

PROVIDER MANUAL

SVHP-0571



Philosophy of Sanford Health Plan

Sanford Health Plan ("the Plan") is a unique alternative to existing health maintenance organizations (HMOs). Other HMOs have been designed to directly lead physicians' practices and hospitals' provision of care against a premium. In contrast, Sanford Health Plan is designed to leave physicians and hospitals in control of the direction of care and together identify a reasonable premium.

The core of Sanford Health Plan is the collaborative effort between Sanford Health, contracting physicians that participate in the Plan, and respective members of the community. These participants have created a not-for-profit system, which is quality driven. The physicians and hospitals will direct the Plan in the best interests of all the patients served. All of the goals and objectives of Sanford Health Plan will be member focused and in compliance with all governing laws.

A Coordinated Effort

Physicians and hospitals, their boards and management, are uniquely prepared in each community to understand the needs of the patients that they serve. Sanford Health Plan is working in compliance with NCQA (National Committee for Quality Assurance). NCQA, along with a broad constituency including the managed care industry, health care purchasers, state regulators, and consumers, has developed standards which measure the managed care organizations' performance. The NCQA Standards were originally established in 1991 and since then have been revised to reflect ongoing review and interpretation. Compliance with the NCQA Standards for Accreditation of Managed Care Organizations verifies that a managed care organization is committed to the principles of quality and is continually improving the clinical care and services it provides. These NCQA standards evaluate managed care organizations in the following areas:

- Quality management and improvement
- Utilization management
- Credentialing
- Member's rights and responsibilities
- Preventive Health Services
- Medical records

Sanford Health Plan has endorsed the NCQA Standards as those standards of practice and performance with which the Health Plan will strictly comply.

A Common Objective

The common objective of Sanford Health Plan, physicians and hospitals, their boards and management work together in each community to understand the needs of the patients they serve and the resources necessary to meet those needs. This opportunity, however, requires an understanding that there will not be infinite resources and that all participants must act in a prudent manner, recognizing that a single premium will have to be shared among all providers in a manner which will maintain the viability of the Plan as a whole.

This being a finite dollar system, each element of the Plan (Primary Care Physicians, Specialty Physicians, the hospital as a provider, and ancillary providers who participate in the Plan) will need to understand that the Plan cannot succeed if any one provider seeks to benefit itself over the other and to prosper at the expense of others. To this end, the various provider groups within Sanford Health Plan share the risks and the advantages intrinsic in the Plan through being capitated either as individuals or collectively in the capitation pools. Sanford Health Plan's management history or goal is to keep overhead to an absolute minimum and therefore returns more than 80% of the premium in the form of care to the members, once start-up costs have been paid back. Management resources have been designated to cover contingencies. The fundamental purpose of these resources is to retain sufficient moneys to pay off the start-up costs, to continue to meet the state-required financial reserves, and to provide a stabilizing affect on the Plan so that the Plan's financial integrity cannot be threatened by occasional increases in expenditures for necessary care. The necessary contingency reserves will typically be equal to two months premium.

A Not-For-Profit Plan

Sanford Health Plan has no equity partners. There is no outstanding stock, and there are no individuals demanding dividends. In configuring the Plan in accordance with the requirements of the Internal Revenue Service, the premium earned will be utilized on behalf of the persons enrolled and will not be used to pay investing partners.

Perhaps of greater importance, since the Plan does not have equity partners, is that the Board of Directors of Sanford Health Plan remains representative of, responsible for, and responsive to physicians, the institution, and the members. This is in contrast to a *for-profit* board whose first goal is to enhance revenue to an investor while limiting dollars accessible for health care to the members.

A Quality Driven Health Plan

Sanford Health Plan is designed to meet the needs of the members within the system. This means that the needs of members will be identified by a medical information system that is responsive to each individual.

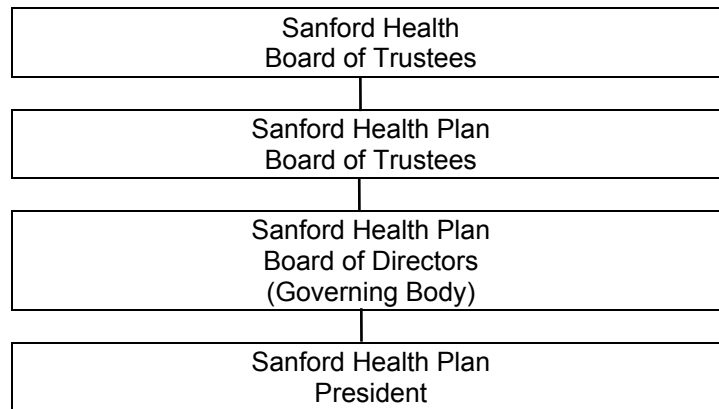
As a quality driven system, Sanford Health Plan is fully supported by a sophisticated ambulatory and institutional quality management program. This program seeks the most cost-effective level of care for each patient's specific need rather than acting as a system that denies necessary care. Sanford Health Plan's quality program identifies the pertinent resource to address a member's recognized problem and will present alternatives to hospitalization.

The quality management system is linked to the Finance Department of Sanford Health Plan so that the financial staff is conscious of the medical outcomes of the financial decisions. In summary, the Plan monitors its use of resources in order to ensure appropriate distribution of assets throughout the entire system.

Sanford Health Plan Corporate Organization

Sanford Health Plan is a wholly owned, non-profit subsidiary of Sanford Health. The System Board of Trustees is ultimately responsible for the governance of the Plan, but has delegated to the Plan's Board of Directors authority to act as the governing body of the Plan. The Vice President is accountable to the Board of Directors.

**Sanford Health Plan
Corporate Organization Chart**



The Board of Directors acts as the conscience of the Plan, looking not only at what the Plan does, but also at what it means to its members and to what extent it has succeeded in meeting its almost conventional relationship with the members. The Board of Directors is charged with guardianship of the goals and the long-term vision of the organization. These goals are expressed in the content of the health care package that is offered to the community.

To assure the success of Sanford Health Plan, physicians on the Board of Directors have a central role in the functioning of the Board as they participate in strategic planning and policy development. Physicians are charged with bringing to the Board of Directors the oversight management of the entire Plan as they work with patients and recognize their needs.

Organizational Description

Sanford Health Plan has five distinct administrative areas: Client Services, Finance, Provider Relations, Operations and Health Services. Each of these departments has a Director responsible and accountable to the President.

Under the general direction of and in conjunction with the Board of Directors, the President of the Plan is responsible for development and updating of objectives, policies and directives, and for the oversight of the effective and efficient administration of its programs. The President presents to the Board of Directors annual and long-range goals and objectives, strategies and budget for achieving approved objectives and proposed policies. The President also presents periodic reports on achievements, financial performance, quality of services, and general administrative operations to the Board of Directors.

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In addition to managerial responsibilities, the President is expected to represent the Plan to the local area, including the business, medical, media, governmental, and citizen communities in such a way as to promote the best interests of the Plan. The President plans and directs all administrative and management activities of the Health Plan, including those related to patient care, finance, administration, personnel planning, member relations and outreach.

Additionally, management arranges the necessary support elements needed to meet health care responsibilities, other than those provided by the physician. This includes contracts with extended care facilities, local pharmacies, durable medical equipment companies and all other support elements demanded by members. The Plan will utilize Sanford Health extensive network of quality hospitals, ancillary providers, primary care physicians, and specialty care physicians. In addition, the Plan will attempt to negotiate contracts with additional primary care physicians, specialty care physicians, hospitals, as well as, other ancillary providers as necessary to provide adequate access to members.

In order to provide services for a large rural community, Sanford Health Plan has established products with two levels of benefits which will enable members to access varying levels of care when using network providers and when using out-of-network providers. Members residing in areas in which the Plan has no network providers available will have their benefits paid at the in-network level.

Sanford Health Plan is member focused. The central belief of Sanford Health is the commitment by the community hospital and local physicians to the local members served.

Quality Improvement

Sanford Health Plan and its participating practitioners and providers acknowledge their responsibility to provide high quality care in a cost-effective manner through an ongoing monitoring, evaluation and improvement process. The organized method for monitoring, evaluating, and improving the quality, safety and appropriateness of health care services, including behavioral health care, to members through related activities and studies is known as the Quality Improvement (QI) program.

