Hennepin Health
your community health plan

Provider Manual

2025

612-596-1036, press 2

hennepinhealth.org

Hennepin Health
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Contents

Table of contents

Table of contents

Table of contents

Summary of content changes

Date	Change detail	Section	Type of content changes		
			Update	New	Deletion
10/31/2025	Updated Housing Stabilization Services information	Section 10	X		
Sept. 2025	Added Section 7.3 certified family peer specialists, updated list of interpreter agencies in Section 3.6	Sections 3.6, 7.3	X	X	
7/3/2025	Updated contact information for Restricted Recipient Program, added Recuperative Care Services as Section 6.10	Sections 6.10, 14	X	X	
4/10/2025	Content updates for hearing, DME, and SUD	Sections 5.4, 6.3, 7.2	X		X
12/31/2024	Annual updates throughout manual	All sections	X	X	X
7/8/2024	Content updates	Sections 6.6, 18	X		
3/14/2024	Content updates for optical, hearing, DME and claims	Sections 5.3, 5.4, 6.3, 17.3	X		
1/1/2024	Annual updates throughout manual	All sections	X	X	X
9/1/2023	Updated authorization list text	Section 6.1	X		
6/13/2023	Updated authorization grid	Section 6.1	X		

Section 1: Introduction to Hennepin Health

Hennepin Health provides health care coverage to Hennepin County residents who are enrolled in a Minnesota Health Care Program. Hennepin Health is a nonprofit, state-certified health maintenance organization that contracts with the Minnesota Department of Human Services. More information about Hennepin Health is available on hennepinhealth.org.

Section 2: Enrollment

Members may go to any clinic within the Hennepin Health network for covered services without a referral. Members will receive an identification (ID) card that must be presented at the time of service.

ID cards will state the product type: Hennepin Health-PMAP, Hennepin Health-MinnesotaCare or Hennepin Health-SNBC.

2.1 Product/plan overview

Hennepin Health offers three products/plans for residents of Hennepin County.

Hennepin Health – PMAP

Hennepin Health-PMAP is a managed care plan that offers medical, behavioral, health and social services to Hennepin County residents. To be eligible for Hennepin Health, members must live in Hennepin County, be between the ages of 0 and 64, and be eligible for Medical Assistance (Medicaid).

Hennepin Health – MinnesotaCare

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

Hennepin Health-SNBC

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

Every Hennepin Health-SNBC member is assigned a care guide who assesses the member's needs, provides care coordination services, and serves as a point of contact for the health plan.

2.2 Eligibility

Providers may access information via MN-ITS. If you need to speak directly with someone regarding eligibility, call Hennepin Health Provider Services at 612-596-1036 (800-647-0550), TTY 711 or 800-627-3529. Hennepin Health member eligibility information can also be confirmed on the Hennepin Health Provider portal; see Section 21.2 for more information.

Section 3: Services

3.1 Member rights

- Members will be treated with respect, dignity and consideration for privacy.
- Members shall not be discriminated against based on race, gender, age, religion, sexual preference, national origin, genetic information or health status.
- Members may receive information provided in a format that works for them (translated, Braille, large print or other alternate formats).
- Members' medical information will be kept private according to law.
- Members may choose where to get family planning services, infertility diagnoses, sexually transmitted disease testing and treatment services, and AIDS and HIV testing services. Members may know their treatment and treatment options and participate in decisions regarding their health care.
- Members may request advance directives such as a living will or power of attorney for health care and get written instructions on health care directives.
- Members may register a formal appeal or grievance with Hennepin Health if they have concerns or problems related to their health care coverage or file with the Minnesota Department of Health (MDH). See Section 16 for more information.
- Members may request information about Hennepin Health, Hennepin Health products/plans, providers, physician incentives, drug coverage and health care costs.
- Members may request information about how Hennepin Health pays providers.
- Members may request survey results, if one is required because of Hennepin Health's physician incentive plan, as well as any external quality review study results via the state.
- Members may refuse treatment and receive information about what could happen if they refuse treatment. Members may refuse care from specific providers.
- Members may request and receive a copy of their medical records. They also may ask to have records corrected in the event an error occurs.
- Members will receive a notice if Hennepin Health denies, reduces or stops a service or payment for a service.
- Hennepin Health members/authorized representatives and medical practitioners appealing UM decisions must first file an appeal with Hennepin Health.
- Members may file a grievance at any time.
- Members may request a copy of their handbook (formerly known as the Evidence of Coverage) at least once a year.
- Members may make recommendations about Hennepin Health's rights and responsibilities policies.

3.2 Access to care rights

- Members have the right to receive emergency and urgent care without authorization from Hennepin Health.
- Members have the right to access primary care within 30 minutes or 30 miles of their residence, and hospital services within 60 minutes or 60 miles of their residence. If

network providers are not available within this distance, a service authorization will be approved for receiving care outside of the service area upon notifying Hennepin Health.
- Members have the right to continuity of care, which includes ongoing primary, specialty and maintenance care. Maintenance care includes renal dialysis services provided to members temporarily outside of the Hennepin Health service area.
- Members have the right to receive health care 24 hours a day, seven days a week.
- Members have the right to direct access to mammography screening and influenza vaccinations from an in-network provider.
- Female members have the right to direct access to a network of women's health specialists for routine and preventive services.
- Members have the right to receive a clear explanation of covered nursing home and home care services.
- Members have the right to information about Hennepin Health, Hennepin Health's provider network and covered services.
- Members have the right to choose where they will receive family planning services.
- Members have the right to get a second opinion for medical, mental health and substance use disorder services. See Section 5.5 for more information.

3.3 Health care rights

- Members do not need a referral from a primary care provider to receive services from a specialist within the Hennepin Health service area.
- Members have the right to age-specific vaccinations without a copay.
- Members have the right to receive a health assessment.
- Members have the right to receive health care that is delivered in a culturally competent manner.
- Members have the right to be informed of health conditions that require follow-up and training in self-care as appropriate.
- Members have the right to be free of restraints or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Members have the right to make decisions about their health care.

3.4 Notification rights

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

3.5 Hennepin Health programs

Hennepin Health offers programs geared toward supporting the overall health and well-being of its members. An overview of rewards and wellness programs can be found on the Hennepin Health website at Rewards and wellness | Hennepin Health.

YMCA of the North membership

Hennepin Health-SNBC members have the option of using any YMCA within the Twin Cities metro area where they can benefit from access to group classes and a variety of exercise equipment.

Members also receive one personal training consultation. To get started, Hennepin Health-SNBC members need to present their Hennepin Health-SNBC ID card at any metro YMCA during regular business hours.

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

3.6 Interpreter services

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

Types of interpreter services include:

- Face to face
- Telephonic interpreting
- Sign language

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

- Medical clinic
- Urgent care
- Dental clinic
- Pharmacy
- Outpatient hospital
- Emergency department
- Ambulatory surgical center
- Home care
- Dialysis facility

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

Hennepin Health contracted interpreter agencies:

- All in One Translation: 952-435-0799
- A-Z Friendly Languages: 763-566-4312
- Global Language Connections: 612-249-6100
- Language Line Services, Inc.: 888-259-5761
- Surad Interpreting & Translation: 612-872-8059
- University Language Center: 952-224-5600

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

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

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

3.7 Transportation

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

Bus and metro transit

- Members may be issued a 31-day bus pass if they have four or more medical/dental appointments within a 31-day period. If the member has less than four medical/dental appointments, they will be issued single bus passes.
- All appointments must be verified prior to authorizing bus passes (bus passes are issued in advance of appointments).
- If a provider has a patient who may be in need for transportation services other than public transportation, please contact Member Services at 612-596-1036.
- Taxi rides will not be given to a member with a 31-day pass unless the member has to undergo sedation or an emergency situation arises.

Taxis

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

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

Special transportation

- All special transportation services require a service authorization.
- All medical appointments must be verified prior to authorizing special transportation.
- At the request of a provider, Hennepin Health will authorize monthly rides (as an exception) for members receiving ongoing treatment such as dialysis.
- Members and providers must call Hennepin Health Member Services three days prior to an appointment to schedule a ride unless it is an urgent same-day appointment for immediate care that is non-life threatening or to go to the nearest emergency room. Please call 911 for life-threatening situations.

Basic life support (BLS)

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

Advanced life support (ALS)

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

Section 4: Service authorization

Hennepin Health collaborates with providers to coordinate health care services to ensure members are receiving quality, cost-effective and medically appropriate health care. Service types covered under this section include durable medical equipment (DME), home health care, home IV infusions, surgical procedures (e.g., transplants, reconstructive surgeries) and more. Hennepin Health's prior authorization requirements are noted on the Prior authorization page which can be found under the "Providers" tab of the Hennepin Health website. Service authorization requirements are subject to change based on, but not limited to, state or federal changes (by directive or legislation). Service authorizations apply to:

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

Service authorization process

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

Standard authorization determination

Hennepin Health will process completed requests for service within 10 business days of receipt. Hennepin Health will request further information, if necessary, to assist with the determination. If Hennepin Health is unable to obtain all necessary information to make a determination within 10 business days, the provider request may be denied for lack of information.

If the review of a provider request results in an adverse determination, the provider will be notified by phone or fax within one business day of the decision. A denial notice will be mailed to the provider and member within 10 business days of the receipt of the request. The denial notice will include instructions on how to appeal the adverse decision.

Expedited service authorization determination

To be considered for an expedited service authorization determination, fax a service authorization request form along with required clinical documentation to 612-677-6222 and mark the request as "urgent".

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

Hennepin Health will respond to expedited service authorization requests as follows:

- If a physician believes that waiting for a decision under the standard timeframe could jeopardize a member's life, health, or ability to regain maximum function, Hennepin Health will proceed with an expedited review.
- Hennepin Health will resolve each request as promptly as the member's health requires, but no later than 72 hours after receipt.
- If a service has already been provided, the request will not be processed as expedited.

- If an adverse determination is made for an expedited service authorization request, members and providers will be notified of the decision to deny a request by phone or fax within one day of the decision.
- A written notification will be mailed to members and providers within 72 hours of receipt of the expedited request.
- The notice will inform members of the right to appeal including the process to submit an expedited appeal request.

Retrospective service authorization determination

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

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

Disclosure of review criteria/reviewer credentials

Upon request, Hennepin Health will provide members, physicians and/or providers criteria used to determine the medical necessity, appropriateness and efficacy of a procedure or service. The qualifications of the reviewers, including any license, certification or specialty designation, will be made available upon request.

Continuity of care/transition of care

Hennepin Health provides, upon request, authorization to receive covered health care services from a non-contracted provider for up to 120 days from the member's eligibility with Hennepin Health if the member is engaged in a current course of treatment for one or more of the following conditions:

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

Hennepin Health also provides transitional services for members new to the health plan. If a member becomes eligible with Hennepin Health and the prior managed care organization (MCO) or the state authorized services, Hennepin Health will honor the previous authorization. If previously approved services are being provided by a non-contracted practitioner, Hennepin Health may require the member to transition services to a Hennepin Health contracted provider at the end of the authorization period.

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

Service authorization forms/instructions

Service authorization forms can be found on the prior authorization page of the Hennepin Health website. Providers may also call Customer Service at 800-647-0550 or 612-596-1036, press 2. Hennepin Health has multiple authorization request forms tailored to specific types of requests. Authorization forms include:

- Service authorization form: Providers should submit this form when requesting authorization for services identified on Hennepin Health's prior authorization list.
- Continuity of care form: Non-contracted providers should submit this form when requesting authorization for continued out-of-network services for members who are newly eligible with Hennepin Health.
- Partner provider out-of-network referral form: Hennepin Healthcare and NorthPoint Health and Wellness providers should submit this request form when referring members to non-contracted providers.

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

Billing instructions

When billing for covered services requiring a service authorization, include the authorization number on all claims.

For more billing information, see Section 19 of this manual.

Telehealth services

Hennepin Health outlines telehealth information and resources on the Hennepin Health website at telehealth resources (hennepinhealth.org).

Utilization and incentives

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

4.1 Authorization requirements list

Services that require authorization from, or notification to, Hennepin Health are listed on Hennepin Health's prior authorization webpage.

Please note the following important information regarding authorization requests:

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

- Hennepin Health reserves the right to review and verify medical necessity for all services.
- For services that require authorization, failing to obtain the authorization in advance may result in a denied claim.

If you have a denied claim, please reach out to Hennepin Health's Provider Service team for questions or information at 612-596-1036, press 2.

Section 5: Clinic/physician services

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

- Physician services, including family practice, internal medicine, OB/Gyn, pediatric and specialty providers (e.g., cardiology, urology, neurology, orthopedic, etc.)
- Nurse practitioner services (includes certified nurse practitioner (CNP))
- Physician assistant services
- Preventive health services
- Family planning services
- Early periodic screening, diagnosis, and treatment services, also known as Child & Teen Checkups
- Dental services
- Prenatal care services
- Screening, brief intervention and referral to treatment (SBIRT)

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

5.1 Child and adolescent services

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

Covered services

- Assessment of physical growth
- Vision screening
- Hearing screening
- Health history
- Developmental and behavioral assessment
- Physical examination
- Nutritional assessment
- Immunization and review
- Laboratory tests
- Health education and anticipatory guidance
- Dental services according to the C&TC dental periodicity schedule
- Vaccine counseling only visits

A C&TC visit is not considered complete unless it includes a HIPAA-compliant referral code which must be included on the encounter claim.

Diagnostic services include up to three maternal depression screenings that occur during a pediatric visit for a child under age one.

Periodicity schedule

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

Service authorization requirements

There are no prior authorizations requirements for C&TC services.

Provider network

C&TC services must be obtained from a contracted, in-network provider.

5.2 Chiropractic services

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

Covered services

- Medically necessary manual manipulations of the spine for the treatment of incomplete or partial dislocations and X-rays.
- Initial exam to diagnose subluxation of the spine.
- Twenty-four spinal manipulations per calendar year. Additional treatments require an authorization from Hennepin Health.
- Spinal X-rays when needed to diagnose subluxation.

Non-covered services

- Acupressure
- Laboratory services
- Medical supplies and equipment supplied or prescribed by a chiropractor
- Physiotherapy modalities, including diathermy and ultrasound
- Treatment for neurogenic or congenital condition not related to a diagnosis of subluxation
- Vitamins or nutritional supplements or counseling
- Adjustments other than manipulations for subluxation
- Any evaluation & management (E&M) exams after the initial exam
- Maintenance therapy
- Any X-rays exceeding the initial X-ray to diagnose subluxation

Service authorization requirements

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

Provider network

Chiropractic services are considered open access. Hennepin Health members are not required to access services from a contracted, in-network provider.

5.3 Optical services

Optical services include routine eye exams (i.e., preventative care), glasses/lenses, frames, contact lenses and specialty care. An eye exam entails an evaluation of vision and vision problems, as well as prescriptions for eyeglasses. Eyewear is defined as vision aids prescribed by an optometrist or ophthalmologist.

Covered services

- Medicaid covered eyeglass frames and lenses.
- Deluxe frames only for members 21 years or older diagnosed with cognitive disabilities or seizure disorders.
- Eyeglass repairs: Hennepin Health will pay for repairs to member's eyeglasses when not covered under warranty. This includes eyeglasses not purchased through Hennepin Health if the eyeglasses are medically necessary and the repair is cost-effective.
- Eyeglass replacements are covered for the following reasons:
    - There is a change in correction of 0.5 diopters or greater in either sphere or cylinder power in either eye.
    - There is a shift in axis of greater than 10 degrees in either eye.
    - A comprehensive or intermediate vision examination shows that a change in eyeglasses is medically necessary. For purposes of this part, "change in eyeglasses" means a change in prescription.
    - A change in the member's head size warrants a new pair of eyeglasses.
    - The member has had an allergic reaction to the previous pair of eyeglass frames.
    - The member's eyeglasses are lost, broken or irreparably damaged. In this case, the dispensing provider must obtain a written statement explaining this from the member or their caregiver. An identical pair of eyeglasses will be provided unless the identical frame is not available through the contract vendor.
- Glass, plastic or polycarbonate lenses for children or adults.
- Tinted, ultraviolet (UV), polarized or photochromatic lenses for certain childhood, visual or seizure conditions when standard lenses may pose a risk (a specific diagnosis is required).
- High index lenses when the correction in either eye is plus or minus 6.00 diopters or greater.
- Aspherical hand held magnifiers (3.7 X 11.0 diopter).
- Double segments (FT25, FT28), plastic or glass.
- Fresnel prism, slab off prism.
- Contacts: Medicaid covered contact lenses.
- Disposable contact lenses: Contact lenses are covered without authorization if prescribed for the diagnosis of aphakia, keratoconus, or aniseikonia. Contact lenses prescribed as bandage lenses are also covered without authorization.
    - All other diagnoses or conditions not mentioned above require authorization for contact lens services and supplies.

