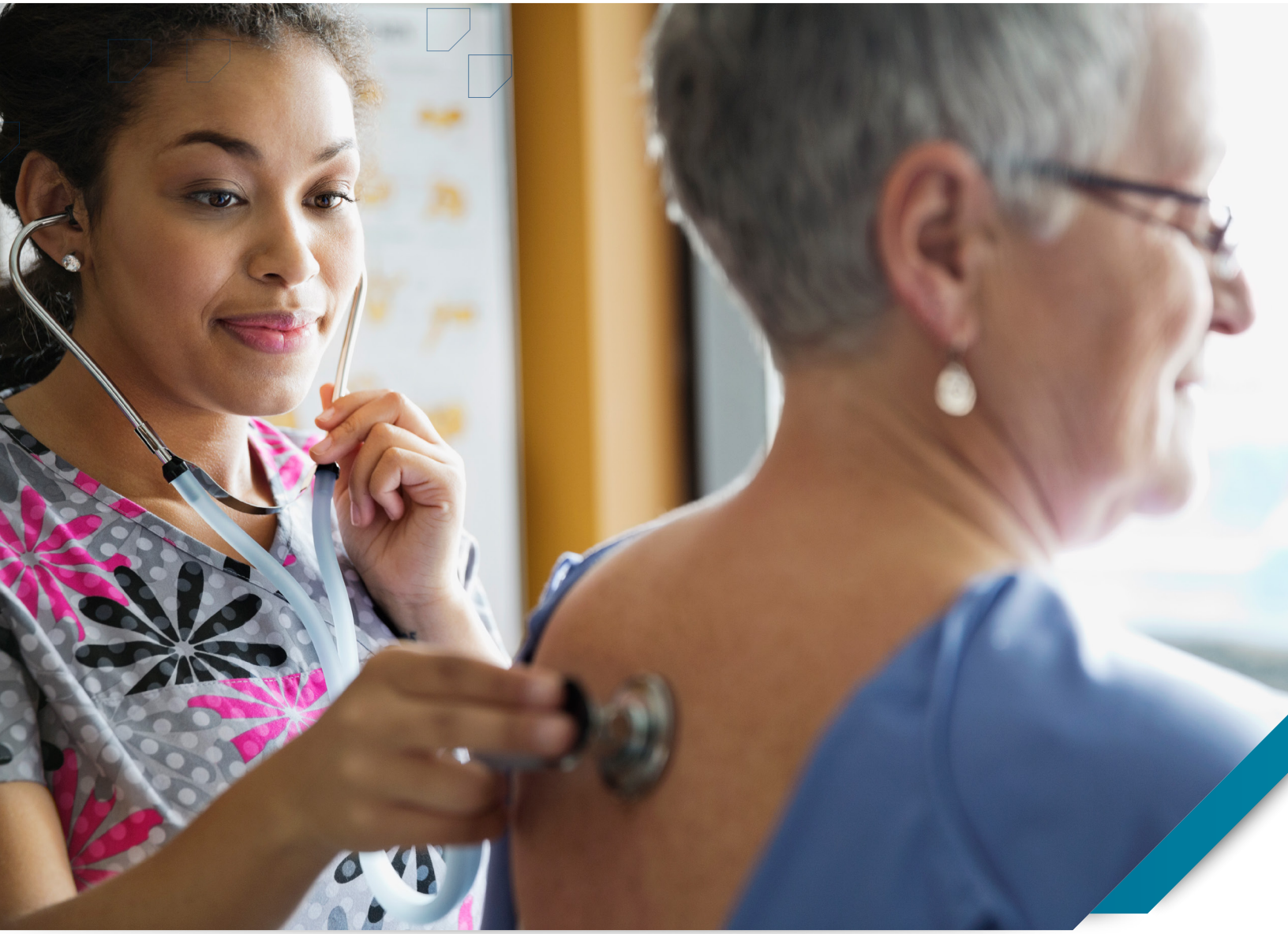
Provider Fast Facts

December 23, 2019 | An eNewsletter from Sanford Health Plan

SANFORD HEALTH PLAN



ERA/835 and EFT Payment Services Have Transitioned to RedCard

Sanford Health Plan is now using RedCard for its Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA/835) services. Providers were notified via letter in September to contact RedCard to initiate these services. **Providers not yet enrolled with RedCard for EFT/ERA services will receive their payments via check and EOPs as hard copy documents.**

