Provider Perspective

QUARTER 2 2026

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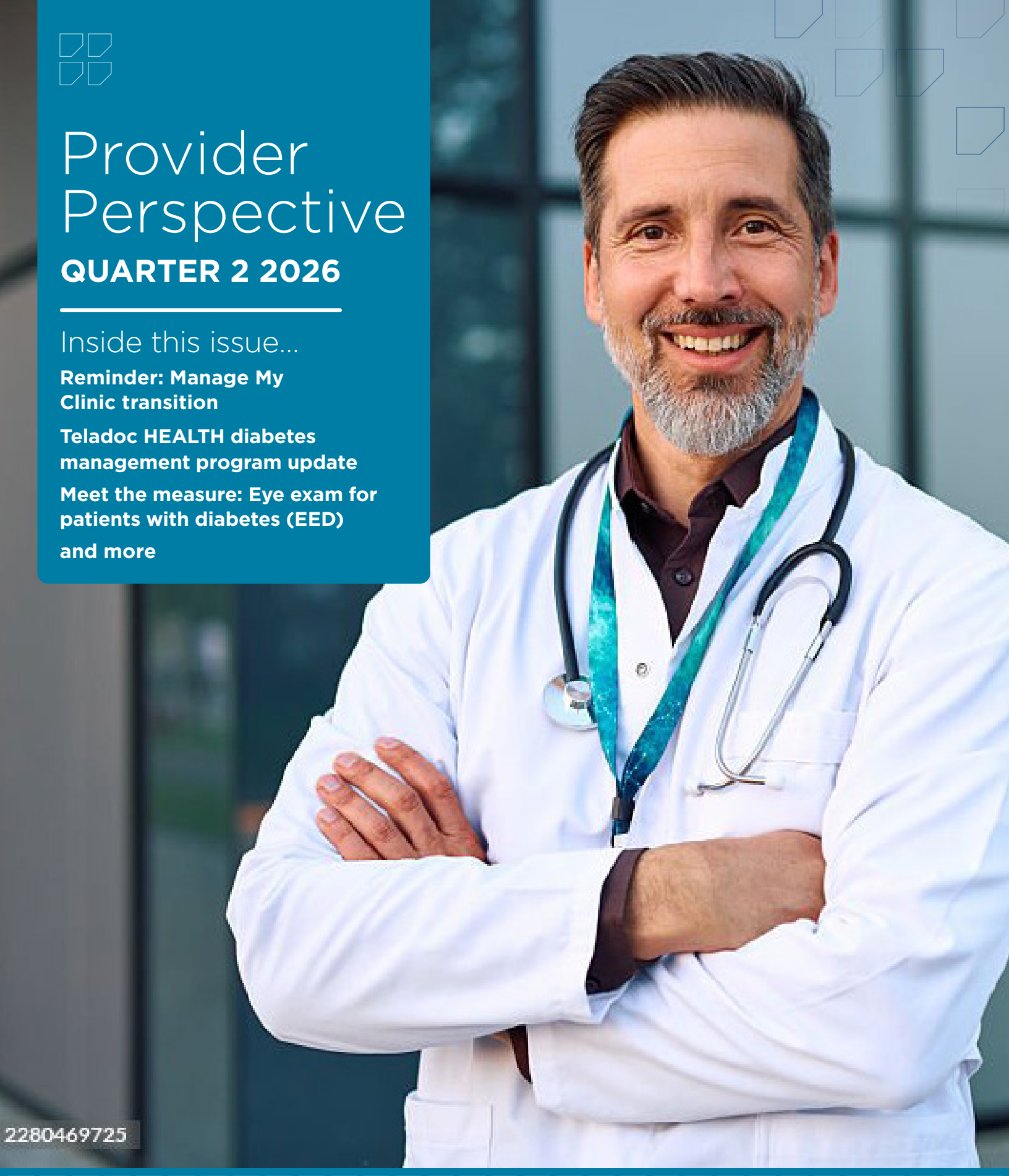

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SANFORD HEALTH PLAN

Reminder: Manage My Clinic transition

Sanford Health Plan is finalizing its transition to Manage My Clinic, a portal user management tool that allows clinics to manage who has access to patient information.

