HealthPartners®

Index:

HealthPartners Referral System

This is a summary of how HealthPartners will work with you to manage referrals.

The model was designed to uniformly configure care systems to include the primary care medical group and its panel of designated specialists and associated hospitals. Each primary care medical group will designate its panel of specialists.

HealthPartners has defined the types of specialties that will comprise a care system. (See attachment) Your medical group will define the *specific* provider group(s) for each type of specialty.

Using input from our providers and our members, this streamlined referral model will improve the overall care delivery experience between physician's and their patients while decreasing the amount of administrative referral work—and re-work—for your medical group as well as the other provider's in your care system.

For members that are enrolled in products that require referrals, your care system will no longer need to enter referrals for any of the provider groups that are represented in your panel of specialists. The claims generated for covered services by the specialty groups in your panel will be processed without a referral.

We believe that care coordination by the patient's primary care physician is an essential aspect of total care. We will continue to communicate the importance of coordination of care by the primary care physician in our member communications and approaches. At the same time, we are eliminating the administrative processes that are member-dissatisfiers; that providers find unmanageable, inefficient and costly; and that are not effective methods of coordinating care for patients and providers. We are keeping referral processes in place that we believe add value to the best care outcome.

HealthPartners member communications will encourage members to coordinate their medical care with their primary care physician to achieve the best outcome.

The following page includes a list of the specialty types that are required to be included in the direct access panel for all members in all care systems.

Care System Specialty Panel

Specialty Type:

Allergy
Cardiology
Cardiovascular Surgery
Colon/Rectal Surgery
Dermatology
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Geriatric Medicine
Hand Surgery
Hematology/Oncology
Infectious Disease
Nephrology
Neurology
Neurosurgery
OB/GYN
Occupational Medicine
Opthamology
Orthopedics
Perinatology
Physiatry / Physical Medicine & Rehab
Physical Therapy
Plastic Surgery
Podiatry
Pulmonary Medicine
Rheumatology
Spine Surgery
Thoracic Surgery
Urology
Vascular Surgery

Additional Options:

Pediatric Subspecialties

Referral Management Policies

A Provider Recommendation for Further Services form may be required each time a provider directs a patient outside their direct access care network or denies a patient's request for a referral.

Please refer to the policies listed below. They are located in **the HPI Administrative Program: Care Delivery and Administrative Policies** that can be found in the Medical Policies section of this Web site.

- Referral Management: Provider Recommendation for Further Services
- Standing Referral Process
- Prior Authorization Review Process
- Prior Authorization Review Process for Medicare Products
- Member Appeals Process for Medicare Products, Primary Care
- Member Appeals Process for Medicare Products, Specialty Care

Contracted Specialty Provider List

HealthPartners Contracted Specialty Provider reports, bookmarked by specialty, are available through the Provider Home Page / Primary Care Reference Materials.

These reports are updated quarterly or as needed.

Contracted Providers can also be located on HealthPartners.com or through the following link:

http://healthpartners.com/locator/location/search/medical.do

HealthPartners

Provider's Recommendation for Further Services Form

General Instructions: ____**New Recommendation** ____**Revision to Current Recommendation**

- Do not authorize any DME or Home Health Care Services. Instead, call 952-883-6333 or toll free 1-888-467-0774.
- Enter only one Provider Recommendation per form
- Please Print
- Complete all sections. Failure to complete all sections may result in delay of entry of this recommendation.

PATIENT INFORMATION

NAME: _____ **DATE OF BIRTH:** _____

Member Number: _____

SERVICE INFORMATION

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

Type of Visit/Recommendation: (Please check one) ___Inpatient ___Outpatient Number of Visits_____

Diagnosis (ICD9 Code): Primary _____ Secondary _____

Service Category (4 Digit Code): _____ _____ _____ _____

Recommendation Status: ____ Approved ___ Denied Reason for Denial: _____ _____

Please Check those that apply:

___Workers' Comp ___MVA ___Third Party ___Other Insurance ___Medicare Primary/Medicare Number

PROVIDER INFORMATION

Services Recommended at:

Facility Name: _____ Federal Tax ID# _____

Address or Site: _____

Phone # _____ Professional's Name: _____

Services Recommended by:

Professional's Name: _____ Professional's UPIN# _____

Form Completed By:

Name: _____ Phone: _____

Clinic #: _____ Date: _____

Comments:_____

Please fax form to HealthPartners Claims Department, Attn: Referral Entry 651-265-1220
OR
Mail form to HealthPartners Inc, Attn: Referral Entry, P.O. Box 1289, Minneapolis, MN 55440-1289

Authorization Service Categories

Consultations

Auth Type = OP

1001 - Consult DX, Test & Treat (No CT/MRI) - In office consultations, diagnostic testing, and treatment (excluding CT Scan & MRI)-Up to 6 visits.

