## St. Luke's Health Plan

# Provider Manual

St Luke's™ Health Plan

# Table of Contents


Welcome to St. Luke's Health Plan ..... 3
Contacting Us ..... 4
Member ID Card ..... 5
Provider Portal Tools ..... 6
Claim Status Inquiry ..... 8
Medical Policies ..... 8
Provider Network ..... 9
Credentialing and Re-credentialing ..... 9
Diversity, Equity and Inclusion (DEI)Training ..... 10
Members' Rights and Responsibilities ..... 10
Provider Directory and Data Management 10
Claims, Billing and Payments ..... 11
Claims Filing Deadlines ..... 11
Prompt Filing ..... 11
Corrected Claims ..... 12
Overpayment Recovery ..... 12
Claims Submissions ..... 12
Electronic Claims Payments and Electronic Remittance Advice ..... 12
Clearinghouse Options ..... 13
Claims Payment Policies ..... 13
Anesthesia Claims ..... 13
Baby's Birth Weight ..... 14
Telehealth ..... 14
Incident To Billing ..... 15
Modifiers ..... 15
Bilateral Procedures ..... 17
Multiple Procedures ..... 17
Multiple and Bilateral Procedures Performed in Same Operative Session ..... 18
Lab Collection and Handling Codes ..... 19
Professional Services Billed on a UB-04 form ..... 19
Claims Editing ..... 19
Drug Billing/Claims Requirements ..... 19
Claims Auditing ..... 19
Fraud Waste and Abuse ..... 19
Observation and Inpatient Admission Policy ..... 19
Coordination of Benefits (COB) ..... 20
Durable Medical Equipment ..... 20
Oxygen Rental and Supplies ..... 20
Skilled Nursing Facility Services ..... 22
Medical Management ..... 25
Population Health Management ..... 25
Shared Decision-Making Aids ..... 25
Medical Necessity and Coverage ..... 25
Prior Authorization ..... 25
Authorization Submission ..... 26
Retroactive Authorization ..... 26
Emergency or Urgent Services ..... 26
Notification for Emergency Admissions ..... 26
Concurrent Review, Discharge Planning and Coordination ..... 26
Care Management Program ..... 27
Higher Level of Coverage Waiver ..... 27
Referrals ..... 27
Appeals ..... 27
Provider Claims Appeals and Informal Reconsideration ..... 27
Provider Appeals on Behalf of a Member . 28
Pharmacy Benefits ..... 28
Covered Medications ..... 28
Pharmacy Network ..... 29
Maintenance Medications and Home Delivery ..... 29
Specialty ..... 29
Prior Authorizations ..... 29
Step Therapy ..... 29
Exceptions Process ..... 29

# Welcome to St. Luke's Health Plan

**Hello.** We're St. Luke's Health Plan. 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 other medical professionals across the healthcare spectrum, St. Luke's Health Plan aims to remove many of the common barriers that are often associated with health insurance. This means fewer prior authorization 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.

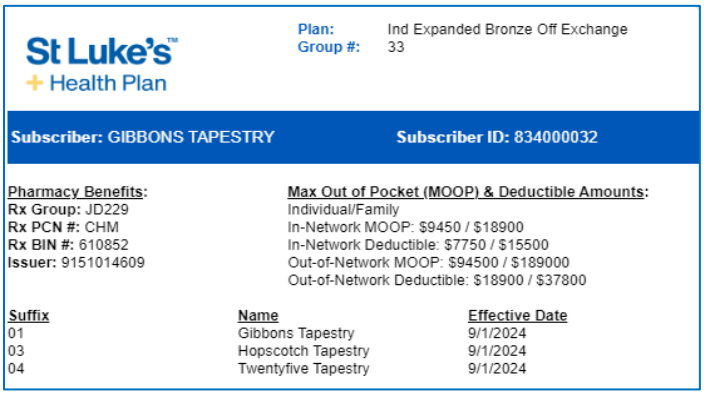
# Contacting Us

We are 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 that you and your office staff need when you see a St. Luke's Health Plan member.

| Area | Topics | Email | Phone |
|---|---|---|---|
| **Customer Service** | Benefits and eligibility, ID cards, other plan inquiries | customerservice@slhealthplan.org | 833-840-3600 |
| **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 |
| **Utilization Management** | Prior authorizations, medical management | preauthcommercial@slhealthplan.org | 833-840-1222 |
| **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. Providers can view ID cards on the provider portal (Community Link), and members can view ID cards and download a digital version in their MyChart account. ID cards contain information that is required to identify eligibility, benefits, network and claims submissions.



St Luke's
Health Plan

Plan: Ind Expanded Bronze Off Exchange
Group #: 33

**Subscriber:** GIBBONS TAPESTRY **Subscriber ID:** 834000032

**Pharmacy Benefits:**
**Rx Group:** JD229
**Rx PCN #:** CHM
**Rx BIN #:** 610852
**Issuer:** 9151014609

**Max Out of Pocket (MOOP) & Deductible Amounts:**
Individual/Family
In-Network MOOP: $9450 / $18900
In-Network Deductible: $7750 / $15500
Out-of-Network MOOP: $94500 / $189000
Out-of-Network Deductible: $18900 / $37800

| Suffix | Name | Effective Date |
|---|---|---|
| 01 | Gibbons Tapestry | 9/1/2024 |
| 03 | Hopscotch Tapestry | 9/1/2024 |
| 04 | Twentyfive Tapestry | 9/1/2024 |

**In-Network:**

St. Luke's Health Partners

**Out-of-Area Preferred:**

First Choice Health. First Health Network

To locate an in-network provider scan QR code or visit www.stlukeshealthplan.org/find-a-doctor

**EDI Payer ID: 92170**

**Contact information:**
Stlukeshealthplan.org
800 E. Park Blvd
Boise, ID 83712

Customer Service: (833) 840-3600
Prior Authorizations: (833) 840-1222
Pharmacy Help Desk: (833) 975-1281

**Prior authorization**: Inpatient admissions and certain outpatient services require prior authorization. Please refer to your Summary Plan Document for details.
**This card does not guarantee coverage.**

# Provider Portal Tools

*St. Luke's Health System providers with Epic access will have access to many of these features and may not require portal access.*

The St. Luke's provider portal, called Community Link, is our secure website through Epic to view claims, request or check the status of prior authorizations, check member benefits and more. Community Link is available at https://epiccarelink.slhs.org/EpicCareLink/common/epic_login.asp.

