HealthPartners

Directly Contracted Provider Manual Outline

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Quick Reference Contact Information

Use the HealthPartners Provider Portal to verify benefits, check claims status, remittance inquiry for reconciliation and much more. You'll find more details on the Portal on page 5, of this manual. For other questions that you have that are not available on the Portal, the contact information is below to help get you to the right place.

For HealthPartners Provider Portal logon and password issues and questions on Electronic Funds Transfer (EFT), contact:

Provider Electronic Commerce:
952-883-7505

For questions on eligibility, benefits, and claims for members with a commercial plan that you weren't able to get on the Portal, contact:

HealthPartners Member Services:

952-883-5000 or 1-800-883-2177

HealthPartners Care (PMAP/MNCare) and Medicare (Seniors plans) questions related to eligibility, benefits and claims that you weren't able to get on the Portal, contact:

Riverview Member Services:

HealthPartners Care (Medical Assistance, MNCare and SNBC) - 952-967-7998 or 866-885-8880
Minnesota Senior Health Options (MSHO) - 952-967-7029 or 888-820-4285

Medicare/Senior plans – 952-883-7979 or 800-233-9645

Provider Relations in the Dental Contracting/Network area:

Provider and clinic changes, dental network participation, Provider Portal training or other questions or issues:

Sharonette 952-883-7511; or Jill 952-883-6140

Specific questions regarding your HealthPartners provider agreement and reimbursement:

Michelle 952-883-5168 or 877-839-8199

You can also email us at dentalcontracting@healthpartners.com Fax: 952-883-5160

HealthPartners Dental Network Participation Information

- Clinic Participation
- Changes Dental Office/Provider changes
- HealthPartners Fee Schedules
- HealthPartners Provider Portal

Clinic/Provider Participation

HealthPartners contracts at the clinic level so all dentists in your office will be required to be credentialed and are considered participating dentists once credentialing is finalized. The clinic agrees to accept the HealthPartners fees, as well as patient co-payments, as full compensation.

Changes to your clinic and or providers - all forms noted below are located in the dental section of the Library on the HealthPartners Provider Portal. Submit all forms and applications to dental contracting.

All clinic and provider changes must be sent in writing to HealthPartners to ensure accurate claims processing and marketing of your clinic information on our website.
Changes include but not limited to:

- Provider changes
- Clinic Name changes, tax id, NPI and ownership changes
- Address, email and updates you would like to include on the HealthPartners website

All forms are located in the dental section of the Library on the HealthPartners Provider Portal. Submit all forms and applications to dental contracting.

Email dentalcontracting@healthpartners.com
Fax (952) 8843-5160

HealthPartners Dental Contracting
P.O. Box 1309
Mail Stop 21113A
Minneapolis, MN 55440-1309

Provider changes –submit the completed Dental Provider Change notice

New providers – all dentists and dental therapists must be credentialed with HealthPartners before providing care to members. The HealthPartners credentialing application is located in the dental section of the Provider Portal; once completed please email or fax the application to dental contracting. If you would like us to verify whether or not your new provider is already credentialed with HealthPartners through a different office, contact us at 952-883-6140, before you have them complete the application but it is important to do this well in advance as the credentialing process can take 45 days or longer once we receive the application. **Any claims submitted from non- credentialed dentists or dental therapists are denied to Provider Liability.** This is in accordance with your provider agreement with HealthPartners.

Ownership changes – submit the completed Ownership Change notice prior to the effective date of the sale to avoid claims issues. This form is required to be signed by the selling provider before we can make any changes in our systems regarding the change in ownership.

Fee Schedule Updates

Fee Schedules are mailed annually in October.

HealthPartners Provider Portal

We have an array of tools available on our HealthPartners Provider Portal that will make it easy for you to verify eligibility, review your remittance advices, and get estimates. See below on how to register if you have not done so already. We also have our dental forms and policies on-line.

Go to www.HealthPartners.com/provider.

No cost! No connection fees! Easy access!

HealthPartners Provider Portal offers these convenient online applications:

Eligibility and Benefits
Claims Status Inquiry
Claim Adjustment/Appeal Requests
Claim Attachment Submissions
Claim Inquiry Requests
Claims Estimator
Provider Data Profiles
Forms and Policies
Remittance Advice – Provider EOB
Provider Training Manuals

You may complete an online registration form for the HealthPartners Provider Portal at www.healthpartners.com/provider, and click on "Register Your Facility" located on the left side of the page under Shortcuts. Complete the Provider Self Registration form and our Electronic Commerce Department will mail you a letter with a PIN to activate your account. After registering this session, you will have immediate access to policies and resources. After activating with the PIN mailed to you, you can access secured applications such as Eligibility, Remittance Inquiry, Claim Status and more.