The goal is for all users to be fully transitioned to Manage My Clinic by Oct. 1, 2026. Users without Manage My Clinic accounts will be deactivated on a rolling basis to achieve the October 1 goal. Deactivated users will need to set up Manage My Clinic to restore access.

If you are not yet set up for Manage My Clinic, and wish to avoid deactivation, please fill out this **form** and email it to ProviderExperienceSanfordHP@sanfordhealth.org

Manage My Clinic allows clinic or site administrators to:

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

Additional information, including answers to frequently asked questions about Manage My Clinic are available on the **Sanford Health Plan website.**

Teladoc HEALTH diabetes management program update

Sanford Health Plan will discontinue its diabetes management program offered through Teladoc HEALTH, effective July 31, 2026. Members currently enrolled in the program will retain access through that date and have been notified directly.

Sanford Health Plan remains committed to supporting members with diabetes through alternative wellness and population health resources, including online wellness tools, virtual health coaching, fitness reimbursement options and access to diabetes-related equipment and supplies. Members may also continue to work directly with their primary care provider to support their diabetic care needs.

Meet the measure: Eye exam for patients with diabetes (EED)

Diabetes remains one of the leading causes of vision loss among adults, making regular diabetic retinal eye exams a critical component of preventive care. The HEDIS® Eye Exam for Patients with Diabetes (EED) measure evaluates whether members ages 18 to 75 with diabetes receive appropriate retinal eye screening to detect diabetic retinopathy before vision-threatening complications occur.

The measure is met when a member receives:

- A retinal eye exam during the measurement year, or
- A negative retinal eye exam performed by an eye care professional in the year prior to the measurement year.

Early detection and treatment of diabetic retinopathy can significantly reduce the risk of vision loss. However, many patients may not experience symptoms until the disease has progressed, making routine screening essential.

Providers can help improve EED performance by:

- Encouraging annual diabetic eye exams during office visits.
- Referring patients to an ophthalmologist or optometrist when needed.
- Following up with patients who have not completed recommended screenings.
- Ensuring eye exam results are received and documented in the medical record.

Accurate documentation is key. Medical records should clearly indicate the date of the exam, the eye care professional who performed the service and the results of the screening.

By working together to promote diabetic eye care, providers can help preserve vision, improve patient outcomes and close an important gap in care for members living with diabetes.

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

Sanford Health Plan earns NCQA accreditation

Sanford Health Plan has been awarded NCQA accreditation across major product lines, including commercial and exchange products.

NCQA accreditation is a comprehensive, voluntary evaluation that assesses how well health plans manage care delivery, including provider networks, utilization management, credentialing and member experience. This achievement reflects a shared commitment to quality, patient-centered care and continuous improvement.

Accreditation also complements NCQA ratings, which measure clinical and patient experience outcomes annually. Together, they reinforce the importance of strong partnerships between health plans and providers in delivering high-quality care.

