St. Luke's Health Plan

Provider Manual

St Luke's™ Health Plan

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Welcome to St. Luke's Health Plan

Hello. We're St. Luke's Health Plan, a health insurance company truly focused on *health*. We are on a bold and ambitious mission to redefine the coverage to care experience for our members and as a network provider, you will play an integral part.

Working closely with doctors and medical professionals across the health care spectrum, St. Luke's Health Plan aims to remove many of the common barriers that are often associated with health insurance. This means doing away with most preauthorization requirements and streamlining the provider-payer relationship. Simply put, we want to make your life easier so you can focus on what you do best, providing exceptional care for your patients.

We're glad you're here. Let's get to work.

St. Luke's Health Plan General Information

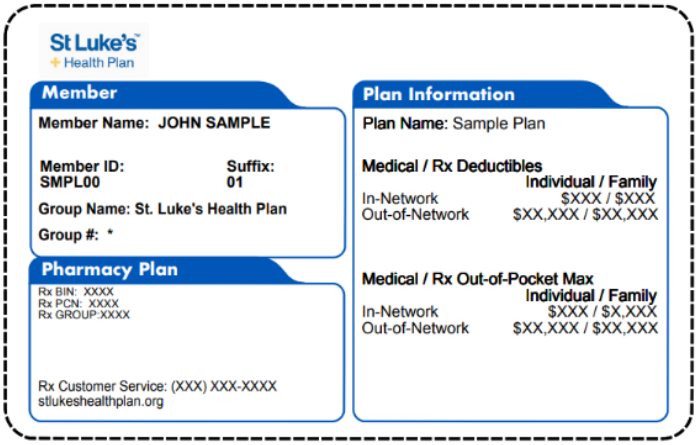
St. Luke's Health Plan is dedicated to giving our providers the highest quality service, with a commitment to working with you in a fair, honest and timely fashion. Please access this manual for basic information you and your office staff need when you see a St. Luke's Health Plan member.

Contacting St. Luke's Health Plan

Area	Topics	Email	Phone
Customer Service	Benefits and eligibility, ID Card, other plan inquiries	customercare@stlukeshealthplan.org	833-478-5853
Provider Relations	Informal inquiries, claims reconsiderations, general questions	providernetwork@slhealthplan.org	208-385-3730
Provider Contracting and Credentialing	Contracting, credentialing, provider information changes	SLHealthpartners@slhs.org	208-381-1564
Medical Management	Pre-authorizations, medical management	Medicalmanagement@stlukeshealthplan.org	833-591-2977
Behavioral Health/Chemical Dependency	Behavioral health/chemical dependency pre-authorization	medicalmanagement@stlukeshealthplan.org	833-613-1103
Care Management	Care management programs	caremanagement@slhs.org	208-493-0332
Pharmacy Services	Medications filled at retail, mail order, or specialty pharmacy	rx@slhealthplan.org	833-975-1281

Member ID Card

St. Luke's Health Plan members are issued a member identification (ID) card. Members can view and order additional ID Cards through the Member Portal. ID cards contain information that is required to identify eligibility, benefits, network and claims submissions.



Contact Information

St. Luke's Health Plan
Customer Service:
(833) 478-5853
www.stlukeshealthplan.org

Pre-Authorizations: (833) 591-2977
Behavioral Health: (833) 613-1103
Out-of-Network Providers: (833) 591-2978

Pre-authorization: Inpatient admissions and certain outpatient services require pre-authorization. Please refer to your Summary Plan Document for details.

Medical Claims Submission

EDI Payor ID: 91131

St. Luke's Health Plan
PO Box 91010
Seattle, WA 98111-9110

This card does not guarantee coverage. If you have any questions regarding benefit coverage, claims, or eligibility please call St. Luke's Health Plan or visit www.stlukeshealthplan.org.

Networks

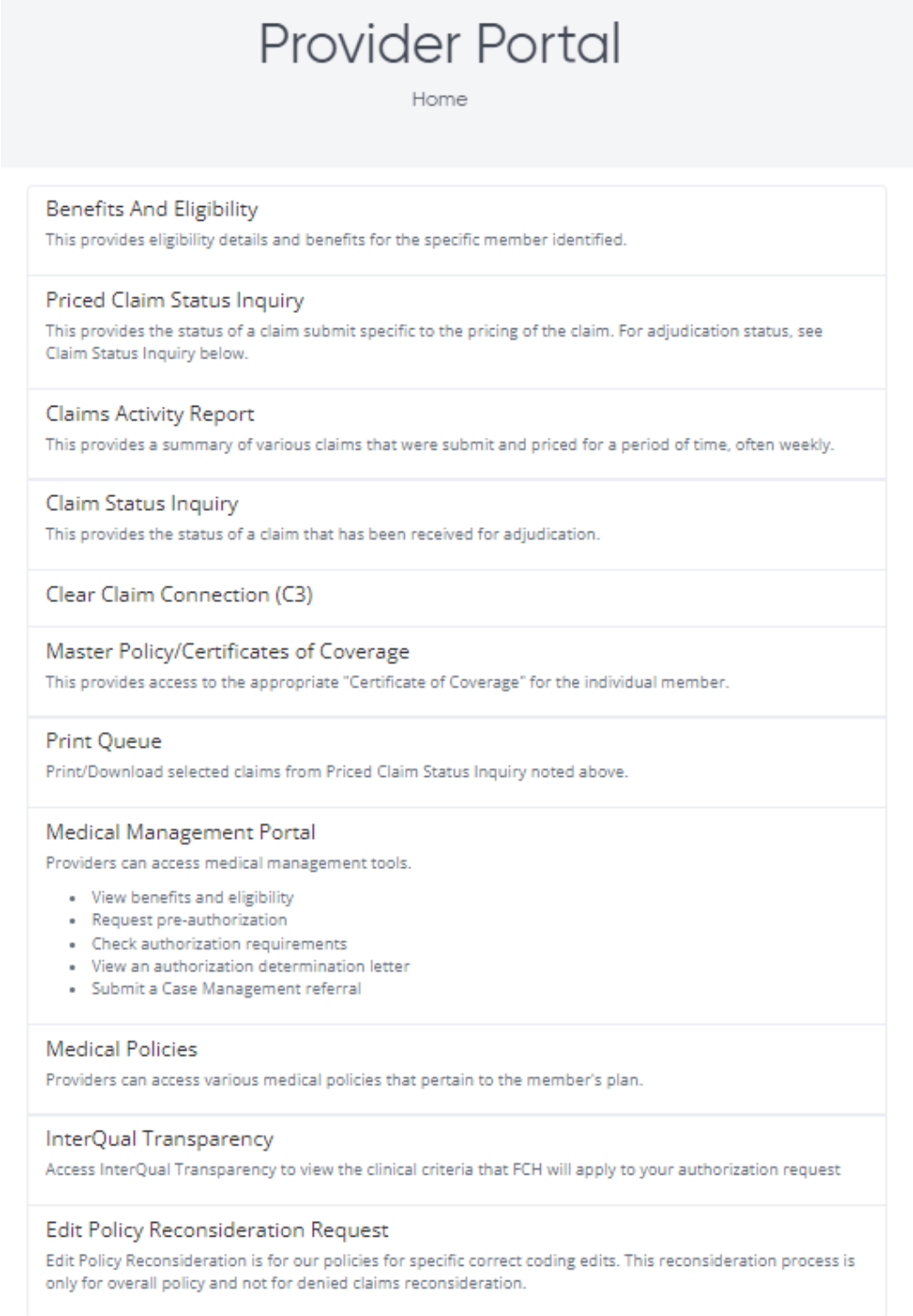
St. Luke's Health Partners
www.stlukeshealthpartners.org

First Choice Health
AK, ID, MT, ND, OR, SD, WA, WY
www.fchn.com

First Health Network
www.firsthealth.com

Provider Portal Tools

The Provider Portal is our secure website to view claims, request or check the status of prior authorizations, check member benefits, and more. The Provider Portal is available at https://www.stlukeshealthplan.org/providers.

