Provider Manual

Mayo Clinic Health Solutions

CHAPTER 1 - INTRODUCTION

Mayo Clinic Health Solutions (f.k.a. MMSI) is a third-party administrator (TPA) and health benefits management company focused on providing outstanding member care. Based in Rochester, MN, Mayo Clinic Health Solutions serves millions of households through our plan administration services and wellness products and programs. Mayo Clinic Health Solutions processes claims, provides customer service support, manages provider networks and performs other administrative functions. A team of specialists provide medical management services to assure plan participants receive quality care at a reasonable cost along with appropriate and effective utilization of health care resources for positive clinical and financial outcomes.

Mayo Clinic Health Solutions has developed this *Provider Manual* for use by participating health care providers and their business office staff. This manual provides information about our commercial claims filing procedures, payment, provider agreements, managed care requirements, communications, and other topics that affect patient accounts and patient relations. As our policies and procedures change, this *Provider Manual* will be revised and you will be notified through:

- The quarterly *eUpdate for* Providers online newsletter
- The Mayo Clinic Health Solutions Online Service for Providers Web site at **www.MayoClinicHealthSolutions.com**.

Important Note: "Commercial" as used in this *Provider Manual*, refers to all Mayo Clinic Health Solutions medical products that are not Medicare, Medicaid, or other governmental products. In the event of a conflict or inconsistency between your contract and this manual, the provisions of your contract with Mayo Clinic Health Solutions will control.

Information for the South Country Health Alliance (SCHA) governmental products can be found in the SCHA Provider Manual,

EUPDATE FOR PROVIDERS NEWSLETTER

The *eUpdate for Providers* newsletter is published quarterly and emailed to the Office Manager's attention at Mayo Clinic Health Solutions-contracted sites. Please notify us if you need to update the designated contact person's email address or add a new contact person to receive the newsletter. Email your request and include your tax identification number to healthsolutionsprovserv@mayo.edu.

MAYO CLINIC HEALTH SOLUTIONS RESOURCES

CUSTOMER SERVICE

Representatives are available to assist you Monday through Friday, 7:00 a.m. to 7:00 p.m. CT. Please refer to the back of the member's member ID card for the Customer Service phone number for their specific plan. Customer Service phone numbers are also listed in the Quick Reference Guide, available when you sign in to your account at **www.MayoClinicHealthSolutions.com.** When you call, please have your National Provider Identification (NPI) number and tax identification number, and the member's membership number and the claim number available to expedite your call.

HEALTH SERVICES

Please refer to the following information to contact Health Services:

Phone 1-800-645-6296

Fax 1-888-889-7822

PHARMACY BENEFIT SERVICES

Please contact Pharmacy Benefit Services by fax: 507-538-5767 or 507-538-5222

PHYSICAL ADDRESSES

Mayo Clinic Health Solutions

4001 41st Street NW

Rochester, MN 55901

ONLINE SERVICES FOR PROVIDERS – www.MayoClinicHealthSolutions.com

Mayo Clinic Health Solutions Online Services for Providers includes tools that give providers access to plan and administrative information. Through the Web site, you have access to:

- Member claims information
- Member eligibility information
- Member health plan documents

In order to access these tools, you must be registered as a Super User or as an End User.

- To register as a Super User, please complete a *Super User Request* fax form, available at www.MayoClinicHealthSolutions.com in the Online Services for Providers under "Provider Forms." There is only one Super User assigned per health care facility.

- To register as an End User, please contact the designated Super User at your health care facility.

CLAIMS ADDRESS

All participating providers with electronic capabilities for claim submission are required to electronically submit all claims. Refer to the back of the membership card for the correct claims mailing address and the correct electronic Payor ID. ***The Mayo Clinic Health Solution electronic Payer ID is 41154***.

MEMBER ID CARDS

Your patient's member ID card contains information that is essential for claims processing. We recommend that you review the patient's member ID card at every visit and have a current copy of the front and back of the card on file. Sample member ID cards are listed in the Quick Reference Guide, available when you sign in to your account at **www.MayoClinicHealth Solutions.com.** The following information is found on the member ID card:

- Name of the plan
- Member number, including alpha prefix
- Member's name and group number
- Prescription coverage information
- Claims submission information
- Customer Service contact information

CHANGES TO DEMOGRAPHIC INFORMATION

Your contract with Mayo Clinic Health Solutions requires you to contact us with demographic changes, including facility location updates. Without proper notification, new facility locations may be considered out-of-network, or your contract may become null and void. Please complete the *Facility Change Update* form, located at **www.MayoClinicHealthSolutions.com** in the Online Services for Providers section under "Provider Forms" and fax a copy to us at 1-507-266-0619.

CHAPTER 2 - PARTICIPATING PROVIDER POLICIES AND PROCEDURES

Participating Providers are those providers who have entered into a written contract with Mayo Clinic Health Solutions in order to establish an independent contractor relationship between the parties for the purpose of engaging the provider to supply medical services to our clients and members.

RESPONSIBILITIES OF PARTICIPATING PROVIDERS

The responsibilities of participating providers include:

- Electronic submission of all claims (if the provider has electronic capabilities).
- Participation in the Mayo Clinic Health Solutions credentialing process.
- Submission of prior notifications or prior authorizations, when required.
- Referral of patients to other participating providers, whenever necessary.
- Acceptance of payment provisions outlined in the Provider Agreement.
- Provision of services within the scope of their registration, license, and training and consistent with community standards for quality and utilization.
- Maintenance and provision of records and documents to Mayo Clinic Health Solutions at no charge, as required by applicable laws, regulations and program requirements.
- Cooperation with Mayo Clinic Health Solutions to facilitate the information and records exchanges necessary for quality management, utilization management, peer review or other programs required for operations.
- Compliance with applicable state and federal laws, regulations and plan requirements.
- Cooperation with Mayo Clinic Health Solutions in the implementation of Member Grievance procedures and assistance in taking appropriate action.
- Maintaining insurance coverage on behalf of themselves, and, if applicable, each of their participating providers.
- Compliance with all Mayo Clinic Health Solutions provider policies and procedures, which may be enacted and revised from time to time.

SITE REVIEWS

As stated in your contract, Mayo Clinic Health Solutions may conduct site reviews to ensure that network facilities and medical records meet our quality standards, and as may be required by applicable law. If findings from the site review show deficiencies, an action plan will be developed to ensure the network facility will be brought up to our standards. This plan should be completed within a reasonable amount of time or the contract may be terminated, according to contract terms.

NON-DISCRIMINATION

Except as medically appropriate, participating providers shall not differentiate or discriminate in the treatment of any member because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status or source of payment.

CULTURALLY COMPETENT CARE

Participating providers must demonstrate cultural competence in their treatment of plan members. This practice ensures that all clinic and non-clinical services are accessible to all members and are provided in a culturally competent manner, including members with limited English proficiency or low reading levels, and those with diverse cultural and ethnic backgrounds.

ADVANCE DIRECTIVES

Participating providers are required to inform all adult patients about their right to accept or refuse medical treatment, as well as the right to execute an advance directive.

Providers must document in the medical record whether or not an individual has executed an advance directive. In addition, providers have the responsibility to inform patients of the right to file a complaint with their State's Health Department regarding noncompliance with advance directive requirements.

CONFIDENTIALITY

Participating providers must comply with HIPAA privacy requirements and all applicable state and federal privacy laws and regulations. All Provider Agreement terms and conditions must remain strictly confidential.

HOW TO APPLY TO BECOME A PARTICIPATING PROVIDER

To learn more about how to become a participating provider, go to Online Services for Providers at **www.MayoClinicHealthSolutions.com** and click on "Join our Network" in the left hand navigation. This page outlines the process for applying to become a participating provider, and provides details on the types of applications we are currently accepting.

As part of this process, you will be required to complete the *Organizational Credentialing* form, available on the Provider Forms page of Online Services for Providers. We will review the application and contact you if additional information is needed. Membership volume, provider location, and provider specialty determine our network needs. Mayo Clinic Health Solutions reviews access to its network providers on an ongoing basis. Submission of an application is not a guarantee the provider will be approved to become a participating provider.

