



Ambetter from Superior HealthPlan

Agenda



- 1) Ambetter Overview
- 2) Provider Portal
- 3) Verification of Eligibility, Benefits and Cost Shares
- 4) Specialty Referrals
- 5) Prior Authorization
- 6) Claim Submission / Payment
- 7) Complaints/Grievances and Appeals
- 8) Specialty Companies/Vendors
- 9) Public Website / Provider Tool Kit
- 10) Contact Information



The Affordable Care Act

The Affordable Care Act



Key objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Changes already in place (pre 2014):

- Dependent coverage to age 26 (without being a full time student)
- No denials based on pre-existing conditions
- No lifetime maximum benefits

Latest addition to complete the essential benefits package:

- Preventative care covered at 100% with no deductibles or co-pays

The 10 Essential Health Benefits

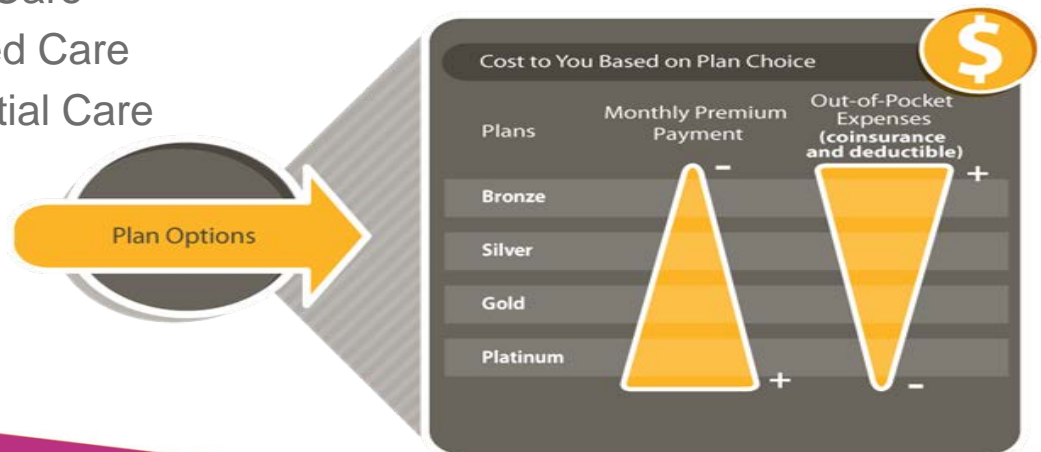


- 1) Preventive and Wellness Services
- 2) Maternity and Newborn Care
- 3) Pediatric Services including Pediatric Vision
- 4) Outpatient or Ambulatory Services
- 5) Laboratory Services
- 6) Various Therapies (such as physical therapy and devices)
- 7) Hospitalization :
- 8) Emergency Services
- 9) Mental Health and Substance Use Services (both inpatient and outpatient)
- 10) Prescription Drugs

Overview of Benefit Structure



- Essential Health Benefits (EHBs) are the same with every plan. Every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.
- Plans vary based on the individual liability limits or cost share expenses to the member.
- Under the Affordable Care Act (ACA), “Metal Tiers” are used to categorize these limits. Each plan offered on the Health Insurance Marketplace (or Exchange) will be categorized within one of these metal tiers: Platinum, Gold, Silver, and Bronze.
- Metal tiers for Ambetter are named:
 - ✓ Gold = Ambetter Secure Care
 - ✓ Silver = Ambetter Balanced Care
 - ✓ Bronze = Ambetter Essential Care



Affordable Care Act Patient Questions?



Are your patients asking you for information on the Affordable Care Act?

Refer them to the government website: <https://www.healthcare.gov/>

What is Healthcare.gov?



Healthcare.gov is an online marketplace for purchasing health insurance.

Potential members can:

- Register
 - Determine eligibility for all health insurance programs under the exchange
 - Shop for plans
 - Enroll in a plan
-
- Exchanges may be State-based or federally facilitated or State Partnership – Texas is a Federally Facilitated Marketplace

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.



What you need to know

Ambetter from Superior HealthPlan





Ambetter from Superior HealthPlan is a commercial HMO product in the Texas Health Insurance Marketplace.

- Patients must choose a Primary Care Provider (PCP).
- Authorizations are required for certain services.
- All out of network services require prior authorizations (unless emergency - matter of life or limb).

Member ID Card



		IN NETWORK COVERAGE ONLY
		TDI
Subscriber: Jane Doe		
Member: John Doe		
ID #:	UXXXXXXXX	Effective Date of Coverage: XX/XX/XX
Plan:	Ambetter Balanced Care 1 + Vision + Adult Dental	Rx BIN#: 008019
<hr/>		
Copays		
PCP:		Coinsurance (Med/Rx):
Specialist:		Deductible (Med/Rx):
ER:		Rx (Generic/Brand):

Ambetter.SuperiorHealthPlan.com

Member/Provider Services:

1-877-687-1196

Relay Texas/TTY: 1-800-735-2989

24/7 Nurse Line: 1-877-687-1196

Numbers below for providers:

Pharmacy Help Desk: 1-855-339-4805

EDI Payor ID: 68069

EDI Help Desk: 1-800-225-2573 ext. 25525

Pharmacy Administer: US Script

Medical Claims:

Superior HealthPlan

Attn: CLAIMS

PO Box 5010

Farmington, MO

63640-5010

Additional information can be found in your Evidence of Coverage. If you have an emergency, call 911 or go to the nearest emergency room (ER). Emergency services by a provider not in the plan's network will be covered without prior authorization. For updated coverage information, visit Ambetter.SuperiorHealthPlan.com.

