Vitamin Supplement Pharmacy Coverage Changes
Sanford Health Plan performs annual reviews of coverage to ensure we are administering benefits accordingly. During the review process, it was discovered that some plans were allowing coverage of vitamins and supplements, which is a benefit not covered by the Plan.

Members who had filled a prescription for the vitamin and/or supplements impacted within the last year received communication letting them know effective March 1, 2018, the vitamin and/or supplement below will no longer be covered as it is available over-the-counter. Members who choose to continue using this product will be responsible for the full cost.

NOTE: NDPERS does and will still cover prenatal vitamins under their plan.

If you have questions about this change, please contact Pharmacy Services between 8 a.m. and 5 p.m. Monday through Friday at (855) 305-5062, or by email pharmacy.services@sanfordhealth.org.

Sanford Health Plan ID Cards
There is a document available to providers on our website at sanfordhealthplan.com/providers that compiles the different ID cards that Sanford Health Plan distributes to our members. This document includes the various cards distributed for our Flexible Spending program as well.

To download a ID Card Reference Sheet CLICK HERE
2018 North Dakota Medicaid Expansion Program Network Changes

Now that we are well in the new year, we wanted to take an opportunity to summarize and provide additional communication regarding the network changes that occurred January 1, 2018 for the North Dakota (ND) Medicaid Expansion Program affecting all provider, pharmacies, suppliers and transportation providers.

Summary:

- **ND Medicaid Expansion’s (NDME) service area:** The service area includes the state of ND and the contiguous counties that border North Dakota in Minnesota, Montana, North Dakota and South Dakota.

- **ND Medicaid Expansion Network:** To be a network provider for ND Medicaid Expansion, the provider must:
  - Reside within the newly defined ND Medicaid Expansion service area; and
  - Be contracted with Sanford Health Plan or Express Scripts (pharmacies); and
  - Be enrolled with the State’s Medicaid Program.

- **ND Medicaid Program Enrollment Requirement:** Federal law [42 CFR §438.602(b)], requires Managed Care Organizations [Sanford Health Plan] to confirm that Network Providers are enrolled with the state’s Medicaid Program prior to payment for dates of service after January 1, 2018. It is important to note for provider that enrollment with the ND Medicaid Program does not require a provider to render services to ND Fee-for-Service (traditional) Medicaid recipients.

Newly contracted (2018 or later) Sanford Health Plan providers within the NDME service area have 120 days from the date of executed contract to enroll with the ND Medicaid Program. If a newly contracted provider does not become enrolled with the ND Medicaid Program within the 120 days, the Sanford Health Plan provider contract to service NDME population will be terminated.

Existing contracted (prior to 2018) Sanford Health Plan providers within the NDME service area should already or be actively pursuing enrollment with the ND Medicaid Program. Those who choose not to enroll with the ND Medicaid Program will be considered non-payable by Sanford Health Plan for any services provided to a NDME recipient and provider cannot seek reimbursement for otherwise covered services from the NDME recipient. **You have 120 days from the date of service to enroll with the State.** Once enrolled, the State communicates to Sanford Health Plan via a weekly roster which is in turn used to update the claims payment system and provider directory. Sanford Health Plan will reprocess any received claims denied as “Provider not enrolled in ND state Medicaid program”; Providers will not have to resubmit these specific claims.

- **Out-of-Network Providers and ND Medicaid Expansion Plan Benefits:** Providers within the NDME Service Area but not contracted with Sanford Health Plan or providers outside of the ND Medicaid Expansion Service Area with or without a Sanford Health Plan contract will be considered Out-of-Network Providers. The ND Medicaid Expansion Plan does not have out-of-network benefits unless one of the following conditions applies:
  - Emergent or Urgent Medically Necessary Services - If emergency care is needed, are always directed to go to the closest hospital or call 911; or
  - Family planning services; or
  - Medically Necessary Services in which services cannot be provided within the network and prior authorization has been obtained from Sanford Health Plan.

Out-of-Network Providers do not have to enroll with the ND Medicaid Program.

Out-of-network Providers will be reimbursed the NDME maximum allowed amount or contracted amount (if contracted with Sanford Health Plan) if one of the above conditions applies to the services provided. The reimbursement of these services would be considered payment in full and the ND Medicaid Expansion recipient cannot be balanced billed.
How to determine your enrollment status or to become an enrolled provider with the ND Medicaid Program: ND Medicaid Program enrollment guidance is available on our site at www.sanfordhealthplan.com/providers/2018-NDME-Network-Changes. This step-by-step guide can be used to determine your ND Medicaid provider enrollment status & enrollment needs. If you are a ND Medicaid Expansion Network Provider and are already enrolled as a traditional Medicaid provider, there is no requirement for a new application. The Department will add the Sanford Health Plan network to your enrollment via a roster provided by Sanford Health Plan. If you are NOT already enrolled as a ND traditional Medicaid provider, an application is required.

