

Superior HealthPlan Provider Training



Introductions & Agenda



- Your Presenters
- Role of PCP
- Eligibility
- Medical Management
- STAR Medicaid/STAR RSA
- CHIP/CHIP Perinate/CHIP RSA
- STAR+PLUS
- Claims
- Provider Relations/Provider Services/Network Development
- Website www.superiorhealthplan.com
- PaySpan Program
- US Script
- Value Added Services



Who is Superior HealthPlan?



- Superior HealthPlan Network is a licensed insurance company in Texas; Superior HealthPlan, Inc. is a licensed HMO in Texas (collectively, SUPERIOR).
- Superior's HMO has been a STAR HMO Contractor since 1999, CHIP HMO Contractor since 2002, and STAR+PLUS Contractor since 2007.
- Superior HealthPlan Network maintains a Statewide contract for STAR Health (Foster care) and CHIP RSA through HHSC.
- Superior has been awarded Medicaid contracts in the Hidalgo and Medicaid Rural Service Areas, scheduled for implementation on March 1, 2012.
- Superior has been awarded STAR+PLUS contracts in the Lubbock and Hidalgo service areas scheduled for implementation on March, 2012.
- Superior will continue to provide Medicaid and CHIP in the Travis, Bexar, El Paso, Lubbock, and Nueces service areas.



PCP Responsibilities



- Serve as a “Medical Home”
- Be accessible to patients 365/24/7
- Responsible for coordination and referrals to Specialists
- Provide Texas Health Steps and/or well exams
- Report all encounter data on CMS1500 or other appropriate documents
- Maintain HIPAA Compliance

PCP Responsibilities



PCP Accessibility & After Hours Care Coverage

- PCP must be available 24 hours a day, 7 days a week which includes telephone coverage
- Arrange coverage with another Superior provider if not available
- Contact Provider Relations if requirement cannot be fulfilled
- After hours calls should be documented in an after hour call log and transferred to the patient's medical record

Telephone Arrangements After Hours

Acceptable

- Phone answered by answering service must be returned within 30 minutes
- Phone answered by answering machine that directs patients to call another number and someone must be available to answer the designated number
- Phone transferred to another location where someone will answer the phone and contact the PCP or on-call provider

Unacceptable

- Phone only answered during office hours or directs patients to leave a message
- Phone message directs patients to the ER



PCP Access to Care Requirements



Routine Care

- Provided within 2 weeks of request

Urgent Care

- Provided within 24 hours of request

Emergency Care

- Provided immediately (Same Day)

Referrals to Specialists:

- Appointments should be available within 30 days of request



Serving Superior's Members



Cultural Sensitivity

Sensitivity to differing cultural influences, beliefs and backgrounds can improve a Provider's relationship with patients and the health and wellness of the patients themselves.

–Attitudes

- Respect the importance of cultural focus
- Respect the importance of spiritual beliefs

–More information regarding Cultural Sensitivity can be found in our Provider Manual at:

–<http://www.superiorhealthplan.com/>



Verify Eligibility



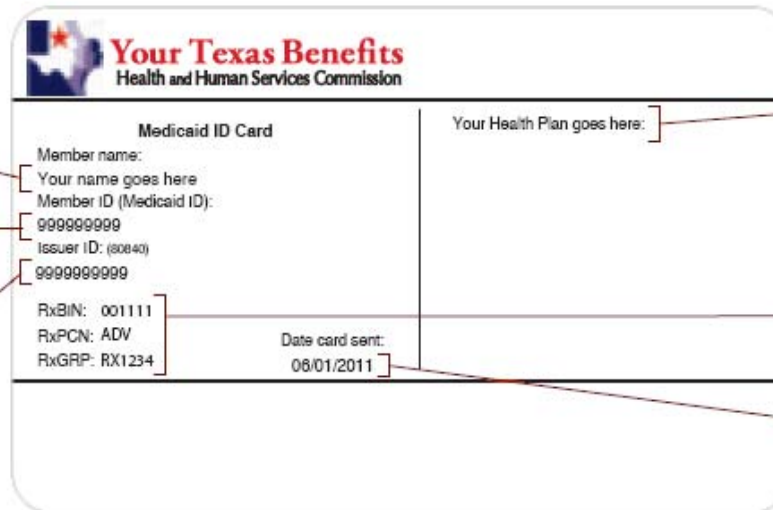
- Texas Medicaid Benefits Card
- Superior HealthPlan Identification Card
- Superior HealthPlan Website: www.superiorhealthplan.com
- Contact Member Services:
 - 1-800-783-5386 STAR, CHIP, CHIP PERINATE
 - 1-866-516-4501 STAR+PLUS
 - 1-800-820-5685 CHIP RSA
 - PENDING – Medicaid Rural Service Area (MRSA)
- Verify eligibility the 1st of each month using our website or by contacting Member Services.



This is where your name appears.

This is your Medicaid ID number.

This is HHSC's agency ID number. Doctors and other providers need this number.



Your Texas Benefits
Health and Human Services Commission

Medicaid ID Card

Member name:
Your name goes here

Member ID (Medicaid ID):
999999999

Issuer ID: (80840)
999999999

RxBIN: 001111
RxPCN: ADV
RxGRP: RX1234

Your Health Plan goes here:

Date card sent:
06/01/2011

If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.

Drug stores use these numbers.

This is the date your card was sent to you.

