Provider Perspective

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March 2022
Prevention Connection: Colorectal Cancer, Cervical Health & Managing A1C

Colorectal Cancer

Keep your patients and our members safe and healthy by encouraging colorectal cancer screening. Colorectal cancer (CRC) is the third most commonly diagnosed cancer in men and women. CRC screening is crucial to achieve positive patient outcomes and promote quality care.

We know many people are hesitant to get a colonoscopy because they don’t have the time or are intimidated by the procedure. If you have patients who are not interested in a colonoscopy or flex sigmoidoscopy, you can educate them about colorectal screening and offer alternative tests that are noninvasive, such as a FOBT or FIT-DNA test.

Support colorectal cancer screening for your patients who are 45-75 years of age by ordering one of the following preventive tests:

- Fecal occult blood test (FOBT)
- FIT-DNA test
- Flexible sigmoidoscopy
- CT colonography
- Colonoscopy

Cervical Cancer

There are over 13,000 women in the United States that are diagnosed with invasive cervical cancer each year. The good news is this disease is preventable with vaccination and appropriate screening. We encourage you to talk to your patients about Pap tests, HPV tests and related vaccines.

The CDC recommends all boys and girls get the HPV vaccine at age 11 or 12 years of age. The vaccine produces a stronger immune response when taken during these preteen years. For this reason, up until age 14, only two doses of the vaccine are required. Be sure to have the HPV vaccine series completed by age 13 to ensure gap closures for HEDIS. Proactive scheduling and call campaigns are often most effective for this measure.

Managing A1C

Managing diabetes can be a difficult challenge for both you and your patient. A healthy diet, a medication plan and a physician recommended exercise regimen can help keep your patient’s disease under control. A good reference to have in your patient’s chart is a history of their hemoglobin A1c levels.

Consider informing your patients that a hemoglobin A1c test is a simple blood test that can provide an estimate of their average blood sugar over the past three months. Providing this information will help the patient to understand how their body handles sugar intake and will help keep them informed and on track with their treatment plan.

Please consider ordering a hemoglobin A1c test as part of a routine work-up for any patient at risk of, or currently managing, diabetes. Encouraging patients to use the Plan’s approved vendor will ensure that the results get communicated without any additional effort.

Urgent Care for Non-emergencies

Often we see members visit emergency rooms for non-life-threatening situations, even though they usually pay more and wait longer. But why? Because they often don’t know where else to go.

As their provider you can give your patients other, often times better, options. Consider providing them with same-day appointments when it’s an urgent problem. And when your office is closed, consider directing them to a participating urgent care center rather than the emergency room, when appropriate.
The No Surprises Act was signed into law on Dec. 27, 2020. Provisions of the law went into effect on Jan. 1, 2022, and Sanford Health Plan is taking steps to comply with the regulation. The purpose of the No Surprises Act is to improve price transparency and protect patients from receiving surprise medical bills.

**Providers and facilities cannot balance bill in the following situations:**

- Out-of-network emergency covered items and services
- Covered medical items and services performed by an out-of-network provider at an in-network facility (ex: patient undergoes planned surgery at in-network hospital with in-network provider but receives anesthesia from an out-of-network anesthesiologist, patient has bloodwork done at an in-network facility, but the testing is outsourced to an out-of-network laboratory.)
- Out-of-network air ambulance service

The law requires carriers to reimburse at the Qualified Payment Amount (QPA) for certain out-of-network providers and services in addition to emergency services. The QPA is generally the median of contracted rates for a specific service in the same geographic region within the same insurance market as of Jan. 31, 2019. Additionally, providers are not able to balance bill members for the difference of the billed amount and the QPA. If the provider does not accept the QPA reimbursement, the Act requires providers to work with insurers to negotiate payment, referred to as the Open Negotiation Period. If the insurer and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) can be initiated, where an outside party will determine the final reimbursement amount.

