is automated.

APPLIES TO:

All products / All providers

Subject: Multiple Surgery

Number: MCM/M02
Approved: MCM
Effective date: July 1993
Last Updated: March 1995
Reviewed: November 2013

EXPLANATION:

Allowable multiple surgical procedures are reduced based on highest dollar billed order: 100%, 50%, 50%, 50%, etc., regardless of separate site of multiple incisions.

ADMINISTRATIVE PROCESS:

Allowable secondary, tertiary, etc., surgical procedures will be reduced to allow 50% of the fee schedule or billed amount, whichever is less, regardless of separate site or multiple incisions.

This multiple surgery pricing is automated.

APPLIES TO:

All products / All providers

Subject: Surgical Trays

Number: MCM/S01
Approved: MCM
Effective date: June 1994
Reviewed: November 2013

EXPLANATION:

Surgical supplies are not reimbursable when billed with an allowable procedure.

COVERAGE:

Procedure A4550 is considered to be integral to all surgical procedures listed in the CPT manual, and select medical procedures and radiological exams that require the use of surgical trays and supplies. It is assumed that these procedures will be performed in a hospital, outpatient, or surgicenter setting and that the supplies will be provided by the management of those facilities. When a procedure is performed in a physician's office, hospital surgicenter or outpatient setting, the supplies and materials essential for the performance of the procedure are not considered over and above the basic value of the service being rendered, and additional reimbursement to the physician is not warranted.

ADMINISTRATIVE POLICY:

HCPCS code A4550 Surgical supplies will be denied when billed with a surgical procedure and select medical and radiological procedures.

APPLIES TO:

All products / All providers

Additional Claims Policies (Alphabetical Listing)

- Interpreter Services for HealthPartners Care Members
- MinnesotaCare Tax
- Reporting Suspicions of Fraud and Abuse

Subject: Interpreter Services for HealthPartners Care Members (Spoken and Sign Language)

Effective: January 2000
Last Updated: October 2008
Reviewed: November 2013

EXPLANATION:

Language interpreter services and sign language interpreter services are covered for members in the HealthPartners Care and Minnesota Senior Health Options (MSHO) plans only.

ADMINISTRATIVE PROCESS:

Coding and Billing:

Services should be billed on a CMS 1500 form or 837P.

Subject: MinnesotaCare Tax

Effective: January 2000
Last Updated: November 2010
Reviewed: November 2013

EXPLANATION:

MinnesotaCare allows provider groups to transfer the additional expense generated by MinnesotaCare taxation to third party purchasers, such as HealthPartners

ADMINISTRATIVE PROCESS:

HealthPartners pays the MinnesotaCare Tax to its contracted providers on a claim-by-claim, line-by-line basis.

Subject: Reporting Suspicions of Fraud and Abuse

Effective: May 2003
Reviewed: November 2013

EXPLANATION:

The Fraud Hotline phone number provides members, providers and employer groups the option to report reasonable and good faith suspicions or concerns regarding possible fraudulent claims activity.

The Hotline gives the caller the opportunity to leave a confidential message that will be investigated by the HealthPartners Claims Special Investigations Unit (SIU).

ADMINISTRATIVE PROCESS:

Contact the Claims Fraud Hotline at 952-883-5099 regarding any suspicions or concerns about possible fraudulent claims activity.

You can also call our Member Services number (located on the back of your insurance card) and ask to be transferred to the fraud and abuse hotline. You may remain anonymous.

You may also mail, fax or E-Mail us at:

HealthPartners Special Investigations Unit (SIU)

Mail route 25110F
P.O. Box 1289
Minneapolis, MN 55440-1289
Fax: 651-265-1333
Email: reportfraud@healthpartners.com

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Provider Recommendation For Further Services

Guidelines for referrals (Recommendation for further services)

HealthPartners offers many types of plans to meet the needs of employers and individuals. Most plans with an open access network do not require referrals, however, some product types and primary clinic based plans may require referrals to process claims.

Providers are encouraged to check eligibility and contact Member Serices to determine if referrals are required. Eligibility may be checked on the Provider Portal at www.HealthPartners.com/provider/. After logging in, select *Eligibility* from the drop down menu under the heading *Applications*.