Provider Data Profiles:

You have the opportunity to provide detailed information about your clinic and providers that we will include on our website to promote your clinic. You can complete this on line with the Provider Data Profiles application or send in a form with the information. Please include your clinic URL, if you have one, and we'll include it on our website so members can link directly to your clinic's site.

Dental Plans, Benefits and Exclusions

- HealthPartners Dental Plans
- Preventive and Embedded Pediatric Dental Plans
- Specialty Care
- Enhanced Dental Benefits
- Sample Member Identification Cards

HealthPartners Dental Plans/Networks

HealthPartners Dental Open Access – this is our largest network that includes the HealthPartners Dental Group and all of our contracted offices. Members have one level of benefits in-network.

Tiered plans - members in tiered plans have different levels of benefits and the level of benefits they receive is based on where they go for their care.

> **Distinctions** – includes two different benefit levels in-network. Benefit Level 1 provides the highest level of benefits and includes the HealthPartners Dental Group and Park Dental. Benefit Level 2 provides the second level of benefits and all other contracted offices are in this tier.
>
> **Distinctions III** – includes three different benefit levels in-network. Benefit Level 1 provides the highest level of benefits and includes the HealthPartners Dental Group. Benefit Level 2 includes Park Dental and Benefit Level 3 provides the third level of benefits and consists of all other contracted clinics.
>
> **Customized Tiered plans** – large employer groups have the ability to customize their plan so we have a few tiered plans that have unique clinic tiering and your tier level can vary by plan/employer group.
>
> The good news is when you login to the Provider Portal and review benefits; you will see only the level of benefits applicable for your tier level.

Regional Dental Open Access - this is a smaller network that is used primarily for our Senior Freedom and preventive dental plans. In the seven county metro area, the network primarily consists of HealthPartners Dental Group and Park Dental clinics. In addition all specialty offices are included regardless of location.

State of MN Employee Network – includes all clinics that are compliant with Rule 101 and accept the State of MN Employer Fee Schedule There is a separate addendum for this network .

HPDG OA – includes HealthPartners Dental Group clinics

Select Dental – includes HealthPartners Dental Group and Park Dental clinics

HealthPartners Care and HealthPartners Inspire – HealthPartners medical assistance and MNCare plans which includes clinics that have elected to participate and sign a separate addendum to their agreement.

Preventive Dental Plans - preventive dental plans are part of the member's medical contract. The benefits include 100% coverage for eligible preventive and diagnostic services. The HealthPartners Regional Dental Network is most commonly used for preventive dental.

Embedded Pediatric Dental - many of the HealthPartners medical plans include the embedded pediatric dental benefit which is part of the requirement under the Affordable Care Act. They often have high medical deductibles that need to be met before they have coverage for their dental services. Members with this benefit have a medical ID card that includes a message on the back that indicates Pediatric Dental.

There is also medically necessary covered orthodontics with a two year waiting period for members in this plan. Strict guidelines for coverage apply and a policy outlining the guidelines is located on the Provider Portal in the Library Section – Admin Program for Dental Providers. All orthodontic cases will require prior authorization with complete records to determine

if there will be coverage. If the case is approved, it is important to remember that payment from HealthPartners, in many cases, will be based on the medical deductible being met. What this means is that payment could change annually, throughout the life of the case, as it will depend on where members are at with their deductibles. Another important aspect is that there is a monthly payment with no initial down payment which is different than the payment structure for commercial plans.

Specialty Care

If you need to refer HealthPartners members for specialty care, please remember to refer to network specialists to ensure members receive their highest level of benefits. We will provide you with a network specialty provider listing when you first contract with HealthPartners. For an updated list, contact us at dentalcontracting@healthPartners.com.

Enhanced Dental Benefits

Diabetes and Maternity Care

Research points to a connection between good oral and overall health, especially for those who are diabetic or pregnant. Our pregnant and/or diabetic members receive 100% coverage in-network for additional exams, cleanings, debridement, and scaling and root planing. HealthPartners will waive deductibles, coinsurance, and annual maximums for these services.

