Provider Perspective

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Quarter 2 2025

SANFORD HEALTH PLAN

Authorizations:
Prior Authorizations Fax Option to Sunset

Sanford Health Plan currently accepts faxed prior authorization requests from our providers. However, this process is both time- and labor-intensive for our teams. To offer a more consistent – and timely – provider experience, we are phasing out the fax lines for most prior authorization requests.

Instead, users will be encouraged to submit prior authorizations through the provider portal. This feature is already available on the portal and improves efficiency by facilitating direct communication between providers and health plan staff to resolve questions. It also allows providers to view the status of the authorization and determination in real time.

Fax lines will close effective Oct. 7, 2025, with the following exceptions:

- Urgent/emergent situations
- Technical issues with the portal
- Pre-approval from the provider relations team

If your organization currently faxes your authorization requests, we encourage you to get familiar with the authorization submission through the portal as soon as possible. If you do not yet use the provider portal, we encourage you to register for the provider portal. You can find registration information on the SHP website: sanfordhealthplan.com/providers/provider-portal-access-request In the quick links section on the Provider Portal, you can find instructions on how to submit authorization requests. If you have additional questions about accessing the provider portal or submitting an authorization through the portal you can call Provider Relations at 800-752-5863, select Option 2, then Option 4. A customer service representative is available to assist with any questions.

Network Exception Authorizations

Network exception authorizations are medical indications for out-of-network services for members with no out-of-network benefits or for members with out-of-network benefits requests in-network coverage. These requests need to be submitted on the provider portal. SHP requires supporting documentation to review the request, so it is recommended to have the referring provider submit the request. To avoid claim denials, network exception requests should be submitted pre-service.

Network Exception requests are reviewed and considered for medical necessity based on the following circumstances:

Access and Availability

- In-network providers with the clinical expertise required to address the member's diagnosis or medical condition are not reasonably available within Sanford Health Plan's geographic access standards or within the availability standards of the member's plan.
- The geographic access standard is defined by certain mileage rules, depending on plan/product and state jurisdiction, as outlined in the member's COI/SPD.

Complexity of Care

- The member has a complex or rare medical condition or requires a specialized medical procedure for which there is no in-network provider with the necessary specialization, training or expertise to provide treatment.
- The health plan will take into consideration the recommendation and opinion of an in-network specialty provider, in which medical necessity is established, that a member receives such services from an out-of-network specialist provider.

Continuity of Care

- When the member has a complex or chronic condition that has been previously authorized due to requiring specialized medical care, the health plan will take in consideration approving for continuity if it is determined the member will be better served continuing care with the out of network provider.

Lack of Capacity:

