

Provider Manual

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PROVIDER MANUAL

Section 1: Getting Started

Suggestion: Please use the Search function to find what you are looking for within our provider manual.

1.1 About Avera Health Plans

Avera Health Plans is a wholly-owned subsidiary of Avera Health, a health maintenance organization (HMO) located in Sioux Falls, South Dakota. We provide health care benefit options to individuals, families, seniors and employers based in South Dakota, Iowa and Nebraska. We maintain a provider network which includes a comprehensive health care delivery system throughout South Dakota, southwestern Minnesota, northwestern Iowa, and northeastern Nebraska. Avera Health Plans contracts with regional and national networks to provide coverage for members who reside out-of-area.

1.2 Avera Health Plans Philosophy

Mission

Our mission is to make a positive impact in the lives and health of persons and communities by providing quality services guided by Christian values.

Vision Statement

We intend to be and to maintain an outstanding health insurance financing and administration service guided by Christian values, with health care provided within a fully integrated care delivery system.

Objectives

1. To provide excellent, affordable, convenient health care services to members
2. To develop and maintain effective long-term alliances with providers who envision the future as a fully integrated care delivery system
3. To develop and successfully manage the most cost-effective care-delivery system, offering a full array of managed care services
4. To develop and offer innovative products that place emphasis on health promotion, health education, wellness, early health-risk detection, screening and disease prevention.
5. To provide a strong, comprehensive care-delivery system guided by Christian values, aligning incentives to promote quality and cost effective care-delivery

across the full continuum of care in the most appropriate and cost effective settings.

6. To be recognized as the industry leader in these areas:
 - Member services
 - Provider network and relationships
 - Care delivery outcomes
 - Health benefits financing
 - Health benefits administration

Values

Avera Health Plans adheres to three important values that guide the actions of our participating providers and staff.

Compassion

The compassion of Jesus, especially for the poor and the sick of body and spirit, shapes the manner in which health care is delivered by Avera's employees, physicians, administrators, volunteers and sponsors. Compassionate caring is expressed through sensitive listening and responding, understanding, support, patience and healing touch. Compassion is the extra element that makes Avera Health Plans the plan of choice.

Hospitality

The encounters of Jesus with each person were typified by openness and mutuality. A welcoming presence, an attentiveness to needs, a gracious manner seasoned with a sense of humor are expressions of hospitality in and by the Avera Health Plans community.

Stewardship

Threaded through the mission of Jesus, was the restoration of all the world to right its relationship with its Creator. In that same spirit, the members of Avera Health Plans treat persons, organizational power and the earth's resources with justice and responsibility. Respect, truth and integrity are the foundation to a right relationship among those who serve and those who are served.

Guiding Principles

- To maximize the quality of care delivered with continuous evaluation for opportunities for improvement.
- To provide for the most efficient use of resources.
- To provide an approach to medical diagnosis and treatment that is based on medical necessity.
- To require the involvement, input and support of the medical staff for the preservation of clinical judgment.
- To recognize the value of prevention and health maintenance through programs and services.
- To implement methods and tools of systems thinking and systems approach to problem solving.
- To support operations that receive the highest satisfaction rate from customers, members, providers and employees.

1.3 Provider Rights and Responsibilities

Rights:

1. To join Avera Health Plans subject to our credentialing plan
2. To receive notice of revisions to our policies
3. To receive claims payments directly, based on the provider's contractual agreement with Avera Health Plans.
4. To receive information, education, and support from our Provider Relations department regarding plan policies and operations as well as for problem resolution

Provider Responsibilities:

1. To utilize our participating specialty providers, hospitals and facilities unless otherwise approved by Avera Health Plans.
2. To provide services to our members in the same manner and quality as those services provided to patients who are not our members.
3. To close enrollment, if applicable, to new members with 60 days notice to Avera Health Plans.
4. To accept our reimbursement as payment in full (minus any Co-pays, Deductibles, or Coinsurance) for each covered service under the member's contract.
5. To recognize all payments are subject to the Coordination of Benefits provisions of Avera Health Plans.
6. To keep all member medical record information complete and confidential.
7. To open medical and administrative records with notice from Avera Health Plans regarding the member, for a review by our staff for the purpose of performing medical management, quality improvement, credentialing, and/or peer review activities.
8. To cooperate with Avera Health Plans to provide precertification, case management, quality improvement and peer review as requested.
9. To comply with all policies and procedures as outlined in Provider Agreement.
10. To provide the necessary information and documentation regarding any appeal.
11. To promptly notify Avera Health Plans regarding the following occurrences:
 - o A change in status of license, certification, specialty board status or DEA registration.
 - o Any circumstance that is required to be reported to the National Practitioner Data Bank, The Health Protection and Integrity Data Bank or any other reporting agency.
 - o If a provider is no longer employed, contracted. or otherwise affiliated with a clinic or facility.
 - o Any change or loss of liability insurance coverage.
 - o If a provider is no longer compliant with our credentialing criteria.
 - o Any circumstance in which a provider is sanctioned (examples: to be suspended, debarred, or excluded from participation in/or convicted of any criminal offense related to the delivery of health care).
 - o Any situation where a provider is charged with a felony or is under formal investigation for fraud or felony.

12. To notify us of a change in address, ownership, tax identification number or network participation.
13. To notify our members in a timely manner if provider no longer participates with our network.
14. To maintain adequate medical records incorporating medical record standards.

1.4 Avera Health Plans Contact Information

If any questions, staff are available Monday through Friday, 8 a.m. to 5 p.m. CT.

| | |
|--|--|
| Provider Relations | 605-322-4545 (local) 1-888-322-2115 (toll-free) Providers@AveraHealthPlans.com |
| Service Center — All Member Inquiries | 605-322-4545 (local) 1-888-322-2115 (toll-free) Service@AveraHealthPlans.com |
| Avera Credentialing Verification Services | 605-322-4550 (local) Avera.CVS@avera.org |
| Claims Submission | 5300 S. Broadband Ln. Sioux Falls, SD 57108-2221 |
| Corrected Claims | 5300 S. Broadband Ln. Sioux Falls, SD 57108-2221 |
| Refund Payment | Avera Health Plans PO Box 6005 Brookings, SD 57006 |
| Medical Management | 1-888-605-1331 1-800-269-8561 (fax) After hours, calls are returned the next business day. |
| Pharmacy Management | Check member's identification Pharmacy benefit manager contact information |
| Website | www.AveraHealthPlans.com |
| Main Business Office Address | 5300 S. Broadband Ln. Sioux Falls, SD 57108-2221 605-322-4500 (local) 605-322-4540 (fax) |

Section 2: Avera Health Plans Products

2.1 Avera Health Plans Products

Overview

Avera Health Plans promotes prevention as the best and most cost effective medicine. Our products focus on preventive health care and wellness. We offer a series of benefit plan designs for fully insured and self-insured clients, including multiple plan designs with a range of deductibles, out-of-pocket maximums and pharmacy benefits.

Avera Health Plans offers products through five main product lines:

- a. Avera Health Plans – Fully insured health insurance plans for large and small employers.
- b. Individual health insurance policies for single and/or families.
- c. Avera Health Plans Benefit Administrators – Self-funded employer groups have access to the Avera Health Plans network, medical management services, eligibility and claims processing experience.
- d. Medicare Supplement Insurance and Medicare Part D products for seniors.
- e. Avera Care System is one of the provider network choices for members of the City of Sioux Falls, Minnehaha County and Home Federal Bank. For members who have chosen the Avera Care System as their network, claims must be sent to Avera Health Plans for pricing and we then forward the claims to United Medical Resources (UMR) for claim processing. Avera Health Plans also performs preauthorization for these members.

If you have any questions, or would like more product information, please contact us our Service Center or you may email inquiries to Service@AveraHealthPlans.com .

Section 3: Provider and Member Resources

3.1 Provider Resources

Overview

Avera Health Plans offers multiple ways for providers and members to ask questions and receive information. When members have questions about the health plan, providers are encouraged to direct members to the resources listed in this section. We are committed to providing outstanding services with information, education, direction and support to all our members, providers, customers and staff.

