superior healthplan™

Nursing Facility Provider Training

Last updated March 2024

Agenda

By the end of this presentation, you will be able to:

- Identify who Superior HealthPlan is and our various departments.
- Explain the difference between Unit Rate and Add-on Services.
- Understand Service Coordination and how they will work with the Nursing Facility staff.
- Obtain authorizations and file claims with Superior.

Who is Superior HealthPlan?

Superior:

- Is a subsidiary of Centene Corporation providing healthcare for Medicaid and CHIP members across Texas.
- Has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Contracted with the state of Texas to provide all Medicaid lines of business, including:
  - STAR/CHIP
  - STAR Kids
  - STAR+PLUS
  - STAR Health (Foster Care)
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - Ambetter Health
  - WellCare By Allwell (HMO and HMO DSNP) Plans
- Among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings.

Nursing Facility Members – STAR+PLUS

Mandatory Members

Adults age 21 and older who:

- Are Supplemental Security Income (SSI) eligible.
- Are Medicaid-eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS waiver eligibility.
- Are covered by both Medicare and Medicaid.
- Reside in a Nursing Facility.

Voluntary Members

Nursing Facility resident, age 21 and over, who:

- Are federally recognized as a tribal member.
- Receive services through the Program of All Inclusive Care for the Elderly (PACE).

Nursing Facility Members – STAR+PLUS

- STAR+PLUS members are always enrolled and disenrolled at the beginning of each month. The period begins on the 1st of each month.
- Nursing facilities should verify member eligibility at the start of each month and before providing services.
- Nursing facilities can verify the member's Resource Utilization Group (RUG) level using Superior's Secure Provider Portal.
- How can eligibility be verified?
  - Superior Identification Card
  - Superior Secure Provider Portal at: Provider.SuperiorHealthPlan.com
  - Call Member Services at:
    - STAR+PLUS – 1-877-277-9772
    - STAR+PLUS MMP – 1-866-896-1844

Nursing Facility Members – STAR+PLUS MMP

STAR+PLUS MMP Population:

- Individuals who meet all of the following criteria will be eligible for STAR+PLUS MMP:
  - 21 years of age or older at the time of enrollment
  - Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B
  - Receive Medicaid benefits through the Superior STAR+PLUS Medicaid program
  - Reside in Bexar, Dallas or Hidalgo Counties
    - *Note: The MMP program is available in 6 counties; these are the 3 which Superior services*.
- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IID), and individuals with developmental disabilities who get services through one of these waivers:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HSC)
  - Texas Home Living (TxHmL)

Opt-out/Passive Enrollment – STAR+PLUS MMP

- Enrollment for eligible individuals into STAR+PLUS MMP may be conducted (when no active choice has otherwise been made) using a seamless, passive enrollment process that provides the opportunity for individuals to make a voluntary choice to enroll or disenroll from STAR+PLUS MMP at any time.
- Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no less than 60 Days prior to the effective date of enrollment and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment.
- Disenrollment from STAR+PLUS MMP MCO and enrollment from one STAR+PLUS MMP MCO to a different STAR+PLUS MMP MCO will be allowed on a month-to-month basis any time during the year.

superior healthplan™

Services, Benefits and Prior Authorizations

Nursing Facility Unit Rate

- The Nursing Facility Unit Rate means the types of services included in the Texas Health and Human Services Commission (HHSC) daily rate for nursing facility providers, such as:
  - Room and board
  - Medical supplies and equipment
  - Personal needs items
  - Social services
  - Over-the-counter drugs
- The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. The Nursing Facility Unit Rate excludes nursing facility add-on services.
  - *Please Note: HHSC will authorize the daily rate. HHSC will authorize and make the medical necessity determinations. Superior will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Questions call THMP at 1-800-626-4117,Option 2.*

Applied Income

- Applied Income (AI) means the portion of the earned and unearned income of the STAR+PLUS member, or if applicable the member and their spouse, that is paid under the Medicaid program to a nursing facility.

