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Welcome to Sanford Health Plan

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. Use it as a reference tool for you and your staff, learn about all our products, or reference our policies and procedures.

If you are viewing this as an electronic version, you can request a printed copy by contacting the Provider Relations Team at (800) 601-5086.

Thank you for your participation.

Sanford Health Plan
2.1 Sanford Health Plan

Sanford Health Plan, headquartered in Sioux Falls, South Dakota, is a non-for-profit, quality-driven, managed care organization that provides products and services to individuals, businesses and government entities. As part of an integrated health system, Sanford Health, we are uniquely positioned to understand the needs of patients, the challenges of health care providers, and the demand of quality, affordable health care coverage for our employers, individuals and families.

Since Sanford Health Plan’s inception in 1998, we have focused on building long-term partnerships. We also partner with local insurance agents in our service area to offer products and services to meet their unique health insurance needs. In addition, we are here to help our partners navigate the complexities of the dynamic health care industry and regulatory environment.

2.2 Sanford Health Plan Corporate Organization

Sanford Health Plan is a wholly owned, non-profit subsidiary of Sanford Health. The Sanford Health Board of Trustees is ultimately responsible for the governance of Sanford Health Plan, but has delegated to the plan’s Board of Directors authority to act as the governing body of the plan. The President of Sanford Health Plan is accountable to the Sanford Health Plan Board of Directors.

The Board of Directors acts as the conscience of the Plan, looking not only at what the Plan does, but also at what it means to its members and to what extent it has succeeded in meeting the expectations associated with its customers. The Board of Directors is charged with guardianship of the goals and the long-term vision of the organization.

To assure the success of Sanford Health Plan, physicians and health care providers on the Board of Directors have a central role in the functioning of the Board as they participate in strategic planning and policy development.

2.3 History of Sanford Health Plan

In 1996, Sioux Valley Hospitals & Health System formulated a corporate response to the changing health care marketplace, the rapid growth in the number of managed care service organizations, and the need to meet the coverage requirements of Medicare-eligible residents within the organization’s tri-state service area.

A panel of health care professionals was assembled and charged with the responsibility of researching, designing, and developing the requisite infrastructure for an outcomes-based health maintenance organization that would be recognized in the local marketplace and associated with quality health care. The result was the formulation of Sioux Valley Health Plan.

In March 2007, Sioux Valley Health Plan changed its name to Sanford Health Plan as a result of a generous gift of $400 million to Sioux Valley Hospitals & Health System from South Dakota businessman, T. Denny Sanford. Subsequently, the Sioux Valley Board of Trustees unanimously voted to re-name the healthcare system “Sanford Health” and Sioux Valley Health Plan was also renamed “Sanford Health Plan.”

Sanford Health Plan is a not-for-profit, community-based HMO that began operations in South Dakota on January 1, 1998. Managed care services are provided to large and small groups in South Dakota, North Dakota, and Iowa by Sanford Health Plan, and in Minnesota by Sanford Health Plan of Minnesota, which is a subsidiary of Sanford Health Plan. Sanford Health Plan was designed to align physicians and hospitals, establish a framework for providers to efficiently manage the delivery of health care services, and operate on the strength of affordable premiums.

Central to the design of Sanford Health Plan is a collaborative effort between Sanford Health, contracted providers, and members of our service area communities. Each of these elements offers unique perspectives, and the acknowledgment that health care resources are finite. Accordingly, maintenance of the Plan’s financial viability is based upon the application of sound, balanced, and efficient healthcare practices.

Sanford Health Plan was granted its Certificates of Authority in 1998 by South Dakota, Iowa and Minnesota, and by North Dakota in 2009. Central health plan operations occur at its corporate office in Sioux Falls, South Dakota.

2.4 Expansion and Rapid Growth

In July 2013, Sanford Health Plan acquired Heart of America Health Plan located in Rugby, North Dakota. In July 2014, Sanford Health Plan was awarded the two-year contract for the North Dakota Public Employee System (NDPERS). As part of our ongoing commitment to serve our members, Sanford Health Plan expanded to offices in Fargo and Bismark, and North Dakota in May 2015.
2.5 Sanford Health Plan’s NCQA Accreditation

Sanford Health Plan is accredited with the National Committee for Quality Assurance (NCQA). Pursuing accreditation includes rigorous on-site and off-site evaluations for over 60 standards and selected HEDIS® measures.

NCQA implements performance-based scoring, requiring Sanford Health Plan to report HEDIS® clinical quality measures and CAHPS® patient experience measures. These are the most widely used and respected tools for assessing quality of care and services in health care.

NCQA publicly reports accreditation results in detailed Health Plan Report Cards and distinguishes performance through levels of accreditation. The organization regularly updates its Health Plan Report Cards on plan performance in five categories: “Staying Healthy,” “Getting Better,” “Living with Illness,” “Qualified Providers” and “Access to Service.”

Quality is also demonstrated by our collaborative relationships with physicians, dentists, pharmacist and health care providers who serve on our board or participate on committees. By the assistance of these talented, highly educated and caring individuals, Sanford Health Plan continually strives for excellence.
3.1 Products & 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 individual and group products, third party administration, Heart of America products and government products.

3.2 Service Area

Our primary service area is North Dakota, South Dakota and select counties in Minnesota and Iowa. For members outside of our service area, we offer the Private Health Care Systems (PHCS) and Multiplan national networks.

3.3 Confidentiality and Disclosure

Sanford Health Plan protects the privacy of all patient and provider information in its administrative functions and among its contracted health care providers. Use of a patient’s personally identifiable health information for any purpose will have a clear and specific consent provided by the patient. Specific provider and member/patient information is collected and used by Sanford Health Plan only to the extent the information is necessary for the Health Plan to ensure efficient high quality care and services to its members. According to HIPAA Privacy Regulation 164.506 (c)(4) , a covered entity may disclose protected health information to another covered entity for certain health care operations of the entity that receives the information if each entity has or has had a relationship with the patient who is the subject of the information and the information pertains to the relationship and the disclosure is for quality-related health care operations (including HEDIS medical record requests) or detection of fraud and abuse or other compliance-related activities. Consequently, the disclosure of medical records between the Health Plan and you as a provider can take place without a signed authorization from the patient as this falls under the HIPAA definition of health care operations between covered entities. The records reviewed by the Plan are kept completely confidential and member specific information is not provided to outside sources, including employers.

Sanford Health Plan’s responses to information requests will reflect a customer service orientation, but will also reflect an awareness of the potentially competing interests of the different categories of our customers (e.g., employer groups and enrolled employees).

In addition, the Plan’s responses to these requests will be consistent with the Plan’s legal obligations, under the law and by contract.

3.4 Fully Insured Commercial Products

Sanford Health Plan offers the following products to individuals, small groups, and large groups through the Marketplace at healthcare.gov. Sanford Health Plan’s commercial products are as follows:

- Individuals: Simplicity, Sanford True, elite1*, Medicare Supplements
- Small business: Simplicity, Signature Series*, Legacy Plans*
- Large group: Signature Series, FEHB Plans, Legacy Plans*, High Deductible HSA compatible plans
- We also offer the following ancillary products: Flex, HRA’s, HSA’s (Vision and dental products under development)

(* denotes plans are no longer being sold, only renewed.)
3.4 Fully Insured Commercial Products:

3.4.1 Simplicity Plans

The Simplicity plans were created in response to the mandates of the Affordable Care Act and are compliant with all the new regulations. These non-grandfathered plans are sold by local agents in the communities we serve and also available on the Marketplace at healthcare.gov. The Simplicity plans offer individuals and small employers a variety of options to meet their needs and budget. The plans vary in deductibles, coinsurance and co-pay options as well as maximum out-of-pocket expenses.

Simplicity individual plans: Offered only in North Dakota and South Dakota. Individuals can purchase plans directly with Sanford Health Plan or through the Marketplace at healthcare.gov where they may qualify for financial assistance.

Simplicity small group employer plans: Offered in North Dakota, South Dakota, Southwest Minnesota and Northwest Iowa. Small group employers can purchase plans directly with Sanford Health Plan or through the Small Business Health Options Program (SHOP) at healthcare.gov.

Provider Network

The network for these plans consist of over 20,000 providers, including the MultiPlan national network (when traveling). Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

To access the provider directory, go to www.sanfordhealthplan.com.

1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Individual-Simplicity or Group-Employer Large & Small from the drop down menu
3. Search for providers by state, city, specialty and sub-specialty

Eligibility, benefits and claims status

Providers can create a secure account to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.
**Claims and payment methodology**

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

Providers will be paid according to their contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

**How to request Prior Authorization**

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.

**The following services require prior authorization:**

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Back Surgery
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections

The services listed below still apply to Simplicity Individual Plans. These plans offer pediatric dental coverage. Therefore, the following procedures require prior-authorization:

- Medically-Necessary Dental Implants for Children Age 0-18 Years**
- Medically-Necessary Orthodontics for Children Age 0-18 Years

**Other periodontic and endodontic procedures do not require prior authorization.

**Specialty Drugs and Selected Injectables:**

- See the Sanford Health Plan formulary for drug prior authorization requirements.
3.4.2 Sanford TRUE

Sanford TRUE is our ACA qualified narrow network plan offered to individuals and families living in the following states and counties:

- South Dakota: Brown, Minnehaha, Lincoln.
- North Dakota: Burleigh, Morton, Oliver, Cass, Traill.

This plan offers a lower premium cost to our members. There is no coverage for out-of-network services, except for emergencies. Individuals and families can purchase Sanford TRUE plans through local agents, directly with Sanford Health Plan, or through the Marketplace at www.healthcare.gov where they may qualify for financial assistance.

Provider Network

The network for this plan consists of over 2,200 providers in the specific counties, with access to ALL Sanford providers in the region. This plan does not have out-of-network benefits.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Individual-Sanford TRUE from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.
Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

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- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.

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- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Back Surgery
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections

The services listed below still apply to Simplicity Individual Plans. These plans offer pediatric dental coverage. Therefore, the following procedures require prior-authorization:
- Medically-Necessary Dental Implants for Children Age 0-18 Years**
- Medically-Necessary Orthodontics for Children Age 0-18 Years

**Other periodontic and endodontic procedures do not require prior authorization.

*Specialty Drugs and Selected Injectables:
- See the Sanford Health Plan Formulary for drug prior authorization requirements.
3.4.3 elite 1 Plans

Our elite1 plans are no longer actively sold, however you may still see members who are enrolled in these grandfathered plans. Eventually, elite1 members must purchase a plan that meets the Affordable Care Act (ACA) requirements.

Provider Network

The network for this plan consists of over 20,000 providers, including the MultiPlan national network (when traveling). Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Individual-Simplicity from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Providers can create a secure account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or providers can call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

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You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.
Products & Services

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• Online: Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”

• Phone: Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.

• Fax: Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

• Airway Clearance Device (DME)
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• Breast Implant Removal, Revision, or Reimplantation
• Breast Reconstrucive Surgery
• Breast Reduction Mammoplasty
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• Continuous Glucose Monitoring (CGM) System and Sensors
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• Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
• Dental Anesthesia for Members with a Developmental Disability
• Selected Durable Medical Equipment
• Enteral / Parenteral Nutrition Therapy and Formulae
• Genetic Testing
• Growth Hormone (Pharmacy)
• Home Health Care Services
• Home Infusion (IV) Therapy
• Hospice Services
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• Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
• Insulin Pump (DME)

• Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
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• Transplant Services
• Vagus Nerve Stimulation

• Varicose Vein Treatment / Ablation:
  o Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  o Other providers must provide proof of appropriate training and request prior authorization.

• Vitamin B12 Injections
• Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.

*Specialty Drugs and Selected Injectables:

• See the formulary for drug prior authorization requirements.
3.4.4 Medicare SELECT Supplement

Our Medicare Select plan is a standard Medicare supplement plan that requires members to use Sanford Health Plan contracted facilities for non-emergency hospital and surgical care (Part A). When members enroll in Sanford SELECT, they agree to use Sanford’s Select network. Members can see any physician (Part B) and are not restricted to a network. Local insurance agents sell Medicare Select to individuals who have Medicare Part A and B in the following states and counties:

- South Dakota greater region: Aurora, Beadle, Bon Homme, Brookings, Brule, Buffalo, Charles Mix, Clay, Clark, Codington, Davison, Day, Deuel, Douglas, Grant, Gregory, Hamlin, Hanson, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Lyman, McCook, Miner, Minnehaha, Moody, Roberts, Sanborn, Spink, Tripp, Turner, Union or Yankton.
- South Dakota Aberdeen region: Brown, Edmunds, Faulk, Marshall or McPherson
- North Dakota: Barnes, Burleigh, Cass, Dickey, Emmons, Grand Forks, Grant, Griggs, Kidder, La Moure, Logan, McIntosh, McLean, Mercer, Morton, Nelson, Oliver, Ransom, Richland, Sargent, Sheridan, Sioux, Steele or Traill.
- Iowa: Clay, Dickinson, Emmet, Lyon, O’Brien, Osceola or Sioux
- Minnesota: Cottonwood, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Nobles, Murray, Pipestone, Redwood, Rock, Watonwan or Yellow Medicine

Provider network

The plan members can receive services from any providers accepting assignment (payment) from Medicare. Members should seek services from in network facilities in order to receive maximum benefits. Facility expenses for members who receive non-emergency services at a non-network hospital or outpatient surgery center will be denied.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Medicare-Select Supplement from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 752-5863.
How to request Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services

- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.

**Specialty Drugs and Selected Injectables:**

- See the formulary for drug prior authorization requirements.
3.4.5 Medicare Supplement Plans

Plan Type

Our Medicare Supplement plans are standard supplement plans and do not require the members to use a specific network. These plans are sold by local agents to individuals with Part A and Part B Medicare coverage in the following states and counties:
- South Dakota: All counties
- North Dakota: All counties
- Iowa: Clay, Dickinson, Emmet, Lyon, O’Brien, Osceola or Sioux
- Minnesota: Cottonwood, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Nobles, Murray, Pipestone, Redwood, Rock, Watonwan or Yellow Medicine

Provider network

The plan members can receive services from any providers accepting assignment (payment) from Medicare. There is no network with Sanford Supplement Plan.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Medicare-Standard Supplement from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Providers should bill Medicare as primary and Sanford Health Plan as secondary.
3.4.6 Signature Series

Plan Type

Our Signature Series plans are sold to large groups through local community agents in northwest Iowa and southwest Minnesota. Employers are able to create their own unique benefits by selecting from a vast array of deductible, copay and out of pocket options that fit the insurance needs of their organization.

These plans are no longer being sold to small groups because of the requirement of the Affordable Care Act. However, you may still see members enrolled in these plans.

Provider network

The network for these plans consist of over 20,000 providers, including the MultiPlan national network (when traveling). Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Group-Employer Large & Small from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
How to request Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)

- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.

*Specialty Drugs and Selected Injectables:

- See the formulary for drug prior authorization requirements.
### 3.4.7 Legacy Plans

**Plan Type**

Our Legacy plans, such as Classic 1500, for example, are no longer being sold, however you may still see members who are enrolled in these plans. Eventually, these businesses must purchase a plan that meets the Affordable Care Act requirements.

**Provider network**

The network for these plans consist of over 20,000 providers, including the MultiPlan national network (when traveling). Members can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Remember that members will pay more if they seek services from a provider not listed in this directory.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Group-Employer Large & Small from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

**Eligibility, benefits and claims status**

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

**Claims and payment methodology**

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.
How to request Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammaplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.

*Specialty Drugs and Selected Injectables:

- See the formulary for drug prior authorization requirements.
3.5 Third Party Administrator (TPA) Services:

Sanford Health Plan provides third party administrator (TPA) services. These services include claims adjudication, member services functions, provider pay or relations, and medical management. Benefits are determined by the employer group, not Sanford Health Plan.

Provider Network

To access the provider directory, go to www.sanfordhealthplan.com.

1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.
Products & Services

How to request Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

• Online: Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
• Phone: Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
• Fax: Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

(Some exceptions may apply. Please contact our Utilization Management Team for a list of services for specific TPA clients.)

• Airway Clearance Device (DME)
• Ambulance Services for Non-Emergency Situations
• Autonomic Testing
• Back Surgery
• Bariatric Surgery
• Blepharoplasty
• Bone Growth Stimulator – External (DME)
• Botulinum Toxin (Botox)
• Brachytherapy
• Breast Implant Removal, Revision, or Reimplantation
• Breast Reconstructive Surgery
• Breast Reduction Mammaplasty
• Clinical Trials
• Cochlear Implant (Device and Procedure)
• Continuous Glucose Monitoring (CGM) System and Sensors
• Cranial Molding Helmet
• Deep Brain Stimulation
• Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
• Dental Anesthesia for Members with a Developmental Disability
• Selected Durable Medical Equipment
• Enteral / Parenteral Nutrition Therapy and Formulae
• Genetic Testing
• Growth Hormone (Pharmacy)
• Home Health Care Services
• Home Infusion (IV) Therapy
• Hospice Services
• Hyperbaric Oxygen Therapy
• Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
• Insulin Pump (DME)
• Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
• Perception Sensory Threshold Test
• Photodynamic Therapy (Cancer)
• Phototherapy UV Light Device (DME)
• Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
• Skilled Nursing Facility Services
• Specialty Drugs & Selected Injectables*
• Swing Bed Services
• Sub-Acute Care Services
• Spinal Cord Stimulator (Device and Implant Procedure)
• Testosterone Injections
• Transplant Services
• Vagus Nerve Stimulation
• Varicose Vein Treatment / Ablation:
  o Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  o Other providers must provide proof of appropriate training and request prior authorization.
• Vitamin B12 Injections
• Medically-Necessary Dental Implants for Children Age 0-18 Years
• Medically-Necessary Orthodontics for Children Age 0-18 Years

*Specialty Drugs and Selected Injectables:

• See the Sanford Health Plan formulary for drug prior authorization requirements.
3.6 Sanford Heart of America Health Plan:

Sanford Health Plan merged with Heart of America Health Plan in 2014. The commercial products for individuals, families, small group and large group are still offered renewals; however products are not actively sold.

3.6.1 Commercial Products - Individual & Group

**Plan Type**

Sanford Heart of America Health Plan health insurance plans are only being renewed and not actively sold to employer groups, families and individuals in the Rugby, Minot, and Bottineau service area. Eventually, these individuals and businesses must purchase a plan that meets the Affordable Care Act requirements.

