Provider Manual 2023

SANFORD
HEALTH PLAN

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Welcome

Dear Sanford Health Plan Provider,

Sanford Health Plan welcomes you to our growing network of providers! This Provider Manual has been designed specifically for you to review prior to and as a reference tool after contracting with us. As a reference tool, you and your staff can learn about all our products, or reference our policies and procedures.

If you are viewing this as an electronic version, you can request a printed copy by contacting the Provider Relations Team at **(800) 601-5086**.

Thank you for your participation.

Sanford Health Plan

About Sanford Health Plan

2.1 Sanford Health Plan

Sanford Health Plan, headquartered in Sioux Falls, South Dakota, is a non-profit, quality-driven, managed care organization that provides products and services to individuals, businesses and government entities. As part of an integrated health system, Sanford Health, we are uniquely positioned to understand the needs of patients, the challenges of health care providers, and the demand of quality, affordable health care coverage for our employers, individuals and families.

Since Sanford Health Plan's inception in 1998, we have focused on building long-term partnerships. We also partner with local insurance agents in our service area to offer products and services to meet their unique health insurance needs. In addition, we are here to help our partners navigate the complexities of the dynamic health care industry and regulatory environment.

2.2 Sanford Health Plan Corporate Organization

Sanford Health Plan is a wholly owned, non-profit subsidiary of Sanford Health. The Sanford Health Board of Trustees is ultimately responsible for the governance of Sanford Health Plan, but has delegated to the plan's Board of Directors authority to act as the governing body of the plan. The President of Sanford Health Plan is accountable to the Sanford Health Plan Board of Directors.

The Board of Directors acts as the conscience of the Plan, looking not only at what the Plan does, but also at what it means to its members and to what extent it has succeeded in meeting the expectations associated with its customers. The Board of Directors is charged with guardianship of the goals and the long-term vision of the organization.

To assure the success of Sanford Health Plan, physicians and health care providers on the Board of Directors have a central role in the functioning of the Board as they participate in strategic planning and policy development.

2.3 History of Sanford Health Plan

In 1996, Sioux Valley Hospitals and Health System formulated a corporate response to the changing health care marketplace, the rapid growth in the number of managed care service organizations, and the need to meet the coverage requirements of Medicare-eligible residents within the organization's tri-state service area.

A panel of health care professionals was assembled and charged with the responsibility of researching, designing, and developing the requisite infrastructure for an outcomes-based health maintenance organization that would be recognized in the local marketplace and associated with quality health care. The result was the formulation of Sioux Valley Health Plan. In March 2007, Sioux Valley Health Plan changed its name to Sanford Health Plan as a result of a generous gift of $400 million to Sioux Valley Hospitals and Health System from South Dakota businessman, T. Denny Sanford.

Subsequently, the Sioux Valley Board of Trustees unanimously voted to re-name the healthcare system "Sanford Health" and Sioux Valley Health Plan was also renamed "Sanford Health Plan."

Sanford Health Plan is a not-for-profit, community-based HMO that began operations in South Dakota on January 1, 1998. Managed care services are provided to large and small groups in South Dakota, North Dakota, and Iowa by Sanford Health Plan and in Minnesota by Sanford Health Plan of Minnesota, which is a subsidiary of Sanford Health Plan. Sanford Health Plan was designed to align physicians and hospitals, establish a framework for providers to efficiently manage the delivery of health care services, and operate on the strength of affordable premiums.

Central to the design of Sanford Health Plan is a collaborative effort between Sanford Health, contracted providers, and members of our service area communities. Each of these elements offers unique perspectives, and the acknowledgment that health care resources are finite. Accordingly, maintenance of the Plan's financial viability is based upon the application of sound, balanced, and efficient healthcare practices.

Sanford Health Plan was granted its Certificates of
Authority in 1998 by South Dakota, Iowa and Minnesota and by North Dakota in 2009. Central health plan operations occur at its corporate office in Sioux Falls, South Dakota.

2.4 Expansion and Rapid Growth

In October 2020, Sanford Health Plan was awarded the two-year contract renewal for the North Dakota Public Employee System (NDPERS). As part of our ongoing commitment to serve our members, Sanford Health Plan expanded to offices in Fargo and Bismarck, North Dakota in May 2015.

2.5 Sanford Health Plan's NCQA Accreditation

Sanford Health Plan is accredited with the National
Committee for Quality Assurance (NCQA). Pursuing accreditation includes rigorous on-site and off-site evaluations for over 60 standards and selected HEDIS® measures. NCQA implements performance-based scoring, requiring Sanford Health Plan to report HEDIS® clinical quality measures and CAHPS® patient experience measures. These are the most widely used and respected tools for assessing quality of care and services in health care.

NCQA publicly reports accreditation results in detailed Health Plan Report Cards and distinguishes performance through levels of accreditation. The organization regularly updates its Health Plan Report Cards on plan performance in five categories: "Staying Healthy," "Getting Better," "Living with Illness," "Qualified Providers" and "Access to Service."

Quality is also demonstrated by our collaborative relationships with physicians, dentists, pharmacist and health care providers who serve on our board or participate on committees. By the assistance of these talented, highly educated and caring individuals, Sanford Health Plan continually strives for excellence.

Products and Services

3.1 Products and Services Overview

Sanford Health Plan offers a suite of products to individuals, businesses and government agencies to provide health care coverage in the form of products and services. Our products and services can be divided into four basic categories: Fully insured commercial, fully insured ACA, third party administration and government products.

Sanford Health Plan membership comes with perks. Through our +PERKS program, members enjoy discounts from local and national retailers on products and services in a variety of categories, including, but not limited to apparel, vision, dental, auto, electronics, entertainment, health and wellness, and restaurants.

3.2 Service Area

Our licensed service area is North Dakota, South Dakota and select counties in Minnesota and Iowa. For members outside of our service area, we may offer the Private Health Care Systems (PHCS) and MultiPlan national networks.

3.3 Privacy Regulation and Medical Records

Privacy Regulations

Participating providers must comply with HIPAA privacy requirements and all applicable state and federal privacy laws and regulations. These regulations control the internal and external use and disclosure of protected health information. These regulations may also create certain individual member rights that providers must accommodate. Information related to Sanford Health Plan's privacy practices can be found HERE.

Medical Records

As necessary for care management, quality management, utilization management, peer review or other required operations, we may request medical records for purposes of treatment, payment or health care operations. Participating providers shall furnish to Sanford Health Plan, at no charge, the requested medical records as allowed by applicable laws, regulations and program requirements.

3.4 Sanford Health Plan Provider Networks

PLAN TYPE	NETWORK		
(Market Segment)	**Broad**	**Tiered**	**Focused**
Simplicity *(Individual or Small Group)*	✔		
Sanford TRUE *(Individual, Small Group or Large Group)*			✔
Sanford PLUS *(Large Group)*		✔	
Signature Series and Legacy* *(Small Group or Large Group)*	✔		
elite1* *(Individual)*	✔		
We also offer ancilary products: Flex, HRA, HSA			

** denotes plans are no longer being sold, only renewed.*

Sanford Health Plan Provider Networks

BROAD NETWORK

Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area. Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

TIERED NETWORK

Sanford Health Plan's Broad network is grouped into two tiers. Member's cost share is based on the tier of the provider from whom they receive care. This plan is offered to employer group members who reside within an approved zip code.

Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities.

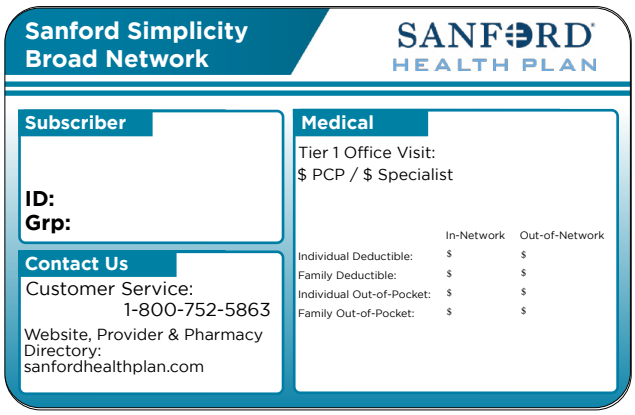
Tier 2 (higher member cost-share) includes the broad network that expands beyond the Sanford Health system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

FOCUSED NETWORK

Consists of providers in our large system of Sanford Health providers, facilities and others necessary to meet network adequacy requirements. This plan is offered to individuals in counties where we have ensured a robust focused provider network is available. The Sanford TRUE plans are offered at a lower cost since eligible individuals agree to use a more focused network of Sanford Health providers and facilities. Members can choose to see any licensed provider in the Sanford TRUE network for covered services without a referral. For routine or non-emergent medical services outside of the TRUE focused provider network, Members will need prior approval to receive in-network benefits. These plans do not have out-of-network benefits.

3.5.2 Simplicity Plans



Simplicity Plans

The Simplicity plans were developed after the Affordable Care Act (ACA) and are compliant with all the ACA regulations. These non-grandfathered plans are sold by local agents in the communities we serve and also available on the Marketplace at healthcare.gov. The Simplicity plans offer individuals and small group employers a variety of options to meet their needs and budget. The plans vary in deductibles, coinsurance and co-pay options as well as maximum out-of-pocket expenses.

Sanford Health Plan's is offering tiered networks for its simplicity plans.

Tier 1 Sanford Preferred (Sanford health providers) lowest member cost-share includes our large care system of Sanford Health providers and facilities.

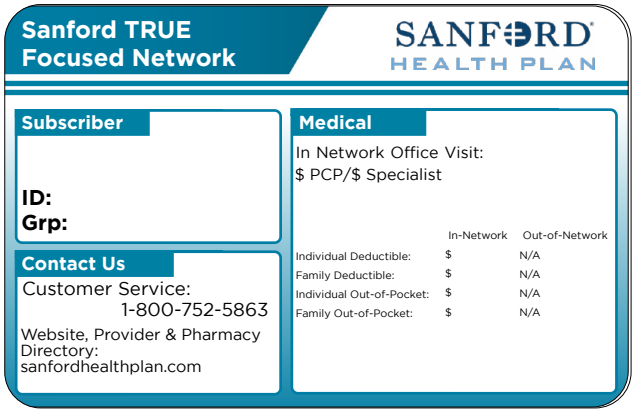
Tier 2 Affiliated (non-Sanford providers currently in the broad network) higher member cost-share includes the board network that expands beyond the Sanford health system, including access to Multiplan's nationwide networks.

Availability

Simplicity individual plans: Offered only in North Dakota and South Dakota. Individuals can purchase plans directly with Sanford Health Plan or through the Marketplace at healthcare.gov where they may qualify for financial assistance.

Simplicity small group employer plans: Offered in North Dakota, South Dakota, Western Minnesota and Northwest Iowa. Small group employers can purchase plans directly with Sanford Health Plan.

3.5.3 Sanford TRUE Plans



Sanford TRUE Plans

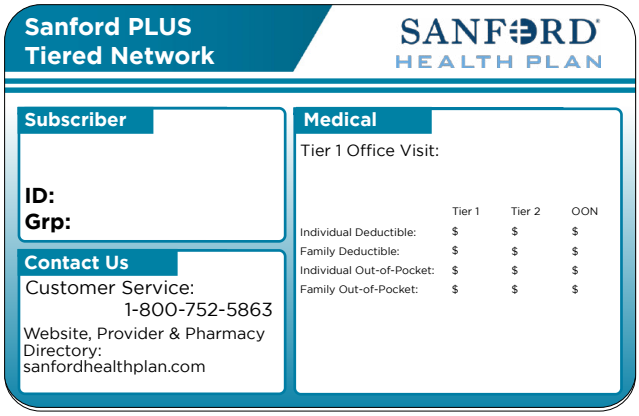
Sanford TRUE is our ACA qualified focused network plan offered to individuals and families living where we have ensured a robust focused provider network is available. The Sanford TRUE plans are offered at a lower cost since eligible individuals agree to use a more focused network of Sanford Health providers and facilities. You can choose to see any licensed provider in the Sanford TRUE network for covered services without a referral. For routine or non-emergent medical services outside of the TRUE focused provider network, you will need prior approval to receive in-network benefits. These plans do not have out-of-network benefits.

Availability

Sanford TRUE is offered to individuals and families living in the following states and counties:

- South Dakota: Brown, Minnehaha, Lincoln.
- North Dakota: Burleigh, Morton, Oliver, Cass, Traill.
- Minnesota (Group Plans Only): Beltrami, Clearwater, Clay, Cottonwood, Hubbard, Jackson, Murray, Nobles, Pennington, Red Lake, Rock
- Iowa (GroupPlans Only): Lyon, O'Brien, Sioux

3.5.4 Sanford PLUS Plans



Sanford PLUS Plans

Sanford PLUS plans are offered through Large Group employer plans, and to be eligible employees must reside within approved zip codes to enroll. Consists of our broad and focused provider networks to create a
Tiered Network.

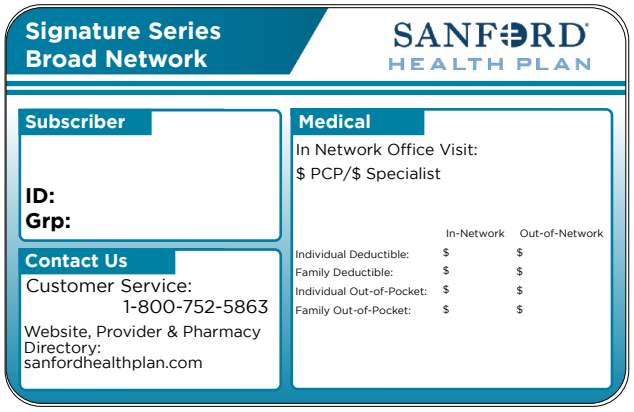
Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa, while Tier 2 (higher member cost-share) includes the broad network that expands beyond the Sanford Health care system, including access to a nationwide network while traveling or for employees residing outside the Sanford Health Plan service area.

Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Claims will pay according to the appropriate level of benefits.

Availability

Sanford PLUS service area consists of eligible zip code areas of South Dakota, North Dakota, Minnesota and Iowa.

3.5.5 Signature Series and Legacy Plans



Signature Series and Legacy Plans

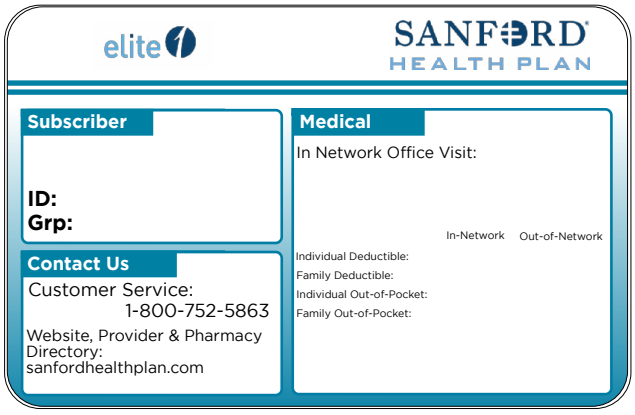
Signature Series plans are sold to large employer groups through local community agents in South Dakota, North Dakota, northwest Iowa and western Minnesota. Employers are able to create their own unique benefits by selecting from a vast array of deductible, copay and out of pocket options that fit the insurance needs of their organization.

Legacy plans, such as Classic 1500, are grandfathered or transitional group plans sold prior to the ACA. They are no longer being sold, however you may still see members who are enrolled in these plans. Eventually, these businesses may lose or give up their ACA grandfathered status to purchase a plan that meets the Affordable Care Act requirements.

Availability

Signature and Legacy plan area offered in South Dakota, North Dakota, and select counties of Minnesota and Iowa.

3.5.6 elite1 Plans



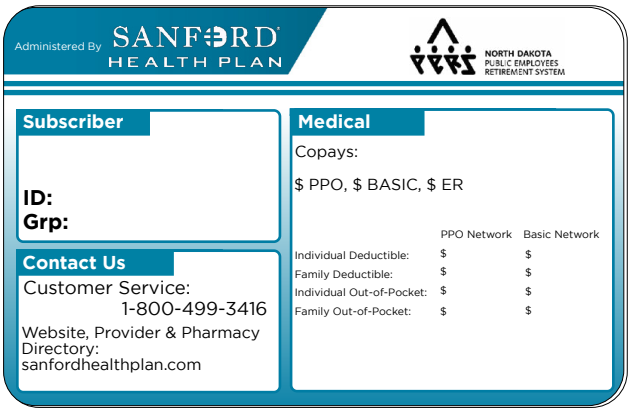
elite1 Plans

Our elite1 plans are grandfathered plans that were developed before the ACA and are no longer actively sold. However, you may still see members who are enrolled in these grandfathered plans.

Availability

elite1 plans are available in South Dakota and North Dakota.

3.5.7 North Dakota Public Employee Retirement System Non-Medicare



Plan type

The North Dakota Public Employees Retirement System (NDPERS) selected Sanford Health Plan as its
new insurance carrier effective July 1, 2015. Sanford Health Plan will provide medical coverage for both the non-Medicare and Medicare members. Total covered lives, including spouses and dependents, are approximately 65,000.

The non-Medicare members have three plans options: grandfathered, non-grandfathered and high deductible. All non-Medicare members will present an ID card with their specific information on the card. Medicare supplement members will present with a different ID card.

Provider network

This plan is offered to members employed with NDPERS ONLY. The network for this plan consists of both PPO and Basic networks, including the MultiPlan national network (when traveling).

To access the provider directory, go to sanfordhealthplan.com**.**

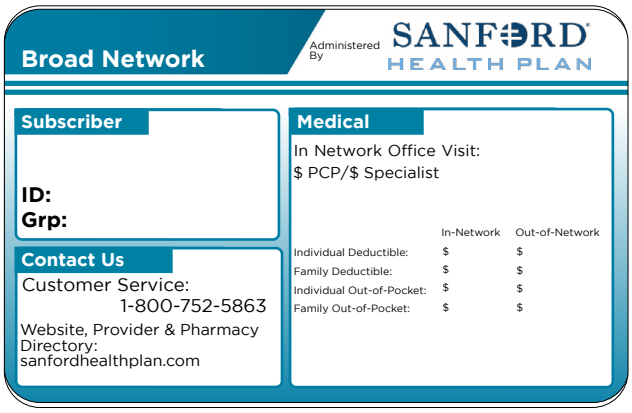
1. On the home page, click on “Find A Doctor” located in the middle of the page..
2. On the provider directory home page, click on “I’m A Member” and enter the first 9 digits of the patient’s Member ID number and last name. OR select ”I’m A Guest” on the directory homepage and choose
   North Dakota Employee Retirement System (NDPERS) Network from the drop down menu.

Eligibility, benefits and claims status

The staff members at NDPERS will continue to administer the enrollment and eligibility.

Providers can create a secure online account to access eligibility, claims status and benefit information. Or, providers can call Customer Service at (800) 499-3416 from 8 a.m. to 5:30 p.m. CST, Monday through Friday.

3.6 Third Party Administrator (TPA) Services:



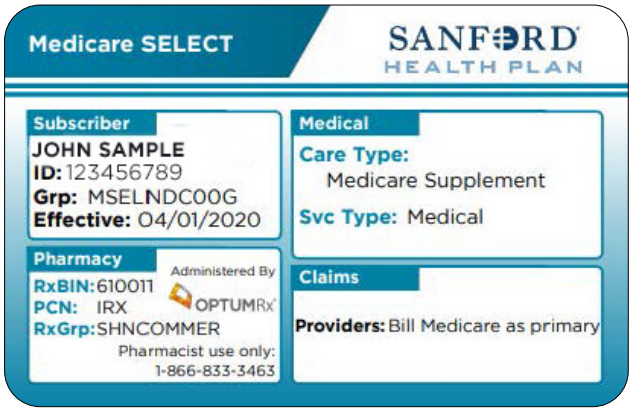
Sanford Health Plan provides third party administrator (TPA) services to employer sponsored self-funded health plans. Benefits are determined by the client, not by the TPA, with the client absorbing the claims risk.

Plan Type

These services include claims adjudication, customer service functions, provider relations and medical management. Benefits are determined by the employer group, not Sanford Health Plan.

3.7 Medicare Plans

3.7.1 Medicare SELECT Supplement Plans



Plan type

Our Medicare Select plan is a Medicare supplement plan that requires members to use Sanford Health Plan contracted facilities for non-emergency hospital and surgical care (Part A). When members enroll in Sanford SELECT, they agree to use Sanford's SELECT network. Members can see any physician (Part B) and are not restricted to a network. Local insurance agents sell Medicare Select to individuals who have Medicare Part A and B in the following states and counties:

- **South Dakota:** Aurora, Beadle, Bon Homme, Brookings, Brown, Brule, Buffalo, Campbell, Charles Mix, Clay, Codington, Corson, Davison, Day, Deuel, Dewey, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hanson, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Lyman, Marshall, McCook, McPherson, Miner, Minnehaha, Moody, Roberts, Sanborn, Spink, Tripp, Turner, Union, Walworth or Yankton.
- **North Dakota:** Barnes, Burleigh, Cass, Dickey, Emmons, Grand Forks, Grant, Griggs, Kidder, LaMoure, Logan, McIntosh, McLean, Mercer, Morton, Nelson, Oliver, Ransom, Richland, Sargent, Sheridan, Sioux, Steele or Traill.
- **Iowa:** Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola or Sioux
- **Minnesota:** Beltrami, Big Stone, Clay, Clearwater, Cottonwood, Grant, Jackson, Lac Qui Parle, Lincoln, Lyon, Mahnomen, Marshall, Martin, Nobles, Norman, Murray, Pennington, Pipestone, Red Lake, Redwood, Rock, Stevens, Traverse, Watonwan or Yellow Medicine

Provider network

Members can receive services from any providers accepting assignment (payment) from Medicare. Members should to seek services from in network facilities in order to receive maximum benefits. Facility expenses for members who receive non-emergency services at a non-network hospital or outpatient surgery center will be denied.

To access the provider directory, go to sanfordhealthplan.com**.**

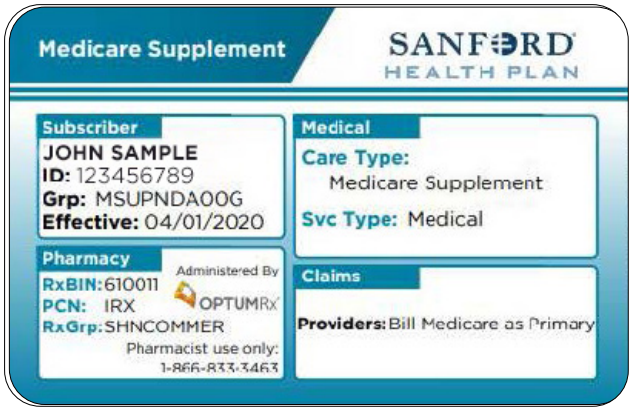
1. On the home page, click on the "Menu" button in the top left-hand corner. Then choose "Find A Doctor".
2. On the provider directory home page, click on "I'm A Member" and enter the first 9 digits of the patient's Member ID number and last name. OR select "I'm A Guest" on the directory homepage and choose
   Medicare-SELECT Supplement from the drop down menu. Eligibility, benefits and claims status

Providers can create a secure online account to access eligibility, claims status and benefit information.
Or, providers can call Customer Service at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Providers should bill Medicare as primary and Sanford Health Plan as secondary.

