

## Chapter 2

# Health Care Programs and Services

The Minnesota Department of Human Services (DHS) ensures basic health care coverage for low-income Minnesotans through the major publicly subsidized health care assistance programs. More than half a million Minnesotans have health care coverage through the DHS-administered Minnesota Health Care Programs (MHCP). PrimeWest Health is contracted with DHS to provide health care coverage through the programs listed below:

1. Medical Assistance (MA)
2. MinnesotaCare
3. Minnesota Senior Care Plus (MSC+)
4. Minnesota Senior Health Options (MSHO)<sup>±</sup>
5. Special Needs BasicCare (SNBC)<sup>‡</sup>

This chapter outlines specifics for each major program and sub-program, including eligibility, income/asset limits, covered services, and service limitations. This chapter also outlines Minnesota's Waivered Services Programs and the Minnesota Restricted Recipient Program (MRRP).

## Definitions

**Copay:** A pre-determined sum for which a PrimeWest Health member is responsible to offset the overall costs for services. Copays are to be paid by the PrimeWest Health member to the provider. Copay amounts for PrimeWest Health members are determined by the Minnesota Legislature and may change. Refer to the *Spenddowns and Copays* section in Chapter 4, [Billing Policy](#), and the *PrimeWest Health Copay Guidelines* section below for additional copay information.

**Emergency Services:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy and/or result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

1. The member must be seen by the medical professional on the same day that the member contacted the medical professional in order for the situation to be considered an emergency.
2. The situation is not considered an emergency if the member contacts the medical professional and is not given an appointment for the same day of the call.
3. Prescheduled services are not considered an emergency.
4. Services provided as follow-up to initial emergency care are not considered emergency services.

**Eyeglasses:** Complete frames and lenses.

**Federal Poverty Guidelines (FPG):** A means by which the federal government measures and evaluates eligibility for publicly subsidized health care and cash programs administered by each state.

<sup>±</sup>PrimeWest Health's name for this program is PrimeWest Senior Health Complete (HMO SNP)

<sup>‡</sup>PrimeWest Health's name for this program for our members with Medicare is Prime Health Complete (HMO SNP)

**Family Planning Services:** A family planning supply or health service, including screening, testing, and counseling for sexually transmitted diseases, such as HIV, when provided in conjunction with the voluntary planning of the conception and bearing of children and related to a member's condition of fertility. "Family planning supply" means a prescribed drug or contraceptive device ordered by a physician or other eligible provider with prescribing authority for treatment of a condition related to a family planning service.

**Institute for Mental Disease (IMD):** A residential facility with 17 or more beds that is primarily engaged in providing diagnoses, treatments, and care, including medical attention, nursing care, and related services, to those with mental diseases.

**Medical Institution:** A hospital, nursing facility, Regional Treatment Center (RTC), Institute for Mental Disease (IMD) hospital, or Intermediate Care Facility for the developmental disabilities (ICF-DD).

**Non-preventive Visit:** An episode of service which is required because of a member's symptoms, diagnosis, or established illness.

**Preventive Medicine Services:** Services that help members stay healthy. These include the following Current Procedural Terminology (CPT) codes:

1. 99381 – 99429; or
2. 99201 – 99215 when provided for the following diagnoses: V03 – V06.9, V20 – V20.2, V21.1, V21.2, V70.0

**Spenddown:** An amount the member is responsible to pay on the first day he/she is eligible for PrimeWest Health. Refer to the *Spenddowns and Copays* section of Chapter 4, [Billing Policy](#), for additional information.

## Medical Assistance (MA)

Medical Assistance, also called MA, established under Title XIX of the Federal Social Security Act, is a program that provides medical care for low-income people. State and Federal governments jointly fund MA. Within broad federal rules, each state decides the types of health care services that will be covered by its MA program. In Minnesota, MA includes the following sub-programs:

1. **MA for Families and Children, and persons who are blind, disabled, or age 65 and over:** Pays for current and future medical bills for covered health care services.
2. **MA for Pregnant Women and Infants:** Pays for covered health care services provided to pregnant women and children under age two.
3. **MA for Disabled Children (TEFRA):** Available for some disabled children who ordinarily would not be eligible for MA because of parental income. Applicants must be reviewed by the State Medical Review Team.
4. **MA for Employed Persons with Disabilities (MA-EPD):** Allows working people with disabilities to qualify for MA under higher income and asset limits.
5. **Program NM:** Available for certain non-citizens who have authorization to reside in the United States but are barred from federal funding under MA. The 1997 Minnesota Legislature passed legislation (MS [256B.06](#), subd. 4) providing MA funding for these non-citizens under program NM. Program NM provides all the same service benefits to members as the MA program. Effective October 1, 2003, program NM covers people receiving services from the Center for Victims of Torture (CVT) who are not otherwise eligible for MA.