**Provider Network**

This plan is offered to residents of ND. The network for this plan consists of providers surrounding the Minot and Rugby area, and ALL Sanford providers in the region. Members can choose to see any licensed provider for covered services without a referral.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select *Group-Heart of America Employer* from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Sample group ID Card
(*Member copay may vary depending on plan selected*)

**Eligibility, benefits and claims status**

Use your secure provider account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.
Products & Services

Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. To check on the status of claims, providers can use their myHealthPlan account or call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Prior authorizations and out-of-network referrals

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Please fax the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharo-plasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectable*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.
- Any services rendered by the Altru Health System need prior authorization because Altru providers and facilities are considered Out of Network.

*SPECIALTY DRUGS AND SELECTED INJECTABLES:

- See the formulary for drug prior authorization requirements.
3.6.2 Sanford Heart of America Medicare Cost Product Health Plans

Sanford Heart of America Health Plan offers health insurance plans to Medicare eligible individuals in North Dakota in the counties of: Burleigh, Morton, and Oliver. The service area includes these parts of counties in North Dakota: Benson, Bottineau, McHenry, Pierce, Rolette, Towner, and Wells, in the following zip codes only: 58313, 58316, 58317, 58318, 58323, 58324, 58329, 58331, 58332, 58337, 58341, 58343, 58346, 58348, 58352, 58353, 58357, 58359, 58363, 58365, 58366, 58367, 58368, 58369, 58372, 58377, 58384, 58385, 58386, 58418, 58422, 58438, 58710, 58712, 58713, 58736, 58740, 58741, 58744, 58748, 58758, 58762, 58778, 58783, 58788, 58789, 58792, 58793.

Provider network

This plan is offered to Medicare members in approved zip codes within ND. The network for this plan consists of providers in approved zip codes in ND and ALL Sanford providers in the region.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Medicare-Heart of America Cost Plan from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

Providers can create a secure mySanfordHealthPlan account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims, claims status and payment methodology

Providers who are contracted with Sanford Heart of America Health Plan and bill for professional services, are to submit claims to Sanford Health Plan as primary and Medicare as secondary.

Providers should bill Medicare as primary and Sanford Health Plan as secondary for all other services.
Prior authorizations and out-of-network referrals

Call Utilization Management at (800) 805-7938 anytime from 8 a.m. to 5 p.m. CST, Monday through Friday. After hours you may leave a message on the confidential voice mail. You may also fax your request to (605) 328-6813 or submit your request online through your secure provider account.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammaplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.
- Any services rendered by Trinity Health need prior authorization because Trinity Health providers and facilities are considered Out of Network.

*Specialty Drugs and Selected Injectables:

- See the formulary for drug prior authorization requirements.
3.7 Government Products:

With proficiency as an insurance company and TPA, combined with our unique perspective as part of an integrated health care system, we are able to provide solutions to government agencies. Sanford Health Plan has three different government products: North Dakota Medicaid Expansion, Federal Employee Health Benefit Plans, North Dakota Public Employee Retirement System (NDPERS).

- The North Dakota Department of Human Services contracts with Sanford Health Plan to administer benefits to Medicaid Expansion members. The North Dakota Department of Human Services manages the application process, and eligibility determination. Sanford Health Plan manages the following services: medical management, claims adjudication, member services, pharmacy network and claims, provider relations and provider network.

- Federal Employee Health Benefit plans are for federal employees, retirees and their survivors. Sanford Health Plan offers HMO plans in North Dakota, Iowa and Minnesota. In South Dakota, Sanford Health Plan offers a choice of two HMO plans, a standard and high option.

- NDPERS selected Sanford Health Plan as the insurance provider for its members effective July 1, 2015. Sanford Health Plan provides medical coverage for both the non-Medicare and Medicare Retiree members.

3.7.1 North Dakota Medicaid Expansion

Effective January 1, 2014 to fill gaps in the coverage for some individuals, the Affordable Care Act (ACA) created a new Medicaid group, called “Medicaid Expansion.” Individuals eligible for this coverage must meet the following criteria:

- Are between the ages of 19 through 64;
- Have incomes below 138% FPL (for a single person, that’s an annual income of $15,856);
- Are legal citizens;
- Are not incarcerated; and
- Are not entitled to Medicare.

The new expansion program allowed an estimated 20,000 residents in North Dakota the ability to enroll in health insurance, so they can have health insurance.

The North Dakota Department of Human Services has contracted with Sanford Health Plan to provide benefits to this new group of Medicaid Expansion recipients, beginning January 1, 2014.
Products & Services

Provider network

This plan is offered to members covered by ND Medicaid Expansion only. The network for this plan consists of over 20,000 providers, including the MultiPlan national network (when traveling). This plan does not have out-of-network benefits.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Individual-ND Medicaid Expansion from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility and benefits

Individuals can apply either on the federal Marketplace at www.healthcare.gov or through the county social service office:
• Online at http://apply.dhs.nd.gov ;
• By paper application which can be completed online, printed and mailed;
• By telephone (855) 794-7308 or ND Relay TTY (800) 366-6888; or
• In-person at a county social service office.

All eligibility determinations are done by the North Dakota Department of Human Services, not Sanford Health Plan. Once the State determines eligibility, enrollment information is sent to Sanford Health Plan for processing.

Providers can create a secure mySanfordHealthPlan account at www.sanfordhealthplan.com/providerlogin to access eligibility, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 752-5863 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

Providers will be paid according to their contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Prior authorizations and out-of-network referrals

Call Utilization Management at (800) 805-7938 anytime from 8 a.m. to 5 p.m. CST, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call. You may also fax your request to (605) 328-6813 or submit your request online through your mySanfordHealthPlan account.
Medicaid Expansion schedule of benefits

Medicaid Expansion members are responsible for the following copayments unless the following criteria are met:

- Members ages 19 and 20, are exempt from all co-payments
- Pregnant women are exempt from all co-payments
- Getting birth control drugs or devices do not require a co-payment
- A Native American member who can get, or are eligible to get, services from Indian Health Services (IHS) or through referral by Contract Health Services (CHS), you are exempt from all co-payments
- Members are exempt from co-payments if they are residing in institutions such as:
  - Nursing Facility, long term care
  - Swing bed, long term care
  - Intermediate Care Facility for the Intellectually Disabled (ICF/ID)
  - State Hospital

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage Description</th>
<th>In-network Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-pocket maximum limit for each calendar year</strong></td>
<td>This is the most a member would pay out of pocket each year. Members will receive a letter telling them when they have reached this limit.</td>
<td>5% of the household’s countable earnings</td>
</tr>
<tr>
<td><strong>Medical office visit</strong>&lt;br&gt;Includes visits to physicians, nurse practitioners and physician assistants</td>
<td>Covered.</td>
<td>$2 for each office visit</td>
</tr>
<tr>
<td><strong>Rural health clinic visit</strong></td>
<td>Covered.</td>
<td>$3 for each office visit</td>
</tr>
<tr>
<td><strong>Federally Qualified Health Center Visit</strong></td>
<td>Covered.</td>
<td>$3 for each office visit</td>
</tr>
<tr>
<td><strong>Preventive care office visit</strong>&lt;br&gt;Includes health screenings, prenatal and postnatal care, and immunizations</td>
<td>Covered.</td>
<td>$0 for each office visit</td>
</tr>
<tr>
<td><strong>Diagnostic tests</strong>&lt;br&gt;Includes x-rays, blood work, MRIs</td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Inpatient hospital stay</strong>&lt;br&gt;You must call to get prior-approval.</td>
<td>Covered.</td>
<td>$75 for each stay</td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong>&lt;br&gt;You must call to get prior-approval.</td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Home health care</strong>&lt;br&gt;You must call to get prior-approval.</td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Skilled nursing facility services</strong>&lt;br&gt;You must call to get prior-approval.</td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Outpatient mental or behavioral health services</strong>&lt;br&gt;Includes medical office visits to physicians, nurse practitioners and physician assistants</td>
<td>Covered.</td>
<td>$0 for 19 and 20 year olds. $2 for each visit for members 21 and older.</td>
</tr>
</tbody>
</table>
## Products & Services

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Coverage Description</th>
<th>In-network Co-payment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient mental health services</strong></td>
<td>You must call to get prior-approval.</td>
<td>$0 for 19 and 20 year olds. $2 for each visit for members 21 and older.</td>
</tr>
<tr>
<td>Including alcohol and drug treatment.</td>
<td>Covered for 19 and 20 year olds.</td>
<td></td>
</tr>
<tr>
<td>Includes overnight hospital stays, residential care, chemical dependency treatment programs and partial hospitalization</td>
<td>Covered at certain hospitals only for members 21 and older.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable medical equipment and prosthetic devices</strong></td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>You must call to get prior-approval.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice care</strong></td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>You must call to get prior-approval.</td>
<td></td>
</tr>
<tr>
<td><strong>Habilitation &amp; rehabilitation services</strong></td>
<td><strong>Physical therapy office visit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Occupational therapy office visit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Speech therapy office visit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Habilitative therapy office visit</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered.</td>
<td>$2 for each visit</td>
</tr>
<tr>
<td></td>
<td>30 visits per therapy per calendar year</td>
<td>$2 for each visit</td>
</tr>
<tr>
<td></td>
<td>30 visits per therapy per calendar year</td>
<td>$1 for each visit</td>
</tr>
<tr>
<td></td>
<td>30 visits per therapy per calendar year</td>
<td>$2 for each visit</td>
</tr>
<tr>
<td><strong>Chiropractic care</strong></td>
<td>Covered.</td>
<td>$1 for each visit</td>
</tr>
<tr>
<td></td>
<td>for spinal manipulations. Limited to 20 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Dental office visits</strong></td>
<td>Covered.</td>
<td>$0 for each office visit</td>
</tr>
<tr>
<td></td>
<td>for spinal manipulations. Limited to 20 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td><strong>Eye exam office visit</strong></td>
<td>Covered.</td>
<td>$0 for each office visit</td>
</tr>
<tr>
<td>Includes optometrists and ophthalmologists</td>
<td>19 and 20 year olds.</td>
<td>$2 for each office visit</td>
</tr>
<tr>
<td></td>
<td>for members 21 and older for non-routine vision exams relating to eye disease or injury of the eye.</td>
<td></td>
</tr>
<tr>
<td><strong>Foot exam office visit</strong></td>
<td>Covered.</td>
<td>$3 for each office visit</td>
</tr>
<tr>
<td>Includes podiatrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency room visit</strong></td>
<td>Covered.</td>
<td>$0 for each emergency visit</td>
</tr>
<tr>
<td></td>
<td>Copay waived if member is admitted to the hospital.</td>
<td>$3 for each non-emergency visit</td>
</tr>
<tr>
<td><strong>Emergency transportation</strong></td>
<td>Included ground and air ambulance services.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Non-emergency transportation</strong></td>
<td>Covered.</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>You must call to get prior-approval.</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>Covered.</td>
<td>$0 copay per 30-day supply</td>
</tr>
<tr>
<td>Drugs listed on the formulary</td>
<td>Generic Drugs</td>
<td>$0 copay per 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Diabetic Supplies</td>
<td>$3 copay per 30-day supply</td>
</tr>
<tr>
<td></td>
<td>Brand Name Drugs</td>
<td>Member pays all costs</td>
</tr>
<tr>
<td>Drugs not listed on the formulary</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>
Prior authorizations and out-of-network referrals

Call Utilization Management at (800) 805-7938 from 8 a.m. to 5 p.m. CST, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call. You may also fax your request to (605) 328-6813 or submit your request online through your mySanfordHealthPlan account.

The following services require prior authorization:

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulinum Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation
- Breast Reconstructive Surgery
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors
- Cranial Molding Helmet
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formulae
- Genetic Testing
- Growth Hormone (Pharmacy)
- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, NICU, Rehabilitation, Mental Health/Chemical Dependency, and Pain Control Services
- Insulin Pump (DME)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections

- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections
- Additionally, referrals to non-participating providers at the recommendation of a participating provider require prior authorization.

*Specialty Drugs and Selected Injectables:

- See the formulary for drug prior authorization requirements.
3.7.3 North Dakota Public Retirement System (NDPERS) Medicare Supplement

Plan Type

The North Dakota Public Retirement System (NDPERS) selected Sanford Health Plan as its new insurance carrier effective July 1, 2015. Sanford Health Plan provides medical coverage for both the non-Medicare and Medicare Supplement members. Total covered lives, including spouses and dependents, are approximately 65,000.

Retirees can opt to enroll in the NDPERS Medicare supplement plan if they have both Medicare Parts A and B and this includes those under 65 if they are on Social Security Disability and have both Medicare Parts A and B. Members who have the NDPERS Medicare Supplement plan will present an ID card with their specific information on the card. Non-Medicare members will present with a different ID card.

Provider network

NDPERS Medicare Supplement plan members can receive services from any provider accepting assignment (payment) from Medicare.

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Medicare-Standard Supplement from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

The staff members at NDPERS administers the enrollment and eligibility.

Providers can create a mySanfordHealthPlan account at www.sanfordhealthplan.com/providerlogin to access member eligibility information, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 499-3416 from 8 a.m. to 5:30 p.m. CST, Monday through Friday.

Claims and payment methodology

Providers should bill Medicare as primary and Sanford Health Plan as secondary.
3.7.3 North Dakota Public Retirement System (NDPERS) Non-Medicare Plans

The North Dakota Public Retirement System (NDPERS) selected Sanford Health Plan as its new insurance carrier effective July 1, 2015. Sanford Health Plan will provide medical coverage for both the non-Medicare and Medicare members. Total covered lives, including spouses and dependents, are approximately 65,000.

The non-Medicare members have three plans options: grandfathered, non-grandfathered and high deductible. All non-Medicare members will present an ID card with their specific information on the card. Medicare supplement members will present with a different ID card.

Provider network

This plan is offered to members employed with NDPERS ONLY. The network for this plan consists of both PPO and Basic networks, including the MultiPlan national network (when traveling).

To access the provider directory, go to www.sanfordhealthplan.com.
1. Click on the tab “Find a Doctor or Pharmacy” and select “Find a Doctor.”
2. On the provider directory home page, enter the first 9 digits of the patient’s Member ID number and last name OR select Group-ND Public Employee Retirement System (NDPERS) from the drop down menu.
3. Search for providers by state, city, specialty and sub-specialty.

Eligibility, benefits and claims status

The staff members at NDPERS administers the enrollment and eligibility.

Providers can create a mySanfordHealthPlan account at www.sanfordhealthplan.com/providerlogin to access member eligibility information, claims status and benefit information online 24 hours a day, seven days a week. Or, providers can call Member Services at (800) 499-3416 from 8 a.m. to 5:30 p.m. CST, Monday through Friday.
Claims and payment methodology

Claims should be submitted to Sanford Health Plan, preferably electronically using Payor ID 91184. Paper claims can be submitted to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

You will be paid according to your contract. For questions or concerns about provider contracts or payment, call the Provider Relations Department at (800) 601-5086 from 8 a.m. to 5 p.m. CST, Monday through Friday.

How to request Prior Authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- Online: Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- Phone: Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- Fax: Send the prior authorization form and supporting documentation to (605) 328-6813.

The following services require prior authorization for NDPERS members.

- Inpatient hospital admissions (includes admissions for medical, surgical, obstetric, NICU, ICU, mental health and/or substance use disorders);
- Selected outpatient procedures including but not limited to:
  - Covered Rhinoplasty surgeries for non-cosmetic reasons;
  - Obstructive Sleep Apnea Treatment, except for Continuous Positive Airway Pressure (CPAP);
  - Medically-Necessary Orthodontics;
- Home Health, Hospice and Home IV therapy services;
- Select Durable Medical Equipment (DME) including the below.
  - Prosthetic Limbs requiring replacement within 5 years;
  - Insulin infusion devices;
  - Insulin pumps;
  - Continuous Glucose Monitoring Systems (CGM);
  - Electric wheelchairs;
- Skilled nursing and sub-acute care;
- Dental Anesthesia and associated Hospitalizations for all Members age 9 and older;
- Back Surgery (effective 6/1/2016);
- Chronic Pain Management;
- Transplant Services;
- Infertility Services, including assisted reproductive technology for GIFT, ZIFT, ICSI and IVF;
- Genetic Testing;
- Osseointegrated implants, including Cochlear implants and bone-anchored (hearing aid) implants;
- Select Specialty Medications including:
  - Restricted Use Medications;
  - Growth Hormone Therapy/Treatment;
- Bariatric Surgery; and
- Referrals to Non-Participating Providers, even if recommended by Participating Providers.
SECTION 4: 
Provider Relations

4.1 Contracting and Provider Relations Department

Our Provider Relations staff members are here to help you with your questions regarding contracting/credentialing, or questions related to claims payment.

Phone: (855) 263-3544 or email to Email: providerrelations@sanfordhealth.org.

4.2 Contracting

In order to provide a full range of health care services to our members, our contracting staff annually evaluates our network against our access and availability standards and state requirements. We contract with physicians, hospitals and other health care providers for appropriate geographic access and to ensure sufficient capacity throughout the entire service area. In addition, we annually assess the cultural, ethnic, racial and linguistic needs of our members to ensure the availability of bilingual practitioners.

To become a participating provider, contract and fee schedule must be signed. A completed credentialing application and W-9 form is also required. When the facility or provider has been approved through the credentialing process, providers are granted participating provider status, allowing them to appear in our online provider directory.

4.3 Credentialing and Re-credentialing

Credentialing is the process of verifying that an applicant meets the established standards and qualifications for consideration in the Sanford Health Plan network. Initial credentialing is performed when an application is received. Re-credentialing is performed every three years. In general, the credentialing and re-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-standi 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.

During the initial credentialing period, providers should submit claims to Sanford Health 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 release for processing. Claims must be submitted within 180 days from the date of service or as defined by your contract.

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- Practitioner Credentialing Policy (PR-06)
- Criteria for Participating Providers (PR-10)
- Institutional Provider Credentialing Policy (PR-20).

4.3.1 Locum Tenans Providers

Locum Tenans arrangement is when a physician is retained to assist the regular physician’s practice for reason 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. However, if the Locum Tenans cover for periods longer than 60 consecutive days, Sanford Health 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
4.3.2 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 towards 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. Sanford Health plan does not require PA’s or APRN’s to bill with the name of their supervising physician on the claim form.