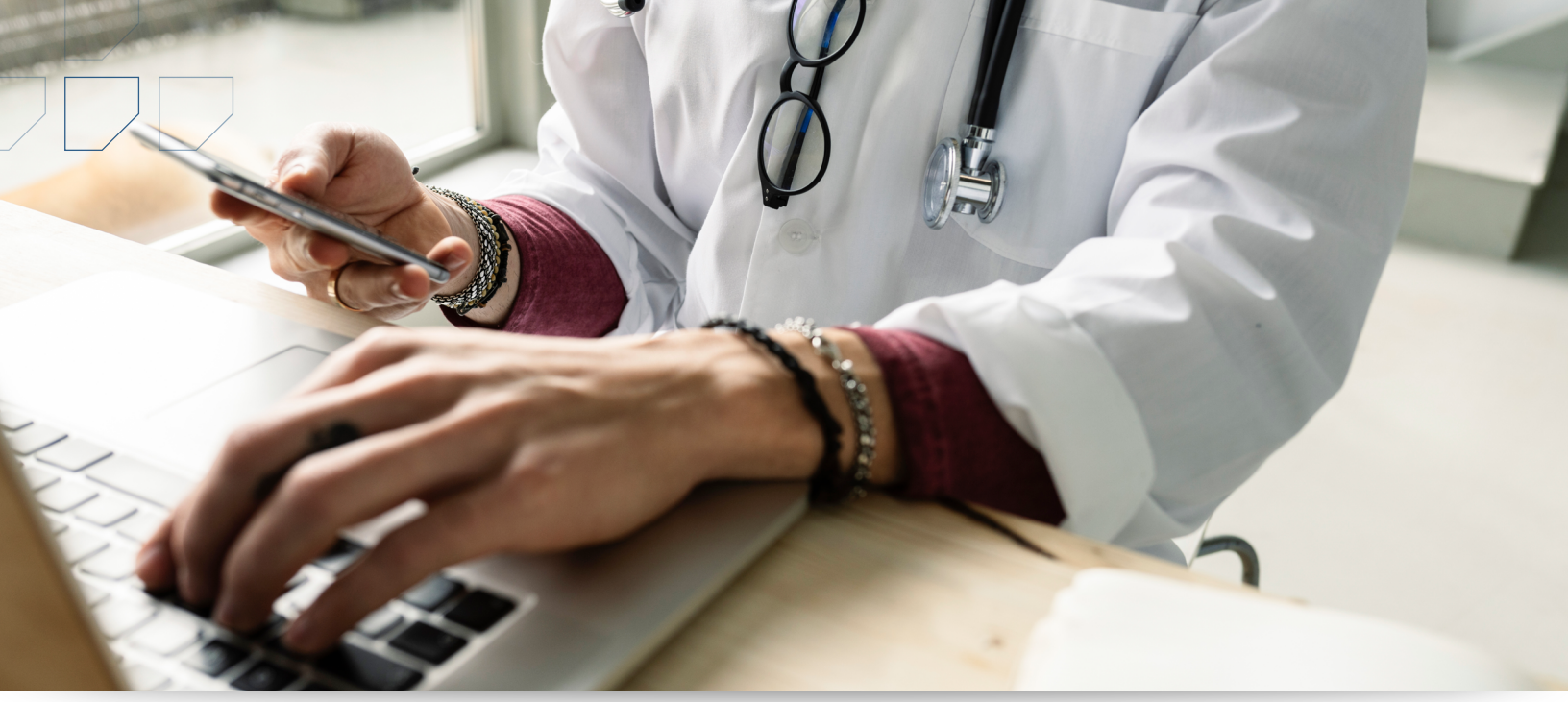
- Medical care situations in which an in-network provider can provide but does not have capacity or availability at the current time.

Services Not Available In-network:

- Network providers are unable to provide the requested medical service.

Timely Access:

- The health plan will take into consideration the recommendation and opinion of an in-network specialty provider in which it is determined care cannot be provided in a timely manner.



Provider Portal Corner:
Provider Portal Tips

In this article, we have provided some tips and recommendations when using the Provider Portal.

Portal User Updates/Changes:

- If you are a current SHP portal user and need to update or change your demographics on your user profile, please reach out to your Manage My Clinic Site Administrator to submit the request on your behalf. If you do not have a Site Administrator, please contact our IT help desk at (877) 949-5678 - option 2 followed by option 1 then option 0 - and our IT department can assist with this.
- If you currently have a Sanford Health Plan portal username but changed employers and need to be linked to a different tax ID number, it is not necessary to submit a new request. Please have your Site Administrator submit a request on your behalf. If there is not a Site Administrator, contact the SHP IT help desk at (877) 949-5678 - option 2 followed by option 1 then option 0 - and our IT department can assist with this.

Provider Appeals

- Reminder: Claim reconsiderations/appeals must be completed using the Provider Portal. The Portal quick links on the home page includes a tutorial "Questions, Appeals, or other Communications Options."
    - o This tutorial provides information on how to submit a claim reconsideration as well as the documentation that is needed in a reconsideration request. In addition, you can find information on what subtopic to select depending on your question/request.
- We have created a new subtopic for pricing appeals. This can be found under the topic provider claim reconsideration > pricing appeal.
    - o Pricing appeals are used to challenge claims that you feel have priced incorrectly. Please be sure to include documentation supporting this appeal and why you feel this claim is priced incorrectly.

Manage My Clinic:
MMC Clinic/Site Administrators Required

We continue towards the full implementation of Manage My Clinic for the Sanford Health Plan Provider Portal. This tool allows your clinic to manage who has access to your patient information. Typically, this is a Clinic or Site Administrator.