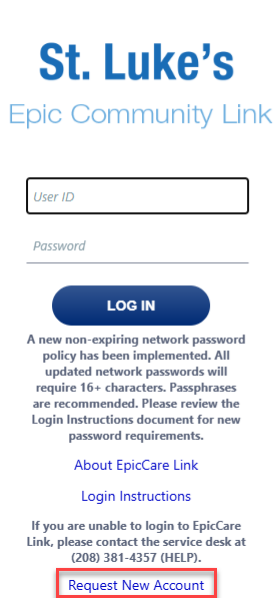
Through Community Link you will be able to:

- **Securely communicate.** Use the in-basket feature to reach the Health Plan's customer service and provider relations teams to resolve your questions.
- **Review insurance information.** Members' coverage and benefits information will be available for reference.
- **Manage prior authorizations.** Providers and staff can submit prior authorization requests electronically and upload additional clinical information. You can also see the status of your authorization requests in real time and view authorization determination letters.
- **Review and track claims.** Claim status can be reviewed even before they have been fully processed.

Once you have been approved for access, a comprehensive user guide is available under the Quick Links section, click the Education link. Under the St. Luke's Health Plan Provider Portal Education, click Provider Portal Quick Start Guide.

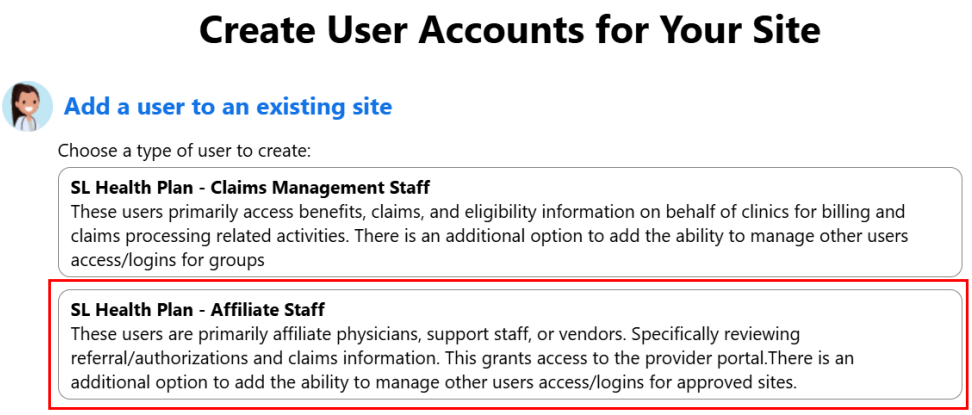
To register go to epiccarelink.slhs.org

From the St. Luke's Epic Community Link homepage, click **Request New Account**.



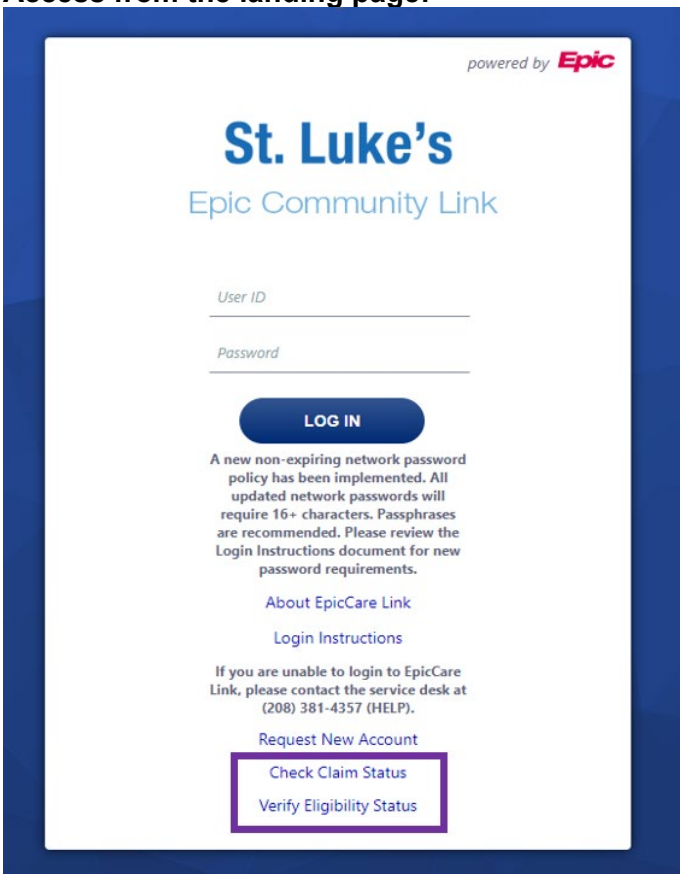

From the Create User Accounts for Your Site menu, click **Add a user to an existing site**.

Choose **SL Health Plan – Affiliate Staff**.