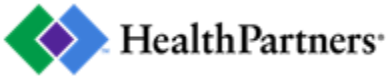
Diabetic members will receive extended benefits as long as they have effective HealthPartners dental coverage and pregnant members will have eight months of extended benefits from the time we receive notification from your office as long as their coverage is in effect with HealthPartners.

Located on the Portal, you will find the form to complete and send in to HealthPartners so we can update our system and allow members to receive the additional benefit

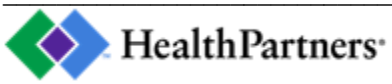
Little Partners

A lifetime of good oral health starts with our youngest members. For most employer groups, we offer the Little Partners benefit with enhanced coverage for children 12 years old and younger. **When Covered Services, are performed by a network dentist for children 12 and under, the receive 100% coverage – deductibles, coinsurance, and annual maximums will be waived (this excludes orthodontics).** Large employer groups have the option to customize their plans designs so they may exclude this benefit.

Sample Dental Member ID Cards



ID	30999999		Group	3200	January
Name	Jane K Doe				
Care Type	**HealthPartners Dental Open Access**			Code	PX999
	PCP	Code	PCP or Network		
Dental	1540	HP Dental Open Access			



ID	31999999		Group	0001	September
Name	Joe M. Smith				
Care Type	**HealthPartners Dental Distinctions**			Code	TX500
	PCP	Code	PCP or Network		
Dental	4040	HP Dental Tiered Plans			

Quality Assurance & Member Appeals

- Quality Assurance
- Credentialing
- Patient Satisfaction Surveys
- Member Concerns and Appeals

Quality Assurance Program

HealthPartners mission calls for quality health care at an affordable cost. To support that objective, HealthPartners provides a consistent review of pre-service and post-treatment claims activity. Dental services are evaluated against contracted coverage and for their appropriateness from a clinical perspective. Licensed dentists provide this review oversight, not administrative personnel. If care falls outside of accepted treatment norms, requests for additional documentation may occur before a pre-service claim is approved or a post-treatment claim is paid. Additionally, should a consistent pattern of practice activities falling outside that norm be determined, HealthPartners reserves the right through its contract agreement with providers to implement an audit of these activities. We strive to work openly and thoughtfully with our contracted dental care providers throughout our network, always with quality care and service being what our members receive.

Credentialing

HealthPartners credentials all dentists who provide care for HealthPartners members. Credentialing includes a formal review of a provider's educational and professional experience. **Providers may not see HealthPartners members until they have been accepted by the HealthPartners Credentialing Committee. Once the provider has been credentialed, a letter of acceptance with the effective date is sent to the provider.**

Information is verified through The National Practitioners Data Bank and State Dental Licensing Board, and is used to check insurance claims history. The following information is required from all dental providers to complete the credentialing process:

- State License Number (copy)
- DEA Number (copy)
- School Attended and year of graduation
- Malpractice insurance (copy)
- Social Security Number
- Date of Birth
- Practice History

Satisfaction Surveys

HealthPartners members are periodically surveyed to ascertain their level of satisfaction. Results will then be compiled and, as appropriate, shared with contracted dental providers.

Member Concerns and Appeals Process

The HealthPartners Member Services Department addresses patient concerns and employs an appeals process to resolve claims and disputes between patients, clinics or dentists. If the concern is regarding the quality of dental care provided, it is referred to the Dental Director for resolution. For any member related concerns, we may need to ask for additional information from the dental office regarding the treatment to help respond and resolve the concern. An external review process is also available to members who are not satisfied with the decision of the Member Appeals Committee

Your provider agreement with HealthPartners includes more detail around the requirement for compliance with this process.

Claims

- Billing Procedures for Submitting Claims
- National Practitioner Identifier (NPI)
- Claims Submission Policies
- Minnesota Care Tax
- Eligibility/Claims Estimator and Pre-Determination of Dental Benefits
- Remittance Advices
- Electronic Funds Transfer (EFT)
- Dual Coverage/Coordination of Benefits
- Medical/Dental Coverage and Claims Submissions
    - Cone Beams
    - Accidental Dental
    - In-patient hospitalization for dental care
    - TM Disorders
    - Oral Cysts/Tumors
    - Cleft Lip/Palate
    - Orthognathic Surgery

Billing Procedures for Submitting Claims

Electronic Dental Claims - HealthPartners Payer ID is CX009

Where to Submit Claims:

HealthPartners Dental Claims
PO Box 1172
Minneapolis, MN 55440-1172
(651) 265-1000

1. Claims must be submitted on a HIPAA compliant electronic dental claim (837d) within 90 days.
2. Current ADA codes from the Current Dental Terminology (CDT) manual are to be used. All services must be appropriately coded before the claim will be paid. The ADA publishes a new CDT manual annually so be sure you are using the current manual or visit their website at www.ADA.org.
3. Bill services at your regular fee schedule, not at HealthPartners contracted amounts.
4. HealthPartners average turn-around time for clean claims is two days.
5. You can check the status of a claim payment on the Provider Portal or contact member services.

