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. 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

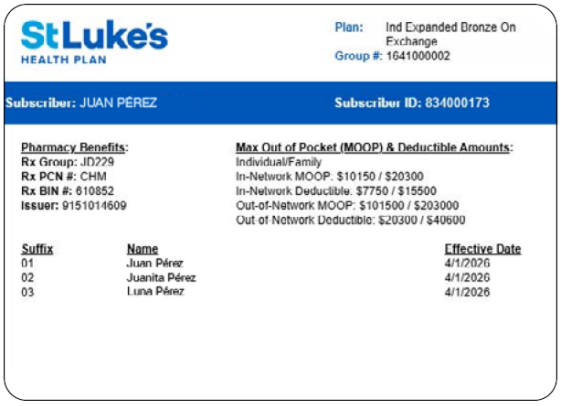
We are dedicated to giving our providers the highest quality service, with a commitment to working with you in a fair, honest and timely fashion. Please access this manual for basic information that you and your office staff need when you see a St. Luke's Health Plan member.

Area	Topics	Email	Phone
Customer Service	Benefits and eligibility, ID cards, other plan inquiries	customerservice@slhealthplan.org	833-840-3600 833-840-1212 *St. Luke's Health System Employee Plan*
Provider Relations	Informal inquiries, claims reconsiderations, payment/contract disputes, Open Negotiations, Independent Disputes, 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 833-840-7333 *St. Luke's Health System Employee Plan*
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 833-755-1282 *St. Luke's Health System Employee Plan*

Member ID Cards

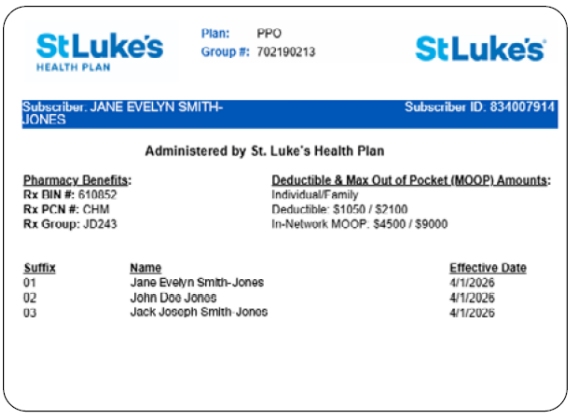
St. Luke's Health Plan members are issued a member identification (ID) card. Providers can view ID cards on the provider portal (Community Link), and members can view ID cards and download a digital version in their MyChart account. ID cards include important details used to verify a member's eligibility, understand their benefits, confirm their network and claim submission.

St. Luke's Health Plan member ID Card





St. Luke's Health System Employee member ID Card





Provider Portal Tools

St. Luke's Health System providers who have access to Epic may already have many of these features available and might not need to use the portal.

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

Through Epic Community Link you will be able to:

- **Securely communicate.** Use the in-basket feature to reach our 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.** View and monitor claim status, even before claims are 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 and follow these instructions.

Site Administrator Requirement

St. Luke's Health Plan requires each organization to designate at least one Site Administrator. This individual is responsible for:

- Managing user access
- Creating and maintaining user accounts
- Coordinating access requests
- Completing quarterly site verification requirements

Quarterly Site Verification Requirements

To maintain the security and integrity of patient information, St. Luke's Health Plan requires quarterly site verification.

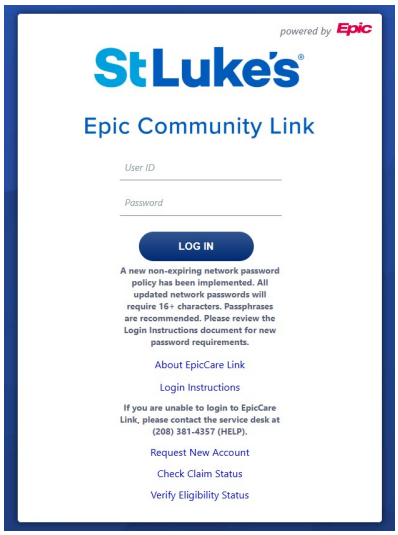
Site Administrators are responsible for completing the following:

- User Access Validation
    - Review and confirm all users with current access.
    - Deactivate accounts for individuals who have left the organization or no longer require access.
- Inactive User Review
    - Consider deactivating users who have not accessed the system within the past 90 days.

