NEW **Provider Reconsideration Form**

To make the reconsideration process easier, we have updated the **provider reconsideration form**. Please follow the updated instructions on the form to expedite your request.

Starting April 1, 2020, all reconsiderations submitted due to lack of medical or pharmacy prior authorization should be submitted directly to the appropriate department (Utilization or Pharmacy Management) for review. For a prior authorization reconsideration, complete a medical or pharmacy prior authorization form, notate as a "retro request" and return with supporting clinical documentation. If a denied prior authorization request is already on file, a Member Appeal is required. For additional details about the Plan's reconsideration policy, review policy PR-014 Provider Claim Reconsiderations.

ADDITONAL OPTIONS AVAILABLE TO RETRIEVE EOPS

Reach out to our Provider Relations staff at **providerrelations@ sanfordhealth.org** for more details on how to access your information on our Zelis clearinghouse portal.

WELCOME TO SANFORD HEALTH PLAN

Jack Griffin
Senior Provider Relations Specialist

I joined Sanford Health Plan as a senior provider relations specialist in November 2019 and my assigned territories are northern Minnesota and northern North Dakota. I attended the University of Iowa and received my Bachelor of Arts in Health and Human Physiology and my master's degree in Healthcare Administration from Des Moines University. My experience includes quality, patient experience, process improvement, supply chain management, and business operations, specifically with UnityPoint Health in Des Moines, Iowa.

Chad Roggow
Director of Provider Relations

Before joining Sanford Health Plan as director of provider relations, I served as director of clinic operations for Sanford Digestive Health on campus at the Sanford Medical Center in Sioux Falls. Prior to joining the Sanford family, I spent twelve years at DAKOTACARE in provider relations. I am very hopeful that my years of experience working in different capacities with physicians, we will be able to focus the SHP Provider Relations team to support bridges in any gaps of communication between the plan and its physician community. One of our main goals will be to enhance the tools we are currently using to communicate with, which will help us work towards more physician involvement with Sanford Health Plan. This will ultimately create a unique and differentiating member experience with our providers for 2020 and into the future.

Medical Prior Authorization Request

As of April 1, 2020, all medical prior authorization requests that are faxed into Sanford Health Plan must be accompanied by a prior authorization form in order to be accepted and processed.

CLICK HERE to link to form.

Risk Score Optimization (RSO) Audit

Sanford Health Plan began the Risk Score Optimization (RSO) chart review audit in November 2019 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 contract.

Provider Onboarding Guide Now Available Online

Sanford Health Plan has recently updated our provider onboarding manual. You can access this online **HERE**.

Prescription Drug Prior Authorization Request

As of April 1, 2020, all prescription prior authorization requests that are faxed into Sanford Health Plan must be accompanied by a prior authorization form in order to be accepted and processed.

CLICK HERE to link to form.

*my*SanfordHealthPlan Provider Portal Tips & Tricks

Creating a message:

✔ Select the "In Basket" at the top of the screen.
  There are multiple options to choose from, which will determine where your message will be sent.

✔ Select the topic that is best fitting to your question.

✔ Select new message and drop down to "Provider Communication."
  There are multiple options to choose from, which will determine where your message will be sent.

✔ Select the topic that is best fitting to your question.
  For example, if you want to submit a claim reconsideration, choose Provider Claim Reconsideration from the drop-down menu so it will be routed to the appeals and denials team for review.

  Each message will have different requirements depending on which topic that was chosen. Fields marked with a red stop sign are required. Boxes with a yellow yield sign are recommended to be completed to ensure adequate information is sent to SHP, but they are not required.

Once all required boxes are completed, click submit and your message will be sent to the appropriate department for review.

COVID-19: IMPORTANT PHARMACY UPDATE

In the midst of the evolving COVID-19 outbreak, we recognize our critical role in making sure you have the latest relevant information. See below for updates related to pharmacy coverage.

We're taking proactive steps to minimize the likelihood of disruption of access to prescription medicine.

• In an effort to mitigate prescription supply issues related to COVID-19, Sanford Health Plan is advocating members follow CDC guidance which recommends acquiring up to 90-day supply of maintenance medications. We have worked with our Pharmacy Benefit Manager to make this possible for our membership.

* Please note this does not apply to specialty medications or opiates.

• Sanford Health Plan is extending prior authorizations an extra 90 days for all existing prescriptions whose prior authorizations will expire in 90 days or fewer. This is happening on an automated basis.

