

Important Information for Providers about Sanford Health Plan

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sanfordhealthplan.com



Sanford Health Plan (Plan) asks you to take some time and review this information. The following annual notices are required to keep you informed of Sanford Health Plan operations and outcomes.

Where can I find important Plan information?

If you have any questions...

Provider Relations	Phone: (800) 601-5086 Email: providerrelations@sanfordhealth.org
Care Management Behavioral Health	Phone: (888) 315-0884 Phone: (888) 315-0876 Email: quality@sanfordhealth.org
Utilization Management	Phone: (800) 805-7938 TTY/TDD: (877) 652-1844 (toll-free) Fax: (605) 328-6813
NDPERS:	Phone: (888) 315-0885 TTY/TDD: (877) 652-1844 (toll-free) Fax: (701) 234-4547
ND Medicaid Expansion:	Phone: (855) 276-7214 TTY/TDD: (877) 652-1844 (toll-free)
Pharmacy Management	Phone: (855) 305-5062 Fax: (701) 234-4568
NDPERS:	Phone: (877) 658-9194
Compliance / Privacy	Email: compliancehotline@sanfordhealth.org
Customer Service	Phone: (800) 752-5863, Monday – Friday, 8 a.m. to 5 p.m. CST
NDPERS:	Phone: (800) 499-3416, Monday – Friday, 8 a.m. to 5:30 p.m. CST
ND Medicaid Expansion:	Phone: (855) 305-5060, Monday – Friday, 8 a.m. to 5 p.m. CST

The Utilization and Pharmacy Management departments are available between the business hours of 8 a.m. to 5 p.m., CT, Monday through Friday (excluding holidays). For North Dakota Public Employees Retirement System (NDPERS), the Utilization and Pharmacy Management departments are available between the business hours of 8 a.m. to 5:30 p.m. CT, Monday through Friday (excluding holidays). After business hours, you may leave a confidential voicemail and someone will return your call the next business day.

Sanford Health Plan’s provider webpage (sanfordhealthplan.com/providers) contents:

- Forms, Documents & Manuals link
 - Provider manual
 - Contracting and credentialing information
 - Miscellaneous forms & documents
 - Request for benefit consideration form
- Referral Center
 - Provider service form
- Provider News link
 - Provider newsletters and annual notices
- Medical Services & Drugs Prior Authorization link
 - Pharmacy benefits/formulary information
 - Locating a provider or pharmacy
 - How to prior authorize and what needs prior authorizations
- Provider EDI Resources link
 - Electronic data interchange services & information
- Clinical Resources link
 - Behavioral health resources & tools
 - Clinical resources & tools
 - Clinical practice guidelines

- Preventive health guidelines
- Various training and education for practitioners and members including those for our clinical areas of improvement
- ND Medicaid Expansion link
 - Appeal rights and filing form
 - Lock in (CSP) program
 - Provider FAQ
 - Provider enrollment guidance
 - Provider network
 - Transportation information
 - Summary of benefits and coverage
 - Transition of care form
- Quality Improvement Program link
 - Quality improvement program
 - HEDIS® report*

mySanfordHealthPlan Provider Portal (sanfordhealthplan.com/providerlogin)

mySanfordHealthPlan is Sanford Health Plan’s online tool available to providers. Through this secure online tool, you have access to information 24/7 to:

- View copay deductibles, coinsurance and out-of-pocket totals for members
- Verify member eligibility and view covered family member(s)
- Submit medical and pharmacy prior authorizations and online claim reconsiderations
- Access the provider manual and policies
- Check status of claims
- Obtain copies of explanation of payments
- View the HEDIS provider guide & toolkit

To request a mySanfordHealthPlan account, follow these steps:

1. Go to sanfordhealthplan.com/providerlogin
2. Click on “Create an Account”
3. Enter all the required account information on the following screens, then click “Finish”

Your information will then be submitted to be reviewed for approval. Once your account has been approved, you will receive an email from Sanford Health Plan. Afterward, you will be able to log on to your provider account using the User ID and Password you created upon setting up your account. If you have any questions or need assistance with setting up an account, please contact Provider Relations.

Fraud, Waste & Abuse and Related Laws

Sanford Health Plan’s (SHP) fraud, waste and abuse policy and program were established to identify and eliminate any fraudulent, wasteful or abusive uses of claims/services perpetrated by employees, members, participating/non-participating providers and facilities. Compliance is the responsibility of every employee of SHP, provider and anyone providing services to members of any of SHP benefit plans. Providers should ensure ALL staff, subcontracted staff and vendors are thoroughly educated on state and federal requirements and appropriate compliance programs are in place.

