June Education
OBJECTIVES

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Thank you for joining us today!

Please make certain that you are muted upon arriving to the session.

Contact Info for Provider Relations: 800-601-5086
ProviderRelations@SanfordHealth.org

Corey Erickson  (SD, IA and MN)  ext. 21054
Corey.Erickson@SanfordHealth.org

Kyle Klintworth  (ND and MN)  ext. 21106
Kyle.Klintworth@SanfordHealth.org
Sanford Health Plan Provider Fast Facts

• What is happening? What is upcoming?
• New Policies?
• How to retrieve this info?

https://www.sanfordhealthplan.com/providers/newsletters

Provider Newsletter

Sign up for our newsletter and stay up to date with development, education opportunities, guidelines, and policy updates.

- Download recent Fast Facts (PDF)
- Download recent Provider Perspective newsletter (PDF)

Sign up for provider newsletter ➔
View past issues here ➔

No Surprises Act:
Provider Updates Due

Beginning Jan. 1, 2022, CMS requires self-funded plans and fully insured individual and group plans to establish a provider directory verification process and establish a procedure for removing providers or facilities with unverifiable information. Sanford Health Plan joins more than 425 payers across the nation that are enlisting Quest Analytics/BetterDoctor services to implement a robust process to verify our provider directory.

What this means for you as a provider:
You will receive communication from our partner, Quest Analytics/BetterDoctor, every 90 days to verify the details we have in our provider directory. Once the details are sent back and verified, directories will be updated within two business days of receiving the provider updates. If no response is received, we are required to remove the provider from our provider directory until information is verified as correct. PROMPT RESPONSE IS KEY.

For additional questions or requests regarding your verification process please contact Quest/BetterDoctor at:
Email support@betterdoctor.com or call (844) 668-2543 8:00 a.m. – 5:00 p.m. CST.

If your organization includes ten or more practitioners at multiple service locations, you’re welcome to submit a roster each quarter instead of using the BetterDoctor online portal to attest.
Contact your Senior Provider Relations Specialist for more details.
Checking Claim Status without Portal Access

https://www.sanfordhealthplan.com/providers/forms

Claim Payments
You can easily check a claim status online HERE. Please allow 30 days from date of submission. This link will allow you to check a single claim. To securely view additional claims, you will need to log into your secure portal HERE.

NOTE: The Claim ID or submitted ID should match what was used when the claim was submitted.

Below is an example of the "Find a Claim" web page:

1. Who submitted the claim?
Enter ONE of the following:
A) Provider NPI
B) Vendor Tax ID

2. What were the claim details?
Enter ONE of the following:
A) ID + Earliest Date of Service
B) ID + Billed Amount
Sanford Health Plan Provider Portal Access

www.sanfordhealthplan.com
Requesting Portal Access

https://www.sanfordhealthplan.com/provider-portal-access-request

Provider Portal Access Request

Are you a Third Party Vendor*  
~ Yes ~ No  

Third Party is defined as a separate individual or organization other than the two principals involved. A third party is typically a company that provides an auxiliary product not supplied by the primary manufacturer to the end user (the two principals); a generic legal term for any individual who does not have a direct connection with a legal transaction but who might be affected by it; a third-party beneficiary is an individual for whose benefit a contract is created even though that person is a stranger to both the agreement and the consideration.

Submit Form
• Not comfortable providing last 4 digits of Social Security Number? No Problem.

• Any 4 numeric digits you will remember is just fine
  • Not accepted ex. 1111, 2222, 9999, etc.

• Please allow 3-4 business days for approval
Provider Resources

www.sanfordhealthplan.com/providers
Provider Portal Navigation Guide

Simply click on the document below to open in Adobe and then you can review, print or save the document.

Claims

- Check your claim status [here](#)
- Claim Reconsideration Form is now located within the [Provider Portal](#).
  - Request Provider Portal Access (External use only: Sanford Health users submit an ESAR)
  - [Provider Portal Navigation guide (pages 7-9)](#)
- [Flu & COVID-19 Vaccine Roster](#)

Credentialing Applications

Detailed Facility and Practitioner Credentialing forms and Sanford Provider HUB information can be found [here](#).