This message is for doctors and other providers. This means they need to make sure you are still in the Medicaid program.

Call this number if you need help using this card.



This card does not guarantee eligibility. La tarjeta no garantiza la elegibilidad.

[Redacted magnetic strip]

Need Help? ¿Necesita Ayuda?

1-800-252-8263

Questions about your doctor? Call your health plan. ¿Preguntas sobre su doctor? Llame su plan de salud.

www.YourTexasBenefits.com

TX-CA-0411

This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.



Go to this website to learn more about this card.

Member ID Cards



STAR

CHIP HMO



Member ID #:
Member Name:

Primary Care Provider
Name:
Phone:
Effective Date:



Member ID #:
Member Name:

Primary Care Provider
Name:
Phone: Effective Date:
Co-Payment

Office Visit RX Brand
In-patient RX Generic
Non-Emergency ER

Member Services/Servicios para Miembros: 1-800-783-5386
Available 24 hours a day/Disponible las 24 horas del día

Behavioral Health/Servicios de salud mental y abuso de sustancias:
1-800-716-5650 Available 24 hours a day/7 days a week
Disponible las 24 horas del día/7 días de la semana

If you need emergency care, go immediately to the nearest
Emergency Room. (Your doctor does not have to refer you for
emergency care.)

Si tiene una emergencia, vaya inmediatamente a la sala de emergencias
mas cercana. (No necesita un envío a servicios de su doctor para recibir
atención de emergencia.)

Member Services/Servicios para Miembros: 1-800-820-5685
Available 24 hours a day/Disponible las 24 horas del día

Behavioral Health/Servicios de salud mental y abuso de sustancias:
1-800-213-9927 Available 24 hours a day/7 days a week
Disponible las 24 horas del día/7 días de la semana

If you need emergency care, go immediately to the nearest Emergency
Room. (Your doctor does not have to refer you for emergency care.)

Si tiene una emergencia, vaya inmediatamente a la sala de emergencias
mas cercana. (No necesita un envío a servicios de su doctor para recibir
atención de emergencia.)

For Prescription Drug Information/Para Información sobre
Medicamentos Recetados: 1-866-274-9154



Member ID Cards






Member ID #:
 Member Name:
 Primary Care Provider
 Name:
 Phone: Effective Date:
 Co-Payment RX Brand
 RX Generic
 Office Visit
 In-patient Non-Emergency ER

Member Services/Servicios para Miembros: 1-800-820-5685
 Available 24 hours a day/Disponible las 24 horas del día
 Behavioral Health/Servicios de salud mental y abuso de sustancias:
 1-800-213-9927 Available 24 hours a day/7 days a week
 Disponible las 24 horas del día/7 días de la semana
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 For Prescription Drug Information/Para Información sobre Medicamentos Recetados: 1-866-274-9154


CHIP RSA




Member ID #:
 Member Name:
 Primary Care Provider
 Name:
 Phone:
 Effective Date:
 No Co-Payments or Cost Sharing
 For Authorizations, call 1-800-218-7508

Hospital Facility Billing –
 Category A: Bill TMHP (if 0-185% Federal Poverty Level (FPL))
 Category B: Bill Superior HealthPlan (if above 185% to 200% FPL)
 Professional/Other Services Billing:
 Superior HealthPlan (regardless of FPL percentage)
 If you need emergency care, go immediately to the nearest Emergency Room. (Your doctor does not have to refer you for emergency care.)
 Si tiene una emergencia, vaya inmediatamente a la sala de emergencias más cercana. (No necesita un envío a servicios de su doctor para recibir atención de emergencia.)
 For Prescription Drug Information/Para Información sobre Medicamentos Recetados: 1-866-274-9154
 For Authorizations, call/ llame para las autorizaciones 1-800-218-7508

CHIP RSA Perinate (Newborn)




Member ID #:
 Member Name:
 Effective Date of Coverage:
 Category A or B:
 Member Services/Servicios para Miembros: 1-800-783-5386
 Available 24 hours a day/7 days a week
 Disponible las 24 horas del día/7 días a la semana

Member Services/Servicios para Miembros: 1-800-820-5685
 Available 24 hours a day/7 days a week
 Disponible las 24 horas del día/7 días de la semana
 Behavioral Health/Servicios de salud mental y abuso de sustancias:
 1-800-213-9927 Available 24 hours a day/7 days a week
 Disponible las 24 horas del día/7 días de la semana
 If you need emergency care, go immediately to the nearest Emergency Room. (Your doctor does not have to refer you for emergency care.)
 Si tiene una emergencia, vaya inmediatamente a la sala de emergencias más cercana. (No necesita un envío a servicios de su doctor para recibir atención de emergencia.)
 For Prescription Drug Information/Para Información sobre Medicamentos Recetados: 1-866-274-9154





CHIP RSA Perinate (Mother)

Member ID Cards



CHIP HMO Perinate (Newborn)

CHIP HMO Perinate (Mother)

  TDI

Member ID #:
Member Name:
Primary Care Provider
Name:
Phone:
Effective Date:

No Co-Payments or Cost Sharing
For Authorizations, call 1-800-218-7508

  TDI

Member ID #:
Member Name:
Effective Date of Coverage:
Category A or B:
Member Services/Servicios para Miembros: 1-800-783-5386

Available 24 hours a day/7 days a week
Disponible las 24 horas del día/7 días a la semana

Hospital Facility Billing –
Category A: Bill TMHP (if 0-185% Federal Poverty Level (FPL))
Category B: Bill Superior HealthPlan (if above 185% to 200% FPL)

Professional/Other Services Billing:
Superior HealthPlan (regardless of FPL percentage)

If you need emergency care, go immediately to the nearest Emergency Room.
(Your doctor does not have to refer you for emergency care.)