Primary care clinics may enter referrals. The preferred method for referral submission is online through the Provider Portal using the Referral Maintenance Application at www.HealthPartners.com/provider. After logging in, select Referral Inquiry or Referral Maintenance to create, update, view and retrieve/answer Referral Authorization Inquiries (RAI). Otherwise a referral can be made by completing a *Provider Recommendation Form* (next page) and faxing or mailing it to the Claims department.

Importance of primary care clinics responding to all RAIs

An RAI is generated when a member receives services outside of their assigned primary clinic's specialty referral network. To process claims primary care providers need to respond to these RAI's even if the care was not referred by the primary clinic care system. RAI notifications are sent to providers via the Provider Portal. There is no indicator on the portal that an RAI has been sent when you log on so it is important to check your work queues regularly to view and respond to RAI's.

For the HealthPartners Transplant Centers of Excellence, HealthPartners Direct Access Mental Health Network, HealthPartners Referral Mental Health Network, the WLS (Weight Loss Surgery) Designated Network, Low Back Pain or other designated networks, please note that the current policies and procedures in place regarding prior authorization or referrals (Recommendation For Further Services) remain in effect.

Provider Recommendation Form

General Instructions: _____ **New Referral** _____ **Revision to Current Referral**

- Enter one Provider/Authorization per form
- Please Print
- Complete all sections. Failure to complete all sections may result in delay of entry of this authorization.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Member Number: _____

SERVICE INFORMATION

Start Date for Services: _____ Expiration Date for Services: _____

Type of Visit: (Please check one) _____ Inpatient _____ Outpatient

Number of visits if outpatient: _____

Diagnosis (ICD9 Code): Primary _____

4 Digit Service Category Code __ __ __ __ **(Refer to Service Category List on following pages for this 4 Digit Code)**

Authorization Status: _____ Approved _____ Denied Reason for Denial: _____

_____

Please check those that apply:

_____ Workers' Comp _____ MVA _____ Third Party _____ Other Insurance

_____ Medicare Primary Medicare Number: _____

PROVIDER INFORMATION

Referred To:

Facility Name: _____ Federal Tax Id# _____

Facility NPI#: _____

Address or Site: _____

Phone # _____ Professional's Name: _____

Referred By:

Professional's Name: _____ Professional's NPI#: _____

Facility Name: _____

Form Completed By:

Name: _____ Phone: _____

Fax : _____ Date: _____

NOTE: Preferred method for referral submission is online via the Provider Portal using the Referral Maintenance Application. After logging into the Portal, select *Referral Maintenance* from the drop down box under *Application* in the header bar healthpartners.com/provider Please fax form to HealthPartners Claims Department, Attn: Referral Entry 651-265-1220 –or- Mail form to HealthPartners Inc, Attn: Referral Entry, P.O. Box 1289, Minneapolis, MN 55440-1289

Service Category List

Consultations

Service Code	Service Category Name	Service Category Definition	Auth Type
1001	Consult Dx, Test, & Treat (No CT/MRI)	In office consultations, diagnostic testing, and treatment (excluding CT Scan & MRI).	OP
1003	Consult-1 visit (No test/treatment)	One visit consultations, follow-up visits, and second opinions-Excluding testing & treatment.	OP
1007	Consult and Treat (No Tests)	In office consultations and treatment, excluding tests.	OP
1008	Consult and Tests (No CT/MRI)	In office consultations and testing (excluding CT Scan & MRI), excluding treatment.	OP
1103	Consult In-Patient Pro-Fees	Inpatient professional visits. An Inpatient facility auth will generate when this category is used by clinic administrative groups.	OP
1104	Same day Procedures & Ancillary Charges	Use for procedures performed on an outpatient basis.	OP
1201	OB Total	Obstetric Care including visits and delivery.	OP

Tests

Service Code	Service Category Name	Service Category Definition	Auth Type
1607	Test-(no CT/MRI)	Tests excluding CT Scan and MRI.	OP
1711	Test-CT Scan	CT Scan testing only.	OP
1803	Test-MRI	MRI Testing only.	OP
2201	Sleep Studies	Sleep Studies performed at sleep centers.	OP