## Eligibility for Medical Assistance

1. People wanting to apply for MA should contact their [local county human services agency](#). Eligibility is determined at the local county human services agency.

2. Under certain conditions, MA eligibility may be available for up to three months prior to the month of application.
3. Adults between the ages of 21 and 65 residing in an IMD are not eligible for MA. In order to meet the income eligibility guidelines for MA, some members may have to pay part of the cost of their medical bills. The portion of the medical bills that the member must pay is called a *spenddown*.
4. People who are inmates of correctional facilities are ineligible for MA. Some inmates who are conditionally released to work release programs may be eligible for MA if they do not reside in a public detention facility and are housed in a non-secure community facility.

## Eligibility for MSC+

Managed care members ages 65 or over who do not choose or qualify for enrollment into MSHO. All seniors enrolled in MA managed care receive their health care through MSC+ health plans. MSC+ includes all Medicaid benefits, as well as Elderly Waiver services and coverage of 180 days of nursing home care.

## Eligibility for MSHO

MSHO enrollment is voluntary. People who are eligible for MA may enroll in MSHO if they meet all of the following:

1. Are age 65 or over
2. Are MA-eligible and have both Parts A and B Medicare

## Eligibility for SNBC

Enrollment in SNBC is voluntary. People who are eligible for MA only or dual eligible for MA and Medicare (must have Parts A and B) may enroll if they meet the following criteria:

1. Are ages 18 – 64. Enrollees who enrolled in SNBC before reaching age 65 may remain enrolled in SNBC after reaching age 65 only if they are not accessing any Elderly Waiver (EW) services or choose not to access EW services. Enrollees who do not have a spenddown may choose to enroll in PrimeWest Health MSHO or MSC+ programs when they reach age 65; **and**
2. Are eligible for MA; **and**
3. Reside within the service area; **and**
4. Are certified as disabled through the Social Security Administration (SSA) or the State Medical Review Team (SMRT); **or**
5. Have a Developmental Disability for the purpose of the DD waiver, as determined by the Local Agency.

MA members with spenddowns who otherwise meet all the enrollment requirements for SNBC are eligible to enroll in SNBC if they agree to pay their spenddown as required on a monthly basis directly to the State.

## PrimeWest Health Benefits by Program – MA/ MSC+/MSHO/SNBC

The following table summarizes covered benefits for MA, MSC+, MSHO, and SNBC. Specific coverage policy is listed in specific provider service chapters in this manual. Members are entitled to these benefits regardless of whether they are Fee-for-Service or enrolled in a prepaid health plan.

Follow the guidelines for these covered services as specified in this manual.

Benefit Set	Medical Assistance (MA)	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)	Special Needs Basic Care (SNBC)
<a href="#">Alcohol and Drug Abuse: Residential and Outpatient Ch. 15</a>	X	X	X	X
<a href="#">Ambulatory Surgical Services Ch. 12</a>	X	X	X	X
<a href="#">County Case Management Ch. 26-A</a>		X	X	X
<a href="#">Child &amp; Teen Checkups Ch. 9</a>	X	X	X	X
<a href="#">Chiropractic Services Ch. 18</a>	X	X	X	X
<a href="#">Clinic Services, Ch. 8</a>	X	X	X	X
<a href="#">Dental Ch. 19</a>	X	X	X	X
<a href="#">Diagnostic Services Ch. 11</a>	X	X	X	X
<a href="#">Doctors and Other Health Services Ch. 6</a>	X	X	X	X
<a href="#">Emergency Room Ch. 14</a>	X	X	X	X
<a href="#">Eye Care Services Ch. 20</a>	X	X	X	X
<a href="#">Family Planning Ch. 10</a>	X	X	X	X
<a href="#">Hearing Services Ch. 17</a>	X	X	X	X
<a href="#">Home Care Services Ch. 24-A</a>	X	X	X	X
<a href="#">Hospice Care Ch. 28</a>	X	X	X	X
<a href="#">Hospital Services Ch. 14</a>	X	X	X	X
<a href="#">Immunizations Ch. 9-A</a>	X	X	X	X
<a href="#">Interpreter Services Ch. 1</a>	X	X	X	X
<a href="#">Medical Equipment and Supplies Ch. 23</a>	X	X	X	X
<a href="#">Mental Health Services Ch. 16</a>	X	X	X	X
<a href="#">Nursing Home Services Ch. 27</a>		X	X	X
<a href="#">Physician and Professional Services Ch. 6</a>	X	X	X	X
<a href="#">Prescription Drugs Ch. 22</a>	X	X	X	X
<a href="#">Preventive Care/Screening Tests Ch. 6</a>	X	X	X	X
<a href="#">Rehabilitation Services Ch. 17</a>	X	X	X	X
<a href="#">Transportation Ch. 21</a>	X	X	X	X

## MinnesotaCare

MinnesotaCare is a state-subsidized health care program for people who live in Minnesota and do not have health insurance. The program is open to all Minnesota residents who meet program guidelines. MinnesotaCare

is funded by member premiums, copays, and statewide taxes.