Si tiene una emergencia, vaya inmediatamente a la sala de emergencias más cercana.
(No necesita un envío a servicios de su doctor para recibir atención de emergencia.)

For Prescription Drug Information/Para Información sobre Medicamentos Recetados: 1-866-274-9154

For Authorizations, call/ llame para las autorizaciones 1-800-218-7508

Hospital Facility Billing –
Category A: Bill TMHP (if 0-185% Federal Poverty Level (FPL))
Category B: Bill Superior HealthPlan (if above 185% to 200% FPL)

Professional/Other Services Billing:
Superior HealthPlan (regardless of FPL percentage)

If you need emergency care, go immediately to the nearest Emergency Room.
(Your doctor does not have to refer you for emergency care.)

Si tiene una emergencia, vaya inmediatamente a la sala de emergencias más cercana.
(No necesita un envío a servicios de su doctor para recibir atención de emergencia.)

For Prescription Drug Information/Para Información sobre Medicamentos Recetados: 1-866-274-9154

For Authorizations, call/ llame para las autorizaciones 1-800-218-7508



Member ID Cards



STAR+PLUS



STAR+PLUS
PROGRAM
Your Health Plan ■ Your Choice

Member ID #:

Member Name:

Primary Care Provider

Name:

Phone:

Effective Date:

Service Coordinator/Coordinadora de Servicios: 1-866-516-4501
Member Services/Servicios para Miembros: 1-866-516-4501
Available 24 hours a day/7 days a week
Disponible las 24 horas del día/7 días de la semana

Behavioral Health/Servicios de salud mental y abuso de sustancias:
1-800-466-4089 Available 24 hours a day/7 days a week
Disponible las 24 horas del día/7 días de la semana

If you need emergency care, go immediately to the nearest Emergency Room. (Your doctor does not have to refer you for emergency care.)

Si tiene una emergencia, vaya inmediatamente a la sala de emergencias mas cercana. (No necesita un envío a servicios de su doctor para recibir atención de emergencia.)

Medicaid recipients who are also eligible for Medicare have Long Term Care Benefits Only.
Recipientes de Medicaid que tambien están eligibles para Medicare tienen solamente Beneficios de Cuidado a Largo Término.



Member ID Cards

- TBD MRSA



Identification (ID) Cards:



All ID Cards will have the following information:

- Member name
- Program eligibility information
- Superior HealthPlan contact information



Medical Management



PCP Referrals

Key Points

- Referral is required when medically necessary care is needed beyond PCP scope
- PCP must initiate the referral
- Specialist may NOT refer to another Specialist

How to Obtain a Referral for services requiring authorizations

- Use the Request for Authorization form found on our website and submit via fax to 1-800-690-7030
- Call in your request to 1-800-218-7508
- Log on to your online account at WWW.SUPERIORHEALTHPLAN.COM to submit a referral
- The following information must be provided to the referral specialist at least 5 working days in advance for non-emergent services
 - Demographics
 - Diagnosis
 - Clinical information for medical necessity
 - Dates of Service

Review your Superior Health Plan Provider Manual for more information.



Medical Management Denials



- When medical necessity cannot be established, a peer to peer review is offered.
- Denial letters will be sent to Member and Provider to include:
 - The clinical basis for the denial (will be indicated)
 - Member appeal rights fully explained

OR

Provider may request an appeal on behalf of Member, if authorized to do so.

Medical Necessity Appeal Address:
Superior HealthPlan
Attn: Appeal Coordinator
2100 S. IH-35, Ste. 202
Austin, Texas 78704



Medical Management



Case & Disease Management Programs

- A plan of care is designed specifically for the needs of each member.
- Superior partners with Nurtur, a disease management company, for members with asthma, diabetes, and other complex health conditions.
- If you have a member who would benefit from case or disease management, contact your local Superior office and ask to speak with the Director or Manager of Case Management.



MRI/MRA, CT/CTA, and PET SCANS AUTHORIZATION



- An authorization will be required for MRI/MRA, CT/CTA and PET SCANS
- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for imaging services
- The PCP will be responsible for obtaining authorization for the procedures
- All other radiology procedures will not require authorization
- Inpatient and ER imaging procedures will not require separate authorization



MRI/MRA, CT/CTA, and PET SCANS AUTHORIZATION - (Continued)



- Servicing providers may request authorization by:
 - Accessing www.radmd.com
 - Utilizing the toll free number 1-800-642-7554

All claims should be submitted to Superior through the usual processes:

- Website: www.superiorhealthplan.com
 - Electronic Claims
 - Paper Claim Submission
- Servicing providers and Imaging facilities may access status of authorizations by:
 - Accessing www.radmd.com
 - Accessing IVR (Integrated Voice Response) through a toll free number 800-642-7554. To check on the status of an auth press 1, 1, then enter or speak the tracking number.





STAR/RSA Medicaid



Star/RSA Medicaid



Who is covered in Texas?

