Important Information for Providers about Sanford Health Plan

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SANFORD HEALTH PLAN

Sanford Health Plan asks that you take a few minutes to review this information. The following annual notices are provided to keep you well informed of the provisions of the Plan. If you have any questions regarding this information, please feel free to call us at (605) 328-6868 or toll free at (877) 305-5463.

Where can I find important plan information?

Important plan information and the Provider Manual can be found at the locations below. You can also obtain copies by calling our Provider Relations Department toll-free at (800) 601-5086. The Provider Manual and the Provider Perspective newsletter on our website contain information on Plan policies and procedures that are pertinent to participating practitioners. Below is a summary of the information you can find on our website and mySanfordHealthPlan web portal. Please visit these sites frequently for updates.

Sanford Health Plan's provider web page

Visit sanfordhealthplan.com/providerlogin to find the following:

- Preventive Health Guidelines
- Prior Authorizations: How to prior authorize and what needs prior authorizations
- Pharmacy Benefits/Formulary Information
- Provider Manual
- Provider News
- Provider Directory: Multiple search functions
- Code Updates
- Electronic Data Interchange
- Forms
- Clinical Resources & Tools, including Clinical Practice Guidelines and many other resources
- Health Management Programs and Quality Improvement Activities; HEDIS® Report

Create a mySanfordHealthPlan account

Sanford Health Plan's mySanfordHealthPlan portal allows practitioners the ability to verify member eligibility, check claim status, view and retrieve explanation of payments and view and submit prior authorization information. To request a mySanfordHealthPlan account, follow the steps below:

1. Go to sanfordhealthplan.com/providerlogin
2. Click "create Provider Account" on the right side of the page
3. Read the license Agreement and click on "Agree"
4. Enter all the Required Account information on the following pages
5. When all the required account information has been added, click on "Finish"
6. After clicking Finish, you will be redirected to the branded site and will then hover on the tab "complete signup" and click on "request access" and send an express request requesting on-line access to Provider Online Claim/ eligibility/authorization access request.

Your information will then be submitted for review and approval. Once your account has been approved, you will receive a confirmation email from us. You will then be able to log on to mySanfordHealthPlan through the Sanford Health Plan website using the User ID and Password you created upon setting up the account. If you have any questions or comments, please contact your Provider Relations Representative or the Provider Relations Department at (605) 328-6877 or (800) 601-5086.

2015 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 Health Plan's QI program and outcomes, see our HEDIS® 2015 Report and the Quality Improvement Program summary, both are located on the Plan's website at sanfordhealthplan.com/memberlogin. You may also call the Health Plan to request a copy of either of these documents at (888) 315-0884. For information on our care management programs listed below and how to enroll, call (888) 315-0884 or visit our website at sanfordhealthplan.com/memberlogin.

Clinical areas of Quality Improvement

Diabetes

Last year's HEDIS® diabetes performance measures showed some areas in need of improvements, this program has included educational materials for the semi-annual mailings. Currently this health management program provides the following services to members with diabetes:

- The diabetic members that are newly identified on a monthly basis are sent a program introduction packet.
- An online health assessment is available for members that allows the Plan to identify the member's individual diabetic needs and provide diabetes educational information to the member.
- Semi-annual mailings.
- Free glucometer.
- Selected employer group health screenings included glucose, total cholesterol and HDL, and blood pressure screenings to identify members who may have gone undiagnosed.
- Practitioners notified of the recommended clinical practice guidelines for diabetes through the provider newsletter and on our website.
- Letters sent to participating eye care providers to remind them of the annual eye exam copay waive benefit and how to submit the claims. Also included a communication form for the eye care professional to notify the primary diabetes care provider of eye exam results.
- A postcard was sent to members with diabetes that reminded them of the clinical practice guidelines to follow.
- A letter was sent to members to remind them to get their annual diabetic eye exam and that it is free of charge.
- A letter was sent to members on specific medications to remind them to get their lab levels checked.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- Sent annual health management program patient satisfaction survey – used suggestions from internal discussions.