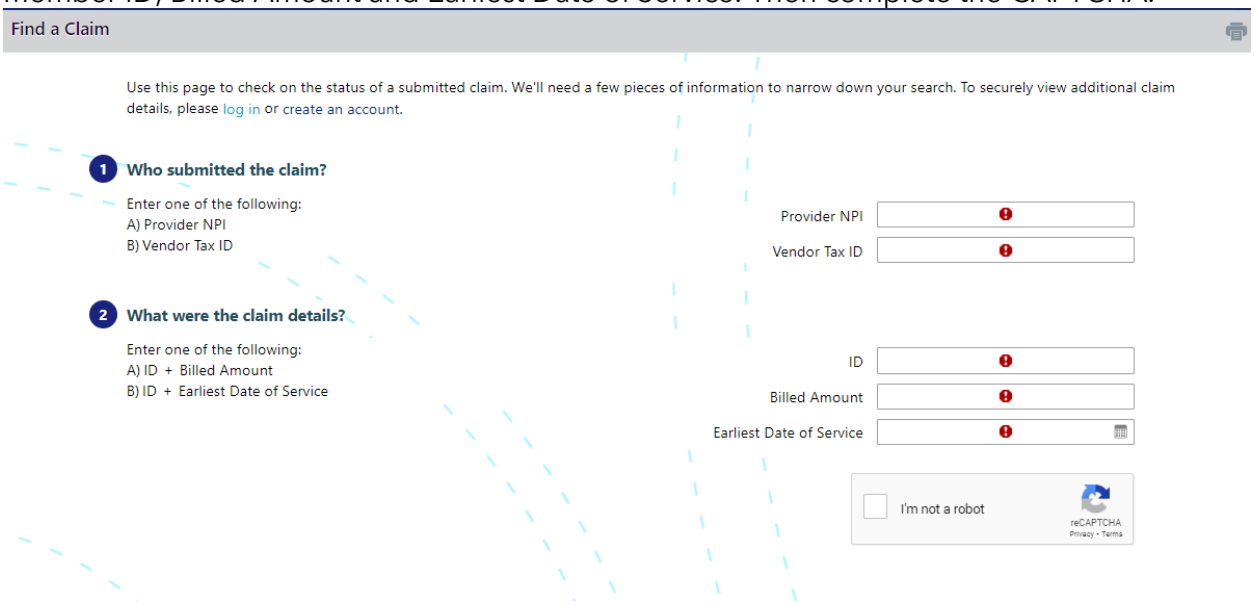
- User Compliance Reinforcement
    - Re-educate all users on the St. Luke's Health Plan Confidentiality and Network Access Agreement, emphasizing that access is strictly for authorized business purposes only.

Guest Access

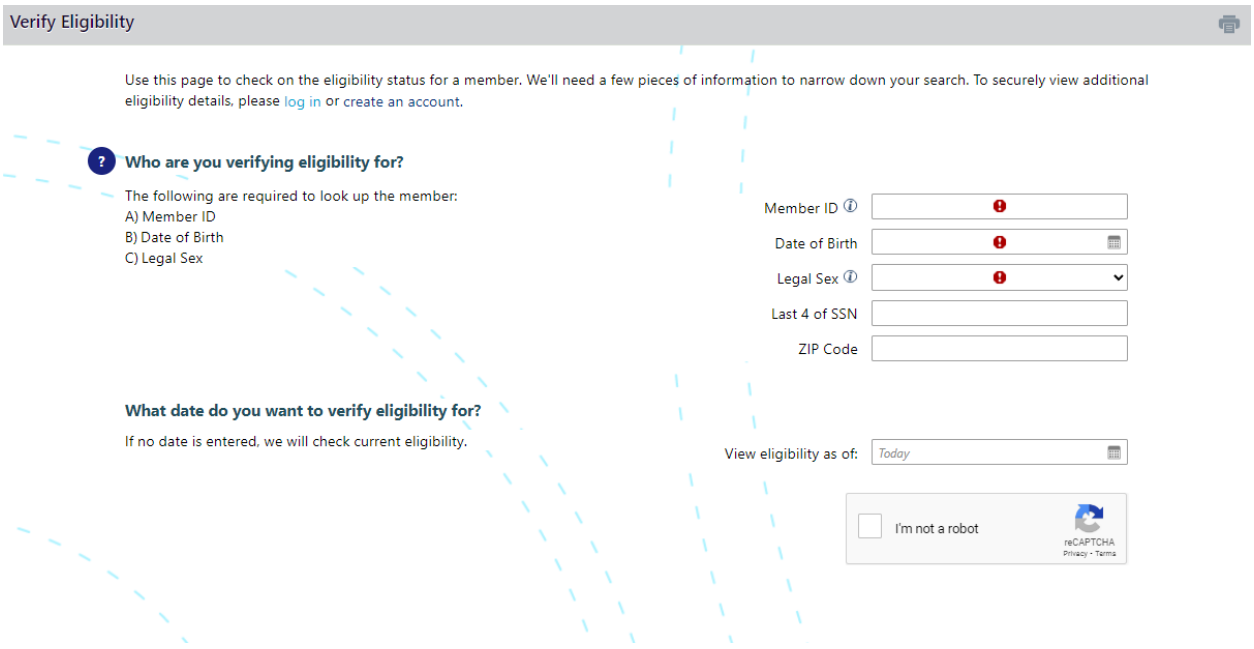
If you don't have a portal login and need quick access, you can use Guest Access from the landing page by clicking *Check Claim Status* or *Verify Eligibility Status*.



To quickly check a claim, click 'Check Claims Status' and enter the Provider NPI, Tax ID, Member ID, Billed Amount and Earliest Date of Service. Then complete the CAPTCHA."



To quickly verify member eligibility without logging in, click 'Verify Eligibility' and enter the Member ID, Date of Birth and Legal Sex. Then complete the CAPTCHA.



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.