Avera Health Plans Service Center

Our Service Center staff is available to answer questions and give instructions when a provider or member has questions or concerns. Our goal is to be available when our providers and members need us, responding quickly, accurately and in a caring manner. Providers should not hesitate to call the Service Center for questions regarding coverage, benefits and other plan related questions.

Provider Relations Representatives

Dedicated provider relations representatives are available and responsible for providing exceptional service to participating providers. The provider relations staff is the provider's first point of contact when issues arise regarding the following topics:

- Contract language and/or fee schedule questions
- Overall plan operations
- Plan policies and procedures
- Ensuring the integrity of the provider's data in health plan records
- Site visits

Provider relations representatives are committed to being a valuable partner to all providers in the network. For assistance in contacting your provider relations representative, please call our Service Center or email inquiries to Providers@AveraHealthPlans.com.

Avera Health Plans Website

Our providers have online access to HIPAA compliant information that is tailored to meet the provider's specific needs.

The Avera Health Plans website contains the most up-to-date information available. Visit www.AveraHealthPlans.com and select Login. Before you log in, on our Providers page you will have access to:

- Important Updates
- Provider Manual
- Steps to Become A Participating Provider
- eviCore Advanced Outpatient Imaging Resources

After you have logged in with your user ID and password, you will be able to access your home page to view communications and resources available to providers such as:

- Forms
- Policies – Medical, Pharmacy and Reimbursement
- Clinical Guidelines
- Pharmacy Benefit Manager contact information, preauthorization lists and drug formulary
- Claims/ Eligibility – Quickly perform membership eligibility inquiries and check on claim status, all in real time. For additional convenience, eligibility searches can be done either individually or in a batch process.
- Coverage guidelines
- Coding Edits

To obtain more information about our website, please call our Service Center.

Provider Directory

Because we offer multiple networks, it is important that you login and click on Claims/Eligibility to access the participating providers for that particular member. Simply enter the Member's ID Number on the eligibility screen to get started. A link for the Provider Directory will appear. Click on the link to view and search for participating providers.

ProviderView

The *ProviderView* is a quarterly newsletter that is emailed to participating providers and is also accessible on our website. The newsletter includes information about health trends and topics, provider updates, current Avera Health Plans initiatives, and other relevant information. All providers that create a login account in the Provider Portal section of our website are automatically enrolled to receive the newsletter electronically. Providers also have the option to receive the newsletter by sending a request to providers@averahealthplans.com.

Member Eligibility Verification

Providers are responsible for verifying that a member is eligible for coverage prior to rendering covered services, except for emergency services. Our member eligibility can be verified by one of the following methods:

- Verify Member eligibility status by logging in and clicking on the Eligibility tab. Enter the member's ID number found on his or her member ID card.
- Contact our Service Center.

3.2 Member Resources

Avera Health Plans Service Center

Our service center staff is available to answer questions and give instructions when a provider or member has questions or concerns. Our goal is to be available when our providers and members need us, responding quickly, accurately and in a caring manner. Providers should direct members to the service center for questions regarding coverage, benefits and other plan related questions. To reach the service center, call 605-322-4545 or toll-free at 1-888-322-2115 Monday through Friday 8 a.m. to 5 p.m. CT.

Online Resources

Our members have online access to review claims, eligibility and benefit information on our website, AveraHealthPlans.com. Members must enter his or her User ID and password to access this portion of the website.

To obtain more information about our website, please contact our Service Center. Members may also email inquiries to service@averahealthplans.com.

MyHealthPlan Mobile App

Avera Health Plans has a free mobile app that all our members can download to access the information found on our member website, quick references to their claims, year to date deductible balances, and contact information. This too requires a password and username set up by the member.

Complaint and Appeals Process

All members have the right to file a complaint or an appeal with Avera Health Plans. There may be times when a member is not fully satisfied with the administration, claims practice, quality of care or service we provide. We make every effort to resolve the issue causing dissatisfaction. If the member wishes to file a complaint or contest the disposition of a claim, they may do so in writing by contacting our Service Center. Additional information and forms can be found online under Member Benefits after logging in at AveraHealthPlans.com.

Interpreter Services

Members who do not speak English also need access to our providers. Avera Health Plans expects participating providers to have onsite or telephonic translation services available to assist in communicating with patients. If you do not have access to onsite or telephonic translation services, and are working with one of our members, you may call the Service Center at 605-322-4545 or toll-free at 888-322-2115 8 a.m. to 5 p.m. CT, Monday through Friday to be connected with translation services.

Member Rights

Member rights and responsibilities are available to members online in the Member Portal, a secure section of our website. Providers can view member rights and responsibilities under the Provider Manual link on the Provider page of our website.

Section 4: Operational Processes

4.1 Closing Practice to New Patients

In order for a provider to close their practice to new patients, a provider must complete the following:

1. Provider must notify Avera Health Plans Provider Relations Department in writing at least 60 days of closing the practice to new patients.
2. Provider must close the practice to all new patients. The provider will not deny care based on age, gender, ethnicity, life expectancy, present or predicted disability, degree of medical dependency, quality of life or other health conditions.
3. Provider must notify Avera Health Plans Provider Relations Department in writing if and/or when the practice re-opens to new patients.

Our Service Center will notify inquiring members that the provider's practice is closed to new patients.

4.2 Effective Date of Participation and Claims Filing During the Credentialing Period

Providers who have submitted a credentialing application for participation with Avera Health Plans are required to withhold submission of their claims until they have been notified that they have been successfully credentialed.

We have provided these guidelines to help providers understand our policies on participation effective dates under several possible circumstances.

Participation Effective Date Guidelines:

- The credentialing period begins on the date that a completed provider application has been accepted by Avera Health Plans Credentialing Services that contains all necessary information to process the application and ends when the final credentialing determination has been made and notice has been sent to the provider.
- If an application is received that is incomplete or is missing information necessary for processing, Avera Health Plans Credentialing Services will send a notice to the provider that will provide a detailed description of all documentation or additional information necessary to complete the credentialing application. These notices shall be sent as soon as possible and no more than 30 days after the receipt of an application that requires additional information for processing.

- Final determinations on completed credentialing applications are typically made within 30 to 45 days with an outer limit of no more than 90 days. In some circumstances, the Avera Health Plans Credentialing Committee may request additional information regarding the application if a special review is required. Additional time to complete the credentialing process is permitted and may be necessary if a special review is required.
- Providers should not submit claims to Avera Health Plans during the credentialing period. Claims submitted by providers during the credentialing period will be subject to denial. After the credentialing determination notice has been sent, the provider should submit all claims to Avera Health Plans for services that were provided during the credentialing period and those claims will be processed. Considerations on timely filing requirements will not begin until the credentialing determination has been made and notice has been sent to the provider.
- Claims filed in error by a provider that have been denied during the credentialing period will need to be re-filed using a Provider Request for Reconsideration once the credentialing determination notice has been sent to the provider. Avera Health Plans will not be responsible for identifying and adjusting any claims that were denied during the credentialing period.
- Non-participating providers who wish to contract with Avera Health Plans must submit a signed participating provider contract with associated reimbursement exhibits as may be applicable to their situation before credentialing invitations will be extended. The process of credentialing is contingent upon contracting. Intent to contract is not considered a substitution for a signed agreement.
- For providers who have joined an existing group practice that has contracted with Avera Health Plans as a provider group, our expectation and the expectation of our members is that the provider's effective date of participation shall be that providers start date with the group practice. If claims are received from what appears to be a new provider who has joined a contracted group practice and a completed credentialing application has not been submitted for consideration, our Provider Relations Team will be notified and will reach out to the group practice to determine the circumstances. In an effort to protect the in-network benefits for our members, Avera Health Plans reserves the right to deny these claims as a provider billing error and will work with that provider group practice to get the necessary credentialing paperwork filed as promptly as possible to minimize revenue disruption and ensure accurate in-network application of benefits for its members.