Please note: There are no current concerns about the availability of prescription drugs, but the CDC and American Red Cross recommend that households maintain at least a 90-day supply of any maintenance medication used by household members.
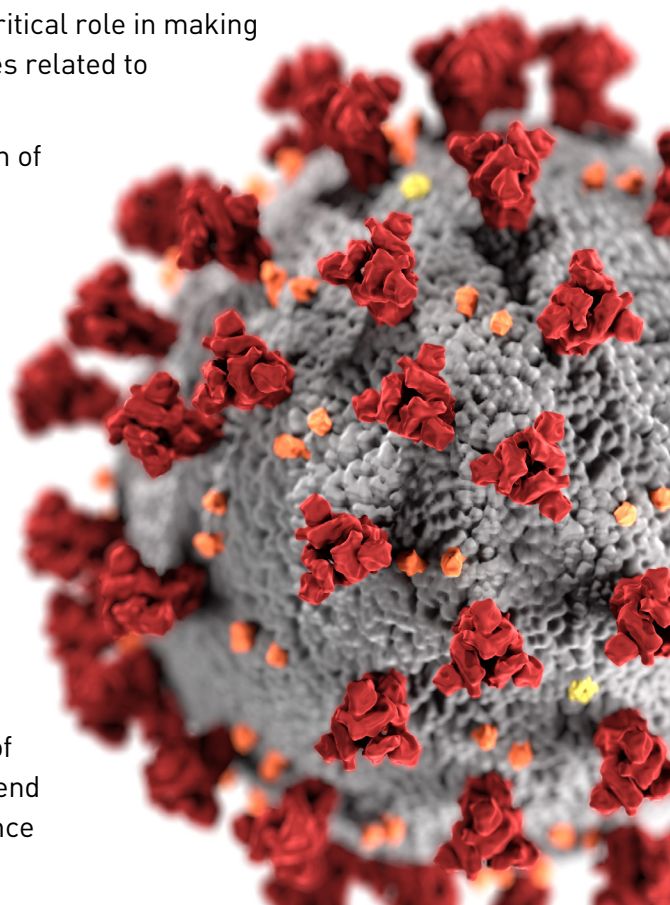
COVID-19: TELEMEDICINE EXPANSION

Given that COVID-19 is a communicable disease, patients are encouraged to utilize Telemedicine as much as possible instead of going in to their provider's office. As a part of Sanford Health Plan, all Members have access to Telemedicine services and we are strongly encouraging their use at this time.

As part of our pledge to help Members receive suitable access to needed health care services, we are now offering all expanded Telemedicine services at no cost-share to the Member. All e-visits, video visits, and telehealth visits are covered for the Member at 100% when received from a participating provider. This coverage is applied to all Sanford Health Plan's fully-insured product line.

COMMON QUESTIONS

Does this include all services, even those not related to COVID-19?

Yes, all services are eligible for coverage regardless of diagnosis.

Is all cost-share waived during this time?

Yes, all visits are covered at 100%.

Will reimbursement for Telemedicine visits where the patient is at home be the same as an in-person visit?

No, providers will still be paid according to their current reimbursement schedule. Sanford Health Plan will reimburse claims when coding according to accepted standards adopted by the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association and the Centers for Medicare & Medicaid Expansion.

Can providers utilize FaceTime to perform services?

Providers are responsible for their compliance with HIPAA and other requirements to protect patient privacy and safety. As long as HSS and OCR are not monitoring for or enforcing HIPAA compliance, Sanford Health Plan will cover telemedicine services in accordance with what is allowable for the duration of the COIVD-19 public health emergency.

Does this include phone conversations with patients?

Yes, audio-only to audio-only is covered at no cost to the Member.

Does the provider have to be licensed in the state they are providing telemedicine services?

Every provider must be licensed and in good standing in the state they are providing telemedicine services unless and until further guidance is issued. At this time, North Dakota recipients of telemedicine services do not need to receive telemedicine services from a North Dakota-licensed provider if the provider is in good standing and is recognized as having a valid license to practice medicine somewhere in the United States.

If you have any questions, please contact Provider Relations at **(800) 601-5086** or **providerrelations@sanfordhealth.org.**

COVID-19 Update: PROVIDER GUIDANCE FOR EXPANDED TELEMEDICINE SERVICES

During the COVID-19 National Emergency, the goal of Sanford Health Plan is to increase our members' access to Telehealth services.