Please note: A provider must have a contract signed by both parties in place in order to be considered a participating provider.

CHAPTER 3 - CREDENTIALING

Credentialing is the process used to determine if an individual applicant is qualified and competent to render acceptable care to the members of Mayo Clinic Health Solutions-administered plans. This policy addresses only the criteria used at the time of practitioner credentialing or re-credentialing. Network Development will determine the need for practitioners in the Health Solutions Supplemental network.

PRACTITIONERS WHO REQUIRE CREDENTIALING FROM MAYO CLINIC HEALTH SOLUTIONS

Mayo Clinic Health Solutions must credential the following types of practitioners interested in becoming participating providers.

Doctoral Level Practitioners (excluding mental health practitioners)**:**

- Physicians *(foreign equivalent to MD)*
- Podiatrists
- Dentists *(when providing oral surgery services)*.
- Doctor of Optometry

Allied Health Practitioners

- Advanced Practice Nurse Prescriber
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Nurse Specialists
- Certified Registered Nurse Anesthetists
- Physicians Assistants

Mental Health

Mayo Clinic Health Solutions credentials practitioners at the highest licensure level, according to their practicing state guidelines.

- Psychiatrists
- Licensed Psychologists

- License Marriage and Family Therapists
- License Professional Clinical Counselors
- Licensed Professional Counselors
- Licensed Clinical Social Workers
- Licensed Independent Clinical Social Workers
- Licensed Independent Social Workers
- Licensed Mental Health Counselors
- Certified Alcohol & Drug Counselors
- Advanced Certified Alcohol & Drug Counselors
- Substance Abuse Counselors
- Clinical Substance Abuse Counselors
- Licensed Alcohol & Drug Counselors
- Certified Nurse Specialists in psychiatric and mental health specialties

PRACTITIONERS NOT CREDENTIALED BY MAYO CLINIC HEALTH SOLUTIONS

Mayo Clinic Health Solutions does not credential the following types of practitioners:

- Alcohol Drug Counselors - Temp
- Art Therapists
- Audiologists
- Certified Athletic Trainers
- Certified Case Managers
- Certified Clinical Supervisors
- Certified Disability Management Specialists
- Certified Hand Therapists
- Certified Laboratory Assistants

- Certified Mammographic Technologists
- Certified Medical Assistants
- Certified Nuclear Medicine Technologists
- Certified Nurse Operating Room
- Certified Occupational Rehabilitative Therapists
- Certified Occupational Health Nurses
- Certified Operation Room Technicians
- Certified Radiologic Technologists
- Certified Surgical Assistants
- Chiropractors
- Dance Therapists
- Hearing Instrument Specialists
- Licensed Dietitians
- Licensed Nutritionists
- Massage Therapists
- Music Therapists
- Occupational Therapists
- Occupational Therapy Assistants
- Oncology Certified Nurses
- Pharmacists
- Physical Therapists
- Physical Therapy Assistants
- Radiology Technicians
- Registered Diagnostic Medical Sonographers
- Registered Dietitians

- Registered Electrodiagnostic Technologists
- Registered Electroencephalographic Technologists
- Registered Nurses
- Registered Physical Therapists
- Registered Play Therapists
- Registered Radiology Technicians
- Registered Respiratory Therapists
- Speech-Language Pathologists
- Speech Therapists/Speech Pathologists

THE PRACTITIONER CREDENTIALING PROCESS

To maximize efficiency and expedite the credentialing process, all practitioners must complete a standard credentialing application form. The *Uniform Initial Credentialing Application* form is located at **www.MayoClinicHealthSolutions.com** on the Online Services for Providers tab, under "Provider Forms." When submitting this form, please include all required attachments and ensure that the Authorization and Release form and Disclosure Questions form are signed and dated.

Submission of an application is not a guarantee the practitioner will be approved to participate in the network. When a complete application has been received, the Credentialing Committee will review the application. Applicants meeting established criteria are eligible for review by our Medical Director. Applications which do not meet established criteria will be reviewed by the Mayo Clinic Health Solutions Credentialing Committee.

PRIMARY VERIFICATION

Mayo Clinic Health Solutions will collect and verify all credentialing criteria in accordance with National Committee for Quality Assurance (NCQA). Applicants are required to cooperate fully in providing all documents requested by Mayo Clinic Health Solutions.

ACTIONS TAKEN BY THE MAYO CLINIC HEALTH SOLUTIONS CREDENTIALING COMMITTEE

The Credentialing Committee may accept, accept with restriction, condition, deny or terminate an applicant's request for participation. The Credentialing Committee may request further

information from an applicant, table an application pending outcome of an investigation, or take any other action it deems appropriate.

APPEALS

An appeals process is available to applicants whose application is restricted, conditioned, denied or terminated. The practitioner must request a hearing, in writing, within 30 days of notification. The Appeals Committee has final authority to act on determinations of the Credentialing Committee regarding individual participation. For full details on the appeals process, please contact the Mayo Clinic Health Solutions Credentialing Unit by email at **RSTHealthSolutionsCredentialing@mayo.edu.**

NOTIFICATION OF DECISION

Applicants will be notified within 60 days of a decision. The notification reports any restrictions that may have been placed on an individual practitioner's participation status. If the Credentialing Committee requires a restriction, the practitioner is notified of the criteria the Credentialing Committee used to make their decision.

Important Note: New practitioners at a contracted facility may not render services to members of Mayo Clinic Health Solutions-administered plans until such time as the practitioner receives notification of Credentialing Committee approval.

RE-CREDENTIALING REQUIREMENTS

Practitioners must be re-credentialed every 36 months in order to maintain their status as participating providers in the network. Mayo Clinic Health Solutions will send pre-populated re-credentialing materials to practitioners at least 120 days prior to the practitioner's re-credentialing due date. Failure to submit these materials in a timely manner will be considered an administrative withdrawal (i.e., termination) from the network.

Re-credentialing is conditional upon the applicant continuing to meet our credentialing and quality standards. The types of quality information consulted in making re-credentialing decisions include, but are not limited to:

- Member complaints
- Results of quality reviews
- Utilization management information
- Member satisfaction surveys, where applicable
- Medical record reviews, when available

- Results of office site visits, where applicable

CREDENTIALING REQUIREMENTS FOR MULTIPLE SITES AND LOCATION TRANSFERS

Practitioners performing outreach services, working at multiple sites or transferring between locations must provide the following information:

- *MN Uniform Practitioner Change form* (available at **www.MayoClinicHealth Solutions.com** on the Online Services for Providers tab under "Provider Forms.")
- Proof of professional liability coverage under new or additional entity
- Practitioner's National Provider Identifier (NPI) number

Mayo Clinic Health Solutions recognizes that certain credentialing information does not change with a change in employer or contracted location and that static information has already been verified. Credentialing status may be maintained for a contracted site employer if the practitioner has terminated in good standing from the network within the past 30 days. During that 30-day period, the practitioner must not have come due for re-credentialing or, if due, must have entered into the re-credentialing process to meet the 36-month deadline. If the re-credentialing due date has passed, the practitioner must submit a new credentialing application. To avoid duplication of effort, currently credentialed practitioners who are adding an additional contract practice site will maintain their credentialing status at the new site.

LOCUM TENENS

An entity that arranges for any health professional to provide temporary practice coverage for contracted providers for one to 119 days must notify our Credentialing Department in writing within two business days of initiating coverage. The notification must include the start date and the anticipated end date.

The Locum Tenens must also supply:

- A current copy of his/her state license,
- A copy of his/her Drug Enforcement Agency (DEA) certificate (if applicable),
- Any state controlled substance certificates (if applicable),
- Proof of current professional liability coverage.

After submitting the required information, services can be provided without going through the full credentialing process for 119 calendar days. Mayo Clinic Health Solutions will send

notification of the effective date of Locum Tenens status as well as the expiration date of such status to the Locum Tenens and the corresponding network credentialing coordinator.