DHS and some local county agencies administer MinnesotaCare. MinnesotaCare applicants and members who reside in participating counties can choose to have their MinnesotaCare case administered by the local county agency or by the DHS MinnesotaCare Operations Office.

All MinnesotaCare members are automatically enrolled in DHS-contracted prepaid health plans.

Some children enrolled in MinnesotaCare may have other health insurance in addition to PrimeWest Health.

## MinnesotaCare Application Materials

MinnesotaCare legislation mandates that application and informational materials be made available to provider offices, local human services agencies, and community health offices. To have applications mailed to your office, contact MinnesotaCare at:

MinnesotaCare  
PO Box 64838  
Saint Paul, MN 55164-0838  
**1-800-657-3672 or 1-651-297-3862**

## Eligibility for MinnesotaCare

1. People may be eligible for either MinnesotaCare or MA, but cannot have coverage from both programs at the same time, with certain time-limited exceptions (for example, certain abortion services) and must choose one. This does not apply to one-month MA retroactive eligibility related to a hospital stay.
2. MinnesotaCare members are no longer required to apply for MA when they are admitted to a hospital. MinnesotaCare members who have expenses not covered by MinnesotaCare may apply for MA if they choose.
3. A person incarcerated in a correctional facility, government owned/operated halfway house, locked juvenile facility, or penal institution is not eligible for MinnesotaCare, regardless of age. A person residing in one of these facilities who is covered by MinnesotaCare will be terminated at his/her renewal date.
4. A person cannot have simultaneous coverage under both MinnesotaCare.
5. A [Service Authorization](#) is required before reimbursement. PrimeWest Health may not reimburse providers when a member has gone outside of the PrimeWest Health network, unless it is for family planning services (including sterilization, abortion services, and pregnancy related services in conjunction with an abortion).

## MinnesotaCare Benefit Sets and Benefit Limits for Inpatient Hospital

MinnesotaCare enrollees receive one of the following four benefit set options:

1. **Expanded Benefit Set** (Program KK or LL): Children (to age 21) and pregnant women. *Inpatient Hospital Benefit Limit:* No annual inpatient hospital coverage limit; no inpatient copays. Some procedures/hospitalizations require [Service Authorization](#).
2. **Basic Plus Benefit Set** (Program FF or JJ): Parents above 175 percent of the FPG. No inpatient copays. Effective July 1, 2009, there will no longer be the \$10,000 limit on inpatient hospital services for a parent (or legal guardian) with household income above 175 percent and at or below 215 percent of the FPG.
3. **Basic Plus One Benefit Set** (Program BB): Adults, age 21 and older, not parents, not pregnant, and at or below 250 percent of the FPG. Inpatient services are not covered.
4. **Basic Plus Two Benefit Set** (Program FF or JJ): Parents at or below 175 percent of the FPG. *Inpatient Hospital Benefit Limit:* No annual inpatient hospital coverage limit; no inpatient copays.

## PrimeWest Health Benefits by Program – Minnesota Care

The following information summarizes covered benefits for the four MinnesotaCare benefit sets. Specific

coverage policy is listed in specific provider service chapters in this manual. Recipients and enrollees are entitled to these benefits regardless of whether they are Fee-for-Service or enrolled in a prepaid health plan.

Follow the guidelines for these covered services as specified in this manual.

<b>MinnesotaCare Programs</b>	<b>Expanded Benefit (KK or LL)</b>	<b>Basic Plus Two (FF or JJ)</b>	<b>Basic Plus One (BB)</b>	<b>Basic Plus (FF or JJ)</b>
Target Members	Pregnant women, and children	Parents	Adults without children	Parents
Income Limit % of Federal Poverty Guidelines (FPG)	≤275%	≤175%	≤250%	>175% ≤275%
<b>Benefit Sets</b>	<b>Expanded Benefit (KK or LL)</b>	<b>Basic Plus Two (FF or JJ)</b>	<b>Basic Plus One (BB)</b>	<b>Basic Plus (FF or JJ)</b>
<a href="#">Adult Mental Health Rehab/Adult Mental Health Crisis Services</a>	X			
<a href="#">Chemical Dependency Services</a>	X	X	X	X
<a href="#">Child &amp; Teen Checkups (C&amp;TC)</a>	X			
<a href="#">Chiropractic</a>	X	\$3 copay	\$3 copay	\$3 copay
<a href="#">County Case Management</a>	X			
<a href="#">Dental</a>	X	X	X	X
<a href="#">Diagnostic Services</a>	X	\$3 copay for diagnostics only (for example, colonoscopies)	\$3 copay for diagnostics only (for example, colonoscopies)	\$3 copay for diagnostics only (for example, colonoscopies)
<a href="#">Doctor and Other Health Services</a>	X	\$3 copay for non-preventive visits	\$3 copay for non-preventive visits	\$3 copay for non-preventive visits
<a href="#">Orthodontia</a>	Included in limited circumstances			