1003 - Consult-1 visit (No test/treatment) - One visit consultations, follow-up visits and second opinions-Excluding testing & treatment.

1007 - Consult and Treat (No tests) - In office consultations and treatment, excluding tests

1008 - Consult and Tests (No CT/MRI) - In office consultations and testing (excluding CT Scan & MRI), excluding treatment-Up to 3 visits.

1104 - Sameday Procedures & Ancillary Charges - Use for procedures performed on an outpatient basis.

1201 - OB Total - Obstetric Care including visits and delivery.

Tests

Auth Type = OP

1607 - Test (no CT/MRI) - Tests excluding CT Scan & MRI.

1711 - Test - CT Scan - CT Scan testing only.

1803 - Test - MRI - MRI testing only.

2201 - Sleep Studies - Sleep Studies performed at sleep centers.

Allergy Testing

Auth Type = OP

3701 - Allergy Injection Only - Allergy injection only

3702 - Allergy Serum Only - Allergy serum only.

Inpatient

Auth Type = IP

5000 - Inpatient - Inpatient services (facility charges only

Therapies

Auth Type = OP

1501 - Therapy-Radiation - Radiation Therapy

1502 - Therapy-Physical - Physical Therapy

1503 - Therapy - Chiropractic - Chiropractic Care

1506 - Therapy Speech - Speech Therapy

1509 - Therapy-Dialysis - Dialysis Services

1510 - Therapy-Rehab - Rehabilitation Therapy

1511 - Therapy-Respiratory - Respiratory Therapy

1512 - Therapy-Chemo - Chemo Therapy

1513 - Therapy-Occupational - Occupational Therapy

1514 - Habilitative Care - Habilitative services-can be PT, OT, ST, etc.

Infertility

Auth Type = OP

3201 - Infertility-DX eval only - Infertility diagnostic evaluation only.

3202- Infertility-Treatment - Infertility treatment only.

3203 - Infertility-Artificial Insemination - Infertility-Artificial Insemination.

Miscellaneous

Auth Type = OP

2502 - Facility Charges - Facility charges for outpatient, emergency room, urgent care and holding bed.

2601 - Blood Transfusion - Blood Transfusion.

3301 - Interpreter-Language & Sign - Language and Sign interpreter services.

3601 - Reconstructive Surgery - Reconstructive surgery.

1 Report: AU000 **HEALTHPARTNERS INC** Report
Page:
2 Run Date: 10/08/97 **REFERRAL AUTHORIZATION INQUIRY** GHI Prod
3 **MH01** 4 **PRIMARY CARE CLINIC NAME**

****

5 **MEMBER NAME AND ADDRESS:**
NAME
6 ADDRESS
CITY,STATE, ZIP

7 **BIRTH DATE:** 10-22-90

8 **MEMBER ID:** 30000000
9 **AUTH#:** 3090000
10 **AUTH TYPE**: MH
11 **CLINIC** 21-404
12 **GROUP**
13 **FACILITY:** REGIONS MH

14 **DIAG/DESC**:303.92 ALCOHOL DEP NEC/N 15 **REQ BY**: KMPETER 16 **REQ TYPE:** ORIG

17 SERV DT	18 ENCTR#	19 PREV AUTH'D	20 PROC/DESC	21 UNITS REQS	22 BILLED AMT
8-31-97	0		MAJOR THERAPY	100	$500.00

23 **COMMENTS FROM REQUESTOR:**
COMMENTS, COMMENTS... 09-05-97
COMMENTS, COMMENTS ...

24 **CLAIMS PAYMENT INFORMATION**
PAYMENT INFORMATION... 09-05-97
PAYMENT INFORMATION...

25 ***** APPROVED/NOT APPROVED**
26 *****SIGNATURE:**_____ **DATE:**_____

27 *****REFERRED BY PHYSICIAN (THIS IS A REQUIRED FIELD)**_____

28 *****COMMENTS:**_____

_____

29 HEALTHPARTNERS
ATTN: CLAIMS DEPARTMENT
8100 24TH AVE S
P.O. BOX 1289
MINNEAPOLIS, MN 55440-1289
FAX NUMBER: 265-1220

HealthPartners
Referral Authorization Inquiry Key

1. Report Name
2. Report Run Date and Run Time
3. Request Location- internal code used for directing authorization requests
4. Care Delivery System Name
5. Member Name
6. Member Address
7. Birth Date
8. Member Number
9. Authorization number generated by HealthPartners
10. Authorization Type (i.e. Mental Health, Inpatient, Outpatient)
11. Primary Care Clinic Number
12. Employer Group Number
13. Provider of Referral Services
14. Diagnosis Code and Description Found on Claim
15. The Claims Examiner who requested the authorization
16. Type of Request
    - ORIG: The original referral request
    - UPDT: Additional visits requested on an already existing authorization
17. Date of Service
18. Encounter number from HealthPartners claims system
19. Number of units/visits previously requested on this authorization
20. Procedure Code and Description
21. Units/visits requested on this authorization
22. Billed amount on the claim
23. Comments from the Claims Examiner who requested the authorization - the date comments were made is also indicated
24. Claims payment information- date is also included
25. Clinic must circle "Approve or Not Approved"
    - *If Clinic circles "Not Approved", clinic must provide reason in field 28*
26. Clinic must sign and date the authorization
27. The name of the referring (primary care physician) must be completed
28. Clinic can write in comments or special processing instructions
29. Address (or Fax Number) where Authorization can be sent