Sanford Health Plan expects First-Tier, Downstream and Related entities (FDRs) (providers) to operate in accordance with all applicable federal and state laws, regulations, Medicare, Medicaid/Medicaid Expansion and Marketplace program requirements including, but not limited to the following:

1. Deficit Reduction Act of 2005
2. Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)
3. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)
4. Civil Remedies False Claims Act 31U.S.C. 22729 - 3372
5. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
6. The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))
7. Physician Self-Referral (“Stark”) Statute (42 U.S.C. § 1395nn)
8. Fraud Enforcement and Recovery Act (FERA) of 2009
9. Social Security Act (United States Code: Social Security Act, 42 U.S.C. §§ 1128c-1128e, 1128k)
10. Minnesota Statutes-609.611 INSURANCE FRAUD
11. South Dakota Code section 58-4A-2: Fraudulent Insurance Acts
12. North Dakota Century Code- CHAPTER 26.1-02.1- INSURANCE FRAUD

* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® results do not include elite1 individual plan membership data.

FWA Training and Education

All health care practitioners/providers or staff who render health care services are required to complete fraud, waste, and abuse (FWA) training (42 CFR 422.503 & 423.504). Examples of plans include but are not limited to Medicare, Medicaid/Medicaid Expansion, Marketplace, etc.

- The training should be completed upon hire (within 90 days) and annually thereafter. The training will be accepted if taken on the Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network website (MLN). Link to the CMS FWA **and** compliance training slides are listed below.
- MLN General Information - Centers for Medicare & Medicaid Services
 - [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-Products.pdf)
 - [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html)
- All health care practitioners/providers and employees that have taken the trainings should maintain records for 10 years to show completion of these trainings.
- Practitioners/providers who utilize vendor services are responsible to attest their oversight of the vendors, compliance and FWA training/education.

Reporting

Sanford Health Compliance actively reviews all reports of suspected FWA or noncompliance. To report suspected fraud, waste or abuse and/or suspected compliance issues email compliancehotline@sanfordhealth.org or call the compliance hotline at 800-325-9402.

You may also call the toll-free hotline established by the Federal Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services. The hotline number is (800) HHS-TIPS ((800) 447-8477). For more information about this hotline and about other ways to contact the OIG, you can go to oig.hhs.gov/fraud/report-fraud/index.asp.

Sanford Health Plan maintains a **NO TOLERANCE** policy in terms of retaliation for anyone reporting issues in good faith; everyone should feel confident that **NO** adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

2019 Quality Improvement Progress Report

Sanford Health Plan and its participating providers are committed to providing high quality health care to our members. The following is a list of the Plan's current quality programs designed to make sure members get the right care, at the right time and the right place. For more information on the Plan's QI program and outcomes, see our HEDIS® Report and the Quality Improvement Program summary on our website. A HEDIS Provider Guide & Toolkit is also available as a resource on our provider portal. This toolkit is designed to help clearly define some of the HEDIS measures and their criteria, along with providing helpful tips for improving rates. You may also call the Plan to request a copy of these documents.

Clinical areas of Quality Improvement

- Population Health – **New 2020**
 - Promoting colorectal and breast cancer screenings for eligible members
 - Members with chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease and hypertension to:
 - Prevent health complications
 - Provide assistance in managing their health
 - Ensure their care is coordinated
- Diabetes Health Quality Improvement Activity
- Improving Antibiotic Utilization Quality Improvement Activity
- Increasing Timely Follow Up after Hospitalization for Mental Illness Quality Improvement Activity

Behavioral Health and Substance Use Disorders

The Plan's activities to improve follow-up after inpatient treatment for behavioral health and/or substance use disorder discharges, and compliance with antidepressant medications, include:

- Letters sent on a monthly basis to members new on antidepressants who have not yet filled their first refill; continue to incorporate depression education/resources into other health management programs
- Behavioral health team makes member referrals to employer groups who participate in the Plan's EAPs
- Practitioners notified of the recommended clinical practice guidelines for depression
- Timeliness of Care Survey completed and included an assessment of a sample of clinics primarily treating behavioral health and substance use disorders, and compliance with the Plan's access standards for behavioral health, including behavioral health and substance use disorder, appointments; clinics included in the survey were sent a follow-up letter to notify them of their compliance with Plan standards

- The Plan's behavioral health team works with the hospital's discharge planners to arrange a follow-up appointment within seven days of discharge
 - Member newsletter included articles on managing chronic health conditions
 - To increase awareness of available behavioral health and substance use disorder treatment services, Quick Reference Behavioral Health Cards are available to help primary care practitioners to assist in locating Sanford Health Plan participating behavioral health and substance use disorder practitioners in their area
 - The Plan also collaborates with behavioral health and substance use disorder treatment professionals and external organizations to ensure the appropriateness of our activities involving behavioral health and/or substance use disorders
 - Behavioral Health Surveys were completed and included an assessment of member satisfaction responses of provider care, access and appointment availability, medication management, and satisfaction of user ability of the Plan's website. The Plan used this data to identify quality improvement activities, implement interventions and measure intervention effectiveness

