

Sanford Health Plan Provider Perspective

July 2016

Help prevent fraud, waste and abuse

Federal and state law requires Sanford Health Plan to have a compliance program which identifies and addresses fraud, waste and abuse (FWA). Our preventive measures include automated claims review, manual chart review and algorithms to help flag for potential inappropriate utilization.

Health care fraud makes up only a small percentage of FWA, but even a small amount can raise the cost of insurance benefits. Health care fraud is a crime. Some examples of provider health care fraud are:

- accepting or giving kickbacks for patient referrals
- billing a non-covered service as a covered service
- billing for services not performed
- filing duplicate claims for services
- intentional incorrect reporting of diagnoses or procedures to maximize payment
- modifying medical records
- obtaining unneeded prescriptions and selling them on the black market
- prescribing additional or unnecessary treatment
- waiving co-pays

How can you help?

The best thing you can do to prevent FWA is to be an active participant. Being thorough and transparent with your documentation and billing practices is a great start.

What can you do if you suspect fraud, waste and abuse?

If you identify or know of potential fraud, waste or abuse, it is not only your right, but also your responsibility to report it. To report FWA, call Provider Relations (605) 328-6808 or Sanford Health Compliance Hotline at (800) 325-9402.

Client update

Southeast South Dakota Activity Center (SESDAC) in Vermillion, SD joined Sanford Health Plan as a self-funded client on July 1, 2016. Previously our fully-insured client, covered members of this group have received new ID cards with new group and member identification numbers. These new ID numbers should be used for claims submitted with dates of services beginning July 1, 2016. ID numbers are available at sanfordhealthplan.com/providerlogin. SESDAC group numbers are:

- TPA0100001 SESDAC INC
- TPA010001C SESDAC INC COBRA

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A valid member ID required for claims submission

One of the most common claim rejections is due to the submission of an invalid member ID number. Our system cannot process claims without a valid member ID. There are two easy ways to verify your patient's member ID number. The easiest option is to obtain a copy of the patient's ID card. The member ID number is located on the upper left side of the card, directly below the Sanford Health logo. Your second option is using the provider portal at sanfordhealthplan.com/providerlogin. To find member information inside the portal, click on "Provider Inquiries," then "Eligibility, Claims/EOPs, Authorizations," and finally enter the member's information. Verifying eligibility through our provider portal is the best way to get the most up to date information.

The screenshot shows the top navigation bar with the Sanford Health Plan logo and links for Provider Inquiries, Provider Resources, Contact Us, and Sanford Health Sites. Below this is a breadcrumb trail: Home • Eligibility, Claims/ EOPs, Authorizations. There are three tabs: Eligibility (selected), Claims, and Authorizations. A hint reads: "Hint: search for an eligibility record and then select the claims or authorizations tab. MEMBER ID is the 11 digit member ID and GROUP is the first 6 characters of the Group ID from the ID card. After selecting Search, click a member to view Eligibility information." The search form includes fields for First Name, Last Name, Member ID(s) - 11 digits, Date of Birth, and Group Number - first 6 digits Only. A Search button is located at the bottom left of the form.



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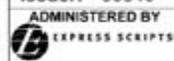
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ABC COMPANY

In Network Office Visit:

\$25 Copay

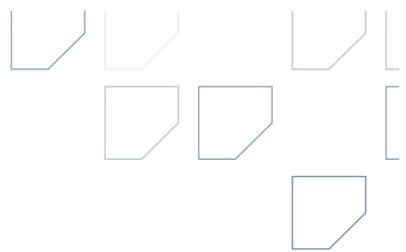
RxBIN: 003858
RxPCN: A4
RxGrp: SVHA
Issuer: 80840



Members: 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 Sanford Health Plan of an admission as soon as it is reasonably possible and no later than 48 hours after physically or mentally able to do so.

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

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Process of Optum's subrogation services

Sanford Health Plan currently partners with Optum for subrogation services. Subrogation is simply the process of determining who is responsible for the medical expenses incurred by an individual (i.e. auto accident). Typically, Optum identifies about 10 percent of our claims in 24 hours, 80 percent take eight calendar days, 90 percent are identified in 14 calendar days and 99 percent in 25 calendar days. The subrogation process is defined as follows:

1. We electronically send claim information to Optum daily.
 2. Optum identifies possible accident related claims.
 3. Optum places a call to the member to ask questions about the cause of the medical claim.
 4. If Optum is unable to reach the member after 3 call attempts, Optum mails an inquiry questionnaire and cover letter. The cover letter explains the relationship between Sanford Health Plan and Optum and the reason for the request. Members have the choice of providing information by phone, mail or online.
 5. If the member does not respond after 10 days, Optum sends the member another letter and waits an additional 10 days for a response. The second letter informs the member that Optum has not received a response and that Sanford Health Plan will be advised to deny the claim until further information is received.
 6. Once the time has expired and no response is received from the member, Optum advises Sanford Health Plan to deny the claim for lack of information.
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