Clinical Guidelines

St. Luke's Health Plan makes the clinical criteria used to support Utilization Management decision-making available to participating practitioners electronically through the Plan's website. Providers may access information regarding applicable clinical criteria online at: stlukeshealthplan.org/providers/clinical-guidelines/

Provider Network

St. Luke's Health Plan provides coverage for members through St. Luke's Health Partners (SLHP) and BrightPath within a 20-county service area. Members may also access care through our wrap network partners when outside the service area. For details on coverage of in-network and out-of-network services, please consult the Member's Plan Policy or visit stlukeshealthplan.org/find-a-doctor.

When receiving care within the service area, members will utilize St. Luke's Health Partners. When traveling or receiving emergent or non-emergent care outside the 20-county service area, services accessed through our out-of-area preferred network will be covered 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 the appropriate network directly for network management.

Network	Network Status	Service Area	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	stlukeshealthplan.org/find-a-doctor
Cigna PPO - Out of Area Preferred	In-network	Areas outside of 20-county service area	

Credentialing and Re-credentialing

St. Luke's Health Plan delegates credentialing activities to St. Luke's Health Partners within our 20-county 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 documentation. 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.

Culturally Competency 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 to conduct advanced analytics that automatically identify outdated, incomplete, or potentially inaccurate 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 your 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 along 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 your 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 three hundred and sixty-five (365) days from the date the services/supply was rendered or sixty (60) days after the servicing provider receives notice that St. Luke's Health Plan is secondary, whichever is later.

Prompt Filing

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

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 identify and recover claim overpayments resulting from claims processing errors, billing inaccuracies, coordination of benefits adjustments, retroactive member eligibility changes, regulatory requirements, or other payment corrections. Providers are encouraged to report identified overpayments promptly upon discovery.

Providers who identify an overpayment should notify St. Luke's Health Plan and return the overpaid amount within sixty (60) calendar days of identification. Written notification should include the reason for the overpayment and sufficient information to facilitate reconciliation.

Recovery Process

St. Luke's Health Plan utilizes an automated recoupment process for provider overpayments whenever permitted by applicable law and the provider agreement.

- Overpayments are generally subject to automatic recovery through offset against future claim payments.
- Automatic recovery may occur in the next available payment cycle following identification or adjustment of the overpayment.
- If the overpayment cannot be fully recovered through automatic recoupment within ninety (90) days, St. Luke's Health Plan may issue a written refund request.
- St. Luke's Health Plan reserves the right to pursue additional collection activities for unresolved overpayments as permitted by applicable law and provider contract terms.

Refund Request Disputes
Providers who disagree with an overpayment determination may submit supporting documentation for review through the claims reconsideration process. Supporting documentation may include, but is not limited to:

- An updated Explanation of Payment (EOP) or remittance advice;
- Coordination of Benefits (COB) information;
- Medical records or chart documentation supporting the original payment; or
- Other information relevant to the payment determination.

Submission of a dispute does not prevent St. Luke's Health Plan from exercising contractual recoupment rights unless otherwise required by applicable law.

St. Luke's Health Plan administers its overpayment recovery program in accordance with applicable federal and Idaho laws and regulations. St. Luke's Health Plan reserves the right to modify its recovery processes as needed to maintain compliance with regulatory requirements or contractual obligations.

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
P.O. Box 1739
Boise, ID 83712-5809

Claims can also be submitted via Epic Community Link.

Please note, all out-of-area Cigna contracted claims are required to be submitted to Cigna for pricing. Please follow the instructions on the back of the Member's ID Card.

Electronic Claims Payments and Electronic Remittance Advice

St. Luke's Health Plan processes electronic claims payments 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 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 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.

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.

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.

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 to be reported with actual anesthesia time in one-minute time increments.
    - If time units are 0.5 or greater, units will be rounded up to the nearest unit.
    - If time units are less than 0.5 units, units will be rounded down to 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

Anesthesia Start and Stop Times

For anesthesia services, providers are required to report the anesthesia start time and stop time on the claim to allow for accurate calculation and adjudication of anesthesia units. Claims submission requirements are as follows:

Electronic Claims (837P)

For electronic claims submitted using the 837 Professional (837P) transaction, anesthesia start and stop times must be submitted in the NTE (Note/Special Instruction) segment associated with the service line.

Paper Claims (CMS 1500)

Anesthesia start and stop times must be submitted in Box 24A of the CMS-1500 claim form as a Service Line Note (above the Date of Service).

Time Format Requirements

To ensure proper claims processing, anesthesia start and stop times must adhere to the following requirements:

- Times must be reported using 24-hour military time format.
- AM/PM designations are not permitted.
- Start and stop times must follow one of the accepted formats listed below to allow for automated parsing during claims adjudication.
- Providers may report anesthesia start and stop times using either of the following formats:

    - Format 1: STARTTIME #### STOPTIME ####
        - Example: Patient under anesthesia for 40 minutes, on the claim enter:
          STARTTIME 0800 **STOPTIME** 0840
    - Format 2: START #### STOP ####
        - Patient under anesthesia for 90 minutes, on the claim enter:
          START 1300 **STOP** 1430

      Additional service line notes may be included following the stop time if necessary.
        - Example: Patient under anesthesia for 90 minutes, with an additional note, on the claim enter:
          START 1300 **STOP** 1430 short note here.