- Families and children, pregnant women – based on income level, depending on age, family income and resources/assets
- Newborns (under 12 months) born to mothers who are Medicaid certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday
- Cash assistance recipients – Based on receipt of Temporary Assistance for Needy Families (TANF) dependent on age
- Star members currently eligible with Supplemental Security Income (SSI)

Effective 3.1.2012 - SSI population will be included in Medicaid Rural Service Area (MRSA) benefits.



STAR/RSA Benefits



- Medical and Surgical Services
- Hospital Services
- Texas Health Steps
- Transplants
- Prescriptions (unlimited)
- Therapy - Physical, Speech, Occupational
- Durable Medical Equipment
- Dental and Vision Services
- Mental and Behavioral Health Services
- Maternity Services



Texas Health Steps Exams



Age-appropriate screenings must include:

- Nutrition
- Developmental
- Autism
- Mental Health
- Vision
- Hearing
- Tuberculosis
- Lead
- Sexually Transmitted Diseases

For complete Texas Health Steps Exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule:

<http://www.tmhp.com/HTMLmanuals/TMPPM/2011/2011TMPPM-19-338.html>



Missed Texas Health Steps Appointments



Providers should complete a Missed Appointment Form and fax it to MAXIMUS who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, child care, money for gasoline, etc.).

- This form is available on the Department of State Health Services website:

http://www.dshs.state.tx/thsteps/Missed%20appointment%20form%200209_secure.doc

- More information is available through your local regional Texas Health Steps Provider Relations Representative:

<http://www/dshs.state.tx.us/THsteps/pdfdocs/ProvReps.pdf>



Superior Outreach & Resources Texas Health Steps



- New members receive a member packet along with reminder outreach for initial exam
- Existing members receive a reminder card and call for annual exam prior to birth date
- Newborns receive a card with all periodic exams required in the 1st three years of life
- “Super Saturday” Texas Health Steps Clinics (contact your local Provider Relations Account Representative for more information)



Texas Health Steps Outreach And Informing



The State's Texas Health Steps Outreach and Informing staff contact newly enrolled Texas Health Steps recipients to inform them of the services they are entitled:

- To encourage them to use the preventive medical and dental checkup services
- Provide them with a list of all Texas Health Steps providers in their area
- To assist them in setting an appointment
- You can make a referral by phone to the State of Texas outreach team at 1-877-THSTEPS (1-877-847-8377)



Refusal of Texas Health Steps Exam



- Superior is required to log all member refusals for service to Texas Health and Human Services Commission (HHSC). Refusal should be recorded in medical record and communicated to Member Services 1-800-783-5386.
- If patient indicates exam was previously done, Superior will:
 - Look for a claim in our system
 - Contact the provider of service to verify statement



Texas Health Steps Training



- Training from the Texas Health and Human Services Commission (HHSC) is mandatory for Texas Health Steps providers
- Free continuing education hours are available on their site: www.txhealthsteps.com



Children of Migrant Farm Workers



- The Texas Health and Human Services Commission (HHSC) defines a migrant farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health care needs, provide direct education about the health care system and the services available, and arrange appointments and transportation.
- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed a “Travel Packet” and other helpful pieces of information to ensure these children get the health care services they need.



Oral Evaluation and Fluoride Varnish



- Program will allow Texas Health Steps and Children with Special Health Care Needs (CSHCN) clients who are 6 months to 35 months of age to receive oral evaluation and fluoride varnish during medical check-ups
- Child may receive up to 10 fluoride treatments per lifetime
- Provider should bill with procedure code 99429 and modifier U5 with the diagnosis V20.2
- Providers must be certified to provide oral evaluations and fluoride varnishes
- The training information is available on the DSHS Oral Health Program website along with the registration form. You can access the information at the following site: <http://www.dshs.state.tx.us/dental/firstdentalhomeTraining.shtm>



Tuberculosis Reporting



Physicians are required to:

- Report all suspected or confirmed cases to the DSHS or local TB control program within one business day of identification. Providers may call 1-800-252-8239 to reach the nearest local health department, or regional health service area
- Ensure all Members who have TB or are at-risk are screened for TB
- Access procedures for reporting TB and appropriate DSHS forms from: <http://www.dshs.State.tx.us/idcu/disease/tb/forms/> or by contacting Superior HealthPlan at 800-783-5386



Early Childhood Intervention



Ensure timeline compliance as needed

Early Childhood Intervention:

1-800-628-5115 or www.dars.state.tx.us

- All health care professionals are required under federal & state regulations to refer children birth through 35 months of age to ECI within two business days of identification of a disability or suspected developmental delay.
- Superior will work with contracted providers to provide ECI services to members who have been determined eligible for ECI services.



Transportation Benefits for Medicaid Members



- Transportation is available for doctor visits.
- If a STAR Medicaid member needs a ride to your office, the Texas Department of Health Medical Transportation Program (MTP) may be able to help. A member should call MTP as soon as they know their next appointment date with your office.
- They must call at least 48 hours before their appointment. Members under 18 years of age may be required to travel with an adult.
- To request services, advise the member to call MTP toll free at 1-877-MED-TRIP (1-877-633-8747). Transportation specialists are available to take requests weekdays 8:00 a.m. to 5:00 p.m.
- MTP offices can help with money for gas for someone who drives the member to an appointment. These drivers can be family members, neighbors or other volunteers. MTP does not furnish transportation when it is included in the daily rates of programs such as nursing homes, day activities and health services.
- As an added benefit, Superior also provides bus tokens for medical and non-medical visits such as health education classes. The member should call the Superior Member Hotline toll-free number listed on the back of their Superior ID card.