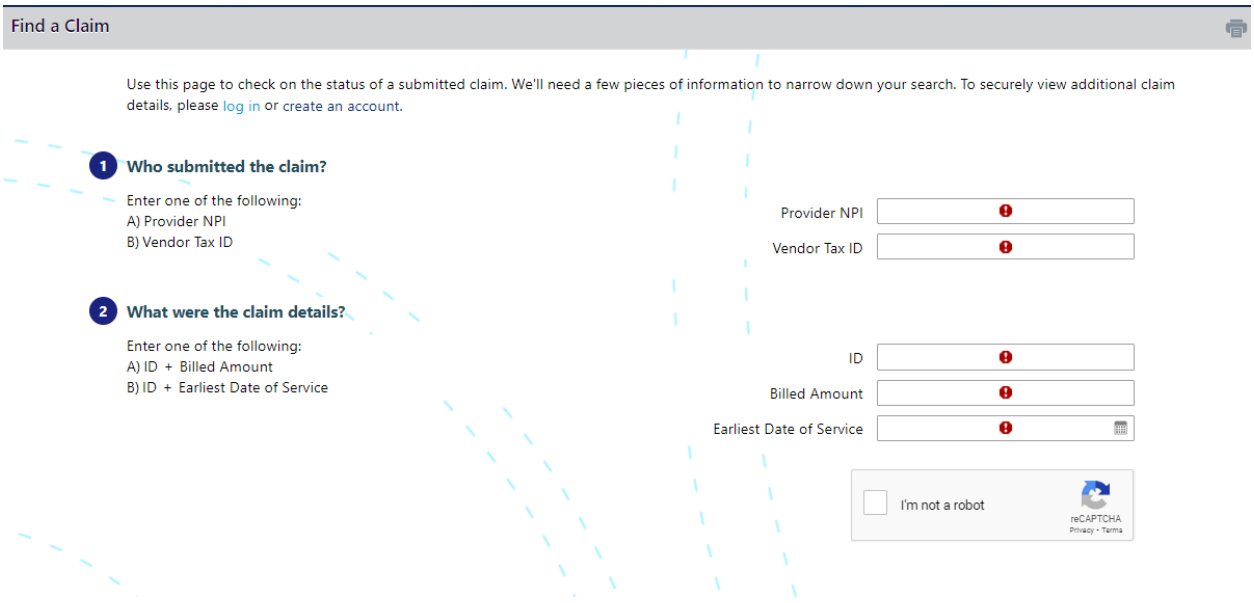



Complete all the required fields on the form and click **Submit Request.**

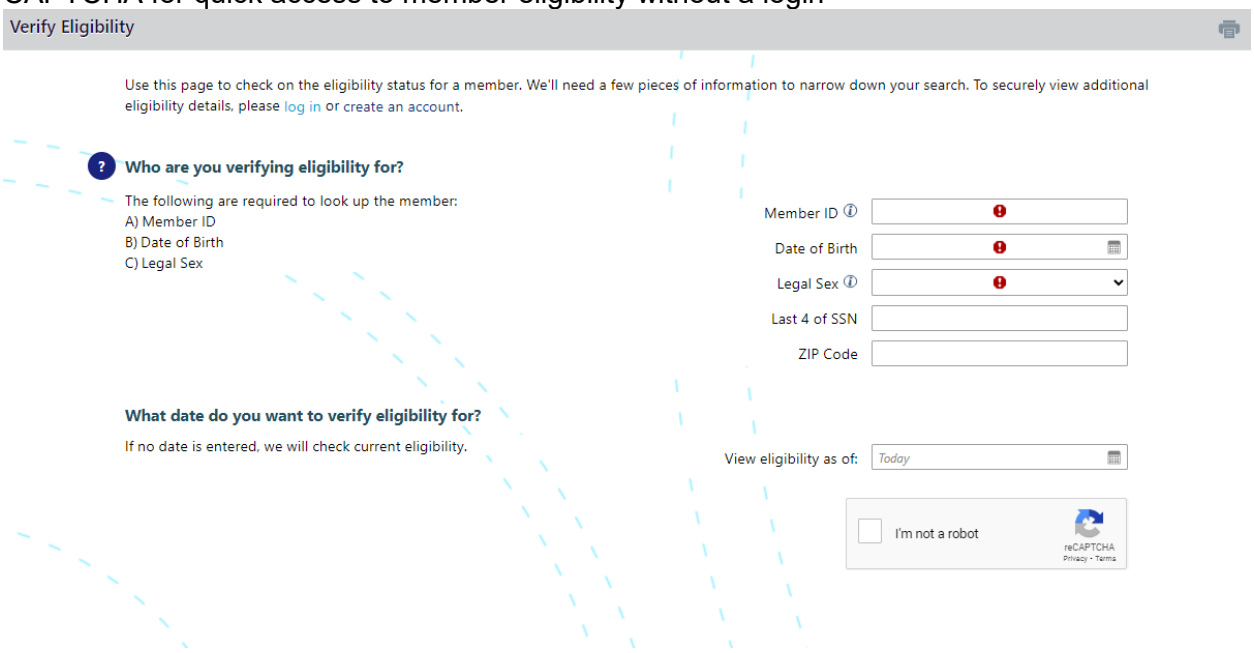
**If you don't have a log in to the portal and need quick access without a log in Guest Access from the landing page:**




Click on Check Claims Status to fill out Provider NPI, Tax ID, Member ID, Billed Amount of the claim and Earliest Date of Service, then click the CAPTCHA for quick access to a claim without a login.