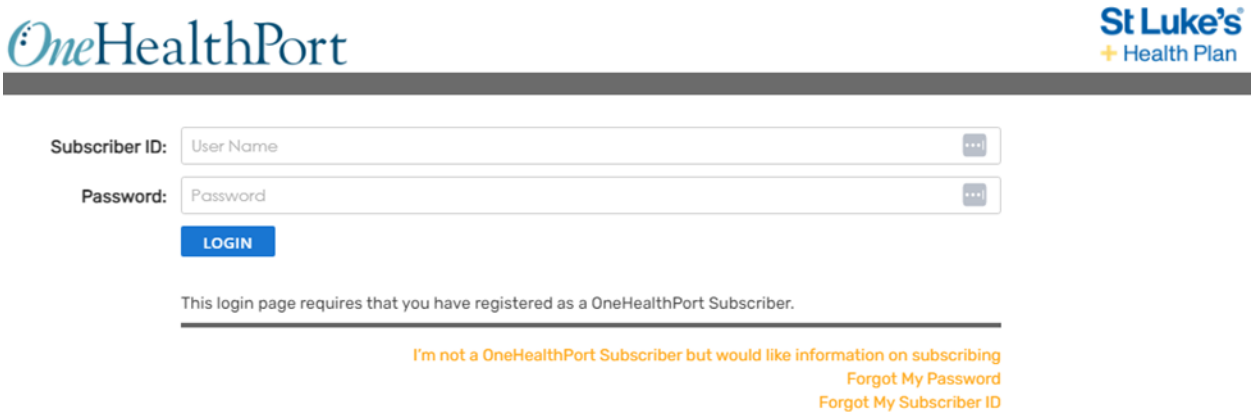


OneHealthPort Login

The Provider Portal is accessed through OneHealthPort, a secure healthcare web portal that offers single sign on capabilities for multiple carriers. If you are new to OneHealthPort, you will need to register to access the Provider Portal. Register with OneHealthPort.

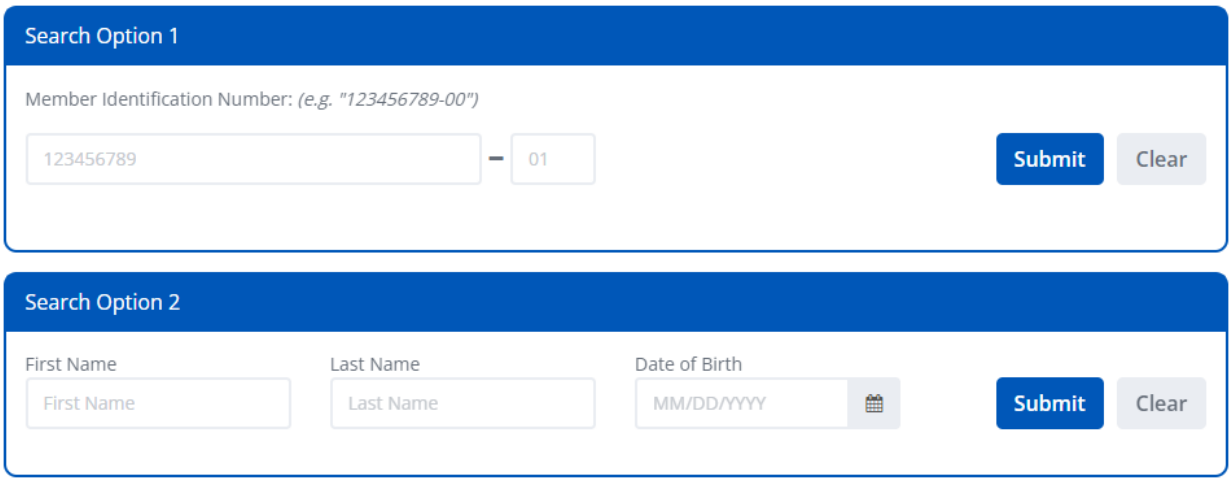
For assistance with accessing the portal please contact OneHealthPort directly at (800) 973-4797 or reach us online.

For assistance navigating the Provider Portal tools, please contact us at (800) 231-6935 or by email at ProviderRelations@fchn.com.



Benefits and Eligibility

In addition to general eligibility information, you can search for benefit details which include specific information such as lifetime, deductible and out-of-pocket amounts, coinsurance levels and benefit maximums. The display will also provide you with details on how much of a specific benefit the patient has satisfied.



Benefits and Eligibility (Results)

Eligibility Results

Eligibility and In-Network Benefits as of 8/26/2022: **Active**

Subscriber Information	
Subscriber Name	BvwTRNnS jdeiWsGAVo
Employer Group	FIRST CHOICE HEALTH
Group Number	1
Identification Number	870002109-01
Plan Name	HDHP with Vision

Dependent Information	Medical Management Portal
Dependent Name	QgrFXooi bwQIfhIaQG
Identification Number	870002109-02
Date Of Birth	7/13/1979
Effective Date	9/1/2021 ▾ Click the down arrow to see previous effective dates
Term Date	
Gender	Male
Address	7745 SWIFT LANE NE edRXmrGITv WA 98516
Phone	(589) 835-1201

Medical Plan Summary

Deductible and Out-of-Pocket Information

Individual

	Network	Period	Amount	Amount Satisfied	Amount Remaining
Out of Pocket	First Choice Health/First Health	Contract Year	$6,900.00	$131.70	$6,768.30
Out of Pocket	Out-of-Network	Contract Year	$28,000.00	$131.70	$27,868.30

Family

	Network	Period	Amount	Amount Satisfied	Amount Remaining
Deductible	First Choice Health/First Health	Contract Year	$2,800.00	$2,800.00	$0.00
Deductible	Out-of-Network	Contract Year	$5,600.00	$2,800.00	$2,800.00
Out of Pocket	First Choice Health/First Health	Contract Year	$10,000.00	$7,325.05	$2,674.95
Out of Pocket	Out-of-Network	Contract Year	$28,000.00	$7,325.05	$20,674.95

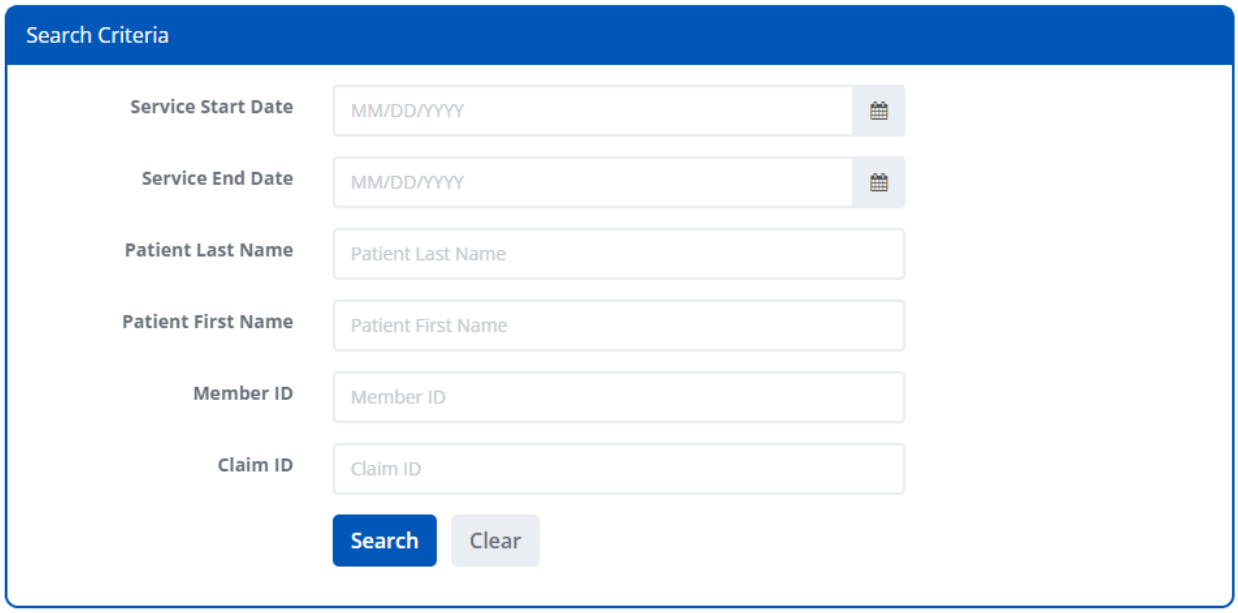
- ⊞ Professional/Physician Services
- ⊞ Emergency Care
- ⊞ Hospital Inpatient Medical and Surgical Care
- ⊞ Hospital Outpatient Surgery and Services
- ⊞ Mental Health Care
- ⊞ Rehabilitation Therapy