Any practitioner acting as a Locum Tenens for 120 calendar days or more must be fully credentialed and approved by Mayo Clinic Health Solutions on or before day 120 in order to maintain network status and serve members of Mayo Clinic Health Solutions-administered plans. A practitioner can request Locum Tenens status for a maximum of two periods (each period up to 119 calendar days) at the same facility. The two Locum Tenens periods at the same facility must be 30 days apart, minimum.

ONGOING MONITORING

Throughout a practitioner's participation in the Health Solutions Supplemental Provider Network, Mayo Clinic Health Solutions will monitor the licensure status. Mayo Clinic Health Solutions will also query the Office of the Inspector General (OIG) and the Excluded Parties List System (EPLS) on a regular basis.

Practitioners are contractually obligated to promptly notify Mayo Clinic Health Solutions of any actions (termination, stipulation, restriction, limitation, condition, suspension, revocation, refusal or voluntary relinquishment) taken by any licensing board or health-related agency organization.

ORGANIZATIONAL CREDENTIALING

Mayo Clinic Health Solutions has established guidelines for initial and ongoing assessment of organizational providers to ensure contracted organizational providers are compliant with state and federal regulations and accreditation standards, as applicable. We utilize the criteria of the National Committee on Quality Assurance (NCQA) as a standard for its credentialing process. Facility types that require organizational credentialing include:

- Behavioral health facilities, including ambulatory, inpatient, and residential facilities
- Durable medical equipment facilities
- Free-standing surgical centers
- Home health agencies
- Hospitals
- Free-standing laboratories
- Nursing homes
- Skilled nursing facilities

ORGANIZATIONAL CREDENTIALING PROCESS

To maximize efficiency and expedite the credentialing process, all organizations must complete a standard application form. The *Organizational Credentialing Form* is located at **www.MayoClinicHealthSolutions.com** on the Online Services for Providers page under "Provider Forms." Please include all required attachments for your type of facility, as applicable. These may include:

- Accreditation Certificate(s)
- CLIA Amendment
- CMS Review
- Federal, Local or State License(s)
- General Liability Declarations Page (showing coverage amounts and dates)
- Medicare Certification
- Ownership Disclosure Form
- Professional Liability Declarations Page (showing coverage amounts and dates)
- State Review
- W9 Form

Please note: Submission of an application is not a guarantee the provider will be approved to participate in the network.

When a complete application has been received, the Credentialing Committee will review the application. Providers meeting established criteria are eligible for review by the Mayo Clinic Health Solutions Medical Director. Applications that do not meet established criteria will be reviewed by the Credentialing Committee.

ACTIONS TAKEN BY THE MAYO CLINIC HEALTH SOLUTIONS CREDENTIALING COMMITTEE

The Credentialing Committee may accept, accept with restriction, condition, deny or terminate an organization's request for participation. The Credentialing Committee may request further information from an organization, table an application pending outcome of an investigation, or take any other action it deems appropriate.

CREDENTIALING TIPS

TIP 1: WHEN TO CONTACT CREDENTIALING

You should contact Credentialing when any of the following events occur:

- A new practitioner joins a facility, either as permanent staff or as locum tenens.
- A new location/facility opens.
- A credentialed practitioner adds or moves to another location within a facility.
- A credentialed practitioner terminates from a facility.
- A credentialed practitioner updates their title, name or specialty.

TIP 2: FREQUENTLY MISSED INFORMATION ON CREDENTIALING APPLICATIONS

To ensure that your application can be processed timely, please submit all required information with your application. Information frequently missed on credentialing applications includes:

- Work history and chronology gaps of more than 6 months (month and year required)
- Education and training history gaps of more than 6 months (month and year required)
- Copy of current unrestricted State Medical License, DEA or CDS permit (if applicable)
- Copy of current Insurance Face Sheet listing company name, policy number, limits and expiration date
- Complete addresses for all facilities (street, city, state, zip code)
- Scope of practice (residents/fellows)

NOTIFICATION OF APPLICANT RIGHTS

Practitioners are notified of the following applicant rights through their initial and re-credentialing application(s):

- The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request.
- The right of practitioners to correct erroneous information.
- The right of practitioners to review information submitted to support their credentialing application.
- The right of practitioners to appeal a decision made by the Credentialing Committee.

Organizational credentialing summary of the appeal rights and processes includes:

- The right to request an appeal to the Appeals Committee, in writing and signed by the provider, within thirty (30) calendar days. The appeal must be addressed to the Medical Director.
- The appeal request must set forth in detail the reasons why the provider believes the Appeals Committee should reconsider the decision of the Credentialing Committee.
- Notice that the Appeals Committee may establish time limitations and other reasonable restrictions.
- Notice that the Provider has the option to be represented by legal counsel or another person of the provider's choice, at the provider's own expense.

CONTACT INFORMATION

You may contact a Credentialing Specialist at 507-538-5155 or 507-538-5141 with any credentialing questions. You may also contact us via e-mail at **RSTHealthSolutions Credentialing@mayo.edu**

To contact the Credentialing Unit in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn: Credentialing Unit
4001 41st Street NW
Rochester, MN 55901

CHAPTER 4 - CLAIMS

ELECTRONIC DATA INTERCHANGE (EDI)

Mayo Clinic Health Solutions offers providers the ability to submit professional and institutional claims via Electronic Data Interchange (EDI). Clearinghouses currently working with us to ensure format compatibility include:

CLEARINGHOUSE	837I	837P	837D	835	270/271
Emdeon *http://www.emdeon.com/* *877-271-0054*	X	X	X	X	X
OptumInsight (f.k.a. CareMedic) *http://www.optuminsight.com/* *800-508-8494*	X	X			
ClaimLynx *https://www.claimlynx.com/* *952-593-5969*		X		X	
HEALTHEC (a.k.a. MNeConnect) *http://www.mneconnect.com/* *877-444-7194*	X	X		X	
RycanTechnologies, Inc. *http://www.rycan.com/* *800-201-3324*				X	

CLAIMS SUBMISSION PROCESS

Effective July 15, 2009, health care providers in the State of Minnesota are mandated by Minnesota Statue, section 62J.536, to submit all claims electronically to payers and group purchasers. Providers in other states are encouraged to submit claims electronically.

To submit claims electronically to Mayo Clinic Health Solutions, you must sign up through one of the clearinghouses on the grid above.

The Mayo Clinic Health Solutions payer identification number for all clearinghouses is 41154.

For practitioners submitting claims on a standard *CMS 1500 or 1450 claim* form,

Mayo Clinic Health Solutions follows general CMS 1500/1450 field completion guidelines, as published in Chapters 25 and 26 of the CMS Medicare Claims Processing Manual, found on the CMS Web site.

Claims for all plans administered by Mayo Clinic Health Solutions should be mailed to the address on the back of the membership card unless you hold a direct contract with Mayo Clinic Health Solutions and have received instruction to submit directly to Mayo Clinic Health Solutions. Some self-insured plans administered by Mayo Clinic Health Solutions use a leased provider network in addition to the Health Solutions Supplemental provider network. The leased network may require the claim to be submitted directly to that network for re-pricing. It is very important for providers to submit claims to the address or payer ID listed on the back of the membership card so claims payment will not be delayed.

ELECTRONIC CLAIM SUBMISSION WITH ATTACHMENTS

Mayo Clinic Health Solutions accepts claims with attachments electronically. When an attachment to a claim is necessary, providers will need to populate the paperwork (PWK) segment in Loop 2300 of the electronic claim. Please refer to the Minnesota Uniform Companion Guides, section 4.2.3.4., for additional instructions regarding how to use the Attachment Control Number. Mayo Clinic Health Solutions follows the submission guidelines as outlined in the Administrative Uniformity Committee (AUC) best practice for claims attachments, found on the AUC Web site.

A cover sheet must accompany each attachment to ensure a proper match to the electronically submitted claims. Please fax the Health Care Claim Attachment Cover Sheet to Mayo Clinic Health Solutions at 1-855-619-0010. The form is posted at www.MayoClinicHealthSolutions.com in the Online Services for Providers area under Provider Forms.