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Possession of an ID Card is not a guarantee of eligibility and benefits.



Verification of Eligibility, Benefits and Cost Sharing

Ways to Verify



Eligibility, Benefits and Cost Sharing can be verified in 3 ways:

1. The Ambetter secure provider portal found at: Ambetter.SuperiorHealthPlan.com
 - If you are already a registered user of the Superior HealthPlan secure portal, you do NOT need a separate registration.
2. Call Provider Service at: 1-877-687-1196
 - Provider services is available to assist you M-F 8:00 AM – 6:00 PM CST.
3. 24/7 Interactive Voice Response system: 1-877-687-1196
 - IVR Quick Nav. Tips:
 - ✓ Press 1: to check member eligibility or hear benefit and co pay information
 - ✓ Press 2: for claims information and processing
 - ✓ Press 3: to submit or check on authorizations
 - ✓ Press 4: for Behavioral Health Services
 - ✓ Press 5: if you are calling for any other reason

Non Payment of Premium



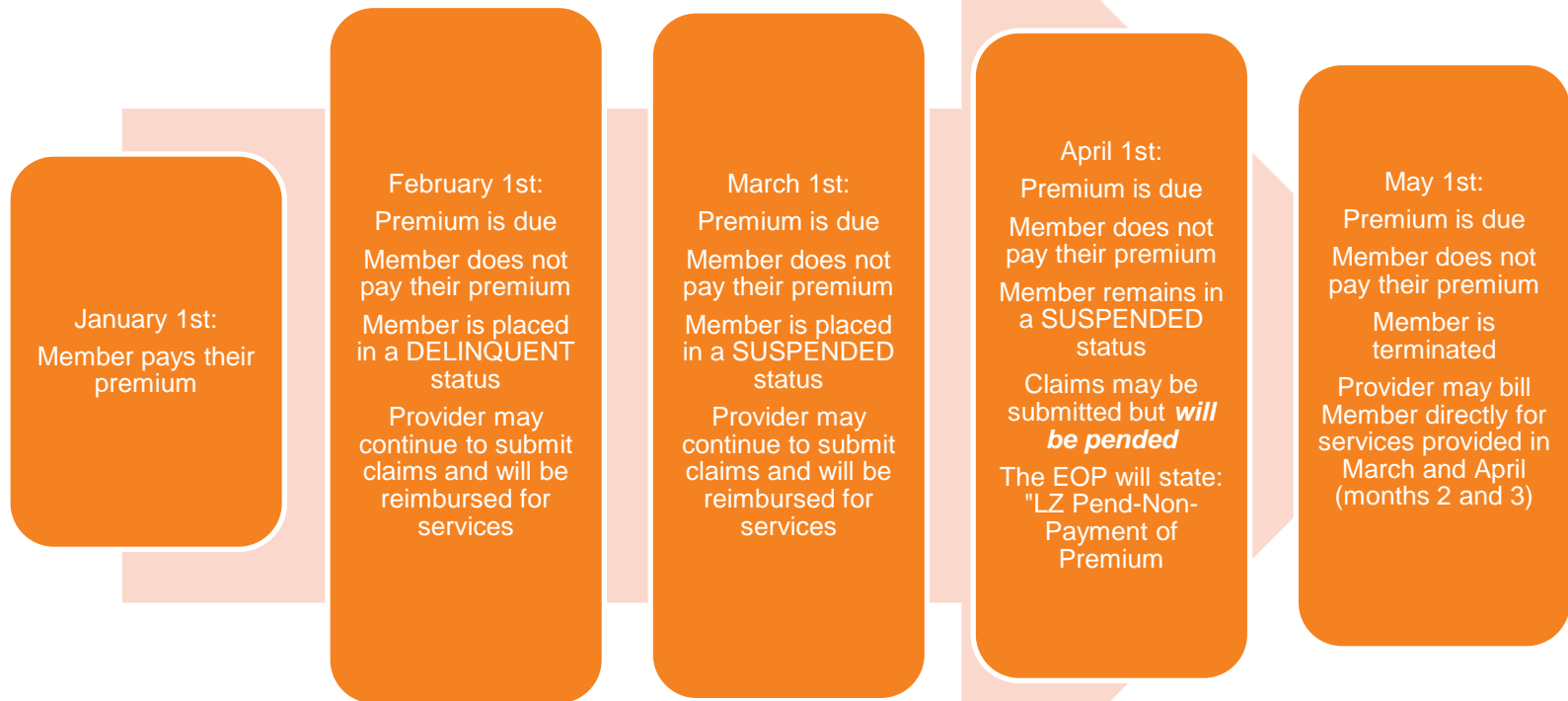
What happens if a member fails to pay their premium?