3.7.2 Medicare Supplement Plans



Plan type

Our Medicare Supplement plans are standard supplement plans and do not require the members to use a specific network. These plans are sold by local agents to individuals with Part A and Part B Medicare coverage in the following states and counties:

- **South Dakota:** All counties
- **North Dakota:** All counties
- **Iowa:** Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola or Sioux
- **Minnesota:** Beltrami, Big Stone, Clay, Clearwater, Cottonwood, Grant, Jackson, Lac Qui Parle, Lincoln, Lyon, Mahnomen, Marshall, Martin, Nobles, Norman, Murray, Pennington, Pipestone, Red Lake, Redwood, Rock, Stevens, Traverse, Watonwan or Yellow Medicine

Provider network

The Plan members can receive services from any providers accepting assignment (payment) from Medicare. There is no network with Sanford Supplement Plan.

To access the provider directory, go to sanfordhealthplan.com**.**

1. On the home page, click on the "Menu" button in the top left-hand corner. Then choose "Find A Doctor".
2. On the provider directory home page, click on "I'm A Member" and enter the first 9 digits of the patient's Member ID number and last name. OR select "I'm A Guest" on the directory homepage and choose **Medicare Standard Supplement Network** from the drop down menu.

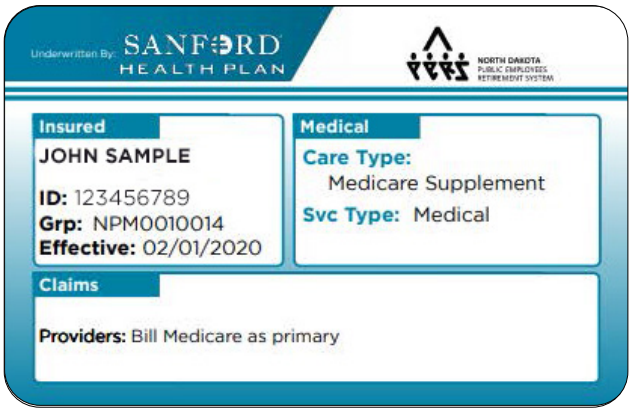
Eligibility, benefits and claims status

Providers will be paid according to their contract. For questions about payment, call Provider Relations at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Providers should bill Medicare as primary and Sanford Health Plan as secondary.

3.7.3 North Dakota Public Employee Retirement System Medicare Supplement



Plan type

The North Dakota Public Retirement System (NDPERS) selected Sanford Health Plan as its new insurance carrier effective July 1, 2015. Sanford Health Plan provides medical coverage for both the non-Medicare and Medicare Supplement members. Total covered lives, including spouses and dependents, average 65,000.

Retirees can opt to enroll in the NDPERS Medicare supplement plan if they have both Medicare Parts A and B; this includes those under 65 if they are on Social Security Disability and have both Medicare Parts A and B. Members who have the NDPERS Medicare Supplement plan will present an ID card with their specific information.

Eligibility, benefits and claims status

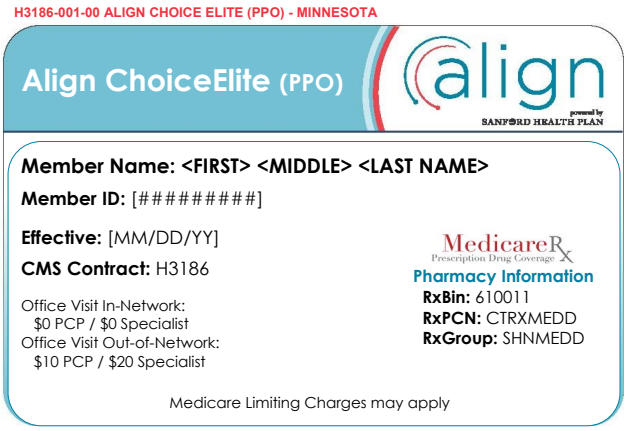
The staff members at NDPERS will continue to administer the enrollment and eligibility.

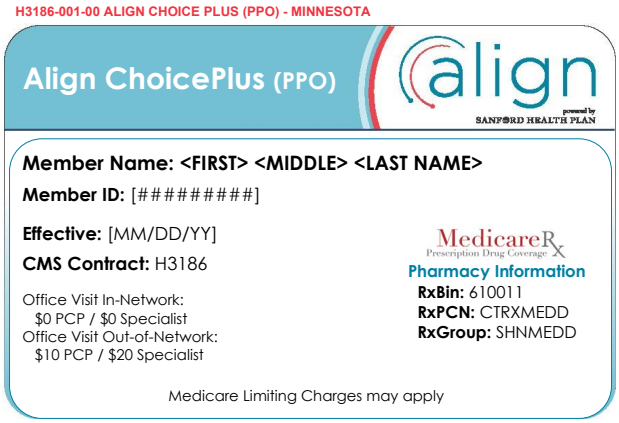
Providers can create a secure online account to access eligibility, claims status and benefit information.
Or, providers can call Customer Service at (800) 499-3416 from 8 a.m. to 5:30 p.m. CST, Monday through Friday.

Claims and payment methodology

Providers should bill Medicare as primary and Sanford Health Plan as secondary.

3.7.4 Medicare Advantage: Align powered by Sanford Health Plan





Our Medicare Advantage plans provide all the benefits of Original Medicare Parts A and B, Part D prescription drug coverage and extra supplemental benefits in one complete plan. The provider network consists of providers in our large system of Sanford Health providers, facilities and others necessary to meet network adequacy requirements. This plan is offered to individuals in counties where we have ensured a robust focused provider network. The Plans are sold by local agents to individuals in the following states and counties:

South Dakota -Lake, Lincoln McCook, Minnehaha, Moody or Turner

North Dakota- Barnes, Burleigh, Cass, McLean, Morton, Ransom, Richland, Steele, or Traill

Minnesota- Becker , Clay, Norman, Otter Tai, Rock or Wilken.

Provider Relations

4.1 Provider Relations Department

Our Provider Relations staff members are here to help you with your questions regarding contracting/credentialing, or questions related to claims payment.

Phone: (800) 601-5086 or email to

Email: providerrelations@sanfordhealth.org.

4.2 Provider Contracting Department

In order to provide a full range of health care services to our members, our provider relations department annually evaluates our network against our access and availability standards and state requirements. We contract with physicians, hospitals and other health care providers for appropriate geographic access and to ensure sufficient capacity throughout the entire service area. In addition, we annually assess the cultural, ethnic, racial and linguistic needs of our members to ensure the availability of bilingual practitioners

To become a participating provider, a contract and fee schedule must be signed. A contract request form can be submitted by following Step 1 on our webpage: sanfordhealthplan.com/providers/contracting-and-credentialing and a provider contracting representative will contact your office directly. When the facility or provider has been approved through the credentialing process, providers are granted participating provider status, allowing them to appear in our online provider directory.

The Provider Contracting department can be contacted by phone: (855) 263-3544; or email: sanfordhealthplan providercontracting@sanfordhealth.org.

Sanford Health Plan partners with BenefitHub in offering a discount and cash back program called +Perks. This program is free and voluntary for our members to join and offered to large employer group, small employer group, individual (on/off exchange) and self-funded groups (some exclusions apply).

4.3 Credentialing and Re-credentialing

Credentialing is the process of verifying that an applicant meets the established standards and qualifications for consideration in the Sanford Health Plan network. Initial credentialing is performed when an application is received. In general, the credentialing and re-credentialing is performed at least every 36 months. Process applies to:

- Practitioners who have an independent relationship with the organization.
- Practitioners who see members outside the inpatient hospital setting or outside free-standing ambulatory facilities.
- Practitioners who are hospital based, but who see the organization's members as a result of their independent relationship with the organization.
- Non physician practitioners who have an independent relationship with the organization who can provide care under the organization's medical benefits.

During the initial credentialing period, providers should submit claims to Sanford Health Plan. However, all claims for the provider will be pended until the credentialing process is complete. Once the provider is approved by the credentialing committee, the pended claims will release for processing.

Claims must be submitted within 180 days from the date of service or as defined by your contract. The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Practitioner Credentialing Policy (PR-006)
- Criteria for Credentialing and Re-credentialing Participating Practitioners (Pr-010)
- Organizational Provider Credentialing (PR-020)

4.3.1 Locum Tenans Providers

Locum Tenans arrangement is when a physician is retained to assist the regular physician's practice for reason such as illnesses, pregnancy, vacation, staffing shortages or continuing medical education. Locum Tenans generally have no practice of their own and travel from area to area as needed. Locum Tenans who are providing coverage for a physician for 60 consecutive days or less do not need to be fully credentialed. However, if the Locum Tenans cover for periods longer than 60 consecutive days, Sanford Health Plan will require the provider to complete the credentialing process and they will no longer be allowed to bill with the absent provider's NPI.

- The locum tenans provider must submit claims using the provider NPI and tax ID of the physician for whom the locum tenans provider is substituting or temporarily assisting.
- Bill with modifier Q6 in box 24d of the CMS-1500 form for each line item service on the claim
- The code(s) being billed must qualify for the Q6 modifier for payment

4.3.2 Supervising Physician

A Supervising Physician is a licensed physician in good standing who, pursuant to US State regulations, engages in the direct supervision of a practitioner with limited licensure. Claims using the supervising physician's name and provider number can be used where the practitioner is still working towards licensure, or has limited licensure. Supervising physicians may not bill separately for services already billed under these circumstances, unless there are personal and identifiable services provided by the teaching physician to the patient they performed in management of the patient. Sanford Health Plan does not require PA's or APRN's to bill with the name of their supervising physician on the claim form.

4.4 Credentialed Providers

The following types of practitioners are eligible for Participating Provider status provided that they possess and provide satisfactory evidence as required through the Sanford Health Plan credentialing process. The types of practitioners requiring credentialing by Sanford Health Plan include, but are not limited to:

- Doctors of Allopathy
- Doctors of Osteopathy
- Physician Assistants *
- Nurse Practitioners *
- Certified Nurse Midwife *
- Certified Diabetic Educator
- Licensed/Registered Dietitian
- Podiatrists
- Chiropractors
- Optometrists
- Audiologists (master's level or higher)
- Speech Pathologists
- Physical Therapists
- Occupational Therapists
- Dentists
- Oral/Maxillofacial Surgeons
- Nurse Anesthetists (nonhospital based or independent relationship)
- Other practitioners with Master's level training or higher who have an independent relationship with Sanford Health Plan
- Locum Tenens providers who have practiced in the same location or on a contracted period of more than 60 consecutive days

- Behavioral Health Practitioners
  - o Psychiatrists
  - o Psychologists, social workers, counselors, marriage and family therapists (licensed at master's level or higher)
  - o Addiction medicine specialists
  - o Clinical nurse specialists or psychiatric nurse practitioners (master level or higher who are nationally or state certified or licensed)
    - (a) Resident must be at a minimum midway through he/she second year (PGY2) of residency training to be eligible for credentialing.
    - (b) A letter from the Residency Program Director must be submitted allowing the resident to moonlight outside of the residency training.
    - (c) Credentialing cycle will end 60 days after estimated residency completion date.
- Anesthesiologist with pain management practices
- Clinical nurse specialists (master level or higher who are nationally or state certified or licensed.)*
- Advanced Practice Registered Nurses (master level or higher who are nationally or state certified or licensed.)
- Telemedicine practitioners who have an independent relationship with the organization and who provide treatment services under the organizations medical benefit. Practitioners providing medical care to patients located in another state are subject to the licensing and disciplinary laws of that state and must possess an active license in that state for their professions.

Nurse Midwives, Nurse Practitioners, Physician Assistants and Clinical Nurse Specialist must have an agreement with a licensed physician or physician group unless the state law allows the practitioner to practice independently. This is in reference to H.R. 3590 – Patient Protection and Affordable Care Act C. 2706, non-discrimination in health care and 42 U.S.C. 300gg-5. Non-discrimination in health care. State laws requiring collaborative agreements will be required by Sanford Health Plan.

4.5 Practitioners Who Do Not Need to be Credentialed/Recredentialed

4.5.1 Inpatient Setting

Practitioners who practice exclusively within the inpatient setting and who provide care for members only as a result of an inpatient stay do not need to be credentialed. Examples include:

- pathologists
- radiologists
- anesthesiologists
- neonatologists
- emergency room physicians
- hospitalists
- board certified consultants
- locum tenens physicians who have not practiced at the same facility for 60 or more consecutive calendar days and do not have an independent relationship with Sanford Health Plan
- nurse anesthetists (hospital based)

4.5.2 Freestanding Facilities

Practitioners who practice exclusively within freestanding facilities and who provide care for members only as a result of members being directed to the facility do not need to be credentialed. Examples include:

- Mammography centers
- Urgent care centers
- Surgical-centers
- Ambulatory behavioral health care facilities (i.e. psychiatric and addiction disorder clinics)

4.5.3 Practitioners who are not accepted by Sanford Health Plan

The following listing of practitioner types will not be credentialed:

- Registered Nurses
- Licensed Practical Nurses
- Certified professional midwives in addition to lay or direct entry midwives

- Practitioners not providing all required documentation in addition to a completed and attested to credentialing application
- Practitioners who have not yet received their required license by their state
- Practitioners who are currently on a leave of absence. In the event that the practitioners credentialing cycle expired during the leave of absence, the practitioner must reapply within 30 days of returning to practice.
- Providers excluded from participation in federal health care programs under either section 1128 or section 1128A of the Balanced Budget Act of 1997 or any provider excluded by Medicare, Children's Health Insurance Program, or Medicaid

4.6 Ongoing Monitoring Policy

Sanford Health Plan identifies and takes appropriate action when practitioner quality and safety issues are identified. Sanford Health Plan monitors ongoing practitioner sanctions or complaints between re-credentialing cycles. Per contract, all practitioners need to report a Serious Reportable Event or a Never Event. Sanford Health Plan and its delegates, will monitor on an ongoing basis:

1. Medicare and Medicaid sanctions
2. State sanctions or limitations on licensure
3. Complaints against practitioners
4. Adverse events

Sanford Health Plan will delegate this responsibility to its contracted delegates as long as the processes in those policies meet the intent of NCQA and Sanford Health Plan standards. A practitioner in good standing means that no sanctions can be identified through the Office of Inspector General (OIG), state sanctions or complaints to that specific practitioner. When sanctions are identified between re-credentialing cycles or the number of Quality Risk Issues exceeds the Sanford Health Plan threshold of five within two years, then the practitioner will be presented to the Sanford Health Plan Credentialing Committee through formal re-credentialing so the sanctions and/or complaints can be peer reviewed.

Sanford Health Plan Credentialing Committee reviews all sanctions, limitations of licensure, adverse events and complaints. The Committee determines the appropriate interventions when instances of poor quality are identified. Recommendations to approve the practitioner with additional education or required supervision, or may require the practitioner a one-year re-credentialing cycle. The Committee may also decide other courses of improvement based on the evidence provided.

In the event that the Committee determines that the practitioner possesses serious quality issues and is no longer fit to participate in the network, the practitioner will be sent formal appeal rights. If the final result is termination of that practitioner from the Sanford Health Plan provider network, the appropriate agencies will be contacted.

All decisions made by the Sanford Health Plan Credentialing Committee are reviewed and approved by the Sanford Health Plan Board of Directors.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Monitoring Policy (PR-024)
- Quality of Care (MM-GEN-030)

4.7 Provider Rights and Responsibilities

4.7.1 Right to Review and Correct Credentialing Information

Practitioners have the right to review information submitted in support of their credentialing applications, however, Sanford Health Plan respects the right of the Peer Review aspects that are integral in the credentialing process. Therefore, practitioners will not be allowed to review references or recommendations or any other information that is peer review protected. All other information obtained from an outside source is allowed for review.

If during the review process, a practitioner discovers an error in the credentialing file, the practitioner has the right to correct erroneous information. The practitioner will be allowed 10 days to provide corrected information. Sanford Health Plan will accept corrected information over the phone, in person, or via voice mail. Corrected

information must be submitted to the appropriate Credentialing Specialist who is processing the file.

Finally, each contracted practitioner retains the right to inquire about their credentialing application status. Contact a representative of the Provider Relations Team.

If there are new practitioners added to existing participating facility/groups, Sanford Health Plan requires the new practitioner complete a Provider Credentialing Application. Our Credentialing Application can be found HERE. Sanford Health Plan only accepts their own credentialing application online.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Practitioner Credentialing Policy (PR-006).

4.7.2 Refusing to Treat a Sanford Health Plan Member

Providers have the right to refuse to provide services to a Sanford Health Plan member. Providers are not to differentiate or discriminate in the treatment of Members or in the quality or timeliness of services delivered to Members on the basis of race, color, ethnicity, sex, age, religion, marital status, sexual orientation, sexual identity, place of residence, national origin, health status, genetic information, lawful occupation, source of payment, credit history, frequency of utilization of services or any other basis prohibited by law. While this is a very rare event, it is required that the provider office contact the Care Management Team at (888) 315-0884 as soon as possible so we can assist the member in transitioning to a new provider.

4.7.3 Member Eligibility Verification

Each provider is responsible for ensuring that a member is eligible for coverage when services are rendered. Member eligibility can be determined by logging on to your secure online provider account. If you don't have an account, see the Online Resources section of this manual. In addition, our Customer Service Team can also assist you with member eligibility status questions. If the provider provides services to a patient not eligible for coverage and remits a claim to Sanford Health Plan, the claim will be denied.

Please note: Sanford Health Plan may be notified by NDDHS that a member has lost eligibility retroactively. When this happens, federal regulations require Sanford Health Plan, as the MCO, to recoup payments made on an individual determined by the state of ND to be ineligible for coverage.

4.7.4 Medical Record Standards

Sanford Health Plan ensures that each provider furnishing services to members maintains a medical record in accordance with professional, State, NCQA and CMS standards as well as standards for the availability of medical records appropriate to the practice site. Contracted practitioners/providers are required to maintain a medical record on each individual member for a minimum of ten years from the actual visit date of service or resident care.

Records of minors shall be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date of service or resident care. Medical records are reviewed by our Care Management Team at a sample of clinics at least once per calendar year. Medical record review is conducted in conjunction with the HEDIS data collection process.

Medical records may be requested by Sanford Health Plan in connection with utilization or quality improvement activities, or may be requested as verification to support a claim. Well documented medical records facilitate communication, coordination and continuity of care; and they promote the efficiency and effectiveness of treatment. Requests for medical records between Sanford Health Plan and a provider office for a Sanford Health Plan Member (past or present) do not require a formal release of information from the member due to the provider's office and Sanford Health Plan being considered covered entities.

A medical record is defined as patient identifiable information within the patient's medical file as documented by the attending physician or other medical professional and which is customarily held by the attending physician or hospital. These medical records should reflect all services provided by the practitioner including, but not limited to, all ancillary services and diagnostic

tests ordered and all diagnostic and therapeutic services for which the member was referred by a practitioner (i.e., home health nursing reports, specialty physician reports, hospital discharge reports, physical therapy reports, etc.).

Medical records are to be maintained in a manner that is accurate, up-to-date, detailed and organized and permits effective and confidential patient care and quality review. Documentation of items from the "Standards and Performance Goals for the Medical Record" demonstrates that medical records are in conformity with good professional medical practice and appropriate health management. The organization and filing of information in the medical record is at the discretion of the participating provider. The Plan's documentation standards for medical record review include 17 components. However, there are only 9 critical elements required in the medical record to demonstrate good professional medical practice and appropriate health management. Periodic medical record documentation reviews will be completed in conjunction with HEDIS medical record reviews.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Medical Record (MM-024)

4.7.5 Practitioner Office Site Quality

Sanford Health Plan has established standards for office-site criteria and medical record-keeping practices to ensure the quality, safety and accessibility of office sites where care is delivered to Sanford Health Plan members. The office site standards are as follows:

1. Physical Accessibility
2. Physical Appearance
3. Adequacy of Waiting and Examining Room Space
4. Adequacy of medical treatment record keeping paper based medical records
5. Electronic Medical Records

Sanford Health Plan monitors member complaints about office site quality. If Sanford Health Plan has received three or more complaints within a six month period, a Provider Relations Specialist will conduct an onsite visit within 60 days of the third complaint. The onsite visit will consist of a assessment of the physical appearance of the clinic, the physical accessibility and adequacy of waiting and patient exam rooms, adequacy of medical record keeping, as well as identification of any other deficiencies. If deficiencies are detected, the practitioner's office will be asked to implement an improvement plan. Sanford Health Plan will conduct additional on site visits every six months until the deficiency has been corrected.

Sanford Health Plan will take into consideration the severity of the complaint and if we feel it is necessary, we reserve the right to conduct an onsite visit at any time regardless if an office has incurred a complaint.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Practitioner Office Site Quality Policy (PR-009)

4.7.6 Cultural and Linguistic Competency

Sanford Health Plan is committed to embracing the rich diversity of people we serve and believes in providing high-quality services to culturally, linguistically and ethnically diverse population, as well as those with physical, mental, visual and hearing impairment. To be Cultural and Linguistic Competent, means that Providers meet the unique, diverse needs of members, values and diversity within the organization, and identifies members with distinct needs in establishing access to care and support. Providers shall recognize and ensure members receive equitable and effective treatment in an understandable and respectful manner, recognizing individual spoken language(s), gender and orientation, and the role culture plays in a member's health and well-being in a culturally sensitive manner.

Cultural competency is a set of congruent behaviors, attitudes and policies that enable effective work and communication cross-cultural situation. The awareness of culture is the ability to recognize the cultural factors, norms, values, communications patterns/types, socio-economic status and world views that shape personal and professional behaviors. Culturally and Linguistic Appropriate services (CLAS) are health care services respectful of, and responsive to, cultural and linguistic needs.

The delivery of culturally competent health care and services requires health care Providers and their staff to integrate and transform skills, service approach, techniques and marketing materials to match population culture and increase the quality and appropriateness of health care services and outcomes.

