STAR+PLUS Medicare-Medicaid Plan (MMP)

Comprehensive Provider Training

Agenda

- What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?
- Who is Superior HealthPlan?
- Role of the provider
- Model of Care
- Eligibility, Referrals, and Authorizations
- Pharmacy
- Compliance
- Cultural Competency and Disability Sensitivity
- Quality Improvement Program
- Claims Submissions
- Provider Portal Training

What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?

STAR+PLUS MMP

- A fully integrated managed care model for individuals aged 21 and over who are enrolled in Medicare and Medicaid.
- Superior HealthPlan offers this program in ***Bexar, Dallas and Hidalgo Counties only.***
- Superior will cover:
  - All Medicare benefits, including parts A, B and D
  - Medicaid benefits, including Long Term Services and Supports (LTSS)
  - Add-on Services and
  - Flexible Benefits.
- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions 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), or
  - Texas Home Living (TxHmL).

STAR+PLUS MMP: Goals

- Ensure one health plan be responsible for both Medicare and Medicaid services.
- Eliminate cost shifting between Medicare and Medicaid.
- Achieve cost savings for the state and federal government through improvements in care and coordination.
- Utilize Care Management Teams for targeted member outreach and care coordination.
- Improve quality and individual experience in accessing care:
  - Improving the coordination of care.
  - Access to care in underserved areas – no traditional means of care.
  - Increase primary care visits.
  - Reduce unnecessary Emergency Room visits.
  - Reducing the need for in-patient hospital care and institutional care.
- Promote independence in the community.

STAR+PLUS MMP: Benefits

Every STAR+PLUS MMP member in a Nursing Facility will be offered the following but are not limited to:

- Doctor and clinic visits
- 24-hour emergency care
- Hospital care
- Surgery
- Ambulance service
- Lab and X-ray services
- Major organ transplants
- Family planning services
- Hearing tests and aids
- Home health services
- Add-on services

STAR+PLUS MMP: Flexible Benefits

For members in a Nursing Facility:

- Extra Vision services
- Extra Hearing services
- Extra Drug Store services
- Extra Food Doctor services
- Extra Tele-monitoring services

Enrollment

- STAR+PLUS MMPs eligible individuals could begin voluntarily opting in starting January 2015, with passive enrollment set to begin on March 1, 2015.
- Nursing Facility residents will receive introduction letters starting May 2015 in Bexar and El Paso counties. Additional counties will follow each month after.
- Enrollment timeframe below – Nursing Facility Residents Only.

Intro letter	60 day reminder	30 day reminder	Enrollment Start Date	Population
May 2015	June 1, 2015	July 1, 2015	August 1, 2015	Bexar and El Paso counties
June 2015	July 1, 2015	August 1, 2015	September 1, 2015	Harris County
July 2015	August 1, 2015	September 1, 2015	October 1, 2015	Hidalgo, Dallas, and Tarrant counties

Disenrollment

- **Voluntary Disenrollment**
  - Members can elect to disenroll from Superior's STAR+PLUS MMP at any time and enroll in another STAR+PLUS MMP, a STAR+PLUS MCO, a Medicare Advantage plan, PACE; or may elect to receive services through Medicare fee-for-service (FFS) and a prescription drug plan and to receive Medicaid services in accordance with the Texas State Plan and any waiver programs (if eligible). This will become effective on the first day of the following month.
- **Discretionary Involuntary Disenrollment**
  - The STAR+PLUS MMP may submit a written request, accompanied by the required supporting documentation to CMS and HHSC, via the CMT, to disenroll a member, for cause.
- **Required Involuntary Disenrollment**
  - Texas and CMS shall terminate a member's enrollment in the STAR+PLUS MMP upon the occurrence of any of the conditions such as loses entitlement to either Medicare Part A or Part B, member dies or MMP's contract with CMS is terminated or reduces it's service area to exclude member's in those areas to name a few.

WHO IS SUPERIOR HEALTHPLAN?

Superior HealthPlan

- Superior HealthPlan has held a contract with HHSC since December 1999.
- Superior HealthPlan provides programs across the State of Texas. These programs include:
  - STAR
  - STAR+PLUS
  - CHIP
  - STAR Health (Foster Care)
  - Medicare Advantage
  - Ambetter by Superior HealthPlan
- Superior HealthPlan, a Centene Corp. subsidiary, manages healthcare for over 900,000 members across Texas.

Care Management Team

Care Management Teams will:

- Identify and engage high-risk and non-compliant members.
- Identify barriers to compliance with treatment plans and goals.
- Facilitate communication across medical /behavioral health specialties.
- Coordinate services, including transportation and referrals.

Service Coordination

- Is a special kind of care management used to coordinate all aspects of care for a member.
- Utilizing a multidisciplinary approach to meet the members' needs including behavioral health referrals and non-clinical social support.
- Members and their respective Nursing Facilities will be assigned the same Service Coordinator.
- Coordinator's names are found on the Provider Portal or on our website.

Provider Services

The Provider Services staff can help you with:

- Questions on claim status and payments.
- Assisting with claims appeals and corrections.
- Finding Superior Network Providers.
- Locating your Service Coordinator and Account Manager.

For claims related questions, be sure to have your claim number, TIN, and other pertinent information available as HIPAA validation will occur.

- You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

1-877-391-5921

Account Management

Account Managers are here to assist you with:

- Face-to-face orientations.
- Face-to-face web portal training.
- Office visits to review ongoing claim trends.
- Office visits to review quality performance reports.
- Provider trainings.

You can also find a map that can assist you with identifying the field office you can call to get in touch with your Account Manager on our website.

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 (i.e. CHIP, STAR Health, Superior HealthPlan Advantage) to existing Superior contracts.
- Checking status of submission of any contract requests.

Contract Packets can be requested on line:

- Superior HealthPlan: SuperiorHealthPlan.com, select link “For Providers” and then “Network Request or Update”- follow the instructions to submit a request. For help, call 1-877-615-9399 x. 22354.

ROLE OF THE PROVIDER

Nursing Facility Services

Nursing Facilities services is a statewide covered benefit of the STAR+PLUS MMP program managed by Superior HealthPlan. The following applies:

DADS will:

- Maintain nursing facility licensing and certification responsibilities.
- Maintain the Minimum Data Set (MDS) function.
- Continue Trust Fund Monitoring.
- Continue its Regulatory Services Division.

Nursing Facilities will:

- Complete and submit the MDS forms.
- Complete and transmit the 3618s and 3619s.
- Submit clean claims to the appropriate parties.

Superior will:

- Contract directly with the Nursing Facility.
- Authorize add-on services.
- Process claims for reimbursement.

Service Coordinator & Nursing Facility Staff

The Service Coordinator (SC) will partners with the Nursing Facility (NF) staff to ensure members' care is holistically integrated and coordinated.

Service Coordinators will:

- Visit members living in Nursing Facilities at least quarterly.
- Participate in Nursing Facility care planning meetings.
- Assist with the collection of applied income, when necessary.
- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) by conducting an assessment within 30 days of receipt of notification of a member's Medicaid-covered stay and develop a plan of care to transition the member back into the community.
- Comprehensively reviewing the member's service plan, including the NF plan of care, at least annually, or when there is a significant change in condition.

This is not an all inclusive list.
For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.

Service Coordinator & Nursing Facility Staff

Nursing Facility staff will:

- Invite the SC to provide input for the development of the NF care plan.
- Provide SC access to the facility, staff, and member's medical information and records.
- Notify the SC within one 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 SC within one business day of an adverse change in a member's physical or mental condition or environment that potentially leads to hospitalization.
- Notify the SC within one business day of an emergency room visit by a member.
- Notifying the SC within 72 hours of a member's death.

This is not an all inclusive list.

For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.

Service Coordinator & Nursing Facility Staff

- The Service Coordination Notification Form should be used when there is a change in the member's medical condition.
- Fax it to the attention of your Service Coordinator at: 1-888-209-4584.
- You can find a copy of this form on our website or contact your Service Coordinator or Account Manager.
- Questions about Service Coordination, call them: 1-877-277-9772.

Primary Care Providers

The Primary Care Provider ("PCP") serves as the "medical home" for the member. The "medical home" concept should assist in establishing a patient-provider relationship and ultimately better health outcomes. Responsibilities include but are not limited to:

- Supervision, coordination, and provision of care to each assigned member;
- Initiation of referrals for medically necessary specialty care;
- Maintaining continuity of care for each assigned member;
- Maintaining the member's medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services;
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral; and
- Screening and identification of members who may need LTSS.
- Update contact information including address, phone number, provider listing or hours of operation to ensure accurate information in Provider Directories.

Primary Care Providers

PCPs should speak to all their members, at least annually, about ways to:

- Reduce Risk of Falling.
- Improve Bladder Control.
- Improve or Maintain Mental Health.
- Improve or Maintain Physical Health.
- Medication Review.

Specialist as the PCP

Members with disabilities, special health care needs, and chronic or complex conditions have the right to designate a specialist as their Primary Care Provider. A specialist may serve as a PCP only under certain circumstances and with approval of Superior's Chief Medical Officer.

To be eligible to serve as a PCP, the specialist must:

- Meet Superior's requirements for PCP participation, including credentialing.
- Contract with Superior as a PCP.
- All requests for a specialist to serve as a PCP must be submitted to Superior. The request should contain the following information:
  - Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
  - A statement signed by the specialist that he/she is willing to accept responsibility for the coordination of all of the member's health care needs.
  - Signature of the member on the completed "Specialist as PCP Request" Form.

Superior will approve or deny the request and provide written notification (including denial reason) of the decision to the **member** no later than thirty (30) days after receiving the request. If denied, the **member** may file a complaint.

PCP Member Selection

Members are encouraged to select a Network PCP to be their Medical Home. Please note:

- Members can select/change their PCP by calling Member Services: 1-877-935-8023.

- A new ID card will be issued in approximately 1 to 2 weeks.

Specialty Care Physicians

- Agrees to partner with the member's PCP and Case Manager to deliver care.
- Maintain ongoing communication with the member's PCP.
- Most visits to Specialist do not require a prior authorization.
- Most Specialists will require a written referral from the member's PCP; however the referral is not required for the claim to be reimbursed by STAR+PLUS MMP.
- Female members can self-refer to an OB/GYN for their annual well-woman checkup or for care related to pregnancy.
- Specialists can elect to limit their practice to established patients only upon request to their Account Manager.