Priced Claim Status Inquiry

This page allows you to search for claims you have submitted to St. Luke's Health Plan for pricing prior to the claim being sent for adjudication. Enter the search criteria information in the fields below.

You will only be able to view patient claim(s) where the claim's associated Tax Identification Number (TIN) matches a TIN in your OneHealthPort credentials.

To obtain claims processing status, please use the Claims Status Inquiry tool.



Claims Activity Report

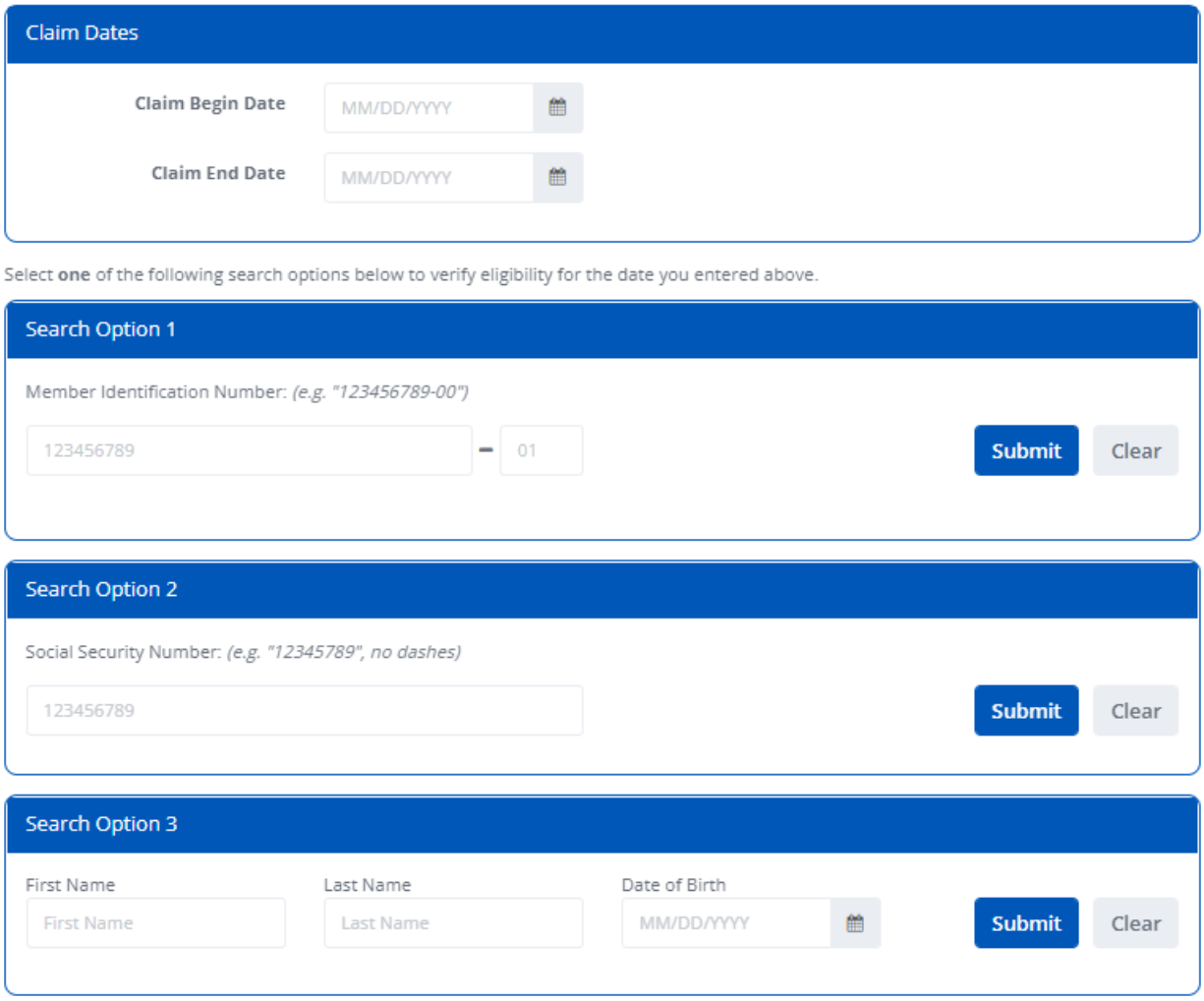
Providers who opted in for weekly Claims Activity Reports will see the reports below. If you would like to opt in, please email ProviderRelations@fchn.com, or call (800) 231-6935 for processing.

The reports are run on a weekly basis every Monday. This report is a summarized list of all claims priced by St. Luke's Health Plan for your Billing Office (determined by Tax Identification Number). It will tell the user:

- How the claim was received for pricing (Batch Type)
- When the claim was received and completed
- The allowed amount
- Disposition of the claim (Forwarded on for processing or returned for errors)
- Error codes associated with the claim
    - *Please note that the error description line will indicate the charge line that is associated with that specific error.*

Claim Status Inquiry

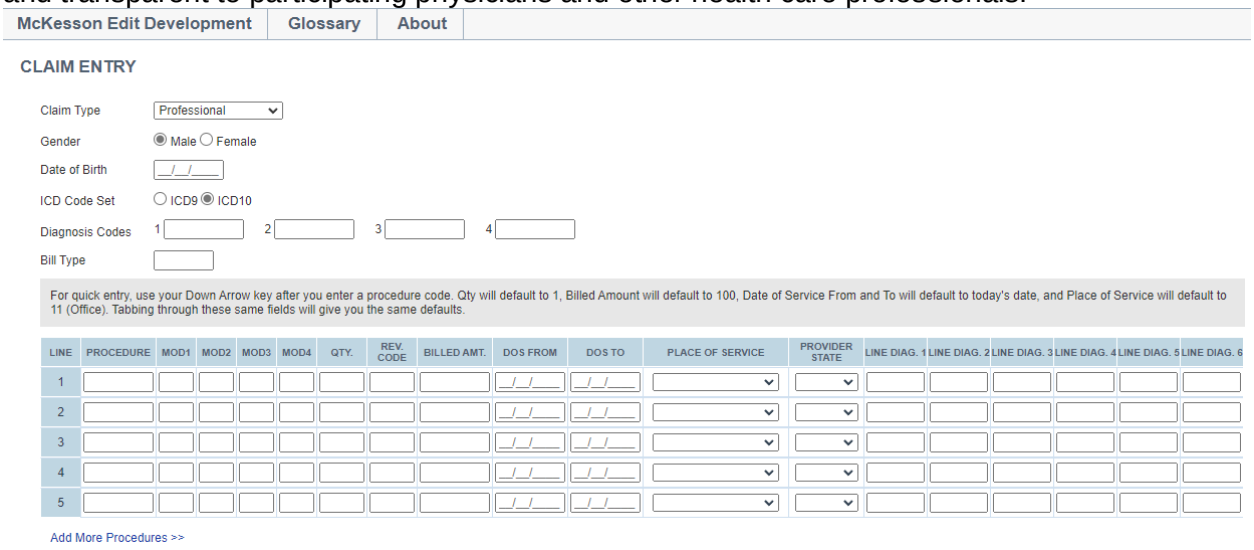
You will only be able to view claim(s) for a member when the Tax ID number associated with the claim matches a Tax ID number in your OneHealthPort credentials.