The objectives of Cultural Competency are to:

- Identify and accommodate those with physical and mental disabilities
- Identify Members who have potential cultural or linguistic barriers and provide alternative communication methods where needed
- Utilize culturally sensitive and appropriate educational materials based on the Member's race, ethnicity and primary language spoken (including American Sign Language).
- Make resources available to meet the unique language barriers and communication barriers existing in the population
- Provide education to associates/staff on the value of cultural and linguistic awareness and differences in the organization and the populations served
- Decrease health care disparities in the minority populations served and understand how socio-economics status impacts care Sanford Health Plan expects Providers to:
- Have written materials available for Members in large print format and certain non-English languages, prevalent in SHP's service areas
- Provide ADA accessible offices, exam tables and equipment
- Telephone system adaptations for Members needing the TTY/TDD lines for hearing impaired services and other auxiliary impairment services
- Access to skilled interpreters to translate in non-English languages including American Sign Language or contact Sanford Health Plan for assistance.
- Obtain Cultural Competency Training including the review of materials on the Sanford Health Plan Provider Portal and/or Newsletters.

For additional free provider and staff education on Cultural and Linguistic Competency and education and training visit HHS.gov national website HERE.

4.8 Primary Care Responsibilities

As a Primary Care Physician contracting with the Plan, the Physician shall provide the following services to Members in accordance with applicable Plan Health Maintenance Contracts:

1. The Physician may have the primary responsibility for arranging and coordinating the overall health care of members who select the Physician as their Primary Care Physician. This includes appropriate referral to specialist Physicians and Providers under contract with the Plan, arranging for the care and treatment of such Member by hospitals, skilled nursing facilities and other health care providers who are Participating Providers, and managing and coordinating the performance of administrative functions relating to the delivery of health services to such Members in accordance with this Agreement.
2. Routine office visits (including after-hours office visits which can be arranged with other Plan Physicians and with Plan approval) and related services of the Physician and other health care providers received in the Physician's office, including evaluation, diagnosis and treatment of illness and injury.
3. Visits and examinations, including consultation time and time for personal attendance with the Member, during a confinement in a hospital, skilled nursing facility or extended care facility.
4. Adult immunizations in accordance with accepted medical practice or Plan policies and protocols.
5. Administration of injections, including injectables for which a separate charge is not routinely made.
6. Well-child care from birth for pediatric Members assigned to Physician.
7. Periodic health appraisal examinations
8. Eye and ear examinations for Members to determine the need for vision or hearing correction.
9. Diagnosis of alcoholism or drug abuse and appropriate referral to medical or non-medical ancillary services, but not the cost of such referral services.

10. Routine office diagnostic testing, including chest x-rays, electrocardiograms, serum chemistries, throat cultures and urine cultures and urinalysis, including interpretation; and interpretation of testing performed outside the Primary Care Physician's office.
11. Miscellaneous supplies related to treatment in Primary Care Physician's office, including gauze, tape, Band-Aids, and other routine medical supplies.
12. Physician visits to the Member's home or office when the nature of the illness dictates, as determined by the Primary Physician.
13. Patient health education services and referral as appropriate, including informational and personal health patterns, appropriate use of health care services, family planning, adoption, and other educational and referral services, but not the cost of such referral services.
14. Telephone consultations with other Physicians and Members.
15. Other primary care services defined by normal practice patterns for Primary Care Physicians in the Plan's service areas required by the Plan.
16. Such minor surgical procedures as the Physician ordinarily provides during the course of his/her practice to his/her patient population on a fee for service or indemnity basis. The list of provided services does not include those services ordinarily provided as a specialty service in consultation.
17. Primary care physicians (PCP) have agreed to be available to members twenty-four (24) hours a day, seven days a week for urgent care. Members should call during normal office hours for routine situations, and only call after hours in emergency or urgent situations. Members who leave messages should receive a return call within thirty (30) minutes, or as soon as possible.

4.9 Access Standards

4.9.1 Primary Care Physician

Through the contract and credentialing process, Primary Care Physicians (PCP) have agreed that urgent care services will be available to members 24 hours a day, seven days a week. Members should call during normal office hours for routine situations, and only call after hours for emergency or urgent care. Members leaving a message with the answering service of the PCP or the doctor on call should receive a call back within 30 minutes or as soon as possible. The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Provider Access and Availability Standards Policy (MM-Q-050)

4.9.2 Emergency Services

In an emergency, members are encouraged to proceed to the nearest participating emergency facility. If the emergency condition is such that a member cannot go safely to the nearest participating emergency facility, then members should seek care at the nearest emergency facility. The member or a designated relative or friend must notify the Plan and the member's Primary Care Physician (if applicable) as soon as reasonably possible and no later than 48 hours after physically or mentally able to do so.

Sanford Health Plan covers emergency services necessary to screen and stabilize members without precertification in cases where a prudent layperson, acting reasonably, believed that an emergency medical condition existed. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

The Health Plan also covers emergency services if an authorized representative, acting for the Plan, has authorized the provision of emergency services.

4.9.3 Urgent Care Situations

An urgent care situation is a degree of illness or injury which is less severe than an emergency condition, but requires prompt medical attention within 24 hours, such as stitches for a cut finger. If an urgent care situation occurs, members should contact their Primary Care Physician (if applicable) or the nearest participating provider, urgent care or after hours clinic.

If a member is admitted to the hospital, the member or a designated relative or friend must notify the Plan and the member's Primary Care Physician (if applicable) as soon as reasonably

possible and no later than 48 hours after physically and mentally able to do so.

If a member is admitted to a non-participating facility, the Plan will contact the admitting physician to determine medical necessity and a plan for treatment. With respect to care obtained from a non-participating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person. This may not require prior authorization if a prudent layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

4.9.4 Ambulance Service

The Plan covers local ambulance services for the following:

- Emergency transfer to a hospital or between hospitals.
- Planned transfer to a hospital or between hospitals.
- Transfer from a hospital to a nursing facility. Planned transfer to a hospital or between hospitals and transfers from a hospital to a skilled nursing facility will only be covered when determined by the Plan to be medically necessary either before or after the ambulance is used. Prior authorization is required for non-emergent ambulance services. The Plan does not cover charges for an ambulance when used as transportation to a doctor's office for an appointment.

4.9.5 Out of Area Services

If an emergency occurs when traveling outside of the Plan's service area, members should go to the nearest emergency facility to receive care. The member or a designated relative or friend must notify the Plan and the member's Primary Care Physician (if one has been selected) as soon as reasonably possible and no later than 48 hours after physically and mentally able to do so.

In-network coverage will be provided for emergency conditions outside of the service area if the member is traveling outside the service area but not if the member has traveled outside the service area for the purpose of receiving such treatment.

If an urgent care situation occurs when traveling outside of the Plan's service area, members should contact their primary care physician immediately, if one has been selected, and follow his or her instructions. If a primary care physician has not been selected, the member should contact the Plan and follow the Plan's instructions.

In-network coverage will be provided for urgent care situations outside the service area but not if the member has traveled outside the service area for the purpose of receiving such treatment.

Out-of-network coverage will be provided for non-emergency medical care or non-urgent care situations when traveling outside the Plan's service area.

4.9.6 Treatment of Family Members

Sanford Health Plan takes the position that it is not appropriate for a provider to provide health care services to immediate family members, including any person normally residing in the Member's home. There are however exceptions: This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the member has the following options:

- The Member may be treated by that Provider if acting within the scope of their practice.
- The Member may also go to a Non-Participating Provider and receive In-Network coverage with an approved prior authorization.

If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the in-Network level.

Claims denied for treatment of family members will deny with the following code: EX40-Charges for treating self/family members are ineligible

4.9.7 Provider Terminations

As stated in our contract(s), all provider (practitioner, organization, and hospital) voluntary terminations must be made in writing to

Sanford Health Plan 60 days prior to the effective termination date. For Minnesota practitioners or facilities, you must give Sanford Health Plan 120 day notice.

Involuntary terminations will be sent to the provider via letter from Sanford Health Plan 60 days prior to the effective termination date.

The following policy(s) are referenced in this section and are available for review on the Sanford Health Plan secure portal under Quick Links, Policies and Medical Guidelines:

- Provider Access and Availability Standards Policy (MM-50)

4.9.8 Notification of Provider Network Changes

Sanford Health Plan performs bi-annual surveys using a random sampling of our provider network to verify the accuracy of information displayed on our provider directory.

If there are changes to the provider network, Sanford Health Plan will notify its members in a timely manner. Members have access to the online provider directory, 24 hours a day, seven days per week via their secure member accounts or at sanfordhealthplan.com. All providers who have agreed to participate with the Plan shall be included in the directory for the duration of their contract.

When a provider terminates his or her contract, a letter is sent to each member who has incurred a service from that provider within the last 12 months. The letter will inform the member that the provider is leaving our network as of a specified date.

If you have changes affecting your clinic, notify us as soon as possible. The following are the types of changes that must be reported:

- New address (billing and/or office)
- New telephone number
- Additional office location
- Provider leaves practice
- New ownership of practice
- New Tax Identification Number
- Accepting new patients
- Change in liability coverage
- Practice limitations (change in licensure, loss of DEA certificate, etc.)
- New providers added to a practice
- Change in Medicare or Medicaid Status

All written notices should be clear and legible. This will ensure accuracy and allow for changes to be completed in a timely manner. A Provider Information Update/Change Form is also available online to submit changes. You can also send us your changes on your letterhead and fax to (605) 328-7224 or you may mail the information to the following address:

Attn: Provider Relations
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Quality Improvement and Medical Management

5.1 Quality Improvement Program

Sanford Health Plan and its participating practitioners and providers are fully supported by a sophisticated ambulatory and institutional quality management program. The organized method for monitoring, evaluating, and improving the quality, safety and appropriateness of health care services, including behavioral health care which encompasses mental health and substance use disorders, to members through related activities and studies is known as the Quality Improvement (QI) Program. The Plan monitors its use of resources in order to ensure appropriate distribution of assets throughout the entire system and provides accountability for the quality of health care delivery and service. This is accomplished through the commitment of the Board of Directors, the Physician Quality and the Health Plan Quality Improvement Committees.

Providers are encouraged to view the programs offered to members at the home screen of sanfordhealthplan.com/providers/quality-improvement-program.

QI Initiatives include:

- Value-based strategies that drive population health improvements
- Innovative and technology-enabled focused projects
- Preventive care and condition based initiatives that promote improved health outcomes
- Data monitoring, analysis and medical record review of clinical outcome data (HEDIS)
- Member Experience analysis and improvement strategies (CAHPS)
- NCQA accreditation-commitment to delivering high quality standards
- Clinical resources and tool development (which can be found here (link is https://www.sanfordhealthplan.com/providers/quality-improvement-program) :
  - Clinical Practice Guidelines
  - Preventive Health Guidelines
  - Quick Reference Behavioral Health Cards
  - Immunization Schedules

HEDIS report booklet

1. HEDIS® and CAHPS® Report
   The HEDIS® Provider Guide and Toolkit on the provider portal provides valuable information on HEDIS measure specifications, member experience survey questions related to providers and tips for improving performance.
2. Clinical resources and tools which include but are not limited to:
   - Clinical Practice Guidelines
   - Preventive Health Guidelines
   - Quick Reference Behavioral Health Cards
   - Immunization Schedules

The following policy(s) are referenced in this section and are available for review in the "Quick

Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Quality Improvement Program (MM-056).

5.2 Medical Management Program

The Medical Management Program (also referred to as Utilization Management or UM) is defined as an organized method for monitoring and evaluating certain services and treatment using evidence-based guidelines. This process reviews the following items to determine if the treatment, as prescribed, is appropriate:

1. Medical necessity of the treatment
2. Setting for the treatment
3. Types and intensity of resources to be used in the treatment
4. Time frame and duration of the treatment

Our Utilization Management Team is available between the hours of 8 a.m. and 5 p.m., CST, Monday through Friday (excluding holidays). After hours, members and providers may leave a message on the confidential voice mail and a representative will return your call the following business day, no later than 24 hours after the initial inquiry call.

Member questions per line of business:

NDPERS: (888) 315-0885
All other: (800) 805-7938

5.2.1 Utilization Review Process

The purpose of Utilization Review is to establish requirements and standards of operation for the certification of medical utilization. The criteria for medical services used by the Utilization Management Department shall be made available, upon request, to Participating Physicians. Clinical review criteria include Milliman Care Guidelines (MCG), eviti, literature review, specialty society standards of care, Medicare guidelines, and health plan benefit interpretation.

If medical necessity and/or criteria are not met, the request is reviewed by a Medical Director/ Officer. UM staff cannot make denial decisions in these cases, but can make authorization decisions based on MCG guidelines, procedures and benefit coverage guidelines. UM staff base their decisions on accepted review criteria, medical record review, and/or consultations with appropriate physicians.

5.2.2 New Medical Service or Product Consideration

Provider may submit the "Request for Benefit Consideration" form found online at sanfordhealth.org/Provider Under Medical Management Forms where there is a new medical service, or product you want Sanford Health Plan to consider for benefit coverage. The form must be completed prior to claim submission of the new product or service for which the benefit coverage consideration is being reviewed. Completing this form does not guarantee coverage of benefits.

5.2.3 Prior Authorizations

Prior authorization (certification or precertification) is the urgent or non-urgent authorization of a requested service prior to receiving the service. The approval for prior authorization is based on appropriateness of care and service and existence of coverage.

Points to remember:

1. Providers are responsible for obtaining prior authorization in order to receive in-network coverage.
2. All requests for certification are to be made by the member or their practitioner's office at least three working days prior to the scheduled admission or requested service. If health care services need to be provided within less than three working days, contact the Utilization Management Department to request an expedited review.
3. All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.
4. A list of services that require prior authorization can be found online at sanfordhealthplan.com/priorauthorization.
5. Failure to obtain prior authorization will result in a denial that will be provider responsible.

For questions on authorizations, please visit sanfordhealthplan.com/priorauthorization or contact at (800) 805-7938.

How to Authorize:

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online (preferred method), by phone or fax: **NOTE: Oncology treatment and services must be entered and authorized through eviti|Connect online at** eviti.com**. High-end imaging services for select members and health plans must be entered and authorized through eviCore at** evicore.com**.**

To request a prior authorization, log into the mySanfordHealthPlan provider portal at sanfordhealth.org/Provider. Open the member record and choose "Create Referral". The tutorial explaining how to request a prior authorization is located within the provider portal.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours.

For Medicare Advantage Align please use the below options to submit prior authorization:

1. Provider portal: healthsuiteadvantage.com
2. Submit prior authorization form that you can find our forms page. sanfordhealthplan.com/providers/forms
3. By Phone 800-805-7938 or Fax 605-312-8219

Additional Medical Management Program Information

You may also find the following information in *my*SanfordHealthPlan provider portal in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

1. The complete Medical Management Program Description, including further operational details, prior authorization and denial and appeal procedures are available.
2. UM criteria is available to practitioners and providers by phone or mail. A physician reviewer is made available by phone to any practitioner to discuss determinations based on medical appropriateness.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines"at sanfordhealth.org/Provider.

- Utilization Management Program policy (MM-01).

5.2.4 Sanford Health Plan Referral Center

The Referral Center assists providers in finding the right specialist or medical resources for your Sanford Health Plan patient. The center will have access to all Sanford Health Plan network specialists, contact information, services and procedures provided and their location(s)/outreaches within our service area. Our staff will give personal attention to each inquiry by gathering details about the patient and will give you available options.

Who can use?

Providers and nursing staff can call the referral center and identify the type of specialty their patient needs.

How do you contact the Referral Center?

The Referral Center will be available for consultation by phone or email. Call 844-836-1616 or (605) 333-1616, or email healthplanreferralcenter@sanfordhealth.org. Staff will be available Monday – Friday, 7:30am-6:30pm CST.

Sanford Health Plan

Prior Authorization List

Effective January 1, 2021

To receive coverage for services or equipment below, you must receive approval from the plan. Requests must be made at least three (3) business days in advance. This list does not guarantee eligibility or coverage; services must be medically necessary and available under your plan.

Procedure or Service	Comments
Admissions	**Admissions include:** • Inpatient Medical, Surgical, Mental Health or Substance Use/Abuse • Inpatient Rehabilitation • Long Term Acute Care Facility • Residential Treatment • Skilled Nursing Facility • Swing Bed
Ambulance Services	**Air ambulance services**
Clinical Trials	**All clinical trials**
Durable Medical Equipment (DME)	**Includes but is not limited to:** • Airway Clearance Device • DME greater than $10,000 (billed charges) • Home DME Phototherapy Device • Hospital or Specialty Beds • Selected Orthotics and Prosthetics • Pneumatic Compression with External Pump • Power Wheelchairs and Accessories • Prosthetic Limbs • Scooters
Home Health	**Home Health Services include:** • Home Health Services
Implants/Stimulators	**Implants and Stimulators include:** • Cochlear Implant (Device and Procedure) • Deep Brain Stimulation • External Electrical Bone Growth • Gastric Stimulator • Spinal Cord Stimulator (Device and Procedure) • Vagus Nerve Stimulator
High-end Imaging	**PET, MRI/MRA, CT/CTA, NUC MED** NOTE: High-end imaging services for select members and health plans must be entered and authorized through eviCore at evicore.com.

SANFORD HEALTH PLAN

Continued on next page

Procedure or Service	Comments
Oncology (Cancer) Services and Treatment	**All chemotherapy and radiation therapy** For Providers: Please go to eviti.com to request authorization. Contact Utilization Management at (800) 805-7938 with questions.
Outpatient Services	**Outpatient services include but is not limited to:** • Applied Behavioral Analysis (ABA) • Botox (Non-cosmetic) • Brachytherapy • Chelation Therapy • Dental Anesthesia (if over age limitations) • Facet Joint Injection • Genetic Testing • Hyperbaric Oxygen Therapy • Medical Nutrition • Neuromuscular Electrical Stimulation • Radiofrequency Ablation • Tissue Engineered Skin Substitute
Outpatient Surgery	**Outpatient surgery includes but is not limited to:** • Abdominoplasty or Panniculectomy • Bariatric Surgery • Blepharoplasty • Breast Implant Removal, Revision or Re-implantation • Breast Reconstruction and Mastectomy • Endoscopic Sinus Surgery • Functional Endoscopic Sinus Surgery (FESS) • Mammoplasty • Orthognathic Surgery • Reconstructive Surgery (Non-cosmetic) • Rhinoplasty • Scar Revision • Septoplasty • Trabeculoplasty and Trabeculectomy (Laser) • Temporomandibular Joint (TMJ) • Turbinate Resection • Vestibuloplasty
Spine (Back) surgery	**All inpatient and outpatient spine surgery**
Transplants	**Includes transplant evaluation and all transplant services**
Transportation	**Non-urgent ground or air transportation**

For complete prior authorization information, please refer to your plan documents located in the secure member portal at sanfordhealthplan.com/memberlogin. Please refer to the formulary for medications that require prior authorization.

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5.2.5 Pharmacy Management and Formulary Program Information

One of Sanford Health Plan's missions is to improve the health status of members by developing a model of quality patient care. We maintain a physician driven Pharmacy and Therapeutics Committee in order to promote unbiased, clinically sound drug therapy for Plan participants covered by the formularies managed by the Plan. Criteria utilized to determine drug status within the Formulary includes clinical efficacy and safety, financial impact of medications to the Member and Employer Group, consistency in formulary decisions, and drug position among therapeutic alternatives. Medications on this list are approved by the Federal Food and Drug Administration (FDA) for use in the United States.
We contract with OptumRx as our Pharmacy Benefits Manager to promote optimal therapeutic use of pharmaceuticals. OptumRx currently supports the Plan's Formulary for self-administered medications payable under the pharmacy benefit. Participating pharmacies can be found through our online, searchable pharmacy directory.

To be covered by the Plan, drugs must be:

1. Prescribed or approved by a physician, advanced practice provider or dentist;
2. Listed in the Plan Formulary, unless pre-approval (authorization) is given by the Plan;
3. Provided by a Participating Pharmacy except in the event of a medical emergency. If the prescription is obtained at a Non-Participating Pharmacy, the member is responsible for the prescription drug cost in full;
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

5.2.6 Sanford Health Plan Formulary

Sanford Health Plan has a list (formulary) of prescribed medications chosen by health care providers on Sanford Health Plan's Pharmacy and Therapeutics Committee. By following the formulary and using generic medications when available, members can save money and help control out of pocket costs. The Plan updates the Formulary on an annual basis and as needed when new drugs enter the market or when a drug is removed from the market.

If changes are made to the formulary, members who are directly impacted receive a letter from Sanford Health Plan with notification of the formulary change.

Resources:

1. Sanford Health Plan website: sanfordhealthplan.com/members/pharmacy-information. Formularies, medications requiring prior authorization or step therapy, Synagis Prior Authorization Form, options on obtaining prior authorization etc. can be found online and within the secure provider portal.
2. OptumRx website: optumrx.com

If you feel that Sanford Health Plan should consider coverage of a medication based on medical necessity for medications not on the Formulary, please complete the online Prescription Drug Prior Authorization Request online at our provider portal.

The Pharmacy Management Department can be reached from 8 a.m. to 5 p.m., Central Time, Monday through Friday at one of the following numbers:

- Main Number:
  (855) 305-5062:
  Fax: (701) 234-4568
- NDPERS:
  (877) 658-9194
  Fax: (701) 234-4568

Pharmacy for Align Members:

OptumRx
Pharmacist Help Line (844) 368-8732
OptumRx Member services (844) 642-9090

Optum Rx Coverage Determinations (Auths)
Prior Authorization Department
P.O. Box 25183
Santa Ana CA 92799
MAPD Plans — OptumRx Phone Number:
(844) 642-9090

Optum Rx Coverage redeterminations (appeals)
Prior Authorization Department
C/O Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799
MAPD Plans — OptumRx Phone Number:
(844) 642-9090

Rx Grievances
OptumRx Attn: Grievance Department
6860 W 115th St.
Overland Park, KS 66211

OptumRx Manual Claims
OptumRx Claims Department
PO Box 650287
Dallas, TX 75265-0287

5.3 Care Management Program

To connect members with the right resources at the right time, we offer case management services to all members with complex or high-risk health conditions. Our services help members better understand their health while coordinating their care to develop and implement a care plan that's focused on their goals and health needs.

The current programs available to members include:

Very high risk case management: Members who have experienced catastrophic or life-changing events where functional level may not return to previous baseline status or who have initiated hospice or palliative care.

Complex case management: Members with multiple chronic conditions, catastrophic events, complex or uncontrolled health conditions.

Specialty case management

Transplant: Members undergoing transplant evaluation or currently on a list for a transplant.

Oncology: Members with an active or complicated cancer diagnosis.

NICU: Newborns with complications or conditions requiring a neonatal intensive care stay.