Specialty Care Physicians

Specialty Care Physicians include, but are not limited to:

- Cardiology
- Gynecology & Women's Services
- Endocrinology
- Gastroenterology
- Geriatrics
- Neurology
- Nephrology
- Oncology
- Ophthalmology
- Orthopedics
- Podiatry
- Pulmonology
- Rheumatology
- Urology

*For a list of Specialties the require authorizations, visit Superior HealthPlan.com.

Behavioral Health Providers

The behavioral health provider serves certain members participating in the STAR+PLUS MMP program that have mental illness through targeted case management and mental health rehabilitative services.

Behavioral health providers are required to provide covered health services to members within the scope of their Cenpatico agreement and specialty license. *Please note: Effective November 1, 2017, behavioral health functions will transition from Cenpatico to Superior HealthPlan.*

A behavioral health provider can provide Targeted Case Management and Mental Health Rehabilitative services to members assessed and determined to have a severe and persistent mental illness such as: schizophrenia, major depression, bipolar disorder and children and adolescents ages 3 through 17 years with a diagnosis of a mental illness who exhibit a serious emotional disturbance. Mental Health Rehabilitative services include the following:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

Targeted Case Management and Mental Health Rehabilitative services.

Self-Directed Care

Superior STAR+PLUS MMP providers that offer PHC/PAS in-home or out-of-home respite, nursing, Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST), have three (3) options available for self-directed care.

1. Consumer-Directed Option
2. Service Related Option
3. Agency Option

Self-Directed Care

Consumer-Directed Option:

- The member or the member's legally authorized representative (LAR) is the employer of record and retains control over the hiring, management, and termination of an individual providing PHC/PAS in-home or out-of-home respite; nursing, PT, OT, and/or ST; or CFC services.
- The member is responsible for assuring that the employee meets the requirements for PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT; or CFC services, including the criminal history check.
- The Enrollee uses a FMSA to handle the employer-related administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT; or CFC services.

Self-Directed Care

Service Related Option:

- The member or the member's Legally Authorized Representative (LAR)is actively involved in choosing their personal attendant, respite Provider, nurse, physical therapist, occupational therapist and/or speech/language therapist, or CFC services, but is not the employer of record.
- The Home and Community Support Services agency (HCSSA) in the STAR+PLUS MMP provider network is the employer of record for the personal attendant employee and respite provider. In this option, the member selects the personal attendant and/or respite provider from the HCSSA's personal attendant employees.
- The personal attendant's/respite provider's schedule is set up based on the member's input, and the member manages the PHC/PAS, in-home or out-of-home respite. The member retains the right to supervise and train the personal attendant. The member may request a different personal attendant and the HCSSA would be expected to honor the request as long as the new attendant is a network provider.

Self-Directed Care

Service Related Option:

- The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of-home respite.
- In this option, the member selects the nurse, physical therapist, occupational therapist, and/or speech/language therapist from the STAR+PLUS MMP's provider network. The nurse, physical therapist, occupational therapist, and/or speech/language therapist's schedule is set up based on the member's input, and the member manages the nursing, PT, OT, and/or SLT services. The member retains the right to supervise and train the nurse, physical therapist, occupational therapist, and/or speech/language therapist. The member may request a different nurse, physical therapist, occupational therapist, and/or speech/language therapist and the STAR+PLUS MMP must honor the request as long as the nurse, physical therapist, occupational therapist, and/or speech/language therapist is a network provider.
- STAR+PLUS MMP establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of nursing, PT, OT, and/or SLT services.

Self-Directed Care

Agency Option:

- STAR+PLUS MMP contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services.
- The HCSSA is the employer of record for the personal attendant, respite Provider, nurse, physical therapist, occupational therapist, and speech language therapist.
- The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of home respite, or CFC services.

MODEL OF CARE

Model of Care: Goal

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

- Ensure 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.
- Access to preventative health care services.
- 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, led by the Case Manager and coordinated with 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 member goes from one care setting to another. This includes inpatient admissions, SNF/Rehab admissions, etc.
- *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, Account Management, Network Development.

Care Coordination

Superior and its providers partner to identify and manage services for all members including persons with disabilities, chronic or complex conditions.

This includes development of a plan of care to meet the needs of the member.

The plan of care is based on health needs, the member's providers and Specialists recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs.

Behavioral Health & Physical Health Services Coordination

Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success.

Providers are required to obtain a consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.

- If the member refuses to release the information, they should indicate their refusal on the release form. providers must document the reasons for declination in the medical record.

Behavioral Health & Physical Health Services Coordination

Primary Care Providers are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must minimally include:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify members who need behavioral health referrals; behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider that referred the member. Make referrals to behavioral health providers when the required Texas Health Steps screen reveals the need for a mental health, substance abuse and/or developmental disability assessment.

Behavioral Health providers are required to refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.

Successful Model of Care

Who do we need to have
a successful Model of Care?

YOU – The provider
The member
Superior staff

We are committed to assisting our providers!

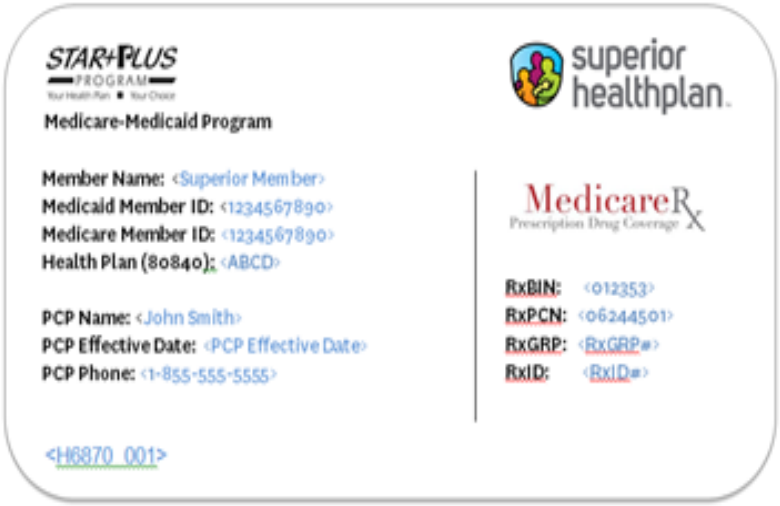
ELIGIBILITY, REFERRALS AND AUTHORIZATIONS

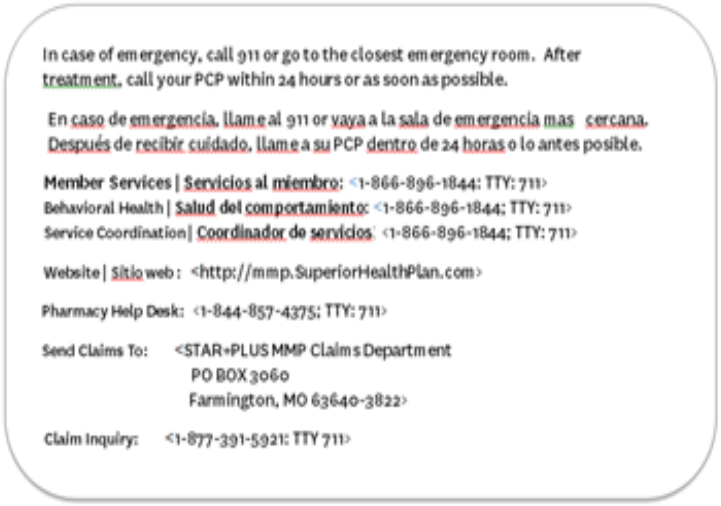
Verifying Eligibility

You can verify Resident Eligibility by:

- Visiting the Provider Portal at www.SuperiorHealthPlan.com.
- Contacting Superior's Member Services Department at: 1-866-896-1844.
- Medicare's Website, www.Medicare.gov.
- Member's issued Plan ID card (Member ID card is not a guarantee of enrollment or payment).

Member ID Card





Available in Bexar, Dallas and Hidalgo counties for Superior members only.

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 a prior authorization.

Self-Referral

Superior STAR+PLUS MMP 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.
- Behavioral health providers.

Prior Authorization – Acute Care Process

Procedures and/or services that require authorization can be found on Superior's website at www.SuperiorHealthPlan.com.

	Timeframes
Expedited Authorization/Concurrent Hospital	One (1) business day after receipt of the request
Standard Authorization	Three (3) business days of receipt of the request
Post Stabilization/Life-Threatening	One (1) hour, except that for Emergency Medical Conditions as they do not require prior authorization.
Retrospective Review	Thirty (30) calendar days

Prior Authorization – Acute Care Services

Some common acute care services that require authorization are:

- Hearing Aids.
- Orthotics/Prosthetics.
- Non-emergent ambulance transportation.

For a full list of acute services that require authorization, call the Prior Authorization Department at 1-800-218-7508, Monday through Friday, 8:00 a.m. - 5:00 p.m. local time and speak to a live agent.

Nursing Facility Members 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 (PT, OT, ST).
- Customized power wheel chairs (CPWC).
- Augmentative communication device (ACD).
- Ventilator care*.
- Tracheostomy care*.

Note: All add-on services require a prior authorizations (*exception of Ventilator and Tracheostomy care).

Acute Care & Add-on Services Authorization Process

Authorizations for these services are requested from the Prior Authorization Department.

That could be done in one of three ways:

1. Calling the Prior Auth Hotline at 1-800-218-7508.

2. Submitting via the secure web portal at www.superiorhealthplan.com.

3. Or by faxing the STAR+PLUS MMP Prior Auth Form found at www.superiorhealthplan.com under Provider Resources/Forms to:
   - **Inpatient:** 1-877-808-9363
   - **Outpatient:** 1-877-259-6960

Behavioral Health Authorizations

- Cenpatico issues authorizations for behavioral health services.
- For Cenpatico Authorization Inquiries:
  - Call: 1-800-466-4089
  - Fax: 1-877-725-7751
  - Visit: www.Cenpatico.com

Please note: Effective November 1, 2017, prior authorization for behavioral health will transition to Superior HealthPlan.

