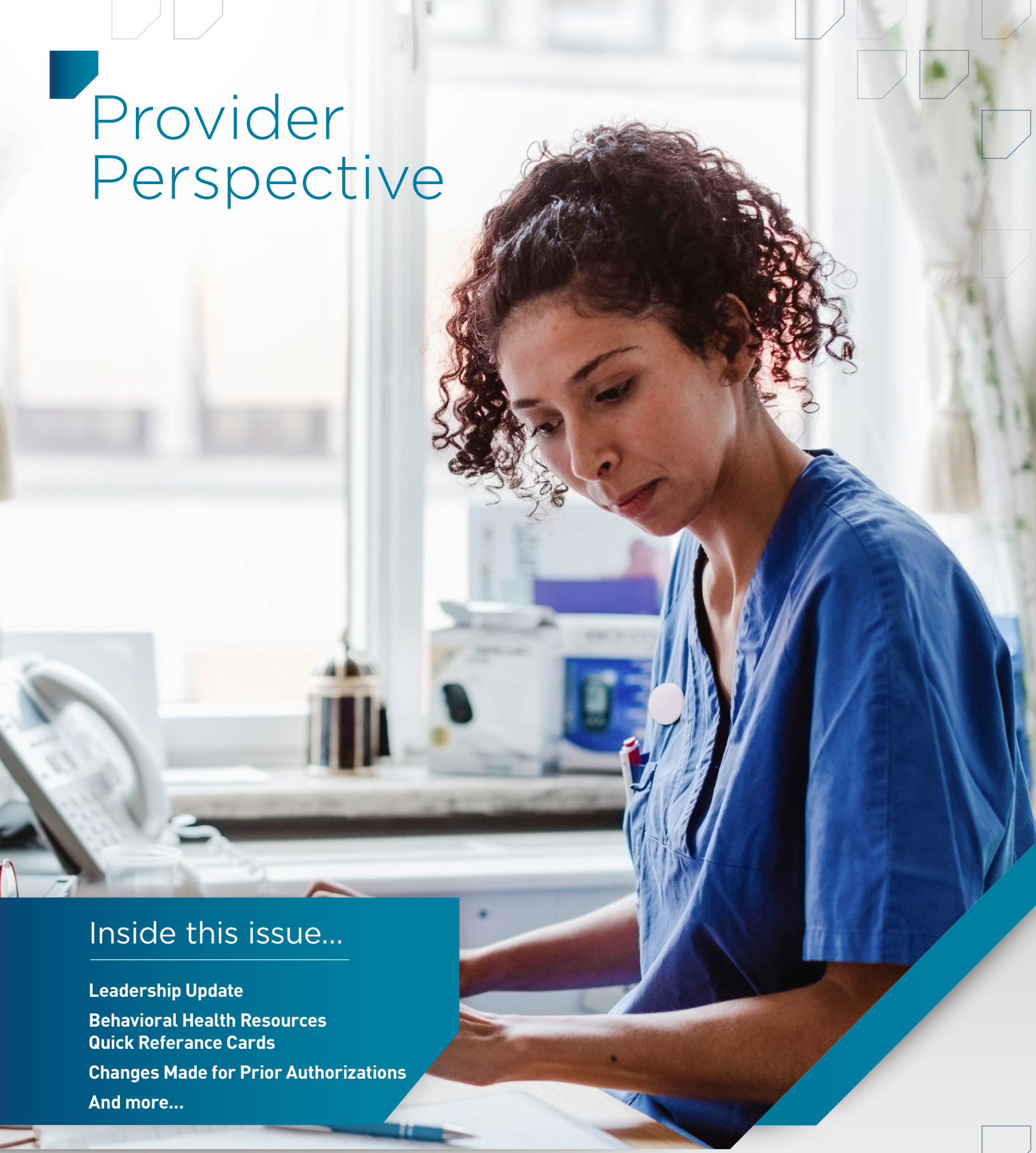
Provider Perspective



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NCQA Special Edition – February 2021

SANFORD HEALTH PLAN

Leadership Update

By: Jeremy M. Cauwels, MD

There are few times (especially in a newsletter for a health plan) that a person gets a chance to express sadness and happiness in a few lines, but today, I am going to try. As most of you are likely well aware, the leadership of Sanford Health as a whole has undergone some changes recently. During these changes, we are embracing the first change in CEO in more than 25 years.