High-risk pregnancy: Expectant mothers with a high-risk pregnancy due to carrying multiples or because of complicated medical conditions.

Behavioral health: Members with substance-use disorders, depression, anxiety, bipolar disorder, schizophrenia or personality disorders with admissions or emergency room use.

Care transitions — medical or behavioral health: Members with inpatient hospitalizations for a medical or behavioral health need that is managed for 30 days.

Social work: To address psychosocial needs, members with identified social determinants of health are referred to a social worker for assistance to connect with community resources.

If you would like more information or need to refer a qualified Sanford Health Plan Member to the program, please contact the Care Management team at (888) 315-0884 or by email at shpcasemanagement@sanfordhealth.org.

For Sanford EPIC users, if a Health Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart. If you are unable to determine the assigned case manager, you can send an in-basket message to SHP CRM CT Case Management.

5.3.1 Complex Case Management Referral Guide

Complex case management (CCM) is a program that provides coordination of care and services to members who have experienced a critical medical event or diagnosis that requires the extensive use of resources and who may need help navigating the health care system to facilitate appropriate delivery of care and services.

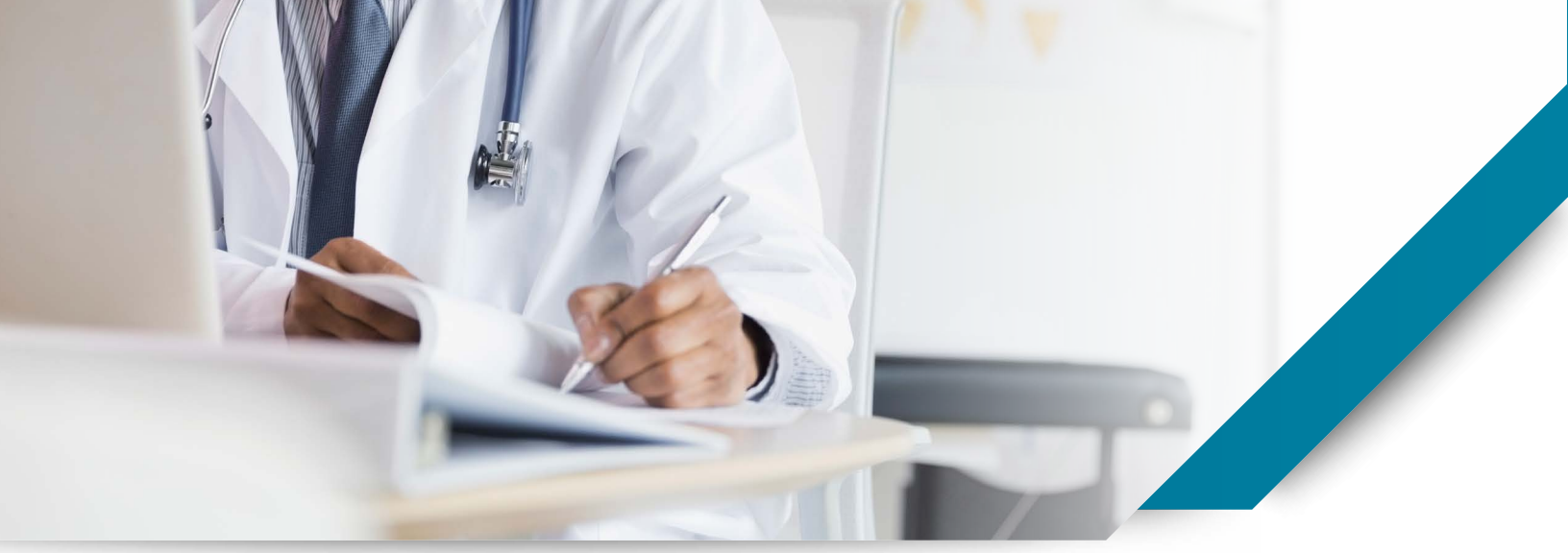
The case managers will focus on members identified as having had: Catastrophic health event; Multiple chronic illnesses or chronic illness resulting in high utilization; High risk or complicated medical conditions

The goal of complex case management is to assist members to regain optimum health or improved functional capability. We ensure member care follows evidence based clinical standards so there are no gaps in care, and ensure members are receiving health care in a cost-effective manner. This program involves a comprehensive assessment of the member's condition; determination of available benefits and resources; development and implementation of a case management plan with performance goals, monitoring and follow-up.

Sanford Health Plan's Complex Case Management Program is available at no cost to qualifying Sanford Health Plan members and their families.

If you would like more information or need to refer a qualified Sanford Health Plan Member to the program, please contact the Care Management team at (888) 315-0884 or by email at shpcasemanagement@sanfordhealth.org.

For Sanford EPIC users, you can also use in-basket messaging. If a Health Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart. If you are unable to determine the assigned case manager, you can send an in-basket message to SHP CRM CT Case Management.



Filing Claims

6.1 Member Eligibility and Benefit Verification

Sanford Health Plan offers two convenient options to verify eligibility and benefits: online or by phone.

Contact our Customer Service Department:

Phone: (800) 752-5863 or (605) 328-6800 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Online: sanfordhealth.org/Provider.

Each provider's office is responsible for ensuring that a member is eligible for coverage when services are rendered or prior to time of service. If a provider's office fails to check eligibility for a member who is not eligible for coverage and submits a claim to Sanford Health Plan, the claim will be denied.

6.2 Claims Submission

Sanford Health Plan participating providers are required to submit claims on members' behalf. Claims should be submitted to Sanford Health Plan electronically using Payor ID 91184. Electronic claims submitted for Medicare Advantage should use Payor ID RP035. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency (Please see Provider EDI Resources in the provider manual or on the website for more information). Accepted claims forms are a standard CMS, UB or ADA claim. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted using current coding and within 180 days, or as defined in your contract even if the member has not exceeded their deductible or copay amounts.

6.2.1 Paper Claims Submission

If you do not wish to file claims electronically, paper claims can be mailed to:

Sanford Health Plan Claims Department
PO Box 91110
Sioux Falls, SD 57109-1110

Paper Claims Submission for Medicare Advantage
Sanford Health Plan/RAM
PO BOX 981813
El Paso, TX 79998-1813

To improve our turnaround time and accuracy of paper claim processing, we use a scanning procedure using the Smart Data Solutions (SDS) system. It is important for you to know that the SDS system uses optical character recognition (OCR). Therefore, when OCR is used, your provider name must match our records in order for the system to correctly identify the "pay to" information. If a mismatch occurs, or if the claim cannot be read, you will receive a letter from SDS asking you for the missing or illegible information. A prompt response will prevent further delay in processing your claim.

When sending paper claims, please follow these guidelines:

- Print on a laser printer
- If a dot matrix printer must be used, make sure it is legible
- Use Courier New 10 point font for clean scanning.
- Use uppercase for optimal scanning.
- Ensure that clean character formation occurs when printing paper claims (i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number).
- Claim forms should be lined up properly
- Do not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc.
- Use an original claim form - not a copied claim form.
- Use a standard claim form (individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly).
- The billing, servicing and/or rendering provider's NPI must be included in the designated locations for accurate matching within the scanning and claim system.
- For a continued claim, please indicate "continued" in the appropriate box of the claim form so the claims can be kept together and whole.
- Do not place the total amount on each of the individual pages.

6.2.2 Corrected/Voided Claims Submission

A corrected claim is defined as a re-submission of a claim, such as changes to CPT codes, diagnosis codes or billed amounts. It is not a request to review the processing of a claim. If you need to submit a corrected claim due to an error or change on an original submission, you can do so electronically or by paper. Corrected claims must be received within 60 days of the date of initial processing as indicated on the Explanation of Payment.

Voided claims are defined as a claim needing to be recouped and no reprocessing is necessary. The entire claim must match the original, with the exception of the claim frequency code and reference to the Sanford Health Plan original claim number.

When submitting corrected or voided claims, do not submit claims electronically and via paper at the same time. Medical records are not required with the submission of a corrected claim and are only needed when specifically requested from us.

Providers using Electronic Data Interchange (EDI) can submit professional and institutional corrected claims. The corrected Claim needs to contain the adjusted coding to help us identify and process the claim accurately.

Corrected claims filed electronically should be submitted with ALL service line items.

- Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, in the 2300 loop in the CLM*05.
- Enter the original claim number as processed by Sanford Health Plan in the 2300 loop in the REF*F8*.

Corrected or voided claims submitted by paper need to be clearly identified as "CORRECTED CLAIM" or "VOIDED CLAIM" at the top of the claim form. If you are correcting or voiding a UB-04 claim, use appropriate type of bill type of XXX7 or XXX8 in box 4. If you are correcting or voiding a CMS claim, use appropriate resubmission code of "7" for a corrected claim or "8" for a voided claim and reference the original claim number that you are correcting or voiding in box 22 of the form.

6.3 Provider EDI Resources

Sanford Health Plan provides a variety of EDI resources for both professional and institutional claims to increase efficiency, track claim status, decrease errors, expedite cash flow, and reduce costs.

6.3.1 EDI Services

- 837 Health Care Claim Transactions Electronic
  Funds Transfer (EFT)
- 835 Health Care Claim Payment/Advice Transactions

- 270/271 Real Time Transactions for Eligibility, Coverage, or Benefit Inquiry and Information
- 276/277 Real Time Transactions for Health Care Information Status Request and Response.

To review these forms, trading partner agreement and companion guides, CLICK HERE. Contact our EDI department if you have questions when completing the forms.

6.3.2 EDI Enrollment

Sanford Health Plan exchanges data with several vendors and clearinghouses. Trading Partners who want to exchange data electronically with Sanford Health Plan will need to complete our Trading Partner Agreement.

For further information or to download the Trading Partner Agreement and our EFT Enrollment Instructions, visit our website at sanfordhealthplan.com/providers/edi-resources

6.4 Instructions for completing the CMS 1500

Physicians and Allied Health Professionals should use the Center of Medicaid and Medicare Services (CMS) form 1500 to bill for medical services. Please follow the link for detailed instructions on how to correctly fill out the CMS 1500 form.

Field	Description and Information	Mandatory or Optional
1	Type of insurance – check appropriate box.	Optional
1a	Insured's ID Number – Enter the member's 9 digit number as it appears on their Sanford Health Plan ID card.	Required
2	Patient's name- Enter the name of the member as it is on the ID card.	Required
3	Patient's birth date and check box for male or female.	Required
4	Insured's name- The name of the policy holder	If applicable
5	Patient's complete address and phone number.	Required
6	Patient relationship to insured.	If applicable
7	Insured's address.	Not required
8	Patient status.	Not required
9 a-d	Other health insurance coverage - Identify other group coverage for accurate coordination of benefits. If the patient has no other group coverage, enter NONE	Not required
10 a-c	Is patient's condition related to coverage for employment, auto or other accident related claims?	Not required
10 d	Reserved for local use.	Not required
11 a-b	Insured's information – Name, policy/group number, employer/ school name, insurance plan/ program name.	Not required
11 c	For Medicare crossover claims, enter the Medicare Carrier Code.	If applicable
11 d	Is there another health benefit plan? Check yes or no.	Required
12	Patient's signature and date.	Not required
13	Insured signature.	Not required
14	The date of first symptom for current illness, injury or last menstrual period for pregnancy.	Required
15	The date the same or a similar illness.	Not required
16	Dates patient unable to work in current occupation.	Not required
17	Name of referring physician.	If applicable
17 a	ID number of referring physician – enter state medical license number.	If applicable
17 b	Enter referring provider's NPI number.	If applicable
18	Hospitalization dates related to current services. Additional claim information.	If applicable
19	Additional claim information.	If applicable
20	Outside lab – check yes when diagnostic test was performed by any entity other than the provider billing the service.	If applicable
21	Enter the patient's diagnosis or condition. Use ICD-10 code and use the highest level of specificity.	Required
22	Resubmission Code.	If applicable
23	Prior authorization number.	If applicable
24 a	Dates of service	Required
24 b	Enter code for place of service.	Required
24 c	Emergency indicator	If applicable
24 d	Procedures, service or supplies – Enter the applicable CPT or HCPCS code(s) and modifiers in this section.	Required
24 e	Diagnosis pointer – enter the diagnosis code number from box 21 that applies to the procedure code in 24 d.	Required
24 f	Charges – Enter the charge in dollar amount format for each listed service. If the item is a taxable medical supply, include the applicable state and county sales tax.	Required

Field	Description and Information	Mandatory or Optional
24 g	Days or Units – Enter the number of medical visits, procedures, units of service, oxygen volume etc. Do not leave blank.	Required
24 h	EPSDT Family Plan – Enter code 1 or 2 if the services rendered are related to family planning (FP). Enter code 3 if the services rendered are Child Health and Disability Prevention screening related.	If applicable
24 i	ID Qualifier -	If applicable
24 j	Rendering Provider ID#/NPI – Enter the rendering provider's NPI number.	If applicable
25	Federal Tax ID Number – Enter the Federal Tax ID Number for the billing provider.	Required
26	Patient's account number	Optional
27	Accept assignment	Not required
28	Total charges for services	Required
29	Amount paid	If applicable
30	Balance due – Enter the difference between the total charges for services and the amount paid.	If applicable
31	Signature of physician or supplier including credentials.	Required
32	Service facility location information – Enter the name, address, city, state and zip code of the location where the services were rendered.	Required
32 a	NPI Number - Enter the NPI number where the services were rendered.	Required
32 b	Other ID number	If applicable
33	Billing provider info and phone number – Enter the provider name, address, city, state, zip code and telephone number.	Required
33 a	NPI number – enter the billing/ group provider's NPI	Required
33 b	Other ID number	Required

6.5 UB-04/CMS-1450 claim form and instructions:

Commonly known as UB-04, the CMS-1450 form is used by institutional providers to bill payors including Sanford Health Plan. Examples of institutional providers include and are not limited to the following:

- Hospital
- End Stage Renal Disease
- Hospices
- Comprehensive Outpatient Rehabilitation Facilities
- Community Mental Health Centers
- Federally Qualified Health Centers
- Skilled Nursing Facilities
- Home Health Agencies
- Outpatient rehabilitations clinics
- Critical Access Hospitals

UB-04/CMS-1500 instructions:

Field location UB-04	Description	Inpatient	Outpatient
1	Provider Name and Address	Required	Required
2	Pay-to Name and Address	Situational	Situational
3a	Patient Control Number	Not Required	Not Required
3b	Medical Record Number	Optional	Optional
4	Type of Bill	Required	Required
5	Federal Tax Number	Required	Required
6	Statement Covers Period	Required	Required
7	Future Use	N/A	N/A
8a	Patient ID	Situational	Situational
8b	Patient Name	Required	Required
9	Patient Address	Required	Required
10	Patient Birthdate	Required	Required
11	Patient Sex	Required	Required
12	Admission Date	Required	Required, if applicable
13	Admission Hour	Required	Not Required
14	Type of Admission/Visit	Required	Required
15	Source of Admission	Required	Not Required
16	Discharge Hour	Required	Not Required
17	Patient Discharge Status	Required	Required
18-28	Condition Codes	Required, if applicable	Not Required
29	Accident State	Situational	Not Required
30	Future Use	Not Required	Not Required
31-34	Occurrence Codes and Dates	Required, if applicable	Required, if applicable

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES | NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Field location UB-04	Description	Inpatient	Outpatient
35-36	Occurrence Span Codes and Dates	Required, if applicable	Required, if applicable
37	Future Use	Not Required	Not Required
38	Responsible Party Name and Address	Required	Required
39-41	Value Codes and Amounts	Required, if applicable	Required, if applicable
42	Revenue Code	Required	Required
43	Revenue Code Description	Required	Required
	NDC Code	Required, if applicable	Required, if applicable
44	HCPCS/Rates	Required, if applicable	Required, if applicable
45	Service Date	N/A	Required
46	Units of Service	Required	Required, if applicable
47	Total Charges (By Rev. Code)	Required	Required
48	Non-Covered Charges	Not Required	Not Required
49	Future Use	N/A	N/A
50	Payer Identification (Name)	Required	Required
51	Health Plan Identification Number	Situational	Situational
52	Release of Info Certification	Required	Required
53	Assignment of Benefit Certification	Not Required	Required
54	Prior Payments	Required, if applicable	Required, if applicable
55	Estimated Amount Due	Required	Required
56	NPI	Required	Required
57	Other Provider IDs	Optional	Optional
58	Insured's Name	Required	Required
59	Patient's Relation to the Insured	Required	Required
60	Insured's Unique ID	Required	Required
61	Insured Group Name	Optional	Optional
62	Insured Group Number	Optional	Optional
63	Treatment Authorization Codes	Required, if applicable	Required, if applicable
64	Document Control Number	Optional	Optional
65	Employer Name	Not Required	Not Required
66	Diagnosis/Procedure Code Qualifier	Required, if applicable	Required, if applicable

Field location UB-04	Description	Inpatient	Outpatient
67	Principal Diagnosis Code/Other Diagnosis Codes	Required	Required
68	Future Use	N/A	N/A
69	Admitting Diagnosis Code	Required	Not Required
70	Patient's Reason for Visit Code	Not Required	Required, if applicable
71	PPS Code	Required	Not Required
72	External Cause of Injury Code	Required, if applicable	Required, if applicable
73	Future Use	N/A	N/A
74	Principal Procedure Code/Date	Required, if applicable	Required, if applicable
75	Future Use	N/A	N/A
76	Attending Name/ ID-Qualifier 1G	Required	Required
77	Operating ID	Required, if applicable	Required, if applicable
78-79	Other ID	Required, if applicable	Required, if applicable
80	Remarks	Required, if applicable	Required, if applicable
81	Code-Code Field/ Qualifiers		
	*0-A0	N/A	N/A
	*A1-A4	Situational	Situational
	*A5-AB	N/A	N/A
	AC – Attachment Control Number	Situational	Situational
	AD-B0	N/A	N/A
	*B1-B2	Situational	Situational
	*B3	Required	Required

6.6 Claims Payment

Claims must be submitted within the filing period of 180 days from date of service or as defined in your contract. For inpatient services, timely filing begins from the date of discharge. Claims submitted outside of the filing period will be denied due to untimely filing. Charges denied for untimely filing are not to be billed to the member, but must be written off.

We reimburse providers for "clean" claims within 30 calendar days of the receipt of the claim. Clean claims are those claims not requiring additional information before processing.

We will respond within 60 days of receipt for claims requiring additional information before processing (i.e. accident details, or other coverage information). If you do not receive an Explanation of Payment (EOP) from the Plan within the 60 days from the claims filing date, it is advisable to check the status through your secure provider account or by calling Customer Service.

No legal action may be brought to recover under this provision within 180 days after the claim has been received as required by your provider contract. No action to recover member expenses may be brought forth after four years from the time the claim is processed.

If the member fails to show their ID card at the time of service and you bill the wrong plan, then the member may be responsible for payment of the claim after the timely filing period has expired. Sanford Health Plan will only process claims with this denial at your request via a claim reconsideration. Please see the Claim Reconsideration section of this Manual for details.. Both you and the Member will receive an EOP and Explanation of Benefits (EOB) showing this denial. At this point, you accept responsibility for settling payment of the claim with the Member.

6.6.1 Process for Refunds or

Returned Checks

Sanford Health Plan processes over-payments by taking deductions on future claims. This includes recoupments on claims that have been reprocessed. You may return the overpayment directly to Sanford Health Plan, but it will only be accepted if the overpayment has not already been offset by other claims. If the overpayment remains outstanding for more than 90 days, our Finance Department will send you a letter requesting payment.

If Sanford Health Plan has paid a claim in error, you may return the check or write a separate check for the full amount paid in error. A copy of the remittance advice, supporting documentation noting reason for the refund should be included with the refund.

Refunds should be sent directly to the Finance Department at this address:

Attn: Finance Department
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES	29 ACDT STATE	30

	31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a															a
b															b

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE _____ OF _____***	***CREATION DATE***		***TOTALS***				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A					A
B					B
C					C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			A
B			B
C			C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS	81CC			
	a			
	b			
	c			
	d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

6.7 How to Read Your Explanation of Payment

1. Contact information for Sanford Health Plan
2. Check / EFT #: Payment information identifying the Tax ID the payment was made under, the payment date and the total amount disbursed.
3. Date(s) of Service: Date the member was seen by healthcare provider/services were rendered.
4. Service Codes: CPT, HCPCS or Revenue Codes Billed.
5. Number of Units: Quantity of service provided.
6. Charged Amount: Total amount billed by the provider for the procedure or service rendered.
7. Allowed Amount: The negotiated rate for which is allowed for in-network providers. For out-of-network providers it is the maximum allowed amount.
8. Discount Amount: The amount deducted (discounted) from the charged amount based on contractual agreements.
9. TPP: A third party payer (TPP) is an entity, outside of Sanford Health Plan, which provides reimbursement to providers for services rendered to members.
10. Copayment: The fixed amount the member owes the provider at the time of service. This amount is not applied to the deductible or co-insurance. Provider can bill the member for this amount.
11. Deductible: The amount of the member's deductible that has been applied to a covered service or procedure. Provider can bill the member for this amount.
12. Coinsurance: Amount of member's coinsurance that has been applied to a covered service or procedure. Provider can bill member for this amount.
13. Member Liability: If present, amount the member is liable for on a non-covered service excluding copayment, deductible, and coinsurance. Provider can bill member for this amount.
14. Provider Liability: If present, amount the provider may be liable for on a non-covered service excluding copayment, deductible and coinsurance. Members may not be billed this amount.
15. Reimbursed Amount: Payment received by the provider for rendering a medical service.
16. Reason code(s): Codes used to explain any claim financial adjustments, reductions or increases in payment. Descriptions will appear at the end of your explanation of payment.

6.8 Provider Reimbursement

6.8.1 Participating Provider Reimbursement

Sanford Health Plan will pay the provider when a member receives covered services from a participating provider (physician, hospital, facility, dentist, etc.). Contracted providers agree to accept negotiated fee schedules as reimbursement in full for covered services provided to members. Provider offices may collect copay, estimated deductible and coinsurance at the time of service. Any non-covered service can also be collected.

Participating providers are not allowed to bill members the difference between the amount charged by the provider and the pre-negotiated Sanford Health Plan allowable reimbursement. The difference between the charged amount and the allowed amount is considered a provider write off. Services not covered by Sanford Health Plan guidelines will be the responsibility of the member. This excludes, but is not limited to, services denied for untimely filing or services medically necessary.