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

Authorizations can be submitted and access status of authorizations can be done by:

- Accessing www.radmd.com; or
- Calling 1-800-642-7554.

Medical Necessity Denials

- When medical necessity cannot be established, a peer to peer conversation may be requested.
- If it is not established, denial letters will be sent to member and provider.
- The clinical basis for the denial will be indicated.
- Appeal rights will be fully explained.

Medical Necessity Timeframes

Providers or members have 30 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal.

- 90 calendar days from the date of notification of adverse determination to file a Fair Hearing.
  - Non-covered Benefit denial also has Fair Hearing rights.
- Do have compliant rights.
- Superior HealthPlan will review and respond to the appeal within 30 calendar days.

Expedited Timeframes

- **Expedited Appeals**
  - IP expedited are processed within 1 working day of appeal request.
  - All other expedited appeals are completed within 3 days.

- **Expedited Appeals Criteria**
  - Will it cause severe pain if not processed within a 30-day time frame.
  - Is it life/limb threatening if not processed within a 30-day time frame.
  - Reviewed by a Medical Director.

PHARMACY

U.S. Script

- U.S. Script is the Pharmacy Benefit Manager for Superior HealthPlan.
- They are responsible for payment of pharmacy claims via the Argus claims platform.
- Provides a pharmacy network for Superior members.
- Responsible for prior authorization of prescriptions, as applicable.
- Quantity Limits (QA)- certain drugs have a limit on how many refills or the 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. Call U.S. Script at **1-866-399-0928**.

U.S. Script: Part D Drug Plan

- Drug Tiers
  - Tier 1: Generic
  - Tier 2: Preferred Brand Name
  - Tier 3: Non-Med Part D Covered Drugs (available via the TVDP Formulary)
- Unlimited number of monthly prescriptions.
- Supply Amounts:
  - Retail: 30-day supply or a 90-day* supply of maintenance drugs.
  - Mail Order: 90-day supply.

*If they are on the maintenance drug list, please write a 90 day prescription.

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.

*Non-Part D Drugs may be potentially Tier 3, if they are part of the TVDP Formulary.

Formulary & 90 Day Supply

- Please check out the formulary and a separate file or list to find out which drugs can be supplied for 90 day periods.
- Members have two options for 90-day supplies, mail order or retail/pharmacy.
- It is good for the member & may encourage them to be consistent in taking medications which improves their health and medication adherence.

Visit mmp.SuperiorHealthPlan.com for a link to the most up-to-date formulary.

Transition Fill Policy

- New 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.
- The transition period allows the member and doctor to either change the drug to one on the formulary or to file an exception to request that the drug be covered.

Transition Fill Policy

- 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 LTSS patients.
- Applies only to Medicare Party D. Drugs (Tier 1 and Tier 2).

72-Hour Emergency Supply

- A 72-hour emergency supply of a Tier 3 (non-preferred) prescribed drug must be provided when a medication is needed without delay and prior authorization is not available.
- This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.
- To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit pharmacy benefit claims electronically through the U.S. Script claims adjudication system.
- Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Providers may bill for up to ten ingredients through the on-line system. Payment requests for ingredients exceeding ten must be submitted to the U.S. Script help desk.
- Contact:
  - For Pharmacy Claims Questions: U.S. Script at 1-877-935-8026 or eftsupport@usscript.com.
  - For Program Information: Provider Services at 1-877-391-5921.

E-prescribing

- E-prescribing is a process allowing prescribers the ability to send prescriptions directly to a pharmacy from the point of care.
- E-prescribing has been shown to reduce errors. Many of our network pharmacies are capable of receiving and processing E-prescriptions.

Please indicate your e-prescribing capability on your demographic form.

Pharmacy Prior Authorization

- Prior Auth List for Part B
- Part B Prior Authorization Forms
- Part D Exception Request Form
- Contact Information:
  - Argus Pharmacy Resolution Help Desk phone: 1-877-935-8021
  - Rx Direct (Mail Order Services) phone: 1-800-785-4197
  - Prior Auth Requests phone: 1-866-399-0928
  - Prior Auth Requests/Exception fax: 1-877-941-0480

COMPLIANCE

Fraud, Waste & Abuse: Definitions

Understanding the terms:

- **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).

- **Waste**

  - The over-utilization of services or other practices that result in unnecessary costs.

- **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.

Fraud, Waste, & Abuse: Reporting

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

You can report to:

- Medicare: 1-800-Medicare
- Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
- Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
- Superior HealthPlan Fraud Hotline: 1-866-685-8664

Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for:

- Electronic health care transactions and code sets.
- Unique health identifiers.
- Security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

A significant component of the rules is the standards applied to protect health information and privacy.

Privacy Regulations

The privacy rules regulate who has access to a member's/patient's personally identifiable health information(PHI), whether in written, verbal or electronic form.

The regulation affords individuals the right to keep their PHI confidential and even from being disclosed.

In compliance with this privacy regulations, Superior provides each Superior member with a privacy notice. The notice describes:

- How Superior can use or share a member's health records
- How the member can get access to their information
- Their privacy rights and how their rights can be exercised

HIPAA Resources

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules.

A summary of the HIPAA Administrative Simplification Rules can be found at: www.cms.hhs.gov/HIPAAGenInfo/Downloads/SummaryofAdministrativeSimplificationProvisions.pdf.

Appointment Availability

A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.

The following standards are established regarding appointment availability:

- **Emergent:** Seen **same day/immediately** upon arrival
- **Urgent Care :** Seen within **24 hours**
- **Urgent Behavioral/Specialty Care:** Seen within **24 hours**
- **Routine Primary Care:** Within **14 days**
- **Preventative Adult Health Care:** Within **90 days**

Appointment Availability

The following standards are established regarding appointment availability:

- **Initial Outpatient Behavioral Visits:** Within **14 days**
- **Referrals to Specialty Care:** No later than **30 days** dependent on medical condition
- **Prenatal Care:** Within **14 days**
- **Prenatal Care – High Risk or Third Trimester (new Patient):** Within **5 days,** unless in an emergency then **Immediately**

NOTE: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare members.

After-hours Protocol

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the enrollee telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special enrollee needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
- Response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues within 30 to 45 minutes.
  - Same day for non-symptomatic concerns.
  - Crisis situations within 15 minutes.

After-hours Protocol

- Scheduling continuous availability and accessibility of professional, allied, and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and transferred to the patient's medical record.

Please Note: If after hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.

Superior will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program.

CULTURAL COMPETENCY AND DISABILITY SENSITIVITY

What is Cultural Competency?

- A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relations with members.
- It is a set of complimentary behaviors, attitudes, and policies that help professionals work effectively with people of different cultures.

How to Become a Culturally Competent Provider

- **Value Diversity and Acceptance of Differences**
  - How does the member define health and family? Consider each person as an individual, as well as a product of their country, religion, ethnic background, language and family system.

- **Self-Awareness**
  - How does our own culture influence how we act and think?
  - Do not place everyone in a particular ethnic group in the same category.

How to Become a Culturally Competent Provider

- **Consciousness of the impact of culture when we interact**
  - Respect cultural differences regarding physical distance and contact, eye contact, and rate and volume of voice.
  - Misinterpretations or misjudgments may occur.

- **Knowledge of member's culture**
  - Become familiar with aspects of culture.
  - Understand the linguistic, economic and social barriers that members from different cultures face which may prevent access to healthcare and social services.
  - Make reasonable attempts to collect race and language specific member information.

How to Become a Culturally Competent Provider

- **Adaptation of Skills**
  - Provide services that reflect an understanding of diversity between and within cultures.
  - Understand that members from different cultures consider and use alternatives to Western health care.
  - Consider the member and their family's background in determining what services are appropriate.
  - Consider the member and their family's perception of aging and caring for the elderly.
  - Treatment plans are developed with consideration of the member's race, country or origin, native language, social class, religion, mental or physical abilities, age, gender, sexual orientation.

Tips for Successful Cross-Cultural Communication

- Let the person see your lips as you speak.
- Be careful with your pronunciation.
- Project a friendly demeanor/attitude.
- Stick to the main point.
- Be aware of your assumptions.
- Emphasize or repeat key words.
- Don’t rush the person.
- Control your vocabulary, avoid jargon, slang, and difficult words.
- Listen carefully.
- Make your statement in a variety of ways to increase the chance of getting the thought across.
- Speak clearly but not more loudly.
- Write down key information for them to refer to later.

Interpreter Services

Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.

To arrange interpreter/translation services:

- Contact Member Services at:
  - 1-866-896-1844 / (TDD/TTY) 1-800-735-2989 or 7-1-1
    - As soon as possible, or
    - At least two business days before the appointment.

Tips for Working with Interpreters

- Family and friends are not the same as a professional interpreter.
- Allow enough time for appointments involving interpreters.
- Speak directly to the member and not to the interpreter.
- Avoid jargon and technical terms.
- Keep your sentences short, pausing to allow for interpretation.
- Ask only one question at a time.
- Be prepared to repeat yourself in different words if your message is not understood.
- Check to make sure that your message is understood.

People with Disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

- A person who has a physical or mental impairment that substantially limits one or more major life activities.
  - This includes people who have a record of an impairment, even if they do not currently have a disability.
  - It also includes individuals who do not have a disability, but are regarded as having a disability.

Accommodating Patients with Disabilities

Physical Accessibility Guidelines:

- Parking: adequate, marked accessible parking.
- Route: access into the facility is stable, firm and slip resistant.
- Entry: zero steps into the building/office, entry doors at least 34” wide, entry door with easy assist system, elevators located on the accessible route with Braille symbols and also audible signals for up and down directions.
- Restrooms: large enough to accommodate a person with a wheelchair/scooter, entry doors at least 36” wide and easy to open, grab bars behind and to the wall side of the toilet, soap and towel dispenses 48” or less from the floor.
- Exam Room: on the accessible route with an entry door at least a 32” clear opening.

Accommodating Patients with Disabilities

Effective Communication

- Use of auxiliary aids and services such as qualified readers and/or interpreters, audio recordings, relay service, Braille, assistive listening devices, large print, captioning.