Providers may still enroll by calling RedCard Provider Service Center at **(844) 292-4066**, or by emailing **support@ach835.com**. **CLICK HERE** to review details on all EDI Transactions.

Providers who have chosen to receive ERA/835s will still receive paper remittance advice documents for the first three (3) payment cycles.

North Dakota Department of Human Services to Take Over Administration of NDME Pharmacy Claims

In compliance with SB 2012, effective Jan. 1, 2020, the North Dakota Department of Human Services will take over administration of processes and pay North Dakota Medicaid Expansion pharmacy claims instead of Sanford Health Plan/ OptumRx®. Members who obtain prescriptions from providers who are not enrolled with the State of ND will not have those prescriptions covered by ND DHS as of Jan. 1, 2020. Only prescriptions written by providers enrolled with the state of ND at the time the prescription is written are eligible for reimbursement through ND DHS.

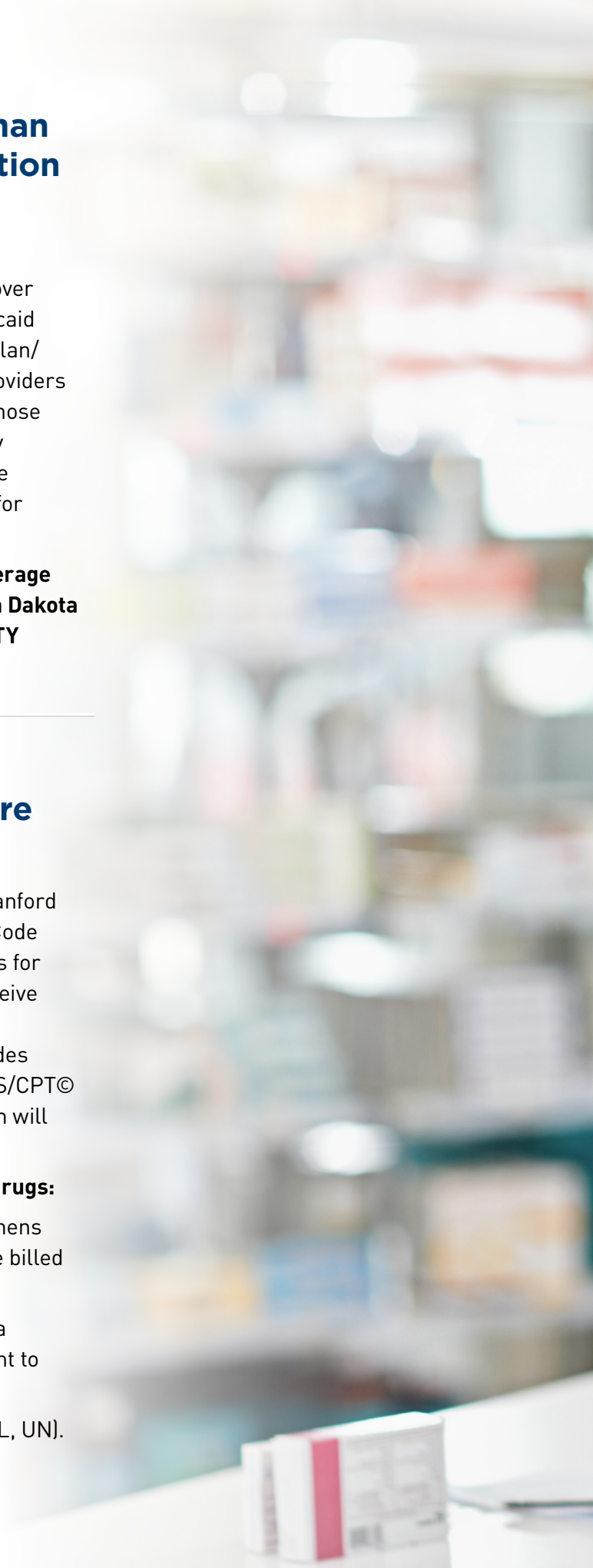
Please direct all questions regarding prescription coverage through North Dakota Medicaid Expansion to the North Dakota Department of Human Services at (800) 755-2604 or TTY (Relay Number): (800) 366-6888.