CLAIMS WITH COORDINATION OF BENEFITS

Mayo Clinic Health Solutions accepts electronic claims with previous payor payment information populated, per the requirements in the Minnesota Uniform Companion Guides. The claims must contain all previous payor group codes, ANSI Adjustment Reason Codes and Remittance Advice Remark Codes as you received them from the previous payor for proper adjudication. These claims will not require an attachment when populated within the claim record.

Refer to the Minnesota Uniform Companion Guides, section 4.2.3.5 for more information.

MEDICARE CROSSOVER

The claims crossover system reduces your paperwork by using the Medicare claim form to process both Medicare and Medicare Supplement benefits. Through the crossover, Medicare generates a second claim automatically for members who have secondary or supplemental benefits with Mayo Clinic Health Solutions.

- **Providers who are contracted directly with Mayo Clinic Health Solutions** have only one claim form to submit—the 837P/CMS-1500 for Medicare Part B or the 837I/CMS-1450 for Medicare Part A. ***Do not submit an electronic or paper claim for claims that crossover electronically to Mayo Clinic Health Solutions from Medicare.***

- **Providers who are NOT contracted directly with Mayo Clinic Health Solutions** must follow the claim submission instructions on the back of the member's ID card.

Our goal is to pay claims as quickly as possible. To ensure the proper administration of benefits, providers should submit claims to the appropriate payer even when their claims have been paid in full by other third parties, such as Medicare. When submitting claims in these cases, the provider shall populate the previous payer's payment information within the claim. Providers must submit claims to the appropriate payer for all services provided, even in cases where the provider suspects a service will not be covered; this will ensure the proper administration of benefits and take advantage of changes in coverage that providers may not be aware of.

Mayo Clinic Health Solutions requires a primary insurances' Explanation of Benefits (EOB) in order to correctly coordinate benefits for members. Providers should refer to the Medicare Claims Processing manual as it relates to billing Medicare non-covered services and appropriate modifier use. Providers that have chosen to opt out of Medicare need to submit this information in writing to Mayo Clinic Health Solutions every two years. Providers should refer to MLN Matters SE1311 for the required information that is needed from the provider. Correspondence should be mailed to:

Mayo Clinic Health Solutions

PO Box 211698

Eagan, MN 55121

CLAIMS RESUBMISSION AND RECONSIDERATION

If submitting a corrected 837I claim, the Type of Bill submitted by the provider will indicate to us if the claim is a corrected/adjusted claim or a replacement of a prior claim. On electronic claims, it is required that the third digit of the Type of Bill is XX7 (replacement) or XX8 (void - no reprocessing is required).

If submitting electronic 837P claim, a claim frequency code of 6, G, M, or I should be submitted to indicate a correction/adjustment.

To ensure provider concerns are documented and addressed, Mayo Clinic Health Solutions has a formal process for providers to submit requests for Review and Reconsideration and a Provider Grievance for post service claim review.

Review and Reconsideration: For requests challenging a claim denial, claim adjudication, claim submission or claim resubmission not acted upon, providers must file this request within 180 days from the initial Remittance Advice denial. Requests of this type may be submitted in writing on the Claim Review and Reconsideration form, or via Mayo Clinic Health Solutions Customer Service, following claims processing and receipt of a formal denial. A written response from Mayo Clinic Health Solutions will be sent to the provider within ten (10) business days following receipt of all necessary information.

Grievances: To dispute a Review and Reconsideration decision, providers can file a grievance. All grievances must be submitted in writing on the Grievance Request form. A written decision will be sent to the provider within thirty (30) business days, following receipt of all necessary information.

REVIEW AND RECONSIDERATION PROCESS

The Review and Reconsideration process is the first level of review a provider can challenge a determination made by Mayo Clinic Health Solutions. The Claim Review and Reconsideration form is to be completed by providers, facilities or ancillary health care professionals to request a formal review of a claim concern. Providers assisting members filing an appeal because of an adverse claim or authorization determination (denial or disapproval) should review the member appeal process in Chapter 7 – Appeals.

If a claim has not been acted upon, i.e. not paid or formally denied, please verify claims status first by calling customer service or visiting www.mayoclinichealthsolutions.com. If the claim has been returned by Mayo Clinic Health Solutions for insufficient or incorrect information, please submit a corrected claim or requested information before submitting the Claim Review and Reconsideration form. Provide relevant supporting documentation including, but not limited to:

- Copy of claim
- Copy of remittance advice
- Medical records
- Previous/related correspondence

Initial Request For Review:

Form	Description	Process	Timeline
Claim Review and Reconsideration	This form should be utilized with first request to review post service claim determination.	The request may be filed verbally or in writing. Submit the request to address or	A written response from Mayo Clinic Health

	The form is submitted by a Provider, or a third party acting on behalf of the provider, requesting review and reconsideration of a claim determination.	fax number listed on the form. To submit a verbal request for review and reconsideration, call Mayo Clinic Health Solutions Customer Service at the phone number on the Remittance Advice or on the back of the member's ID card.	Solutions will be sent to the provider within ten (10) business days following receipt of all necessary information.

GRIEVANCE REQUEST PROCESS

Submitting a grievance is the second level review of a provider submitted concern. The Claim Review and Reconsideration form must have already been submitted and a determination made by Mayo Clinic Health Solutions before the Grievance Request form will be accepted. A Grievance Request must be submitted in writing.

Form	Description	Process	Timeline
Grievance Request	This form should be utilized if the provider or a third party has failed to resolve a claim concern presented via the Request for Review and Reconsideration.	The grievance may only be filed in writing. Submit the request to address or fax number listed on the form.	A written decision will be sent to the provider within thirty (30) business days following receipt of all necessary information.

REPLACEMENT CLAIMS

A replacement claim is submitted when an element of data on the claim was either not previously sent or needs to be corrected. Replacement or void of prior claim should not be done until prior submitted claim has reached final adjudication status. Examples include incorrect dates of service, number of units, diagnosis codes, or procedure codes. To qualify for a replacement claim, certain identifying information must remain the same. If these values change, then the prior claim must be voided and a new claim will be sent with the appropriate frequency.

- Provider (2010AA Loop)
- Patient (2010CA Loop)
- Payor (2010BB Loop)
- Subscriber (2010BA Loop)
- Institutional statement period (2300, DTP Segment).

When submitting a replacement claim, Mayo Clinic Health Solutions recoups the entire original claim amount and pays you for the services entered on the new claim. Do not delete lines that previously paid if you want them to pay on the replaced claim.

VOIDED CLAIMS

A voided claim may be requested when the entire claim needs to be recouped and no reprocessing is necessary. The entire claim must match the original, with the exception of the claim frequency code, condition code, and the payor-assigned claim number. Examples include: incorrect provider, patient or payor; or if patient did not want the insurer to be billed for services. There is no need to send negative values on a voided claim. The claim frequency code indicates that the values are negated.

NATIONAL PROVIDER IDENTIFIER (NPI)

The NPI is a unique, 10-digit number assigned by the Centers for Medicare & Medicaid Services (CMS). The NPI replaces all payor-assigned provider identifiers, individual and facility, and is the single provider identifier with which you should do business. Provider types that are not assigned a NPI are assigned a Unique Minnesota Provider Identifier (UMPI). In compliance with the HIPAA NPI requirement, Mayo Clinic Health Solutions requires all providers submitting claims to submit a UMPI or rendering (Type I) and billing (Type II) NPI. Claims submitted without a rendering and billing NPI will be denied. Services provided by different rendering practitioners need to be submitted on separate claim forms. Mayo Clinic Health Solutions contracted providers must provide us with all Type II NPIs or claims payment may be denied.

PLACE OF SERVICE CODES

Only nationally-assigned place of service codes are accepted. Current place of service codes, as of November 2012, are available on the CMS Web site.

CLAIM SERVICE DATES

The AUC has published a best practice regarding claim service dates in the same calendar month. The purpose of this best practice is to avoid split claims and rejections. Most eligibility changes occur at the beginning or end of a calendar month. Some payor systems require claims contain only services that are associated with a particular eligibility period. Current practice is to split these claims at the payor site to push through systems or to reject the claim.

