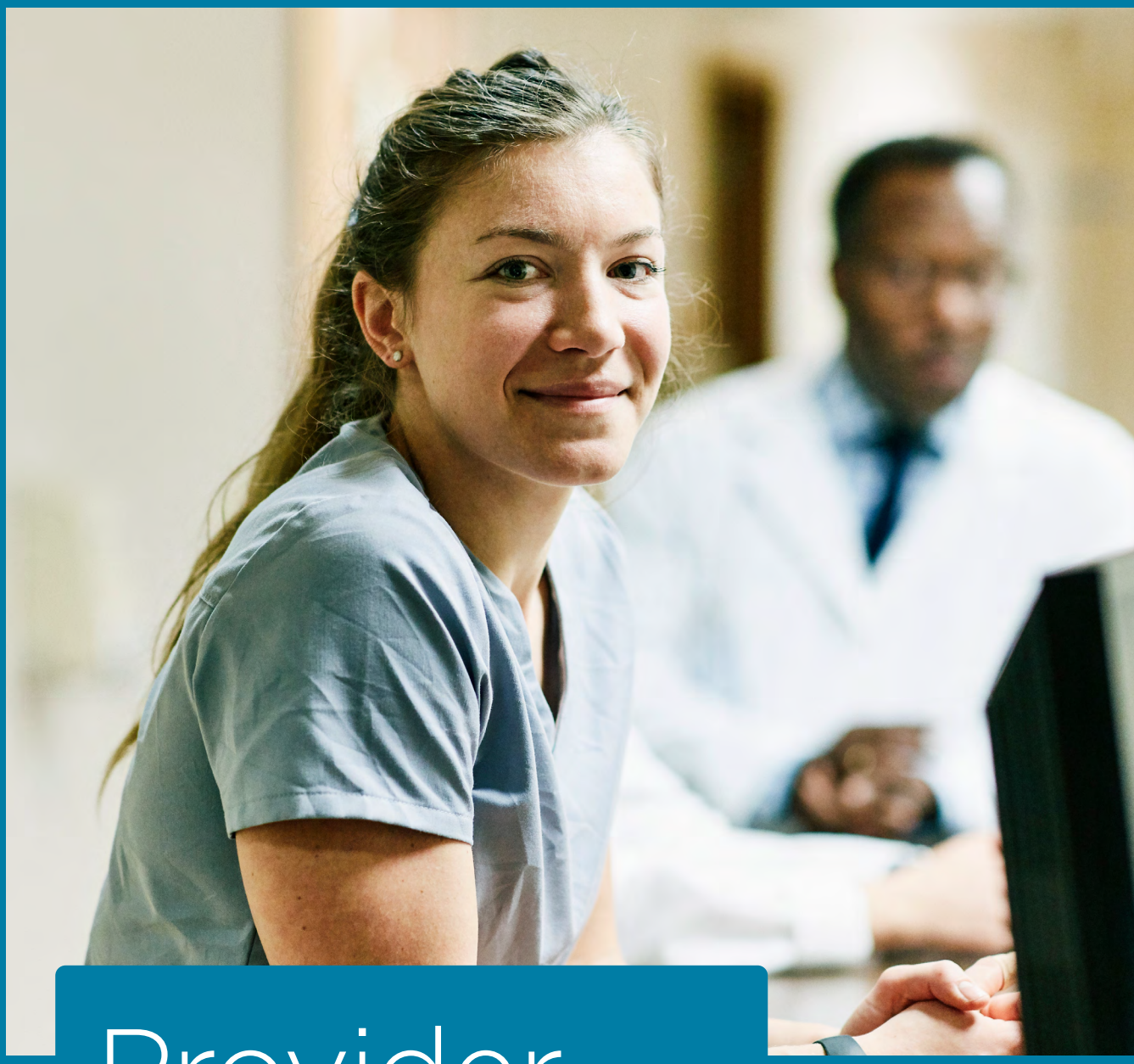
SANFORD
HEALTH PLAN



Provider Manual

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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.

This manual serves the administrative purposes of several companies, which include Sanford Health Plan and Sanford Health Plan of Minnesota, which are separate entities that may be referred separately in this manual or collectively referred to as Sanford Health Plan (SHP).

This manual also services the administrative purposes of Good Samaritan Insurance Plan of Nebraska (GSIPNE), which is a joint venture with Vetter Senior Living. Collectively the companies outlined in this paragraph will be referred to in this Manual as "the Plan".

Thank you for your participation.

Sanford Health Plan

Provider tools and resources

Our Provider Experience team is here to serve you. You can request assistance through:

Provider Customer Service

SHP Products: (800) 752-5863

Medicare Advantage Products: (844) 637-4760

1.1 Provider Portal

SHP Provider Portal: **provider.sanfordhealthplan.org/portal**. Sanford Health Plan provider portal allows you to submit a question, verify eligibility, check claim status, submit authorization requests and claim reconsideration requests. In addition, you can view current Sanford Health Plan policies regarding benefits, coverages and reimbursement. If you don't have access to the Provider Portal, you can request access at **sanfordhealthplan.com/providers/provider-portal-access-request**

Medicare Advantage Provider Portal: The ehealthsuite provider portal allows providers to verify member eligibility and claim status for Medicare Advantage members. The portal also provides an option to submit your 1500 format claim. You can request register for the ehealthsuite portal at **ehealth-shp.healthsuiteadvantage.com**

1.2 Online Resources

Sanford Health Plan website: **sanfordhealthplan.com**

Medicare Advantage websites:

- Align: **align.sanfordhealthplan.com**
- Align DUALPartnership: **align.sanfordhealthplan.com/dual**
- Great Plains Medicare Advantage: **greatplainsmedicareadvantage.com**

1.3 Provider Notifications

Our newsletter, Provider Perspective, is released quarterly and is available on our website **sanfordhealthplan.com/providers/newsletters**. We provide timely and current updates via email, called Fast Facts, which can also be found on our website **sanfordhealthplan.com/providers/news-and-alerts**. 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**.

Contact us

Department	Services Provided	Contact Information
Provider Relations	Connect with our Provider Relations team Monday through Friday from 8 a.m. to 5 p.m. CST.	(800) 752-5863 **providerrelations@sanfordhealth.org**
Appeals & Grievance	All commercial plan appeals must be submitted via the Sanford Health Plan Provider Portal. **sanfordhealthplan.com/providers** Medicare Advantage Appeals Provider Portal: **ehealth-shp.healthsuiteadvantage.com**	Medicare Advantage appeals can be mailed if provider doesn't have portal access **MAIL:** Sanford Health Plan Attn: Appeals P.O. Box 91110 Sioux Falls SD 57109-1110 **FAX:** (605) 312-8217
Claims	Get set up for electronic claim submission. See: **sanfordhealthplan.com/providers/edi-resources** Commercial Claims Payor ID: 91184 Medicare Advantage Claims: Payor ID RP035	**COMMERCIAL CLAIMS** Sanford Health Plan ATTN: Claims P.O. Box 91110 Sioux Falls, SD 57109-1110 **MEDICARE ADVANTAGE CLAIMS** Great Plains Medicare Advantage P.O. Box 31041 Tampa, FL 33631-3041
Care Management		(888) 315-0884 **shpcasemanagement@sanfordhealth.org**
Utilization Management	General Business Hours: 8 a.m. to 5 p.m. CST Monday-Friday NDPERS Business Hours: 8 a.m. to 5:30 p.m. CST Monday-Friday	**GENERAL LINE:** (800) 805-7938 **FAX:** (605) 328-6813 **um@sanfordhealth.org** **NDPERS LINE:** (888) 315-0885 **FAX:** (605) 328-6813 **um@sanfordhealth.org**
Pharmacy Management	General Business Hours: 8 a.m. to 5 p.m. CST Monday-Friday NDPERS Business Hours: 8 a.m. to 5:30 p.m. CST Monday-Friday	**GENERAL LINE:** (855) 305-5062 **FAX:** (701) 234-4568 **pharmacyservices@sanfordhealth.org** **Align powered by Sanford Health Plan:** (844) 642-9090 **pharmacyservices@sanfordhealth.org** **NDPERS LINE:** (877) 658-9194 **FAX:** (701) 234-4568 **pharmacyservices@sanfordhealth.org**
OptumRX		(844) 368-8732
Evicore	**evicore.com/resources/healthplan/sanford**	(800) 918-8924
Eviti	**connect.eviti.com/connect/account/login**	(855) 949-6268

Service area

The Plan does business within North Dakota, South Dakota and select counties within Minnesota, Nebraska and Iowa. Throughout these areas" the Plan offers various products with specified geographic coverage areas and networks.

Provider networks

Network	Description
Commercial	
Broad	A network that serves the products of Signature and Simplicity. This network may also be accessed by other Plan members upon prior authorization. This network is open to eligible providers who are located within the geographic coverage area of these products in North Dakota, South Dakota and select counties in Iowa and Minnesota.
Tiered	A network that serves the products of Sanford Plus. This network is comprised of two tiers: Tier 2 is comprised of the Broad Network of providers while Tier 1 is limited to eligible providers with a practice location within the geographic coverage area of these products, which is select counties in North Dakota, South Dakota, Iowa and Minnesota. In some states the Tier 1 network may be closed, or additional terms and conditions may apply.
Focused	A network that serves the products of Sanford True. This network is limited to eligible providers with a practice location within the geographic coverage area of these products, which is select counties in North Dakota, South Dakota, Iowa and Minnesota.
Client Specific	
North Dakota Public Employees Retirement System (NDPERS)	A network that serves the North Dakota Public Employee Retirement System. This network is comprised of two tiers: tier 2 is comprised of the Broad Network of providers while tier 1 is open to eligible providers who are located within the geographic coverage area of North Dakota, as well as counties contiguous to the state of North Dakota.
Sanford Employee Group Health (SGH)	A network that serves the employees of Sanford, a self-funded employer client of Sanford Health Plan. This network is curated by and for the employer. Providers of the Broad network may be included as determined by the client.

Medicare	
Medicare Select Supplement	A network of facilities that serves the members of our Medicare Select supplement product. This network is closed to new provider enrollment. The Medicare Select product is no longer being sold to new membership. It was previously available in select counties in Minnesota, North Dakota, Iowa and South Dakota.
Medicare Advantage MN/ND/SD/IA	A network that serves Medicare Advantage products of Align powered by Sanford Health Plan and are available in select counties in Minnesota, North Dakota, Iowa and South Dakota.
Special Needs Plans ND	A network that serves the following: 1. Institutional Special Needs Plans: Sanford's Great Plains Medicare Advantage 2. Dual Eligible Special Needs Plan: Align DUALPartnership Available in select counties in North Dakota. This is an open network.
Institutional Special Needs Plans SD/IA	A network that serves Institutional Special Needs Plan products sold with the name Great Plains Medicare Advantage. Iowa or South Dakota and are available in select counties in Iowa and South Dakota.
Institutional Special Needs Plans NE	A network that serves Institutional Special Needs Plan products sold via a joint venture with Vetter Health under the name: Good Samaritan Insurance Plan of Nebraska. Available in select counties in Nebraska. This is an open network.

**** Exceptions to provider network eligibility may apply from time to time to maintain network adequacy. Please check member directories to verify network status before rendering non-emergent care.***

For all members, it is important to check their specific online provider directory before care is rendered to ensure your network status. You can do this at any time on **sanfordhealthplan.com**.

In accordance with applicable regulation, the Plan has the sole right to establish provider networks and products (which may contain different tiers or levels of coverage) with such networks and products to be comprised of health care providers selected by the Plan or Employer Plan from the Plan's Panel of Participating Providers based on its selection criteria. Claims will be adjudicated according to the Member's Health Maintenance Contract or Employer Plan, as applicable.

2.1 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.

Medicare Advantage (MAPD)

Align Choice PLUS and Align Choice ELITE

3.1 Program Description

Align powered by Sanford Health Plan 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. 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 based on where they reside. See eligible counties and enrollment for more information.

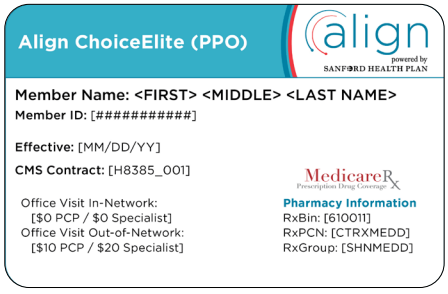
The network for Align powered by Sanford Health Plan consists of providers in our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas and Minnesota. For members to receive the highest level of benefits, they should see providers in our network. If an out-of-network provider is used, members' share of the costs for services may be higher. Providers must be eligible to participate with Medicare to provide out-of-network services, except for emergency care. Providers in our network are listed in the Provider Directory found at **align.sanfordhealthplan.com**.

