Provider Overview - 2015

Available in Bexar, Collin, Dallas, Nueces, and Rockwall Counties

Updated March 2015

Agenda

- Superior HealthPlan Advantage
- Model of Care & Value Added Services
- Steps to Getting Started
- Pharmacy Benefits
- Claims Filing
- Resources to Remember
- Fraud, Waste & Abuse

Model of Care: Goal

The goal of our Model of Care (MOC) is to improve health outcomes for our members.

- Provide access to medical, behavioral health, and social services.
- Provide coordination and continuity of care.
- Arrange for seamless transition of care across health care settings, providers, and health services.
- Provide access to preventative health care services.
- Provide access to the most appropriate and cost efficient health care services.
- Monitor the over and underutilization of health care services.
- Partner with the medical team and enrollee/caregiver to promote self-management, functional status and improved mobility.

Model of Care: Team

The goals of the MOC are achieved through Care Management and the Interdisciplinary Care Team (ICT).

- Case Managers work with providers to form an effective partnership to address the needs of our members.
- Case Managers will coordinate the sharing of information with providers including Transition of Care when a member goes from one care setting to another. This includes inpatient admissions and SNF/Rehab admissions.
- Interdisciplinary team (not limited to):
  - Member caregiver, case manager, social worker, service coordinator, primary care physician, appropriate specialists, therapists, behavioral health providers, dietician, pharmacist, SHP Compliance, QI, Case Management, Service Coordination, Provider Relations, Network Development

Model of Care: Success

Who do we need for the Model of Care to be successful?

- YOU, the Provider
- Member
- Plan Staff

Superior HealthPlan is committed to assisting our providers!

Value Added Services

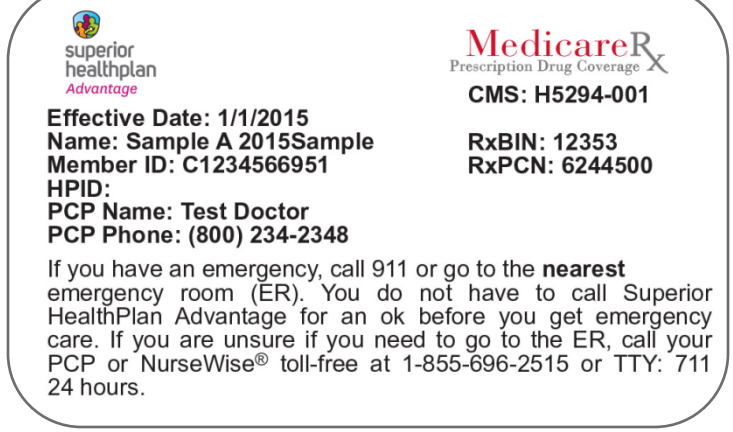
- Over The Counter (OTC) Supplies
- Transportation
- Hearing Services
- Silver Sneakers Program
- Dental Services
- Vision Services
- 24 Hour nurse line, NurseWise
- For more details, contact Member Services at 1-877-935-8023

Steps to Get Started: Verifying Eligibility

There are many ways to verify member eligibility prior to delivering service at each visit:

- Superior Provider Portal at www.SuperiorHealthPlan.com
- Advantage Member Services: 1-877-935-8023
- CMS website at www.Medicare.gov
- Member's Advantage issued ID card (Member ID card is not a guarantee of enrollment or payment).

Steps to Get Started: Advantage Member ID Card


superior healthplan Advantage

MedicareRx Prescription Drug Coverage

CMS: H5294-001

Effective Date: 1/1/2015
Name: Sample A 2015Sample
Member ID: C1234566951
HPID:
PCP Name: Test Doctor
PCP Phone: (800) 234-2348

RxBIN: 12353
RxPCN: 6244500

If you have an emergency, call 911 or go to the **nearest** emergency room (ER). You do not have to call Superior HealthPlan Advantage for an ok before you get emergency care. If you are unsure if you need to go to the ER, call your PCP or NurseWise® toll-free at 1-855-696-2515 or TTY: 711 24 hours.