- **On a professional claim**, service date spans should only be within the same calendar month. Multiple claims may be submitted for different dates within the same calendar month based on the provider's billing practices.
- **On an institutional outpatient claim**, statement and service date spans should only be within the same calendar month. Observation, extended recovery and emergency department services beginning before and completing after midnight are exceptions to this best practice if performed during the same visit. Procedures beginning on one day and ending on another should be billed together. This best practice does not apply to an institutional inpatient claim.
- **Pharmaceuticals** should be billed with the administration/dispensed date rather than a span of dates. Monthly equipment rental should be billed with the start date of the rental period only rather than the span of days.
- **Equipment rented on other than monthly basis** needs both from and through dates. Units of service should be reported as one (1) per rental period. These service date spans should only be within the same calendar month. An example would be daily rental of equipment.
- **Supplies** should be billed with the purchase date rather than the span of days.

For additional guidance on service date coding, refer to Appendix A of the MN Uniform Companion Guides found on the AUC Web site.

If a claim is submitted and payment or rejection is not received within 60 days, contact Customer Service. Keep a copy of the claim to provide information to the Customer Service Representative.

TIME LIMIT FOR FILING CLAIMS

For best results, submit claims within 60 days of the date of service. For most Mayo Clinic Health Solutions-administered plans, claims must be submitted within 365 days of the initial date of service in order to receive maximum reimbursement for services rendered.

CODING GUIDELINES

Mayo Clinic Health Solutions requires providers to stay current with billing and coding requirements for their area of service and requires submission of valid codes to report medical services and supplies on professional, institutional, and dental claims. This includes Healthcare Common Procedural Coding System (HCPCS) codes, current edition of International Classification of Diseases, Clinical Modification (ICD-CM) diagnosis and procedure codes, and Revenue codes. The Health Insurance Portability and Accountability Act (HIPAA) Transaction and Code Set regulation stipulates submission and acceptance of approved medical code sets. HCPCS and ICD-CM codes are among the approved HIPAA medical code sets and must be valid for the actual date of the service.

Revenue codes are a data element of the institutional claim (837I or CMS 1450) and must be valid for the date of submission. If a Revenue, HCPCS or ICD-CM code is not valid for the date of service, the claim will be denied.

Mayo Clinic Health Solutions requires that diagnosis codes and procedures performed be compatible. These conditions are identified separately not only to assure correct coding, but also appropriately apply benefits.

Revenue codes must also be compatible with the claim Type of Bill (TOB). Some revenue codes are very specific to the place where the service was rendered. A TOB is a code indicating the specific type of bill (e.g., hospital inpatient, outpatient, replacements, voids, etc.). The first digit is a leading zero. This zero is not included on electronic claims. The second digit identifies the type of facility. The third digit classifies the type of care being billed. The fourth digit indicates the sequence of the bill for a specific episode of care. The TOB is reported in FL 04 on the CMS 1450 claim form.

Modifiers: A modifier is used to indicate that the service or procedure that has been performed has been altered by some specific circumstance but has not changed the definition or code. Modifiers are also used to identify the rental, lease, purchase, repair or alteration of a medical supply.

CODING TIPS

1. The code that most accurately identifies the service performed should be submitted.
2. Documentation in the patient's medical record must support the code submitted.

3. Multiple codes should not be used when services can be represented by a single code.

4. Unlisted codes should only be used if no code exists to describe the service or supply. ***Note: If billing an unlisted code, documentation and/or narrative description must be attached or noted on the claim. Mayo Clinic Health Solutions will reject a claim that is submitted with an unlisted code without complete description of the service.***

5. All services for the same date of service (if performed by the same provider) should be submitted on the same claim.

6. In some situations, it may be appropriate to determine the CPT code by total length of time spent with a patient. If a provider is using time as a controlling factor to determine the level of service billed, the provider must document the total time spent face-to-face with the patient and should describe the counseling and/or coordination of care activities in the medical record. It is also recommended that the provider document the start and end time of the face-to-face service.

MEDICAL RECORD DOCUMENTATION GUIDELINES

CLINICAL DOCUMENTATION TIMELINESS

Entries in the medical record should never be made in advance of the service. Mayo Clinic Health Solutions requires practitioners to document services during or as soon as practicable after it is provided in order to maintain an accurate medical record. In general, Mayo Clinic Health Solutions will consider entries made within 24 to 48 hours of the completion of medical services to be reasonable. Providers should not add signatures to medical records beyond this short delay that takes place during the transcription process. Instead, Mayo Clinic Health Solutions will accept a provider attestation.

Providers may not submit a claim to Mayo Clinic Health Solutions until the clinical documentation is completed. This includes appropriately documenting the service(s) in the medical record and properly signing the record. Items documented in the medical record after claim submission will be considered undocumented. Undocumented services will be treated as if they were never performed.

TEMPLATES

Mayo Clinic Health Solutions understands that record templates are useful tools but urges caution when using template language in the medical record to ensure the information does not appear to be cloned from one record to another. Information is considered cloned when it is worded exactly alike or similar to previous record entries for the same patient and/or other patients. Cloned documentation will not meet the medical necessity requirements as it lacks specific, individual information.

SIGNATURE REQUIREMENTS

Mayo Clinic Health Solutions requires that all services provided/ordered be authenticated by the provider. Signatures can be electronic or handwritten.

Electronic Signatures: Practitioners should employ adequate policies and procedures to ensure electronic signatures comply with recognized standards and laws.

Handwritten Signatures: Handwritten signatures must be legible. If the signature is illegible, Mayo Clinic Health Solutions may consider evidence in a signature log or provider attestation to determine the author of the medical record. If the clinical documentation is missing the practitioner signature, the record will be considered undocumented unless the practitioner attests to the clinical record entry.

Providers are expected to enter all relevant information in the medical record at the time they render the service. A patient's medical record is a legal document and modification of the record should not be standard practice. However, if upon review of the medical record, a provider discovers that the medical record needs to be amended or corrected. Mayo Clinic Health Solutions will expect the provider to follow specific recordkeeping principals. Amendments and corrections must:

1. Clearly and permanently identify any amendment, correction, or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction, or delayed entry, and
3. Not delete, but instead clearly identify all original content

Electronic Health Record (EHR): In addition to the principals outlined above, amendments, corrections, or delayed entries into the EHR must:

1. Be distinctly identified as an amendment, correction, or delayed entry, and
2. Clearly identify the original content, the modified content, the date of modification, and the author of the modification

Paper Medical Records: It is important that paper medical records are legible to ensure proper patient care. Illegible documentation may result in inappropriate patient care and/or errors in the medical record. Appropriate patient care should be a provider's top priority. Mayo Clinic Health Solutions will treat illegible information as if it were undocumented.

The provider should not delete, but may strike through, any information that is being corrected. The struck information must still be legible. The correction must be signed and dated by the author. Additionally, amendments or delayed entries must be clearly identified as such and dated upon entry to the medical record.

REQUESTS FOR MEDICAL RECORDS

To ensure timely processing of medical records, please include the following:

1. Copy of the letter you received from Mayo Clinic Health Solutions which requested the medical record.
2. All supporting information needed to establish medical necessity of the services rendered.

REIMBURSEMENT/RECONCILIATION

Please refer to your provider contract for professional provider payment methodology details. Mayo Clinic Health Solutions maintains a 30-day turnaround time on all clean claims received. A clean claim is defined as a claim that has no defect or impropriety, including lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (42 CFR 447.45 and 447.46, and Minnesota Statutes, section 62Q.75). A claim is considered clean if it can be paid at the time of receipt and is complete in all aspects, including complete coding, itemization of charges, date of service, billed amounts and provider identification.

A claim submitted with any of the following is not considered a clean claim and will be denied and sent back to the practitioner:

- Missing or invalid place of service
- Missing rendering and billing NPI
- Illegible writing or typing
- Missing practitioner name and/or title
- Missing or invalid diagnosis codes, CPT, HCPC or modifiers
- Negative charges
- Non-Mayo Clinic Health Solutions member number
- Missing or incorrect tax ID number
- Any manual alterations (for example, white-out, cross-outs, etc.)