Click on Verify Eligibility fill out the Member ID, Date of Birth, Legal Sex, then click the CAPTCHA for quick access to member eligibility without a login




## Claim Status Inquiry

Claims status can be reviewed on our provider portal at epiccarelink.slhs.org or by calling our customer service team at 833-940-3600.

## Medical Policies

Medical policies may be available upon request.

# Provider Network

St. Luke's Health Plan provides coverage for members through St. Luke's Health Partners and BrightPath within the 20-county service area. Members can also receive care from our partners First Choice and First Health Network for care outside the service area. Please refer to Master Policy for coverage of in-network and out-of-network services.

When receiving care within the service area, 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, First Choice Health and First Health will be at the in-network benefit level.

Information for credentialing, the provider directory and data management for St. Luke's Health Partners providers are included here. Please note that all wrap providers should contact First Choice Health or First Health directly for network management.

| Network | Network Status | Service Area | Phone | Website |
|---|---|---|---|---|
| **SLHP & BrightPath** | 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 | 800-467-5281 | https://myfch.sapphirethreesixtyfive.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/ |

## 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 St. Luke's Health Partners, 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. St. Luke's Health Partners

formally re-credentials its practitioners at least every three (3) years to assess and evaluate a provider's or facility's ability to deliver quality care between credentialing and re-credentialing cycles.

The contracting and credentialing team allows St. Luke's Health Partners 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 the National Committee for Quality Assurance (NCQA) and complies with state and federal statutes.

St. Luke's Health Partners 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 participants 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: SLHealthpartners@slhs.org.

## Diversity, Equity and Inclusion (DEI)Training

To support our providers in delivering care to diverse populations, St. Luke's Health Plan offers the "Think Cultural Health" e-learning program, created by the U.S. Department of Health and Human Services. This program provides knowledge, skills and awareness to effectively serve your patients. It is available at no cost, and physicians, physician assistants and nurse practitioners can earn continuing education credits.

Access the training here: https://thinkculturalhealth.hhs.gov/education/physicians.

## Members' Rights and Responsibilities

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

To ensure members have easy access to the Members' Rights and Responsibilities notice. This essential information it is always available on St. Luke's Health Plan website. Members can conveniently access these by visiting Member Rights & Responsibilities at: 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 ninety (90) days to ensure provider demographic information is current and accurate. St. Luke's Health Partners 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 compliant.

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 the changes or termination of a specific practice address. Include your NPI and Tax Identification Number (TIN) to ensure accuracy in processing the request.

- **To change/add a billing address:** A billing address is the "pay to" address 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 TIN to ensure accuracy in processing the request.

- **To update or change a Tax Identifier Number (TIN):** Email a W-9 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 TIN to ensure accuracy in processing the request.

If provider information changes are not submitted in a timely manner, it may impact the accuracy of the claims processing. For more information and to access Provider Change Forms, visit the St. Luke's Health Partners website.

# Claims, Billing and Payments

Unless otherwise specified, "days" will reference calendar days and not business days.

## Claims Filing Deadlines

Claims must be submitted to St. Luke's Health Plan within the following timeframe (whichever is later): Three hundred and sixty-five (365) days from the date the service/supply was rendered or three hundred and sixty-five (365) days from the date the claim was paid by the primary insurance per the Explanation of Payment (EOP), when St. Luke's Health Plan is not the primary insurer.

## Prompt Filing

Claims are required to be submitted within three hundred and sixty-five (365) days from date of service. If a claim is not received within prompt filing deadlines, the claim will be denied.

## Corrected Claims

Requests for claims adjustments or corrections must be submitted within three hundred and sixty-five (365) days 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.

## Overpayment Recovery

St. Luke's Health Plan may initiate recoupments of an overpayment. Overpayments are subject to auto recovery. This means that an auto recovery could be taken in the next paid claims payment run immediately following the overpaid claims adjustment.

If auto-recovery cannot be completed within thirty (30) days, we will send a refund request letter, with a follow-up letter after sixty (60) days. If after ninety (90) days monies cannot be recouped, your account will be sent to a third-party to collect.

## 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 **92170**. Please note the following when submitting EDI claims:

- **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 P.O. 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
800 E Park Blvd
Boise, ID 83712

Claims can also be submitted via Community Link.

## Electronic Claims Payments and Electronic Remittance Advice

St. Luke's Health Plan processes electronic claims payments (ECP) using InstaMed, a JP Morgan product. InstaMed accelerates and improves efficiency of claims payment processing and provides:

- Use of an online portal for no-fee Automated Clearing House (ACH) direct payments
- Improved cash flow with faster payments and secondary filing/patient collections
- Access to your payment remittance remotely and securely 24/7
- Streamlined reconciliation with automated payment posting capabilities

- Electronic remittance advice (ERA) via download (835, PDF) or clearinghouse delivery. Payment remittances are stored securely online for seven (7) years

To register for InstaMed:
- Visit https://register.instamed.com/eraeft to start the registration process.
- For more information or assistance, please call 866-467-8263 or email support@Instamed.com.

### Clearinghouse Options
If you do not currently work with a clearinghouse for claims submission, Office Ally, our preferred clearinghouse partner, offers a free service option for electronic claims submissions. Register at https://cms.officeally.com.

# Claims Payment Policies

This section covers any type of service where the provider's contractual allowance is affected by certain billing methodologies. Unless otherwise specified, St. Luke's Health Plan pays claims in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines.

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

- St. Luke's Health Plan requires time-based anesthesia services be reported with actual anesthesia time in one-minute time increments.
    - If time units are 0.5 or greater, units will be rounded up the nearest unit.
    - If time units are less than 0.5 units, units will be rounded down the nearest unit.
- 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).

| Modifier | Modifier Description |
|---|---|
| **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/cents 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 denied.