- It is the responsibility of the nursing facility to make reasonable efforts to collect AI, document those efforts and notify Superior's Service Coordinator when two unsuccessful attempts in one month have been made to collect AI.

- The Service Coordinator will also ensure that the member and their family understand that if the AI remains unpaid, then the member may not be allowed to stay at the facility.
  - Superior's Service Coordinator will assist the nursing facility with the collection of AI from the member.

Nursing Facility Add-on Services

- Nursing Facility Add-on Services mean the types of services that are provided in the facility setting by the provider or another network provider and are outside of the Nursing Facility Unit Rate.
- Add-on Services include but are not limited to:
  - Emergency dental services
  - Physician-ordered rehabilitative services, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)
  - Customized Power Wheelchairs (CPWC)
  - Augmentative Communication Device (ACD)
  - Non-Emergent Medical Transportation
  - Ventilator care
  - Tracheostomy care
- All add-on services require a prior authorizations with the exception of Ventilator and Tracheostomy care, unless the authorization request is for supplemental payment for members 21 years of age and older.

STAR+PLUS Nursing Facility Value-Added Services

- Superior offers added benefits beyond the traditional Medicare and Medicaid benefits. These include, but are not limited to:
  - GED Support Services
  - Nicotine recovery program
  - Online mental health resources
  - A welcome kit when a member is placed in a nursing facility

Please Note: Benefits are subject to change and additional benefits vary by the service delivery area. For a current list, please visit Superior's value-added services webpage.

STAR+PLUS Non-Urgent Transportation

- Superior's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- For nursing facility members, this program is only available for dialysis appointments.
- Superior's Medical Ride Program may also reimburse mileage for the client, a caregiver/medical consenter, friend or someone else to take the client to healthcare services if the trip is scheduled in advance and the driver abides by the program's guidelines.
- Transportation services are provided by SafeRide.
- Appointments must be made at least two business days in advance and can be requested Monday through Friday, 8:00 a.m. – 6:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).
- For questions, concerns or complaints about SafeRide, Superior medical providers and nursing facilities can contact 1-855-932-2322 (Monday through Friday, 8:00am – 6:00pm CST) for assistance.

Non-emergent Ambulance Transport

- Authorization Tips
  - Nursing facility providers must follow the steps below:
    - A physician or physician extender writes an order for non-emergency transport.
    - Nursing Facility staff should contact Superior's member services line, utilization management department, or the assigned Service Coordinator to find an ambulance company that is in-network.
    - The Nursing Facility staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI and other business information.
    - The ambulance provider will document the request was initiated by the Nursing Facility staff and include name, time and date.
    - The Nursing Facility must sign and submit the form to Superior for review along with documentation to support medical necessity.
    - The ambulance company and Nursing Facility will coordinate the scheduling of the appointment.

Non-emergent Ambulance Transport

- Approvals
  - Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider.
  - The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied.
- Denials
  - Any service denied will have standard appeal rights for denials of medical necessity.
  - Providers may follow the standard provider appeal process.
  - Members may also file an appeal.

Add-on and Acute Care Services Authorization

- STAR+PLUS (Medicaid only):
  - Call the Superior Prior Authorization Department at 1-800-218-7508
  - Submit through the Secure Provider Portal at Provider.SuperiorHealthPlan
  - Fax the Prior Authorization Form to 1-800-690-7030
    - Inpatient: 1-800-732-7562
    - Outpatient: 1-866-570-7517
- Dual-Eligible members (non-STAR+PLUS MMP):
  - Contact the Member's Medicare carrier
- STAR+PLUS MMP:
  - Call the Superior Prior Authorization Department at 1-800-218-7508
  - Submit through the Secure Provider Portal at Provider.SuperiorHealthPlan
  - Fax the Prior Authorization Form to:
    - Inpatient: 1-877-259-6960
    - Outpatient: 1-877-808-9368

Referrals

Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope, such as mental health referrals.
  - There may be times when a referral to an out-of-network may be appropriate. Superior will review the out-of-network request and make a medical necessity decision on the request.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.
- Members may self-refer for the following services:
  - Family planning
  - Texas Health Steps
  - True emergency services
  - Case management for children and pregnant women
  - Behavioral health
  - Vision
  - Well woman annual examinations