Another of these changes affects me directly and all of you as well. I have been asked to transition to the role of Chief Physician for Sanford Health. Unfortunately, I am also told that I will not be able to maintain my abilities as the Chief Medical Officer for the Sanford Health Plan. For me, this is a point of sadness as I can tell you that I have truly enjoyed my work with the Sanford Health Plan. I am excited about the direction that the leadership team, spearheaded by John and Emily, are taking the health plan.

My happiness comes from the opportunity to help with finding a new CMO for the health plan's work. It truly is an exciting time to be part of Sanford and I believe it will only get better as we continue to improve.

Jeremy M. Cauwels, MD
Chief Physician, Sanford Health

Behavioral Health Resources
Quick Reference Cards

As you know, clinical depression is one of the most common mental illnesses and second leading cause of disability worldwide. Depression is a serious, but treatable, medical condition that can cause people to disengage with their daily lives, complicate and interfere with treatment of other medical conditions, or become deadly if left untreated.

At Sanford Health Plan, we have implemented steps to encourage our members to seek effective treatment upon diagnosis and continue that treatment to ensure they enjoy healthy productive lives. Because the primary care practitioner is most often the first and perhaps only place that people seek help, Sanford Health Plan has developed tools for these encounters. This information is also available to neurologists, psychologists and counselors to assist in the referral process for members in need of behavioral health care services. These tools include Quick Reference Behavioral Health Cards, which list behavioral health care providers available for referrals.

We ask you to consider these as resources for patients that come in with symptoms of a behavioral health or substance use disorder. Sanford Health Plan has resources and screening tools available on depression, anxiety, ADHD and bipolar disorder available on our **WEBSITE**. These **QUICK REFERENCE CARDS** are available for the following regions: IA, MN, ND, SD- all regions.

Changes Have Been Made for Prior Authorizations

As of January 2021, participating providers are responsible for obtaining authorizations. If a provider is non-participating, the member will be responsible for obtaining the prior authorization. In the event that an authorization is not obtained, and a retrospective authorization is requested and deemed not medically necessary after review, the provider will be responsible for the charges, resulting in provider write off. Some exceptions will be made on a case-by-case basis.

For example, if a provider submits a prior authorization that results in a denied request and the member chooses to still have the procedure done, it will be considered the member's responsibility. In this event, the provider should bill with a GA or GY modifier so that the responsibility is on the member. If the modifier is not used, the provider may submit a reconsideration for review. The provider must submit documentation that proves to member agreed to proceed with the care despite insurance not approving the request. Additionally, the member may also appeal if they feel they are being held responsible when not appropriate, and documentation must be submitted to prove whether the member consented to proceed with the procedure.

For further questions regarding these changes, please see our FAQ document **HERE** or call Provider Relations at **(800) 601-5086**.

Q: Will the entire claim deny to provider responsibility if no authorization is in place?
A: No, the denial will continue to be at the line item level

Q: What is the time period given to submit a retroactive authorization?
A: As of 1/1/21, the time period for retroactive authorizations to be accepted has been shortened from 180 days to 60 days.

Phone Prompts Have Recently Changed

To provide you with you the best experience we have updated our phone systems and with this change there may be some differences. You will still use the numbers at the end of this publication to reach the appropriate departments. Prior to arriving at the appropriate department, you will be prompted to enter if you are a member, provider or have sales inquiry. Once within the provider menu your call will be routed to the team that will most efficiently be able to answer your questions. We thank you for your patience as we embark on innovative technology to create the best experience for you as a provider and our members.

Timeliness of Care Survey

Sanford Health Plan takes pride in ensuring that our members have proper access and availability to quality health care providers. We feel it is important to monitor the established policies and procedures of plan participating providers to ensure member access to medical care and services is timely and appropriate. Find the criteria **HERE** for the appropriate access and availability included in these policies.

To measure compliance with the NCQA required standards, Sanford Health Plan sent a paper survey to a sampling of network providers.