<a href="#">Emergency Room</a>	X	\$6 copay on non-emergency ER visits	\$6 copay on non-emergency ER visits	\$6 copay on non-emergency ER visits
<a href="#">Eye Care Services</a>	X	\$3 copay	\$3 copay	\$3 copay
<a href="#">Eyeglasses</a>	No copay	\$25 copay	\$25 copay	\$25 copay
<a href="#">Family Planning</a>	X	X	X	X
<a href="#">Hearing Services</a>	X	X	X	X
<a href="#">Home Care Services</a>	Includes private duty and PCA	Excludes private duty and PCA	Excludes private duty and PCA	Excludes private duty and PCA
<a href="#">Hospice Care</a>	X	X	X	X
<a href="#">Immunizations</a>	X	X	X	X
<a href="#">Hospital Services</a>	X	X	Inpatient services not covered	No copay, \$10,000 annual limit. Effective July 1, 2009, there will be no \$10,000 annual limit for parents with a household income above 175% and at or below 215% of FPG.
<a href="#">Interpreter Services</a>	X	X	X	X
<a href="#">Medical Equipment and Supplies</a>	X	X	X	X
<a href="#">Mental Health Services</a>	X	X	X	X
<a href="#">Nursing Home/ICF-DD Facility</a>				
<a href="#">Outpatient Surgical Center</a>	X	X	X	X
<a href="#">Prescription Drugs</a> (no copay on anti-psychotics)	No copay	\$3 copay	\$3 copay	\$3 copay
<a href="#">Preventive Care, Screening, and Tests</a>	X	X	X	X
<a href="#">Rehabilitation Services</a>	X	X	X	X
<a href="#">Transportation</a>	Emergency and special trans	Emergency only	Emergency only	Emergency only

### Waivered Services Programs (Available to MSC+ and MSHO enrollees only)

Waivered Services are programs that have received federal approval for expanded coverage of services to MA

members that are not usually covered by MA. PrimeWest Health provides services under the Elderly Waiver (EW) program for eligible members ages 65 and over.

Services included under EW are:

1. Adult Day Care
2. Customized Living
3. 24 Hour Customized Living
4. Chore Services
5. Companion Services
6. Environmental Modifications/Adaptations
7. Adult Foster Care
8. Home Delivered Meals
9. Homemaker Services
10. Extended Personal Care
11. Respite Care

Refer to [HCBS Waivered Services and Elderly Waiver, Chapters 26 and 26A](#), for additional information about the Waivered Services programs.

## Copays

### PrimeWest Health Copay Guidelines

1. MA and MinnesotaCare members are responsible to pay copays to providers.
2. Providers are responsible to collect copays from PrimeWest Health members.
3. Payment to providers will be reduced by the amount of the copay, except that payment for prescription drugs will not be reduced after a member has reached the monthly maximum listed on the coverage chart.
4. Copays will be applied to claims after the spenddown has been met. Members are responsible for 100 percent of the spenddown.
5. Providers serving PrimeWest Health members should contact PrimeWest Health regarding the providers' contractual requirements.

### Member Inability to Pay PrimeWest Health Copays

Federally funded MA or MinnesotaCare members are protected from denial of service based on inability to pay as long as they inform the provider that they are unable to pay the copay.

Providers must continue to accept their assertion of inability to pay.

Providers cannot deny services to members who are unable to pay copays. A provider must accept a member's assertion that he or she is unable to pay a copay and cannot require additional documentation of inability to pay.

Providers must allow members time to pay their copays.

When a member has a copay obligation, PrimeWest Health will pay only the allowable minus the copay.

### Copays for PrimeWest Health Members Enrolled in a Prepaid Health Plan

1. MA and MSC+ members in PrimeWest Health are required to pay copays.
2. MinnesotaCare enrollees in PrimeWest Health must pay any copays that apply in their benefit sets.

**MA, MSC+, MSHO, and SNBC Member Copays**

Type of Copay	MA Copays	MSC+ Copays	MSHO Copays	SNBC Copays
Non-preventive visit: Non-preventive services provided by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, physician assistant, audiologist, optician, and optometrist	\$0	\$0	\$0	\$0
<b>Eyeglasses – frames and lenses</b>	\$0	\$0	\$0	\$0
<b>Non-emergency visit</b> to a hospital-based emergency room	\$6	\$6	\$0	\$0
<b>Drugs</b>	\$3 for brand name \$1 for generic Maximum \$7.00 per month	\$3 for brand name \$1 for generic Maximum \$7.00 per month	MA only and long-term institutionalized members: \$0  Dual members: \$3.30 or \$6.30 for brand name; \$1.10 or \$2.50 for generic;	MA only and long-term institutionalized members: \$0  Dual members: \$3.30 or \$6.30 for brand name; \$1.10 or \$2.50 for generic
Restorative adult dental services	(Not applicable)	\$0	\$0	\$0
Copay Limits	One per day per <b>treating</b> provider, except drugs	One per day per <b>treating</b> provider, except drugs	See note 1	See note 1