Accessible Medical Equipment

- Height adjustable exam tables.
- Hoyer-type lift available to transfer a patient onto an exam table.
- Wheelchair accessible weight scales.
- Moveable exam chairs.

Be Prepared - Know Your Patients!

- When scheduling the appointment, ask about accommodations that may be required.
- Record information in patient's charts or electronic health records.
- If making referrals to other providers that the patient may not have previously seen, communicate with the receiving provider regarding the necessary accommodations.

Medical vs. Independent Living Model

Medical Model	Independent Living Model
Decisions made by rehabilitation professional.	Decisions made my the individual.
Focus is on problems or deficiencies/disability.	Focus is on social and attitudinal barriers.
Having a disability is perceived as being unnatural and a tragedy.	Having a disability is a natural, common experience in life.

Person First Language

A person is not defined by their disability. Be conscious of how you address or refer to patients under your care.

Avoid	Instead, use
Handicap/Handicapped	Accessible Parking/Accessible Seating
Handicapped parking/seating	Accessible Parking/Accessible Seating
Stricken/Victim/Suffering from	Had or has a Disability
Retard/Mongoloid	Cognitive or Intellectual Impairment
Wheelchair bound/confined	Uses a wheelchair
Dumb/Deaf/Mute	Person with a Communication Disorder
The Deaf	A person who is Deaf
The Blind	A person/people who are blind

Disability Etiquette - Tips to Remember

Mobility Impairments	Don't push or touch someone's wheelchair. Don't lean on the chair. When possible, bring yourself down to their level to speak to them.
Visually Impaired	Identify yourself. Do not speak or touch a guide dog, who is working
Deaf or Hard of Hearing	Speak directly to the person not the interpreter. Do not assume they can read your lips. Do not chew gum, wear sunglasses or otherwise obscure your face.
Speech Disorders	Don't finish the person's sentences. Ask the person to repeat or you can repeat to make sure you understood.
Seizure Disorders	Do not interfere with the seizure, protect their head during the event. Do not assume they need you to call 911.
(MCS) Respiratory Disorders	Do not wear perfumes. Do not use sprays or chemicals. Maintain good ventilation.
Developmental Disabilities	Speak clearly using simple words. Do not use baby talk or talk down to the person. Do not assume they cannot make their own decisions unless you have been told otherwise.

Tips to Remember

Providers need to make reasonable accommodations for members including by are not limited to:

- Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments.
- Ensuring that all written materials are available in formats compatible with optical recognition software.
- Reading notices and other written materials to patients upon request.
- Assisting patients with filling out forms over the telephone.
- Ensuring effective communication to and from individuals with disabilities through email, telephone, personal assistance, and other electronic means.
- Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the Deaf.
- Providing individualized forms of assistance.

Office Site Survey

Superior conducts site visits to the provider/practitioner's office to investigate member complaints related to physical accessibility, physical appearance, etc.

Site visits conducted by Superior Representatives include but not limited to:

- Staff information
- Access for the Disabled
- Licensure
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained
- Cultural competence
- Physical accessibility (Access, Office Hours, Wait Time, Preventive Health Appointment)
- Physical appearance
- Availability of emergency equipment
- Medication administration/dispensing/ storage of drug samples
- Adequacy of medical records keeping practices

QUALITY IMPROVEMENT PROGRAM

Quality Improvement

Quality Assessment and Performance Improvement (QAPI)

- Monitors quality of services and care provided to members:
  - Appointment availability audits.
  - After-hours access.

- Providers Participate in QAPI by:
  - Volunteering for Quality Improvement Committees.
  - Responding to surveys and requests for information.
  - Vocalizing opinions.

- Quality Improvement Committee:
  - 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.

CLAIMS SUBMISSIONS

Claims Filing: Important Definitions

- Clean Claim – A claim for services rendered to a member with the data necessary for Superior to adjudicate and accurately report the claim.
- 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:
Nursing Facility Billing

Nursing Facilities Daily Unit Rate:

- **Preferred** Way to Submit Claims – Superior's Web Portal, as claims will be received immediately by Superior.
- Can also submit claims through TMHP's portal, which will redirect to Superior.
- Cannot submit Daily Unit Rate via paper.
- The prevailing rate for the date of service is set by regulatory entities such as CMS and HHSC.
- Nursing Facilities have within **365** days to submit the claims from the date of service.
- Superior will follow the clean claim criteria used by CMS and DADS.
- Superior HealthPlan 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 daily SAS file.

Claims Filing:
Nursing Facility Billing

Nursing Facilities Add-on Services:

- **Preferred** Way to Submit Claims – Superior's Web Portal, as claims will be received immediately by Superior.
- Nursing Facilities can also submit claims through TMHP's portal, which will redirect to Superior.
- Nursing Facilities have to submit the claims within **95** days from the date of service.
- Superior will follow the clean claim criteria used by DADS.
- Superior HealthPlan has **30** days to pay clean claims from the date of submission.
- Nursing Facilities may submit claims for NF add-on physician-ordered therapies on behalf of employed or contracted therapy providers.
- Add-on Therapy claims must be submitted separately from the NF Unit Rate Claims.
- All other add-on providers must submit claims directly to Superior.

Acute Care & Add-on Services

- **Preferred** Way to Submit Claims – Superior's Web 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 HealthPlan has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing acute care claims include: Through a clearinghouse or on the red and white paper claim.
  - For a list of preferred clearing houses, visit our website.
  - For 1st time claims, mail them to:
    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims
    P. O. Box 3060, Farmington, MO 63640-3822
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI (or Atypical ID) are all required when billing Superior claims.

Bill Code Crosswalk

- Details on required coding for claims submission can be found on the LTC Bill Code Crosswalk.
- This document updates periodically. For the most current LTC Bill Code Crosswalk – NF Add-on Services visit: http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/starplus-adding-nursing.shtml.

Nursing Facility Billing Reminders

- Nursing Facility identification requirements remain in effect
  - Nursing Facilities must be contracted, certified, and licensed by DADS to submit claims.
  - You must use your valid DADS 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 DADS, your claims my result in denials as Superior cannot pay your claim until this information is corrected.
- Valid Attending Provider NPI, TIN and Principle Diagnosis Code are required when submitting claims
  - Entry of invalid format for the National Provider Identifier (NPI), Tax Identification Number (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.

Auto Adjusted Claims

- There may be occasions in which a claim which is in a paid status may require a payment adjustment of the **daily unit rate**. Superior will be informed of the need to re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are **automatic** and Nursing Facilities are not required to take any action.
- Some of the reasons a claim may require an adjustment are due to changes in:
  - Nursing Facility Daily Rates
  - Provider Contracts
  - Service Authorizations
  - Applied Income
  - Level of Service (RUG)
- In each of these instances, Superior will automatically re-adjudicate claims affected by the change. Payment on adjusted claims will be made within **30** days from receipt of the adjustment reason.

Nursing Facility Claims – Resubmit/Correct

- Examples where the claim will not auto adjust and the Nursing Facility will need to correct/resubmit their claim:
  - 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.

Corrected Claims Filing

- Must reference original claim # from EOP.
- Must be submitted within 120 days of adjudication paid date.
- Resubmission of claims can be done via your clearinghouse or through Superior's web portal.
  - To send both individual and batch claim adjustments via a clearinghouse, you must provide the following information to your billing company: the CLM05-3 must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
  - For batch adjustments, upload this file to your clearinghouse or through Superior's web portal.
  - To send individual claim adjustments through the web portal, log-in to your account, select claim and then the Correct Claim button.
- Corrected or adjusted paper claims can also be submitted to:

Superior HealthPlan STAR+PLUS MMP
Attn: Claims
P. O. Box 4000, Farmington, MO 63640-4000

Corrected Claims Filing

- There may be occasions in which a Nursing Facility will need to resubmit/submit a corrected claim, if they billed incorrectly. 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.

Appealing Denied Claims

- Submit appeal within **120** days from the date of adjudication or denial.
- Claims appeals may be submitted one of two ways:
  - In writing:
    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims
    P. O. Box 4000, Farmington, MO 63640-4000
  - Or through the secure web portal.
    - At this time, batch adjustments are not an option via the SHP secure portal.
- Attach & complete the claim appeal form from the website.
- Include sufficient documentation to support appeal.
- Include copy of UB04 or CMS1500 (corrected or original) or EOP copy with claim # identified.

Appeals Documentation

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

- A copy of the SHP EOP (required).
- A letter from the provider stating why they feel the claim payment is incorrect (required).
- A copy of the original claim.
- An EOP from another insurance company.
- Documentation of eligibility verification such as copy of ID 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.

Billing the Member

It is imperative that providers verify benefits, eligibility, and cost shares each time a Superior member is scheduled to receive services.

- Providers may NOT balance bill members for covered services.
- Superior reimburses only those services that are medically necessary and a covered benefit; an Explanation of Payment is provided that will detail reimbursement for each claim submitted.
- Additional details can be found in your provider contract with Superior HealthPlan.

SECURE PROVIDER PORTAL - SUBMITTING CLAIMS

Provider Portal & Website

Superior HealthPlan is committed to providing you with all of the tools, resources and support you need to be make your business transactions with Superior as smooth as possible. One of the most valuable tools is our web portal. Once you are registered you get access to the full site.

- Secure Provider Portal:
  - Up-to-date member eligibility and Service Coordinator assignment.
  - Claim submission portal you can submit claims for FREE!
  - A claim wizard tool that walks you through filling in a claim to submit on-line.
  - Claim status and payment information.
  - Check the status of an authorization.