Non-covered services

- Replacement of frames or lenses to change the style or color
- Cosmetic services
- Dispensing services related to noncovered services
- Fashion tints or polarized lenses unless medically necessary
- Protective coating for plastic lenses
- Edge and anti-reflective coating of lenses
- Industrial, sport eyeglasses unless they are the member's only pair and are necessary for vision correction
- Invisible bifocals or progressive bifocals
- Replacement of frames due to provider error in prescribing, frame selection or measurement
- Saline or other solutions for the care of contact lenses
- Services or materials that are considered experimental or not clinically proven by prevailing community standards or customary practice
- Repair of eyeglasses during the warranty period if the repair is covered by warranty
- Backup eyeglasses or split prescription into two pairs of eyeglasses
- Transition lenses
- Reading glasses without a prescription

Service authorization requirements

There are no prior authorization requirements for optical services.

Provider network

- Routine eye exam and eye wear services must be obtained from a contracted, in-network provider
- Specialty vision services
    - SNBC members may access services from any licensed specialty provider practicing within the State of Minnesota and who accepts Medicaid members
    - PMAP/MinnesotaCare members must access specialty optical services from a contracted, in-network provider

5.4 Hearing services

Hearing devices are used to treat hearing loss that affects a member's daily activities or requires special assistance or intervention.

Covered services

- Batteries
- Ear impressions
- Ear molds, including open-dome style ear molds (not disposable) replaced approximately every three months
- Hearing aids
- Parts and accessories
- Programming/reprogramming (hearing aid checks)
- Re-casing, re-makes and shell modifications
- Chargers for rechargeable hearing aids

- Replacing battery doors and microphone protectors
- Routine hearing screening

Limitations

- One routine screening/calendar year.
- Hearing aids: Limited to one set in 5 years.
- Repairs: Only covered after manufacturer's warranty is expired. Repairs are not to exceed the value of a new hearing aid.
- Replacements: If lost, stolen, irreparably damaged, or a change in hearing, limited to two replacements in 5 years.

Non-covered services

- Replacement batteries provided on a scheduled basis regardless of actual need
- Services specified as part of the contract price when billed separately for payment, including charges for repair of hearing aids under warranty
- Routine screening of individuals or groups for identification of hearing problems
- Over the counter (OTC) hearing aids
- Separate reimbursement for postage, handling, taxes, mileage or pickup and delivery
- Disposable hearing aids, non-electronic hearing aids and battery chargers
- Alarm systems including but not limited to:
    - Vibrating bed alarms
    - Doorbell transmitters (door announcer)
    - Baby monitors
    - Personal signaling system
- Adapters for telephones, television or radio including but not limited to:
    - Telephone amplifiers
    - Amplifying phone handsets
    - Visual telephone ringers
    - Personal television and radio amplifying systems
- Hearing aid maintenance and retention products including but not limited to:
    - Swim molds/swim plugs
    - Ear plugs
    - Swimmers' headband
    - Dry aid kits and dehumidifiers
    - Moisture guard (i.e., Super Seals®)
    - Wax filters, wax guards and cerumen guards
    - Microphone protectors
    - Retention cords and safety clips such as OtoClips and Critter Clips™
- Ear care and comfort products including but not limited to:
    - Ear comfort creams
    - Ear cleansers/cleaning solutions
    - Wax removal kits/systems
    - Hearing aid pads
- Regularly scheduled maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician
- Loaner hearing aid charges
- Canal type hearing aids [in-the-canal (ITC) and completely-in-the-canal (CIC)]

- No extra charge may be made for the following:
  - Casing color choice
  - Hypo-allergenic cases
  - Soft canal casing or other shell treatments
  - Conventional or screw-set volume control

Service authorization requirements
There are no prior authorization requirements for hearing services.

Provider network
- SNBC members may access hearing services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.
- PMAP/MinnesotaCare members must access hearing services from a contracted, in-network provider.

5.5 Second opinion
Hennepin Health will pay for a second medical opinion within the Hennepin Health network upon member request or arrange for the member to obtain one outside the network, at no cost to the member.

Covered services
Second opinion office visit with a physician or provider, whether contracted or not contracted with Hennepin Health.

Non-covered services
Experimental, investigational or cosmetic services or procedures are not covered.

Service authorization requirements
Hennepin Health does not require authorization for second opinion office visits.

Provider network
Second opinion office visits are considered open access. Hennepin Health members are not required to access services from a contracted, in-network provider.

Section 6: Specialty services

6.1 Surgery services

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

Service locations

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

Exclusions and limitations

- Cosmetic surgery is not covered unless it is related to a congenital defect, previous procedures or trauma.
- Reconstructive surgery is a covered benefit when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part.
- Reconstructive breast surgery is provided if the mastectomy is medically necessary as determined by the attending physician.

Non-Covered services

- Services included in the global surgery package (office visits, labs and/or diagnostics) are not separately reimbursable
- Cosmetic surgery (except as stated above under the exclusions and limitations section)
- Hysterectomy for the sole purpose of voluntary sterilization
- Investigational/Experimental procedures

Service authorization requirements

- Gastric bypass surgery (includes revisions or replacements):
    - Biliopancreatic diversion with duodenal switch
    - Laparoscopic adjustable gastric binding
    - Rou-en-Y gastric bypass
    - Sleeve gastrectomy
- Any surgery, procedures or treatment that could be considered reconstructive, cosmetic, experimental or investigational:
    - Blepharoplasty
    - Chemical peel
    - Cryotherapy
    - Facelift
    - Lipectomy
    - Otoplasty
    - Rhinoplasty
    - Scar revision
    - Subcutaneous injection of collagen
    - Tattooing
    - TMD/TMJ procedures

    - Uvulopalatopharyngoplasty (UPPP) and laser assisted uvulopalatoplasty (LAUP) throat surgeries
- Transplants, except kidney and corneal
- Circumcision
- Gender confirmation surgery
- Insertion of penile prosthesis
- Neurostimulator implantation:
    - Cranial nerve stimulator
    - Peripheral nerve stimulator
    - Spinal cord stimulator
- Radiofrequency ablation
- Vein procedures:
    - Endovascular ablation
    - Sclerotherapy

Note: This is not an all-inclusive list.

Provider network

- SNBC members may access hearing services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.
- PMAP/MinnesotaCare members must access hearing services from a contracted, in-network provider.

6.2 Home health care services

Covered services

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

Non-covered services

- Supervision of HHA services.
- Home health aide visits for the sole purpose of providing household tasks, transportation, companionship or socialization.
- Services that are not medically necessary (determined by the UM review).
- Services provided in a hospital, nursing facility (NF) or intermediate care facility (ICF).
- More than one HHA visit per day.

Service authorization requirements

- SNBC members with Waiver: The Waiver CM will communicate home care recommendations to Hennepin Health via a 5841 form. Hennepin Health will contact the home care agency for treatment plan and authorization.
- SNBC members without a Waiver: Authorization is required for more than 9 visits per calendar year.
- PMAP/MinnesotaCare members: SNVs exceeding nine per calendar year.
- Home infusion therapy (includes medication, supplies and skilled nursing visits).

A signed order from an MD, PA, or NP must be submitted to Hennepin Health along with relevant medical records to complete a medical necessity review.

Provider network

All home care services must be provided by a Hennepin Health contracted, in-network provider.

6.3 Durable medical equipment, prosthetics, orthotics and medical supplies

Hennepin Health covers medical supplies and equipment subject to limitations, authorization and other requirements. Additional coverage restrictions apply to supply and equipment coverage for members residing in long term care (LTC) facilities including some wheelchairs, oxygen, enteral/parental nutrition, repairs, etc.

Rent for most durable medical equipment is covered up to 13 months, or to the purchase price of the equipment. After 13 months of rental or when the purchase price is reached, the item is considered the member's property.

All purchased equipment must be new upon delivery to the member. Equipment that is intended to rent until converted to purchase must be new equipment. Used equipment may be used for short-term rental, but if eventually converted to purchase must be replaced with new equipment.

DME must be ordered by a physician, physician's assistant or nurse practitioner. A signed order must be submitted along with medical records for a prior authorization review.

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

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

Covered services

Examples of covered items include but are not limited to:

- Electronic equipment for augmentative communication
- Breast pump
- Wheelchair
- Walker
- Hospital bed
- Oxygen
- Incontinence products
- Nebulizer
- PAP/CPAP
- Orthotics for the spine
- Orthotics for the hip
- Lower limb orthotics
- Upper extremity orthotics
- Cranial molding orthotics

- Prosthetic and orthotic repairs
- Seizure detection devices

Non-covered services

The DHS provider manual has a complete list of non-covered services. Examples of non-covered services include:

- Air conditioners
- Bathroom scales
- Bathtub wall rails
- Air purifiers
- Humidifiers
- A device whose primary purpose is to serve as a convenience to a person caring for the member
- A device that serves to address social and environmental factors and that does not directly address the member's physical or mental health
- A device that is supplied to the member by the physician who prescribed the device or by a provider who is an affiliate of the physician who prescribed the device
- Repair costs for a prosthetic or orthotic device that is under warranty
- Repair costs for rented equipment
- Orthotics when used to prevent injury in a previously uninjured limb
- Orthotics that are to be used only during sports or other leisure activities
- A custom fabricated orthotic when the member's needs can be met with a prefabricated orthotic
- Stance control orthotics (L2005)
- Externally powered upper extremity orthotics (L3904)
- Electronic /microprocessor-controlled orthotics including the Sensor Walk and E-MAG
- Lower limb prosthetics for recipients who have been found to have functional ability or potential functional ability of level 0
- User-adjustable heel height feature (L5990) is considered not medically necessary

Service authorization requirements

- DME, prosthetics and orthotics greater than $5,000 total billed amount
- Wheelchairs greater than $3,000 total billed amount
- Medical supplies greater than $3,000 billed amount
- Unlisted DME codes greater than $250 billed amount
- Bone growth stimulators
- Cranial electrotherapy stimulator (CES) and other neurostimulators
- Electrical stimulators
- Automatic external defibrillator (e.g., LifeVest)
- Negative pressure wound therapy (i.e., wound vacs)
- High frequency chest wall oscillation (i.e., The Vest)
- External ambulatory infusion pumps, including insulin pumps

Provider network

DME, medical supplies, orthotics and prosthetics must be provided by a Hennepin Health contracted provider.

6.4 Nursing facility care

Coverage for nursing facility services is based on the member's plan eligibility. This section is organized by plan type.

PMAP/MinnesotaCare members

Covered services

Items/services covered by Hennepin Health include (not an all-inclusive list):

- Complex medical equipment (e.g., Group 3-4 wheelchairs)
- Rehabilitation services (PT, OT, speech therapy)
- Prescription medications
- Physician, physician assistant and nurse practitioner visits

Non-covered services

- Nursing facility room and board (covered by DHS).
- A private room unless the doctor orders it for a medical reason.
- Personal comfort items such as TV, phone barber/beauty services and guest services.
- OBRA assessment.
- Hennepin Health is not responsible for payment of nursing facility services for newly eligible members who are residing in a nursing facility at the time of enrollment with Hennepin Health.

Service authorization requirements

There are no prior authorization requirements for nursing facility services for PMAP and SNBC members.

SNBC with Medicare: Medicare may be primary payer. If so, a portion of the SNF stay may be reimbursed by Medicare before Hennepin Health assumes coverage and payment.

See PAS Bulletin #17-25-06.

This is not a covered benefit for MinnesotaCare members.

Provider network

PMAP members may access nursing facility services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

SNBC members

Prior to admission to a Minnesota Medicaid-certified nursing facility, the member must go through the pre-admission screening (PAS) process accessed through the Senior Linkage Line at 800-333-2433. This process must be coordinated by a provider or provider's representative (e.g., social worker, discharge planner, etc.).

DHS pre-authorization is required for members under age 21. Hennepin Health must receive a copy of the DHS approval before moving forward with the nursing facility authorization.

Covered services

Hennepin Health covers room and board for the first 100 days of a nursing facility stay. After 100 days, DHS is responsible for coverage and payment of the nursing facility admission.

In addition to the 100 days of room and board, the following items/services are covered by Hennepin Health (not an all-inclusive list):

- Complex medical equipment (e.g., Group 3-4 wheelchairs)
- Rehabilitation services (PT, OT, speech therapy)
- Prescription medications
- Physician, physician assistant and nurse practitioner visits

Non-covered services

- Nursing facility room and board after the first 100 days.
- Services included in the per diem rate such as nursing services, use of some medical equipment, laundry and linen services, dietary services, personal hygiene items and over-the-counter medications.
- A private room unless the doctor orders it for a medical reason.
- Personal comfort items such as TV, phone, barber/beauty services and guest services.
- OBRA assessment.
- Hennepin Health is not responsible for payment of nursing facility services for newly eligible members who are residing in a nursing facility at the time of enrollment with Hennepin Health.

Service authorization requirements

Nursing facilities must fax a DHS Nursing Facility Communication (NFC) form with a copy of the completed pre-admission screening (PAS) to Hennepin Health's Utilization Management department at 612-677-6222.

Provider network

SNBC members may access nursing facility services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

6.5 Rehabilitation therapies

This section addresses coverage for rehabilitation therapies provided in an outpatient setting. For therapies provided in a home setting, refer to the Home care section of the provider manual.

Covered services

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

- Occupational therapy
- Physical therapy
- Speech-language pathology services
- Pool therapy
- Cardiac rehabilitation
- Respiratory therapy services

Non-covered services

- Specialized maintenance therapy for Hennepin Health members age 21 and over
- Art and craft activities for the purpose of recreation
- Services that are not:
    - Medically necessary

    - Documented in the member's health care record
    - Part of the member's plan of care
    - Designed to improve or maintain the functional status of a member's physical impairment, or cognitive or psychological deficit
- Services provided by a therapy aide or therapy student
- Psychosocial services
- Record keeping, documentation and travel time (the time taken to wait for and transport a member to and from therapy sessions)

Service authorization requirements

A prior authorization is ONLY required when services are being rendered by a non-contracted, out-of-network provider.

Provider network

All Hennepin Health members are required to access rehabilitation therapy services from a contracted, in-network provider.

6.6 Obstetrics, gynecology, and reproductive services

Obstetric, gynecologic and reproductive services are services and procedures that are performed by a provider to promote health and prevent disease in women. Services covered under this section also include family planning services.

Service locations

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

Covered services

- Consultation, examination, and medical treatment, including an annual preventative exam
- Contraceptive devices (e.g., diaphragm, intrauterine device (IUD))
- Contraceptive injections (e.g., Depo-Provera)
- Emergency contraception (e.g., Plan B)
- Family planning counseling
- Family planning methods (e.g., birth control pills, patch, ring, IUD, injections, implants)
- Family planning supplies with prescription (e.g., condom, sponge, foam, film, diaphragm, cap)
- Pregnancy care including prenatal, delivery and postpartum care
- Childbirth classes
- Hospital services for newborns
- Doula services by a certified doula registered with the Minnesota Department of Health (MDH)
- Services provided by a licensed health professional at licensed birth centers including certified nurse midwives and licensed traditional midwives.
- Genetic counseling
- HIV blood screening and counseling (performed before and after HIV blood screening test)

- Infertility services limited to diagnosis and treatment of medical problems causing infertility (e.g., pituitary or ovarian tumor, testicular mass)
- Laboratory examination and tests including pregnancy testing as clinically indicated
- Medical abortion: mifepristone and misoprostol billed as a pharmacy claim
- Testing for sexually transmitted infections (STIs)
- Treatment of non HIV-related STIs
- Voluntary sterilization, both female and male members and including vasectomy

Non-covered services

- Elective abortion is not covered by Hennepin Health but may be covered by DHS. Refer to the DHS provider manual for detailed coverage information.
- Artificial insemination including in-vitro fertilization (IVF).
- Fertility drugs and all associated services.
- Hysterectomy for the sole purpose of voluntary sterilization.
- Reversal of voluntary sterilization.
- Planned home births.
- Mifepristone and misoprostol, when used for a medical abortion, may not be used in the three weeks following a surgical abortion.