**Note: 1.** All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, the member must spend \$4,350 out-of-pocket for the year. When the total amount the member has paid toward copays and the cost for covered Part D drugs after the member reaches the initial coverage limit reaches \$4,350, the member will qualify for catastrophic coverage. During catastrophic coverage the member will not have to pay copays for the rest of the year.

**Copay Exemptions – MA Members**

The following MA members may be exempt from copays related to PrimeWest Health services:

1. Members under age 21

2. Pregnant woman whose pregnancy has been verified and coded in the DHS Medicaid Management Information System (MMIS)
3. Members who have elected hospice care
4. Members residing for 30 days or more in a medical institution

The following services are exempt from copays:

1. 100 percent federally funded services provided by a facility of the Indian Health Service
2. Antipsychotic drugs and contraceptive drugs
3. Case management services
4. Copays that exceed one per day per treating provider for non-emergency visits to a hospital-based emergency room
5. Emergency services
6. Eyeglasses
7. Family planning services and supplies
8. Hearing aids
9. Home and Community Based waived services
10. Home-based services, including home health and personal care attendant services
11. Inpatient professional visits
12. Lab services
13. Medical supplies and equipment
14. Mental health services, including community mental health center services and, regardless of provider: psychotherapy, psychiatrist services, day treatment, clozaril monitoring, partial hospitalization, and health and behavior assessment and intervention
15. Occupational therapy, physical therapy, speech therapy
16. Office visits
17. Orthotics and prosthetics
18. Preventive services as defined above
19. Radiology
20. Repair of eyeglasses
21. Services paid by Medicare for which MA pays the coinsurance and deductible

### MinnesotaCare Copays

**Copays do not apply to children under age 21 and pregnant women (Expanded Benefit Set).**

Type of Copay	Basic Plus Two, Basic Plus One, and Basic Plus
Inpatient hospital stays	10% of inpatient hospital charges up to \$1,000 for Basic Plus One only
Hospital-based emergency room visit, when the service was an emergency	\$0
Hospital- based emergency room visit when the service was not an emergency	\$6
Non-preventive visit services provided by a physician, physician assistant, advanced practice nurse, chiropractor, podiatrist, audiologist, optometrist, or optician	\$3
Mental health services	\$0
Drugs	\$3 for each prescription No monthly maximum
Copay Limits	One per day per treating provider, except drugs
Eyeglasses	\$25 for each pair of eyeglasses

## Copay Exemptions – MinnesotaCare Members

The following MinnesotaCare members are exempt from copays related to PrimeWest Health services:

1. Members under age 21
2. Pregnant women whose pregnancy has been verified and coded in the DHS Medicaid Management Information System (MMIS)
3. Members residing or expecting to reside for 30 days or more in a medical institution \*
4. Members who have elected hospice care \*

MinnesotaCare members are exempt from copays for the following services:

1. 100 percent federally funded services provided by a facility of the Indian Health Service \*
2. Antipsychotic drugs and contraceptive drugs \*
3. Case management services
4. Copays that exceed one per day per treating provider for non-preventive visits, eyeglasses, and non-emergency visits to a hospital-based emergency room
5. Emergency services
6. Family planning services and supplies
7. Hearing aids
8. Home-based services, including home health and personal care attendant services
9. Inpatient visits
10. Interpreter services
11. Lab
12. Medical supplies and equipment
13. Mental health services, including community mental health center services and, regardless of provider: psychotherapy, psychiatrist services, day treatment, clozaril monitoring, partial hospitalization, and adult rehabilitative mental health services (ARMHS), health and behavior assessment and intervention \*
14. Occupational therapy, physical therapy, speech therapy
15. Orthotics and prosthetics
16. Preventive services as defined above
17. Radiology
18. Repair of eyeglasses

\*These exceptions apply to MinnesotaCare enrollees only when they are in Fee-for-Service.

## Member PrimeWest Health ID Numbers and Cards

When members are approved for PrimeWest Health, they are assigned an 8-digit PrimeWest Health ID number that is printed on their PrimeWest Health ID card.