Please Note: Any benefit information provided on the portal, including eligibility status, is not a guarantee of payment. Final payment determination will be made upon claim adjudication. If you have questions, please call Customer Care at (833) 478-5853.

Clear Claim Connection (C3)

The McKesson Clear Claim ConnectionTM tool, a web-based code editing disclosure solution, helps ensure that our code auditing rules for various code combinations are easily accessible and transparent to participating physicians and other health care professionals.



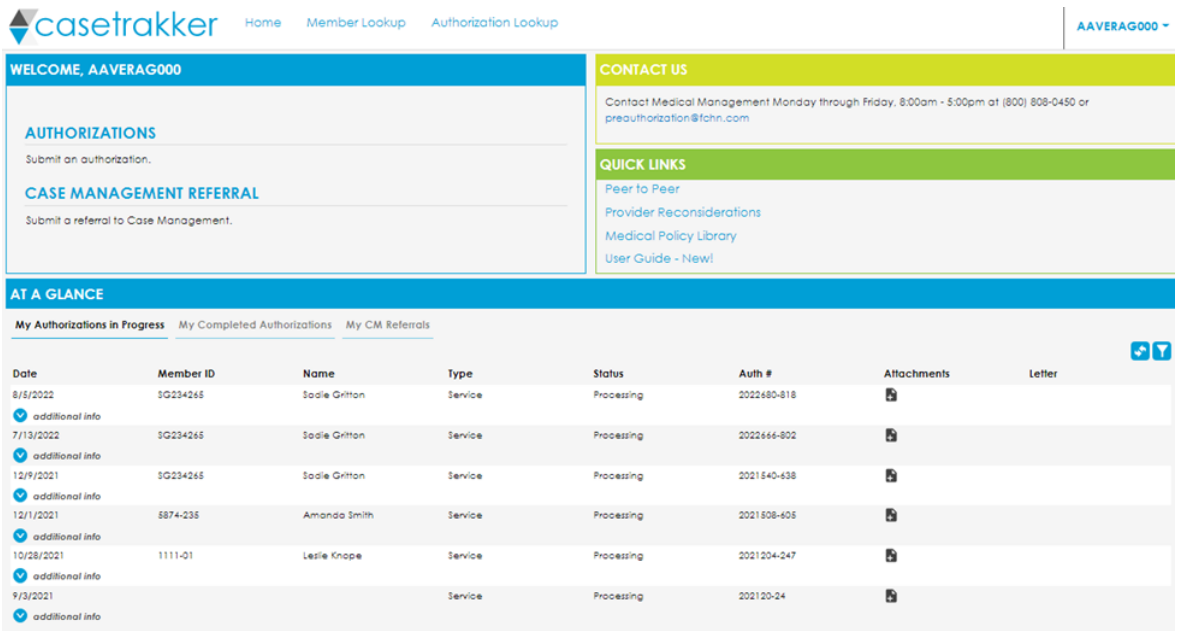
Master Policy/Certificates of Coverage

Use this section to access and view St. Luke's Health Plan Master Policies and Certificates of Coverage.

Medical Management Portal

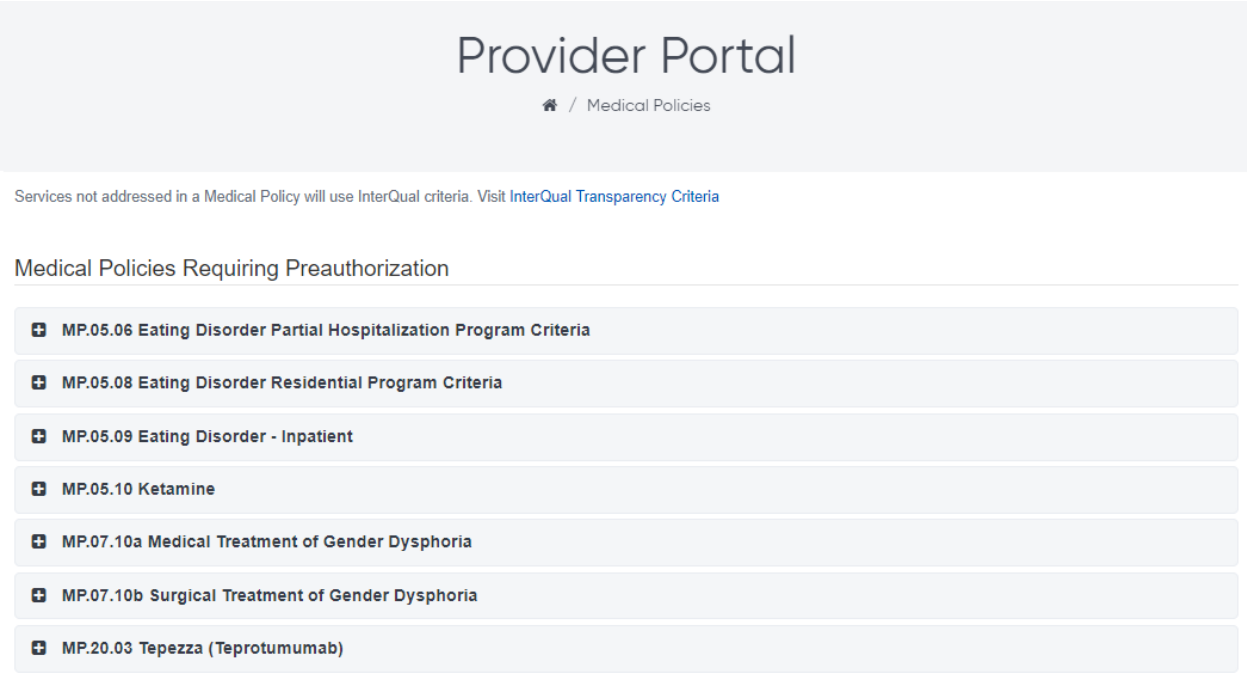
Providers can access medical management tools in this section for medical benefit services, including:

- View benefits and eligibility
- Request pre-authorization
- Check authorization requirements
- View and authorization determination letter


casetrakker
Home
Member Lookup
Authorization Lookup
AAVERAG000
WELCOME, AAVERAG000
AUTHORIZATIONS
Submit an authorization.
CASE MANAGEMENT REFERRAL
Submit a referral to Case Management.
CONTACT US
Contact Medical Management Monday through Friday, 8:00am - 5:00pm at (800) 808-0450 or preauthorization@fchn.com
QUICK LINKS
Peer to Peer
Provider Reconsiderations
Medical Policy Library
User Guide - New!
AT A GLANCE
My Authorizations in Progress
My Completed Authorizations
My CM Referrals
Date
Member ID
Name
Type
Status
Auth #
Attachments
Letter
8/5/2022
SG234265
Sadie Gritton
Service
Processing
2022680-818
additional info
7/13/2022
SG234265
Sadie Gritton
Service
Processing
2022666-802
additional info
12/9/2021
SG234265
Sadie Gritton
Service
Processing
2021540-638
additional info
12/1/2021
5874-235
Amanda Smith
Service
Processing
2021508-605
additional info
10/28/2021
1111-01
Leslie Knope
Service
Processing
2021204-247
additional info
9/3/2021
Service
Processing
202120-24
additional info