3.2 Member Eligibility

Each provider is responsible for ensuring that a member is eligible for coverage at the time services are rendered.

- Eligibility can easily be verified using these tools:
  - eHealthsuite provider portal at **ehsprd-shp300hs.healthsuiteadvantage.com**
  - Call the Customer Service Department at (844) 637-4760

3.3 ID Card



3.4 Billing Requirements

Electronic claims submitted for Medicare Advantage should use Payor ID RP035. If you do not wish to file claims electronically, paper claims can be mailed to:

Medicare Advantage Sanford Health Plan/RAM
PO Box 31041
Tampa, FL 33631-3041

3.5 Member Supplemental Benefits

Information on the supplemental benefits included in these plans are available on our website **sanfordhealthplan.com/align/benefits**

Dual Eligible Special Needs Plan (D-SNP)

Align DUALpartnership (HMO D-SNP)

4.1 Program Description

The D-SNP covers members in North Dakota beginning January 1, 2025. D-SNPs are designed for individuals who are dually enrolled in Medicare and Medicaid. These individuals are often referred to as "dual eligibles" or "dually eligible individuals".

4.2 Member Eligibility

Those eligible for D-SNP include members who:

- Qualify for Medicare because of age (65 or older) or due to disability;
- **AND** are eligible for Medicaid because they meet the requirements to qualify for Medicaid in North Dakota
- Live in the SHP D-SNP service area

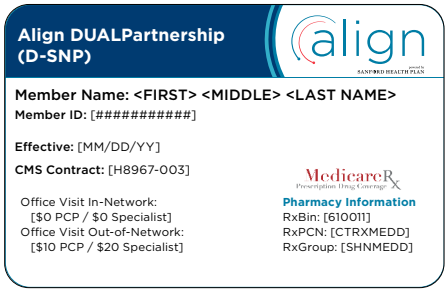
D-SNP is designed to help dual-eligible members more easily get the care they need. The D-SNP plan streamlines access to care by coordinating:

- Medicare and Medicaid benefits, such as professional, acute care, ancillary, and pharmaceutical services that are covered by Medicare and Medicaid
- Medicaid waiver services such as cost-sharing, transportation, attendant care, assisted living and other services.

D-SNP care coordination model addresses social determinants of health by identifying members who may benefit from housing and food support services and then connecting them with community agencies. Each member is connected to a care coordinator. See Model of Care section for additional information on how our D-SNP members are served

- Verifying eligibility
  - Member ID Card. ***Note that changes do occur and the card alone does not guarantee member eligibility***.
  - Verify eligibility online using our eHealthsuite provider portal at **ehsprd-shp300hs.healthsuiteadvantage.com**
  - Call the Customer Service Department at (844) 637-4760

4.3 ID Card



4.4 Billing Requirements

D-SNP provider agrees to accept SHP's D-SNP Medicare reimbursement as payment in full for services rendered to Dual Eligible Members, or to bill North Dakota Medicaid as applicable for any additional Medicare payments that may be reimbursed by Medicaid.

Electronic claims submitted for Medicare Advantage should use Payor ID RP035. If you do not wish to file claims electronically, paper claims can be mailed to:

Medicare Advantage Sanford Health Plan/RAM
PO Box 31041
Tampa, FL 33631-3041

After Sanford Health Plan/RAM processes the D-SNP claim, the provider must submit any remaining balance to North Dakota Medicaid as a Medicare Crossover Claim. ND Medicaid would be billed for any remaining deductible, copay and/or coinsurance. The provider should follow their normal process for submitting the remaining balance of the D-SNP claim to ND Medicaid.

4.6 Member Supplemental Benefits

sanfordhealthplan.com/align/lp/dsnp/dual-eligible-special-needs-plans

Institutional Special Needs Plan (I-SNP)

Great Plains Medicare Advantage (GPMA)

5.1 Program Description

Great Plains Medicare Advantage (HMO SNP) ("GPMA") is a Medicare Advantage Institutional Special Needs Plan designed to improve the care for the residents of Skilled Nursing, Assisted Living or Basic Care Facilities in Nebraska, North Dakota and South Dakota. The Plan's target population is a Medicare beneficiary who resides or is expected to reside in a facility for 90 days or longer. This coverage includes supplemental vision, hearing and dental.

5.2 Member Eligibility

These individuals have Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), live in the plan's service area, and live in the community but need the level of care a facility offers, or live (or are expected to live) for at least 90 days straight in a facility like a:

- Nursing home
- Intermediate care facility
- Skilled nursing facility
- Rehabilitation hospital
- Long-term care hospital
- Swing-bed hospital
- Psychiatric hospital
- Other facility that offers similar long-term, health care services and whose residents have similar needs and health care status as residents of the facilities listed above

5.3 Verifying Eligibility

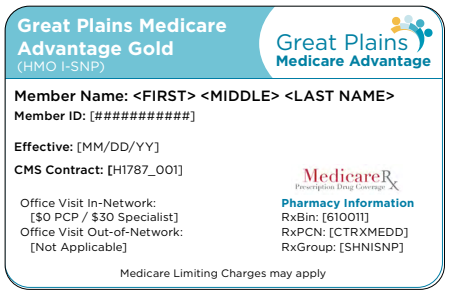
All participating providers are responsible for verifying a member's eligibility during each visit, or before the appointment.

GPMA has the most current eligibility information. You can verify member eligibility through the following ways:

- Member ID Card. ***Note that changes do occur and the card alone does not guarantee member eligibility.***
- Verify eligibility online using our eHealthsuite provider portal at **ehsprd-shp300hs.healthsuiteadvantage.com**
- Call the Customer Service Department at (844) 637-4760

Note: Membership data is subject to change. CMS may retroactively terminate members for various reasons and recoup payments it made to the plan. When this occurs, the Plan's claims recovery unit will request a refund from the provider for any services furnished when the member was ineligible. The provider must then contact CMS Eligibility to determine the member's actual benefit coverage for the date of service in question and resubmit the claims to the CMS if appropriate. Typically, the beneficiary is disenrolled from the GPMA plan and enrolled in Traditional Medicare fee-for-service. If the Medicare timely filing period for claims submission has passed, Federal law gives providers an extra six months after GPMA's recoupment to file a claim.

5.4 ID Card



5.5 Billing Requirements

Electronic claims submitted for Medicare Advantage should use Payor ID RP035.

GPMA also offers the ability to submit professional 1500 claims through our eHealthsuite Provider Portal at **ehealth-shp.healthsuiteadvantage.com**. Instructions on how to gain access to the portal can be found on the GPMA website: **greatplainsmedicareadvantage.com**.

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

Great Plains Medicare Advantage
P.O. Box 31041
Tampa, FL 33631-3041

Medicare Advantage benefits and services

All Medicare Advantage members receive benefits and services as defined in their Evidence of Coverage (EOC). Benefits and Services are subject to change on January 1st of each year. Providers may contact Customer Service for information on covered services and verification of applicable member copayments and/or cost-sharing owed by the member to the provider for the provision of services.

All participating providers are obligated to bill and collect applicable member copayments and/or cost-sharing as permitted by GPMA and by law. Participating providers of Great Plains Medicare Advantage are, however, prohibited from balance-billing members' copayments and/or cost-sharing when members are determined qualified and eligible for benefits under the state Medicaid program. For more information, go to **cms.gov/MLNMattersArticles/Downloads/SE1128.pdf.**

6.1 Emergent and Urgent Services

Medicare Advantage follows the Medicare definitions of "emergency medical condition", "emergency services" and "urgently needed services" as defined in the Medicare Managed Care Manual, Chapter 4 Section 20.2.

6.2 Emergency Medical Condition

"A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part."

6.3 Emergency Services

"Covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services; and needed to evaluate or treat an emergency medical condition."

6.4 Urgently Needed Services

"Covered services that are not emergency services as defined above but:

- Are medically necessary and immediately required as a result of an unforeseen illness, injury or condition;
- Are provided when the member is temporarily absent from the plan's service area or under unusual and extraordinary circumstances when the member is in the service area, and the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services through the Plan network."

The Plan's provider network includes multiple hospitals, emergency rooms and providers able to treat the emergent conditions of our members twenty-four (24) hours a day, seven (7) days a week. Emergent services should be obtained from the closest facility that can provide the service. All emergency and urgently needed services may occur without prior authorization or referrals. For emergent issues occurring onsite in the member's nursing home or in the service area, the PCP/NFist is generally responsible for providing, directing or facilitating a member's emergent care. This includes emergent services provided onsite in the nursing facility ("treatment in place"). The PCP/NFist or his/her designee must be available 24 hours a day, 7 days a week to assist members needing emergent services.

Emergent issues requiring services or expertise not available onsite in the member's nursing home are addressed by transferring the member to an acute care hospital or emergency room able to provide the needed care. The PCP/NFist, working with the Plan Advanced Practice Provider, is generally responsible for coordinating the transition of the member to the hospital or emergency room, including communicating with the hospital or emergency room about the Member. Members may have a copayment responsibility for outpatient emergency visits unless it results in an admission.

While most members remain in the service area, members may at times receive emergency services and urgently needed services from any provider regardless of whether services are obtained within or outside Medicare Advantage authorized service area or network. In unusual circumstances, when the member is in the service area and the network is temporarily unavailable or inaccessible, prior approval is needed and will be approved for only continuity of care.

Medicare Advantage network includes contracts with ambulance transport services when an ambulance is required for member safety. In cases where ambulance services are dispatched through 911 or a local equivalent, the Plan follows Medicare rules on coverage for ambulance services as outlined in 42 CFR 410.40. Due to the emergency medical condition, members are only liable for the applicable cost-sharing.

6.5 Excluded Services

In addition to any exclusions or limitations described in the members' Evidence of Coverage (EOC), the following items and services are not covered under the Original Medicare Plan or by Medicare Advantage:

- Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan
- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered.
- Orthopedic shoes, unless they are part of a leg brace and included in the cost of the brace (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Supportive devices for the feet (exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease).
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services unless otherwise specified in the EOC.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hypogamy unless otherwise included in the member's Part D benefit. Please see the formulary for details.
- Reversal of sterilization measures and non-prescription contraceptive supplies.
- Naturopathic services.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergencies received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under the Plan, the Plan will reimburse veterans for the difference. Members are still responsible for the Plan cost-sharing amount.

6.6 Continuity of Care

Medicare Advantage's policy is to provide for continuity and coordination of care with medical practitioners treating the same patient and coordination between medical and behavioral health services. When a practitioner leaves Medicare Advantage's network and a member is in an active course of treatment, our Utilization Management staff will attempt to minimize any disruption in care by potentially offering continuity of care services with the current provider for a reasonable period of time.

In addition, members undergoing active treatment for a chronic or acute medical condition will have access to the existing provider through the current period of active treatment or a maximum of 90 calendar days, whichever is shorter.

If the Plan terminates a participating provider, we will work to transition a member into care with a participating physician or other provider within Great Plains Medicare Advantage's network. The Plan is not responsible for the health care services provided by the terminated provider following the date of termination under such circumstances.

Medicare Advantage also recognizes that new members join our health plan and may have already begun treatment with a provider who is not in Great Plains Medicare Advantage's provider network. Under these circumstances, the Plan will work to coordinate care with the provider by identifying the course of treatment already ordered and offering the member a transition period of up to 90 calendar days to complete the current course of treatment.

Medicare Advantage will honor plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, specialist referrals and any other on-going services) initiated prior to a new member's enrollment for a period of up to 90 calendar days or until the Primary Care Physician evaluates the member and establishes a new plan of care. For additional information about continuity of care or to request authorization for such services, please contact our Prior Authorization Department at (800) 805-7938 (TTY: (888) 279-1549).

6.7 Referrals

Medicare Advantage uses a gatekeeper model, meaning referrals and testing should be reviewed in advance by the member's PCP or Plan Advanced Practice Provider to help in care coordination.

A member's PCP or Plan's Advanced Practice Provider may make referrals for in-network specialists. Whenever possible, in-network specialists are encouraged to provide member visits in the member's nursing facility for safety and comfort. All specialist physician services must be approved by the member's PCP or Plan Advanced Practice Provider.

Whether the referral originates with the PCP, Plan Advanced Practice Provider or specialists, referrals should be made to Medicare Advantage participating physicians/facilities. The PCP or Plan Advanced Practice Provider must approve the referral.

Referrals to "out of network" physicians or facilities require prior authorization from the Plan's Utilization Management team. Out-of-network referrals may be allowed in certain circumstances where in-network providers or services are not reasonably available to the member, or there is a continuity of care concern (see section on Continuity of Care).