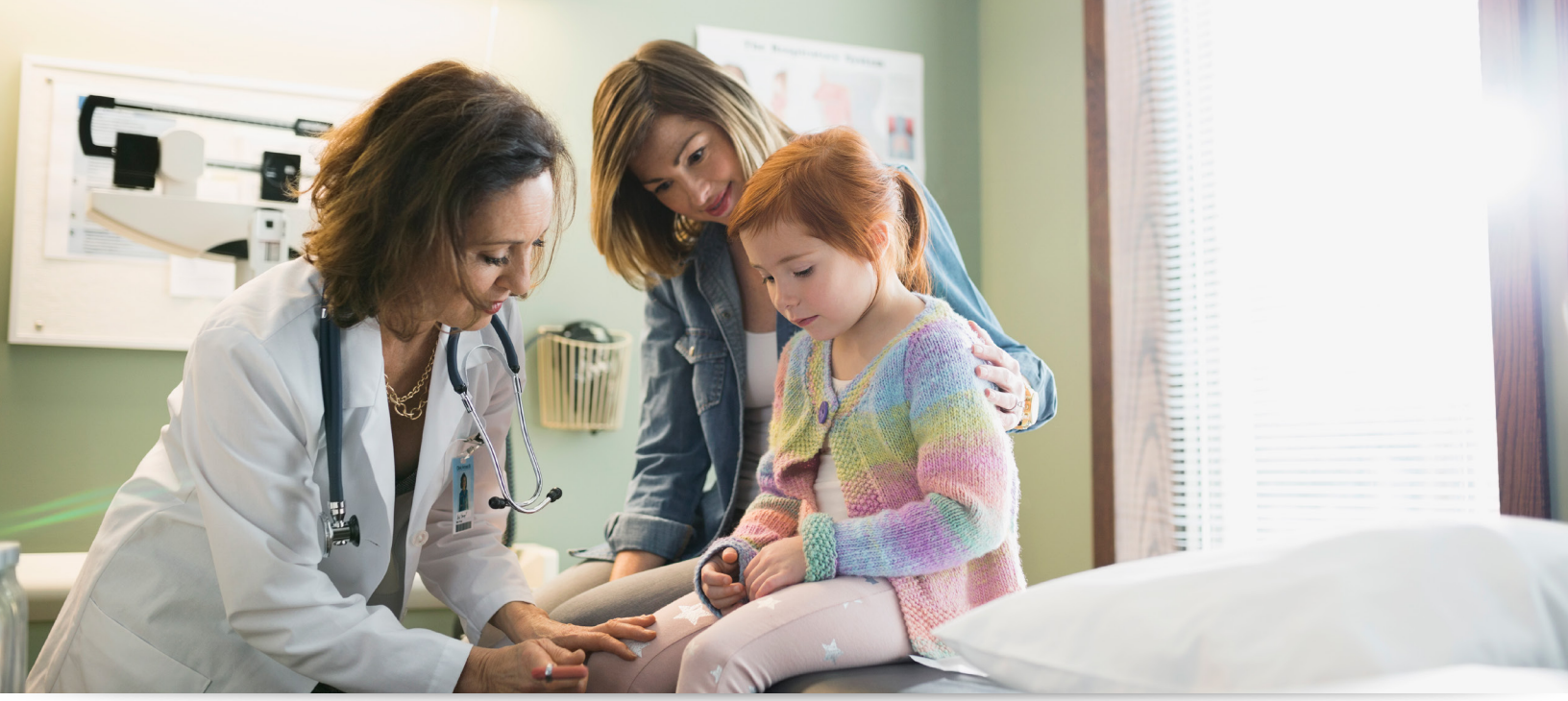
National Drug Code (NDC) Requirement for ALL non-Medicare Claims Jan. 1, 2020