Additional Guidance

- The anesthesia start time is defined as the time when the anesthesia provider begins preparing the patient for the induction of anesthesia.
- The anesthesia stop time is defined as the time when the anesthesia provider is no longer in personal attendance and the patient may be safely placed under post-operative supervision.
- Claims submitted without the required start and stop time information, or submitted in an incorrect format, may be subject to clearinghouse rejections, processing delays or denial due to incomplete billing information.

Providers are responsible for ensuring that anesthesia time documentation in the medical record supports the times reported on the claim.

Moderate (Conscious) Sedation with Diagnostic and Therapeutic Procedures

St. Luke's Health Plan allows separate reimbursement for sedation services (CPT 99151–99153) when performed by the same physician or qualified health professional performing the primary procedure.

Coverage Criteria

St. Luke's Health Plan may cover conscious sedation when the following criteria are met:

- Medical Necessity: Sedation is required due to patient anxiety, behavioral challenges, or procedural pain that cannot be managed by local anesthesia alone.
- Approved Setting: Services are performed in an appropriately equipped facility with trained personnel and monitoring consistent with current guidelines (e.g., ASA, ADA, or state requirements).
- Provider Qualifications: Sedation is administered by a qualified licensed provider trained in conscious sedation with appropriate monitoring and emergency capabilities.
- Documentation:
    - The medical record must clearly indicate
        1. The clinical indication for sedation
        2. Medications, dosage, and route
        3. Monitoring methods during and after the procedure
        4. Patient response and recovery status

Non-Covered Situations

- Conscious sedation will not be covered when:
    - Used for patient convenience or preference without medical necessity
    - Administered in an unapproved or inadequately equipped setting
    - Administered by providers not trained or credentialed for sedation
    - Used in conjunction with procedures already requiring general anesthesia, unless medically justified.

Billing and Coding

- Submit conscious sedation codes separate from the primary procedure, as allowed by CPT/HCPCS guidelines.
- Include appropriate modifier(s) and ensure documentation supports medical necessity for payment.
- Services provided concurrently with general anesthesia or deep sedation must be clearly documented and justified; otherwise, claims may be denied as duplicate or non-covered services.

Provider Responsibilities

- Ensure documentation supports the medical necessity of conscious sedation.
- Use appropriate CPT/HCPCS codes and modifiers for billing.
- Maintain current credentials, training, and facility equipment in compliance with local and national guidelines.

Medical Review

St. Luke's Health Plan reserves the right to review documentation for medical necessity and appropriateness of conscious sedation services.

Qualifying Circumstances Anesthesia Services

Claims containing qualifying circumstance CPT codes 99100–99140 are not eligible for separate reimbursement, whether billed alone or in combination with other services, as these codes are considered integral components of the primary procedure.

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) is 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, 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, the provider 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, the provider 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 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 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 would be priced next.
- Modifiers that do not alter the allowed contract 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 by 50%.
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	Reduce allowable 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. Only reimbursable when billed by a professional.
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 as 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	Reduce allowable by 50%.
53	Discontinued procedure	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	Reduce by 50%.
74	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia	100% of allowable.
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.

Non-Reimbursable Outpatient Services

Unless otherwise specified by contract, reimbursement policy, or benefit plan provisions, St. Luke's Health Plan follows applicable Centers for Medicare & Medicaid Services (CMS) guidelines and utilizes claim editing software to promote accurate coding, billing, and reimbursement practices.

Hospital Outpatient Services
Services assigned a CMS Outpatient Prospective Payment System (OPPS) Status Indicator of "N" are considered packaged services and are not separately reimbursable. Reimbursement for these services is included in the payment for the associated primary service or procedure.

Ambulatory Surgical Center (ASC) Reimbursement

Unless otherwise specified in the Participating Provider Agreement, applicable reimbursement policy, or the Member's Benefit Plan, St. Luke's Health Plan reimburses Ambulatory Surgical Center (ASC) facility services in accordance with the current Centers for Medicare & Medicaid Services (CMS) ASC Payment System, including applicable annual updates to ASC Addenda AA, BB, and EE, as well as applicable National Correct Coding Initiative (NCCI) edits, claim editing software, and other CMS claim editing methodologies.

Non-Reimbursable ASC Services

St. Luke's Health Plan does not separately reimburse services, procedures, supplies, or devices that CMS designates as packaged, bundled, conditionally packaged, contractor-priced, or otherwise non-separately payable under the ASC Payment System, including those identified in the current CMS ASC Addenda AA, BB, and EE. Reimbursement for these items is considered included in the payment for the associated covered surgical procedure or other payable service, unless otherwise required by applicable law, regulation, or the Provider Agreement.