Allergy Testing

Service Code	Service Category Name	Service Category Definition	Auth Type
3701	Allergy Injection Only	Allergy Injection Only	OP
3702	Allergy Serum Only	Allergy Serum Only	OP

Service Category List (continued)

Therapies

Service Code	Service Category Name	Service Category Definition	Auth Type
1501	Therapy-Radiation	Radiation Therapy	OP
1502	Therapy-Physical	Physical Therapy	OP
1503	Therapy-Chiropractic	Chiropractic Care	OP
1506	Therapy-Speech	Speech Therapy	OP
1509	Therapy-Dialysis	Dialysis Services	OP
1510	Therapy-Rehab	Rehabilitation Therapy	OP
1511	Therapy-Respiratory	Respiratory Therapy	OP
1512	Therapy-Chemo	Chemo Therapy	OP
1513	Therapy-Occupational	Occupational Therapy	OP

Infertility

Service Code	Service Category Name	Service Category Definition	Auth Type
3201	Infertility-DX eval only	Infertility diagnostic evaluation only.	OP
3202	Infertility-Treatment	Infertility treatment only.	OP
3203	Infertility-Artificial Insemination	Infertility-Artificial Insemination	OP

Miscellaneous

Service Code	Service Category Name	Service Category Definition	Auth Type
2502	Facility Charges	Facility charges for outpatient, emergency room, urgent care and holding bed.	OP
2601	Blood Transfusion	Blood transfusion	OP
3301	Interpreter-Language & Sign	Language & Sign Interpreter services	OP
3601	Reconstructive Surgery	Reconstructive Surgery	OP

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Resources to help you provide great care to patients from all cultures

HealthPartners is committed to recognizing each other's cultural values in every human interaction– doctor and patient, interpreter and nurse, family member and chaplain, staff and customer – you name it.

Starting a health outreach program

Q: How do I start a health outreach program?

A: There are four critical steps to an effective health outreach program, no matter what health message you are trying to convey, or to whom.

- Gather background information about the community that you want to serve.
- Assess your own organization.
- Establish contacts and develop relationships with community members and organizations.
- Plan and implement your outreach program.

Learn about the Community and Yourself

There are some obvious ways to start learning about communities that are unfamiliar to you. Start picking up cultural community newspapers. For instance, the Hmong Times is one of several newspapers the cover the local Hmong Community. Lavender is a newspaper for the area's gay, lesbian, bi- and transsexual community. Attend community events and celebrations to chat informally with people, and to learn about the community's geography and key institutions. Consult with local academics, health and social service professionals and influential figures within the community. Check the internet, the public library and medical or academic journals.

But don't forget to look at your own work area as well. Are your colleagues willing and prepared to take on an outreach effort? Are any members of the target group on your staff? If not, your claim that you're interested in the community might fairly be taken with a large dose of sale.

Build Relationships

Before you host your first event or print your first flyer, work to develop solid relationships with key community members and institutions. Meet with key leaders to learn about their perspectives, but also make it a point to talk to a broad range of people in the community. The leaders who are most easily found might not be the most influential. Conduct focus groups or a survey. Develop a network of professionals who provide similar services to the community.

Don't be surprised if your fist attempts to meet with people are viewed with suspicion or hostility. Many communities have experience with health researchers and institutions that want to do something to them, rather than with them. Finally, listen to what people say. If you're told repeatedly that the community neither needs nor wants your program, it's time to go back to the drawing board.

Plan and Implement a Program

Start with your health care facility or program's image. Do your logo, phone messages and office decoration suggest that you deal only with one race or gender? Do you have an advisory board of community members that can help guide you toward success? Are any of your program managers or staff from the community you hope to influence?

Consider collaborating with volunteers in your target community, or with faith-based organizations. If you're developing a media campaign, make sure that it's focused on media that are used and respected by your target audience. Be aware of inexpensive opportunities, such as taking a booth at a community event, that allow you to

get the word out and to make more community contacts. Take a look at using community-based peer educators - they've been shown to be very effective at delivering health outreach messages.