## Telehealth

St. Luke's Health Plan recognizes federal and state regulations and mandates regarding telehealth services.

**Telehealth services include but is not limited to:**

- Telehealth visit means healthcare services conducted with technology that includes live real-time audio and video communication between the member 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 seven (7) days. Only eligible services will be reimbursed.
- Electronic visit (evisit) 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 and St. Luke's eVisit Claims:**

- Bill 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 rate.
- Originating site fees are not reimbursable.

**Audio-Only Telehealth -93 Modifier**
Synchronous telemedicine refers to a real-time interaction between a physician or qualified healthcare professional and a patient who is located at a distant site.

For the telemedicine service to be considered equivalent to an in-person visit, the communication between the healthcare provider and the patient must be comprehensive enough to meet the same key components and requirements as the corresponding face-to-face service.

Services billed with a -93 modifier will only be eligible for payment if they are billed using a CPT code listed in Appendix T of the American Medical Association (AMA) CPT coding guidelines. Claims submitted with codes outside this range will be denied to provider write-off.

## Incident To Billing

St. Luke's Health Plan allows "incident to" billing for healthcare professionals who are not eligible to be credentialed by St. Luke's Health Partners. We do **not** allow "incident to" billing for providers who are eligible for credentialing.

For services to be billed under the "incident to" status. The following guidelines are required:

- If required, must hold an active license required by law and must work under the supervision of a physician or qualified non-physician provider.
- If a license is not required, must work under the supervision of a physician or qualified non-physician provider.
- The services must be medically necessary.
- Services billed under "incident to" must be billed under the credentialed supervising provider.
- Medical records must be authenticated by both the rendering and supervising providers.

## Modifiers

St. Luke's Health Plan recognizes valid CPT, HCPCS and modifier codes, although not every modifier code will affect a negotiated allowable. There may be modifiers billed that do impact pricing. The following modifier table is not inclusive of all modifiers that may or may not warrant a change in reimbursement. 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 the Health 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, 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 based on contract. |
| **50** | Bilateral procedure | 150% of allowable. |
| **51** | Multiple procedure | Reduce allowable by 50%. |
| **52** | Reduced services | Upon medical review, if determined appropriate, recommended reimbursement reduce allowable |

| | | |
|---|---|---|
| | | by 50%. |
| **53** | Discontinued procedure | Upon medical review, if determined appropriate, recommended reimbursement 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, a determination is made on how much of the procedure was not done. It is then reduced by 50%. |
| **74** | Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia | Upon medical review, 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.

## Multiple Procedures

Multiple surgeries are separate procedures or services performed during the same session or on the same day, for which separate billing is allowed. This applies to professional, hospital, other facility claims and scope procedures. Unless specified, reductions will apply in the following cases:

- When multiple procedures are performed on the same day or at the same session by the same provider, the primary procedure or service should be reported.
- Any additional procedures or services should be billed with modifier -51 on each additional procedure/service.

- Procedure codes that are classified as multiple procedures in the CMS Billing Manual and coding guidelines as “2” or “3” as outlined the Medicare Physician Fee Schedule, “Y” as outlined Ambulatory Surgery Centers CMS Addendum, “T” as outlined on the CMS Outpatient Prospective Payment System (OPPS) addendum and will be processed according to CMS multiple procedure guidelines.

St. Luke’s Health Plan will use the following payment structure for multiple procedure claims:

- Primary procedure/services: 100% of the fee allowance or billed charges whichever is less.
- Any subsequent procedures/services: 50% of the fee allowance billed charges whichever is less.

Multiple procedure reductions will not apply in the following cases:

- Evaluation and management services billed on the same date of services
- If the code is modifier -51 exempt or an add-on code, it will be processed using 100% of the contracted allowed

Please make sure when you are billing for multiple procedures that you submit the full billed amount. Our system will not recognize when a code(s) has already been reduced, and we will reduce again according to the multiple surgery guidelines.

## Multiple and Bilateral Procedures Performed in Same Operative Session

Bilateral procedures performed during the same operative session should be identified by adding modifier 50 to the appropriate CPT code. A single claim representing all services should be billed.

Bilateral procedures are reimbursed according to the following guidelines:

- First bilateral procedure = 150% percent of the fee schedule allowance, not to exceed billed charges.
- Second bilateral procedure = 50% of the fee schedule of the bilateral allowance (150% of the fee schedule) for the procedure equaling 75%, not to exceed billed charges.

When billing two bilateral procedures:

- Primary bilateral = 150% of the fee schedule allowance for the procedure, not to exceed billed charges
- Secondary bilateral = 50% of the fee schedule of the bilateral allowance for the procedure equaling 75%, not to exceed billed charges.

When billing a primary, unilateral procedure and a secondary bilateral procedure:

- Primary procedure = 100% percent of the fee schedule allowance for the procedure, not to exceed billed charges
- Secondary bilateral procedure = 50% percent of the fee schedule of the bilateral allowance for the procedure equaling 75%, not to exceed billed charges.
- When billing a primary bilateral procedure and a secondary non-bilateral procedure:
    - Primary bilateral = 150% of the fee schedule allowance for the procedure, not to exceed billed charges.
    - Secondary procedure = 50% of the fee schedule allowance for the procedure, not to exceed billed charges.