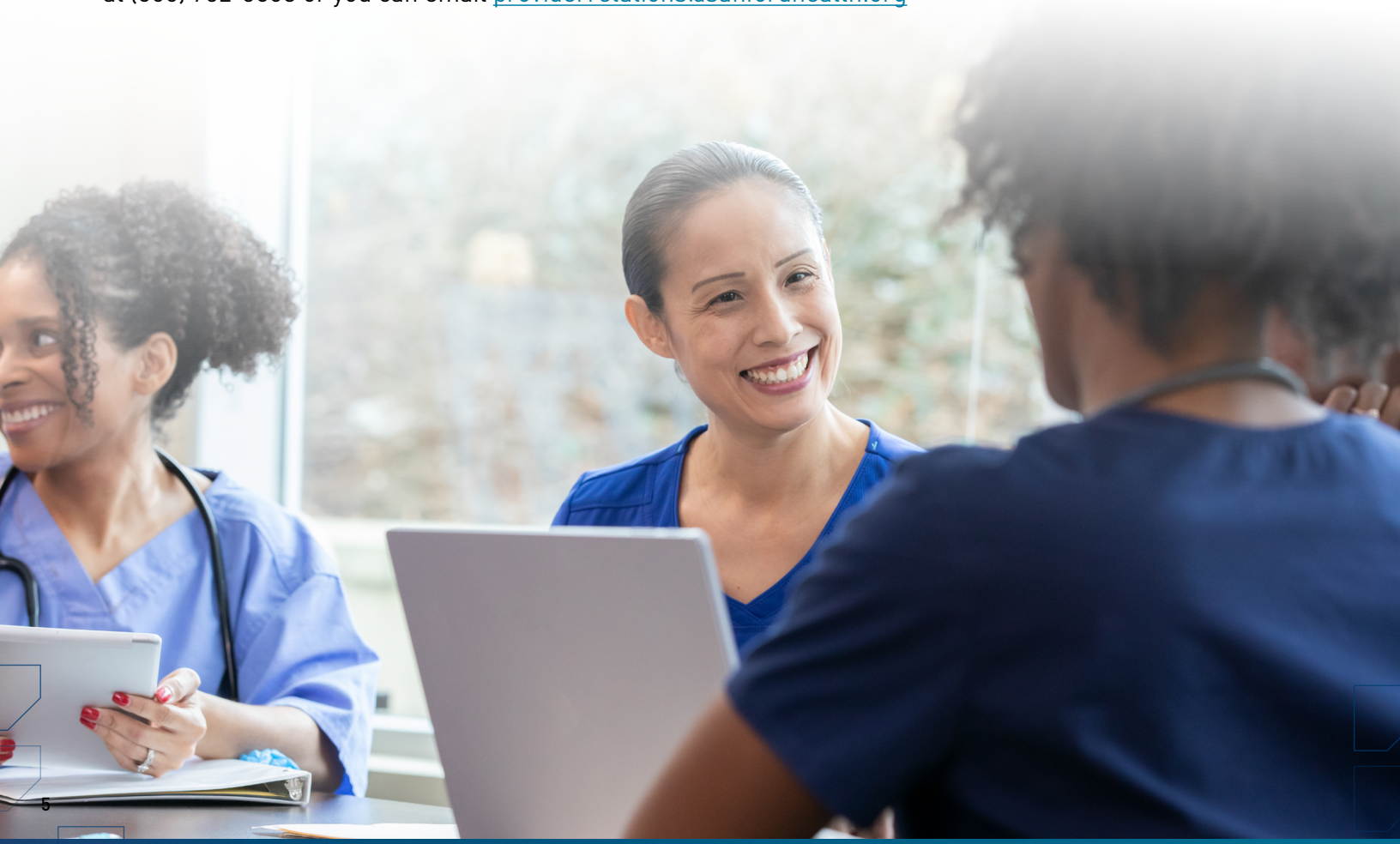
Manage My Clinic comes with tools like:

- Reactivate users
- Inactivate users who have left employment
- Complete quarterly verification of active users
- Request or update access

For Sanford Health Plan to roll this out to your facility successfully, we need you to designate an individual who will be able to verify all users under your tax ID(s) and be able to complete the tasks listed above regularly.