Upcoming change to maternity care billing

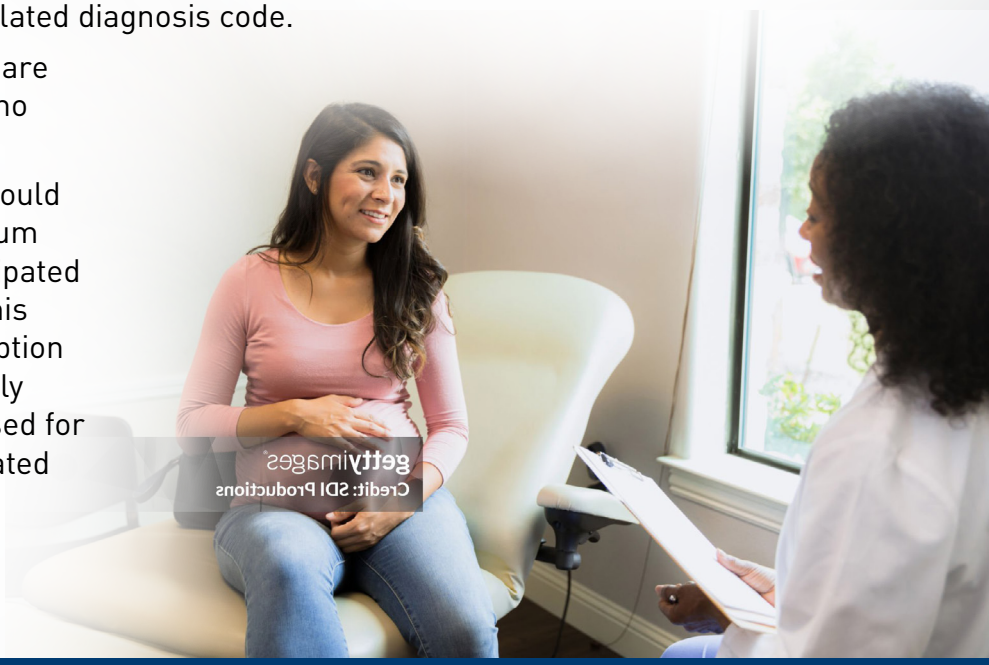
Billing for maternity care services will transition from the use of global maternity care codes to an itemized billing structure effective Jan. 1, 2027.

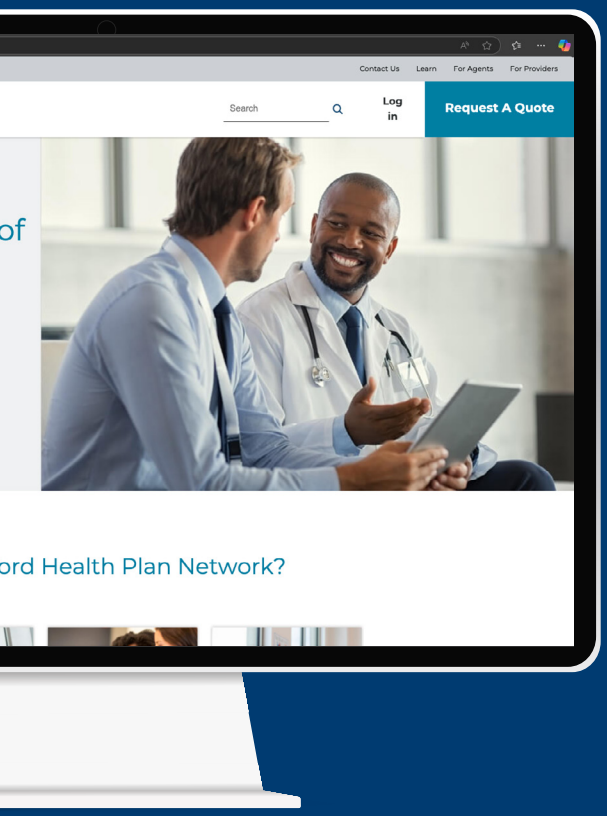
Under this new approach:

- Antepartum care must be reported per encounter using the appropriate Evaluation and Management (E/M) code, modifier TH 'Obstetrical treatment/services, prenatal or postpartum' and pregnancy related diagnosis code.
- The current global maternity care codes will be deleted and will no longer be valid for billing.

Implementation Guidance: Providers should begin adopting E/M coding for antepartum visits now for any patients with an anticipated delivery date on or after Jan. 1, 2027. This will ensure compliance, minimize disruption during the transition and avoid any timely filing issues. Global OB codes can be used for visits with patients who have an anticipated delivery before Jan. 1.

Additional resources are available through the AMA **here** and **here**.





Reminder: Portal access by line of business

As a reminder, Sanford Health Plan has separate provider portals for Medicare Advantage (MA) and non-MA lines of business.