Referrals for Non-Capitated Services

- Non-capitated services are excluded from covered services; however, STAR+PLUS members may be eligible to receive from them from Texas Medicaid providers on a Fee-for-Service basis.
- When it is determined that a member may need a non-capitated service, Superior staff will assist the member in requesting these services.
- Services include:
  - Texas Health Steps environmental lead investigation (ELI)
  - Texas School Health and Related Services (SHARS)
  - HHSC Blind Children's Vocational Discovery and Development Program
  - Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation)
  - HHSC hospice services
  - Mental Health Targeted Case Management and Mental Health Rehabilitative Services for dual-eligible members
  - Texas Department of Family and Protective Services (DFPS) Nurse-Family Partnership (NFP)
- Claims for non-capitated services should be submitted directly to the HHSC Claims Administrator for reimbursement.

Change of Ownership

Change of Ownership

- If a nursing facility undergoes a Change of Ownership (CHOW), the following form must be completed and submitted to Superior IN ADVANCE of the CHOW, including the effective date of the change:
  - SuperiorHealthPlan.com/ChangeOfOwnership
- When undergoing a CHOW, the nursing facility will be loaded with the new Tax ID as non-par in the system until credentialing is complete.
- Nursing facilities will still be completely reimbursed.
- The effective date the facilities receives for the new ownership will be prospective (i.e. it will not align with the CHOW effective date assigned by the State).

Claims Submissions

Nursing Facility Claims – Room and Board

- Preferred way to submit claims – Superior's Secure Provider Portal.
- Nursing facilities can also submit Room and Board claims through the Texas Medicaid & Healthcare Partnership (TMHP) portal, which will redirect to Superior.
- HHSC will set the prevailing rate for the date of service as found on their website.
- Nursing facilities have **365** days from the date of service to submit first time claims.
- Superior has **10** days to pay clean claims from the date of submission.
- All rate adjustments will be processed no later than **30** days after the receipt of the HHSC rate notification.

Nursing Facility Claims – Add-on Services

- Preferred way to submit claims – Superior's Secure Provider Portal.
- Nursing facilities have to submit the claims within **95** days from the date of service.
- Superior has **30** days to pay clean claims from the date of submission.
- Nursing facilities may submit claims for nursing facility add-on physician-ordered therapies on behalf of employed or contracted therapy providers.
- Add-on therapy claims must be submitted separately from the Nursing Facility room and board claims.
- Providers must submit claims directly to Superior for Durable Medical Equipment (DME) add-on services.
- Emergency Dental claims must be submitted to dental carrier.

Acute Care Services

- Preferred way to submit claims – Superior's Secure Provider Portal, as claims will be received immediately by Superior.
- Acute care providers have **95** days from the date of service to submit their claims.
- Superior will follow the clean claim criteria as set by TMHP billing guidelines.
- Superior has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing claims for add-on services include filing through a clearinghouse or on the red and white paper claim.
  - For a list of preferred clearing houses, visit our website: SuperiorHealthPlan.com/Billing
  - For 1st time paper claims, mail them to:
    Superior HealthPlan, Attn: Claims
    P.O. Box 3003
    Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Nursing Facility Billing Reminders

- The following nursing facility identification requirements remain in effect:
  - Nursing Facilities must be contracted, certified and licensed by HHSC to submit claims.
  - You must use your valid HHSC contract number, vendor number and NPI for both contracting with Superior and on the claims when billing Superior.
  - If they differ from what is on record at HHSC, your claims may result in denials as Superior cannot pay your claim until this information is corrected.
- Valid Attending Provider National Provider Identifier (NPI), Tax Identification Number (TIN) and Principle Diagnosis Code are required when submitting claims
  - Entry of invalid format for the NPI, TIN, or Principle Diagnosis Code on a claim may result in rejection or denial from Superior.
- Questions for TexMedConnect Portal Contact:
  - 1-800-626-4117, Option 1

Billing – STAR+PLUS

DUALS

These are members who receive both Medicare and Medicaid. Members may select a managed care Medicare plan and have Superior as their STAR+PLUS Medicaid plan.

- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services), Skilled Nursing Facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the RUG.

- Superior STAR+PLUS covers Vent and Trach add-on services and is the primary payor for the *co-insurance* for the SNF Unit Rate for days 21-100 (if the stay meets qualifying hospital stay criteria and skillable needs) and add-on services and is the primary payor for the NF Unit Rate starting day 101.

NON-DUALS

Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.

- Covers acute care, add-on services and the NF Unit Rate.

Billing – STAR+PLUS MMP

- Superior STAR+PLUS MMP reimburses providers for acute care services, including behavioral health as well as the approved SNF amounts.
- For SNF claims, providers must file 2 claims:
  - One claim with the standard Medicare revenue code.
  - A second claim for the Medicaid coinsurance revenue code 101.
- The Superior Medicare Explanation of Payment (EOP) is not required to be filed with the coinsurance claim.
- The claims must be filed within 365 days after the date of service or 95 days after the date on the EOP from the Medicare payment.

Auto Adjusted Claims – Room and Board

- Some of the reasons a claim may require an adjustment are due to changes in:
  - Nursing facility daily rates - Applied income
  - Provider contracts - Level of service (RUG)
  - Service authorizations - Forms 3618/3619 submitted late
  - Non-compliance with spending and staffing requirements as dictated by HHSC's Direct Care Rate Enhancement Program.
- In each of these instances, Superior will re-adjudicate claims affected by the change. Claim will be reprocessed within **30** days from receipt of the adjustment reason.
- There will be times when a claim gets adjusted, and the claim denies. In these cases, the provider will need to submit a corrected claim. These will not be automatically adjusted.

Claim Adjustments, Disputes & Reconsiderations

- If a provider wants to adjust/correct a claim or submit a claim appeal, it must be received within **120** days from the date of notification or denial.
  - Adjusted or Corrected Claim: The provider is changing the original claim. Correction to a prior-finalized claim that needed correction as a result of a denied or paid claim.
  - Claim Appeals: Often require additional information from the provider.
    - **Request for Reconsideration**: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - **Claim Dispute:** Provider disagrees with the outcome of the Request for Reconsideration.
- Both can be submitted via the Secure Provider Portal or through paper. Paper claims require a Superior Corrected Claim or Claim Appeal form, found at SuperiorHealthPlan.com/ProviderForms.

Corrected Claims Filing

- There may be occasions in which a nursing facility will need to submit a corrected claim. These claims will not auto adjust. Nursing facilities should submit a corrected claim, if:
  - Billed across multiple months i.e. 2/15-3/15.
  - Billed for days spans that include unauthorized days i.e. SAS approves 3/5-3/31 provider bills 3/1-3/31.
  - Billed for days when the member is in an acute care facility.
  - Billed for days that span across multiple years i.e. 12/31/2015 - 1/5/2016.
  - Billed for Medicare coinsurance days when non-Medicare days are authorized.
  - Billed for non-Medicare days when only Medicare coinsurance days are authorized.
  - Billed with different RUG/service levels. Claims must only be billed for one RUG/service level.

Appeals Documentation

- Examples of supporting documentation may include but are not limited to:
  - A copy of the Superior EOP is required.
  - A letter from the provider stating why they feel the claim payment is incorrect is required.
  - A copy of the original claim.
  - An EOP from another insurance company.
  - Documentation of eligibility verification such as copy of ID card, Texas Medicaid Benefit Card (TMBC), TMHP documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing.
  - Centene EDI acceptance reports showing the claim was accepted by Superior.
  - Prior authorization number and/or form or fax.