4.4 Credentialed Providers

The following types of practitioners are eligible for Participating Provider status provided that they possess and provide satisfactory evidence as required through the Sanford Health Plan credentialing process. The types of practitioners requiring credentialing by Sanford Health Plan include, but are not limited to:

- Doctors of Allopathy
- Doctors of Osteopathy
- Physician Assistants *
- Nurse Practitioners *
- Podiatrists
- Chiropractors
- Optometrists
- Audiologists (master’s level or higher)
- Speech Pathologists
- Physical Therapists
- Occupational Therapists
- Dentists
- Oral/Maxillofacial Surgeons
- Nurse Anesthetists (non hospital 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 (doctoral or master’s level who are state certified or licensed)
  - Social Workers (master’s level or higher who are state certified or licensed)
  - Addiction medicine specialists
  - Clinical nurse specialists or psychiatric nurse practitioners (master level or higher who are nationally or state certified or licensed)
  - Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently

- Residents in his/her third or fourth year of residency training. Credentialing cycle will end 60 days after estimated residency completion date. A recredentialing cycle will be completed to include residency verification.
- 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 organizations 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 Adorable Care Act C. 2706, non-discrimination in health care and 42 U.S.C. 300gg-5. Non-discrimination in health care. State laws requiring collaborative agreements will be required by Sanford Health Plan.
4.5 Practitioners Who Do Not Need to be Credentialed/Recredentialed

4.5.1 Inpatient Setting

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)

4.5.2 Freestanding Facilities

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)
- Practitioners Who Are Not Accepted by Sanford Health Plan

The following listing of practitioner types will not be credentialed:

- Registered Nurses
- Licensed Practical Nurses
- 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 practitioners 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

4.6 Ongoing Monitoring Policy

Sanford Health Plan identifies and takes appropriate action when practitioner quality and safety issues are identified. Sanford Health Plan monitors ongoing practitioner sanctions or complaints between re-credentialing cycles. Sanford Health 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

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

Sanford Health Plan Credentialing Committee reviews all sanctions, limitations of licensure 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, or may require the practitioner a one-year re-credentialing cycle. The Committee may also decide other courses of improvement based on the evidence provided.

In the event that 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 Sanford Health Plan provider network, the appropriate agencies will be contacted.

All decisions made by the Sanford Health Plan Credentialing Committee are reviewed and approved by the Sanford Health Plan Board of Directors.

The following policy(s) are referenced in the section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- (PR-24).
4.7 Provider Rights & Responsibilities

4.7.1 Right to Review and Correct Credentialing Information

Practitioners have the right to review information submitted in support of their credentialing applications, however, Sanford Health 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 request a The practitioner will be allowed 10 days to provide corrected information. Sanford Health 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 process 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, Sanford Health Plan requires the new practitioner complete a Provider Credentialing Application. Our Credentialing Application can be found here. Contact the Provider Relations Team at (800) 601-5086 if you have questions.

The following policy(s) are referenced in ths section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

• Practitioner Credentialing Policy (PR-06).

4.7.2 Refusing to Treat a Sanford Health Plan Member

Providers have the right to refuse to provide services to a Sanford Health Plan member. While this is a very rare event, it is required that the provider office contact the Care Management Team at (888) 315-0884 as soon as possible so we can assist the member in transitioning to a new provider.

4.7.3 Member Eligibility Verification

Each provider is responsible for ensuring that a member is eligible for coverage when services are rendered. Member eligibility can be determined by logging on to your secure provider account. If you don’t have a secure account, see the Online Resources section of this manual. In addition, our Member Services Team can also assist you with member eligibility status questions. They are available from 8 a.m. to 5 p.m. Monday through Friday at (800) 752-5863. If the provider provides services to a patient not eligible for coverage and remits a claim to Sanford Health Plan, the claim will be denied.

4.7.4 Medical Record Standards

Sanford Health 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. 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. Records of minors shall be retained until the minor reaches the age of majority plus an additional two years, but no less than ten years from the actual visit date of service or resident care. Medical records are reviewed by our Care Management Team at a sample of clinics at least once per calendar year. Medical record review is conducted in conjunction with the HEDIS data collection process. The Care Management Team will complete the medical record review.

Medical records may be requested by Sanford Health 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.

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 17 components. However, there are only 11 critical 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. For the list to review the elements, please see

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- MM-24 Medical Records

### 4.7.5 Practitioner Office Site Quality

Sanford Health Plan has established standards for office-site criteria and medical record-keeping practices to ensure the quality, safety and accessibility of office sites where care is delivered to Sanford Health Plan members. The office site standards are as follows:

1. Physical Accessibility
2. Physical Appearance
3. Adequacy of Waiting and Examining Room Space
4. Adequacy of medical treatment record keeping paper based medical records
5. Electronic Medical Records

Sanford Health Plan monitors member complaints about office site quality. If Sanford Health Plan has received three or more complaints within a six month period, a Provider Relations Representative will conduct an onsite visit within 60 days of the third complaint. The onsite visit will consist of an assessment of the physical appearance of the clinic, the physical accessibility and adequacy of waiting and patient exam rooms, adequacy of medical record keeping, as well as identification of any other deficiencies. If deficiencies are detected, the practitioner's office will be asked to implement an improvement plan. Sanford Health Plan will conduct additional onsite visits every six months until the deficiency has been corrected.

Sanford Health Plan will take into consideration the severity of the complaint and if we feel it is necessary, we reserves the right to conduct an onsite visit at any time regardless if an office has incurred a complaint.

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- Practitioner Office Site Quality Policy (PR-09).
4.8 Primary Care Responsibilities

As a Primary Care Physician contracting with the Plan, the Physician shall provide the following services to Members in accordance with applicable Plan Health Maintenance Contracts:

1. The Physician may have the primary responsibility for arranging and coordinating the overall health care of members who select the Physician as their Primary Care Physician. This includes appropriate referral to specialist Physicians and Providers under contract with the Plan, arranging for the care and treatment of such Member by hospitals, skilled nursing facilities and other health care providers who are Participating Providers, and managing and coordinating the performance of administrative functions relating to the delivery of health services to such Members in accordance with this Agreement.

2. Routine office visits (including after-hours office visits which can be arranged with other Plan Physicians and with Plan approval) and related services of the Physician and other health care providers received in the Physician’s office, including evaluation, diagnosis and treatment of illness and injury.

3. Visits and examinations, including consultation time and time for personal attendance with the Member, during a confinement in a hospital, skilled nursing facility or extended care facility.

4. Adult immunizations in accordance with accepted medical practice or Plan policies and protocols.

5. Administration of injections, including injectables for which a separate charge is not routinely made.


7. Periodic health appraisal examinations.

8. Eye and ear examinations for Members to determine the need for vision or hearing correction.

9. Diagnosis of alcoholism or drug abuse and appropriate referral to medical or non-medical ancillary services, but not the cost of such referral services.

10. Routine office diagnostic testing, including chest x-rays, electrocardiograms, serum chemistries, throat cultures and urine cultures and urinalysis, including interpretation; and interpretation of testing performed outside the Primary Care Physician’s office.

11. Miscellaneous supplies related to treatment in Primary Care Physician’s office, including gauze, tape, Band-Aids, and other routine medical supplies.

12. Physician visits to the Member’s home or office when the nature of the illness dictates, as determined by the Primary Physician.

13. Patient health education services and referral as appropriate, including informational and personal health patterns, appropriate use of health care services, family planning, adoption, and other educational and referral services, but not the cost of such referral services.

14. Telephone consultations with other Physicians and Members.

15. Other primary care services defined by normal practice patterns for Primary Care Physicians in the Plan’s service areas required by the Plan.

16. Such minor surgical procedures as the Physician ordinarily provides during the course of his/her practice to his/her patient population on a fee for service or indemnity basis.

17. The list of provided services does not include those services ordinarily provided as a specialty service in consultation.

18. Primary care physicians (PCP) have agreed to be available to members twenty-four (24) hours a day, seven (7) days a week for urgent care. Members should call during normal office hours for routine situations, and only call after hours in emergency or urgent situations. Members who leave messages should receive a return call within thirty (30) minutes, or as soon as possible.
4.9 Access Standards

4.9.1 Primary Care Physician

Through the contract 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 under “Provider Resources” at sanfordhealthplan.com/providerlogin.

• MM-50 Provider Access and Availability Standards Policy.

4.9.2 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.

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

4.9.3 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 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 of 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.

4.9.4 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 transfer 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.

4.9.5 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. In-network coverage will be provided for emergency conditions 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.
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 urgent care situations outside the service area but not if the member has traveled outside the service area for the purpose of receiving such treatment.

Out-of-network coverage will be provided for non-emergency medical care or non-urgent care situations when traveling outside the Plan’s service area.

**4.9.6 Provider Terminations**

As stated in our contract(s), all provider (practitioner, organization, and hospital) voluntary terminations must be made in writing to Sanford Health Plan 60 days prior to the effective termination date. For, Minnesota, practitioners or facilities must give Sanford Health Plan 120 day notice. Involuntary terminations will be sent to the provider via letter from Sanford Health Plan 60 days prior to the effective termination date.

**4.9.7 Notification of Provider Network Changes**

If there are changes to the provider network, Sanford Health 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 his or her 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
- Hospital affiliation
- Change in board certification status
- 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 available to submit changes. You can also send us your changes on your letterhead and fax to (605) 328-7224 or you may mail the information to the following address:

Attn: Sanford Health Plan
Provider Relations Department
PO BOX 91110
Sioux Falls, SD 57109-1110
5.1 Quality Improvement Program

Sanford Health 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 in order 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.

Providers are encouraged to view the programs offered to members at the home screen of sanfordhealthplan.com/providerlogin.

1. Health Management programs provide members with disease management services. We contact our members by phone, through educational tools and with support. By doing so, members are equipped to control and understand their condition, thereby lessening complications. Learn more in our “clinical toolbox.” The programs offered are:
   - Asthma
   - Coronary Artery Disease
   - Diabetes
   - Healthy Heart (hypertension)
   - Heart Failure

2. Quality improvement activities

3. HEDIS® and CAHPS® Report

4. Clinical resources and tools which include but are not limited to:
   - Clinical Practice Guidelines
   - Preventive Health Guidelines
   - Quick Reference Behavioral Health Cards
   - Immunization Schedules

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- MM-56 Quality Improvement Program.

5.1.1 Complex Case Management Referral Guide

Complex case management (CCM) is the coordination of care and services provided 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 goal of complex case management is to assist members to regain optimum health or improved functional capability by monitoring their care. We can also ensure member care follows evidence based clinical standards so there are no gaps in care, and to ensure members are receiving health care in a cost-effective manner. This plan also involves the comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Sanford Health Plan’s Complex Case Management Program is available at no cost to qualifying Sanford Health Plan members and their families. Concentrating on catastrophic or chronic cases, case managers consult and manage the following:

- Multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses resulting in high utilization
- Individuals with physical or developmental disabilities, serious and persistent mental illness, or severe injuries
- Specific diagnoses as identified by our reinsurance provider
- Multiple readmissions
- Individuals identified from predictive modeling reports based on high cost, likelihood of hospitalization, projected total risk, etc.

**HEDIS®** is a registered trademark of the National Committee for Quality Assurance (NCQA).

**CAHPS®** is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
If you would like more information or need to refer a Sanford Health Plan member to the program, please contact our Care Management Team at (888) 315-0884 or quality@sanfordhealth.org. If you are a Sanford Health practitioner, please use “in basket” messaging to contact a case manager.

### 5.2 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 the course of treatment given by all health care personnel, given a standard of desirable care. 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 at (800) 805-7938 between the hours of 8 a.m. and 5 p.m., Central Time, 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.

#### 5.2.1 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. MCG will be used as a length of stay guideline only. Clinical review criteria may also be developed based on literature review, specialty society standards of care, DME criteria, Medicare guidelines and health plan benefit interpretation. Local medical review policies will be utilized for decisions regarding Medicare coverage.

Medical policies and clinical practice guidelines will be reviewed and updated on an annual basis or as often as needed. UM staff reviews all cases and can refer to the VP, Medical Officer or Behavioral Health Practitioner where medical necessity and/or criteria are not met. UM staff cannot make denial decisions in these cases, but can make authorization decisions based on policies, procedures and benefit coverage guidelines. UM staff bases their decisions on accepted review guidelines, medical record review, and/or consultations with appropriate Physicians.

#### 5.2.2 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. Members are ultimately responsible for obtaining prior authorization in order to receive in-network coverage. However, information provided by your office will also satisfy this requirement.
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/providerlogin.

**How to Authorize:**

Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- **Online:** Select “Submit/Request/Report” under “Provider Inquiries” on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on “Submit a preauthorization/precertification.” Once you complete the required information click “Submit.”
- **Phone:** Call (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8:00am to 5:00pm Central Standard Time, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- **Fax:** Send the prior authorization form and supporting documentation to (605) 328-6813.
Quality Improvement & Medical Management

If you are calling after hours, you may leave a message on the confidential voice mail and someone will return your call the next business day. You can also fax the authorization to the attention of the UM Department at (605) 328-6813. 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.

Sanford Health Plan does not compensate practitioners and/or providers or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Additional Medical Management Program Information

You may also find the following information on the Plan’s website at sanfordhealthplan.com/providerlogin

1. The complete Medical Management Program Description, including further operational details, prior authorization and denial and appeal procedures are available
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 under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- MM-49 Utilization Management Program policy

5.2.3 Sanford Health Plan Referral Center

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

5.2.4 Coordinated Services Program (CSP)

Sanford Health Plan administers a CSP as allowed under 42 CFR § 431.54 specifically for the ND Medicaid Expansion population. The CSP is in place to restrict a Member (who meets specific criteria) in to a pharmacy and/or a primary care physician. Case Managers work with the member in coordinating healthcare services to match their medical needs, improve quality of care by building a patient-doctor relationship, and to promote proper use of health care services and medications.

Members in this program will have one CSP doctor and one CSP pharmacy. Sanford Health Plan selects the CSP doctor and pharmacy based on past utilization. Members do have the right to appeal their participation in the program and have 30 days from the time they are notified to request a change in their CSP doctor or pharmacy.

Providers chosen as a CSP doctor will be notified that they are the primary contact for medical needs, with the exception of emergencies. CSP members will be required to get all prescriptions from the assigned CSP pharmacy. Case managers will monitor and review members on an annual basis for continuation in the CSP program. You will be notified when a member is no longer required to be in the CSP program. CSP doctors will agree to:

- Manage all medical care for the member
- Educate the member on the appropriate use of services
- Provide referrals to specialty physicians
- Be available telephonically or ensure a provider of comparable specialty is available 24 hours a day, 7 days a week for urgent or emergent medical situations
- Manage acute and/or chronic pain through a variety of services or treatment options
- Approve or deny medications prescribed by other providers when contacted by the specific CSP pharmacy
- Work with pharmacists and other specialty physicians to share pertinent information regarding the member.
5.2.5 Pharmacy Management and Formulary Program Information

One of Sanford Health Plan’s missions is to improve the health status of members by developing a model of quality patient care utilizing cost-effective medications as established by sound clinical evidenced based medicine. We contract with Express Scripts Inc. as our Pharmacy Benefits Manager to promote optimal therapeutic use of pharmaceuticals. ESI currently supports the Plan’s Formulary for oral and injectable medications. The Pharmacy Management Department can be reached from 8 a.m. to 5 p.m., CT, Monday through Friday at one of the following numbers:

• Commercial, TPA and Sanford Health Plan Heart of America products - (855) 305-5062
• North Dakota Medicaid Expansion - (855) 263-3547
• NDPERS - (877) 658-9194

To be covered by the Plan, drugs must be:

1. Prescribed by a licensed health care professional within the scope of his or her practice;
2. Listed in the Plan Formulary, unless certification 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;

5.2.6 Sanford Health Plan Formulary

Sanford Health Plan’s Formulary is a list of medications that are the most effective for the treatment of disease and maintenance of health according to the clinical judgment of the practitioners, pharmacists, and other health care professionals who helped develop the Plan’s Formulary. Sanford Health Plan realizes that prescription drugs are a significant portion of health care costs. Our team of health care professionals works hard to develop the best formulary for our members. They review the formulary each year to ensure that the medications included on the formulary are the most effective for the treatment of disease and maintenance of the health of our members. If changes are made to the formulary, members who are directly impacted receive a letter from Sanford Health Plan with notification of the formulary change.

Resources:

1. Sanford Health Plan Formulary, including drug prior authorization, step therapy, generic substitution requirements, etc. can be found within your secure provider account.

2. Express Scripts website:

If you feel that Sanford Health Plan should consider coverage of a medication based on medical necessity for medications not on the Formulary, please follow the Exception to Formulary Process in your Policy or contact Pharmacy Management at (605) 312-2756 or (855) 305-5062. For NDPER members, call (877) 658-9194 and for ND Medicaid members, call (855) 263-3547.
SECTION 6
Filing Claims

6.1 Member Eligibility and Benefit Verification
Sanford Health Plan offers two convenient options to verify eligibility and benefits: online or by phone. Contact our Member Services Department at:

Phone: (800) 752-5863 or (605) 328-6800 from 8 a.m. to 5 p.m. CST, Monday through Friday.

Online: www.sanfordhealthplan.com/providerlogin.

Each provider’s office is responsible for ensuring that a member is eligible for coverage when services are rendered or prior to time of service. If a provider’s office fails to check eligibility for a member who is not eligible for coverage and submits a claim to Sanford Health Plan, the claim will be denied.

6.2 Claims Submission
Sanford Health Plan participating providers are required to submit claims on members’ behalf. Claims should be submitted to Sanford Health Plan electronically using Payor ID 91184. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency (Please see Provider EDI Resources for more information). Accepted claims forms are a standard CMS, UB or ADA claim. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted using current coding and within 180 days, even if the member has not exceeded their deductible or copay amounts.

6.2.1 Paper Claims Submission
If you do not wish to file claims electronically, paper claims can be mailed to:

Sanford Health Plan Claims Department
PO Box 91110
Sioux Falls, SD 57109-1110

To improve our turnaround time and accuracy of paper claim processing, we use a scanning procedure using the Smart Data Solutions (SDS) system. It is important for you to know that the SDS system uses optical character recognition (OCR). Therefore, when OCR is used, your provider name must match our records in order for the system to correctly identify the “pay to” information. If a mismatch occurs, or if the claim cannot be read, you will receive a letter from SDS asking you for the missing or illegible information. A prompt response will prevent further delay in processing your claim.

When sending paper claims, please follow these guidelines:

• Print on a laser printer
• If a dot matrix printer must be used, make sure it is legible
• Use Courier New 10 point font for clean scanning.
• Use uppercase for optimal scanning.
• Ensure that clean character formation occurs when printing paper claims (i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number).
• Claim forms should be lined up properly
• Do not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc.
• Use an original claim form - not a copied claim form.
• Use a standard claim form (individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly).
• The billing, servicing and/or rendering provider’s NPI must be included in the designated locations for accurate matching within the scanning and claim system.
• For a continued claim, please indicate “continued” in the appropriate box of the claim form so the claims can be kept together and whole.
• Do not place the total amount on each of the individual pages.