National Practitioner Identifier (NPI)

Claims require Type 1 and Type 2 NPIs. For offices with only one provider, you may use a Type 1 for both. The important thing to remember is that you need to give us the NPI information, for provider(s) and clinic(s), in advance to ensure our systems are set up according to how you will be submitting information on the claims. If they don't match, claims will be denied.

Type I - issued to individual providers who render health and dental care.

Type 2 - issued to health and dental care organizations. If your practice includes more than one location and you want to receive checks at separate locations, you will need a separate Type 2 NPI for each office. If you have questions regarding NPI and how to apply, please go on-line to: https://nppes.cms.hhs.gov/nppes/welcome.doc

Claim Submission Policies

Please review the claim submission policies located on the Provider Portal in the Admin Program for Dental Providers.

Minnesota Care Tax:

When submitting MNCare tax on electronic claims, it is important to remember that you need to use the HIPPA compliant format and code set which requires that tax be included in the billed charge. This is also a requirement through your provider agreement with HealthPartners. If you want to itemize the tax, there is a field in the claim format to show the subset of the billed charge which is tax. If your file layout does not include a place for you to indicate the tax as a subset of the fee and you want to show the tax separately, you will need to contact your software management company. However, HealthPartners does not require you to list the tax separately.

Eligibility/Claims Estimator and Predetermination of Benefits

The Provider Portal has a variety of great tools that will help you obtain benefit information and estimates for your HealthPartners patients. The Eligibility tool gives you a breakdown of coverage by category of care including where the member is with preventive limits and their annual maximum. You can also get a detailed estimate when you use the Claims Estimator which allows you to enter the treatment plan and the estimation will process in our Claims system as if it were a normal claim so it will apply member deductibles, co-insurance and provider write-offs. In some cases, HealthPartners requires dentist review of claims that may include reviewing x-rays and chart notes so please refer to our claims policies in the Dental Admin Program on the Portal for more information. **We also recommend for high cost services, you submit a pre-determination of benefits.**

Remittance Advices

Remittance Advices are available through the Remittance Inquiry Application on the Provider Portal. Once you receive the claim payment, you can enter the claim information or check number to retrieve the member information and reconcile your payment.

Electronic Funds Transfer (EFT)

If you are interested in having direct deposit into your account, you can fill out a request on the Provider Portal. You will find the link for registration under e-Services. If you have any questions regarding the process or related questions contact our Provider EC area at 952-883-7505.

Dual Coverage/Coordination of Benefits

Claim Submission for Dual Coverage: The claim should be filed with the insurance carrier who has the primary responsibility as determined using the "Birthday Rule". File the claim with HealthPartners after payment is received from other carrier if the non-HealthPartners plan has primary responsibility. Make sure to include the primary carrier's Explanation of Benefits, which should include the line-level payment information, provider discount and member liability.

How do we determine which plan is primary?

- HealthPartners determines its order of benefits using the first of the following rules, which apply. This is in accordance with *Minnesota Rule 2742.0400 Rules for Coordination of Benefits*
  Nondependent/Dependent
  Dependent Child / Parents Separated or Divorced
  Joint Custody
  Active / Inactive Enrollee
  Longer / Shorter Length of Coverage
- When HealthPartners is considered the Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
- When HealthPartners is the Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

Medical/Dental Coverage and Claims Submissions

Where to submit Claims:

- Submit your electronic claim on a Health Insurance Claim Form (HCFA 1500)
  See list of Payor Id's on the Provider Portal under E Services
  HealthPartners Medical Claims
  Mail Stop 25510F
  P.O. Box 1289
  Minneapolis, MN 55440-1289
  Call 952-883-7755 or 1-800-444-4588 for medical claims status questions.