6.8.2 Non-Participating Provider Reimbursement

A non-participating provider is defined as a Practitioner and/or Provider who has not signed a contract with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan. When a member receives covered services from a non-participating provider, Sanford Health Plan will allow the Sanford Health Plan's established maximum allowed amount. Maximum allowed amount is the amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. Sanford Health Plan's Maximum Allowed Amount is the lesser of:

a) the amount charged for a Covered Service or supply; or

b) inside Sanford Health Plan's Service Area, negotiated schedules of payment developed by Sanford Health Plan, which are accepted by Participating Practitioner and/or Providers; or

c) outside of Sanford Health Plan's Service Area, using current publicly available data adjusted for geographical differences where applicable:

   i. Fees typically reimbursed to providers for same or similar professionals; or

   ii. Costs for Facilities providing the same or similar services, plus a margin factor.

Sanford Health Plan accepts claims directly from non-participating providers. If the non-participating provider does not submit claims to Sanford Health Plan, members may submit a member claim form. Claims, whether directly from providers or from members, must be submitted within 180 days from the date of service or date of inpatient discharge. The member may contact Sanford Health Plan's Customer Service Department to discuss how to submit the required information. Payment will be sent directly to the Provider. If the Provider refuses direct payment, the member will be reimbursed the maximum allowed amount for the service. Only the maximum allowed amount is applied to the Member's benefits. SHP may take additional reductions based on the member's benefits. The payment reduction does not apply toward the member's out-of-pocket maximum amount.

The following policy referenced below can be access on Sanford Health Plan's secure portal under Quick Links, Policies and Medical Guidelines.

- Non-Participating Provider Compensation (PC-032)

SANFORD
HEALTH PLAN
PO BOX 91110
SIOUX FALLS SD 57109-1110

20191111B04
J796
8509 23794

J796 [129] 1 of 235

[EP-]

Forwarding Service Requested

J796 129

Facility Name
PO BOX X
City, State Zip Code

1

Contact Us

Benefits, eligibility & claim status:
Customer Service (800) 752-5863

Recoupments & W9s:
Provider Relations (800) 601-5086

Medical service authorizations:
Utilization Management (800) 805-7938

Pharmacy/drug authorizations:
Pharmacy Management (855) 305-5062

2

Claim Payment Summary

Vendor Tax ID #: XXXXXXXXX
Remittance Date: 11-07-2019
Sanford Account ID: SHP

Total Claims Amount	**XXXXXX.XX**
Adjustment Recovery Applied	**0.00**
Recoupment Balance	**0.00**
Total Amount Disbursed	**XXXXXX.XX**

SANFORD
HEALTH PLAN

Pay To: Facility Name
Vendor Tax ID #: XXXXXXXXX
Account ID: SHP
Remittance Date: 11-07-2019
Check/Trace #: XXX-X-XXXXXXX-XXXXXXXXX

Patient: Sample, Mary A
Claim #: 28125011
SHP Member ID: XXXXXXXXX
Patient Account #: XXXXXXXXX
Provider: Sample, Dr. Jane

Date(s) of Service	Service Codes	Number of Units	Charged Amount	Allowed Amount	Discount Amount	TPP	Copayment	Deductible	Coinsurance	Member Liability	Provider Liability	Reimbursed Amount	Reason Code(s)
06/06-06/06/19	36415	-1.000	-$13.00	-$7.46	-$5.54	$0.00	$0.00	-$7.46	$0.00	$0.00	$0.00	$0.00	
		CLAIM TOTAL	-$13.00	-$7.46	-$5.54	$0.00	$0.00	-$7.46	$0.00	$0.00	$0.00	$0.00	

3 4 5 6 7 8 9 10 11 12 13 14 15 16

6.8.3 Modifiers

Modifiers are two digit codes which are used to indicate when a service or procedure has been altered or modified by some specific circumstance without altering or modifying the basic definition of the CPT code. The use of some modifiers may affect reimbursement. The following chart lists modifiers that Sanford Health Plan recognizes for pricing increases or decreases.

Modifier Code	Description	Allowance of Fee Schedule
22	Increased Procedural Services	115%
50	Bilateral Procedure	150%
51	Multiple Procedures	100/50/50%
52	Reduced Services	50%
53	Discontinued Procedure	50%
54	Surgical Care Only	85%
62	Two Surgeons	62.5%
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	50%
80	Assistant Surgeon	20%
81	Minimum Assistant Surgeon	20%
82	Assistant Surgeon (when qualified resident or surgeon not available to assist the primary surgeon)	20%
AD	Medically supervised by a physician, more than four concurrent anesthesia procedures.	50%
AS	Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist for Assistant at Surgery services	20%
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: with medical direction by a physician	50%
QY	Medical direction of one CRNA by an anesthesiologist	50%

6.8.4 Claim Edits for Claims

Sanford Health Plan utilizes Optum Claims Editing System software to apply correct coding and standardization for editing of professional and facility claims. We consider and apply industry standard edits as outlined by National Correct Coding Initiative, American Medical Association and Centers for Medicare and Medicaid Services guidelines. Authorizations or referrals do not override system claim edits. Edits made to claims are considered to be a provider adjustment and not billable to the member. Edits will be applied to both participating and non participating providers. To see edits and advice on current claims or to validate if certain coding will hit one of these edits, please use the Optum CES Editor tool located within the Sanford Health Plan Provider Portal.

6.8.5 Inpatient Services

Services are considered inpatient when a member has been admitted to the hospital (exception: less than 24 hours). All charges incurred during the hospital stay are to be submitted timely for reimbursement. The Plan includes the day of admission, but not the day of discharge when computing the number of facility days provided to a Member. Timely filing begins from the date of discharge.

Interim claims, sometimes referred to as split-bills, allow hospitals to submit a claim for a portion of the patient's inpatient stay.

Interim claims are accepted by Sanford Health Plan for bill types 112 (first claim in series) where the billed amount exceeds the greater of $100,000 or the contracted outlier threshold where applicable. Continuing claims in the series should be submitted as corrected claims (bill type 117) and include all charges from date of admission and have patient status of 30 (still a patient). Final bill with all remaining billed charges should be submitted with bill type 117 and have a discharge status other than 30. The claims not meeting these criteria will be denied. Provider may resubmit interim claims under this criteria or file all charges with bill type 111 (admission through discharge).

6.8.6 DRG Grouper for Inpatient Services

Sanford Health Plan uses Optum's DRG grouper software for grouping and assigning a CMS MS-DRG code to each inpatient claim for payment purposes where the provider contract uses DRG methodology. Claims that are ungroupable or group to an invalid DRG will be denied. The Plan will use the grouper version released by CMS annually in October, or as specified in your contract, effective on the date of admission.

6.8.7 Payment Integrity Review

Sanford Health Plan utilizes various systems to ensure accurate, appropriate, and fair payments on claims. This process includes but is not limited to cost-avoidance with coordination of benefits, correct coding, duplicate or erroneous payment detection, pre- or post-payment claim reviews, and fee negotiation. These activities may require providers to submit requested documentation to support billing or correct claims in order for claims to be adjudicated.

6.8.8 Skilled Nursing Health Levels of Care

Skilled Nursing Facility (SNF) is a facility, either freestanding or part of a hospital that accepts patients in need of rehabilitation and/or medical care that is of a lesser intensity than that received in a hospital. Sanford Health Plan reimburses providers based on the levels of care billed. Providers are required to bill the appropriate level of care for which services were provided. The following levels of care and services shall be made available to members in accordance with Plan policies.

Level 1: Semi private room and board; general nursing up to three hours of nursing per patient day (PPD) Including:

- Wound Care
- State I and II pressure ulcers
- Incontinent care; bowel and bladder training
- Colostomy/Ilestomy care
- Foley catheter care (maintenance and irrigation); including teaching
- Insulin dependent diabetic care; including teaching
- Dressing changes
- Routine laboratory
- X-rays
- Pharmacy; (oral medications)
- Routine supplies
- Routine durable medical equipment (wheel chairs, walkers, canes, etc.)
- Respiratory therapy – 2 small volume nebulizers (Nursing Department)
- Low flow oxygen, 3 LPM or less
- Restorative therapy including ROM, functional maintenance

Level 2: All Level I services and supplies and nursing hours greater than 3.5 and up to 5.0 hours of Nursing care per patient per day (PPD) including:

- Stage III and IV pressure ulcers
- Old tracheotomy care and supplies (2 or more suctionings per shift-3 shifts per day)
- NG, GI, G tube patient (enteral feeding pumps included)
- Simple IV therapy (hydration plus one medication is “simple”)
- Wound isolation not requiring a private room
- Respiratory therapy 3 or more small volume (Nursing Department)
- PT/OT/ST once a day (minimum 2 fifteen minute units) up to one hour of therapy per day, 5 days per week including therapy evaluation

Level 3: All Level I and II services and supplies and all general nursing services that require 5.0 – 6.5 Nursing hours per patient per day including:

- Post-surgery care and monitoring every four hours
- Complex medical care*
- Complex IV management (multiple medications) NOTE: The costs of the IV medication is excluded from the per diem rate in excess of $35.00 PPD
- Rehabilitation (PT, OT, ST a combination of 1-3 hours per day BID)
- New tracheotomy; including teaching

**Complex care is beyond routine skilled care where the client needs a higher level of monitoring and/or nursing intervention.*

DRG categories that are candidates for subacute include:

- Pulmonary/Respiratory
- Cardiac/Circulatory
- Orthopedic
- Gastrointestinal
- Pancreas, liver, gall bladder and spleen disease
- Cancers and malignancies
- Kidney, urinary tract
- Wound/skin
- Endocrine and metabolic disease

- Neurological/spinal
- Infections
- Amputations
- Trauma

Level 4: Clients that are outside the perimeters of Levels 1-3 are reviewed on a case by case basis for admission. Admission would be dependent on the Provider's competencies to administer the appropriate care and upon an agreement for reimbursement. (i.e. all ventilator care with and without weaning; nursing hours are greater than 6.5 PPD)

6.8.9 Claim Reconsiderations

Providers will receive a one time claim reconsideration if requests are submitted within 180 days of the determination (original EOP) date. After this time, reconsideration requests will no longer be accepted. Provider Reconsiderations must be submitted on mySanfordHealthPlan portal. Paper requests will not be processed or receive a response. Once you have access to the Provider Portal at sanfordhealth.org/Provider, select "InBasket" from the Menu bar, choose "New Message" and then "Provider Communication." A window with a drop down box will appear, at which time "Claim Reconsideration" should be chosen. Documentation is required for submission.

The following policy(s) are referenced on our secure portal in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Claim Re-Considerations (PR-014)

Medicare Advantage Claim Reconsideration:

In order to request an appeal of a denied claim, Provider must submit a request within 60 calendar days from the date of the denial. This request should include:

- Provider Claim Reconsideration Request Form (located on provider portal)
- Any clinical records and other documentation that support your case for reimbursement
- Waiver of Liability form , holding the enrollee harmless, regardless of the outcome of the appeal (For Non-Participating Providers

Submit Claim Reconsiderations by:

Provider Portal: ehealth-shp.healthsuiteadvantage.com
Mail: Sanford Health Plan Attn: Appeals, PO Box 9110, Sioux Falls SD 57109-1110
Fax: (605) 312-8217

6.8.10 Proof of Timely Filing

Sanford Health Plan participating providers are contractually obligated to file claims within 180 days. Sanford Health Plan processes a "clean claim" within 30 days of receipt of the claim and 60 days for a "non-clean" claim. In North Dakota, Sanford Health Plan will pay clean claims within 15 days of receipt of the claim. Therefore, all claims are to be paid or processed within 60 days. Required documentation includes screen prints from the billing system showing the date the claim was sent to the Plan. If claims are filed electronically, required documentation includes a dated screen print, with the documented name of the clearinghouse being used, of the claim being accepted without error by the Plan. Timely filing for Medicare Advantage is 365 days.

6.8.11 Claim Overpayments

Sanford Health Plan reviews paid claims to identify overpayments made to a provider. An overpayment is an amount paid by Sanford Health Plan to a provider in error.

Examples of overpayments include, but are not limited to:

(1) provider billing or claims processing errors, (2) duplicate payment for the same service, (3) payments for health services planned but not performed or for non-covered health services, (4) changes due to a member's eligibility including coordination of benefits. (5) itemized bill reviews can result in overpayment being identified.

6.9 Reporting Fraud, Waste, and Abuse (FWA)

Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone. Sanford Health Plan encourages providers, members, affiliates, facilities, vendors, consultants and contractors to report any suspected Fraud, Waste or Abuse to the SHP Compliance Officer directly by calling, emailing or anonymously through the hotline.

Sanford Health Plan will protect its corporate assets and the interests of its members, employers, and providers against those who knowingly and willingly commit fraud or other wrongful acts. We will identify, resolve, recover funds, report, and when appropriate, take legal actions, if suspected fraud, waste, and/or abuse have occurred.

A provider's submission of a claim for payment also constitutes the provider's representation the claim is not submitted as a form of, or part of, fraud, waste and abuse as listed below, and is submitted in compliance with all federal and state laws and regulations. The definitions of fraud, waste and abuse and examples follow.

Provider is responsible for providing guidance to employees, independent contractors, and subcontractors regarding how to report potential compliance issues. Provider is responsible for promptly addressing and correcting all issues brought to your attention.

Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents. Sanford Health Plan routinely verifies charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the member's medical record. All payments are subject to prepayment audits, post-payment audits and retraction of over-payments. Any amount billed by a provider in violation of this policy and paid by Sanford Health Plan constitutes an overpayment and is subject to recovery. A provider may not bill members for any amounts due resulting from a violation of this policy.

Prevention Techniques

Fraud, waste and abuse can expose a Provider, contractor, or subcontractor to criminal and civil liability. Waste is generally not considered to be caused by criminally negligent actions, but rather the misuse of resources.

Provider is responsible for implementing methods to prevent fraud, waste, and abuse. Listed below are some common prevention techniques. This list is not meant to be all-inclusive.

- Education related to Fraud, Waste and Abuse
- Validate all member ID cards prior to rendering service (Cross-checking with another form of government issued photo ID is a good practice.)
- Ensure accuracy when submitting bills or claims for services rendered
- Submit appropriate Referral and Treatment forms
- Avoid unnecessary drug prescription and/or medical treatment
- Report lost or stolen prescription pads and/or fraudulent prescriptions
- Screen all employees and contractors at time of hire/contract and monthly thereafter to prevent reimbursement of excluded and/or debarred individuals and/or entities. Two of the review resources are:
    - SAM– The Excluded Parties List System ("EPLS") is maintained by the GSA, now a part of the System for Awards Management ("SAM"). The EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and non-financial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States. sam.gov
    - LEIE – List of Excluded Individuals and Entities list is maintained by HHS OIG and provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, Marketplace and all Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. exclusions.oig.hhs.gov

How to report?

Sanford Health Plan requires everyone to exercise due diligence in the prevention, detection and correction of Fraud, Waste and Abuse (FWA). Sanford Health Plan promotes an ethical culture of compliance with all State and Federal regulatory

requirements, and mandates the reporting of any suspected or actual FWA to the Sanford Health Plan Compliance team. The compliance team can be reached by emailing SHPCompliance@sanfordhealth.org or calling the anonymous Compliance Hotline: (877) 473-0911.

Definitions and Examples:

Fraud is defined as: knowingly and willingly executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Health care fraud examples include but are not limited to the following:

- Misrepresentation of the type or level of service provided
- Misrepresentation of the individual rendering service

Waste is defined as: practices which directly or indirectly result in unnecessary costs such as overusing services. It is the misuse of resources.

Abuse is defined as: the practice of directly or indirectly, result in unnecessary costs and includes any practice inconsistent with providing patients with medically necessary services meeting professionally recognized standards.

Examples of abuse include:

- Billing for unnecessary medical services
- Charging excessively for services or supplies
- Misusing codes on a claim, such as upcoding or unbundling codes

6.10 Accident Policy

Accident information is essential for determining which insurance company has primary responsibility for a claim. Common situations where another insurance company may be liable for paying claims are motor vehicle accidents, or injuries at work. Sanford Health Plan contracts with Optum to contact members about claims which another party may be liable.

Claims are sent to Optum based on diagnosis codes. When sending claims, accident date should be on the claim. Members are contacted by Optum to investigate if a third party is liable. Claims will be denied if another party is responsible for the payment of the claim or there is no response from the member.

Optum's process is as follows. Sanford Health Plan will electronically send claim information to Optum daily. Optum then identifies possible accident related claims and calls the member three times by phone. If they are unable to reach them, they send out an inquiry questionnaire (IQ) and cover letter. The cover letter explains the relationship between Sanford Health Plan and Optum and why the information is needed. The IQ inquires whether the claim in question is due to an accident and gives the member a choice of providing the information to Optum on the questionnaire, or by calling Optum's toll-free number and talking directly to an Optum representative.

Once Optum has sent the IQ, they wait ten days for a response. If after ten days they have no response from the member, they send out a close out letter and wait another ten days for a response. The close out letter explains that Optum has been unsuccessful in their attempts to reach the member and will be required to notify Sanford Health Plan to deny the claim(s) in question.

If Optum has not received a response within this second 10-day period, they send advice to Sanford Health Plan to deny the claims in question for lack of information. This process normally takes approximately 25 days assuming Optum does not receive a response. Optum will identify about 10% of Sanford Health Plan's claims in 24 hours, 80% in 8 calendar days, 90% in 14 calendar days and 99% in 25 days. Optum's toll free number that members can call to relay the requested information is (800) 529-0577.

6.11 Coordination of Benefits

Coordination of Benefits (COB) is a provision that allows members to be covered by more than one health benefit plan and to receive up to 100% coverage for medical services. If

a member is covered by another health plan, insurance, or other coverage arrangement, then Sanford Health Plan and/or insurance companies will share or allocate the costs of the member's health care by a process called Coordination of Benefits. Sanford Health Plan follows all statutory and administrative laws concerning coordination of benefits, as applicable to the state in which the plan is domiciled.
The member has two obligations concerning Coordination of Benefits:

1. The member must inform Sanford Health Plan and/or their provider regarding all health insurance plans.
2. The member must cooperate with Sanford Health Plan by providing any information that is requested.

6.11.1 Applicability

The order of benefits determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is called the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

6.11.2 Order of Benefit Determination Rules

The Plan determines its order of benefits using the first of the following rules which applies:

6.11.3 Non-Dependent/Dependent

The plan that covers the person as a employee, policyholder, retiree, member or subscriber (that is other than as a dependent) is the primary plan. The plan that covers the individual as a dependent is the secondary plan. If the person is also a Medicare beneficiary, Medicare is:

- secondary to the plan covering the person as a dependent
- primary to the plan covering the person as other than a dependent

6.11.4 Dependent Child Covered Under More Than One Plan Who Has Parents Living Together

For a dependent child whose parents are married or living together (married or not) unless there is a court order stating otherwise,the order of benefits is:

- The primary plan is the plan of the parent whose birthday is earlier in the year.
- If both parents have the same birthday, the plan that covered either of the parents longer is primary.

6.11.5 Dependent Child of Separated or Divorced Parents Covered Under More Than One Plan

For a dependent child whose parents are not married, separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- If a court decree states that one of the parents is responsible for the child's health care expense and the plan is aware of the decree, the plan of that parent is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.
- If a court decree states that both parents are responsible for the child's health care expenses, health care coverage, or assigns joint custody without specifying responsibility, the rule for "Dependent Child Who Has Parents Living Together" will apply
- If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order is as follows:
    - o The plan of the custodial parent;
    - o The plan of the spouse of the custodial parent;
    - o The plan of the noncustodial parent; and then
    - o The plan of the spouse of the noncustodial parent.

6.11.6 Dependent Child Covered Under More Than One Plan of Individuals Who Are Not The Parents

The order of benefits shall be determined using the rule for "Dependent Child Who Has Parents Living Together" as if the individuals were the parents of the child.

6.11.7 Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- Primary, the benefits of a plan covering the person as an Employee, Member, or Retiree Subscriber (or as that person's Dependent);
- Secondary, the benefits under the continuation coverage.

6.11.8 Longer or Shorter Length of Coverage

If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

6.11.9 Primary Plan Determination

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

6.12 Calculation of Benefits, Secondary Plan

When Sanford Health Plan is secondary, we shall reduce benefits so that the total benefits paid or provided by all plans for any claim or claims do not exceed more than 100 percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, we calculate the benefits that we would have paid in the absence of other insurance and apply that calculated amount to any allowable expense that is unpaid by the primary plan. We may reduce our payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

6.13 Coordination of Benefits with Medicare

Medicare benefits provisions apply when a member has health coverage under Sanford Health Plan and is eligible for insurance under Medicare Parts A and B, (whether or not the member has applied or is enrolled in Medicare). This provision applies before any other coordination of benefits provision of Sanford Health Plan.

If a provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Our allowable expense is the Medicare allowable amount. We will pay the difference between what Medicare pays and our allowable expense.

The Plan shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage. Sanford Health Plan will make this determination based on the information available through CMS.

6.14 Coordination of Benefits with Medicaid

A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of the member. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and Sanford Health Plan will honor any subrogation rights the State may have with respect to benefits that are payable. When an individual covered by Medicaid also has coverage with Sanford Health Plan, Medicaid is the payer of last resort. If also covered under Medicare, Sanford Health Plan pays primary, then Medicare, and Medicaid is tertiary. See provisions below on Coordination of Benefits with TRICARE, if a member is covered by both Medicaid and TRICARE.

6.15 Coordination of Benefits with TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent

that the service provided is also covered under the other plan. Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans. TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim. When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last). TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Coverage in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

6.16 Coordination of Benefits for Medicare Advantage

Medicare Coordination of Benefits - If the provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when the Medicare Advantage Plan pays secondary.

Other coverage is primary over a Medicare Advantage plan in the following instances:

- Aged employees: For members who are entitled to Medicare due to age, a commercial plan is primary over the Medicare plan if the employer group has 20 or more employees.
- Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, a commercial plan is primary to the Medicare plan if the employer group has 100 or more employees.

6.17 Members with End Stage Renal Disease (ESRD)

The Plan has primary responsibility for the claims of a Member:

a. Who is eligible for Medicare secondary benefits solely because of ESRD, and;

b. During the Medicare coordination period of 30 months, which begins with the earlier of:

i. the month in which a regular course of renal dialysis is initiated, or

ii. in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

The Plan has secondary responsibility for the claims of a Member:

a. Who is eligible for Medicare primary benefits solely because of ESRD, and;

b. The Medicare coordination period of 30 months has expired

6.18 Billing Requirements

6.18.1 Multiple Surgeries

Multiple surgeries are defined as multiple procedures performed at the same session by the same provider. Sanford Health Plan allowances are reduced for multiple surgical procedures. Multiple surgical procedures should be identified with a modifier 51. Multiple surgery fees should not be billed pre-cut. Sanford Health Plan uses the following payment structure for multiple surgery claims.

