Provider Perspective

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SANFORD HEALTH PLAN

NPI required on Dental Claim forms

To ensure proper and timely processing of your dental claims with SHP all claim information must be entered correctly on the American Dental Association (ADA) claim form.

Individual/Treating Dentist NPI

The treating dentist NPI should be entered in field 54.

Facility/Billing NPI

- Field 48 on the ADA form is the Billing Dentist or Dental Entity section
  - o This field provides information on the name of the facility/group practice.
  - o This field should include the name of the facility, and the primary billing address.
- Field 49 on the ADA claim form should include the facility NPI that matches the facility/group listed in Field 48.

Treating dentist and treatment location information must be completed on all claims.

For more information on completing dental claims, **check out this guide.**

Pre-service Appeals

Sanford Health Plan appreciates the close collaboration we have with our providers and members. As continued efforts are made to review and streamline our processes, we have created an additional way to submit an internal appeal to the health plan if you have received a denial letter. You can now submit an internal preservice appeal with the necessary supporting documentation online at

sanfordhealth.formstack.com/forms/online appeals.

If you have any questions about appeals, please reach out to the Appeals and Grievances Department.

Provider Manual Update

The 2024 Provider Manual is available online. Head to the **Forms and Manuals** page on our website to view the document.

Policy Updates-

For ND ACA Plans ONLY - Effective 1/1/25:

1. PA will not be required for CPT 78815, HCPCS 9588, and HCPCS A9515 when a member has prostate cancer diagnosis (ICD-10: C61, R97.21, or Z85.46). Upon initial prostate cancer diagnosis, at minimum, coverage shall be provided for two PET Scans and additional PET scans may be completed every six months for the life of the consumer, if requested by a physician.

2. SHP will allow coverage for diagnosis and treatment of periodontal disease in adults with acute or chronic disease state if recommended by a board-certified medical practitioner based on health-related impacts or on further deterioration in disease state due to gum disease. This includes CPT codes D4341, D4342, D4346, D6081, D4240, and D4241. Claims must be billed with one or more of the following diagnosis codes: K05.221, K05.222, K05.223, K05.229, K05.30, K05.311, K05.312, K05.313, K05.319, K05.321, K05.322, K05.323, K05.329, K05.4, K05.5, or K05.6.

3. SHP Policy "Vision Services Benefit Reimbursement" is updated effective 7/1/2024 to include coverage for an annual diabetic eye exam to be covered with zero cost to the member when supported by an appropriate diabetes-related diagnosis code. Please refer to the Vision Services Benefit Reimbursement policy for details on coverage eligibility and for the appropriate diagnosis code(s) that must be included in the claim in order for the service to be $0 to the member.

4. Due to changes in the USPSTF preventive care guidelines, SHP's coverage of Aspirin 81mg is changing. Effective 1/1/25, the 81mg dosage of Aspirin will no longer be covered for those at risk for cardiovascular disease. This aligns with other similar medications that are available in this strength over the counter. The preventive guidelines still provide coverage for 81mg Aspirin for pregnant women at risk for preeclampsia, which will continue to be allowed (OTC, with prescription).

5. Hyaluronic Acid Effective date: 9/1/2024

   Change: SHP will now only cover the following Hyaluronic Acid products

   - SynviscOne [J7325] – 1 shot / avian / HMW / made by GenZyme
   - Euflexxa [J7323] – 3 injections / human (non-avian) / HMW / made by Ferring Pharmaceutical
   - GelOne [J7326] – 1 injection / avian / made by Zimmer Biomet
   - Suprartz [J7321] – 3-5 injections / avian / HMW / made by Bioventus

All other Hyaluronic products will be reviewed for non-formulary.

Sanford Health Plan to begin serving DSNP in 2025

A Dual Special Needs Plan (D-SNP) is a type of Medicare Advantage plan that combines hospital (Part A), physician, diagnostic tests, post-acute, and other services (Part B), and prescription drugs (Part D), plus additional supplemental benefits.

Enrollment in a D-SNP is limited to individuals who are entitled to both Medicare and full Medicaid (Dual Eligibles).