REMITTANCE ADVICE

Mayo Clinic Health Solutions sends claims payments directly to our participating providers. Payments are sent weekly with a Remittance Advice for providers that bill using the CMS 1500

and 1450. The Remittance Advice lists the claims processed, amount paid and reasons for denial. Payment/non-payment code explanations are listed at the bottom of each Remittance Advice.

The Member Responsibility field reflects the total member liability, which the member is responsible to pay. You may have already billed for applicable copayments up front. Members are generally responsible for applicable deductible, coinsurance, copayment, and non-covered services. Deductible and coinsurance amounts owed by the member will not be identified separately in this column. It will be a total amount owed by the member.

The Provider Responsibility field reflects the total provider liability. This amount includes the provider's contracted discount and the difference between the billed and allowed amount.

Providers are encouraged to review their Remittance Advice when received. Please address questions to the Customer Service phone number listed on the Remittance Advice, not by resubmission of the claim. We recommend retention of Remittance Advices according to individual business record retention policies.

ELECTRONIC REMITTANCE ADVICE

Effective December 15, 2009, the last phase of the electronic transactions required by Minnesota Statue, section 62J.536, requires all Minnesota health care providers and licensed group purchasers to exchange remittance advices (835s) electronically. Mayo Clinic Health Solutions is contracted with Emdeon, ClaimLynx, HEALTHEC (fka IGI), and Rycan Technologies, Inc. clearinghouses for this process. ***The Mayo Clinic Health Solutions Payer ID number is 41154.***

All providers/organizations that would like to receive our Electronic Remittance Advice (ERA) from Emdeon must be contracted and/or implemented to receive ERAs, either directly, via a third party organization, such as a software vendor, a billing service, or another clearinghouse that is contracted for ERA with Emdeon.

If your organization already has an ERA relationship with Emdeon, the ERA *Provider Setup Form* must be completed and returned to Emdeon's Enrollment Dept. The completed form should be submitted via email to batchenrollment@emdeon.com or faxed to 1-615-885-3713. To access this form, go to **www.emdeon.com.** Under the Resources heading, choose "Enrollment Forms." Under the Enrollment Categories heading, choose "Setup Forms."

Emdeon provides resources to answer providers' questions regarding enrollment and the *ERA Provider Setup Form*. The *Emdeon Enrollment Guide* and *Enrollment Frequently Asked Questions* documents are found on the "Enrollment" page. Please see links below.

If you have any questions, please call 1-800-845-6592, Option 1.

LINKS TO EMDEON FORMS

- Emdeon ERA Setup Form

- Emdeon Enrollment Guide
- Emdeon Enrollment FAQ

Providers will continue to receive paper remits from Mayo Clinic Health Solutions for 45 calendar days after enrolling with Emdeon.

Providers /organizations interested in receiving ERAs from HEALTHEC should call 1-877-444-7194, or follow these steps:

1. Login to HEALTHEC portal/ MNeConnect at www.mneconnect.com.
2. Click on Billing account admin tab and then click on payer registrations.
3. Under payer registrations, search for Mayo Clinic Health Solutions /SCHA.
4. Once the payer name appears, select the ERA check box and save selection by clicking on Save.
5. Once the selection is saved, HEALTHEC enrollment department will extract enrollment data and provide access to your ERAs.

Providers/organizations interested in receiving ERAs from ClaimLynx should call 1-952-593-LYNX (1-952-593-5969) or visit www.claimlynx.com.

Providers/organizations interested in receiving ERAs from Rycan Technologies, Inc. should call 1-800-201-3324, or visit www.rycan.com.

ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the most cost-effective way of doing business for our valued providers for claims payments. Through a secured automated clearinghouse process, you will be able to receive your claims payments directly deposited into your chosen bank account and streamline your account receivables.

HOW TO ENROLL IN ELECTRONIC FUNDS TRANSFER (EFT)

Complete and submit the Electronic Funds Transfer Authorization Form, located under "Provider Forms" at **www.MayoClinicHealthSolutions.com.** Follow all instructions indicated on the form and attach a bank letter or voided check.

When you enter your National Provider Identifier on the form, please complete one of the following based on your provider type:

- **For Individual Providers:** Enter your National Provider Identification (NPI) number in the applicable section. Enter only one provider number per application form.

- **For Multiple Providers:** Providers with multiple NPI numbers must submit a signed attachment on original letterhead listing all NPIs to be placed on EFT.
- **For Group Practices:** Enter the group NPI if payment is made to a group practice. Enter only one provider number per application form. **Provider Groups that receive payments under the Group number need only complete a single enrollment form for the Group NPI.** However, members of Provider Groups who also bill individually may enroll by submitting a separate enrollment form using their individual NPI number.

Mail or fax the form and all attachments to Mayo Clinic Health Solutions:
Mayo Clinic Health Solutions
Attention: Claims Payable Unit
PO Box 211698
Eagan, MN 55121
Fax: 507-538-5036

Please allow a minimum of two to four weeks for your request to be processed.

To check the status of your EFT enrollment, please call the Claims Payable Unit at 507-538-5220. EFT files that have not been received after three business days of receipt of the corresponding ERA file can be researched by calling Customer Service at (507)-538-6804 (local) or 1-888-656-8495.

You must contact your financial institution to arrange for the delivery of the CORE required Minimum CCD+ data elements needed for reassociation of the electronic payment and the electronic remittance advice (ERA). For more information, please view information about the CORE Phase III Rules listed online: http://www.caqh.org/CORE_phase3.php

HOW TO CHANGE YOUR EFT ENROLLMENT

To make a change to your EFT enrollment (for example: to change your banking information):

1. Complete the entire Electronic Funds Transfer Authorization Form and include the new information.
2. Attach a letter on company letterhead indicating changes to your account, as detailed on the new EFT Authorization form.
3. If changing banking information, attach a bank letter or voided check.
4. Mail or fax the form and all attachments to Mayo Clinic Health Solutions.
   Mayo Clinic Health Solutions
   Attention: Claims Payable Unit
   PO Box 211698
   Eagan, MN 55121
   Fax: 507-538-5036

Please allow a minimum of two to four weeks for your request to be processed. To avoid a delay in payment, please do not close your old account until your new account is set up and receiving payments.

HOW TO CANCEL YOUR EFT ENROLLMENT

If you are closing your business and wish to cancel your EFT enrollment:

- Complete all sections of the Electronic Funds Transfer Authorization Form *except* the Financial Institution Information section.
- Mail or fax the form and any attachments to Mayo Clinic Health Solutions.
  Mayo Clinic Health Solutions
  Attention: Claims Payable Unit
  PO Box 211698
  Eagan, MN 55121

  Fax: 507-538-5036

Please allow a minimum of two to four weeks for your request to be processed.

SPECIAL INVESTIGATIONS UNIT (SIU)

Mayo Clinic Health Solutions has an active Special Investigations Unit (SIU) that investigates possible fraudulent, wasteful, or abusive claims from both providers and members. Examples of fraud, waste, and abuse (FWA) include, but are not limited to, upcoding, billing for services not rendered, forged or altered claims, and/or billing for medically unnecessary services. An investigative audit may include, but is not limited to, complete medical record requests, unannounced site audits, and/or member survey letters. Failure to cooperate with an investigation may result in claim denial or reversals and/or termination from the Health Solutions Supplemental provider network.

Mayo Clinic Health Solutions coordinates investigations and criminal proceedings with outside agencies, such as the state attorney general's office, the FBI, or other law enforcement agencies. The SIU works diligently to protect our clients from FWA.

We recommend that all providers verify the identity of each patient by keeping up-to-date photocopies of the member ID card and by asking for additional picture identification. Having the current member ID card will allow you to submit claims with the appropriate information and avoid unnecessary claim payment delays. If you suspect fraudulent use of a member ID card, please contact the SIU at the contact information listed below.