Mission

The mission of the QI Program is to provide accountability for the quality of health care delivery and service. This is accomplished through the commitment of the Board of Directors and the Physician Quality Committee and the Health Plan Quality Improvement Committees to develop and carry out a Quality Assurance Plan that has a systematic approach to assessing, measuring, defining and resolving medical care, and behavioral health and service issues.

Philosophy

The Plan believes that the only way to achieve continuous quality improvement is to have its entire organization embrace a well defined Quality Improvement Program and Annual Work Plan in their day to day activities.

I. GOALS AND OBJECTIVES

- Assure high quality of care to all Plan members.
- Continuously monitor and improve the quality and safety of patient care and health delivery services by all practitioners with delineated clinical privileges.
- Continuously monitor and improve behavioral health care through education and collaboration with behavioral health practitioners. This will be accomplished through reporting and analyzing behavioral health related HEDIS measures, the involvement of a behavioral health practitioner on the Physician Quality Committee to assist in decisions regarding behavioral health related utilization management (UM) issues and quality improvement activities, and the collaboration with area behavioral health practitioners to improve the continuity and coordination of the behavioral health care that our members receive.
- Oversee and assess medical care systems, processes and outcomes.
- Oversee and assess components of health service delivery.
- Oversee the credentialing and recredentialing of all health care practitioners and providers.
- Implement standards of care and practice guidelines as recognized by national specialty academics, nationally recognized authorities, and standards developed by the Quality Improvement Committee. Communicate standards and guidelines to practitioners and providers, when appropriate.

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- Review and/or update criteria, guidelines and standards of care and services at least annually based upon UM (Utilization Management) and QI (Quality Improvement) activities and results.
- Monitor compliance with standards of care and services.
- Monitor compliance with Medical Record standards.
- Implement improvement interventions as necessary.
- Monitor member and practitioner/provider complaints and grievances/appeals, the reasons for the complaint and grievance/appeal, and the Plan's resolution turnaround time.
- Develop and maintain a monitoring system to detect trends.
- Assess effectiveness of improvement interventions.
- Establish and maintain a preventive process that identifies potential risk management issues.
- Conduct special reviews as specified by major employer groups and insured clients.
- Identify and report Public Health issues as it pertains to maintaining/improving the health status of the population.
- Recognize and evaluate new health care services, technologies, procedures, and pharmacological treatments, as well as their application for the population served.
- Demonstrate a commitment to improving safe clinical practice by fostering a supportive environment to help practitioners and providers improve the safety of their practices. This may be accomplished through the distribution of information to practitioners to assist in facilitating a safer clinical environment.
- Distribute information to members to improve their knowledge about prevention of illness and clinical safety as it relates to their own healthcare. Also to distribute information regarding clinical safety to facilitate informed decision making.
- Address patient safety issues in existing quality improvement activities and health management programs through prevention and educational activities.

II. SCOPE

- Quality Improvement (QI) encompasses the entire delivery system, including, but not limited to, hospital care, ambulatory care, ancillary services, emergency services, behavioral health services, preventive services, vision services, pharmacy, dental services, home health care, hospice care and extended care facilities.
- QI addresses both the quality and safety of clinical care and the quality of non-clinical aspects of service, including availability, accessibility, coordination and continuity of care, including referrals, case management, discharge planning, prior authorizations, practitioner and provider reimbursements, and complaints.
- The medical delivery system is monitored for both quality and utilization activities. Both over-utilization and under-utilization are addressed.
- Departments that support and may be included in the QI process are the Health Services Department, Information Services, Provider Relations, Client Services/Marketing and Member Services.
- The Plan provides for ongoing Internal Peer Review activities to ensure continuous quality improvement and will solicit the assistance of External Peer Review Organizations every two years to collect benchmark data to evaluate the Plan's overall performance.
- Satisfaction Surveys are also conducted to obtain information pertaining to member and practitioner/provider perceptions of Plan policy and procedure.
- The Plan will achieve any performance levels as established by CMS (Centers for Medicare & Medicaid Services), State, or NCQA (National Committee of Quality Assurance) with respect to standard measures. Performance measures may be contained in standardized national data collection and reporting instruments such as HEDIS (Health Plan Employer Data and Information Set) and CAHPS (Consumer Assessment of Health Plan Survey) and/or by State or CMS (Centers for Medicare & Medicaid Services) specific.

Confidentiality

Sanford Health Plan complies with all applicable HIPAA, state and NCQA regulations regarding privacy and confidentiality. Any Plan employee or any participating provider engaging in QI activities must uphold the established principles of patient/physician confidentiality and individual privacy. Each employee will sign an affidavit of confidentiality on an annual basis.

All QI worksheets, study results and other related materials will remain confidential. Reference to physician/providers as well as members will be by number or symbol only. Committee members will not release any

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information regarding a provider or a member unless it is required by law or is necessary to coordinate health care services or secure the health or safety of a member.

Please refer to the policy MM-56 Quality Improvement Program for further details. This policy can be found in section 7 of the Provider Manual.

Medical Management Program

I. Definition

The Medical Management Program (also referred to as Utilization Management or UM) is an organized method for monitoring and evaluating the course of treatment rendered by all health personnel, given a standard of desirable care. It is a process that looks at the following to determine if the treatment, as prescribed, is appropriate:

- a. The medical necessity of the treatment
- b. The setting for the treatment
- c. The types and intensity of resources to be used in the treatment
- d. The time frame and duration of the treatment

II. Purpose/Objectives

The purpose of this Medical Management Program is:

1. To monitor the delivery of medical and behavioral health services to ensure that those services are performed at the appropriate level of care in a timely, effective, and cost-efficient manner.
2. To study patterns of health services utilization for physician credentialing, sanctioning, and continuing education of the medical staff, administration and consumers regarding health care cost containment.

In addition, the Medical Management and Quality Improvement team will:

1. Identify problems by utilizing a system in which network practitioners, members and Sanford Health Plan staff can refer issues, concerns and potential opportunities for improvement.
2. Develop and implement practice guidelines and/or clinical indicators. This includes structure, process and outcome indicators that are derived from current research and studies.
3. Establish a monitoring and evaluation process for staff and committees to select appropriate topics, develop study parameters, retrieve and summarize data, and implement improvement interventions.
4. Review the following quality performance measures on an ongoing basis:
 - Preventive Services
 - Health Education Programs
 - Obstetrical Care
 - Acute and Chronic Illness
 - Mental Health and Substance Abuse
 - Data from Satisfaction Surveys such as CAHPS.
5. Distribute any QI results, which may warrant improvement interventions, sanctions, improvement opportunities or concerns to the credentialing files for coordination in the annual recredentialing process.
6. Perform medical record review at practitioner and/or provider offices.
7. Perform peer review activities consisting of medical care reviews that assess the utilization of services and the quality of care rendered by practitioners and/or providers. Results of the peer review process will be available for recredentialing purposes.
8. Evaluate healthcare quality related complaints, grievances and appeals on a quarterly basis.
9. Perform quality improvement studies as it relates to timeliness of access, to care/services and to member service activities.

III. Scope

Sanford Health Plan's Medical Management Program applies to any companies with which The Plan has a service agreement to provide such utilization management services. The Medical Management Program addresses both the quality and safety of clinical care and the quality of non-clinical aspects of service including availability, accessibility, coordination and continuity of care. The Medical Management Program includes authorizations of services, concurrent reviews, retrospective reviews, focused reviews, case management and discharge planning. Sanford Health Plan does not delegate any of these Medical Management (Utilization Management) activities.

IV. Authority

The Plan is authorized to perform Medical Management functions as described in the service agreements with each company or carrier. The Physician Quality Committee and the Sanford Health Plan Board of Directors shall review the Medical Management Program for updates as needed, but at least once every year. Accountability for the overall Medical Management Program lies with the Board of Directors. The Medical Director, who serves as the chairman of the Physician Quality Committee, reports to the Board of Directors. Minutes for the Physician Quality Committee meetings are submitted to the Board of Directors in confidence.

V. Access to Records and Confidentiality

The Physician Quality Committee and the Plan's Privacy Official will uphold the established principles and written procedures pertaining to patient/physician confidentiality and individual privacy. (Notice of Privacy Practices, Sanford Health Plan Privacy Officer Designation, and HIPAA Confidentiality Policies CO-2, CO-5, CO-6, CO-8, CO-11, and CO-13). Patient-specific information obtained during utilization reviews (except summary data that does not provide enough information to allow identification of individual patient) will be:

- Kept confidential in accordance with applicable federal and state laws:
 - Minnesota Statute 144.335;
 - Iowa Code §514B.30 & §228.7;
 - South Dakota Codified Laws §58-41-74; and
 - Federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Used solely for the purposes of utilization review, quality assurance, discharge planning, and case management.
- Shared only with organizations or persons that have the authority to receive such information in accordance with State and Federal privacy laws.