A provision of the Affordable Care Act requires that Ambetter allow members receiving subsidies a three month grace period to pay premiums before coverage is terminated.

When providers are verifying eligibility through the Secure Web Portal, the following results may appear:

- Month 1 of non-payment of premium, the member will be confirmed as enrolled and eligible.
- Months 2-3 of non-payment, the member will be confirmed as enrolled and eligible however an additional alert message will be returned indicating nonpayment of premium.

Grace Period Flow





Secure Provider Portal

Provider Portal

To Login or Register



The screenshot shows the Superior HealthPlan website for providers. The browser address bar displays "www.superiorhealthplan.com/for-providers/". The page header includes the Superior HealthPlan logo, navigation links for "Find a Doctor", "For Members", and "For Providers" (which is highlighted), and links for "Search", "Newsroom", and "Calendars". A magenta arrow points to the "Login or Register" button in the "For Providers" section. Below this section, there are two columns of links: "Network Participation", "Pharmacy", "Pre-Auth Needed?", "Medicare Advantage", "Electronic Transactions", "Primary Care Update", and "Resources". To the right of these links is a photo of a smiling female healthcare professional in orange scrubs. Below the "For Providers" section, there is a "Service Coordination – Authorization Approval Letter Change for LTSS Providers" announcement and a "Provider Services" section with contact information for Ambetter.

Superior HealthPlan

Find a Doctor | For Members | **For Providers**

Superior HealthPlan > For Providers

For Providers

Login or Register

Network Participation

Pharmacy

Pre-Auth Needed?

Medicare Advantage

Electronic Transactions

Primary Care Update

Resources

Service Coordination – Authorization Approval Letter Change for LTSS Providers

Beginning December 15, 2014, LTSS Providers will see a change on the Superior prior authorization approval letter. We will begin to provide information of the Member's STAR+PLUS eligibility status in the approval letter, indicating whether the Member is "HCBS STAR+PLUS Waiver" eligible, or "NON Waiver Eligible." The procedure code(s) for the authorized service(s) will also...

[Read More](#)

Provider Services



In order to expedite your call, please have your Tax Identification number, NPI, Member ID, DOB, billed amount and date of service available.

Ambetter
(877) 687-1196

Provider Portal




Go Back to Superior HealthPlan


 FROM  superior healthplan.


[Learn More](#) [Our Health Plans](#) [Health and Wellness](#) [For Members](#) [For Providers](#)

[For Brokers](#) [Language ▾](#) [Login ▾](#) [Find A Provider](#) [Contact Us](#)

Open Enrollment is here! Call us today to enroll! 1-877-687-1196 [Enroll Now >](#)

 **Find the Right Health Plan**



 **Learn About Ambetter**

 **Save Money on Healthcare**

Provider Portal



[Go Back to Superior HealthPlan](#)

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[Open Enrollment is here! Call us today to enroll! 1-877-687-1196](#) [Enroll Now >](#)

[Login](#)

[Join Our Network](#)

[Pharmacy](#)

[Provider Resources](#)

[Provider News](#)

For Providers


Healthy partnerships are our specialty.

[f](#) [t](#) [e](#) [v](#)

With Ambetter, you can rely on the services and support that you need to deliver the best quality of patient care. You're dedicated to your patients, so we're dedicated to you.

When you partner with us, you benefit from years of valuable healthcare industry experience and knowledge. We're dedicated to helping your practice run as efficiently as possible, which is why we always strive for prompt claims processing.

At the end of the day, our job is to make yours easier. That way, you can focus on your patients. They've always been able to count on you. And, as a partner with Ambetter, you'll be able to count on us.



To Login or Register



Choose “Create An Account” if this is your first time to the portal.
Choose “Login” if you are a returning user.

A screenshot of the ambetter. portal homepage. The header includes the Superior HealthPlan logo, "ADVANTAGE" branding, and the ambetter. logo. A "CREATE ACCOUNT" button is in the top right. The main content area is titled "The Tools You Need Now!" and lists three services: "Check Eligibility", "Authorize Services", and "Manage Claims". A "Login" modal is centered on the screen, showing fields for "User Name (Email)" and "Password", a "Login" button, and a "Forgot Password / Unlock Account" link. Below the modal, there is a "Need To Create An Account?" section with a "Create An Account" button, and a "How to Register" section with links for "Provider Registration Video" and "Provider Registration PDF". Two red arrows point from the right side of the slide to the "Login" button and the "Create An Account" button.

Begin Your Registration

The process could take up to 48 hours for approval.

A screenshot of the "Register Provider" web form. The form is titled "Register Provider" and includes a "Your Progress" indicator with three steps, the first of which is highlighted. A "Cancel" button is in the top right. Under "Your Details", there are tabs for "Medical Provider", "Dental Provider", and "Vision Provider", with a dropdown menu for "Foster Care Member, Medical Consenter, Foster Parent, DFPS Staff, RTC/CPA Staff, CASA Staff, SSCC". The form fields include: Tax ID (placeholder: XXXXXXXXX), First Name (placeholder: First), Last Name (placeholder: Last), Email (placeholder: name@domain.com), Re-enter Email (placeholder: name@domain.com), Password (placeholder: Password), and Retype Password (placeholder: Password). A magenta arrow points from the text "Your email address is your login." to the Email field. A green "Next ->" button is at the bottom right. The footer contains links for "Terms & Conditions", "Privacy Policy", and "Copyright © 2014, Centene Corporation".