Who do I contact if I have questions regarding enrollment? Contact ND DHS Provider Enrollment at dhсенrollment@nd.gov for questions with enrollment.

UPDATED INFORMATION: Previous guidance indicated reimbursement for services could not be collected from the recipient; however, if certain criteria, as indicated below are met, then Network providers and Out-of-Network providers may seek reimbursement from the Medicaid Expansion recipient.

Important Reminder: Network providers and out-of-network providers may obtain payment from the ND Medicaid Expansion recipient only in the following scenarios:

- Item or service which are never covered or not a covered ND Medicaid Expansion benefit; or
- Recipient was informed and agreed (in writing) to be responsible for payment prior to receiving the item or service and at least one of the following applies:
  - Item or service prior authorization request not approved by Sanford Health Plan; or
  - Item or service not considered reasonable or necessary under established criteria for the benefit.

For items or services requiring a prior authorization, screening, or an assessment before the item or service is provided, the Provider may not bill the recipient when any of the before mentioned items were not submitted in a timely manner to Sanford Health Plan.

Standardized patient/financial responsibility forms which providers or facilities have all individuals receiving services sign are not to be considered as the recipient agreeing to be responsible for payment prior to receiving the item or service. This agreement must be individualized with regard to both the recipient and item or services being provided.

Prior authorization requests for elective services must be submitted 3 days prior to scheduled service/procedure. For North Dakota Medicaid Expansion, claims must be submitted to Sanford Health Plan within 365 days from the date of service. For inpatient services, timely filing begins from the date of discharge.
**New Skilled Nursing Facility Denial Code:**
Providers will see a new denial code on claims where there is a difference between what Skilled Nursing Facility (SNF) services were authorized and what was received on submitted on claims. (Ex. Sanford Health Plan authorized level 2 care and the provider billed revenue code level 1). In the past, claims with these differences have denied with “CLMCT – claim not submitted according to contract”, which was confusing to providers.

Moving forward, the denial code for claims in these circumstances will be “SNFLVL – level of care billed does not match level authorized”.

The new SNFLVL denial will show as provider responsibility and have a remittance code of 284 and a remark code of N188 on electronic remittance advice. The claims department reviews all SNF claims, so this denial would be applied after their review has been completed.

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**Eviti Authorization Update—Discontinued Coverage of CPT 77014:**
Beginning July 1, 2018, Eviti in conjunction with Sanford Health Plan will no longer authorize or cover services billed with CPT code 77014 – Computed tomography guidance for placement of radiation therapy fields. The appropriate code, which was created in 2015 to use and request authorization for image guidance is CPT code 77387 – Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed.

Non-Medicare payers have the discretion as to whether they will accept the image-guided radiation therapy (IGRT) G-codes or CPT code 77387. A provider is able to report 77387 globally, or by attaching the -26 modifier to 77387 to designate the PC of the code.

Sanford Health Plan would expect the 77387 with -26 modifier (this is global for the PC/TC). 77387-TC should not be reported with IMRT delivery codes 77385 and 77386. Subsequent visits for the technical component (TC) are to be reported with 77385 or 77386.

The technical component of IGRT code 77387 is bundled into intensity-modulated radiation therapy (IMRT) delivery codes 77385 and 77386. When IGRT is bundled, as with IMRT, the hospital should modify its charge master such that the IMRT delivery charges reflect the included IGRT work. In the hospital setting, the professional component (PC) of IGRT should still be reported with IMRT by attaching the -26 modifier to G6001, G6002 and/or 77387.

Questions regarding this change can be directed to Eviti Case Manager, Sheri Otta at email sheri.otta@sanfordhealth.org or phone 605-328-2717.

As a reminder, an Eviti FAQ and training is available online at sanfordhealthplan.com/providers. Providers are responsible for obtaining authorization for these services prior to administration.
Sanford Health Plan’s Medicare SELECT plan service area has expanded to South Dakota counties: Campbell, Corson, Dewey and Walworth. Medicare SELECT is a standard Medicare supplement plan that requires Members to use a network of facilities for inpatient, non-emergency hospital and surgical care. When Members enroll in Sanford SELECT, they agree to use Sanford’s SELECT network.

Sanford Health Plan Medicare SELECT service area expansion:

Policy Updates:

The following medical policies have been updated.

Medical Policy Updates: To view this policy, log in to the provider portal mySanfordHealthPlan; medical policies are located under the ‘Medical Guidelines’ tab.

- A-002-S017 Home Health Care

Pharmacy Policy Updates: Effective March 1, 2018. To obtain a copy of these policies, contact pharmacy.services@sanfordhealth.org.

- PMB-05 Brand with Generic Available

Other Policy Updates: Copies of these policies can be obtained by signing in to mySanfordHealthPlan; policies are located under the ‘Resources’ tab.

PC-032 Non-Participating Provider Compensation
PR-09 Practitioner Office Site Quality
PR-24 Monitoring Policy