| Circumstance | Participation Effective Date |
|--|---|
| A new provider who signs a participating provider agreement. | Participation effective date shall begin with 1) the practice effective date, on the condition that the receipt of the completed provider application is received within the first 30 days of the practice start date and is contingent upon successful credentialing, or 2) upon receipt of the completed provider application. <i>Provider is responsible for holding claims until credentialing is completed.</i> |
| A non-participating provider who has been actively submitting claims and chooses to become a participating provider. | Participation effective date shall begin with the receipt of the completed provider application and is contingent upon successful credentialing. <i>Provider is responsible for holding claims until credentialing is completed.</i> |
| A new provider who joins an existing participating provider group practice. | Participation effective date shall begin with the provider's start date with the group practice and is contingent upon successful credentialing. Our members should have a reasonable expectation that any new provider joining an existing participating provider group practice will be participating under the group practice from their start date. <i>Provider is responsible for holding claims until credentialing is completed.</i> |
| A new provider group practice seeking to contract as a participating provider group. | The participation effective date for the group shall be established as the date of receipt of the completed application for the first successfully credentialed provider. All eligible providers must complete credentialing before the contract can be executed. <i>Provider group is responsible for holding claims until credentialing is completed.</i> |
| A provider who is already credentialed who starts a new practice. | Participation effective date shall correspond to the date of receipt of their signed participating provider agreement. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken to confirm that our claims system is ready to accept claims.</i> |

| | |
|---|---|
| <p>A hospital-based provider who is participating under a provider agreement held by the facility that is not required to be credentialed individually by NCQA credentialing standards.</p> | <p>Participation effective date shall be equal to the provider's start date as a hospital-based provider. This is contingent upon timely notice of the provider addition to the facility's provider agreement and may be limited by timely filing criteria. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken so our claims system is ready to accept claims.</i></p> |
| <p>An existing provider group or individual provider who is already contracted that adds participation for an additional line of business for which they are not currently contracted.</p> | <p>Participation effective date for the additional line of business shall be equal to the date of receipt of the signed Reimbursement Exhibit for the additional line of business. <i>We recommend working with your Provider Relations Representative before submitting claims to make sure all appropriate steps have been taken so our claims system is ready to accept claims.</i></p> |

4.3 Informed Medical Decision Making

Avera Health Plans does not prohibit providers from or penalize providers for:

1. Freely communicating with members about all treatment options available to them, including medication treatment options, regardless of Avera Health Plans position on the treatment and regardless of any member benefit limitations;
2. Advocating on behalf of covered members within the utilization review or grievance processes established by Avera Health Plans; or
3. Reporting to state and/or federal authorities any act or practice by the health plan that may jeopardize patient health or welfare.

4.4 Medical Record Standards

The provider is responsible for assuring the medical records of members are secure, complete, accurately documented, organized and readily accessible. All records should be maintained in a format that facilitates retrieval of information in an efficient manner.

The provider must maintain a record of health services rendered to each member and medical records must be stored in a secured manor only accessible to authorized personnel.

Content

The record should be legible and include:

- patient demographic information
- patient medical history and physical examination documentation
- allergies and adverse reactions
- a medical, family and social history
- documentation of clinical findings and evaluation for each visit
- preventive services or risk screenings
- diagnostic and therapeutic services
- immunization records
- ambulatory encounters
- consults, X-rays and laboratory reports
- referral services
- current medication list
- problem list
- any other specific medical information or services provided by the participating provider

Availability

Providers shall make Avera Health Plans members' medical records, or a copy thereof, available to other participating providers and to the individual member.

Confidentiality

The provider will be responsible for assuring that the security and privacy of medical records and information contained therein is held in confidence and in conformity with the Health Insurance Portability and Accountability Act of 1996, and the regulations promulgated there under. It is understood that at the time of enrollment, our members have signed a consent giving access of the medical record to the member, his or her representatives, regulatory and/or accreditation bodies, and for all other purposes that relate to the member's treatment, payment of claims for services rendered, or other health care operations.

The provider shall ensure that staff receives periodic training in confidentiality of member information.

Assessment

Avera Health Plans may periodically conduct a review of medical records to assess, ensure or improve the quality of patient care. The results of this review will be communicated to the provider and are used in conjunction with our quality improvement activities.

We will provide professional consultations on medical record assembly and maintenance as needed or when requested.

Modification of Medical Records

Avera Health Plans will not accept corrections or legally amended medical records after the medical necessity review is completed or after the submission, adjudication or payment of a claim. If these changes appear in the medical record following medical necessity review or payment determination, only the original record will be reviewed in determining payment of services billed to Avera Health Plans.

4.5 Access Standards

To ensure that our members have timely access to services, providers are required to have set access standards and a process to monitor compliance to these standards.

Primary Care: A primary care provider is a participating provider who is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP) or a physician assistant (PA). Participating care providers are available in the fields of family practice, internal medicine, general practice, obstetrics / gynecology and pediatrics.

Specialist means any physician who has a specific practice of medical care other than primary care. A specialist can also include a behavioral healthcare provider. The minimum appointment access standards for primary and specialty care are:

| Type of Care | Access Standard |
|------------------|---|
| Preventive Care | 4 weeks |
| Routine Care | 14 days |
| Urgent Care | 24 hours (depending on severity) |
| Emergency Care | Immediate access to 911 and emergency care facilities |
| Telephone Access | 24 hours, 7 days a week, 365 days per year |

Behavioral Health:

A behavioral health provider is a participating provider who is a master's level behavioral health provider or a licensed psychologist. The minimum appointment access standards are:

| Type of Care | Access Standard |
|-------------------------------|---|
| Routine Care | 10 days |
| Nonlife-Threatening Emergency | 6 hours |
| Urgent Care | 48 hours |
| Emergency Care | Immediate - access to 911 and emergency care facilities |
| Telephone Access | 24 hours, 7 days a week, 365 days per year |

4.6 Compliance

Referral to Participating Providers

We will work with providers to educate and inform them of available in-network providers when patterns of referrals outside of the network are identified.

4.7 Patient Waivers

Patients may elect to sign a Patient Waiver Form assuming financial responsibility for services(s) that will or are likely to be deemed by Avera Health Plans to be not medically necessary, experimental, investigational or unproven, and therefore not covered under the plan. The provider must explain both verbally and in writing to the patient that the services in question do not or may not meet Avera Health Plans' medical necessity criteria. The provider must give the patient a reasonably accurate estimate of the patient's potential financial liability, the patient must sign the Patient Waiver Form prior to services performed and the provider must bill for such services with an appropriate GA modifier.

A Patient Waiver Form must be completed with each incident. Keep on file with your patient's records as evidence of his or her informed consent. NOTE: Do not file the Patient Waiver Form with the claim.

The Patient Waiver Form must contain the following elements to be valid

- Date
- Place of Service
- Description of the service(s)
- An attached copy or summary of Avera Health Plans medical policy or preservice adverse determination
- A reasonably accurate cost estimate of the service(s)
- A statement acknowledging the provider informed the patient that the services provided may not be considered medically necessary by the patient's health insurance policy and that the patient is agreeing to accept full financial liability for the services.

The process of offering the Patient Waiver Form for patient signature must be a deliberate and specific preservice action by the provider. Therefore, blanket or generic waivers that attempt to preserve the provider's right to bill for any and all services may be denied as not medically necessary, experimental, investigational or unproven will not be considered valid.

4.8 Contract Disputes

Contract disputes are a way for providers to contest a claims-processing determinations. At this time, there are no regulations that define this process; however, Avera Health Plans strives to respond to inquiries in a timely manner.

Complaints and grievances against the health plan can be filed by a member or a provider can file a grievance on behalf of the member as the member's authorized representative if

the member specifies this in writing. Avera Health Plans strictly adheres to all state regulations and guidelines pertaining to this matter. All complaints and grievances will be acknowledged and decided on within a specified time frame specified by federal, state and accreditation entities.

Please utilize our **Provider Request for Reconsideration Form** and **Provider Reconsideration Guidelines** to help expedite the contract dispute process.

NOTE: Forms are located at AveraHealthPlans.com by clicking on the Provider page and looking under provider resources.. Please make sure to provide all the pertinent information with the initial request so there is not a delay with the review process.

If you have any questions pertaining to the process, please call our Service Center.

4.9 National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for health care providers. The HIPAA final rule adopted the National Provider Identifier (NPI) as this standard. The NPI is a 10-digit numeric identifier that does not carry information about health care providers, such as specialty or location of practice.