1. All member PrimeWest Health ID cards are issued in the same format and contain the same general information.
2. PrimeWest Health ID numbers do not change and follow members through any changes in program, eligibility, or address.
3. If approved for one of the health care programs, each member of a household is issued his/her own individual PrimeWest Health ID card.
4. The PrimeWest Health ID card does not include information about spenddowns, other health insurance coverage, Medicare coverage, or member restriction.
5. Verify eligibility each month for each member or on the day the service is rendered:
  - a. [PrimeWest Health Web Portal](#). Prior registration is required using the [Web Portal Registration Form](#).
  - b. PrimeWest Health Provider Contact Center: **1-866-431-0802** (toll free)
  - c. [DHS MN-ITS web portal](#)
  - d. DHS EVS Line: **1-651-431-2700** or **1-800-657-3613** (toll free)

- e. [Emdeon](#): 1-866-369-8805 (toll free)
6. Members within the same family may have multiple versions of the card.

## PrimeWest Health ID card



## Covered Service Requirements

In order to be covered, a health service must be determined by prevailing community standards or customary practice and usage to be all of the following:

1. Medically necessary
2. Appropriate and effective for the medical needs of the patient
3. The most cost effective health service available for the medical needs of the patient
4. Able to meet quality and timeliness standards
5. Able to represent an effective and appropriate use of program funds
6. Able to meet specific limits outlined in rules adopted by DHS and explained in this manual
7. Personally furnished by a provider, except as specifically authorized in this manual

## Non-Covered Services

The following services are not covered:

1. Health services paid for directly by the member or other source, except when the member made the payment for services incurred during the member's retroactive eligibility period. Refer to Chapter 4, [Billing Policy](#).
2. A health service, other than an emergency health service, provided to a member in a long-term care facility that is not in the member's plan of care and has not been ordered, in writing, by a physician when an order is required
3. Artificial insemination
4. Autopsies
5. Aversive procedures, including cash penalties, unless otherwise authorized under state law
6. Ear/body piercing
7. Environmental products, such as air filters and purification systems, humidifiers and dehumidifiers (central or room), and hypoallergenic bedding and linens
8. Health services for which a physician's order is required but not obtained
9. Health services not documented in the member's health/medical record
10. Health services not in the member's plan of care, individual treatment plan, IEP, or individual service plan
11. Health services not provided directly to the member unless the service is identified as a covered service in this manual
12. Health services of a lower standard of quality than the prevailing community standard of the provider's professional peers (providers of services that are determined to be of low quality must bear the cost of these

services)

13. Health services that do not contain documentation of supervision, if supervision is required
14. Health services, other than emergency health services, provided without the full knowledge and consent of the member or the member's legal guardian
15. Home modifications, such as: grab bars, handrails, widening of doorways, bathroom modifications, stair lifts, or ramps
16. Missed appointments (PrimeWest Health members may not be billed for missed appointments)
17. More than one home visit for a particular type of home health service by a home health agency per member per day, except for respiratory therapy visits or skilled nurse visits as specified in the member's plan of care.
18. Reversal of voluntary sterilizations
19. Surgery primarily for cosmetic purposes
20. Vehicle modifications: adapted seating, door handle replacements, door widening, motorized lifts, wheel chair lifts, wheelchair securing devices
21. Vocational or educational services, including functional evaluations or employment physicals, except as provided under IEP-related services

**Services not covered by SNBC but still available under State Plan (Fee-for-Service):**

1. Personal Care Assistant services
2. Private Duty Nursing services
3. Personal Care Qualified Professional Supervision services
4. Services provided through the CAC, CADI, TBI or DD Medical Assistance Waivers

**Other non-covered items include:**

- |  |   |
|--|---|
| 1. Adaptive furniture                                | 33. Medical identification bracelets  |
| 2. Air conditioners                                  | 34. Menses products (sanitary pads)   |
| 3. Appliances  | 35. Non-prescription over-the-counter ointments, creams, and lubricants       |
| 4. Bed baths   | 36. Orthopedic mattresses   |
| 5. Bedboards   | 37. Personal computers and printers   |
| 6. Beds (oscillating and lounge)                     | 38. Pulse tachometers   |
| 7. Bicycles  | 39. Ramps   |
| 8. Blankets  | 40. Reading glasses   |
| 9. Blood glucose analyzers (reflectance colorimeter) | 41. Reachers  |
| 10. Bottle washers                                   | 42. Stock orthopedic shoes (unless attached to a leg brace or for a diabetic) |
| 11. Cell phones                                      | 43. Switches  |
| 12. Cervical rolls or pillows                        | 44. Surrogate pregnancy and related services                                  |
| 13. Computers  | 45. Surgical masks/gowns  |
| 14. Control units and battery device adapters        | 46. Table foods   |
| 15. Diathermy machines                               | 47. Tableware   |
| 16. Disinfectants                                    | 48. Tape recorders  |
| 17. Disposable wipes                                 | 49. Telephone   |
| 18. Electric toothbrushes/water picks                | 50. Telephone alert systems   |
| 19. Elevators and stair lifts                        | 51. Telephone answering machines  |
| 20. Enuresis or bedwetting alarms                    | 52. Telephone arms  |
| 21. Exercise equipment                               | 53. Tennis/gym shoes  |
| 22. Feeding instruments                              | 54. Terbutaline pump therapy  |
| 23. Food blenders                                    | 55. Therapeutic tables  |
| 24. Home security systems                            | 56. Thermometer covers  |
| 25. Hot tubs   | 57. Toothettes/tooth brushes  |
| 26. Hygiene supplies and equipment                   |   |