We have pledged to help members receive suitable access to needed health care services at no cost-share to the member when received from a participating provider. To further this endeavor, we want to collaborate with providers to make this option as seamless as possible and make sure coding and reimbursement are right in order to process our members' claims.

Please review the following to understand how we can better collaborate.

Covered Telehealth Services

Telehealth coverage extends to the following services at no-cost to members:

- Audio-only visits
- Behavioral health and substance use disorder treatment
- Diabetes education
- Nutrition counseling
- Occupational therapy (OT) plan evaluation
- Office visits
- Physical therapy (PT) evaluation
- Speech therapy (ST) plan evaluation

Telehealth services must:

- Maintain visual or audio contact between the provider and member.
- Be medically appropriate and necessary with supporting documentation included in the member's clinical medical record.
- Use appropriate coding as noted below.

We will continue to cover many services when rendered via Telehealth as covered under our existing Telehealth policy. This includes services delivered via a non-HIPAA compliant platform as long as the COVID-19 National Emergency is in effect.

Sanford Health Plan will allow the lifting of license requirements for Telehealth providers in those states that have allowed for non-licensed providers in good standing to provider services. All other standard credentialing and billing practices still apply. Provider reimbursement will be subject to current contractual terms.

Required Coding

Applicable Modifier(s)	"GT" or "95"	Via interactive audio and video telecommunication systems. Billed by performing provider for real-time interaction between the provider and member who is located at a distant site from the reporting provider.
Place of Service	"02"	Telehealth — the location where health services and health related services are provided or received, through a telecommunication system.
Temporary Expanded Coverage	CPT®/HCPCS Code 99441-99443 98966-98968	Telephone services

Excluded Telehealth Services

Telehealth coverage does not cover:

- Acupuncture
- Benefits excluded from coverage based on the member's policy
- Chiropractic care
- Deferrable elective care
- Dental care
- Medically inappropriate services or services that cannot be performed adequately via Telehealth for the medical condition
- Occupational therapy (OT)
- Physical therapy (PT)
- Speech therapy (ST)

If you have questions regarding this information, please contact Sanford Health Plan Provider Relations at **providerrelations@sanfordhealth.org.**

# How to Access *my*SanfordHealthPlan Provider Portal

Sanford Health Plan has received an overwhelming number of requests to access the new *my*SanfordHealthPlan Provider Portal, which was launched October 2019. Due to this large volume, the creation of usernames has taken longer than expected. To verify your request is still in process, please send an email to **providerrelations@sanfordhealth.org**. Please include your first and last names, your personal email address, and facility name in the email.

Providers who have not yet requested access to the new *my*SanfordHealthPlan Provider Portal (launched October 2019) please follow the steps below.

1. Using Chrome web browser, go to **sanfordhealthplan.com/providers**.

2. In the top right corner, click "Login."

3. Click the Request Access link and complete ALL FIELDS as directed.
   a. First and last names and individual email address are required. Usernames will only be assigned to individuals. Usernames will not be assigned to groups.
   b. Enter the provider's Tax ID number in the Tax ID field – do not enter an NPI.
   c. The last four digits of the requester's Social Security number are required for future username/password recovery.
   d. Usernames will not be issued if any data is missing or incorrect on the form.
   e. Verify the accuracy of each entry prior to submission.
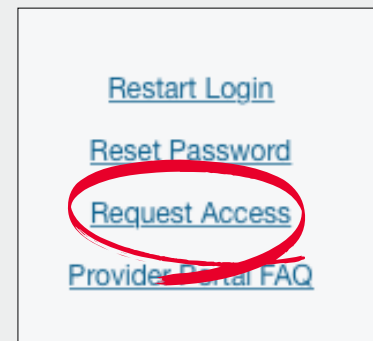
4. When Sanford Health Plan receives the request form, data will be verified for accuracy. Forms with missing or incorrect information will be rejected.

5. After the username is created, SHP will send two emails to the email address on the form. The first email message will include the username, and the second will include the temporary password.

6. The first time the user logs into the portal with the temporary password, the user will be prompted to enter a permanent password.

7. Requests to reset a password should be made by clicking the "Reset Password" link, as shown above.

Please contact Provider Relations at **(800) 601-5086** if you have any additional questions or concerns.

Sanford Health Plan Implementing Additional Optum® CES Edits

Sanford Health Plan will be implementing the additional Optum CES edits seen below on April 1, 2020.
The current Optum CES edits can be found **HERE**.