The survey sampled:

- Three percent of Primary Care providers
- Five percent of Behavioral/Mental Health and/or Substance Use disorder prescribing and non-prescribing providers
- Five percent of Maternity/OBGYN providers
- Five percent of High-Volume Specialty providers (excluding maternity/OBGYN since this is assessed in a separate sample)
- Five percent sample of High-Impact Specialty providers (excluding maternity/OBGYN since this is assessed in a separate sample)

The survey asks what appointment options were available for patients with emergent, urgent and routine needs, as well as coverage for after hours and on-call providers. Specialty standards applied to each type of high volume and high impact specialty noted in the definitions.

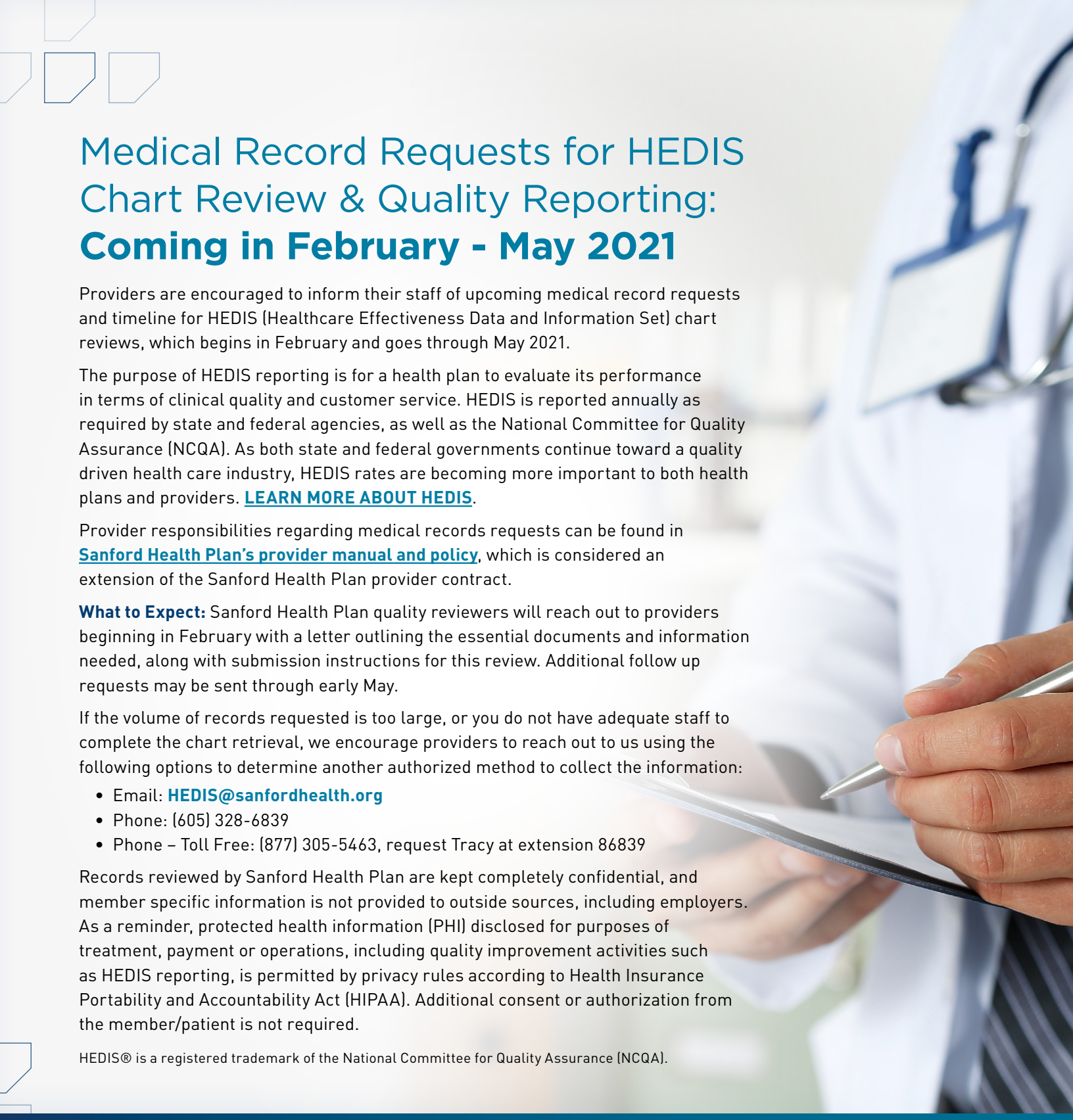
Congratulatory letters were sent to those clinics meeting the standards. Letters were also be sent to clinics not meeting the standards, and action plans have been requested from them. Sanford Health Plan Provider Relations department are currently following up with these clinics to measure compliance with the failed standard(s).