## Lab Collection and Handling Codes

The following procedures will be denied as unbundled when billed with any E&M, procedure, or laboratory codes:

- CPT 36415 – collection of venous blood by venipuncture
- CPT 36416 – collection of capillary blood specimen

The following procedures will be denied as unbundled when billed with any E&M code:

- CPT 99000 – handling and/or conveyance of a specimen for transfer from a physician's office to a laboratory
- CPT 99001 - handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory
- CPT 99002- handling, conveyance, and/or any other service in connection with the implementation of an order involving devices (eg, designing, fitting, packaging, handling, delivery or mailing) when devices such as orthotics, protectives, prosthetics are fabricated by an outside laboratory or shop but which items have been designed, and are to be fitted and adjusted by the attending physician or other qualified health care professional

## Professional Services Billed on a UB-04 Form

Professional services submitted on a UB-04 form will be denied. To be eligible for reimbursement, professional services must be billed using the CMS 1500 form.

## Claims Editing

Unless specified, St. Luke's Health Plan follows CMS guidelines and utilizes claim editing software to promote correct coding, billing and editing practices within our organization.

## Drug Billing/Claims Requirements

St. Luke's Health Plan requires the National Drug Code (NDC) number when billing drug-related claims for outpatient and professional claims. All drug-related claims must include the NDC number, quantity and unit of measurement to be considered for reimbursement. This requirement will apply to CMS-1500, UB-04, and Electronic Data Interface (EDI) transitions.

## Claims Auditing

St. Luke's Health Plan reserves the right to audit claims for appropriate payment in compliance with provider agreements, policies, procedures, state and federal regulations and our Provider Manual.

## Fraud Waste and Abuse

St. Luke's Health Plan is committed to maintaining the integrity of our healthcare programs and safeguarding resources for those we serve. We actively investigate all instances of suspected fraud, waste and abuse (FWA) to ensure compliance with applicable laws and regulations.

Providers are expected to report any concerns or suspected FWA promptly. Our team reviews all reports thoroughly and confidentially to take appropriate action. To report FWA, providers may contact the Health Plan's Compliance Hotline (866) 291-4324 or email us at slplancompliance@slhs.org.

## Observation and Inpatient Admission Policy

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

A patient admitted for 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 forty-eight (48) hours should be billed in the non-covered column.

When a patient is admitted as inpatient, the inpatient calculation we will be based on the admission date.

## 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 order of benefit determination rules governs the order in which each plan will pay a claim. 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 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule identifies capped rental items as category CR. After thirteen (13) months of rental, a beneficiary owns the capped rental DME item and St. 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 (4) to thirteen (13).

## Oxygen Rental and Supplies

St. Luke's Health Plan processes oxygen and oxygen equipment-related claims according to CMS guidelines. Noridian documentation is linked here for reference: Noridian Healthcare Solutions/Oxygen.

Reimbursement for oxygen equipment is limited to thirty-six (36) monthly rental payments. During the 36-month capped rental period, oxygen contents are considered incidental to/included in the equipment rental and are not separately payable.

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the 36 monthly payments for stationary equipment. If monthly rental is paid for a stationary unit (concentrator, gaseous or liquid) then contents are not payable for stationary or portable equipment.

Once the cap on the stationary oxygen equipment is reached, the supplier can start billing separately for the contents (stationary and/or portable, as applicable). If the portable oxygen equipment has not met the 36-month cap, payment for the portable equipment would continue

until the end of the 36-month rental period for that equipment even though payment was also being made for the portable contents.

If the patient requires greater than four (4) liters per minute (LPM) of oxygen and meets the requirements for portable oxygen, payment made for the stationary system is at a higher level.

**Reasonable useful lifetime (RUL)**

- The reasonable useful lifetime for oxygen equipment is five years (60 months). The RUL is not based on the chronological age of the equipment; It starts on the initial date of service and ends five years from that date. If there is a change in oxygen equipment modalities, e.g., from a concentrator to a stationary liquid oxygen system, prior to the end of the RUL period, this does not result in the start of a new RUL period or a new 36-month payment period.
- If oxygen equipment isn't functioning properly and needs to be replaced prior to the end of the RUL period, the action does not result in the start of a new RUL period or a new 36-month payment period.
- If the beneficiary switches to a new supplier and new equipment prior to the end of the RUL period, the action does **not** result in the start of a new RUL period or a new 36-month payment period. After the 36-month RUL period ends, the member will pay no more rental fees, and the supplier will still own the equipment. The member can keep the equipment for up the twenty-four (24) additional months. For continued use of oxygen tanks and cylinders, the member's benefit would apply. At the end of the 60-month period the member has the choice to either get new oxygen equipment from your current supplier or switch suppliers which restarts the 36-month rental period.

| **Equipment*** | | **Contents Payment after 36-month Cap** | | |
|---|---|---|---|---|
| Description | **HCPC Code(s)** | **Payment** | **Description** | **HCPC Code(s)** |
| Stationary oxygen concentrator | E1390 | None | N/A | N/A |
| Stationary oxygen concentrator | E1391 | None | N/A | N/A |
| Portable oxygen concentrator | E1392 | None | N/A | N/A |
| Portable gaseous transfilling equipment | K0738 | None | N/A | N/A |
| Portable liquid transfilling equipment | E1399 | None | N/A | N/A |
| Stationary gaseous oxygen system | E0424 | Yes | Stationary gaseous contents | E0441 |
| Stationary liquid oxygen system | E0439 | Yes | Stationary liquid contents | E0442 |
| Portable gaseous oxygen system | E0431 | Yes | Portable gaseous contents | E0443 |
| Portable liquid oxygen system | E0434 | Yes | Portable liquid contents | E0444 |

**Contents are considered incidental to/included in the equipment rental and are not separately payable.*

If a member enters a hospital or skilled nursing facility (SNF) or joins a Medicare HMO and continues to need/use oxygen, once member returns home the payment will resume where left off.