Service authorization requirements

A prior authorization is ONLY required when OB/GYN services that must be accessed by a contracted, in-network provider are being rendered by a non-contracted, out-of-network provider.

Provider network

Hennepin Health members have "direct access" to OB-GYN providers for the following services:

- Annual preventive health exam including follow-up exams that a qualified health care provider determines are necessary
- Maternity care
- Evaluation and treatment for gynecologic conditions or emergencies

All Hennepin Health members must receive preventative OB/GYN services and pregnancy/maternity care from a contracted, in-network provider.

PMAP/MinnesotaCare members must receive specialty OB/GYN services from a contracted, in-network provider.

SNBC members may access specialty OB/GYN services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

6.7 Medications administered in an office or outpatient hospital setting

Services include injectable medications administered in the setting of a provider office or outpatient hospital. These medications are described using J-codes and are payable by Hennepin Health under the medical benefit. These services are not payable under the pharmacy benefit.

Service authorization requirements

Some medications administered in an office or outpatient hospital setting require prior authorization. See the Hennepin Health prior authorization list for specific medications requiring authorization.

Provider network

Hennepin Health members enrolled in either a PMAP or MinnesotaCare group plan are required to access these services from a Hennepin Health contracted, in-network provider. Members enrolled in an SNBC group plan may access these services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

6.8 Hospice care services

Hospice services include a comprehensive package of services offering palliative care support to terminally ill members and their families. Hospice care offers holistic support and relief from pain and other symptoms of the terminal illness. Hospice services must be provided by a Medicare-certified hospice agency. When a Medicare-certified hospice agency is not available, services provided by a non-Medicare certified agency equivalent to those provided in a Medicare-certified hospice agency are allowed. Members choosing to receive hospice care services must make the hospice election for benefit coverage with the State of Minnesota. This hospice election process is similar to the hospice election process required by Medicare and used by Medicare-certified hospice agencies.

Members prescribed hospice care services must be certified by a physician as terminally ill (life expectancy of six months or less).

Covered services

- Physician services
- Nursing services
- Medical social services
- Counseling (bereavement counseling does not qualify for additional payment)
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Non-covered services

Members ages 22 and older waive the following services that are not covered while the member is in hospice care:

- Other forms of health care for treatment of the terminal illness for which hospice care was elected.
- Other forms of health care for a condition related to the terminal illness.

- Other hospice services or services equivalent to hospice care except those provided by the designated hospice or its contractors.
- Services provided under home and community-based services waivers that are related to the terminal illness.

Service authorization requirements
There are no prior authorization requirements for hospice services.

Provider network
All Hennepin Health members may access hospice services from any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

6.9 Early Intensive Developmental and Behavioral Intervention (EIDBI) services
Early Intensive Developmental and Behavioral Intervention (EIDBI) services offer medically necessary treatment to members under the age of 21 with autism spectrum disorder (ASD) and related conditions, enrolled in Medical Assistance (MA), MinnesotaCare, Minnesota Tax Equity and Fiscal Responsibility Act (TEFRA) or other qualifying health care programs. DHS considers EIDBI services to be classified as EPSDT (early and periodic screening, diagnostic and treatment services) pediatric preventative services, not mental health services.

Covered services
- Comprehensive multi-disciplinary evaluation (CMDE) behavior identification assessment
- Individual treatment plan (ITP) development and monitoring
- Coordinated care conference: Medical team conference
- EIDBI intervention – individual: Adaptive behavior treatment by protocol
- EIDBI intervention – group: Group adaptive behavior treatment by protocol
- Intervention - individual: Observation and direction; adaptive behavior treatment with protocol modification
- Family or caregiver training and counseling – individual: Family adaptive behavior treatment guidance
- Family or caregiver training and counseling – group: Multiple family group adaptive behavior treatment guidance
- Travel time

Non-covered services
- Does not include services provided by a parent, legal guardian or legally responsible person.
- When a member is a no-show or does not receive services, transportation will not be covered for that date of service.
- Services provided by an individual who has a relationship that violates ethical guidelines for dual relationship or would result in a conflict of interest as defined by the modality or licensure.

Service authorization requirements
The following services require authorization:

- EIDBI intervention – individual: Adaptive behavior treatment by protocol
- EIDBI intervention – group: Group adaptive behavior treatment by protocol
- Intervention – higher intensity: Adaptive behavior
- Intervention - individual: Observation and direction; adaptive behavior treatment with protocol modification
- Family or caregiver training and counseling – individual: Family adaptive behavior treatment guidance
- Family or caregiver training and counseling – group: Multiple family group adaptive behavior treatment guidance
- Travel time

Provider network

Members can access services from any EIDBI provider enrolled with DHS.

6.10 Recuperative Care Services

Recuperative care, also known as medical respite, is a program that provides medical care and support services for individuals experiencing homelessness who are not able to recover from illness or injury while staying in a shelter or are unhoused, but are not ill enough to require hospitalization. This program is designed for individuals in need of short-term care for less than 60 days. Members must be referred by a hospital or clinic.

Hennepin Health members ages 21 years or older are eligible if they have Medical Assistance, or 19 years or older if they have MinnesotaCare. Recuperative care services are available to Hennepin Health PMAP adult members age 21 and older.

Services include room, board, and medical care coordination in a post-acute setting. Members must meet clinical criteria established by the state that indicates medical need for recuperative care and not have a behavioral health need greater than what can be managed by the provider within the setting.

Covered services

Recuperative care services encompass the following:

- Basic nursing care including monitoring physical health and pain level
- Wound care
- Medication support
- Patient education
- Immunization review and update
- Clinical goals development for the recuperative care period and discharge plan
- Care coordination including initial assessment of medical, behavioral, and social needs
- Care plan development
- Support and referral assistance for legal, housing, transportation, case management and community social services
- Support and referral assistance for health care benefits, health, and other eligible benefits
- Care plan implementation follow-up and monitoring
- Medical, social, and behavioral (counseling and peer support) services that can be provided in the recuperative care setting

• Community health worker services

Recuperative Care Facility Requirements
• 24-hour access to a bathroom (shower, sink and toilet)
• 24-hour access to a bed
• Access to three meals per day (included in per diem)
• Availability to environmental services
• Access to a telephone
• Secure place to store the member's belongings
• Staff available within the setting to provide a wellness check as needed (minimum of once every 24 hours)

Non-covered services

Room and board charges for recuperative care are submitted to DHS as fee-for-service.

The member's behavioral health needs cannot be greater than what can be managed by the provider within the setting.

The member needs to be independent with activities of daily living and not need a higher level of care. For example, the member may have a temporary cast on their arm, however, needing assistance to stand or get to the bathroom is more than what can be offered in the recuperative care setting.

Prior authorization

Providers must notify Hennepin Health on day 1 of member admission. A continued stay authorization is needed for stays greater than 21 days. Please see the Hennepin Health website for additional information.

Provider network

Currently, members can see any provider within the state of MN who is registered with DHS and payable by Hennepin Health at Medical Assistance rates. However, Hennepin Health anticipates limiting payment to contracted providers of this service sometime in Fall 2025.

Billing guidelines

Recuperative Care Health Services Claims (Professional Claim)

- Bill on 837P claim format.
- Bill CPT code T2033 for the recuperative care bundled payment.
- Bill place of service 16 (temporary lodging).
- Bill all CPT or HCPCS codes on the same DOS and same claim that describes the services rendered with a $0.00 charge (these will be zero pay).
- Report the enrolled MHCP MD, PA or APRN NPI as the rendering provider who is supervising health services.
- **If the recuperative care facility affiliates with an advance practice professional:** The recuperative care facility can bill for the recuperative care health services claim (professional claim) for providing the services. The recuperative care facility would report their supervising MHCP enrolled advance practice provider on the claim as the rendering provider.

- **If the recuperative care facility affiliates with a health services group provider:** The health services group providers will bill the recuperative care health services (professional claim) for providing the services. The health service group would report their supervising MHCP enrolled advance practice provider on the claim as the rendering provider. The recuperative care facility will not be able to bill for the health services rate because they did not provide the service.
- One of the ICD-10 diagnosis codes for homelessness also needs to be on the claim. It is the provider's responsibility to determine the appropriate diagnosis code for the service that was provided.

Section 7: Behavioral health services

7.1 Mental health services

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

Covered services

- Adult crisis response services (COPE)
- Adult rehabilitative mental health services (ARMHS)
- Adult residential crisis stabilization services (RCS)
- Adult state regional treatment centers
- Assertive community treatment services (ACT)
- Certified peer specialist services*
- Children's crisis response services
- Children's residential MH treatment facility
- Children's therapeutic services and supports (CTSS)
- Cognitive remediation training
- Consultation about care between primary care doctor and psychiatrist
- Day treatment
- Diagnostic assessment
- Dialectical behavior therapy (DBT)
- Emergency room crisis services
- Explanation of findings
- Forensic assertive community treatment services (FACT) for adults
- Inpatient hospital stay
- Intensive rehabilitative mental health services (IRMHS)
- Intensive residential treatment services (IRTS)
- Intensive treatment in foster care (ITFC)
- Medication management
- Mental health targeted case management (MH-TCM)
- Partial hospitalization
- Physician services including:
    - Health and behavior assessment/intervention
    - Inpatient visits
    - Physician consultation, evaluation and management (office visits)
- Psychological and neuropsychological assessment and testing
- Psychotherapy for crisis
- Psychotherapy including individual, group and family therapy, and biofeedback
- The diagnosis and treatment of mental disorders
- Youth assertive community treatment (Youth ACT)

*Members must be 18 years or older and must be receiving ACT, IRTS, ARMHS, adult crisis and SUD services or be enrolled in a CCBHC to receive peer specialist services.

Non-covered services

- Room and board for IRTS admissions
- Room and board for Rule 5 children's residential treatment

Room and board coverage is available through the member's county of residence. Hennepin Health coordinates this service with the county.

Notification requirements

Notification of admission or enrollment into the above treatment programs or services allows the Hennepin Health care coordination team to provide optimal transitional care support for appropriate members.

The following services require notification to Hennepin Health:

- Facilities are required to notify Hennepin Health within one day of admission when members are admitted for acute psychiatric or partial hospital program services
- IRTS admissions
- MH-TCM services
- ACT services

Authorization requirements

- Comprehensive diagnostic assessment greater than two assessments in a calendar year
- Psychiatric residential treatment facility (PRTF) admission
- IRTS greater than 90 days

Provider network

Mental health services are considered open access. Hennepin Health members may access these services from any licensed provider practicing within the State of Minnesota, enrolled with DHS and who accepts Medicaid members.

7.2 Substance use disorder

This section details both residential (facility) and non-residential (outpatient) services.

Substance use disorder (SUD) services include an assessment of needs, treatment planning and interventions required to address member needs resulting from substance use. Room and board services are reimbursed by DHS; provider should bill DHS for these services. All other services listed under the Covered services section below are covered and paid for by Hennepin Health.

SUD treatment is accessed directly by a member going to a SUD provider. This is known as direct access. For members directly accessing residential treatment services, the SUD provider will complete a comprehensive assessment, which must be faxed to the Hennepin County Addiction and Recovery Services Unit at 612-466-9546 immediately upon completion. For questions related to the review of residential treatment services, providers may call the Hennepin County Addiction and Recovery Services Unit at 612-879-3671.

Covered services

- Nonresidential (outpatient) individual and group treatment services

- Residential high, medium and low-intensity treatment services
- Room and board for MinnesotaCare members
- Hospital-based inpatient treatment
- Comprehensive assessment (must be administered face to face by an alcohol and drug counselor)
- Treatment coordination
- Recovery peer support (certified peer specialist)
- Smoking cessation
- Residential withdrawal management (245F license)
- Substance use disorder treatment with medications for opioid use disorder (SUD-MOUD). SUD-MOUD services are reimbursed on a per diem basis and may also be included as an add-on to the residential treatment service per diem. SUD-MOUD may include:
    - SUD-MOUD – Methadone
    - SUD-MOUD – Other
    - SUD-MOUD - Methadone-PLUS
    - SUD-MOUD - Other-PLUS

Limitations

- Recovery peer support services: Eight units per day
- Treatment coordination services: Eight units per day

Non-covered services

- Room and board (when associated with SUD residential treatment) except for MinnesotaCare members
- Freestanding room and board (when associated with SUD nonresidential (outpatient) treatment)
- Detoxification services
- Comprehensive assessment, treatment coordination, peer support and nonresidential (outpatient) treatment services provided by the residential provider receiving a per diem payment for the same date of service and for the same client.

Service authorization

Hennepin Health requires authorization for residential treatment services only. Residential treatment providers must fax a completed client placement agreement (CPA) to the Hennepin County Addiction and Recovery Services Unit at 612-321-3781. The Addiction and Recovery Services Unit will review the proposed residential treatment plan for medical necessity utilizing American Society of Addiction Medicine (ASAM) criteria. The CPA must be completed accurately and legibly.

The residential treatment facility must also fax the completed CPA to Hennepin Health at 612-321-3781 to ensure proper and timely claim payment.

Provider network

Hennepin Health members may access all SUD services from any licensed provider practicing within the State of Minnesota, enrolled with DHS and who accepts Medicaid members.

7.3 Certified family peer specialists

Certified family peer specialists (CFPS) work with the family of a child or youth who has an emotional disturbance or a severe emotional disturbance defined under Minnesota Statutes, 245 and is receiving mental health treatment to promote the resiliency and recovery of the child or youth. Certified family peer specialists provide nonclinical family peer support building on the strengths of the family and help them to achieve desired outcomes.

Scope

Certified family peer specialists are required to follow guidelines in the Treatment Supervision section of the MHCP Provider Manual according to Minnesota Statutes, 245I.06. Certified family peer specialists under Treatment Supervision of a mental health professional must:

- Provide services to increase the child's ability to function in the child's home, school, and community
- Provide family peer support to build on a member's family's strengths and help the family achieve desired outcomes
- Provide nonadversarial advocacy to a child and the child's family that encourages partnership and promotes the child's positive change and growth
- Support families in advocating for culturally appropriate services for a child in each treatment setting
- Promote resiliency, self-advocacy, and development of natural supports
- Support maintenance of skills learned from other services
- Establish and lead parent support groups
- Assist parents in developing coping and problem-solving skills
- Educate parents about mental illnesses and community resources, including resources that connect parents with similar experiences to one another

Eligible providers

Certified family peer specialist programs must operate within an existing mental health community provider.

The certified family peer specialist must meet all of the following qualifications:

- Be at least 18 years of age
- Have raised or are currently raising a child with a mental illness
- Be currently navigating or have experience navigating the children's mental health system
- Successfully complete the Minnesota Department of Human Services-approved Certified Family Peer Specialist Training and Certification exam

Eligible members

To be eligible for certified family peer specialist services, a child or youth must be eligible for MHCP and receiving any one of the following services:

- Inpatient hospitalization
- Partial hospitalization
- Residential treatment
- Treatment foster care
- Day treatment
- Children's therapeutic services and supports (CTSS)

- Crisis services programs

Service authorization

Authorization is required for more than 300 hours (1200 units) per client per calendar year for a combined total of certified family peer specialist services and certified family peer specialist services in a group setting.

For additional information, please refer to the prior authorization list for medical and behavioral services on the Hennepin Health website.

Section 8: Inpatient hospital services

A member is considered admitted as an inpatient to an acute facility or hospital when a physician or other health care practitioner writes a formal order to admit the member to the facility. Members may be admitted to an acute hospital on an emergent basis via the emergency department or electively for a planned procedure.

Members may receive care in an acute hospital setting for multiple days and not be considered inpatient. Without a formal physician order to admit a member to a facility, care provided while in the facility is considered outpatient/observation.