VI. Organization

A. Physician Quality Committee

The Physician Quality Committee consists of physician members. Members of the Committee are appointed by the Medical Director who is the chairperson. The Committee meets eight times a year. Minutes shall be kept for each Committee meeting and submitted to the Board of Directors in confidence. The Committee responsibilities include developing and continually evaluating the review criteria used in the evaluation of appropriate utilization. The Committee will utilize nationally developed and accepted review criteria from Milliman and InterQual. Milliman will be used as a length of stay guideline only. The physician group may also develop their own criteria based on literature review, specialty society standards of care, durable medical equipment (DME) criteria, Medicare guidelines, and Health Plan benefit interpretation. Local medical review policies will be utilized for decisions regarding Medicare coverage. The review criteria shall be reviewed no less than once annually. Any recommended changes in the criteria or any other program changes must be approved by the Board of Directors.

B. Health Services Department

The Health Services Department staff will perform the daily Utilization Management functions. The Plan will ensure that these individuals are properly trained, qualified, appropriately licensed as appropriate, and supervised. The department consists of the following roles:

1. Health Services Director, a registered nurse, who shall have responsibilities that include the following:
 - a. Train and supervise decisions and activities of the Utilization Management Coordinator(s)/Technician(s), Case Manager(s) and Quality Improvement Coordinator(s).
 - b. Review decisions and activities of the Utilization Management Coordinator(s)/Technician(s), Case Manager(s) and Quality Improvement Coordinator(s) for consistency of application of criteria by the Coordinator(s). (Refer to Medical Management Staff Reviewer Reliability MM-22)
 - c. Ensure that Utilization Management program protocols and policies are implemented.
 - d. Ensure that Case Management program protocols and policies are implemented.
 - e. Ensure and coordinate continuing education, performance and competency of Utilization Management (UM) Coordinator(s)/Technician(s), Case Manager(s) and Quality Improvement (QI) Specialist(s).
 - f. Refer to job descriptions for training, orientation, and education requirements.

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2. The Utilization Management Supervisor reports to the Health Services Director and has the following responsibilities:
 - a. Handle the day-to-day operations contacts for the UM staff for ESI, UM questions and will act as the liaison between UM and the physician when necessary.
 - b. Act as the computer resource individual concerning 1) Health Services queries, 2) InterQual, 3) Diamond, 4) Milliman, 5) various Map Quest requirements, and 6) other computer situations as needed.
 - c. Act as the Diamond resource individual for the Health Plan's Claims, Member Services and Health Services Departments.
 - d. Assist in periodic review of UM programs.
 - e. Conduct annual competencies, annual evaluations and co-evaluations with the Health Services Director for the UM staff supervised.
3. Utilization Management Coordinator(s)(Registered Nurses) or Technicians (Licensed Practical Nurses, Medical Assistants) report to the Health Services Director. Their responsibilities include the following:
 - a. Prior authorization of services (See insert listing prior authorization in the back cover).
 - b. Concurrent reviews.
 - c. Retrospective reviews.
 - d. Focused reviews.
 - e. Identification of any quality assurance issues.
 - f. Medical Director referrals.
 - g. Compilation of utilization data.
 - h. Coordinate admission prior authorizations.
 - j. Compile utilization data.
 - l. Act as central coordinator of utilization records.
 - m. Denial of services based on policies, procedures and/or benefit coverage.
 - n. Education of members with no in-network benefit options.
4. Case Manager(s) report to the Health Services Director. Their responsibilities include the following:
 - a. Review of employer group data.
 - b. Compilation of employer group utilization data (over and under).
 - c. Health education to employer groups.
 - d. Risk Screening to employer groups.
 - e. High risk member identification and management.
 - f. Education of members with no benefit options.
 - g. Resource management.
 - h. Referral management (Social Service Agencies).
 - i. Identification of any quality assurance issues.
 - j. Transplant coordination.

C. Medical Director and Physician Consultant Responsibilities

The Medical Director or his designee, who is a board certified physician, is responsible for the overall Utilization Management (UM) program and implementation. The Medical Director shall review the medical appropriateness of any UM decision, especially denials of care during prior authorization or concurrent review. Medical appropriateness is determined by approved clinical review criteria. Denial and appeal decisions will be determined by a practitioner with a current license to practice without restriction and with the appropriate education, training and professional experience in medical or clinical practice.

A behavioral health practitioner is represented on the Physician Quality Committee as well as the Board of Directors providing practitioner involvement in advising the Committee on issues of implementation and management of behavioral health care aspects of the UM program and/or quality concerns.

A physician or appropriate behavioral health practitioner (i.e., psychiatrist, doctoral-level clinical psychologist or certified addictions medicine specialist) reviews any denials of behavioral health care that is based on medical necessity. For Sanford Health Plan of Minnesota enrollees: For chiropractic, mental health and dental determinations not to certify, the review must be performed by a chiropractor, psychiatrist (certified by the American Board of Psychiatry and Neurology and licensed in the state of Minnesota) or

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dentist. In all other situations, on appeal the case must be reviewed by a practitioner practicing in the same or similar specialty.

When a board certified specialty physician is not represented on the Physician Quality Committee, the Committee shall designate a specialist physician consultant, who is certified by the American Board of Medical Specialties, to provide that expertise when needed.

Specialty physician consultant functions include but are not limited to the following:

1. Making recommendations to the Physician Quality Committee concerning criteria;
2. Settling disputes (as described in this MM-49 UM Program Policy regarding medical necessity appeals); and
3. Providing opinions regarding appropriateness of medical care.

Please refer to section 7 to view policy MM-49 UM program for further operational details, prior authorization and denial and appeal procedures.

Sanction Policy

The sanction policy outlines the mechanism utilized for evaluating and recommending changes in a physician's practice patterns to comply with the medical standards established by the Plan.

The purpose of this policy is to educate and communicate with providers that have developed a pattern of care that does not meet the quality standards of the Plan or uses cost ineffective procedures. Listed below are examples of practitioner patterns/trends that may be identified by means of concurrent and/or retrospective review analysis:

- Questionable quality of care (life threatening issues will be handled immediately by the concurrent review process).
- Management resulting in increased costs due to delay in scheduling, pre-op admission days with no medical justification and delay in discharge and/or transfer orders.
- Extensive length of stay based on Plan established length of stay criteria and/or DRG guidelines.
- Performing inpatient surgical procedures that are on the Sanford Health Plan's approved outpatient list without prior committee authorization and/or medical justification.
- Hospital admissions for diagnostic work-ups that could safely be completed on an outpatient basis.
- Extensive and/or questionable psychiatric/substance abuse cases identified by the concurrent and retrospective review process.
- Identified pattern of over-utilization of ancillary services and/or consultations.

The sanction procedure will be implemented as follows:

1. The physician will receive a letter from the Medical Director with the Board approved Plan Sanction Procedure, reiterating the problem and recommendations for corrective actions.
2. If the documented practice pattern continues, the physician will receive a warning letter stating that, if the problem is not corrected, a recommendation for exclusion of membership in Sanford Health Plan will be forwarded to the Board of Directors within thirty days of the documented incident.
3. If the practice pattern still continues, the recommendation for expulsion of membership would be forwarded to the Board of Directors. The appeal mechanism outlined in the Practitioner Dispute Resolution Policy will be followed should a request for reconsideration be filed.

Sanford Health Plan Information Systems

Software Support Systems

Sanford Health Plan has purchased its information systems support for its Plan operations. The selected vendor, PEROT, has proven that it has one of the leading managed care software products available in the market. The software package purchased has been developed specifically to support health maintenance and managed care organizations, rather than those products developed to support insurance companies and third-party administrators.

Sanford Health Plan recognizes that it may be desirable to supplement the primary managed care software product with a select number of specialized software products, which support specific functions more capably than the more broadly based system. This approach will enable Sanford Health Plan to combine the benefits of operating a broadly based, integrated software system with the benefits of utilizing "the best" specialized applications. The following functions will be part of the specialized software packages:

- **Credentialing**- Specialized credentialing systems offer managed care organizations superior support for credentialing and recredentialing providers in a timely and comprehensive manner, thereby increasing the ability of Sanford Health Plan to assure that members are served by a high quality provider network.
- **Care Management**- For example, it may be necessary to use a specialized system to appropriately support the unique needs of behavioral health care management.