Member Services: 1-877-935-8023 TTY: 711
http://advantage.superiorhealthplan.com/

Providers: This card does not guarantee eligibility or authorization.
For eligibility, call 1-877-935-8023.
For prior auth or case management referral, call 1-800-218-7508.
For questions, pharmacists can call 1-888-210-3879.
For pharmacy prior auth, call 1-866-399-0928.

Non-participating providers must obtain prior auth on all services, except for emergency care. Call 1-800-218-7508 for prior auth.
Claims submissions:
Superior HealthPlan Advantage (HMO SNP)
P.O. Box 3060, Farmington, MO 63640-3822

Steps to Get Started: Primary Care Physicians (PCPs)

- Advantage Members need to choose a PCP. We do not default them to one however. It is their choice.
- It is important to have a medical home, which is the primary care physician.
- PCPs are responsible for initiating prior authorizations for hospital admission and referrals/authorization to specialists.
- Members selecting or changing PCP's can call Member Services (1-877-935-8023) and a new ID card will be issued in approximately 1 to 2 weeks.

Steps to Get Started: Primary Care Physicians (PCPs)

We encourage PCPs to speak at least annually to all of their Advantage members about:

- Reducing their Risk of Falling
- Improving Bladder Control
- Improving or Maintaining Mental Health
- Improving or Maintaining Physical Health
- Reviewing their medication

Steps to Get Started: Referrals

- PCP's refer Members to a Specialist when the medical need is beyond their scope.
- PCP must initiate the referral to an in-network specialist.
- Specialist may NOT refer to another Specialist (only via PCP).
- If you need to refer to an out of network specialist, please obtain an authorization for the specialist or advise the specialists to obtain prior authorization.

Steps to Get Started: Self-Referral

- Medicare Advantage members can self-refer for the following services:
  - Routine women's health care, including breast exams, mammograms, pap test, etc.
  - Flu shots, pneumonia vaccinations (in network)
  - Urgent /Emergent medical need
  - Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area

Steps to Get Started: Prior Authorizations

- Authorizations & Referrals
- Medical Management: 1-800-218-7508
- Visit our website for the latest PA Lists, Authorization Forms, Information for Medical, Imaging and Rx Services and more:
  - http://www.superiorhealthplan.com/for-providers/advantage-providers/