Covered services

- Acute medical admission
- Acute psychiatric admission
- Admissions to community behavioral health hospitals
- Admissions to state regional treatment centers
- Long-term acute care hospital (LTACH) admission
- Room and board
- Diagnostic procedures
- Surgery
- Drugs
- Medical supplies
- Therapy services
- Professional services

Non-covered services

- Coverage excludes a private room unless ordered by a physician for a medical reason.
- In-room phones and amenities such as a television.
- Covered drugs and biologicals must be consistent with United States Pharmacopeias or the American Dental Association Guide to Dental Therapeutics and approved by the FDA as safe and effective. Drugs and biologicals that have not received final FDA approval are not covered. Off-label use may be permitted.
- Detox or withdrawal services unless determined to be medically necessary.
- Cosmetic surgery.
- Experimental/Investigational procedures.

Notification requirements for medical and psychiatric inpatient admissions

The decision to admit a member to an acute facility is based on the severity of the member's symptoms, current clinical status and medical history. Admission to an acute facility must be considered medically necessary and appropriate. When a Hennepin Health member is admitted to an acute facility through the emergency room, facilities must notify Hennepin Health within 24 hours of the admission. The notification requirements are as follows:

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

- Level of care

If a medical necessity review is required, Hennepin Health team members will reach out to the facility's utilization review team to request relevant progress notes. For members who are inpatient for longer periods of time, Hennepin Health will perform continued stay reviews. Updated progress notes must be faxed to Hennepin Health at 612-288-2878 on the day after the last day approved by the Hennepin Health review nurse. Updated progress notes must include discharge planning information.

For planned admissions for elective procedures, facilities must follow the same process of notifying Hennepin Health within (after) 24 hours of the member admit. If the planned, elective procedure required a medical necessity review (refer to the Hennepin Health PA list), the provider's office responsible for performing the procedure should have completed a prior authorization request before the member admission.

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

The Hennepin Health inpatient admission notification form may be used to notify us of an individual member admission (vs. a daily admission report). In that case, the inpatient admission notification form must be faxed to the Utilization Management department at 612-288-2878.

Authorization requirements

All out-of-network medical admissions and out-of-state admissions require authorization from the first day of admission.

Provider network

Hennepin Health members may access emergency room care from any facility within the U.S. For elective admissions, Hennepin Health members are required to access services from an in-network facility.

Section 9: Outpatient services

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

Covered services

- Urgent care
- Surgery
- Procedures
- Hydration, infusion, drug injections and chemotherapy administration
- Prolonged intravenous therapy
- Blood transfusions
- Cardiac rehabilitation
- Diagnostic tests and X-rays
- Dialysis
- Emergency room services for a medical emergency
- Post-stabilization care

Non-covered services

- Services provided by an employee of the hospital such as an intern or a resident.
- Services lasting 24 hours or more, except for members under observation status.
- Detoxification not medically necessary to treat an emergency.
- Patient convenience items.
- Facility fees, ancillary charges and other procedure or service charges related to outpatient hospital charges for noncovered services.
- Hospital charges when related to outpatient hospital care for investigative services, plastic surgery or cosmetic surgery which are not covered unless determined medically necessary through the medical review authorization process and for services designated as non-covered.
- Outpatient observation services provided in addition to a surgical procedure, unless the observation is monitoring or treatment beyond the community standard for the surgical procedure.
- For the convenience of the member, member's family or provider.

Service authorization requirements

A service authorization may be required for specific outpatient services. Please refer to Hennepin Health's prior authorization list for services requiring authorization in an outpatient setting.

Provider network

PMAP/MinnesotaCare members: Except for emergency, urgent care or mental health services, outpatient services must be accessed from a contracted, in-network provider.

SNBC members: Outpatient services may be provided by any licensed provider practicing within the State of Minnesota and who accepts Medicaid members.

Section 10: Housing Stabilization Services

As of Nov. 1, 2025, DHS terminated the Housing Stabilization Services (HSS) benefit. As a result of this, HSS is no longer a covered benefit for Hennepin Health members. Please visit the HSS DHS website for more information: Housing Stabilization Services / Minnesota Department of Human Services.

Section 11: Health care homes

Interaction with Hennepin Health

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

Care coordination requirements

- Inform the individual about participation in a HCH.
- Have a standardized method of determining whether the complexity of an individual's medical condition(s) makes them eligible to participate in a HCH.
- Document in the individual's medical record their acceptance to participate in a HCH and the agreed upon start date for participation to begin.
- Establish the individual's complexity tier and willingness to participate in care coordination.
- Reevaluate the individual's complexity tier annually or more often if warranted by a change in the patient's medical condition(s).

Section 12: Pharmacy

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

Hennepin Health members' pharmacy benefits include:

- Prescription drugs included in the Hennepin Health formulary.
- Over-the-counter drugs when prescribed or included in the Hennepin Health Medicaid formulary or approved as a formulary exception.

12.1 Non-formulary drugs

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

To request a non-formulary drug, complete the Minnesota Uniform Formulary Exceptions form and submit it to Hennepin Health by secure fax at 612-677-6222 or encrypted email at HH.Pharmacy.PA@hennepin.us.

For questions regarding coverage and formulary exceptions, call Navitus Health Solutions Services 24/7 at 833-210-5966.

12.2 Antipsychotic drugs

Hennepin Health will provide coverage for an antipsychotic drug prescribed to treat emotional disturbance or mental illness regardless of whether the drug is in the formulary as long as the prescribing provider does all of the following:

- Indicates to the dispensing pharmacist (orally or in writing) that the prescription must be dispensed as communicated.
- Certifies in writing to Hennepin Health that the provider has considered all equivalent drugs in the formulary.
- Has determined that the prescribed drug will best treat the member's condition.

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

12.3 Cash payment for medications

Hennepin Health will inform pharmacies and providers of members' right to pay cash for medications under certain circumstances. The list below describes the circumstances under which this is allowed. It is the pharmacist's and prescriber's responsibilities to document the event, using the form (Advance Member Notice of Noncovered Prescription, DHS-3641-PDF) required by the Department of Human Services (DHS). Hennepin Health does not require pharmacies or providers to submit the DHS-3641 form, but the form must be kept on file and be made available to Hennepin Health or DHS upon request.

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

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

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

Hennepin Health will authorize cash payment if the pharmacy and member complete their sections of the DHS-3641 and the prescriber confirms the following:

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

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

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

Section 13: Dental services

Hennepin Health has a partnership with Delta Dental of Minnesota to coordinate access to dental services and providers for Hennepin Health members. Delta Dental has a network of dentists who are able to see Hennepin Health members and provide care.

For questions or to refer a Hennepin Health member, please contact Delta Dental Customer Service at 866-298-5549.

See Section 16.4 for dental appeals and grievances information.

Section 14: Restricted Recipient Program

14.1 Program details

The Minnesota Restricted Recipient Program (MRRP) is a program operated under the direction of the Minnesota Department of Human Services (DHS) that identifies Minnesota Health Care Program (MHCP) recipients who may be abusing or misusing health care services. The MRRP applies to all Hennepin Health members including Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and Special Needs Basic Care (SNBC) members. Hennepin Health follows standards for this program as set forth in Minnesota Rules.

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

Universal rules established among all Managed Health Care Programs ensures the restriction follows individuals regardless of which health plan is managing care. Restricted recipients who transition from one managed care plan to another or change from a managed care plan to MHCP fee-for-service will remain under restriction with Hennepin Health. The restriction remains in place until the restricted recipient has satisfied the time period of the restriction. Restricted recipients do not lose eligibility with Hennepin Health due to placement in the MRRP.

The contact information for the Restricted Recipient Program is as follows:

- Phone: 612-543-9944
- Fax: 612-288-2837
- Email: HH.RestrictedRecipientTeam@hennepin.us

Eligible providers

Hennepin Health network providers:

- Primary care physician
- Primary care clinic
- Hospital
- Pharmacy

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

Emergency room (ER) services

Services provided to a restricted recipient in the ER of a non-designated hospital will be denied. Hennepin Health will pay the professional services component but will deny the facility component. To receive payment for the facility component, the non-designated hospital must submit for reconsideration of the denial. The non-designated hospital is required to provide

documentation of the emergency circumstances in support of payment for the emergency service claim. Documentation must indicate that the provider reviewed the member's eligibility, identified that the member was a restricted recipient, performed the necessary screening required under the Emergency Medical Treatment and Labor Act (EMTALA), delivered the services necessary to stabilize the member, and then referred the member to the member's designated providers for follow-up. For more information on the claims reconsideration process, please see section 19.1, below "claim adjustment/reconsideration requests."

Authorization requirements

If a MRRP member or member's designated provider wants the member to be seen by a provider other than the designated provider (i.e., a non-designated provider), the MRRP member's designated provider must submit a referral request to Hennepin Health. All referrals must be in writing and faxed to Hennepin Health for processing. Restricted recipients cannot self-refer to non-designated providers. Referrals must be received by Hennepin Health within 90 days to be considered. The 90-day timeline starts from the date of service the member was seen by the non-designated provider. Hennepin Health cannot accept referral requests that are received more than 90 days from the date of service. Hennepin Health will also not accept referrals for care provided in the emergency room of a non-designated hospital.

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

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

14.2 Restricted Recipient Program referral guidelines

Referrals required from designated primary care provider (PCP)	No referrals from designated primary care provider (PCP)
The designated PCP must submit a referral before a restricted recipient receives services from a provider that is not one of the members' designated providers for all of the services listed in this column. All restricted members will have a designated: • Primary care provider (PCP) • Clinic • Hospital • Pharmacy	Restricted recipients may directly access the services listed in the column below without needing a restricted recipient referral.

Referrals required from designated primary care provider (PCP)	No referrals from designated primary care provider (PCP)
Note: If care is needed by a specialist or other provider outside of the primary care clinic, the designated PCP may authorize a restricted program referral.	
• All specialty care services including services provided by oral surgeons. • Hospital services not provided in the designated hospital. *Note: Only one referral necessary for all services during an inpatient stay.* • Behavioral health services provided by a psychiatrist, clinical nurse specialists or any mental health provider who can order medications. • Vision care provided by an ophthalmologist. • Suboxone prescriber. • Pain clinic providers, including anesthesiologists. • Urgent care.	• Partners of the designated primary care provider at the same clinic/ practice location when the PCP is not available. • Medicare covered services for members covered by Medicare • Long-term care facilities • Annual routine eye exam by optometrist • Audiologist and hearing aides • Behavioral health therapists, counselors or psychologist • Dental services • Methadone clinic • PT/OT, speech therapy and respiratory therapy • Home care services • Radiology, imaging services (X-ray, CT, MRI, ultrasound, etc.) • DME and supplies • Laboratory services • Chiropractor • Dietician

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

Section 15: Fraud and abuse

15.1 Anti-fraud policy

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

Legal requirements

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

- Has developed and follows a compliance plan.
- Has developed and follows a fraud, waste and abuse plan.
- Reports annually to DHS.
- Refers suspected fraud, waste and abuse to appropriate state and federal agencies.

15.2 Health service records

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

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

Health records must contain the following information when applicable.

- The member's name must be on each page of the member's record.
- Each entry in the health services record must contain:
    - The date on which the entry is made.
    - The date or dates on which the health service is provided.
    - The length of time spent with the member if the amount paid for the service depends on time spent.
    - The signature and title of the person from whom the member received the service.
    - Reportage of the member's progress or response to treatment and changes in the treatment or diagnosis.
    - When applicable, the countersignature of the vendor or the supervisor.
    - Documentation of supervision by the supervisor.
- The record also must state:
    - The member's case history and health condition as determined by the provider's examination or assessment.
    - The results of all diagnostic tests and examinations.

    - The diagnosis resulting from the examination.
- In addition, the record must contain reports of consultations that are ordered for the member as well as the member's plan of care, individual treatment plan or individual program plan.
- The record of laboratory or X-ray service must document the provider's order for services.
- Upon discharge, the record must contain a discharge summary including the status relative to goal achievement, prognosis and further treatment conditions.

Protection of health services record information

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

- Abide by all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. The provider must safeguard the privacy of any information that identifies a particular patient and implement procedures that specify:
    - For what purpose the information will be used within the organization.
    - To whom and for what purposes it will disclose the information outside the organization.
- Ensure that medical information is released only in accordance with applicable state and federal laws and regulations.
- Maintain medical records and information in an accurate manner.
- Ensure timely access by members to the records and information that pertain to them.
- Obtain a member's written consent before releasing information not required to be released by law.

Record-keeping requirements

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

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

Access to records

Hennepin Health has the right to access records pursuant to the provider contract and the member's consent signed in accordance with Minnesota Statute § 256B.27. Hennepin Health will provide no less than 24 hours before obtaining access to a health service or financial record unless the provider waives notice.

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

Providers shall submit copies of the records requested by Hennepin Health by the due date listed in the request. If a provider fails to comply, Hennepin Health has the right to withhold reimbursement for health services until the provider fully complies and Hennepin Health and/or its authorized agents have reviewed the information and records. Failure to comply with a Hennepin Health records request may also result in a referral to DHS and the Medicaid Fraud Control Unit of the Attorney General's office.

Retention of records

A provider shall retain all health service and financial records related to the health services for which payment was received or billed for at least five years after the initial date of billing.

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

Record copying

Hennepin Health prefers records be sent electronically via fax, secure email or other secure method of data exchange. If a provider requests that Hennepin Health staff manually copy records, Hennepin Health will at its own expense provide staff to photocopy or otherwise duplicate any health service or financial record related to a health service for which a claim or payment was made by Hennepin Health. Photocopying shall be done on the provider's premises unless removal is specifically permitted by the provider. If Hennepin Health is not allowed to use the provider's equipment to photocopy or duplicate any health service or financial record on the premises, the provider must furnish copies at the provider's expense within two weeks of the request for copies by Hennepin Health.

15.3 Reporting fraud or abuse

Fraud

Fraud is any intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person including attempts or conspiracies. Acts which can be defined as fraud are:

- Theft, perjury, forgery or financial transaction card fraud.
- Making a false statement, claim or representation to a program where the individual knows or should reasonably know the statement, claim or representation is false.

- Receiving remuneration in return for the provision of health care services in violation of the federal Stark Law or the Anti-Kickback Statute.

Abuse

Abuse is the excessive or improper use of services or practices that are inconsistent with sound fiscal, business or health service practices, and that result in unnecessary costs to Hennepin Health or in reimbursement for services not medically necessary, or that fail to meet the professionally recognized standards for health services.

Examples include:

- Submitting repeated claims
- Using procedure codes that overstate the level or amount of health service provided
- Ordering unnecessarily expensive equipment or tests

Waste

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

Examples include:

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

Reporting

To report suspected fraud or abuse against Hennepin Health, please contact Hennepin Health at hh.fwa@hennepin.us, anonymously using the Hennepin Health Compliance reporting website at mhp.alertline.com, or the Hennepin Health fraud helpline at 844-440-3290.

Hennepin Health will make every attempt to keep the identity of reporters confidential. Suspected fraud or abuse by a provider may also be reported to DHS Surveillance and Integrity Review Section (SIRS) at 651-431-2650 or 800-657-3750.

Investigative process

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

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

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

A Hennepin Health investigation may include:

- Examination of health care service and financial records.
- Examination of equipment, materials, prescribed drugs or other items used in providing health service to a member.
- Examination of prescriptions written for Hennepin Health members.
- Data mining.
- Interviews with anyone providing information pertinent to the allegation of fraud or abuse.
- Verification of the professional credentials of a provider, provider employees and entities under contract with the provider.
- Determination of whether health care services provided were medically necessary.
- Suspension of claims payment until the investigation is complete.

Following completion of the investigation, Hennepin Health will determine whether:

- Providers are in compliance with requirements of their provider agreements and Hennepin Health policies and procedures.
- Sufficient evidence exists to support that fraud, theft or abuse has occurred.
- Evidence of fraud, theft or abuse supports administrative, civil or criminal action.

After completing the determination, Hennepin Health will take one or more of the following actions:

- Close the investigation when no further action is warranted.
- Impose administrative sanctions.
- Seek monetary recovery.
- Refer the investigation to the appropriate state regulatory agency.
- Refer the investigation to the appropriate local law enforcement officials for review pursuant to Minnesota law.

Administrative sanctions that may be imposed include:

- Placing restrictions on the provider.
- Referral to the appropriate licensing board.
- Suspension or termination of the provider contract.
- Suspension or termination of the participation of any person or corporation with whom the provider has any ownership or controlling interest.
- Requiring a contract that stipulates specific condition of participation.
- Review of provider claims before payment.
- Suspending payments to the provider.