Clinics and participating providers will continue to receive education regarding the standards. Sanford Health Plan will also provide further materials throughout the year to all providers regarding access, availability, the standards and more.

COVID-19: Updated Coverage Announcement

Stay up-to-date on all COVID-19 information and find resources specifically for providers by visiting this **webpage**. Have additional COVID-19 questions? Submit your questions **HERE**.

Medical Record Requests for HEDIS Chart Review & Quality Reporting: **Coming in February - May 2021**



Providers are encouraged to inform their staff of upcoming medical record requests and timeline for HEDIS (Healthcare Effectiveness Data and Information Set) chart reviews, which begins in February and goes through May 2021.

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

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

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

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

- Email: **HEDIS@sanfordhealth.org**
- Phone: (605) 328-6839
- Phone – Toll Free: (877) 305-5463, request Tracy at extension 86839

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

Did you know...

Clinical Practice Guidelines

The Sanford Health Plan Physician Quality Committee reviews and has adopted yearly the clinical practice guidelines. They are currently reviewing 2020's updates. The complete listing from 2019's adopted guidelines can be found HERE.

How to Access Medical Guidelines

Sanford Health Plan makes medical guidelines available to providers within the ***my*SanfordHealthPlan provider portal**.

We follow Milliman Care Guidelines (MCG) medical guidelines in most cases, but also have some of our own developed medical guidelines and add-on addenda. Cite for Guideline Transparency (CGT) provides access to MCG medical guidelines. **Note:** Providers will be required to sign in and receive a pass code each time they access CGT.

To access all of Sanford Health Plan's medical guidelines, go to the 'Medical Guidelines' tab in the provider portal. To sign up for an account, **CLICK HERE**.

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

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

Any questions regarding the medical guidelines should be directed to Utilization Management.

Nominate Other Providers

Do you know a Primary Care Provider, specialist, therapist, counselor, psychiatrist, or psychologist that would be a benefit to your patients to be contracted with Sanford Health Plan? Did you know you can nominate them online or by calling customer service? You can **follow the instructions online** to complete the nomination request. Sanford Health Plan will contact the provider that has been nominated to see if they are interested to start the credentialing process.

Annual Notices

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

Provider Annual Notices will be coming out later in the year.

Utilization Management and Prior Authorizations

The goal of Sanford Health Plan's Utilization Management (UM) program is to encourage the highest quality care from the right provider in the right setting. We aim to ensure that provided services are medically necessary and in compliance with the benefits of the plan.

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

Prior authorizations for health care services should be obtained online by logging in to the ***my*SanfordHealthPlan provider portal**. Open the member record and choose *"Create Referral"*. The tutorial explaining how to request a prior authorization is located within the provider portal. **NOTE**: Oncology treatment and services must be entered and authorized through eviti|Connect online at **eviti.com**. High-end imaging services for select members and health plans must be entered and authorized through **eviCore**.

A list of services requiring prior authorization can be found **HERE**.

All requests for certification must be made at least three business days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three business days, contact UM to request an expedited review. The provider is ultimately responsible for obtaining prior authorization.