Services Included in the ASC Facility Payment

Unless otherwise specified in the Provider Agreement, the ASC facility payment includes, but is not limited to, the following services and supplies furnished in connection with a covered surgical procedure:

- Nursing and Technical Personnel: Services provided by nurses, technicians, orderlies, and other personnel involved in the patient's care during the surgical encounter.
- Use of the ASC Facility: Use of the operating room, procedure room, recovery area, preoperative and postoperative care areas, waiting areas, and other facility resources associated with the surgical procedure.
- Drugs and Biologicals: Drugs and biologicals routinely furnished by the ASC in connection with the surgical procedure that are not intended for patient self-administration.
- Surgical Dressings: Primary surgical dressings and therapeutic or protective coverings applied during the procedure. Dressings obtained separately for home use may be reimbursed separately when covered under the Member's Benefit Plan.
- Supplies, Splints, and Casts: Routine surgical supplies, splints, casts, gowns, drapes, gloves, masks, scalpels, and other disposable items furnished during the procedure.
- Appliances and Equipment: Equipment, instruments, implants, and appliances used during the procedure, including intraocular lenses (IOLs).
- Diagnostic and Therapeutic Services: Diagnostic and therapeutic services integral to the surgical procedure. Laboratory services performed by an independently certified laboratory, independent laboratory, or hospital laboratory may be separately billable by the performing entity. Preoperative diagnostic testing performed solely to determine a patient's suitability for surgery is not included in the ASC facility payment unless otherwise required as part of the covered procedure.
- Administrative and Facility Services: Medical records, scheduling, housekeeping, and other administrative or operational services necessary to support the surgical encounter.
- Anesthesia Services and Supplies: Supplies, medications, gases, equipment, and other materials required for the administration of anesthesia.

St. Luke's Health Plan reserves the right to apply current CMS payment indicators and claim editing methodologies, as updated periodically, when determining reimbursement.

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 or 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

When a service is billed with multiple units and is subject to a multiple procedure reduction, the reduction will be applied to the additional units in accordance with the methodology outlined above.

- For example, if CPT 59025 is billed with two (2) units, the first unit will be reimbursed at 100% of the allowable amount and the second unit will be reimbursed at 50% of the allowable.

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.

Modifier 33

St. Luke's Health Plan will not process preventive care claims solely based on the presence of modifier 33. Modifier 33 was developed in response to the ACA's preventive service requirements. Preventive care services are dependent upon claim submission using a preventive diagnosis and procedure codes to be identified and covered as preventive care services.

Lab Collection and Handling Codes

The following procedures will not be reimbursed and will be denied to provider write off 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 specimens 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 Billed with revenue code 0510 on a UB-04 form will be denied to provider write off and not billable to the member. To be eligible for reimbursement, professional services must be billed using the CMS 1500 form.

National Provider Identifier (NPI) Requirement

All providers are required to include the appropriate National Provider Identifier (NPI) on every claim submitted for reimbursement. This requirement applies to all electronic and paper claim formats.

Billing Requirements:

- Billing Provider NPI: Must be reported in the Billing Provider fields on all claims.
- Rendering/Servicing Provider NPI - Must be reported when the individual practitioner rendering the service differs from the Billing Provider.
- Facility and Organizational NPIs: Must be reported when applicable.
- Referring, Ordering, or Supervising Provider NPIs: Must be included when required by the service type.

Claims submitted without the required NPI(s) will be considered incomplete and may be rejected, denied, or returned to the provider for correction. Repeated failures to comply may impact timely payment and claims processing.

Providers are responsible for ensuring that all NPIs reported on claims are accurate, valid, and properly registered with the appropriate national database.

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.

Drug Wastage Reporting (JW/JZ Modifiers)

For drugs supplied in single-dose containers, providers must report any discarded amount using the JW modifier. The administered amount and the wasted amount must be billed on separate claim lines using the same HCPCS code as follows:

- The administered units should be billed on the first claim line without a modifier.
- The discarded units should be billed on a second claim line with the JW modifier.
- When no drug wastage occurs from a single-dose container, the JZ modifier must be reported.

Wastage is only eligible for reimbursement when it results from the use of the smallest available single-dose vial or package size and must be supported by documentation in the medical record. Discarded amounts from multi-dose vials are not eligible for reimbursement.

Claims that do not include the appropriate JW or JZ modifier when required may be denied.

Interest on Late Claim Payments

This policy describes how St. Luke's Health Plan handles interest on late claim payments for commercial health plans in compliance with Idaho state law and prompt payment requirements. This policy applies to all commercial providers submitting claims for covered services rendered to members enrolled in St. Luke's Health Plan commercial products in Idaho.

Prompt Payment Requirements

St. Luke's Health Plan processes clean claims in accordance with Idaho prompt pay statutes. A clean claim contains all information necessary for adjudication.

- Electronic claims: Payment, denial, or request for additional information within 30 days of receipt.
- Paper claims: Payment, denial, or request for additional information within 45 days of receipt.

If additional information is requested within the applicable timeframe, the prompt payment period is paused until the requested information is received.

Interest on Late Payments

If St. Luke's Health Plan fails to pay, deny, or request additional information within the required statutory timeframe, interest will be paid on the unpaid portion of the claim that is ultimately determined to be due and owing.

- Interest accrues from the date the payment was due until the date payment is issued.
- Interest is calculated using the statutory legal interest rate in effect under Idaho law at the time the payment became overdue.
- Interest amounts less than $4.00 will not be paid, as allowed by statute.

Payment of Interest

Interest may be included in the claim payment or issued separately. When applicable, interest amounts will be identified on the Explanation of Payment (EOP) or remittance advice.

Exclusions

Interest will not be paid in the following situations:

- Claims that are incomplete or missing required information until such information is received
- Claims denied within statutory timeframes
- Claims paid timely under Idaho prompt pay requirements
- Claims for which no additional reimbursement is owed after review or reconsideration

Provider Responsibilities

Providers must submit complete, accurate claims, respond promptly to requests for additional information, and comply with timely filing requirements outlined in their provider agreement and this manual.