6.2.2 Corrected/Voided Claims Submission
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. 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. Corrected claims must be received within 60 days of the date of initial processing as indicated on the Explanation of Payment. 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 Sanford Health Plan original claim number. Do not submit corrected or voided claims electronically and via paper at the same time.
Filing Claims

Medical records are not required with the submission of a corrected claim and are only needed when specifically requested from us.

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 item.

- Enter Claim Frequency Type code (billing code) 7 for a replacement/correction, or 8 to void a prior claim, 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” or “VOIDED CLAIM” at the top of the claim form.

- If you are correcting or voiding a UB-04 claim, use appropriate type of bill type of XXX7 or XXX8 in box 4.

- If you are correcting or voiding a CMS 1500 claim, please complete box 22. For a corrected claim, enter resubmission code 7 in the left side of box 22 and enter the original claim number of the claim you are replacing in the right side of box 22. If you are voiding a claim, enter resubmission code 8 on the left side of box 22 and enter the original claim number of the paid claim you are voiding on the right side of box 22.

6.3 Provider EDI Resources

Sanford Health Plan provides a variety of EDI resources for both professional and institutional claims to increase efficiency, track claim status, decrease errors, expedite cash flow, and reduce costs.

6.3.1 EDI Services

- 837 Health Care Claim Transactions Electronic Funds Transfer (EFT)
- 835 Health Care Claim Payment/Advice Transactions
- 270/271 Real Time Transactions for Eligibility, Coverage, or Benefit Inquiry & Information
- 276/277 Real Time Transactions for Health Care Information Status Request and Response.

To review these forms, trading partner agreement and companion guides, click here. Call our EDI department if you have questions when completing the forms.

6.3.2 EDI Enrollment

Sanford Health Plan exchanges data with several vendors and clearinghouses. Trading Partners who want to exchange data electronically with Sanford Health Plan will need to complete our Trading Partner Agreement.

For further information and to download the Trading Partner Agreement and our EFT Enrollment Instructions.

For offices interested in 270/271 transactions, email at Healthplan_edi@sanfordhealth.org
6.4 Instructions for completing the CMS 1500

Physicians and Allied Health Professionals should use the Center of Medicaid and Medicare Services (CMS) form 1500 to bill for medical services. Please follow the link for detailed instructions on how to correctly fill out the CMS 1500 form.
6.5 UB-04/CMS-1450 claim form and instructions:

Commonly known as UB-04, the CMS-1450 form is used by institutional providers to bill payors including Sanford Health Plan. Examples of institutional providers include and are not limited to the following:

- Hospital
- End Stage Renal Disease
- Hospices
- Comprehensive Outpatient Rehabilitation Facilities
- Community Mental Health Centers
- Federally Qualified Health Centers
- Skilled Nursing Facilities
- Home Health Agencies
- Outpatient rehabilitations clinics
- Critical Access Hospitals
- Rural Health Clinics
Filing Claims

6.6 Claims Payment

Claims must be submitted within the filing period of 180 days from date of service or as defined in your contract. For inpatient services, timely filing begins from the date of discharge. Claims submitted outside of the filing period will be denied due to untimely filing. Charges denied for untimely filing are not to be billed to the member, but must be written off. If it was not reasonably possible to send a claim to Sanford Health Plan within the filing period, you must follow up appropriate documentation within 60 days from the date of the denial shown on the Sanford Health Plan Explanation of Payment. For North Dakota Medicaid Expansion members, providers have 365 days from the date of service to submit claims.

We strive to reimburse providers for “clean” claims within 30 days of the receipt of the claim, and in North Dakota 15 days of receipt of a clean 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 the 60 days from the claims filing date, it is advisable to check the status through your secure provider account or by calling Member Services.

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 forth after four years from the time the claim is processed.

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. Sanford Health Plan will only process claims with this denial at your request. 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.

6.6.1 Process for Refunds or Returned Checks

Sanford Health Plan processes overpayments by taking deductions on future claims. You may return the overpayment directly to Sanford Health 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, our Finance Department will send you a letter requesting payment.

If Sanford Health 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
PO Box 91110
Sioux Falls, SD 57109-1110
6.7 Understanding Your Check Adjustment Report

The purpose of this report is to show you claim(s) affected by a check adjustment. This can be created through a negative balance, ad hoc adjustment, or a check amount not matching the remittance advice amount.

The following is a description of what you will find on the report and how to apply the funds to claims.

<table>
<thead>
<tr>
<th>Vendor Name</th>
<th>Run Number</th>
<th>Vendor ID</th>
<th>Checking Account</th>
<th>Check Number</th>
<th>Check Amount</th>
<th>Check Date</th>
<th>Claim Amount</th>
<th>Adjustment Total</th>
<th>Negative Balance Amount</th>
<th>Refund Amount</th>
</tr>
</thead>
</table>

This section provides check information in referencing the EOP associated with the report. The EOP will arrive a few days after receiving this report. If you would like to view the EOP, log on to your secure account and search the EOP by check number.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Account Number</th>
<th>DOS</th>
<th>Claim ID</th>
<th>Claim Amount</th>
<th>AP Date</th>
<th>Original Claim</th>
<th>Vendor ID</th>
</tr>
</thead>
</table>

This section shows claims from the EOP and are affected by a check adjustment. If there are no claims listed, reference the EOP sent separately from this report. We have included patient name and your account number for your reference.

<table>
<thead>
<tr>
<th>Adjustment Description</th>
<th>Claim ID</th>
<th>Amount</th>
<th>AP Date</th>
<th>Comment Line</th>
</tr>
</thead>
</table>

This section shows the amount that was applied from a previously paid and adjusted claim. This claim will be reflected in the section below.

Claim amount equals the total net payable of the claims on the EOP. Negative Balance Amount equals the amount applied to the check. Refunds Amount equals refunds that have been processed. Ad Hoc Amount equals a payment made to make previous checks whole. This amount should be applied to those claims. Check amount equals the check/EFT total you received or will receive shortly.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Patient Name</th>
<th>Account Number</th>
<th>DOS</th>
<th>Claim ID</th>
<th>Claim Amount</th>
<th>AP Date</th>
<th>Reversed Claim ID</th>
<th>Check Number</th>
<th>Check Date</th>
</tr>
</thead>
</table>

This section will show which claim(s) have been adjusted and payment amount. These funds should be applied to the claims associated with the EOP in order to make the check whole.
6.8 How to Read Your Explanation of Payment

1. Need more information: Contact information for Sanford Health Plan.

2. Check / EFT #: Payment information identifying the Tax ID the payment was made under, the payment date and the check or EFT transaction number.

3. Service Date(s): Actual date the health service was provided.

4. Diag # / Drg #: ICD-10 Diagnosis code or Diagnosis-related group code.

5. Proc #: Type of services provided.

6. Days / Units: Quantity of specific service rendered.

7. Charged Amount: The total amount billed by the provider of services.

8. Amount Not Covered: Amount not eligible for payment from Sanford Health Plan.

9. Discount Amount: The amount the primary payer deducted from the charged amount based on contractual agreement between the provider and Sanford Health Plan.

10. Allowed Amount: The pre-negotiated rate paid to In-Network providers for covered services. For Out-of Network providers it is the Usual, Customary and Reasonable cost.

11. Ded./CoPay./Colns.:

   • Deductible: The amount patient pays the provider for covered services before Sanford Health Plan begins to pay.

   • Copay: The amount patient owes the provider at the time of service and is not part of the deductible or out-of-pocket maximum.

   • Coinsurance: The patient’s share of the cost of covered services.

12. TPP: A Third-Party Payer is any institution or company, outside of Sanford Health Plan, which provides reimbursement to providers for services rendered to patients.

13. Payment Amount: The amount Sanford Health Plan paid to the provider for this claim.

14. Withhold Amount: A type of risk-arrangement entered into by providers. The term refers to a percentage of a set dollar amount deducted from providers’ payment amount. It is set aside in risk pools and may or may not be returned depending on specific predetermined factors or events.

15. Explanation: Codes used to explain any claim financial adjustments, such as denials, reductions or increases in payment.

16. Post Date: The date payment was made by Sanford Health Plan to the provider.
6.9 Provider Reimbursement

6.9.1 Participating Provider Reimbursement

Sanford Health Plan will pay the provider when a member receives covered services from a participating provider (physician, hospital, facility, dentist, etc). Contracted providers agree to accept negotiated fee schedules as reimbursement in full for covered services provided to members. Provider offices may collect copay, estimated deductible and coinsurance at the time of service. Any non-covered service can also be collected. Participating providers are not allowed to bill members the difference between the amount charged by the provider and the pre-negotiated Sanford Health Plan allowable reimbursement. The difference between the charged amount and the allowed amount is considered a provider write off. Services not covered by Sanford Health Plan guidelines will be the responsibility of the member. This excludes, but is not limited to, services denied for untimely filing or services medically necessary.

6.9.2 Non-Participating Provider Reimbursement

A non-participating provider is defined as a provider who is not directly or indirectly contracted with SHP. When a member receives covered services from a non-participating provider, Sanford Health Plan will pay the provider according to a fee schedule based on usual and customary reimbursement (U&C) not to exceed the charged amount. U&C reimbursement amounts are based on a combination of Medicare rates and the SHP geographic service area.

SHP accepts claims directly from non-participating providers. If the non-participating provider does not submit claims to SHP, members must submit a member claim form. Claims, whether directly from providers or from members, must be submitted within 180 days from the date of service or date of inpatient discharge. The member may contact SHP’s Member Services Department to discuss how to submit the required information. If the Provider refuses direct payment, the member will be reimbursed the U&C reimbursement amount for the service.

Member is responsible for all charges above the U&C reimbursement amount in addition to any copayment, deductible, and coinsurance which may be incurred. Only the U&C reimbursement is applied to the Member’s benefits. SHP 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.

6.9.3 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.

<table>
<thead>
<tr>
<th>Modifier Code</th>
<th>Description</th>
<th>Allowance of Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>20%</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>20%</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (when qualified resident or</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>surgeon not available to assist the primary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>surgeon)</td>
<td></td>
</tr>
<tr>
<td>AS</td>
<td>Physician Assistant, Nurse Practitioner, or</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>Clinical Nurse</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Reduced Services</td>
<td>85%</td>
</tr>
<tr>
<td>21</td>
<td>Prolonged Evaluation Services</td>
<td>115%</td>
</tr>
<tr>
<td>22</td>
<td>Surgical Care Only</td>
<td>115%</td>
</tr>
<tr>
<td>54</td>
<td>Increased Procedural Services</td>
<td>85%</td>
</tr>
</tbody>
</table>

6.9.4 Claim Edits for Professional Claims

Sanford Health Plan utilizes Experian editing software to apply correct coding and standardization for editing of professional claims. We consider and apply industry standard edits as outlined by National Correct Coding Initiative, American Medical Association and Centers for Medicare & Medicaid Services guidelines. Authorizations or referrals do not override system claim edits. Edits made to claims are considered to be a provider adjustment and not billable to the member. Edits will be applied to both participating and nonparticipating providers.
6.9.5 APC Pricing for Outpatient Services

Sanford Health Plan implemented Ambulatory Payment Classification (APC) pricing methodology for outpatient services in 2016 using 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 UB-04 claim (or electronic equivalent) with bill types 13X or 14X. This was the result of a national trend in decreased inpatient volume and an increase in outpatient services.

It is intended to provide an opportunity to level set for both the provider and payer, while reimbursing the provider for the resources utilized for the services. To see more specific billing information regarding APCs, refer to the Billing Requirement section of the provider manual.

6.9.6 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. They contain bill types 112, 113 and 114. Interim claims are not accepted by the Sanford Health Plan and will be denied.

6.9.7 DRG Grouper for Inpatient Services

Sanford Health 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 grouper version used will be based on the most current version available or as specified in your contract effective on the date of admission.

6.9.8 Claim Reconsiderations

You will be granted a one-time review for claim reconsiderations if you think your claim was processed incorrectly. Follow up on an adverse benefit determination that affects claims processing must be submitted 60 days from the date the Explanation of Payment (EOP) was issued. After this time frame has expired, claims may no longer be reviewed.

Corrected claims, including but not limited to claims denied for unspecified or nonspecific coding, must be received within 60 days from the date of denial. After this time frame has expired, claims may no longer be reviewed. The original claim number must be identified in the corrected claim.

For instructions on submitting corrected or voided claims, refer to the Claims Submission section. These items can be submitted online through your mySanfordHealthPlan provider account under the “Provider Resources” tab in the Express Request section.

6.9.9 Proof of Timely Filing

Sanford Health Plan participating providers are contractually obligated to file claims within 180 days. For North Dakota Medicaid Expansion member, providers can file claims within 365 days. Sanford Health Plan processes a “clean claim” within 30 days of receipt of the claim and 60 days for a “non-clean” claim. In North Dakota, Sanford Health Plan will pay clean claims within 15 days of receipt of the claim. Therefore, all claims are to be paid or 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, 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.

6.10 Fraud, Waste, and Abuse Payment Policy

Sanford Health 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.

Sanford Health Plan will identify, resolve, recover funds, report, and when appropriate, take legal actions, if suspected fraud, waste, and/or abuse have occurred.

Detecting and preventing fraud, waste, and abuse (FWA) is the responsibility of everyone, including providers, members and sub-contractors.
Filing Claims

A provider’s submission of a claim for payment also constitutes the provider’s representation that the claim is not submitted as a form of, or part of, fraud 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 are listed below.

Providers are responsible for, and these provisions likewise apply to, the actions of their staff members and agents. 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.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for Sanford Health Plan.

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 pre-payment audits, post-payment audits and retraction of overpayments.

Definitions:

**Fraud:** Healthcare fraud is defined as intentionally submitting false claims to insurers or federal programs such as Marketplace, Medicare or Medicaid for the purpose of obtaining un-entitled funds.

Fraud (as defined in healthcare context) occurs when a person(s):

- Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for a payment of a health care benefit; or
- Knowingly and willfully presents or causes to be presented an application for a health care benefit containing any false statement or representation of a material fact; or
- Knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to a health care benefit, including whether goods or services were medically necessary in accordance with professionally accepted standards.

**Abuse:** Includes actions that may, directly or indirectly, result in unnecessary costs. Abuse involves payment for items or services when there is not legal entitlement to payment but the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

**Waste:** Waste includes incurring unnecessary costs as a result of inefficient or ineffective practices, systems, or controls. This could be the overutilization of services or other practices directly or indirectly resulting in unnecessary costs to the health care system.

Examples of fraud, waste, or abuse may include, but are not limited to, the following:

- Billing for services not rendered.
- Deliberately billing for services more complex than what was actually rendered.
- Performing (and billing for) services not medically necessary to obtain an insurance payment.
- Changing the rendering physician and/or services to get the claim paid (after the claim was denied).
- Falsifying a diagnosis to support testing or services not otherwise necessary/covered.
- Soliciting, offering, or receiving a kickback for referral of patients in exchange for other services.
- Prescribing a prescription with no legitimate or medical purpose.
- Practicing “defensive medicine” by ordering medical tests or procedures as a safeguard against possible malpractice liability, not to ensure a patient’s health.
- Excessive charges for services, procedures, or supplies.
- Submitting claims for services not medically necessary, or services not medically necessary to the extent rendered (for instance a panel of tests is ordered when based upon the patient’s diagnosis only a few of the tests, if any at all, within the panel were actually necessary).
- Unbundling.
- Duplicate billing.

6.11 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. Sanford Health Plan contracts with Optum to contact members about claims which another party may be liable.

Claims are sent to Optum based on diagnosis codes and are pended for investigation. Members are contacted by Optum and claims are released if not found to be liable from another third party. Claims will be denied if another party is responsible for the payment of the claim or there is no response from the member.
Filing Claims

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

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

If Optum has not received a response within this second 10-day period, they send advice to Sanford Health Plan to deny the claims in question for lack of information. This process normally takes approximately 25 days assuming Optum does not receive a response. Optum will identify about 10% of Sanford Health Plan’s claims in 24 hours, 80% in 8 calendar days, 90% in 14 calendar days and 99% in 25 days. Optum’s toll free number that members can call to relay the requested information is (800) 529-0577.

6.12 Coordination of Benefits

If a member is covered by another health plan, insurance, or other coverage arrangement, then Sanford Health 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 member has two obligations concerning Coordination of Benefits:

1. The member must inform Sanford Health Plan and/or their provider regarding all health insurance plans.

2. The member must cooperate with Sanford Health Plan by providing any information that is requested.

6.12.1 Applicability

The order of benefits determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. 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 plan that pays after the primary plan is called the secondary plan. 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.

6.12.2 Order of Benefit Determination Rules

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

6.12.3 Non-Dependent/Dependent

The plan that covers the person as a Group member, member or subscriber (that is other than as a dependent), are determined before those of the plan which covers the person as a Dependent. The plan that covers the individual as a dependent is secondary. 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

6.12.4 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), or has a joint custody agreement that does not specify one party has the responsibility to provide health care coverage, 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.
6.12.5 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 have ever 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 or assigns joint custody without specifying responsibility, the rule for “Dependent Child Who Has Parents Living Together” will apply.
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, the first rule which applies to non-dependent/dependent listed above shall determine the order of benefits or:
  - If the parents are not married, or are separated (whether or not they have been married) or are divorced and there is no court decree allocating responsibility for the child’s health care expenses or coverage, the order is as follows:
    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the noncustodial parent; and then
    - The plan of the spouse of the noncustodial parent.
  - Active/Inactive Group Member

- Primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person’s Dependent);
- Secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Group Member, Member or Subscriber longer is primary.

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.

6.13 Calculation of Benefits, Secondary Plan

Sanford Health Plan uses the Classic method for determining payments as a secondary payer. If Sanford Health Plan is secondary, it shall reduce its 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 Sanford Health 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.

6.14 Coordination of Benefits with Medicare

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

If a provider has accepted assignment of Medicare, Sanford Health 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.

6.12.6 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:
6.15 Members with End Stage Renal Disease (ESRD)

1) The Plan has primary responsibility for the claims of a Member:
   a) Who is eligible for Medicare secondary benefits solely because of ESRD, and;
   b) During the Medicare coordination period of 30 months, which begins with the earlier of:
      i) the month in which a regular course of renal dialysis is initiated, or
      ii) in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

2) The Plan has secondary responsibility for the claims of a Member:
   a) Who is eligible for Medicare primary benefits solely because of ESRD, and;
   b) The Medicare coordination period of 30 months has expired.