Where to send the prior authorization information:

HealthPartners Medical Services Department
Attn. Prior Authorization
Mail Stop 21108T
P.O. Box 1309
Minneapolis, MN 55440-1309

Cone Beam CT under our Dental and Medical Plans

Dental Coverage: Though coverage may vary by plan design, in general coverage may exist when done in conjunction with dental implant procedures and complex third molar extraction procedures.

- Coverage is at the complex oral surgery benefit (Basic Care II).
- Coverage is for in-network providers only.
- The benefit meters against the contracted annual maximum for coverage under the plan.

Medical Coverage: Though coverage may vary by plan design, the following are common instances when coverage may exist under medical policy. Note that coverage for Cone Beam CT typically does not exist if the associated procedure is also not covered under medical policy.

- Evaluation for dental implants when coverage criteria is met under accidental dental
- Removal of maxilla-facial tumors, cysts (non-odontogenic) and other neoplasms that may encroach on critical anatomic structures.
- Arthroplasty of the TMJ or TM joint replacement.
- Developmental mid-facial syndromes like cleft palate, Treacher-Collins Syndrome, etc.
- Surgical reconstruction following severe oral-facial trauma.
- For orthognathic surgery procedures when coverage criteria has been met.

Accidental Dental

If treatment is due to an accident, a prior authorization is required. (address above) The medical plan covers services dentally necessary to treat and restore damage done to sound, natural, unrestored teeth, as a result of an accidental injury (not including injury caused by biting or chewing). Clinical documentation is necessary to support the claim of injury including x-rays and/or photos that show the condition of the teeth prior to the date of the accident.

Same Day/In-patient Hospitalization for Dental Care

- If dental care needs to be performed at a hospital HealthPartners will cover the facility and anesthesia charges if at least one of the following statements is true:
- The member has a severe disability
- The member has a medical condition that requires hospitalization or general anesthesia for dental care
- The member is under 5 years of age
- The member is between the age of 5-12 and care in dental offices has been attempted unsuccessfully, and or there are extensive amounts of restorative care needed; exceeding 4 appointments
- There are psychological barriers to receiving dental care, regardless of age
- **Prior Authorization** is not required for members under 13 years of age

  Prior authorization is required for members 13 years of age and older, members who are severely disabled, members who have a psychological barrier to receiving care, or members with a medical condition that requires hospitalization or general anesthesia for dental care.

  Prior authorization is required for surgeries through our Medical Policy Department (QUI). See address above.

TM Disorders (TMD)

(Temporo Mandibular Disorders) Benefits for TMD fall under the member's medical plan. Prior Authorization is required for surgeries.

Oral Tumors/Cyst Removal

Pathologies of medical origin are benefited under the member's medical plan. If the cyst is of dental origin (i.e., cyst associated with third molar) there is no coverage under HealthPartners medical plan. If comprehensive dental coverage is in force through HealthPartners, the oral surgery level of benefits would apply.

Cleft Lip/Palate

Treatment of cleft lip and cleft palate of a dependent child (up to age 19, or 24 if a student), including office visits (covered under the Cleft Lip/Cleft Palate benefit), oral surgery (covered under the outpatient or inpatient benefit), speech therapy (covered under the Speech Therapy benefit) and orthodontia (covered under the Cleft Lip/Cleft Palate benefit), is covered.

Treatment of cleft lip and cleft palate for members other than a dependent child is covered only if they meet the requirements of reconstructive surgery or have impaired function. Adults who have not had initial repair of a cleft lip/cleft palate are not eligible for surgery unless medically necessary, as determined by our medical director.

Orthognathic Surgery

(See the Orthognathic policy for more details and rules – this is located on the Provider Portal – Dental Admin Program)

After the request for Orthognathic Surgery benefit is reviewed by HealthPartners, a letter is sent to both the member and provider. This letter informs both parties of the decision. Call the Medical Policy Intake line @ 952-883-5724 for questions on the prior authorization process.

HPI Admin Program

As a participating provider with HealthPartners, you are required to comply with the HealthPartners (HPI) Admin Program. Additional information regarding compliance is located in your HealthPartners Provider Agreement. The policies are located on HealthPartners Provider Portal in the Library section.