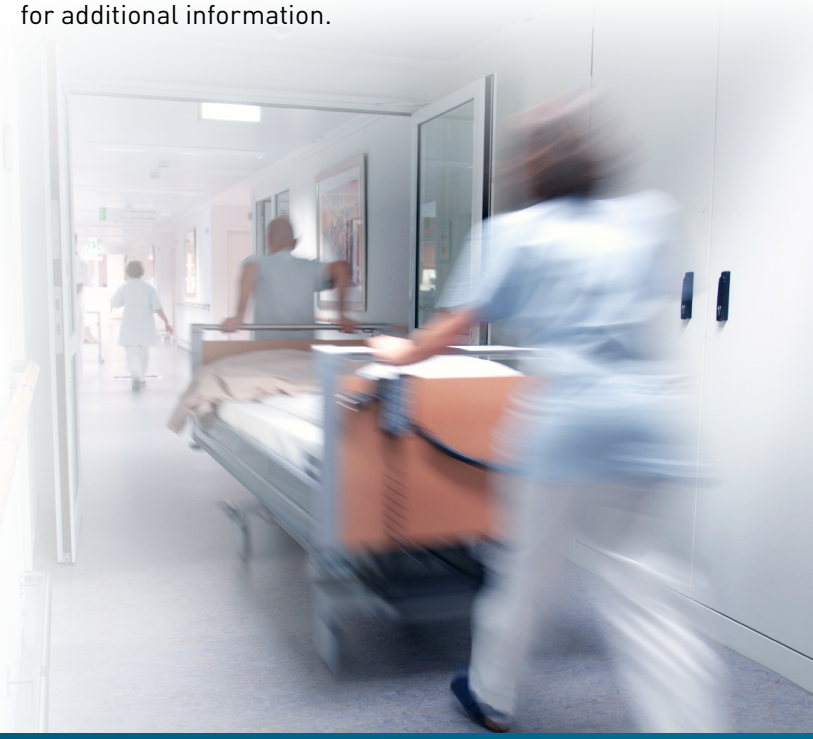
The date of receipt for all requests will be the actual date of receipt, whether or not it is received during normal business hours. After normal business hours, callers may leave a message on the confidential voicemail of the Customer Service, UM, Pharmacy, or Appeals and Denials department and a representative will return their call the following business day. Communications received after normal business hours are returned on the next business day and communications received after midnight on Monday-Friday are responded to on the same business day. Staff will place outbound calls regarding inquiries during normal business hours as needed, and no later than 24 hours after the initial inquiry call.

REMEMBER

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

SERVICES REQUIRING PRIOR AUTHORIZATION

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



Ensuring Your Patients Get Screened for Colorectal Cancer

Many times your patients rely on your professional recommendation and the discussions you have with them about their options can encourage them to schedule their screening for colorectal cancer. As you discuss the available colorectal screening options, it may also be helpful to discuss a few key points about each type of screening—including what the patient's responsibility is for each type of screening. By letting your patients know what to expect, you can help make their preparation process much more manageable and less intimidating.

One of the best ways you can help increase colorectal cancer screening among patients is to make sure you manage expectations before the screening even occurs. This includes discussing coverage and the potential cost implications associated with screenings.

Most insurance plans classify colorectal cancer screening as a preventive health care service and, therefore, cover the cost of the screening. However, your patients should know that preventive services like screening tests sometimes result in a follow-up diagnostic procedure, especially if a polyp is found and biopsied. While preventive services like colorectal cancer screening may be covered by insurance, once a service becomes diagnostic, this may alter a patient's coverage. The patient may then be required to pay an out-of-pocket expense (co-pay, deductible, coinsurance).

Additionally, a deductible may need to be paid if the colonoscopy is prescribed to diagnose an unknown health problem, like if a patient is experiencing such symptoms as bleeding or irregularity. In this circumstance, the procedure would be considered diagnostic.

Below is a chart with patient-friendly language that you may use to help educate patients.

Preventive Screening vs Diagnostic Testing

Understanding the Differences and Resulting Impact on Coverage

Preventive Screening	Diagnostic Testing
A test (eg, colonoscopy, FIT, stool DNA test, or FOBT) performed on a patient who does not have symptoms but who is in a group at risk for colorectal cancer, such as those: • Between the ages of 45 and 75 • With a family history of colorectal cancer With few exceptions, health care plans cover screenings with no out-of-pocket cost to the patient.	A colonoscopy to diagnose a health condition in response to symptoms, such as: • Bleeding or irregularity • Positive results of a preventive screening The patient may have to pay a co-pay, coinsurance, or deductible.
Example A: For a patient's 45th birthday, he chooses to have a simple FOBT.	**Example A:** The FOBT has a positive result; his doctor recommends a colonoscopy to determine the cause of the bleeding. The colonoscopy may be considered diagnostic since it will be used to determine why the patient has blood in his stool.
Example B: A patient's mother had colorectal cancer, so she opts for a colonoscopy.	**Example B:** During the preventive screening colonoscopy, polyps are found, removed, and sent to a lab for testing. The testing itself may be considered diagnostic since the lab results will need to be reviewed to determine if the polyp is cancerous.