For more information on the No Surprises Act, visit the Sanford Health Plan dedicated web page [HERE](#), which includes a FAQ for Consumers and Providers.
How Sanford Health Plan is complying with the No Surprises Act

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 a.m. – 5 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.

How to Access Milliman Care Guidelines (MCG)

Sanford Health Plan makes medical guidelines available to providers within the mySanfordHealthPlan provider portal.

Sanford Health Plan partners with MCG Health to implement Cite Guideline Transparency. As a provider, you are able to access this feature through the mySanfordHealthPlan provider portal. **Note:** Providers will be required to sign in and receive a pass code each time they access CGT.

Utilization management (UM) decision making is based only on medical necessity and service and existence of coverage. Sanford Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.

Any financial incentives offered to UM decision makers do not encourage decisions that result in under-utilization and do not encourage denials of coverage or service care. Decision makers sign an “Affirmative Statement Regarding Incentives” verifying the above conditions.

Any questions regarding the medical guidelines should be directed to Utilization Management at (800) 805-7938.
Recognizing that members have diverse views is critical to meeting their needs. The cultural factors that will likely impact your relationships with them include age, gender identity, language, religion and values. The changing demographics of our country create new challenges for the provision of care. You may see that change happening in your own community. It’s important to respect and respond to your patients’ distinct values, beliefs, behaviors and needs when caring for them.

Our commitment is to meeting all the National Committee for Quality Assurance (NCQA) standards. Each year, we measure our members’ perspectives via the Consumer Assessment of Healthcare Provider and Systems (CAHPS®) health plan survey. Survey replies help us learn about network providers’ ability to meet our members’ needs. This data is then used to monitor, track and enhance member experiences.

Cultural education for health care professionals is an important component of improving the quality of care delivered to diverse patient populations and can help in addressing racial/ethnic disparities in health care. Below are a list of resources:

- **U.S. Department of Health and Human Services:** Information on National CLAS Standards and education including free continuing education e-learning programs, resources to recorded presentations, quarterly newsletters, case study video units and more.

- **American Indian and Alaska Native Culture Card:** The culture card enhances cultural competence when serving American Indian and Alaska Native communities. It covers regional differences, cultural customs, spirituality, communication styles, the role of veterans and older adults, and health disparities.

- **Office of Minority Health - Cultural Competency Section:** The Office of Minority Health addresses disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services and barriers to health care for racial and ethnic minorities. Key strategies focused on fostering research, establishing networks and funding programs that can contribute to health policy and the effectiveness of strategies for improving health. For additional information, please visit the Office of Minority Health website.

We also have training and other resources available on our provider website available. Those trainings are located [HERE](#).
The goal of Sanford Health Plan’s Utilization Management program is to encourage the highest quality care from the right provider in the right setting. We aim to ensure that provided services are medically necessary and in compliance with the benefits of the plan.

Utilization Management (UM) decision-making is based on appropriateness of care and service and existence of coverage. Sanford Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to UM decision-makers do not encourage decisions that result in under-utilization and do not encourage denials of coverage or service. Decision-makers sign an “Affirmative Statement Regarding Incentives” verifying the above conditions. All physicians that are at Sanford Health Plan are willing to visit with you regarding our decision-making or for a Peer-to-Peer discussion. Please contact the Appeals and Denials Department to schedule an appointment with a physician.

Prior authorizations for health care services should be obtained online by logging in to the mySanfordHealthPlan provider portal at sanfordhealthplan.com/providers. Open the member record and choose “Create Referral”. The tutorial explaining how to request a prior authorization is located within the provider portal.

Remember • Prior authorization is never needed for emergency care• All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization• Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an out-of-network facility will be denied unless authorized prior to being incurred.