Heart Disease (Coronary Artery Disease)

This program was just implemented July 1, 2015. Measures for this program in 2016 include:

- Persistence of Beta Blocker Treatment After a Heart Attack (PBH)
- Annual Monitoring of Patients with Persistent Medications (MPM)
- Statin Therapy for Patients with Diabetes (SPD)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)
- Currently, this health management program will provide the following services to members with heart disease:
  - New heart disease members identified monthly and sent a program introduction packet.
  - An online health assessment is available for members that allows the Plan to identify the member's individual needs and provide educational information to the member specific to heart disease.
- Semi-Annual mailings.
- Practitioners notified of the recommended clinical practice guidelines for heart disease through the provider newsletter and on our website.
- A letter was sent to members on specific medications to remind them to get their lab levels checked.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- Sent annual health management program patient satisfaction survey – used suggestions from internal discussions.
- A letter was sent to members on specific medications to remind them to get their lab levels checked.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- Sent annual health management program patient satisfaction survey – used suggestions from internal discussions.

Heart Failure (HF)

The rate of ACE Inhibitor/ARB/Beta Blocker utilization was 92.93 percent and the rate of inpatient hospital stays for members with HF decreased compared to the previous year. Currently, the HF Health Management Program provides the following services to members in the program:

- The heart failure members that are newly identified on a monthly basis are sent a program introduction packet.
- An online health assessment is available for members that allows the Plan to identify the member's individual heart failure needs and provide educational information specific to heart failure.
- Semi-annual member educational materials include educational information on symptoms, treatment and management of heart failure.
- Practitioners are notified of the recommended clinical practice guidelines for HF through the provider newsletter and on our website.

- Participation in the community/Lewis Drug hypertension initiative.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- A letter was sent to members on specific medications to remind them to get their lab levels checked. Sent annual health management program patient satisfaction survey – used suggestions for internal discussions.

Hypertension

Members identified with hypertension for the Healthy Heart Health Management Program received the following services over the past year:

- The hypertensive members that are newly identified on a monthly basis are sent a program introduction packet.
- An online health assessment is available for members that allows the Plan to identify the member's individual hypertension needs and provide educational information specific to hypertension.
- Semi-annual educational mailings to members.
- Practitioners notified of the recommended clinical practice guidelines for hypertension through the provider newsletter and on our website.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- Participation in the community/Lewis Drug hypertension initiative.
- A letter was sent to members on specific medications to remind them to get their lab levels checked.
- Sent annual health management program patient satisfaction survey - used suggestions for internal discussions.

Healthy Pregnancy

Sanford Health Plan provides maternity care benefits from prenatal through postpartum care. The main objective of the program is to assist a member in identifying early concerns so she and her health care provider can take steps to prevent or minimize any problems and ensure a healthy pregnancy. Pregnant members are encouraged to join the Healthy Pregnancy Program during their first trimester of pregnancy. Members who enrolled enjoyed the following benefits:

- An online health assessment is available for members that allows the Plan to identify the member's individual needs and to provide educational information specific to those needs.
- Personal phone calls from a care management nurse for high risk members.
- Educational materials as requested by the member.

Asthma

The HEDIS® rate for appropriate asthma medication utilization was 93.50 percent for ages 5 to 64. However, only 44.79 percent of members were shown to be compliant with their asthma medication at least 75 percent of the time. Members identified for the Asthma Health Management Program received the following services over the past year:

- New asthmatic members identified on a monthly basis and sent a program introduction booklet.
- An online health assessment is available for members that allows the Plan to identify the member's individual hypertension needs and provide educational information specific to asthma.
- Semi-annual educational mailings to members.
- Member Messenger newsletter contained an article on managing chronic conditions and compliance, which included information on the Better Choices, Better Health® Online Workshop available to members.
- Free peak flow meter and spacer offer.
- Practitioners notified of the recommended clinical practice guidelines for asthma through the provider newsletter and on our website;
- Phone calls made to members who discharged from the hospital after an asthma-related stay.
- Postcards were mailed to members regarding asthma medication compliance.