Dispute Process

If a provider believes interest was not paid correctly, a written inquiry or dispute may be submitted through St. Luke's Health Plan claims reconsideration process.

Regulatory Compliance

This policy is administered in compliance with Idaho state law governing prompt payment and interest on late claims. St. Luke's Health Plan reserves the right to update this policy to remain consistent with applicable statutes or regulations.

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 will be based on the admission date.

Coverage and Payment Determination

Facility Claims:

Admission Prior to Coverage Effective Date

- If a member is admitted to a facility before their effective date of coverage with St. Luke's Health Plan, inpatient facility claims for that stay will be denied in full. Eligibility on the date of admission is required for any portion of the inpatient claim to be covered.

Admission During Eligibility with Discharge After Termination

- If a member is admitted to a facility while eligible but their coverage terminates prior to discharge, St. Luke's Health Plan will consider the entire inpatient facility stay as covered. This includes
    - Claims reimbursed via Diagnosis Related Group (DRG) methodology
    - Claims reimbursed as a percentage of billed charges.
- Coverage will apply to the entire continuous stay as long as the admission date falls within the member's active coverage period

Professional and Ancillary Claims:

Professional services and ancillary charges (e.g., labs, radiology, therapy) are evaluated based on the member's eligibility at the time the service was rendered, regardless of the inpatient facility claim eligibility.

- If a professional or ancillary service occurs after coverage termination, it will be denied as the member was no longer eligible at the time of service.
- Services provided on or after the effective date of coverage are eligible, assuming all other plan criteria are met.

Provider Responsibilities:

- Providers are encouraged to verify member eligibility prior to admission and confirm eligibility during extended stays.
- Claims submitted that do not meet the eligibility requirements as described will be denied, with the appropriate denial reason code and explanation.

Appeals and Exceptions:

- Appeals for denied inpatient claims where the admission date does not fall within an active coverage period will not be overturned.
- Professional or ancillary claim denials due to lack of eligibility at the time of service will not be overturned unless documentation shows eligibility was incorrectly terminated or misrepresented.

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 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 the member's Master Policy for additional information.

Breast Cancer Screening Coverage (Idaho Code § 39-2301)

In accordance with Idaho law (Idaho Code § 39-2301) effective January 1, 2026, commercial fully insured plans are required to cover *one* annual supplemental breast cancer screening at $0 cost for members at increased risk when performed in-network.

Members at heightened risk of breast cancer, including but not limited to:

- Genetic predisposition (e.g., BRCA1/BRCA2 mutations)
- Personal or family history of breast cancer
- Prior therapeutic thoracic radiation therapy
- Extremely or heterogeneously dense breast tissue
- Syndromes such as Li-Fraumeni, Cowden, or Bannayan-Riley-Ruvalcaba

Procedure Codes:

Procedure	Procedure Code
Non-MRI (Mammograms and Ultrasounds)	76641, 76642, 77061, 77062, 77065, 77066, 78800, G0279
Magnetic Resonance Imaging, MRI (with contrast)	77046, 77047, 77048, 77049, C8903, C8905, C8906, C8908, C8937
Abbreviated MRI (with contrast)	Currently no CPT code unique to abbreviated MRI. The American College of Radiology endorses use of the modifier, "-52" (limited) exam, in combination with full protocol MRI CPT code 77049
Contrast & Administration Ancillary	A9573, A9575–A9578, A9585, J7050, Q9967, 96374

Diagnosis Codes:

High Risk Category	Diagnosis Code	Diagnosis Description
Breast Density	R92.30–R92.343	Mammographic density found on imaging of breast
Abnormal Breast Imaging	R92.0–R92.8	Abnormal or inconclusive breast imaging results
Hereditary Syndromes	Q85.01, Q85.81, Q85.82, Q85.89, Q87.89, E71.440	Cowden/PTEN/NF1/related hereditary cancer syndromes
Genetic Susceptibility / Carriers	Z15.01, Z15.09,	BRCA-related & other hereditary cancer predispositions
Personal & Family History / Risk Status	Z80.3, Z84.81, Z85.3, Z86.000, Z86.03, Z90.10–Z90.13	History of breast cancer, in-situ, or carriers, acquired breast absence
Radiation History	Z92.3	Personal history of irradiation (specifically to the chest/thorax)
Screening	Z12.31, Z12.39	Breast cancer screening encounters (mammogram or other screening).

Billing & Documentation:

- Document risk factors and screening purpose in the medical record.
- Use screening codes for preventive services; diagnostic codes apply only when abnormality is suspected.

Discuss the risk with eligible patients and ensure screenings are coded and documented correctly.

Dentist Billing for Medical Claims

St. Luke's Health Plan (the Plan) reimburses covered dental or oral procedures under the medical benefit only when services are medically necessary to diagnose or treat a medical condition, disease, injury, or abnormality of the oral cavity, jaw, or related structures. Services that are routine, preventive, elective, or purely dental in nature are not eligible for reimbursement under the medical benefit, even when performed by a licensed dentist.

Claims submitted by dental or dental specialty providers under the medical benefit are subject to post-service review to determine medical necessity, appropriate medical intent,

and compliance with Plan benefits, coding requirements, and documentation standards. Prior authorization approval does not guarantee payment.