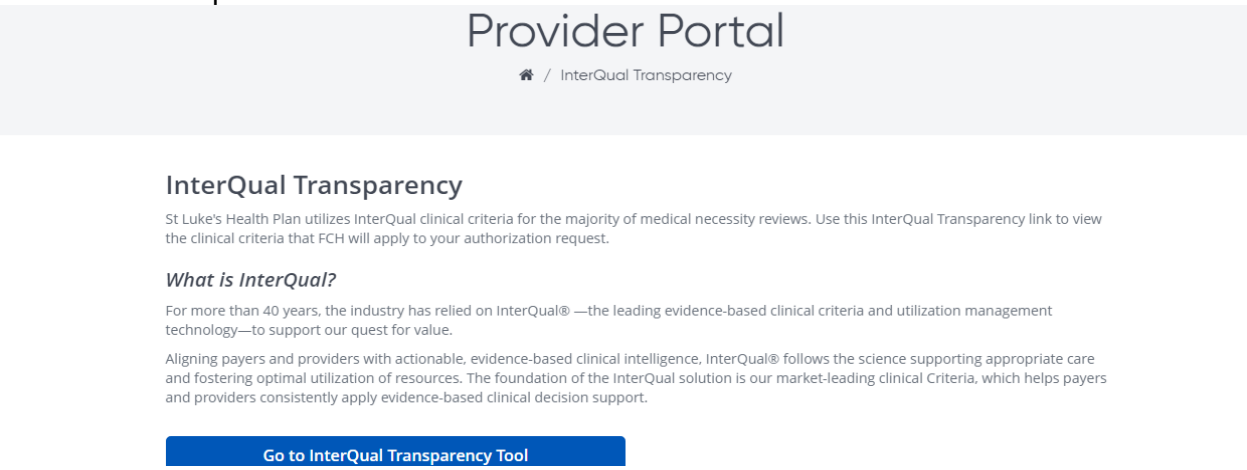
Medical Policies

Providers can use this section to access medical policies that apply to the member's plan.



InterQual Transparency

St. Luke's Health Plan utilizes InterQual clinical criteria for the majority of medical necessity reviews. For some services, we use internally developed medical policies. Use this section of the Provider Portal to view the clinical criteria that St. Luke's Health Plan will apply to your authorization request.



Edit Policy Reconsideration Request

Please use the Edit Policy Reconsideration Request Form located on the Portal to have edits reconsidered for:

- Bundled Services
- Pre and Post Op Visits within the Global Period
- Incidental and Mutually Exclusive Procedures
- Modifier-Procedure Combination Validity
- Assistant Surgeon Necessity
- New Patient


Provider Portal
/ Edit Policy Reconsideration Request Form
Edit Policy Reconsideration Request Form
No Personal Health Information as defined by HIPAA should be included in this transaction. A copy of this request will be sent to the Requestor's Email Address noted below. St Luke's Health Plan will respond via email.
Date
8/26/2022
Organization Name
Organization Name
Provider Name
Provider Name
Requestor's Information
Name
Name
Email
Email
Phone
Phone
Format: (123) 456-7890 x1234
Edit to be reconsidered
(check one)
Bundled Services
Pre-post op visits in global period
Incidental and Mutually Exclusive
Modifier Procedure Combination Validity
Assistant Surgeon Necessity
New Patient
Coding example
Date Of Service
Procedure Code
Modifiers

Provider Network

St. Luke's Health Plan (Plan) provides coverage for members through St. Luke's Health Partners (SLHP) and BrightPath (BP) within the service area. Members can also receive care from our partners, First Choice and First Health Network, which serve as networks for services outside the service area. Please refer to Master Policy for coverage of In-Network and Out of Network services.
When receiving care within the 20 counties, members will utilize St. Luke's Health Partners. When traveling or receiving care (emergent and non-emergent care) out of the 20-county service area, FCH and FH will be at the in-network benefit level.

Information for credentialing and provider directory and data management for SLHP providers are included herein. Please note, all wrap providers should contact First Choice Health or First Health directly for network management.

Network	Network Status	Service Area	Phone	Website
SLHP & BP	In- Network	Idaho Counties: Ada, Adams, Blaine, Boise, Camas, Canyon, Cassia, Custer, Elmore, Gem, Gooding, Jerome, Lemhi, Lincoln, Minidoka, Owyhee, Payette, Twin Falls, Valley, and Washington	208-381-1564	www.stlukeshealthplan.org
First Choice Health Network, Inc.	In-Network Out-of-area Preferred	Idaho counties not served by St. Luke's Health Partners, as well as all counties in AK, MT, OR, UT, SD, WA, WY	800-226-5116	www.fchn.com
First Health	In-Network Out-of-area Preferred	All states/areas not served by St. Luke's Health Partners or First Choice Health Network, Inc.	800-226-5116	www.myfirsthealth.com/

SLHP Credentialing and Re-credentialing

St. Luke's Health Plan delegates credentialing activities to St. Luke's Health Partners within our service area. Providers must meet credentialing criteria and relevant accreditation requirements to participate with SLHP, and subsequently St. Luke's Health Plan. To qualify for participation, all eligible providers, except for those considered facility-based, must submit a credentialing application and all required attachments. SLHP formally re-credentials its practitioners at least

every three years and assesses and evaluates a provider's or facility's ability to deliver quality care between credentialing and re-credentialing cycles.
The contracting and credentialing department is comprehensive and allows SLHP to:

- Recruit and retain a quality network of providers
- Ensure ongoing access to care
- Validate that all providers and facilities are continuously in compliance with network policies, procedures, and any applicable regulatory and accreditation requirements

Credentialed providers include those who have an unrestricted, current, and valid license and a National Provider Identification (NPI) Number. The process follows standards outlined by NCQA and complies with state and federal statutes.
SLHP accesses information from national certifying boards, appropriate state licensing boards, the Office of the Inspector General Exclusions list, the National Provider Data Bank, and other sources as required. Providers are not considered participating in the network until after the credentialing and contracting processes are complete, and approval has been granted by the Participating Provider Committee.
Credentialing applications can be submitted to SLHP at: SLHealthpartners@slhs.org,

Members' Rights and Responsibilities

Respecting member rights and clearly outlining responsibilities is crucial for fostering effective health care. By respecting member rights and clearly explaining member responsibilities under their health plan, we will promote effective healthcare.

We want to ensure members have easy access to the Members' Rights and Responsibilities. This essential information is always available on St. Luke's Health Plan website. Members can conveniently access these by visiting Member Rights & Responsibilities at: www.stlukeshealthplan.org

Provider Directory and Data Management

Effective January 1, 2022, Congress passed the No Surprises Act (NSA) which dictates how health plans (fully insured health plans, insurance carriers and self-funded medical plans) and provider organizations communicate and share data. NSA requirements include:

1. **Attestation every 90 days.**
   Providers must attest every 90 days to ensure provider demographic information is current and accurate. St. Luke's Health Plan engages with a third-party vendor for advanced analytics that automatically flag stale, incomplete, or otherwise suspect directory data for follow up. Validation processes include on-demand human resolution, as well as closed-loop feedback interactions with participating providers. The database integrates seamlessly with the Provider Directory to ensure that directory updates are accurate, reliable and maintain compliance.

2. **Out of compliance providers must be removed from Provider Directory.**
   Providers that have not attested to their demographic information may be removed from the Provider Directory, in accordance with the NSA. The provider will remain an in-network provider but will not be visible in the Provider Directory.

Please use the following processes to submit Provider information changes to St. Luke's Health Partners:

- **To term an existing practice address:** Email SLHealthPartners@slhs.org with information detailing changes or termination of a specific practice address. Include your NPI and Tax Identification numbers to ensure accuracy in processing the request.

- **To change/add a billing address:** A billing address is the pay to address and where your payments will be mailed. To update this address type, send an email to SLHealthPartners@slhs.org indicating you wish to change your billing address. Include your NPI and Tax Identification numbers to ensure accuracy in processing the request.

- **To update or change a Tax Identifier Number (TIN):** Email a W9 to SLHealthPartners@slhs.org along with a request for a new contract to indicate that you have added a new TIN or are changing to a different TIN. Please indicate if you are terming an existing TIN with the effective date of the termination.