6.8 Notification of Inpatient Admissions

Medicare Advantage requires providers to notify the plan of an inpatient admission. For notification, providers should call (800) 805-7938.

Emergent admission notification must be received within one business day of admission. For observation stays, Medicare Advantage expects hospitals (including critical access hospitals) to furnish the Medicare Outpatient Observation Notice (MOON) as required by law. This obligation exists even though Medicare Advantage waives the three-day stay requirement.

6.9 Prior Authorization

Requests for prior authorizations of services should be made before or at the time of scheduling the service. Plan PCPs, Practitioners and Specialists are responsible for requesting prior authorization for the services they order. Facilities may also request prior authorizations for scheduled admissions, elective admissions, procedures and outpatient services ordered by the PCP or Advanced Practice Provider.

Medicare Advantage recommends calling at least fourteen (14) days in advance of an elective admission, procedure or service. For prior authorizations, providers can fax a Request Prior Authorization form to (605) 312-8219 or call our Utilization Management department at (800) 805-7938.

NOTE: Oncology treatment and services must be entered and authorized through Eviti Connect online at eviti.com.

6.10 Services Requiring Prior Authorization

Providers should refer to the provider section of the plan's website for the listing of services typically requiring authorization. The presence or absence of a service or procedure on the list does not determine coverage or benefit. Please visit **sanfordhealthplan.com/align/help** and refer to the Prior Authorizations section.

6.11 Documentation for Prior Authorizations

The Utilization Management department evaluates requests using CMS guidelines as well as nationally accepted criteria to process prior authorization requests and notifies the provider and member of the determination.

Decisions and Time Frames

- **Expedited:** When you as a provider believe waiting for a decision under the routine time frame could place the member's life, health or ability to regain maximum function in serious jeopardy, you may request an expedited request. Expedited requests will be determined within 72 hours or as soon as the member's health requires.
- **Routine:** If all required information is submitted at the time of the request, CMS generally mandates a health plan determination within 14 calendar days.

Once the Utilization Management department receives the request for authorization, Medicare Advantage will review the request using nationally coverage determinations (NCDs) or local coverage determinations (LCDs) or nationally recognized industry standard criteria. If the request for authorization is approved, Medicare Advantage will assign an authorization number and enter the information in the Plan's medical management system.

The authorization number is only used for reference, it does not signify approval. **Claims for services requiring prior authorization must be submitted with the assigned authorization numbers.** This authorization number can be used to reference the admission, service or procedure.

6.12 Concurrent Review

Concurrent Review is the process of initial assessment and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital, rehabilitation, SNF or other inpatient admission to ensure:

- Covered services are provided at the appropriate level of care; and
- Services are administered according to the individual facility contract

The Plan's Utilization Management department uses CMS guidelines and Milliman Care Guidelines (MCGs) to conduct a medical necessity review. Medicare Advantage is responsible for final authorization.

Medicare Advantage's preferred method for concurrent review is a live dialogue between our Utilization Management nursing staff and the facility UM staff within one business day of notification or on the last covered day. If clinical information is not received within 24 hours of admission or on the last covered day, an administrative denial may be issued, or the medical necessity will be made on the existing clinical criteria. Facilities must fax the member's clinical information within one business day of notification to (605) 312-8219.

Review is not required for readmission to the referring Facility (the member's primary nursing facility); however, if the patient is transitioning to an alternate facility, requests for review should be faxed to (605) 312-8219.

A Plan Medical Director reviews all acute, rehab, long-term acute care (LTAC) and SNF confinements that do not meet medical necessity criteria and issues a determination. If the Plan Medical Director determines that the inpatient or SNF confinement does not meet medical necessity criteria, the Plan will issue an adverse determination (a denial). The Utilization Management nurse or designee will notify the provider(s), verbally and in writing and will notify the member as required by law. The criteria used for the determination is available to the practitioner/facility upon request. To request a copy of the criteria on which a decision is made, please contact Customer Service at (844) 637-4760.

For members receiving hospital care and for those who transfer to a non-referring SNF or Acute Inpatient Rehabilitation Care, Medicare Advantage will approve the request or issue a denial if the request is not medically necessary. Medicare Advantage will also issue a denial if a member who is already receiving care in an Acute Inpatient Rehabilitation Facility has been determined to no longer require further treatment at that level of care. This document will include information on the members' or their authorized representatives' right to file an expedited appeal, as well as instructions on how to do so if the member or member's physician does not believe the denial is appropriate.

Medicare Advantage also issues written Notice of Medicare Non-Coverage (NOMNC) determinations by CMS guidelines. The facility is responsible for delivering the notice to the member or their authorized representative/power of attorney (POA) and for having the member, authorized representative or POA sign the notice within the written time frame listed in the Adverse Determination section of the provider manual. The facility is expected to fax a copy of the signed NOMNC back to Utilization Management department at the number provided. The NOMNC includes information on members' rights to file a fast-track appeal. . **Capitated Nursing Facilities must continue to follow their standard NOMNC process for capitated services. The Plan will not generate these NOMNCs.**

6.13 Rendering of Adverse Determinations (Denials)

In some instances, the Utilization Management staff is authorized to render an administrative denial decision to participating providers based only on contractual terms, benefits or eligibility. Late authorization, or not providing clinical information as requested, will result in an administrative adverse determination and does not allow the provider to appeal.

Only a Medicare Advantage Medical Director, or delegated physician, may render an adverse determination (denial) based on medical necessity, but he/she may also decide based on administrative guidelines. When making a decision based on medical necessity, the Plan requests necessary information, including pertinent clinical information from the treating provider, to allow the Medical Director to make appropriate determinations. The Medical Director may suggest an alternative Covered Service to the requesting provider. If the Medical Director makes a determination to deny or limit an admission, procedure, service or extension of stay, Medicare Advantage notifies the facility or provider's office of the denial of service. Notices are issued to the provider, the member or the member's authorized representative documenting the original denied request and the alternative approved service, along with the process for appeal.

Medicare Advantage employees are not compensated for denial of services. The PCP/NFist or Attending Physician may request a peer-to-peer phone call with the Plan Medical Director to discuss adverse determinations by calling Utilization Management at (844) 637-4760.

After the adverse determination is rendered, the decision may not be changed unless an appeal is initiated.

6.14 Notification of Adverse Determinations (Denials)

The reason for each denial, including the specific utilization review criteria with pertinent subset/information or benefits provision used in the determination of the denial, is included in the written notification and sent to the provider and/or member as applicable. Written notifications are sent to the members and requesting provider as follows:

- For non-urgent pre-service decisions-within 14 calendar days of the request.
- For urgent pre-service decisions–*within 72 hours of the request.
- For urgent concurrent decisions–*within 24 hours of the request.

*Denotes initial oral notification of the denial decision is provided with electronic or written notification given no later than three calendar days after the oral notification.

Medicare Advantage complies with CMS requirements for written notifications to members, including rights to file appeals and grievances.

6.15 Supplemental Services for Medicare Advantage Members

Supplemental Vision: Medicare Advantage members have access to supplemental vision benefits such as routine eye exams, glasses and contacts in accordance with their evidence of coverage (EOC). The benefits for these services are processed through VSP Vision. For additional information, you may contact VSP at (844) 344-4768 or review their website at **vsp.com**.

Supplemental Hearing: Medicare Advantage members have access to supplemental hearing benefits such as hearing exams and hearing aids in accordance with their evidence of coverage (EOC). The benefits for these services are processed through NationsHearing. For additional information, you may contact NationsHearing at (877) 212-0858 or review their website at **nationshearing.com/alignsanfordhealthplan**.

Supplemental Dental

Delta Dental – MN, ND, NE
Electronic Claims: Payor ID 07000
Paper Claims: Delta Dental, P.O. Box 9120, Farmington Hills, MI 48333-9120

Delta Dental – SD, IA
Electronic Claims: Payor ID SDCMS
Paper Claims: Delta Dental, P.O. Box 9215, Farmington Hills, MI 48333-9215
Delta Dental customer service phone: (866) 502-9753 (TTY-711) – 8 a.m. to 5 p.m. CST Monday through Friday.

Special Needs Plans Model of Care

7.1 The Centers for Medicare and Medicaid Services (CMS) require all special needs plans (SNPs) to provide initial and annual Model of Care (MOC) training to network providers that are contracted to see SNP members and out-of-network providers who routinely see SNP members.

Sanford Health Plan offers SNPs and therefore required by CMS to make training available. This training should be completed upon hiring and annually thereafter. Training should be done by providers and other staff who may participate in a SNP member Interdisciplinary Care Team, responsible for implementation of the member's Care Plan, or manage planned or unplanned transitions of care.

Document and maintain MOC training completion records and provide such records upon request to validate that the training has been completed. Records must include the provider's or staff person's name, their department or title, and the date the training was completed. If a provider fails to complete the CMS required training and remains non-compliant, they may be required to develop a Corrective Action Plan or be subject to other remediation activities.

Sanford Health Plan's Model of Care

8.1 GPMA and D-SNP are required to have a Model of Care (MOC). The MOC provides members with a patient-centered, primary care-driven care experience. Focusing on the prevention of avoidable hospitalizations and reduction of acute exacerbations, the MOC is designed to improve the quality of life for members while providing access to the same services covered by Original Medicare. Goals of the MOC include:

- Improve coordination of care through an identified point of contact
- Improve transitions of care across health care settings and providers
- Improve access to preventive health services;
- Improve member health outcomes

SHP's policy, Model of Care Training for Provider Network, details our obligation to provide high quality coordinated care consistent with the Centers for Medicare and Medicaid Services (CMS) rules and regulations as provided under section 1859(f)(7) of the Social Security Act related to developing and operationalizing a Model of Care approved by the National Committee for Quality Assurance (NCQA) on behalf of CMS. CMS requires Medicare Advantage Special Needs Plans to establish a MOC to provide the foundation and structure for implementing and operating a Special Needs Plan (SNP).

The MOC has four focus areas to address member needs:

- Description of the Special Needs Population
- Care Coordination
- Provider Network
- Quality Measurement and Performance Improvement

SHP performs training for providers (both contracted and out of network providers that routinely see members). This training is provided as part of the initial enrollment and annually thereafter. Providers are required to attest each year that MOC training for their staff was completed. The complete MOC can be viewed in the Medicare Advantage Provider Portal.

Provider responsibilities

9.1 Access to Care

Members have access to care 24 hours a day, 7 days a week as medically necessary. Medicare Advantage has additional policies in place to make sure members have timely access to routine, preventive and urgent care services.

- PCPs, referred to by Great Plains Medicare Advantage as NFists, are required to provide routine, preventive care and monitoring visits for their assigned members on-site at the member's nursing facility residence every 60 days for all members and more frequently (every 30 days) for members identified as a moderate or high risk.
- Routine visits for non-urgent new-onset symptoms or conditions or condition exacerbations within one week (7 days) on-site at member's nursing facility residence.
- Immediate urgent and emergent care on-site at member's nursing facility residence or in the physician's office or telephonically in coordination with the Nurse Practitioner.
- 24 hours a day, 7 days a week telephonic access for medically necessary member care, with approved and contracted physician coverage during time off (call coverage), with emergency care calls, both weekdays or after-hours, responded to immediately; urgent care calls, weekdays and after-hours, responded to within 30 minutes; and routine care calls returned by the end of the day.
- Specialists are required to be available for a consultation or new patient appointment within 21 days of the initial request and to be immediately available to PCPs for an urgent or emergent consult regarding a member.
- Telephone Access (applicable to all contracted providers regarding calls from members, members' caregivers, Great Plains Medicare Advantage Advanced Practice Providers, Great Plains Medicare Advantage Medical Director and Utilization Management staff and nursing home facility staff).
- Emergency care calls, both weekdays and after-hours calls, will be dealt with immediately.
- Urgent care calls, both weekdays and after-hours calls, will be returned within 30 minutes.
- Routine care calls, both weekdays and after-hours calls, will be returned promptly. All calls are answered promptly by the provider, provider staff and/or a reliable paging service or answering service.

9.2 Balance Billing Members

Participating providers cannot balance bill members for covered services, other than for amounts attributed to deductible, coinsurance or copayments. Member requested or non-covered services may only be billed to the member with advanced written member consent which should include an estimate of the charges. A copy of the consent is to be kept on file and a copy available upon Plan request.

Sanford Health Plan Medicare Advantage providers may not balance bill D-SNP members for any services determined by the Plan to be non-covered, or for amounts attributed to deductible, coinsurance or copayments. Per the Department of Health and Human Services, Medical Services Division, the D-SNP provider agrees to accept the D-SNP Medicare reimbursement as payment in full for services rendered to Dual Eligible Members, or to bill North Dakota Medicaid as applicable for any additional payments that may be reimbursed by Medicaid.

