



Managed Care Service Authorization Request Processes

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Minnesota Health Care Programs (MHCP)

The Minnesota Department of Human Services (DHS) offers several publicly funded health care programs to people who qualify for them, based on program rules and income and asset limits. A brief summary is located in the brochure [DHS-3182](#), and in the Reference Guide at the end of this document. DHS contracts with managed care organizations (MCOs) to provide these programs:

Families and Children: A Minnesota managed health care program (MHCP) for low-income families and children. Enrollment is mandatory for people on Medical Assistance under age 65, unless the member is excluded from managed care because of program regulations.

The Families and Children managed health care program offers services available for:

- a) Medical Assistance/Pregnant Woman - Women who are pregnant and meet Medical Assistance eligibility requirements.
- b) Medical Assistance/Children Under 21 - Children who meet Medical Assistance eligibility requirements.
- c) Medical Assistance/Adults with Children – Parents and relative caretakers of children who meet Medical Assistance eligibility requirements.
- d) Medical Assistance/Adults without Children – Adults 21- 64 who meet Medical Assistance eligibility requirements.
- e) MinnesotaCare Enrollees

Families and Children offers comprehensive primary and acute medical, hospital, preventive, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, and home care services.

Further information is available on [coverage, cost sharing, and service limits](#) in the document DHS-3860.

Minnesota Senior Care Plus (MSC+): A Minnesota managed health care program (MHCP) for people age 65 years and older, who are eligible for Medical Assistance (MA). Enrollment in MSC+ is mandatory for people age 65 or older on MA, unless the member chooses to enroll in MSHO or is excluded from managed care because of program regulations.

[MSC+](#) combines into one seamless package the [services](#) available in

- Medical Assistance,
- For those eligible, the Elderly Waiver, and
- The first 180 days of nursing facility care.

MSC+ covers comprehensive primary and acute medical, hospital, preventive, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, home care, care coordination, and long term care (Elderly Waiver if eligible, and nursing facility care) and support services, and medications not paid by the Medicare Part D program.

- MSC+ is similar to MSHO in the long-term care services it covers but does not include Medicare services or Medicare Part D drugs.
- Seniors enrolled in MSC+ must obtain their Medicare Part D drugs through a separate Medicare prescription drug plan

Minnesota Senior Health Options (MSHO): A Minnesota managed health care program (MHCP) for people age 65 years and older, who are eligible for Medical Assistance (MA) and Medicare Parts A and B. Enrollment in MSHO is voluntary; seniors can choose to enroll in MSHO or stay in MSC+.

[MSHO](#) integrates into one seamless package [services](#) available in

- Medicare Parts A, B, and D,
- Medical Assistance,
- For those eligible, the Elderly Waiver, and
- The first 180 days of nursing facility care.

MSHO covers comprehensive primary and acute medical, hospital, preventive, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, home care, care coordination, and long term care (Elderly Waiver and nursing facility) and support services.

Special Needs BasicCare (SNBC): A Minnesota managed health care program (MHCP) for people with disabilities ages 18 through 64 who are eligible for Medical Assistance. If a person is eligible for Medicare, they must have both Medicare Parts A and B. Enrollment in SNBC is voluntary; eligible people have the choice to enroll or disenroll any month.

SNBC combines into one seamless package the services available in

- Medical Assistance and
- The first 100 days of nursing facility care.
- Some SNBC plans also integrate Medicare covered services for people with Medicare coverage. Contact the health plan for more information.

SNBC covers comprehensive primary and acute medical, hospital, preventive, diagnostic, therapeutic, behavioral, rehabilitative, medication, immunization, dental, eye exam, home care, care coordination, up to 100 days of nursing facility care, and support services.

[SNBC](#) members may have a care coordinator or navigator to help them access health care and support services. SNBC MCOs coordinate with other payers including Medicare Parts A, B and D coverage for members who have that coverage. SNBC MCOs coordinate with the lead agency when a SNBC member is also on a home and community based services (HCBS) waiver.