Beginning with dates of service Jan. 1, 2020 and after, Sanford Health Plan will require the appropriate National Drug Code (NDC) and NDC units for specific drug claim submissions for all providers. Our goal is to ensure that all providers receive the appropriate reimbursement and avoid claim denials. Additionally, claims that are billed with drug revenue codes must be submitted with the appropriate NDC and HCPCS/CPT© codes. Failure to use the correct NDC number on a claim will result in claim denials.

NDC billing requirements on all claims for outpatient drugs:

- Valid NDC (11-digit billing format, with no spaces, hyphens or special characters) number that corresponds to the billed HCPCS/CPT© code(s).
- If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- Accurate unit of measure of the NDC billed (F2, GR, ML, UN).
- NDC must be active for the date of service.





New ID Cards Coming in 2020

Sanford Health Plan will be issuing new subscriber ID cards in 2020. However, not all Sanford Health Plan members will receive them immediately as cards will be issued as member groups are renewed for the year.

The new ID card will be easier to read and the type will be larger. The new ID card will display only the subscriber name and ID. It will display the nine- (9) digit Subscriber number and omit the two- (2) digit suffix (02, 03, etc.,) which was previously used to identify a spouse and dependents. Providers will no longer need to submit the 2-digit suffix when submitting claims, as Sanford Health Plan does not need those digits for processing. Claims for all members under this subscriber's number should be submitted with the 9-digit number.

Subscribers will receive two copies of the card and it can be used for all dependents. Members may order additional cards by contacting Member Services. Members with single coverage will receive one (1) card.

Please note these changes when submitting hard copy claims:

- Field 1a (Insured's ID Number): enter Subscriber ID number
- Field 2 (Patient's Name): enter patient's name
- Field 4 (Insured's Name): enter patient's name – not subscriber
- Field 6 (Patient's relationship to self): check 'self'

CLICK HERE to see ID card samples.

Renewal Season is a Good Time for Benefits & Eligibility Checks

January marks the time for a large amount of renewals and changes to health insurance coverage. Having up-to-date information ensures accurate and timely claims processing. Resources available to providers checking member eligibility and benefits:

- Portal – ***my*SanfordHealthPlan**
- Customer Service
- **270/271 Electronic Transactions – Eligibility & Benefits Inquiry (Real Time Transactions)**

Changes for Glucose Monitor Coverage

Sanford Health Plan's coverage of continuous glucose monitors (CGMs) is changing Jan. 1, 2020. The current plan covers CGMs under the medical benefit, which means supplies must be obtained from a durable medical equipment (DME) provider. Beginning Jan. 1, 2020, members can also obtain CGMs at in-network pharmacies.

Members who obtain CGMs from a pharmacy will pay the Preferred Brand copay or coinsurance. Members who continue to obtain CGM supplies through DME providers will be subject to deductible and/or coinsurance.

Currently, pharmacies have three CGMs available to dispense: Dexcom G5®, Dexcom G6® and Freestyle Libre®.

This change is anticipated to be more cost effective and convenient for Sanford Health Plan members. Letters have been mailed to members who may be impacted, providing them with options that will be available, and talking points for them to ask providers.

Members with Medicare, Medicaid Expansion, and Northern Plains Insurance Pool will not be affected by this change.