Overpayments, Refunds and Recoupments

- If a provider identifies an overpayment, or receives payment from another payer, Superior must be notified within 30 days of discovery. The provider has the option to refund the overpayment, or they can request for Superior to recoup the funds.
  - The notification can be submitted several ways:
    - 'Contact Us' form on the Superior website
    - Email: Provider_Operations@centene.com
    - Mail: Superior HealthPlan
      P.O. Box 3003
      Farmington, MO 63640-3803
- If a recoup is requested, the erroneous payment(s) will be reversed by Superior within 30-60 days. The reversal of the payment will be reflected on the provider's EOP.
- If the provider opts to submit a refund, they should send a copy of the EOP along with the refund check to:
  - Superior HealthPlan
    P.O. Box 664007
    Dallas, TX 75266-4007

Secure Provider Portal - Submitting Claims

Superior's Website and Secure Provider Portal

SuperiorHealthPlan.com/Provider

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for additional Provider Resources

Provider.SuperiorHealthPlan.com

Submit:

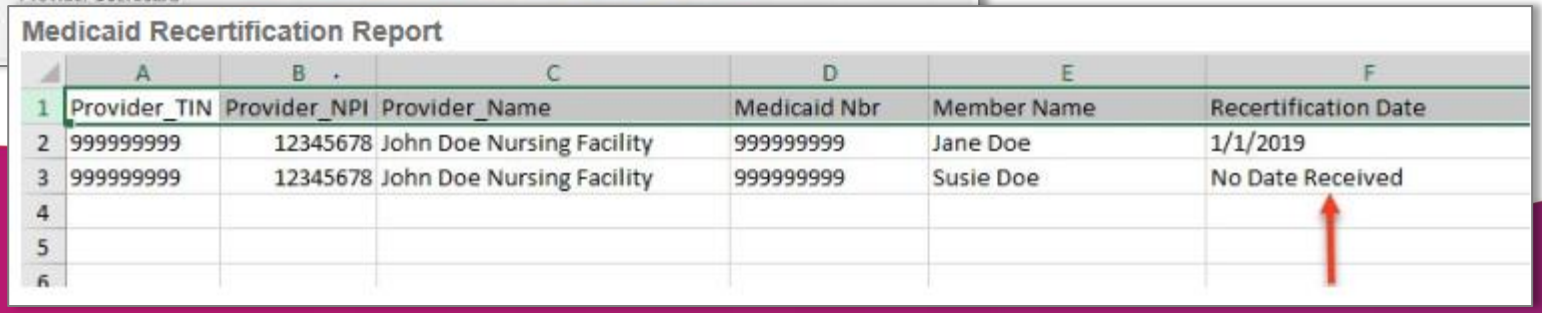
- Claims
- Request for EOPs
- Provider Complaints
- Coordination of Benefits (COB) Claims
- Corrected Claims

Verify:

- Member Eligibility
- Claim Status

Medicaid Recertification Date

- The **Medicaid Recertification Report** can be found under **Reports** at Provider.SuperiorHealthPlan.com.
- This report allows you to work with Superior members to ensure they are recertified prior to their expiration date, preventing any unnecessary lapse in coverage.
- If no recertification date is provided, **No Date Received** will be listed under **Report Date**.
- Updates to the report will be made within the first week of every month.

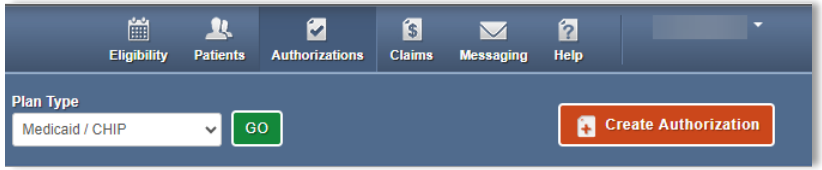


Medicaid Recertification Report

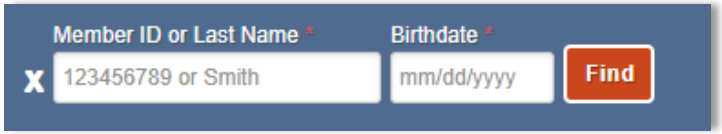
	A	B	C	D	E	F
1	Provider_TIN	Provider_NPI	Provider_Name	Medicaid Nbr	Member Name	Recertification Date
2	999999999	12345678	John Doe Nursing Facility	999999999	Jane Doe	1/1/2019
3	999999999	12345678	John Doe Nursing Facility	999999999	Susie Doe	No Date Received
4						
5						
6						

Creating an Authorization

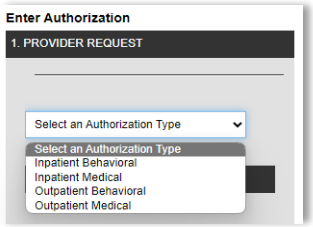
1. To create an authorization in the portal, go to the Authorizations tab then click **Create Authorization**.