Behavioral health and substance use disorders

The Plan's HEDIS® measure for follow-up after inpatient hospitalizations for the treatment of behavioral health and/ or substance use disorders decreased last year, and the HEDIS® measure for antidepressant medication management showed an increase in the acute phase rates, but a decrease in the continuation phase rate. The Plan's activitiesto improve follow-up after inpatient treatment for behavioral health and/or substance use disorder discharges, and compliance with antidepressant medications, included:

- Letters sent on a monthly basis to members new on antidepressants who have not yet filled their first refill - education included side effects, compliance, etc. Continued to incorporate depression education/resources into other health management programs.
- The Worksite Wellness Life Advocates are making several member referrals to employer groups who participate in the Plan's EAPs.
- Practitioners notified of the recommended clinical practice guidelines for depression through the provider newsletter and on our website.
- The Timeliness of Care Survey was completed and included an assessment of a sample of clinics primarily treating

behavioral health and substance use disorders, and their 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 or noncompliance and what those standards are.
- The Plan's Life Advocates work with the hospital's discharge planners to arrange a follow-up appointment within seven days of discharge.
- Member Messenger 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 were updated and made available on the website to 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 to ensure the appropriateness of our activities involving behavioral health and/or substance use disorders.

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 a postcard that offers a toolkit with education on the symptoms, treatment and follow-up recommendations for patients taking ADHD medications.
- Practitioners are notified of the recommended clinical practice guidelines for ADHD through the provider newsletter and on our website. Tools are also available for practitioners on the website. Practitioners also notified of the information available on the website via the provider newsletter.
- Quick Reference Behavior Health cards were updated and made available via the Plan's website.

Adolescent health

The adolescent well care visit rate increased again. Our adolescents and their parents/guardians received the following information:
- A birthday card is sent monthly to those members turning 11 and 12 as a reminder to make sure they are up-to-date on immunizations by their 13th birthday and to remind them to get an annual wellness exam.
- The Plan's website contains a KidsHealth website link to a great deal of educational information for kids and parents.
- Immunization schedule is available on the Plan's website.
- The Member Messenger newsletter included an article on adolescent wellness visits and their benefit versus a sports physical. There was also an article on HPV and meningococcal vaccine recommendations.
- Notified practitioners of Clinical Practice Guidelines in the Provider Perspective newsletter.

Cancer screening

The cancer screening activity 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 are updated and printed annually in the member newsletter and are available at sanfordhealthplan.com.
- Birthday cards are sent to women turning 21, 40, 50 and 60 and men turning 40, 50 and 60 to remind them of important screening tests (like mammogram, Pap smear, colonoscopy, etc.) and the Plan's benefits for those tests.
- Additional mammogram reminder mailings sent to those members who are 3 months past their 40th birthday.
- A colorectal cancer screening postcard was sent to members twice.
- Practitioners are notified of the recommended clinical practice guidelines for cancer screening through the provider newsletter and on our website.
- A Crandell's Corner email was sent to practitioners which included discussion of colorectal cancer screening options, including the FIT test, as well as colonoscopy and FOBT.
- 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.
- The member and provider newsletters contained various newsletter articles regarding cancer screening tests and the Plan's benefits.
- The member and provider newsletters contained various newsletter 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 reminder to age specific members regarding cancer screenings.
- Preventive screening reminders are being added to the phone system's hold message.

Tobacco cessation

The following activities were 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 Programs and other quality improvement activities and member newsletters stress the importance of smoking cessation, the many resources available to our members to help them quit, and 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 can lead tobacco cessation classes upon request from clients. The educators are continuing to provide one-on-one counseling with members as needed.
- Tobacco cessation web pages were added to the member and provider pages of the website and include education and resources (for adults and kids).
- Practitioners are notified of the recommended clinical guidelines for tobacco cessation through the provider newsletter and on our website.
- The Member Messenger newsletter contained articles on smoking cessation along with available resources.

Non clinical areas of Quality Improvement: CAHPS® Member Satisfaction Survey

The Plan's member satisfaction survey takes place on a yearly basis. This survey is conducted by an independent survey vendor and provides information on the experiences of our members with our Health Plan and how well we meet our members' expectations. There are four overall ratings of satisfaction in addition to seven 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 CAHPS® rates, refer to our HEDIS® 2015 Report as referenced at the beginning of this article.

Member services phone calls

This activity involves ongoing monitoring of the Member Services 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 has 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 to the Plan's participating practitioners. Phone calls are made 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 did not meet the standards were asked to develop an action plan to assist them in meeting the Plan's appointment access standards.