You may receive a call or email from your Provider Relations Team asking who should be your Site Administrator. Go Live dates for your facility will be assigned and shared as more information becomes available.

If you're ready to transition to this tool at this time, please reach out to a Provider Relations team member at (800) 752-5863 or you can email providerrelations@sanfordhealth.org



You Asked, *We Answered*

How do I enroll in electronic Explanation of Payments (EOP) and Electronic Funds Transfer (EFT)?

You can make changes in how you receive your EOPs (remits) & payments. You can find information on electronic EOPs and EFT on the SHP website: sanfordhealthplan.com/providers/edi-resources.

- On the EDI Resources page, you will find information on electronic claim submission as well as electronic remittance advice (ERA), and Electronic Funds Transfer (EFT).
- The ERA section includes both a phone number and email address for the Epayment Center.
- Epayment Center is SHP's vendor for setting up both ERAs and EFTs.
- The ERA & EFT are great options for receiving your remits and payments quicker than standard paper transactions.

Claims Corner: Orthodontic Services

Sanford Health Plan will pay for the placement fee of orthodontic devices when medical necessity is met.

Claims for orthodontic services should be submitted for the full amount of the treatment plan, such as appliances, adjustments, insertion, removal, and post-treatment stabilization (retention). Orthodontic services will apply toward member's deductible and coinsurance.

Prior authorization may be required for orthodontia services. See the Orthodontic Benefit Reimbursement policy found on the SHP provider portal. The policy provides details on covered services and criteria for coverage. To locate this policy, go to Quick Links, Policies & Medical Guidelines, Orthodontic benefit reimbursement.

If you have additional questions regarding orthodontic services, please contact the Provider Experience team at (800) 752-5863.

Meet the Measure:
COB – Concurrent Use of Opioids and Benzodiazepines

What is the COB Measure?

The COB measure tracks the percentage of Medicare Part D beneficiaries who are concurrently prescribed opioids and benzodiazepines—a combination associated with increased risk of overdose and death.

Measure Criteria:

- Patients 18 years or older
- Two or more opioid prescriptions on different dates, totaling 15 or more days of supply during the measurement year
- 30 or more cumulative days of benzodiazepine prescriptions overlapping with opioid therapy

Patients Excluded from the Measure:

- Cancer diagnosis
- Sickle cell disease
- Enrollment in hospice or palliative care

Why It Matters

Combining opioids and benzodiazepines can have dangerous—often fatal—consequences:

- CNS depressant effects increase the risk of respiratory depression and overdose
- A JAMA Psychiatry study links this combination to a significant proportion of prescription drug-related deaths
- CMS is targeting polypharmacy to prevent avoidable hospitalizations and improve medication safety
- Reducing concurrent use supports the broader national effort to combat the opioid epidemic

Best Practices for Providers

Help meet the measure—and protect your patients—by integrating these strategies into clinical workflows:

1. Medication Review and Risk Monitoring

- Conduct regular medication reconciliation
- Use Prescription Drug Monitoring Programs (PDMPs) to track controlled substances across prescribers

2. Consider Safer Alternatives

- For anxiety: Use SSRIs (e.g., sertraline) or SNRIs (e.g., duloxetine)
- For insomnia: Recommend CBT-I or non-benzodiazepine sleep aids (e.g., zolpidem)

3. Implement Tapering Protocols

- Avoid abrupt discontinuation
- Follow CDC guidelines for tapering opioids and benzodiazepines safely

4. Educate Patients

- Discuss risks of combined opioid and benzodiazepine use
- Reinforce adherence to one coordinated care plan

5. Coordinate Care

- Collaborate with behavioral health, addiction specialists, and pain management providers for comprehensive care plans

Drugs Included in the COB Measure

Opioid medications		
benzhydrocodone	hydrocodone	oxycodone
buprenophine	hydromorphone	oxymorphone
butorphanol	levorphanol	pentazocine
codeine	meperidine	methadone
dihydrocodeine	morphine	tapentadol
fentanyl	opium	tramadol
Benzodiazepine medications		
alprazolam	diazepam	oxazepam
chlordiazepoxide	estazolam	quazepam
clobazam	flurazepam	temazepam
clonazepam	lorazepam	trizolam
clorazepam	midazolam	

Final Takeaway

The COB measure is a critical step toward safer prescribing practices. As a provider, your role is central in identifying at-risk patients, preventing dangerous drug interactions, and improving outcomes through evidence-based prescribing and coordinated care.

Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults

In Measurement Year (MY) 2025, the Centers for Medicare & Medicaid Services (CMS) introduces a new star measure: POLY-ACH—Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults. This measure targets an important and modifiable risk factor in geriatric care: excessive anticholinergic medication use.

What Is the POLY-ACH Measure?

The POLY-ACH measure tracks the percentage of Medicare Part D beneficiaries aged 65 or older who are prescribed two or more unique anticholinergic medications on different dates of service during the measurement year.

Purpose:

To reduce anticholinergic burden—a known contributor to cognitive impairment, falls, and increased mortality in older adults.

Exclusion:

- Patients enrolled in hospice at any time during the measurement year

Why This Measure Matters

Older adults are particularly vulnerable to adverse drug effects due to:

- Slower metabolism and reduced renal clearance
- Greater likelihood of polypharmacy
- Decreased physiologic reserve

Risks of anticholinergic use:

- Confusion, blurred vision, dry mouth
- Constipation, urinary retention
- Increased risk of falls, cognitive decline, and functional impairment

Supporting Evidence:

- A study in JAMA Internal Medicine linked long-term anticholinergic use to a higher risk of dementia
- Deprescribing these medications is associated with better functional outcomes and improved quality of life

Best Practices for Meeting the Measure

1. Medication Review and Deprescribing

- Perform routine medication reviews
- Prioritize discontinuation of high-risk anticholinergics
- Use a structured approach guided by deprescribing protocols

2. Use Non-Pharmacologic & Safer Alternatives

- For insomnia: Recommend CBT-I or melatonin
- For urinary incontinence: Encourage pelvic floor exercises, bladder training, and behavioral therapy

3. Assess Anticholinergic Burden

- Use clinical tools like the Anticholinergic Cognitive Burden (ACB) Scale
- Aim to minimize total ACB score where possible

4. Patient & Caregiver Education

- Explain risks of anticholinergic medications
- Engage in shared decision-making to explore safer options

5. Collaborate Across Disciplines

- Work with pharmacists, geriatricians, and behavioral health providers
- Optimize treatment regimens with a team-based approach

Measure medications:

Antihistamine medications			
brompheniramine	cyproheptadine	diphenhydramine (oral)	pyrilamine
carbinoxamine	dexbrompheniramine	doxylamine	triproldine
chlorpheniramine	dexchlorpheniramine	hydroxyzine	
clemastine	dimenhydrinate	meclizine	
Antiarrythmic medications			
disopyramide			
Antidepressant medications			
amitriptyline	doxepin (>6 mg/day)	paroxetine	
amoxapine	imipramine	protiptyline	
clomipramine	nortiptyline	trimipramine	
Antiemetic medications			
prochlorperazine		promethazine	
Antimuscarinic (urinary incontinence) medications			
darifenacin	flavoxate	solifenacin	trospium
fesoterodine	oxybutynin	tolterodine	
Antiparkinsonian agent medications			
benztropine		trihexyphenidyl	
Antipsychotic medications			
chlorpromazine	loxapine	perphenazine	trifluoperazine
clozapine	olanzapine	thioridazine	
Antipasmodic medications			
atropine (excludes ophthalmic)	dicyclomine		methscopolamine
belladonna alkaloids	homatropine (excludes ophthalmic)		propantheline
clinidium-chlordiazepoxide	hycoscyamine		scopolamine (excludes ophthalmic)
Skeletal muscle relaxant medications			
cyclobenzaprine		orphenadrine	

Final Takeaway

The POLY-ACH measure addresses a critical safety issue in older adults: overuse of medications with anticholinergic effects. Proactive deprescribing, patient-centered care, and interdisciplinary collaboration are key to reducing harm and improving outcomes.

