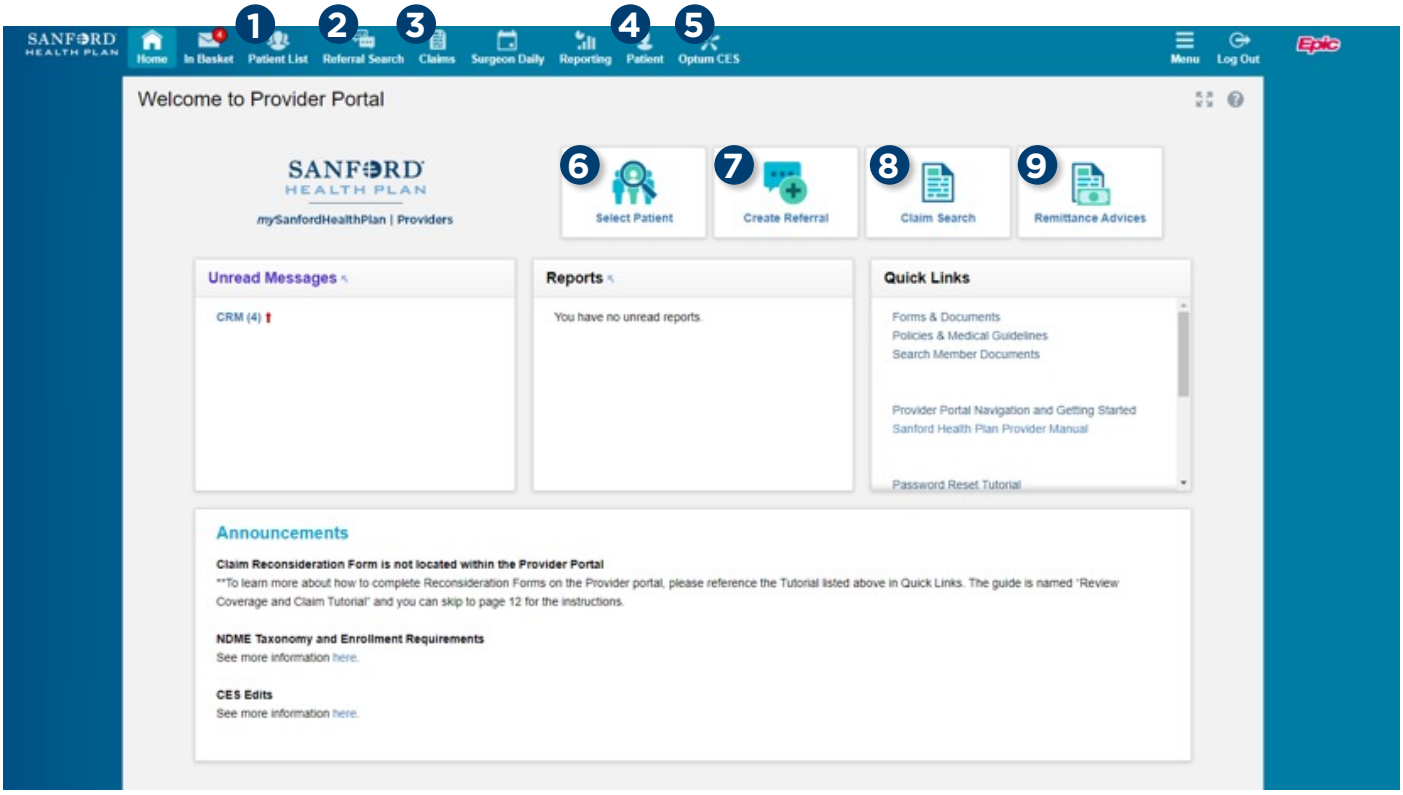
Provider Portal Tools and Features Map

SANFORD HEALTH PLAN



OPTUM CES

The ❺**Optum CES** feature can be used to review if claims will hit or why they hit a CES Edit.

PATIENT INFORMATION

Use ❶**Patient List**, ❹**Patient** or ❻**Select Patient** to view eligibility, benefits information, claims, and to view or submit a prior authorization.

To look up a new patient, you will need:

- Patient's name
- Date of birth
- Gender

Once a patient is selected, the ❹**Patient** tab will switch to their name.

PRIOR AUTHORIZATION

To open a prior authorization, you can start by looking up the patient, or using the ❼**Create a Referral** feature and then looking up the patient.