9.3 Price Disclosure to Patients

Providers and facilities are required to give patients cost estimates ahead of a service as well as potential out-of-network costs. The consolidated Appropriations Act of 2021 established requirements for providers, facilities, and providers of air ambulance services to protect consumers from surprise medical bills. These requirements are collectively referred to as "No Surprise" rules. Among other things, these include prohibiting balance billing in certain circumstances and requiring disclosure about balance billing protections, requiring transparency around health care costs, providing consumer protections related to continuity of care, and establishing requirements related to provider directories. Please refer to the SHP website for more information on the No Surprises Act and requirements at **sanfordhealthplan.com/no-surprises-act**.

9.4 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 or any other basis prohibited by law. In the rare event, a provider decides to refuse to treat a Member, the Provider must contact the Plan's Care Management team at (888) 315-0884 as soon as possible so we can assist the Member in transitioning to a new provider.

For Medicare Advantage members, PCP/NFists have a limited right to request a member be assigned to a new PCP/NFist. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member and a physical or behavioral health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.
- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists.

If the member's behavior cannot be remedied through reasonable efforts and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to Sanford Health Plan. The Plan will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment. If so, The Plan will document all actions taken by the provider and The Plan to cure the situation, including member education and counseling. A PCP/NFist cannot request disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member also may request a change in PCP/NFist for any reason. The PCP/NFist change requested by the member will be effective the first (1st) of the month following the receipt of the request unless circumstances require an immediate change.

9.5 National Provider Identifier Numbers (NPI)

Health care providers acquire a unique 10-digit National Provider Identifier (NPI) to identify themselves in a standard way throughout their industries. Individuals or organizations apply for an NPI through the CMS **National Plan and Provider Enumeration System (NPPES)**. Providers submitting claims to the Plan must use their assigned NPI on their claim for.

9.6 National Plan and Provider Enumeration System (NPPES) Updates

It is essential that you update your information with both the Plan and the CMS NPPES database to ensure accurate provider data is displayed for our members and that accurate processing of claims can occur.

If the NPPES database is kept up to date by providers, our organization can rely on it as a primary data resource for our provider directories, instead of calling your office for this information. With updated information, we can download the NPPES database and compare the provider data to the information in our existing provider directory to verify its accuracy.

If you have any questions pertaining to NPPES, you may reference NPPES help at **nppes.cms.hhs.gov/webhelp**

9.7 Privacy Regulation

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.

9.8 Provider Agreement Terminations

Provider (practitioner, organization, and hospital) voluntary terminations must be made in writing to the Plan 60 days prior to the effective termination date. For Minnesota practitioners or facilities, you must give the Plan 120-day notice. All written notices should be clear and legible. This will ensure accuracy and allow for changes to be completed in a timely manner.

Send the termination notification on your organization's letterhead and fax to (605) 328-7224 or you may mail the information to the following address:

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

You may receive an inquiry as to the reason behind termination as an effort to improve our provider network relations.

9.9 Cultural and Linguistic Competency

The 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**.

9.10 Medical Records

The 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. The medical record communicates the Member's past medical treatment and history, past and current health status, diagnosis, treatment plans for future health care and referred service notes. 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.

Medical records may be requested by the 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 the Plan and a provider office for a Member (past or present) do not require a formal release of information from the member due to the provider's office and the 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 21 elements. However, there are only 6 core 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 **sanfordhealthplan.com/providers**.

- Medical Record (MM-024)

9.11 Supplying Medical Records Upon Request

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 the Plan, at no charge, the requested medical records as allowed by applicable laws, regulations and program requirements.

Provider marketing guidelines

10.1 Below is a general guideline to assist Medicare Advantage providers in determining what marketing and patient outreach activities are permissible under the CMS guidelines. CMS has advised Medicare Advantage plans to prohibit providers from steering or attempting to steer an undecided potential enrollee toward a specific plan based on the financial interest of the provider

Providers should remain neutral parties to the extent they assist beneficiaries with enrollment decisions.

Providers can:

- Mail or provide a letter to patients notifying them of their affiliation with Medicare Advantage.
- Provide objective information to patients on specific plan attributes and formularies, based on a patient's medications and health care needs in the course of treating the patient.
- Answer questions or discuss the merits of a plan or plans, including cost-sharing and benefit information (these discussions may occur in areas where care is delivered).
- Refer patients to other sources of information, such as the State Health Insurance Assistance Programs (SHIPS), Medicare Advantage marketing representatives, State Medicaid or 1-800-Medicare to assist the patient in learning about the plan and making a health care enrollment decision.
- Provide beneficiaries with communication materials furnished by the Plan in a treatment setting.
- Refer patients to the plan marketing materials available in common areas.
- Display and distribute in common areas Medicare Advantage marketing materials. The office must display or offer to display materials for all participating Medicare Advantage plans if requested by the plan.
- Provide information and assistance in applying for the Low-Income Subsidy.
- Display promotional items with the Plan's Medicare Advantage logo.
- Allow the Plan to have a room/space in provider offices completely separate from where patients receive health care services, to provide Medicare beneficiaries with access to a Medicare Advantage sales representative.

Providers cannot:

- Offer anything of monetary value to induce enrollees to select them as their provider.
- Distribute marketing materials/applications in an exam room.
- Urge or steer towards any specific plan or a limited set of plans based on the provider's own interest.
- Collect/accept enrollment applications or scope of appointment forms on behalf of the plan.
- Offer inducements to persuade beneficiaries to enroll in a particular plan or organization.
- Health Screen potential enrollees when distributing information to patients, health screening is prohibited.
- Expect compensation directly or indirectly from the plan for beneficiary enrollment activity.
- Call members who are disenrolling from the health plan to encourage re-enrollment in a health plan.
- Call patients to invite patients to the sales and marketing activities of a health plan.
- Advertise using the Plan's name without the Plan's prior consent and potentially CMS approval depending upon the content of the advertisement.

Join the Network

11.1 Become a Participating Provider

Complete our online Contract Request Form found online at sanfordhealthplan.com/providers. A provider contract specialist will contact you once the Contract Request Form has been reviewed. We respond to all contract requests, but we do not guarantee that a contract offer will be extended. If the contract is extended, you will be asked to complete additional steps before your participation is implemented.

For details, please visit our website at **sanfordhealthplan.com/providers/contracting-and-credentialing**. There, you will find instructions about how to submit a request, enrollment, credentialing and other important information.

Credentialing

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

Credentialing requirements and process

11.3 Initial Credentialing

For Individual Providers: All new providers must complete our Initial Credentialing Application Request Form. The Plan utilizes the Sanford Provider Hub for the Individual Provider credentialing process. For currently contracted providers, please also complete our Provider Information Update/Change Form. If you have questions regarding the Sanford Provider Hub, please see this **FAQ**.

For Facilities: Please complete our Facility Credentialing Application for any newly contracted facility, or when adding a facility to your existing contract. Once completed, email the application and all supporting documentation to **provnetcontract.shp@sanfordhealth.org** for processing. An on-site survey may be deemed necessary to approve an application.

During the initial credentialing period, providers should submit claims to the 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 be released for processing.

The Credentialing 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.

11.4 Recredentialing

All participating practitioners and facilities must be recredentialed at least every 36 months. At the time of your recredentialing, Verification Services will send an email providing you the next steps for use of the Provider Hub. Add **verificationservices@sanfordhealth.org** to your safe sender list to ensure you receive this email.

For any additional questions regarding credentialing, please contact our Credentialing Department at:

- **Phone:** (605) 312-7600
- **Email:** **verificationservices@sanfordhealth.org**

11.5 Credentialing Policies

The Plan maintains policies for our credentialing and recredentialing process. For access to our policies, simply click on the appropriate link below. 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 **sanfordhealthplan.com/providers.**

- **Practitioner Credentialing Policy {PR-006}**
- **Organizational Provider Credentialing {PR-020}**

11.6 Right to Review and Correct Credentialing Information

Practitioners have the right to review information submitted in support of their credentialing applications, however, the 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. The 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, the Plan requires the new practitioner to complete a Provider Credentialing Application. Our Credentialing Application can be found **HERE**. The 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 **sanfordhealthplan.com/providers** and logging into the Provider Portal.

- Practitioner Credentialing Policy (PR-006).

11.7 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 practitioner's 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

11.8 Practitioners Who Do Not Need to be Credentialed/Recredentialed

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)

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)

11.9 Practitioners Who are Recognized by the Plan for Credentialing

The following types of practitioners are eligible for Participating Provider status provided that they possess and provide satisfactory evidence as required through the Plan credentialing process. The types of practitioners requiring credentialing by the 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
- Psychiatrists
- Psychologists, social workers, counselors, marriage and family therapists (licensed at master's level or higher)
- Addiction medicine specialists
- 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 organization's 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. Nondiscrimination in health care. State laws requiring collaborative agreements will be required by Sanford Health Plan.*

11.10 Ongoing Monitoring Policy

The Plan identifies and takes appropriate action when practitioner quality and safety issues are identified. The 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. The 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

The Plan will delegate this responsibility to its contracted delegates as long as the processes in those policies meet the intent of NCQA and The 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 Plan threshold of five within two years, then the practitioner will be presented to the Plan Credentialing Committee through formal re-credentialing so the sanctions and/or complaints can be peer reviewed.

The 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 may require the practitioner to be placed on a one-year re-credentialing cycle. The Committee may also decide on other courses of improvement based on the evidence provided.

In the event 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 provider network, the appropriate agencies will be contacted.

All decisions made by the Credentialing Committee are reviewed and approved by the 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" on the Provider Portal.

Access and availability standards for providers

12.1 Primary Care Physician

Through the contracting 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" on the provider portal at **sanfordhealthplan.com/providers**.

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

12.2 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.

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

12.3 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 an 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.

12.4 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 transfers 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.

12.5 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.

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 emergency and urgent care services 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.

Please note that not all plans are eligible for out-of-network benefits, please review the individual member's certificate of insurance for details.

12.6 Treatment of Family Members

The 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 may be 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.

12.7 Provider Terminations

Agreement and network terminations are subject to regulation and the provider agreement. Involuntary terminations will be sent to the provider via letter from the Plan 60 days prior to the effective termination date.

The following policy(s) are referenced in this section and are available for review in the "Quick Links" section under "Policies and Medical Guidelines" on the provider portal at **sanfordhealthplan.com/providers** Provider Access and Availability Standards Policy (MM-50)This section is subject to any agreement and consistent state regulations.

12.8 Notification of Provider Network Changes

The Plan performs quarterly surveys of our provider network to verify the accuracy of information displayed in the provider directory

If there are changes to the provider network, the 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 their 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 notify us of changes on your letterhead and fax the notice to (605) 328-7224 or you may mail the information to the following address:

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

The Plan has established written standards to ensure access to care that meets or exceeds the standards established by CMS, to ensure all standards are communicated to providers, to continuously monitor compliance with the standards and to take corrective action as needed. The Plan also requires providers to offer standard hours of operation that (1) do not discriminate against members and (2) are convenient for members, the facilities where members reside and facility staff who aid in member care. PCPs are NOT to provide routine visits for Medicare Advantage members at times that coincide with regular facility mealtimes or interfere with expected member sleep patterns by occurring before 8 am or after 8 pm or occur during nursing staff shift changes.

12.9 Network Access Monitoring and Compliance

Using valid methodology, the Plan will collect and perform regular analyses of provider data to measure performance against the Plan's written standards. Examples of measurement tools include:

- **NFist visit frequency report:** Utilizes claims data to monitor the frequency of NFist routine visits for members.
- **Medical specialty appointment access:** Utilizes the third next available appointment methodology to survey selected high-volume specialists like cardiology, endocrinology, neurology, ophthalmology, pulmonology and urology for availability of consultation or new patient appointment within 21 calendar days
- **After-hours care telephone survey:** Annual survey of nursing facility staff and Nurse Practitioners about the after-hours availability and responsiveness of NFists to routine and urgent calls.
- **Member satisfaction survey:** Annual survey includes questions related to accessibility and availability of network services.

In addition to regularly scheduled performance measurement, the Plan will review monthly utilization reports to track utilization trends and identify significant changes in utilization that may indicate an accessibility issue. Complaints related to access to care (provider or after hours) are collected through Medicare Advantage Member Services Department line or submissions to the Quality Improvement Committee. Access complaints are analyzed quarterly and reported through the Quality Improvement Committee with immediate action taken to rectify situations where access may cause harm to a member.

Performance consistently falling outside of written standards, with failure to make progress in corrective actions, may result in the recommendation to close primary care panels, contracting with additional practitioners or providers if needed, and adverse credentialing or contracting decisions in cases of persistent failure to make progress towards meeting standards.

Fraud, waste and abuse

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

The 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 action 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.