Hennepin Health has the authority to simultaneously seek monetary recovery and administer sanctions. Hennepin Health will notify the provider in writing of any intent to recover money or impose sanctions.

15.4 False claims

False Claims Act

The False Claims Act (31 U.S.C. § 3729) establishes liability for any person who knowingly presents, or causes to be presented, false or fraudulent claims to the U.S. government for

payment. Health care providers can be prosecuted and/or subject to civil monetary penalties for a wide variety of conduct that leads to the submission of fraudulent claims to the government such as knowingly making false statements, falsifying records, double billing for items or services, submitting bills for services never performed or items never furnished, or otherwise causing a false claim to be submitted.

Liability

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

Examples

Examples of violations include but are not limited to:

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

Reporting

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

Section 16: Grievances and appeals

Grievances and appeals are highly regulated by federal and state agencies. Hennepin Health has a grievance system in place that includes a grievance/complaint process, an appeal process and access to the state appeal process (a.k.a state fair hearing). The grievance system also includes the handling and processing of member quality of care (QOC) and quality of service (QOS) grievances.

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

A member, their authorized representative or a provider wishing to act on behalf of the member with the member's written consent may file a grievance or an appeal with Hennepin Health orally or in writing. When needed, a member may provide written consent by completing a release of information form. The member's attending health care professional may appeal a utilization review decision without the written signed consent of the member. Hennepin Health provides reasonable assistance to members in completing forms and taking other procedural steps including but not limited to providing interpreter services and toll- free numbers that have adequate TTY/TDD and interpreter capability during the grievance and appeal processes.

Table 1 outlines the process and timeframes for handling grievances and appeals.

Table 1: Grievance and appeal process

	Acknowledgement letter timeline	Resolution timeline	Communication method
Oral grievance	N/A	10 calendar days	Oral or in writing
Written grievance	10 calendar days	30 calendar days	In writing
Oral/Written appeal	10 calendar days	30 calendar days	In writing
Expedited grievance or appeal	N/A	72 hours from receipt	Oral and in writing

16.1 Grievances

Grievances may be filed at any time either orally or in writing. A member, their authorized representative or a third party (e.g., provider, family member, friend) acting with a member's written consent, can submit a grievance. Members may file a grievance with Hennepin Health in the following ways:

- Orally by calling Member Services at 612-596-1036. This phone number is also listed on the back of the member's ID card.
- In writing by submitting a letter or using the grievance form on the Hennepin Health website and mailing it to:

Hennepin Health
Attn: Appeal and grievance coordinator
300 South Sixth Street, MC 604
Minneapolis, MN 55487-0604

Grievances are resolved within the timeframes outlined in Table 1. However, Hennepin Health may extend the timeframe for resolution of a grievance by an additional 14 days if the member requests the extension or if Hennepin Health justifies that an extension is in the member's best interest. Hennepin Health provides written notice to the member of the reason for the decision to extend the timeframe if Hennepin Health determines that an extension is necessary. Hennepin Health issues the resolution no later than the date the extension expires.

All grievances are investigated by the appeal and grievance (A&G) coordinator and a decision on a grievance is made by an individual not involved in any previous level of review or decision-making regarding the issue being grieved. If a grievance is regarding the denial of an expedited resolution of an appeal or one that involves clinical issues, the individual making the decision must be a health care professional with appropriate clinical expertise in treating the member's condition or disease. This type of grievance determination is made in accordance with the expedited appeal timeframe.

The member is informed at the time of resolution that if the resolution is partially or wholly adverse to the member or if the oral grievance is not resolved to the satisfaction of the member, the grievance may be submitted in writing. The Hennepin Health staff resolving a grievance will offer to assist the member in submitting a written grievance if needed. Assistance offered includes completion and mailing of the grievance form to the member for signature.

Whether the grievance is resolved orally or in writing, the grievance resolution provided to the member includes:

- Results of the investigation and actions related to the grievance.
- Information about the options for further review and assistance through the DHS Managed Care Ombudsperson and/or review by MDH.

Quality of care grievance

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

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

Substantiated QOC/QOS issues are communicated to the Credentialing department on a quarterly basis. The Credentialing department records the information within the provider's

credentialing file and follows the Credentialing department internal process for review and determination.

Verbal or written complaints received by the provider

According to 4685.1110 and 4685.1900, Providers are required to report verbal and/or written complaints which originate at the provider level to Hennepin Health each quarter. Quality of care and service complaints directed to the medical group are to be investigated and resolved by the medical group. Quality complaint form.

16.2 Appeals

An appeal to review a notice of action may be filed orally or in writing. If filed orally, it is not required to be reduced to writing and signed by the member. If a member wishes to file an appeal in writing, Hennepin Health will assist the member, or the provider filing on behalf of the member, to complete a written appeal. Hennepin Health provides members with any reasonable assistance required to compete forms and take other procedural steps including but not limited to providing interpreter services and toll-free numbers that have adequate TTY/TDD.

The appeal must be filed with Hennepin Health within 60 days of the denial termination reduction (DTR) notice or other action taken by Hennepin Health. More time may be allowed if the member has a good reason for missing the deadline. Attending health care professionals may appeal utilization review decisions to Hennepin Health without the written signed consent of the member.

Providers who wish to file a pre-service appeal directly with Hennepin Health can either:

1. Fax a letter with appeal information to 612-766-5713 for medical services.
2. Fax the prescription drug reconsideration request to 612-766-5713 for prescription drug appeals.

Appeals are resolved within the timeframes outlined in Table 1 above. Hennepin Health may take an extension of up to 14 additional days for a standard appeal to make the decision if the member requests the extension or if Hennepin Health justifies that an extension is in the member's best interest. Hennepin Health will make reasonable efforts to provide prompt oral notice and provide written notice within two calendar days to the member of the reason for the decision to extend the timeframe if Hennepin Health determines that an extension is necessary. For an appeal involving a Utilization Management (UM) decision, the attending health care professional is informed of the extension in writing for a standard appeal. Hennepin Health will resolve and communicate the appeal decision no later than the date the extension expires.

Hennepin Health provides only one level of appeal for members. Members and attending health care professionals appealing UM decisions must first file an appeal with Hennepin Health before proceeding to a state appeal. In the event Hennepin Health fails to adhere to the notice and timing requirements of an appeal as outlined in Table 1, the member is deemed to have exhausted the Hennepin Health appeals process and may proceed to a state appeal.

A medical necessity appeal is an appeal to review Hennepin Health's initial decision not to certify a health care service. For a medical necessity appeal request, Hennepin Health may request that copies of part, or all, of the medical record and a written statement from the attending health care professional be submitted with the appeal. Hennepin Health will never take punitive action against an attending health care professional who supports a member's appeal.

Continuation of benefits pending decision

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

Process

Hennepin Health ensures that any individual(s) making the appeal decision was not involved in any previous level of review or decision-making and is not a subordinate of the person making the previous decision. The member may provide additional information regarding the appeal in person, by telephone or in writing. The member is provided an opportunity, before and during the appeals process, to examine their case file including medical records and any other documents and records considered during the appeal process. The member may request and receive copies of all documents relevant to the appeal free of charge upon request.

The member is informed in writing of the appeal decision. For appeals involving a UM decision, the attending health care professional is informed of the appeal decision. If the appeal resolution is adverse to the member, the member is informed of their right to request a state appeal.

If Hennepin Health is deciding an appeal regarding a denial of a service based on lack of medical necessity, a grievance regarding denial of an expedited resolution of an appeal, or a grievance or appeal that involves clinical issues, Hennepin Health will ensure that the individual making the decision is a board-certified physician of the same or a similar specialty as typically manages the medical condition, procedure or treatment under discussion, who is reasonably available to review the case, and who did not make the initial determination not to certify.

Hennepin Health will take into account all comments, documents, records and other information submitted by the member without regard to whether the information was submitted or considered in the initial action.

Expedited appeals

An appeal is processed as an expedited appeal and is resolved no later than 72 hours after receiving the request when the member's life, health or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a standard appeal decision. For expedited appeal resolutions the member is informed of the limited time available to present evidence in support of the appeal. An expedited appeal is always granted when the member's attending health care professional determines the standard appeal timeframe could seriously jeopardize the member's life, health or ability to attain, maintain or regain maximum function. Hennepin Health will not take any punitive action against an attending health care provider who requests an expedited appeal resolution.

When a determination not to certify a health care service is made prior to or during an ongoing service, and the attending health care professional believes that an expedited appeal is warranted, Hennepin Health will ensure that the member and the attending health care professional have an opportunity to appeal the determination over the telephone. In such an

appeal, Hennepin Health will ensure reasonable access to Hennepin Health's consulting physician.

A member's request for an expedited appeal without physician support will be reviewed to determine if it meets the expedited criteria. If Hennepin Health denies a request for an expedited appeal, Hennepin Health will transfer the denied request to the standard appeal process, preserving the first filing date of the expedited appeal request. Hennepin Health will notify the member of that decision orally within 24 hours of the request and follow up with a written notice within two calendar days.

Communication of appeal resolution to the member and provider

Hennepin Health provides a written notice of resolution for all appeals that includes the following information:

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

For appeals of UM decisions, the written notice of resolution is sent to the member and the attending health care professional.

If the appeal resolution results in a decision not to certify the requested services, Hennepin Health will provide the following information to the member and attending health care professional in the resolution letter:

- A complete summary of the review findings.
- Qualifications of the reviewers.
- The relationship between the member's diagnosis and the review criteria used as the basis for the decision including the specific rationale for the reviewer's decision.

16.3 State appeals

State human services judges may review any action by Hennepin Health. The parties to the state appeals include Hennepin Health, the member, his/her authorized representative or the legal representative of a deceased member's estate.

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

Members and their representatives can submit a state appeal to DHS in two ways:

1. Online: Visit Appeal to State Agency (DHS-0033) and complete the form electronically
2. Print the online form Appeal to State Agency (DHS-0033) and mail the completed form to: Appeals Division, P.O. Box 64941, St. Paul, MN 55164-0941

If a member makes a written request for a state appeal with DHS and requests continuation of benefits within the time allowed, Hennepin Health will not reduce or terminate the service until

DHS issues a written decision in the state appeal or the member withdraws the request for the state appeal. "Within the time allowed" means the request is made on or before the date that is 10 days after Hennepin Health sends its notice of resolution of the appeal. In the case of a reduction or termination of ongoing services, services must be continued pending outcome of all appeal or state appeal if there is an order for services by an authorized provider.

Once the state appeal final administration action is received, Hennepin Health complies with the decision promptly and as expeditiously as the member's health condition requires.

If the member disagrees with the state appeal decision, the member may consider seeking legal counsel to identify further legal recourse. Additional appeal rights are outlined in the state appeal notice and include:

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

16.4 Dental appeals and grievances

Dental services are provided through Delta Dental of Minnesota. All dental appeals and grievances, including QOC, QOS and state appeals, are routed to Delta Dental to review and process. Providers who wish to file an appeal directly may contact Delta Dental at 866-298-5549.

16.5 Continuity of care for new members

To ensure members continuity of care is not compromised, Hennepin Health allows new members to continue receiving medical services from their current provider for a pre-determined time frame.

Hennepin Health will review a request for continued care from an out-of-network provider and may grant the request to receive services through the current provider when the member meets following criteria.

- The member is engaged in a current course of treatment for:
  - An acute condition
  - A life-threatening mental or physical illness
  - A pregnancy beyond the first trimester

    - A physical or mental disability defined as an inability to engage in one or more major life activities
    - A disabling or chronic condition that is in an acute phase
    - Culturally appropriate services and Hennepin Health does not have an in-network provider with expertise in the applicable culture of that member
- The member does not speak English and Hennepin Health does not have an in-network provider who can communicate with the member

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

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

Hennepin Health will provide transitional services:

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

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

Section 17: Clinical practice guidelines

Hennepin Health adopts and disseminates clinical practice guidelines relevant to our members for the provision of preventive, acute or chronic medical services and behavioral health care services. The clinical practice guidelines support sound decision-making by health care professionals and members, improve health care outcomes, and meet state and federal regulations.

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

Hennepin Health, through the Clinical Quality Outcomes Committee (CQOC), adopts medical and behavioral health/substance use disorder clinical practice guidelines from nationally or locally recognized sources. Practice guidelines are based on valid, reliable clinical evidence. At a minimum, the practice guidelines are reviewed and updated at least every two years or more frequently if the guidelines change within the two-year period. The adopted clinical practice guidelines are disseminated to the primary and specialty care, behavioral health/substance use disorder and/or medical home providers through the provider manual at least every two years or upon any revisions being made.

Guidelines are embedded in the decision algorithms used by the Hennepin Health Medical Administration area and are applied to utilization management decisions, member education, coverage or services, and any other area for which the guidelines are applicable.

To request a paper copy of the Hennepin Health clinical practice guidelines, contact Provider Services at 612-596-1036, press 2 (800-647-0550), TTY 711 or 800-627-3529.

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

Medical

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

- **Preventive services for adults**
  Primary sources: Agency for Healthcare Research and Quality (AHRQ) for the United States Preventive Services Task Force (USPSTF): 2014
  The Guide to Clinical Preventive Services 2014 includes both new and updated recommendations released from 2004-2014 in a brief, easily usable format meant for use at the point of patient care. The most up-to-date version of the recommendations, as well

as the complete USPSTF recommendation statements, are available along with their supporting scientific evidence at www.USPreventiveServicesTaskForce.org.

The Guide to Clinical Preventive Services 2014 (ahrq.gov)
A Note About Clinical Preventive Service Recommendations | AAFP

- **Preventive services for children/adolescents**
  Primary sources: Agency for Healthcare Research and Quality (AHRQ) for the United States Preventive Services Task Force (USPSTF): Section 3
  American Academy of Pediatrics (AAP) Bright Futures and Bright Futures Periodic Schedule
  Minnesota Department of Health Child & Teen Checkup
- **Diabetes Type 1 and 2: Diagnosis and management**
  Primary source: American Diabetes Association
- **Prenatal/postpartum care**
  Primary sources: American College of Obstetricians and Gynecologists

  American Academy of Family Physicians
- **Pain management: Non-opioid treatment options and opioid management**
  Primary source: Center for Disease Control

Behavioral health/substance use disorder

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

- **Attention deficit hyperactivity disorder (ADHD) – children/adolescents**
  Primary sources: American Academy of Pediatrics
  American Academy of Child and Adolescent Psychiatry
- **Treatment of patients, adults and children with major depressive disorders**
  Primary source: American Psychiatric Association
- **Treatment of patients with schizophrenia**
  Primary source: American Psychiatric Association
- **Treatment of patients with substance use disorders (SUD)**
  Primary source: American Psychiatric Association
- **Treatment of patients with alcohol dependence**
  Primary source: American Psychiatric Association

Section 18: Quality Management

Healthcare Effectiveness Data and Information Set (HEDIS) data collection

The purpose of HEDIS is data collection, validation and reporting using the HEDIS technical specification from the National Committee for Quality Assurance (NCQA). HEDIS data is also used to meet the Minnesota Community Measurement requirements and may also be used to measure compliance with practice guideline standards. The annual HEDIS data collection is audited by an outside NCQA accredited agency to assure accuracy and to meet the data collection and reporting needs of Hennepin Health, DHS and MDH. Contracted providers and healthcare systems are required to participate in this activity. Hennepin Health does not provide payment for providing requested medical records.

Advance directives

The Patient Self-Determination Act (PSDA) is a federal law passed by Congress in 1990 which requires providers to inform all adult patients, 18 years and older, about their rights to accept or refuse medical or surgical treatment and the right to execute an "advance directive." The Code of Federal Regulations (CFR) §489 outlines the requirements for providers, including hospitals, critical access hospitals, rural emergency hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices and religious nonmedical health care institutions. Minnesota Statute §Chapter 145B and 145C outlines the State requirements for advance directives.

An advance directive is a written instruction such as a living will or durable power of attorney for health care recognized under state law relating to the provision of health care when the individual is incapacitated.