Resources

Getting the Word Out: Effective Health Outreach to Cultural Communities
Thanks to Medtronic Foundation for the advice above, discussed in much greater detail in this manual.

Translated Materials

Translated Appointment, Shots, Lab and Survey Forms

Here's another way to better serve patients who struggle with English. You can use the following forms in English, Hmong, Oromo, Spanish, Somali and Vietnamese to remind patients of lab tests, appointments for adults and children, or lab tests. You'll also find a patient satisfaction survey. It's another step we're taking to ensure equal access to quality health care by people of all cultures and languages.

How to use this material:

Print the appropriate document and fill in the blanks. If sending an appointment, lab or shots letter, underline what the patient needs. Print and fill in the English version also, so that staff or English-reading family members know the content of the letter.

English Forms

Adult Shots - English
Appointment - English
Child Appointment - English
Lab Test - English
Survey - English

Hmong Forms

Adult Shots - Hmong
Appointment - Hmong
Child Appointment - Hmong
Lab Test - Hmong
Survey - Hmong

Oromo Forms

Adult Shots - Oromo
Appointment - Oromo
Child Appointment - Oromo
Lab Test - Oromo
Survey - Oromo

Somali Forms

Adult Shots - Somali
Appointment - Somali
Child Appointment - Somali
Lab Test - Somali
Survey - Somali

Spanish Forms

Adult Shots - Spanish
Appointment - Spanish
Child Appointment - Spanish
Lab Test - Spanish
Survey - Spanish

Vietnamese Forms

Adult Shots - Vietnamese
Appointment - Vietnamese

Frequently Asked Questions

1. Where can I find out more about the health of a particular group of people?
2. How should I talk about death with patients from different cultures?
3. Where can I find out more about how different diseases affect different groups?
4. Why should I use a professional interpreter rather than a patient's family member or friend?

Stumped by how to deal with end-of-life issues with a Native American patient and family?
Wondering when you really need an interpreter?

Here's the place to look for answers to frequently asked questions in cross-cultural care.

1. Where can I find out more about the health of a particular group of people?

   A. Here are some links to information on racial, ethnic and sexually-identified groups.

   - Sub-Saharan Africans, including Somalis
   - Hispanics/Latinos
   - African Americans
   - Native Americans
   - Asians, including Hmong
   - Pacific Islanders
   - West Asians/Middle Easterners
   - Eastern Europeans
   - Gay, Lesbian, Bisexual, Transgender and Intersex Patients

2. How should I talk about death with patients from different cultures?

A. Here's some advice from Rev. Don Patterson, Regions Hospital Pastoral Care who has years of experience in comforting families and counseling patients as they approach death. The law, and the cultural traditions of Western medicine, hold that patients should be fully informed about their medical condition and participate to the extent they are able in devising a treatment plan.

When words can hurt
Patients from other countries and traditions don't necessarily share those assumptions. In some Native American traditions, for example, discussing the possibility of death frankly is seen as setting in motion cosmic forces that make death more likely, says Patterson.

Who decides?
Western notions of medical decision-making don't necessarily correspond with those from other countries and traditions. People from some Middle Eastern and Asian cultures assume that end-of-life decisions will be made by male elders, not by the patient, nor by a female spouse.

Cultural Norms, Individual Differences
There will always be tremendous variation in the beliefs of individuals within any culture. Patterson is no longer surprised if the priest who blesses a terminally ill Christian Hmong patient is hardly out the door before a shaman appears.

Ask questions
The key is use an "and/also" approach to care rather than "either/or. The best approach is put yourself into the role of student, Patterson advises. The patient and the family are your teachers. Ask them how they make important decisions. Ask what they want and don't want to know. Ask what ceremonies or actions are critical to them.

Be Flexible. Be Creative.
In many cases, even desires that seem initially impossible to honor within a hospital can be met, says Patterson. He ministered to a Native American family that wanted to perform a ceremony with smoldering sweet grass within an intensive care unit. The obvious risk of fire in proximity to oxygen tanks was just one of many concerns. But Patterson found a compromise that satisfied both the family and medical staff. Smoke from sweet grass burned outside was captured in a bottle. At the critical moment in the ceremony later held at the patient's bedside, the bottle was opened, releasing a trace of the smoke.