Provider Portal Sample

Verification of Benefits page



[Back to Eligibility Check](#)

Overview

Benefit Tracker

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Pharmacy PDL

Coordination of Benefits

Claims

Summary of Benefits

This patient is eligible as of today, Oct 3, 2014.

Patient Information

Name

Gender F

Birthdate Sep 2, 1982

Age 32 years old

Member # U9002549401

Address

PCP Information

UNASSIGNED PCP

[View PCP History](#)

[Care Gaps](#)

Due for annual adult physical

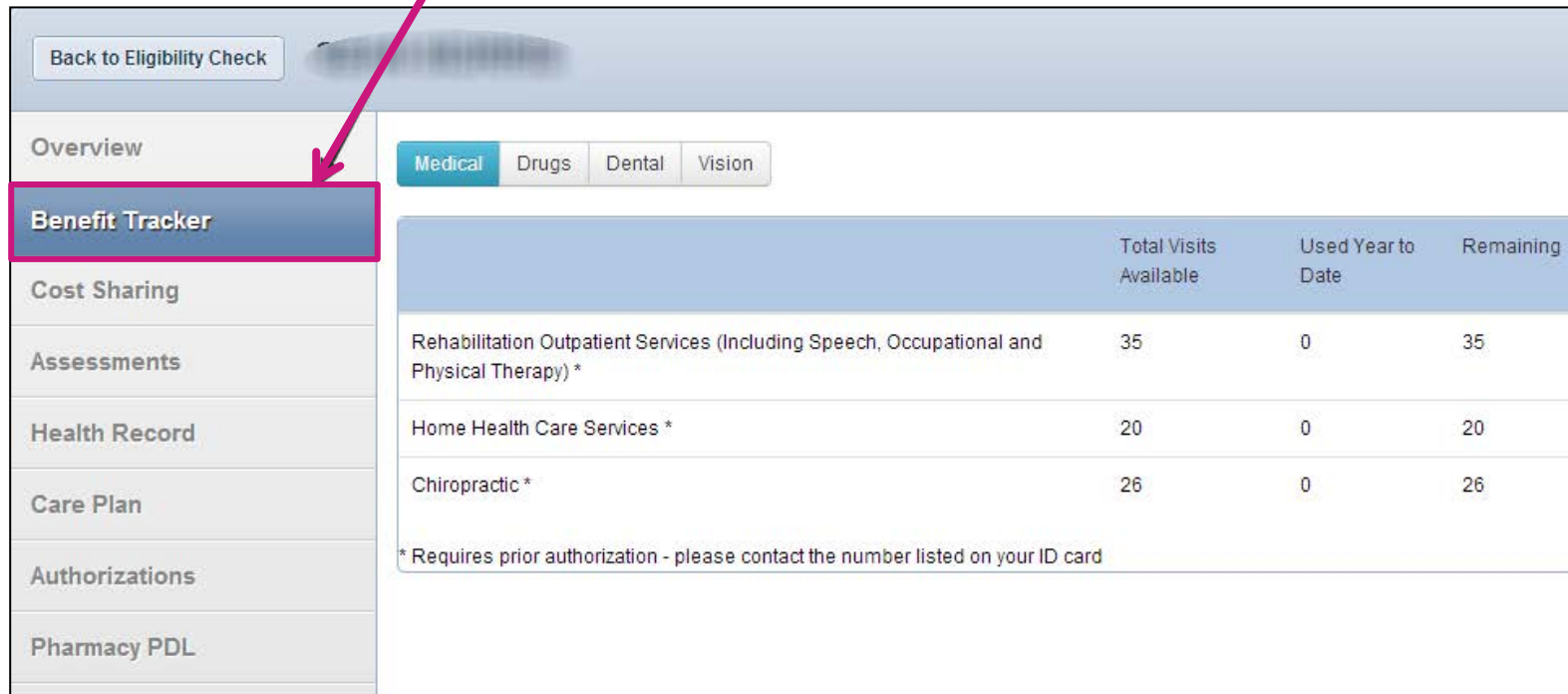
Eligibility History

Start Date	End Date	Product Name
Mar 1, 2014	Dec 31, 9999	

Benefit Limitation Tracking



Tracker shows total visits, used, and remaining allowed.



Back to Eligibility Check

Overview

Benefit Tracker

Cost Sharing

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Health Record

Care Plan

Authorizations

Pharmacy PDL

Medical Drugs Dental Vision

	Total Visits Available	Used Year to Date	Remaining
Rehabilitation Outpatient Services (Including Speech, Occupational and Physical Therapy) *	35	0	35
Home Health Care Services *	20	0	20
Chiropractic *	26	0	26

* Requires prior authorization - please contact the number listed on your ID card

“Used Year to Date” is updated nightly based on claims processed.