State plan Services

MHCP covers certain health care services for people on Medical Assistance (MA). These are often referred to as "[MA State plan services](#)" because they are listed in the plan approved by the federal Center for Medicare and Medicaid Services (CMS) for Minnesota Medical Assistance.

For people enrolled in an MCO, contact the MCO for benefit and copay information.

State plan Home Care Services

Some managed care programs offer specific home care services. Each MCO provides benefit coverage and prior authorization information on their website ([see page 9 for web addresses](#)), in member materials, and through their [Provider Services](#) area.

MCO prior authorization may be required for certain State plan home care services including:

- [Home health aide services](#)
- [Personal Care Assistance \(PCA\) services](#)
- [Private duty nursing services](#)
- [Skilled nursing visits](#)
- [Tele-home-care visits](#)
- [Equipment and supplies](#)
- [Home care therapies](#)

The online [Community-Based Services Manual \(CBSM\)](#) includes MA policy criteria on [Skilled Nursing Visit](#), [Private Duty Nursing](#), home health aide ([HHA](#)), personal care assistance ([PCA](#)), and [therapies](#).

Home and Community Based Programs

Minnesotans with disabilities or chronic illnesses who need certain levels of care may qualify for home and community based programs. [Home and community based programs](#) are approved exceptions to MA standards designed to meet the needs of targeted populations.

Minnesota's home and community-based programs are available to persons who choose to reside in the community and meet the eligibility criteria.²

- [Alternative Care \(AC\)](#) is for persons age 65 years and older who are at risk of nursing home placement and choose to live in the community, and are not on Medical Assistance.
- [Brain Injury \(BI\) Waiver](#) is for persons with a traumatic, acquired or degenerative brain injury who require the level of care provided in a nursing facility that provides specialized services for persons with brain injury or who require the level of care provided in a neurobehavioral hospital, and who choose to live in the community.
- [Community Alternative Care \(CAC\) Waiver](#) is for chronically ill and medically fragile persons who need the level of care provided in a hospital and who choose to live in the community.
- [Community Alternatives for Disabled Individuals \(CADI\) Waiver](#) is for persons with disabilities who require the level of care provided in a nursing facility and who choose to live in the community.
- [Developmental Disabilities \(DD\) Waiver](#) is for persons with developmental disabilities or a related condition who require the level of care provided in an Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) and who choose to live in the community.
- [Elderly Waiver \(EW\)](#) is for persons age 65 years and older who require the level of care provided in a nursing facility and who choose to live in the community.

Extended Waiver Services

People on a waiver program first use Medical Assistance (MA) State plan services up to the designated limits. If a person is assessed and found to need more services than the State plan services provide, services may be authorized through the waiver program. Waiver services are approved exceptions to the standard State plan services. Extended waiver services exceed the amount, duration or frequency specified for the MA State plan service description.

- [Extended waiver home care services](#) exceed the amount, duration, and/or frequency specified for the MA State plan home care service description. The scope of the service is the same as defined in the State plan.
- [Extended waiver Personal Care Assistance \(PCA\) services](#) exceed the amount, duration, or frequency of the MA State plan PCA service. The scope of the service is the same as defined in the State plan.

Waiver program	PCA	Private Duty Nursing	Home Health Aide	Physical, Occupational, Speech, and Respiratory Therapy
EW	X	X	X	X
CAC	X	X	X	X
CADI	X	X	X	X
BI	X	X	X	X
DD	X			

MCO Additional or Substitute Health Services

The MCO may pay for or provide substitute health services for the MA-covered services described in Article 6 of their program contract with DHS, if such services are medically appropriate and cost-effective.

The MCO may provide or arrange to have provided services in addition to the services described in Article 6 of their program contract with DHS, if the provision of such services is medically necessary.

Tribal Provided Services

For purposes of this document, "tribal provided services" are services other than those paid for by MA, a waiver program, or the MCO, that the tribe has determined are necessary and appropriate for the person.

A tribe may have been providing, arranging, and paying for some services for people who did not have MA eligibility, or services for MCO members in addition to those services paid for through the MCO.