North Dakota passed legislation to implement a D-SNP option for 2025. The D-SNP will be a coordination-only model which requires coordination of benefits only and is not a Managed Care Plan.

Sanford Health Plan (SHP) is participating in the D-SNP by working with 3 counties in North Dakota beginning 1/1/2025. The 3 counties include Cass, Burleigh, and Morton, with an estimated 200 members in 2025.

With SHP entering the D-SNP market it allows our health system partners the ability to help shape the administration of the model of care for these members. It also allows partnership in sharing feedback for consideration with internal processes such as prior authorizations. As a local plan serving the D-SNP members we have the ability to ensure that patient care is delivered efficiently providing the best health outcomes.

As a D-SNP we are required to have a Model of Care. The Model of Care describes the population we will service and our care coordination model. The Model of Care also provides details on the provider network that serves the D-SNP members ensuring that we have an adequate network of providers to serve these members. SHP will provide education to our provider network on the Model of Care which includes quality measurement and performance improvement.

SHP will have ongoing collaboration with the ND State Medicaid Agency to facilitate successful implementation and renewals of the D-SNP each year.

We look forward to working with our network providers in serving this new population in 2025.

CARC/RARC Codes on Claims

As a best practice, Sanford Health Plan routinely reviews Claim Reason Adjustment Codes (CARC) and Remittance Advice Remit Codes (RARC) to ensure explanations of claim payment are the most accurate and descriptive reflection pertaining to claim adjudication. You may notice changes to some CARC and RARC codes in the coming months as adjustments are made. An example of a CARC you may see on the EOP is PR*275. This CARC may be used when the primary insurance allowed more than SHP allowed amount in a multiple payer claim. If you have any questions about these updates, please contact Provider Relations.

Submitting Authorizations

Sanford Health Plan requires authorizations to be submitted via the Provider Portal. To make this easy to complete, there are several tutorials that can provide detailed guidance under the Quicklinks section of the Provider Portal Homepage.

A few tips to keep in mind while submitting

1. Ensure you pick the correct authorization type to avoid delays or denials. See the tutorials for a breakdown of the types available.
2. There is a Notes field at the end of the authorization to add any other pertinent information that you were unable to add in a specific field or attach to the authorization itself.

You asked... We answered

What is required to submit a corrected or voided claim electronically?

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

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

You can find more details on submitting corrected claims in the **provider manual** (page 41).

Meet the Measure: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

The overprescription of antibiotics presents a significant health concern in the United States, directly associated with the rise of antibiotic resistance. Notably, patients with acute bronchitis/bronchiolitis typically experience recovery without the need for antibiotics, particularly those without concurrent health conditions. Sanford Health Plan is steadfast in its commitment to collaborating with health care providers to ensure the appropriate use of antibiotics for patients with acute bronchitis/bronchiolitis, with the aim of averting detrimental side effects and the potential development of antibiotic resistance. (NCQA, 2024). It has been observed that a considerable percentage of our members diagnosed with bronchitis/bronchiolitis are being prescribed antibiotics within three days of diagnosis, a practice that does not align with HEDIS guidelines.

What is the measure?

The AAB HEDIS measure examines the percentage of episodes for members aged 3 months and older with the diagnosis of acute bronchitis/bronchiolitis that did NOT lead to a prescription of antibiotics. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment.

What meets the measure?

- Episodes that did not result in an antibiotic dispensing event.
- A dispensed prescription for an antibiotic medication on or 3 days after the episode date if there is a comorbidity such as Emphysema or COPD within the last 12 months.
- Possible exclusions: hospice, death, inpatient admission

How Can You Help Improve HEDIS Scores?