Referrals & Authorizations

Specialty Referrals





- Ambetter from Superior HealthPlan is an HMO Benefit Plan.
- Members enrolled in Ambetter must use in-network participating providers, except in the case of emergency services.
- If an out-of-network provider is used (except in the case of emergency services), the member will be 100% responsible for all charges.
- Members and providers can find other participating providers by visiting www.Ambetter.SuperiorHealthPlan.com and clicking on Find a Provider.

Specialty Referrals






Go Back to Superior HealthPlan

 FROM  superior healthplan.	Learn More	Our Health Plans	Health and Wellness	For Members
				For Providers

For Brokers Language ▾ Login ▾ **Find A Provider** Contact Us Search Ambetter from Superior HQ 🔍


Open Enrollment is here! Call us today to enroll! 1-877-687-1196 [Enroll Now >](#)

 Find the Right Health Plan	 Learn About Ambetter	 Save Money on Healthcare
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Specialty Referrals



Find a Provider




Please Enter Your Location

City or Zip Code:

- OR -


County:
Select County


[Click to View the 2015 Participating Pharmacy Network](#)


 **We've Mapped Your Location**


This helps us find a provider closer to you

If it's not right, change it here


 **Search the Way You Want**

 **Provider** - search the person's last name

 **Hospital** - search the hospital by name

 **Other** - there are many other types of medical providers such as:

- FQHC - Federally Qualified Health Center
- RHC - Rural Health Clinic Health Departments, DMEs and Pharmacies and many more

 **Not Seeing a Search Option?**

[Click the Advanced Search ▼ link for more search options](#)

Specialty Referrals



- Members are encouraged to first seek care or consultation with their Primary Care Provider.
- When medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.
- Paper referrals are not required for members to seek care with in-network specialists.
- The referring provider should be listed in the appropriate block on the claim form (if applicable).

Prior Authorization



Procedures / Services*

- Potentially cosmetic
- Experimental or investigational
- High tech imaging, i.e., CT, MRI, PET (*facilitated by NIA*)
- Infertility
- Obstetrical ultrasound – two allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists. For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management – must have prior auth except if performed on the same day as surgery.

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department with questions at 1-877-687-1196.

All Out of Network (Non-Par) services require prior authorization excluding emergency services.

Prior Authorization



Inpatient Authorization

- All elective/scheduled admission notifications requested at least 5 business days prior to the scheduled date of admit including:
 - ✓ All services performed in out-of-network facilities
 - ✓ Behavioral Health/substance use
 - ✓ Hospice care
 - ✓ Rehabilitation facilities
 - ✓ Transplants, including evaluation
- Observation stays exceeding 23 hours require inpatient authorization. Observation stays 23 hours or less require notification to Ambetter from Superior HealthPlan.
- Urgent/Emergent Admissions
 - ✓ Within **1 business day** following the date of admission.
 - ✓ Newborn deliveries must include birth outcome.
- Partial inpatient, PRTF and/or intensive outpatient programs

All Out of Network (Non-Par) services require prior authorization excluding emergency services.

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department with questions at 1-877-687-1196.

Prior Authorization



Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- DME
- Home health care services including:
 - Home infusion and therapy
 - Hospice
 - Furnished medical supplies & DME
- Orthotics/Prosthetics
- Hearing aid devices including cochlear implants
- Genetic testing
- Quantitative urine drug screen – Except for urgent care, ER and inpatient place of service.
- Therapy, including Occupational, Physical, Speech – each has benefit limits. Once member uses the benefit limit, no additional coverage is available.

All Out of Network (Non-Par) services require prior authorization excluding emergency services.

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department with questions at 1-877-687-1196.

Prior Authorization Request Timeframes



Service Type	Timeframe
Elective/Scheduled Admissions	<u>5 business days</u> prior to the scheduled admission date
Emergent inpatient admissions	Notification within <u>1 business day</u>
Emergency room and post stabilization, urgent care, and crisis intervention	Notification within <u>1 business day</u>
Maternity admissions	Notification within <u>1 business day</u>
Newborn admissions	Notification within <u>1 business day</u>
NICU admissions	Notification within <u>1 business day</u>
Outpatient dialysis	Notification within <u>1 business day</u>

Utilization Determination Timeframes



Prior Authorization Type	Timeframe
Prospective/Urgent	Three (3) calendar days of receipt of request.
Prospective/Non-Urgent	Three (3) calendar days of receipt of the request.
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day) of request, followed by a letter within 3 working days.
Concurrent/Non-Urgent	Two (2) business days of request. Three (3) business days for an adverse determination

Prior Authorization



Prior Authorization can be requested in 3 ways:

1. The Ambetter secure portal found at Ambetter.SuperiorHealthPlan.com
 - If you are already a registered user of the Superior HealthPlan portal, you do NOT need a separate registration!
2. Fax Requests to: 1-855-537-3447.
 - The fax authorization forms are located on our website at Ambetter.SuperiorHealthPlan.com
3. Call for Prior Authorization at 1-877-687-1196.

Prior Authorization



Prior Authorization will be granted at the CPT code level.

