Provider Fast Facts
February 2021 | An eNewsletter from Sanford Health Plan

SANFORD HEALTH PLAN

Coming Soon:
Online Application for Credentialing

An online application process for credentialing is coming mid-2021, “Sanford Provider Hub.” Watch for further details coming in the following months.

Policies Update

Below, you'll find the latest policy updates—additions, deletions, edits—for your reference. Please let us know if you have any questions.

New Policies:

- Add-On Codes
- Inpatient/Outpatient Unbundling of Routine Services and Supplies
- NCCI Procedure-to-Procedure (PTP) Edits
- Non-Covered Services (replaces MemE-REB-044 Non-Covered Services / Plan Exclusions)

Deleted Policy:

- Tobacco Cessation - See Preventive Health Guidelines Policy for tobacco cessation benefits

Updated Policies:

In addition to the following changes, formatting was updated for all policies listed below.

- Allergy Testing and Immunotherapy
  - o Updated with 1/1/21 code changes
- Assistant at Surgery
  - o Updated eligible code list
  - o Added note that Assistant at Surgery services are reimbursed at 20%
- Behavioral Health and Substance Use Disorders
  - o Updated applicable lines of business table
  - o Updated with 10/1/21 and 1/1/21 code changes
- Breast-Related Procedures
  - o Updated with 1/1/21 code changes
- Cardiac Rehabilitation
  - o Updated applicable lines of business table
  - o Updated E/M code range based on 1/1/21 code changes
- Care Management
  - o Update with 1/1/21 code changes
- Category III Codes
  - o Changed 0042T from not covered to PA required
  - o Updated with 1/1/21 code changes
- Chiropractic Care
  - o Updated E/M code range based on 1/1/21 code changes
- COVID-19 Testing and Treatment
  - o ***NEW* ADDED U0005 TO EXCLUSIONS**
  - o Added 87428, 87636, 87637, 87811, 0240U, 0241U, M0239, and M0243 to reimbursable table
  - o Added Q0239 and Q0243 to exclusions
  - o Removed "Coronavirus" from title
  - o Revised description of 87426
  - o Updated with 1/1/21 code changes
- Durable Medical Equipment (DME)
  - o Added A4561 and A4562
  - o Added note to L8699 for diagnoses that allow the code without PA
  - o Changed L8010, L8015, L8020, L8030, L8031, L8032, L8033, L8035, L8039 to No PA required
  - o Changed PA requirements for certain custom orthotics and prosthetics (only required if $5,000+)
  - o Removed skin substitutes and biologics codes (See Prior Authorization Policy)
  - o Updated with 1/1/21 code changes
  - o Corrected E0431 and E0600 so they are on separate lines
  - o Moved E1392 back to rent-to-purchase list
- Genetic and Molecular Testing
  - o Added note that no PA is required for 88367-88369, 88373, and 88374
  - o Added note that 81420 and 81507 allow without PA for ages 35+
  - o Updated with 1/1/21 code changes
- Habilitative Therapy
  - o Added related MCG Guidelines
  - o Consolidated revenue code list
  - o Deleted link to spreadsheet and added appendix of diagnosis codes to document
  - o Updated with 10/1/21 diagnosis code changes
  - o Updated applicable lines of business table

Policies Update (cont.)

- Hearing Services
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
- Home Health Care
  - Changed language from "is limited to a certain number of visits.." to "may be limited..."
  - Updated applicable lines of business table
- Immunizations
  - Added COVID-19 vaccine and administration codes
  - Updated applicable lines of business table
- Infertility Testing
  - Updated with 1/1/21 code changes
- Infertility Treatment
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
- Infusion Services
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
  - Moved 0269 & 0649 from exclusions to table of revenue codes
- Lab and X-Ray Rider
  - Updated with 1/1/21 code changes
- Lab, X-Ray, and Minor Procedure Rider
  - Updated with 1/1/21 code changes
- Obstetric (Pre- and Post-Natal)
  - Added note that 81420 and 81507 allow without PA for ages 35+
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
- Preventive Health Guidelines
  - Added note on annual limits for tobacco cessation counseling
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
- Rehabilitative Therapy (PT/OT/ST)
  - Updated links to new version of Habilitative Therapy policy
  - Updated applicable lines of business table
- Services Requiring Prior Authorization
  - Added note to L8699 for diagnoses that allow the code without PA
  - Added new rows: Penile Prosthesis Surgery, Radiology Services - High End Imaging, and Sacroiliac Joint Fusion
  - Added note about dollar thresholds for DME in DME Other, Orthotics, and Prosthetics rows
  - Added note that 81420 and 81507 allow without PA for ages 35+
  - Removed 88367-88369, 88373, 88374, and L8010-L8039
  - Removed MemE-REB-10 from Skin Substitutes row
  - Updated with 1/1/21 code changes
- Spine Surgery
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes
- Telehealth
  - Updated applicable lines of business table
  - Updated with 1/1/21 code changes

COVID-19: Updated Coverage Announcement

Stay up-to-date on all COVID-19 information and find resources specifically for providers by visiting this **webpage**.