Attention Deficit/Hyperactivity Disorder (ADD/ADHD)

The ADHD activity focuses on improving the rates of appropriate follow-up for members prescribed ADHD medications:

- Newly identified members with ADHD are sent educational materials on the symptoms, treatment and follow-up recommendations for patients taking ADHD medications
- Practitioners are notified of the recommended clinical practice guidelines for ADHD; tools are also available on the webpage (as shown above in the Website Content Listing)
- Quick Reference Behavioral Health cards were updated

Adolescent Health

Our adolescents and their parents'/guardians' are offered educational information about the importance of wellness visits and staying up-to-date on immunizations. Examples include:

- KidsHealth website – this site includes a great deal of educational information for kids and parents. It is located in our Member Portal
- Bright Futures Adolescent Wellness Office Visit Questionnaire
- Immunization schedule
- The member newsletter included articles on adolescent wellness visits and their benefit versus a sports physical and HPV and meningococcal vaccine recommendations
- In addition, practitioners are notified of Clinical Practice Guidelines

Cancer Screening

Cancer screening activities focuses on improving the rates of screening for breast cancer, cervical cancer and colorectal cancer. The following are activities completed to improve these rates:

- Preventive Health Guidelines include cancer screenings
- Practitioners are notified of the recommended clinical practice guidelines for cancer screening
- With the implementation of Sanford Health's electronic medical record system, OneChart, the health maintenance screen helps to remind physicians of those patients who are due for screening tests
- Newsletters also contain various articles regarding cancer screening tests and the Plan's benefits
- Preventive screenings are addressed by the nurse case managers in private conversations with members, when applicable
- Email reminders to age specific members regarding cancer screenings
- Postcards sent to members in targeted age groups who had not had a mammogram offered screening options: locations, phone numbers and hours of operation (expanded hours at some of the facilities in October)
- FIT postcard sent to members (55-59 years old) who did not have a colorectal cancer screening; the postcard outlined FIT as a screening option and encouraged members to talk to their doctor about getting screened
- A letter and well-woman visit checklist was sent to members (20-24 years old) to encourage yearly visits and to talk with their doctor about what screenings and vaccinations are appropriate

Tobacco Cessation

The following activities are offered to promote tobacco cessation among the Plan's membership:

- The Plan covers tobacco cessation counseling and medications as part of the preventive benefits.
- All Sanford Health Plan Health Management program sand other quality improvement activities and member newsletters stress the importance of smoking cessation and the many resources available to our members to help them quit as well as the Plan's tobacco cessation benefit information
- Care Management nurses discuss tobacco use with members and also assist in coordinating resources for tobacco cessation
- Smoking cessation information included in the Member Messenger newsletter
- Sanford Health Plan's Wellness Educators are certified as health and wellness coaches; they lead tobacco cessation classes upon request from clients; the educators continue to provide one-on-one counseling with members as needed
- Tobacco cessation web pages were added to our website and include education and resources (for adults and kids)

- Practitioners are notified of the recommended clinical guidelines for tobacco cessation

Non-clinical areas of Quality Improvement (QI)

Member Experience Surveys

The Plan's member experience surveys take place on a yearly basis. These surveys are conducted by an independent survey vendor and provide information on the experiences of our members with the Plan and how well we meet our members' expectations. There are overall ratings of satisfaction in addition to more focused composite scores which summarize survey responses in key areas. The Plan's QI Committee analyzes the results and takes actions for improvement. For more information on the Plan's rates, refer to our HEDIS® Report as referenced in the Website Content section above.

Customer Service phone calls

This activity involves ongoing monitoring of the Customer Service department phone call statistics including calls answered, abandoned calls, and average answer speed of calls. Additional training and staff meetings are held to improve these rates and representatives are shown their individual statistics to help them improve their personal performance. Additional staff have been added to address the increasing volume of calls over time and to improve performance in these rates.

Timeliness of Care

This project monitors the appointment access of the Plan's participating practitioners. Starting in 2017, surveys were mailed to a random sample of clinics to determine their compliance with the Plan's standards for access. All clinics receive a copy of their results and a list of the Plan's access standards. Clinics who do not meet the standards are asked to develop an action plan to assist them in meeting the Plan's appointment access standards.