To search for a prior authorization, click on the ❷**Referral Search**.

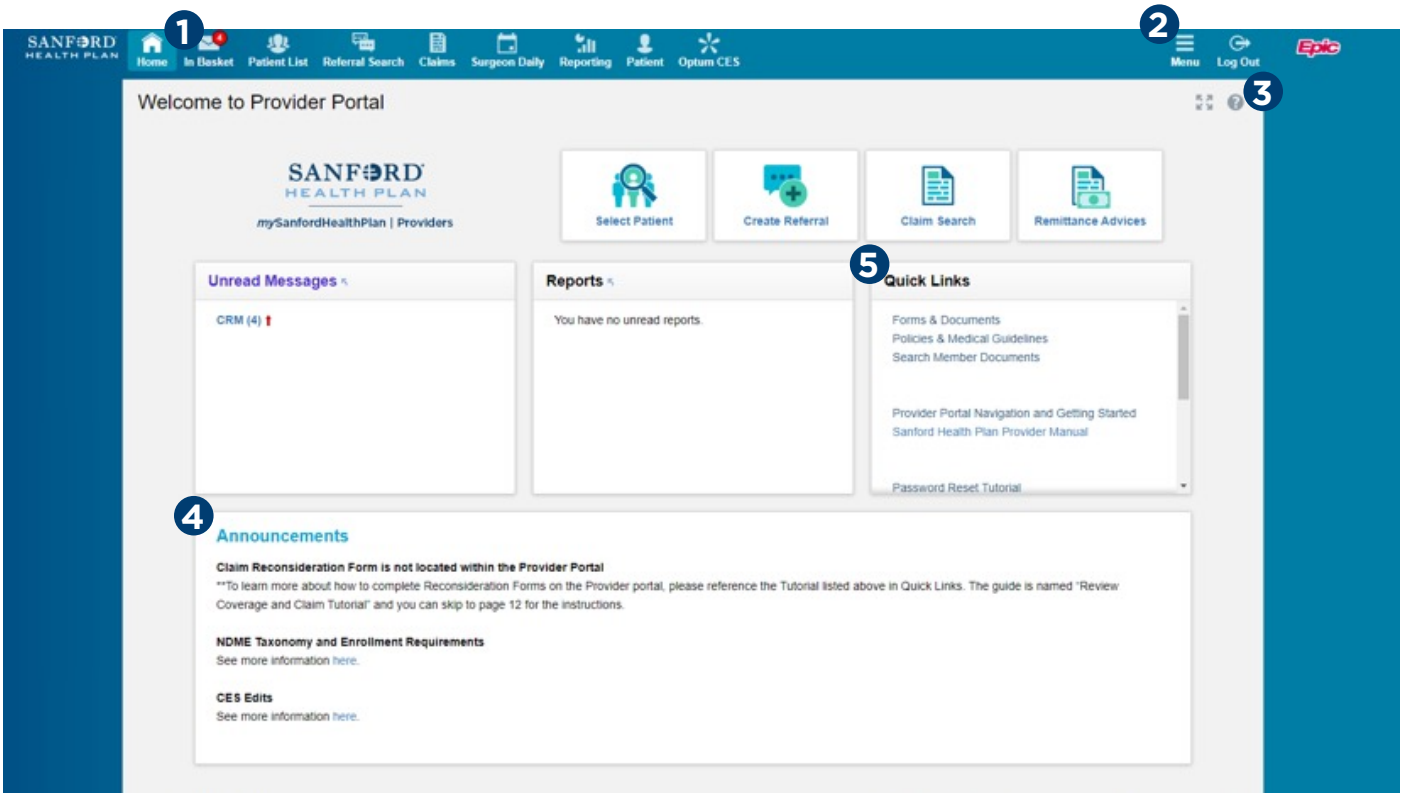
CLAIMS

Use the ❸**Claims** or ❽**Claim Search** options to locate and view copies of specific claims. Once you have opened a claim, you'll be able to view the Explanation of Payment PDF.

Use the ❾**Remittance Advices** feature to find a specific Explanation of Payment PDF also.

Provider Portal Tools and Features Map (cont.)

SANFORD HEALTH PLAN



NOTIFICATIONS

The ❶**Inbasket** feature will take you to your notifications regarding questions, authorization submissions, and any other communication that may be sent via the portal.