CHIP/RSA (Children's Health Insurance Program)



CHIP Cost-Sharing



- Most families in CHIP pay an annual enrollment fee to cover all children in the family.
- CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care, and non-emergent care provided in an emergency setting.
- Annual enrollment fees and co-pays vary based on family income.
- The total amount that a family must contribute out-of-pocket is capped based on family income.
- The amount of the co-pay is listed on the front of the member's ID card provided by SHP.



CHIP Enrollment Period



- CHIP members are allowed to change Health Plans yearly during re-enrollment
- CHIP members must reapply yearly on their original enrollment date



CHIP Benefits



- Medical/Surgical Services
- Maternity Services
- Transplants
- Preventive medicine including well-child exams and immunizations
- Prescriptions (unlimited)
- Therapy- Physical, Speech, Occupational
- Durable Medical Equipment
- Dental Services
- Vision Services
- Mental and Behavioral Health Services
- Medically Necessary Family Planning Services



CHIP PERINATE OVERVIEW



CHIP Perinate Review



The Children's Health Insurance Program (CHIP) perinate coverage provides prenatal care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child will receive CHIP benefits for the duration of the 12-month coverage period.

For more information on CHIP Perinate, please review your Provider Manual.



Coverage



- Coverage starts on the 1st of the month the unborn child is determined eligible; example: application is filed February 20, 2009, and eligibility is determined March 12, 2009. Coverage would start March 1, 2009.
- Coverage lasts for 12 months for babies born to mothers with income from >185% FPL to <200% FPL; example: If baby is enrolled when mother is four months pregnant, and is born at full term, the baby will have six months of prenatal care (including month of enrollment) and six months of CHIP coverage upon delivery.
- Mothers will apply for Medicaid at the time of birth for babies born to mothers <=185% FPL.
- Clients must notify CHIP Perinate of the birth by calling 1-800-647-6558. CHIP Perinate will need to know the following information: date baby was born, baby's gender, and baby's name.



CHIP PERINATE Newborn Coverage FOR NEWBORN $\leq 185\%$ FPL



- The federal government has directed HHSC to provide 12 months of continuous Medicaid coverage from the date of birth for newborns born on or after September 1, 2010.
- Hospital Facility services and Professional services claims will be billed to Medicaid rather than the CHIP Perinate Health Plan.
- The newborn will be enrolled in 'traditional' Medicaid as of the date of birth, and will then be in the 'pool' of Medicaid recipients eligible for Managed Care. At this time, the member will go through the same enrollment process as any other Medicaid eligible to include a choice of Plan and PCP.
- The newborn will be prospectively enrolled in Medicaid Managed Care if he or she qualifies and lives in a Medicaid Managed Care area.



Benefits



- Up to 20 prenatal care visits (more if medically necessary)
 - First 28 weeks of pregnancy – 1 visit every 4 weeks
 - 28 to 36 weeks of pregnancy – 1 visit every 2-3 weeks
 - 36 weeks to delivery – 1 visit per week
 - Additional visits allowed if medically necessary
- Prescriptions based on CHIP formulary
- Case management and care coordination
- Three ultrasounds of the baby when medically indicated
- Labor *with* delivery of child for clients at certain income levels
- Two postpartum visits for mother within 60 days of delivery



Non Covered Services



- What services are not covered?
 - A mother's hospital visits for services not related to labor with delivery
 - Supplies affiliated with certain diagnoses (e.g. DME supplies not covered for diabetes)
 - Specialty treatment for the mother, such as care for asthma, heart conditions, mental health or substance abuse

For more information on CHIP Perinate, please review your Provider Manual.



Hospital Benefits



- For women with income **at 186% up to 200% FPL**, all hospital facility and professional charges are covered by CHIP Perinate and paid by Superior HealthPlan.
- For women with income **at or below 185% FPL**, all hospital facility and professional charges are covered by Medicaid and paid by Texas Medicaid.

Regardless of FPL, it is helpful to instruct women to bring their CHIP Perinate Health Plan ID card with them.



Hospital Billing



- Expectant mothers $\leq 185\%$ FPL will receive Form 3038 from HHSC a month before her due date, along with a letter reminding her to send information about the birth of her child after delivery.
- Form 3038 is the same form currently required to complete Emergency Medicaid certification.
- Once HHSC receives the completed Form 3038, Emergency Medicaid coverage will be added for the mother for the period of time identified by the health care provider.
- CHIP Perinate mother will not be required to fill out a new application or provide new supporting documentation to apply for Emergency Medicaid.



Hospital Billing (Cont.)



- HHSC will determine the woman's eligibility for Emergency Medicaid by using income and other information the mother provided when she originally applied for CHIP Perinate coverage as well as information included on the Form 3038.
- If the woman fails to send back the Form 3038 within a month after her due date and the hospital cannot locate a Type Program 30 for her in the TMHP online provider look-up system, the hospital can bill her for facility fees incurred during her stay.