The provider is responsible for providing guidance to employees, independent contractors, and subcontractors regarding how to report potential compliance issues. The 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.

13.1 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 negligent actions, but rather the misuse of resources.

The 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**.

13.2 How to Report

The Plan requires everyone to exercise due diligence in the prevention, detection and correction of Fraud, Waste and Abuse (FWA). The 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 The Plan's Compliance team. The compliance team can be reached by emailing **shpcompliance@sanfordhealth.org** or calling the anonymous Compliance Hotline: (877) 473-0911.

Special Investigations Unit (SIU)
The Plan is committed to program integrity efforts by early identification, correction and prevention of health care FWA through its Special Investigations Unit (SIU). The SIU utilizes various methods in its efforts to address FWA including, but not limited to, investigation and data analytics tools. These resources assist in detecting unusual claim patterns, outlier behavior, over-utilization and potentially inappropriate billing practices.

Procedures are in place to promptly address noncompliance and potential FWA issues, as well as reporting identified issues to appropriate authorities. Actions taken by the SIU may include things such as interviews, medical record reviews, verbal/written provider education, written and documented corrective action plans, recoupment of funds, appropriate federal and state law enforcement/ MEDIC referrals or other legal action.

The provider shall give the SIU the right to audit, evaluate and inspect books, contracts, documents, papers, medical records, patient care documentation and any other pertinent records. A provider audit may result in recoupment, suspension, or termination. The provider shall be notified of the determination by letter. The date on the letter will be deemed as the date of the determination.

If a provider disagrees with the audit results, they may dispute it by responding to the Special Investigations Unit as outlined in the determination letter. Disputes must be submitted to the Plan within 30 days of the initial determination. Providers are entitled to one dispute per audit granted there are no extenuating circumstances.

13.3 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

Quality

14.1 NCQA Accreditation

The Plan is accredited with the National Committee for Quality Assurance (NCQA). Pursuing accreditation includes more than 100 measured elements on standards such as quality, utilization management, population health management, member experience, and network management. NCQA implements performance-based scoring, requiring the Plan to report HEDIS® clinical quality measures and CAHPS® patient experience measures. HEDIS® includes more than 90 measures across six domains of care, such as effectiveness of care, access to care, and experience of care. These are the most widely used and respected tools for assessing quality of care and services in health care. NCQA publicly reports accreditation results and HEDIS® in Health Plan Report Cards on plan performance.

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

14.2 Quality Improvement Program

The 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 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.

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 found at **sanfordhealthplan.com/providers**.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Immunization Schedules

HEDIS report booklet:

1. **HEDIS® and CAHPS® Report:** The HEDIS® Report 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
    - 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" on the provider portal at **sanfordhealthplan.com/providers**.

- Quality Improvement Program (MM-056).

14.3 Medicare Advantage Quality Improvement

The purpose of the Quality Improvement Program (QI Program) at is to continually take a proactive approach to assure quality care and improve the way the Plan provides care and engages with its members, partners, and other stakeholders so the Plan may fully realize its vision, mission, and commitment to member care. In the implementation of the QI Program, the Plan will be an agent of change, promoting innovations throughout the organization, sites of

care and in the utilization of resources, including technology, to deliver health care services to meet the health needs of its target population. The QI Program is designed to objectively, systematically monitor and evaluate the quality, appropriateness, and outcome of care/services delivered to members. to the QI Program also provides mechanisms for continuous improvement and problem resolution.

Quality improvement activities include the following:

- Monitoring/review of provider accessibility and availability
- Monitoring/review of member satisfaction/grievances
- Monitoring/review of member safety
- Monitoring/review of continuity and coordination of care
- Clinical measurement and improvement monitoring of the SNP Model of Care and all QI activities
- Documentation, analysis, re-measurement and improvement monitoring of member health outcomes
- Chronic Care Improvement Program (CCIP)
- Collection and reporting of Healthcare Effectiveness Data and Information Set (HEDIS)
- Credentialing and re-credentialing
- Provider peer review oversight
- Clinical practice guidelines
- Monitoring and analysis of under and over utilization
- Monitoring and analysis of adverse outcomes/sentinel events
- Collection and reporting of Part C Reporting Elements
- Collection and reporting of Part D Medication Management data (Pharmacy Department)

14.4 Quality of Care Issues

Quality of Care issues include Clinical Quality Indicators and Quality of Care Complaints. Quality Indicators are those issues identified by the Utilization Management staff and referred to the Quality Improvement Department staff. They may be defined as an adverse outcome occurring in the inpatient or ambulatory care setting indicative of potential inappropriate or incomplete medical care. Quality of Care Complaints are those concerns reported by members, families or providers indicating a potential problem in the provision of quality care and services.

The purpose of identifying these issues is to track concerns related to the provision of clinical care and service, evaluating member satisfaction and trending specific provider involvement with potential quality of care issues. Clinical Quality Indicators include the following:

- Unplanned readmission to the hospital (within 30 days)
- Inpatient hospitalization following outpatient surgery
- Post-op complications (including an unplanned return to the Operating Room)
- Unplanned removal, injury or repair of organ or structure during the procedure (excludes incidental appendectomy)
- Mortality review (in cases where death was not an expected outcome)

Quality complaints are categorized as:

- Access to care
- Availability of services
- Clinical quality concerns
- Provider/staff concerns

All Quality of Care issues are reviewed and investigated. The Plan may request records from providers and facilities as part of the investigation. The Quality Improvement Committee reviews trends related to Quality of Care issues. Any action taken based on severity or trend is documented in the health plan provider record and reviewed by the Credentialing Committee at the time of re-credentialing.

Medical management and utilization review

15.1 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

15.2 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 (NCDs and LCDs for Medicare products) and health plan benefit interpretation.

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

15.3 New Medical Service or Product Consideration

Provider may submit the "Request for Benefit Consideration" form found online at **sanfordhealthplan.com/providers** under Medical Management Forms where there is a new medical service, or product you want the 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.

15.4 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.

Providers need to submit prior-authorization requests electronically through the Provider Portal, unless there are technological issues prohibiting portal submission. In the event a provider is unable to submit electronically, the UM department will accept a faxed request. Verbal requests may also be accepted, but only in time- sensitive or urgent scenarios. Prior-authorization requests need to be complete with supporting clinical documentation to be processed. Out-of-network requests will require the Out-of-network Prior Authorization Request form and/or letter of medical necessity be provided to the UM department at time of the request. Failure to follow procedures will delay processing of the request. For questions on authorizations, please visit **sanfordhealthplan.com/priorauthorization** or contact UM at (800) 805-7938.

15.5 How to Authorize

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online in the Plan Provider Portal (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 provider portal at **sanfordhealthplan.com/providers**. 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 members, please use the below options to submit prior authorization:

1. Provider portal: **ehealth-shp.healthsuiteadvantage.com**
2. Submit prior authorization using the form found on under "Medical Management Forms" at **sanfordhealthplan.com/providers/forms**
3. **By Phone:** (800) 805-7938 or **By Fax:** (605) 312-8219

15.6 Additional Medical Management Program Information

You may also find the following information in the provider portal in the "Quick Links" section under "Policies and Medical Guidelines" at **sanfordhealthplan.com/providers**.

1. The complete Medical Management Program Description, operational details, prior authorization, denials and appeal procedures.
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 **sanfordhealthplan.com/providers**.

- Utilization Management Program policy (MM-01).

15.7 Sanford Health Plan Referral Center

The Referral Center assists providers in finding the right specialist or medical resources for your patient. The center will have access to all Plan network specialists, contact information, services, and procedures provided and their location(s) including outreach locations 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.

Pharmacy management

One of the 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 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.

16.1 Plan Formulary

The Plan has a list (formulary) of prescribed medications chosen by health care providers on the 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 the Plan with notification of the formulary change.

Resources:

1. The 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 the Plan should consider coverage of a medication based on medical necessity for medications not on the Formulary, please complete the 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 Medicare Advantage Members

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

MAPD Plans – OptumRx Phone Number:
(844) 642-9090

Optum Rx Coverage Determinations (Auths):
Prior Authorization Department
P.O. Box 25183
Santa Ana CA 92799

Optum Rx Coverage Redeterminations (appeals):
Prior Authorization Department
C/O Appeals Coordinator
P.O. Box 25184
Santa Ana, CA 92799

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

OptumRx Manual Claims:
OptumRx Claims Department
P.O. Box 650287
Dallas, TX 75265-0287

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.

17.1 Current Care Management Programs

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.

Kidney Care: Members with an active diagnosis of chronic kidney disease or undergoing dialysis

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

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.

17.2 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.

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

If you would like more information or need to refer a qualified 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.

Claim submission

Sanford Health Plan provides a variety of EDI resources for both professional and institutional claims to increase The Plan provides a variety of resources for both professional and institutional claims to increase efficiency, track claim status, decrease errors, expedite cash flow, and reduce costs. The Plan exchanges data with several vendors and clearinghouses. Trading Partners who want to exchange data electronically with the Plan will need to complete our Trading Partner Agreement.

To review these forms, trading partner agreement and companion guides please review our EDI Resources online at **sanfordhealthplan.com/providers/edi-resources**.

Providers may use practice management system vendors, billing services, or clearinghouses to submit claims and other electronic data interchange (EDI) transactions to the Plan. These types of vendors offer a variety of EDI solutions to the health care community and charge fees or transaction costs for their services. ***Note: the Plan does not specifically recommend or endorse any vendor or billing service.***

18.1 837 Transactions - Electronic Claims Submission

The 837-transaction set is an electronic version of a Health Care Claim. The Plan encourages the use of EDI transactions to increase efficiency and reduce errors. The Plan will accept ANSI 837 version 5010 compliant claim transactions meeting our companion guide criteria.

- 837 Institutional and Professional Companion Guide
- 837 Dental Companion Guide

18.2 Clearinghouse Options

The Plan does not endorse any specific clearing house as each offers different services at different costs. Below is a list of clearing houses that currently connected with the Plan. If your clearinghouse is not listed, refer to your clearinghouse's website for a listing of payer ID numbers.

Payor ID Information
Sanford Health Plan ID: 91184
Sanford Health Plan Medicare Advantage ID: RP035

Clearinghouse	Phone Number
Availity	(800) 282-4548 (toll free)
Change Healthcare (formerly Emdeon)	(866) 924-4634 (toll free)
Change Healthcare (formerly Relay Health)	(800) 527-8133 (toll free)
ClaimLinx	(952) 593-5969
Claim MD	(855) 757-6060
Electronic Dental Services (EDS)	(800) 482-3518 (toll free)
Eligible	(888) 909-3055 (toll free)
eProvider Solutions	(605) 323-0800
HealthEC	(877) 444-7194 (toll free)
Office Ally	(866) 575-4120 (toll free)
Passport	(888) 661-5657 (toll free)
TriZetto	(800) 969-3666 (toll free)
Waystar	(877) 494-7633 (toll free)
Experian Health	(888) 661-5657 (toll free)

18.3 Electronic Remittance Advice (ERA)

The 835 document type is an electronic version of a Health Care Claim Payment/Advice.

The Plan has a partnership with E-Payment Center to send 835/ERA transactions. To enroll, go to **sanfordhealth.epayment.center/registration**.

You will continue to receive paper remittances for up to 30 days after ERA enrollment. After this timeframe has expired, paper remittances will no longer be sent. However, these documents will continue to be available electronically.

Questions? Contact E-Payment Center's Provider Service Center at:

Phone: (855) 774-4392 | **Email:** **help@epayment.center**

18.4 Electronic Funds Transfer (EFT)

EFT is the electronic transfer of money from one bank account to another, either within a single financial institution or across multiple institutions, via computer-based systems, without the direct intervention of bank staff.

The Plan partners with E-Payment Center to deliver EFT services. By enrolling to receive EFTs, Providers experience quicker receipt of payments and same-day access to funds. To enroll, go to **sanfordhealth.epayment.center/registration**.

Note: The update to EFT may take 10-12 days from sign-up before seeing payments via EFT.

Questions? Contact E-Payment Center's Provider Service Center at:

Phone: (855) 774-4392 | **Email:** **help@epayment.center**

18.5 Claim Submission Requirements

Participating providers are required to submit claims on members' behalf. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency. For specific details regarding what electronic data transactions Sanford Health Plan supports, please visit **sanfordhealthplan.com/providers/edi-resources**.

