ProviderView Newsletter – June 5, 2023

HeathRules Payor System Conversion Update

We appreciate the loyalty and grace you have granted Avera Health Plans as we replaced our core claims processing system and the resulting service disruptions. We are happy to report that we are transitioning work streams to their 'business as usual' functional owners and automating manual jobs. Our cross-departmental Incident Command Team will continue to meet to address any variances from standard operating procedures.

Please note that we continue to work to resolve the below outstanding issues. Customer service has always been and remains our top priority. If you have issues that are not discussed below, please call our new, dedicated Providers Relations phone number at 833-964-0711, send a secure message through your Provider Portal or email Service@AveraHealthPlans.com. We apologize for any inconvenience or hardship this may have caused you.

- Failed 835 files/missing ERAs: We have identified some dates of failed payments and missing 835s/remittance advices. We are identifying these files so we can reprocess and get them to your provider portal and to our print vendor.
- Recoupments: Once overpayments are identified, Avera Health Plans must clearly identify the funds being recovered and the patient encounter that created the receivable.
    - As part of the core system conversion to HRP, it was discovered that the provider remittance advices (both 835s and paper EOPs), did not clearly identify the patient control/ID number of claim that created the receivable and in some circumstance, was identifying the incorrect patient control/ID number.
    - This may be causing providers to recoup money from the wrong patients.
    - We fixed the provider remittance advices (both 835s and paper EOPs) on March 25, 2023, so that any 835/EOP generated going forward will have the fix, regardless if it is an old or new payment.
    - If we made an advance payment to you, this will complicate any recoupments you may also have. To help affected providers with historical remittance advices (issued before the fix on March 25), Avera Health Plans will generate a report to help you reconcile your accounts.
    - Identified overpayments are recovered on a first-in/first-out basis, meaning that all overpayments to a provider will be entered into a queue. The overpayments will be recovered in the order in which they were first identified by Avera Health Plans, regardless of whether the overpayment recovery is for a self-insured plan or for a fully insured plan.
- Claim Adjustments: After an audit of our records for 2022, it was determined that some members were charged incorrect cost sharing amounts after they exceeded their deductible - but they did not exceed their maximum out of pocket amount. In these circumstances, we will adjust claims.

What's New

Provider Directory Accuracy

The Centers for Medicare & Medicaid Services (CMS) requires Avera Health Plans to have the most current information for our network providers. We use this information to populate our Provider Directory, help our members contact practitioners, and to ensure correct and timely claims processing. In order to validate your provider directory information you (or someone from your organization) must have an account set up in your

provider portal. It's vital that someone in your organization be responsible for review and update information in your portal as soon as a change occurs. We appreciate your attention to maintaining accurate data for the sake of our members and your patients.

July is our Second Busiest Group Renewal Date

Second to January, July is our second busiest time of the year for employer groups to renew or switch plans. This is a good time to remind your staff to verify member eligibility, benefits and network participation. Please ensure you and your scheduling staff understand Avera Health Plans' networks. Your patient's network, and/or benefits may change at their renewal. In order to avoid payment delay and ensure coverage, we encourage you to:

- Request the most current ID card;
- Confirm your participation in the network; and
- Verify eligibility and benefits by logging into you Provider Portal.

Utilization & Care Management Updates

Avera Health Plans Updates 2023 Prior Authorization (PA) List

Avera Health Plans updated the 2023 list of medical services requiring prior authorization. The most significant changes involve the removal of PA requirements for many covered services impacting a number of therapeutic areas. Notable removals include:

- Removal of PA requirements after visit limits have been exceeded for Physical Therapy, Occupational Therapy, Speech Therapy, and Chiropractic services
- Select genetic testing and cytogenetic studies
- Select Durable Medical Equipment codes
- Select outpatient surgery procedures
- Select dental services
- Inpatient hospice services

For the complete list of services requiring medical prior authorization, please refer to the Avera Health Plans' website or login to your Avera Health Plans' provider portal.

Member Benefit Updates

What the end of of the Public Health Emergency (PHE) means for Member Benefits

The end of the COVID-19 Public Health Emergency (PHE) Declaration means that Avera Health Plans will no longer be waiving the members' cost shares for the following COVID-19related services effective May 12, 2023. Members will be required to pay their normal deductible or coinsurance costs as outlined in their Summary of Benefits and Coverage or Evidence of Coverage.

- Over-the-Counter COVID-19 at home tests will no longer be covered (Flex or HSA/HRA dollars can still be used)
- Visits to a provider office, urgent care clinic, and/or emergency room for COVID-19-related care, including any lab services performed as part of the COVID-19-related care.
- Coverage of COVID-19 testing-related services.
- *Out-of-network* reimbursement for COVID-19 related testing and services.
- Cost sharing for COVID-19 vaccines provided *out of network*
- State licensing waivers for providers to be able to provide COVID-19 related telehealth.
- Emergency use authorizations of non-FDA-approved medications.