Steps to Get Started: Prior Authorization Process

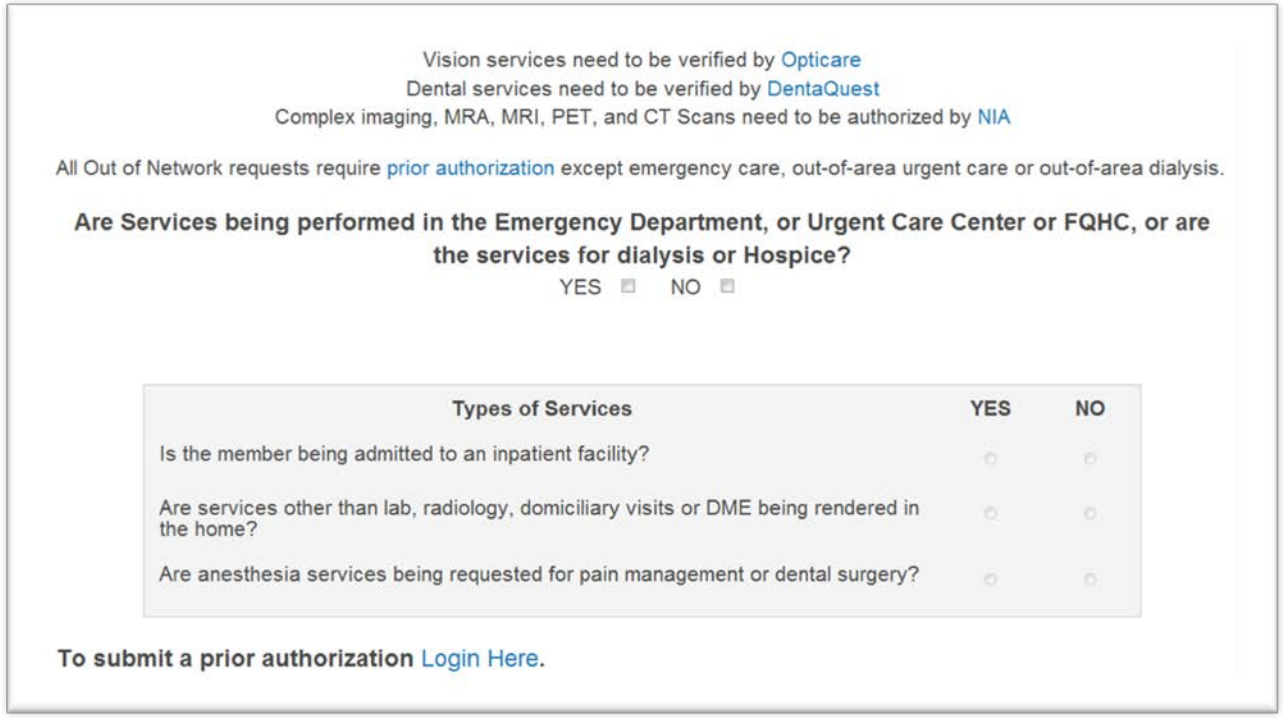
- Procedures and/or services that require authorization can be found on Superior's website: www.SuperiorHealthPlan.com.
- Standard (Non-Expedited) will be completed within 14 calendar days.
- Expedited Requests will be completed within 72 hours
  - Expedited Requests can be requested if the provider feels applying the standard 14 day timeframe could seriously jeopardize the member's health, life or ability to regain maximum function.

Steps to Get Started: How to Submit Authorization Requests

- Fax: Use the Request for Authorization form found on the website, complete and submit via fax to 1-800-808-9368
- Phone: Call in your request to 1-800-218-7508.
- Secure Web Portal: www.SuperiorHealthPlan.com

Steps to Get Started: PRE-AUTH Screening Tool

Located on our website: http://www.superiorhealthplan.com/for-providers/pre-auth-needed/medicare-pre-auth-needed



Vision services need to be verified by Opticare
Dental services need to be verified by DentaQuest
Complex imaging, MRA, MRI, PET, and CT Scans need to be authorized by NIA

All Out of Network requests require prior authorization except emergency care, out-of-area urgent care or out-of-area dialysis.

Are Services being performed in the Emergency Department, or Urgent Care Center or FQHC, or are the services for dialysis or Hospice?

YES ☐ NO ☐

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are services other than lab, radiology, domiciliary visits or DME being rendered in the home?	○	○
Are anesthesia services being requested for pain management or dental surgery?	○	○

To submit a prior authorization Login Here.

Steps to Get Started: Behavioral Health Authorizations

Cenpatico Behavioral Health

- Contracts Behavioral Providers (Provides the Network).
- Issues authorizations for Services.
- Submits behavioral health claims for Advantage members to Superior HealthPlan.
- Cenpatico Authorization Inquiries: 1-877-264-6550
- Website: www.cenpatico.com

Steps to Get Started: Radiology Authorizations

- Prior authorization is required for the following outpatient radiology procedures through NIA:
  - CT/CA
  - MRI/MRA
  - PET Scan
  - CCTA
  - Nuclear Cardiology/MPI
  - Stress Echo
- To submit authorizations or access status of authorizations please do one of the following:
  - Visit this website: www.radmd.com
  - Call 1-800-642-7554

Steps to Get Started: Pharmacy Authorization

- The Advantage Formulary is located on our website: http://www.superiorhealthplan.com/for-providers/advantage-providers/
- These forms are also posted for your convenience:
  - Prior Authorization List for Part B
  - Part B Prior Authorization Form
  - Part D Exception Request Form
- Prior Auth Requests Phone: 1-800-218-7508
- Medicare Pharmacy Help Desk: 1-877-935-8021

Steps to Get Started: Medical Necessity Denials

- When medical necessity cannot be established, a peer to peer conversation may be requested.
- Denial letters will be sent to member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.