Documents

- [Prior Authorization List](#)
- [Claim Edit List](#)
- [Sanford Health Plan ID cards](#)
- [Understanding Your Check Adjustment Report](#)

Manuals

- [Provider Manual](#)
- [Provider Manual (PDF)](#)
- [Provider Onboarding Manual](#)

Medicare Advantage
Claim Reconsiderations
Claim Reconsiderations

• The claim reconsideration function should not be used for the following inquiries:
  • Incorrect Reimbursement
  • Multiplan/DataIsight Reimbursement
  • Retrospective Authorization Requests
  • Corrected Claims
  • Coordination of benefits

• Medicare Advantage Claim Reconsiderations
  • Provider Claim Reconsideration Request Form (located on provider portal)
    • Include Clinical Records and other documentation that support your case for reimbursement
    • Waiver of Liability form, holding the enrollee harmless, regardless of the outcome of the appeal (for non-participating providers)
  • Submit Claim Reconsiderations By:
    • Provider Portal: ehealth-shp.healthsuiteadvantage.com
    • Mail: Sanford Health Plan Attn: Appeals,
      PO BOX 91110, Sioux Falls, SD 57109-1110
    • FAX: (605) 312-8217
Claim Reconsiderations (cont.)

- After 10/1/2021 any reconsideration not submitted on the provider portal will not be processed or receive a response.
Claim Reconsiderations (cont.)

1. From **Claim by Member**, click **Submit a claim reconsideration or Claim question.**
Claim Reconsiderations (cont.)

• Complete all required fields and attach any relevant documentation
• Providers will receive a one-time claim reconsideration if requests are submitted within 180 days of the determination (original EOP) date.
Claim Questions

1. From Claim by Member, click Submit a claim reconsideration or Claim question.

“Ask A Question”
- Claim Question
- Payment Information
- Member Demographic Update
Prior Authorizations
Prior Authorizations

Open a member’s record

1. Click Select Patient.

2. Click Search all Patients. Enter the member’s name, birth date, or MRN and click Search.

• Providers are responsible for obtaining prior authorizations on behalf of members to received in-network coverage.

• All referrals to non-participating providers require prior authorization

• Failure to obtain prior authorization will result in a denial that will be provider responsibility
  • Providers have 60 days from the date of service to request a retro-authorization if one was not obtained prior to services rendered
3 Confirm that you are opening up the correct patient chart and select the Reason. Click on the magnifying glass to view the types of reasons that are available and hit select when you are wanting to open this patient chart.
Prior Authorizations: Create a new Referral

From a member’s workspace, click New Referral and choose the correct referral type.

Referral Type:

<table>
<thead>
<tr>
<th>Referral Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHP Rx – Medical Benefit</td>
<td>For medications to process under the medical benefit.</td>
</tr>
<tr>
<td>SHP Rx – Pharmacy Benefit</td>
<td>For oral or self-administered medications that process under the pharmacy</td>
</tr>
<tr>
<td></td>
<td>benefit, adjudicates through the PBM and not through the claims system.</td>
</tr>
<tr>
<td>SHP Injection - In Office</td>
<td>In-office injections that need prior authorization, such as botox</td>
</tr>
<tr>
<td>SHP Home Health Visits</td>
<td>Home health visits (nursing, PT, OT, ST, aide)</td>
</tr>
<tr>
<td>SHP Home IV Infusion</td>
<td>Home IV infusion authorization requests</td>
</tr>
<tr>
<td>SHP Observation Admit</td>
<td>Observation Admit that needs prior-authorization (such as at out-of-network</td>
</tr>
<tr>
<td></td>
<td>facility, for back surgery, cosmetic procedure, or other surgery that</td>
</tr>
<tr>
<td></td>
<td>needs prior-authorization)</td>
</tr>
<tr>
<td>SHP Consult</td>
<td>Any referral to out-of-network provider/second-opinion that</td>
</tr>
<tr>
<td></td>
<td>needs prior-authorization</td>
</tr>
<tr>
<td>SHP Ambulance/Transportation</td>
<td>Urgent Air Ambulance and Non-urgent ground ambulance requests</td>
</tr>
<tr>
<td>SHP Outpatient Surgery</td>
<td>Outpatient surgery that requires a prior-authorization</td>
</tr>
<tr>
<td>SHP Genetic Testing</td>
<td>Genetic Testing</td>
</tr>
<tr>
<td>SHP Durable Medical Equipment</td>
<td>DME requiring prior-authorizations, whether rental or purchase</td>
</tr>
<tr>
<td>SHP Transplant</td>
<td>Transplant authorization requests</td>
</tr>
<tr>
<td>SHP Inpatient Admission</td>
<td>Inpatient authorization requests</td>
</tr>
<tr>
<td>SHP Other Outpatient Services</td>
<td>Other outpatient services that are not surgical that require prior-</td>
</tr>
<tr>
<td></td>
<td>authorization, such as out-of-network services.</td>
</tr>
<tr>
<td>SHP NICU</td>
<td>Neonatal Intensive Care Unit admissions</td>
</tr>
<tr>
<td>SHP ABA Therapy</td>
<td>Applied Behavioral Analysis therapy when a covered benefit</td>
</tr>
</tbody>
</table>
Prior Authorizations: Create a new Referral