- When an MCO learns a member is or may be receiving tribal-provided services, the MCO should contact the tribal case manager for information on those services, to coordinate services and avoid duplication of services.

- When a tribe learns a person is enrolled in an MCO and the tribe has services in place, the tribal case manager should contact the MCO care coordinator and any lead agency case manager, to coordinate services and avoid duplication of services.

Authorization of services

The purpose of authorization of medical services is to evaluate and determine the necessity and appropriateness of a medical service based on criteria, medical necessity, and benefit coverage. Medical necessity criteria do not apply to authorization determinations for home and community based services.

When a Minnesota Health Care Programs (MHCP) member is enrolled in a Minnesota managed care organization (MCO), there must be communication between the member, the MCO, the other lead agency(ies), and providers.

When a member is also on a waiver, there must be communication between the waiver case manager and the MCO to ensure appropriate State plan, extended, and waiver services are provided and to avoid duplication of assessments, services, and effort.

Providers may have to obtain a Service Authorization from the MCO before providing certain services. This may be needed so the MCO can set up their claims payment system to pay for the service. MCOs have information on their websites about their authorization request process, and they have a provider assistance / service unit to answer questions and give technical support.

- There are differences in benefits between the programs.
- Each MCO may have different authorization processes.
- Providers must follow the MCO billing policy guidelines
- The member must be eligible for coverage at the time the service is provided for the MCO to pay the claim. Receiving an approval for a Service Authorization request does not automatically guarantee payment
- Requests for authorization after the service has been provided follow the same utilization review criteria as those requests that are received before the service is provided.

MCO Decision Making on Authorization Requests

To make authorization decisions on health care services, the MCO or its delegates use written medical necessity review criteria based on clinical evidence.

- The MCO may have its medical authorization and notification requirements available on its website.
- You can ask the MCO for the criteria used to evaluate an individual request.
- You may contact or speak to the MCO appeals unit or medical director who reviewed an authorization request.

Authorization decisions on other services are based on the member's needs, the appropriateness of the care or the service requested, and the member's benefits. Medical necessity criteria do not apply to authorization determinations for home and community based services.

MCOs cannot reward providers or other individuals for issuing denials of coverage or services.
MCOs cannot encourage decisions through financial or other means that results in under-utilization of services.

Approval of an authorization request does not guarantee payment.
Payment is subject to the member's eligibility status at the time of the service and the covered program benefits.

A decision is made on the authorization request to fully approve, partially approve, end, or deny the service or item. The MCO or its delegates send a notice to the provider and to the member with the decision. Members can appeal the decision if they disagree with it. Information on how to do that is included in the notice of denial, termination, or reduction (DTR).

County, Tribe, and Health Plan Communication

Service Authorizations

For Special Needs BasicCare (SNBC) and Families and Children (F&C) programs:

- The MCO will communicate with the county/tribe about the authorization of Medical Assistance (MA) home care service for people on a disability waiver (CAC, CADI, BI, and DD) so those can be accounted for in the person's waiver budget.
- The county/tribe will communicate with the MCO about the authorization of waiver services, PCA, and PDN for people enrolled in that MCO. Otherwise, the MCO is not involved with authorizing waiver services for SNBC and F&C but both entities need to be aware of the authorized services.

For MSHO and MSC+ programs:

- The MCO is responsible for managing the EW services and funding.
- The MCO will communicate with the county / tribe on the authorization of MA home care services for people on a disability waiver (CAC, CADI, BI, and DD) so those can be accounted for in the person's waiver budget.

Service Denials, Terminations, or Reductions

The entity that is responsible to review a request for authorization of a service is also responsible for determining when a request for that service should be denied, a current service should be terminated (ended), or an existing service or a service request should be reduced. A Notice of Action, either of denial, termination, or reduction of services (DTR), is sent to the person and the provider.