Provider requirements:

- Give written information to all adults receiving services of their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and to formulate advance directives.
- Provide the written information to an individual upon each admission to a medical facility and each time an individual comes under the care of a home health agency, personal care provider or hospice.
- Maintain written policies and procedures concerning advance directives for all adults receiving care or services and inform the individual in writing of these policies. The policies must include a clear and precise explanation of any objection a provider or provider's agent may have, on the basis of conscience, to honoring an individual's advance directive. At a minimum, a provider’s statement of limitation should:
    - Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;
    - Identify the state legal authority permitting such objection; and
    - Describe the range of medical conditions or procedures affected by the conscience objection.
- Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of changes to State law,

- Document in the patient's medical record whether or not an individual has executed an advance directive.
- Inform individuals that they may file a complaint concerning the advance directives requirements and/or a provider's non-compliance with advance directive requirements with the State survey and certification agency.
- Not discriminate against an individual based on whether he or she has executed an advance directive.
- Ensure compliance with State law (whether statutory or recognized by the courts of the State) requirements regarding advance directives.
- Provide education to staff and the community on advance directives. This education must minimally include what an advance directive is, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state law concerning advance directives.

The Hennepin Health Prepaid Medical Assistance Program/MinnesotaCare and Special Needs BasicCare contracts require Hennepin Health to conduct an annual medical record audit to ensure that the provider has documented whether or not an individual has executed an advance directive in the member's medical record or has had a discussion with the individual about implementing an advance directive. Additional member information about health care directives, including access to advance directive forms, can be found at https://www.hennepinhealth.org/members/advance-directive.

18.1 Hennepin Health's medical record standards

Health services records are any electronically stored data and written documentation of the nature, extent and medical necessity of a health service provided to a Hennepin Health member by a provider and billed to Hennepin Health. Health services records must be developed and maintained as a condition to contract with Hennepin Health. Each health service occurrence must be completely, promptly, accurately and legibly documented in the member's health record. Hennepin Health funds that are paid for services which are not documented in the health record are subject to monetary recovery.

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

- Is the record secured from public access during and after office hours?
- Do all pages contain patient ID?
- Is there biographical/personal data?
- Are all entries signed/initialed and/or have a unique electronic identifier or initials?
- Are all entries dated?
- Is the record legible?
- Is there a completed problem list?
- Is the use of tobacco, alcohol and substances documented?
- Is the purpose of the visit stated?
- Does the encounter include subjective and objective information related to complaints?
- Are current medications and supplements noted in the medical record?
- Is a diagnosis present for each encounter?
- Is there a follow-up plan for each encounter?
- Is there evidence of a system review and/or follow-up on test results?

- Is there documentation of immunizations?
- Is there documentation regarding advanced directives?
- Are allergies/adverse reactions present?
- Is there a medical, psycho-social and family history?
- Are consultant use and referrals documented?
- Is health education documented?
- Is there evidence of counseling regarding high-risk behaviors?
- Is there evidence of screening for mental health status?
- Is there evidence of preventive screening?

Section 19: Claims

Hennepin Health follows the Minnesota Health Care Programs (MHCP) provider manual for claims-related administration including benefit-specific coding and billing guidelines. Please reference the MHCP guidelines as the primary source of information. The claims section of the manual encompasses Hennepin Health's claim-related business processes for providers to reference.

19.1 General billing requirements

Providers are responsible to follow basic claims submission rules:

- Reference the MHCP provider manual for benefit specific billing requirements.
- Submit claims only after the Hennepin Health covered service has been provided.
- Dates of service must reflect the date when the service was provided.
- Bill only one calendar month of service per claim.
- Bill the provider's usual and customary charge.
- All claims require valid diagnosis codes (ICD-10).
- As part of the 2011 Minnesota Legislative session, all claims for supplies or services that are based on an order or referral must include the ordering or referring provider's National Provider Identifier (NPI) (Minnesota Statute section 256B.03, subd. 5). The ordering or referring provider must also be enrolled in MHCP. Claims submitted without this information will deny as "Referring/ordering provider is not registered with MHCP."
- If attending, rendering or referring providers are present in the claim transaction, the NPI or Unique Minnesota Provider Identifier (UMPI) must be present for Hennepin Health to pay the claim. If not present, the claim will be rejected back to the provider.
- Federally Qualified Health Clinics (FQHC) must submit PMAP and SNBC claims directly to Minnesota Department of Human Services (DHS). Claims for members with other insurance or MinnesotaCare should be submitted directly to Hennepin Health.

Void claims

If a provider has billed a claim to Hennepin Health in error and needs to void that claim transaction, a void claim must be submitted. For 837P claims, the claim frequency code must be "8". For 837I transactions, the last digit of the type of bill must be "8". All data elements of the void claim must match the original claim. A void claim transaction will cancel the original claim in its entirety.

Examples of when a void claim would be used:

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

Replacement claims

If a provider needs to correct or add a data element on a claim that has already been billed, a replacement claim must be submitted. Replacement claims may also be referred to as corrected claims. A replacement claim must be submitted with a claim frequency code of "7" for 837P transactions. For 837I transactions, the last digit on the type of bill must be "7". A replacement claim should not be submitted until the original claim has reached the final adjudication status.

Final adjudication status is considered when a claim has been processed and either paid or denied.

Examples of when a replacement claim would be used:

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

Claim adjustment/reconsideration requests

Hennepin Health has a form to request a claim adjustment or a claim reconsideration. The claim adjustment/reconsideration request form should only be used in cases where an electronically submitted void or replacement claim has been unsuccessful or is not appropriate. The claim adjustment/reconsideration request form should not be used in lieu of submitting a void or replacement claim or to request refunds that the provider considers due.

A claim adjustment/reconsideration request form should be used when the provider believes that a claim was denied in error or incorrectly paid due to a special circumstance that needs explanation, and is requesting that Hennepin Health reconsider the claim to be paid or for additional payment.

When a claim adjustment/reconsideration request form is determined necessary and appropriate, the provider must make sure that all the data provided is complete and accurate.

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

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

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

Practitioners/providers can appeal a claim denial; however, practitioners/providers are not allowed to bill members in accordance with MN Rule 9505.0225.

19.2 Coordination of benefits

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

As a Minnesota Medicaid Managed Care Organization, Hennepin Health coordinates benefits to ensure that all other sources of health care coverage are billed and paid by the primary insurance carrier (as applicable) before processing claims.

Hennepin Health members may have other health care coverage. It is the provider's responsibility to verify member eligibility and primary coverage before providing services and to also follow the primary payor requirements. If a member has Medicare or other third-party

liability (TPL), the provider must bill the insurance and receive payment to the fullest extent possible before billing Hennepin Health. Hennepin Health is considered the payer of last resort. Third party payers may include:

- Private or public health insurance coverage
- Accident/injury insurance (auto, tort, workman's compensation)
- Medicare
- Veteran's benefits

Verification of benefits

To verify benefits and other coverage information for a Hennepin Health member, please contact Hennepin Health Provider Services at 612-596-1036, press 2 (800-647-0550), TTY 711, or utilize the Hennepin Health Provider Portal (see Section 21). Eligibility and other coverage information may also be obtained through the DHS, MN-ITS application.

Reporting other health insurance coverage

Notify Hennepin Health of any new member health insurance coverage or termination. Information can be faxed to Hennepin Health with a cover letter and the verification printout from the primary insurance. The cover letter must include the following:

- Member Hennepin Health ID
- Member name
- Insurance carrier name
- Insurance policy number
- Insurance effective and termination date
- Provider NPI and name
- Provider contact information

Fax to: Hennepin Health COB, 612-336-1334

Billing third-party liability (TPL) claims

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

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

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

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

Services covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare as the primary payer.

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

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

Unsuccessful third-party liability (TPL) billing

Providers may submit claims to Hennepin Health after they have made three unsuccessful attempts to collect from the TPL payer except when the TPL payer has made payment directly to the recipient. Providers must not bill claims earlier than 90 days from the initial TPL attempt.

- Do not bill claims earlier than 100 days from the initial TPL attempt for a member whose TPL coverage is through a parent whose obligation to pay child support is being enforced by DHS.
- Each TPL billing attempt must be 30 days from the previous attempt.

Providers may submit a claims adjustment request for claims denied by Hennepin Health for the TPL. The claim adjustment request must meet the minimum attempts and the time span criteria, and the supporting documentation must be attached.

- Screen print or copy of the first claim sent to the TPL payer
- Documentation of two additional billing attempts
- All written communication received from the TPL payer

19.3 Prompt payment and timely filing requirements

A clean claim:

- Does not have defects or impropriety including any lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.
- Includes required provider and biller information on the claim that is consistent with what is on record with Hennepin Health.
- Includes a valid standardized code set (ICD-10, CPT-4, HCPCS, revenue codes, etc).
- Includes diagnosis coding that is not discrepant with the service provided.
- Includes valid authorization codes when required.
- Is submitted without attachment(s).

Complex claims include:

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

Complex claims will be paid or denied within 60 days.

Prompt payment

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

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

of the information noted above on how to submit a claim may result in Hennepin Health considering the claim "complex" for processing and it will not be eligible for interest payment (see 17.6) due to delayed processing.

Timely filing requirement

Providers must submit claims within 180 days from the date of service. Providers are required to submit interim claims for inpatient claims with an anticipated stay longer than 30 days in a calendar month. The only exception is when Hennepin Health is the secondary payer. In this case, the member's claim and primary payer's explanation of benefits (EOB) shall be submitted within 180 days of the primary payer's determination.

Please see provider manual Section 19.1 for submitting information related to a Timely Filing reconsideration.

19.4 Fee schedules

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

19.5 Duplicate claim

Claims billed more than once for a member by the same provider, with the exact CPT/HCPC code and date of service, will be denied as duplicate unless submitted as a replacement claim.

Standard duplicate rules

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

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

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

- Exact date of service
- Exact charge amount
- Exact service
- Exact place of service
- Exact procedure code
- Exact provider identifier

Duplicate claims review and recovery:

- All duplicate submissions will be reviewed.

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

Duplicate claims monitoring:

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

19.6 Interest payment

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

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

19.7 Auto recoveries

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

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

Example of an auto recovery from the 835 ERA:

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

19.8 Electronic Data Interchange (EDI)

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

Providers are required to adhere to State of Minnesota Uniform Companion guide requirements and the Administrative Uniformity Committee (AUC) best practices for claims submission. These documents are available on the AUC website. Hennepin Health requires all claims to be

submitted via an electronic institutional (837I) and professional (837P) EDI compliant transactions with no exceptions.

19.9 Clearinghouses

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

Hennepin Health requires claims be submitted directly or indirectly to one of our contracted clearinghouses. If you do not use one of these clearinghouses, contact your clearinghouse for intermediary access. Refer to the EDI page on the Hennepin Health website for more information about contracted clearinghouses.

Electronic attachments

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

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

19.10 Claims payment and electronic remittance advice (ERA)

Automated Clearinghouse (ACH) funds transfer

You must sign up to receive ACH payments for claims by completing a Hennepin County Automated Clearinghouse ACH enrollment form. If you do not choose to receive ACH payments you will receive a Hennepin County physical check (Hennepin Health is a Hennepin County department) along with the accompanying electronic remittance advice. ACH payments with accompanying electronic remittance advice documents are the preferred payment methodology unless otherwise specified. If the address on the check and/or the remittance does not match, is incorrect or needs to be updated, immediately contact Hennepin Health Provider Services at 612-596-1036, press 2 (800-647-0550), TTY 711. Claim payments are made on a weekly basis.

Electronic remittance advice (ERA)

Minnesota state statutes requires all health care transactions to be conducted electronically. These transactions include electronically transmitting provider's remittance advice.

Hennepin Health does not distribute paper remittance advice. Providers are required to contact one of the Hennepin Health contracted electronic remittance advice clearinghouses to set-up systems in order to begin receiving electronic remittance advices.

Hennepin Health requires the following information to set up your electronic remittance advice:

- Name of your electronic clearinghouse
- The agency's NPI or UMPI number and TIN number
- An agency contact person and phone number

19.11 Coding guidelines

Care guide case management for SNBC

The services listed below must be a designated benefit within the Hennepin Health SNBC providers contract agreement to be considered for coverage. Hennepin Health-SNBC providers submit claims with the codes listed in the grid below. If a diagnosis is not determined on date of service, please submit R69 on the claim. The supervising clinician is billed as treatment provider.

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

19.12 Out-of-network billing requirements

Out-of-network providers within Minnesota

Hennepin Health members can receive services from out-of-network providers in specific instances. Contact Hennepin Health Provider Services at 612-596-1036 (800-647-0550), TTY 711 or 800-627-3529 to inquire if the services you provide to a Hennepin Health member may be covered without a contract.

Provider information requirements

Hennepin Health requires specific provider information prior to processing an out-of-network provider claim. The information required for registration may be found at Non-Contracted Registration.

Completed registration information may be submitted to hhnetworkmanagement@hennepin.us.

Remember to indicate your electronic clearinghouse for claim submission and receipt of a remittance advice on the Non-contracted provider information form.

Claim submission requirements

- Providers practicing outside the State of Minnesota are required to submit claims electronically.
- Claims need to be submitted on the appropriate form for type of service provided.
- Claims need to be submitted electronically.
- Claims need to be submitted timely within one year from the date of service.
- Bill only one month of services per claim when billing multiple dates of service.

Refer to information on electronic claim submissions in this manual for instruction or by calling Hennepin Health Provider Services at 612-596-1036, press 2 (800-647-0550), TTY 711 or 800-627-3529.

Section 20: Credentialing

The Hennepin Health Credentialing Program is a comprehensive program that incorporates all aspects of the credentialing process and governance and is provided upon request.

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

This credentialing program may be changed at any time upon approval by the Hennepin County Board, the Hennepin Health Credentialing Committee (CC) or designee. Changes in legal, regulatory or accreditation requirements are automatically be incorporated into the Credentialing Program and made effective as of the requirement's effective date. Changes are effective for all new and existing providers from the effective date of the change. Hennepin Health makes every effort to communicate changes to Providers at least 60 calendar days of their implementation via provider communication channels including, but not limited to, this manual.

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

20.1 Policy on non-discrimination

Hennepin Health does not discriminate against any practitioner who is acting within the scope of their license under state law with respect to participation, reimbursement or indemnification solely on the basis of such licensure. Hennepin Health believes that our continued success depends on a positive environment complete with a network of qualified individuals regardless of race, ethic/national identity, national origin, religion, creed, gender, gender expression, sexual orientation or identification, disability, age, marital or military status, the types of procedures a practitioner performs within his or her scope of practice, the types of patients a practitioner sees, or any other characteristic protected under applicable local, state and federal laws. Participation criteria as set forth in the Credentialing Program are applied uniformly to all applicants for initial and continued participation.

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

a. The Credentialing department processes applications based on oldest received date.
b. A percentage of applications are peer audited prior to submission to CC or designee.
c. Quality Management (QM) investigates all complaints/grievances alleging discrimination and reports those findings to the CC.
d. Hennepin Health does not request, record, or track practitioner religion, national origin, creed, sexual orientation or disability.
e. Hennepin Health collects providers' birth dates, race, ethnicity, languages spoken for the purposes of access and accessibility for members. This information is not presented during the credentialing or recredentialing process.
f. Cases presented to CC for review are redacted of all identifying information. The Credentialing department is responsible for redacting CC discussion threads relating to the details of a case in the event the case is submitted for external or peer review.

Reports are generated on a monthly basis to determine the age of credentialing applications to ensure the oldest applications are processed first.

20.2 Policy on confidentiality of data

All committees described in the Credentialing Program, the Hennepin County Board of Commissioners and Credentialing staff supporting credentialing actions operate as review organizations pursuant to Minnesota Statute § 145.61 et seq. and professional review bodies pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 et seq.

Information obtained, created or reported pertaining to, or in support of, Provider credentialing is secured in the credentialing system with access limited to authorized individuals. Credentialing information and data gathered during the Credentialing process is not released except to the extent necessary to carry out one or more of the purposes of the review organization as described in Minnesota Statute § 145.64, or otherwise permitted or required by law. Release of credentialing information to any external organization or individual may only occur upon approval from Hennepin Health Provider Operations and Compliance leadership.