   • 50% of the fee schedule for the second highest value
   • 25% of the fee schedule for any additional surgical procedures

6.16 Billing Requirements

6.16.1 Multiple Surgeries

Multiple surgeries are defined as multiple procedures performed at the same session by the same provider. Sanford Health Plan allowances are reduced for multiple surgical procedures. Multiple surgical procedures should be identified with a modifier 51. The exceptions to the above are subsidiary codes listed by Medicare. These subsidiary codes should not be coded with a 51 modifier and the allowance. Multiple surgery fees should not be billed pre-cut. Sanford Health Plan uses the following payment structure for multiple surgery claims.

   • 100% of the fee schedule for the highest value procedures
   • 50% of the fee schedule for the second highest value
   • 25% of the fee schedule for any additional surgical procedures

6.16.2 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 follow the same reimbursement percent guidelines as listed above under multiple surgical procedures. Bilateral procedures should be billed on one line. See the below example.

Example: Bilateral procedures billed on one line (two services).

<table>
<thead>
<tr>
<th>CPT</th>
<th>Modifier</th>
<th>Description</th>
<th>Charges</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>69210</td>
<td>50</td>
<td>Removal of impacted cerumen requiring instrumentation, unilateral</td>
<td>$400.00</td>
<td>1</td>
</tr>
</tbody>
</table>

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.

6.16.3 Assistant Surgeons

Assistant surgeon claims can be identified by modifier 80, 81 or 82. Claims with modifiers 80, 81 or 82 will be adjudicated according to the Milliman Healthcare Management Guidelines for Assistant Surgeon Care. If the surgery does not require an assistant, the claim will be denied and is not billable to the member; therefore, making it a provider write-off. If the surgery does allow an assistant, it will be reimbursed at 20 percent of the applicable fee schedule.

Assistant surgeon fees should not be billed pre-cut. Requests for reconsideration of denied assistant surgeon charges must be received within 60 days of the denial date on the EOP. Please include a reference to the claim number, code(s) being asked for reconsideration and a copy of the medical record.

Assistant surgeon charges that are denied may not be billed to the member. Participating providers are contractually obligated to write off assistant surgeon fees that are not covered by Sanford Health Plan.
6.16.4 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.

6.16.5 Newborn Additions

A newborn is eligible to be covered from birth. Member’s 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 will be denied or rejected electronically as “member not eligible.” Providers will need to re-file claims after the newborn is enrolled for proper claims processing and reimbursement.

6.16.6 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.

<table>
<thead>
<tr>
<th>Never Event</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Reportable Event</td>
<td>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.</td>
</tr>
</tbody>
</table>

Sanford Health 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 conditions which are not reimbursable include the 28 events listed on the National Quality Forum (NQF) website.

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

- MM - 09 Never Events and Avoidable Hospital Conditions policy

6.17 Ambulatory Payment Classification (APC) Payment

Sanford Health Plan follows the general principles, billing, pricing, and edit guidelines of the Center for Medicare & Medicaid Services (CMS) outpatient prospective payment/ambulatory payment classifications (OPPS/APC’s) unless otherwise stated in individual contracts.

Sanford Health 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 UB-04 claim (or electronic equivalent) with bill types 13X or 14X. This product seamlessly integrates with Sanford Health Plans’ EPIC Tapestry host systems. We began using Ambulatory Payment Classification (APC) pricing methodology in 2016 to help control cost and utilization of services. This is the result of a national trend in decreased inpatient volume and an increase in outpatient services. It is intended to provide an opportunity to level set for both the provider and payer, while reimbursing the provider for the resources utilized for the services.

APC methodology is used for covered outpatient services at Prospective Payment System hospitals and General Acute Care facilities.
Filing Claims

**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 six H or S codes;
• Physician/professional services. Providers will need to submit separate claims for these services.

### 6.17.1 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 of 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 a number of 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. Services within an APC are similar clinically and with respect to hospital resource use.

### 6.17.2 APC Billing Rules

Sanford Health 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.

**Sanford Health Plan deviates from CMS on the following guidelines:**

• Therapy services: These modifiers and G-codes will be accepted but not required.
  o Modifiers GN, GO, GP
  o Non-payable therapy G-codes
  o Functional severity Modifiers (CH – CN)

• 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.
  o Condition Codes 49 or 50
  o Value Amount on claims that include Value Code FD
- Payment rules for Partial Hospitalization: Payment for outpatient mental health services will be based on Rev Codes or one of six H or S HCPCS codes below per individual contract language.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9480</td>
<td>Intensive outpatient psychiatric services, per diem</td>
<td>PHP</td>
</tr>
<tr>
<td>H2035</td>
<td>Alcohol or other related drug treatment program, per hour</td>
<td>IOP</td>
</tr>
<tr>
<td>H0015</td>
<td>Alcohol and/or drug services</td>
<td>IOP</td>
</tr>
<tr>
<td>H0035</td>
<td>Mental PHP, treatment, less than 24 hours</td>
<td>IOP</td>
</tr>
<tr>
<td>S0201</td>
<td>PHP services, less than 24 hours, per diem</td>
<td>PHP</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral health day treatment, per hour</td>
<td>PHP</td>
</tr>
</tbody>
</table>

- 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.

<table>
<thead>
<tr>
<th>Outpatient Code Editor (OCE) Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Questionable covered service</td>
</tr>
<tr>
<td>18</td>
<td>Inpatient procedure</td>
</tr>
<tr>
<td>21</td>
<td>Medical visit same day as significant procedure without modifier 25</td>
</tr>
<tr>
<td>29</td>
<td>Partial hospitalization service non-mental health diagnosis</td>
</tr>
<tr>
<td>30</td>
<td>Insufficient services on day or partial hospitalization</td>
</tr>
<tr>
<td>35</td>
<td>Only mental health education &amp; training services provided</td>
</tr>
<tr>
<td>45</td>
<td>Inpatient separate procedures not paid</td>
</tr>
<tr>
<td>46</td>
<td>Partial hospitalization condition code 41 not appropriate for bill type</td>
</tr>
<tr>
<td>49</td>
<td>Service on same day as inpatient procedure</td>
</tr>
<tr>
<td>61</td>
<td>Service can only be billed to the DMERC</td>
</tr>
<tr>
<td>65</td>
<td>Revenue code not recognized by Medicare</td>
</tr>
<tr>
<td>80</td>
<td>Mental health code not approved for Partial Hospitalization Program</td>
</tr>
<tr>
<td>81</td>
<td>Mental health services not payable outside Partial Hospitalization Program</td>
</tr>
</tbody>
</table>
6.17.3 APC Pricing Rules

Sanford Health 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

Sanford Health Plan will also apply the following guidelines:

- 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

6.17.4 OCE Edits

The role of OCE is to edit claims for errors, notify Sanford Health Plan what action to take with a “problem” claim, 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.

<table>
<thead>
<tr>
<th>OCE Edit</th>
<th>OCE Edit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Invalid Diagnosis Code</td>
</tr>
<tr>
<td>005</td>
<td>E-Code as Reason for Visit</td>
</tr>
<tr>
<td>006</td>
<td>Invalid HCPS Procedure Code: invalid code, or code invalid for service dates</td>
</tr>
<tr>
<td>027</td>
<td>Only incidental services reported</td>
</tr>
<tr>
<td>048</td>
<td>Revenue center requires HCPCS code</td>
</tr>
</tbody>
</table>

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

SHP will send annual reimbursement notice that will include conversion factor and RCC.

SHP will provide notice of 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 & B Updates where APC states codes are updated:
Members

The following individuals have the right to file a complaint or appeal of any adverse determination made by Sanford Health Plan:

• a member
• a health care provider with knowledge of the member’s medical condition, or
• a member’s authorized representative or an attorney.

For members of the North Dakota Medicaid Expansion Program, a provider must obtain written consent from the member prior to filing a complaint or appeal on their behalf.

7.1 Oral Complaint

A complaint can be submitted by calling the Member Services Department. If the complaint is not resolved within 10 business days of receipt of the complaint, then a Complaint Form will be sent to the person calling. The form must be completed and returned to the Member Services Department for further consideration.

The completed form can be accompanied by comments, documents, records and other information relating to the reason for filing a written complaint. Member Services will notify the individual that filed the complaint within 10 business days upon receipt of the information, unless the complaint has been resolved to the complainant’s satisfaction within those 10 business days.

A written notification including the decision regarding the complaint will be sent to the complainant who filed the complaint within 30 calendar days from the receipt of the complaint. In certain circumstances, the time period may be extended to 14 days beyond the initial 30 days. For North Dakota Medicaid Expansion members, the time frame to respond is 90 days with an optional 14 day extension.

7.1.1 Written Complaint

Complete a Complaint Form and return to:
Sanford Health Plan
Member Services Department
PO Box 91110
Sioux Falls, SD 57109-1110

7.2 Appeals

7.2.1 Expedited Appeal

An Expedited Appeal for Urgent Care is a request to change a previous adverse determination made by Sanford Health Plan for a urgent care request. If the member’s situation meets the definition of urgent, a determination will be made within 72 hours (24 hours for South Dakota members).

7.2.2 Prospective Appeal

A Prospective (pre-service) Appeal is a request to change an adverse determination that Sanford Health Plan approved in whole or in part in advance of the member obtaining care or services. A determination will be sent in writing or electronically within 30 calendar days of receipt of the appeal to the member or their representative and/or any practitioner involved in the appeal.

7.2.3 Retrospective Appeal

Retrospective (post service) Appeal is a request to change an adverse determination that the Plan must approve in whole or in part in advance of the member obtaining care or services. A determination will be sent in writing or electronically within 60 calendar days of receipt of the appeal (30 calendar days for Iowa and Minnesota) to the member or their representative and/or any practitioner involved in the appeal. For North Dakota Medicaid Expansion members the time frame is 45 days.

The filing deadline for appeals can be made within 180 days from notification of the adverse determination (there is no filing deadline in Minnesota). For North Dakota Medicaid Expansion members, appeals can be made within 30 days from notification of the adverse determination.

For more information or questions about the complaint or appeals process, contact the Member Services Department at (800) 752-5863.

The following policy(s) are referenced in this section and are available for review under “Provider Resources” at sanfordhealthplan.com/providerlogin.

• MM-49 Medical Management Program policy.
7.3 Member Rights & Responsibilities

Minnesota Member Rights:

In accordance with the Minnesota Department of Health, and the National Committee for Quality Assurance (NCQA), you have certain rights as member of the Sanford Health Plan in Minnesota:

1. Members have the right to available and accessible services including emergency services, as defined in the Benefits Policy, 24 hours a day and seven days a week;

2. Members 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. Members have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the Plan and its health care Practitioners and/or Providers, in accordance with existing law;

4. Members have the right to file a complaint with the Plan and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the Plan or its health care Practitioners and/or Providers;

5. Members have the right to a grace period of 31 days for the payment of each service charge for individual coverage falling due after the first premium during which period coverage shall continue in force;

6. Medicare members have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law;

7. Medicare members have the right to a clear description of nursing home and home care benefits covered by the Plan;

8. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; sex; gender identity; sexual orientation; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; disability; national origin, age, or sources of payment for care;

9. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity;

10. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;

11. 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, they have the right to choose another PCP;

12. 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 Minnesota law;

13. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other provider is primarily responsible for their individual care. Members also have the right to receive information about the Plan’s clinical guidelines and protocols;

14. Members have the right to a candid discussion (with the practitioner(s) and/or providers responsible for coordinating their care) of 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 planning;

15. Members have the right to give informed consent before the start of any procedure or treatment;

16. When a member does not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician who is able to communicate with the member;

17. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read;

18. Members have the right to appeal any decision regarding medical necessity made by the Plan and its Practitioners and/or providers;

19. Members have the right to terminate from the Plan, in accordance with Employer and/or Plan guidelines;

20. Members have the right to receive information about the organization, its services, its practitioners and providers and members’ rights and responsibilities; and

21. Members have the right to make recommendations regarding the organization’s Member Rights and Responsibilities policies.
7.3 Member Rights & Responsibilities

Minnesota 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.

3. Members are responsible for following all access and availability procedures.

4. Members are encouraged to seek care for an Emergency Medical Condition at a Plan participating emergency Facility whenever possible. In the event an ambulance is used, state law requires 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.

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 notifying the Plan within thirty (30) days at (800) 752-5863 or TTY/TDD: (877) 652-1844 (toll-free) if they change their name, address, or telephone number.

10. Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.
7.3 Member Rights & Responsibilities

South Dakota, North Dakota and Iowa 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 receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; sex; gender identity; sexual orientation; medical condition, religious beliefs, national origin, age, or sources of payment for care.

2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.

3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.

4. 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 or she has the right to choose another PCP.

5. 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 State law.

6. 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.

7. Members have the right to a candid discussion (with the practitioner(s) and/or providers responsible for coordinating their care) of 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 planning.

8. Members have the right to give informed consent before the start of any procedure or treatment.

9. When members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter.

The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the member.

10. 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.

11. 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.

12. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners.

13. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.

14. Members have the right to receive information about the organization, its services, its practitioners and providers and members’ rights and responsibilities.

15. Members have the right to make recommendations regarding the organization’s members’ rights and responsibilities policies.
7.3 Member Rights & Responsibilities

South Dakota, North Dakota and Iowa 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 law in North Dakota, Iowa, and South Dakota requires 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.

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 told by the Doctor mainly 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 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 notifying the Plan within thirty (30) days at (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free) if they change their name, address, or telephone number.

10. Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.
Sanford Health Plan offers online tools specifically designed to help you obtain the information you need as quickly as possible.

8.1 mySanfordHealthPlan

mySanfordHealthPlan is Sanford Health Plan’s online benefits tool available to providers. Through this secure online tool, you have access to information 24/7. With mySanfordHealthPlan you will be able to:

- View deductibles, coinsurance and out-of-pocket totals for members
- Verify member eligibility
- Submit prior authorizations, online claim reconsideration, formulary exception through Express Request
- Access the provider manual and policies
- View check numbers to track payments – identify if a check has posted or cleared
- Report a member date of birth or ID number discrepancies and receive a reply within one business day

To request a mySanfordHealthPlan account; follow these steps:

1. Go to www.sanfordhealthplan.com/providerlogin
2. Click on “create a provider account”
3. Read the License Agreement and click on “Agree”
4. Enter all the required account information on the following screens, then click “Finish”
5. You will be redirected to the site and will then hover on the tab “to complete sign-up” and click on “Request Access”.
6. Click on the link “Provider Online Claim/Eligibility/Authorization Access Request”.
7. Review your pre-filled information and hit “Submit”.

Your information will then be submitted to be reviewed for approval. Once your account has been approved you will receive an email from Sanford Health Plan. Afterward, you will be able to log on to your provider account using the User ID and Password you created upon setting up your account.

If you have any questions or need assistance with setting up an account, please contact the Provider Relations Department at (605) 328-6877 or (800) 601-5086. You can also send an email to providerrelations@sanfordhealth.org.

8.2 Provider Directories

You can access the provider directory through mySanfordHealthPlan:

- Go to sanfordhealthplan.com/memberlogin
- Log in to your secure member account using your username and password
- Click on the “My Information” tab
- On the drop down menu, click “Find a provider”
- Access the member login section on the right side of the page
- Enter your member ID and last name

8.3 Forms

For your convenience, you will find our forms posted outside the secure login of mySanfordHealthPlan for providers. Some of our commonly used forms include: Claim Reconsideration Form, credentialing applications for providers, Provider Information Update/ChangeForm, Health Management Referral Form and more. To access a form, click here. You will find the forms link on the left-hand side of the screen.

8.4 Sanford Health Plan ID Card & Benny Card

What do our ID cards look like? The answer depends on our products and services. We created a two page document that gives you a high level overview of our ID cards and basic information. To view or print a sample click here.

The Benny Card is a special purpose Visa® card that gives members an easy, automatic way to pay for eligible healthcare expenses. The card is given to members who sign up for a medical FSA (Flexible Spending Account), Health Reimbursement Account (HRA) or Health Savings Account (ASA). To view or print a sample click here.