All health care providers—individual and/or organizational—are eligible for NPIs and must obtain an NPI to identify themselves in HIPAA standard transactions. By May 23, 2007, HIPAA-covered entities—including health care providers (individuals or organizations), health care clearinghouses and all but small health plans—must use only the NPI to identify HIPAA-covered health care providers in standard transactions.

Note: A sole proprietor/sole proprietorship is an individual and is eligible for a single NPI.

Our claims system will maintain and match HIPAA transactions using providers' NPIs. Please submit a listing of NPIs for providers in your office, as well as for your organization:

By Fax: 605-322-4540, Attn: Provider Relations

By Email: Providers@AveraHealthPlans.com

4.10 Continuation of Covered Services

Avera Health Plans provides continuity of care to current members whose providers terminate from the network and members who are new to the plan and have already begun a defined course of treatment with a non-participating provider. A course of treatment is the therapeutic interventions including what is going to be done, when the interventions will be completed and by whom. The course of treatment must consider each of the members' needs and define clear ways of dealing with each problem. Avera Health Plans also provides continuity of care to current members in the second or third trimester of pregnancy through the postpartum period whose providers terminate from the network. Avera Health Plans does not provide continued access in the following circumstances:

- The provider is unwilling to continue to treat the member or accept Avera Health Plans' payment or other terms
- The member accesses a provider group, rather than to an individual provider and the other providers in the group continue to be contracted with Avera Health Plans.
- The provider's contract was discontinued based on a professional review action, as defined in the Health Care Quality Improvement Act of 1986 (as amended, 42 U.S.C. section 1101 et seq.)

Section 5: Credentialing

5.1 Credentialed Providers and Facilities

Credentialing Overview

The credentialing program involves the initial and ongoing collection, verification and review of information necessary for selection and retention of providers. These providers must meet Avera Health Plans credentialing standards. Eligibility for providers is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility. Providers must also conform to our utilization and quality management requirements.

Only those providers meeting our participation criteria are included in the network. In addition to the credentialing standards, selection criteria may be considered in contracting with providers. The credentialing standards and the selection criteria are found in the Avera Health Plans Credentialing Plan.

Credentialed Providers and Facilities

Credentialed Provider Types

The credentialing program applies to the following providers that meet defined criteria as set forth in the Credentialing Plan.

| |
|---|
| Physicians (MD and DO) |
| Physician Assistants |
| Advanced Registered Nurse Practitioners |
| Chiropractors |
| Podiatrists |
| Masters Level Behavioral Health Providers |
| Licensed Psychologists |
| Optometrists |
| Dentists and Oral Surgeons |

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| Physical Therapists |
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| Speech Language Pathologists (Speech Therapist/SLPs) and Audiologists |
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| Occupational Therapists |
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Credentialed Facility Types

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| Hospitals |
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| Home Health Agencies |
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|----------------------------|
| Skilled Nursing Facilities |
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| Free-Standing Surgical Centers |
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| Behavioral Health Facilities (those that provide inpatient, residential and ambulatory mental health and substance abuse services) |
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5.2 Non-Credentialed Providers

The following provider types are not credentialed:

- Athletic trainers
- Certified first assistants
- Dieticians and nutritionists
- Emergency department physicians
- Hospitalists
- Locum tenens
- Massage therapists
- Pharmacists

5.3 Credentialing Process

There are two main types of credentialing:

- 1) Initial credentialing
- 2) Recredentialing.

Initial Credentialing

The main steps in the credentialing process are outlined below:

1. **Applications.** Applicants for participation must complete an Avera Health Plans Credentialing Application form. Additional supporting documents must be included. A list of the required documents, including the liability insurance requirements, is included in the Credentialing Plan. To begin the online application process, contact Avera Health Plans Provider Relations department.
2. **Credentials Verification.** Credentials verification determines if the applicants meet defined requirements for education, licensure, professional standing, service

availability and accessibility. Additionally, credentials verification determines if our utilization and quality management requirements are met.

3. **Office Site Survey.** Avera Health Plans may conduct a site visit for the applicant's offices for internal medicine, family practice, general medicine, pediatrics and obstetrics and gynecology and high volume behavioral health specialists. Site visits are typically completed prior to submitting the application to the Credentialing Committee.
4. **Credentialing Decision.**
 - **Streamlined Credentialing** refers to the process used at our discretion when a provider has submitted all required application materials. If credentialing staff determines that all participation criteria are met, Avera Health Plans has the capability to complete the credentialing process for the provider before the next scheduled Credentials Committee meeting. Applications not approved during this process are brought forth to the Credentials Committee Review.
 - **Credentials Committee Review** refers to the process used for applications not approved or reviewed via the Streamlined Credentialing process. The Credentialing Committee review completed applications and their recommendations are presented to the Board of Directors. Written notification of approval or denial, including reconsideration procedures, is sent to the provider.

Recredentialing

Participation in Avera Health Plans generally extends for two years pursuant to the cycle set up for each provider. Participation expires at the end of such period unless renewed by Avera Health Plans through a formal recredentialing process.

The main steps in the recredentialing process are outlined below:

1. **Request for Renewal of Participation.** A recredentialing application is sent to the provider at least 120 days prior to the expiration date of the last credentialing date. Providers are asked to update the application and submit any requested supporting documentation.
 - **Termination from Network:** Subsequent to follow up requests from Avera Health Plans, a Provider may be terminated from the network for two reasons:
 - Failure to Respond to renewal application request
 - Incomplete Applications
 - Notice of termination is sent to the provider via certified mail.
2. **Credentials Verification.** Credentials verification determines if the applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, as well as for conformity to our utilization and quality management requirements.
3. **Recredentialing Decision.** Our Credentialing Committee reviews completed applications. Written notification of approval or denial, including reconsideration procedures are sent to the provider.

5.4 Credentialing Accountability

Board of Directors

The Avera Health Plans Board of Directors has the ultimate authority regarding credentialing matters. The Board of Directors has the authority over approval and denial of providers' participation, as well as approval of any credentialing policies and procedures.

Credentialing Committee

The Avera Health Plans Credentialing Committee is accountable to the Board of Directors. This multidisciplinary peer review committee consists of at least 4 participating providers selected by Avera Health Plans Chief Medical Officer.

5.5 Site Visits

Avera Health Plans has standards and performance thresholds for the offices of all practitioners that are credentialed. These standards assure practitioners meet standards for physical accessibility, physical appearance, adequacy of waiting and exam room space, availability of appointments and adequacy of medical / treatment record keeping practices. Avera Health Plans can conduct office site quality reviews as a mechanism to verify office standards are met. The office site quality review may be incorporated into Avera Health Plans' credentialing decision-making, quality improvement and performance monitoring processes. Office site quality reviews may also be conducted for relocated practitioners. Member complaints, adverse events, sanction or substandard consumer survey results may substantiate the need for an office site quality review.

Site Survey Data

A copy of the survey outcome is sent to the provider. In addition, a copy of the survey is also filed at the Avera Health Credentialing Verification Services.

5.6 Provider Credentialing Rights

Providers and applicants have the following rights:

- To be notified of their rights to review information submitted to support the credentialing application.
 - Providers and applicants have the right to review information obtained from outside sources, such as malpractice insurance carriers or state licensing boards, to support their credentialing application. Avera Credentialing Verification Services is not required to make available information obtained from references, recommendations or peer-review protected information.
- To correct erroneous information
 - If information is obtained during the credentialing process that varies substantially from the information submitted by the provider, Avera Credentialing Verification Services contacts the provider via letter with notification of the discrepancy. The applicant is notified by the credentialing specialist in writing within 30 calendar days of receipt of the discrepant information. The notification includes a description of the discrepancy, the source of the information as appropriate and the provider's right to correct erroneous information submitted by another party. Avera Credentialing Verification Services is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law

prohibits disclosure.

Applicants are instructed to respond to the credentialing specialist, in writing, within 30 calendar days and that failure to respond is considered a withdrawal of the application with resulting in non-participating status. Avera Credentialing Verification Services documents receipt of corrected information in the provider's credentialing file.

