Provider View

Avera Health Plans

September 17, 2024

Going for Gold

From July 26, all eyes were tuned into the 2024 Olympics and Paralympic Games in Paris. What a pure spectacle! From women and men's gymnastics team, to badminton (wow, could those birdies fly), and cheering on a Sioux Falls native in women's beach volleyball, it was one of the highlights of the summer for me. It was also a nice memory of my days as a student volleyball player.

Similarly, our team here at Avera Health Plans aspires towards a gold medal performance. We work hard to ensure your experience with us is positive and fulfilling. To gauge our performance, we held our annual provider satisfaction survey last month. A big thank you to those of you who took the time to share your feedback and experience with us. Information collected has provided insight into what you as a partner value: a seamless provider portal experience, quick claims processing, friendly and knowledgeable customer service, to recognize those of most importance. Read on to learn more about our next steps and areas of focus.

As I mentioned in last month's edition, Avera Health Plans continues to make great strides as we implement a number of initiatives and enhancements for the coming 2025 plan year. We expect to see positive outcomes from the changeover to Cohere for our Musculoskeletal (MSK), Cardiac Services and Advanced Imaging prior authorizations this month. We also launched our new AgilityPlus Medicare Select products, making more innovative benefit options available to our senior members.

We encourage you to share this news with your colleagues and invite them to register on our provider portal to be connected to all of the exciting things taking shape at Avera Health Plans.

Sincerely,

Josephine

Josephine
Vice President, Network Development, Provider Relations and Contracting

The Results are In, and…

This past month, Avera Health Plans conducted their annual provider satisfaction survey. While this is performed annually for our NCQA accreditation, results are also leveraged to identify where we met the mark and pinpoint key opportunities for improvement.

As compared to previous year's results, we saw significant improvement with the satisfaction of Avera Health Plans in almost every category. Satisfaction with our utilization management process increased 20%, while claims processing and timely payment jumped to 84% in 2024.

Similarly, we noted a 20% or higher increase in the areas of communication, responsiveness and ease to work with. This reflects our attention to service excellence and continued dedication to a great provider experience. While satisfaction with our online provider tools also increased by around 20%, we recognize the provider portal is a highly utilized tool by our provider partners and a key area of focus for our team for enhancing. Initiatives on our provider portal roadmap include expanding remittance advice search functionality, increasing submission of prior authorizations electronically and integrating with care partners for a seamless digital experience.

Meet Compliance Watchdog- New Vendor Assisting with Credentialing

Avera Health Plans has used Avera Credentialing Verification Services for decades; however, the process of credentialing applications will transition to another vendor this fall.

Beginning in October, Compliance Watchdog will provide the primary source verification to process applications submitted by Avera Health Plans participating providers. This change will use a new platform, also called Compliance Watchdog, for the completion of applications. The data transfer from the existing system is taking place now, and going forward providers will receive application invites from Compliance Watchdog. Reappointment applications will continue to be prepopulated and there will be an online portal to complete the application and upload requested documents. We are also working toward a solution so providers can check the status of their application online. Additional information will be provided in next month's ProviderView

Tips and Tricks for Submitting Claims: Billing for Medications or Unlisted Codes

Additional information is required when billing for medications, or with the use of an unlisted code (also referred to as unspecified). Submitting this additional information with the first claim will help to avoid denials, and increase the processing and payment of the claim. Check out the details and tips below for properly submitting these types of claims.

Unlisted Codes

An unlisted code typically ends with a '99' like 27599- Unlisted procedure, femur or knee. These codes should be used in rare circumstances when no other code applies to the service rendered for the member. Due to the generic nature of these codes, an explanation is needed of the service rendered so we can accurately apply the member's benefits and pricing.

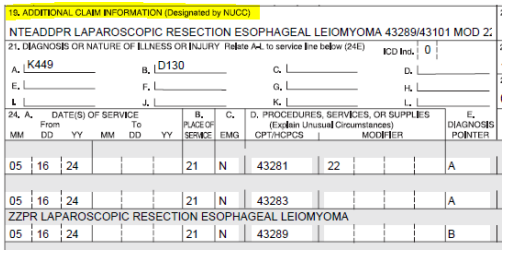
What additional information is needed for unlisted codes?

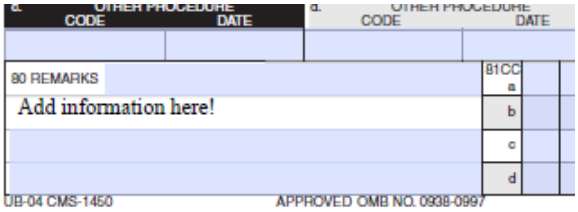
1. Description of the service you provided.
2. The closest comparable code to the service you provided.
3. Optional: Include Clinic or Operative notes with your paper claim submission that may describe or justify the unique situation for using an unlisted code.

How do I submit this information on a claim?

A detailed description of the unlisted code can be submitted electronically for a UB-04 in Loop 2400 Segment SV202-7 and for a CMS-1500 in Loop 2400 Segment SV101-7. You may need to consult your electronic claim submission vendor, if applicable. For paper claims, use box 19 for a CMS-1500 and box 80 (Remarks Section) of a UB-04.

Paper Claim Examples:





Medications and Unlisted Medications

You may need to bill for medication used in the care of a member or during a procedure. This would occur when billing outside the member's pharmacy benefits for typical monthly medications, such as when using J codes.

What additional information is needed for medications?

1. NDC number
2. Quantity Measurement Type [UN=units, F2=international units, GR=gram, ML=milliliter]
3. Quantity
4. Compounded medications- provide description of compounded ingredients

How do I submit this information on a claim?

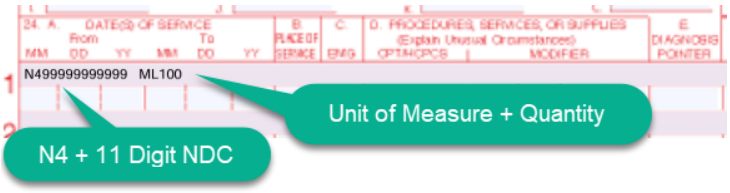
For electronic claims of both the 837P (CMS-1500) and 8337I (UB-04), the information is provided in Loop 2410 and LIN Segment: LIN02 (NDC Qualifier), LIN03 (NDC Code), CTP04 (Quantity), CTP05 (Quantity Measurement Type). A detailed description compounded medication should be submitted electronically for a UB-04 in Loop 2400 Segment SV202-7 and for a CMS-1500 in Loop 2400 Segment SV101-7. You may need to consult your electronic claim submission vendor, if applicable.

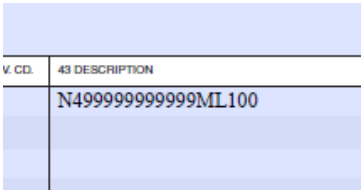
When using a paper CME 1500 form, submit the NDC code in box 24 in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left

justify and space-fill the remaining positions (e.g., UN2 or F2999999). For compounded drugs, provide description in box 19.

When using a paper UB-04, submit information in box 43 (Description) with the format of (Qualifier- N4)(NDC Number)(Quantity Unit of Measure)(Quantity). For compounded drugs, provide description in box 80 (Remarks Section).

Examples:





Resources for more information on claims:

The American Medical Association (AMA) publishes the *CPT Assistant*, which is a great resource for CPT coding guidance.

The *Medicare Claims Processing Manual, Chapter 26* gives guidance on billing requirements when using a CMS-1500 form.