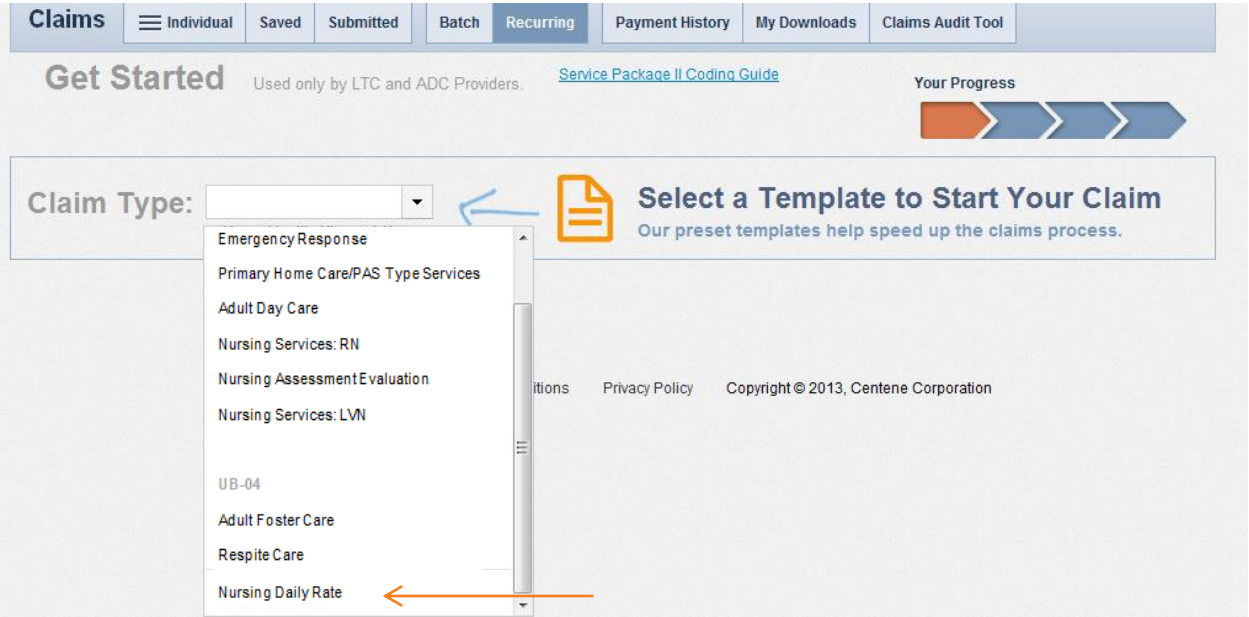
- Public Site:
  - View our Provider Directory and on-line lookup.
  - Locate the field office number of your Account Manager.
  - Review current and archives of newsletters, bulletins, the Provider Manual, and link to important sites to keep you up to date on any new changes that may affect you.

Registration

https://provider.Superiorhealthplan.com/sso/login

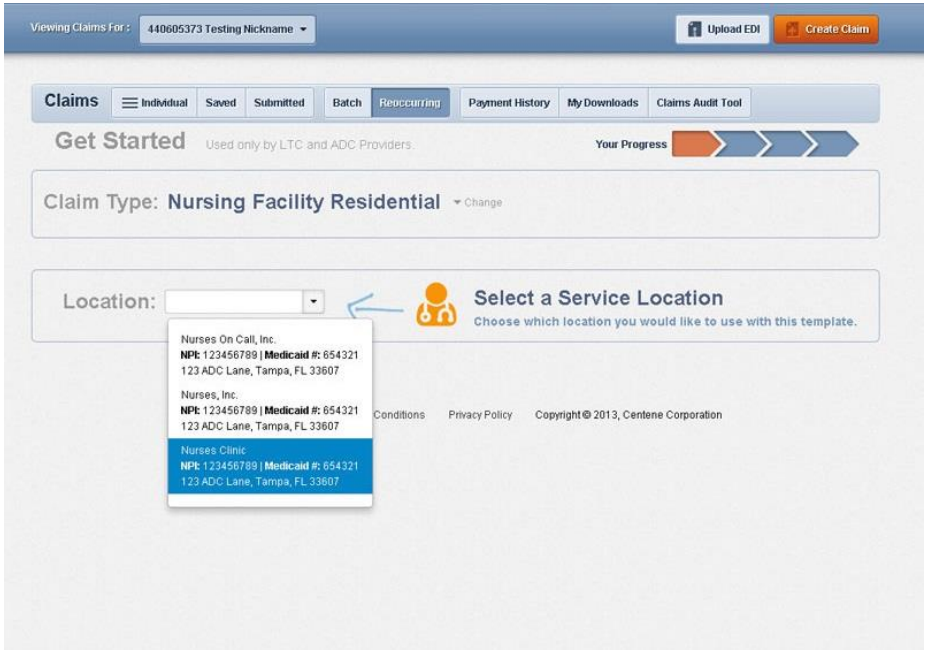
- A user account is required to access the Provider Secure area.
- If you do not have a user account, click **Register** to complete the 4-step registration process.

Create Recurring UB-04 Claims



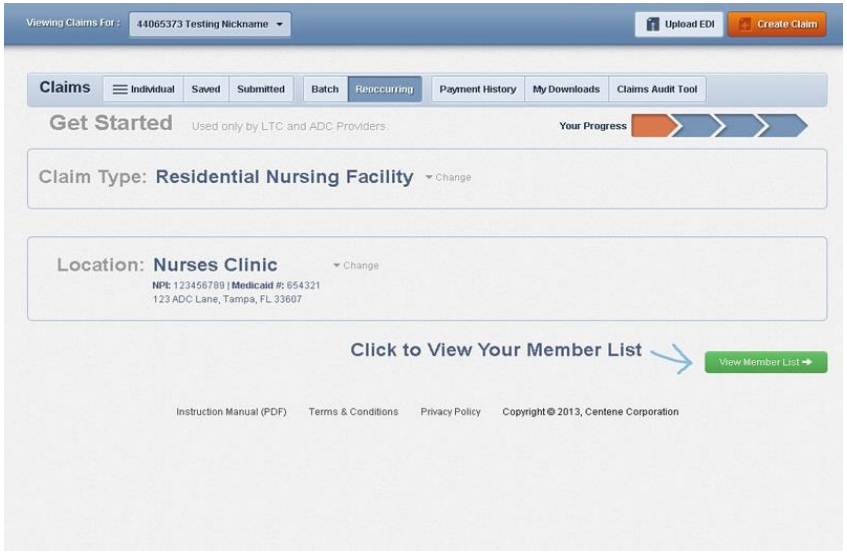
Select Nursing Daily Rate

Create Recurring UB-04 Claims

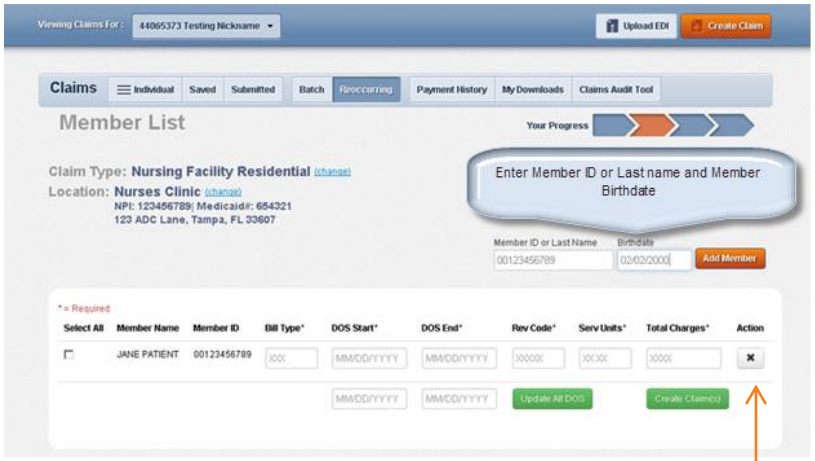


Select Your Service Location

Create Recurring UB-04 Claims

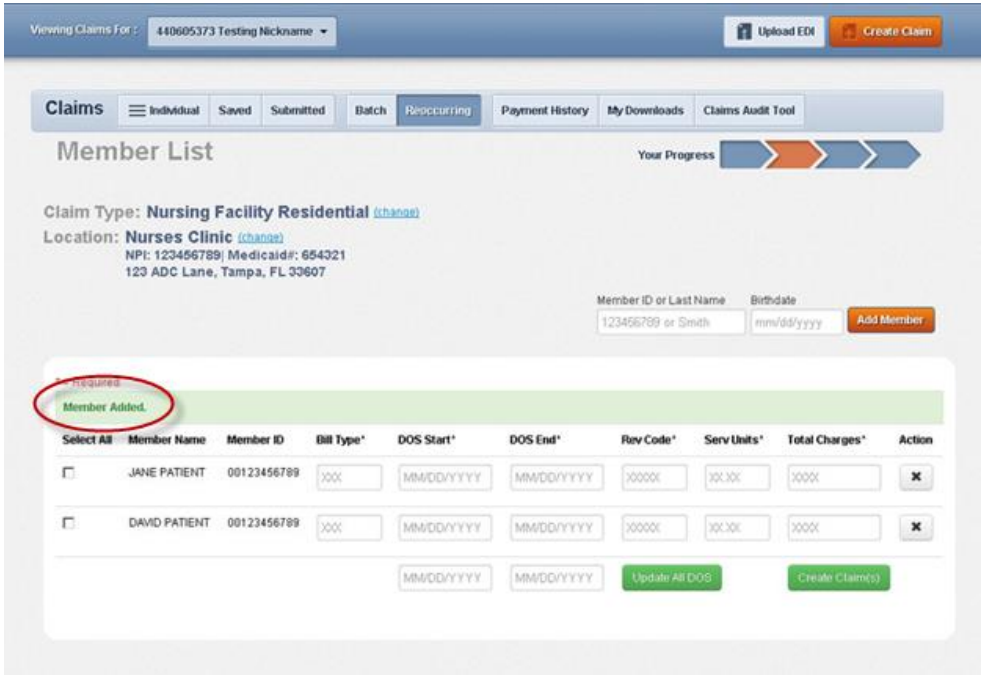


- Click on View Your Member List. Member Lists only need to be created once during your first time using the Multiple Claims Wizard.
- Enter Member ID or Last Name and Birthdate. Member ID is the Medicaid ID on the Member ID card.