8.5 Provider Newsletters

The Provider Perspective is a monthly email newsletter for providers and their office staff. Each month, we share information about a variety of topics to keep you up-to-date. To see past issues or to sign up to receive the newsletter if you currently don’t receive it, click here.
### 9.1 Glossary of Terms

<table>
<thead>
<tr>
<th>Terms/Common Acronyms</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>270 (ANSI ASC X12) Electronic Eligibility/Benefits Request</td>
<td>Type of EDI Transaction: Health Care Eligibility/Benefit Inquiry (From Provider)</td>
</tr>
<tr>
<td>271 (ANSI ASC X12) Electronic Eligibility/Benefits Response</td>
<td>Type of EDI Transaction: Health Care Eligibility/Benefit Response (From Health Plan)</td>
</tr>
<tr>
<td>276 (ANSI ASC X12) Electronic Claims Status Request</td>
<td>Type of EDI Transaction: Health Care Claim Status Request (From Provider)</td>
</tr>
<tr>
<td>277 (ANSI ASC X12) Electronic Claims Status Response</td>
<td>Type of EDI Transaction: Health Care Claim Status Notification (From Health Plan)</td>
</tr>
<tr>
<td>278 (ANSI ASC X12) Electronic Authorization Certification / Review Information</td>
<td>Type of EDI Transaction: Health Care Service Review Information</td>
</tr>
<tr>
<td>820 (ANSI ASC X12) Electronic Premium Payment</td>
<td>Type of EDI Transaction: Payroll Deducted and other group Premium Payment for Insurance Products</td>
</tr>
<tr>
<td>834 (ANSI ASC X12) Electronic Eligibility</td>
<td>Type of EDI Transaction: Benefit Enrollment and Maintenance Set</td>
</tr>
<tr>
<td>835 (ANSI ASC X12) ERA (Electronic Remittance Advice)</td>
<td>Type of EDI Transaction: Health Care Claim Payment/Advice Transaction Set (Electronic Remittance)</td>
</tr>
<tr>
<td>837 (ANSI ASC X12) Electronic Claim (837P / 8371)</td>
<td>Type of EDI Transaction: Health Care Claim Transaction Set (Inbound / Outbound / Professional / Institutional)</td>
</tr>
</tbody>
</table>

**Accountable Care Organization (ACO)**
A healthcare 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.
### 9.1 Glossary of Terms

<table>
<thead>
<tr>
<th>Terms/Common Acronyms</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acuity / Bed</td>
<td>Level of severity of an illness / patient care</td>
</tr>
<tr>
<td>Acute / Sudden Onset</td>
<td>Brief and severe</td>
</tr>
<tr>
<td>Acute Care / Urgent Care</td>
<td>Short-term medical treatment; urgent medical care</td>
</tr>
<tr>
<td>American Dental Association</td>
<td>Lobbyist group for American dentists.</td>
</tr>
<tr>
<td>Americans with Disability Act</td>
<td>Federal law protecting the rights of individuals with disabilities.</td>
</tr>
<tr>
<td>Adjudication</td>
<td>Processing claims to determine pricing (allowances) and benefits (member liability) amounts.</td>
</tr>
<tr>
<td>Adjustment</td>
<td>Reprocessing of a claim to make a correction</td>
</tr>
<tr>
<td>ADL (Activities of Daily Living)</td>
<td>Routine activities that people do everyday without needing</td>
</tr>
<tr>
<td>Advance Directive (Living Will / Healthcare Power of Attorney)</td>
<td>Written statement of a person’s wishes regarding medical treatment and how those wishes should be carried out</td>
</tr>
<tr>
<td>Adverse Event (Sentinel Event / Never Event)</td>
<td>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 healthcare management.</td>
</tr>
<tr>
<td>Adverse Selection</td>
<td>The common phenomenon in which healthy people choose not to insure and a disproportionate number of unhealthy people enroll</td>
</tr>
<tr>
<td>Affordable Care Act (ACA / PPACA)</td>
<td>Enacted to increase quality and affordability of health insurance</td>
</tr>
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<thead>
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<tbody>
<tr>
<td>Agent / Insurance Agent</td>
<td>Person who is employed by the broker, who works with the member, to find an insurance plan that fits their needs.</td>
</tr>
<tr>
<td>ALOS (Average Length-of-Stay)</td>
<td>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.</td>
</tr>
<tr>
<td>AMA (American Medical Association)</td>
<td>Physician lobbyist group</td>
</tr>
<tr>
<td>Ambulance</td>
<td>Vehicle for transportation to provide for medical services</td>
</tr>
<tr>
<td>Ambulatory/Outpatient</td>
<td>Medical care provided on an outpatient basis (clinic/office or hospital outpatient department)</td>
</tr>
<tr>
<td>AMP (Average Manufacturer Price)</td>
<td>Average price paid by wholesalers to manufacturers for drugs distributed to retail pharmacies.</td>
</tr>
<tr>
<td>Ancillary Provider</td>
<td>Providers who provide necessary services within the network of physicians</td>
</tr>
<tr>
<td>ANSI (American National Standards Institute)</td>
<td>Format for transmitting industry standardized electronic information and forms</td>
</tr>
<tr>
<td>AOB (Assignment of Benefits)</td>
<td>Accepting payment from a health plan or federal program for services rendered to a patient</td>
</tr>
<tr>
<td>APC (Ambulatory Payment Classification / OPPS)</td>
<td>A type of outpatient prospective payment system</td>
</tr>
<tr>
<td>Appeal</td>
<td>Request by the member or provider to change an official decision</td>
</tr>
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<tr>
<td>Approved Clinical Trial</td>
<td>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.</td>
</tr>
<tr>
<td>ASP (Average Sales Price)</td>
<td>Used for pharmacy reimbursement/allowance calculation - average price at which a particular product or commodity is sold across channels or markets</td>
</tr>
<tr>
<td>Assistant at Surgery / Assistant Surgeon / Surgical Tech</td>
<td>Defined as a physician or allied health practitioner who actively assists the operating surgeon</td>
</tr>
<tr>
<td>Authorization / Referral / Prior Notification / Prior Authorization</td>
<td>Agreement to allow a member to access a specified service</td>
</tr>
<tr>
<td>Authorized Representative</td>
<td>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.</td>
</tr>
<tr>
<td>Auto-Adjudication (Rate) / AA / AAR</td>
<td>Claims process automatically without pending; often improves efficiency and reduces expenses required for manual claims</td>
</tr>
<tr>
<td>Avoidable Hospital Conditions</td>
<td>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.</td>
</tr>
<tr>
<td>AWP (Any Willing Provider / Average Wholesale Price)</td>
<td>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</td>
</tr>
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<tr>
<td>AWPL (Any Willing Provider Laws)</td>
<td>Laws that require managed care organizations to grant network participation to health care providers willing to join and meet the network requirements</td>
</tr>
<tr>
<td>Balance Billing (Also see UC&amp;R)</td>
<td>The practice of a healthcare provider billing a patient for the difference between what the patient’s health insurance chooses to reimburse and what the provider chooses to charge</td>
</tr>
<tr>
<td>Bariatric / Weight Management</td>
<td>Branch of medicine that deals with the causes, prevention, and treatment of obesity.</td>
</tr>
<tr>
<td>Bilateral Procedure</td>
<td>Procedures that are performed on both sides of the body during the same procedure.</td>
</tr>
<tr>
<td>Brand Name Drug</td>
<td>A drug that has a trade name and is protected by a patent.</td>
</tr>
<tr>
<td>Cafeteria Plan</td>
<td>Health plan where members have the option to choose between different types of benefits.</td>
</tr>
<tr>
<td>(CAH) Critical Access Hospital</td>
<td>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.</td>
</tr>
<tr>
<td>CAHPS (Consumer Assessment of Healthcare Providers and Systems)</td>
<td>The CAHPS Health Plan Survey is a tool for collecting standardized information on enrollees’ experiences with health plans and their services</td>
</tr>
<tr>
<td>Calendar Year</td>
<td>A period of one year which starts on January 1st and ends December 31st.</td>
</tr>
<tr>
<td>Capitation</td>
<td>Payment arrangement that pays a physician or group of physicians a set amount for each enrolled person assigned to them.</td>
</tr>
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<tr>
<td>Carrier (Health Plan)</td>
<td>A company that creates and manages insurance products; control underwriting, claims, pricing and overall guidance of the company.</td>
</tr>
<tr>
<td>Carve-Out</td>
<td>A specifically defined benefit or group of benefits in a plan.</td>
</tr>
<tr>
<td>Case Management (CM)</td>
<td>A coordinated set of activities conducted for individual Member management of chronic, serious, complicated, protracted, or other health conditions.</td>
</tr>
<tr>
<td>Case Rate</td>
<td>A pricing method in which a flat amount, often a per diem rate, covers a defined group of procedures and services</td>
</tr>
<tr>
<td>Category II CPT Code</td>
<td>Codes that describe clinical components usually included in evaluation and management or clinical services</td>
</tr>
<tr>
<td>Category III CPT Code</td>
<td>A temporary set of codes for emerging technologies, services, and procedures</td>
</tr>
<tr>
<td>CDC (Centers for Disease Control)</td>
<td>Government organization that manages infectious disease protocol and guidelines</td>
</tr>
<tr>
<td>(CDHP) Consumer-Directed Health Plan</td>
<td>A tier of health plans that allow consumers to manage medical expenses using HSAs, HRAs, or similar payment methods</td>
</tr>
<tr>
<td>(CDT) Current Dental terminology</td>
<td>Code set for reporting dental services and procedures</td>
</tr>
<tr>
<td>Certificate of Creditable Coverage (COC)</td>
<td>Document that outlines the dates of coverage for the member through their insurance carrier.</td>
</tr>
<tr>
<td>Certification</td>
<td>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.</td>
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<tr>
<td>Chemical Dependency / Substanc Abuse/Chem Dep / SUD / CD</td>
<td>Addiction to a mood or mind altering drug</td>
</tr>
<tr>
<td>CHIP / SCHIP</td>
<td>Low-cost health insurance program designed for children of families whose income level was too high to qualify for Medicaid.</td>
</tr>
<tr>
<td>Chronic Disease</td>
<td>A long-lasting condition that can be controlled but not cured</td>
</tr>
<tr>
<td>(CHS) Contract Health Services</td>
<td>Regulated under IHS, CHS is a secondary program for medical/dental care provided away from an IHS or tribal health</td>
</tr>
<tr>
<td>Clinical Criteria</td>
<td>Guidelines that provide recommendations for internal medicine physicians treating patients with certain ailments</td>
</tr>
<tr>
<td>Clinical Trial</td>
<td>Research studies that test how well new medical approaches work with patients</td>
</tr>
<tr>
<td>(CMS) Centers for Medicare and Medicaid</td>
<td>Government organization that administers Medicare, Medicaid, CHIP, and parts of the Affordable Care Act (ACA)</td>
</tr>
<tr>
<td>CMS-1500 / AKA HCFA-1500</td>
<td>The standard claim form for professional or outpatient claims.</td>
</tr>
<tr>
<td>COBRA</td>
<td>A continuation of healthcare coverage for a member who leaves their employer.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>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.</td>
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<tr>
<td>[This] Contract or [The] Contract</td>
<td>The Policy, including all attachments, the Group’s application, the applications of the Subscribers and the Health Maintenance Contract.</td>
</tr>
<tr>
<td>Convalescent Care / Rehab / Post-Op</td>
<td>A range of health services designed to help people recover from serious illness, surgery or injury</td>
</tr>
<tr>
<td>Coordination of Benefits (COB)</td>
<td>Ensures a person with multiple insurance policies isn’t compensated more than once</td>
</tr>
<tr>
<td>Copay</td>
<td>An amount that a Member must pay at the time the Member receives a Covered Service.</td>
</tr>
<tr>
<td>CORF (Comprehensive Outpatient Rehabilitation Facility), Outpatient Rehab</td>
<td>A medical facility that provides outpatient diagnostic, therapeutic, and restorative services for the rehabilitation of your injury, disability, or sickness.</td>
</tr>
<tr>
<td>Cosmetic</td>
<td>Involving or relating to treatment intended to restore or improve the person’s appearance.</td>
</tr>
<tr>
<td>Cost Sharing</td>
<td>Costs that a member is expected to pay as part of their plan</td>
</tr>
<tr>
<td>Coverage (CVG)</td>
<td>Policy that covers the insured in the event of an unforeseen event</td>
</tr>
<tr>
<td>Coverage Gap</td>
<td>Time between insurance coverage when a patient is not covered.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Those Health Care Services to which a Member is entitled under the terms of their Contract.</td>
</tr>
<tr>
<td>CPT Procedure Code / Current Procedure Terminology</td>
<td>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</td>
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<tr>
<td>Credentialing</td>
<td>The process of establishing qualifications of licensed professionals and assessing their background.</td>
</tr>
<tr>
<td>Creditable Coverage</td>
<td>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.</td>
</tr>
<tr>
<td>Deductible</td>
<td>The amount that a Member must pay each Calendar Year before the Plan will pay benefits for Covered Services.</td>
</tr>
<tr>
<td>Dependent</td>
<td>The Spouse and any Dependent Child of a Subscriber.</td>
</tr>
<tr>
<td>Dependent Child</td>
<td>a. A Subscriber’s biological child; b. A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement; c. A stepchild of the Subscriber; or d. A foster child or any other child for whom the Subscriber has been granted legal custody.</td>
</tr>
<tr>
<td>DHS (Department of Human Services, HHS (Federal))</td>
<td>Agencies tasked with protecting the health of all Americans and providing essential health services</td>
</tr>
<tr>
<td>Diagnosis (DX)</td>
<td>Identification of an illness or other problem by examination of the symptoms</td>
</tr>
<tr>
<td>Disallowed Amount</td>
<td>The difference between the actual amount of the procedure and the amount agreed upon by the insurance company.</td>
</tr>
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<tbody>
<tr>
<td>Discount</td>
<td>Reduction to the prices of services; usually provided when seeing an in-network provider</td>
</tr>
<tr>
<td>Disease Management</td>
<td>A system of coordinated health care interventions and communications for defined patient populations with conditions where self-care efforts can be implemented.</td>
</tr>
<tr>
<td>DOI (Department of Insurance)</td>
<td>State departments that regulate insurance products and agents.</td>
</tr>
<tr>
<td>DOL (Department of Labor)</td>
<td>U.S. or State Department of Labor</td>
</tr>
<tr>
<td>Domiciliary Care (Dom Care)</td>
<td>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.</td>
</tr>
<tr>
<td>DOS (Date of Service)</td>
<td>Date when services were rendered</td>
</tr>
<tr>
<td>DRG (Diagnostically-Related Grouping)</td>
<td>System used to classify hospital cases</td>
</tr>
<tr>
<td>Dual-Eligible</td>
<td>Patient is eligible for both Medicare and Medicaid</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Any medical equipment used in the home to aid in a better quality of living</td>
</tr>
<tr>
<td>(EBSA) Employee Benefits Security Administration</td>
<td>An agency within the U.S. Department of Labor; provides information concerning rights under COBRA</td>
</tr>
<tr>
<td>(EDI) Electronic Data Interchange</td>
<td>Transfer of data from one computer system to another by standardized message formatting</td>
</tr>
<tr>
<td>Efficacy / Effectiveness</td>
<td>Determination that a particular course of treatment is effective in managing a health condition</td>
</tr>
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### Appendix

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<tr>
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<tbody>
<tr>
<td>Elective</td>
<td>Related to an elective procedure; not medically necessary</td>
</tr>
<tr>
<td>Eligible Dependent</td>
<td>Any “Dependent” who meets the specific eligibility requirements of the Plan under applicable State and Federal laws and rules.</td>
</tr>
<tr>
<td>Eligible Group Member</td>
<td>Any Group Member who meets the specific eligibility requirements of the Group’s Plan.</td>
</tr>
<tr>
<td>Emergency Medical Condition</td>
<td>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.</td>
</tr>
<tr>
<td>EMR (EHR / Electronic Medical Record / Electronic Health Record)</td>
<td>Digital version of a paper chart in a clinician’s office</td>
</tr>
<tr>
<td>Endodontic</td>
<td>Dentistry specialty concerned with the study and treatment of the dental pulp</td>
</tr>
<tr>
<td>(EOB) Explanation of Benefits</td>
<td>A statement sent by a health insurance company to covered individuals explaining what medical services were paid</td>
</tr>
<tr>
<td>EOP (Explanation of Payment / RA)</td>
<td>Report that accompanies claims which provides a detailed report on how they were paid, denied, or adjusted</td>
</tr>
<tr>
<td>ePrescribing / Electronic Prescribing</td>
<td>Allows the physician and other medical practitioners to write and send prescriptions to participating pharmacies electronically</td>
</tr>
<tr>
<td>(ERA) Electronic Remittance Advice</td>
<td>ANSI transaction for claim payment I remittance.</td>
</tr>
<tr>
<td>ERISA (Employee Retirement Income Security Act)</td>
<td>Protects the assets of Americans so that funds placed in retirement plans during which the person works will be available</td>
</tr>
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<tr>
<td>ESRD (End-State Renal Disease)</td>
<td>Failure of the renal system (kidneys)</td>
</tr>
<tr>
<td>Essential Health Benefits (EHB)</td>
<td>Based on 10 benefits that are covered across the board: ER, prescription, inpatient/outpatient, therapies, labs, preventative, pediatric, prenatal, mental health/ substance abuse</td>
</tr>
<tr>
<td>Exchange / Marketplace, HIX, healthcare.gov</td>
<td>State or federal marketplace for the purchasing of health insurance for individuals and small groups</td>
</tr>
<tr>
<td>Exclusion</td>
<td>Not covered</td>
</tr>
<tr>
<td>Expedited Appeal</td>
<td>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</td>
</tr>
<tr>
<td>Experimental</td>
<td>Refers to the status of a drug, service, medical treatment or procedure that currently doesn’t present any credible evidence for treatment or diagnosis.</td>
</tr>
<tr>
<td>Experimental Drugs</td>
<td>Medicinal product that has not yet received approval from governmental regulatory authorities for routine use</td>
</tr>
<tr>
<td>Experimental or Investigational Services</td>
<td>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.</td>
</tr>
<tr>
<td>Facility</td>
<td>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.</td>
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<td>Fee Schedule</td>
<td>A complete listing of fees used by Medicare to pay doctors or other providers/suppliers</td>
</tr>
<tr>
<td>Fee-For-Service</td>
<td>Comprehensive listing of fee maximums is used to reimburse a physician or providers based on fee-for-service basis</td>
</tr>
<tr>
<td>FEHBP (Federal Employees Health Benefits Program)</td>
<td>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</td>
</tr>
<tr>
<td>Fiduciary</td>
<td>A trustee; person who holds legal or ethical relationship of trust between him/herself and one or more parties</td>
</tr>
<tr>
<td>Flexible Spending Account (FSA)</td>
<td>Employee benefit program that allows a member to set aside money for certain health care needs</td>
</tr>
<tr>
<td>Form 1099</td>
<td>Tax form that reports the year-end summary of all-employee compensation</td>
</tr>
<tr>
<td>Form W9</td>
<td>Form used by the provider and is used to verify the taxpayer identification</td>
</tr>
<tr>
<td>Formulary</td>
<td>An official list of medications that may be prescribed; covered prescribed medicines</td>
</tr>
<tr>
<td>FQHC (Federally Qualified Health Centers)</td>
<td>A reimbursement designation for several health programs; community-based organization that provides care to persons of all ages regardless of their ability to pay.</td>
</tr>
<tr>
<td>Fully-Funded / Fully Insured</td>
<td>Employer pays the premium of the health coverage</td>
</tr>
<tr>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Gatekeeper</td>
<td>HMO that restricts access to specialists or out of network providers using a referral process.</td>
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<td>Generic Drug</td>
<td>Drug product that is comparable to a brand drug product</td>
</tr>
<tr>
<td>Global Surgery</td>
<td>Surgery and usual pre and post operative work will be billed as a global package; global surgery fee</td>
</tr>
<tr>
<td>GPCI (Geographic Pricing Cost Index)</td>
<td>Categories used by Medicare to determine allowable payment amounts for medical procedures</td>
</tr>
<tr>
<td>GPO (Group Purchasing Organization)</td>
<td>Used by groups of businesses to obtain discounts based on their collective buying power</td>
</tr>
<tr>
<td>Grandfathered (GF)</td>
<td>A provision in which an old rule continues to apply to some existing situations, while a new rule will apply to all future cases</td>
</tr>
<tr>
<td>[The] Group</td>
<td>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.</td>
</tr>
<tr>
<td>Group Health Plan</td>
<td>Employee benefit plan; maintained by the employer number (TIN)</td>
</tr>
<tr>
<td>Group Member</td>
<td>Any employee, sole proprietor, partner, director, officer or Member of the Group.</td>
</tr>
<tr>
<td>Guaranteed Issue</td>
<td>Portion of PPACA that states individuals can not be denied insurance coverage</td>
</tr>
<tr>
<td>Habilitative Services</td>
<td>Health care services that help a person keep, learn or improve skills and functioning for daily living</td>
</tr>
<tr>
<td>HCFA (The Health Care Finance Administration)</td>
<td>Federal agency that administers the Medicare program and works in partnership to administer Medicaid, SCHIP, and health insurance portability standards, such as HIPAA.</td>
</tr>
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<tr>
<td>HDHP (High Deductible Health Plan)</td>
<td>Plan that consists of a high deductible.</td>
</tr>
<tr>
<td>Healthcare Power of Attorney (POA)</td>
<td>Becomes active when a person is unable to make decisions or consciously communicate intentions regarding treatments</td>
</tr>
<tr>
<td>Health Care Services</td>
<td>Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease</td>
</tr>
<tr>
<td>HEDIS (Healthcare Effectiveness Data and Information Set)</td>
<td>A tool used by a member’s health plan to measure performance on important dimensions of care and service</td>
</tr>
<tr>
<td>HHS (Health and Human Services)</td>
<td>Protects the health of all Americans and provides essential human services for the general public</td>
</tr>
<tr>
<td>HIPAA (Health Insurance Portability and Accountability Act of 1996)</td>
<td>Protects the privacy of individually identifiable health information; sets national standards for the security of electronic protected health information.</td>
</tr>
<tr>
<td>HIPAA 5010 (ANSI ASC X12)</td>
<td>New standard that regulates the electronic submission of specific health care transactions</td>
</tr>
<tr>
<td>HMO (Health Maintenance Organization)</td>
<td>Organization that provides or arranges managed care for health insurance</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Care that is provided within a member’s home in lieu of combined or anticipated hospitalization</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>Involves the administration of intravenous (IV) medication, such as antibiotics and chemotherapy</td>
</tr>
<tr>
<td>Hospice</td>
<td>End-of-life care</td>
</tr>
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## 9.1 Glossary of Terms