HealthPartners®

Pended Referral Information Form

To:_____ Date:_____
Fax#:_____

The attached authorization has been PENDED due to missing or incomplete information. Claims will not be processed against this referral until missing information is received.

Please complete identified information on attached referral and fax or return to address at bottom of this page. If you have questions, contact your Network Management Coordinator.

- ☐ Check box of product in which member is enrolled. Products not identified on form should be considered "HealthPartners".

Patient Information

- ☐ **Name**: Please provide full name including middle initial.
- ☐ **Date of Birth**: Please use four-digit century notation, (i.e. 2003)
- ☐ **Member Number**: This is the HealthPartners assigned member number.

Service Information

- ☐ **Start Date**: First date authorization should begin.
- ☐ **Expiration Date**: Final *valid* date of authorization.
- ☐ **Type of Visit**: Check appropriate box.
- ☐ **Number of visit**: Enter the maximum number of visits authorized.
- ☐ **Diagnosis (ICD9 Code):** A primary code of health condition must be submitted. Please include secondary diagnosis if applicable.
- ☐ **Service Category (4 Digit Code):** This code defines what services are approved. Please use four-digit code. Verbiage will not be accepted.
- ☐ **Authorization Status**: Designate whether your response is approved or denied.
- ☐ **Secondary coverage**: Please check box of appropriate secondary coverage if applicable. Policy Number of secondary coverage is required for "Other Insurance" or "Medicare Primary".

Provider Information

Referred To:

- ☐ **Facility Name**: Name of facility to which the patient is being referred.
- ☐ Federal Tax ID#
- ☐ **Address**: Please use complete address of facility.
- ☐ **Phone#:** Include area code.
- ☐ **Professional's Name**: Name of professional to which patient is being referred.

Referred By:

- ☐ **Professional's Name**: Provider authorizing referral services.
- ☐ **Professional's UPIN/NPI**: Providers unique identification number. If provider does not carry UPIN, please check appropriate box.

- ☐ Legibly complete last section of form with complete information. This information is required for entry of data and for use when questions arise regarding referral.

Referral Authorization Form
may be **faxed** to:
651-265-1220

Referral Authorization Form
may also be **mailed** to:
HealthPartners
PO Box 1289
Minneapolis, MN 55440-1289

Authorized Care Outside the Service Area

Overview-

Out of Area Care / Authorized Care Outside the Service Area is a benefit available to dependent students and members temporarily outside the service area for short-term travel. It covers certain medical outpatient services that cannot wait until the member will be back in the service area and is generally covered for members who do not have out of network benefits. Care needs to be medically necessary during the member's time outside the HealthPartners service area. Services require prior authorization by the health plan.

Please direct members inquiring about this benefit to Member Services for assistance.

Travelers-

For travelers, care must be follow-up services to a condition, which was diagnosed, and treatment started **prior** to the member leaving the service area. Coverage is available for 3 one-week periods per calendar year. They may be consecutive or non-consecutive weeks.

Dependent Students-

For dependent students, care does not need to be follow-up services to a condition, which was diagnosed, and treatment started prior to the member leaving the service area. Coverage is not limited to 3 one-week periods per calendar year.

Members Needing Unexpected Care While Traveling Outside the Service Area

Members may need unexpected care when traveling outside the service area.

HealthPartners members have access to the extensive Private Healthcare Systems (PHCS) network of providers for emergency and urgent care services. The network consists of approximately 300,000 providers across the country who have all met the PHCS provider credentialing standards.

If the member has questions about providers who participate in PHCS, have them call 1-800-530-4966 or visit the web site at www.phcs.com.

If a member is hospitalized while outside the area, they need to contact the CareCheck$_{sm}$ program at 1-800-942-4872 within two working days or as soon as reasonably possible to help HealthPartners manage their care and to ensure they receive the maximum benefit coverage.

These phone numbers are on the back of member cards.

HealthPartners Chiropractic Services

HealthPartners uses Chiropractic Care of Minnesota, Inc. as their contracted chiropractic network.

An updated list of these providers is included on the contracted specialty list that is sent on a regular basis to your clinic or managed care office and can also be located at HealthPartners.com.