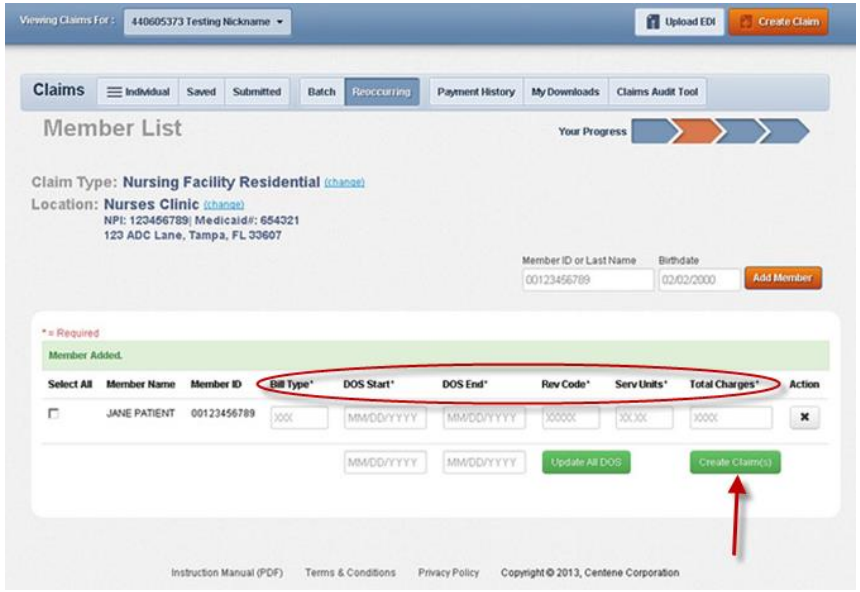
Delete

Create Recurring UB-04 Claims



- Once members are added, you'll be alerted with a members Added remark at the top of the list.
- Members are listed in alphabetic order by last name.
- If you can't find a member, check that the ID and birthdate were entered correctly.

Create Recurring UB-04 Claims



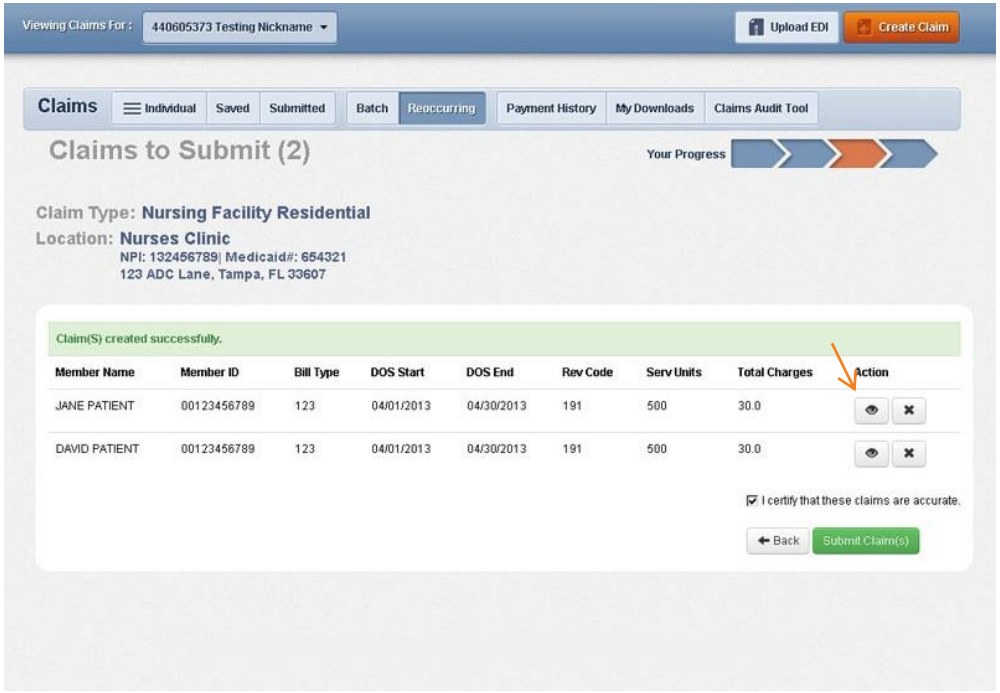
Create claim(s) by selecting the appropriate member(s) from Member List.

For each member selected enter the:

- Bill Type
- First date of service (DOS Start)
- Last date of service (DOS End)
- Rev Code (Revenue Code)
- Serv Units (days or service units)
  - Note: Serv Units must match the total number of days
- Total Charges

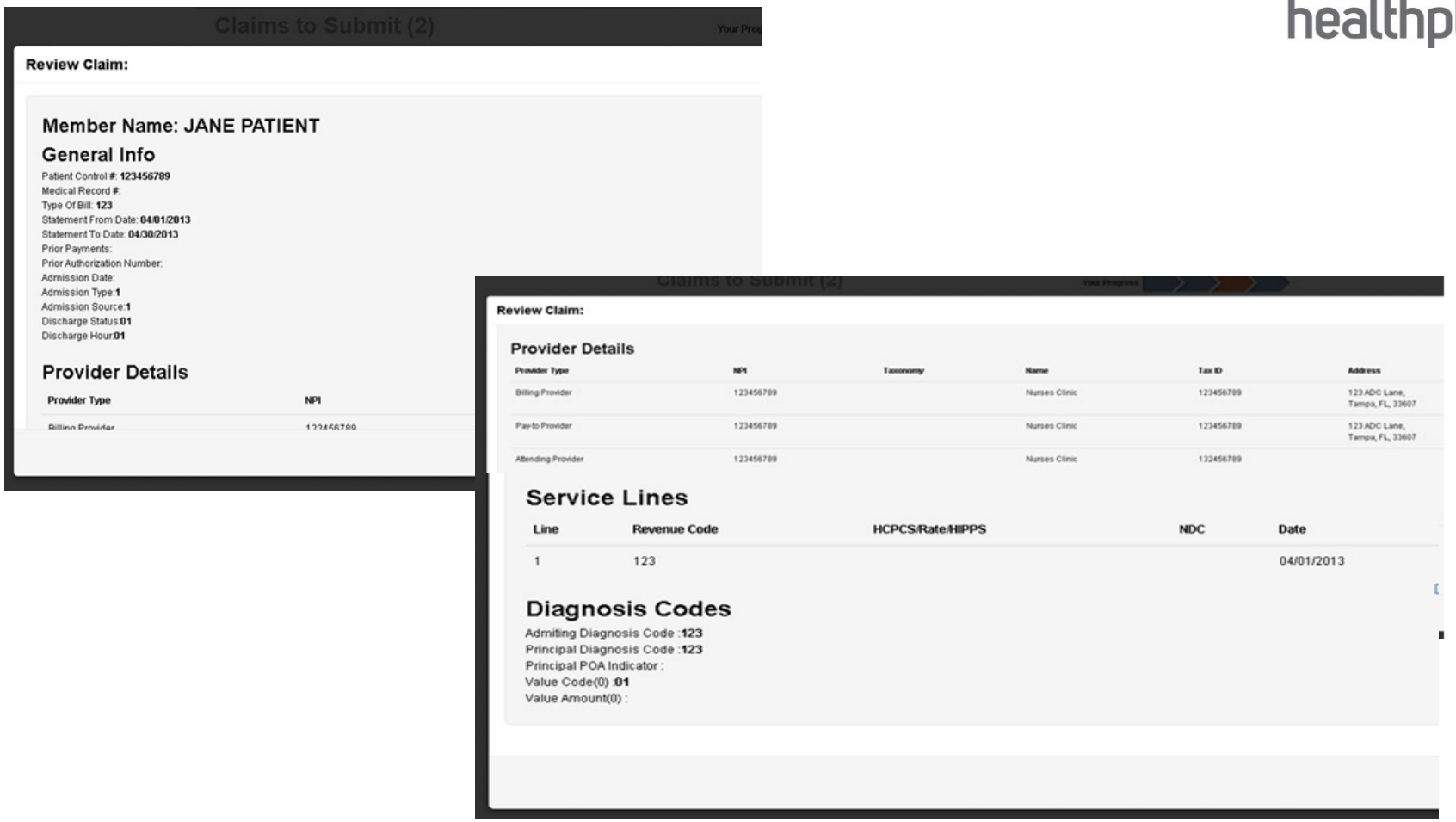
After entering all the required information, click Create Claim(s). Click on X under Action to delete the claim.

Create Recurring UB-04 Claims

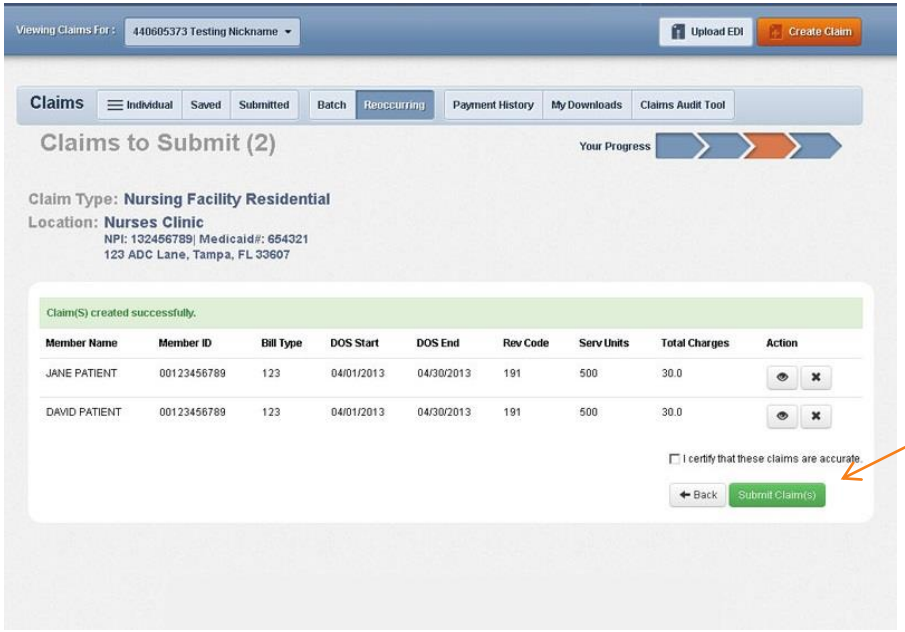


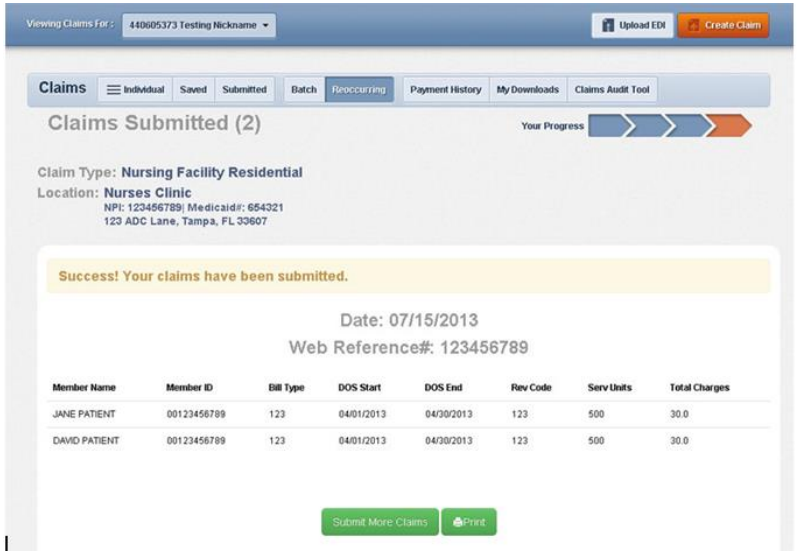
- You can review claims prior to submitting.
- To review click on the eye. You can review the claim or change some of the fields pre-coded for you. Some fields may not allow you to edit. If those fields need to be changed you will need to delete the claim and start over.
- You can click on the X to delete claim.