- To be informed of the status of the credentialing/recredentialing application upon request.
 - Providers and applicants are notified of their right to receive status information from a statement on the provider application stating: "I understand that I have the right to be informed of the status of my credentialing or recredentialing application upon request to the credentialing specialist." Requests may be made in writing or by telephone. The Avera Credentialing Verification Services staff responds to these requests in writing, no more than 10 business days after the request is received. The response to providers does not include disclosure of information prohibited by law, references, recommendations or other information that is peer-review protected.

The cover letter for the Provider application packet contains a specific reminder for the Provider to review the Credentialing Policy for credentialing/recredentialing rights.

5.7 Avera Health Plans Credentialing Plan

Please refer to a separate document titled Credentialing Plan located on our website provider portal. Call our Service Center if you have any questions.

Section 6: Quality Program

6.1 Quality Program Overview

The Quality Program provides a framework for the evaluation of the entire spectrum of Avera Health Plans operations based upon the philosophy of continuous quality improvement. The Quality Improvement Program Description includes program structure, behavioral health quality improvement initiatives, patient safety, provider involvement, Quality Improvement Program oversight, work plan and objectives including serving members with cultural and linguistic diversity and complex needs.

The Quality Improvement Program Description also includes:

- Committee structure including relationships between Pharmacy and Therapeutics Committee, Credentialing Committee, Medical Policy Work Group, Operations Work Group and Behavioral Health Service Line
- Description of resources for clinical and service quality improvement, including staff roles and responsibilities and technical resources
- Specified activities for linguistic and cultural diversity

If you would like a copy of the Quality Improvement Program Description, contact our Service Center.

6.2 Clinical Practice and Preventive Health Guidelines

Avera Health Plans adopts practice guidelines relevant to our members for the provision of preventive and nonpreventive acute and chronic medical services. Avera Health Plans uses the guidelines to help providers and members make decisions about appropriate health care.

Clinical practice guidelines include medical and behavioral health guidelines which address acute or chronic conditions. Preventive health practice guidelines include health guidelines for prevention of acute or chronic conditions. At a minimum, Avera Health Plans adopts evidence-based preventive health guidelines for perinatal care, care for children up to 24 months old, care for children 2-19 years old, care for adults 20-64 years old, and care for adults 65 years and older.

Clinical Practice and Preventive Health Guidelines are available on the provider portal of the Avera Health Plans website.

6.3 Patient Safety

Avera Health Plans strives to serve as a critical link for providers to access patient safety information and helps to improve the safety within their practices.

Helpful links for patient safety include:

- Joint Commission International Center for Patient Safety, www.jcipatientsafety.org .
- The Leap Frog Group, www.leapfroggroup.org.
- Minnesota Alliance for Patient Safety, www.maps.org.
- Institute for Health Improvement, www.ihl.org.
- National Quality Forum, www.qualityforum.org.
- Department of Health and Human Services Agency for Healthcare Research and Quality, www.ahrq.gov.

Avera Health Plans works to create a culture that supports our providers and offers tools to improve the safety in their practices. To facilitate a culture of patient safety, Avera Health Plans conducts Quality of Care review on the following indicators:

- Readmission
- Mortality
- Surgical or Clinical Procedural Error, Complication or Infection
- Unexpected Trauma During Treatment
- Unexpected Return to Surgery
- Access/Availability to Care
- Delay in Diagnosis, Treatment or Service
- NICU Admission
- Quality of Care Complaints from members

The Avera Health Plans Chief Medical Officer reviews these cases and assigns a severity level. Selected cases are blinded to protect the confidentiality of the provider and member and sent to peer review at the Quality Improvement and Utilization Management Committee. Based on committee findings, a case may be referred back to the treating facility or provider for review of procedures.

Section 7: Medical Management

7.1 Preauthorization

The provider must initiate the preauthorization process before the scheduled services are rendered. Not all our members follow the same guidelines. It is important to view their member ID card, the back will address where you should call for the preauthorization. If the logo on the front has Benefit Administrators, you may have different phone numbers to call for preauthorizations.

| Identifies Fully Insured Members | Identifies Self-Funded Members |
|--|--|
|  |  |
| Subscriber: JOHN SAMPLE Group: MYPLAN SOUTH DAKOTA ON EXCHG Member: JOHN SAMPLE | Subscriber: JOHN A SAMPLE Group: AMI Member: JOHN A SAMPLE |
| Subscriber #: 9999999901 Group #: SDMP11 Member #: 9999999901 | Subscriber #: 9999999901 Group #: AH0201 Member #: 9999999901 |
| Rx Copays: Generic \$12 (\$100 Deduct waived) Formulary/Preferred \$35 Non-Formulary \$60 | Medical Copays: Office Copay: Avera Medical Provider: \$20 Office Copay: Other AHP Par Provider: \$35 In Network: \$850 Deduct, 80/20 Coinsurance |
| Pharmacy Plan Pharmacy Help Desk: | Pharmacy Plan Pharmacy Help Desk: |

Instructions for obtaining preauthorization are available on the Provider Portal of the Avera Health Plans website. Look online at the member's List of Services Requiring Preauthorization document for the services which require preauthorization.

To verify benefits, please contact our Service Center or login on our website.

7.2 Care Coordination

Care coordination is an Avera Health Plans benefit for all members and providers. The medical management role is to coordinate patient care and function as the point of contact between the patient and all their care givers. The medical management staff member makes sure the patient gets the care and treatment they need.

Care coordination provides a single-point of contact to help members find their way through the health care system. Medical management staff members assist members with resources and information necessary to their care.

For questions regarding care coordination, please contact our Service Center.

7.3 Complex Case Management

Avera Health Plans empowers members to take control of their health care needs across the care continuum. Eligible members may have serious complex conditions that may be disabling or life threatening, requiring treatments and/or services across a variety of domains of care (both medical and social).

Registered nurses make calls to eligible members and perform the following:

- Thorough assessment
- Development of an individualized care plan
- Weekly documented interactions
- Education for condition management
- Follow-up and track progress made toward goals including collaboration with the member's provider team.

Providers can refer members to Complex Case Management by contact our Medical Management department.

7.4 Disease Management

This program helps members regain optimum health or improved functional capability. Disease Management is offered to members diagnosed with the following diseases:

- Asthma (includes adult and pediatric patients)
- Chronic obstructive pulmonary disease
- Coronary artery disease
- Diabetes (includes adult and pediatric patients)
- Heart failure

Participants are assigned to a registered nurse team that conducts a comprehensive assessment of the participant's disease status, contributing co-morbid conditions, medication regimen and treatment plan approved by the primary care physician. Individualized intervention strategies and goals are developed with each participant.

Providers can refer members to Disease Management by contacting our Medical Management Department.

7.5 Non-Participating Provider Referrals

Avera Health Plans may allow in-network benefits for non-emergency services provided by out-of-network providers when Avera Health Plans determines network inadequacy exists for the service requested. If network inadequacy exists, covered services specific to the condition are covered at the member's in-network benefit level. Emergency situations are addressed by member coverage documents.

7.6 Avera Health Plans Advanced Outpatient Diagnostic Imaging Preauthorization Requirements Managed by eviCore

Avera Health Plans has a utilization and quality management relationship with eviCore. All participating providers are required to obtain a preauthorization for certain advanced

outpatient diagnostic imaging services provided to select Avera Health Plans members. The ordering provider is contractually responsible for obtaining the authorization on a pre-service basis and the rendering provider is responsible for ensuring a preauthorization is in place before rendering the service. Failure to obtain and verify the preauthorization could result in the denial of services as a provider liability under the Provider Agreement.

Some self-funded clients of Avera Health Plans Benefit Administrators may have their own radiology authorization requirements not managed by eviCore and providers are encouraged to inquire when checking eligibility and benefits.


Please refer to our outpatient radiology preauthorization list for a full listing of CPT codes with procedure descriptions that require preauthorization. This reference listing can be found on our website on the Provider page.

eviCore Radiology Preauthorization Requirements Apply to these Avera Health Plans Members

- Avera Health Plans' fully insured employer group members
- Avera *MyPlan* individual members
- Avera Health Employee Plan members

How Can These Members Be Identified by Their ID Cards?