- The entity that sends the DTR notice is also responsible to notify the other lead agencies (the MCO, county, and/or tribe) involved in the person's care and support of any denial, termination, or reduction of services that the other lead agency needs to know about. For example, when an MCO changes a State plan service for a member on a waiver program, the MCO notifies the county/tribe so the waiver care plan and budget can be adjusted as necessary.

The MCO has an internal complain, grievance, and appeals process. The person, or a provider acting on behalf of the person with the person's written consent, may make an oral or written request (an appeal) to the MCO for review of an Action. Refer to the MCO website, the Evidence of Coverage, or contact member services for more information.

In addition to the MCO appeal process, federal and state law gives people the right to [appeal](#) to the State and to request a [State Fair Hearing](#) when they disagree with a county, state, or health plan service DTR decision that affects their human services benefits, payments, or services. The DHS Appeals and Regulations Division hears and decides these appeals.

The [Ombudsman for State Managed Health Care Programs](#) helps health plan members with access, service and billing problems. The office provides information about the managed health care grievance and appeal process that is available through the health plan and the state.

Claim Denials

Sometimes a health plan issues a claim denial. A claim denial is different from a service denial. The provider may have received a service authorization, but then received a claim denial after they submitted the claim for that authorized service. The claim denial will include a denial reason. Claim and payment issues and denials are often due to errors on the claim. The MCO will answer questions about claim denials and other payment issues.

If a provider of a service that was authorized by an MCO contacts the county /tribe/lead agency about a payment issue or a claim denial, the county / tribe/ lead agency refers the provider to the MCO's provider help desk or contract manager, or to the DHS contract manager for that program.

The county/tribe/ lead agency is not able to make changes to the existing MCO service authorization or to the claim but they may be able to assist the person with an appeal.

Links to MCO Service Authorization grids

[these will be added/updated to a more specific site when the plans put their grid online]

Blue Cross of Minnesota

<http://www.bluecrossmn.com>

Health Partners

<http://www.healthpartners.com>

IM Care (Itasca Medical Care)

<http://www.co.itasca.mn.us/Home/Departments/Health%20and%20Human%20Services/IMCare/Pages/default.aspx>

Medica

<http://www.medica.com/default.aspx>

Metropolitan Health Care (MHP)

<http://www.hennepin.us/portal/site/HennepinUS/menuitem.c821986e7144921df8735443fbe06498/?vgnnextoid=b42e65c830fe1210VgnVCM100000c80f4689RCRD>

PrimeWest Health

<http://www.primewest.org/>

South Country Health Alliance (SCHA)

<http://www.mnscha.org/>

UCare

<http://www.ucare.org>

Glossary

Additional / supplemental services: Services provided or arranged to be provided by the MCO in addition to the services described in the DHS contract(s) with the MCOs, as permitted by the Centers for Medicare and Medicaid Services, for those members, in the judgment of the MCO's staff, the provision of such services is Medically Necessary.¹

Approve: Make a determination or a recommendation that a requested service or item is medically necessary or otherwise eligible for payment.

Authorization (or Service Authorization): A person's request, or their authorized representative's request, or a provider's request on behalf of a person, for the provision of a service, and DHS's or the MCO's determination of the Medical Necessity for the service prior to the delivery or payment of the service.¹

Authorized representative: A person who has assumed the responsibilities outlined in and pursuant to Minnesota Rules, [Part 9505.0085, subpart 2](#).¹

Care coordinator: A person who facilitates the assessment, care planning, and medical and supportive services a member needs. Care coordination is the responsibility of the MCO or its designee, and must be provided in accordance with the [contract with DHS](#).¹

Care management: The overall method of providing ongoing health care in which the MCO manages the provision of primary health care services with additional appropriate services provided to a person enrolled in that MCO. See [Model Contract\(s\)](#) for more details.¹

Care manager: A person who facilitates the provision of on-going health care in which the MCO manages the provision of preventive, primary, acute, post-acute, rehabilitative, specialty and pharmacy services with additional appropriate services provided to a member.¹

Case management: Waiver activities that help people access, coordinate and monitor needed services as they relate to the person's assessed needs and preferences. [Case management](#) is available through the waivers and for other targeted populations.²