Claim Adjudication/Electronic Data Processing

Sanford Health Plan providers are to file paper or electronic claim forms. The claim form should be a standard HCFA 1500 or UB92 claim. All claims should be submitted to Sanford Health Plan even if the member does not exceed their deductible or copay amounts.

Claims are to be submitted to:

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

These trading partners are currently contracted with Sanford Health Plan:

APS Medical Billing
Business Resources, Ltd
Caremedic System, Inc
COBA – GHI, Inc
eProvider Solutions
Healthcare Administration Tech, Inc
MedAvant Healthcare Solutions (formerly Proxymed)

To discuss direct claim submittal or for general EDI questions please contact Sheridan Zhu at 605-328-6823 or HEALTHPLAN_EDI@SANFORDHEALTH.ORG.

All claims must be received by Sanford Health Plan within 120 days of the date of service and include the following information:

1. Patient's name and current demographic information
2. Patient's entire ID number including patient suffix (ex. xxx-xx-xxxx-02). This information is found on each Sanford Health Plan member's card
3. Provider's name
4. Provider's Sanford Health Plan Provider Identification Number in by PIN# in box #33 (HCFA 1500) or box #51 (UB92)
5. Provider's Tax Identification Number, Billing address, Location of services, Phone number
6. Pertinent ICD-9 diagnosis codes with primary code indicated
7. Pertinent CPT-4 procedure codes
8. Name of employer and group number

All claims received after 120 days from the date of service to Sanford Health Plan will be denied due to untimely filing. Charges denied for untimely filing are not to be billed to the member, but must be written off by the provider. If it was not reasonably possible to send a claim to the Plan within 120 days from the date of service, the provider

Sanford Health Plan Information Systems

must follow up within sixty (60) days from the date of the denial shown on the Sanford Health Plan Explanation of Payment.

The Plan will reimburse the provider for “clean” claims within thirty (30) days of receipt of the claim and will respond within sixty (60) days of receipt for “non-clean” claims. Clean claims are those claims not requiring additional information. Non-clean claims are those claims requiring additional information, i.e. accident details, pre-existing condition information or other coverage information. If you do not receive an Explanation of Payment (EOP) from the Plan within the sixty (60) day time frame regarding claims submitted, it is advisable to follow up with a Provider Relations Representative as to the status or sign up for a Digital Health Plan account and check claim status online at www.sanfordhealthplan.com.

When in full automation, Sanford Health Plan will move away from a claims based system to a real time, on-line, authorization and encounter based system which will provide an immediate (with in 20 seconds) display of members copayment / deductible obligation.

Follow up on claims processed with regards to denials, reimbursement levels, or other Plan determinations that effect claims processing must be submitted within 180 days from the date of service. If the claim is past the 120 day filing period, follow up on claims must be made within 60 days from the date the Explanation of Payment was issued to the provider. After this time frame has expired, claims will no longer be allowed to be reviewed.

National Provider Identifier (NPI)

As you all are well aware that NPI numbers will be required for electronic submission effective May 2007, Sanford Health Plan is capable of storing these numbers immediately! Once you or your practitioners have a NPI number, please submit the number to Sanford Health Plan by mail, fax or email. We ask that you include the practitioner's name, Sanford Health Plan current provider number and a contact person with their phone number for questions. Claims will still need to be submitted with the practitioner's Sanford Health Plan provider number until May 2007. Please feel free to contact the Provider Relations Department with questions at 800-601-5086.

Digital Health Plan

Sanford Health Plan's Digital Health Plan allows practitioners the ability to check member eligibility, claim status, explanation of payments and prior authorization information online upon signing up for an account.

Requesting a Digital Health Plan account; follow the steps below:

1. Go to Sanford Health Plan's website www.sanfordhealthplan.com
2. Click on the link Access Your “Digital Health Plan”
3. Click on the link “Sign up for Provider Account”
4. Read the statement on the Web Request screen and Select “I agree” or “cancel”
5. Enter all the Required Account information on the screen indicated by a red ►
6. When all the required account information has been added, click on “Submit”

Your information will then be submitted to be reviewed for approval. Once your account has been approved you will receive an email from Sanford Health Plan stating whether or not your account has been approved or denied.

Once your account has been approved for access, you will be able to log on to Digital Health Plan 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 toll free 800-601-5086.

Sanford Health Plan's Webpage - www.sanfordhealthplan.com

Sanford Health Plan strives to keep practitioners and members up to date with the most current information and to achieve this we use the website. Below is a summary of what you can find in the Healthcare Provider section on the webpage:

- Digital Health Plan: Online access to member eligibility, claim status, explanation of payments and prior authorization information
- Provider Directory: Search by zip code, city or specialty

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- Credentialing Information: SD, IA or MN applications and Sanford Health Plan's credentialing policies
- Clinical Practice Guidelines
- Electronic Data Interchange: Companion Guide information
- Forms: Flu Roster, Medication Request Form, Provider Change Form and W-9 Form
- Medical Management: Disease Management Programs
- Pharmacy Information: Pharmacy Directory, Formulary, Generic Medication Information
- Prior Authorizations: How to prior authorize and what needs prior authorizations
- Provider Manual: Provider information regarding Sanford Health Plan
- Provider News
- Provider Newsletters: Medical Update Newsletters and Provider Perspective Newsletters
- Preventative Health Guidelines: Spreadsheet of Adult and Child Preventative Health Guidelines with CPT codes
- Quality Improvement Activities: Asthma, Congestive Heart Failure, Diabetes, Healthy Pregnancy Program

Helpful information that can be found under the Member section on the webpage:

- Group Certificate of Coverage
- Health and Wellness Education
- Member Handbook

Sanford Health Plan's Delivery System

Provider Access and Availability Standards

Sanford Health Plan will periodically evaluate its network and add providers to meet identified member needs. In addition, the Plan will make available sufficient personnel to meet the access and availability standards set forth by the state requirements.

All of the providers within the Sanford Health System have been contracted to participate with the Plan. The Plan will continue to contract with physicians outside of the Sanford Health System to provide appropriate geographic access to its enrollees and to ensure sufficient capacity throughout the entire service area. Additional hospitals will also be added to the Plan's network based on identified member needs and access requirements.

Please refer to the policy MM-50 Provider Access and Availability Standards, for further details on the Plan's Access and Availability requirements.

Health Care Specialists

The list below illustrates the specialists that the Sanford Health Plan network expects to provide to its members. In the event that it is a necessity for a member to access a provider whose specialty is not included within the Sanford Health Plan network, Sanford Health Plan will contract directly with those specialty providers.

Allergy/Immunology	Occupational Medicine
Anesthesiology	Oncology
Audiology	Ophthalmology
Cardiology	Optometry
Chiropractor	Orthopedics
Dermatology	Pathology
Durable Medical Equipment	Physical Medicine/Rehab
Emergency Medicine/Trauma	Podiatry
Ear Nose & Throat	Psychology/Behavioral Medicine
Gastroenterology	Psychiatry
Genetics	Pulmonary Disease
Hematology	Radiology
Infectious Disease	Rheumatology
Mental Health/Substance Abuse	Skilled Nursing Facility
Neonatology	Surgery
Nephrology	Urology
Neurology	

Credentialing

All providers will be reviewed to verify that standards are met in accordance with the Practitioner Credentialing Policy at the time of initial credentialing and at the time of recredentialing (two years after initial credentialing date) with the following exceptions below:

- The provider is based at a JCAHO- accredited or a state licensed hospital and the members' medical records are retained in the hospital medical records department.
- Facilities in which the specialist interprets diagnostic testing, but does not have contact with the member.
- Situations where review of the facility has been delegated by contract to an outside organization.

Any new providers adding to existing participating facility/groups are required to fill out a Provider Credentialing Application in order to be considered participating within the Sanford Health Plan network. Claims will be accepted from a practitioner in the credentialing process and held by Sanford Health Plan until the practitioner has been approved by the Credentialing Committee. No payment will be made until the practitioner's credentialing has been approved. If the Credentialing Committee denies a practitioner's credentialing file claims will be denied and these claims will not be billable to the member. If you are in need of a Practitioner Credentialing Application and Criteria, please contact the Provider Relations Department at (800)-601-5086 or visit our website www.sanfordhealthplan.com. Please reference the Criteria for Participating Practitioners Policy PR-10 and the Practitioner Credentialing/Recredentialing Policy PR-6.