Platelet Rich Plasma Update for Jan. 1, 2020

Sanford Health Plan has provided coverage for Platelet Rich Plasma (PRP) for the treatment of osteoarthritis of the knee. With the data from the MCG Care Guidelines 23rd Edition, and after an in-depth review of current evidence-based literature, the Sanford Health Plan Physician Quality Committee has voted to discontinue coverage for this therapy effective on Jan. 1, 2020. For those members currently undergoing treatment for osteoarthritis of the knee with PRP, coverage will continue until the treatment course has completed. For questions, call the Utilization Management team.

Risk Score Optimization (RSO) Audit: Coming in November 2019 – March 2020

Sanford Health Plan began the RSO chart review audit in November and runs through March 2020. Risk Adjustment is the payment methodology used by Centers for Medicare and Medicaid Services (CMS) for our Marketplace members based on the health status of the member. We have partnered with CIOX Health to collect medical records as part of the chart review. Providers are encouraged to inform their staff of upcoming medical records and timeline for RSO chart reviews.

To complete the audit, we are asking those providers who receive a Chart Review Request to submit complete medical record documentation on the selected members.

CIOX will send a letter communicating to those providers selected for chart reviews outlining the specific request and where to submit the documentation.

Provider responsibilities regarding medical record requests can be found in Sanford Health Plan's provider manual and policy, which is considered an extension of the Sanford Health Plan provider.

Medical Services and Drug Prior Authorization Policy Updates

Sanford Health Plan's prior authorization list has been updated and can be found online **HERE**.

This prior authorization list is based on our commercial plan and is subject to change based upon Sanford Health Plan Medical Management updates. Authorization requirements for other plans offered by Sanford Health Plan may vary slightly. Contact Sanford Health Plan's UM Department for additional information.

Notable Changes Effective Jan. 1, 2020

Prior authorization requirement removed:

- Phototherapy UVB Light Devices
- Home infusion services
- Photodynamic therapy
- Varicose vein therapy
- Intrathecal pain pumps
- Cranial molding helmets
- Alopecia treatment
- Platelet Rich Plasma (PRP)
- Biofeedback
- Continuous Glucose Monitor Sensors

Prior authorization list update or change:

- DME greater than $10,000 *Clarification: Threshold for DME prior authorizations has been increased from a billed amount of $5,000 to $10,000
- Clarified: External Electrical Bone Growth Stimulators

Remember:

1. Prior authorization is never needed for emergency care.
2. All referrals to non-participating providers require prior authorization.
3. Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an Out-of-Network facility will be denied unless authorized prior to being incurred.

The list of medications for which medical services require prior authorization is available at **HERE**.

The list of medications that require prior authorization is available **HERE**.

The list of medications that require step therapy is available **HERE**.

To request prior authorization, or a Step Therapy override, please complete the prescription drug authorization request or Formulary Exception form located in the Quick Links section of the ***MY*SANFORDHEALTHPLAN PROVIDER PORTAL**.

Happy Holidays

As the year ends, we think about all we are grateful for — and that is you. Thank you for the opportunity to serve you and your staff. We wish you a Happy Holiday season and much success in the New Year. Sanford Health Plan offices are closed Wednesday, December 25, and Wednesday, January 1, 2020.

Policy Updates

Benefit Reimbursement Policy Updates: To review these policies inside the ***MY*SANFORDHEALTHPLAN PORTAL**, click the "Policies and Medical Guidelines" link in the Quick Links section.

- Infertility Testing
- Infertility Treatment
- Category III Codes
- Telehealth
- Home Health
- Transportation Services
- Hyaluronic Acid
- Preventive Health

DME Rental Policy Updates

Beginning Jan. 1, 2020 Sanford Health Plan will only offer a rent to purchase option for up to ten (10) months for durable medical equipment (DME) below, and will process DME items as either a rental or purchase dependent on the modifier used on the claim. Once the 10-month rental period limit has been met, DME items will be considered to be owned by the Member.

Should the item be purchased before the rental period limit is met, all charges accumulated towards the rental period limit will be excluded from the purchase price of the item. DME may be replaced after 5 years, unless there is a documented case of loss or theft, or the equipment is irreparable, per the Member's policy document.