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

**CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). CAHPS® results also do not include elite1 individual plan membership data.*

Special communication services:

In compliance with the ADA and §508 of The Rehabilitation Act, we have this notice in other formats. Please call us if you need help understanding information at (800) 752-5863 at (toll-free). We can read items to you over the phone and we offer free oral translation in any language through our translation services.

Translation services

We can arrange for translation services. Free written materials are available in many different languages and free oral translation services are available. Call Member Services toll-free (800) 752-5863 for help and to access translation services.

- **Spanish (Español):** Para obtener asistencia en Español, llame al (800) 892-0675 (toll-free).
- **Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 (toll-free).
- **Chinese (中文):** 如果需要中文的帮助，请拨打这个号码 (800) 892-0675 (toll-free).
- **Navajo (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 892-0675 (toll-free).

Services for the deaf, hearing impaired, and/or visually impaired

If you are deaf or hearing-impaired, and need to speak to us, call TTY/TDD: (877) 652-1844 (toll-free). Please contact us toll-free at (800) 752-5863 if you are in need of a large print copy or cassette/CD of this notice or any other plan document.

Complex Case Management referral guide

What is the Complex Case Management Program?

Complex case management (CCM) is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The goal of complex case management is to assist members in regaining optimum health or improved functional capability. This is done by monitoring:

- Care to ensure it follows evidence based clinical standards aimed at care gap closure
- Members are appropriately using healthcare resources
- Health care needs are met in a cost-effective manner.
- CCM involves the comprehensive assessment of the member's condition, determination of their available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Is there a cost for the program?

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

How does the program work?

A designated case manager, who is a registered nurse, is responsible for managing these complex cases to ensure high quality, cost effective and appropriate utilization of health services. The case manager acts as a member advocate, seeking and coordinating creative solutions to a member's health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone and mail and acts as a resource, educator and/or coordinator of medical care if needed.

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 this program, or if you would like to refer a Sanford Health Plan member that you feel may meet the criteria for the program, please contact our Care Management Team at (888) 315-0884 or quality@sanfordhealth.org.

If you are a Sanford practitioner, please feel free to use in basket messaging to contact a Health Plan case manager.
If a case manager is currently following a member, they will be listed on the patient care team in One Chart. You can also send an in basket message to "SHP CRM CT Case Management" if you are unable to determine the assigned case manager.

Utilization Management 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 Vice President of 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 Vice President of 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.

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

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 and approved practice guidelines for numerous conditions for use as the Plan's primary clinical practice guidelines.

Please visit our website at sanfordhealthplan.com/providerlogin 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 the Plan at (605) 328-6877 or (800) 601-5086.

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-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/providerlogin 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 the Plan at (605) 328-6800 or (800) 752-5863.

Physician reviewer availability:

A physician reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness from 8 a.m. and 5 p.m., CT, Monday through Friday at (605) 328-6807 or (800) 805-7938.

Sanford Health Plan statement on Utilization Management:

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.

The Utilization Management Department performs three primary functions: utilization review (prospective or pre-service review, concurrent review, retrospective or post-service reviews), case management and discharge planning.

For information on how to obtain language assistance to discuss Utilization Management issues, please see the Special Communication Services section on page 6.

Utilization review

Utilization review is the process of monitoring and evaluating the medical necessity, appropriateness, and efficacy of health care services and procedures; as well as having the services at appropriate facilities. There are three types of utilization reviews:

- Prospective review (pre-service prior authorization)
- Concurrent review
- Retrospective (post-service) review.

Reviews are subject to specific decision and notification time standards; per state and federal laws, and NCQA (National Committee for Quality Assurance) standards.

The Utilization Management Department will review member profile information against standard criteria. Determinations and notifications of decisions to the member and practitioner and/or provider are made by the Utilization Management Department within the timeframes required by state law and NCQA standards. Certain circumstances may allow for an extension, for example, due to lack of necessary information to make the determination. Please refer to your Policy for Sanford Health Plan's procedure for timely handling of retrospective (post-service) review requests and for details on extensions for special circumstances. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Member Services.

The Utilization Management Department is available between the business hours of 8 a.m. to 5 p.m., CT, Monday through Friday (excluding holidays.) practitioners, providers and members may call the Plan's toll-free number (800) 805-7938 | TTY/TDD: (877) 652-1844 (toll-free). After business hours, you may leave a confidential voicemail and someone will return your call on the next business day. The Utilization Management fax number is (605) 328-6813.