Member Eligibility Verification

Each provider is responsible for assuring that a member is eligible for coverage when services are rendered. Member eligibility can be determined by contacting Sanford Health Plan Member Services Department directly at (800) 752-5863 or (605) 328-6800. Representatives in the Member Services Department will verify eligibility status upon request. Member eligibility can also be verified on our website www.sanfordhealthplan.com through an account on Digital Health Plan. Please see the Digital Health Plan section.

If a provider fails to check eligibility at the time the patient presents for services and provides services to a member who is not eligible for coverage, the provider will not be reimbursed.

Medical Record Standards

Sanford Health Plan ensures that each Provider furnishing services to members maintains a medical record in accordance with professional, State, NCQA and CMS standards as well as standards for the availability of medical records appropriate to the practice site. Practitioners/Providers are contractually required to maintain a medical record on each individual member. Medical records are reviewed at a sample of clinics at least every year. Medical record review is conducted as part of the initial credentialing practitioner site visits and is also conducted with the HEDIS data collection process. The provider relations department and health services department will complete the medical record review.

When requested, each provider will make member medical records, or a copy thereof, available during reasonable hours to other contracted providers to which the member is referred or to the member themselves. Medical records may be transmitted to Sanford Health Plan in connection with utilization or quality assurance activities, or may be furnished as back-up to claims information. Well documented medical records facilitate communication, coordination and continuity of care; and they promote the efficiency and effectiveness of treatment.

Medical records are to be maintained in a manner that is current, detailed and organized and permits effective and confidential patient care and quality review. Documentation of items from the medical record review summary sheet (the Plan's tool for reviewing medical record documentation standard compliance) demonstrates that medical records are in conformity with good professional medical practice and appropriate health management. The organization and filing of information in the medical record is at the discretion of the participating provider.

Each provider is responsible for assuring that the medical records of members are secure, complete, accurately documented, organized, readily accessible and maintained in a format that facilitates retrieval of information in an efficient manner. The provider is responsible for assuring that the medical record and information contained within it, is held in strictest confidence by implementing an office confidentiality policy. It is understood that Sanford Health Plan members have signed a contract with Sanford Health Plan giving access of the medical record to the patient, his/her representatives, and/or regulatory/accreditation bodies.

The Plan's documentation standards for medical record review include 25 components. There are eleven critical elements required in the medical record to demonstrate good professional medical practice and appropriate health management. At the time of the participating clinic site visit, the provider relations representative will review individual clinic's organization of the medical record and assess these documentation standards. Periodic medical record documentation standards reviews will also be completed in conjunction with HEDIS medical record reviews. Please refer to policy MM-24 Medical Records for details.

Performance Standards

Sanford Health Plan has detailed standards for provider office staff performance that will be considered as part of the Credentialing Process. These standards include such areas as telephone communications, patient handling, patient problem solving and overall professional standards.

Members expect to receive quick, courteous and accurate responses to their questions and concerns. Sanford Health Plan can assist in those areas. Call the Provider Relations Department at (800) 601-5086 for more information on Telephone Standards, Patient Handling Standards, Communication Standards, Problem Solving Standards, Interoffice Standards, or Professional Standards. Copies of these standards follow for your review and information.

Telephone Standards

Your patients expect smooth and efficient telephone communication with all staff members in your practice.

- Answer the telephone within 3 rings and state your practice and name.
- Speak to callers in a friendly, helpful tone of voice.
- When putting callers on hold always ask, "Will you hold, please? Is this number long distance?"
- Keep callers apprised of their hold status every 60 seconds by saying, "I'm sorry to keep you holding, [state reason], will you remain on hold for a few moments longer?"
- When returning to the line say, "Thank you for holding" and then continue by handling their question and/or problem.
- Always say good-bye and allow the patient to hang up first.

Patient Handling Standards

Your patients expect that they will be greeted and treated with a "How may I help you" attitude by all staff members in your practice.

- Greet/acknowledge patients/visitors immediately upon arrival; establish eye contact.
- Introduce yourself by name to every patient. When appropriate, give the patient your business card when introducing yourself to establish a business relationship with that patient.
- Use the patient's name during each encounter; call the patient by first and last name using Mr., Mrs., Ms. or Miss unless the patient insists on being called by their first name.
- If a patient has other business elsewhere in your facility, escort the patient when they ask for directions whenever possible.
- Conclude every patient encounter with a "Thank you."

Communication Standards

Your patients expect to receive quick, courteous and accurate responses to their questions and concerns.

- Make sure the information you provide is accurate.
- Use layperson's language when speaking to patients.
- Explain procedures and policies to patients.
- Look for ways to reassure anxious patients.
- Ask for questions and repeat instructions as often as necessary.

Problem Solving Standards

Your patients expect that you will solve their problems in a responsive and professional manner.

- Stay calm -- don't take complaints personally.
- Listen for the facts -- let the patient tell you the whole story.
- Refer abusive patients immediately to a supervisor if you are unable to resolve a situation.
- Make a statement of regret or empathy -- avoid making excuses.
- Tell the patient what you plan to do to correct the situation -- never make promises you can't keep and always follow through on all promises made to patients.

Interoffice Standards

Your patients expect that you will work effectively with each other to make their visit as smooth as possible.

- Recognize that everyone's job is important to your patients and the functionality of your business as a whole.
- Help fellow employees in overload situations without being asked whenever possible.
- Respond to requests from other departments in a timely, positive and pleasant manner.
- Keep your promises to other employees.
- Treat all fellow employees with respect.
- Follow through with requests.
- Always be courteous and friendly when answering in-house calls.
- Exercise a willing and helpful spirit over the telephone.

Professional Standards

Your patients expect you to present an image of top-quality healthcare and dedication to your profession.

- Present yourself in business-like attire and maintain a professional attitude.
- Be courteous with providers and staff members.
- Don't complain in front of patients or coworkers.
- In the community, represent your practice in a positive and professional manner.

Physician Compensation

Sanford Health Plan recognizes the need to develop methods to ensure that network providers provide health care in a manner that is consistent with the quality and financial goals of the Plan. The Plan will use a method that is a combination of sound internal utilization and quality management programs, consistent provider education and financial incentives to meet Plan goals.

When a member receives covered services from a participating provider, the Plan will pay the participating provider directly, and the member will not have to submit claims for payment. The member's only payment responsibility, in this case, is to pay the participating provider at the time of service, any copayment, which is required for that service.

Physicians contracting with Sanford Health Plan will be compensated under a fixed fee schedule that will be based initially on the Medicare Resource Based Relative Value System (RBRVS) for 1997. This fee schedule is based on reasonable and customary charges for procedures performed in the primary market. Physicians and other non-facility providers under contract to Sanford Health Plan will agree to accept this fee schedule as reimbursement in full for services provided to the Plan's members.

Physicians and other providers not contracted with the Plan, accessed via the out-of-network provisions in the Plan, will be paid according to a fee schedule based on usual and customary reimbursement (UCR) levels. This level will be established at the median level of physician charges, the 50th percentile. Non-contracted providers will have the right to collect from the members that portion of their fee not covered by the schedule.

Hospital Compensation

Hospitals and other facilities that provide services on an inpatient basis and who are under contract to Sanford Health Plan will typically be paid on a per diem (per day) and/or per case basis. These entities agree to accept a maximum reimbursement per day based on the contract and will be prohibited from collecting additional reimbursement from the member. There will be occasional situations when the Health Plan will sign contracts with reimbursement agreements that include a discount from charges.

Hospitals and other facilities that provide services on an outpatient basis (especially ambulatory surgery) and are under contract to the Plan will typically be paid a fixed fee based on ambulatory surgery groupings and similar methods. These entities will agree to accept a maximum reimbursement from the plan. There will be occasional situations when the Plan will sign contracts with reimbursement agreements that include a discount from charges.

Non-Participating Provider Compensation

When a member receives covered services from a non-participating provider, the Plan will arrange for direct payment to that non-participating provider. If the provider refuses direct payment, the member will be reimbursed for the reasonable costs of the services in accordance with the terms of this contract. Irrespective of the payment method, the member will be responsible for any expenses that exceed reasonable costs, as well as any copayment, deductible, or coinsurance which is required for the covered service.