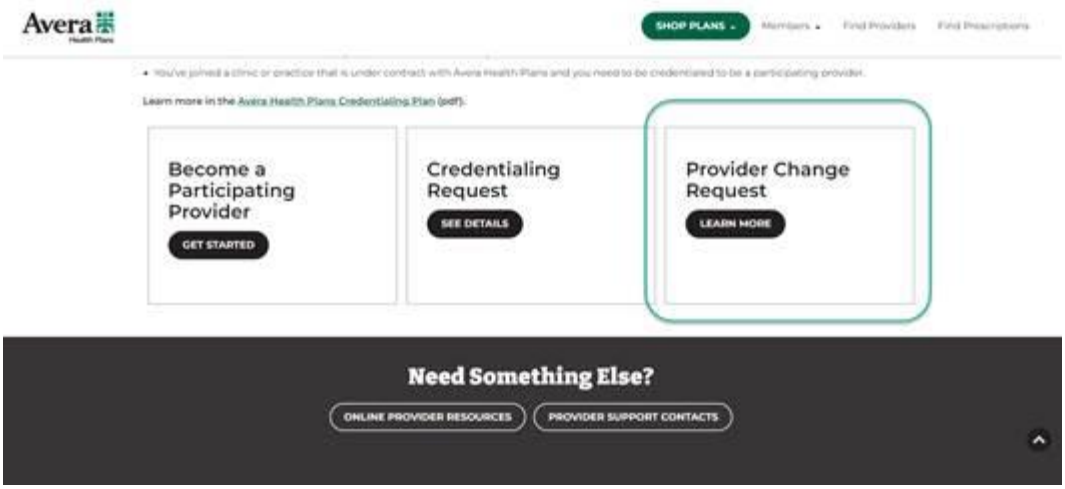
It's important to note that some COVID-19 vaccines will continue to be covered at 100% (no cost share applies) after the PHE ends, this includes the administration of the vaccination by a provider.

Claim Submission Updates

Tips for Clean Claims – Getting it Right the First Time:

Billing errors result in claims being denied and, for your practice, results in an increase in time for you to receive payment. Here are a few reminders and clarifications to ensure you have a clean claim the first time, and every time! If you would like to learn more, review the Avera Health Plans Provider Manual.

1. **Do not use the claim form to communicate a change in your information**. If a claim is received that does not match the initial set up of the business or practitioners information, it will be denied due to mismatched information. To update your business or practitioner information, please fill out the Provider Change Request Form available at AveraHealthPlans.com → For Providers → Contracting & Credentialing → Provider Change Request.



2. **Rendering Practitioner**- When billing on a CMS 1500 or electronic version- Reminder that a rendering practitioner is required, except in just a few circumstances. The rendering practitioners NPI number should be listed in box 24Jb. The name of the practitioner associated with that NPI in NPPES should match the name and credentials/degrees listed in box 31.
3. **Taxonomy Code**: Taxonomy codes are used to identify the practitioner area of specialization or organization classification. These codes are used to determine reimbursement eligibility related to rendered services.
    a. For practitioners: In 24Ia use the qualifier ZZ and in 24Ja use the taxonomy appropriate to the service rendered.
    b. For Providers (Business): In 33b use qualifier ZZ and then the appropriate group taxonomy code
4. **Box 25 Federal Tax ID Number**: This is a unique 9 digit number provider by the Federal Government and can be either a social security number if operating as a sole proprietor or an Employer ID number (EIN). Please ensure the appropriate box is checked to identify if you are submitting a SSN or EIN.
5. **Box 33 Billing Provider Info & Phone #**: To clarify, the term 'provider' references the business or organization that should be paid for rendered services on the claim.
    a. In box 33 list:
        i. **Phone Number**: In space provided to the right of the title
        ii. **1st Line**: Provider (Business) Name
        iii. **2nd Line**: Provider (Business) Address
        iv. **3rd Line**: City, State, ZIP
    b. In Box 33a: List the Provider (Business) NPI. This should be a type 2 NPI that is associated with your Federal Tax ID in box 25. This is validated upon set-up using NPPES. The only time you can use the practitioner NPI is when your business is set up as a sole proprietor and has not obtained a group NPI.
        i. NOTE: if you have multiple locations that are all using the same NPI for billing, only one address is able to be associated at this time.

Taxonomy definition: https://nppes.cms.hhs.gov/webhelp/nppeshelp/TAXONOMY%20PAGE.html#:~:text=A%20taxonomy%20code%20is%20a,%3A%2F%2Ftaxonomy.nucc.org%2F

NUCC CMS-1500 Manual: https://nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2022_07-v10a.pdf