- Discuss realistic expectations for recovery time with your patients (e.g., a cough can last for four weeks without being "abnormal").
- For patients requesting an antibiotic:
  - Provide a brief explanation.
  - Write a prescription for symptom relief instead of an antibiotic.
- Discuss when the patient should come back if symptoms do not get better.
- Submit comorbid conditions and competing diagnosis codes on the claim.
- Patient education flyers are available online at sanfordhealthplan.com/providers/resources to direct patients how to treat their symptoms.
- If you are a Sanford Health provider, patient education flyers are also available in Epic through Krames On Demand.
- Use posters highlighting alternative treatment options in exam rooms and other patient areas.
- Only about ten percent of cases of acute bronchitis are due to a bacterial infection, so in most cases antibiotics will not help.
- View Sanford Health Plan's adopted Clinical Practice Guidelines at **sanfordhealthplan.com/providers/resources.**

Provider Website Corner

This quarter we are focusing on the Inbasket! This handy tool shows responses to your submitted questions, inquiries and reconsiderations.

Where to locate: On the Home screen of the Sanford Health Plan Provider Portal, the top left side of the screen. Once clicked on, you should see your messages and a couple of other options.

Review your messages to see responses to previously sent inquiries.

Click on the New Msg button and from that drop down, select Provider Communication. This will load a standard Service Request. Select the appropriate Topic and the form will update to the appropriate questions or options.

Currently Available Topics:

CLAIM QUESTION: Generic Claims information like Claim Status, information regarding a denial or other generic questions regarding a claim.

PAYMENT INFORMATION: Questions on Payments

MEMBER COVERAGE: Request member's coverage details such as group number or coordination of benefits status.

BENEFIT QUESTION: Verify benefits of a particular member.

PROVIDER RECONSIDERATION: Submit a Provider Reconsideration.

OTHER: Other inquiries not related to one of the other subtopics.

FEE SCHEDULE/PRICING: Request a copy of your current fee schedule or submit a pricing appeal

PHARMACY/DRUG AUTHORIZATION QUESTION: Questions regarding Pharmacy/Drug authorizations. DOES NOT GENERATE AN AUTHORIZATION.

MEDICAL AUTHORIZATION QUESTION: Questions regarding Medical authorizations. DOES NOT GENERATE AN AUTHORIZATION.

ITEMIZED BILL REVIEW: Request results from an itemized bill review, appeal an itemized bill review or submit a copy of an itemized bill.

It is essential that you select the correct topic and subtopic to ensure your inquiry is processed in a timely manner.

PRO TIP: Go to ***My Sent Messages*** at the bottom left-hand side of the Inbasket screen to access messages you've previously sent to the teams at Sanford Health Plan.

Medical Record Standards

An important piece in the care of Sanford Health Plan (SHP) members is documentation of the services provided to your patients, our Members.

What is a Medical Record?

A medical record is defined as all 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.).