- 100% of the fee schedule for the highest allowable procedures
- 50% of the fee schedule for the second highest allowable
- 50% of the fee schedule for any additional surgical procedures

6.18.2 Bilateral Procedures

If a procedure is performed on both sides of the body it is considered to be bilateral. Bilateral procedures are identified with a modifier 50. Bilateral procedures should be billed on one line. See the below example.

Example: Bilateral procedures billed on one line (two services).

CPT	Modifier	Description	Charges	Units
69210	50	Removal of impacted cerumen requiring instrumentation, unilateral	$400.00	1

To ensure accurate payment, please make sure to bill the full billed amount versus billing with the pre-cut amount. We are not able to recognize a claim pre-cut, and our system will cut according to the bilateral procedures guidelines.

6.18.3 Assistant at Surgery

Assistant at Surgery claims can be identified by modifier 80, 81, 82 or AS. Claims with modifiers 80, 81, 82 or AS will be adjudicated according to the CMS guidelines for Assistant at Surgery and should not be billed pre-cut. Surgeries that allow an Assistant at Surgery will be reimbursed 20% of the applicable allowable.

The list of codes eligible for Assistant at Surgery reimbursement will follow the Assistant at Surgery indicator published by CMS in the National Physician Fee Schedule Relative Value File, released annually in the Fall prior to the effective date in January. Sanford Health Plan will not apply any CMS mid-year updates.

Claims will be denied for those surgeries that do not require an Assistant at Surgery and these charges should not be billed to the member. Participating providers are contractually obligated to write off Assistant at Surgery fees that are not covered by Sanford Health Plan. Requests for reconsideration of denied Assistant at Surgery charges must be received within 60 days for Medicare Advantage and within 180 days for all other products. The denial date on the EOP and can be submitted using the claim reconsideration form found online. Please include a reference to the claim number, code(s) being asked for reconsideration and a copy of the medical record.

6.18.4 OB/GYN Global Package Billing/Antepartum Care

Claims must be submitted within 180 days from the date of delivery. After this time frame has expired, claims will no longer be reviewed. Required documentation includes date of delivery.

6.18.5 Newborn Additions

A newborn is eligible to be covered from birth. Members must complete and sign an enrollment application form requesting coverage for the newborn within 31 days of the infant's birth. Because of this timeframe to add newborn dependents to a policy, providers should not file claims prior to the 31 days of an infant's birth. Claims received prior to the newborn being added to a policy may be denied or rejected electronically as "member not eligible." Providers will need to re-file claims timely after the newborn is enrolled for proper claims processing and reimbursement.

6.18.6 Never Events, Avoidable Hospital Conditions and Serious Reportable Events

Never events, avoidable hospital conditions, and serious reportable events are defined in the following table. The definitions have been developed by the National Quality Forum and CMS in collaboration with multiple partners, including the AMA.

Avoidable Hospital Conditions	Conditions which could have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients and that identify a problem in the safety and credibility of a health care facility.
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of an individual or a loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility. Serious events also include loss of a body part and death.

Sanford Health Plan does not provide reimbursement for services associated with a Never Event, Avoidable Hospital Condition, or Serious Reportable Event when permitted by contract. Providers are not permitted to bill members for these services and must notify the Plan, within five days of the occurrence.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" at sanfordhealth.org/Provider.

- Quality of Care (MM-GEN-030)

6.18.7 Site of Service Differential

Site of Service Differential: Some professional services may be provided either in a facility or a non-facility setting. When a professional service is provided in a facility, the costs of the clinical personnel, equipment, and supplies are incurred by the facility, not the physician practice. For this reason, reimbursement for professional services provided in a facility may be lower than if the

services were performed in a non-facility setting. This difference in reimbursement, based on where the professional service is performed, is referred to as a "site of service differential."

In accordance with CMS guidelines, professional providers will be reimbursed based on the site of service where the selected procedures are performed. Only codes that have a site of service differential are included in Sanford Health Plan's list of applicable procedures for differential reimbursement. This only applies to provider contracts that include Site of Service differential.

The CPT® codes and nomenclature used in this Policy are subject to revision and/or change by the American Medical Association. In the event of such changes, the Policy will continue to be in force, albeit applied to the new or amended coding so issued until such time as the Policy is reviewed and updated to reflect the new or amended coding.

Sanford Health Plan uses CMS's list of procedure codes where there is a difference between the facility and non-facility RVUs that are in effect at the time Sanford Health Plan's current fee schedule year was implemented. Sanford Health Plan will review the list of site of service procedures codes and places of service upon contract renewal.

The table below includes current national place of service code set information that identifies the facility and non-facility designations for each code.

POS	Description
02	Telehealth
19	Outpatient Hospital – Off campus
21	Inpatient Hospital
22	Outpatient Hospital – On campus
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
26	Military Treatment Facility
31	Skilled Nursing Facility (SNF) – Part A
34	Hospice
41	Ambulance - Land
42	Ambulance – Air or Water
51	Inpatient Psych Facility
52	Psych Facility – Partial Hospitalization
53	Community Mental Health Center
56	Psych Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

6.18.8 Anesthesia

Anesthesia is the administration of a drug or anesthetic agent by an anesthesiologist or certified registered nurse anesthetist (CRNA) for medical or surgical purposes to relieve pain and/or induce partial or total loss of sensation and/or consciousness during a procedure. Sanford Health Plan covers the administration of anesthesia for medically necessary services rendered to Sanford Health Plan members.

Medically directed anesthesia: Sanford Health Plan utilizes the base value unit, as reported by CMS, and the actual time units necessary to perform the anesthesia service to determine its reimbursement amount. The physician and the CRNA shall append the appropriate modifiers to all anesthesia services provided. Services submitted with medical direction or supervision, modifiers AD, QK, QX, or QY, will be reimbursed at 50% of the allowed amount, due to the supervision/services shared between two providers. Time-based anesthesia services must be reported with actual anesthesia time in one-minute increments. Anesthesia time calculates a unit for every 15 minute interval, rounding up to the next unit for 8-14 minutes, rounding down for 1 to 7 minutes. Sanford Health Plan will not reimburse for services billed by anesthesia students.

Billing instructions:

- Services involving administration of anesthesia require the use of a valid five digit procedure code plus the appropriate modifier code.
- Providers are to bill the full charge amount for services.
- Report elapsed time in minutes in item 24g on the CMS-1500 claim form.
- Convert hours to minutes and enter total minutes.

Time-Based Anesthesia claims are typically paid based on the following:

([Base Unit + Time Units] x Anesthesia Conversion Factor) x Modifier Percentage

Modifier Code	Description	Allowance of Fee Schedule
AA	Anesthesia services performed personally by an anesthesiologist	100%
AD	Medically supervised by a physician, more than four concurrent anesthesia procedures.	50%
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: with medical direction by a physician	50%
QY	Medical direction of one CRNA by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%

Labor Epidurals - Time related to neuraxial labor anesthesia is different than operative anesthesia according to the American Society of Anesthesiologists (ASA). The number of minutes and charges billed should only reflect the time the anesthesiologist or CRNA is present for preparation, insertion and monitoring of the epidural which should coincide with the intensity and direct time involved for performing and monitoring neuroaxial labor analgesia. Complications that are present and that require the constant attendance of the anesthesiologist or CRNA should be billed appropriately with time unites that reflect the full time the epidural catheter is in place but should not be the standard. Consistent with a method described in the ASA guidelines, Sanford Health Plan will cap the Time Units used to reimburse labor epidurals (CPT code 01967) at 5 Units (75 minutes) unless constant attendance by an anesthesiologist or CRNA is medically necessary.

([Base Unit + Time Units (Not to Exceed 5)] x Anesthesia Conversion Factor) x Modifier Percentage

6.18.9 Outpatient Pre-Labor Monitoring Services

Sanford Health Plan separately reimburses outpatient pre-labor monitoring services based on individual provider contract percent of charges. The following billing and claim submission requirements will apply:

Billing instructions:

- Providers must bill pre-laboring monitoring services with revenue code 072x – Labor Room/Delivery (excluding revenue code 0723 – circumcision).
- Providers must bill the following HCPCS code for these services:
  - S4005: Interim labor facility global (labor occurring but not resulting in delivery)
- Units must reflect the number of hours the patient was being monitored.
- Pre-labor monitoring using revenue code 072x and HCPCS S4005 should not be submitted on the same claim as observation using G0378 as this reflects duplication of services.
- Additional nursing charges in the labor/delivery room are not separately billable.
- Fetal monitoring and fetal stress or non-stress tests should be billed using revenue code 0732 with the appropriate CPT®/HCPCS code.

Additional claims criteria:

- Patient presents with early labor and is sent home and then subsequently delivers at a later date; appropriate to submit separate charges or payment for pre-labor monitoring services.
- Patient presents on multiple, distinct, encounters with early labor; each encounter should be submitted separately
- Patient delivers while being monitored for early labor; no separate outpatient charges or payment should be submitted and should subsequently be included in the inpatient delivery stay.
- Other ancillary services will continue to be billed separately on the same claim.
- Additional services submitted will be subject to APC logic when the provider is under an APC contract.
- OM, functional maintenance

6.18.10 Home Health Care Services

Home health care is a wide range of health care services that can be given in your home for an illness or injury. Home health care is usually less expensive, more convenient, and considered just as effective as care received in a hospital or skilled nursing facility (SNF). Home health care services are billed using a combination of revenue codes, HCPCS codes and units. Units are calculated for every 15 minute interval for which services were rendered.

Home Health Service	Revenue Code	HCPCs Code
Skilled nurse visit	550 or 551	G0299 or G0300 or successor codes
Physical therapy visit	421	G0151 or successor codes
Occupational therapy visit	431	G0152 or successor codes
Speech therapy visit	441	G0153 or successor codes
Home health aid visit	571	G0156 or successor codes

6.18.11 Hospice and Respite Care Services

Hospice services are for those who are terminally ill (with six months or less to live). The goal of hospice is to provide comfort for terminally ill patients and their families, not to cure illness. Respite care is a very short inpatient stay given to a hospice patient so that the usual caregiver can rest. Hospice and respite services are to be billed with the appropriate revenue code in box 42 of the UB-04 claim form.

Hospice Service	Revenue Code
Home Care (routine)	651
Home Care (continuous)	652
Inpatient Respite Care	655
General Inpatient	656

6.19 Ambulatory Payment Classification (APC) Payment for Outpatient Services

Sanford Health Plan implemented APC pricing methodology for outpatient service in 2016. We follow the general principles, billing, pricing, and edit guidelines of the Center for Medicare and Medicaid Services (CMS) outpatient prospective payment/ambulatory payment classifications (OPPS/APC's) unless otherwise stated in individual contracts. APC methodology is used for covered outpatient services at Prospective Payment System hospitals and General Acute Care facilities.

Sanford Health Plan uses Optum's EASYGroup™, ECM Pro, Client Hosted Web. Strat Rate Manager APC software to deliver Ambulatory Payment Classification (APC) pricing methodology for outpatient services billed via the UB-04 claim (or electronic equivalent) with bill types 13X or 14X. This product seamlessly integrates with Sanford Health Plans' EPIC Tapestry host systems. We began using Ambulatory Payment Classification (APC) pricing methodology to help control cost and utilization of services. This is the result of a national trend in decreased inpatient volume and an increase in outpatient services. It is intended to provide an opportunity to level set for both the provider and payer, while reimbursing the provider for the resources utilized for the services.

APC pricing/methodology is not considered for:

- Durable Medical Equipment (DME) services. Providers will need to submit separate claims for these services;
- Ambulance services. Providers will need to submit separate claims for these services;
- Critical Access Hospitals;
- Indian Health Service Hospitals;
- Maryland hospitals under PPS waiver;
- Hospitals in Guam, Saipan, America Samoa, and the Virgin Islands;
- Partial Hospitalization. Payment for outpatient
  mental health services are will be based on one of five H or S codes;

- Physician/professional services. Providers will need to submit separate claims for these services.

6.19.1 APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an APC group. The payment rate for an APC applies to all of the services assigned to the APC. APC payment rates are calculated using the following methodology: (Provider specific conversion factor x APC-specific weight). A hospital may receive a number of APC payments for the services furnished to a patient on a single day on the same claim; however, certain services are subject to discounting for multiple procedures. Services within an APC are similar clinically and with respect to hospital resource use.

6.19.2 APC Billing Rules

Sanford Health Plan will follow CMS APC billing guidelines including:

- Instances where CMS requires an alternative code (ex. Observation, clinic, MRIs);
- CPT/HCPCS code on lines with Self-Administrable Drugs (Rev Code 637);Outpatient observation services and pay observation on a comprehensive APC basis;
- Packaging rules within CMS Outpatient Code Editor (OCE);
- Late charges – a corrected claim must be submitted if all services are not included on the original claim.

Sanford Health Plan deviates from CMS on the following guidelines:

- Chemotherapy Medications: Imatinib, 100 mg, for both Imatinib and Gleevac will require HCPCS S0088 to be billed for appropriate payment.
- Invalid Billing of Device Credit Logic: These condition codes, value amounts, and value codes will be accepted but not required. Payment will be adjusted, similar to Medicare's pricing policy, when the condition codes, value amounts, and value codes are submitted on a claim.
    - Condition Codes 49 or 50
    - Value Amount on claims that include Value Code FD
- Observation: The Plan will process and reimburse observation claims spanning greater than 72 hours as follows:
    - The first 72 hours of observation will be billed on one UB-04 claim line with the admit date of service;
    - Any additional hours over 72 will be billed on a separate UB-04 claim line with a different date of service than the admit date.
    - These two lines of observation, reflecting the entire stay, must be billed on the same UB-04 claim form.
    - For observation billing, the admit date of service is defined to be the date when observation services are initiated.
- Pre-labor Monitoring: Pre-labor monitoring services should be submitted according to SHP guidelines. Providers should submit revenue code 072x, excluding 0723 (circumcision) for pre-labor monitoring services using HCPCS S4005. The units should reflect the number of hours the patient was being monitored.
- Take Home Drugs/Supplies and Self-Administrable Drugs: The following revenue codes require valid HCPCS codes and should be submitted with the most specific code available.
    - 0253: Take Home Drugs
    - 0273: Take Home Supplies
    - 0637: Self-Administrable Drugs

(Providers should not use HCPCS code A9270, non-covered item or service, as this is a member liable denial per benefit design.) Any take-home drugs or supplies without a specific code should be submitted on the generic revenue codes below:

- 0250: Pharmacy, General
- 0259: Pharmacy, Other
- 0270: Medical/Surgical Supplies, General

For services submitted with a HCPCS code, reimbursement will be driven off of the OPPS

status indicator associated with the procedure code submitted and will be reimbursed either at the fee schedule rate or the default percent of charges per the provider's contract. Services submitted under one of the generic revenue codes above will be either packaged into the reimbursement for the other primary services on the claim that were paid under APC's or they will be reimbursed at the default percent of charges per the provider's contract.

- Therapy services: These modifiers and G-codes will be accepted but not required.
  - o Modifiers GN, GO, GP
  - o Non-payable therapy G-codes
  - o Functional severity Modifiers (CH – CN)

Payment rules for Partial Hospitalization and Intensive Outpatient Treatment: Payment for outpatient mental health services will be based on Rev Codes or one of five H or S HCPCS codes below per individual contract language.

Code	Description	Service Type
S9480	Intensive outpatient psychiatric services, per diem	IOP
H2035	Alcohol or other related drug treatment program, per hour	IOP
H0015	Alcohol and/or drug services	IOP
H0035	Mental PHP, treatment, less than 24 hours	PHP
S0201	Partial hospitalization services, less than 24 hours, per diem Service type	PHP
H2036	Alcohol and/or other drug treatment program, per diem Service	IOP
H0001	Alcohol and/or drug assessment	IOP
H0002	Behavioral health screening to determine eligibility for admission to treatment program	IOP

Codes mapped out of relevant OCE and paid at either fee schedule rate or default to percent of charge due to differences in demographic and benefit design.

Outpatient Code Editor (OCE) Number	Description
12	Questionable covered service
18	Inpatient procedure
21	Medical visit same day as significant procedure without modifier 25
29	Partial hospitalization service non-mental health diagnosis
30	Insufficient services on day or partial hospitalization
35	Only mental health education and training services provided
45	Inpatient separate procedures not paid
46	Partial hospitalization condition code 41 not appropriate for bill type
49	Service on same day as inpatient procedure
61	Service can only be billed to the DMERC
65	Revenue code not recognized by Medicare
80	Mental health code not approved for Partial Hospitalization Program
81	Mental health services not payable outside Partial Hospitalization Program

6.19.3 APC Pricing Rules

Sanford Health Plan will follow CMS APC pricing rules including the following:

- CMS APC Weight File
- CMS Lab packaging(PSI Q4)
- CMS Lab paneling / multi-channeling logic
- Limit fee schedule payment to line item charge (i.e. Lab, DME, Therapies)
- Cost outliers pricing logic applied
  - o Source for ratio of cost to charge (RCC) will be CMS value effective based on date quoted in provider contract. RCC will be held constant until the updating processing associated with the next provider contract year
  - o Cost outlier payment percent to be comparable to CMS (ex. 50%) effective at the start of the contract year
  - o Source for payment factor (ex. 1.75) will be CMS value effective at the start of the contract year

- Source for fixed threshold (ex. $3,250) will be CMS value effective at the start of the contract year

Sanford Health Plan will also apply the following guidelines:

- Claim level lesser of logic
- Provider specific conversion factors
- No wage adjustments
- Categories of covered codes with no specific pricing will default to specific % of charge stated in the contract (i.e. Inpatient Only Procedures PSI C, dialysis on TOB 13x/14x)
- Vaccines (PSI F and L): Pay based on code specific fee schedule amounts where available. If no fee schedule available, pricing will default to contract specific rate percent of billed charges
- CMS fee schedules for North Dakota, South Dakota, and Minnesota will be used based on where services were rendered

6.19.4 OCE Edits

The role of OCE is to edit claims for errors, notify Sanford Health Plan what action to take with a "problem" claim, assign payment categories/groups and pre-process data for APC pricing. Editing categories used in OCE include:

- Validity edits
- Invalid age
- Invalid sex
- Diagnosis/procedure and age or sex conflicts
- Appropriate use of modifiers
- Volume/unit edits
- Revenue code that require HCPCS codes
- Conditions not payable under OPPS per CMS regulations
- National Correct Coding Initiative (CCI)
- Edits that implement payment policies
- Plan/DME exclusions
- Composite APCs

Due to OCE claim edits, your claim may be returned or denied.

OCE Edit	OCE Edit Description
001	Invalid Diagnosis Code
005	E-Code as Reason for Visit
006	Invalid HCPS Procedure Code: invalid code, or code invalid for service dates
027	Only incidental services reported
048	Revenue center requires HCPCS code
H2012	Behavioral health day treatment, per hour

APC Updates:

Sanford Health Plan will review updates released by CMS.

These updates may result from:

- Changes in technology
- Changes in CPT codes
- Codes removed from Inpatient Only List
- New procedures or services
- Changes in resources used to perform services

Updates include: Quarterly updates to:

- New CMS codes
- OCE files including CMS CCI/MUE (Medically Unlikely Edits
- CMS Payment weights
- Packaging rules within CMS Outpatient Code Editor (OCE)

Annual updates to:

- Payment adjustments
- Reweighting of conversion factor implemented based on the January CMS date
- RCC factor based on latest RCC available for Optum through HCRIS
- APC Grouper Version
- The Plan will apply updates for applicable APC groupings, new codes, and weights according to the final rule published by CMS quarterly.

1.

1. The Plan will delay implementation of the quarterly update one calendar month to provide adequate time for review of CMS updates, configuration, and testing.
    - o May 1
    - o August 1
    - o November 1
    - o February 1
2. Claims received by the Plan during one month interim will be reimbursed according to the groupings, weights, and codes in the payment system at the time received which will reflect the previous quarter's updates based on date of service.

    Example: Claims submitted with January dates of service in January will be reimbursed according to the groupings, weights, and codes from the 4th quarter of the previous year
3. Claims received by the Plan after the one month delay will be reimbursed according to the updated file in the payment system at the time received based on date of service.

    Example A: Claims submitted with February dates of service in February will be reimbursed according to the groupings, weights, and codes from the 1st quarter of that year.

    Example B: Claims submitted with January dates of service in February will be reimbursed according to the groupings, weights, and codes from the 4th quarter of the previous year.
4. Claims incurred by the Plan during the one month interim will not be reprocessed by The Plan.
5. The Plan will reimburse any new codes according to the contracted Outpatient All Other Services % of charge for claims received by The Plan during one month delayed implementation.
6. For the January CMS update, the Plan will implement an adjustment factor budget neutral to the Plan based on the aggregate weight change between the new APC weights and the current weights derived from historical claims.

Sanford Health Plan Provider Contracting will send annual reimbursement notice that will include conversion factor and RCC.

We will provide notice of action plan in the event CMS has a delay in releasing updates.

We encourage providers to visit the following CMS website links for further details regarding APC claim processing.

Addendum A and B Updates where APC states codes are updated

General CMS Hospital Outpatient OPPS Information

National Correct Coding Initiative Edits/ MUE's:

Select facility outpatient services MUE table at the bottom of the page.

Members

7.1 Problem Resolution

Members, providers with knowledge of a member's condition or an authorized representative have the right to file a complaint or appeal of any adverse determination made by Sanford Health Plan.

- The Member has the right to participate in decisions and express preferences regarding his or her health care, including traditional, alternative, and non-treatment options and each option's associated risks, benefits, alternatives and consequences, if applicable.
- If the Member's plan based in Minnesota, providers are not required to obtain the member's signature to file an appeal or complaint.
- Medicare Advantage members can appoint a representative to file a complaint (grievance) on their behalf. This may be a relative, friend, lawyer, advocate, health care provider, or anyone else to act on your behalf. The member should complete the CMS Appointment of Representative form (CMS Form 1696). Once compete the form can be mailed or faxed to:
  Sanford Health Plan
  PO Box 91110, Sioux Falls, SD 57109
  or Fax to (605) 312-8217.
- ND Medicaid Expansion will is no longer administered by SHP. However, you should follow the below instructions for services that happened prior to 1/1/2022.
- For ND Medicaid Expansion, the member's signature is required.
- Appeals by a Member, an Authorized Representative of the Member (as designated in writing by the Member) or Provider and/or Practitioner (with written consent from the Member) must be made within 180 calendar days from the date printed on the notification of an Adverse Benefit Determination.
- Requests for a State Fair Hearing, through the State of ND Department of Human Services, must be made within 120 days of the appeal determination made by Sanford Health Plan. Note that Non-Covered Service Determinations are not eligible for State Fair Hearings.
- Grievances (complaints) may be filed orally or in writing by the Member, an Authorized Representative of the Member (as designated in writing by the Member) or Provider and/or Practitioner (with written consent from the Member) at any time with Sanford Health Plan.
- Help is available to assist with any of these processes by contacting Customer Service at (855) 305-5060. If a Member wishes the services being appealed to continue during an appeal, the appeal must occur within 10 calendar days of receiving the notice of Adverse Benefit Determination. The Member may be required to pay for the disputed services provided while the appeal decision is pending if the final decision is determined to be unfavorable.
- For all other plans, the provider may only file an appeal or complaint on the member's behalf without the member's

signature if the situation is considered urgent (waiting the routine processing time may seriously jeopardize the member's life or health, ability to regain maximum function or subject them to severe pain that cannot be managed without the service or treatment).