Behavioral Health Survey

Once a year, the Plan conducts a member experience survey from its population of members who have used behavioral health services. Surveys are mailed to members to determine member satisfaction of provider care, medication management, appointment availability, access to provider satisfaction, and user ability of the Plan's website. From this data, the Plan is able to identify quality improvement activities, implement interventions and measure intervention effectiveness.

Our Commitment to Quality

Have you received mailings, emails or phone contacts from Sanford Health Plan and wondered why?

Sanford Health Plan is more than just an insurance company. We are part of a large integrated health system with a variety of resources to offer. This includes health information and tools to help manage health needs, assistance finding a primary care practitioner or specialist, as well as assistance with benefit coverage. In addition, we do quality improvement activities and care management programs for members who have more serious health needs. These programs and activities are intended to provide information and tools to improve health and quality of life.

Complex Case Management and CCM Referral Guide

Sanford Health Plan's Complex Case Management Program is available at no cost to qualifying Plan members and their families. Complex Case Management (CCM) is the coordination of care and services provided to members who have experienced a critical event or have a complex medical condition requiring the extensive use of resources and who need help navigating the health care system. The goal of the CCM program is to assist members in regaining optimum health or improved functional capability by monitoring their care to ensure it follows evidence based clinical standards to promote care gap closure, appropriate use of health care resources and cost-effectiveness. The CCM program involves a comprehensive assessment of the member's condition, determination of available benefits and resources, development and implementation of a case management plan with performance goals, monitoring and follow-up.

Is there a cost for the CCM program?

No – Sanford Health Plan's Complex Case Management Program is available to qualifying Plan members and their families at no cost.

How does the program work?

A designated case manager is responsible for managing these complex cases to ensure high quality, cost-effective and appropriate utilization of health services. Case managers are registered nurses and behavioral health counselors who act as member advocates, seeking and coordinating creative solutions to meet health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone or mail and acts as a resource, educator and coordinator of medical services.

What qualifies a member for the program?

Concentrating for the most part on catastrophic or chronic cases, case managers consult and manage:

- Multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses resulting in high utilization
- Individuals with physical or developmental disabilities, serious and persistent mental illness, or severe injuries
- High risk or complicated medical conditions (i.e., transplants, spinal cord injuries, cancer)
- Multiple re-admissions

- Individuals identified from predictive modeling reports based on high cost, likelihood of hospitalization, projected total risk, etc.

How do I refer a Sanford Health Plan member for the program?

If you would like more information about CCM, or if you would like to refer a qualified Sanford Health Plan member for the program, please contact our Care Management department.

For Sanford practitioners: If a Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart. Please feel free to use in-basket messaging to contact the Plan case manager directly. You can also send an in-basket message to “SHP CRM CT Case Management” if you are unable to determine the assigned case manager.

Clinical Practice Guidelines

Sanford Health Plan is responsible for adopting and distributing clinical practice guidelines for acute, chronic and behavioral health care services that are relevant to our membership. The Plan’s multi-specialty physician committee, the Physician Quality Committee, has reviewed, approved and updated practice guidelines for numerous conditions for use as the Plan’s primary clinical practice guidelines.

Please visit our website at sanfordhealthplan.com/providers/resources to find links to the adopted guidelines. If you have any questions or suggestions regarding these guidelines, or to request a copy of the guidelines, please call Provider Relations.

Preventive Health Guidelines

Sanford Health Plan recognizes that health promotion and disease prevention are the best opportunities to reduce the ever-increasing portion of resources spent to treat preventable illnesses and impairments. As a Plan, we want to educate our members on how to cut health care costs, prevent premature onset of disease and disability, and to help all members achieve healthier and more productive lives.

Preventive Health Guidelines are age- and gender-specific. They describe prevention or early detection interventions, recommendations for frequency and conditions under which the interventions are required. Appropriate practitioners are involved in the development of preventive health guidelines (i.e., practitioners who are from specialties that would use the guidelines).

Members of Sanford Health Plan are encouraged to utilize preventive health services, health education and health promotion through preventive health services, educational classes and other articles on prevention in special mailings or in the Member Messenger newsletters.

Current Preventive Health Guidelines are available on our website at sanfordhealthplan.com/providers/resources for both members and practitioners (the practitioner version includes the codes that are to be used for these preventive services). A paper copy is available by calling Provider Relations.

Utilization Management (UM)

Utilization Management (UM) decision-making is evidence-based and reviewed for medical necessity in accordance with Plan coverage. Sanford Health Plan does not reward practitioners or other individuals conducting utilization review for issuing denials. Financial incentives are not offered to UM decision-makers, and do not encourage any decisions that result in under-utilization, nor denials of service or coverage. Decision-makers sign an “Affirmative Statement Regarding Incentives” verifying the above conditions.