Medicare Advantage

- For claims with dates of service on or after Jan. 1, 2026, **login here.** The portal access request form is **available here.**
- For claims with dates of service BEFORE Jan. 1, 2026, **login here.**

Individual & Family Plans, Employer-Sponsored Plans

- The portal for non-MA plans is **available here.**
  The portal access request form is **available here.**

Sanford Health Plan updates Milliman Care Guidelines (MCG) to 30th edition

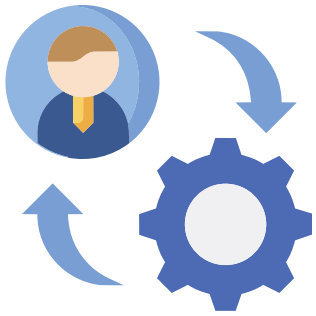
Sanford Health Plan is committed to ensuring that our clinical decision-making processes are grounded in the most current, evidence-based practices. As part of this commitment, we use Milliman Care Guidelines (MCG) as a trusted clinical resource to support consistent, high-quality care determinations.

Effective Jun 1, 2026, we adopted the MCG 30th edition, which incorporates the latest revisions and newly developed guidelines.

MCG is recognized for its rigorous and systematic approach to clinical content development. Each year, all MCG guidelines undergo a comprehensive evidence review conducted by an expert editorial team. This process evaluates the latest clinical research, best practices and emerging trends in healthcare. In addition, MCG content is subjected to an annual external review by actively practicing healthcare professionals, further ensuring that the guidelines reflect real-world clinical expertise and applicability.

As a result of these thorough review processes, new clinical content is introduced annually and existing guidelines are updated to reflect the most current evidence and standards of care. These enhancements help support accurate, consistent and transparent utilization management decisions.

If you have questions regarding this update or how MCG is applied within our processes, please contact our provider experience team at (800) 752-5863.



Updated subrogation review process

Sanford Health Plan is updating its subrogation process in mid-June. This update is intended to improve how claims involving potential third-party liability (TPL) payers are handled. While the same guidelines will continue to apply, the order in which the process is implemented will change.

When a claim is identified as potentially involving a TPL payer, it will enter a pending status while we contact the member to obtain additional information. If the member does not respond to our inquiry within 30 days, the claim will be denied to the member. Providers may bill the member for the charges as member responsibility.

As a provider, you will no longer receive recoupments due to members not completing their accident/injury investigation review. This will now be completed prepayment, avoiding repeated claim recoupments.

Closing gaps in care: A team effort to improve quality outcomes

As healthcare continues to evolve, quality measurement remains an important tool for improving patient outcomes and ensuring members receive recommended preventive and chronic care services. Many of these measures are evaluated through the Healthcare Effectiveness Data and Information Set (HEDIS®), a nationally recognized set of performance measures used by the National Committee for Quality Assurance (NCQA).

Providers play a critical role in helping health plans and patients achieve success on these measures. Annual wellness visits, preventive screenings, immunizations, chronic disease management and timely follow-up care all contribute to improved quality scores and, more importantly, better health outcomes.

One of the most effective ways to improve performance is to address care gaps during every patient encounter. Whether a visit is scheduled for an acute concern or chronic condition follow-up, taking a few moments to review preventive care needs can help ensure patients receive recommended services before they leave the office.

Accurate and complete documentation is equally important. HEDIS and NCQA measures rely on medical record documentation and administrative data to demonstrate that care was provided. Ensuring diagnoses, screenings, assessments, and treatment plans are documented appropriately helps reflect the quality care already being delivered.

Thank you for your continued partnership and commitment to providing high-quality care. Together, we can improve health outcomes, enhance the patient experience, and support the overall health of the communities we serve.

Changes coming to prior authorization verification process

As part of ongoing preparation to comply with interoperability rules that go into effect Jan. 1, 2027, Sanford Health Plan is updating prior authorization workflows within the provider portal. The change streamlines workflows, making it easier for providers to verify what services require authorization.

Providers will be able to determine if a procedure or service needs prior authorization before creating and submitting a referral. In some situations, providers will be directed to eviCore or Eviti to submit required documentation; in others, submissions will be completed directly within the portal.