Services requiring prior authorization
Sanford Health Plan’s prior authorization list is based on our commercial plan and is subject to change based upon Sanford Health Plan Medical Management policy updates. Please note that authorization requirements for other plans offered by Sanford Health Plan may vary slightly. Contact Sanford Health Plan’s Utilization Management department for additional information.
Contacting Utilization Management

If you need additional information regarding prior authorizations, please contact Sanford Health Plan’s Utilization Management department at (800) 805-7938. They are available from 8 a.m. to 5 p.m. CST, Monday through Friday. After hours voice messages are returned the next business day. Toll-free communication services are available, as are toll-free communication services for the deaf, hard of hearing or speech impaired members, and language assistance for members and providers.

Successful Prior Authorization Submissions and Tips

We have had great success with providers submitting prior authorizations electronically on our Provider Portal. As a reminder this requirement went into effect Oct. 1, 2020. Authorizations (both Medical and Pharmacy) that are not urgent will be returned to providers when sent to us in paper form and could delay your authorization. Please see the instructions below to help you navigate how to submit an electronic authorization:

- **SANFORD EMPLOYEES AND INTERNAL USERS:** Please see the training resource HERE, or sign up for additional classes in the Sanford Success Center.

- **EXTERNAL PROVIDERS:** Please submit authorization requests via Provider Portal HERE. For questions, please contact Provider Relations at (800) 601-5086.

Additional tips include:

1. Requests should be made electronically through our Provider Portal to ensure real time determinations, quicker turn-around times
2. Selecting the correct "Auth Type" will route the request to the appropriate department to allow for quicker processing. Please refer to the “Auth Type Resource Guide” under the “Quick Links” section in the Provider Portal.
3. The Provider Portal/Electronic Prior-authorization process allows two-way communication between the requester and health plan. This communication can be accessed in the "notes" section using the “SHP Provider Comments” note type.
4. Records, both initial, additional and concurrent, can be downloaded within the portal.
5. Please ensure that once a request is submitted that clinical is attached. Incomplete authorization requests may result in unnecessary denials due to lack of information.
Did you know...

Specialty Referrals
If you have a Sanford Health Plan member requiring a specialist, and the practitioner they are requesting is unavailable, please assist them by offering alternative options. In some instances, the members may need to be seen by a specialist, but that specialist is unavailable for a variety of reasons.

Often times, a similar specialist may offer services right in your own clinic. In those instances, we ask for your assistance in offering these patients the option to see other like specialists in your clinic. If your specialist is unavailable and you do not have other options available in your clinic, please refer that patient to Sanford Health Plan Customer Service Department at (800) 752-5863 and our team can assist the patient in finding an alternate practitioner.

Annual Notices
Member Annual Notices will start going out in the mail to all subscribers by the end of March. These annual notices will go over any benefits and updates to that subscriber’s plan for the coming year. These notices are broken down into sections for the members to help with ease of understanding those benefits. Such sections include: Claims, Utilization Management, Pharmacy, etc. Provider Annual Notices will be coming out later in the year.

Clinical Practice Guidelines
The Sanford Health Plan Physician Quality Committee reviews and has adopted yearly the clinical practice guidelines. They are currently reviewing 2022’s updates. The complete listing from 2021’s adopted guidelines are available on our website HERE.

Provider Manual Updates
The 2022 version of our Provider Manual is now available. The link is located on the Provider Resource Forms and Resources page HERE.

Nominate other Providers
Do you know a Primary Care Provider, specialist, therapist, counselor, psychiatrist, or psychologist that would be a benefit to your patients to be contracted with Sanford Health Plan? Did you know you can nominate them online or by calling customer service?

Follow the instructions online at https://www3.viiad.com/shp/public/nominate_provider.asp to complete the nomination request. Sanford Health Plan will contact the provider that has been nominated to see if they are interested to start the credentialing process.
Medical Record Requests for HEDIS Chart Review & Quality Reporting

Providers are encouraged to inform their staff of upcoming medical record requests and timeline for HEDIS chart reviews, which began in February and go through April.