U.S. Script

- U.S. Script is Superior's Pharmacy Benefit Manager.
  - Responsible for payment of pharmacy claims via the Argus claims platform.
  - Provides pharmacy network for Superior Members.
  - Responsible for prior authorization of prescriptions, as applicable.
  - Quantity Limits (QL) - certain drugs have a limit on number of refills or quantity of drugs refilled. For example, if is considered safe to take one pill a day, we may limit coverage to no more than one pill per day or a 30 pills for a one month supply.
- Clinical Pharmacy Services:
  - Allows the provider to speak with a pharmacy tech, manager or pharmacist at 1-866-399-0928, if requested.

U.S. Script: Part D Drug Plan

Drug Tiers:

- Tier 1 - Generic
- Tier 2 - Preferred Brand Name
- Tier 3 - Non-Preferred Brand Name
- Tier 4 - Injectables (note: there can be generic injectables)

Highlights:

- Includes unlimited number of monthly prescriptions.
- Includes a 30 day supply or a 90 day supply of maintenance drugs. If patient is on the maintenance drug list, please write a 90 day prescription at a retail pharmacy or via mail order. Mail order pharmacy is Rx Direct.
  - Generic Drug Co-pays $0
  - Brand name drugs, non-preferred drugs and non-generic injectables will have a co-pay from $0, $3.60 or $6.60 in 2015 depending on the members LIS level

U.S. Script: Categories not covered

- Not all drugs are covered under Part D.
- Certain drugs, such as some of the following, may be covered under Part B:
  - Antigens
  - Osteoporosis
  - Erythropoietin
  - Hemophilia clotting factors
  - Injectable drugs
  - Immunosuppressive drugs dependent on transplant status
  - Some oral cancer/oral anti-nausea drugs
  - Inhalation and infusion drugs

U.S. Script: Categories not Covered

By law, certain categories of drugs are not covered under Medicare Part B **or** Medicare Part D:

- Non-prescription (over the counter drugs)
- Drugs used to promote fertility
- Drugs used to relieve cough or cold systems (over the counter)
- Drugs used for cosmetic purposes
- Drugs used to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations when medically necessary
- Drugs used for the treatment of sexual or erectile dysfunction such as, Viagra, Cialis, Levitra and Caverject
- Drugs used for treatment of anorexia, weight loss or weight gain

Formulary & 90 Day Supply

- Please check out the formulary to find out which drugs can be supplied for 90 day periods - Members have two options for obtaining (mail order & some pharmacies).
- 90 day refills are good for the member because they may encourage them to be consistent in taking medications, which improves their health and medication adherence.
- The formulary can be found here under the Pharmacy section: http://www.superiorhealthplan.com/for-providers/superior-healthplan-advantage/

Transition Fill Policy

- New Advantage plan members can receive a one time 30-day transitional fill for a non-formulary drug or a drug requiring coverage determination within the first 90 days of their membership.
- This policy also applies to current members if any of their current drugs are placed on the excluded list beginning in January of the following year.
- When members are transitioning from one care setting to another they may also be entitled to transition fills – i.e. hospital to SNF, or home.
- Certain additional allowances are made for Long Term Care patients.

E-prescribing

- E-prescribing is a process allowing prescribers the ability to send prescriptions directly to a pharmacy from the point of care/ This decreases transcription errors and improves quality of care.
- The Medicare Modernization Act (MMA) of 2003 gave momentum to the e-prescribing movement.
- E-prescribing has been shown to reduce errors. Many of our in-network pharmacies are capable of receiving and processing e-prescriptions.
- Please indicate your e-prescribing capability on your demographic form.