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<thead>
<tr>
<th>Terms/Common Acronyms</th>
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<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>HRA (Health Reimbursement Account)</strong></td>
<td>Employer funded, health benefit plans that reimburse employees for out-of-pocket medical expenses</td>
</tr>
<tr>
<td><strong>HSA (Health Savings Account)</strong></td>
<td>Medical savings account available to taxpayers enrolled in high deductible policy.</td>
</tr>
<tr>
<td><strong>Iatrogenic Condition / Nosocomial Condition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>IBNR Expenses / Incurred but Not Reported, future</strong></td>
<td>Term for the collective claims that will be filed in the future for current medical conditions</td>
</tr>
<tr>
<td><strong>ICD-10 CM / International Statistical Classification of Diseases</strong></td>
<td>10th revision of ICD; will eventually replace ICD-9</td>
</tr>
<tr>
<td><strong>ICD-10 PCS / Procedure Coding System</strong></td>
<td>Responsible for maintaining the inpatient procedure code set; will replace ICD-9-PCS</td>
</tr>
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</table>
# 9.1 Glossary of Terms

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<thead>
<tr>
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<tbody>
<tr>
<td>ICD-9 CM (International Statistical Classification of Diseases, Clinical Modification)</td>
<td>The official system for assigning codes to diagnoses and procedures</td>
</tr>
<tr>
<td>ICD-9 PCS (Procedure Coding System)</td>
<td>Responsible for maintaining the inpatient procedure code set</td>
</tr>
<tr>
<td>IDS (Integrated Delivery System)</td>
<td>A network of health care organizations under one parent company</td>
</tr>
<tr>
<td>IHS (Indian Health Services)</td>
<td>Operating division within HHS that is responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives</td>
</tr>
<tr>
<td>Implantable</td>
<td>Device that is surgically implanted in the patient, usually to provide medical treatment.</td>
</tr>
<tr>
<td>Indemnity / IND, Fee for service</td>
<td>A health care plan where the member can see any provider (no network), and is reimbursed a set amount or percentage</td>
</tr>
<tr>
<td>In-Network / IN / Participating / PAR / Contracted</td>
<td>Contracted with health plan; in network provider</td>
</tr>
<tr>
<td>Inpatient (INPT)</td>
<td>A patient who stays in the hospital while under treatment &amp; incurs room and board charges</td>
</tr>
<tr>
<td>Institutional Service / Hospital Services</td>
<td>Service that was provided at a facility</td>
</tr>
<tr>
<td>Intensive Outpatient Program (IOP)</td>
<td>Treatment service and support program used primarily to treat mental illness and chemical dependency</td>
</tr>
<tr>
<td>IPPS (Inpatient Prospective Payment System)</td>
<td>Payment system with 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.</td>
</tr>
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<tbody>
<tr>
<td><strong>L</strong></td>
<td><strong>Letter of Medical Necessity (LOMN)</strong> Documentation that is submitted by a provider who is requesting certain services for the patient.</td>
</tr>
<tr>
<td></td>
<td><strong>Lifetime Maximum</strong> The maximum dollar amount that will be paid on for a member’s health plan</td>
</tr>
<tr>
<td></td>
<td><strong>Limited Cost Sharing (LCS)</strong> A plan available to members of federally recognized tribes, those who income is above 30% of federal poverty line which is available through the Marketplace.</td>
</tr>
<tr>
<td></td>
<td><strong>Living Will / Advance Health Care Directive</strong> Written statement of a person’s wishes regarding medical treatment and how those wishes should be carried out</td>
</tr>
<tr>
<td></td>
<td><strong>Locum Tenens</strong> Written statement of a person’s wishes regarding medical treatment and how those wishes should be carried out</td>
</tr>
<tr>
<td><strong>M</strong></td>
<td><strong>Long-Term Residential Care</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>Maintenance Care</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>LOS (Length-of-Stay)</strong> Duration of a single episode of hospitalization</td>
</tr>
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<tr>
<td>Managed Care (MC, MCO)</td>
<td>System of health care in which patients agree to visit only certain doctors and hospitals</td>
</tr>
<tr>
<td>Mandated Benefit</td>
<td>A benefit that is legally required by state or federal law</td>
</tr>
<tr>
<td>Marketplace / Exchange</td>
<td>Also known as the Health Insurance Exchange; where people without health insurance can search for insurance options and purchase an insurance plan.</td>
</tr>
<tr>
<td>Maxillofacia</td>
<td>Refers to the head, neck, face and jaw</td>
</tr>
<tr>
<td>Maximum Allowed Amount</td>
<td>The dollar amount the health plan will pay to a provider</td>
</tr>
<tr>
<td>MCO (Managed Care Organization, Managed Care)</td>
<td>System of health care in which patients agree to visit only certain doctors and hospitals</td>
</tr>
<tr>
<td>Medically Necessary / Medical Necessity</td>
<td>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</td>
</tr>
<tr>
<td>Medicare Advantage - SNP / Special Needs Plan</td>
<td>Limited membership to people with specific diseases to tailor their benefits</td>
</tr>
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<tr>
<td>Medicaid</td>
<td>Social health care program for families and individuals with low income and limited resources</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>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</td>
</tr>
<tr>
<td>Medical Home</td>
<td>A concept that focuses on the care of children with special health care needs</td>
</tr>
<tr>
<td>Medical Loss Ratio / Loss Ratio / MLR</td>
<td>A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees</td>
</tr>
<tr>
<td>Medical Management</td>
<td>A collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to disabled, ill or injured individuals</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>Defined as accepted health care services and supplies provided by health care entities with the applicable standard of care.</td>
</tr>
<tr>
<td>Medically-Fragile</td>
<td>Defined as a chronic physical condition, which results in prolonged dependency on medical care for which daily skilled intervention is medically necessary</td>
</tr>
<tr>
<td>Medicare</td>
<td>Social insurance program; provides health insurance to members who are 65 or older, those who are disabled, or have ESRD</td>
</tr>
<tr>
<td>Medicare Advantage / Medicare Part C / Medicare Replacement / MA</td>
<td>Covers for medically necessary care that members receive from nearly any hospital or doctor who accepts Medicare.</td>
</tr>
<tr>
<td>Medicare Advantage / Health Maintenance Organization (HMO)</td>
<td>Allows members to utilize providers or hospitals that are in their provider list; will need a referral to see providers that are OON</td>
</tr>
<tr>
<td>Medicare Cost Plan</td>
<td>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.</td>
</tr>
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<tr>
<td>Medicare Part A</td>
<td>Covers hospital care, skilled nursing facility care, Hospice, home health services.</td>
</tr>
<tr>
<td>Medicare Part B</td>
<td>Covers for medically necessary services and supplies, preventative services, mental health, second opinion, and limited outpatient prescription drugs.</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>Medicare prescription drug benefit</td>
</tr>
<tr>
<td>Medicare SELECT</td>
<td>Type of Medigap plan that works like a HMO (in network)</td>
</tr>
<tr>
<td>Medicare Summary Notice (MSN) (similar to an EOB)</td>
<td>Notice that shows all services and supplies that providers and suppliers have billed to Medicare within a 3 month period, and what Medicare paid.</td>
</tr>
<tr>
<td>Medicare Supplement / Medigap</td>
<td>Sold by private insurance companies; can help pay for health care costs that Medicare doesn’t cover.</td>
</tr>
<tr>
<td>Member</td>
<td>An individual who belongs to an entity</td>
</tr>
<tr>
<td>Member (Patient) Liability</td>
<td>The dollar amount that an insured is legally obligated to pay for services rendered by a provider.</td>
</tr>
<tr>
<td>Mental Health / Behavioral Health</td>
<td>Includes emotional, psychological, and social well-being</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>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.</td>
</tr>
<tr>
<td>MHPA (Mental Health Parity Act)</td>
<td>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.</td>
</tr>
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<tr>
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</thead>
<tbody>
<tr>
<td>(MIPPA) Medicare Improvements for Patients and Providers Act</td>
<td>Funding that is received to help Medicare beneficiaries apply for Medicare Part D</td>
</tr>
<tr>
<td>MMA (Managed Medical Assistance)</td>
<td>Medicaid program where patients are managed by a provider or network organization</td>
</tr>
<tr>
<td>MOOP / OPM / MOP</td>
<td>Maximum out of pocket; total amount that the member will need to pay before their health plan will pay at 100%.</td>
</tr>
<tr>
<td>MSA (Medical Savings Account)</td>
<td>A medical savings program for self-employed individuals to set aside tax-deferred money to pay for medical expenses</td>
</tr>
<tr>
<td>MS-DRG Weighted Fee Schedule (DRG)</td>
<td>System for the bundling of claims for hospital services based on diagnosis, complications, length of stay, and other factors.</td>
</tr>
<tr>
<td>Multiple Surgery</td>
<td>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.</td>
</tr>
<tr>
<td>NAIC (National Association of Insurance Commissioners)</td>
<td>US standard-setting and regulatory support organization created and governed by the chief insurance regulators from all states and US territories.</td>
</tr>
<tr>
<td>Natural Teeth</td>
<td>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.</td>
</tr>
<tr>
<td>NCQA (National Committee for Quality)</td>
<td>Leader in health care accreditation; works to improve health care</td>
</tr>
<tr>
<td>NDI (National Drug Code)</td>
<td>System that provides each drug with a unique product identifier</td>
</tr>
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<tbody>
<tr>
<td>Network</td>
<td>A group of two or more entities that are linked together</td>
</tr>
<tr>
<td>Never Event</td>
<td>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.</td>
</tr>
<tr>
<td>Non-Covered Services</td>
<td>Health Care Services that are not part of benefits paid for by the Plan.</td>
</tr>
<tr>
<td>Non-Grandfathered</td>
<td>Refers to an old rule that no longer applies to the policy</td>
</tr>
<tr>
<td>Non-Participating Provider</td>
<td>A Provider has not directly or indirectly contracted with the Plan.</td>
</tr>
<tr>
<td>NPI (National Provider Identifier)</td>
<td>Identification number that is assigned to a provider or facility</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>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.</td>
</tr>
<tr>
<td>Obstetric / Maternity / OB</td>
<td>Care in relation to pregnancy, childbirth, postpartum period and processes associated with it</td>
</tr>
<tr>
<td>Open Access</td>
<td>Unrestricted access - no provider network limitations.</td>
</tr>
<tr>
<td>Open Enrollment</td>
<td>A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.</td>
</tr>
<tr>
<td>OPPS (Outpatient Prospective Payment System)</td>
<td>Medicare’s reimbursement system for outpatient services, primarily based on APCs</td>
</tr>
</tbody>
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# Appendix

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<thead>
<tr>
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<tbody>
<tr>
<td>Orthodontic</td>
<td>Treatment of improper bites and crooked teeth</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Specialty that focuses on the design, manufacture, and application of orthoses.</td>
</tr>
<tr>
<td>OTC (Over the Counter)</td>
<td>Medicines sold directly to a consumer without a prescription from a provider.</td>
</tr>
<tr>
<td>Out-of-Network (OON) / ON / Non-PAR / Non Participating</td>
<td>Provider or facility that is not in network under the member’s insurance policy</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum Amount</td>
<td>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</td>
</tr>
<tr>
<td>Outpatient (OTPT)</td>
<td>One who received medical treatment without being admitted to a hospital</td>
</tr>
<tr>
<td>Palliative</td>
<td>Relieving pain or alleviating a problem without dealing with the underlying cause.</td>
</tr>
<tr>
<td>Participating Provider</td>
<td>A Practitioner and/or Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan.</td>
</tr>
</tbody>
</table>
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<tbody>
<tr>
<td>Partial Hospitalization Program</td>
<td>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.</td>
</tr>
<tr>
<td>PBM (Pharmacy benefit manager)</td>
<td>Third party administrator of prescription drug programs</td>
</tr>
<tr>
<td>PCP (Primary Care Provider)</td>
<td>A specialist in Family Medicine, Internal Medicine, Obstetrics &amp; 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.</td>
</tr>
<tr>
<td>Per Diem / Per Day</td>
<td>Daily allowance for expenses</td>
</tr>
<tr>
<td>PHI (Protected Health Information)</td>
<td>Data that is protected under HIPAA and must not be disclosed when discussing a patient or member’s affairs</td>
</tr>
<tr>
<td>PHO (Physician-Hospital Organization)</td>
<td>A group formed by a hospital and its providers in order to contract with an MCO</td>
</tr>
<tr>
<td>Physician / MD, DO, PhD, DC, DPM</td>
<td>Professional who practices medicine</td>
</tr>
<tr>
<td>Place of Service Type / Office, outpatient, inpatient, urgent care, ER, lab, etc.</td>
<td>Codes for the place of service are used for billing purposes to determine how the patient’s healthcare plan will pay.</td>
</tr>
<tr>
<td>PMPM (Per Member Per Month)</td>
<td>Capitation payment methodology</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Branch of medicine associated with foot, ankle and related</td>
</tr>
<tr>
<td>Policy</td>
<td>Decisions, plans and actions that are undertaken to achieve specific health care goals</td>
</tr>
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<tr>
<td>Policyholder</td>
<td>A person or group in whose name an insurance policy is held</td>
</tr>
<tr>
<td>POS (Place of Service)</td>
<td>Defined by codes placed on health care claims which indicate the setting in which a service was provided to the member.</td>
</tr>
<tr>
<td>PPO (Preferred Provider Organization)</td>
<td>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</td>
</tr>
<tr>
<td>Practitioner/Provider</td>
<td>Someone who is qualified or registered to practice medicine</td>
</tr>
<tr>
<td>Pre-Existing Condition (Pre-Ex)</td>
<td>A medical condition that started before the member's health insurance went into effect</td>
</tr>
<tr>
<td>Premium</td>
<td>The amount that the insured pays for health insurance</td>
</tr>
<tr>
<td>Preventive</td>
<td>A yearly exam that helps keep a member free of disease</td>
</tr>
<tr>
<td>Primary Carrier</td>
<td>The first carrier that covers the insured; first payer</td>
</tr>
<tr>
<td>Primary Payor</td>
<td>Refers to who will pay first in regards to member's claims</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Nurses who provide private duty care by working one-on-one with individual clients</td>
</tr>
<tr>
<td>Procedure</td>
<td>Medical treatment or service</td>
</tr>
<tr>
<td>Professional Service</td>
<td>A service provided to a member of the health plan</td>
</tr>
<tr>
<td>Prompt Payment</td>
<td>Ensures that agencies pay vendors in a timely manner</td>
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<tr>
<td>Prophylactic / Preventive</td>
<td>Medication or a treatment designed and used to prevent a disease from occurring</td>
</tr>
<tr>
<td>Prospective Review</td>
<td>Used in UM to review upcoming services</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>An artificial limb</td>
</tr>
<tr>
<td>Prosthodontic</td>
<td>Dental prosthetics; area of dentistry that focuses on dental</td>
</tr>
<tr>
<td>Prudent Layperson</td>
<td>Person with medical training who exercises those qualities of attention, knowledge, intelligence and judgment. A standard for determining the need to visit the ER.</td>
</tr>
<tr>
<td>QHP (Qualified Health Plan)</td>
<td>A health plan certified by the Marketplace to meet new benefit and cost sharing standards</td>
</tr>
<tr>
<td>Primary Payor</td>
<td>Refers to who will pay first in regards to member’s claims</td>
</tr>
<tr>
<td>Qualifying Event</td>
<td>A change in your life that can make you eligible for a special enrollment period to enroll in health coverage.</td>
</tr>
<tr>
<td>Radiology</td>
<td>Medical specialty that uses imaging to diagnose and treat diseases and injuries within the body</td>
</tr>
<tr>
<td>Reasonable Costs</td>
<td>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.</td>
</tr>
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<tr>
<td>Reconstructive</td>
<td>The use of surgery to restore the form and function of the body</td>
</tr>
<tr>
<td>Recoupment</td>
<td>The use of surgery to restore the form and function of the body</td>
</tr>
<tr>
<td>Reduced Payment Level</td>
<td>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.</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>To restore to good health or useful life; through therapy</td>
</tr>
<tr>
<td>Reinsurance</td>
<td>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</td>
</tr>
<tr>
<td>Residential Care</td>
<td>Refers to long-term care given to adults or children who stay in a residential setting rather than their own home.</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>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.</td>
</tr>
</tbody>
</table>
## 9.1 Glossary of Terms