The purpose of HEDIS (Healthcare Effectiveness Data and Information Set) reporting is for a health plan to evaluate its performance in terms of clinical quality and customer service. HEDIS is reported annually as required by state & federal agencies, as well as the National Committee for Quality Assurance (NCQA). As both state and federal governments continue toward a quality driven health care industry, HEDIS rates are becoming more important to both health plans and providers. Learn more about HEDIS HERE.

Provider responsibilities regarding medical records requests can be found in Sanford Health Plan’s provider manual and policy, which is considered an extension of the Sanford Health Plan provider contract.

What to Expect:

Sanford Health Plan reviewers will reach out to providers beginning in February with a letter outlining the essential documents and information needed, along with submission instructions for this review. Additional follow up requests may be sent through late April.

If the volume of records requested is too large, or you do not have adequate staff to complete the chart retrieval, we encourage Providers to reach out to us using the following options to determine another authorized method to collect the information:

Email: HEDIS@sanfordhealth.org
Phone: (605) 328-6839, or toll free: (877) 305-5463, request Tracy at extension 86839

Records reviewed by Sanford Health Plan are kept completely confidential, and member specific information is not provided to outside sources, including employers. As a reminder, protected health information (PHI) disclosed for purposes of treatment, payment or operations, including quality improvement activities such as HEDIS reporting, is permitted by privacy rules according to Health Insurance Portability and Accountability Act (HIPAA). Additional consent or authorization from the member/patient is not required.

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

Provider Connection Webinars

You asked, we listened! Plan to be a part of our new quarterly events. Provider Connection events are designed to provide insights and answers to current questions or concerns brought to our team. These events will also connect you with the resources and people at Sanford Health Plan Provider Relations that are your partners to ensure success as you provide care for our members.

The inaugural December 2021 Provider Connection event summary can be found HERE.

Save the dates for the 2022 Provider Connection webinars listed below.

- March 18, 2022
- June 17, 2022
- September 16, 2022
- December 16, 2022

All meetings will take place at 10 a.m. CST. Register HERE.
## Contact Us

**CONTACT FOR:** Member eligibility & benefits, member claim status, provider directory, complaints, appeals, report member discrepancy information

- **memberservices@sanfordhealth.org**
  - Customer Service
    - Monday-Friday, 7:30 a.m. to 5 p.m. CST | (800) 752-5863
  - NDPERS Customer Service
    - Monday-Friday, 7:30 a.m. to 5:30 p.m. CST | (800) 499-3416
  - Northern Plains Insurance Pool (NPIP) Customer Service
    - Monday-Friday, 7:30 a.m. to 5 p.m. CST | (877) 225-4930
  - MHN (Three Affiliated Tribes)
    - Monday-Friday, 7:30 a.m. to 5 p.m. CST | (877) 701-0792

**CONTACT FOR:** Preauthorization/precertification of prescriptions or formulary questions

- **pharmacyservices@sanfordhealth.org**
  - Pharmacy [855] 305-5062
  - NDPERS Pharmacy [877] 658-9194

**CONTACT FOR:** Preauthorization/precertification for medical services

- **um@sanfordhealth.org**
  - Utilization Management (800) 805-7938
  - NDPERS Utilization Management [888] 315-0885

**CONTACT FOR:** Assistance with fee schedule inquiries, check adjustments and reconciling a negative balance, request explanation of payment (EOP), claim reconsideration requests, W-9 form, change/updating information, provider education

- **providerrelations@sanfordhealth.org**
  - Provider Relations (800) 601-5086

**CONTACT FOR:** Requests to join the network and contract-related questions and fee schedule negotiation

- **sanfordhealthplanprovidercontracting@sanfordhealth.org**
  - Provider Contracting [855] 263-3544

**CONTACT FOR:** Align powered by Sanford Health Plan Medicare Advantage PPO

- Utilization Management [800] 805-7938
- Pharmacy Dept [844] 642-9090

**CONTACT FOR:** Great Plans Medicare Advantage (ISNP)

- Utilization Management [800] 805-7938
- Pharmacy Dept [855] 800-8872

Hearing or speech impaired TTY | TDD 711