3. Where can I find out more about how different diseases affect different groups?

   A. Many conditions and diseases occur at different rates in different populations. For instance, Vietnamese-American women have the country's highest rates of cervical cancer. Africans and Asians are commonly lactose intolerant. You can find an excellent introduction to this subject, with common health problems sorted by race and ethnicity, in the federal government's site, the Provider's Guide to Quality and Culture.

4. Why should I use a professional interpreter rather than a patient's family member or friend?

   A. You should call an interpreter unless the patient refuses. Here's why:

Accuracy: X-Rayed or Microwaved?
In one study using ad hoc interpreters, between a quarter and half of the words and phrases were incorrectly communicated. A Minneapolis teenager translating for his mother told her she was going to be microwaved instead of x-rayed. Clear communication leads to more accurate diagnosis and treatment.

Ethical Care
Use of family members and friends as interpreters strips patients of confidentiality and privacy and it can reap inaccurate information, if the patient is embarrassed to reveal personal information to a relative or friend.

It's the Law
The federal Office of Civil Rights has consistently ruled that trained and qualified interpreters must be provided in health care settings. Courts have held that a physician's failure to overcome language barriers for non-English speaking patients can establish a lack of informed consent to treatment. Judges have ruled that doctors are responsible for making certain that they fully understand the complaints of patients, whether or not the patient speaks English.

Resources

Bridging the Language Gap: Meeting the Need for Interpreters in Minnesota
Available from the Center for Cross-Cultural Health. Call 612-379-3573, or e-mail ccch@crosshealth.com

Where to find language services

Medical providers who receive funding from Medicaid or Medicare are required to provide interpreter services under Title VI of the Civil Rights Act of 1964.

The federal law requires clinics to provide access to health care services, including language interpreting services, for all patients who have limited English proficiency (LEP), not only those patients who are actually enrolled in a public financial health program.

Under the law, health care providers need to notify all LEP patients regarding their right to language assistance services and to provide them

HealthPartners has providers who speak 63 languages from American Sign Language to Yiddish. Search by language for a doctor or dentist in HealthPartners network

Interpreter services in Minnesota:

Kim Tong Translation Service
2994 Rice St.
Little Canada, MN 55113
Phone: 651-252-3200
Fax: 651-252-3214
24 Hour Service
Face to face and phone interpretation

Website: *http://kttsmn.com/*

Itasca Corporation
1560 Livingston Ave
uite 101
est St. Paul, MN 55118
Phone: 651-457-7400
Fax: 651-457-7700
24 Hour Service

Website: *http://www.itascacorp.biz*

The Language Banc
1625 Park Ave
Minneapolis MN 55404
Phone: 612-588-9410
Fax 612-588-9420
24 Hour Service

Website: *http://www.thelanguagebanc.com*

The Minnesota Language Connection, INC
International Court Building
2550 University Ave W, Suite 245-N
Saint Paul, MN 55114
Phone:(651)644-7100
Fax: (651)644-7600
24 Hour Service

Website: *www.MinnesotaLanguageConnection.com*

The Bridge World Language Center, Inc.
110 2nd St S Ste 213
Waite Park, MN 56387
Phone: (320) 259-9239
Fax: (320) 654-1698
24 Hour Service

Website: *http://www.bridgelanguage.com*

Garden and Associates
4301 Highway 7 Suite 140
St. Louis Park, MN 55416
Phone: 952-920-6160
Fax: 952-922-8150
24 Hour Service
Website: *http://www.gardentranslation.com/*

Arch Language
1885 University Avenue West, Suite 75
Saint Paul, MN 55104
Phone: (651) 789-7897
Fax: (651) 789-7898
24 Hour Service

Website: *www.ArchLanguage.com*

Telephone interpreter services: The Language Line provides 24 hour interpreter service for more than 150 languages. To use the service, providers must supply the organization name and a personal code. Call 800-874-9426. For emergencies call 800-523-1786.