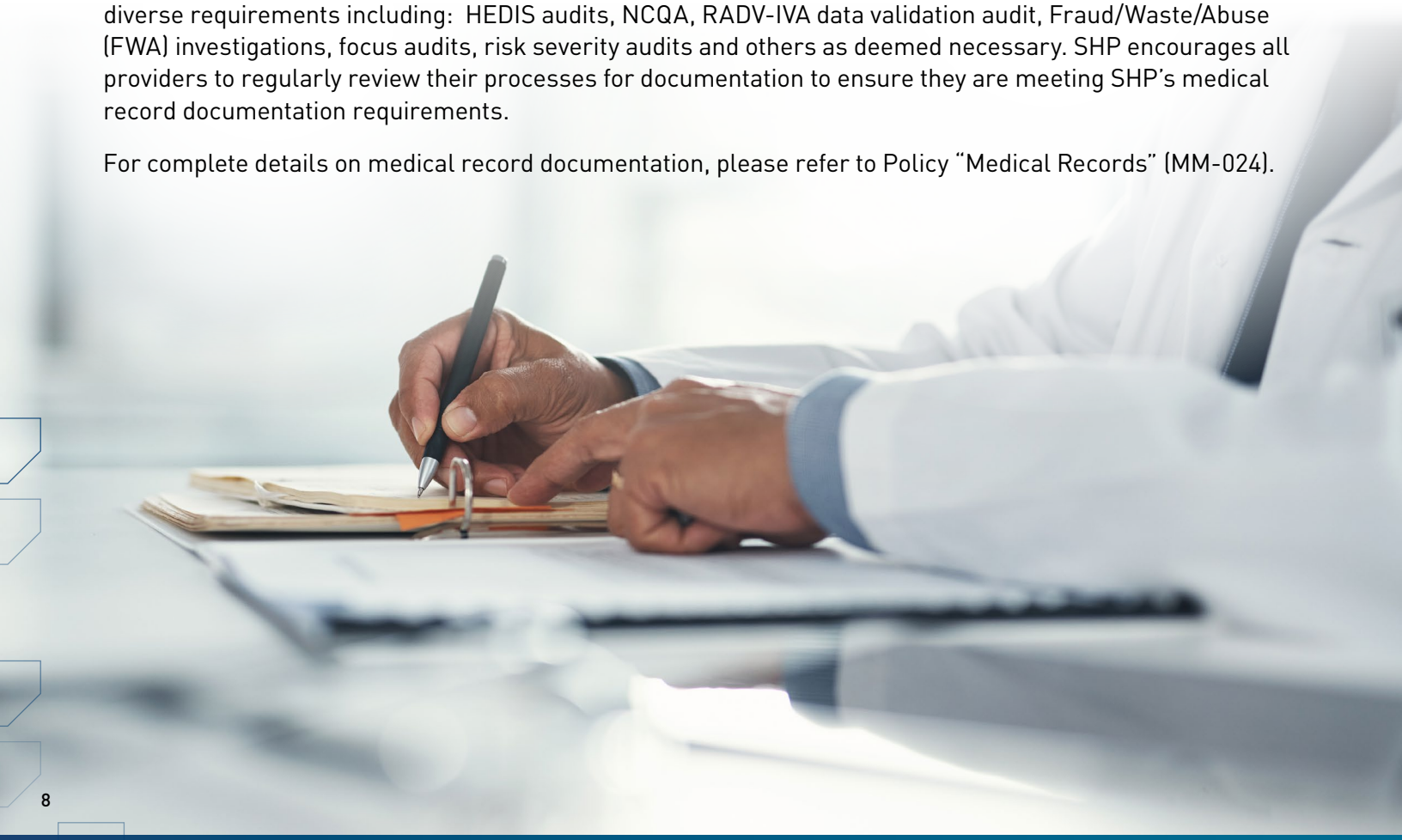
Medical records should be maintained for each individual member. It is a means to communicate the Member's past medical treatment and history, past and current health status, diagnosis, treatment plan for future health care and referral information.

Contractually, practitioners and providers are required to maintain medical records in accordance with professional, State, NCQA, and CMS standards. These standards include adequate documentation on who and what services were performed with appropriate dates and signatures.

Medical Record Review

SHP reviews medical records on a routine basis based on a sample of provider facilities. These reviews fulfill diverse requirements including: HEDIS audits, NCQA, RADV-IVA data validation audit, Fraud/Waste/Abuse (FWA) investigations, focus audits, risk severity audits and others as deemed necessary. SHP encourages all providers to regularly review their processes for documentation to ensure they are meeting SHP's medical record documentation requirements.

For complete details on medical record documentation, please refer to Policy "Medical Records" (MM-024).



Contact Us

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

Customer Service (800) 752-5863
Monday-Friday, 7:30 a.m. to 5 p.m. CST
memberservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

Pharmacy (855) 305-5062
pharmacyservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification for medical services

Utilization Management (800) 805-7938
um@sanfordhealth.org

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

Provider Relations (800) 601-5086
providerrelations@sanfordhealth.org

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

Provider Contracting (800) 752-5863
sanfordhealthplanprovidercontracting@sanfordhealth.org

CONTACT FOR: Align powered by Sanford Health Plan Medicare Advantage PPO

Customer Service (888) 278-6485 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (844) 642-9090

CONTACT FOR: Great Plans Medicare Advantage (ISNP)

Customer Service (844) 637-4760 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (855) 800-8872

Hearing or speech impaired TTY | TDD 711

SANFORD HEALTH PLAN

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