- |   |                     |
|---|---------------------|
| 27. Ice packs (disposable)                        | 58. Toys            |
| 28. Instructional materials (pamphlets and books) | 59. Trampolines     |
| 29. Isolation gowns                               | 60. Transfer boards |
| 30. Lotion  | 61. Treadmills      |
| 31. Magnifying glasses                            | 62. Underwear       |
| 32. Massage devices                               | 63. Utensils        |
|   | 64. Video recorders |
|   | 65. Water beds      |

**Out-of-country care:** PrimeWest Health does not cover emergency or other health care services received from providers located outside the United States and Canada. For the purpose of this section, United States includes the fifty states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, America Samoa, and the Northern Mariana Islands.

## Minnesota Restricted Recipient Program (MRRP)

The purpose of the Minnesota Restricted Recipient Program (MRRP) (formerly the Health Care Designated Provider Program [HCDPP]) is to identify PrimeWest Health members who have used services at a frequency or amount that is not medically necessary and/or who have used health services that resulted in unnecessary costs to the program. Once identified, such members will be placed under the care of a primary care physician and/or other designated providers who will coordinate their care for a 24-month period.

### Investigation

The PrimeWest Health Care Coordinator conducts investigations to determine if:

1. A fraud, theft or abuse situation exists and can be supported by documentation;
2. Sufficient justification exists to support restricting a member to a primary care physician and/or other designated providers; and/or
3. Sufficient evidence exists to support the imposition of other sanctions.

**Abuse:** In the case of a member, the use of health services that results in unnecessary cost to PrimeWest Health or in reimbursement for services that are not medically necessary. The following practices are deemed to be abuse:

1. Obtaining equipment, supplies, drugs, or health services that are in excess of PrimeWest Health limitations, or that are not medically necessary and that are paid for by PrimeWest Health
2. Obtaining duplicate services for the same health condition from multiple providers. Duplicate service does not include an additional opinion that is medically necessary for the diagnosis, evaluation, or assessment of the member's condition or required under PrimeWest Health rule, or a service provided by a school district as specified in the member's individualized education plan under MS [256B.0625](#), subd.26.
3. Continuing to engage in practices that are abusive of the program after receiving a written warning from PrimeWest Health that the conduct must cease
4. Altering or duplicating the PrimeWest Health ID card for the purpose of obtaining additional health services billed to PrimeWest Health
5. Using a PrimeWest Health ID card or ID number that belongs to another person, or allowing others to use their PrimeWest Health ID card or ID number to obtain services, drugs, or equipment
6. Using the PrimeWest Health ID card to assist an unauthorized individual in obtaining a health service for which PrimeWest Health is billed
7. Duplicating or altering or falsifying prescriptions
8. Misrepresenting material facts as to physical symptoms for the purpose of obtaining equipment, supplies, health services, or drugs

9. Furnishing incorrect eligibility status or information to a provider
10. Furnishing false information to a provider in connection with health services previously rendered to the member that were billed to PrimeWest Health
11. Obtaining health service by false pretenses
12. Obtaining health services that are potentially harmful to the member
13. Repeatedly obtaining emergency room health services for non-emergency care
14. Using medical transportation to obtain health services from providers located outside the local trade area when health services are available within the local area

### **Grounds for Sanctions against Members**

The PrimeWest Health care coordinator may impose administrative sanctions against members for the use of health services that result in unnecessary costs to PrimeWest Health or in reimbursements for services that are not medically necessary.

### **Sanctions against Members**

PrimeWest Health may impose any of the following sanctions:

1. Referring the member to the appropriate authority for possible criminal or civil legal action
2. Recovery from the member, to the extent permitted by law, all amounts incorrectly paid by PrimeWest Health
3. Restricted status: Requiring that the member receive health care from a designated primary care physician and other designated health service providers for a period of 24 months

A member may be given an additional 36 months of restricted status if patterns of program abuse continue and are supported by documentation.

### **Notification and Member Rights to Appeal**

PrimeWest Health must notify members in writing of any sanctions to be imposed. A member may Appeal any sanction proposed by PrimeWest Health.

### **MCO Restriction Status**

PrimeWest Health and DHS have developed universal restriction, which is put in place by either PrimeWest Health or DHS and stays in effect for the entire period of restriction, regardless of whether the member:

1. Changes health plans;
2. Moves from fee-for-service to PrimeWest Health; or
3. Moves from PrimeWest Health to fee-for-service.