Prior authorization/certification

Prior authorization (certification or precertification) is the urgent or non-urgent authorization of a requested service prior to receiving the service. The approval for prior authorization is based on appropriateness of care and service and existence of coverage.

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 certification 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:

- Online: Select "Submit/Request/Report" under "Provider Inquiries" on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on "Submit a preauthorization/precertification." Once you complete the required information click "Submit."
- Phone: (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8 a.m. to 5 p.m., CT, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- Fax: Please fax the prior authorization form and supporting documentation to (605) 328-6813.

Services requiring 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. The following services require prior authorization. New services added to the list are in red.

- Airway Clearance Device (DME)
- Ambulance Services for Non-Emergency Situations
- Autonomic Testing
- Back Surgery
- Bariatric Surgery
- Blepharoplasty
- Bone Growth Stimulator – External (DME)
- Botulin Toxin (Botox)
- Brachytherapy
- Breast Implant Removal, Revision, or Reimplantation when a non-Cancer diagnosis
- Breast Reconstructive Surgery & Mastectomy
- Breast Reduction Mammoplasty
- Clinical Trials
- Cochlear Implant (Device and Procedure)
- Continuous Glucose Monitoring (CGM) System and Sensors for over age 18 from an Endocrinologist
- Cranial Molding Helmet if not done by a Neurosurgeon
- Deep Brain Stimulation
- Dental Anesthesia for Children Under Age 5 Years (If Not Performed at a Sanford Health Facility)
- Dental Anesthesia for Members with a Developmental Disability
- Selected Durable Medical Equipment
- Enteral / Parenteral Nutrition Therapy and Formula
- Genetic Testing
- Growth Hormone (Pharmacy)

- Home Health Care Services
- Home Infusion (IV) Therapy
- Hospice Services
- Hyperbaric Oxygen Therapy
- Inpatient Hospital Admission: Medical, Surgical, obstetric (non-maternity), NICU, ICU, Rehabilitation, Mental Health/Chemical Dependency
- Insulin Pump (DME)
- Neuromuscular Electrical Stimulation
- Ossatron (ESWT)
- Selected Orthotics (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Pain Control Program
- Perception Sensory Threshold Test
- Photodynamic Therapy (Cancer)
- Phototherapy UBV Light Device (DME)
- Prosthetic Limb (Including Repair, Replacement Parts, Supplies, & Maintenance)
- Radio Frequency Ablation
- Selected Outpatient Surgeries
- Skilled Nursing Facility Services
- Specialty Drugs & Selected Injectables*
- Swing Bed Services
- Sub-Acute Care Services
- Spinal Cord Stimulator (Device and Implant Procedure)
- Testosterone Injections
- Transplant Services
- Vagus Nerve Stimulation
- Varicose Vein Treatment / Ablation:
  - Including but not limited to VNUS Closure, Endovenous Laser (EVL) and Sclerotherapy, are covered when medically indicated. These procedures do not require prior authorization when performed by a general surgeon, vascular specialist or interventional radiologist.
  - Other providers must provide proof of appropriate training and request prior authorization.
- Vitamin B12 Injections

*Specialty Drugs and Selected Injectables: See the Sanford Health Plan Formulary for drug prior authorization requirements.

Additional services requiring prior authorization for Simplicity and TRUE members

The services listed above still apply to Simplicity and TRUE members. These plans offer pediatric dental coverage. Therefore, the following procedures require prior-authorization:

- Medically-Necessary Dental Implants for Children Age 0-18 Years**
- Medically-Necessary Orthodontics for Children Age 0-18 Years
- **Other periodontic and endodontic procedures do not require prior authorization.

Additional services requiring prior authorization for Bethany Retirement Living members

The listing below is a complete listing for Bethany Retirement Living members.