- **To inquire about other changes not listed above (new practice address, name change, specialty change, etc.):** Send an email to SLHealthPartners@slhs.org indicating you wish to update your demographic information. Include your NPI and Tax Identification numbers to ensure accuracy in processing the request.

If provider information changes are not submitted timely, it may impact the accuracy of the claims processing. For more information, and to access Provider Change Forms, visit the SLHP website.

Claims, Billing and Payments

Claims Filing Deadlines

Claims must be submitted to St. Luke's Health Plan within the following timeframes (whichever is later):

- 12 months of the date the service/supply was rendered; or
- 12 months from the date the provider receives the primary insurance explanation of benefits, when St. Luke's Health Plan is not the primary insurer.

Prompt Filing

While claims may be filed up to 12 months from date of service, we strongly encourage providers to file claims within 30 days. The benefits are filing a claim promptly include:

- Members receiving an Explanation of Benefits (EOB) before receiving a provider bill for out-of-pocket costs; and
- Increased reliability and accuracy on member accumulators and out of pocket cost information quoted; and
- Providers receive prompt payment.

When members receive an EOB before receiving the bill, it allows for improved customer experience and better understanding of their bill(s).

Corrected Claims

Requests for claims adjustments or corrections must be submitted within 12 months of the date the claim was first processed, except under extenuating circumstances and when evidence is provided showing the request for adjustment or correction was filed as soon as reasonably possible.

Claims Submissions

Claims can be submitted via mail or electronically. We strongly encourage the electronic submission method via Electronic Data Exchange (EDI). Our electronic payer ID is 91131. Please note the following when submitting EDI claims:

- **Both Group ID and Group Name information are used to match claims appropriately.** If valid group information is not provided, we may be unable to accurately associate the claim.
- **Use only a street address as the billing provider address under the Version 5010 transactions.** The billing provider address is reported in the billing provider loop (2010AA, N3S01, and N302) of the 837-claim transaction.
- **EDI claims transactions submitted with a post office (P.O.) box in the billing provider address field will be rejected to comply with HIPAA.** Providers who want payments to be sent to PO boxes or lockboxes need to report this address in the "pay-to" address field on the EDI transaction (Loop 2010AB).
- **HIPAA requires that all 5010 transactions be billed with extended zip codes (ZIP+4) in the billing provider address** (Loop 2010AA N403). St. Luke's Health Plan requires all transactions to include a complete address (a complete address is defined as including the full 9-digit ZIP code—the traditional five digits plus the extra four digits for localized mail delivery).

If you need to submit a paper claim, the mailing address is:

St. Luke's Health Plan
P.O. Box 91010
Seattle, WA 98111-9110

Electronic Claims Payments and Electronic Remittance Advice

St. Luke's Health Plan processes electronic claims payments (ECP) using Zelis Payments. Zelis Payments accelerate and improve efficiency of claims payment processing and provides:

- Use of an online portal for no-fee Automated Clearing House (ACH) direct payments
- Improves cash flow with faster payments and secondary filing/patient collections
- Allows you to access your payment remittance remotely and securely 24/7
- Streamlines reconciliation with automated payment posting capabilities
- Electronic remittance advice (ERA) available via download (835, PDF) or via clearinghouse
- delivery
- Payment remittances are stored securely online for 7 years

To register for Zelis ePayment Center:

1. Visit epayment center and follow the instructions to obtain a registration code (a link will be sent to you).
2. Follow the link to complete your registration and set up your account
3. Log in to the portal and enter your bank account information
4. Review and accept the ACH Agreement and click "Submit"

For more information or assistance, contact a Zelis Provider Enrollment Advisor by calling (844) 292-4066 or email help@epayment.center.

Claims Payment Policies

This section of the provider manual covers any type of service where the provider's contractual allowance is affected by certain billing methodologies. St. Luke's Health Plan contracts with First Choice Health as a Third-Party Administrator for operational services such as claims adjudication and benefit administration.

Anesthesia Claims

Anesthesiology services are calculated using base units plus time units. Unless stated differently in your provider contract, the following guidelines apply:

- All applicable codes are assigned base units on each fee schedule. Total anesthesia units are calculated by adding the calculated time units to the specific base anesthesia units that are listed on the fee schedule for the CPT code billed.
- CPT codes ranging from 0019T-0042T are Category III codes and are considered temporary (anesthesia logic does not apply). These codes will be priced at the Default Discount for each fee schedule when payable.
- Plan will not accept CPT codes billed with time units for contracted anesthesia. providers.
- Only bill appropriate CPT anesthesia codes (00100-01999).
- Every anesthesia procedure billed must include one of the following anesthesia HCPCS modifiers:

Modifier	Modifier Denotes
AA	Anesthesia services performed personally by anesthesiologist or when an anesthetist assists a physician in the care of a single patient
QY	Medical direction of one qualified non-physician
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
QX	Qualified non-physician anesthetist service: with medical direction by a physician
QZ	Qualified non-physician anesthetist service: without medical direction by a physician

Baby's Birth Weight

The Value Code "54" is to be reported with the baby's birth weight in grams in the Value Codes Amount field on the UB-04 claim form. A valid birth weight is at least a three-digit number. Right justify the weight in grams to the left of the dollars/cent's delimiter. (If billing software requires the decimal in the "Value Code Amount" field, enter the weight in grams then decimal point 00 e.g., 2499.00). Baby's birth weight should be billed in EDI Loop 2300.

Inpatient admission claims that do not have this Value Code and valid birth weight included on the claim or encounter submission will be rejected.

Telehealth

Telehealth Services includes but is not limited to:

- Telehealth Visit means health care services conducted with technology that includes live audio and video communication between the Participant and a Provider in compliance with state and federal laws.
- Scheduled Telephone Visit (STV) means a telephonic visit initiated by patient and scheduled for a specific time with a designated provider, and not related to any previous visits within 7 days.
- Electronic Visit (e-visit) means a visit of non-urgent clinical information between a provider and a patient conducted over a secure encrypted web portal. E-visits must be scheduled with a designated provider and not be related to any visit within the last seven (7) days.
- Remote Patient Monitoring means the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the Provider.
- Videoconference Consultation means the use of medical information exchanged from one site to another via electronic communications.

Telehealth/Telemedicine/St. Luke's On Demand Virtual Care/St Luke's eVisit services are required to be submitted with place of service 02 or 10. Modifiers 95, GT, GQ, G0, FQ, and FR can also be appended as appropriate but is not required if the correct place of service is used. Telehealth services will be reimbursed at the non-facility site of service differential and according to the Medicaid or Medicare fee schedules as appropriate.

Modifiers

Plan recognizes all valid CPT/HCPCS modifier codes, although not every modifier code will affect a negotiated allowable. There may be modifiers billed that do not impact pricing. The following modifier table is not inclusive of all modifiers that may or may not warrant a change in reimbursement. The modifiers on the following pages are only applied to professional claims unless otherwise noted in your contract. Adjustments applied to codes billed with modifiers will be limited to the charge line in which the code and modifier were billed.
The following guidelines will be used by Plan to ensure correctly priced modifiers:

- Modifiers that alter the contract allowed amount due to the provider agreement should always be priced according to that agreement first.
- Modifiers that result in an allowed amount greater than the contract allowed amount are priced next.
- Modifiers that result in an allowed amount less than the contract allowed amount are priced next.
- Modifiers that do not alter the contract allowed amount are informational only.

Modifier	Modifier Denotes	Description
AA	Anesthesia component	The allowable amount is based on the start and end times of the procedure and is calculated in conjunction with the predetermined base units.
AD	Anesthesia component	Reduce allowable by 50%.
AS	PA services for assistant at surgery	Reduce allowable by 80%.
NU	New DME	The allowable amount is contractually predetermined.