Effective Date	Optum® CES Edit Code	Edit Description	Institutional Claim Edit	Professional Claim Edit	Explanation Of Payment Code & Definition	835 Claim Adjustment Reason Code & Definition
4/1/2020	001ICM		X		M76: Facility Outpatient Invalid Principal Diagnosis	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	010ID		X		M76: Inpatient Invalid Other Diagnosis	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	01PID		X		M76: Invalid Principal Diagnosis	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	020CCP		X		CES51: Procedure Code Considered Component Of Another Procedure Code	CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
4/1/2020	021emo		x		CES49: Missing/Inconsistent Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
4/1/2020	040CCO		X		CES51: Procedure Code Considered Component Of Another Procedure	CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
4/1/2020	AOPf		X		CES1: Add-On Code Reported Without Required Primary Procedure Code	CO-107: The related or qualifying claim/service was not identified on this claim.
4/1/2020	ARMf		X		CES49: Deny Missing/Inconsistent Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
4/1/2020	CDL			X	CES8: Deleted Procedure Code	CO-181: Procedure code was invalid on the date of service.
4/1/2020	CPT			X	CES4: Invalid Procedure Code	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	FTDf		X		M52: Missing or Invalid Admission Date	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	GSP			X	CES53: Surgical Global Follow-up – Same Provider	CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
4/1/2020	HACNf		X		CES27: Medicare HAC Non-exempt Diagnosis Code	CO-233: Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
4/1/2020	ICD			X	M76: Invalid Diagnosis Code	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	ICM			X	M76: Missing Diagnosis Code	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	POAf		X		CES26: POA Diagnosis or Indicator Code	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	POAEf		X		CES27: Exempt Diagnosis Code	CO-233: Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
4/1/2020	POANF		X		CES27: POA Non-exempt Diagnosis Code	CO-233: Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
4/1/2020	PRE			X	CES53: Pre-op Procedure One Day Before Surgery	CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
4/1/2020	RFVRf		X		CES36: Patient Reason for Visit Required	CO-16: Claim/service lacks information or has submission/billing error(s).
4/1/2020	sAP			X	CES38: Medicaid Add-On Procedure – Primary Procedure Flagged	CO-B15: This service/procedure requires that a qualifying service/procedure be received and covered.
4/1/2020	SAS			X	EX27: Typically No Surgical Assistant	CO-54: Multiple physicians/assistants are not covered in this case.

Effective Date	Optum® CES Edit Code	Edit Description	Institutional Claim Edit	Professional Claim Edit	Explanation Of Payment Code & Definition	835 Claim Adjustment Reason Code & Definition
1/1/2020	074UBP			X	CES3: Units Greater Than One for Bilateral Procedure Billed With Modifier 50	CO-16: Claim/service lacks information or has submission/billing error(s).
1/1/2020	26TC			X	CES50: Service Performed During Active Global Period and Not Allowed	CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
1/1/2020	IM27f		X		CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	IMC			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	IMO			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	LNM			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	LNMf		X		CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	LPR			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	M27f		X		CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	MOD			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	NPT	New Patient Code Billed for Established Patient		X	CES24: Claim Lacks Required Qualifying Visit/Patient Code	CO-B16: 'New Patient' qualifications were not met.
1/1/2020	PCM			X	CES49: Missing/Invalid Modifier	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	sBC	Medicaid Bundled Edit		X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	sBI	Medicaid Bundled Edit		X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	MGK			X	CES29: Modifier GK or GZ	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	sMGZ			X	CES29: Modifier GK or GZ	CO-4: The procedure code is inconsistent with the modifier used or a required modifier is missing.
1/1/2020	sNP	Medicaid Non-Physician Services		X	CES46: Code not allowed when performed by this specialist at location	CO-171: Payment is denied when performed/billed by this type of provider in this type of facility.
1/1/2020	sSB	Medicaid Add-on Procedure without Primary Procedure		X	CES1: Add-on code reported without required primary procedure code	CO-107: The related or qualifying claim/service was not identified on this claim.
1/1/2020	sUN	Medicaid Unbundle		X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	sUNf	Medicaid Unbundle	X		CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	UEX	Unbundle		X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	UIN			X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately
1/1/2020	UNB			X	CES44: Procedure code is bundled and not separately payable	CO-234: This procedure is not paid separately

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