- Claims – Required Attachments
- Claims – Age Limitations
- Claims – Restorative Exclusions
- Claims – Rework on Bridges, Crowns and Dentures
- Claims – Prior Auth Requirements for Children and Adolescents
- Claims – Cone Beams
- Claims – Prior Auth Requirements for Children and Adolescents
- Claims – Attrition and Cosmetic Related Dental Services
- Claims – Miscellaneous Rules
- Continuity of Care
- Credentialing
- Dental Clinic Initiated Involuntary Reassignment of Member Clinic Assignment
- Medicare Bill of Rights for Medicare Products
- Medicare Member Appeals Process
- Member Rights and Responsibilities
- Orthognathic Surgery
- Physician Incentive Plans
- Privacy
- Provider Portal Electronic Data Access
- Preventing, Detecting & Reporting Fraud, Waste & Abuse

HealthPartners Forms

The forms below are available on the Provider Portal – once you login go to the Library section and choose Dental Provider Information.

- Dental Provider Change Notice Form
- Dental Clinic Ownership Change Notice
- W-9 form for Tax ID and Legal Name Changes
- Diabetes and Maternity Care Notification Form
- Provider Notification of additional Prophy's needed - HealthPartners Care Disabled Members
- DHS Waiver for Non Covered Services – HealthPartners Care Members

HealthPartners Care

- Participation
- Member Eligibility/Verification Process
- Benefits
- Minnesota Care - copayments
- Prior Authorization Requirements and Collection of Payment
- Specialty Care
- Orthodontic Guidelines and Record Submission Requirements
- Childhood Screening Recommendations
- Critical Access Providers
- Failed Appointments
- Language Interpreters
- Ridecare

Participation - this section applies only to clinics that are participating with HealthPartners Care network.

- HealthPartners Care – includes PMAP (Prepaid Medical Assistance Program), MSC+ (Minnesota Senior Care), MNCare, SNBC (Special Needs Basic Care) and MSHO (Minnesota Senior Health Options) members.
- Clinics that participate with this network agree to participation and have a separate payment addendum to their provider agreement. Providers agree to the reimbursement rates for this plan identified in your HealthPartners Government Programs Payment Addendum.

Verifying Member Eligibility

It is important for dental offices to verify member eligibility and dental benefits prior to the date of service. Members often change plans and/or their qualifying status may change resulting in termination or changes in their coverage. You can verify HealthPartners members' eligibility by using the HealthPartners Provider Portal or call HealthPartners Riverview Member Services.

DHS Website MN-ITS – Online

If you are not sure if the patient has HealthPartners Care or a different government programs plan, use the online service through DHS. http://mn-its.dhs.state.mn.us/

Benefits for HealthPartners Care members

Please refer to the HealthPartners Care Benefit Guide for coverage determination and limitations by ADA code. The grid includes different categories of benefits based on the plan the member is enrolled under: (PMAP, MNCare, MSC+, SNBC (Inspire) or MSHO). To obtain specific benefits including what benefits are remaining for a member, check Eligibility on the Provider Portal.

Children under age 21, and pregnant women have the most comprehensive benefits (expanded benefit set). Adult women on Minnesota Care who become pregnant move to the expanded benefit set during their pregnancy.

Minnesota Care

Health Insurance program through the State for Minnesotans with lower incomes who cannot get affordable insurance through their employer, and do not quality for Medical Assistance.

Beginning January 1, 2019, MNCare Adults will have a $15.00 copayment on all non-preventive/diagnostic Covered services. We have updated our HealthPartners Care Benefit Guide (located on the Provider Portal) to include the copayment information for the applicable members by ADA code.

You will collect one copayment of $15.00 per appointment for which a Covered service occurs that is non-preventive or diagnostic. For follow up visits that are not billable, you will not collect a copayment.

HealthPartners Minnesota Care members with Copays, have a new package code (PC08A), and are in group #4190. This information is located on the member identification card as well as the Provider Portal so you will see this when you are verifying benefits. The remittance advice will also include the Copay.

Below are the rules we have received from DHS (Department of Human Services) on the rules around the collection of Copays.

If a MinnesotaCare recipient cannot pay the copay at the time of the visit, follow the steps below:

- Inform the recipient of his or her copay obligation for the services
- Provide services for the current visit
- Inform the recipients of their debt and give them the opportunity to pay using standard office policies and procedures
- Inform the recipient of your office policy on serving patients with outstanding debt or unpaid copays
- If it is your standard office policy to refuse services to patients who are unable to pay the copay or have outstanding debt, you may refuse to provide ongoing services because of the recipient's inability to pay their copay

Prior Authorization and Claims Payment

If a procedure is identified on the HealthPartners Care Benefit Grid as requiring a prior authorization, it is very important to send in a prior authorization before the patient receives the recommended treatment. Coverage is based on medical necessity and services not covered are denied to provider liability.