Standard CMS required data elements must be present for a claim to be considered a clean claim. The claim standards can be found in the CMS Claims Processing manuals: **cms.gov/manuals/downloads/clm104c12.pdf**

If provider does not wish to submit claims electronically, paper claims can be sent to the following:

Sanford Health Plan Commercial and Small Group plans:

Sanford Health Plan Claims
P.O. Box 91110
Sioux Falls, SD 57109-1110

Medicare Advantage Claims:

Medicare Advantage
Sanford Health Plan/RAM
P.O. Box 31041
Tampa, FL 33631-3041

Medicare Advantage claims for the professional 1500 claims can also be submitted through the ehealthsuite Provider Portal at **ehealth-shp.healthsuiteadvantage.com**

18.6 Timely Filing Requirements

All claims, including those paid by any third party or insurance coverage, should be submitted using current coding and within 180 days of the date of service, or as defined in your contract. Timely submission of all claims helps ensure that members receive appropriate credits towards any deductible and/or out-of-pockets amounts when applicable (such as coordination of benefits with other insurance policies).

Medicare Advantage claims must be submitted within 365 days from the date of service or as defined in the provider contract. For inpatient services, timely filing begins from the date of discharge.

Claims submitted outside the filing period will be denied due to untimely filing. Charges denied for untimely filing are considered provider responsibility and cannot be billed to the member.

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. The 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.

18.7 Locum Tenans Providers

Locum Tenans arrangement is when a physician is retained to assist the regular physician's practice for reasons 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.

If the Locum Tenans cover for periods longer than 60 consecutive days, the 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

18.8 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 toward 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.

The Plan does not require PA's or APRN's to bill with the name of their supervising physician on the claim form.

18.9 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. The Plan contracts with a third party vendor to contact members about claims which another party may be liable.

Claims are sent to the vendor based on diagnosis codes. When sending claims, the accident date should be included in the claim. Members are contacted by the vendor 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.

The vendor's process is as follows: The Plan will electronically send claim information to the vendor daily. The vendor then identifies possible accident-related claims and calls the member three times by phone. If they are unable to reach the member, Othe vendor will send out an inquiry questionnaire (IQ) and cover letter. The cover letter explains the relationship between the Plan and the vendor 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 the vendor on the questionnaire, or by calling the vendor's toll-free number and talking directly to a vendor representative.

Once the vendor 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 the vendor has been unsuccessful in their attempts to reach the member and will be required to notify the Plan to deny the claim(s) in question.

If the vendor has not received a response within this second 10-day period, they send advice to the Plan to deny the claims in question for lack of information. This process normally takes approximately 25 days assuming the vendor does not receive a response.

Members can contact the vendor to relay the requested information at (800) 529-0577.

18.10 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 the Plan and/or insurance companies will share or allocate the costs of the member's health care by a process called Coordination of Benefits. The Plan follows all statutory and administrative laws concerning COB, as applicable to the state in which the plan is domiciled. Members have two obligations concerning Coordination of Benefits:

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

18.11 Order of Benefits

The order of benefits determination rules governs the order in which each plan will pay a claim for benefits. 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 secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100 percent of the total allowable expense.

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

- **Non-Dependent/Dependent:** The plan that covers the person as an 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
- **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.
- **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.
- **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.
- **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.
- **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 is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
- **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.

When the 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 the 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.

18.12 Coordination of Benefits with Medicare

Medicare benefits provisions apply when a member has health coverage under the 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 the Plan.

If a provider has accepted assignment of Medicare, the 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. The Plan will make this determination based on the information available through CMS.

18.13 Coordination of Benefits with Medicaid

A Covered Individual's eligibility for any State Medicaid benefits will not be considered 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 the state's Medicaid program. The 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 The Plan, Medicaid is the payer of last resort. If also covered under Medicare, the Plan pays primary, then Medicare, and Medicaid is tertiary. See the provisions below on Coordination of Benefits with TRICARE, if a member is covered by both Medicaid and TRICARE.

18.14 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. The Plan pays first if an individual is covered by both TRICARE and the Plan, as either the Member or Member's Dependent if the service 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 the Plan, and also entitled to either Medicare or Medicaid, the Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary. 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.

18.15 Coordination of Benefits for Medicare Advantage

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.

18.16 Commercial Members with End Stage Renal Disease (ESRD)

The Plan will pay first for 30 months as determined by Medicare ESRD coordination. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member's claims under ESRD.

Billing requirements

19.1 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 & Description	Commercial	**Medicare Advantage** (Effective Jan. 1, 2026 for Sanford Health Plan)
22 – Increased Procedural Services	120% of fee schedule	120% of fee schedule
24 – Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	Does not affect payment	Does not affect payment
25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service	Does not affect payment	Does not affect payment
26 – Professional Component	% of global fee	As allowed per Medicare Fee Schedule
50 – Bilateral Procedure	150% of fee schedule or 75% of contracted allowable, unless otherwise agreed to	150% of Fee Schedule
51 – Multiple Procedures	50% of base fee	50% of base fee
52 – Reduced Services	50% of base fee	50% of base fee
53 – Discontinued Procedure	50% of base fee	50% of base fee
54 – Surgical Care Only	80% of base fee	Does not affect payment
55 – Post Op Management Only	20% of base fee	20% of base fee
56 – Pre Op Management Only	0% of base fee	Does not affect payment
59 – Distinct Procedural Service	Does not affect payment	Does not affect payment
62 – Two Surgeons	62.5% of base fee	62.5% of base fee
63 – Procedure Performed on Infants < 4kg	100% of fee schedule	Does not affect payment
66 – Surgical Team	Does not affect payment	Does not affect payment
73 – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia	50% of base fee	50% of base fee
76 – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	Does not affect payment	Does not affect payment
77 – Repeat Procedure by Another Physician or Other Qualified Health Care Professional	Does not affect payment	Does not affect payment
78 – Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	Does not affect payment	Does not affect payment
79 – Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	Does not affect payment	Does not affect payment
80 – Assistant Surgeon	16% of fee schedule	16% of fee schedule
81 – Minimum Assistant Surgeon	16% of fee schedule	16% of fee schedule
82 – Assistant Surgeon (when qualified resident surgeon not available)	20% of fee schedule	16% of fee schedule
90 – Reference (Outside) Laboratory	Does not affect payment	Does not affect payment
AA – Anesthesia services performed personally by anesthesiologist	Does not affect payment	Does not affect payment

Modifier & Description	Commercial	**Medicare Advantage** (Effective Jan. 1, 2026 for Sanford Health Plan)
AQ – Physician providing a service in an unlisted health professional shortage area (HPSA)	Does not affect payment	Must be submitted for HPSA Bonus
AD – Medical Supervision by a physician; more than 4 concurrent anesthesia procedures	Need more analytics – TBD	Does not affect payment
AS – PA, NP or clinical nurse specialist services for assistant at surgery	16% of physician base fee	16% of physician base fee
AT – Acute treatment (This modifier should be used when reporting service 98940, 98941, 98942)	Does not affect payment	Does not affect payment
CO – OP OT services furnished in whole or part by OTA	85% of fee schedule	85% of fee schedule
CQ – OP OT services furnished in whole or part by PTA	85% of fee schedule	85% of fee schedule
CS – Cost-sharing waived for specified COVID-19 testing-related services that result in an order for, or administration of, a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in Rural Health Clinics and Federally Qualified Health Centers during the COVID-19 public health emergency	For COVID-19 testing-related services, waives member cost-share, if used appropriately	For COVID-19 testing-related services, waives member cost-share, if used appropriately
P1 – A normal healthy patient	Does not affect payment	Does not affect payment
P2 – A patient with mild systemic disease	Does not affect payment	Does not affect payment
P3 – A patient with severe systemic disease	No additional payment	No additional payment
P4 – a patient with severe systemic disease that is a constant threat to life	No additional payment	No additional payment
P5 – A moribund patient who is not expected to survive without the operation	No additional payment	No additional payment
P6 – A declared brain-dead patient whose organs are being removed for donor purposes	Not payable	Not payable
Q6 – Service furnished under a fee-for-time compensation arrangement by a substitute physician or by a substitute physical therapist furnishing outpatient physical therapy services in a health professional shortage area, a medically underserved area, or a rural area	Does not affect payment	Does not affect payment
QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50% of base fee	50% of base fee
QS – Monitored anesthesiology care service	Does not affect payment	Does not affect payment
QX – CRNA service: with medical direction by a physician	50% of base fee	50% of base fee
QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	50% of base fee	50% of base fee
QZ – CRNA service: without medical direction by a physician	Does not affect payment	Does not affect payment
RA – Replacement of a DME, orthotic or prosthetic item	Does not affect payment	Does not affect payment
RB – Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair	Does not affect payment	Does not affect payment
RR – Rental (use the RR modifier when DME is to be rented)	Total monthly rentals not to exceed purchase price	As allowed per Medicare fee schedule
SG – Ambulatory surgical center (ASC) facility service	Does not affect payment	Not used for Medicare ASC facility claims
TC – Technical component; Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles	% of global fee	As allowed per Medicare fee schedule

19.2 Multiple Procedures or Surgeries

Multiple surgeries are defined as multiple procedures performed at the same session by the same provider. The Plan allowances are reduced for multiple surgical procedures. Multiple surgical procedures should be identified with modifier 51. Multiple surgery fees should not be billed pre-cut. The 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

19.3 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.

19.4 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. The 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 cannot be billed to the member. Participating providers are contractually obligated to write off Assistant at Surgery fees that are not covered by the 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. This is based on the denial date on the EOP and can be submitted using the claim reconsideration form found in the Provider Portal. Please include a reference to the claim number, code(s) being asked for reconsideration and a copy of the medical record.

19.5 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.

19.6 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.

19.7 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.

The 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" on the provider portal at **sanfordhealthplan.com/providers**.

- Quality of Care (MM-GEN-030)

19.8 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 the 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. The 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 the Plan's current fee schedule year was implemented. The 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

POS	Description
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

19.9 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. The Plan covers the administration of anesthesia for medically necessary services rendered to members.

The 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. The 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 professional 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%

19.10 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 units 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, the 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

19.11 Outpatient Pre-Labor Monitoring Services

The Plan separately reimburses outpatient pre-labor monitoring services based on individual provider contract percentage 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).
- 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. It is appropriate to submit separate charges or payments 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.

19.12 Home Health Care Services

Home health care includes a wide range of health care services that can be provided in a member's home for an illness or injury. Home health care services are billed using a combination of revenue codes, HCPCS codes, and units. Units are calculated in 15-minute intervals 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

19.13 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

19.14 Ambulatory Payment Classification (APC) Payment for Outpatient Services

The Plan uses APC pricing methodology for outpatient services. 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.

The 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 837I claim format with bill types 13X or 14X.

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.

19.14.1 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 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 several 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.

19.14.2 APC Billing Rules

The 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.

The 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

19.14.3 APC Pricing Rules

The 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
  - 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
  - Cost outlier payment percent to be comparable to CMS (ex. 50%) effective at the start of the contract year
  - 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

Additional guidelines include:

- 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

19.14.4 Therapy services

These modifiers and G-codes will be accepted but not required.

- Modifiers GN, GO, GP
- Non-payable therapy G-codes
- Functional severity Modifiers (CH – CN)

19.14.5 Partial Hospitalization & 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

19.14.6 OCE Edits

The role of OCE is to edit claims for errors, notify the Plan what action to take with the claim, and 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. Some examples of OCE edits are listed below. Please note this is not an all-inclusive list:.

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

19.14.7 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. 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 the 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.
    - o **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.
    - o **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.
    - o **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.
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.

The Provider Contracting department will send an annual reimbursement notice that will include conversion factor and RCC. We will provide notice of the 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/MUEs.
Select facility outpatient services MUE table at the bottom of the page.

Hospital billing

20.1 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 the 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).

20.2 DRG Grouper for Inpatient Services

The 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.

20.3 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.

20.4 Critical Access Hospital Claims – Medicare Advantage

Providers should submit Critical Access Hospital (CAH) claims using Method 1. The Plan does not have current capability to process Method II for CAH claims. This is targeted as a future enhancement to our claims processing systems.

20.5 Critical Access Hospitals (CAH)/Rural Health Clinics (RHC)/Federally Qualified Health Centers (FQHC) Reimbursement

For covered services rendered to Medicare Advantage Members, Providers considered by CMS to be: Critical Access Hospitals, Rural Health Clinics, and Federally Qualified Health Centers (are responsible to notify the Plan of changes to their CMS rates. Documentation of the change is made by submission of the applicable CMS Rate letter to the Plan, as soon as is reasonable. Rate changes will be implemented and effective within 30 days from the date notice was received at the Plan, or the effective date of the change, whichever is later. Claims will be processed against the rates in the system at the time of adjudication.

Notification to the Plan can be submitted as follows:

Email: **providerrelations@sanfordhealth.org**

Fax to (605) 312-8237.

20.6 Hospital Part A to Part B Rebilling – Medicare Advantage

When an inpatient admission is found to be not reasonable and necessary, payment is allowed for all hospital services furnished that would have been reasonable and necessary in an outpatient setting.