NAVIGATION

Use the ❷**Menu** button to access most of the features shown on the home screen and to access your user settings and event monitoring settings.

HELP

This button should appear on every screen you navigate to, but the ❸**Help** content will change based on which screen you are viewing. It is meant to provide further instruction.

❹ANNOUNCEMENTS

Look here for any important general notifications regarding changes or downtime.

QUICK LINKS

❺**Quick Links** is a section dedicated to links to other features to assist you in understanding Sanford Health Plan policies, benefits, and other navigation resources.

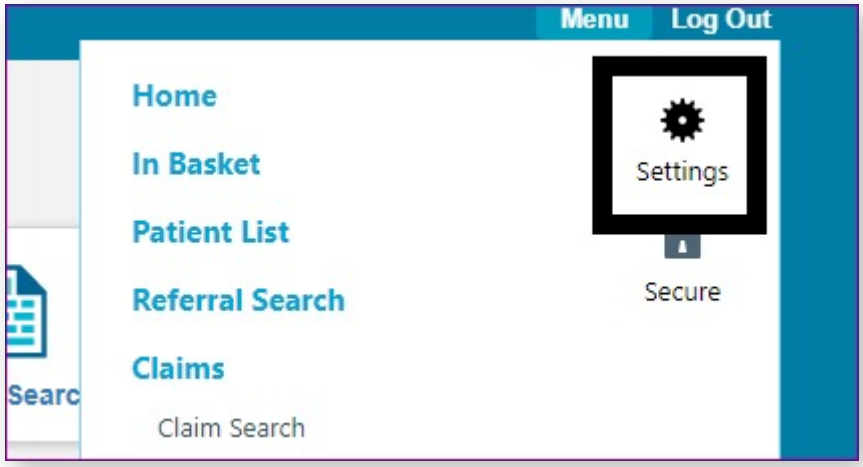
You will also find tutorials listed here.

Provider Portal Tools and Features Map (cont.)

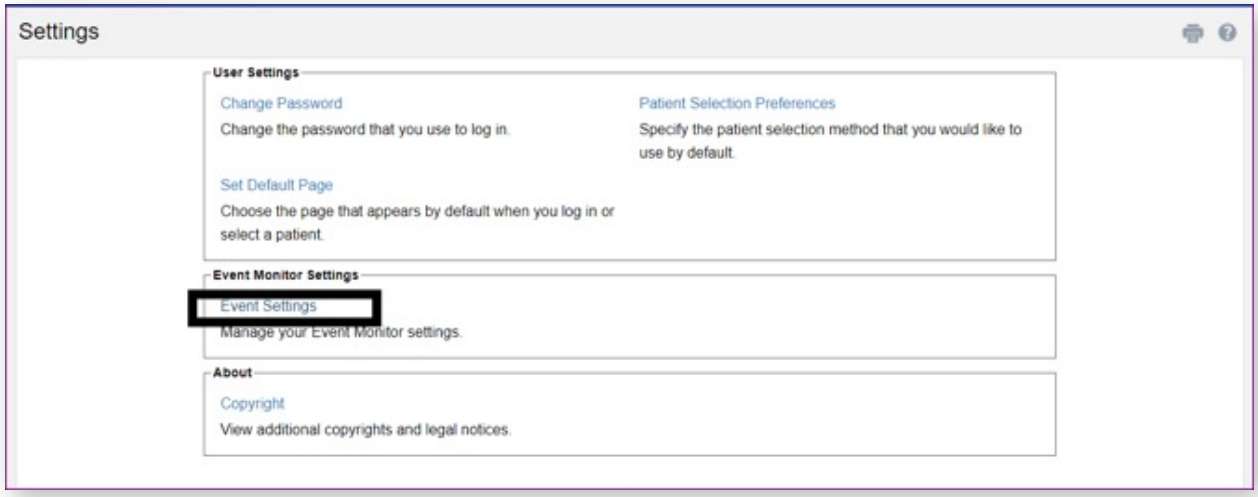
SANFORD HEALTH PLAN

To show notifications for Authorizations that you submitted click into the Menu button at the top right.

Go into the Settings.