P3	A patient with severe systemic disease	One base unit will be added.
P4	A patient with severe systemic disease that is a constant threat to life	Two base units will be added.
P5	A moribund patient who is not expected to survive without the operation	Three base units will be added.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Reduce allowable by 50%.
QX	CRNA service: with medical direction by a physician	Reduce allowable amount by 50%.
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	Reduce allowable amount by 50%.
RR	Rental DME	The allowable amount is contractually predetermined.
RT	Procedure done on the right side of the body	100% of allowable
LT	Procedure done on the left side of the body	100% of allowable
TC	Technical component	The allowable amount is contractually predetermined.
UE	Used DME	The allowable amount is contractually predetermined.
22	Unusual procedural services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to increase to 125% of allowable.
24	Unrelated evaluation and management service by the same physician during a post-operative period	100% of allowable
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100% of allowable
26	Professional component	The allowable amount is contractually predetermined.
50	Bilateral procedure	150% of allowable
51	Multiple procedure	Reduce allowable by 50%.
52	Reduced services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to reduce allowable by 50%.
53	Discontinued procedure	Upon medical review by payor if determined appropriate, recommended reimbursement is to reduce allowable by

		50%.
54	Surgical care only	Reduce the contract allowed by 20% per applicable charge line.
55	Post-operative management only	Reduce allowable by 80%.
56	Pre-operative management only	Reduce allowable by 90%.
58	Staged or related procedure or service by the same physician during the post-operative period	100% of allowable
59	Distinct procedural service	It may be appropriate to review supporting documentation for this distinct procedural service.
62	Two surgeons	Reduce allowable by 37.5% for a surgical procedure.
73	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by50%.
74	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by 25%, 50%, or 75%.
78	Return to the operating room for a related procedure during the post-operative period	Reduce allowable by 20% for a surgical procedure.
80	Assistant surgeon	Reduce allowable by 80%.
81	Minimum assistant surgeon	Reduce allowable by 80%.
82	Assistant surgeon (when qualified resident surgeon not available)	Reduce allowable by 80%.

Bilateral Procedures

A valid bilateral adjustment as indicated by CMS should be billed on one line with modifier 50. These are procedures with a Medicare Physician Fee Schedule Database (MPFSDB) bilateral indicator of one (1). If a bilateral procedure is eligible for bilateral adjustment, it should be processed with one (1) unit of service and reimbursed at 150% of allowed charges, not to exceed billed charges.

For Hospitals, multiple surgical procedures (CPT Code Range 10000-69999, except for 36415) performed on the same date of service shall be reimbursed as follows: primary procedure (determined by the highest allowable) shall be at 100% of the fee schedule amount and all subsequent procedures shall be at 50% of the fee schedule amount. Multiple bilateral surgical procedures performed during the same encounter and billed with modifier 50 first shall be reimbursed at 150% of the fee schedule amount. Subsequent bilateral procedures billed with modifier 50 shall be reimbursed at 100% of the fee schedule amount (which is effectively reimbursing each individual procedure at 50% of the fee schedule).

Observation and Inpatient Admission Policy
A patient admitted to observation and then admitted to inpatient status on the same day should be billed using inpatient admission codes only.

A patient admitted to observation and then admitted to inpatient status on a different day may be billed with both the initial observation codes and the hospital admission codes on the subsequent day. Any observation hours exceeding 48 hours should be billed in the non-covered column.

Claims Editing
Claims are subject to standard claims editing software utilized by payors to detect bundling and unbundling and incorrect billing.

Coordination of Benefits (COB)
When a member has healthcare coverage under more than one health benefit plan, we will coordinate Medical Benefits with the other healthcare coverage according to the coordination of benefits (COB) rules set forth in Idaho DOI Rule 18.01.74.

The COB provision applies when a person has health care coverage under more than one health plan. The order of benefit determination rules governs 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 the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense. Please refer to member's Master Policy for additional information.

Durable Medical Equipment
The CMS DMEPOS fee schedule identifies capped rental items as category CR. After 13 months of rental, a beneficiary owns the capped rental DME item and Sy. Luke's Health Plan pays for reasonable and necessary repairs and servicing of the item (i.e., parts and labor not covered by a supplier's or manufacturer's warranty). Capped DME modifiers may include:

- KH - DMEPOS item, initial claim, purchase or first month rental.
- KI - DMEPOS item, second or third month rental.
- KJ - DMEPOS item, rental months four to 13.

Medical Management

Population Health Management
St. Luke's Health Plan contracts with St. Luke's Health Partners, an affiliated financially and clinically integrated network, to engage with participating providers to deliver high quality and cost-effective health care services to our members. One mechanism of engagement for Primary Care Providers is through Stellar Health, which activates value-based metrics at the point of care, and rewards providers and their full care team for completing these activities in real time. Through workflow transformation, Stellar Health aids providers to perform in value-based arrangements and take on risk. For more information, please contact St. Luke's Health Partners Population Health team at PopHealthSLHP@slhs.org.

Shared Decision-Making Aids

Shared decision-making (SDM) aids provide evidence-based information about potential treatment options and outcomes. They are designed to complement counselling given to patients by providers, and to facilitate discussion about treatment decisions. There is a large library of SDMs available on our website at no cost to you. Find them under "Member Resources" at www.stlukeshealthplan.org.

Medical Necessity and Coverage

Services must be medically necessary and covered under the benefits plan to be eligible for reimbursement. “Medically Necessary” describes a medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition.
- It is the most appropriate supply or Level of Care that is essential for the diagnosis or treatment of the patient’s covered medical condition.
- It is known to be effective in improving health outcomes for the patient’s medical condition in accordance with sufficient scientific evidence and professionally recognized standards.
- It is not furnished primarily for the convenience of the patient or provider of services.
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient. The fact that a service or supply is furnished, prescribed, or recommended by a physician or other Provider does not, of itself, make it Medically Necessary. A service or supply may be Medically Necessary in part only.

Determinations regarding medical necessity are based upon established, evidence-based criteria set. For services for which criteria have not yet been established, St. Luke’s Health Plan relies upon the latest evidence-based research, as well as the judgement of medical experts, to determine medical necessity. When an authorization request or claim does not seem appropriate for a diagnosis or condition, or when a length of stay seems longer than appropriate, the case is referred to a physician or other qualified healthcare provider for review. A member can appeal any service denied, including services denied based on medical necessity.

Preauthorization

To minimize the time providers spent submitting paperwork, St. Luke’s Health Plan only requires authorization for a few select services, including:

- Inpatient Admissions, including:
    - o Behavioral/Mental Health
    - o Chemical Dependency
    - o Residential Treatment
    - o Acute Inpatient Rehabilitation
    - o Skilled Nursing Facilities
    - o Long-Term Acute Care Facilities
- Gender affirming surgeries
- Bariatric revision surgeries
- Most medications over $5,000 per year, including gene therapy, and immunotherapy.
- Durable Medical Equipment: o Equipment with costs of more than one thousand dollars ($1,000), (including rent-to-purchase items)

    - o Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)
- Blood clotting factors

Authorization requests can be submitted via fax, email, or electronically through the Provider Portal.

When submitting via fax or email, please use the Authorization Request Form, which is available on our website as well electronically as on the Provider Portal.

To maximize efficiency of the authorization process and to accelerate the promptness with which we can issue a determination, please submit all relevant clinical information pertaining to the request when submitting it. We will issue a determination for a standard, non-urgent authorization request within 2 business days, assuming all the necessary supporting clinical information is provided with the request.

If additional information is required for us to render a determination, we will notify you as soon as possible. Your prompt response to such outreach for additional information is deeply appreciated and will expedite the authorization process.

If you have any questions about the pre-authorization process, including coverage criteria, submitting a request, and accessing the Authorization Form, don't hesitate to contact the Medical Management Department. They can be reached by phone at 833-591-2977 or email at medicalmanagement@stlukeshealthplan.org.