- E0565 – Compressor, air power source for equipment which is not self-contained or cylinder driven
- E0562 – Humidifier, heated, used with positive airway pressure device
- E0550 – Humidifier, durable for extensive supplemental humidification during ippb treatments or oxygen delivery
- K0003 – Lightweight wheelchair
- E0570 – Nebulizer, with compressor
- E0470 – Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
- K0001 – Standard wheelchair
- E0720 – Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation
- E0730 – Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
- E0135 – Walker, folding (pickup), adjustable or fixed height
- E0601 – Continuous positive airway pressure (CPAP) device
- B9002 – Enteral nutrition infusion pump, any type
- E0260/E0265 – Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
- E0265 – Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress
- E0650 – Pneumatic compressor, non-segmental home model
- E0651 – Pneumatic compressor, segmental home model without calibrated gradient pressure
- ~~E1390 – Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate~~*
- E0431 – Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
- E1392 – Portable oxygen concentrator, rental
- E0600 – Respiratory suction pump, home model, portable or stationary, electric

Use of an appropriate rental-coding modifier will be required on claims to indicate if the equipment is a rental or purchase. If a DME item is returned before reaching the purchase price, a new capped rental period can begin if there was 60+ consecutive days of non-usage due to lack of medical necessity.

Rental modifiers include:

- RR – Rental
- KH – Initial claim, purchase or first month rental
- KI – Second or third monthly rental
- KJ – Capped rental months four to fourteen
- KR – Partial month

Purchase modifiers include:

- NU – New equipment (use the NR modifier when DME that was new at the time of rental is subsequently purchased)
- NR – New when rented

Additional DME reimbursement rules are shown below for your reference:

- Oxygen concentrators: Available to rent for 3 years with 2 years maintenance (allowed every 6 months during the 2-year maintenance period). Modifier Code MS (six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty) should be utilized to indicate DME maintenance.
    - Oxygen contents and supplies (cannulas, etc.) utilized with concentrators will only be paid separately during the maintenance period when a portable is being rented. A portable option does not reach a cap because the rental of the portable includes the oxygen and supplies.
- Ventilators: Only available for continuous rental due to regular maintenance.
- Equipment repairs are covered per the Member's policy document when item is no longer covered under warranty and the repair price does not exceed a new item's purchase price.
- Used equipment (modifier UE) is not covered by the Plan.

** This code was printed in error. The article was corrected in the January 2020 issue.*

Sanford Health Plan Implementing Additional Optum® Edits

Sanford Health Plan will be implementing the additional Optum CES edits seen below on Jan. 1, 2020.

The current Optum CES edits can be found **HERE**. When the edits listed below become effective on Jan. 1, 2020, they will also be located at that link.

Optum CES Edit Code	Explanation of Payment Code & Definition	Professional Claim Edit	Institutional claim Edit	835 Claim Adjustment Reason Code and Definition
LPR	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
sMGK	CES29: Modifier GK or GZ	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
sMGZ	CES29: Modifier GK or GZ	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
074UBP	CES3: Units Greater Than One For Bilateral Procedure Billed With Modifier 50	X		CO-16: Claim/service lacks information or has submission/billing error (s).
ASD	CES43: Anesthesia Secondary Procedure with Modifier Override	X		CO-59: Processed based on multiple or concurrent procedure rules.
UIN	CES44: Procedure Code Is Bundled And Not Separately Payable	X		CO-234: This procedure is not paid separately.
UNB	CES44: Procedure Code Is Bundled And Not Separately Payable	X		CO-234: This procedure is not paid separately.
022IMO	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
IM27f	CES49: Missing/Invalid Modifier		X	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
IMC	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
IMO	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
LNM	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
LNMf	CES49: Missing/Invalid Modifier		X	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
M27f	CES49: Missing/Invalid Modifier		X	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
MOD	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
PCM	CES49: Missing/Invalid Modifier	X		CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
26TC	CES50: Service Performed During Active Global Period And Not Allowed	X		CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

NOTE: Services denied due to a claim edit are not billable to the member. Information on filing corrected claims is provided in the Sanford Health Plan Provider Manual. Optum® CES utilizes national coding edits, edits based on CPT® guidelines, specialty society edits and clinically derived edits.