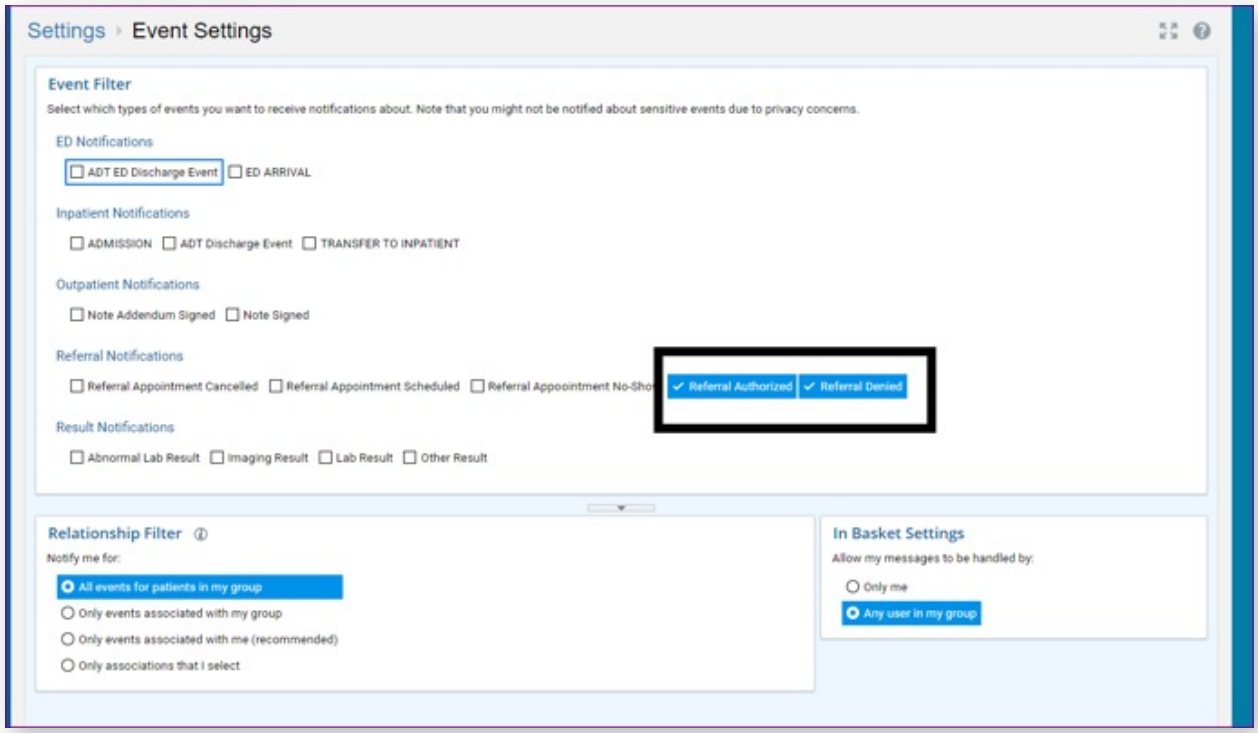
Select Event Settings.



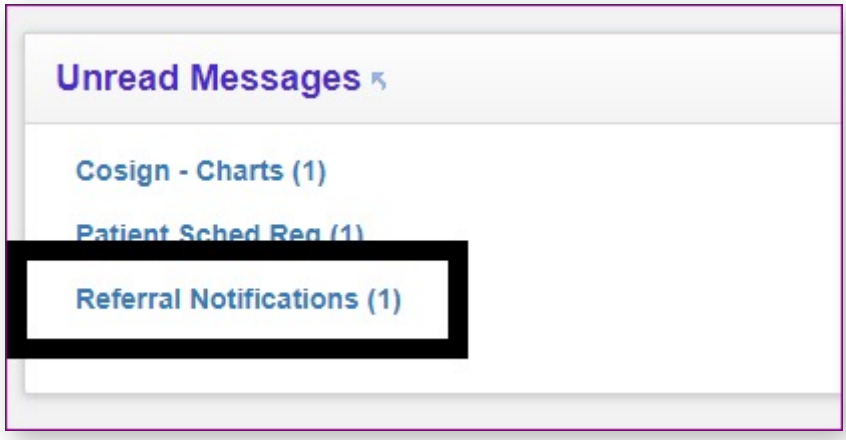
Provider Portal Tools and Features Map (cont.)

SANFORD HEALTH PLAN

And click Referral Authorized and Referral Denied boxes. Make sure you click Accept at the bottom right of the screen to save your changes.



Now you have Referral Notifications turned on!