If your patients have questions regarding their benefits, they can call the Customer Service number found on their Sanford Health Plan ID card or log into ***my*SanfordHealthPlan member portal**.

*Insurance coverage for colorectal cancer screening at **American Cancer Society website***

Social Determinants of Health and Continuity and Coordination of Care

Sanford Health Plan appreciates the care and attention you provide to our members. To help track and address social needs our members experience, we invite you to incorporate Social Determinants of Health (SDOH) ICD-10 Z codes on the claims you submit.

What are Social Determinants of Health?

Social determinants of health are defined as "the conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life"(1). These social factors can impact significant barriers to a person's health and wellness.

How and Why to Use Social Determinants of Health

What does this mean for you and your staff? Each patient brings more to your office than the symptoms they present on the surface. SDOH may be impacting a patient's willingness or ability to adhere to their recommended treatment plan and it is vital to adopt a "whole-person" approach to care. Annually, Sanford Health Plan conducts a population health assessment and through the utilization of ICD-10 Z code data, Sanford Health Plan will be able to better understand the unique social needs of our members. Together, we can help remove barriers to quality care, connect members to available resources, and enhance the continuity and coordination of non-health, medical and behavioral healthcare for members that facilitate improved quality of life to members.

What You Can Do:

- Educate staff on the need to screen, document and code data on patients' SDOH needs.
- Ask patients about their SDOH needs. Patients may not know the importance of discussing non-medical issues with their provider and may need to be prompted.
- Document any SDOH by utilizing the SDOH ICD-10 Z codes listed in this document and add them to claims you submit to Sanford Health Plan.

Resources: https://www.who.int/social_determinants/en/

SOCIAL DETERMINANTS OF HEALTH (SDOH)

Contact with and Suspected Exposure to Arsenic, Lead or Asbestos

- Z77.010 Contact with and suspected exposure to arsenic
- Z77.011 Contact with and suspected exposure to lead
- Z77.090 Contact with and suspected exposure to asbestos

Educational Circumstances

- Z55.0 Illiteracy and low level literacy
- Z55.1 Schooling unavailable and unattainable
- Z55.2 Failed school examinations
- Z55.3 Underachievement in school
- Z55.4 Education maladjustment and discord with teachers and classmates
- Z55.8 Other problems related to education and literacy
- Z55.9 Problems related to education and literacy, unspecified

Effects of Work Environment

- Z56.0 Unemployment, unspecified
- Z56.1 Change of job
- Z56.2 Threat of job loss
- Z56.4 Discord with boss and workmates
- Z56.89 Other problems related to employment
- Z56.9 Unspecified problems related to employment
- Z57.0 Occupational exposure to noise
- Z57.2 Occupational exposure to dust
- Z57.31 Occupational exposure to environmental tobacco smoke
- Z57.39 Occupational exposure to other air contaminants
- Z57.4 Occupational exposure to toxic agents in agriculture
- Z57.5 Occupational exposure to toxic agents in other industries
- Z57.8 Occupational exposure to other risk factors
- Z57.9 Occupational exposure to unspecified risk factor

Foster Care/Parenting/Child/Family

- Z62.0 Inadequate parental supervision and control
- Z62.1 Parental overprotection
- Z62.2 Upbringing away from parents
- Z62.21 Child in welfare custody
- Z62.22 Institutional upbringing
- Z62.3 Hostility towards and scapegoating of child
- Z62.6 Inappropriate (excessive) parental pressure