If the member elects to receive services that are not covered, the DHS Waiver for Non-Covered Services needs to be signed by the member. Please note the approved version through DHS is on the Provider Portal so be sure to use this form. The patient cannot be held responsible for payment, for non-covered services unless you have them sign this form prior to the date of service. Minnesota State law also prohibits offices from billing members the difference between a covered service and non-covered service. (Example: benefits that are applicable for a stainless steel crown cannot be applied to a porcelain crown which is a non-covered service). In addition, payment for posterior composites is at the amalgam rate and members cannot be billed the difference.

Please note that State law also prevents you from ever billing a government programs member for covered services and the difference in the payment from the plan and your billed charge is the Provider Write-off. The waiver can only used for non-covered services.

Specialty Care

If specialty care is needed outside of your office, please remember to direct members to contracted HealthPartners Care Specialty providers. We have provided you a list of those providers specific to the HealthPartners Care network. For updates, please contact us at dentalcontracting@healthpartners.com.

HealthPartners Care Orthodontic Guidelines for General Dentists

Orthodontic benefits through HealthPartners Care are based upon a review of **medical necessity;** they are available for malocclusions that are **severe and handicapping**. Each case submitted to HealthPartners by our contracted orthodontist is reviewed and a determination on the applicability of benefits is made by HealthPartners Dental Director or designee.

Listed below are some **guidelines** for our HealthPartners Care general dentists to use in determining whether or not a case should be referred to the contracted orthodontist for analysis and work up. Following these guidelines will help to ensure that the most appropriate malocclusions are referred for care that may be found to be medically necessary.

Some of the criteria for medically necessary care are:

- Impeded eruption of teeth
- Increased over jet, greater than 9mm
- Reverse over jet greater than 3.5mm with masticatory and speech difficulty
- Defects associated with clefts and other craniofacial anomalies
- Ankylosed (submerged) primary teeth
- Anterior or posterior cross bite with a functional slide greater than 2mm
- Posterior lingual cross bites (100% buccal over jet) with no functional occlusion
- Severe, generalized contact point displacements greater than 4mm
- Extreme anterior or lateral open bites
- Increased overbite with gingival or palatal trauma

- Partially erupted teeth, tipped and impacted against adjacent teeth

Orthodontic transfer patients in the Minnesota Prepaid Medical Assistance Plan

Having a patient transfer into your practice while under orthodontic treatment can be a difficult situation. There are potential issues when a patient under your care changes their insurance coverage into or out of HPCare.
Below are some of the situations that can occur and how they are managed:

- ✓ A patient with prior approval by another Minnesota PMAP plan whose insurance has transferred to HPCare will follow different processes depending on whether active treatment has begun.
  If the patient is in treatment please forward copies of the authorization and payments to date with the orthodontic claim information. This allows us to continue payments under HPCare. No new case review is required.
  If the patient has not started active treatment the case must be submitted to HealthPartners for authorization. The claim form and records, (a panographic radiograph and photos), will be reviewed and eligibility determined.

- ✓ It is not uncommon for a patient to become eligible for HPCare while under active treatment. Whether they have moved from out of state or only recently become eligible for Minnesota PMAP, the case must be reviewed for eligibility. The same criteria are used as if they were not in treatment. Preoperative records can be submitted, as can current records, if the preop is not available.
  States differ in the criteria used for orthodontic coverage; it cannot be assumed that if the patient had coverage for orthodontic care in a different state that there will be coverage under Minnesota DHS criteria. Should the patient or family desire no further treatment, a claim for debanding and retention will generally be authorized.

Critical Access Providers (CAD)

DHS sends health plans the Critical Access Provider listing monthly. For providers identified by DHS as CAD eligible, we process the additional payment quarterly, based on claims paid the previous quarter for applicable members. For any questions related to the Critical Access payment process for HealthPartners Care members, contact Michelle at 952-883-5168.

Early and Periodic Screening, Diagnosis and Treatment of Children

The Surgeon General's Report on Oral Health was released June, 2000. As expected it pointed out the unmet need for management of dental caries in children. The American Academy of Pediatric Dentistry (AAPD) encourages parents and other care providers to help every child establish a dental home by 12 months of age. A dental home should provide: comprehensive oral health care, assessment for oral disease, development of a preventive dental health program, review of anticipatory guidance, information on care of the teeth and oral cavity, dietary counseling, and referral to a pediatric dentist if necessary.