To Locate a Patient

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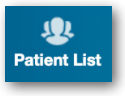
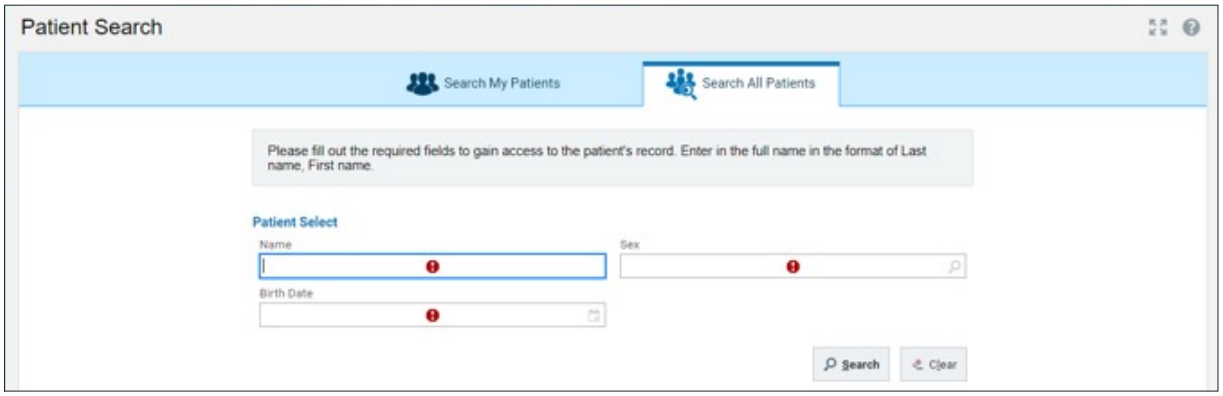
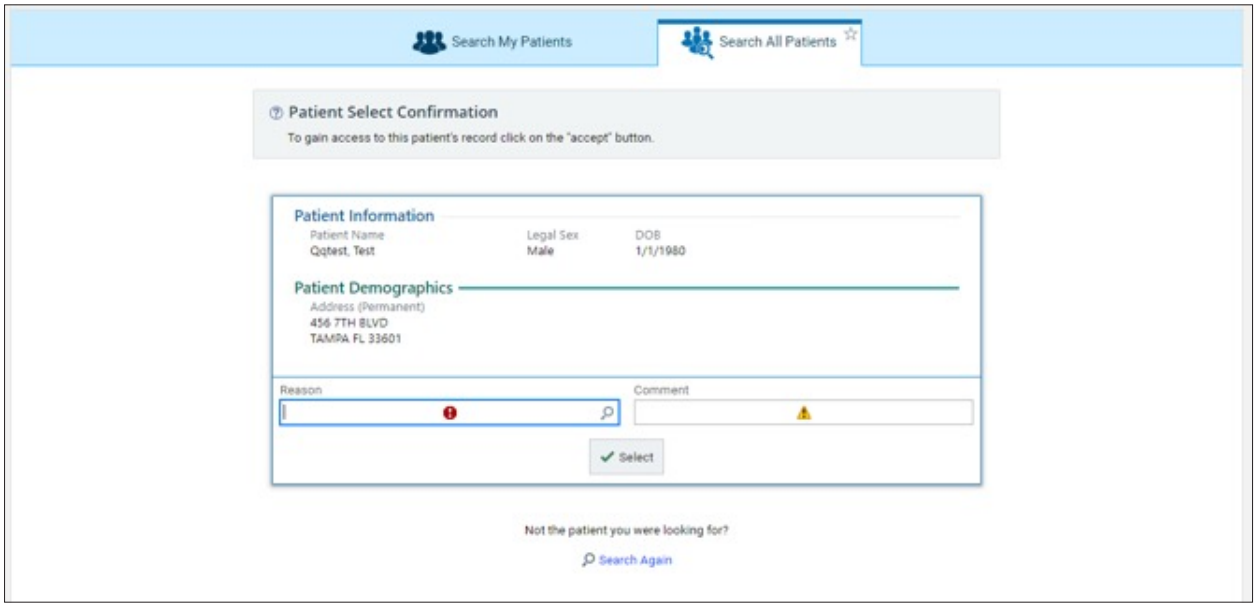
1. Click on **Patient List**. 

2. Determine which option is more appropriate for your search.
   a. Search **My Patients** if you've looked up this patient before and then browse or search your list for their name.
   b. Use **Search All Patients** if you have not looked up this patient before.