CHIP Perinate Helpful Tips



- Must call in authorizations for ALL deliveries regardless of members income (FPL)
- Providers should inform mothers they must call and report birth to state 1-800-647-6558 or 1-877-KIDS-NOW



Helpful Billing Hints



- Prenatal visits
 - Initial visits bill with E & M codes (99201 - 99205) with modifier TH to indicate prenatal visit
 - Subsequent visits bill with E & M codes (99211-99215) with modifier TH to indicate prenatal visits
- Postpartum visits bill CPT code 59430
- Three Sonograms allowed per pregnancy. Additional Sonograms are covered if the patient has a high risk diagnosis
- Primary diagnosis for all covered services must be pregnancy-related (all other services are not covered benefits)





STAR+PLUS



STAR+PLUS MODEL



- STAR+PLUS coordinates acute and long term care services for aged and/or disabled Medicaid consumers
- Service Coordination is the cornerstone of the model



STAR+PLUS MEMBERSHIP



- Mandatory enrollment of SSI population ages 21 and older including dual eligible (members with Medicare and Medicaid)
- Membership is voluntary for SSI children under age 21
- All members must select a primary care physician to act as a medical home except those who are dual eligible (members with Medicare & Medicaid)



STAR+PLUS Dual Eligibles



- Receive both Medicare and Medicaid services
- Medicare is primary payer for all acute services
- Medicaid Acute Care (TMHP) - Covers co-insurance, deductible, and some Long Term Care Services (ex: incontinent supplies)
- STAR+PLUS – Covers Long Term Support Services (ex: PAS, DAHS etc.)

All non LTSS services must be billed through Medicare as primary payer and TMHP as secondary.



Medicaid Non-Dual Services



- Superior HealthPlan pays for all Acute and LTSS services
- Superior HealthPlan has contracted with US Script as the Pharmacy Benefit Manager (PBM) **effective March 1, 2012**



Long Term Services & Supports



- Personal Attendant Services (PAS)
- Day Activity & Health Services (DAHS)
- STAR+PLUS Waiver Services
 - Skilled Nursing
 - PT/OT/ST
 - Minor Home Modification
 - DME
 - Residential Care/Assisted Living
 - Adult Foster Care
 - Medical Supplies
 - Home Delivered Meals
 - Adaptive Aids
 - Emergency Response System (ERS)

Service Coordination



- All members receiving LTSS services will be assigned to a Service Coordinator
- Service Coordination is available to all STAR+PLUS members
- Service Coordinators will:
 - Review assessments and develop plan of care utilizing input from member, family and providers
 - Coordinate with the member's PCP, Specialist and LTSS providers to ensure the member's health and safety needs are met in the least restrictive setting
 - Refer members to support services such as disease management and community resources
 - Authorize services

Service Coordination Teams



- Service Coordination utilizes a multidisciplinary approach in meeting member's needs including behavioral health referrals and non-clinical social support
- Service Coordinators are divided into three teams consisting of: Exceptional Needs, Dual Eligible and Waiver/Long Term Care
- Service Coordination Teams are located in Bexar, Nueces and Dallas Service Areas and are assigned by zip codes (coming soon: Lubbock and Hidalgo)

Assessment



- Members receiving Long Term Services & Support (LTSS) services are assessed annually or as needed to continue services
- Service Coordinators review the assessment(s) to identify service needs in developing a plan of care
- Assessed again upon notification of a change of condition
- Discharge planning assessment during an inpatient hospitalization

KEY POINTS TO REMEMBER



- 24/7 day care is not provided in a member's home, this includes nursing care.
- Superior does not contract with Nursing Facilities. The nursing facility will bill TMHP.
 - Notify Superior of any Nursing Facility Admissions – superioradmissions@centene.com
- Members under 21 will be assessed for STAR+PLUS services to assure their needs are met in the least restricted environment. This will be done utilizing the Personal Care Assessment Form.



KEY POINTS (cont.)



- Initial evaluations for PAS services ARE NOT a billable service
- Most Durable Medical Equipment are for rent to purchase on a 12 month agreement such as hospital beds, CPAP, and Hoyer lifts
- Assisted Living/Residential Care is a Waiver covered benefit only

EFFECTIVE 3.1.2012

- Inpatient hospital stays (non-dual members only) for medical-related diagnoses are paid through Superior HealthPlan



Services Requiring Pre-Authorization



- DAHS, Assisted Living, Respite, PAS or PHC, Home Health, Home Delivered Meals, Adult Foster Care, Emergency Response Services, Consumer Directed Services, and Minor Home Modifications
- DME over \$500 (per unit)
- Skilled Nursing, Physical Therapy, Occupational Therapy and Speech Therapy - EXCEPT at Initial Evaluation

Note: Refer to the Provider Manual for complete guidelines



Process for Pre-Authorizations



- For LTSS services (e.g. PAS, DAHS) please call the Service Coordination Department:
 - Bexar area: Phone: 1-866-615-9399 Fax: 1-866-224-8254
 - Nueces area: Phone: 1-800-656-4817 Fax: 1-866-703-0903
 - Dallas area: Phone: 1-866-529-0294 Fax: 1-855-707-5475Coming Soon! Contact information TBD
- Valley
- Lubbock
- Authorizations for Skilled Nursing, PT/OT, or other acute care services, request through Superior website: www.superiorhealthplan.com. You may also fax authorization requests to 1-800-690-7030 EXCEPT at Initial Evaluation





Superior HealthPlan OB & Postpartum Program



OB and Newborn Programs



- **“Start Smart for Your Baby”** consists of case management services, education (baby showers),* and orientation to all members who are pregnant.
- The program eliminates barriers our pregnant members have in accessing care and provides information and assistance on benefits.
- Outreach workers with knowledge of community resources and agencies are ready to assist members with housing, transportation, employment, and continued education.
- In order for your patients to be able to receive these benefits from Superior HealthPlan, please send in a Notification of Pregnancy Form for each of your Superior patients.