County / tribe case manager: A lead agency staff that assists persons to access, coordinate and monitor needed services as they relate to the person's assessed needs, regardless of the funding source. This lead agency staff is referred to as the [waiver case manager](#) when the person has a home and community-based services (HCBS) waiver.²

DTR: If the MCO denies, reduces or terminates services or claims that are: 1) requested by a member; 2) ordered by a Participating Provider; 3) ordered by an approved, non-Participating Provider; 4) ordered by a care manager; or 5) ordered by a court, the MCO must send a Denial, Termination, or Reduction (DTR) Notice of Action to the member. The MCO must notify the provider of the Action. See the DHS [Model Contract](#), Article 8 for details.¹

▪ **Deny:** Make a determination that a requested service or item is not medically necessary or otherwise not eligible for payment. See MN Stat [§62M.05](#) and [§62M.09](#).¹

- **Terminate:** Make a determination that a previously authorized service or item is now not medically necessary or otherwise not eligible for payment.¹
- **Reduce:** Make a determination that a previously authorized service or item is not medically necessary or otherwise not eligible for payment at the level of the previous authorization, so a lesser amount or frequency is authorized.¹

Extended Home Care Services: Services that exceed the amount, duration and/or frequency specified for the MA State plan home care service description. The scope of the service is the same as the State plan home care service. [Extended home care services](#) are not covered services when MA State plan home care services have not been fully authorized and used.²

Health plan: As defined in the Code of Federal Regulations, an individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 USC 300gg-91(a)(2)). [Health plan](#) includes, when applied to government-funded programs, the components of the government agency administering the program.³

Lead agency: A county, tribal health entity, or a participating MCO that is responsible to put into effect appropriate Home and Community Based Waiver functions as delegated by the State, for any person who meets waiver program eligibility criteria. The lead agency may or may not be the local agency.¹

Local agency: A county, multi-county, or tribal agency that is authorized to determine a person's eligibility for the Medical Assistance program.¹

Managed Care Organization (MCO): an entity that has, or is seeking to qualify for, a comprehensive risk contract, and that is: 1) a Federally Qualified HMO that meets the advance directives requirements of 42 CFR § 489.100-104; or 2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: a) makes the services it provides to its Medicaid recipients as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and b) meets the solvency standards of 42 CFR [§438.116](#).¹

Medical necessity / medically necessary: Pursuant to Minnesota Rules, Part 9505.0175, subpart 25, a health service that is 1) consistent with a person's diagnosis or condition; 2) is recognized as the prevailing standard or current practice by the provider's peer group; and 3) is rendered according to one of the following:

- (A) In response to a life threatening condition or pain;
- (B) To treat an injury, illness or infection;
- (C) To treat a condition that could result in physical or mental disability;
- (D) To care for the mother and unborn child through the maternity period;
- (E) To achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; or
- (F) Is a preventive health service defined under Minnesota Rules, Part 9505.0355.¹

Notice of Action: A Denial, Termination, or Reduction of Service Notice (DTR) or other Action as defined in 42 CFR [§438.400\(b\)](#).¹

Prior Authorization: An approval by the MCO or its designee prior to the delivery of a specific service, treatment, item, or medication. Prior authorization requests require a clinical review by qualified, appropriate professionals to determine if the service, treatment, item, or medication is:

- medically necessary,

- an eligible expense, and
- appropriate, less expensive alternatives have been considered.¹

Recommend: Provide information to the MCO or its delegate in support of authorizing or providing a requested service or item.¹

Request: Ask for a service or item to meet the needs of a member. A request can come from the member, guardian or legal representative, family member, medical professional, service provider, or other person.¹

Utilization Management (UM): A formal written structure and applied policies and procedures consistent with state and federal regulations and current NCQA: *Standards and Guidelines for the Accreditation of Health Plans* that detects both under-utilization and over-utilization of services. See Model Contract(s) for more details.¹