Emergency Services and Urgent Care Services never require a Pre-Authorization. For urgent or emergent needs, please direct members to the nearest available facility for treatment.

Notification for Emergency Admissions

The Plan requests that you give notice of any Emergency Admission by calling (((800) 808-0450 within two (2) business days after the admission, or as soon as possible, unless there are extenuating circumstances (as determined by St. Luke's Health Plan). The number to contact the Plan is also listed on member's ID card.

Concurrent Review, Discharge Planning and Coordination

All inpatient stays are subject to periodic clinical review ("Concurrent Review") to evaluate Medical Necessity of ongoing inpatient care. If a Concurrent Review determines that continued hospitalization or treatment in the facility is not Medically Necessary, St. Luke's Health Plan will not pay for further hospitalization or treatment in the facility. St. Luke's Health Plan also assists with discharge planning and coordination for Members transferring from the hospital to home or another facility. Concurrent Review is conducted on the following admissions:

- Acute Care Admissions
- Skilled Nursing Facility and Long-Term Acute Care Admissions
- Behavioral/Mental Health
- Chemical Dependency
- Residential Treatment
- Rehabilitation (Acute Inpatient Rehabilitation)

Authorization requests can be submitted via fax, email, or electronically through the Provider Portal.

Care Management Program

St. Luke's Health Partner's Care Management program provides members access to a team of licensed professionals, including registered nurses, licensed clinical social workers, pharmacists and registered dieticians. They support members with a wide variety of issues and conditions, with an aim to educate people on how to better manage their health. They also can help members struggling with social determinants of health issues, such as access to food and housing.

Care Management is offered at no cost to members. If you have a patient who might benefit from this program, please send the referral to St. Luke's Health Partners via email at mailto:caremanagement@slhs.org or by phone at (208) 493-0332. St. Luke's providers using Epic can also make referrals electronically through Epic.

Higher Level of Coverage Waiver

All members have out-of-network benefits, meaning they are allowed to see out-of-network providers without a referral. However, members receive reduced benefits when going out-of-network, meaning it will cost more out-of-pocket. If you believe your patient needs services that are not available within the St. Luke's Health Partners, First Choice or First Choice Health (FCH) or First Health (FH) network, we ask that you submit a Higher Level of Benefits Waiver request on behalf of your patient. We will review the waiver request to determine if we have a provider within our network who can provide the services. If not, we will approve the member to see the
out-of-network provider at the higher benefit level. To request a waiver,
please use our Higher Level of Benefit Waiver Request Form on our website. Contact us at (833) 591-2978 if you have any questions.

Note: St. Luke's Health Plan does not require members to obtain referrals before seeing a specialist.

Informal Reconsideration and Claims Inquiry Requests

When an issue arises regarding claims payment between a provider and St. Luke's Health Plan, resolution will be attempted by discussions in good faith between appropriate representatives of both parties. We are often able to resolve concerns or inquiries over the phone or email, without further action being required. These requests should be initiated within 12 months of the date of service of the claim; however, this time limit may be extended when good cause can be shown by the provider. If you believe your claim was processed incorrectly, please contact Provider Relations at providernetwork@slhealthplan.org or Customer Service at customercare@stlukeshealthplan.org for assistance.

Provider Appeals

The Provider Appeals process should be used if a provider disagrees with a denial from St. Luke's Health Plan. Providers are required to submit a Provider Appeal within 180 days of the denial, using the Provider Appeals form on our website.

Provider Appeals include denials regarding:

- Medical Necessity
- Prior authorization
- Investigational or experimental determinations
- Application of coding edits or the coding of claims

Please note: this Provider Appeals process does not apply to appeals related to credentialing decisions, contract terminations, or member appeals initiated by a provider. For issues regarding credentialing and contracting, please email providernetwork@slhealthplan.org

Grievances

We strive to offer the highest quality of customer service. If you are dissatisfied with us for any reason other than a utilization management determination, you can file a grievance. Grievances can be submitted orally or in writing. If you want to submit your grievance in writing, you can use our Grievance Form, but you are not required to do so. Send completed forms via fax, email, or mail: Fax: 888-400-1654.

Email: appeals@stlukeshealthplan.org Mail: ATTN: Appeals Coordinator, St. Luke's Health Plan, PO Box 91010 Seattle, WA 98111 Questions? Call the Appeals Department at 833-353-0312.

Every grievance is carefully reviewed and investigated. We provide a written response to every grievance received, whether received verbally or in writing.

Pharmacy Benefits

Covered Medications

The St. Luke's Health Plan, Inc. Pharmacy Benefit Manager (St. Luke's PBM) administers pharmacy benefits to ensure our members have access to safe, effective and affordable medications.

A Drug Formulary is a comprehensive and complete list of medications covered by a health plan. The Formulary applies only to outpatient prescription medications. There is also a Prescription Drug List (PDL) that contains the most commonly prescribed medications in their most common strengths and formulations available at **stlukeshealthplan.org**. It is not a complete list of all medications covered by the Formulary.

The PDL is typically updated on a monthly basis. We do not routinely send notification when the PDL is updated. However, we do notify members negatively impacted by a formulary change, for example, if a medication they are currently taking is removed from the Formulary.

For questions about covered medications please call St. Luke's PBM at (**833) 975-1281**.

Pharmacy Network

Our pharmacy network is broad including all major national, regional and independent pharmacies across all 50 states including the District of Columbia, Guam, Puerto Rico and the Virgin Islands. A list of Idaho pharmacies is available at available on our website. For questions about the pharmacy network, please call St. Luke's PBM at **(833) 975-1281**.

Maintenance Medications and Home Delivery

St. Luke's Health Plan offers a maintenance Pharmacy Benefit, allowing members to obtain up to a 100-day supply of certain medications through St. Luke's Outpatient Pharmacies, St. Luke's Medication Lockers or St. Luke's Home Delivery. To connect with the St. Luke's Home Delivery, call **(208) 706-6245**.

Specialty

Specialty medications are high-cost medications used to treat rare or complicated conditions such as cancer, rheumatoid arthritis, and multiple sclerosis. Most specialty medications must be filled through St. Luke's Specialty Pharmacy. The St. Luke's Specialty Pharmacy offers best-in-class care and support. To learn more about the preferred specialty pharmacy, call **(208) 205-7779**.

Prior Authorizations

Any medication on the PDL with a "PA" next to it requires Prior Authorization. Prior Authorization is also required for any medication that is prescribed in such a way that it exceeds specified Plan limits in terms of quantity, duration of use and/or maximum dose. The most current information regarding whether a medication has a Prior Authorization can be found on our website. To submit a Prior Authorization request for a medication, please call the St. Luke's PBM at **(833) 975-1281** or fax the Prior Authorization form to **833-850-0172**. If a medication requires Prior Authorization, please verify the Prior Authorization has been obtained before having the member purchase the medication. Members can choose to buy these medications without Prior Authorization in place, but they will not be covered.

Step Therapy

Certain medications require the member to have already tried an alternative medication preferred by St. Luke's Health Plan. This process is called "step therapy". The alternative medication is generally a more cost-effective therapy that does not compromise clinical quality. If you feel that the alternative medication does not meet your patient's needs, St. Luke's Health Plan may cover the medication without step therapy if St. Luke's Health Plan determines it is Medically Necessary. Medication samples may not be applicable to satisfying the step therapy requirement.

Prescription medications that require step therapy are identified on the Prescription Drug List. The letters "ST" appear next to each medication that requires step therapy.

Exceptions Process

If any of the following apply, you can request an exception through the Prior Authorization process by calling **(833) 975-1281**:

1. Your patient requires a certain drug that is not on our Formulary;
2. You believe your patient should not be subject to Step Therapy requirements;
3. Your patient has already met the Step Therapy requirements;
4. Your patient needs a medication prescribed in such a way that it exceeds our limits in terms of quantity, duration, or dosage.