20.3 Credentialing Committee (CC)

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

The CC is a peer review body with members drawn from providers participating within the Hennepin Health network. The CC is responsible for reviewing and approving the credentialing program, granting authority and/or determining if a provider's Hennepin Health application for initial or ongoing participation meets the minimum professional criteria established by Hennepin

Health. This includes reviewing cases which meet the threshold for review, professional conduct concerns, substantiated QOC/QOS complaints and grievances. The CC may approve, deny, suspend, restrict or terminate a provider's status with Hennepin Health.

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

All other cases are delegated to CMO and/or AMD for review, reserving the right to escalate a case to CC for review. Emergent decisions may be made by the CMO or designee when reasonable information has been submitted indicating Hennepin Health member(s) may be endangered by potentially unsafe, unethical or inappropriate care or treatment. When an emergent decision is made resulting in the suspension, restriction or termination of a provider, written notification is sent to the provider.

If the CC takes action against an applicant or provider, the applicant or provider is notified within 30 calendar days following the date of the credentialing decision. The notification includes a written explanation, summary of reasons for the disciplinary action and a detailed description of the appeal process.

This description includes the following Applicant/Provider rights:

- To request a reconsideration of Hennepin Health's decision through an appeal proceeding.
- To be represented by an attorney or other person of applicant's choice.
- To be provided the date, time, and place of the appeal proceeding.
- To have a record made of the proceedings by a court reporter.
- To call, examine and cross-examine witnesses.
- To present evidence determined to be relevant by the AC regardless of its admissibility in a court of law.
- To submit a written statement at the close of the proceeding.
- The fax number, email address and USPS address to submit an appeal.

An applicant/provider must submit a written request for reconsideration of an adverse credentialing determination to the CC within 30 calendar days of receiving notification from Hennepin Health. Requests for reconsideration must address the issues identified by the CC including providing additional information and/or supporting documentation. Upon receipt of a reconsideration request, Hennepin Health sends the applicant/provider an acknowledgement communication. Failure to submit a written request for reconsideration within 30 calendar days of receiving notification of an adverse credentialing decision from Hennepin Health is deemed a waiver of the applicant/providers' right to appeal. Requests for postponement or extension, or failure to appear at the appeal proceeding without good cause, is deemed a waiver of the applicant/providers' right to appeal.

20.4 Appeals Committee (AC)

Appeal rights are not offered to providers with an active federal or state exclusion. Pursuant to Hennepin Health's contract with DHS as well as federal law, Hennepin Health is prohibited from contracting with any individual or entity listed on a federal or state exclusion list.

Appeal rights are offered to an applicant/provider when the CC denies an initial credentialing or recredentialing application, approves an application with conditions, alters the condition of Hennepin Health network participation or determines an applicant has privileges reduced, suspended, terminated or otherwise subject to adverse action based on professional conduct or competence.

AC members are selected by Hennepin Health's CMO and Compliance team. The AC consists of one member of the Compliance team serving as chairperson, and four practitioners holding an active MN medical license and are practicing within the same health care specialty as the appealing provider and are participating within the Hennepin Health network.

The AC facilitates scheduling and case review not less than 30 calendar days of receipt of applicant/provider appeal. Appeal proceedings occur prior to the effective date of the termination or other disciplinary action except in the case of an actual or potential danger to a Hennepin Health member, or a disciplinary action limited to less than 30 calendar days. The AC notifies the applicant/provider in writing of its intent to review the appeal including date, time and location of the AC hearing and other administrative details.

The AC reviews all pertinent documentation and any new information relating to the original decision. The AC makes its determination based on the information and evidence produced at the appeal proceeding including the oral testimony of witnesses, summary oral and written statements, all officially noticed matters, and all documentary evidence submitted to the CC and at the hearing. Following the appeal proceeding and the receipt of any written statements, the AC convenes to review and determine the case. The AC may uphold, reject or modify the original action. The AC's decision is by majority vote. The applicant/provider is sent written notification within 30 calendar days following the date of the AC's decision that includes a basis statement for the decision. Final determinations are binding and are not subject to further appeal. Upon completion of the appeals proceeding, no further rights to appeal or appear before the AC is extended.

If participation from the Hennepin Health network is denied or terminated, the applicant/provider is ineligible for credentialing reapplication for two years following the effective date of denial or termination unless the AC, in its sole discretion, deems a shorter period to be appropriate.

20.5 Hennepin Health credentialing staff

Hennepin Health credentialing staff develop and maintain the Credentialing Program and any credentialing manuals, policies, procedures, work guides and workflows necessary to ensure compliance with NCQA credentialing standards and guidelines, Hennepin Health, and applicable state and federal rules and regulations.

Credentialing staff are responsible for notifying applicants/providers of the following rights:

- To review information obtained and used to evaluate a credentialing application except for references, recommendations and/or peer-review protected information.

- To access the provider manual at any time via the Hennepin Health website.
- To receive information regarding Hennepin Health, its services, member rights and responsibilities.
- To receive the status of their credentialing or recredentialing application via email or phone call within three days of the initial request.
- To access information obtained by credentialing staff from outside sources such as state licensing boards and malpractice carriers used to evaluate credentialing applications.
- To access redacted copies or information summaries (redaction may be required to protect the confidentiality of an individual who provided information to the CC).
- To be offered ability to correct erroneous, missing, incomplete or discrepant information.

Hennepin Health, consistent with MN DHS protocol, considers the information listed on the NPI as issued by NPPES as the source of truth for name and taxonomy. Discrepancies noted between the NPI and other supporting documents are be presented to the provider for review and resolution.

In accordance with Minnesota Statute 62Q.97, a determination on the applicant's initial application must be made within 45 days after receiving the clean application unless the health plan identifies a substantive quality or safety concern in the course of provider credentialing that requires further investigation. An Applicant is notified within 3 business days, via email, of the discovery of an application discrepancy, missing documents or incomplete information. An Applicant is provided 10 business days from notification by Credentialing staff to correct erroneous, missing, incomplete or discrepant information obtained during the Credentialing process that varies substantially from the information provided by the Applicant and to submit a corrected statement and/or supporting documents via email to hhcredentialing@hennepin.us. The Applicant or designee is notified that failure to respond within 10 business days from the notification by Credentialing staff, results in the application being closed for lack of response. The Applicant or designee has the option to reapply once all requested information is received. Appeal rights are communicated via the Provider Manual and automated email response from the Credentialing inbox. Upon notice to the health care provider, clinic or facility, the health plan company is allowed 30 additional days to investigate any quality or safety concerns.

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

Information and documents obtained by Hennepin Health as part of the credentialing or recredentialing process must be collected and verified prior to all credentialing decisions. Credentialing staff are responsible for notifying providers within 60 days of approval for initial credentialing.

20.6 Acceptance of practitioners

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

The following practitioner types are subject to this credentialing program:

- Advanced practice registered nurses (APRN): nurse practitioners, nurse anesthetists and certified nurse mid-wife
- Acupuncturists
- Doctor of chiropractic (DC)
- Doctors of optometry (OD)
- Doctor of osteopath (DO)
- Doctors of podiatric medicine (DPM)
- Interventional radiologists
- Licensed alcohol and drug counselor (LADC)
- Licensed marriage and family therapist (LMFT)
- Licensed professional clinical counselor (LPCC)
- Licensed psychologist (LP)
- Master's-level clinical social workers (LICSW)
- Medical doctor (MD)
- Mental health rehabilitative professionals
    - Adult rehabilitative mental health services (ARMHS)
    - Intensive rehabilitative mental health services (IRMHS)
- Physician assistants (PA)
- Psychiatrists
- Psychologists doctoral or master's-level (Ph.D., Psy.D, Ed.D, MA, MS)
- Psychotherapists (Ph.D., Psy.D, Ed.D, MA, MS)
- Oral and maxillofacial surgeons

Practitioners that do not require credentialing include but are not limited to: Physical, Speech-Language and Occupational Therapists, Certified Registered Nurse Anesthetist (CRNA), Traditional Mid-wife, Doula, Anesthesiologist, Diagnostic radiologist or Critical Care, Emergency Medicine or Hospitalist Practitioner solely in a hospital.

20.7 Criteria for participation

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

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

- Applicant has not been sanctioned or excluded by federal, state or local government programs.
- Applicant does not have a history of professional liability lawsuits or other incidents, or the applicant fails to disclose such history that constitute a pattern and/or indicate a potential QOC/QOS concern.
- Applicant has not been involuntarily terminated from professional employment as hospital medical staff, or resigned from professional employment or as hospital medical staff after knowledge of an investigation into applicant's conduct, or in lieu of disciplinary action.
- Applicant has not disclosed an ongoing medical or physical condition likely to adversely affect applicant's ability to perform the essential functions of applicant's profession with or without reasonable accommodation.
- Applicant has not disclosed an ongoing medical or physical condition that could adversely affect applicant's ability to practice safely and/or constitute a direct threat to the health and safety of others.
- Applicant has not used illegal drugs during the past three years.
- Applicant has not engaged in disruptive behavior as specified in Hennepin Health policies that inhibits the performance of the job responsibilities of Hennepin Health staff.
- Applicant has not engaged in other behavior, related to applicant's role as a health care professional, which calls into question applicant's judgment, honesty, character and/or suitability to provide care to Hennepin Health members.

20.8 Initial credentialing process

Hennepin Health follows a defined process and makes all credentialing decisions using criteria based on the provider's ability to deliver care. Upon receipt of an application, credentialing staff review the application to ensure it meets the participation criteria set forth in the credentialing program. Practitioners must be credentialed and approved for network participation prior to providing care to members, submitting claims or being listed in any member materials or provider directories.

An applicant is required to undergo initial credentialing if:

1. Applicant is new to the Hennepin Health network.
2. Applicant has had a break in network participation greater than 30 days.
3. Applicant failed to recredential in a timely manner.
4. Applicant is no longer affiliated with a Hennepin Health delegate.
5. Applicant initial credentialing file was closed due to non-responsiveness.

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

Credentialing staff presents applicants to the CMO or designee for clean file and administrative review, and to CC for those meeting thresholds for review. The CC will rescind approval of an applicant for participation in the event the applicant is not actively practicing at a Hennepin Health contracted facility within 180 calendar days of the CC's decision.

Hennepin Health does not fully credential locum tenens hired to cover practitioners for less than 90 days. Locum tenens is defined as a practitioner who is filling in for another practitioner on a temporary basis and does not have an independent relationship with Hennepin Health. Practitioner information must be submitted for the locum tenens and the primary source verification of license, sanctions and adverse actions must be completed with no adverse results. Locum tenens with adverse events are required to complete initial credentialing.

20.9 Recredentialing process

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

Credentialing staff sends an email request to the provider credentialing contact to notify them of the practitioner(s) recredentialing due date with Hennepin Health. Credentialing staff emails a Minnesota Uniform Recredentialing application form and checklist of supporting documents, within three business days of request.

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

Credentialing staff reviews all applications and determine completion status. If an application is incomplete, credentialing staff follows the recredentialing follow-up process. Credentialing staff presents practitioners to the CMO or designee for clean file and to the CC for those meeting thresholds for review.

20.10 Primary source verification

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

- The primary source (or its website).
- A contracted agent of the primary source (or its website) where Hennepin Health has obtained documentation indicating a contractual relationship between the primary source and the agent that entitles the agent to verify credentials on behalf of the primary source.
- State Medicaid agency or intermediary.
- List of Excluded Individuals and Entities maintained by the Office of the Inspector General (OIG).

- Medicare exclusion database.
- Federal Employee Health Benefits Plan (FEHB) Program department record published by the Office of Personnel Management, Office of the Inspector General.
- National Plan and Provider Enumeration System (NPPES).
- Excluded Parties List System (EPLS) via Systems for Awards Management.
- Drug Enforcement Agency (DEA) or copy of DEA certificate.
- American Medical Association (AMA) Physician Masterfile, American Osteopathic Association (AOA) Official Osteopathic Physician Profile Report or Physician Master File (DEA only).
- Social Security Death Master (SSDM).

20.11 Sanction information

Sanction verification is required for credentialing and recredentialing and must be completed within 180 days prior to the CC approval date. Hennepin Health verifies Medicare and Medicaid sanctions, state sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides care to Hennepin Health members.

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

- State agencies
- Federation of State Medical Boards (FSMB)
- Minnesota Board of Chiropractic Examiners
- Federation of Chiropractic Licensing Boards' Chiropractic Information Network-Based Action Databank (CIN-BAD)
- Minnesota Board of Dentistry
- Minnesota Board of Podiatric Medical Boards
- Federation of Podiatric Medical Boards
- Minnesota Board of Behavioral Health and Therapy
- Minnesota State Board of Nursing
- Minnesota Board of Marriage and Family Therapy
- Minnesota Board of Psychology
- State of Minnesota Board of Social Work

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

- State Medicaid agency or intermediary

- List of Excluded Individuals and Entities maintained by the Office of the Inspector General (OIG)
- Medicare exclusion database
- Federal Employee Health Benefits Plan (FEHB) Program department record published by the Office of Personnel Management, Office of the Inspector General
- Federation of State Medical Boards (FSMB)
- NPDB
- Social Security Death Master File (SSDM) via Social Security Administration
- Minnesota Health Care Programs (MHCP) Excluded Provider Lists (Individuals and Groups) Medicare/Medicaid Provider Enrollment (DHS Provider File)

Any applicant discovered on a sanction or exclusion report results in an immediate halting of the initial credentialing process and denial of the applicant's applications. If the provider is currently in Hennepin Health's network, the provider is immediately suspended from the network and submitted to the CC for review and determination. The CC review includes information from the applicable agency and/or written statements from the provider. If a previously issued Medicare/ Medicaid sanction is lifted, the provider must present a copy of the reinstatement letter as issued by the applicable government and/or state agency to Hennepin Health for further consideration. Any credentialing or recredentialing file involving a previously issued sanction that has since been lifted is submitted to the CC for review.

20.12 Site visits

Hennepin Health conducts a quality assessment site visit if the provider's location(s) meets the following threshold:

1. The provider has not had a MDH or DHS site visit within the last 36 months.
    a. If MDH or DHS suspends site visits due to a public health emergency, Hennepin Health follows the policies of those agencies.
2. The provider is not accredited through one of the following:
    a. American Association for Accreditation of Ambulatory Surgery Facilities
    b. Accreditation Association for Ambulatory Health Care
    c. American Academy of Sleep Medicine
    d. Accreditation Commission for Health Care
    e. Commission on Accreditation of Birth Centers
    f. Commission on Accreditation of Rehabilitation Facilities
    g. Continuing Care Accreditation Commission
    h. Community Health Accreditation Program
    i. Council on Accreditation
    j. Healthcare Facilities Accreditation Program

k. National Committee for Quality Assurance

l. The Joint Commission

m. Utilization Review Accreditation Commission

3. A location is opened under an existing contract where provider policies have changed or new services have been added.
4. An organization is undergoing a pre-Delegation or Delegation audit

Hennepin Health reserves the right to conduct a site visit on a facility that meets the threshold for review including sites that have member complaints or those with professional conduct concerns or those with an in-process or current Hennepin Health Delegated Credentialing Agreement.

20.13 Delegated credentialing

In addition to the terms of the credentialing program, providers interested in entering, or currently entered, into a delegated credentialing agreement with Hennepin Health to perform practitioner credentialing on behalf of Hennepin Health are subject to the process set forth in the Delegated Credentialing Manual. The Delegated Credentialing Manual is provided upon request.

20.14 Ongoing monitoring and interventions

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

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

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

QOC/QOS grievance and complaint resolution

Credentialing staff make every effort to resolve complaints against a provider in an efficient and thorough manner. If the credentialing team is made aware of a member complaint or grievance against a provider in relation to QOC/QOS, the complaint or grievance and all supporting documentation, including any previous complaints, concerns or adverse actions, is escalated to QM for investigation within one business day of receipt. If the Provider has prior complaints, these complaints are submitted to QM as part of the historical file.

If there are objective findings to substantiate a claim and it involves a reportable offense under the appropriate regulatory agency, the provider is immediately suspended from the Hennepin

Health network. Credentialing staff submits all findings to the CC or designee for review and determination. At minimum, on a bi-annual basis, a report of all adverse actions and QOC/QOS complaints or grievances is generated and reviewed by leadership. Providers who reach the threshold for review are submitted to the CC for review and determination. Provider retaliation of any kind against a complainant may result in disciplinary actions including, and up to, termination from the Hennepin Health network.