SIU CONTACT INFORMATION

Providers should report any suspected fraudulent, abusive, or wasteful conditions to the Mayo Clinic Health Solutions Fraud, Waste, and Abuse Hotline at **1-855-384-0001** (toll free). The Hotline is answered by SIU staff Monday through Friday, 7 am to 4 pm, CT. Confidential voicemail is available at all other times. Information regarding referrals is kept confidential to the extent allowed by law.

Another option to report suspected FWA is to complete and submit the online *Fraud, Waste, and Abuse Referral* form. The referral form is available at **www.MayoClinicHealthSolutions.com** in the Online Services for Providers section under "Provider Forms." Submit the form through email, fax, or by mail according to the contact information on the form. Each referral will be investigated by the SIU and kept strictly confidential to the fullest extent allowed by law.

CLAIMS CONTACT INFORMATION

You may contact Customer Service for questions regarding claims (see the customer service number listed on the back of the membership card, or refer to the Quick Reference Guide available when you sign in to your account at **www.MayoClinicHealthSolutions.com**.) To contact Claims in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn.: Claims
PO Box 211698
Eagan, MN 55121

CHAPTER 5 - MEDICAL MANAGEMENT

PRIOR AUTHORIZATION

OVERVIEW

Prior authorization is defined as authorization from the health plan that is required for specific Covered Services before they are received (as described below). If an authorization is not obtained before such services are rendered, coverage may be reduced or denied. The reviewer at Mayo Clinic Health Solutions uses member plan documents and clinical review criteria to assist in making a medical necessity determination. Authorization for a service, device, or drug does not in itself guarantee coverage but notifies you that as described, the service, device, or drug meets the established criteria for medical necessity.

Decisions regarding an individual's health care/treatment remain the responsibility of the treating provider and the patient. Decisions reflect the health plan's responsibility of coverage of the requested treatment or services.

PROCESS

When prior authorization is required, you must submit a request to Health Services *prior* to the service being provided. Requests should be faxed prior to the service date.

Copies of prior authorization forms are available on the Provider Forms page at www.MayoClinicHealthSolutions.com. Prior authorization procedures and forms may vary depending on the type of service. Prior authorization forms are separated into the following categories: Behavioral Health, Medical/Surgical, and Pharmacy.

All prior authorization requests should be submitted with the following information:

- Member name and ID number
- Contact phone and fax number
- Specific service being requested
- Rendering practitioner
- Requesting practitioner
- Place of service
- Date of service
- Diagnosis and procedure codes

Clinical notes supporting the requested services also should be submitted, including:

- Physical findings, with appropriate diagnosis
- Diagnostic tests (completed or requested)
- Conservative treatments attempted prior to requested surgery (medications, therapies, etc.)
- Length of treatment requested
- Plan of care
- Any other pertinent information that may help determine medical necessity

Mayo Clinic Health Solutions will evaluate your description of services and medical documentation and will make a determination once all the necessary medical information is received. Decisions will be made and communicated within 10 business days. You will be notified by phone, fax, or letter of the decision regarding health plan coverage after the decision is made.

URGENT OR EMERGENCY SERVICES REQUESTS

Urgent pre-service (prior authorization) claim requests: An urgent pre-service claim request is a utilization review request submitted by a physician, member, or authorized representative on behalf of the member when a need for an urgent review exists. An urgent request has a turnaround time (TAT) of 72 hours instead of the standard 10 business day turnaround time for a non-urgent request. A copy of the Urgent pre-service claim form is available on the Provider Forms page at www.MayoClinicHealthSolutions.com.

Urgent requests are made when a longer TAT jeopardizes the health or life of the member, the member's ability to regain maximum function, or causes the member severe pain that cannot be adequately managed without the requested treatment. A physician is required to complete an urgent pre-service request form in its entirety, explaining that the timeframe for making a non-urgent determination would seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Emergency services utilization review and prior authorization requests. Mayo Clinic Health Solutions does not conduct utilization review or require a prior authorization for emergency services. Emergency services include services for a medical condition of sufficient severity that the absence of immediate medical attention could result in serious health consequences to an individual or an unborn child, serious impairment to bodily functions or to organs, or result in death.

Members have the right to available and accessible emergency care services using a "prudent layperson" standard, 24 hours a day, 7 days a week without prior authorization and regardless of whether the services are obtained in-network or outside the plan network. "Prudent layperson" means a person without medical training and who draws on his or her practical experience when making a decision regarding the need to seek medical treatment.

In assessing whether a prudent layperson standard applies, the presenting symptoms are considered, not the discharge diagnosis for emergency or urgent services.

SERVICES REQUIRING PRIOR AUTHORIZATION

The following list provides examples of common services that require prior authorization or notification:

- Direct admit by MD – notification only within 48 hours
- Elective Surgeries, including:
    - Bariatric surgery or any weight reduction surgery
    - Breast surgery
    - Oral surgery
    - Podiatry/foot surgeries/procedures
    - Varicose vein treatment
    - Back surgeries/procedures
    - Vision correction surgeries/procedures/therapies
    - Oral Surgeries/orthognathic procedures/TMJ
    - Cosmetic surgeries/procedures
    - Nasal surgeries/procedures
- Psychological testing
- Plan specified prescription drugs
- Transplants/transplant workup
- Assistive reproductive technologies/infertility services by infertility specialist
- Skilled care unit/acute rehab
- Home health care
- Hospice
- Durable medical equipment purchases exceeding $750 or rentals exceeding 4 months
- Therapies (occupational, physical and speech) after 30 visits, or when a the patient is under 17 years of age

This list is not all-inclusive and does not apply to all Mayo Clinic Health Solutions-administered plans. You should contact Customer Service if you have any questions regarding whether prior authorization is required for a specific service under a specific Plan. You may also access member plan documents by signing in to our secure Web site, www.MayoClinicHealthSolutions.com. You will need the membership number to access the member's plan materials.

MEDICAL RECORDS

As necessary for quality management, utilization management, peer review or other programs required for operations, we may request medical records/clinical documentation for purposes of treatment, payment or health care operations.

Per your provider contract, participating practitioners/providers shall maintain and furnish to Mayo Clinic Health Solutions, at no charge, the requested medical records/clinical documentation, as may be required by applicable laws, regulations and program requirements.

CONTACT INFORMATION

Please contact Customer Service at the phone number on the back of the membership card with questions regarding the prior authorization process. You may fax your prior authorization requests to Health Services department at 1-888-889-7822. To contact Health Services in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn.: Health Services Department
PO Box 211698
Eagan, MN 55121

REFERRALS

***Definition**: Any electronic or written documentation of a referral from a primary care practitioner to a practitioner not practicing at the primary care location.*

PROCESS

Although most Mayo Clinic Health Solutions-administered plans no longer require referrals for in-network services, some plans still require a referral for members to see a specialist or obtain a second opinion. To determine if the member belongs to a referral-based plan, please contact Customer Service at the phone number listed on the back of the membership card. If referral authorization is not obtained prior to services being rendered, the member is at risk for denial of coverage.

For referral-based plans, a written referral is required in advance when a practitioner refers a member to a specialist who does not practice at the member's primary care location. A written referral is not required when practitioners refer members within their primary care location.

If you are referring a member to an out-of-network practitioner, please be aware that each Plan may or may not have an out-of-network benefit for their members. To verify a member's out-of-network benefits, please contact Customer Service at the phone number on the back of the membership card.

When a referral is required, you must submit the request to Health Services prior to the service being provided. Requests should be faxed to Health Services prior to the service date and should include the information listed below:

- Member name
- Plan name
- Member identification number
- Date of birth
- Diagnosis and treatment information
- Clinical information or appropriate documentation to support the clinical condition
- Level and date of service proposed
- Proposed specialist name, title, address
- Contact name, phone and fax number
- Reason for referral

The *Managed Care Referral Request* form can be found on the Provider Forms page at www.MayoClinicHealthSolutions.com.