   If you need to search for a new patient, you will need their name, sex, and birthdate. Complete the fields and click **Search**.



3. A list of patients based on the criteria you entered will show on the page. Once you have found the correct patient you will be asked to confirm that you are opening the correct patient's record. You must answer the reason but do not need to put in a comment. Then click **Select**.



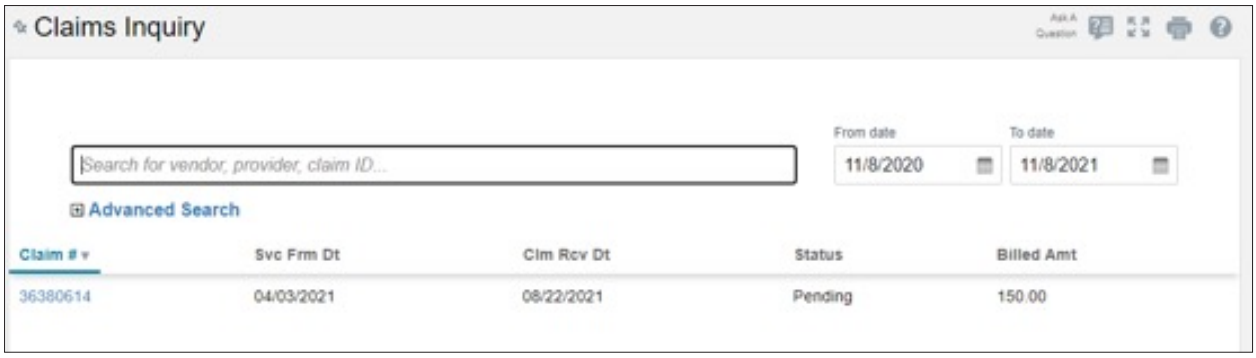
How to Locate a Claim and EOP

SANFORD HEALTH PLAN

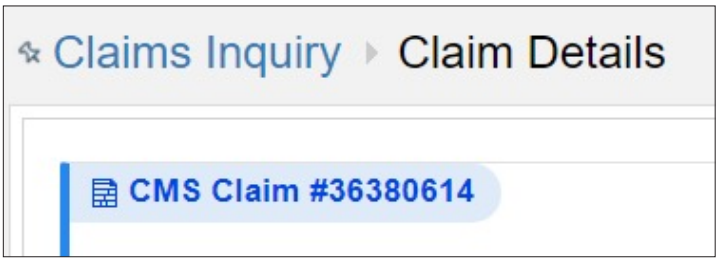
1. Locate a patient by following the previous instructions.

2. Once on the patient record, navigate to the **Claim by Member** feature.

3. Ensure the date range is appropriate for the claim you are looking for. The Portal will automatically go back one year from the date you are accessing the portal. Click the **blue claim ID** on the left side of the screen.



4. Basic claim information will be located on this screen. If an explanation of payment is available for that claim, you will locate the button to download the PDF on the top left of the screen.