**Break in medical necessity (break in need):** If need/use of oxygen ends for less than sixty (60) days, plus the remainder of the rental month of discontinuation and then resumes, payment resumes where it left off.

- During the 36-month rental period, if need/use of oxygen ends for more than sixty (60) days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new 36-month rental period would begin.
- During months 37-60, if need/use of oxygen ends for more than sixty (60) days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new rental period does not begin. The supplier who provided the oxygen equipment during the 36-month rental month must provide all necessary items and services for the duration of the RUL.

**Ventilators**

St. Luke's Health Plan will approve ventilator equipment as a rental item only and will not cap the purchase price. Specific member plan limitations and medical necessity determines coverage.

## Skilled Nursing Facility Services

St Luke's Health Plan will provide reimbursement for skilled nursing facility (SNF) services when the services are medically necessary, meet the criteria for skilled care and are rendered in an appropriately certified facility.

**1. Medical Necessity Criteria**

To be eligible for payment of SNF services, the following conditions must be met:

- **Post-acute care need:** The member must require skilled nursing services due to a condition that warrants intensive, ongoing care following a hospitalization. This includes, but is not limited to, post-surgical recovery, rehabilitation following a stroke, or medically complex conditions requiring nursing supervision and/or therapy services.
- **Skilled care requirement:** The care provided must be "skilled" in nature, meaning it requires the expertise of licensed nursing staff or other licensed healthcare professionals (e.g., physical, occupational, or speech therapists) to manage or assess the member's medical condition. This includes services like wound care, intravenous therapy, physical therapy and other medically necessary interventions that require professional supervision or administration.
- **Duration of stay:** The member must meet the eligibility criteria for continued stays. Payment will be authorized for the shortest duration necessary based on the member's clinical needs and progress toward goals. Authorization for extended stays will be subject to periodic reviews to determine ongoing medical necessity.

**2. Coverage Criteria**

- **Admission requirements:**
  The member must be admitted to the SNF directly following a qualifying inpatient hospital stay of at least three days (72 hours), unless the member is transitioning from another approved care setting, such as a rehabilitation hospital.
- **Appropriate SNF:**
  The SNF must be a Medicare-certified facility or one that meets state and federal regulatory requirements for skilled nursing care. Facilities that do not meet these standards will not be eligible for reimbursement.
- **Plan benefits and prior authorization:**
  Coverage for SNF services is subject to the member's specific health plan benefits, including any applicable limitations (e.g., number of days of coverage, co-payments, etc.). Prior authorization is required for all SNF admissions and levels of care to ensure that services meet medical necessity criteria. SNF services provided without prior authorization may be denied payment.

**3. Reimbursement Guidelines and Revenue Codes**
Per diem payments include, but not limited to, room and board (semi-private), professional nursing services, skilled services, rehabilitation therapies and social services.

The following reimbursement structure applies to SNF services based on the level of therapy provided:

- **Revenue Code 191 - Level 1:**
  - **Therapy requirement:** Two (2) hours of therapy per day, five (5) days per week
  - **Description:** For members who require a lower level of therapy (2 hours/day), typically for individuals with less complex conditions that require minimal skilled nursing services.
- **Revenue Code 192 - Level 2:**
  - **Therapy requirement:** three (3) hours of therapy per day, five (5) days per week
  - **Description:** For individuals who require a moderate level of therapy (3 hours/day), such as those recovering from moderate to severe conditions where therapy is a primary component of care.
- **Revenue Code 193 - Level 3:**
  - **Therapy requirement:** three (3) hours of therapy per day, five (5) days per week
  - **Additional care requirement:** Skilled nursing services, such as wound care, intravenous (IV) drug administration or other complex skilled nursing needs.
  - **Description:** For individuals with higher-level needs, including those requiring intensive therapy (3 hours/day) along with additional skilled nursing services (e.g., wound care, IV therapy, etc.).

**4. Exclusions**
St Luke's Health Plan will not provide reimbursement for the following SNF-related services:

- **Custodial care:**
  Services that do not require skilled care, such as custodial or maintenance care, will not be reimbursed. Custodial care includes non-skilled services such as assistance with activities of daily living (ADLs), unless they are part of a rehabilitative program or other medically necessary service.

- **Non-medically necessary services:**
  Services that do not meet the criteria for medical necessity or skilled care will not be reimbursed.
- **Non-certified facilities:**
  Services provided in a facility that is not Medicare-certified or otherwise does not meet regulatory requirements for skilled nursing care will not be reimbursed.
- **Respite care:**
  SNF stays intended solely for respite or long-term care purposes are not covered.

**5. Payment Structure**

- **Payment for skilled nursing services:**
  Payment will be made according to the contracted rate with the skilled nursing facility (SNF) as outlined in the provider agreement.
- **Co-payments and deductibles:**
  Members may be responsible for co-payments, co-insurance or deductibles, depending on their plan benefits. These amounts are outlined in the member's benefit documents and may vary based on the type of care provided.
- **Documentation and billing requirements:**
  All claims for SNF services must include complete and accurate documentation of the member's medical condition, the level of skilled care provided and any progress toward rehabilitation goals. Claims that lack sufficient documentation or do not meet medical necessity criteria will be subject to denial.

**6. Care Management and Re-Authorization**

- **Care management oversight:**
  Members receiving SNF care will be closely monitored by St. Luke's care management team to ensure that it remains medically necessary and appropriate. Periodic reviews of clinical progress and treatment plans will be conducted.
- **Re-authorization process:**
  If an extended stay in the SNF is required, re-authorization will be required at regular intervals. The member's care team must submit updated clinical information, including progress toward established goals, to justify the continued need for SNF care. The Health Plan reserves the right to review and deny payment for extended stays that are not supported by medical necessity.