Physician or pharmacist reviewer availability

A physician or pharmacist reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness.

Services that require pre-approval (pre-authorization/certification)

Inpatient hospital or other facility admissions, including medical, surgical, neonatal intensive care nursery, mental health and/or substance use disorders, select outpatient services, home health services, skilled nursing and sub-acute care, transplant and oncology services, prosthetic limbs, genetic testing, insulin infusion devices, requests to non-participating providers recommended by participating providers, dental anesthesia (for certain ages and conditions), bariatric surgery (if a covered benefit), and/or external hearing aids (that is not due to the gradual deterioration that occurs with aging or other lifestyle factors) if a covered benefit. For a more complete listing of services that require prior authorization, please visit sanfordhealthplan.com/providers/prior-authorization.

Not all services prescribed or recommended by yourself or health care practitioner may be covered by the Plan.

Services

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.

Points to remember:

- **The member is ultimately responsible** for obtaining prior authorization from the Utilization Management department in order to receive in-network coverage. However, information provided by your office will also satisfy this requirement.
- All requests for authorization are to be made by the member or their practitioner's office at least three (3) working days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management department to request an expedited review.
- All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.

How to request prior authorization

Prior authorizations for health care services can be obtained by contacting the Utilization Management department online, by phone or fax. NOTE: Oncology treatment and services must be entered and authorized through eviti|Connect online at eviti.com.

- Online: Select "Authorizations" in your secure *mySanfordHealthPlan* account. Click on either "Submit a Pharmacy Preauthorization" or "Submit a Medical Preauthorization" depending on your request. Once you complete the required information click "Submit."

Criteria

Every year, the Plan's Physician Quality Committee reviews the Plan's medical policies and procedures, quality programs and clinical practice guidelines. The Physician Quality Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on issues of care.

The Committee consists of physician members from various specialties, including a behavioral health practitioner, and meets at least six times a year. The Plan's Senior Director, Medical Services reports on the Committee's activities to the Board of Directors on a quarterly basis. The Committee is actively involved in the development of quality initiatives and health management programs. It is also responsible for approving and annually reviewing utilization management criteria. Any recommended changes in the criteria or any other program changes are approved by the Board of Directors.

The Pharmacy and Therapeutics Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on pharmaceutical coverage. The Committee membership consists of physicians and pharmacists representing retail and hospital-based pharmacies. Specific specialty physicians are also invited to attend meetings per drug topic or disease managed state reviewed if current Committee membership does not support the topic up for review. The Pharmacy Benefit Manager (PBM) has an assigned clinical pharmacist that actively participates in all aspects of formulary development, ongoing management, and resource management. Sanford Health Plan employs clinical pharmacists to assist in the day-to-day management of the pharmacy program. No incentives are given to providers or pharmacists for using specific drugs. Sanford Health Plan currently does have some mandated generic substitution programs in place in their pharmacy benefit program, as well as some step-therapy protocols for multiple drug categories.

All practitioners are welcome to have input into the activities of both committees. Suggestions concerning quality programs, health management programs, clinical practice guidelines, and utilization management criteria are welcome and can be directed to the Senior Director, Medical Services by mail or by phone at (605) 328-6807 or (800) 805-7938.

To access medical policy criteria, providers may log into our Cite Transparency® through the Provider Portal at sanfordhealthplan.com/providerlogin to access. You may also request a copy of the criteria used by contacting the Utilization Management Department.

New medical technologies/new applications for existing technologies, experimental/investigational procedures

To ensure members access to safe and effective care, Sanford Health Plan has adopted a process to evaluate and address new developments and new technology in medical and behavioral health procedures, pharmaceuticals and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, medical and behavioral health procedures, pharmacological treatments and devices as well as their application for the Plan members. The Physician Quality Committee includes a practitioner who specializes in behavioral health care in this decision-making process. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee, may be invited to present the technological aspects of the service/procedure/pharmacological treatment, as needed.

Published scientific evidence and information from literature and the internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. Investigational and experimental treatments/medications will not be approved for usage under the Sanford Health Plan Benefits Policy guidelines.

To be eligible for consideration of coverage all of the following must be met:

1. The technology must have final approval from appropriate government regulatory bodies (i.e. FDA).
2. The published scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. (literature, internet or specialist review).
3. The technology must improve net health outcomes.
4. The technology must be at least as beneficial as all established alternatives.
5. The health benefit must be attainable outside an investigative setting.
6. External health care experts utilized in the review process shall include licensed or qualified health care professionals in the field of study or treatment for which the experimental treatment review is taking place, i.e., licensed chiropractors will review experimental/investigative treatments in the area of chiropractic care.