Hospitals may also be paid for Part B inpatient services if it's determined that a beneficiary should have received hospital outpatient services rather than inpatient services and the patient has already been discharged from the hospital.

Submit Part A to Part B Rebilling claims the same as you submit to traditional Medicare.

Claim processing timelines

We strive to 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 the60 days from the claims filing date, it is advisable to check the status through your secure Provider Portal 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 forward four years from the time the claim is processed.

21.1 Claim Pricing

Standard claim processing will include pricing the claim according to the provider contract. Claims processing includes application of correct coding edits and multiple procedure payment reductions (MPPRs) as outlined by CMS. The Plan also follows the AMA CPT and CMS HCPC coding guidelines. Bundling, multiple procedure reductions, or payment modifiers may impact contracted allowances.

Original Medicare typically has market-adjusted prices by code (i.e. CPT, or HCPCS) for services traditional Medicare covers. However, there are occasions where the Plan may offer a covered benefit for which there is no Medicare pricing. To expedite claims processing and payment in these situations, the Plan will arrive at a fair market price by researching other external, publicly available pricing sources such as other carriers, fiscal intermediaries, or state-published schedules for Medicaid. The Plan requests providers make every effort to submit claims with standard coding. As described in this Manual and/or your agreement, providers retain the right to submit a request for reconsideration if the provider feels reimbursement is incorrect.

21.2 Claim Edits for Claims

Sanford Health Plan utilizes industry standard claim editing software for primary and secondary editing. Our claim editing processes promote correct coding and implement, to the extent possible, claim payment policies that are broad in scope, simple to understand and that come from regulatory guidance.

As a payor, under federal fraud and abuse guidelines, Sanford Health Plan is restricted from instructing providers on how to bill. Sanford Health Plan takes into consideration historical claims experience, as well as policy guidelines from the following sources:

- AMA CPT coding guidelines
- National and regional Medicare policies
- National specialty academy guidelines
- Medicaid guidelines (as appropriate)

Sanford's Health Plan's payment policies focus on areas such as, but not limited to:

- AMA CPT Procedure Code Definition & Guidelines
- National Correct Coding Initiative (CCI)
- Modifier usage
- ICD Diagnosis Code Guideline
- Global Surgery period
- Evaluation & Management Guidelines
- Add On code usage
- Professional, technical, global policy
- Diagnosis to Procedure
- Place of Service
- Age appropriateness
- CMS' National and Local Coverage Determinations
- Revenue Code Validation

21.3 Claims Encounter Data

Providers who are paid under capitation must submit claims to capture encounter data within 365 days or the same timely filing limit required in their provider agreement.

21.4 Non-Payment/Claim Denial

Any denials of coverage or non-payment for services are addressed on the Explanation of Payment (EOP) or Remittance Advice (RA). An adjustment/denial code will be listed for each billed line if applicable. An explanation of all applicable adjustment codes per claim are listed below that claim on the EOP/RA. Per your Provider Agreement, the member may not be billed for non-covered services unless the member is notified in writing before the service was provided and the member indicated they wanted to receive the services regardless of coverage. The member may not be billed for a covered service when the provider has not followed the Plan's procedures. In some instances, providing the needed information may reverse the denial (i.e., referral form with a copy of the EOP/RA, authorization number, etc.). When no benefits are available for the member or the services are not covered, the EOP/RA will alert you to this. Obtaining pre-service review will reduce denials.

21.5 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. The 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/Ileostomy 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 (wheelchairs, 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 cost 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)

21.6 Processing of Hospice Claims

When a Medicare Advantage (MA) member has been certified as hospice, the financial responsibility for that member shifts from Medicare Advantage to Original Medicare. Original Medicare retains payment responsibility for all hospice and non-hospice-related claims for traditional Medicare benefits beginning on the date of the hospice election.

The only services Medicare Advantage is financially responsible for during this time include any supplemental benefits (e.g., hearing, dental, vision) that the plan offers in addition to Original Medicare benefits.

Members can revoke hospice elections at any time. If revoked and once notified by CMS, the Plan will resume coverage for the member the first of the following month. These rules apply for both professional and facility charges.

When a member elects hospice, bill the claims as instructed below:

- Hospice-related services to CMS
- Services covered under Medicare Part A and B (unrelated to the terminal illness) to the Medicare administrative contractor
- Supplemental vision to VSP
- Supplemental hearing exams, fittings and hearing aids to Nations Hearing
- Supplemental dental benefits to Delta Dental

21.7 Claim Adjustments or Recoupments

The 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 the 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, The Plan's Finance Department will send the provider a letter requesting payment.

If The 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:

Sanford Health Plan
ATTN: Finance Dept
P.O. Box 91110
Sioux Falls, SD 57109-1110

21.8 Corrected Claims

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 180 days of the date of initial processing as indicated on the Explanation of Payment.

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 the Plan.

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 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" at the top of the claim form. If you are correcting a UB-04 claim, use appropriate type of bill type of XXX7 in box 4. If you are correcting a CMS 1500 claim, use an appropriate resubmission code of "7" for a corrected claim and reference the original claim number that you are correcting in box 22 of the form.

21.9 Voided Claims

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 Plan's original claim number.

Do not submit voided claims electronically and via paper at the same time.

Providers using Electronic Data Interchange (EDI) can submit professional and institutional voided claims. Voided claims filed electronically should be submitted with ALL service line items.

- Enter Claim Frequency Type code (billing code) 8 for a replacement/correction 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 "VOIDED CLAIM" at the top of the claim form. If you are voiding a UB-04 claim, use the appropriate type of bill type of XXX8 in box 4. If you are voiding a CMS 1500 claim, use an appropriate resubmission code of "8" for a voided claim and reference the original claim number that you are voiding in box 22 of the form.

21.10 Non-participating Provider Reimbursement

A non-participating provider is defined as a Practitioner and/or Provider who has not signed a contract with the Plan, directly or indirectly, and not approved by the Plan to provide health care services to Members.

When a member receives covered services from a non-participating provider, the Plan will allow the established maximum allowed amount. Maximum allowed amount is the amount established by the Plan using various methodologies for Covered Services and supplies. The Plan's Maximum Allowed Amount is the lesser of:

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

b) inside the 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 the Plan's Service Area, using current publicly available data adjusted for geographical differences 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.

The Plan accepts claims directly from non-participating providers. If the nonparticipating provider does not submit claims to the Plan, members may submit a member claim form. Claims, whether directly from providers or from members, must be submitted within 180 days of the date of service or date of inpatient discharge.

The member may contact the 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 with the maximum allowed amount for the service. Only the maximum allowed amount is applied to the Member's benefits.

The Plan 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 the Plan's secure provider portal under Quick Links, Policies and Medical Guidelines.

- Non-Participating Provider Compensation (PC-032)

21.11 Claim Reconsideration/Appeal

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 the provider portal. Paper requests will not be processed or receive a response. This includes any mail received that is track-able or needs a signature. While the mail is accepted into the building, no response will be provided. Once you have access to the Provider Portal at **sanfordhealthplan.com/providers**, 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 **sanfordhealthplan.com/providers**.

- Claim Reconsiderations (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
P.O. Box 91110
Sioux Falls SD 57109-1110

Fax: (605) 312-8217

Please note Medicare Advantage appeals will be accepted via the ehealthsuite provider portal or by mail.

21.12 Proof of Timely Filing

The Plan's participating providers are contractually obligated to file commercial claims within 180 days of the date of service. The Plan processes a "clean claim" within 30 days of receipt of the claim and 60 days for a "non-clean" claim. In North Dakota, the Plan will pay clean claims within 15 days of receipt of the claim. All claims are 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, the 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.

21.13 Provider Claims Payment Dispute

If your claim was paid and you dispute the payment amount, please follow this process. Payment dispute procedures are separate and distinct from appeal procedures.

A formal payment dispute request is required from the provider to contest a paid amount on a claim which does not include a medical necessity or administrative denial. All Payment Disputes must be:

- Submitted in writing within 60 days from the original payment
- Include a cover letter with:
  - Claim Identifiable information
  - The specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
  - Copy of the original remittance advice (RA)
  - All applicable medical records or other attachments supporting additional payment

Providing the above information enables the Payment Dispute Unit to properly and promptly review the request. Requests that do not follow all of the above may delay resolution.

Medicare Advantage will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Mail or Fax provider claims payment disputes to:

Sanford Health Plan
Appeals and Grievance Department
P.O. BOX 91110
Sioux Falls, SD 57109

Fax: (605) 312-8217

21.14 Participating Provider Administrative Plea/Appeals Responsibility

A provider may submit a formal request to review a previous decision where a determination was made stating the participating provider failed to follow administrative rules, assigning liability to the provider (see original decision letter) where the services were rendered.

All requests must be:

- Submitted in writing
- Submitted within 60 days from the decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - The specific rationale as to why the administrative rules were not followed, requiring an exception to be made or extenuating circumstance warranting a re-review of the request for provision of payment.
- Include necessary attachments:
  - Copy of the original decision
  - All applicable medical records

Mail or fax Provider Administrative Plea/Appeal to:

Sanford Health Plan
Appeals and Grievance Department
P.O. BOX 91110, Sioux Falls, SD 57109
Fax: (605) 312-8217

In the event Medicare Advantage waives the administrative requirement, and the request requires a medical review, Medicare Advantage will not request additional records to support the provider's argument. The provider is expected to submit the necessary information to substantiate the request for payment.

Providing the above information enables the appeals team to properly and promptly review requests within 60 business days. In the event Medicare Advantage waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable timeframes. Requests that do not follow the above requirements may be delayed.

21.15 Non-Participating Provider Appeals Rights

In accordance with CMS regulations, providers who are not contracted with the Plan's Medicare Advantage may file a standard appeal for a claim that has been denied but only if they submit a completed Waiver of Liability. If you complete a Waiver of Liability, you waive the right to collect payment from the member, with the exception of any applicable cost-sharing, regardless of the determination made on the appeal.

When submitting the reconsideration, a signed Waiver of Liability form must be included. A waiver of liability form can be obtained on the Plan's website in the provider section. The provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. The provider should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement.

The appeal must be in writing and can be faxed or mailed:

Sanford Health Plan
Appeals and Grievance Department
P.O. BOX 91110, Sioux Falls, SD 57109
Fax: (605) 312-8217

Members

22.1 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 the 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 complete, the form can be mailed or faxed to:
  Sanford Health Plan
  P.O. Box 91110, Sioux Falls, SD 57109
  or Fax to (605) 312-8217.
- 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).

22.2 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 on the website**.

22.3 Appeals

22.3.1 Expedited Appeal: Providers may request an urgent (or expedited) appeal on behalf of the member without the member's signature. To determine when an appeal may be considered urgent, please see the Plan's definition above.

22.3.2 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.

22.3.3 Retrospective Appeal: A post-service appeal may be requested 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 plan's decision.

Members have the following deadlines to file an appeal:

- 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.

Member rights and responsibilities

23.1 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 refuse treatment.
2. 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.
3. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
4. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
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 South Dakota, North Dakota, Minnesota, and Iowa law.
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 provide access to 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 practitioners and/or 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 make recommendations regarding the organization's member's rights and responsibilities policies.
16. Members have the right to receive information about the organization, its services, its practitioners and providers and members' 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.

Member Responsibilities

Each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) 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.
3. Members are responsible for following all access and availability procedures.
4. 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 laws require that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
5. 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 or as soon as reasonably possible.
6. 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.
7. Members are responsible for following their treatment plan as recommended by the Practitioner 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.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for providing name, address, or telephone number changes within thirty (30) days. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.
10. Members are responsible for reporting any changes of eligibility that may affect their membership or access to services. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.

23.2 For Minnesota Enrollees

Important Enrollee Information

The HMO coverage described in this Policy may not cover all your health care expenses. Read this Policy carefully to determine which expenses are covered. **The laws of the State of Minnesota provide Members of an HMO certain legal rights, including the following:**

1. COVERED SERVICES. Services provided by SHP will be covered only if services are provided by participating SHP providers or authorized by SHP. Your Policy fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. PROVIDERS. Enrolling in SHP does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the SHP network, you must choose from remaining SHP network providers.