- Inpatient Hospitalizations at Out-of-Network Facilities (includes Out-of-Network inpatient non-emergency (planned) admissions for medical and/or surgical reasons; and non-emergency (planned) admissions for treatment of a mental health and/or substance use disorder);
- Residential Treatment Facility admissions; and
- Skilled Nursing Facility Admissions (In-and Out-of-Network);
- Long Term Acute Care Facility Admissions (In-and Out-of-Network);
- Transitional Care Unit Admissions (In-and Out-of-Network);
- Home Health, Hospice, and Home IV therapy services (In-and Out-of-Network);
- Infertility Services, including assisted reproductive technology for GIFT, ZIFT, ICSI and IVF (In-and Out-of-Network); and
- Genetic Testing (In-and Out-of-Network).

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

In order to ensure members access to safe and effective care, Sanford Health Plan has adopted a formal mechanism to evaluate and address new developments in medical procedures, including behavioral health and substance use disorder treatment services, pharmaceuticals and devices. New technology to be reviewed includes clinical interventions, procedures, pharmacological treatments and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, medical and behavioral health procedures and pharmacological treatments and devices, as well as their application for Plan members. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee will be invited to present the technological aspects of the service/procedure/pharmacological treatment, as needed. Behavioral health and substance use disorder treatment professionals will be involved in the decision- making process for behavioral health and/or substance use disorder treatment services. 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. The technology must also meet all predetermined criteria established in the New Technologies policy. The Physician Quality Committee will complete the review and make coverage determinations on the new technology.

Experimental, investigational or unproven services means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes or requires approval by any governmental authority and such approval has not been granted prior to the service being rendered. Experimental and/or investigational procedures/services are not covered and are specifically excluded from coverage in the member's Benefits Policy. A participating practitioner or member may request a review of a denied experimental/investigational procedure by initiating the appeal procedure.
Experimental/investigational health care is that which does not, as determined by the Vice President of Medical Services on a case by case basis, meet all of the established criteria.

The Vice President of 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 our Member Services Department at (605) 328-6800 or (800) 752-5863.

Formulary statement

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

For a complete listing of the formulary, pharmacy locator, generic substitution information, medication side effect and interaction information, and other benefit information, log into your mySanfordHealthPlan account at sanfordhealthplan.com/memberlogin.

By following the Sanford Health Plan Formulary, and asking your health care Practitioner for generic medications, you will save money and help control the costs of your health care. If you request a brand-name medication when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay, unless the medication is a contraceptive as outlined in your Policy. When your practitioner prescribes a medication for you, you can ask that he or she refer to the Sanford Health Plan Formulary found on their mySanfordHealthPlan provider account at sanfordhealthplan.com/providerlogin.

To be covered by the Plan, 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. If the prescription is obtained at a non-participating pharmacy, the member is responsible for the prescription medication cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Types of Formulary Programs*

2-Tier Formulary:

A 2-Tier medication benefit that uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at one of these tiers: *

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

3-Tier Formulary:

A 3-Tier medication benefit that uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: *

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

4-Tier Formulary

A 4-Tier medication benefit that uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: *

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: formulary or specialty name brand medications exceeding a contracted value of $400

**The higher the tier, the higher the copay*

A brand name medication is a medication manufactured and marketed under a trademark or name by a specific manufacturer.

A generic medication is a medication that (1) is approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the brand name medication, (2) contains the same active ingredient as the brand name equivalent, and (3) typically costs less than the brand name equivalent.

Injectable Medication Program

Sanford Health Plan has contracted with Accredo for specialty medications. (Please refer to your Pharmacy Handbook for a list of injectable and high cost medications that must be obtained from Accredo.) Accredo will ship your medication and all the supplies you need for your injection directly to your home or health care practitioner's office within 24 to 48 hours after the request is approved and medication is ordered. Administration supplies (syringes, needles etc.) are free; you are not required to pay additional copays for those supplies. Prior to all shipments, a Patient Admission Specialist will contact you to discuss the copay for your medication and arrange delivery.

To enroll in the Accredo program, call toll-free at (866) 333-9721 and a customer service representative will ask the following information:

- Your name and date of birth
- Your phone number and address
- The name of your injectable medication to be filled
- Your doctor's name and phone number

Accredo will mail a letter to your doctor explaining the program and how to send your prescription orders to Accredo. By participating in specialty care, you are automatically enrolled in a medication therapy management program. This program entitles you to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours a day, 365 days a year for questions related to your specialty medication and the illness the medication is treating.
- Medication refills reminders if you forget to call for your refill, and a convenient refill process.
- Free delivery of your medication and supplies to your home, practitioner's office, or designated location.