When reviewing the Avera Health Plans' member ID card, look at their Group Number.



Subscriber: JOHN SAMPLE
Group: MYPLAN SOUTH DAKOTA ON EXCHG
Member: JOHN SAMPLE

Subscriber #: 9999999901
Group #: SDMP11
Member #: 9999999901

PCP Office Copay: \$25.00
Specialist Copay: \$50.00

Pharmacy Plan Pharmacy Help Desk:

Group Numbers Starting With:

- **SD, IA and NE** = Fully Insured members
- **SDMP, IAMP or SIND** = Avera *MyPlan* members
- **AH or AAH** = Avera Health Employee Plan members

What if the member ID card is not available?

eviCore can be verified online at www.CareCoreNational.com. You will need the member's ID number and date of birth for eviCore to determine the eligibility for management of the imaging preauthorization process.

7.7 Obtaining and Verifying A Preauthorization with eviCore

The ordering provider or designee (a member of the ordering provider's office staff) is responsible for obtaining the preauthorization either online at www.CareCoreNational.com or by calling eviCore at 1 (866) 668-8295, 7 a.m. to 7 p.m. CT., Monday through Friday.

Patient Waivers

In the event of an adverse determination on a preauthorization request for imaging services, the rendering provider is entitled to present the patient with an opportunity to sign an Outpatient Imaging Informed Consent Waiver Form to preserve their rights to balance bill. As the name implies, the waiver process requires informed consent and therefore is only valid when signed on a pre service basis and with complete disclosure of the adverse determination.

Patient waivers do not need to be submitted to Avera Health Plans and should be kept in the patients file for documentation in the event of the need substantiate the balance billing of a patient in a dispute. Patient waivers must be presented to Avera Health Plans upon request if necessary to resolve any balance billing disputes. We recommend you use the Outpatient Imaging Informed Consent Waiver Form located on our website by clicking on the CareCore link on the Provider page. If you prefer to use your own form for this waiver process, you are encouraged to talk with your Provider Relations Representative to review the form to ensure adequacy.

7.8 Obtaining Utilization Management Criteria

Providers have the right to access copies of utilization management guidelines, criteria, policies or protocols used in utilization management decisions. All internally developed policies and guidelines are available on the provider portal of the Avera Health Plans website. If a provider would like copies of the utilization management guidelines, criteria, policies or protocols used in utilization management decisions, contact our Medical Management department.

7.9 Affirmative Statement about Incentives

Avera Health Plans makes utilization management decisions based only on appropriateness of care and service and existence of coverage. Avera Health Plans does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

Section 8: Pharmacy Management Guidelines

8.1 Pharmacy Overview

Avera Health Plans utilize pharmacy benefits managers for all members. Check each members' member identification card to determine which pharmacy benefit manager is assigned to each member.

8.2 Drug Formulary

To view the most current formularies and pharmacy information, login to access the Pharmacy Benefits for Members link.

8.3 Preauthorization

Avera Health Plans requires preauthorization for certain medications. The current preauthorization lists can be viewed by clicking the Preauthorization link on the provider page, logging in and clicking on the Pharmacy tab to view the preauthorization requirements.

8.4 Step Therapy

Step Therapy is designed to promote the use of lower cost alternatives to the newer medications within a therapeutic class.

To view the most current step therapy information, login and access the Pharmacy Benefits for Members link.

8.5 Mail Order

If the member would like to use mail order, new prescriptions can be ordered by calling the pharmacy benefit manager listed on the member's identification card.

Section 9: Claims

9.1 Claims Overview

Claims must be submitted on the standard UB-04 or CMS 1500 forms or electronically in those formats. In order to process a claim within the regulatory requirements the claim must be submitted as a clean claim. Submitted claims must include all required fields, claims that are not complete will be denied. The denial code on the provider's Explanation of Payment will indicate what information is necessary to reprocess the claim.

Providers must also ascertain from the patient at the time of the initial visit whether an injury is work-related or caused by a third party, such as an automobile accident. If an injury is work related or caused by a third party, the provider agrees to relay this information to Avera Health Plans as soon as possible. This information is required to determine if workers' compensation insurance applies and if coordination of benefits or subrogation rights should be invoked.

Electronic Claims Submission

Avera Health Plans uses clearinghouses for electronic claim submission. In order to receive electronic remittance advice, you must be able to submit claims to e-Provider Solutions. Our payer ID Number is 46045. The payer ID number assigned for John Morrell and Curley's claims is 38310.

Manual Claims Submission

Avera Health Plans encourages electronic claims submission for more timely and accurate processing. Avera Health Plans uses optical character recognition (OCR) technology when processing manually submitted claims. OCR allows for a more automated process, resulting in shorter claims turnaround and improved quality; however, electronic claims submission remains the industry standard for fastest and most accurate form of claims submission.


If you must submit a manual claim, submit claims to the following address:

Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

When a claim is returned to providers or denied by Avera Health Plans, please resubmit corrected claims to the following address:

Avera Health Plans
5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221

Uniform Bill Form (UB-04), page 1 **SAMPLE—Do not use.**

Avera 
Health Plans

| | | | | | | | | | |
|----------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Required | Required | Required | Required | Required | Required | Required | Required | Required | Required |
| 10 PATIENT NAME | 11 PATIENT ADDRESS | | | | 12 STATE | | 13 CITY | | 14 ZIP |
| 15 BIRTH DATE | 16 SEX | 17 DATE | 18 ADMISSION TYPE | | 19 SEC | 20 DHR | 21 STAY | 22 CONDITION CODES | |
| 23 OCCURRENCE DATE | 24 CODE | 25 OCCURRENCE DATE | 26 CODE | 27 OCCURRENCE DATE | 28 CODE | 29 OCCURRENCE DATE | 30 CODE | 31 OCCURRENCE DATE | 32 CODE |
| 33 OCCURRENCE DATE | 34 CODE | 35 OCCURRENCE DATE | 36 CODE | 37 OCCURRENCE DATE | 38 CODE | 39 OCCURRENCE DATE | 40 CODE | 41 OCCURRENCE DATE | 42 CODE |
| Conditionally Required | | | | | Required if inpatient | | | | |
| 43 DRUG CD | 44 DESCRIPTION | | | 45 HCP(S) NAME / HSP(S) CODE | | 46 DRUG DATE | 47 DRUG UNITS | 48 TOTAL CHARGES | 49 REVENUE CHARGES |
| Required | Required | | | Required | | Required | Required | Required | Required |
| 50 PAYER NAME | 51 HEALTH PLAN ID | 52 PLAN ID | 53 PRIOR PAYMENTS | 54 EST. AMOUNT DUE | 55 NPI | 56 NPI | 57 OTHER DRG ID | 58 INSURER'S NAME | 59 INSURER'S UNIQUE ID |
| Required | Required | Required | Conditionally Required | Required | Required | Required | Required | Required | Required |
| 60 TREATMENT AUTHORIZATION CODES | | 61 DOCUMENT CONTROL NUMBER | | | 62 EMPLOYER NAME | | | | |
| Conditionally Required | | | | | | | | | |
| 63 ADMIT DATE | 64 ADMIT REASON CODE | 65 OTHER PROCEDURE CODE | 66 OTHER PROCEDURE DATE | 67 OTHER PROCEDURE CODE | 68 OTHER PROCEDURE DATE | 69 OTHER PROCEDURE CODE | 70 OTHER PROCEDURE DATE | 71 ATTENDING LAST | 72 OPERATING LAST |
| 66 Required | 66 Required | 66 Required | 66 Required | 66 Required | 66 Required | 66 Required | 66 Required | Required | Required |
| 73 REMARKS | 74 OTHER PROCEDURE CODE | 75 OTHER PROCEDURE DATE | 76 OTHER PROCEDURE CODE | 77 OTHER PROCEDURE DATE | 78 OTHER PROCEDURE CODE | 79 OTHER PROCEDURE DATE | 80 OTHER PROCEDURE CODE | 81 OTHER PROCEDURE DATE | 82 OTHER PROCEDURE CODE |
| 69 Required | 69 Required | 69 Required | 69 Required | 69 Required | 69 Required | 69 Required | 69 Required | 69 Required | 69 Required |
| 83 OTHER PROCEDURE CODE | 84 OTHER PROCEDURE DATE | 85 OTHER PROCEDURE CODE | 86 OTHER PROCEDURE DATE | 87 OTHER PROCEDURE CODE | 88 OTHER PROCEDURE DATE | 89 OTHER PROCEDURE CODE | 90 OTHER PROCEDURE DATE | 91 OTHER PROCEDURE CODE | 92 OTHER PROCEDURE DATE |
| Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required | Conditionally Required |