<table>
<thead>
<tr>
<th>Terms/Common Acronyms</th>
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<tr>
<td>Respite (Hospice)</td>
<td>Type of care that focuses on chronically ill or terminally ill patients, residential setting rather than their own home.</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>A post treatment assessment of services on a case-by-case basis after treatment has already been provided.</td>
</tr>
<tr>
<td>Revenue Code (REV Code)</td>
<td>3-digit numbers that are used on hospital bills to indicate where the patient was receiving treatment</td>
</tr>
<tr>
<td>Rider</td>
<td>An additional provision that is added to the member’s policy</td>
</tr>
<tr>
<td>Risk</td>
<td>The potential of losing something of value</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>An actuarial tool used to calibrate payments to health plans or other stakeholders based on the relative health of the at-risk</td>
</tr>
<tr>
<td>Risk Pool</td>
<td>Practiced by insurance companies; come together to form a pool to provide a safety net against catastrophic risks.</td>
</tr>
<tr>
<td>Routine Dental</td>
<td>Yearly dental checkup</td>
</tr>
<tr>
<td>Routine Vision</td>
<td>Yearly vision checkup</td>
</tr>
<tr>
<td>RX (Prescription Drug)</td>
<td>A measure of value used by Medicare as a reimbursement formula for physician services</td>
</tr>
<tr>
<td>Schedule of Benefits &amp; Coverage (SBC)</td>
<td>Detailed, standard descriptions of a member’s health care benefits</td>
</tr>
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<tr>
<td>Screening</td>
<td>Used to identify an unrecognized disease in individuals without signs or symptoms</td>
</tr>
<tr>
<td>Secondary Carrier</td>
<td>The second insurance carrier that insures the patient</td>
</tr>
<tr>
<td>Self-Funded / Self-Insured</td>
<td>A self-insurance arrangement whereby an employer provides health or disability benefits to employees with its own funds</td>
</tr>
<tr>
<td>SEP (Special Enrollment Period)</td>
<td>A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage</td>
</tr>
<tr>
<td>Service Area</td>
<td>The area in which the member can access providers; generally based on the area where the member lives.</td>
</tr>
<tr>
<td>Service Charge</td>
<td>The amount paid by the Group to the Plan on a monthly basis for coverage for Members under this Contract</td>
</tr>
<tr>
<td>Skilled Nursing (SNNF)</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>Specialty</td>
<td>A branch in medical practice; further medical education</td>
</tr>
<tr>
<td>Specialty Care</td>
<td>Scope of care for patients within a specific specialty (Ex. gastroenterology)</td>
</tr>
<tr>
<td>Specialty Drug</td>
<td>High cost prescribed drug</td>
</tr>
<tr>
<td>Special Enrollment Period</td>
<td>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.</td>
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<td>Spouse</td>
<td>An individual who is a Subscriber’s current lawful Spouse.</td>
</tr>
<tr>
<td>SSA (Social Security Administration)</td>
<td>Social insurance program consisting of retirement, disability, and survivor’s benefits.</td>
</tr>
<tr>
<td>Step Therapy</td>
<td>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</td>
</tr>
<tr>
<td>[This] State</td>
<td>The State of South Dakota.</td>
</tr>
<tr>
<td>Subrogation (SUBRO)</td>
<td>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.</td>
</tr>
<tr>
<td>Subscriber</td>
<td>An Eligible Group Member who is enrolled in the Plan. A Subscriber is also a Member.</td>
</tr>
<tr>
<td>Summary of Pharmacy Benefits</td>
<td>Document that outlines the coverage of prescription drugs</td>
</tr>
<tr>
<td>Summary Plan Description</td>
<td>Document that outlines the dates of coverage for the member through their insurance carrier.</td>
</tr>
<tr>
<td>T</td>
<td></td>
</tr>
<tr>
<td>Tax Identification Number / TIN / EIN / Employer Identification Number</td>
<td>An identifying number used to identify a business entity</td>
</tr>
<tr>
<td>Telemedicine / Telehealth</td>
<td>The use of telecommunication and information technologies in order to provide clinical health care at a distance.</td>
</tr>
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<td>Tertiary Care</td>
<td>Specialized consultative care; usually a referred provider</td>
</tr>
<tr>
<td>Third-Party Payer</td>
<td>An institution or company that provides reimbursement to health care providers for services rendered to a third party</td>
</tr>
<tr>
<td>Tiered Co-payment Benefits</td>
<td>Prescription benefit; co-payments are split into three tiers for nonformulary, formulary and brand name</td>
</tr>
<tr>
<td>Timely Filing (TF)</td>
<td>The amount of time the provider has to submit a claim to the insurance plan for payment</td>
</tr>
<tr>
<td>TMJ (Temporamandibular Joint)</td>
<td>Associated with the jaw and surrounding muscles of the face</td>
</tr>
<tr>
<td>TPA (Third Party Administrator)</td>
<td>Arrangement where a health plan administers various aspects of an insurance plan while the plan sponsor retains risk</td>
</tr>
<tr>
<td>Transitional Small Group</td>
<td>Small groups who must transition to QHPs under new ACA regulations</td>
</tr>
<tr>
<td>Type of Bill</td>
<td>Codes that are three digit codes located on a claim form that describes the type of bill a provider is submitting to a payer</td>
</tr>
<tr>
<td><strong>U</strong></td>
<td></td>
</tr>
<tr>
<td>UBo4 / Institutional / UB UB92 / Facility</td>
<td>Uniform instructional billing claim form used by hospitals, clinics, ambulatory surgery centers, etc.</td>
</tr>
<tr>
<td>Unbundling</td>
<td>Charge for items or services separately rather than as a part of a package</td>
</tr>
<tr>
<td>Uninsured</td>
<td>Patient who doesn’t have health insurance</td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Urgent Care (UC)</td>
<td>Acute care; walk-in clinic focused on the delivery of ambulatory care.</td>
</tr>
<tr>
<td>Urgent Care Request</td>
<td>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.</td>
</tr>
<tr>
<td>Us/We</td>
<td>Refers to Sanford Health Plan</td>
</tr>
<tr>
<td>Usual, Reasonable &amp; Customary / U&amp;C / UCR / URC / Reasonable &amp; Customary</td>
<td>The amount paid for a medical service in a geographic area based on what providers in the area is reimbursed, not to exceed charged amount, for the same or similar medical service.</td>
</tr>
<tr>
<td>Utilization / Use / Usage</td>
<td>The “use” of; in regards to the use of benefits while controlling costs and monitoring quality of care</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>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</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>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.</td>
</tr>
<tr>
<td>Waiting Period</td>
<td>The period of time between when an action is requested or mandated and when it occurs; period where insurance will not pay.</td>
</tr>
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<td>WHO (World Health Organization)</td>
<td>International group that directs and coordinates international health within the United Nations’ system</td>
</tr>
<tr>
<td>Women’s Preventive Health (ACA)</td>
<td>Preventative, maternity and contraceptive services for women that are covered at 100% for non-grandfathered, ACA-compliant</td>
</tr>
<tr>
<td>Workers’ Compensation (WC) / WorkComp</td>
<td>A form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange of mandatory relinquishment</td>
</tr>
<tr>
<td>Write-off / Discount</td>
<td>The reduction of value (provider write off)</td>
</tr>
<tr>
<td>Zero-Cost Sharing (ZCS)</td>
<td>A plan available to members of federally recognized tribes and Alaka Native Claims Settlement Act (ANCSA); no deductible, co-payments, or coinsurance</td>
</tr>
</tbody>
</table>
9.2 Modifiers

21. Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the E/M code number. A report may also be appropriate.

22. Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

23. Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding the modifier 23 to the procedure code of the basic service.

24. Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier 24 to the appropriate level of E/M service.

25. Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

26. Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier 26 to the usual procedure number.

32. Mandated Services: Services related to mandated consultation and/or related services (e.g., PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure.

47. Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding the modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

50. Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate five digit code.

51. Multiple Procedures: When multiple procedures, other than E/M services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated “add-on” codes.

52. Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53. Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure.
Appendix

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54. Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the usual procedure number.

55. Postoperative Management Only: When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number.

56. Preoperative Management Only: When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number.

57. Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E/M service.

58. Staged or Related Procedure or Service by the Same Physician during the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

59. Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

62. Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with the modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier 80 or modifier 82 added, as appropriate.

63. Procedure Performed on Infants less than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding the modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

66. Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of the modifier 66 to the basic procedure number used for reporting services.
76. **Repeat Procedure by Same Physician**: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service.

77. **Repeat Procedure by Another Physician**: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78. **Return to the Operating Room for a Related Procedure During the Postoperative Period**: The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure. (For repeat procedures on the same day, see 76.)

79. **Unrelated Procedure or Service by the Same Physician During the Postoperative Period**: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79. (For repeat procedures on the same day, see 76.)

80. **Assistant Surgeon**: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number(s).

81. **Minimum Assistant Surgeon**: Minimum surgical assistant services are identified by adding the modifier 81 to the usual procedure number.

82. **Assistant Surgeon (when qualified resident surgeon not available)**: The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

90. **Reference (Outside) Laboratory**: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier 90 to the usual procedure number.

91. **Repeat Clinical Diagnostic Laboratory Test**: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

99. **Multiple Modifiers**: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

### Anesthesia Physical Status Modifiers

The Physical Status modifiers are consistent with the American Society of Anesthesiologists ranking of patient physical status, and distinguish various levels of complexity of the anesthesia service provided. All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-03108) with the appropriate physical status modifier appended.

Example: 00100-P1

Under certain circumstances, when another established modifier(s) is appropriate, it should be used in addition to the physical status modifier.

Example: 00100-P4-53

| P1 | A normal healthy patient |
| P2 | A patient with mild systemic disease |
| P3 | A patient with severe systemic disease |
| P4 | A patient with severe systemic disease that is a constant threat to life |
| P5 | A moribund patient who is not expected to survive without the operation |
| P6 | A declared brain-dead patient whose organs are being removed for donor purposes |
**CENTER (ASC) HOSPITAL OUTPATIENT USE**

### CPT Level I Modifiers

- **25** Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
- **27** Multiple Outpatient Hospital E/M Encounters on the Same Date
- **50** Bilateral Procedure
- **52** Reduced Services
- **58** Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
- **59** Distinct Procedural Service
- **73** Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
- **74** Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
- **76** Repeat Procedure by Same Physician
- **77** Repeat Procedure by Another Physician
- **78** Return to the Operating Room for a Related Procedure During the Postoperative Period
- **79** Unrelated Procedure or Service by the Same Physician During the Postoperative Period

### Level II (HCPCS/National) Modifiers

- **E1** Upper left, eyelid
- **E2** Lower left, eyelid
- **E3** Upper right, eyelid
- **E4** Lower right, eyelid
- **F1** Left hand, second digit
- **F2** Left hand, third digit
- **F3** Left hand, fourth digit
- **F4** Left hand, fifth digit
- **F5** Right hand, thumb
- **F6** Right hand, second digit
- **F7** Right hand, third digit
- **F8** Right hand, fourth digit
- **F9** Right hand, fifth digit
- **FA** Left hand, thumb
- **LC** Left circumflex coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **LD** Left anterior descending coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **LT** Left side (used to identify procedures performed on the left side of the body)
- **QM** Ambulance service provided under arrangement by a provider of services
- **QN** Ambulance service furnished directly by a provider of services
- **RC** Right coronary artery (Hospitals use with codes 92980-92984, 92995, 92996)
- **RT** Right side (used to identify procedures performed on the right side of the body)
- **T1** Left foot, second digit
- **T2** Left foot, third digit
- **T3** Left foot, fourth digit
- **T4** Left foot, fifth digit
- **T5** Right foot, great toe
- **T6** Right foot, second digit
- **T7** Right foot, third digit
- **T8** Right foot, fourth digit
- **T9** Right foot, fifth digit
- **TA** Left foot, great toe

### GENETIC TESTING CODE MODIFIERS

This listing of modifiers is intended for reporting with molecular laboratory procedures related to genetic testing. Genetic test modifiers should be used in conjunction with CPT and HCPCS codes to provide diagnostic granularity of service to enable provider to submit complete and precise genetic testing information without altering test descriptors. These modifiers are categorized by mutation. The first (numeric) digit indicates the disease category and the second (alpha) digit denotes gene type. Introductory guidelines in the molecular diagnostic and molecular cytogenetic code sections of CPT provide further guidance in interpretation and application of genetic test modifiers.
Neoplasia (solid tumor)

0A BRCA1 (Hereditary breast/ovarian cancer)
0B BRCA2 (Hereditary breast cancer)
0C Neurofibromin (Neurofibromatosis, type 1)
0D Merlin (Neurofibromatosis, type 2)
0E c-RET (Multiple endocrine neoplasia, types 2A/B, familial medullary thyroid carcinoma)
0F VHL (Von Hippel Lindau disease)
0G SDHD (Hereditary paraganglioma)
0H SDHB (Hereditary paraganglioma)
0I Her-2/neu
0J MLH1 (HNPCC)
0K MSH2 (HNPCC)
0L APC (Hereditary polyposis coli)
0M Rb (Retinoblastoma)
1Z Solid tumor, not otherwise specified

Neoplasia (lymphoid/hematopoetic)

2A AML1 – also ETO (Acute myeloid leukemia)
2B BCR – also ABL (Chronic myeloid, acute lymphoid leukemia)
2C CGF1
2D CBF beta (Leukemia)
2E ML (Leukemia)
2F PML/RAR alpha (Promyelocytic leukemia)
2G TEL (Leukemia)
2H bcl-2 (Lymphoma)
2I bcl-1 (Lymphoma)
2J c-yc (Lymphoma)
2K lgH (Lymphoma/leukemia)
2Z Lymphoid/hematopoetic neoplasia not otherwise specified

Non-neoplastic hematology/coagulation

3A Factor V (Leiden, others) (Hypercoagulable state)
3B FACC (Fanconi anemia)
3C FACD (Fanconi anemia)
3D Beta globin (Thalassemia)
3E Alpha globin (Thalassemia)
3F MTHFR (Elevated homocysteine)

3G Prothrombin (Factor II, 20210A) (Hypercoagulable state)
3H Factor VIII (Hemophilia A/VWF)
3I Factor IX (Hemophilia B)
3J Beta globin
3Z Non-neoplastic hematology/coagulation, not otherwise specified

Histocompatibility/blood typing

4A HLA-A
4B HLA-B
4C HLA-C
4D HLA-D
4E HLA-DR
4F HLA-DQ
4G HLA-DP
4H Kell
4Z Histocompatibility/blood typing, not otherwise specified

Neurologic, non-neoplastic

5A Aspartoacylase A (Canavan disease)
5B FMR-1 (Fragile X, FRAZA, syndrome)
5C Frataxin (Freidreich’s ataxia)
5D Huntington (Huntington’s disease)
5E GABRA (Prader Willi-Angelman syndrome)
5F Connexin-26 (GJB2) (Hereditary deafness)
5G Connexin-32 (X-linked Charcot-Marie-Tooth disease)
5H SNRPN (Prader Willi-Angelman syndrome)
5I Ataxin-1 (Spinocerebellar ataxia, type 1)
5J Ataxin-2 (Spinocerebellar ataxia, type 2)
5K Ataxin-3 (Spinocerebellar ataxia, type 3, Machado-Joseph disease)
5L CACNA1A (Spinocerebellar ataxia, type 6)
5M Ataxin-7 (Spinocerebellar ataxia, type 7)
5N PMP-22 (Charcot-Marie-Tooth disease, type 1A)
5O ECP2 (Rett syndrome)
5Z Neurologic, non-neoplastic, not otherwise specified
Muscular, non-neoplastic

6A Dystrophin (Duchenne/Becker muscular dystrophy)
6B DMPK (Myotonic dystrophy, type 1)
6C ZNF-9 (Myotonic dystrophy, type 2)
6D SMN (Autosomal recessive spinal muscular atrophy)
6Z Muscular, not otherwise specified

Metabolic, other

7A Apolipoprotein E (Cardiovascular disease, Alzheimer’s disease)
7B Sphingomyelin phosphodiesterase (Nieman-Pick disease)
7C Acid Beta Glucosidase (Gaucher disease)
7D HFE (Hemochromatosis)
7E Hexosaminidase A (Tay-Sachs disease)
7Z Metabolic, other, not otherwise specified

Metabolic, transport

8A CFTR (Cystic fibrosis)
8Z Metabolic, transport, not otherwise specified

Metabolic-pharmacogenetics

9A TPT (thiopurine methyltransferase) (patients on antimetabolite therapy)
9L Metabolic-pharmacogenetics, not otherwise specified

Dysmorphology

9M FGFR1 (Pfeiffer and Kallmann syndrome)
9N FGFR2 (Crouzon, Jackson-Weiss, Apert, Saethre-Chotzen syndromes)
9O FGFR3 (Achondroplasia, Hypochondroplasia, Thanatophoric dysplasia, types I and II, Crouzon syndrome with acanthosis nigricans, Muenke syndromes)
9P TWIST (Saethre-Chotzen syndrome)
9Q Catch-22 (22q11 deletion syndromes)
9Z Dysmorphology not otherwise specified

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

9.3 Place of Service Codes

03. School: A facility whose primary purpose is education.

04. Homeless Shelter: A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).

05. Indian Health Service Free-standing Facility: A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.

06. Indian Health Service Provider-based Facility: A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.

07. Tribal 638 Free-standing Facility: A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.

08. Tribal 638 Provider-based Facility: A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
11. **Office**: Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

12. **Home**: Location, other than a hospital or other facility, where the patient receives care in a private residence.

13. **Assisted Living Facility**: Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (effective 10/1/03)

14. **Group Home**: A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).

15. **Mobile Unit**: A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.

20. **Urgent Care Facility**: Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

21. **Inpatient Hospital**: A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

22. **Outpatient Hospital**: A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

23. **Emergency Room – Hospital**: A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

24. **Ambulatory Surgical Center**: A freestanding facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.

25. **Birthing Center**: A facility, other than a hospital’s maternity facilities or a physician’s office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

26. **Military Treatment Facility**: A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

31. **Skilled Nursing Facility**: A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

32. **Nursing Facility**: A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

33. **Custodial Care Facility**: A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

34. **Hospice**: A facility, other than a patient’s home, in which palliative and supportive care for terminally ill patients and their families are provided.

41. **Ambulance – Land**: A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

42. **Ambulance – Air or Water**: An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

49. **Independent Clinic**: A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (effective 10/1/03)

49. **Federally Qualified Health Center**: A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
50. Inpatient Psychiatric Facility: A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

51. Psychiatric Facility-Partial Hospitalization: A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

52. Community Mental Health Center: A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

54. Intermediate Care Facility/Mentally Retarded: A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

55. Residential Substance Abuse Treatment Facility: A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

56. Psychiatric Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

57. Non-residential Substance Abuse Treatment Facility: A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (effective 10/1/03)

60. Mass Immunization Center: A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

61. Comprehensive Inpatient Rehabilitation Facility: A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

62. Comprehensive Outpatient Rehabilitation Facility: A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

65. End-Stage Renal Disease Treatment Facility: A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

71. Public Health Clinic: A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician. (effective 10/1/03)

72. Rural Health Clinic: A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

81. Independent Laboratory: A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician’s office.

99. Other Place of Service: Other place of service not identified above.