2. Input the member's ID or last name along with his or her Date of Birth and click **Find**.

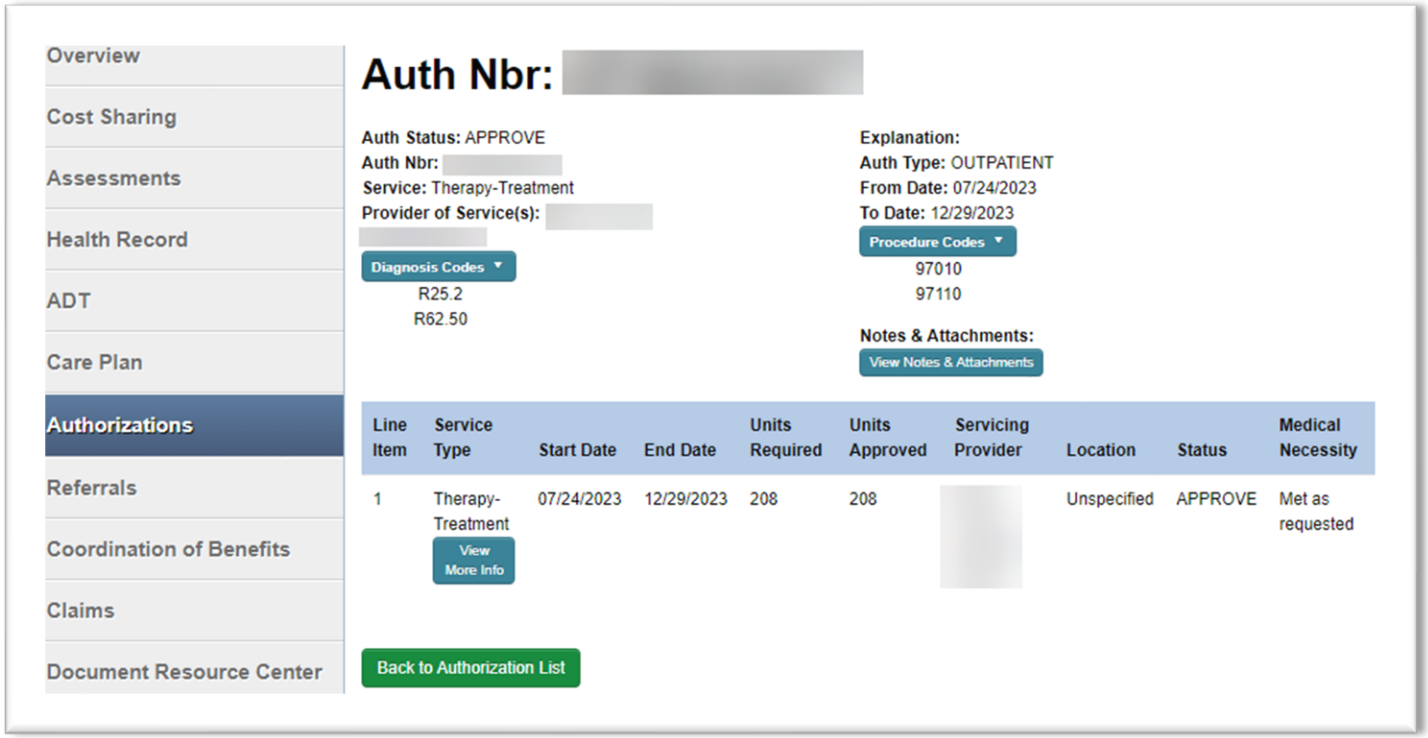


3. Follow the prompts to create your authorization – first **Select an Authorization Type**.



Authorization Response

- Once the authorization has been submitted and approved, you will be able to see it in the list of authorizations and in the member's profile:



Service Coordination

Service Coordination

- A special kind of care management used to coordinate all aspects of care for a member.
- Utilizes a multidisciplinary approach in meeting members' needs.
- Is available to all STAR+PLUS and STAR+PLUS MMP members.
- Superior residents will be assigned the same Superior Service Coordinator.
- Service Coordinators participate with the member, their family or representative, the nursing facility staff, and other members of the interdisciplinary team to provide input for the development of the nursing facility plan of care.
- Work with the nursing facility discharge planning staff to plan discharge and transition from the nursing facility.

Service Coordinator and Nursing Facility Staff

- The Service Coordinator will partner with the Nursing Facility staff to ensure members' care is holistically integrated and coordinated.
- Service Coordinators will:
  - Conduct quarterly member visits (may be less for Hospice residents).
  - Participate in Nursing Facility care planning meetings.
  - Assist with issues pertaining to Applied Income.
  - Comprehensively review the member's service plan, including the nursing facility plan of care, at least annually, or when there is a significant change in condition.
  - Notify the Nursing Facility within 5 days of a change in their assigned Service Coordinator.

Please note: This is not an all-inclusive list. For a complete list of responsibility, please refer to Superior's Nursing Facility Provider Manual.

Service Coordinator and Nursing Facility Staff

- Nursing Facility staff will:
  - Invite the Service Coordinator to provide input for the development of the nursing facility care plan.
  - Provide Service Coordination access to the facility, staff and member's medical information and records.
  - Notify the Service Coordinator within 1 business day of admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, non-contracted bed, or another nursing or long-term care facility.
  - Notify the Service Coordinator within 1 business day of an adverse change in a member's physical or mental condition or environment that potentially leads to hospitalization.
  - Notify the Service Coordinator of any discharge plans or requests.
  - Notify the Service Coordinator within 1 business day of an emergency room visit by a member.
  - Notifying the Service Coordinator within 72 hours of a member's death.
  - Submit Form 3618 or Form 3619 to HHSC to notify them of admissions, readmissions or discharges within 72 hours.

**Please note: This is not an all-inclusive list. For a complete list of responsibility, reference Superior's Nursing Facility Provider Manual.*

Service Coordinator and Nursing Facility Staff

- To notify Superior's Service Coordinator, Nursing Facility staff must fill out the applicable areas of the Service Coordination Notification Form and fax it to the attention of your Service Coordinator at: 1-855-277-5700.
  - You can find a copy of this form at: SuperiorHealthPlan.com/NursingFacilities.
- For questions, contact Service Coordination at 1-877-277-9772 or the Nursing Facility Account Management team at AM.NF@SuperiorHealthPlan.com.

Quality Improvement

Quality Improvement

Quality Assessment and Performance Improvement (QAPI):

- Monitors quality of services and care provided to members through:
  - Appointment availability audits
  - After-hours access audits
  - Tracking/ trending of complaints
- Providers participate in QAPI by:
  - Volunteering for Quality Improvement Committees
  - Responding to surveys and requests for information
  - Vocalizing opinions
- Quality Improvement Committee (QIC)
  - Comprised of contracted providers from different regions and specialties.
  - Appointed by Superior's Chief Medical Director
  - Serves as Peer Review Committee
  - Advises on proposed quality improvement activities and projects
  - Evaluates, reviews and approves clinical practice and preventative health-care guidelines

Superior HealthPlan Departments

Contact Us

- **Account Management: AM.NF@SuperiorHealthPlan.com**
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
- **Provider Services: 1-877-391-5921**
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time
- **Member Services: 1-877-277-9772 (STAR+PLUS); 1-866-896-1844 (MMP)**
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Available Monday – Friday, 8:00 a.m. to 5:00 p.m. local time

Questions and Answers