Utilization Review (UR): A formal evaluation of the medical necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities. Reviews are completed, by a person or entity other than the attending health care professional to determine the medical necessity of the service or admission. See Model Contract(s) for more details.¹

Waiver Programs: Federally approved [home and community based services programs](#) that include services that exceed limitations of the regular Medical Assistance program but do not exceed the comparable cost of institutionalization.²

References

1. The [annual DHS contract with health plans](#) to provide managed care for people receiving services through a Minnesota Health Care Program (MHCP).
2. The online [Community-Based Services Manual / Disability Services Program Manual](#).
3. [Code of Federal Regulations](#),
4. The online [Prepaid Minnesota Health Care Programs Manual](#).

2013 Reference Guide to Minnesota Health Care Programs Available through MCOs

	Families and Children		SNBC	MSC+	MSHO
Must be enrolled in:	Medical Assistance	MinnesotaCare	Medical Assistance If eligible for Medicare, must have Medicare Parts A & B and certified as disabled	Medical Assistance	Medical Assistance and Medicare Parts A & B
Ages	0-64 at age 65 move into MSC+ unless choose MSHO	0-65+	18-64 can stay on when turn 65 unless want EW services (then must switch to MSC+ or MSHO)	65+	65+
Will the person on MA be in Managed Care?	Mandatory (some exclusions)	Mandatory (some exclusions)	Voluntary (can opt out at any time, effective the end of a month) (some exclusions)	Mandatory (some exclusions)	Voluntary (can opt out at any time, effective the end of a month) (some exclusions)
Could the member be on a HCBS waiver?	Yes: CAC, CADI, BI, or DD	No	Yes: CAC, CADI, BI, or DD	Yes: EW, CAC, CADI, BI, or DD	Yes: EW, CAC, CADI, BI, or DD
Basic Covered Services	MA basic services Authorized and paid by MCO	MinnesotaCare basic services Authorized and paid by MCO	MA basic services Authorized and paid by MCO	MA basic services Authorized and paid by MCO	MA basic services Authorized and paid by MCO
PDN and PCA Services	Authorized and paid by MCO	Authorized and paid by MCO	PDN authorized by DHS through contracted entity, paid by FFS	Authorized and paid by MCO	Authorized and paid by MCO

	Families and Children		SNBC	MSC+	MSHO
			PCA authorized by county / tribe, paid by FFS		
SNV, HHA, Therapies	Authorized and paid by MCO	Authorized and paid by MCO	Authorized and paid by MCO	Authorized and paid by MCO	Authorized and paid by MCO
Extended Waiver Services	If person has a waiver, authorized by county / tribe, paid FFS.	Not available	If person has a waiver, authorized by county / tribe, paid FFS.	If person has an EW: Authorized and paid by MCO If person has a CAC, CADI, BI, or DD waiver: Authorized by county / tribe, paid FFS.	If person has an EW: Authorized and paid by MCO If person has a CAC, CADI, BI, or DD waiver: Authorized by county / tribe, paid FFS.
HCBS Waiver Services: CAC , CADI , BI , DD	If person has a waiver, authorized by county / tribe, paid FFS.	Not available	If person has a waiver, authorized by county / tribe, paid FFS.	If person has a waiver, authorized by county / tribe, paid FFS.	If person has a waiver, authorized by county / tribe, paid FFS.
HCBS Waiver Services: EW	Not available	Not available	Not available	Authorized and paid by MCO	Authorized and paid by MCO
Medical Equipment and Supplies	Equipment and supplies allowable through the State plan that meet medical necessity criteria are authorized and paid by the MCO. If person has a waiver and this is an allowable waiver expense, authorized by county / tribe, and paid FFS.	Authorized and paid by MCO	Equipment and supplies allowable through the State plan that meet medical necessity criteria are authorized and paid by the MCO. If person has a waiver and this is an allowable waiver expense, authorized by county / tribe, and paid FFS.	Authorized and paid by MCO	Authorized and paid by MCO

	Families and Children	SNBC	MSC+	MSHO
Tribal Members	Tribal members may opt out of managed care at the end of any month.			