Create Recurring UB-04 Claims



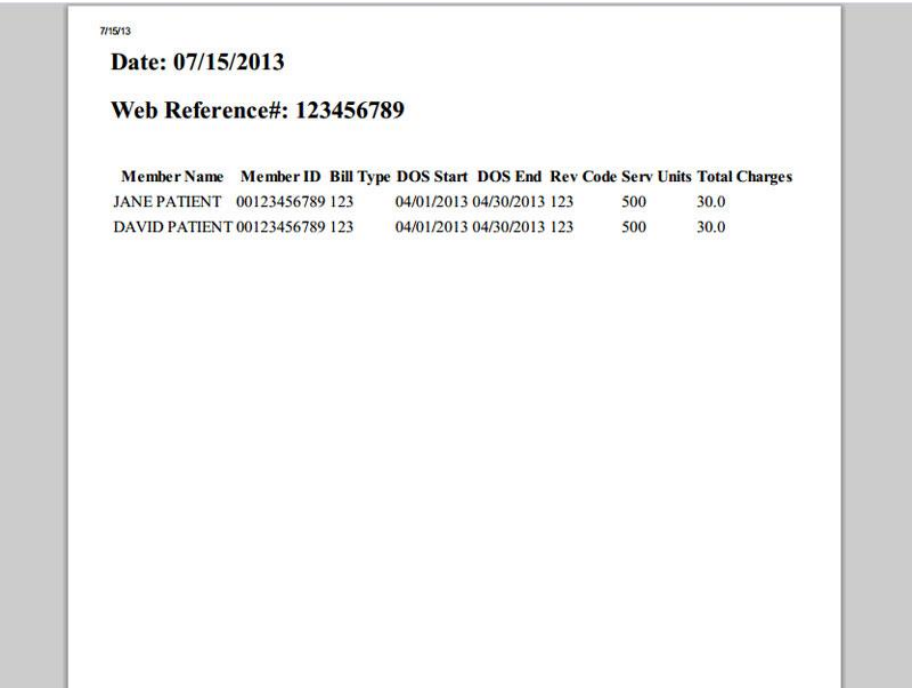
Create Recurring UB-04 Claims





After all the claims have been reviewed for accuracy, select “I certify that these claims are accurate” and click Submit Claims.

Create Recurring UB-04 Claims



7/15/13

Date: 07/15/2013

Web Reference#: 123456789

Member Name	Member ID	Bill Type	DOS Start	DOS End	Rev Code	Serv Units	Total Charges
JANE PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0
DAVID PATIENT	00123456789	123	04/01/2013	04/30/2013	123	500	30.0

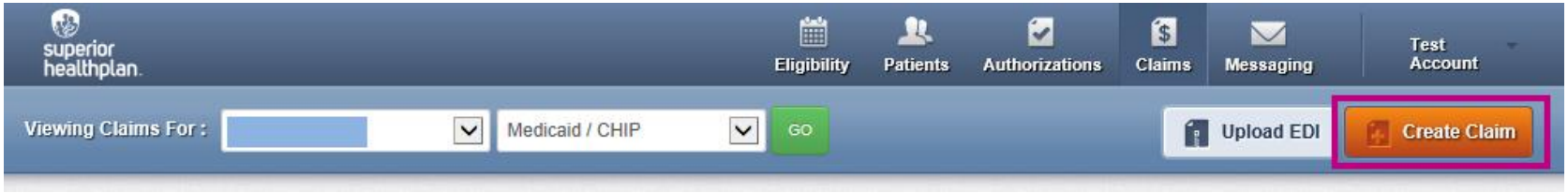
- Click Print to print a copy of the claims submitted including the Web Reference#.
- Click Submit More Claims to request a new template or move on to other functions.

Create Professional Claims

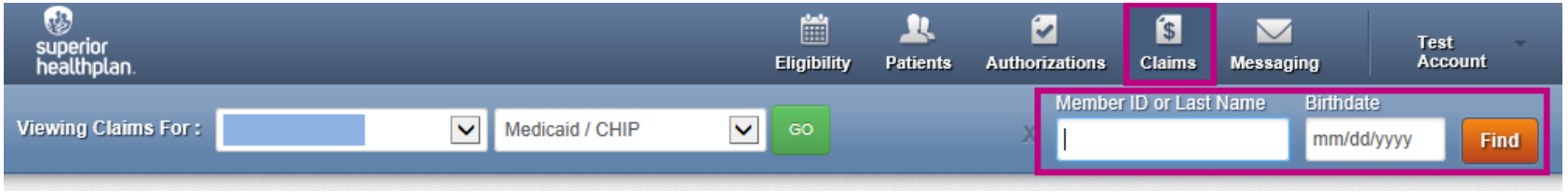
From the navigation menu select:

Claims at the top of the landing page

Then select Create Claim



Create Professional Claims

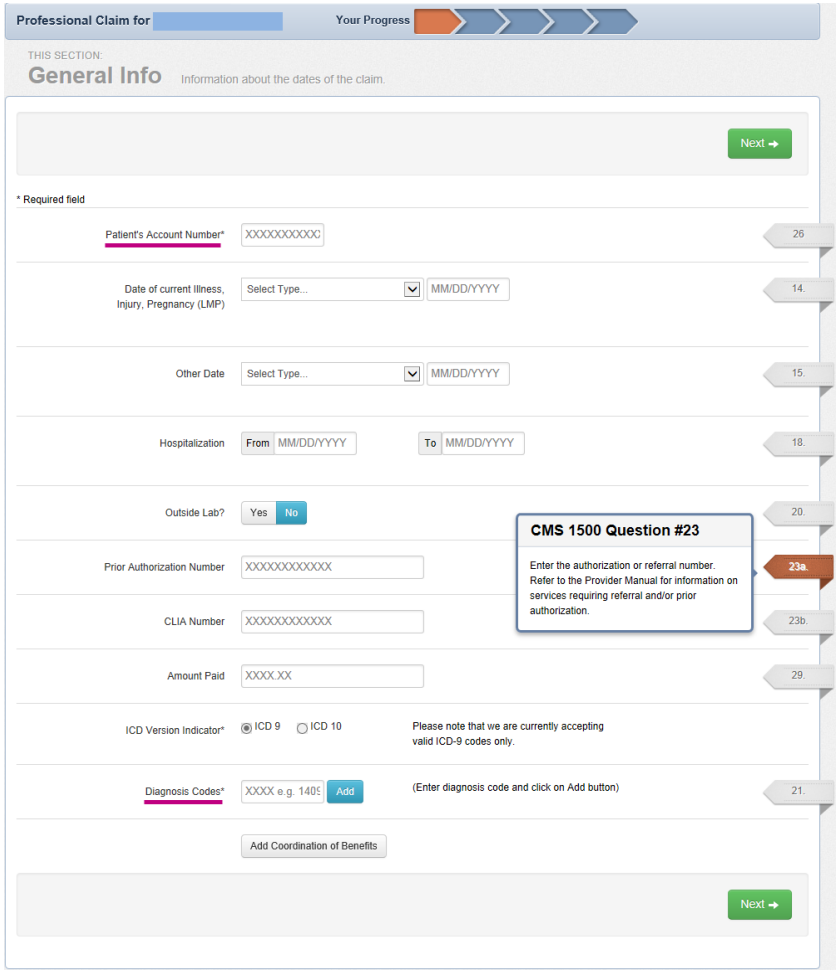


- Enter the **member's Medicaid ID** or **Last Name** and **Birthdate**
- Click the **Find** button

Create Professional Claims

- Choose a Claim Type
- Select **Professional Claim**

General Information



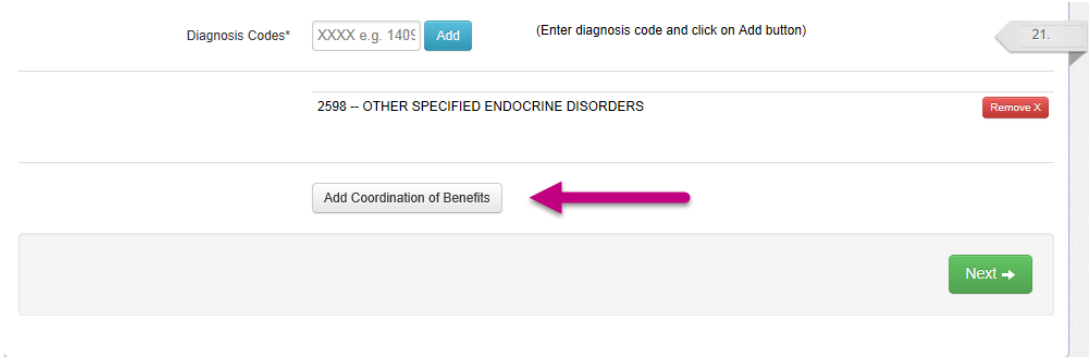
Required Fields:

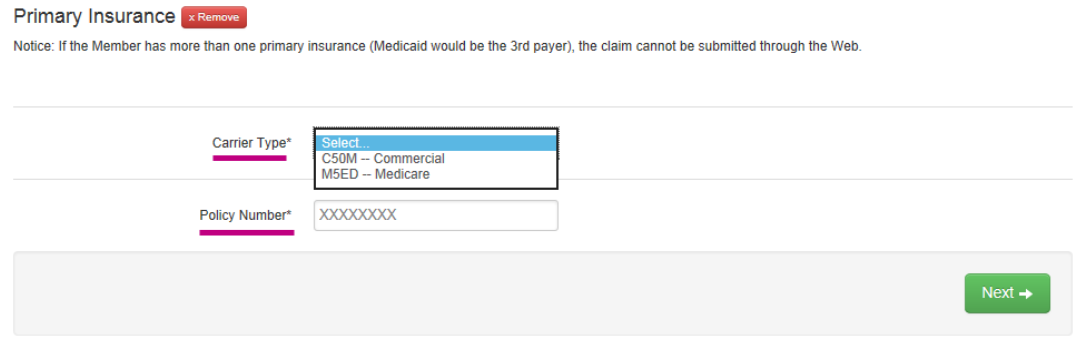
- ✓ **Patient Account Number**
- ✓ **Diagnosis Codes**

Enter other pertinent information for the claim as necessary.

