ProviderView — April 29, 2022

Avera Health Plans Migrates to New Claims Platform May 1

Avera Health Plans will implement a new claims system to create a better experience for members and providers. The special April 13 issue of ProviderView offered insight on the upcoming claims system conversion. You can read it in full on the Providers page of AveraHealthPlans.com.

Providers Should Create New Accounts Starting Next Week

On May 18, we will launch new-and-enhanced portals for members, employers and providers. The enhanced portal provides a number of features around benefits, claims, authorizations, messaging and document management. It also offers an improved security structure to allow each office account management privileges.

Your site's local administrator must create a new login account for security purposes as Avera Health Plans transitions to a new provider portal provided through partnership with HealthTrio. You can follow this link for instructions on how to enroll. A URL will be sent to you when the account registration is live.

Please note: Each provider office, designated by its tax ID number (TIN), is responsible for selecting an individual to serve in the local administrator role. This person must first create their account in the provider portal, and is then responsible for the creation and management of all additional user accounts at your respective office. We're asking that only the local administrators register before May 18.

Claims data has been suspended within our current portal until May 18 when we launch our new portal. Once our new portal is live, you will be able to see both three years' worth of historical claims data as well as new claims data. Users still have access to information and can communicate through the current portal, however, the data is stagnant. For real-time information, contact our Customer Care team at 888-322-2115. You may experience increased wait times.

Active Authorizations during Transition from CareSTEPP to GuidingCare

On May 1, Avera Health Plans will transition authorization processing systems from CareSTEPP to GuidingCare. This transition allows us to continue elevating the level of service we provide our partners. While the move to a new software platform will result in some minor changes, no changes will be made to any currently active authorizations. All open and historical authorizations will migrate from CareSTEPP to GuidingCare as part of our data transfer processes. All approval letters will remain valid for the dates of service listed. Resubmission of active or historical authorizations will not be needed as a result of our software transition. Please continue normal business processes surrounding the submission of new authorizations and renewal of expiring authorizations.

Changes to Second-Opinion Pathways

Avera Health Plans is changing the referral pathway for providers who request second opinions with out-of-network specialists. In order to provide the best service, we will identify appropriate referrals for in-network specialists so that members may benefit from receiving care closer to home, having their medical records readily available to them. This can improve continuity and coordination of care, and potentially lower costs.

Avera Health Plans reserves the right to approve a provider that is an alternative to the provider who is requested. We help providers and members seeking a second opinion, including:

- Navigating members to in-network providers for second opinions if the appropriate specialty is available.
- Navigating members to alternative out-of-network providers when Avera Health Plans has a working relationship with them.

For questions related to second opinions and other referrals, please contact Avera Health Plans' Population Health Services department at 605-322-4625; option 2.

Provider Directory Accuracy Communication

The No Surprises Act (NSA) passed as part of the Consolidated Appropriations Act in December 2020. It includes a requirement for Provider Directory Accuracy. The intent behind this provision is to hold the member harmless in the event that they are provided misinformation about a provider's status as an in-network provider. As you know, a patient that receives services from an out-of-network provider may be responsible for a greater cost-share of the bill which may be a "surprise bill" for the patient.

Under the NSA, health plans are required to verify the accuracy of their provider directory every 90 days. This means health plans will contact the contracted provider office and hospital/facility every 90 days to confirm the accuracy of name, address, specialty, phone number and digital contact information (email address and/or URL). Avera Insurance Division will reach out to our providers to confirm this information. It is important that we receive a timely response to each verification request. The NSA requires the health plan to update provider directory information within two business days of receipt. The NSA also requires removal of the provider from the provider directory if the provider's data cannot be verified. Avera Insurance Division will suppress the provider's listing from the provider directory if a response to verify information is not received within 180 days after the last verification date.

Questions and More Information

If you have questions about any part of the transition, contact the Provider Relations team.

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