Providers do not need to enter referrals for chiropractic care when members are directed to a provider that is in the HealthPartners Chiropractic Network.

Chiropractic "Equal Access" Law

In 1994 the Minnesota legislature enacted a law relating to chiropractic services that took effect July 1, 1997. The law, Minn. Stat. 62A.15, subd. 2 provides: All benefits provided by any policy or contract relating to expenses incurred for medical treatment or services of a physician must also include chiropractic treatment and services of a chiropractor to the extent that the chiropractic services and treatment are within the scope of chiropractic licensure.

This subdivision is intended to provide equal access to benefits for insured and subscribers who choose to obtain treatment for illness or injury from a doctor of chiropractic, as long as the treatment falls within the chiropractor's scope of practice. **This subdivision is not intended to change or add to the benefits provided for in these policies or contracts.** Fully insured members who use clinics or providers who do not refer to chiropractors can call Member Services and make arrangements for chiropractic care. All chiropractic care must be provided by a chiropractor who contracts with HealthPartners. Most member contracts cover chiropractic services for the treatment of acute neuro-musculoskeletal conditions.

HealthPartners Routine Eye Exam Network

HealthPartners has a designated network that members can access for routine eye exams. This network gives members a wide choice of eye providers but restricts the procedures to routine eye exams only. A referral from the clinic group may be necessary for any other evaluation or procedure.

The list of routine eye providers is included in the contracted specialty provider list that is routinely sent to your clinic / managed care office or can be located through HealthPartners.com

Direct Access to Obstetric and Gynecologic Services

Here are some reminders about the Direct Access to Obstetric and Gynecologic Services law that was effective January 1998. This law allows female enrollees direct access (meaning no referral required) to obstetricians and gynecologists affiliated with their designated clinic group.

If your clinic group has ob-gyn providers on staff, the enrollees will have direct access to them. Clinic groups that do not have these providers on staff have supplied names of the ob/gyn clinics that their members will have direct access to. These names are available to members via Member Services, our web page and in our provider directories.

Clinic groups may add ob-gyn provider groups at any time. Under the Department of Health's interpretation of the law, any ob-gyn provider that your clinic group uses on a regular basis for routine obstetric/gynecologic services must be available on a direct access basis. Please notify us immediately so we can include the names of any additional ob-gyn providers in our internal resource materials and in our printed directories.

There will be no change in the services that are covered or in the services that need to be prior authorized by the HealthPartners medical director.

Claims Payment:

There is no need to enter a referral when one of your designated ob-gyn physicians admits a patient to the appropriate hospital. If an ob/gyn provider admits to a non-preferred hospital or directs to a non-panel or non-contracted provider, a RAI may be generated to your clinic and should be approved if the physician is a direct access provider. It is important to know that claims cannot be denied for a member who used their designated ob-gyn provider and then was directed to a facility for medically necessary ancillary services or treatment.

Habilitative Benefit

Habilitative speech therapy, occupational therapy, or physical therapy is care rendered for conditions which have significantly limited the successful initiation of normal speech and motor development.

Please refer to the policies listed below. These policies are located in the" HPI Administrative Program Care Delivery and Administrative Policies" that can be found in the Medical Policies section of this Web site.

- Speech Therapy Outpatient – Habilitative
- Physical & Occupational Therapy- Outpatient Habilitative

How does this affect you?

When you see a patient who could benefit from a habilitative consultation, direct or refer the patient to a contracted HealthPartners habilitative provider **for one visit for a consultation only**. Your clinic will not be responsible for entering any further referrals for the habilitative therapies.

The list of contracted habilitative providers is included with the contracted specialty provider list frequently sent to your clinic or managed care office. If you do not have a current list, contact your Primary Care Relations & Contracting Service Specialist.

After the consultation, the contracted provider will send needed information to HealthPartners to determine if the patient meets the criteria for habilitative therapies. If approved, our case managers, in consultation with you, will follow the patient and enter any needed further authorizations for the therapies. The provider of therapy services **must have prior authorization** from HealthPartners or the charges will be their liability.
.
If you have further questions about a patient call 952-883-6333 or toll free 888-467-0774.

Summary of the benefit:

Habilitative speech, physical or occupational therapy will be covered for conditions that have significantly limited the successful initiation of normal speech and motor development. To be considered "Habilitative Therapy", functional improvement and measurable progress must be made toward achieving functional goals, within a predictable period of time toward a members' maximum potential ability.

Coverage is based on criteria outlined in HealthPartners Habilitative Therapy Coverage Policies.

Case Managers will determine whether the patient's policy includes this benefit. Self-insured employer groups may not offer habilitative services to their employees. Please have the member verify with Member Services Nurse Navigators to determine if they are eligible for services. The benefit has been effective for all fully insured members since November 1998.