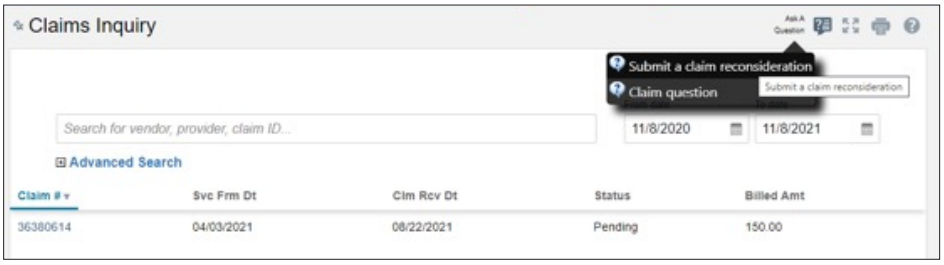


How to Submit a Claim Reconsideration

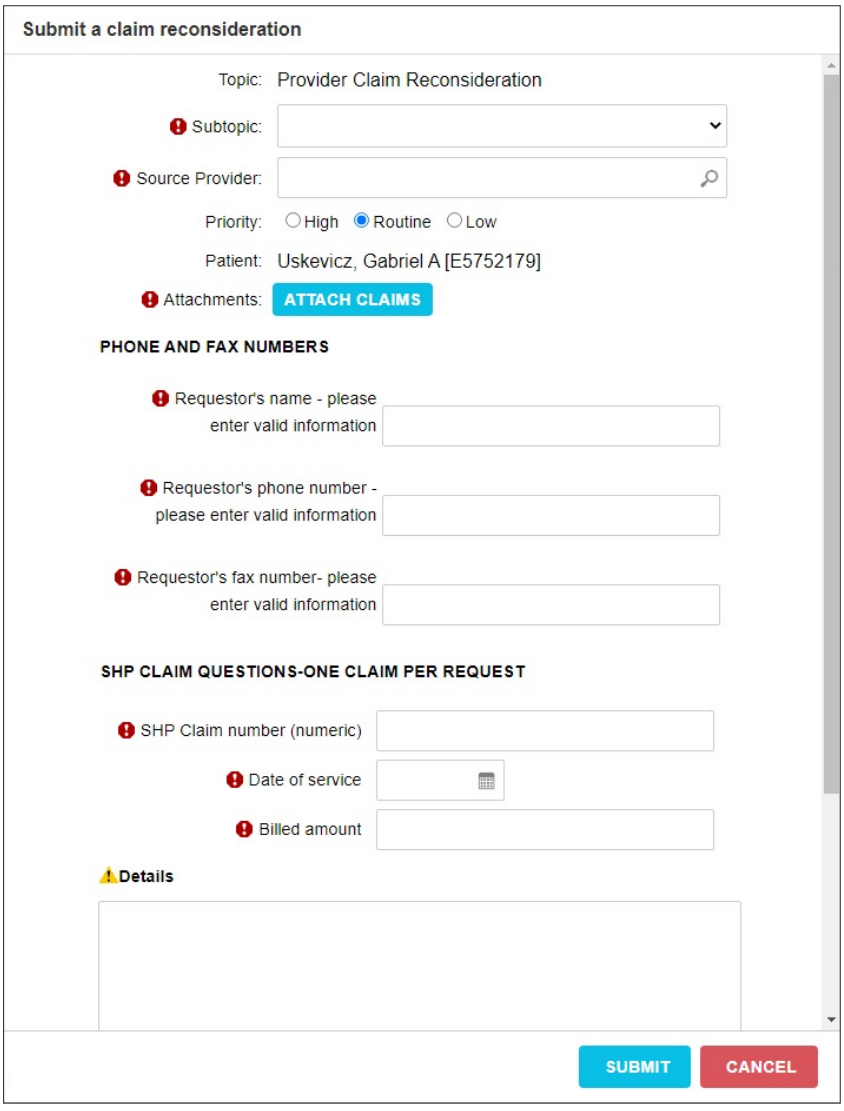
SANFORD HEALTH PLAN

Note: A claim reconsideration is not to be used for the following inquiries: incorrect reimbursement, Multiplan/DataIsight reimbursement, retrospective authorization requests, corrected claims, or coordination of benefits. For more details on these types of questions, please see further details listed at the end of this tutorial. (1.1)