7.1.1 Oral and Written Complaints

An oral complaint can be submitted by calling Customer Service.

Written complaints can be submitted by mail or fax by accessing the Appeals and Denials Complaint Form found in Provider Resources.

7.2 Appeals

7.2.1 Expedited Appeal

Providers may request an urgent (or expedited) appeal on behalf of the member without the member's signature (except for ND Medicaid Expansion members). To determine when an appeal may be considered urgent, please see the Plan's definition above.

7.2.2 Prospective Appeal

A pre-service appeal may be requested for covered services as described above if an authorization request is denied in whole or in part. Determinations will be made within 30 days unless additional information is required; in these cases a time extension may occur. The member, their authorized representative and the provider will be sent a determination letter after the review has occurred.

7.2.3 Retrospective Appeal

A post-service appeal may be requested as described above if a service has already occurred. After an appeal is received, a determination will be sent via mail within 30-60 days to the member, their representative and the provider involved in the appeal to inform them of the plans decision.

Members have the following deadlines to file an appeal:

- 60 days for ND Medicaid Expansion members
- 180 days for most plans
- No deadline for Minnesota Members

For more information or questions about the complaint or appeals process visit the Provider Portal to view the full policy or contact the Appeals and Denials Department at (877) 652-8544.

7.3 Member Rights

7.3.1 South Dakota, Iowa, Minnesota and North Dakota Member Rights:

The Plan is committed to treating members in a manner that respects their rights. In this regard, the Plan recognizes that each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; gender identity; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; national origin; age; or sources of payment for care, in accordance with access and quality standards.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right to request and receive a copy of medical records used by the plan during a coverage determination from their originating provider and to request any amendments or corrections. No copies will be forwarded from the health plan (NDME Only).

5. Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
6. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Federal and State laws.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
8. Members have the right to a candid discussion with the practitioner(s) and/or Provider(s) responsible for coordinating appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners and/or Providers in decision-making regarding their treatment plan.
9. Members have the right to give informed consent before the start of any procedure or treatment.
10. When Members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and read.
12. Members have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.
13. Members have the right to appeal any decision regarding medical necessity made by the Plan and its Providers.
14. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.
15. Members have the right to receive information about the organization, its services, its Providers and Members' rights and responsibilities, in accordance to 42 CFR §438.10 (NDME Only).
16. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
17. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, or the use of restraints and seclusion (NDME Only).

7.3.2 Minnesota Member Rights:

In accordance with the Minnesota Department of Health, and the National Committee for Quality Assurance (NCQA), you have certain rights as member of Sanford Health Plan of Minnesota, including the following:

1. COVERED SERVICES. These are network services provided by participating Sanford Health Plan network providers or authorized by those providers. Your Policy fully defines what services are covered and described procedures you must follow to obtain coverage.
2. PROVIDERS. Enrolling with Sanford Health Plan does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the Sanford Health Plan network, you must choose amount from remaining Sanford Health Plan network providers.
3. EMERGENCY SERVICES. Emergency services from providers outside the Sanford Health Plan network will be

covered only if proper procedures are followed. Read this Policy for the procedure, benefits and limitations associated with emergency care from Sanford Health Plan network and non-Sanford Health Plan network providers.

4. EXCLUSIONS. Certain service or medical supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
5. CANCELLATION. Your coverage may be canceled by you or Sanford Health Plan only under certain conditions. Read your Policy for the reasons for cancellation of coverage.
6. NEWBORN COVERAGE. A newborn infant is covered from birth. Sanford Health Plan will not automatically know of the newborn's birth or that you would like coverage under this Plan. You should notify Sanford Health Plan of the newborn's birth and that you would like coverage. If your Policy requires an additional payment for each dependent, Sanford Heath Plan is entitled to all enrollment payments due from the time of the infant's birth until the time you notify the Plan of the birth. Sanford Health Plan may withhold payment of any health benefits for the newborn infant until any enrollment payment you owe is paid.
7. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT. Enrolling with Sanford Health Plan does neither guarantees that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Policy year.

ENROLLEE BILL OF RIGHTS (Minnesota Only)

1. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
2. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
3. Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers.
4. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
5. Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
6. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

7.4 Member Responsibilities for Minnesota, North Dakota, Iowa, and South Dakota

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incapacitated) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are

responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.

2. Members are responsible for carrying their Plan ID cards with them, and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services. Members are responsible for following all access and availability procedures.
3. Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, Members are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State law in North Dakota, Iowa, and South Dakota requires that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
4. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice.
5. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
6. Members are responsible for following their treatment plan as recommended by the Provider primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health care conditions, including mental health and/or substance use disorders.
7. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
8. Commercial Members are responsible for notifying the Plan through their employer within thirty (30) days if they change their name, address, or telephone number. Medicaid Expansion Members are responsible for notifying the North Dakota Department of Human Services Division of Medical Services within ten (10) days at toll-free at
(844) 854-4825 | ND Relay TTY: (800) 366-6888 (toll-free) if they change their name, address, or telephone number. NDPERS Members are responsible for notifying NDPERS within thirty-one (31) days if they change their name, address, or telephone number.
9. Commercial Members are responsible for notifying their employer and/or the Plan of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan. NDPERS Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. NDPERS is responsible for notifying the Plan.

Online Tools, Publications and Forms

Sanford Health Plan offers online tools specifically designed to help you obtain the information you need as quickly as possible.

8.1 mySanfordHealthPlan Provider Portal

*my*SanfordHealthPlan provider portal is Sanford Health Plan's online portal available to providers. Through this secure online tool, you have access to information 24/7. With *my*SanfordHealthPlan provider portal you will be able to:

- Request prior authorizations
- View copay, deductibles, coinsurance and out-of-pocket totals for members
- Verify member eligibility and view covered family member(s)
- Submit medical and pharmacy prior authorizations and online claim reconsiderations
- Access the provider manual and policies
- Check status of claims
- Obtain copies of Explanation of Payments

To request a *my*SanfordHealthPlan provider portal account, follow these steps:

1. Go to sanfordhealth.org/Provider
2. Click on "Request Access"
3. Enter all the required account information on the following screens, then click "Finish"

Your information will then be submitted to be reviewed for approval. Once your account has been approved you will receive an email from Sanford Health Plan Provider Relations. Afterward, you will be able to log on to your provider account using the User ID and Password you created upon setting up your account.

If you have any questions or need assistance with setting up an account, please contact Provider Relations at (605) 328-6877 or (800) 601-5086. Choose option 2 and then option 4. You can also send an email to providerrelations@sanfordhealth.org.

8.2 Provider Directory

You can access the provider directory on our site sanfordhealthplan.com. On the home page, click on the "Find a doctor" it is located in the middle of the page in the blue section on the right hand side.

8.3 Forms

For your convenience, you will find our forms posted outside the secure login of *my*SanfordHealthPlan for providers. Some of our commonly used forms include: Claim Reconsideration Form, credentialing applications for providers, Provider Information Update/ChangeForm, Health Management Referral Form and more. To access a form, CLICK HERE.

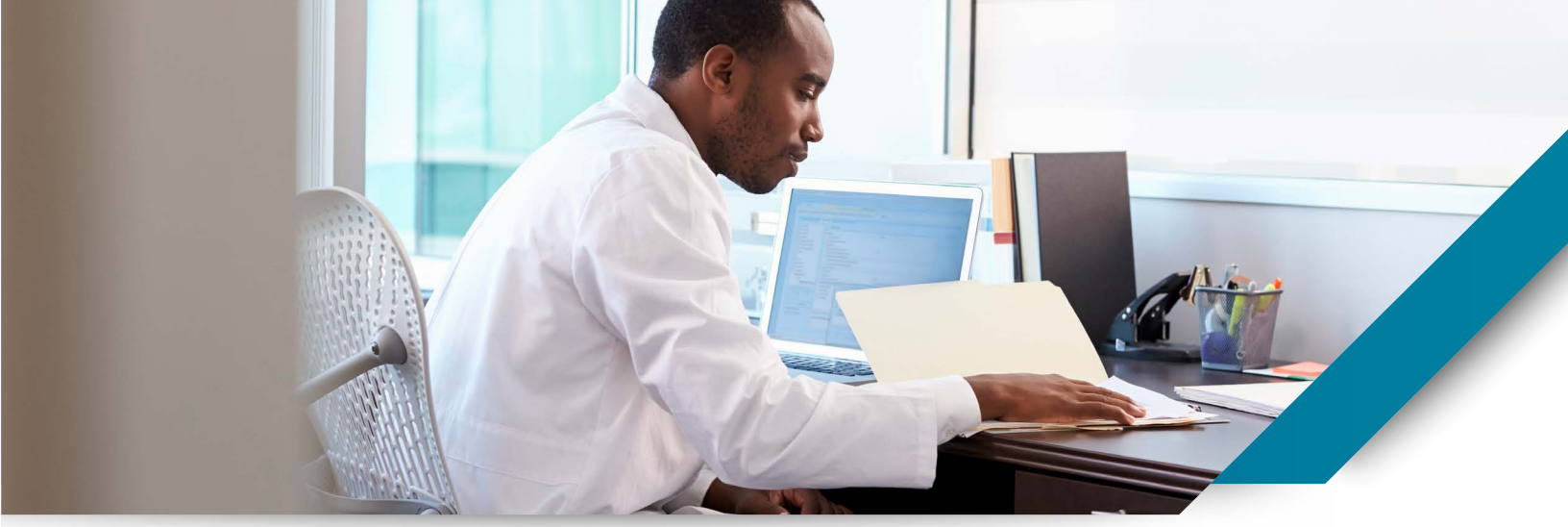
8.4 Sanford Health Plan ID Card and Benefit Card

What do our ID cards look like? The answer depends on our products and services. We created a document that gives you a high level overview of our ID cards and basic information. To view or print a sample CLICK HERE go to Documents and select "Sanford Health Plan ID cards.

The Benefit Card is a special purpose Visa® card that gives members an easy, automatic way to pay for eligible healthcare expenses. The card is given to members who sign up for a medical FSA (Flexible Spending Account), Health Reimbursement Account (HRA) or Health Savings Account (HSA). To view or print a sample CLICK HERE.

8.5 Provider Newsletters

The *Provider Perspective* and *Fast Facts* are electronic newsletters for providers and their office staff. With each newsletter, we share information about a variety of topics to keep you up-to-date. You can view past issues or sign up to receive the newsletter on our provider website, CLICK HERE.



Appendix

9.1 Glossary of Terms

Terms/Common Acronyms	Definitions
270 (ANSI ASC X12) Electronic Eligibility/ Benefits Request	Type of EDI Transaction: Health Care Eligibility/Benefit Inquiry(From Provider)
271 (ANSI ASC X12) Electronic Eligibility/ Benefits Response	Type of EDI Transaction: Health Care Eligibility/Benefit Response (From Health Plan)
276 (ANSI ASC X12) Electronic Claims Status Request	Type of EDI Transaction: Health Care Claim Status Request (From Provider)
277 (ANSI ASC X12) Electronic Claims Status Response	Type of EDI Transaction: Health Care Claim Status Notification(From Health Plan)
278 (ANSI ASC X12) Electronic Authorization Certification /Review Information	Type of EDI Transaction: Health Care Service Review Information
820 (ANSI ASC X12) Electronic Premium Payment	Type of EDI Transaction: Payroll Deducted and other group Premium Payment for Insurance Products
834 (ANSI ASC X12) Electronic Eligibility	Type of EDI Transaction: Benefit Enrollment and Maintenance Set
835 (ANSI ASC X12)ERA (Electronic Remittance Advice)	Type of EDI Transaction: Health Care Claim Payment/ Advice Transaction Set (Electronic Remittance)
837 (ANSI ASC X12) Electronic Claim (837P / 8371)	Type of EDI Transaction: Health Care Claim Transaction Set(Inbound / Outbound / Professional / Institutional)
A	
Accountable Care Organization (ACO)	A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.
Actuary	A professional who works with statistics and large numbers. In insurance, an actuary leads analytics, underwriting, pricing, benefit design, and financial performance activities.
Terms/Common Acronyms	Definitions
Acuity / Bed	Level of severity of an illness / patient care
Acute / Sudden Onset	Brief and severe
Acute Care / Urgent Care	Short-term medical treatment; urgent medical care
American Dental Association	Lobbyist group for American dentists.

Terms/Common Acronyms	Definitions
Americans with Disability Act	Federal law protecting the rights of individuals with disabilities.
Adjudication	Processing claims to determine pricing (allowances) and benefits (member liability) amounts.
Adjustment	Reprocessing of a claim to make a correction
ADL (Activities of Daily Living)	Routine activities that people do every day without needing assistance
Advance Directive (Living Will / Healthcare Power of Attorney)	Written statement of a person's wishes regarding medical treatment and how those wishes should be carried out
Adverse Event(Sentinel Event / Never Event)	Medical event or error that causes an injury to a patient as the result of a medical intervention rather than the underlying medical condition. It represents an unintentional harm to a patient arising from any aspect of healthcare management.
Adverse Selection	The common phenomenon in which healthy people choose not to insure and a disproportionate number of unhealthy people enroll
Affordable Care Act (ACA / PPACA)	Enacted to increase quality and affordability of health insurance
Agent / Insurance Agent	Person who is employed by the broker, who works with the member, to find an insurance plan that fits their needs to find an insurance plan that fits their needs.
ALOS (Average Length-of-Stay)	Metric computed by dividing the total number of in-patient hospital days, in all hospitals, counted from the date of admission to the date of discharge by the total number of discharges (including deaths) in all hospitals during a given year.
AMA (American Medical Association)	Physician lobbyist group
Ambulance	Vehicle for transportation to provide for medical services

Terms/Common Acronyms	Definitions
Ambulatory/Outpatient	Medical care provided on an outpatient basis (clinic/ office or hospital outpatient department)
AMP (Average Manufacturer Price)	Average price paid by wholesalers to manufacturers for drugs distributed to retail pharmacies.
Ancillary Provider	Providers who provide necessary services within the network of physicians
ANSI (American National Standards Institute)	Format for transmitting industry standardized electronic information and forms
AOB (Assignment of Benefits)	Accepting payment from a health plan or federal program for services rendered to a patient
APC (Ambulatory Payment Classification / OPPS)	A type of outpatient prospective payment system
Appeal	Request by the member or provider to change an official decision
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: a. A federally funded or approved trial; b. A clinical trial conducted under an FDA investigational new drug application; or c. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
ASP (Average Sales Price)	Used for pharmacy reimbursement/allowance calculation - average price at which a particular product or commodity is sold across channels or markets
Assistant at Surgery / Assistant Surgeon / Surgical Tech	Defined as a physician or allied health practitioner who actively assists the operating surgeon
Authorization / Referral / Prior Notification / Prior Authorization	Agreement to allow a member to access a specified service

Terms/Common Acronyms	Definitions
Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Auto-Adjudication (Rate) / AA / AAR	Claims process automatically without pending; often improves efficiency and reduces expenses required for manual claims
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions.
AWP (Any Willing Provider / Average Wholesale Price)	Requires managed care plans to accept any qualified provider who is willing to accept the terms and conditions of a managed care plan / Pricing for pharmaceutical reimbursement/allowances
AWPL (Any Willing Provider Laws)	Laws that require managed care organizations to grant network participation to health care providers willing to join and meet the network requirements
B	
Balance Billing (Also see UC&R)	The practice of a healthcare provider billing a patient for the difference between what the patient's health insurance chooses to reimburse and what the provider chooses to charge
Bilateral Procedure	Procedures that are performed on both sides of the body during the same procedure.
Brand Name Drug	A drug that has a trade name and is protected by a patent
C	
Cafeteria Plan	Health plan where members have the option to choose betweendifferent types of benefits.
(CAH) Critical Access Hospital	A rural hospital (25 beds or less) designated by CMS as a facility that is at least 35 miles from another acute hospital or CAH; receives cost-based reimbursement from CMS.
CAHPS (Consumer Assessment of Healthcare Providers and Systems)	The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees' experiences with health plans and their services
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Capitation	Payment arrangement that pays a physician or group of physicians a set amount for each enrolled person assigned to them.
Carrier (Health Plan)	A company that creates and manages insurance products; control underwriting, claims, pricing and overall guidance of the company.
Carve-Out	A specifically defined benefit or group of benefits in a plan.
Case Management (CM)	A coordinated set of activities conducted for individual Member management of chronic, serious, complicated, protracted, or other health conditions.
Case Rate	A pricing method in which a flat amount, often a per diem rate, covers a defined group of procedures and services

Terms/Common Acronyms	Definitions
Category II CPT Code	Codes that describe clinical components usually included in evaluation and management or clinical services
Category III CPT Code	A temporary set of codes for emerging technologies, services, and procedures
CDC (Centers for Disease Control)	Government organization that manages infectious disease protocol and guidelines
(CDHP) Consumer-Directed Health Plan	A tier of health plans that allow consumers to manage medical expenses using HSAs, HRAs, or similar payment methods
(CDT) Current Dental terminology	Code set for reporting dental services and procedures
Certificate of Creditable Coverage (COC)	Document that outlines the dates of coverage for the member through their insurance carrier.
Certification	Certification is a determination by the Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.
Chemical Dependency / Substance Abuse/ Chem Dep / Substance Use Disorder / CD	Addiction to a mood or mind altering drug
CHIP / SCHIP	Low-cost health insurance program designed for children of families whose income level was too high to qualify for Medicaid.
Chronic Disease	A long-lasting condition that can be controlled but not cured
Claim	A bill for services, a line item of service, or all services for one beneficiary within a bill.

Terms/Common Acronyms	Definitions
Clean Claim	A clean claim means a claim that has no defect or impropriety (including any lack of substantiating documentation, including, but not limited to coordination of benefits information) to determine eligibility or adjudicate the claim. A clean claim does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent or a claim for which fraud or abuse is suspected.
(CHS) Contract Health Services	Regulated under IHS, CHS is a secondary program for medical/dental care provided away from an IHS or tribal health
Clinical Criteria	Guidelines that provide recommendations for internal medicine physicians treating patients with certain aliments
Clinical Trial	Research studies that test how well new medical approaches work with patients
(CMS)Centers for Medicare and Medicaid	Government organization that administers Medicare, Medicaid, CHIP, and parts of the Affordable Care Act (ACA)
CMS-1500 / AKA HCFA-1500	The standard claim form for professional or outpatient claims.
COBRA	A continuation of healthcare coverage for a member who leaves their employer.
Coinsurance	The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.

Terms/Common Acronyms	Definitions
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital Inpatient care, including care at a Residential Treatment Facility, and ongoing outpatient services, including ambulatory care.
[This] Contract or [The] Contract	The Policy, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
Convalescent Care / Rehab / Post-Op	A range of health services designed to help people recover from serious illness, surgery or injury
Coordination of Benefits (COB)	Ensures a person with multiple insurance policies isn't compensated more than once
Copay	An amount that a Member must pay at the time the Member receives a Covered Service.
CORF (Comprehensive Outpatient Rehabilitation Facility), Outpatient Rehab	A medical facility that provides outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of your injury, disability, or sickness.
Cosmetic	Involving or relating to treatment intended to restore or improve the person's appearance.
Cost Sharing	Costs that a member is expected to pay as part of their plan
Coverage (CVG)	Policy that covers the insured in the event of an unforeseen event
Coverage Gap	Time between insurance coverage when a patient is not covered.

Terms/Common Acronyms	Definitions
Covered Services	Those Health Care Services to which a Member is entitled under the terms of their Contract.
CPT Procedure Code / Current Procedure Terminology	The code set that describes medical, surgical, and diagnostic services and is designed to communicate uniform information about these services and procedures among physicians, coders, patients, and payers for administrative, financial, and analytical
Credentialing	The process of establishing qualifications of licensed professionals and assessing their background.
Creditable Coverage	Benefits or coverage provided under: a. Medicare or Medicaid; b. An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan; c. An individual health insurance policy; d. Chapter 55 of Title10, United States Code; e. A medical care program of the Indian Health Service or of a tribal organization; f. A state health benefits risk pool; g. A health plan offered under Chapter 89 of Title 5, United States Code; h. A public health plan; i. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504) (e));j. College plan; or k. A short-term limited-duration policy.
D	
Deductible	The amount that a Member must pay each Calendar Year before the Plan will pay benefits for Covered Services.
Dependent	The Spouse and any Dependent Child of a Subscriber.