- Z62.810 Personal history of physical and sexual abuse in childhood
- Z62.811Personal history of psychological abuse in childhood
- Z62.812 Personal history of neglect in childhood
- Z62.819 Personal history of unspecified abuse in childhood
- Z62.82 Parent-child conflict
- Z62.820 Parent-biological child conflict
- Z62.821 Patent-adopted child conflict
- Z62.822 Parent-foster child conflict
- Z62.898 Other specified problems related to upbringing
- Z62.890 Parent-child estrangement NEC
- Z62.891 Sibling rivalry
- Z62.21 Child in welfare custody
- Z63.0 Problems in relationship with spouse or partner
- Z63.3 Absence of family member
- Z63.4 Disappearance and death of family member
- Z63.5 Disruption of family by separation and divorce
- Z63.6 Dependent relative needing care at home
- Z63.7 Other stressful life events affecting family and household
- Z63.72 Alcoholism and drug addiction in family
- Z63.8 Other specified problems related to primary support Group
- Z64.0 Problems related to unwanted pregnancy

Homelessness/Other Housing Concerns

- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.8 Other problems related to housing and economic circumstances
- Z60.2 Problems related to living alone
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.9 Problems related to housing and economic circumstances, unspecified

Problems related to medical facilities and other healthcare

- Z75.3 Unavailability and inaccessibility of health care facilities
- Z75.4 Unavailability and inaccessibility of other helping agencies

Problems related to legal, Crime and other psychosocial circumstances

- Z65.0 Conviction in civil and criminal proceedings without imprisonment
- Z65.1 Imprisonment and other incarceration
- Z65.2 Problems related to release from prison
- Z65.3 Problems related to other legal circumstances
- Z65.4 Victim of crime and terrorism
- Z65.5 Exposure to disaster, war and other hostilities
- Z65.8 Other specified problems related to psychosocial circumstances

Problems related to social environment

- Z60.0 Problems of adjustments to life-cycle transitions
- Z60.3 Acculturation difficulty
- Z60.4 Social exclusion and rejection
- Z60.5 Target of (perceived) adverse discrimination and persecution
- Z60.8 Other problems related to social environment
- Z60.9 Problems related to social environment, unspecified
- Z72.810 Child and adolescent antisocial behavior
- Z72.811 Adult antisocial behavior

Lifestyle Factors

- Z71.3 Dietary counseling and surveillance
- Z71.6 Tobacco abuse counseling
- Z71.82 Exercise counseling
- Z71.9 Counseling, unspecified
- Z72.0 Tobacco use
- Z72.3 Lack of physical exercise
- Z72.4 Inappropriate diet and eating habits
- Z72.51 High risk heterosexual behavior
- Z72.52 High risk homosexual behavior
- Z72.53 High risk bisexual behavior
- Z72.6 Gambling and betting
- Z72.820 Sleep deprivation
- Z72.821 Inadequate sleep hygiene
- Z72.89 Other problems related to lifestyle
- Z72.9 Problem related to lifestyle, unspecified
- Z73.810 Behavioral insomnia of childhood, sleep-onset association type
- Z73.811 Behavioral insomnia of childhood, limit setting type
- Z73.812 Behavioral insomnia of childhood, combined type
- Z73.819 Behavioral insomnia of childhood, unspecified type
- Z73.82 Dual sensory impairment
- Z73.89 Other problems related to life management difficulty
- Z91.82 Personal history of military deployme

Contact Us:

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

memberservices@sanfordhealth.org

Customer Service
Monday-Friday, 7:30 a.m. to 5:00 p.m. CST | 800) 752-5863

NDPERS Customer Service
Monday-Friday, 8:00 a.m. to 5:30 p.m. CST | (800) 499-3416

ND Medicaid Expansion
Monday-Friday, 7:30 a.m. to 5:00 p.m. CST | (855) 305-5060

CONTACT FOR: Preauthorization/precertification of prescriptions or formulary questions

pharmacyservices@sanfordhealth.org

Pharmacy (855) 305-5062

NDPERS Pharmacy (877) 658-9194

ND Medicaid Expansion (800) 755-2604 | TTY: 711

CONTACT FOR: Preauthorization/precertification for medical services

um@sanfordhealth.org

Utilization Management (800) 805-7938

NDPERS Utilization Management (888) 315-0885

ND Medicaid Expansion Utilization Management (855) 276-7214

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

providerrelations@sanfordhealth.org

Provider Relations (800) 601-5086

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

sanfordhealthplanprovidercontracting@sanfordhealth.org

Provider Contracting (855) 263-3544

Hearing or speech impaired TTY | TDD (877) 652-1844

Translation Assistance for Non-English Speaking Members (800) 892-0675

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