- If a claim is submitted that contains CPT codes that were not authorized and were not submitted for update, the services will be denied.
- If during the procedure additional procedures are performed, contact the health plan within 72 hours of the procedure to update the authorization. Update must be made prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will not retro authorize services. If there are extenuating circumstances that led to the lack of authorization, the claim may be submitted for a reconsideration or a claim dispute.

Prior Authorization Pre-Screen Tool



Access from www.SuperiorHealthPlan.com

A screenshot of the Superior HealthPlan website's "For Providers" page. The browser address bar shows "www.superiorhealthplan.com/for-providers/". The page has a blue header with the Superior HealthPlan logo and navigation links: "Find a Doctor", "For Members", and "For Providers" (which is highlighted). A search bar and links for "Contact Us", "Newsroom", and "Calendars" are also present. A magenta arrow points to the "Pre-Auth Needed?" link in a list of provider resources. The list includes "Login or Register", "Network Participation", "Pharmacy", "Pre-Auth Needed?", "Medicare Advantage", "Electronic Transactions", "Primary Care Update", and "Resources". To the right of the list is a photo of a smiling female healthcare worker in orange scrubs. Below the list, there is a section titled "Service Coordination – Authorization Approval Letter Change for LTSS Providers" with a paragraph of text and a "Read More" link. To the right of this is a "Provider Services" section with a paragraph of text and the Ambetter contact number (877) 687-1196.

Prior Authorization Pre-Screen Tool

Access from SuperiorHealthPlan.com


A screenshot of the Superior HealthPlan website. The page has a white background with a magenta header bar. In the top left corner is the Superior HealthPlan logo. In the top right corner are links for "Find a Doctor", "For Members", and "For Providers", along with "Search", "[español]", "Contact Us", "Newsroom", and "Calendars". Below the header, a breadcrumb trail reads "Superior HealthPlan > For Providers > Pre-Auth Needed?". A large blue banner with the text "Pre-Auth Needed?" is centered. Below this banner is a sidebar on the left with a list of links: "Pre-Auth Needed?", "Ambetter Pre-Auth Needed?", "Medicaid/CHIP/Foster Care Pre-Auth Needed?", "Medicare Pre-Auth Needed?", "Electronic Transactions", "ICD-10 Overview", "Health Passport", "Primary Care Update", "Medicare Advantage", "Network Participation", "Pharmacy", "Public Policy", "QAPI Program", "Resources", and "Secure Web Portal". The main content area on the right has a heading "Select Health Plan" above a dropdown menu. The dropdown menu is open, showing options: "Ambetter", "Select...", "Medicaid/CHIP/Foster Care", "Medicare Advantage", and "Ambetter" (highlighted in blue). A magenta arrow points to the highlighted "Ambetter" option.

Prior Authorization Pre-Screen Tool

Access from Ambetter.SuperiorHealthPlan.com






Go Back to Superior HealthPlan

	Learn More	Our Health Plans	Health and Wellness	For Members For Providers
For Brokers	Language ▾	Login ▾	Find A Provider	Contact Us

Search Ambetter from Superior HQ

Open Enrollment is here! Call us today to enroll! 1-877-687-1196 [Enroll Now >](#)

 Find the Right Health Plan	 Learn About Ambetter	 Save Money on Healthcare
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Prior Authorization Pre-Screen Tool



Access from Ambetter.SuperiorHealthPlan.com

The screenshot shows the website's header with navigation links: "For Brokers", "Language", "Login", "Find A Provider", and "Contact Us". A search bar is on the right. Below the header is a magenta banner with the text "Open Enrollment is here! Call us today to enroll! 1-877-687-1196" and an "Enroll Now" button. The main content area is titled "For Providers" with the tagline "Healthy partnerships are our specialty." and social media icons. A circular image shows a doctor examining a child. The left sidebar contains links: "Login", "Join Our Network", "Pharmacy", "Provider Resources" (highlighted with a pink box and a pink arrow), and "Provider News".

Prior Authorization Pre-Screen Tool



Access from Ambetter.SuperiorHealthPlan.com

A screenshot of the Ambetter Provider Resources page. The page has a magenta header with the text "Open Enrollment is here! Call us today to enroll! 1-877-687-1196" and a green "Enroll Now >" button. A left sidebar contains links: "Login", "Join Our Network", "Pharmacy", "Provider Resources" (highlighted in magenta), and "Provider News". A red arrow points from the "Provider Resources" link to the "Pre-Auth Needed?" link in the "Medical Management" section. The main content area is titled "Provider Resources" and includes social media icons, a welcome message, a link to provider training, and two sections: "Reference Materials" and "Medical Management".

Open Enrollment is here! Call us today to enroll! 1-877-687-1196 [Enroll Now >](#)

Login

Join Our Network

Pharmacy

Provider Resources

Provider News

Provider Resources

[f](#) [t](#) [e](#) [v](#)

Ambetter provides the tools and support you need to deliver the best quality of care.