A detailed tip sheet is linked here, but these are the key things to know about the upcoming change:

- The system identifies whether authorization is required for a particular service within the "Prior Authorization Requirements" activity tab. This eliminates the need to reference an outside resource or to contact customer service.
- A service can be searched by procedure (CPT/HCPCS code), and then any combination of the following additional criteria, though "diagnosis and "referred to provider" are the most important fields for ensuring an accurate response:
    - Coverage
    - Diagnosis
    - Referred by provider
    - Referred to provider
    - Referred to vendor
    - Place of service type
    - Referred to location

Please note: Certain healthcare services or treatments associated with specific diagnoses may be excluded from coverage unless otherwise stated in a member's applicable benefit plan documents. Prior authorization requirements and authorization determinations do not guarantee coverage or payment. Coverage determinations remain subject to member eligibility, benefit limitations and exclusions, medical necessity, coding accuracy, provider network status and all applicable reimbursement policies in effect at the time services are rendered. Please reference the applicable plan documents and/or benefit reimbursement policies for additional details regarding exclusions and limitations, including those related to diagnosis codes (ICD-10-CM), CPT/HCPCS codes, modifiers, revenue codes, provider specialty, place of service, frequency limits and documentation requirements.

We'll post an announcement on the provider portal when the new functionality goes live.

Questions can be directed to our provider experience team at (800) 752-5863.

EviCore, Eviti authorization revisions and downcoding requests

How to request authorization revisions to the high-end imaging submitted through EviCore:

- Downcoding (lower-level CPT code)
    - The requesting provider may:
        1. Update the authorization directly through the EviCore Provider Portal, or
        2. Call EviCore Intake for assistance.
- Upcoding (higher-level CPT code)
    - The requesting provider must call EviCore's intake department at (844) 635 7225 to request this change.
- Facility changes
    - Only the requesting provider can request a facility update.
    - This change must be made by calling EviCore's intake department at (844) 635 7225.

Eviti Radiation Oncology downcoding requests

The health plan does not accept automatic downcoding of radiation oncology services. Radiation treatment codes are not always equivalent.

If a provider believes a different code is more appropriate after submitting prior authorization for the radiation treatment plan, the recommended best practice is to **resubmit the updated treatment plan for prior authorization review.** This ensures the codes match the actual clinical approach and supports accurate processing.

Thank you for your cooperation in maintaining accurate coding and documentation.

Working together for better member health in 2026

Sanford Health Plan is launching a coordinated campaign designed to help Medicare Advantage members take meaningful steps to improve their health while aligning closely with the care you provide.

Members received monthly messages focused on annual wellness visits (AWV), preventive screenings, CAHPS and HOS survey readiness, medication adherence and pharmacy access throughout the first calendar quarter of the year. Throughout the second quarter, messages are focused on bladder health, physical activity, fall prevention, mental health, immunizations and more. Communications will be delivered through a variety of channels, giving members simple, actionable prompts to build health literacy and encourage follow through.

To support you throughout the year, we will also share regular updates and insights in our provider newsletters. These updates will outline upcoming member communication topics, tips for reinforcing key messages during visits and reminders about available resources – ensuring you always know what your patients are receiving and how best to complement those efforts. Click the links to view the latest flyers about **Improving collaboration and quality outcomes** and **Supporting proactive care conversations.**

We appreciate your role in shaping outcomes with our members. Together, we can help members stay engaged, empowered and connected to the care they need throughout 2026.

Contact Us

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

Customer Service (800) 752-5863
Monday-Friday, 8 a.m.–5 p.m. CST
providerexperience.sanfordhp@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/update information, provider education

Provider Experience (800) 752-5863
providerexperience.sanfordhp@sanfordhealth.org

CONTACT FOR: Demographic updates, W-9 submissions, change/update information and other provider record changes

Provider Configuration (800) 752-5863
providerconfig@sanfordhealth.org

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

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

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

Customer Service (877) 509-4979 | TTY: 711
Utilization Management (877) 509-4979
Pharmacy Dept (844) 642-9090

CONTACT FOR: Great Plans Medicare Advantage (ISNP)

Customer Service (877) 492-5189 | TTY: 711
Utilization Management (877) 492-5189
Pharmacy Dept (855) 800-8872

Hearing or speech impaired TTY | TDD 711

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647-334-569 Rev. 6/26