Services must be rendered by licensed Doctors of Dental Surgery (DDS) or Doctors of Dental Medicine (DMD) with valid state licensure, National Provider Identifier (NPI), and appropriate credentialing and contracting with the Plan. Providers must also meet all applicable federal and state exclusion screening requirements prior to participation or payment.

Subject to member benefit, covered services under the medical benefit may include, when medically necessary:

- Trauma and injury-related treatment of the oral cavity and facial structures
- Medically indicated oral surgery
- Temporomandibular joint (TMJ) services, based on applicable benefit design
- Sleep apnea oral appliance therapy when supported by medical necessity and appropriate diagnosis
- Hospital-based dental services required for management of systemic medical conditions or significant medical comorbidities

Non-Covered Services
Services that are dental-only in nature, routine, preventive, elective, or not medically indicated are not covered under the medical benefit.

Documentation Requirements
All services must be supported by complete clinical documentation demonstrating medical necessity and appropriate indication for coverage under the medical benefit.

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).

Notwithstanding the capped rental requirements above, St. Luke's Health Plan may permit outright purchase of certain capped rental DME items, when all of the following criteria are met:

- The equipment is a replacement item, not an initial trial or first-time use;
- The member has documented long-term, compliant use of the same or similar equipment;
- A treating provider documents continued medical necessity for ongoing use of the equipment;
- Prior authorization is obtained, explicitly approving purchase in lieu of rental;
- The DME supplier agrees to a contracted or otherwise approved purchase price;

- Ownership transfers to the member at the time of purchase, and the supplier and member acknowledge that post-purchase servicing and repair coverage will follow standard plan and warranty provisions.

If these criteria are not met, capped rental DME items must be billed in accordance with standard capped rental requirements, including use of applicable KH, KI, and KJ modifiers.

Oral Appliances for Sleep Apnea

St. Luke's Health Plan covers the fabrication and fitting of oral appliances for obstructive sleep apnea (HCPCS E0486) are covered under the medical benefit when supported by documentation of medical necessity and a qualifying sleep study diagnosis.

Dental providers must bill all eligible medical devices and appliances under the Durable Medical Equipment (DME) benefit using an active DME supplier enrollment. These items may not be billed under the dental (CDT) or medical professional (CPT) provider number.

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 is admitted to a hospital or skilled nursing facility (SNF), or enrolls in a Medicare HMO, and continues to require oxygen, payment for oxygen services will resume upon their return home from where it previously stopped.

Break in medical necessity (break in need): If the use of oxygen is discontinued for less than sixty (60) days, plus the remainder of the rental month in which it was stopped, and then resumed, payment will continue from the point at which it was previously paused.

- 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 determine coverage.

Robotic-Assisted Surgery and Computer-Assisted Navigation

Robotic surgical system services and computer-assisted navigation for musculoskeletal surgical services are techniques used to perform the main surgical procedure and not a separate service. These techniques are represented by codes S2900, 20985, 0054T, and 0055T, all of which are add-on codes. As such, when these add-on codes are billed, the robotic surgical system code and the computer-assisted navigation codes are considered bundled/included as part of the primary surgical procedure and not separately reimbursable, whether billed separately or in conjunction with a primary procedure.

Timed Therapy Services

St. Luke's Health Plan utilizes the CMS 8-minute rule methodology for reimbursement of outpatient timed therapy services, including Physical Therapy, Occupational Therapy, and Speech-Language Pathology services.

Timed therapy services will be reimbursed based on total aggregate treatment time per date of service, in accordance with CMS guidelines.

- Billing and Unit Calculation
- Aggregation of all medically necessary timed therapy minutes performed on the same date of service is allowed.
- Total timed minutes will be used to determine the appropriate number of billable 15-minute units.
- Individual CPT codes are not required to independently meet an 8-minute threshold; however, all billed services must be supported by medical documentation.
- Unit assignment will follow CMS time conversion methodology for 15-minute increments.

Documentation Requirements

- Providers must maintain documentation that clearly supports:
- Total timed minutes of skilled therapy provided per date of service
- Time spent on each individual service or intervention
- Medical necessity for all services rendered

Compliance Services that are not adequately supported by documentation, or that do not reflect accurate total timed minutes, may be subject to adjustment, denial, or recoupment.

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) or upon medical necessity as determined by St. Luke's Health Plan, 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.

Never Events

St. Luke's Health Plan adopts the definition of Never Events (also known as Serious Reportable Events) as outlined by the National Quality Forum (NQF). These are egregious errors in medical care that are:

- Clearly identifiable and measurable
- Usually preventable
- Serious in consequence
- Indicative of systemic problems in care delivery

In alignment with Centers for Medicare & Medicaid Services (CMS) policy and industry best practices, St. Luke's Health Plan does not reimburse for services associated with Never Events. Providers are also prohibited from billing members for these events.

Criteria for Inclusion as a Never Event
To be classified as a Never Event by NQF, an incident must be:

- Unambiguous: Clearly defined and measurable.
- Usually Preventable: While recognizing the complexity of healthcare.
- Serious: Causes death, disability, or significant functional loss.

- Indicative of Safety Failure: Reflects system or procedural deficiencies.
- Relevant to Accountability: Important for transparency and public trust.