This review will start with the completion and submission of the Request for Benefit Consideration form (Forms, Documents & Manuals link) that will be reviewed for medical content and prioritization. This process will consider factors such as medical impact, safety, efficacy, clinical trial phase, and cost-to-benefit ratios. After submitting the Request for Benefit Consideration form, it may take several months to be incorporated into a covered benefit option.

The completion of the Request for Benefit Consideration form does not guarantee coverage of benefits, and the request must be completed prior to claim submission of the new product or service.

The next step is the determination of coverage or a denial. This step will be a review by many departments in the Plan. Once the coverage options are discovered, it will move onto a Physician Quality Committee review. Once the new technology or new application of an existing technology has been reviewed by the Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future. The Medical Management policy that uses the MCG (Milliman Care Guidelines) criteria will be developed by the Medical Management staff and will be presented at the same time. This would become the policy for this new health care service, medical and behavioral health procedure, pharmacological treatment or device.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, Sanford Health Plan will notify practitioners by way of the newsletter, if appropriate.

The Senior Director, Medical Services and the Physician Quality Committee will consider all requests for coverage based on the Benefits Policy guidelines. If you would like more information on either of these policies, please contact Utilization Management.

Pharmacy and Formulary information

The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic medications chosen by health care providers on the Pharmacy and Therapeutics (P&T) Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Changes are made throughout the year as warranted, with a complete review performed each year.

A listing of the formularies, medications requiring step therapy, medications requiring prior authorization, and a link to pharmacy directories are available online at sanfordhealthplan.com/providers/pharmacy-information.

To be covered, medications must be

1. Prescribed by a licensed health care professional within the scope of his or her practice.
2. Listed in the Plan Formulary, unless certification is given by the Plan.
3. Provided by a participating pharmacy except in the event of a medical emergency.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Formulary Designs

Depending on the plan, prescriptions may apply toward a tiered copay structure when choosing generic or preferred brand name medications, or medications may go toward the deductible if it's a high deductible health plan. If the benefit plan offers tiered formularies, the higher the tier means the higher the copay/cost-share (except for high-deductible HSA plans).

2-Tier Formulary

- Tier 1: generic medications
- Tier 2: covered brand name medications

3-Tier Formulary

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications

4-Tier Formulary

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: specialty medications*

5-Tier Formulary

- Tier 1: preferred generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: preferred specialty medications*
- Tier 5: non-preferred specialty medications*

*Specialty Medications – Specialty medications are typically used to treat complex medical conditions. These medications may require frequent dosing adjustments, close monitoring, special training, or compliance assistance. In addition, specialty medications may need special handling and/or administration, and may have limited or exclusive product availability and distribution.

Step Therapy Program

A program that requires certain medications to be used in a specific order, or by “steps.” If there’s a trial of a “first-step” medication and it does not work, the member experiences adverse side effects, or any of the other exceptions listed in the Step Therapy policy, then the next step medication may be tried, etc. This program is designed to save the member money by trying alternative medications before more expensive medications are used.

Pre-approval of medication (pre-authorization/certification)

Select medications require prior-authorization before coverage. Prior authorizations for medications may be obtained by contacting the Pharmacy Management Department:

- **Online:** Providers: Select “Authorizations” in your secure *mySanfordHealthPlan* account. Click on “Submit a Pharmacy Preauthorization”. Once you complete the required information click “Submit.”
- **Fax:** Fax the Prescription Drug Prior Authorization Request and Formulary Exception Form and supporting documentation (this form is REQUIRED for all requests submitted via fax).

Exceptions to the Formulary

If the member, or you, as their health care practitioner, feels that a certain non-formulary medication is medically necessary for their condition, an exception may be available. They must first try formulary medications before an exception to the formulary will be made for non-formulary medication, unless the member has contraindications to all covered formulary medications or there is a specific clinical basis where the formulary medications are not appropriate (clinic notes documenting the contraindications or clinical basis for exception must be provided). To request an exception, you, as their provider, must complete the Prescription Drug Prior Authorization Request and Formulary Exception form, and return to Sanford Health Plan (along with supporting clinical documentation), or submit an exception request through the Provider Portal at sanfordhealthplan.com/providerlogin. Requests will be reviewed and the member and provider will be notified of the determination by mail. For urgent requests, or requests for members with MN-based benefit plans, the determination will also be communicated via telephone or telecommunication device.

The Plan will use appropriate pharmacists and/or practitioners to consider exception requests and promptly grant an exception to the formulary, including exceptions for anti-psychotic and other behavioral health medications, when the health care practitioner prescribing the medication indicates to the Plan that:

1. The formulary medication causes an adverse reaction in the patient;
2. The formulary medication is contraindicated for the patient; or
3. The prescription medication must be dispensed as written to provide maximum medical benefit to the patient.