3. Enter the referral class. Referral classes include:
   • **Within Sanford Health System:** The referral is being submitted by a Sanford facility, doctor, or authorization team. The referral request originated outside your organization and requests a service to be performed within your organization. The referral request originated inside your organization and requests a service to be performed within your organization.
   • **Outside Sanford Health System — The referral is being submitting by a provider that does not work for Sanford Health.**

4. Select the correct Start and Expiration Dates for the authorization. If this is a retrospective authorization, click the check box next to Retroactive referral.

5. In the Referred by section of the General Information form, enter as much information as you can. Use the magnifying glass icon to search for the provider who referred the member for this service. You are able to search for both individual physicians and facilities/departments. Once you have selected the provider, you may see a Provider Address field be added to the document. Select the provider’s address where the provider is located.
Prior Authorizations: Create a new Referral

6 In the Referred to section, search for the provider or facility that will be performing the services requiring authorization.

Note: If your facility or provider cannot be located, please enter ‘99999’ and then add the pertinent information on the free-form field on the next section of the authorization. If you are having issues or questions please call into Provider Relations at (800) 601-5086 press option 2 and follow that up with option 4.

7 Click Next.

8 On the Diagnoses/Services form, enter a diagnosis code in the Diagnoses (coded) field. If there are multiple Diagnosis codes to be submitted, click the Add plus sign.
Prior Authorizations: Create a new Referral

9. Enter a procedure code in the **Services** field.

![Services field]

**Note:** If you’re entering codes but don’t have a diagnosis code, enter a description in the Diagnoses (coded) field and press ENTER to search for a code.

10. Scroll down and complete the Questionnaire with your contact information. Once this is completed, use the **Note Summary** free-form areas to provide more details. Please Note that this a place to add the provider information if you needed to use the '99999' on the previous screen.

![Notes field]
Prior Authorizations: Create a new Referral

11 Scroll down and click Add File, select an appropriate file.

Note:

- If the referring provider is Non-Sanford, please download and attach medical notes.
- If the referring provider is with Sanford (with medical notes in Epic), please specify where to locate the correct medical notes.
- If there is an attachment, notes are required.

12 Please check and make sure that all required fields are completed. Once all those fields are filled the referral or prior authorization can be submitted by clicking the Request Referral button.
Prior Authorizations: Review Referrals

1. From a member’s workspace, click **Referral by Member**.

   **Note:** If you are unable to locate the Referral you submitted, it may be because you submitted the referral to A- a different area under a different Tax ID, or B- You used the '99999' in the Referred To field. This number is not attached to any tax ID and will not show until our Utilization Management team has reviewed the request and has updated the referral with the correct provider information.

2. Click the **Referral ID** to view referral details.

3. Once the Referral has been reviewed and finalized, the Letter from Sanford Health Plan is viewable within the **Referral Notes** section.
Prior Authorizations: Referral Search

1. From the Home page, click Referral Search.

2. Select from Referral Type, Referred To, Referral Status and a date range to search for a referral.
Prior Authorizations: Ask a question about a referral

1. From Referral by Member, click **Ask a Question**.

2. Select the **type of question**: Pharmacy/Drug or Medical.
Prior Authorizations: Ask a question about a referral (cont.)

3 Enter as much information as you can, making sure to change the site to appropriate site.

**Details:** Enter your question and include the Referral number if available.

4 Click **Submit** to route the question to an appropriate user. You will receive a response within 1 business day.
1. Click **In Basket**.

2. Select **New Message**

3. **Provider Communication** — all items submitted to the Health Plan via In Basket or Ask a Question.
Questions?
Contact Provider Relations
1-800- 601-5086
ProviderRelations@sanfordhealth.org