Tips for Using *my*SanfordHealthPlan Provider Portal

How to Search for Members and Benefits:

First, "Select Patient".

Providers can "Search My Patients" which will result in patients who are already on their list.

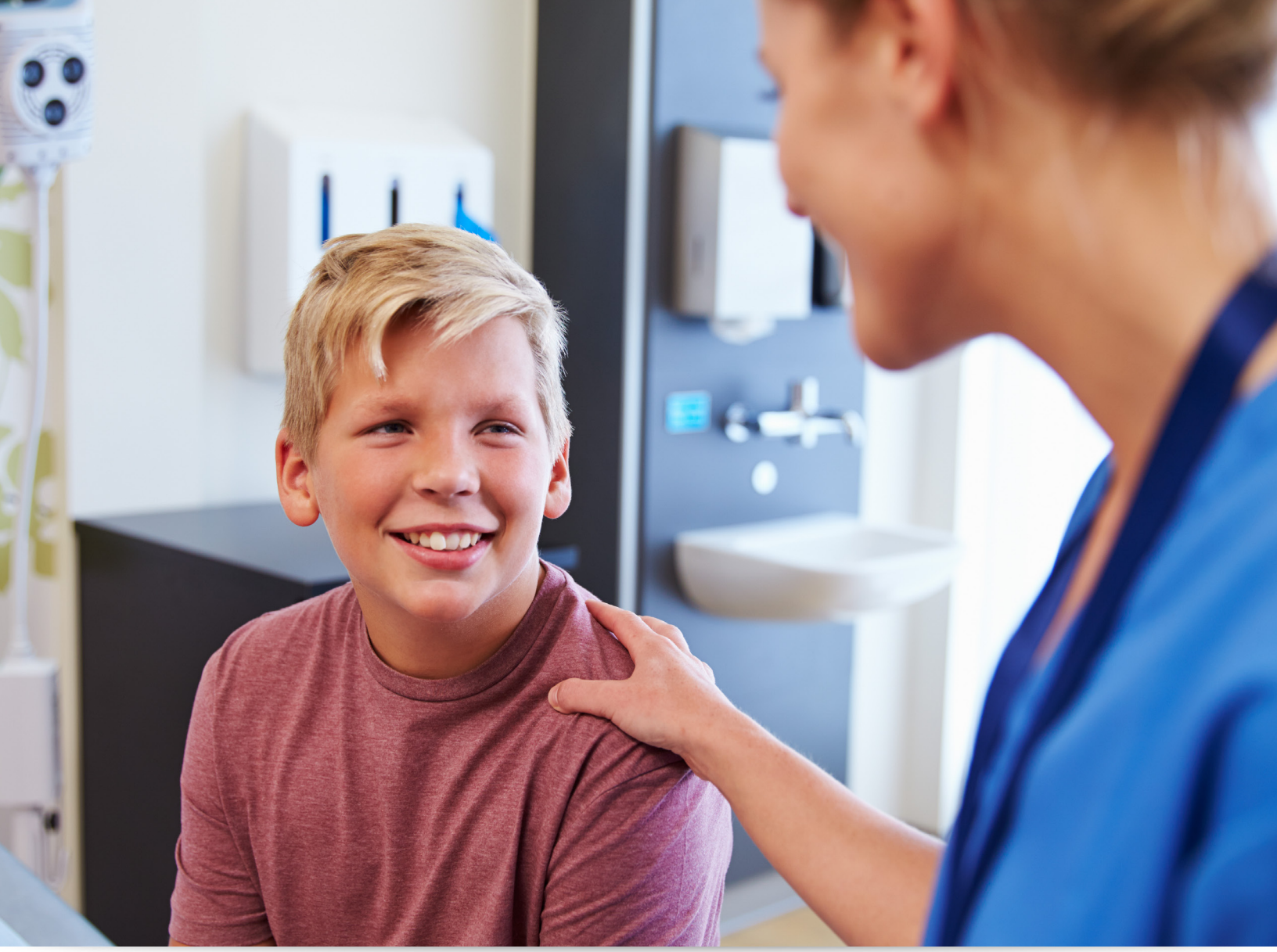
Providers can also "Search All Patients" by entering last name, first name, date of birth, and sex and then selecting "Search".