**7. Appeal Process**

- **Denied claims:**
  If a claim for SNF services is denied based on lack of medical necessity, failure to meet criteria or other reasons, the provider or member may request an appeal by submitting relevant documentation supporting the necessity of the care.
- **Appeal timelines:**
  Requests for appeals must be submitted within thirty (30) days from the date of the denial notice. All appeals will be reviewed by the Health Plan's Medical Director or a designated peer reviewer with expertise in the relevant medical field.

# 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 healthcare 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 helps 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 counseling given to patients by providers and to facilitate discussion about treatment decisions. There is a free library of SDMs available on our website under "Member Resources" at 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 an 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 denied service, including those based on medical necessity.

## Prior Authorization

St. Luke's Health Plan only requires prior authorization for a few select services. Please use the new Prior Authorization Requirements tool in the Community Link portal, member plan documents or contact our Provider Relations team at (208) 385-3730 or email: providernetwork@slhealthplan.org.

## Authorization Submission

*St. Luke's Health System providers can submit authorization requests for our members **directly through Epic** using the 'electronic medical preauthorization,' or 'eMPA' tool. These providers do not need to use a separate portal to submit authorizations.*

For all other providers, authorization requests can be submitted via fax or electronically through Community Link. When submitting via fax (**833-840-3414)**, please use the Authorization Request Form available on our website.

To process and issue prompt determinations, submit all relevant clinical information when submitting the initial request. We will issue a determination for a standard, non-urgent authorization request within two (2) business days, so long as complete medical information to support the request is provided.

If additional information is needed to render a determination, we will request it and make a decision within two (2) business days of receiving it. Regardless of whether additional information is required or received, we will render a decision within fifteen (15) calendar days of receiving the request.

If the situation is clinically urgent, and there is evidence of urgency, a decision will be rendered within seventy-two (72) hours. If additional information is required for us to make a determination, we will notify you as soon as possible.

## Retroactive Authorization

St. Luke's Health Plan allows retroactive authorizations. Retroactive authorizations must be submitted via the prior authorization process within thirty (30) days of the claim denial date.

If you have any questions about the prior authorization process, including coverage criteria or submitting a request, contact the utilization management department by phone at 833-840-1222 or email at preauthcommercial@slhealthplan.org.

## Emergency or Urgent Services

Emergency services and urgent care services do not require a prior authorization. For urgent or emergent needs, please direct members to the nearest available facility for treatment.

## Notification for Emergency Admissions

The Health Plan requests that you give notice of any emergency admission by submitting a request via the Community Link portal or calling 833-840-1222 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).

## 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, the Health Plan will not pay for further hospitalization or treatment in the facility. The 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
- Long-term acute care
- Behavioral/mental health

- Chemical dependency
- Residential treatment
- Rehabilitation (acute inpatient rehabilitation)

Authorization requests can be submitted via the St. Luke's Health Plan's Community Link portal or fax to 833-840-3414.

### 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, nurses and pharmacists and registered dieticians. They support members with a wide variety of issues and conditions to help educate people about how to better manage their health or chronic condition. 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 member who might benefit from this program, please send the referral to St. Luke's Health Partners via email at caremanagement@slhs.org or call 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 may 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 Health or First Health 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 833-840-3600 if you have any questions.

### Referrals

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

# Appeals

### Provider Claims Appeals and Informal Reconsideration

When an issue arises between a provider and the Health Plan regarding claim denials, nonpayment of claims or claim allowance, 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 three hundred and sixty-five (365) days from the date of service or the first claim process date; however, this time limit may be extended when good cause can be shown by the provider.

If you believe your claim was processed incorrectly or if you have any questions, please contact provider relations at providernetwork@slhealthplan.org or 208-385-3730 or customer service at customerservice@slhealthplan.org or 833-840-3600 for assistance.

### Provider Appeals on Behalf of a Member

The appeals process should be used if a provider disagrees with a decision made by St. Luke's Health Plan. The timeline for filing an appeal is within one hundred and eighty (180) days of the denial date. Please use the Provider Appeals form on our website. Appeals submitted one hundred and eighty (180) days or more from the date of denial will be dismissed.

Provider appeals on behalf of a member include denials related to:

- Medical necessity
- Prior authorization
- Investigational or experimental determinations

Please submit your appeal through one of the following:

**Email**: slplanappeals@slheathplan.org

**Mail**:
ATTN: Appeals
St. Luke's Health Plan
PO Box 1739
Boise, ID 83702

# Pharmacy Benefits

### Covered Medications

St. Luke's Health Plan's Pharmacy Benefit Manager (St. Luke's PBM) administers pharmacy benefits through our dedicated in-house team 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. Visit **stlukeshealthplan.org**. Note it is not a complete list of all medications covered by the formulary.

The PDL is typically updated on a quarterly 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 or email rx@slhealthplan.org**.

## Pharmacy Network

Our broad pharmacy network includes most major national, regional and independent pharmacies across the U.S., including the District of Columbia, Guam, Puerto Rico and the Virgin Islands. A list of Idaho pharmacies is 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 complex 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 requires prior authorization can be found on our website.

To submit a prior authorization request for a medication, please submit it via electronic prior authorization (ePA) vendor, call the St. Luke's PBM at **(833) 975-1281** or fax the form to (**833) 850-0172**. 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 it is deemed medically necessary. Medication samples cannot be used to satisfy the step therapy requirement.

Prescription medications that require step therapy are denoted by the letters "ST" on the Prescription Drug List.

## 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.