Quality:
Addressing QHP Language Needs: A Guide for Healthcare Providers

As frontline healthcare professionals, providers play a pivotal role in delivering equitable care to diverse patient populations. With the growing number of individuals enrolled in Qualified Health Plans (QHPs) through the Health Insurance Marketplace, it's essential for providers to understand and support the language access requirements tied to these plans.

Why Language Access Matters in Clinical Care

Effective communication is fundamental to quality care. For patients with Limited English Proficiency (LEP), language barriers can lead to misunderstandings, reduced adherence to treatment plans, and increased risk of medical errors. Ensuring clear communication is not only a regulatory obligation—it's a clinical imperative.

QHP enrollees come from a wide range of cultural and linguistic backgrounds. Providers who recognize and respond to these language needs help bridge health disparities and improve outcomes.

Regulatory Background: What Providers Should Know

Under the Affordable Care Act (ACA) and related federal laws (including Section 1557 and Title VI of the Civil Rights Act), QHP issuers are required to:

- Provide free oral interpretation services in any language.
- Translate vital documents into languages spoken by a significant portion of the population (as defined by state or federal thresholds).
- Include language assistance taglines on communications to inform patients of their rights.

  While these are obligations for insurers, healthcare providers working with QHP enrollees must also understand and integrate these practices into the care setting.

Practical Steps for Providers

Here's how healthcare providers can support QHP language needs effectively:

1. Use Qualified Interpreters

Always use trained medical interpreters—not family members or untrained staff—for patients with LEP. This ensures accurate communication and protects patient confidentiality.

2. Document Language Preferences

Record the patient's preferred spoken and written language in their medical record and flag any need for interpreter services at future visits.

3. Provide Translated Materials

Make sure patient education materials, consent forms, and discharge instructions are available in the languages your patient population needs.

4. Train Staff on Cultural Competence

Conduct regular training on cultural humility and effective communication strategies to improve patient-provider interactions.

5. Leverage Technology

Utilize language access technologies such as telephonic or video interpretation services, multilingual patient portals, and translation software—especially in fast-paced clinical environments.

6. Partner with QHP Issuers

Collaborate with the patient's health plan to ensure they're aware of available language resources and can help coordinate support when needed.

Why It Matters to Providers

Investing in language access improves:

- Patient safety and clinical outcomes
- Patient trust and satisfaction
- Compliance with federal nondiscrimination regulations
- Reimbursement potential, as miscommunication can lead to denied claims or unnecessary utilization

Moreover, providing language-concordant care reduces disparities and strengthens the overall quality of the healthcare system.

Final Thoughts

Language access is not just a policy issue—it's a clinical one. As a provider, your role in identifying and addressing the language needs of QHP enrollees is crucial to delivering safe, respectful, and effective care. By fostering clear communication, you help ensure every patient is truly heard and understood.

The Medicare Health Outcomes Survey (HOS): What Healthcare Providers Need to Know

As a healthcare provider serving Medicare Advantage (MA) enrollees, understanding the Medicare Health Outcomes Survey (HOS) is essential to delivering high-quality care and improving patient satisfaction. Launched by the Centers for Medicare & Medicaid Services (CMS) in 1998, the HOS is the first national survey to assess functional health outcomes in the Medicare population over time. Its results have a direct impact on CMS Star Ratings and your organization's quality improvement efforts.

What Is the HOS?

The Medicare HOS is a patient-reported outcomes survey that measures the physical and mental health status of MA beneficiaries. Participants are surveyed at baseline and again two years later to assess changes in health over time. CMS uses these data to evaluate the effectiveness of care and how well plans support beneficiaries in maintaining or improving their health.

The survey focuses on:

- Physical functioning (e.g., mobility, daily living tasks)
- Mental health (e.g., depression, anxiety)
- Chronic disease management
- Pain, fatigue, and fall risk
- Health promotion and education
- Provider-patient communication

Why It Matters for Healthcare Providers

1. Impacts Star Ratings and Reimbursement

HOS results are directly tied to the Medicare Advantage Star Ratings, which influence plan enrollment and determine financial incentives. Poor outcomes can negatively affect a plan's rating, while improvements in patient-reported outcomes can boost ratings and revenue.