Click on "Coverages & Benefits" for eligibility. Double click on the blue hyperlink for a more in-depth view of coverage information.

Providers can search a more complete summary of benefits by selecting "Search Member Documents".

Once in "Search Member Documents", enter in the unique Sanford Health Plan Member ID number.

There you will find a complete list of coverage and benefit details, including a downloadable summary and benefit coverage document.



Applied Behavior Analysis Coverage

The South Dakota Division of Insurance recently underwent a review of the state essential health benchmark plan all carriers must match for benefit offerings on their plans. Because of that review, a new benchmark plan was approved to begin in 2021. One of the differences between the current benchmark and the 2021 benchmark is the addition of Applied Behavioral Analysis (ABA) as a covered benefit for children with Autism Spectrum Disorder.

Leading up to the implementation of the 2021 benchmark plan, Sanford Health Plan voluntarily decided to offer ABA coverage to our off-exchange individual and small group plans for the 2020 plan year. There is no ABA coverage in 2020 for on-exchange plans. This benefit is subject to all plan management programs, medical necessity reviews, and preauthorization requirements. Coverage for ABA will be on par with the hours set in the 2021 benchmark plan:

- Age 0-6: 1,300 hours per year
- Age 7-13: 900 hours per year
- Age 14 -18: 450 hours per year

Certificate of Coverage will still have ABA therapy listed as an excluded benefit. This is because the same Certificate of Coverage for describing covered benefits for off-exchange plans is used for on-exchange plans. At this time, on-exchange plans do not have ABA coverage, so the listed ABA exclusion will remain. The South Dakota Division of Insurance has approved SHP's choice to voluntarily offer this benefit within the parameters set forth.

Contact Us:

CONTACT FOR: Member eligibility & benefits, member claim status, provider directory, complaints, appeals, report member discrepancy information

memberservices@sanfordhealth.org

Customer Service
Monday-Friday, 8:00 a.m. to 5:00 p.m. CST | 800) 752-5863

NDPERS Customer Service
Monday-Friday, 8:00 a.m. to 5:30 p.m. CST | (800) 499-3416

ND Medicaid Expansion
Monday-Friday, 8:00 a.m. to 5:00 p.m. CST | (855) 305-5060

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

pharmacyservices@sanfordhealth.org

Pharmacy (855) 305-5062

NDPERS Pharmacy (877) 658-9194

ND Medicaid Expansion (855) 263-3547

CONTACT FOR: Preauthorization/precertification for medical services

um@sanfordhealth.org

Utilization Management (800) 805-7938

NDPERS Utilization Management (888) 315-0885

ND Medicaid Expansion (855) 276-7214

CONTACT FOR: Assistance with fee schedule inquiries, check adjustments & reconciling a negative balance, request explanation of payment (EOP), claim reconsideration requests, W-9 form, change/updating information, provider education

providerrelations@sanfordhealth.org

Provider Relations (800) 601-5086

CONTACT FOR: Requests to join the network and contract-related questions and fee schedule negotiation

sanfordhealthplanprovidercontracting@sanfordhealth.org

Provider Contracting (855) 263-3544

Hearing or speech impaired TTY | TDD (877) 652-1844

Translation Assistance for Non-English Speaking Members (800) 892-0675

SVHP-2860 Rev. 1/20