Terms/Common Acronyms	Definitions
Dependent Child	A Subscriber's biological child; A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement;A stepchild of the Subscriber; or A foster child or any other child for whom the Subscriber has been granted legal custody.
DHS (Department of Human Services, HHS (Federal))	Agencies tasked with protecting the health of all Americans and providing essential health services
Diagnosis (DX)	Identification of an illness or other problem by examination of the symptoms
Disallowed Amount	The difference between the actual amount of the procedure and the amount agreed upon by the insurance company.
Discount	Reduction to the prices of services; usually provided when seeing an in network provider
Disease Management	A system of coordinated health care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented.
DOI (Department of Insurance)	State departments that regulate insurance products and agents.
DOL (Department of Labor)	U.S. or State Department of Labor
Domiciliary Care (Dom Care)	A supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental or visual disabilities.
DOS (Date of Service)	Date when services were rendered
DRG (Diagnostically-Related Grouping)	System used to classify hospital cases
Dual-Eligible	Patient is eligible for both Medicare and Medicaid
Durable Medical Equipment (DME)	Any medical equipment used in the home to aid in a better quality of living

Terms/Common Acronyms	Definitions
E	
(EBSA) Employee Benefits Security Administration	An agency within the U.S. Department of Labor; provides information concerning rights under COBRA
(EDI) Electronic Date Interchange	Transfer of data from one computer system to another by standardized message formatting
Efficacy / Effectiveness	Determination that a particular course of treatment is effective in managing a health condition
Elective	Related to an elective procedure; not medically necessary
Eligible Dependent	Any "Dependent" who meets the specific eligibility requirements of the Plan under applicable State and Federal laws and rules.
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of the Group's Plan.
Emergency Medical Condition	Sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.
EMR (EHR / Electronic Medical Record /Electronic Health Record)	Digital version of a paper chart in a clinician's office
Endodontic	Dentistry specialty concerned with the study and treatment of the dental pulp
(EOB) Explanation of Benefits	A statement sent by a health insurance company to covered individuals explaining what medical services were paid
EOP (Explanation of Payment / Remittance Advice)	Report that accompanies claims which provides a detailed report on how they were paid, denied, or adjusted

Terms/Common Acronyms	Definitions
ePrescribing / Electronic Prescribing	Allows the physician and other medical practitioners to write and send prescriptions to participating pharmacies electronically
(ERA) Electronic Remittance Advice	ANSI transaction for claim payment I remittance.
ERISA (Employee Retirement Income Security Act)	Protects the assets of Americans so that funds placed in retirement plans during which the person works will be available
ESRD (End-Stage Renal Disease)	Failure of the renal system (kidneys)
Essential Health Benefits (EHB)	Based on 10 benefits that are covered across the board: ER, prescription, inpatient/ outpatient, therapies, labs, preventative, pediatric, prenatal, mental health/ substance abuse
Exchange / Marketplace, HIX, **healthcare.gov**	State or federal marketplace for the purchasing of health insurance for individuals and small groups
Exclusion	Not covered
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted
Experimental	Refers to the status of a drug, service, medical treatment or procedure that currently doesn't present any credible evidence for treatment or diagnosis.
Experimental Drugs	Medicinal product that has not yet received approval from governmental regulatory authorities for routine use
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or b. Requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
F	
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Fee Schedule	A complete listing of fees used by Medicare to pay doctors or other providers/ suppliers
Fee-For-Service	Comprehensive listing of fee maximums is used to reimburse a physician or providers based on fee-for-service basis
FEHB (Federal Employees Health Benefits)	Consumer driven and high deductible plans that offer catastrophic risk protection with higher deductibles, health savings accounts, and lower premiums, or Fee-for-Service plans, PPO/ HMO plans
Fiduciary	A trustee; person who holds legal or ethical relationship of trust between him/herself and one or more parties
Flexible Spending Account (FSA)	Employee benefit program that allows a member to set aside money for certain health care needs
Form 1099	Tax form that reports the year-end summary of all-employee compensation

Terms/Common Acronyms	Definitions
Form W9	Form used by the provider and is used to verify the taxpayer identification
Formulary	An official list of medications that may be prescribed; covered prescribed medicines
FQHC (Federally Qualified Health Centers	A reimbursement designation for several health programs; community-based organization that provides care to persons of all ages regardless of their ability to pay.
Fully-Funded / Fully Insured	Employer pays the premium of the health coverage
G	
Gatekeeper	HMO that restricts access to specialists or out of network providers using a referral process.
Generic Drug	Drug product that is comparable to a brand drug product
Global Surgery	Surgery and usual pre and post-operative work will be billed as a global package; global surgery fee
GPCI (Geographic Pricing Cost Index)	Categories used by Medicare to determine allowable payment amounts for medical procedures
GPO (Group Purchasing Organization)	Used by groups of businesses to obtain discounts based on their collective buying power
Grandfathered (GF)	A provision in which an old rule continues to apply to some existing situations, while a new rule will apply to all future cases
[The] Group	The entity that sponsors this health maintenance agreement as permitted by SDCL-58-41 under which the Group Member is eligible and applied for this Contract.
Group Health Plan	Employee benefit plan; maintained by the employer number (TIN)

Terms/Common Acronyms	Definitions
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Guaranteed Issue	Portion of PPACA that states individuals can not be denied insurance coverage
H	
Habilitative Services	Health care services that help a person keep, learn or improve skills and functioning for daily living
HCFA (The Health Care Finance Administration)	Federal agency that administers the Medicare program and works in partnership to administer Medicaid, SCHIP, and health insurance portability standards, such as HIPAA.
HCPCS Procedure Code /"Hix-Pix"/ Healthcare CommonProcedure Coding System	A set of health care procedure codes based on Current Procedural Terminology (CPT).
HDHP (High Deductible Health Plan)	Plan that consists of a high deductible.
Healthcare Power of Attorney (POA)	Becomes active when a person is unable to make decisions or consciously communicate intentions regarding treatments
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease
HEDIS (Healthcare Effectiveness Data and Information Set)	A tool used by a member's health plan to measure performance on important dimensions of care and service
HHS (Health and Human Services)	Protects the health of all Americans and provides essential human services for the general public
HIPAA (Health Insurance Portability and Accountability Act of 1996)	Protects the privacy of individually identifiable health information; sets national standards for the security of electronically protected health information.

Terms/Common Acronyms	Definitions
HIPAA 5010 (ANSI ASC X12)	New standard that regulates the electronic submission of specific health care transactions
HMO (Health Maintenance Organization)	Organization that provides or arranges managed care for health insurance
Home Health Care	Care that is provided within a member's home in lieu of combined or anticipated hospitalization
Home Infusion	Involves the administration of intravenous (IV) medication, such as antibiotics and chemotherapy
Hospice	End-of-life care
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Physician's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities.
Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes a stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.

Terms/Common Acronyms	Definitions
HRA (Health Reimbursement Account)	Employer funded, health benefit plans that reimburse employees for out-of-pocket medical expenses
HSA (Health Savings Account)	Medical savings account available to taxpayers enrolled in high deductible policy.
I	
Iatrogenic Condition / Nosocomial Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
IBNR Expenses / Incurred but not Reported, future	Term for the collective claims that will be filed in the future for current medical conditions
ICD-10 CM / International Statistical Classification of Diseases	10th revision of ICD; replaced ICD-9
ICD-10 PCS /Procedure Coding System	Responsible for maintaining the inpatient procedure code set; replaced ICD-9-PCS
ICD-9 CM (International Statistical Classification of Diseases, Clinical Modification)	The official system for assigning codes to diagnoses and procedures
ICD-9 PCS (Procedure Coding System)	Responsible for maintaining the inpatient procedure code set
IDS (Integrated Delivery System)	A network of health care organizations under one parent company
IHS (Indian Health Services)	Operating division within HHS that is responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives

Terms/Common Acronyms	Definitions
Implantable	Device that is surgically implanted in the patient, usually to provide medical treatment.
Indemnity / IND, Fee for service	A health care plan where the member can see any provider (no network), and is reimbursed a set amount or percentage
In-Network Benefit Level	The upper level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating Practitioner and/or Provider designated by Sanford Health Plan, in its sole discretion, as part of this Certificate of Coverage's defined network.
Inpatient (INPT)	A patient who stays in the hospital while under treatment and incurs room and board charges
Institutional Service / Hospital Services	Service that was provided at a facility
Intensive Outpatient Program (IOP)	Treatment service and support program used primarily to treat mental illness and chemical dependency
IPPS (Inpatient Prospective Payment System)	Payment system which categorizes cases into a diagnosis-related group (DRG). The base payment rate is divided into labor-related and non-labor share, which is then adjusted by wage index applicable to the area where the hospital is located.
L	
Letter of Medical Necessity (LOMN)	Documentation that is submitted by a provider who is requesting certain services for the patient.
Lifetime Maximum	The maximum dollar amount that will be paid on for a member's health plan
Limited Cost Sharing (LCS)	A plan available to members of federally recognized tribes, those whose income is above 30% of federal poverty line which is available through the Marketplace.
Living Will /Advance Health Care Directive	Legal document in which a person specifies actions that should be taken for their health when they are no longer capable to make that decision for themselves.
Locum Tenens	Written statement of a person's wishes regarding medical treatment and how those wishes should be carried out
Long-Term Residential Care	The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day-to-day activities and responsibilities) to Members with physical, mental health and/or substance use disorders. Care may be provided in a long-term residential environment known as a transitional living Facility; on an individual, group, and/or family basis; generally provided for persons with a lifelong disabling condition(s) that prevents independent living for an indefinite amount of time.
LOS (Length-of-Stay)	Duration of a single episode of hospitalization
M	
Maintenance Care	Treatment provided to a Member whose condition/ progress has ceased improvement or could reasonably be expected to be managed without the skills of a Practitioner and/or Provider.
Managed Care (MC, MCO)	System of health care in which patients agree to visit only certain doctors and hospitals
Mandated Benefit	A benefit that is legally required by state or federal law

Terms/Common Acronyms	Definitions
Marketplace / Exchange	Also known as the Health Insurance Exchange; where people without health insurance can search for insurance options and purchase an insurance plan.
Maxillofacial	Refers to the head, neck, face and jaw
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. Sanford Health Plan's Maximum Allowed Amount is the lesser of: a) the amount charged for a Covered Service or supply; or b) inside Sanford Health Plan's Service Area, negotiated schedules of payment developed by Sanford Health Plan, which are accepted by Participating Practitioner and/or Providers; or c) outside of Sanford Health Plan's Service Area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or j. Costs for Facilities providing the same or similar services, plus a margin factor.
MCO (Managed Care Organization, Managed Care)	System of health care in which patients agree to visit only certain doctors and hospitals

Terms/Common Acronyms	Definitions
Medically Necessary / Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and a. help restore or maintain the Members health; or b. Prevent deterioration of the Member's condition; or c. Prevent the reasonably likely onset of a health problem or detect an incipient problem; or d. Not considered Experimental or Investigative
Medicare Advantage - SNP /Special Needs Plan	Limited membership to people with specific diseases to tailor their benefits
Medicaid	Social health care program for families and individuals with low income and limited resources
Medicaid Expansion	Social health care program for families and individuals with low income and limited resources for members who reside in ND and are 19 and older
Medical Home	A concept that focuses on the care of children with special health care needs
Medical Loss Ratio / Loss Ratio / MLR	A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees
Medical Management	A collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to disabled, ill or injured individuals

Terms/Common Acronyms	Definitions
Medical Necessity	Defined as accepted health care services and supplies provided by health care entities with the applicable standard of care.
Medically-Fragile	Defined as a chronic physical condition, which results in prolonged dependency on medical care for which daily skilled intervention is medically necessary
Medicare	Social insurance program; provides health insurance to members who are 65 or older, those who are disabled, or have ESRD
Medicare Advantage / Medicare Part C / Medicare Replacement / MA	Covers for medically necessary care that members receive from nearly any hospital or doctor who accepts Medicare.
Medicare Advantage / HealthMaintenance Organization (HMO)	Allows members to utilize providers or hospitals that are in their provider list; will need a referral to see providers that are OON
Medicare Cost Plan	Offered in certain areas; members can join if they are only enrolled in Part B, can go to an out of network provider, can join and leave at any time.
Medicare Part A	Covers hospital care, skilled nursing facility care, Hospice, home health services.
Medicare Part B	Covers for medically necessary services and supplies, preventative services, mental health, second opinion, and limited outpatient prescription drugs.
Medicare Part D	Medicare prescription drug benefit
Medicare SELECT	Type of Medigap plan that works like a HMO (in network)
Medicare Summary Notice (MSN) (similar to an EOB)	Notice that shows all services and supplies that providers and suppliers have billed to Medicare within a 3 month period, and what Medicare paid.

Terms/Common Acronyms	Definitions
Medicare Supplement / Medigap	Sold by private insurance companies; can help pay for health care costs that Medicare doesn't cover.
Member	An individual who belongs to an entity
Member (Patient)Liability	The dollar amount that an insured is legally obligated to pay forservices rendered by a provider.
Mental Health / Behavioral Health	Includes emotional, psychological, and social well-being
Mental Health and Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
MHPA (Mental Health Parity Act)	Requires that annual or lifetime dollar limits on mental health benefits be no lower than any such dollar limits for medical benefits offered by a group health plan.
(MIPPA) Medicare Improvements for Patients and Providers Act	Funding that is received to help Medicare beneficiaries apply for Medicare Part D
MMA (Managed Medical Assistance)	Medicaid program where patients are managed by a provider or network organization
MOOP / OPM / MOP	Maximum out of pocket; total amount that the member will need to pay before their health plan will pay at 100%.
MSA (Medical Savings Account)	A medical savings program for self-employed individuals to set aside tax-deferred money to pay for medical expenses
MS-DRG Weighted Fee Schedule (DRG)	System for the bundling of claims for hospital services based on diagnosis, complications, length of stay, and other factors.

Terms/Common Acronyms	Definitions
Multiple Surgery	Separate procedures performed by a single physician or physicians in the same group practice on the same patient, at the same operative session, or on the same day.
N	
NAIC (National Association of Insurance Commissioners)	US standard-setting and regulatory support organization created and governed by the chief insurance regulators from all states and US territories.
Natural Teeth	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
NCQA(National Committee for Quality)	Leader in health care accreditation; works to improve health care
NDI (National Drug Code)	System that provides each drug with a unique product identifier
NDME	North Dakota Medicaid Expansion
Network	A group of two or more entities that are linked together
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Members for services related to Never Events.
Non-Covered Services	Health Care Services that are not part of benefits paid for by the Plan.
Non-Grandfathered	Refers to an old rule that no longer applies to the policy

Terms/Common Acronyms	Definitions
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
NPI (National Provider Identifier)	Identification number that is assigned to a provider or facility
Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
O	
Orthodontic	Treatment of improper bites and crooked teeth
Orthotics	Specialty that focuses on the design, manufacture, and application of orthotics.
OTC (Over the Counter)	Medicines sold directly to a consumer without a prescription from a provider.
Out-of-Network (OON) / ON / Non-Participation	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

Terms/Common Acronyms	Definitions
Out-of-Pocket Maximum Amount	The total Copay, Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility each calendar year. When the Out-of-Pocket Maximum Amount is met, the Plan will pay 100% of the Reasonable Costs for Covered Services. The Out-of-Pocket Maximum Amount resets on January 1 of each calendar year. Medical and prescription drug Copay amounts apply toward the Out-of-Pocket Maximum Amount
Outpatient (OTPT)	One who received medical treatment without being admitted to a hospital
P	
Palliative	Relieving pain or alleviating a problem without dealing with the underlying cause.
Participating Provider/ PAR/ Participating/ Contracted	Practitioner, institution or organization or someone on their behalf has signed a contract with the Plan or one of the Plan's contracted vendors to provide Covered Services to Members and, as a result of signing such contract, is a participating provider in the Plan's Panel of Providers.
Partial Hospitalization Program	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/ or substance use disorders who require coordinated, intensive,comprehensive and multi-disciplinary treatment with such program lasting a minimum of six (6) or more continuous hours per day.
PBM (Pharmacy benefit manager)	Third party administrator of prescription drug programs

Terms/Common Acronyms	Definitions
PCP (Primary Care Provider)	A specialist in Family Medicine, Internal Medicine, Obstetrics and Gynecology or Pediatrics who provides the first contact for a patient with an undiagnosed health concern and takes continuing responsibility for providing the patient's comprehensive care.
Per Diem / Per Day	Daily allowance for expenses
PHI (Protected Health Information)	Data that is protected under HIPAA and must not be disclosed when discussing a patient or member's affairs
PHO (Physician-Hospital Organization)	A group formed by a hospital and its providers in order to contract with an MCO
Physician / MD, DO, PhD, DC, DPM	Professional who practices medicine
Place of Service Type/ Office, outpatient, inpatient, urgent care, ER, lab, etc.	Codes for the place of service are used for billing purposes to determine how the patient's healthcare plan will pay.
PMPM (Per Member Per Month)	Capitation payment methodology
Podiatry	Branch of medicine associated with foot, ankle and related
Policy	Decisions, plans and actions that are undertaken to achieve specific health care goals
Policyholder	A person or group in whose name an insurance policy is held
POS (Place of Service)	Defined by codes placed on health care claims which indicate the setting in which a service was provided to the member.
PPO (Preferred Provider Organization)	A managed care organization of providers and facilities who have agreed with an insurer or third-party administrator to provide health care at reduced rates
Practitioner/Provider	Someone who is qualified or registered to practice medicine

Terms/Common Acronyms	Definitions
Pre-Existing Condition (Pre-Ex)	A medical condition that started before the member's health insurance went into effect
Premium	The amount that the insured pays for health insurance
Preventive	A yearly exam that helps keep a member free of disease
Primary Carrier	The first carrier that covers the insured; first payer
Primary Payor	Refers to who will pay first in regards to member's claims
Private Duty Nursing	Nurses who provide private duty care by working one-on-one with individual clients
Procedure	Medical treatment or service
Professional Service	A service provided to a member of the health plan
Prompt Payment	Ensures that agencies pay vendors in a timely manner
Prophylactic / Preventive	Medication or a treatment designed and used to prevent a disease from occurring
Prospective Review	Used in UM to review upcoming services
Prosthetics	An artificial limb
Prosthodontic	Dental prosthetics; area of dentistry that focuses on dental
Prudent Layperson	Person with medical training who exercises those qualities of attention, knowledge, intelligence and judgment. A standard for determining the need to visit the ER.
Q	
QHP (Qualified Health Plan)	A health plan certified by the Marketplace to meet ACA benefit and costsharing standards
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.

Terms/Common Acronyms	Definitions
R	
Radiology	Medical specialty that uses imaging to diagnose and treat diseases and injuries within the body
Reasonable Costs	Those costs that do not exceed the lesser of: (a) negotiated schedules of payment developed by the Plan, which are accepted byParticipating Practitioners and/or Providers or (b) the prevailing marketplace charges.
Reconstructive	The use of surgery to restore the form and function of the body
Recoupment	Direct or indirect recovery of funds spent; in regards to claims for patients.
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Practitioner and/or Provider without Plan certification or prior-authorization when certification/prior-authorization is required.
Rehabilitation	To restore to good health or useful life; through therapy
Reinsurance	Insurance that is purchased by an insurance company from one or more other insurance companies directly through a broker as a means of risk management
Residential Care	Refers to long-term care given to adults or children who stay in a residential setting rather than their own home.

Terms/Common Acronyms	Definitions
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/ counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Respite (Hospice)	Type of care that focuses on chronically ill or terminally ill patients,residential setting rather than their own home.
Retrospective Review	A post treatment assessment of services on a case-by-case basis after treatment has already been provided.
Revenue Code (REV Code)	3-digit numbers that are used on hospital bills to indicate where the patient was receiving treatment
Rider	An additional provision that is added to the member's policy
Risk	The potential of losing something of value
Risk Adjustment	An actuarial tool used to calibrate payments to health plans orother stakeholders based on the relative health of the at-risk

Terms/Common Acronyms	Definitions
Risk Pool	Practiced by insurance companies; come together to form a pool provide a safety net against catastrophic risks.
Routine Dental	Yearly dental checkup
Routine Vision	Yearly vision checkup
RX (Prescription Drug)	A measure of value used by Medicare as a reimbursement formula for physician services
S	
Schedule of Benefitsand Coverage (SBC)	Detailed, standard descriptions of a member's health care benefits
Screening	Used to identify an unrecognized disease in individuals without signs or symptoms
Secondary Carrier	The second insurance carrier that insures the patient
Self-Funded / Self-Insured	A self-insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds
SEP (Special Enrollment Period)	A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage
Service Area	The area in which the member can access providers; generally based on the area where the member lives.
Service Charge	The amount paid by the Group to the Plan on a monthly basis for coverage for Members under this Contract
Skilled Nursing (SNNF)	Nursing Home
Specialty	A branch in medical practice; further medical education
Specialty Care	Scope of care for patients within a specific specialty (Ex. gastroenterology)
Specialty Drug	High cost prescribed drug

Terms/Common Acronyms	Definitions
Special Enrollment Period	A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.
Spouse	An individual who is a Subscriber's current lawful Spouse.
SSA (Social Security Administration)	Social insurance program consisting of retirement, disability,and survivor's benefits.
Step Therapy	The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progresses to other more costly therapies only if necessary
[This] State	The State of South Dakota.
Subrogation (SUBRO)	The right for an insurer to pursue a third party that caused an insurance loss to the insured; means of recovering the amount of the claim paid to the insured for the loss.
Subscriber	An Eligible Group Member who is enrolled in the Plan. A Subscriber is also a Member.
Summary of Pharmacy Benefits	Document that outlines the coverage of prescription drugs
Summary Plan Description	Document that outlines the dates of coverage for the member through their insurance carrier.
T	
Tax Identification Number / TIN / EIN / Employer Identification Number	An identifying number used to identify a business entity
Telemedicine / Telehealth	The use of interactive audio, video, or other telecommunications technology that is used by a health care provider or health care facility at a distant site to deliver health services at an originating site and that is delivered over a secure connection that complies with the requirements of state and federal laws. This includes the use of electronic media for consultation relating to health care diagnosis or treatment of a patient in real time or through the use of store-and-forward technology. Audio-only telephone, email or fax are not included.
Tertiary Care	Specialized consultative care; usually a referred provider
Third-Party Payer	An institution or company that provides reimbursement to health care providers for services rendered to a third party
Tiered Co-paymentBenefits	Prescription benefit; co-payments are split into three tiers for non-formulary, formulary and brand name
Timely Filing (TF)	The amount of time the provider has to submit a claim to the insurance plan for payment
TMJ (Temporamandibular Joint)	Associated with the jaw and surrounding muscles of the face
TPA (Third Party Administrator)	Arrangement where a health plan administers various aspects of an insurance plan while the plan sponsor retains risk
Transitional Small Group	Small groups who must transition to QHPs under new ACA regulations
Type of Bill	Codes that are three digit codes located on a claim form that describes the type of bill a provider is submitting to a payer
U	

Terms/Common Acronyms	Definitions
UB04 / Institutional / UB/ UB92 / Facility	Uniform instructional billing claim form used by hospitals, clinics, ambulatory surgery centers, etc.
Unbundling	Charge for items or services separately rather than as a part of a package
Uninsured	Patient who doesn't have health insurance
Urgent Care (UC)	Acute care; walk-in clinic focused on the delivery of ambulatory
Urgent Care Request	Means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: 1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or 2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We	Refers to Sanford Health Plan
Utilization / Use / Usage	The "use" of; in regards to the use of benefits while controlling costs and monitoring quality of care
Utilization Management	The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities under the provisions of the health plan
Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion,Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
W	
Waiting Period	The period of time between when an action is requested or mandatedand when it occurs; period where insurance will not pay.
WHO (World Health Organization)	International group that directs and coordinates international health within the United Nations' system
Women's Preventive Health (ACA)	Preventative, maternity and contraceptive services for women that are covered at 100% for non-grandfathered, ACA-compliant
Workers' Compensation (WC) / Work Comp	A form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange of mandatory relinquishment
Write-off / Discount	The reduction of value (provider write off)
Z	
Zero-Cost Sharing (ZCS)	A plan available to members of federally recognized tribes and Alaska Native Claims Settlement Act (ANCSA); no deductible, co-payments, or coinsurance

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