Claims Filing: Important Definitions

- **Adjusted or corrected claim:** A provider is CHANGING the original claim.
- **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.

Claims Filing: Submitting Claims

- Initial, Adjusted and Corrected Claims by paper:

  Superior HealthPlan Advantage
  P. O. Box 3060
  Farmington, MO 63640-3822

- Reconsiderations and Disputes by paper only:

  Superior HealthPlan Advantage
  Corrections, Reconsiderations, or Appeals
  P.O. Box 4000
  Farmington, MO 63640-4000

- Electronic Claims:
  - Emdeon ID 68069 Visit the web for a list of our Trading Partners:
    - http://www.superiorhealthplan.com/for-providers/electronic-transactions/
    - Web Portal: www.superiorhealthplan.com

Claims Filing: Billing Tips

- Use the same codes and modifiers as original Medicare.
- Hospitals must include, when appropriate, the “Present on Admission” and “Hospital Acquired Conditions” indicators on claims.

Claims Filing: Deadlines

First Time Claim Submission

- Contracted Providers: 95 days from date of service
- Non-Contracted Providers: 365 days from date of service

Adjusted or Corrected Claims (By paper only)

- Contracted Providers: 120 calendar days from last timely processed claim
- Non-Contracted Providers: 365 calendar days from the last timely processed claim

Claim Reconsiderations and Disputes (By paper only)

- Contracted and Non-Contracted Providers: 120 calendar days from last timely processed claim
- Must use the corrected claim form as your cover letter

Resources to Remember: Provider Services

- Provider Services handles the following:
  - Claims status
  - Claims payment questions
  - Instructions on how to complete claims
  - Billing questions
  - Connects you with your local Provider Relations Team
- Provider Services Department: 1-877-391-5921

Resources to Remember: Provider Relations

- Responsible for Provider Orientations and Education:
  - New Billing Requirements
  - New Products, Programs & Processes
- Offers online webinar trainings along with local group training sessions
  - Calendar is listed under “Events” on our web site
- Serves as liaisons between providers, staff and Superior HealthPlan

Resources to Remember: Network Development

- A centralized, dedicated team that handles all contracting for new and existing providers to include:
  - New provider contracts
  - Adding providers to existing Superior contracts
  - Adding additional products to existing Superior contracts
  - Checking status of submission of any contract requests
- Contract packets can be requested via the following:
  - Website: www.superiorhealthplan.com, select link “For Providers” and then “Network Participation”- follow the instructions to submit a request.
  - Phone: 1-877-615-9399 x 22534

Resources to Remember: Secure Web Portal

- Search eligibility
- Submit authorizations
- Submit claims / create claim templates
- View panel Lists based on product
- Print EOP’s
- Secure messaging to communicate with Superior HealthPlan representatives
- Access multiple Tax ID’s from one account
- Ability to manage support users, allowing control of website access to your office staff
- Viewing historical patient health records

Waste, Fraud and Abuse: Definitions

Understanding the terms:

- Waste
  - The over-utilization of services or other practices that result in unnecessary costs.
- Fraud
  - Intentional deception or misrepresentation to obtain the money or property of a health care benefit program (by means of false or fraudulent pretenses, representations, or promises).
- Abuse
  - Obtaining payment for items or services when there is no legal entitlement to that payment, but without knowing and/or intentional misrepresentation of facts to obtain payments.

Waste, Fraud and Abuse: Reporting

Everyone is responsible for reporting suspected fraud, waste and abuse.

- You can report to:
  - Medicare: 1-800-Medicare
  - OIG (Office of Inspector General): 1-800-436-6148
  - ***Superior's Waste, Abuse, Fraud Hotline:*** 1-866-685-8664

QUESTIONS?

Thank you for attending!