When PrimeWest Health restricts a member, PrimeWest Health must fax the following information to MRRP at **1-651-431-7422**:

1. Name and PrimeWest Health ID number of the restricted member;
2. Name(s) and PrimeWest Health ID number(s) of the provider(s) to whom the member is restricted;
3. The date span of the restriction; and
4. The reason codes for the restriction.

### **Denial, Termination, or Reduction (DTR) of Benefits Notice**

For members enrolled in PrimeWest Health, any change in [Service Authorization](#) or denial of a claim from a non-designated provider requires a denial, termination, or reduction (DTR) notice to the member. Placement in MRRP is not grounds for a DTR.

## Obtaining Restriction Information

Providers may obtain information about the types of services to which a member is restricted by verifying eligibility (by phone at **1-866-431-0802**, through the [Provider Portal](#), or through [MN-ITS](#)). Typically, a member is restricted to one primary care physician, pharmacy, and hospital. A member may also be restricted to other designated providers or referred by the primary care physician to other providers, if appropriate. Members may receive services that are not subject to restriction from any enrolled PrimeWest Health provider. Long-term care facility services are not subject to restriction.

## Selection of Providers by MRRP

A member placed on restriction is required to select a primary care physician, hospital, and a pharmacy to coordinate his/her care. If the member fails to choose providers, PrimeWest Health will assign providers based on considerations of geographic proximity, the member's prior experience with a specific physician, and the physician's willingness to provide health care services.

Members may be restricted to physician assistants (PAs) and nurse practitioners (NPs); however, if a member is restricted to a PA, PrimeWest Health will restrict the member to the primary care provider the PA works under. PrimeWest Health can restrict the member to an NP if the NP has privileges at the member's assigned hospital.

## Responsibilities of the Primary Care Physician

Any physician enrolled as a general practitioner, internal medicine, or family practice physician may be selected by the member as his/her primary physician. The primary care physician will be asked to review each member's profile of utilization, develop an appropriate care plan, and authorize referrals. To participate as a primary care physician, the physician must be enrolled as a PrimeWest Health provider.

## Limitations on Physician Participation

The commissioner may limit a primary care physician's participation in MRRP based on the quality or quantity of health care services delivered or a review of sanctions previously imposed by PrimeWest Health or by the physician's professional licensing board. The commissioner also may limit the number of members restricted to an individual primary care physician.

## Medical Referral for Minnesota Restricted Recipient Program Recipient Form

The primary care physician must complete a PrimeWest Health [Medical Service Authorization Request](#) form as soon as a recipient is referred to another physician for care. This information is necessary for the referring provider's claim(s) to be processed in a timely manner.

## Emergency Services

Emergency health care services may be provided to a PrimeWest Health member without the authorization of the primary care physician if these services are provided in response to a condition that, if not immediately diagnosed and treated, could cause a person serious physical or mental disability, continuation of severe pain, or death. PrimeWest Health may require documentation of the emergency situation in order to determine payment of the claim.

## Program Requirements

In addition to MRRP, the provider(s) must follow all PrimeWest Health requirements (such as authorization, second surgical opinion, program limitations, etc.).

## Claims Reimbursement

Services provided to a PrimeWest Health member will be reimbursed when:

1. The service is provided by the member's primary care physician or his/her designee;
2. The primary care physician has submitted a PrimeWest Health [Medical Service Authorization Request](#) form as soon as a recipient is referred to another physician for care; or
3. The service is of a provider or service type that is not listed as restricted on the member's file.

## Discharging a PrimeWest Health Member

If a provider chooses to discontinue care for a PrimeWest Health member, the provider must notify PrimeWest Health and the member in writing with the effective date and reason. PrimeWest Health is obligated to ensure that members have access to medical care. PrimeWest health will furnish the member with names, addresses, and telephone numbers of other participating providers in the same area of medical specialty and a PrimeWest Health care coordinator will assist the member in locating a new medical home.

## Reporting Suspected Misuse of Services or Requests for Additional Information

To report actual or suspected fraud, abuse, or mis-utilization of service by a PrimeWest Health member, or for questions regarding PrimeWest Health's Restricted Recipient program, call **1-866-431-0802** (toll free).

For other questions regarding MRRP, call **1-651-431-2648** or **1-800-657-3674**.

## Legal References

MS [256B.02](#)

MS [256B.055 – 256B.061](#); [256L.01 – 256L.15](#)

MS [256B.0625](#); [256D.03](#); [256L.03](#)

MN Rules [9505.0010 – 9505.0140](#)

MN Rules [9505.0010 – 9506.0090](#)

MN Rules [9505.0170 – 9505.0475](#)

MN Rules [9505.2160 – 9505.2245](#)

42 CFR 435 (MA Eligibility)

42 CFR 440 (MA Services)

42 CFR 456 (MA Utilization Control)