* In some areas



Notification of Pregnancy (NOP)



- Program implemented to identify Superior members who may have a history of preterm delivery and/or other disease that may complicate pregnancy
- Providers may complete the NOP form online at www.superiorhealthplan.com and submit or may fax in to 866-681-5125
- Provider Incentive Plan available for completing NOP forms within five (5) days of the Initial/First Provider visit based on number of forms submitted correctly
 - * 5-10 forms = \$100.00
 - * 11-20 forms = \$200.00
 - * 20+ forms = \$400.00
- Incentives will be provided as a gift card
- Opportunity to outreach to providers about 17P use and initiate case management for high risk members
- Contact your Provider Relations Department for further information



Baby Showers



- Monthly education meeting for pregnant members covering prenatal care and what to expect
- Car seat or diaper bag incentives provided for attendance
- Held throughout area to allow access for all members
- Providers can refer members to Connections for invites and follow up
- Spanish translation available
- Not available in all areas





Claims and Payment Processing



Claims Filing



- Claims must be filed within **95** days from the Date of Service (DOS).
- All requests for reconsideration or adjustment must be received within **120** days from the date of adjudication.
- Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved.
- Filed on CMS 1500 or UB04.
- Filed electronically through clearinghouse.
- Filed directly through website.
- Filed on paper claim – 1ST time paper claims, mailed to:
Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803
- Claims must be completed in accordance with TMHP billing guidelines.



CMS1500-box 24J



24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims

1500
HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA OTHER
 (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (AD)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE MM | DD | YY SEX M | F

5. PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

8. PATIENT STATUS Single | Married | Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO:
 a. OTHER INSURED'S POLICY OR GROUP NUMBER
 b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M | F
 c. EMPLOYER'S NAME OR SCHOOL NAME
 d. INSURANCE PLAN NAME OR PROGRAM NAME

11. INSURED'S POLICY GROUP OR FECA NUMBER 12. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorize payment of medical benefits to the undersigned provider or supplier for services described below.)
 SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorize payment of medical benefits to the undersigned provider or supplier for services described below.)
 SIGNED DATE

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident or PREGNANCY)(LMP) 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT INABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE 20. OUTSIDE LAB? YES | NO \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Please Items 1, 2, 3 or 4 to best describe) 22. MEDICAD RE-SUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE (NEMS) EMS	C. D. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. UNITS	H. RATE	I. AMOUNT	J. ORDERING PROVIDER ID #

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If yes, attach assignment card) YES | NO

28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$

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 in good faith.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

SIGNED DATE * NPI #

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)



Common Billing Errors



- Member DOB or name not matching ID card/ member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- No itemized bill provided when required
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate
- Illegible paper claim

Corrected Claims



- Must reference original claim # on EOP
- Must be submitted within 120 days of adjudication
- Must be submitted to:

**Superior HealthPlan
Attn: Claims
PO Box 3003
Farmington, MO 63640-3803**

- Cannot be submitted electronically

To expedite your claims, please use the corrected claim form found on our website:

http://www.superiorhealthplan.com/wp-content/uploads/2008/11/corrected_claim_form.pdf



Corrected Claims vs. Appeals



Corrected claim – Adjustment requiring no supporting documentation from the provider could be prompted by the provider or by the Plan (i.e. wrong date of birth, incorrect modifier).

Appeal- Request from a provider for adjustment to a claim that requires supporting documentation from the provider to consider the request (i.e. medical records, proof of timely filing, etc.). If appeal is a medical appeal, please review information provided earlier in the presentation.



Appealing Denied Claims



- Submit appeal within **120** days from the date of notification or adjudication
- Attach a copy of the appeal form:

http://www.superiorhealthplan.com/wp-content/uploads/2008/11/claims_appeal_form.pdf

- Include the supporting documentation
- Include copy of UB04 or CMS1500 and EOP with claim # identified
- **Claims appeals must be submitted to:**

Superior HealthPlan
Attn: Claims Appeals
P.O. Box 3000
Farmington, MO 63640-3800



Appeals Documentation



Examples of supporting documentation may include but are not limited to:

- A copy of the Superior EOP (required)
- A letter of explanation from the provider (required)
- A copy of the claim
- An EOP from another insurance company
- Documentation of eligibility verification such as screen shot of the Superior website, TMBC, TMHP documentation, etc.
- Centene EDI acceptance reports showing the claim was accepted by Superior
- Prior authorization fax confirmation



Present on Admission (POA)



- POA value will be mandatory for all inpatient hospital claims that are paid using prospective payment basis methodology services for Dates of Service 1/1/2012 and later.
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, and outpatient surgery, are considered POA.
- For further information regarding POA, please visit TMHP.COM.