[Click here to view our schedule of upcoming Provider trainings.](#)

Reference Materials

- [Provider Manual](#)
- [Billing Manual](#)
- [Quick Reference Guide](#)
- [ICD-10 Information](#)
- [FAQ – Ambetter Administrative Questions](#)
- [FAQ – Suspended Status](#)

Medical Management

- [Pre-Auth Needed?](#)
- [Inpatient Prior Authorization Fax Form](#)
- [Outpatient Prior Authorization Fax Form](#)
- [Discharge Consultation Documentation Fax Form](#)
- [Electroconvulsive Therapy \(ECT\) Authorization Request Form](#)

Prior Authorization Pre-Screen Tool

Access from Ambetter.SuperiorHealthPlan.com



[Login](#)
[Join Our Network](#)
[Pharmacy](#)
[Provider Resources](#)
[Pre-Auth Needed?](#)
[Provider News](#)
[ICD-10 Overview](#)

Pre-Auth Needed?

[Facebook](#) [Twitter](#) [Email](#) [LinkedIn](#)

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Behavioral Health/Substance Abuse need to be verified by [Cenpatico](#)
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by [NIA](#)
Vision services and all services performed by an Ophthalmologist or Optometrist need to be verified by [Opticare](#)
Services provided by Out-of-Network providers are not covered by the plan. [Join Our Network](#)

Emergency Services do NOT require prior authorization

Type of Service	Authorization Required?
The information below supersedes responses by the code lookup tool.	
All inpatient admissions and associated physician services	YES
Observation Services	YES
Anesthesia Provider Outpatient services only requires an auth for pain management and oral surgery	YES
Hospice	YES
Services rendered in the home	YES
Services from an Ophthalmologist, Optometrist or Optician are only covered if the member has elected the Vision Rider	CONDITIONAL

Note: Services related to an authorization denial will result in denial of all associated claims.

Enter the code of the service you would like to check:

To submit prior authorization to Texas Ambetter [Login here.](#)



Claim Processes

Claim Submission



The timely filing deadline for initial claims is **95 days from the date of service** or date of primary payment when Ambetter is secondary.

Claims may be submitted in 3 ways:

1. The secure web portal located at Ambetter.SuperiorHealthPlan.com
2. Electronic Clearinghouse
 - Payor ID 68069
 - Clearinghouses currently utilized by Ambetter from Superior HealthPlan will continue to be utilized.
 - For a listing of our clearinghouses, please visit our website at:
<http://www.superiorhealthplan.com/for-providers/electronic-transactions/>
3. Paper claims may be submitted to:

Ambetter from Superior HealthPlan
PO Box 5010
Farmington, MO 63640-5010

Claim Submission

Other helpful information



Rendering Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim.

Claim Submission



Rendering Provider Taxonomy Code

- Claims must be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present. This is necessary in order to accurately adjudicate the claim.

Scenario One: Rendering NPI and Billing BPI are the same

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the "ZZ" Qualifier	Box 33b	2000A 2010AA	PRV03 REF01 REF02

Claim Submission



Rendering Provider Taxonomy Code

Scenario Two: Rendering NPI is different than Billing NPI

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	<u>Unshaded</u> portion of box 24J	2310B 2420A	NM109 NM109
Taxonomy Qualifier "ZZ"	<u>Shaded</u> portion of box 24 I	2310B 2420A	PRV02 REF01 PRV02 REF01
Rendering Provider Taxonomy Number	<u>Shaded</u> portion of box 24J	2310B 2420A	PRV03 REF02 PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Group Taxonomy utilizing the "ZZ" Qualifier	Box 33b	2000A 2010AA	PRV03 REF01 REF02

Claim Submission



Rendering Provider Taxonomy Code - CMS 1500 Example

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DATE OR UNITS	H. EPSDT (Only)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To					(Explain Unusual Circumstances)							
MM	DD	YY	MM	DD	YY		MODIFIER						
1												NPI	
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER		SSN EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
		<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$			
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 a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED			DATE		a. NPI		b. NPI		c. NPI			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Group NPI

Group Taxonomy with ZZ Qualifier

Claim Submission



Rendering Provider Taxonomy Code - UB04 Example

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form

The image shows a portion of a UB04 form. On the left, the '80 REMARKS' section is visible. In the center, a box labeled 'B3 Qualifier' has an arrow pointing to the 'B3' code in the '81CC' field. Another box labeled 'Taxonomy' has an arrow pointing to the 'CC' code in the same '81CC' field. To the right, the provider information section is shown, including fields for 'LAST' and 'FIRST' names, and '78 OTHER' and '79 OTHER' NPI fields. At the bottom right, the NUBC logo is present.

Claim Submission



CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a CMS 1500 paper claim form, or in the appropriate loop for EDI claims.
- CLIA number is not required on UB04 submissions.
- Claims will be rejected if the CLIA number is not on the claim.