Dentists and staff have the opportunity to significantly enhance the evaluation, risk assessment, and intervention of children for dental caries. The first step in this process is the oral evaluation/examination of the patient as early as possible. Current recommendations (AAPD) suggest that a child should have their first oral evaluation/examination no later than their first birthday.

After assessing the child's dental caries risk, the dentist can recommend appropriate interventions. Most children will be in the low-risk category and require only an initial oral debridement with a toothbrush. The use of a disclosing agent will afford the opportunity to assess oral hygiene skills and the need for instruction and assist in supporting the suggested recall interval. Following the oral debridement, the application of a fluoride varnish using a disposable brush is equal to or more effective and less time consuming than the traditional application of a fluoride gel using disposable trays. For low risk children, the recommended recall interval can be 12 months. For high-risk children, the same procedures should be used, but additional interventions, therapeutic treatments, or more frequent fluoride varnish application should be appointed.

Failed Appointment/Short Notice Cancellation Charges

Federal regulation also states that providers cannot bill Public Program recipients for failed appointments or short notice cancellations.

Spoken language interpreter services

Below are the spoken language interpreter agencies that are contracted to serve HealthPartners Care members. You can also view an up to date list on the Provider Portal. Go to Cultural Care under Clinical Resources.

Kim Tong Translation Service 2994 Rice St. Little Canada, MN 55113 Phone: 651-252-3200 Fax: 651-252-3214 24 Hour Service *Face to face and phone interpretation* Website: **kttsmn.com**	**Itasca Corporation** 1560 Livingston Ave Suite 101 West St. Paul, MN 55118 Phone: 651-457-7400 Fax: 651-457-7700 Website: **itascacorp.biz**
The Bridge World Language Center, Inc. 110 2nd St S Ste 213 Waite Park, MN 56387 Phone: 320-259-9239 Fax: 320-654-1698 Website: **bridgelanguage.com**	**Garden and Associates** 4301 Highway 7 Suite 140 St. Louis Park, MN 55416 Phone: 952-920-6160 Fax: 952-922-8150 24 Hour Service Website: **gardentranslation.com**
The Language Banc 1625 Park Ave Minneapolis, MN 55404 Phone: 612-588-9410 Fax: 612-588-9420 24 Hour Service Website: **thelanguagebanc.com**	**Arch Language** 1885 University Avenue West, Suite 75 Saint Paul, MN 55104 Phone: 651-789-7897 Fax: 651-789-7898 24 Hour Service Website: **ArchLanguage.com**
The Minnesota Language Connection, Inc. 1327 County Road D Circle East Saint Paul, MN 55109 Phone: 651-644-7100 Fax: 651-644-7600 24 Hour Service Website: **minnesotalanguageconnection.com**	

RideCare

Ride Care is a transportation service that is available for PMAP (Medical Assistance) members of our HealthPartners Care plan. Ride Care is not a benefit for Minnesota Care members through HealthPartners Care. Minnesota Care members must call the Department of Human Services Minnesota Care office at 651-297-3862, and speak with the Access Services Coordinator, to determine if they are eligible for services.

- Ride Care™ is a non-emergency transportation program. These transports are available for HealthPartners Care members only, who have no other means of transport for a health care appointment.
- All transports are non-emergent. Patients must be ambulatory and capable of self-transfer.
- For specialized transports see Transportation Guidelines.
- The centralized number is (952) 883-7400 and Transportation/Referral Assistants will coordinate the ride.

- Transportation is provided to all HealthPartners Care provider sites in the HealthPartners Care network, including medical clinics (staff model and contracted medical groups), dental clinics, mental and chemical health clinics, hospitals (non-emergency care), urgent care sites, community clinics, school based clinics, and referral providers.
- After patients have set up their health care appointments they should call the Ride Care number to arrange transportation. Rides should be arranged at least three days prior to appointment when possible. Transports for same day urgent care appointments are also available through Ride Care.
- HealthPartners Care members will be sent vouchers for use on the MCTO (formerly MTC) buses. If bus services are not available or appropriate, the Ride Care Transportation Assistant will facilitate alternate transportation.
- Clinics are responsible for verifying HealthPartners Care eligibility when scheduling health appointments. Clinics are responsible for calling the MN-ITS or contacting a PSR (Patient Service Representative) or business office representative if necessary in clarifying eligibility.
- This is a service offered by HealthPartners and is not a benefit.