Other Superior Departments and Provider Supports



Member Affairs



Connections Team

- Assist provider with non-compliant members
- Offer member education on program benefits via phone
- Coordinate assistance for members with socio-economic issues (food pantry, utility bills, etc)
- Assist with transportation needs for members - also assists with bus tokens and educates on other mileage reimbursement options when Medical Transportation Program (STAR) is not accessible or available
- 100% bi-lingual staff in English and Spanish
- Providers may contact the MCA team for any member related issues at
STAR 1-800-783-5386
STAR+PLUS 1-866-516-4501



Provider Services



Assists with:

- Claims status
- Payment questions
- Completion of claim forms
- Provider demographic changes

1-877-391-5921, option 3



Provider Relations



- Responsible for Provider Orientation and Education
 - Billing Clinics
 - New Products, Programs or Processes
- Provider Relations now offers online webinar trainings along with local group training sessions
- Visit <http://www.superiorhealthplan.com/events/> for the orientation calendar



Provider Complaints



Superior requires complaints be submitted in writing. The website contains a complaint form that can be completed and submitted online or printed, completed, and faxed or mailed to Superior for resolution response.

- **Address:**
Superior HealthPlan
2100 South IH-35, Suite 202
Austin, Texas 78704
ATTN: Complaint Department
- **Fax number:**
1-866-683-5369
- **Website Links:**
<http://www.superiorhealthplan.com/contact-us/complaint-hotline/complaint-form> (submit online)
<http://www.superiorhealthplan.com/wp-content/uploads/2008/11/Provider-Complaint-Form-03-02-10.pdf>
(form)



Provider Network Contracting and Implementation



- The Network Development & Contracting Department is a centralized team that handles all contracting for new and existing providers to include:
 - New provider contracts
 - Adding providers to existing Superior contracts
 - Adding additional products (i.e. CHIP, Foster Care) to existing Superior contracts
 - Amendments to existing contracts
- Contract Packets can be requested
 - <http://www.superiorhealthplan.com/providers/become-a-provider/>
 - 877-391-5923 x 22534



Provider Re-Credentialing



- Completed every three (3) years from date of initial credentialing
- Applications and notices mailed 120, 90, 60, and 30 days out from due date
- Lack of timely submission can result in members being reassigned and system termination

PaySpan Health



- Superior has partnered with PaySpan Health to offer expanded claim payment services to include:
 - Electronic Claim Payments (EFT)
 - Online remittance advices (ERA's/EOPs)
 - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com
- For further information contact 1-877-331-7154 or email Providersupport@PAYSPANHEALTH.COM



US Script



PHARMACY BENEFIT MANAGER (PBM)

Superior HealthPlan has contracted with US Script as the Pharmacy Benefit Manager (PBM) **effective March 1, 2012.**

Pharmacy Benefit as of March 1, 2012:

- US Script will be responsible for payment of pharmacy claims
- US Script will provide pharmacy network for Superior Members (more than 95% of Vendor Drug pharmacies are contracted)
- US Script will be responsible for prior authorization of prescriptions, as applicable
- State formulary will be adopted for Medicaid and CHIP



US Script Contact Information



Out-Patient Rx (PBM: US Script)

Pharmacy Help Desk:
800-460-8988

Prescriber Prior Authorization Requests Phone:
866-399-0928

Prescriber Prior Authorization Requests Fax:
866-399-0929



US Script Contact Information *cont.*



Superior Department of Pharmacy

Fax: 866-683-5631

E-forms: <http://www.superiorhealthplan.com/contact-us/>



HIPAA, Fraud, Abuse and Waste



Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines (<http://www.hhs.gov/ocr/privacy>)

Fraud, Abuse and Waste (Claims/Eligibility)

- Providers and Contractors are all required to comply with State and Federal provisions that are set forth
- To report Fraud, Abuse and/or Waste contact the Office of Inspector General (OIG)

1-800-436-6184



NurseWise Call Center



- Encourage members you are serving to call NurseWise for any health care questions after hours!
- 1-800-783-5386
- 24 hour call line for members with health care questions
- Staffed by Registered Nurses



Web Site



www.superiorhealthplan.com

- SUBMIT:
 - Claims (may be batched)
 - Online Authorization Requests
 - Request for EOPs
 - Provider Complaints
 - Notification of Pregnancy (NOP)
- VERIFY:
 - Eligibility
 - Claim Status
- VIEW:
 - Provider Directory
 - Provider Manual
 - Provider Training Schedule
 - Links for additional Provider Resources
 - Claim Editing Software



Superior HealthPlan Contact Information



- Claims Inquiry
 - Provider Services 877-391-5921, Option 3
- Eligibility Verification
 - Member Services 800-783-5386
- Authorizations & Referrals
 - Outpatient 800-218-7508
 - Inpatient Refer to Quick Reference Guide (found on the SHP website) for local #
- NurseWise 800-783-5386, Option 7
- Web Portal 866-895-8443

Claims Address

Superior HealthPlan
PO Box 3003
Farmington, Missouri 63640-3803

Appeals Address

Superior HealthPlan
PO Box 3000
Farmington, Missouri 63640-3800

www.superiorhealthplan.com

AUTHORIZATIONS, MEMBER ELIGIBILITY, AND CLAIMS SUBMISSION ON-LINE!



Superior Health Plan Value Added Services



Superior offers a diverse array of Value Added Services (VAS) for each product line

Value Adds are updated twice a year on 3/1 and 9/1

Examples of current value adds include:

- Free cell phones for high risk members

- 24/7 Nurseline

- Home visits to new moms after hospital discharge

- Baby Showers (prenatal education)

- ..and many more!

Complete listing of current value added services can be found on the Superior HealthPlan website at www.superiorhealthplan.com.



QUESTIONS AND ANSWERS