CLIA Number – CMS 1500 Example

A diagram of a CMS 1500 form. The form is divided into several sections. On the left, section 21 is titled "21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)" and contains a grid of boxes labeled A through L. To the right of this is section 22, titled "22. RESUBMISSION CODE" and "ORIGINAL REF. NO.". Below section 22 is section 23, titled "23. PRIOR AUTHORIZATION NUMBER". An arrow points from a box labeled "CLIA Number" to section 23.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	22. RESUBMISSION CODE	ORIGINAL REF. NO.
A. _____	B. _____	C. _____	D. _____			
E. _____	F. _____	G. _____	H. _____			
I. _____	J. _____	K. _____	L. _____			
					23. PRIOR AUTHORIZATION NUMBER	

CLIA Number

Claim Submission

Billing the Member



- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The secure web portal will indicate the amount of the deductible that has been met.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

Preventative Visits

HEDIS Measures



My Health Pays Reward Logic				
	REWARD TYPE	Provider limits	Logic	Codes
Well Visit	Annual Adult Well Visit	PCP or OBGYN	one per year	Proc codes: 99385, 99386, 99387, 99395, 99396, 99397 or Diag Code: V700, V703, V705, V706, V708, V709 or HCPCS code: G0344, G0402, G0438, G0439
	Annual Childhood Well Visit over age 3	PCP or OBGYN	one per year	Proc codes: 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395 or Diag Code: V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits under age 3	PCP only	Max of 6 from birth to age 1; Max of 3 between age 1 and age 2; Max of 2 between age 2 and age 3	Proc codes: 99381, 99382, 99391, 99392 or Diag Code: V202, V203x, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits under 15 months	PCP only	Reward if 6 visits occur prior to the age of 15 months	Proc codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 or Diag Code: V202, V203x, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits age 3,4,5,6	PCP only	one per year	Proc codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, or Diag Code: V20.3, V20.31, V20.32, V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Adolescent Well Care	PCP or OBGYN	one per year	Proc codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461 or Diag Code: V20.3, V20.31, V20.32, V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
Flu Shot	Flu shots (all)	Any	one per flu season (October through April)	Proc codes: 90654-90664, G0008, Q2035 - Q2039

Claim Payment

PaySpan



- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer.
- If you currently utilize PaySpan for other Superior products, you will be auto-enrolled in PaySpan for the Ambetter product.
- **If you do not currently use PaySpan:** To register, call 1-877-331-7154 or visit www.payspanhealth.com



Claim Reconsiderations, Disputes and Appeals

Claim Reconsiderations

Claim Reconsiderations Process



- A claim reconsideration is a written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within **120 days** of the Explanation of Payment.
- Claim Reconsiderations may be mailed to:

Ambetter from Superior HealthPlan
Claims Reconsiderations
PO Box 5010
Farmington, MO 63640-5010

Claims Disputes

Claim Disputes Process



- A Claim Dispute form can be found on our website at Ambetter.SuperiorHealthPlan.com.
- Must be submitted within **120 days** of the Explanation of Payment.
- The completed Claim Dispute form may be mailed to:

Ambetter from Superior HealthPlan

Claim Disputes

PO Box 5000

Farmington, MO 63640-5000

Complaints/Grievances/ Appeals



Claims

- A provider must exhaust the claims reconsideration and claims dispute process before filing a Complaint/Grievance.

Complaints/Grievances

- Must be filed within **30 calendar days** of the Notice of Action (denial letter).
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days.

Complaints/Grievances/ Appeals



Appeals

- For claims processing issues follow the claim reconsideration, claim dispute and complaint/grievance process. Appeals are reserved for medical necessity determinations.

Medical Necessity

- Must be filed within **180 calendar days** from the Notice of Action (denial).
- Ambetter shall acknowledge receipt within 10 business days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed 24 hours.

Complaints/Grievances/ Appeals



- Members may designate providers to act as their representative for filing appeals related to medical necessity.
 - Ambetter requires that this designation by the member be made in writing and provided to Ambetter.
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative.
- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at:

Ambetter.SuperiorHealthPlan.com



Additional Information

Specialty Companies/Vendors



Behavioral Health – Cenpatico www.cenpatico.com Phone: 1-877-687-1196 – Payor ID 68069	Dental Services – DentaQuest www.dentaquest.com Phone: 1-888-308-4766 – Payor ID CX014
High Tech Radiology Imaging Services – NIA www.radmd.com Phone: 1-800-424-4916	Pharmacy Services – US Script www.usscript.com Phone: 1-866-768-0468 – BIN # 008019
Vision Services – Total Vision Health Plan www.opticare.com Phone: 1-866-753-5779 – Payor ID 56190	24 hours Nurse Advice Line - Nurse Response http://www.nurseresponse.com/ Phone: 1-877-687-1196

Online Provider Resources

Information contained on our website:



- Provider Manual
- Billing Manual
- Quick Reference Guides
- Forms - Prior Authorization Fax forms, Claim Dispute Forms, etc.
- The Prior Authorization Pre-Screen Tool
- The Pharmacy Preferred Drug Listing
- Find a Provider Tool
- HEDIS Guides
- FAQ's – ACA, Suspended Status, and Administrative Questions

Provider Toolkit



- Ambetter Provider Introductory Brochure
- Provider Quick Reference Guide
- FAQ
- PaySpan Quick Reference Guide
- Secure Website Portal Flyer
- Window Decal

Contact Information



Ambetter from Superior HealthPlan

Phone: 1-877-687-1196

TDD/TTY: 1-800-735-2989

Ambetter.SuperiorHealthPlan.com



Questions?