Step Therapy Program

A program that requires certain medications to be used in a specific order, or by "steps." If you try a "first-step" medication and it does not work for you, or if you experience adverse side effects, then the next step medication may be tried, etc. This program is designed to save you money by trying alternative medications before more expensive medications are used.

Exception to formulary

If your or your practitioner feels that a certain medication is medically necessary for your condition, an Exception to the Formulary Process is available. (Please refer to the Exception to the Formulary Process in your Policy.) Please note that participating practitioners have been given instructions on how to obtain exceptions to the formulary.

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, for you 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. Note: You must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use. To request an exception to the formulary, please call Pharmacy Management at (800) 805-7938.

If you receive an adverse determination to your request for an exception to the formulary, please follow the Complaints and Appeals Procedure and the External Review Rights in the Policy. 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 following documents for specific medication coverage information. You received this information upon enrollment but can also obtain a copy online at sanfordhealthplan.com/memberlogin or by calling Member Services at (800) 752-5863.

- Summary of Benefits and Coverage – describes the payments for which you are responsible when purchasing prescription medications and supplies;
- Pharmacy Handbook – describes specific information on medication exclusions, medications that require certification, quantity level limits on medications, the Plan's specialty medication program, and the formulary.
- Policy – describes how and where to obtain your prescription medications and supplies, dispensing limitations, and excluded medications and supplies.

Member Rights & Responsibilities Statements

Minnesota Member Rights

In accordance with the Minnesota Department of Health, and the National Committee for Quality Assurance (NCQA), you have certain rights as a member of the Sanford Health Plan in Minnesota:

1. Members have the right to available and accessible services including emergency services, as defined in the Benefits Policy, 24 hours a day and seven days a week;
2. Members 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;
3. Members have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the Plan and its health care practitioners and/or providers, in accordance with existing law;
4. Members have the right to file a complaint with the Plan and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the Plan or its health care practitioners and/or providers;
5. Members have the right to a grace period of 31 days for the payment of each service charge for individual coverage falling due after the first premium during which period coverage shall continue in force;
6. Medicare members have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law;
7. Medicare members have the right to a clear description of nursing home and home care benefits covered by the Plan;
8. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; sexual orientation; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; disability; national origin, age, or sources of payment for care;
9. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity;
10. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;
11. Members have the right, but are not required, to select a primary care physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, they have the right to choose another PCP;
12. 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 Minnesota law;
13. 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;
14. Members have the right to a candid discussion (with the practitioner(s) and/or providers responsible for coordinating their care) of 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 planning;
15. Members have the right to give informed consent before the start of any procedure or treatment;
16. When a member does not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician who is able to communicate with the member;
17. 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;
18. Members have the right to appeal any decision regarding medical necessity made by the Plan and its Practitioners and/or providers;
19. Members have the right to terminate from the Plan, in accordance with Employer and/or Plan guidelines;

20. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities; and
21. Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies.

South Dakota, North Dakota and Iowa Member Rights (including Sanford employees)

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 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; gender; sexual orientation; medical condition, religious beliefs, national origin, age, 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 physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he or 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 practitioner 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 practitioner(s) and/or providers responsible for coordinating their care) of 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 planning.
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, the Plan will make its best 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.
10. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and 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 the Plan and its practitioners.
13. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.
14. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
15. Members have the right to make recommendations regarding the organization's members' rights and responsibilities policies.
16. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations, or the use of restraints and seclusion.

South Dakota, North Dakota and Iowa Member Responsibilities (including Sanford employees)

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 Plan ID cards with them and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, members are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State law in North Dakota, Iowa, and South Dakota 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 forty-eight (48) hours 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 practitioner or the hospital.
7. Members are responsible for following their treatment plan as told by the Doctor mainly 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 the Plan within thirty (30) days at (800) 752-5863 or (605) 328-6800 | TTY/TDD: 1-877-652-1844 (toll-free) if they change their name, address, or telephone number.
10. Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.
11. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
12. Members have the right to make recommendations regarding the organization's members' rights and responsibilities policies.
13. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations, or the use of restraints and seclusion.