Corrective action plan monitoring

A provider may be placed on a corrective action plan (CAP) if a concern is identified during the credentialing or recredentialing process or intervals between cycles, a pattern of substandard professional performance is identified, or there is a failure to comply with the requirements of the Hennepin Health credentialing program. All CAPs are submitted to the CC and Hennepin Health Compliance team for review and approval.

Credentialing staff monitors CAP compliance and reports status updates to the CC and Compliance department. Monitoring may include site visits or credentialing audits of the provider. Provider timelines for completion of a CAP are determined on a case-by-case basis based on the severity of the noncompliance with best efforts made to provide a minimum of 60 days for provider to address and implement corrective actions. Hennepin Health reserves the right to determine the monitoring frequency of the CAP progress which is typically monthly. CAP progress and final results are submitted to the CC for review and determination of CAP closure. When all CAP interventions are completed, Hennepin Health provides written confirmation of the CAP closure to the provider.

The CC may deny or suspend a provider based on the nature or severity of an open CAP. Failure to comply with CAP requirements may result in disciplinary action including termination of a provider from the Hennepin Health network. Notification of professional conduct concerns that are unrelated to an existing and active CAP results in initiation of a new investigation.

20.15 Disciplinary action

If Hennepin Health receives information suggesting that a disciplinary action or professional conduct concern exists with a provider, an investigation is conducted that includes:

1. Contacting the provider to conduct an initial discussion of the findings.
2. Obtaining the provider's explanation in writing of the details regarding the alleged professional conduct concern or disciplinary action including:
    a. Details and nature of the action.
    b. Date(s) of allegation, findings summary and investigation closure.
    c. Requirements to satisfy adverse action, complaint, grievance or other judgments placed by a licensing board or other official.
    d. Limits on practice if any.
    e. Nature of a condition that may impact their ability to practice.
    f. Length of time provider is or was affected by the condition.
3. Obtaining court or board documents regarding the action or concern.

The credentialing staff compiles all relevant information noted above and refers the matter to the CC or designee for review and determination. The CC or designee may request case review and involvement from a member of the Compliance department and/or Special Investigations Unit (SIU).

The CC or designee, on its own initiative or following a recommendation from credentialing or the SIU, may request a) further information/statements from the provider, b) further information/statements from the reporting source, and/or c) direct the provider to appear before the CC to discuss issues relevant to the investigation.

Providers will be notified of the disciplinary action within 30 calendar days of when the action is taken. The notification includes a written explanation, summary of reasons for the disciplinary action and a detailed description of the appeal process.

Professional conduct concerns

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

Hennepin Health will investigate reports regarding provider conduct or business practices that may include, but are not limited to:

- Unethical or unsafe practices (in violation of state/city/county safety codes or regulations).
- Unsanitary conditions or those in violation of OSHA and/or ADA standards.
- Violations of privacy or security of patients' data as required by federal, state or local laws and regulations.
- Evidence of malfunctioning or unmaintained medical equipment.
- Evidence of substance use disorders impacting patient care.
- Discrimination against patients.
- Practicing outside the scope of their license/certification.
- Conflict with Hennepin Health or industry health care standards and requirements.
- QOC/QOS complaints or grievances.

The CMO reserves the right to determine if an act or practice falls under the definition of a professional conduct concern. The CC or CMO may determine that a professional conduct concern does not currently warrant disciplinary action or termination from participation with Hennepin Health. The CC or CMO, in its sole discretion, determines any ongoing monitoring and the duration required, and has the right to extend, end or reverse the monitoring duration. New information and/or findings brought forth during any monitoring period is submitted to the CC or CMO for review and determination.

Hennepin Health determines whether and when any actions are reported to the appropriate federal, state or local agencies or authorities, state licensing board, national licensing board or NPDB. Notification to such authorities takes place within 10 business days from the CC or CMO determination.

Administrative suspension by credentialing staff

Credentialing staff may administratively suspend a Practitioner if a leave of absence exceeds the practitioner's current 36-month recredentialing cycle, if a practitioner fails to complete the recredentialing process or if a practitioner's MHCP status is denied or terminated. Exceptions are made for reasons of Family Medical Leave Act (FMLA) or military leave as appropriate.

Credentialing staff immediately administratively suspends a provider upon notice of a provider's license being revoked or suspended, an exclusion from participation in any federal, state or local government program, failure to meet Hennepin Health's minimum malpractice insurance requirements or loss of active MHCP enrollment status. In such cases, credentialing staff submits a notification of the findings to the CC or designee for review and determination.

Section 21: Provider rights and responsibilities

21.1 Provider rights

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

21.2 Provider responsibilities

- As providers, you are expected to verify member eligibility and coverage.
    - Hennepin Health member eligibility information is available through Change Healthcare Payer Connectivity Services™ (PCS). To access the PCS portal, you or your organization must be registered with PCS. To register, contact PCS Support Services at 877-411-7271 or chc_pcssupport@changehealthcare.com.
    - Hennepin Health member eligibility information can also be confirmed on the Hennepin Health provider portal. Administrators can request access to the provider portal by emailing HennepinHealth.ProviderPortal@hennepin.us.
- Provide services consistent with professional standards of care.
- Inform members of follow-up health care and offer training in self-care or other measures to promote their own health.
- Obtain a thorough patient history to avoid duplication of services.
- Help arrange or coordinate other covered services (X-rays, laboratory tests, therapies, DME, etc.); contact Hennepin Health Provider Services at 612-596-1036, press 2 (800-647-0550), TTY 711 (800-627-3529) for more information, such as finding in-network providers and phone numbers to contact.
- Provide care in collaboration with members or authorized representatives.
- Notify Hennepin Health of members whose care will be transitioned to another provider due to the member's refusal to follow the clinic and health plan guidelines. To notify Hennepin Health of this decision, providers should call Member Services at 612-596-1036.
- Notify Hennepin Health of complex discharge plans. Call Member Services at 612-596-1036 and ask to speak to a medical services coordinator.
- Providers must be licensed by the state to provide services to any plan members.
- Provide health care to members in a culturally competent manner.
- Providers agree to participate in Quality Management initiatives and cooperate with Quality of Care and Quality of Service complaint reviews.
- Document prominently an advance directive (living will, health care power of attorney) in members' medical records.

- Comply with the U.S. Civil Rights Act, Americans with Disabilities Act, Rehabilitation Act of 1973, Age Discrimination Act and applicable federal and state funds laws.

Section 22: Provider accessibility, availability and continuity of care

22.1 Appointment guidelines

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

- Urgent or acute: same day access or within 24 hours
- Routine: physicals or health maintenance exams - 45 days

Access and availability survey

As one of several methods for gathering appointment availability, Hennepin Health sends an annual survey to providers to collect information for both urgent and routine visits. Access survey results are shared with Hennepin Health's Network Management, Medical Administration and Quality Management departments who address actionable items in the survey results to improve member access.

22.2 Continuity of care

In the case of a provider termination, Hennepin Health will provide a mechanism to ensure that an adequate provider network is available to members and to ensure that continuity of care for members is not compromised.

Termination for cause

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

Termination not for cause

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

Notification

Hennepin Health will review provider/patient history within six months or the remaining current calendar year to identify affected members, and will inform affected members regarding the provider termination (for cause) at least 15 days prior to the termination effective date or as soon as possible.

Hennepin Health will review provider/patient history within six months or the remaining current calendar year to identify affected members, and will inform affected members via letter

regarding the provider termination (not for cause) at least 30 days prior to the termination effective date or as soon as possible.

The member will receive instructions on the procedure by which members will be transferred to another provider and/or practitioner. Under "not for cause" terminations, members with special medical needs, special risks or other special circumstances that require the member to have a longer transition period will be notified of the change.

Authorization for continued specialty care

Service authorizations are not needed for accessing specialty physician care from any Hennepin Health contracted provider. For members newly enrolled with Hennepin Health, the Medical Administration team will provide authorization to receive covered services through the member's current provider for the following conditions:

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

Transportation

For new health plan members, Hennepin Health will honor prior public transportation exemptions and/or STS certifications for a period of one year from the member's initial enrollment effective date with Hennepin Health. The members will need to provide a copy of the certification and/or exemption forms prior to scheduling any rides.

New health plan members with established transportation services at the time of initial enrollment, and receiving such services through non-contracted providers, will be allowed to continue receiving services from the non-contracted provider for 30 days. After 30 days, Hennepin Health will transition transportation services to a contracted transportation provider.

The need for continuing utilizing a non-contracted provider for a period longer than 30 days must brought to the attention of Hennepin Health at a minimum of 14 days prior to the expiration of the initial 30 days grace period.

A prior authorization is required for non-contracted providers before services are rendered.

Limitations

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

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

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

22.3 Provider non-interference

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

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

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

Section 23: Non-discrimination affirmative action

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

Section 24: Culturally competent care

24.1 Provider requirements

Cultural competence requires organizations and their personnel to:

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

Hennepin Health makes an effort to recruit and retain providers able to meet the cultural needs of our members.

24.2 Provider responsibilities

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

Section 25: Sub-contractual relationship and delegated entity

Hennepin Health retains the responsibility for performance of all delegated activities. Hennepin Health implements review and reporting requirements to ensure that the delegated entity performs all delegated activities appropriately, and ensures subcontractors have the capacity to deliver and maintain performance standards for delegated activities through a formal agreement. All delegated activities are performed as required by Hennepin Health and in accordance with applicable law, any applicable standards set forth by the National Committee for Quality Assurance (NCQA), and other state or federal regulatory bodies.

Physician incentives and disclosures

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

Section 26: Marketing/Communication and Outreach (MCO)

Providers must contact Hennepin Health prior to the distribution of marketing/communication materials that reference Hennepin Health plans as outlined in the provider contract. In addition, materials must meet state and federal requirements. Any marketing, communication or outreach materials providers would like to distribute must be submitted to Hennepin Health for approval by the Minnesota Department of Human Services (DHS). Approval can take up to 30 days.

26.1 Provider activities

Providers may:

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

Providers cannot:

- Quote or compare benefits to patients.
- Provide false or misleading information including asserting that a patient must enroll in a specific plan in order to obtain or maintain covered benefits.
- Say that a particular plan is endorsed by the state.
- Persuade a patient to enroll in a particular plan with the use of rewards, favor or compensation.
- Steer patients toward a health plan.
- Provide information to patients that compares the benefits of health plans without prior approval of all health plans involved and DHS.
- Mail plan information to patients without Hennepin Health's consent and approval.
- Discriminate against patients when providing permitted marketing.

Section 27: Glossary

Appeals and grievances definitions

Action: 1) The denial or limited authorization of a requested service including the type or level of service; 2) the reduction, suspension or termination of a previously authorized service; 3) the denial in whole or in part of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure of Hennepin Health to act within the timeframes defined in DHS contracts; or, 6) for a resident of a rural area with only one managed care organization (MCO), the denial of an member's request to exercise his or her right to obtain services outside the network.

Appeal: An oral or written request from the member, or the provider acting on behalf of the member with the member's written consent, to Hennepin Health for review of an action. Attending health care professionals may appeal a Utilization Management decision without the member's written consent.

Attending health care professional: The health care professional providing care within the scope of the professional's practice and with primary responsibility for the care provided to a member. Attending health care professionals include physicians, chiropractors, dentists, podiatrists, mental health professionals and advanced practice nurses.

Expedited appeal: A request from an attending health care professional, a member or their authorized representative that Hennepin Health reconsider its decision to wholly or partially deny authorization for services as soon as possible but no later than 72 hours after receiving the request because the member's life, health or ability to regain maximum function could be jeopardized by waiting 30 calendar days for a decision. The request is made prior to, or during, an ongoing service. An attending health care professional request to have an appeal reviewed as an expedited appeal is always granted by Hennepin Health.

Grievance system: The overall system that includes grievances/complaints and appeals handled by Hennepin Health and with access to the state appeal process.

Grievance (also known as a complaint): An expression of dissatisfaction about any matter other than an action, including but not limited to, the quality of care or services provided or failure to respect the member's rights.

Medical necessity: A health service pursuant to Minnesota Rules, part 9505.0175, subpart 25, that is:

1. Consistent with the member's diagnosis or condition.
2. Is recognized as the prevailing standard or current practice by the provider's peer group.
3. Is rendered:
    a. In response to a life-threatening condition or pain.
    b. To treat an injury, illness, or infection.
    c. To care for a mother and child through the maternity period.
    d. To achieve a level of physical or mental function consistent with prevailing community standard for diagnosis or condition.
    e. As preventive health defined under Minnesota Rules, Part 9505.0355.

Notice of action: Notice of action includes a denial, termination or reduction (DTR) of service notice or other action as defined in 42 CFR § 438.400(b).

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

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

Clinical services definitions

Durable medical equipment (DME) is equipment that:

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

Elective admissions: Pre-planned, elective admissions to out-of-network facilities require an authorization prior to admission.

Emergency admissions: Hennepin Health members may access emergency services from any emergency department within the United States

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

Home care: A range of medical care and support services provided in a member's home. Services range from assistance with daily activities to more complex services involving nursing assessment and intervention.

Long-term acute care hospital admissions (LTACH): All LTACH admissions require authorization prior to the member transfer to a LTACH level of care.

Non-durable medical supplies includes supplies that:

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

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

Prosthetics are devices that:

- Replace all or part of a limb.
- Replace all or part of the function of a permanently inoperative or malfunctioning limb.

- Must be ordered and/or prescribed by a physician, physician's assistant, or nurse practitioner.

Psychiatric admissions: Hennepin Health members may access acute psychiatric services from any hospital within the State of Minnesota.

Credentialing definitions

Administrative review: Credentialing files that meet a set of criteria which are submitted with affirmative disclosure of misdemeanor convictions or other administrative variances that do not meet the qualifications for Credentialing Committee review.

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

Applicant: A practitioner or provider that submitted the required documentation and is seeking to become or continue to be a credentialed provider within the Hennepin Health network.

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

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

Clean file: Credentialing files for providers that have been reviewed by credentialing staff and approved by the CMO or designee as complete without variation from professional or administrative criteria.

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

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

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

Credentialing program: A written document which contains Hennepin Health's credentialing and recredentialing requirements, policies and procedures and includes, by reference, the Organization Credentialing Manual and the Credentialing Delegation Manual.

Delegate: Provider that enters into a delegated credentialing agreement and agrees to manage the credentialing and recredentialing process for designated practitioners employed and/or contracted with the delegate in a manner consistent with the Hennepin Health credentialing

program, Nationally Committee for Quality Assurance (NCQA) credentialing standards and guidelines, statutory and regulatory requirements.

Delegated credentialing agreement: A formal process by which Hennepin Health delegates certain credentialing and recredentialing functions to a specific participating organization ("delegate") giving the organization authority to perform practitioner credentialing on behalf of Hennepin Health consistent with the standards of Hennepin Health's credentialing program.

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

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

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

Practitioner appeals: Practitioners or providers participating with Hennepin Health who appeal a CC or designee decision.

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

Professional conduct concern: A problem or situation that puts a member at risk, fails to meet quality of care standards for a practitioner's peer group, or represents a departure from a provider's scope of practice or licensure.

Professional review: Credentialing files that meet a set of criteria which are submitted with affirmative disclosure of criminal, professional or malpractice incidents with impact to license to practice or related to clinical performance, and which meet the threshold for CC review.

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

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

Recredentialing: The re-review of qualifications and credentialing criteria for providers every 36 months in accordance with the process described herein.

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

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

Culturally competent care definitions

Culture: The thoughts, communication, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.

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

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

Cultural and linguistic competence: The ability of health care providers and organizations to understand and respond effectively to member cultural and linguistic needs.

Fraud, waste, and abuse definitions

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

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

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

Claim: For purposes of the False Claims Act (FCA), a claim includes any request or demand for money that is submitted to the U.S. government or its contractors such as an HMO contracting with CMS to provide Medicare or Medicaid benefits.

Provider accessibility and availability definitions

Emergency: Care which is medically necessary to preserve life, prevent serious impairment to bodily functions, organs or parts, or prevent placing the physical or mental health of the member in serious jeopardy.

Urgent: Acute, episodic medical services available on a 24-hour basis that are required in order to prevent a serious deterioration of the health of a member.

Routine, non-urgent: Medical services that are not urgent in nature, i.e., preventative services or well-visits.

Contact information

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