Have additional COVID-19 questions? Submit your questions **HERE.**

Risk Score Optimization Audit: Now through March 2021

Sanford Health Plan has begun the Risk Score Optimization (RSO) chart review audit, which runs from December 2020 through March 2021. 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.

Electronic Prior Authorization

To better serve our members and providers, we will require electronic prior authorization submission effective Oct. 1, 2020. Providers currently not using the electronic submission option will need to submit referrals electronically. Sanford Employees and internal users: Please see the training resource **HERE** , or sign up for additional classes in the Sanford Success Center.

EXTERNAL PROVIDERS: Please submit authorization requests via Provider Portal **HERE**. For questions, please contact Provider Relations at (800) 601-5086.

Covid Vaccine Administration Allowed Amount

Sanford Health Plan has established the following allowed amounts for administration of the Covid vaccine. Please note this is for administration only. We will continue monitoring vaccine developments and will add administration allowed amounts for vaccines produced by other manufacturers when they become available.

Code	Description	Allowed Amount
0001A	Pfizer 1st dose	$28.81
0002A	Pfizer 2nd dose	$48.29
0011A	Moderna 1st dose	$28.81
0012A	Moderna 2nd dose	$48.29

Utilization Management: **Innovating to Improve Access to Medically Necessary Care**

PA REQUIREMENTS FOR ADVANCED IMAGERY

Sanford honors its commitment to you, our providers, and most certainly our patients / members by continuing to look for ways to optimize efficiencies across our enterprise operations. As a part of these ongoing efforts, we are working to modernize our Utilization Management (UM) capabilities by enhancing Prior Authorization (PA) processes to alleviate administrative and provider burden while improving the overall patient experience and access to high quality care.

Last month we provided detail on one of Sanford Health Plan initiatives which will expand the authorization process to include advanced imaging through our partnership with eviCore Healthcare. Based on evidence-based clinical guidelines, this effort will enable the organization to confidently provide the highest quality, appropriate care to our patients. **Beginning Dec. 14th, 2020, select Sanford Health members will require prior authorization from eviCore for dates of service Jan. 1, 2021 and thereafter.** Services performed without authorization may not be reimbursed.

Standardization and automation of PA processes will offer additional support and efficiency across key UM functions and will enable improved outcomes and an enhanced patient experience by providing the right care, with the right provider, and in the right setting. Stay tuned for more information and updates on our progress regarding these exciting enhancements, and to learn more about Sanford's efforts to deliver greater value to you and the communities we serve.

To learn more about this new requirement please check out the dedicated website for Providers HERE. On the dedicated website you will be able to:

1. Register for training (in General Resources Tab, Registration Instructions)
2. Register for sign in (in General Resources Tab, Registration Instructions)
3. Review CPT code list for services that require authorization (in Solution Resources Tab, Radiology icon)
4. Access Evidence Based Clinical Guidelines

For questions on how to get started please call: eviCore's call center is open from 7 a.m. to 7 p.m. CST **(844) 635-7225**.

Phone Prompts Have Recently Changed

To provide you with you the best experience we have updated our phone systems and with this change there may be some differences. You will still use the numbers at the end of this publication to reach the appropriate departments. Prior to arriving at the appropriate department, you will be prompted to enter if you are a member, provider or have sales inquiry. Once within the provider menu your call will be routed to the team that will most efficiently be able to answer your questions. We thank you for your patience as we embark on some amazing technology to create the best experience for you as a provider and our members.

Optum CES Edits

Sanford Health Plan continues to implement additional claims edits. Check periodically for details of future edits to be released. A document detailing the claim edits is available to you here on the **PROVIDER RESOURCES PAGE.** The resource will be updated as Sanford Health Plan implements new edits.

Changes Coming for Prior Authorizations

Participating providers will be responsible for obtaining authorizations starting in 2021. If a provider is non-participating, the member will be responsible for obtaining the prior authorization. In the event that an authorization is not obtained, and a retrospective authorization is requested and deemed not medically necessary after review, the provider will be responsible for the charges, resulting in provider write off. Some exceptions will be made on a case by case scenario. For example, if a provider submits a prior authorization that results in a denied request and the member chooses to still have the procedure done, it will be considered member responsibility. In this event, the provider should bill with a GA or GY modifier so that the responsibility is on the member. If the modifier is not used, the provider may submit a reconsideration for review. The provider must submit documentation that proves to member agreed to proceed with the care despite insurance not approving the request. Additionally, the member may also appeal if they feel they are being held responsible when not appropriate, and documentation must be submitted to prove whether the member consented to proceed with the procedure. For further questions regarding these changes, please see our FAQ document **HERE** or call Provider Relations at **(800) 601-5086**.

Q: Will the entire claim deny to Provider Responsibility if no Authorization is in place?

A: *No, the denial will continue to be at the line item level*

Q: What is the time period given to submit a retroactive authorization?

A: *As of 1/1/21 the time period for retroactive authorizations to be accepted has been shortened from 180 days to 60 days.*

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 (800) 755-2604 | TTY: 711

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

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