2. Drives Quality Improvement

For providers, HOS data reveal patterns in patient outcomes that can be used to enhance clinical practices, strengthen care coordination, and identify patients at risk. For example, frequent reports of mobility limitations or fall risk can lead to new interventions in physical therapy or home safety programs.

3. Strengthens Patient Engagement

The HOS gives patients a structured opportunity to report on how they experience care and manage their health. By encouraging patients to reflect on their health status, the survey helps reinforce the provider-patient partnership and promotes self-management.

How You Can Help Improve HOS Scores

While the survey is conducted independently by CMS and its contractors, providers play a critical role in influencing patient responses through daily clinical care. Here are ways to make an impact:

- Focus on functional health: Evaluate and address patients' ability to perform daily tasks. Use validated screening tools for fall risk and mental health.
- Enhance communication: Ensure patients feel heard and understand their care plans. Clear communication correlates strongly with better HOS scores.
- Promote preventive care: Educate patients about flu shots, physical activity, and chronic disease self-management.
- Document interventions clearly: CMS looks for evidence-based care management—clear records help plans demonstrate improvement.

Your Role in a Larger System

Even though providers are not directly involved in survey administration, your interactions and interventions have long-term effects on patient outcomes that are captured by the HOS. By aligning care with HOS domains, you help improve both individual health and system-wide quality benchmarks.

Final Thoughts

The Medicare Health Outcomes Survey is more than just a data collection tool—it's a mirror reflecting the patient-centeredness and effectiveness of care delivery within Medicare Advantage. As a healthcare provider, your role is pivotal. By prioritizing functional health, promoting preventive strategies, and maintaining clear, compassionate communication, you help drive better outcomes—both for your patients and for your organization.

Policy Updates:

The following policies were reviewed and updates made during Q2 2025:

Topic	Details
Applied Behavior Analysis (ABA)	Removed ABA therapy limits from SD Small Group/Individual Off-Exchange plans to comply with the MPHAEA which requires autism spectrum disorder to be classified as a mental health condition per the DSM and SHP cannot apply more stringent requirements than what is applied to medical/surgical benefits.
Behavior Health and Substance	CPT codes G2082 & G2083 will be covered for all Lines of Business with Prior Authorization for S0013.
Services Requiring PA	The Oncology code section was updated to align with the Eviti code list
Sleep Study	To better align criteria for allowing home sleep apnea testing with clinical practice guidelines, Home Sleep Apnea Testing (HSAT) covers adults ages 18+ when indicated with at least two of the following diagnosis codes: G47.10, G47.13, G47.14, G47.19, G47.30, G47.33, G47.39, I10, R06.83, R09.89.
	Additional policies reviewed in Q2 with no changes made in the policy include: • Biofeedback • Breast-Related Procedures • Consultation Services • Global Surgical Package • Increased Procedural Services • Lab, X-Ray and Minor Procedure • PG Pilot Program • Prolonged Services • Provider Preventable Conditions • Pulmonary Rehabilitation • Reconstructive Surgery • Religious Exemption Rider • Routine Foot Care • Spine Surgery • Transgender Coverage

Contact Us

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

Customer Service (800) 752-5863
Monday-Friday, 8 a.m. to 5 p.m. CST
memberservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

Pharmacy (855) 305-5062
pharmacyservices@sanfordhealth.org

CONTACT FOR: Preauthorization/precertification for medical services

Utilization Management (800) 805-7938
um@sanfordhealth.org

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

Provider Relations (800) 752-5863
providerrelations@sanfordhealth.org

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

Provider Contracting (855) 263-3544
sanfordhealthplanprovidercontracting@sanfordhealth.org

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

Customer Service (888) 278-6485 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (844) 642-9090

CONTACT FOR: Great Plans Medicare Advantage (ISNP)

Customer Service (844) 637-4760 | TTY: (888) 279-1549
Utilization Management (800) 805-7938
Pharmacy Dept (855) 800-8872

Hearing or speech impaired TTY | TDD 711

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