MEDICAL GUIDELINES

Medical criteria are used for case review, including InterQual, ASAM, Hayes Medical Technology and Mayo Clinic Health Solutions benefit interpretations**.** These medical guidelines may be consulted in determinations for:

- Type of treatment
- Frequency of treatment; level, setting and duration for members' diagnoses or conditions
- Diagnostic testing
- Appropriate level of care
- Experimental/investigational procedures, products or services

INTEGRATED CASE MANAGEMENT

***Definition**: Services provided to high-risk health plan members who require complex medical care. Integrated Case Management is a collaborative, systematic, and ongoing management of members with complex diagnosis, catastrophic injuries or illnesses, chronic health problems, and/or poor histories of self-management or compliance.*

Mayo Clinic Health Solutions case managers are licensed health care professionals (RNs and LPN's). Case managers coordinate health care services and manage plan benefits in cooperation with members and providers. Case managers advocate for members living with medical and behavioral health conditions that require a variety of different specialists and ongoing or intermittent care. Integrated Case management ensures the coordination of benefits and health services across the continuum of care for members with a variety of health care needs.

CONTACT INFORMATION

If your patient is a member of a Mayo Clinic Health Solutions-administered plan whom you believe may benefit from the special assistance of case management, please contact Customer Service at the phone number on the back of the membership card. To contact Health Services in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn.: Health Services Department
PO Box 211698
Eagan, MN 55121

CHAPTER 6 - MENTAL HEALTH & CHEMICAL DEPENDENCY

Members enrolled in a Mayo Clinic Health Solutions-administered plan may seek an initial mental health or chemical dependency visit from an in-network practitioner without a referral from their primary care practitioner. It is the responsibility of the network mental health/chemical dependency practitioner to contact Customer Service after the initial outpatient visit to determine *any* requirements of the member's health plan.

When prior notification is required, you must submit the request to Health Services *prior* to the service being provided (please refer to the list of services requiring prior authorization in the Medical Management chapter). Requests should be faxed prior to the service date.

For inpatient/residential services, please fax your request prior to the admission date.

Information required for prior authorization includes:

- Member name
- Member identification number
- Plan name
- Date of initial evaluation
- Brief description of problem or clinical need
- ICD code/GAF
- Level of care
- Number of days/services
- Practitioner name, credentials and telephone number

Mayo Clinic Health Solutions licensed behavioral health review staff use standardized and evidence-based clinical criteria to determine appropriate treatment and level of care for mental health and chemical dependency services, including: inpatient, partial hospitalization, residential, day treatment and outpatient level of care settings. Criteria are reviewed annually for effectiveness, appropriateness and consistent application based on clinical practice advances in the field of behavioral health, review of current scientific literature and input from currently practicing behavioral health care practitioners.

MENTAL HEALTH & CHEMICAL DEPENDENCY TREATMENT FORMS

A treatment plan form is necessary if a change is made to the treatment plan or facility program that received prior authorization. Contact Health Services to request an update to the prior authorization if one of the following changes occurs:

- A member's length of stay exceeds the initial plan
- A change is made in the level of care
- A change is made in the type of service
- A new practitioner is caring for the member

Failure by the practitioner to submit notification or to request prior authorization may result in denial or reduction of payment. A copy of the *Universal Outpatient Mental Health/Chemical Health Authorization* form, or other appropriate forms, can be accessed on Provider Forms page at **www.MayoClinicHealthSolutions.com.**

CONTACT INFORMATION

Please contact Customer Service at the phone number on the back of the member's membership card with questions regarding the prior authorization process. You may fax your mental health prior authorization requests to Health Services at 1-888-889-7822. To contact Health Services in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn.: Health Services Department
PO Box 211698
Eagan, MN 55121

CHAPTER 7 - APPEALS

The Mayo Clinic Health Solutions Appeals Department mission is to ensure claims that require in-depth review are thoroughly researched and paid in a manner consistent with contractual obligations, generally accepted billing practices, and legal and regulatory requirements.

ADVERSE BENEFIT DETERMINATION

An adverse benefit determination has to occur to be considered an appeal. An adverse benefit determination is a denial, reduction, termination of or failure to provide or make payment (in whole or in part) for a benefit, including for non-grandfathered plans any such denial, reduction, termination, failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan.

ERISA APPEAL PROCEDURE

Members may submit a written appeal by following the procedures below if they receive an adverse benefit determination for an ERISA plan. ERISA stands for Employee Retirement Income Security Act. Providers cannot appeal on behalf of members on post service claims, unless the member completes the *Authorized Representative Form.* This form allows providers to act on behalf of the member in filing an appeal. A copy of this form is available under Member Forms on MayoClinicHealthSolutions.com and must be completed by the Member. The Claims Administrator typically reviews the first level of appeal. There are different timeframe requirements for different types of claims. Please refer to the member's plan documents for these timelines.

Written appeals must contain the following information:

- The name of the Plan
- Information regarding the claim you are appealing, such as a copy of the appeal denial letter
- Identity of the member (including name, address, date of birth)
- A Statement that the member is requesting an appeal
- An explanation of why an appeal is being requested, including the particular aspect of the adverse benefit determination and any new or additional information to support your appeal

If there is an adverse benefit determination by the Claims Administrator on the first level of appeal, the member may request a second level of review, typically by the Plan Administrator. The member would follow the same procedures listed above to file a second level appeal.

EXTERNAL REVIEW BY AN INDEPENDENT REVIEW ORGANIZATION

The Patient Protection and Affordable Care Act (PPACA) permits members to appeal to an independent review organization that does not work for the health plan. This is only available to plans that are considered non-grandfathered plans under healthcare reform and members must exhaust the internal appeals process first. The request must be submitted *within four months* following the date of receipt of the final internal adverse benefit determination. A filing fee may be required by the Plan. For further information contact Customer Service.

COMPLAINT AND APPEAL PROCEDURES FOR MINNESOTA PLANS

There are multiple levels of review for denied claims and other complaints. There are different requirements for different types of claims or complaints. Please refer to the member's plan documents for these requirements.

Under Minnesota law, anyone can file a complaint/appeal on behalf of a member; however, due to the Health Insurance Portability and Accountability Act (HIPAA), Mayo Clinic Health Solutions may only send the determination and other related communication to the member, the treating provider or the authorized representative.

Requests that do not meet definition of an appeal include:

- corrected claims
- re-submissions for referrals or authorizations to health services
- letters of explanation from providers
- pay and chase documentation
- requests related to provider contracts
- requests related to credentialing issues

AUTHORIZED REPRESENTATIVE

For the purpose of the Plan's claims and appeal procedures, an authorized representative may act on a member's behalf with respect to any aspect of a claim or appeal. For pre-determinations, pre-service claims, urgent pre-service claims, and concurrent care claims, the Plan will recognize a health care provider with knowledge of the member's medical condition (e.g., the treating physician) as the member's authorized representative for both claims and appeals, unless the member provides specific written direction otherwise. For post-service claims, an authorized representative form must be received by the Plan in order for a person to be recognized as a member's authorized representative for both claims and appeals. Such forms are available by calling or writing the claims administrator's customer service department.

PRE-SERVICE CLAIMS

A pre-service claim is defined as any claim for a benefit under the Plan where receipt of the benefit is specifically conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care. Benefits under the Plan that are pre-service claims (i.e., subject to approval in advance) are listed in the *Utilization Management* section as services that require prior authorization.

URGENT PRE-SERVICE CLAIM

An urgent pre-service claim is defined as any claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. If a physician with knowledge of the member's medical condition determines that a claim is an urgent pre-service claim, the claim will be treated as an urgent pre-service claim.

A physician will be required to complete an *Urgent Pre-Service Request Form* stating that the timeframes for making a non-urgent determination would seriously jeopardize the life or health of the member or the member's ability to regain maximum function. This form will be supplied upon request of the urgent pre-service request.

CONTACT INFORMATION

Contact Customer Service at the phone number on the back of the membership card with questions regarding the appeals process. To contact Mayo Clinic Health Solutions Appeals in writing, please mail your request or question to:

Mayo Clinic Health Solutions
Attn.: Member Appeals
4001 41st Street NW
Rochester, MN 55901