If there is an adverse determination regarding the request, or if there is a wish to appeal, please follow the Complaints and Appeals Procedure and the External Review Rights, located in the Provider Manual. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

For more detailed pharmacy information

Please refer to the Pharmacy Information link for the following documents for specific medication coverage information. Members received this information upon enrollment, but copies may also be obtained (1) online on our Provider Portal or (2) by calling Customer Service.

1. **Summary of Benefits and Coverage** – describes the payments for which members are responsible when purchasing prescription medications and supplies;
2. **Policy/SPD/COC/COI** – describes how and where to obtain prescription medications and supplies, dispensing limitations, and excluded medications and supplies.
3. **Covered Medication List or Formulary**– list containing the most commonly prescribed medications that are covered under a member’s benefit plan (for the complete list, or for specific details about drug coverage, login to the Provider Portal and click “Covered Medication List” under the specific member.)

Filing Claims

Sanford Health Plan participating providers are required to submit claims on members’ behalf. Claims should be submitted to Sanford Health Plan. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency. Accepted claims forms are a standard CMS, UB or ADA claim. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted using current coding and within 180 days, or as defined in your contract, even if the member has exceeded their deductible or copay amounts. For more information on what EDI transactions are available to you through Sanford Health Plan, see the ‘Provider EDI Resources’ page on our website, or view the information in the provider manual.

Paper Claims Submission

If you cannot file claims electronically, paper claims may be mailed to:

Sanford Health Plan Claims Department
PO Box 91110
Sioux Falls, SD 57109-1110

To improve our turnaround time and accuracy of paper claim processing, we use a scanning procedure through the Smart Data Solutions (SDS) system. It is important for you to know that the SDS system uses optical character recognition (OCR). Therefore, when OCR is used, your provider name must match our records in order for the system to correctly identify the “pay to” information. If a mismatch occurs, or if the claim cannot be read, you will receive a letter from SDS asking you for the missing or illegible information. A prompt response will prevent further delay in processing your claim. When sending paper claims, please follow the ‘Paper Claims Submission’ guidelines outlined in the Provider Manual.

Member Rights & Responsibilities

Important Member Enrollee Information (Minnesota Plan Members Only)

The HMO coverage described in a Member's policy may not cover all their health care expenses. Providers can review the policy in detail or contact Customer Service to determine which expenses are covered.

The laws of the state of Minnesota provide Members of an HMO certain legal rights, including the following:

1. **COVERED SERVICES.** These are network services provided by participating Sanford Health Plan network providers or authorized by those providers. Your Policy fully defines what services are covered and described procedures you must follow to obtain coverage.
2. **PROVIDERS.** Enrolling with Sanford Health Plan does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the Sanford Health Plan network, you must choose amount from remaining Sanford Health Plan network providers.
3. **EMERGENCY SERVICES.** Emergency services from providers outside the Sanford Health Plan network will be covered only if proper procedures are followed. Read this Policy for the procedure, benefits and limitations associated with emergency care from Sanford Health Plan network and non-Sanford Health Plan network providers.
4. **EXCLUSIONS.** Certain service or medical supplies are not covered. Read your Policy for a detailed explanation of all exclusions.
5. **CANCELLATION.** Your coverage may be cancelled by you or Sanford Health Plan only under certain conditions. Read your Policy for the reasons for cancellation of coverage.
6. **NEWBORN COVERAGE.** A newborn infant is covered from birth. Sanford Health Plan will not automatically know of the newborn's birth or that you would like coverage under this Plan. You should notify Sanford Health Plan of the newborn's birth and that you would like coverage. If your Policy requires an additional payment for each dependent, Sanford Health Plan is entitled to all enrollment payments due from the time of the infant's birth until the time you notify the Plan of the birth. Sanford Health Plan may withhold payment of any health benefits for the newborn infant until any enrollment payment you owe is paid.
7. **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT.** Enrolling with Sanford Health Plan does neither guarantees that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Policy year.

ENROLLEE BILL OF RIGHTS (Minnesota Plan Members Only)

1. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
2. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
3. Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers.
4. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
5. Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
6. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

South Dakota, Iowa, Minnesota and North Dakota Individual and Group Policy Member Rights

Sanford Health Plan is committed to treating Members in a manner that respects their rights. In this regard, Sanford Health Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; color; national origin; gender; gender identity; age; sex; sexual orientation; medical condition, including current or past history of a mental health and/or substance use disorder; disability; religious beliefs; or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right, but are not required, to select a Primary Care Practitioner (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
5. Members have the right to expect communications and other records pertaining to their care, including the

source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable State law.

6. Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
7. Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or Medically Necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make interpreter services available. Sanford Health Plan provides Member information in plain language and in a manner that is accessible and timely. Sanford Health Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
10. Members have the right to receive printed materials that describe important information about their coverage in a format that is easy to understand and easy to read.
11. Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
12. Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
13. Members have the right to terminate coverage, in accordance with employer/and or Sanford Health Plan guidelines.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. Members have the right to receive information about Sanford Health Plan, its services, its Practitioners and Providers and Members' rights and responsibilities.

Member Responsibilities for Minnesota, North Dakota, Iowa, and South Dakota

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their ID cards with them and for having Member identification numbers available when telephoning or contacting Sanford Health Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at an In-Network Participating Practitioner and/or Provider whenever possible. In the event an ambulance is used, the Member must direct the ambulance to the nearest In-Network Emergency Facility unless the condition is so severe that the Member must use the nearest Emergency Facility. State law requires that the ambulance transport the Member to the Hospital of his/her choice unless that transport puts the Member at serious risk.
5. Members are responsible for notifying as soon as reasonably possible and Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
7. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for notifying Sanford Health Plan within thirty (30) days at (800) 752-5863 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*) or (605) 328-6800 if they change their name, address, or telephone number.
10. Members are responsible for notifying Sanford Health Plan or the Group of any changes of eligibility that may affect their membership or access to services. If the Member notified the Group, the Group is responsible for notifying Sanford Health Plan.

North Dakota Medicaid Expansion Member Rights

The Plan is committed to treating Members in a manner that respects their rights. In this regard, the Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is incapacitated) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care, in accordance with access and quality standards.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity and personal privacy.
3. Members have the right to request and receive a copy of medical records in the possession of the Plan and to request that they be amended or corrected.
4. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
5. Members have the right, but are not required to, select a Primary Care Practitioner (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
6. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota and federal laws.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about the Plan's clinical guidelines and protocols.
8. Members have the right to receive information on diagnosis (to the degree known), available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand, regardless of Member cost or coverage benefit for available treatment options. Members also have the right to participate in treatment decisions regarding their health care, including the right to refuse treatment.
9. Members have the right to give informed consent before the start of any procedure or treatment.
10. When Members do not speak or understand the predominant language of the community, the Plan will make reasonable efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
12. Members have the right to a clear grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
13. Members have the right to Appeal any decision regarding medical necessity made by the Plan and its Providers.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. Members have the right to receive information about the organization, its services and Providers and Members' rights and responsibilities, in accordance with 42 CFR §438.10.
16. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
17. Members have the right to be free to exercise all rights and that by exercising those rights; they shall not be adversely treated by the State, the Plan, and/or its Network Providers.

North Dakota Medicaid Expansion Member Responsibilities

Each Member (or the Member's parent, legal guardian or other representative if the Member is incapacitated) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking Emergency care at a Network Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest Network Emergency Facility unless the condition is so severe that you must use the nearest Emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an Emergency admission as soon as reasonably possible and no later than *ten (10) days* after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying

the responsible Provider or the Hospital.

7. Members are responsible for following their treatment plan as recommended by the Provider primarily responsible for their care. Members are also responsible for participating in treatment and understanding, to the degree possible, their health care needs. This includes developing mutually agreed-upon treatment goals and understanding any needs for managing chronic conditions, including mental health and substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the Provider's instructions.
9. Members are responsible for notifying the North Dakota Department of Human Services Division of Medical Services within ten (10) days at toll-free at (844) 854-4825 | ND Relay TTY: (800) 366-6888 (*toll-free*) if they change their name, address, or telephone number.
10. Members are responsible for notifying the North Dakota Department of Human Services Division of Medical Services of any changes of eligibility that may affect their membership or access to services.

Non-Discrimination Policy Statement

In compliance with state and federal law, Sanford Health Plan shall not discriminate on the basis of age, gender, gender identity, sex, color, race, national origin, disability, marital status, sexual preference, religious affiliation, public assistance status, a person's status as a victim of domestic violence, or whether an advance directive has been executed. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Coverage, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance (complaint) with the Sanford Enterprise Section 504 Coordinator.

Call (888) 411-0800 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free) or write to Sanford, Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57104. You can file a grievance in person or by mail or phone. You may also submit information via your *mySanfordHealthPlan* secure provider portal at sanfordhealthplan.com/providerlogin.

If you need help filing a grievance, our Civil Rights Coordinator will help you.

To speak with someone for free in a language other than English, call (800) 892-0675.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at hhs.gov/ocr/office/file/index.html.