Categories of Never Events
St. Luke's Health Plan adopts the full NQF list, including but not limited to:
1. Surgical or Invasive Procedure Events
    - Surgery on wrong site or wrong patient
    - Wrong procedure
    - Retention of foreign object
    - Death in ASA Class 1 patient intra/post-op
2. Product or Device Events
    - Use of contaminated products
    - Device malfunction or misuse
    - Air embolism in a care setting
3. Patient Protection Events
    - Discharge to unauthorized person
    - Patient elopement with injury or death
    - Suicide or serious self-harm in care
4. Care Management Events
    - Medication or transfusion errors
    - Maternal/neonatal injury in low-risk delivery
    - Pressure ulcers (Stage 3/4/unstageable) acquired in care
    - Mismanagement of test results
5. Environmental Events
    - Electric shock
    - Gas delivery errors
    - Burns or injuries from restraints
6. Radiologic Events
    - Metal object injury in MRI area
7. Potential Criminal Events
    - Impersonation of provider
    - Patient abduction
    - Sexual or physical assault on premises

Reimbursement Policy
- No payment will be made for services directly associated with a Never Event.
- Claims flagged with modifiers -PA, -PB, or -PC are denied.
- Follow-up care may be reimbursed only when rendered by providers not responsible for the original Never Event.

Required Coding & Modifiers

Modifier	Description
PA	Surgery or Other Invasive Procedure on Wrong Body Part
PB	Surgery or Other Invasive Procedure on Wrong Patient
PC	Wrong Surgery or Other Invasive Procedure on Patient

Providers must report applicable modifiers on claim submissions per CMS guidelines. Claims without accurate modifiers may be subject to post-payment review.
Documentation Requirements

Medical records and documentation must be available upon request to validate claim submission accuracy and modifier usage.

Intraoperative Neuromonitoring (IONM)

St. Luke's Health Plan will consider reimbursement for intraoperative neuromonitoring (IONM) services only when performed by a licensed physician or other qualified health care provider acting within the scope of their license and in constant, physical attendance in the operating room throughout the procedure.

The following conditions must be met for reimbursement eligibility:

- The provider performing IONM must be physically present in the operating room for the entire duration of the monitored procedure.
- The provider performing IONM must not be the operating surgeon, surgical assistant, or anesthesiologist administering anesthesia for the procedure.
- The IONM provider must be recognized by the Plan as an eligible billing provider and able to submit claims under their own NPI.

Reimbursement will not be provided for CPT code 95941 (remote or online IONM). The Plan will only consider IONM services billed under CPT 95940 and HCPCS G0453 when reported with a place of service (POS) code 19, 21, 22, or 24, in alignment with guidance from the American Academy of Neurology.

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.

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 Lightbeam Health Solutions, which allows for viewing value-based metrics at the point of care. Lightbeam helps providers to perform well 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. Lukes Health System employees and dependents will have different prior authorization guidelines please use new Prior Authorization Requirement tool in Community Link or call our dedicated St. Luke's Health System employee customer service line at: (833) 840-1212.

For other St. Luke's Health Plan members, 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, email preauthcommercial@slhealthplan.org or electronically through Community Link. When submitting via fax 833-840-3414 or email preauthcommercial@slhealthplan.org, 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

Claims submitted without required prior authorization will be denied in accordance with this payment policy.

This policy applies only to St. Luke's Health Partners and BrightPath contracted providers. All other providers are subject to the authorization, payment and timely filing provisions outlined in their applicable provider contract and are not governed by this payment policy.

Retroactive Authorization Requests

- Contracted providers may submit a request for retroactive authorization within sixty (60) days of the initial denial date.
- Requests are encouraged to be submitted via Epic Community Link or by completing the designated authorization form from our website and submit to Utilization Management by email or fax.
- Approval of a retroactive authorization request is not guaranteed and does not ensure payment.

Provider Responsibility

Providers are responsible for verifying prior authorization requirements and obtaining all required approvals prior to rendering services. Claims submitted that do not comply with this Payment Policy, including failure to obtain required prior authorization, will be denied and are the provider's financial responsibility. Such denials are not billable to the member and must be written off by the provider.

Prior authorization requirements can be reviewed through Epic Community Link or by contacting our customer service team at 833-840-3600.

Emergency or Urgent Services

Emergency services and urgent care services do not require 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 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 in our available networks, we ask that you submit a Higher Level of Benefits Waiver request. We will review the waiver request to determine if we have a provider within our network who can provide the services. If no network providers are available, we will review to allow 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 if the provider demonstrates good cause.

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

Providers who disagree with a determination made by St. Luke's Health Plan may submit an appeal within one hundred eighty (180) days of the denial date. To submit an appeal on behalf of a member, providers must complete and submit both a Provider Appeal Form and a Designation of Authorized Representative (DAR) form completed by the member, authorizing the provider or entity to act on the member's behalf. Both forms are available on our website.

Appeals received more than one hundred eighty (180) days after the denial date will be dismissed as untimely.

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@slhealthplan.org

Fax: 833-840-2748

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 Department 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 notifications 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 Pharmacy Department Customer Service 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 Pharmacy Department Customer Service 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 Pharmacy Department Customer Service 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.