1. From the Claims Inquiry screen, hover over the **Ask a Question** button.



2. Select the **Submit Claim Reconsideration** option.



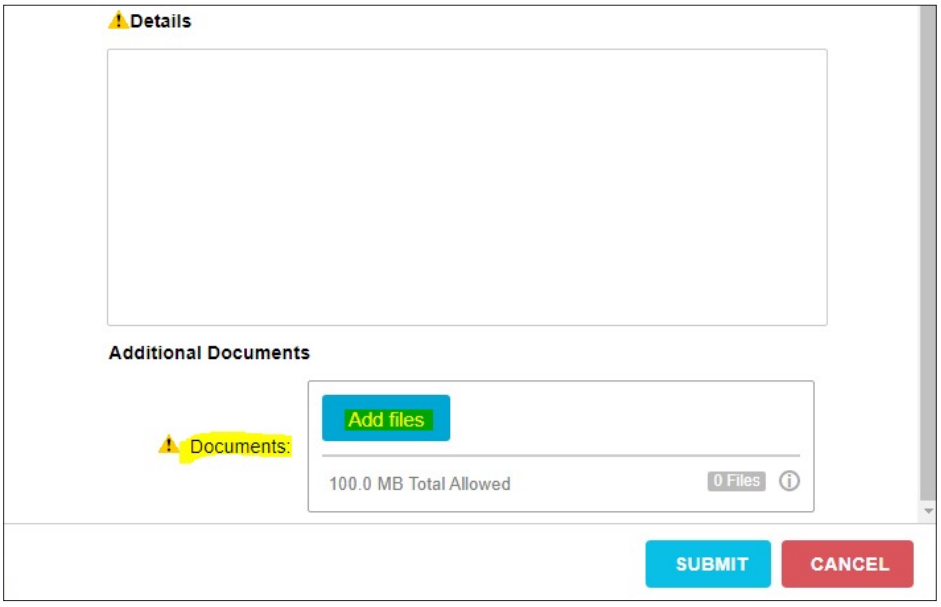
How to Submit a Claim Reconsideration

SANFORD HEALTH PLAN

3 Complete all fields and ensure that you have uploaded the appropriate documentation required for the subtopic you've selected and then **Submit**.

Subtopic	Use when	Required Documentation
Duplicate Claim	When a first-time claim submission denied as a duplicate filing, or the services on the claim were denied as a duplicate.	Original explanation of payment medical records verifying services were not a duplicate, rather were an additional, separate encounter.
Code Review	When you feel that the denied claim was coded correctly.	Provide explanation/rationale.
Timely Filing	A first-time claim submission that denied for timely filing. Timely filing is the number of days show from the date of service, date of inpatient discharge or paid date on the primary payor's explanation of payment. • 180 days for participating providers • 365 days for non-participating providers and any provider who cares for North Dakota Medicaid Expansion Members.	Screen print from the billing system showing the date the claim was sent to Sanford Health Plan. If filed electronically, the name of the clearinghouse used with evidence that the claim was accepted by the Plan without error must also be included. If a primary payor is involved, a copy of the dated explanation of payment showing it was within timely limits.
Request for Additional Information	A first-time claim submission that denied for additional information, due to an unlisted/ unspecified procedure code that was submitted without supporting documentation or a procedure code that was not submitted with operative or anesthesia notes, a pathology report, and/or office notes.	Provide explanation/rationale and relevant clinical documentation.
Other	Choose this box for scope of practice, experimental/investigational denials or other to request claim reconsideration for topics not mentioned above.	Provider explanation/rationale.

3 Add documentation, appeal letters, etc to the **Add Files** button. PDF submissions are best. This will add the attachment to the CRM that you are creating to send over to Appeal and Denials.



How to Submit a Claim Reconsideration (cont.)

SANFORD HEALTH PLAN

5 Responses to your reconsideration will be located in your **In basket** once the request has been reviewed and processed.

Note 1.1: A claim reconsideration is not to be used for the following inquiries: incorrect reimbursement, Multiplan/DataIsight reimbursement, retrospective authorization requests, corrected claims, or coordination of benefits. Rather, complete the following this is one of your inquiries.

Inquiry Type	First	Next Step	Exceptions
Incorrect Reimbursement	Review your contract and reimbursement exhibit(s) to ensure claims are coded appropriately and that you are using the correct pricing factors. If applicable, use the Optum CES tool to review the claim edit details.	Fax OCE Edits or code updates with supporting clinical documentation and/or rationale to Provider Relations at (605) 328-7224.	Assistant surgeon reimbursement is not eligible for reconsideration; instead see PR-035 Assistant at Surgery Reimbursement Policy.
Multiplan or DataIsight Reimbursement	Call MultiPlan at (800) 950-7040 or DataIsight at (866) 835-4022 to file a reimbursement appeal.	Follow up with Multiplan with your assigned ticket number.	
Corrected Claim	The correct filing indicator is the appropriate areas for the Plan to know you are submitted a correction or a void. Ensure the original claim ID is also noted on the claim.	Resubmit the claim electronically or by fax to (605) 328-6840	
Retrospective Authorization	Contact Customer Service to ensure that the service is a covered benefit.	Submit a Medical or Pharmacy Prior Authorization via the Provider Portal. Indicate the Retrospective nature.	If a denied prior authorization request in on file, complete a Member Appeal form. If your retro authorization request is more than 60 days old, first submit a timely filing reconsideration.
Coordination of Benefits	Fax the other carrier's EOP/ EOB to (650) 328-6840	After 5 business days, check on the Provider Portal to see if the claim has been reprocessed. If not, email providerrelations@sanfordhealth.org to confirm that the fax was received and is in processing.	