ProviderView —August 1, 2022

HealthRules Payor® System Updates

The migration to the new claims system, HealthRules Payor® (HRP), has presented some unexpected delays which we are diligently addressing. Here are updates on the HRP issues:

- Electronic Remittance Advices (835s):
  - Thank you to the providers who are going paperless by submitting EFT paperwork!
  - As some of you may have noticed, we experienced disruption last week on sending out 835s. We apologize for this gap in 835 distribution and commit to resuming a regular file cadence this week.
  - For providers treating Medicare SELECT members, we are continuing to try to resolve issues with the structure of the 835
- Paper EOPs/Paper Checks:
  - NOTE: This scenario ONLY affects providers who have elected paper EOPs. Providers on 835-EFT-only are not affected. We continue to encourage providers to opt-in to 835-EFT-only. We have discovered that some paper EOPs are not reconciling because some paper EOPs are missing recoupment information on them. This will take 3-4 weeks to resolve with our technical coding team. We apologize for this inconvenience. In order to help you reconcile your paper EOPs, we will manually insert a document to help you reconcile.

Update on ID Cards

To date, we have processed and mailed 2,247 ID cards for all lines of business. All ID cards are in production with the exception of those members/dependents who live outside the AHP service area and need an additional network on their card. That consists of about 313 members that we are still working through. This affects our commercial, individual and AHEHP lines of business. Medicare Supplement does not get additional networks.

Cards will be generated when a group is new or an update is made to a member's benefit plan. These cards will not be able to be generated ahead of time; we recognize this issue and are working on a fix to this. In the meantime for all lines of business, the date a group is active will be when the ID card will be flagged for production and mailed.

Reminder: As a contingency plan, letters were sent to members that included their ID numbers that can serve as proof of insurance. Please accept this letter and their ID numbers from them until they receive their cards.

New Website for Avera Health Plans

Avera Health Plans (AHP) will debut its new website on Wednesday, Aug. 3. The new site will give users a more streamlined digital experience with navigational improvements for those shopping for insurance plans and for members looking for information. Data analytics have shown that AHP's site has been increasing in mobile usage over the last several years. The new site will be better optimized for mobile usage, providing a more user-friendly experience.

The new website will help improve the positioning for new member growth from a sales perspective. Users will be able to shop and navigate much easier to be able to find what plan works best for them. The sales/shop user experience includes stronger alignment with paid marketing efforts year-round, which will be particularly beneficial during open enrollment periods. The modernization of the site has a look and feel that is more aligned with the AHP brand and will help stand out competitively in the market. Over time, Marketing is also working on search engine optimization to better perform when people are searching for health insurance online.

A For Providers section will still be included that has all relevant links, information and resources. Please be sure to check out the new site after its launch on Wednesday.

Who, How and What Do I Do to Get a Preauthorization, Pre-Determination or Cost Estimate?

It has recently come to light that we may be speaking two, or in some cases, three different languages when working with providers to submit a request. To provide clarity, we've offered definitions for each of these requests, alongside of the process for submission.

Cost Estimate – When customer requests a cost estimate with benefits applied for planned procedure/service.

- To submit a request for a cost estimate, please complete the "Cost Estimate – Pre-Determination Form," located on our website, and submit via fax or secure email.
- Please allow 30 days for the request to be completed.
- A letter will be generated with details and sent to the submitter once processed.

Preauthorization – When a provider requests approval of a health care service or medication before the care starts for anything that is on the preauthorization (PA) list, requiring review before the anticipated procedure takes place. It is not a guarantee of benefits: it is a criteria review.

- To submit a request for a preauthorization, complete the appropriate form located on our website, and submit via fax or secure email.
- Once reviewed, a determination will be faxed back to the submitter.

Predetermination – When provider requests review of a procedure or service to determine if and how coverage will apply. Typical predetermination requests are: cosmetic, dental, unspecified codes and anything not on the PA list that provider inquires as to if it is covered and how we will cover it.

- To submit a request for a medical predetermination, please complete the "Cost Estimate – Pre-Determination Form" located on our website, and submit via fax or secure email.
- Please allow 30 days for the request to be completed. A letter will be generated with details and sent to the submitter once processed.

- To submit a request for a dental predetermination, please complete the standard ADA Dental Claim forms with the designated Header information of the Type of Transaction for Request for Predetermination/Preauthorization.