Written Notice of Claim

The member must give the Plan written notice of the costs to be reimbursed within twenty days after the costs begin to be incurred, or as soon as reasonably possible thereafter. The notice must be sent to the Plan or the Plan's agent, and must include:

- Name of subscriber
- Group contract number
- Nature of the cost incurred

Claim forms and requirements for information needed on the claim are, available from the Plan's Administrative Offices to aid in this process.

Other Payment Issues

Physical Examination or Autopsy

The Plan, has the right to have the member examined as often as reasonably necessary while a claim is pending. The Plan may also have an autopsy made, at its expense, unless not allowed by law.

Time of Payment

The payment for reimbursement of the member's costs will be made when the Plan receives a complete written or electronic claim with all required supporting information. All "clean" claims shall be paid within 30 days from the date they were received by the Plan. Note that claims must be given to the Plan within 120 days from the date services incurred. If there is a span of services submitted on one claim form, the 120 days will be taken on the first date services were rendered.

Legal Action for Reimbursement Time Limitations

No legal action may be brought to recover under this provision within 120 days after the claim has been received as required by this contract. No action to recover member expenses may be brought after four years from the time the claim is required to be given.

Eligibility Verification

Providers must always verify a Member's insurance information and eligibility with the Plan for the most current information by contacting the Plan's Member Services Department at (800) 752-5863 or (605) 328-6800. If a provider fails to check eligibility and provides services to a Member who is not eligible for coverage, then the provider will not be reimbursed.

Balance Billing

Sanford Health Plan participating providers are not allowed to balance bill members the difference between the amount charged by the Provider and the pre-negotiated Sanford Health Plan allowable reimbursement. The difference between the charged amount and the allowed amount is to be a Provider write off.

Multiple Surgeries

Sanford Health Plan allowances are reduced for multiple surgical procedures. If a surgeon performs more than one procedure on the same patient on the same day, the plan allows 100% of the fee schedule for the highest value procedure only. The second procedure is allowed at 50% of the fee schedule and any additional surgical procedures are allowed at 25% of the fee schedule. Multiple surgical procedures can be identified with a modifier 51. The claims processing system is configured to adjudicate the claim according to the above guidelines. The exception to the above are subsidiary codes, listed by Medicare. These subsidiary codes should not be coded with a 51 modifier and the allowance will not be cut to 50%.

Bilateral Procedures

If a procedure is performed on both sides of the body it is considered to be bilateral. Bilateral procedures are identified with a modifier 50. Bilateral procedures follow the same reimbursement percent guidelines as listed above under multiple surgical procedures.

Assistant Surgeons

Assistant Surgeon claims can be identified by modifier 80, 81 or 82. Claims with modifiers 80, 81 or 82 will be pended with a code of AS in the claims processing system. Claims will be adjudicated according to the Milliman Assistant Surgeon Care Guidelines. If the surgery does not require an assistant, the claim will be denied and is NOT billable to the member therefore it is a provider write off. If the surgery does allow an assistant, it will be reimbursed at 20% of the applicable fee schedule.

Non-Covered Services

Any services not covered by Sanford Health Plan guidelines will be the responsibility of the member. This excludes, but is not limited to, services denied for untimely filing and services found to be medically unnecessary.

Financial Incentives

Physician Performance Pools

The plan has developed a claims target for expected use of physician services. This target is based on actuarially developed estimates of members' utilization of services. On an annual basis, approximately 120 days after the end of the Health Plan's fiscal year, an analysis will be conducted of actual versus expected financial performance. If there is a positive variance between the actual collective physician utilization and the Health Plan's target, seventy five percent of the savings will be eligible to be returned to the physician group, up to a maximum savings of ten percent. The remaining savings will be retained by the Plan to increase risk reserves. If there is a negative

Provider Payment

variance between the actual collective physician utilization and the Plan's target, the physician's fee schedule for subsequent periods will be adjusted downward, but by no more than five percent in any fiscal year.

Hospital Performance Pools

Sanford USD Medical Center

Sanford Health Plan has developed a claims target for expected use of services at Sanford USD Medical Center. This target has been based on existing utilization levels adjusted moderately for the expected impact to the Plan's Utilization Management programs. On an annual basis, approximately 120 days after the end of the Plan's fiscal year, an analysis will be conducted of actual versus expected utilization levels. If there is a positive variance between the actual inpatient and/or outpatients serviced and the targeted service level, the savings, up to 10% of the total budget, will be distributed in the following manner: one-half to the hospital, one-fourth to the participating physicians and one-fourth to the Health Plan to be held as risk reserve.

Other Hospitals

The incentive pool for network hospitals other, than Sanford USD Medical Center will be developed in the same manner as with Sanford USD Medical Center. The Plan's utilization target will be established based on the aggregate expected utilization of all of these hospitals. On an annual basis, approximately 120 days after the end of the Plan's fiscal year, an analysis will be conducted of actual versus expected utilization levels. If there is a positive variance between the actual inpatient and/or outpatients serviced and the targeted service level, the savings, up to 10% of the budget, will be distributed in the following manner: one-half to the hospitals, one-fourth to the participating physicians and one-fourth to the Plan to be held as risk reserve. There may be some variance in hospital payouts depending on the specific relationship that hospital has with Sanford Health.

Plan Policies

The Plan shall distribute all applicable policies and procedures to providers in the Provider Manual or by way of the Provider Perspective newsletter or other special mailings. Updates will be distributed as appropriate.

The Plan will make health care services available and accessible to its members during The hours of 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday. The Health Services phone message indicates business hours and what to do in an Emergency Situation. Messages left for Health Services is an acceptable practice for prior authorization. The Health Services Registered Nurses will return calls during the above listed hours of operation.

The Member Services Department is the entrance to the Health Plan for Members and Providers calling its toll-free number (800-752-5863) during its hours of operation - 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.

Primary Care Physician

Primary care physicians (PCP) have agreed to be available to members twenty-four (24) hours a day, seven (7) days a week for urgent care. Members should call during normal office hours for routine situations, and only call after hours in emergency or urgent situations. Members will leave a message with the answering service of the PCP or the doctor on call will return the Member's telephone call within thirty (30) minutes or as soon as possible thereafter.

Emergency Services

If an emergency condition arises, Members should proceed to the nearest emergency facility that is a Participating Provider. If the emergency condition is such that a Member cannot go safely to the nearest participating emergency facility, then the Member should seek care at the nearest emergency facility. The Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician (if one has been selected) as soon as reasonably possible and no later than 48 hours after physically or mentally able to do so.

The Health Plan covers emergency services necessary to screen and stabilize members without precertification in cases where a prudent layperson, acting reasonably, believed that an emergency medical condition existed.

With respect to care obtained from a non-participating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson reasonably believed that use of a Participating Provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

The Health Plan also covers emergency services if an authorized representative, acting for the Plan, has authorized the provision of emergency services.

Urgent Care Situations

An urgent care situation is a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger. If an urgent care situation occurs, Members should contact their Primary Care Physician (if one has been selected) or the nearest participating provider immediately and follow his or her instructions. A Member may always go directly to a participating urgent care or after hours clinic.

If a Member is admitted to the hospital, the Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician (if one has been selected) as soon as reasonably possible and no later than 48 hours after physically and mentally able to do so.

If a Member is admitted to a non-participating facility, the Plan will contact the admitting physician to determine medical necessity and a plan for treatment. With respect to care obtained from a non-participating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the emergency, or if a

provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

Ambulance Service

The Plan covers local ambulance services for the following:

- Emergency transfer to a hospital or between hospitals.
- Planned transfer to a hospital or between hospitals.
- Transfer from a hospital to a nursing facility.

Planned transfer to a hospital or between hospitals and transfers from a hospital to a skilled nursing facility will only be covered when determined by the Plan to be medically necessary either before or after the ambulance is used. Prior authorization is required for non-emergent ambulance services. The Plan does not cover charges for an ambulance when used as transportation to a doctor's office for an appointment.

Out of Area Services

If an Emergency or urgent care situation occurs when traveling outside of the Plan's Service Area, Members should go to the nearest emergency facility to receive care. The Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician (if one has been selected) as soon as reasonably possible and no later than 48 hours after physically and mentally able to do so. In-network coverage will be provided for Emergency Conditions outside of the Service Area if the Member is traveling outside the Service Area unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

Provider Terminations

As stated in the Sanford Health Plan provider contract(s), all provider (practitioner, organization, and hospital) voluntary terminations must be made in writing to Sanford Health Plan sixty (60) days prior to the effective termination date. Any involuntary terminations will be made known to the provider in writing from Sanford Health Plan sixty (60) days prior to the effective termination date.