3. REFERRALS. Certain services are covered only upon referral. See your Policy for referral requirements. All referrals to non-SHP network providers and certain types of health care providers must be authorized by SHP.
4. EMERGENCY SERVICES. Emergency services from providers who are not affiliated with SHP will be covered. Your Policy explains the procedures and benefits associated with emergency care from SHP network and non-SHP network providers.
5. EXCLUSIONS. Certain service or medical supplies are not covered. You should read the Policy for a detailed explanation of all exclusions.
6. CONTINUATION. You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your Policy.
7. CANCELLATION. Your coverage may be canceled by you or SHP only under certain conditions. Your Policy describes all reasons for cancellation of coverage.
8. NEWBORN COVERAGE. If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating SHP network providers or authorized by SHP. Certain services are covered only upon referral. SHP will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify SHP of the infant's birth and that you would like coverage. If your Policy requires an additional premium for each dependent, SHP is entitled to all enrollment premiums due from the time of the infant's birth until the time you notify SHP of the birth. SHP may withhold payment of any health benefits for the newborn infant until any premiums you owe is paid.
9. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT. Enrolling in SHP does not guarantee 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.

23.3 Enrollee Bill Of Rights (Minnesota Only)

1. Enrollees have the right to available and accessible services including emergency services, as defined your contract, 24 hours a day and seven days a week.
2. 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.
3. 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.
4. 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. Enrollees are entitled to file a complaint with the Minnesota Commissioner of Health for investigation at any time by calling (800) 657-3602.
5. 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.
6. 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.
7. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

23.4 Advance Medical Directives

The Federal Patient Self-Determination Act ensures the patient's right to participate in health care decision-making, including decisions about withholding resuscitative services or declining/withdrawing life-sustaining treatment. Through guidelines established by the CMS, HEDIS requirements and the Plan's policies and procedures, Medicare Advantage requires all participating providers to have a process in place under the intent of the Patient Self Determination Act. All providers contracted directly or indirectly with Medicare Advantage may be informed by the member that the member has executed, changed or revoked an advanced directive. At the time a service is provided, the provider should ask the member to provide a copy of the advance directive to be included in his/her medical record. If the PCP/NFist and/or treating provider cannot as a matter of conscience fulfill the member's written advance directive, he/she must advise the member and Medicare Advantage. Medicare Advantage and the PCP/NFist and/or treating provider will arrange for a transfer of care. Participating providers may not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive. However, nothing in the Patient Self-Determination Act precludes the right under state law of a provider to refuse to comply with an advance directive as a matter of conscience. To ensure providers maintain the required processes to advance directives, Medicare Advantage conducts periodic patient medical record reviews to confirm the required documentation exists.

23.5 Additional Rights

23.5.1 The right to be treated with dignity and respect: Members have the right to be treated with dignity, respect and fairness at all times. Medicare Advantage and its contracted providers must obey the laws against discrimination to protect members from unfair treatment. These laws say Medicare Advantage and its' providers cannot discriminate against members because of a person's race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin. Providers may not discriminate against enrollees based on their payment status or refuse to serve enrollees because they receive assistance with Medicare cost-sharing from a State Medicaid program. If members need help with communication, such as a language interpreter, they should be directed to call the Member Services Department. The Member Services Department can also help members in filing complaints about access to facilities (such as wheelchair access). Members can also call the Office for Civil Rights at (800) 368-1019 or TTY/TDD (800) 537-7697, or the Office for Civil Rights in their area for assistance.

23.5.2 The right to see participating providers, get covered services and get prescriptions filled promptly
Members will get most or all their health care from participating providers – the doctors and other health providers who are part of Medicare Advantage. Members have the right to choose a participating provider. Medicare Advantage will work with members to ensure they find physicians who are accepting new patients. Members have the right to go to a women's health specialist (such as a gynecologist) without a referral. Members have the right to timely access to their providers and to see specialists when care from a specialist is needed. Members also have the right to access their prescription benefit promptly. Timely access means members can get appointments and services within a reasonable amount of time. The Evidence of Coverage (EOC) explains how members access participating providers to get the care and services they need. It also explains their rights to get care for a medical emergency and urgently needed care.

23.5.3 The right to know about treatment choices and to participate in decisions about their health care
Members have the right to get full information from their providers when they receive medical care and the right to participate fully in treatment planning and decisions about their health care. Medicare Advantage's providers must explain things in a way that members can understand. Members have the right to know about all of the treatment choices that are recommended for their condition, including all appropriate and medically necessary treatment options, no matter what their cost or whether Medicare Advantage covers them. This includes the right to know about the different Medication Management Treatment Programs Medicare Advantage offers and those in which members may participate. Members have the right to be told about any risks involved in their care.

Members have the right to receive a detailed explanation from Medicare Advantage if they believe a plan provider has denied care that they believe they are entitled to receive or care they believe they should continue to receive. In these cases, members must request an initial decision. Initial decisions are discussed in members' EOC.

Members have the right to refuse treatment, including the right to leave a hospital or other medical facility even if their doctors advise them not to leave, and the right to stop taking their medication. If members refuse treatment, they accept responsibility for what happens as a result of refusing treatment.

23.5.4 The right to make complaints
Members have the right to file a complaint if they have concerns or problems related to their care or coverage. Members or an appointed/authorized representative may file appeals or grievances regarding care or coverage determinations. If members make a complaint or file an appeal determination, Medicare Advantage must treat them fairly and not discriminate against them because they made a complaint or filed an appeal or coverage determination. Members should be directed to call the Member Services Department to obtain information relative to appeals, grievances or concerns and/or coverage determinations.

23.5.5 Member Assignment to New PCP/NFist

Medicare Advantage PCP/NFists have a limited right to request a member be assigned to a new PCP/NFist. A provider may request to have a member moved to the care of another provider due to the following behaviors:

- Fraudulent use of services or benefits.
- The member is disruptive, unruly, threatening or uncooperative to the extent his/her membership seriously impairs the provider's ability to provide services to the member and a physical or behavioral health condition does not cause the behavior mentioned above.
- Threats of physical harm to a provider and/or his/her office staff.
- Non-payment of required copayment for services rendered.

- Receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or not medically necessary.
- Repeated refusal to comply with office procedures essential to the functioning of the provider's practice or to accessing benefits under the managed care plan.

The provider should make reasonable efforts to address the member's behavior which has an adverse impact on the patient/physician relationship, through education and counseling, and if medically indicated, referral to appropriate specialists. If the member's behavior cannot be remedied through reasonable efforts and the PCP/NFist feels the relationship is irreparably harmed, the PCP/NFist should complete the Member Transfer Request form and submit it to Medicare Advantage. Medicare Advantage will research the concern and decide if the situation warrants requesting a new PCP/NFist assignment. If so, Medicare Advantage will document all actions taken by the provider and Medicare Advantage to cure the situation, including member education and counseling. A Medicare Advantage PCP/ NFist cannot request a disenrollment based on an adverse change in a member's health status or utilization of services medically necessary for treatment of a member's condition.

A member also may request a change in PCP/NFist for any reason. The PCP/NFist change requested by the member will be effective the first (1st) of the month following the receipt of the request unless circumstances require an immediate change.

23.6 Member Grievances and Appeals

23.6.1 Appeals: Members of Medicare Advantage have the right to appeal any decision about Medicare Advantage's failure to provide or pay for what they believe are covered services.
These include, but are not limited to:

- Reimbursement for urgently needed care outside the service area or Emergency Services worldwide;
- A denied claim for any other health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for or reimbursed by Medicare Advantage
- Services they have not received, but believe are the responsibility of Medicare Advantage to pay; and/or
- A reduction in or termination of service a member feels is medically necessary.

Also, a member may appeal any decision if they feel they are being discharged from the hospital too soon. In this case, a notice will be given to the member with information about how to appeal. The member will remain in the hospital while the decision is reviewed. The member will not be held liable for charges incurred during this period regardless of the outcome of the review. Please refer to Medicare Advantage Evidence of Coverage (EOC) for additional information.

For pre-service determinations, the enrollee's treating physician acting on behalf of the enrollee may submit an appeal. An appeal is a reconsideration of a previous decision not to approve or pay for a service, including a level of care decision (includes not just outright denials, but also "partial" ones). Appeals will receive an independent review (made by someone not involved in the initial decision). Requesting an appeal does not guarantee the request will be approved, or the claim paid.

The appeal decision may still be to uphold the original decision.

A request for a standard appeal must be submitted to the address/fax listed below within 60 days from the original decision. Appeal requests should include a copy of the denial and any medical records supporting why the service is needed.

A request for an expedited appeal (pre-service requests only) may be filed orally or in writing. To request an appeal orally, please call (844) 637-4760. An enrollee or physician may request an expedited appeal where they believe deciding within the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers contracted with Medicare Advantage may not use the member appeal process to file an appeal for post-service payment disputes. Contracted providers should use the process outlined in the "Billing and Claims" section of this manual or in their provider agreement if they believe a claim was denied for payment in error or if there are additional circumstances the Plan should consider.

Part C Appeals Phone and Fax Number

- **Phone:** (844) 637-4760 (TTY 711)
- **Fax:** (800) 541-9048

23.6.2 Grievances: Members of Medicare Advantage have the right to file a complaint, also called a grievance, about problems they observe or experience with the health plan. Situations for which a grievance may be filed include but are not limited to:

- Complaints regarding issues such as waiting times, physician behavior or demeanor and adequacy of facilities and other similar member concerns;
- Involuntary disenrollment situations; and/or
- Complaints concerning the quality of services a member receives.

Complaints may be received by Advanced Practice Providers, Nursing Facilities, Plan Customer Service representatives and through Member Services. All complaints are logged, categorized and worked to resolution per CMS guidelines for Medicare Advantage plans.

Complaints or grievances should be reported to Member Services. Providers must cooperate with Medicare Advantage in investigating grievances related to the provider or provider's services.

Disclaimer: Sanford Health Plan will make changes to this manual from time to time and in its sole discretion. Please check back often for the most up-to-date information.

Appendix

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 health care 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

Terms/Common Acronyms	Definitions
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.
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/Health Care 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 health care 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.

Terms/Common Acronyms	Definitions
AMA (American Medical Association)	Physician lobbyist group
Ambulance	Vehicle for transportation to provide for medical services
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 health care 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

Terms/Common Acronyms	Definitions
C	
Cafeteria Plan	Health plan where members have the option to choose between different 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
Category II CPT Code	Codes that describe clinical components usually included in evaluation and management or clinical services
Category Ill 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

Terms/Common Acronyms	Definitions
(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.
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

Terms/Common Acronyms	Definitions
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 health care 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.
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.

Terms/Common Acronyms	Definitions
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.
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
ePrescribing/ Electronic Prescribing	Allows the physician and other medical practitioners to write and send prescriptions to participating pharmacies electronically

Terms/Common Acronyms	Definitions
(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, preventive, 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.

Terms/Common Acronyms	Definitions
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
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

Terms/Common Acronyms	Definitions
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)
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Guaranteed Issue	Portion of Patient Protection and Affordable Care Act (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.

Terms/Common Acronyms	Definitions
HCPCS Procedure Code/ "Hix-Pix"/Healthcare Common Procedure 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.
Health Care 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.
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

Terms/Common Acronyms	Definitions
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.
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

Terms/Common Acronyms	Definitions
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
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.

Terms/Common Acronyms	Definitions
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.
MCO (Managed Care Organization, Managed Care)	System of health care in which patients agree to visit only certain doctors and hospitals
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

Terms/Common Acronyms	Definitions
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
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/ Health Maintenance 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, preventive 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)

Terms/Common Acronyms	Definitions
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.
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 for services 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
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
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.

Terms/Common Acronyms	Definitions
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.
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.

Terms/Common Acronyms	Definitions
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
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 health care plan will pay.
PMPM (Per Member Per Month)	Capitation payment methodology
Podiatry	Branch of medicine associated with foot, ankle and related

Terms/Common Acronyms	Definitions
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
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 Utilization Management to review upcoming services
Prosthetics	An artificial limb
Prosthodontic	Dental prosthetics; area of dentistry that focuses on dental

Terms/Common Acronyms	Definitions
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 Affordable Care Act benefit and cost-sharing standards
Qualifying Event	A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.
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 by Participating 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 or other stakeholders based on the relative health of the at-risk
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

Terms/Common Acronyms	Definitions
RX (Prescription Drug)	A measure of value used by Medicare as a reimbursement formula for physician services
S	
Schedule of Benefits and 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.
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
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.

Terms/Common Acronyms	Definitions
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

Terms/Common Acronyms	Definitions
Tiered Co-payment Benefits	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 (Temporomandibular 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 that 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	
UB04/Institutional/UB/UB92/ Facility/CMS 1450	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.

Terms/Common Acronyms	Definitions
Us/We	Refers to Sanford Health Plan
Utilization/Use/Usage	The "use" of; in regard 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 mandate and when it occurs; period where insurance will not pay.
WHO (World Health Organization)	International group that directs and coordinates international health within the United Nation's system
Women's Preventive Health	Preventive, maternity and contraceptive services for women who are covered at 100% for non-grandfathered, ACA-compliant plans.
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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