UNIFORM BILL FORM (UB-04) CMS 1500

UB-04 Required Field Information

| Field No. | Field Name | Explanation |
|--------------|--|---|
| 1 | None | Enter the facility's name and address. |
| 3a | Pat. CNTL# | |
| 3b | Med Rec. # | <i>Conditionally required:</i> |
| 4 | Type of Bill | Enter the appropriate four-digit code (e.g., 011X) as specified in the <i>UB-04 Data Specifications Manual</i> . 1 st digit Leading zero (0) 2 nd digit Type of facility 3 rd digit Type of care 4 th digit Indicates the sequence of the bill for a specific episode of care |
| 5 | Federal Tax Number | Enter your facility's nine-digit number for the type of bill you are submitting (e.g., NN-NNNNNNN) |
| 6 | Statement Covers Period (From-Through) | Enter dates in the MM/DD/YY format. |
| 8a | Patient Name | Enter the patient's last name, first name and middle initial. |
| 8b | Patient ID Number | Enter the patient's ID number if different from the policyholder's ID number. |
| 9a-d | Patient Address | Enter the patient's full address, even if the patient's address is the same as the policyholder's. |
| 10 | Patient Birth Date | Enter the correct date of birth (MM/DD/YYYY). |
| 11 | Sex | Enter the sex of the patient. |
| 12 | Admission/ Start of Care Date | Enter the date the patient was admitted for inpatient care. |
| 13 | HR | <i>Conditionally required:</i> |
| 14 | Priority (Type) of Admission or Visit | Required on inpatient only. This code indicates priority of admission (e.g., emergency=1, urgent=2, elective=3, etc.) Refer to the <i>UB-04 Data Specifications Manual</i> for a listing of codes. |
| Field | Field Name | Explanation |

| No. | | |
|-------|---|---|
| 15 | Point of Origin for Admission or Visit (formerly Source of Admission) | <i>Conditionally required:</i> The point of origin is where the patient came from before presenting to the health care facility. Refer to the <i>UB-04 Data Specifications Manual</i> for a listing of codes. |
| 17 | Patient Discharge Status | The patient status code indicates the patient's status as of the "Through" date of the billing period (FL 6). |
| 18-28 | Condition Codes | <i>Conditionally required:</i> refer to the <i>UB-04 Data Specifications Manual</i> on how to complete FLs 18-28. |
| 31-34 | Occurrence Codes and Dates | <i>Conditionally required:</i> occurrence codes are required when there is a condition code that applies to the claim. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of occurrence codes. |
| 35-36 | Occurrence Span Codes and Dates | <i>Conditionally required:</i> Enter event codes and a beginning and ending date that define a specific event relating to the billing period. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of value codes. |
| 39-41 | Value Codes and Amounts | Enter the two-digit value code(s) and dollar or unit amount(s) necessary to process the claim. Refer to the <i>UB-04 Data Specifications Manual</i> for a list of value codes. |
| 42 | Revenue Code | Enter the four-digit revenue code that represents a specific accommodation, ancillary service, or billing calculation. Revenue codes must be valid for the Type of Bill (FL 4) indicated on the claim form. |
| 44 | HCPCS/Rate/HIPPS Codes | |
| 45 | Service Date | You must provide a specific date for each service billed on a line. |
| 46 | Service Units | This field identifies the number of services the patient received or the time required to provide a specific service. To calculate units round up to the nearest whole number. |
| 47 | Total Charges | Submit a charge for each revenue code billed. Even if there is no charge, you must either enter 0.00 or N/C on the line item or |

| | | |
|------------------|----------------------------|---|
| | | the claim will be returned. |
| Field No. | Field Name | Explanation |
| 48 | Non-Covered Charges | |
| 49 | | |
| 50 | Payer Name | |
| 51 | Health Plan ID | |
| 52 | | |
| 54 | Prior Payments | <i>Conditionally required:</i> enter any amount the facility has received toward payment of this bill prior to the billing date by the indicated payer in FL 50. |
| 56 | National Provider ID (NPI) | Enter the facility's NPI number. |
| 58 | Insured's Name | Enter the last and first name of the policyholder. |
| 59 | Patient's Relationship | Enter a code that indicates the relationship of the patient to the policyholder. Refer to the <i>UB-04 Data Specifications Manual</i> for a complete list of appropriate codes you should use to complete this field. |
| 60 | Insured's Unique ID | Enter the alpha prefix and identification (ID) number as it appears on the patient's ID card. |
| 61 | Group Name | |
| 62 | Insurance Group Number | |
| 63 | Treatment Authorization | <i>Conditionally required:</i> enter the authorization numbers. Line A: Procedure authorization number Line B: Facility authorization number |
| 64 | Document Control Number | <i>Conditionally required:</i> |
| 65 | Employer Name | <i>Conditionally required:</i> |
| Field No. | Field Name | Explanation |

| | | |
|-------|--|--|
| 67 | Principal Diagnosis | Enter the principal ICD-9-CM diagnosis for the condition established, after study, as responsible for the patient's admission. |
| 67a-q | Other Diagnosis Codes Present on Admission Indicator (POA) | Enter the full ICD-9-CM codes for additional conditions if they co-exist at the time of admission, or develop subsequently and have an effect on treatment or length of stay. |
| 69 | | |
| 70 | | <i>Conditionally required:</i> |
| 71 | PPS Code | <i>Conditionally required:</i> |
| 74 | Principal Procedure Code and Date | <i>Conditionally required:</i> On inpatient claims, submit a valid principal ICD-9-CM Volume 3 procedure code when revenue codes 0360-0369, 0490-0499, and 0750-0759 are billed. |
| 76 | Attending Physician Name and Identifiers | Enter the name and NPI number of the licensed physician who normally would be expected to certify and rectify the medical necessity of the services provided, and/or who has primary responsibility for the patient's medical care and treatment during an inpatient stay. |
| 77 | Operation Physician Name and Identifiers | <i>Conditionally required:</i> required when a surgical procedure code is listed on the claim. |
| 80 | Remarks | <i>Conditionally required:</i> |



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

| | |
|---|--|
| <input type="checkbox"/> PICA PICA <input type="checkbox"/> | |
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK/LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (For Program in Item 1) | |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Required | |
| 3. PATIENT'S BIRTH DATE Required SEX <input type="checkbox"/> M <input type="checkbox"/> F | |
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) Required | |
| 5. PATIENT'S ADDRESS (No., Street) Required | |
| 6. PATIENT RELATIONSHIP TO INSURED Set <input type="checkbox"/> Sp <input type="checkbox"/> S <input type="checkbox"/> Other <input type="checkbox"/> Conditional | |
| 7. INSURED'S ADDRESS (No., Street) | |
| 8. RESERVED FOR NUCC USE | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 9a-d Conditional | |
| 10. IS PATIENT'S CONDITION RELATED TO: Required | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER Required | |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. Required | |
| 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Required | |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) Required | |
| 15. OTHER DATE Required | |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION Required | |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Conditional | |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES Required | |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Conditional | |
| 20. OUTSIDE LAB? Conditional | |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Refer to service line below (24E). ICD-9 Required | |
| 22. RESUBMISSION CODE ORIGINAL REF. NO. | |
| 23. PRIOR AUTHORIZATION NUMBER Conditional | |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. G. DAYS OR UNITS H. I. J. RENDERING PROVIDER ID, # | |
| 25. FEDERAL TAX ID NUMBER SSN/EIN Required | |
| 26. PATIENT'S ACCOUNT NO. Required | |
| 27. ACCEPT ASSIGNMENT? For 80A, 81, and 82, see back. Required | |
| 28. TOTAL CHARGE \$ Required | |
| 29. AMOUNT PAID \$ Required | |
| 30. Rev'd for NUCC Use | |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) Required | |
| 32. SERVICE FACILITY LOCATION INFORMATION Required | |
| 33. BILLING PROVIDER INFO & PH# Required | |

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

All fields required except C, and H.