Open Communication

The Plan allows and supports open communication between practitioner and member regarding appropriate treatment alternatives. In no way will the Plan penalize the Physician for discussing medically necessary or appropriate care for the member.

Notification of Provider Network Changes

Sanford Health Plan will notify its members of changes in its provider network in a timely manner. Each year, or at the time of enrollment, a full provider panel directory which contains all Primary Care Physicians, specialists, and facilities will be provided to each member of the Plan. All providers who have agreed to participate with the Plan shall be included in the directory for the duration of their contract.

A complete up to date Provider Directory can be found on the Sanford Health Plan website www.sanfordhealthplan.com.

In the event that a provider has terminated from the Plan, a letter will be sent to each member who has submitted a PCP selection form to Sanford Health Plan choosing that provider as a PCP, or who has had any open authorization(s) for treatment with that provider, or has had any service provided from that provider within 12 months of the termination. The letter will inform the member that as of a specifically referenced date the provider will no longer be an active provider in the Sanford Health Plan network.

The following are the types of changes that must always be reported as soon as possible to the Plan:

- New Address (Billing and/or office)
- New telephone number
- Additional office location
- Provider leaves practice
- New ownership of practice

- New Tax Identification Number
- Hospital Affiliation
- Change in board certification status
- Change in liability coverage
- Practice limitations
- New Providers added to a practice
- Change in Medicare or Medicaid Status

It is vital that all written notices be as clear and precise as possible. This will ensure accuracy and allow for changes to be completed in a timely manner. Sanford Health Plan has created an Add/Change Form that can be found on our website www.sanfordhealthplan.com under the Healthcare Provider link that can be used to notify us of the changes above. Please address all written change notices to the following address:

Sanford Health Plan
Provider Relations Department
PO BOX 91110
Sioux Falls, SD 57109-1110

Physician Compensation Policy

Physicians under contract with Sanford Health Plan shall be compensated as follows for service rendered by them to Sanford Health Plan Members:

1. The aggregate of all payments for services provided by the physician to Sanford Health Plan Members for which claims have been submitted to, and approved by Sanford Health Plan during the preceding month, less any adjustments required for the purpose of coordination of benefits or any other overpayment, shall be paid within 30 days from receipt of a claim.
2. Payments to physician groups shall be made to the group or the group's designee according to the same formula and shall include the aggregate of all amounts due to all participating physicians in the group.
3. A statement (Explanation of Payment) itemizing the payments made to the physician or group in accordance with Sections 1 and 2 shall be sent to the physician or group with each payment. Any statement denying payment, which will be furnished to the provider on or before thirty working days of the Plan's receipt of such claims, will identify the specific claim denied and the reason for the denial. Each statement shall include information describing the Covered Services for which a claim was submitted, the status of approval/denial regarding such claim, the amount charged, the amount allowed, payments due (if any) from the member, adjustments for withholds (as applicable) and the name(s) of the Plan, the Product and the Payor (if other than the Plan). A sample Explanation of Payment is included in this manual for review.
4. When there is a pattern of late payments or unfair payment practices of claims submitted to the Plan, the Plan, upon notice from the provider of such pattern, shall make good faith effort to research and notify the provider regarding the cause of such delay and the status of payment for any delayed claims. The Plan shall require its agents and employees to respond to provider claim payment inquiries within a reasonable time of the provider's inquiry.
5. This policy may be amended by the Board of Directors of Sanford Health Plan, which amendments shall not become effective until all participating physicians and groups shall be given at least ninety (90) days written notice.
6. Any questions or problems concerning the implementation of this policy shall be resolved in accordance with the Sanford Health Plan provider problem resolution procedures.

Coordination of Benefits

If a member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" (COB) so that the same care is not paid for twice.

The Member must tell Sanford Health Plan about any other plans or insurance that cover health care for the Member and provide any information requested by Sanford Health Plan. Failure of the member to satisfy either of these two obligations will result in disenrollment.

Plan Policies

In all cases, the provider shall bill the plan that is determined primary for all services rendered. If, however, the provider bills Sanford Health Plan first and payment is made, and the Plan later determines it is not the primary payor, the provider agrees to allow the Plan to obtain reimbursement for payment from the primary payor.

When Sanford Health Plan is the Primary Plan, its benefits are determined before those of the other plan without considering the other plan's benefits. If Sanford Health Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits and at no time will the Plan pay more than the contracted rate.

The Plan determines its order of benefits using the following rules:

- Non-Dependent/Dependent - The benefits that cover the person as a Member are determined before those, which cover the person as a dependent, except for Medicare beneficiaries. Medicare pays secondary to the Plan covering the person as a dependent and Primary to the plan covering the person as other than a dependent, i.e. a retired Member.
- Dependent Child/Parents Not Separated or Divorced - When Sanford Health Plan and another plan cover the same child or dependent of a Sanford Health Plan parent, the benefits of the plan whose birthday falls earlier in the year will be the Primary Plan ("Birthday Rule"). If both parents have the same birthday, the benefits of the plan which covered the parent longer will be the Primary Payor. If the other plan does not use the "birthday rule", instead has a rule based on gender of the parent, and the plans do not agree on the order of benefits, the other plan's rule will determine the order of payment.
- Dependent Child/Parents Separated or Divorced - If two or more plans cover a dependent child of separated or divorced parents, benefits are determined in the following order:
 - i. Plan of the parent with custody of the child
 - ii. Plan of the spouse of the parent with custody of the child
 - iii. Plan of the parent not having custody of the child

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, the benefits of the plan of that parent are determined first.

- Dependent Child/Parents Separated or Divorced/Joint Custody - In cases of joint custody, if the terms of joint custody do not state that one parent is responsible for health care benefits, the "birthday rule" applies. If the joint custody order states one parent is responsible, the rules for Parents Separated or Divorced applies.
- Active/Inactive Group Member - The benefits of a plan which covers a person who is neither laid off or retired are determined before the plan of the laid off or retired person.
- Continuation Coverage - If a person is covered under a right of continuation pursuant to a federal or state law and also covered under another plan, the benefits under continuation coverage is the Secondary Plan.
- Longer/Shorter Length of Coverage - If none of the above rules apply, the plan which has covered the person longer shall be the Primary Plan.

If the amount of the payments made by the Plan is more than it should have paid under these COB provisions, the Plan may recover the excess from the persons it has paid, insurance companies, or other organizations

Subrogation

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, Sanford Health Plan may be able to recover health care costs from the party responsible for the injury or illness (i.e. automobile insurance, personal property liability insurance, etc.). This is called "subrogation".

The Plan will provide health care services to the Member for the illness or injury, just as it would in any other case. If the Member accepts the services from the Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Sanford Health Plan shall subrogate to all rights of recovery from any person or organization for the Member and shall be entitled to receive an amount up to the Usual and Reasonable Charges for the services provided by the Plan from any recovery. The Member will execute and deliver any papers as may be required and will do whatever else is necessary to secure those rights to Sanford Health Plan to the extent that statutes or the courts of the State apply. The Plan may subrogate to the extent of the benefits received under the Member's Contract, and also includes the Plan's right to bring suit against the third party in the Member's name.

The Plan shall have a lien on all funds received by the Member up to the Usual and Reasonable Charge for the health care services provided by Sanford Health Plan and may give notice of that lien to any party who may have contributed to the loss.

Confidentiality and Disclosure

Sanford Health Plan will protect the privacy of all patient and provider information in its administrative functions and among its contracted health care providers in any setting where privacy can be breached. Use of a patient's personally identifiable health information for any purpose will have a clear and specific consent provided by the patient. Specific provider and member/patient information is collected and used by Sanford Health Plan only to the extent the information is necessary for the Health Plan to ensure efficient high quality care and services to its members.

Sanford Health Plan's responses to information requests will reflect a customer service orientation, but will also reflect an awareness of the potentially competing interests of the different categories of our customers (e.g., employer groups and enrolled employees). In addition, the Plan's responses to these requests will be consistent with the Plan's legal obligations, under the law and by contract.