CMS-1500 Required Field Information

| Field No. | Field Name | Explanation |
|-----------|--|---|
| 1a | Insured's ID Number | Enter the policyholder's alpha prefix and ID number as shown on his/her identification card. |
| 2 | Patient's Name | Enter the patient's full given name (no nicknames). |
| 3 | Patient's Date of Birth | Enter the correct date of birth (MM/DD/YYYY) and sex of the patient. |
| 4 | Insured's Name | Enter the policyholder's name. |
| 5 | Patient's Address | Required if it is not the same as the policyholder's address |
| 6 | Patient Relationship to Insured | <i>Conditionally required:</i> |
| 7 | Insured's Address | Enter the complete address of the policyholder. |
| 9 | Other Insurance Information | Required if 11d is marked "yes". If you determine the patient has other coverage, please enter the name of the other insured. |
| 9a | Other Insured's Policy or Group Number | <i>Conditionally required:</i> Enter the other insured's policy or group number in this field. |
| 9b | Reserved for NUCC use | <i>Conditionally required</i> |
| 9c | Reserved for NUCC use | <i>Conditionally required</i> |
| 9d | Insurance Plan Name or Program Name | <i>Conditionally required :</i> Enter the insurance plan name or program. |
| 10 | Is Patient's Condition Related To | Check the appropriate box if the patient's condition is related to employment or an auto accident or check "other." |
| 11 | Insured's Policy Group or FECA Number | |
| 11a | Insured's Date of Birth | Enter the correct date of birth (MM/DD/YYYY) and sex of the insured. |
| 11b | Other Claim ID | Designated by NUCC |
| 11c | Insurance Plan Name or Program Name | |
| 11d | Is There Another Health Benefit Plan? | Request this information from the member. If the answer is "yes" go back and complete blocks 9-9d. |

| Field No. | Field Name | Explanation |
|-----------|--|--|
| 12 | Patient's or Authorized Person's Signature | Signature on file okay |
| 13 | Insured's or Authorized Person's Signature | |
| 17b | ID Number of Referring Physician (NPI) | <i>Conditionally required: if you fill out field 17.</i> |
| 19 | Additional Claim Information | <i>Conditionally required:</i> |
| 20 | Outside Lab? Charges | <i>Conditionally required: Check the appropriate box if an outside lab was used. If "yes" list the charges.</i> |
| 21 | Diagnosis or Nature of Illness or Injury | For dates of service through September 30, 2014 enter an ICD-9-CM code. For dates of service starting October 1, 2014 enter ICD-10 codes. |
| 23 | Prior Authorization Number | <i>Conditionally required</i> |
| 24a | Dates of Service | If you submit office or hospital outpatient services, submit each service and/or each date of service on a separate line with the same "from" and "to" dates. |
| 24b | Place of Service | Enter the place of service code. |
| 24d | Procedures, Services or Supplies | Submit valid CPT or HCPCS codes. Enter a current two-digit CPT or HCPCS modifier when applicable. |
| 24e | Diagnosis Pointer | When there is more than one diagnosis on a claim, enter the primary diagnosis reference number from field 21 that relates to the reason each service was performed. If more than one diagnosis is appropriate for a service, the first number (letter) listed in 24e must be the primary diagnosis for that service. |
| 24f | Charges | Submit a charge for each service billed on a line. |
| 24g | Days or Units | Enter the appropriate number of services (in whole numbers) based on the time period or amount designated by the procedure code. You must enter at least one unit. |
| | | |

| Field No. | Field Name | Explanation |
|-----------|---------------------------------------|--|
| 24i | ID Qual | |
| 24j | Rendering Provider ID | Enter the practitioner's individual rendering/performing NPI number. |
| 25 | Federal Tax ID Number | Enter your practitioner/supplier federal taxpayer identification number (TIN). |
| 26 | Patient's Account Number | Enter the patient's account number. |
| 28 | Total Charge | Enter the total of all charges from 24f. The line items submitted must equal the Total Charge in field 28 or the claim will be returned. |
| 29 | Amount Paid | |
| 31 | Signature of Physician or Supplier | The physician's signature, a computer-printed name, a stamp facsimile, "signature on file", or the signature of an authorized person is acceptable. |
| 32 | Service Facility Location Information | Enter the facility's NPI number. |
| 33 | Billing Provider Information | Enter the provider's or supplier's billing name, address, zip code, and phone number. |
| 33a | NPI | If you have a group/organization NPI number, enter it in this field. If you do not have a group/organization NPI, enter your individual practitioner's/supplier's NPI number in this area. |

9.2 Timely Filing Guidelines

Providers have one year from the date of service to submit, process, and pay claims*. This time schedule includes any corrected claims, provider requests for reconsiderations, and payment adjustments. Claims submitted more than one year from the date of service will be denied as provider liability. The full text of the Claims Adjustment and Time Limitations Reimbursement Policy can be found in the Policies section after logging into the Provider Portal at AveraHealthPlans.com.

*Exception: Providers have 180 days from the date of service to submit claims for members of the John Morrell network, and have until one year from the date of service to dispute claims for those members. For members of the Behavior Management Systems (BMS) group, providers have 182 days or 6 months to file a claim.

9.3 Explanation of Payment

Avera Health Plans uses many Explanation of Payment (EOP) codes to communicate with providers. These codes assist the provider in identifying what information is needed to process the claim or why a claim was denied. These codes are listed on the last page of each EOP. Avera Health Plans has adopted the standard transaction sets for EOP codes in order to comply with HIPAA regulations.

9.4 Overpayment of a Provider

Refund Process

If Avera Health Plans processes a claim and determines that it was initially overpaid to the provider, that amount will be automatically deducted from the provider's next payment. For providers who have already requested that overpayments be automatically deducted from their next payment, there will be no charge. If you find a situation where a claim has been overpaid and the overpayment has not automatically been deducted from your next payment, you can contact our Provider Relations Department to assist you in refunding the overpayment.

Recoupment Process

Recoupment involves offsetting the amount owed against future claim payments. Future claim payments will be reduced until the full amount of the overpayment is recovered by Avera Health Plans. Recoupment may also be used initially if the provider has requested this as their preferred recovery procedure. If you are interested in being set up for automatic recoupment, please contact our Service Center or email providers@averahealthplans.com.

9.5 Denied Claims – Request for Reconsideration

When submitting your request for reconsideration, the [Provider Request for Reconsideration Form](#) is required to be attached and our Provider Reconsideration Guidelines will help you expedite the dispute process. The form will ensure all pertinent information is included with the initial request and reduce delay within the review process.

9.6 Coordination of Benefits

Coordination of Benefits (COB) means a provision establishing an order in which plans pay their claims permit secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable charges. Coordination of Benefits helps eliminate duplicate payments when a member has healthcare coverage under more than one plan. Coordination of Benefits is designed to protect members and their employers from higher premiums that result when two insurance companies make duplicate reimbursements.

Avera Health Plans will take specific steps to coordinate benefits for members who have healthcare coverage under more than one plan. The order of benefit Determination Rules found in the Avera Health Plans Member Handbook determines which plan will pay as the primary plan. If the amount of payments made by Avera Health Plans is more than it should have paid under this COB provision, we may recover the excess from one or more of the members we have paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered member.

Additional information about coordination of benefits can also be found in member's Certificate (Evidence) of Coverage, Individual Policy or Summary Plan Document.

9.7 Subrogation

Subrogation is a legal right held by healthcare providers and payers to recover expenses when members or employees are injured in certain types of accidents and the expenses related to the accidents should have been reimbursed by another party. 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, Avera Health Plans will take steps to recover their healthcare costs from either the member or the party responsible for the injury or illness. Payment for healthcare services provided to the member due to injury or illness caused by a third party shall be in accordance with Certificate of Coverage.