Sample copy of Statement of confidentiality

**SANFORD HEALTH PLAN
Statement of Confidentiality**

I, _____, agree to hold all Sanford Health Plan information in confidence. I agree not to discuss or otherwise divulge names, situations, or conditions related to Sanford Health Plan members, clients, and practitioners with anyone except Sanford Health Plan administrative staff and those individuals who have a legal right to such privileged information.

Signature

Frequently Asked Questions

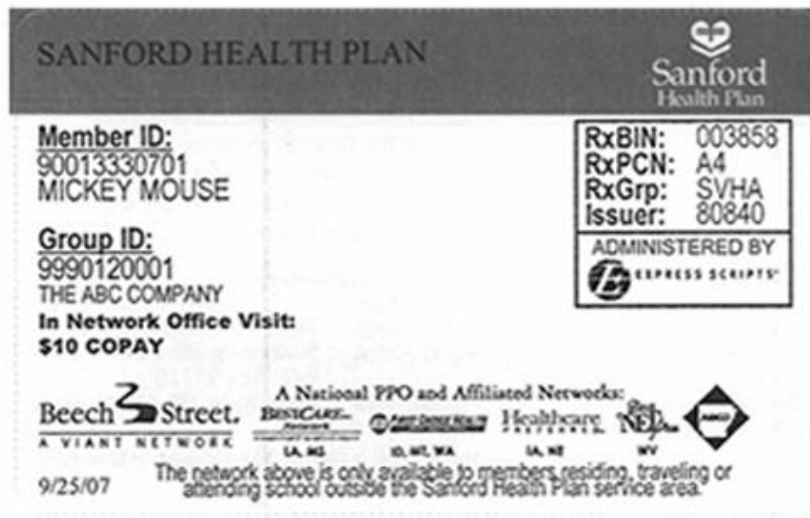
A Sanford Health Plan member is required to show an identification card when presenting for any medical care, including office visits, pharmacy, hospital, outpatient services, and any out-of-plan care. Each member, including all eligible dependents, will receive their own identification card. The identification card is only to be used by the person listed on the card. It may not be used by anyone else.

The Sanford Health Plan identification card is easily recognizable for both the member and the office staff. The identification card contains the following information on the front of the card:

- *The member's first and last name
- *The member's identification number
- *The member's group number
- *A summary of In-network copayment
- *The member services department phone number

The reverse side of the card provides directions for emergency, urgent care or out of area services, as well as some commonly used Sanford Health Plan telephone numbers. Refer to the Sanford Health Plan identification card below.

FRONT ————— FRONT



BACK ————— BACK

Eligibility: This card is for identification purposes only.
It does not constitute proof of eligibility.

For urgent or emergency care when you are out of the local service area, seek treatment at the nearest medical facility or call 911. Notify the plan of an admission as soon as reasonably possible and no later than 48 hours after physically or mentally able to do so.

Member Contact Information:	www.sanfordhealthplan.com	
Customer Service (Local)	1-605-328-6800	Submit claims to: Sanford Health Plan P.O. Box 91110 Sioux Falls, SD 57109-1110
Customer Service (Toll Free)	1-800-752-5863	
Pre-certification/Authorization	1-800-805-7938	
Provider Contact Information:		
Provider Relations	1-800-601-5086	
Pharmacist Use Only	1-800-824-0898	

Minnesota Plan Members may call the Department of Health at 1-800-657-3916 for appeals and complaints.

Frequently Asked Questions

Question: Where do I send my claim forms to be processed?

Answer: The address to submit claims can be found on the back of the member's identification card; Sanford Health Plan Claims Department, PO Box 91110, Sioux Falls, SD 57109-1110.

Question: What form should I submit my claims on?

Answer: Claims should be submitted on the standard HCFA-1500 form for physician claims and UB-92 for hospital claims.

Question: How long do we have to file claims to Sanford Health Plan?

Answer: Sanford Health Plan participating providers are obligated to file claims within 120 days from the date of service. In the event Sanford Health Plan is the secondary insurance carrier, claims are to be filed within 120 days from the date on the primary insurance carrier's Explanation of Payment.

Question: How long do we have to send in a corrected claim?

Answer: Providers are allowed 180 days from the date of service to send in a corrected claim. After this time frame has passed, the claim will be denied.

Question: What do I need to do if I feel a claim was not processed correctly?

Answer: First, contact someone in the Provider Relations Department by calling either (877) 305-5463 or (605) 328-6877. The claim will be reviewed by a Provider Relations Representative.

Question: Our office is moving to a new location. What information does Sanford Health Plan need?

Answer: Your office can send any change of information to the attention of the Provider Relations (PR) Department. The PR department needs the new address (office and billing), the effective date of the new address and any other pertinent information that may change as a result of the new address (i.e. TIN change). Please send this information on letterhead or fill out an Add/Change Form found on the website – www.sanfordhealthplan.com - under the Healthcare Providers link and then the Forms link. The information is updated and kept on file with your contracts.

Question: Can you check to see if you show these claims are in your system? We have not heard back from Sanford Health Plan since we first submitted them.

Answer: We encourage providers to follow up on any unpaid claims within sixty (60) days of being submitted. Sanford Health Plan pays "clean" claims within thirty (30) days of being received. If additional information has been requested (i.e. medical records, pre-existing condition information etc.), the claim will be paid within 60 days of receipt. To check claim status online sign up for a Digital Health Plan account on our website www.sanfordhealthplan.com.

Question: How will providers be notified of any changes Sanford Health Plan makes?

Answer: Any changes Sanford Health Plan makes will always be printed in the provider newsletter, Provider Perspective. The newsletter is sent out bimonthly or six times a year. The newsletter can also be found on the website, www.sanfordhealthplan.com under Healthcare Providers link.

Question: What codes are we suppose to use for the preventative health benefit?

Answer: In order for the preventative health benefit to qualify, claims should be submitted according to the preventative health guideline codes. Any updates to these codes are always printed in the Provider Perspective and on the website under Provider Preventive Health Guidelines link.

Question: Sanford Health Plan is the secondary insurance carrier and you paid, but I cannot tell from your EOP what the member owes?

Answer: A provider can determine what a member owes by subtracting the third party payment (TPP) and any Sanford Health Plan payment from the allowable.

Question: Can we balance bill?

Answer: Under the contract between the provider and Sanford Health Plan, patients are not to be balance billed the difference between the charged amount and the Sanford Health Plan allowed amount.

Frequently Asked Questions

Question: A new provider is joining our practice, what do we need to do to add him/her to our current contract with Sanford Health Plan?

Answer: If a new provider is joining a group already participating with Sanford Health Plan, they need to fill out a Credentialing Application and also send this notice on a piece of letterhead stating the official start date. When the information is received, the Sanford Health Plan databases are updated and the Credentialing Application forwarded to the Central Verification Office (CVO) to begin the Credentialing process. You can request a Credentialing Application by contacting a Provider Relations Representative at (877) 305-5463 or by printing one off of our website under the Healthcare Providers link and then the Credentialing Information link. Please return all Credentialing Applications to Sanford Health Plan in the pre-paid self addressed envelope that is sent with the application.

Question: How long does it take for the Credentialing process to be completed?

Answer: From the time the CVO received the Credentialing Application, the process can take up to 180 days (6 months).

Question: Who can we refer our patients to if they need specialty care services?

Answer: Providers need to refer patients to Sanford Health Plan network providers. If no participating provider is available, services must be authorized by the Health Services Department at (800) 805-7938. Services rendered to Sanford Health Plan members by non-participating providers with no prior authorization granted from Health Services will be paid at the low benefit level and is more costly to the patient.

Question: Why didn't I receive a check with my Explanation of Payment (EOP)?

Answer: This is a result of a recoupment and there may be a negative balance remaining on your account with Sanford Health Plan. In the event there is a negative balance remaining, future payments will be deducted until the negative balance is exhausted. When there is a negative balance the claims detail remains on the EOP with an asterisk behind the claim number until the negative balance is exhausted. The asterisk behind the claim number is an indication that you have seen the claim details on a prior EOP however there is still a negative balance.

Question: Can I send a refund check instead of having Sanford Health Plan recoup this amount from my next payment?

Answer: Because Sanford Health Plan is not set up to handle collections at this time, we cannot accept a refund check, unless it is received and processed prior to your next payment being sent out. It is advised to not send a refund check because Sanford Health Plan pays claims weekly. If your refund check is received after claims have been paid, your check will be returned to your office. If there is a negative balance remaining after three months, the Finance Department will then request a refund at that time.