Use any of the field tabs to get details for what information should be entered.

Coordination of Benefits



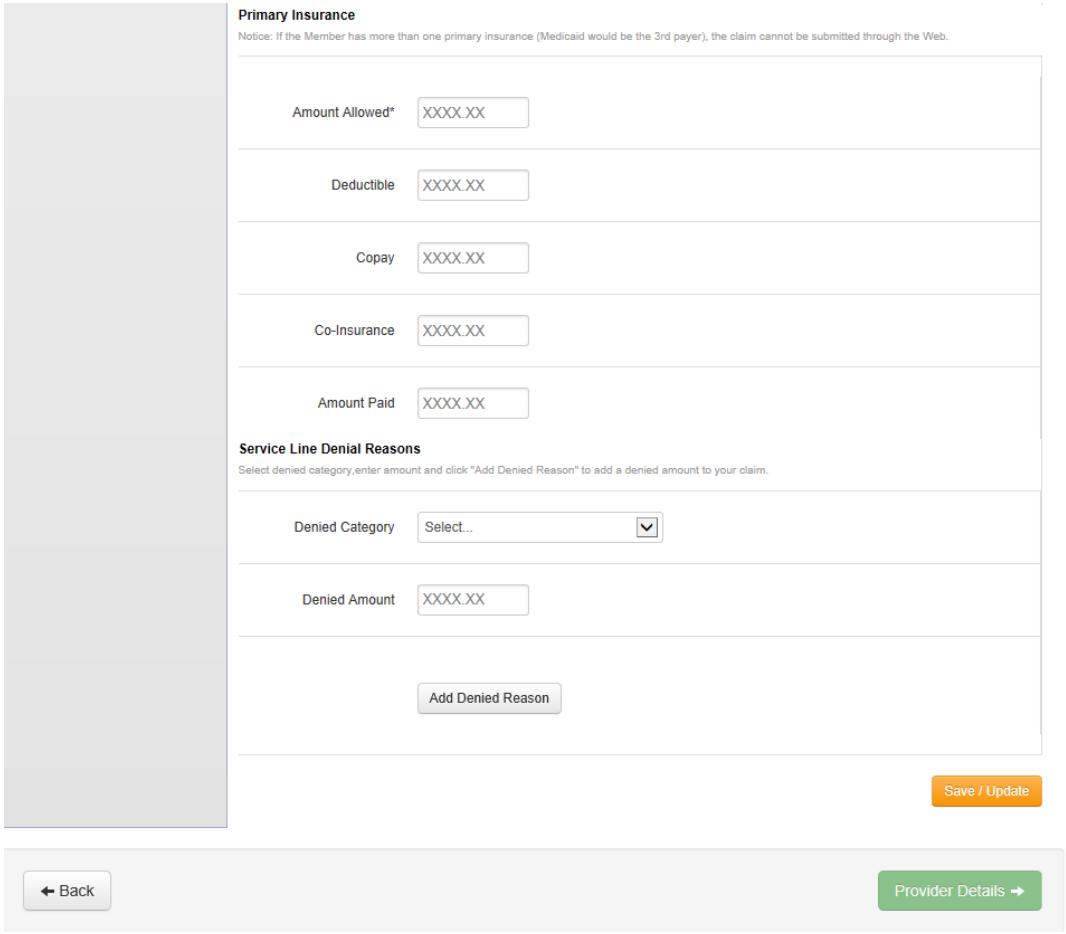


Use the **Add Coordination of Benefits** button to include primary insurance information when applicable.

New fields will appear to enter the **Carrier Type** and the **Primary Insurance Policy Number**.

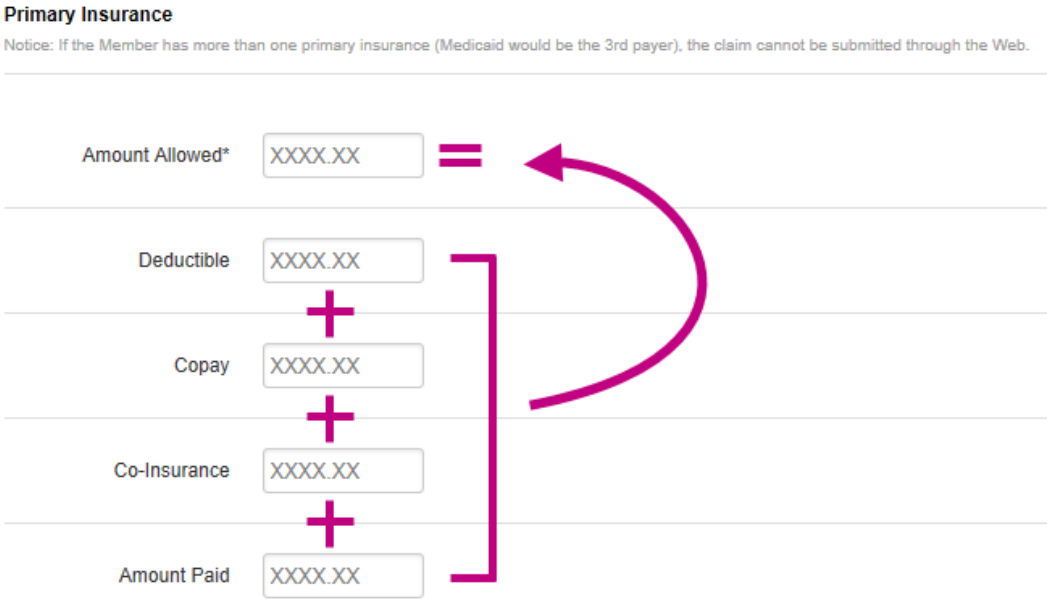
If the member has more than one primary insurance (Medicaid would be the 3rd payer) the claim cannot be submitted via the Web

Coordination of Benefits



The **Primary Insurance** and **Service Line Denial Reasons** fields will be present when Coordination of Benefits is selected at step one. Complete based on the primary insurance EOP.

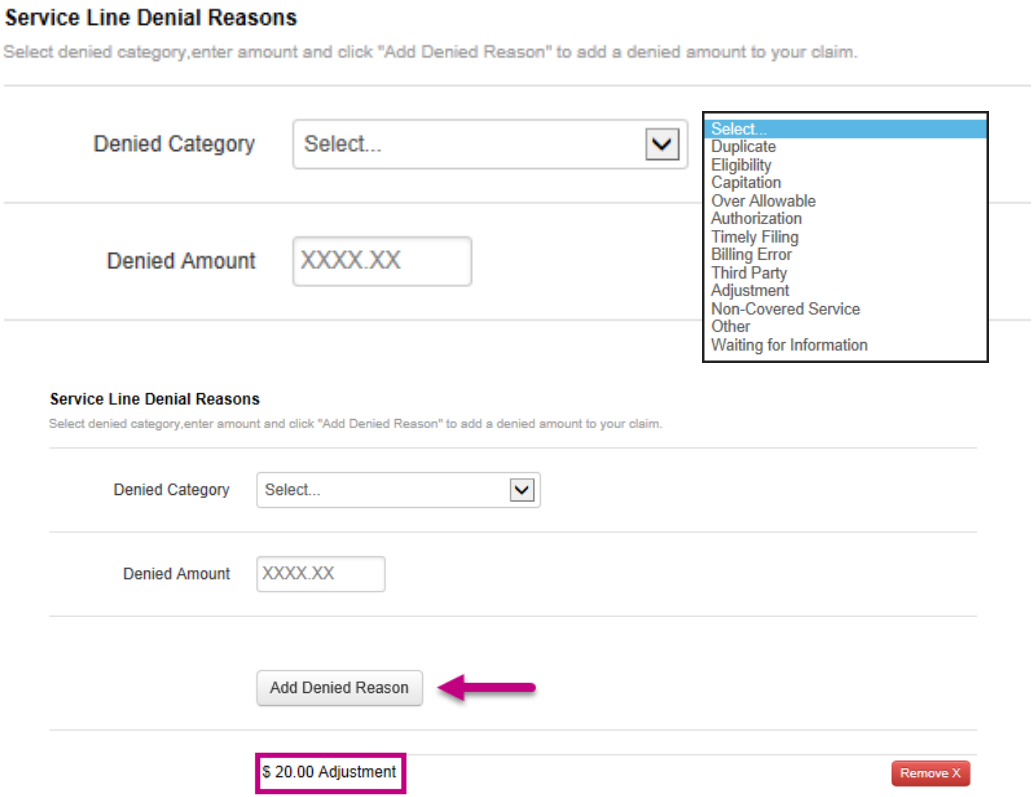
Coordination of Benefits



The **Primary Insurance** fields perform a calculation to help ensure accuracy when billing.

Deductible + Copay + Co-Insurance + Amount Paid = Amount Allowable

Coordination of Benefits

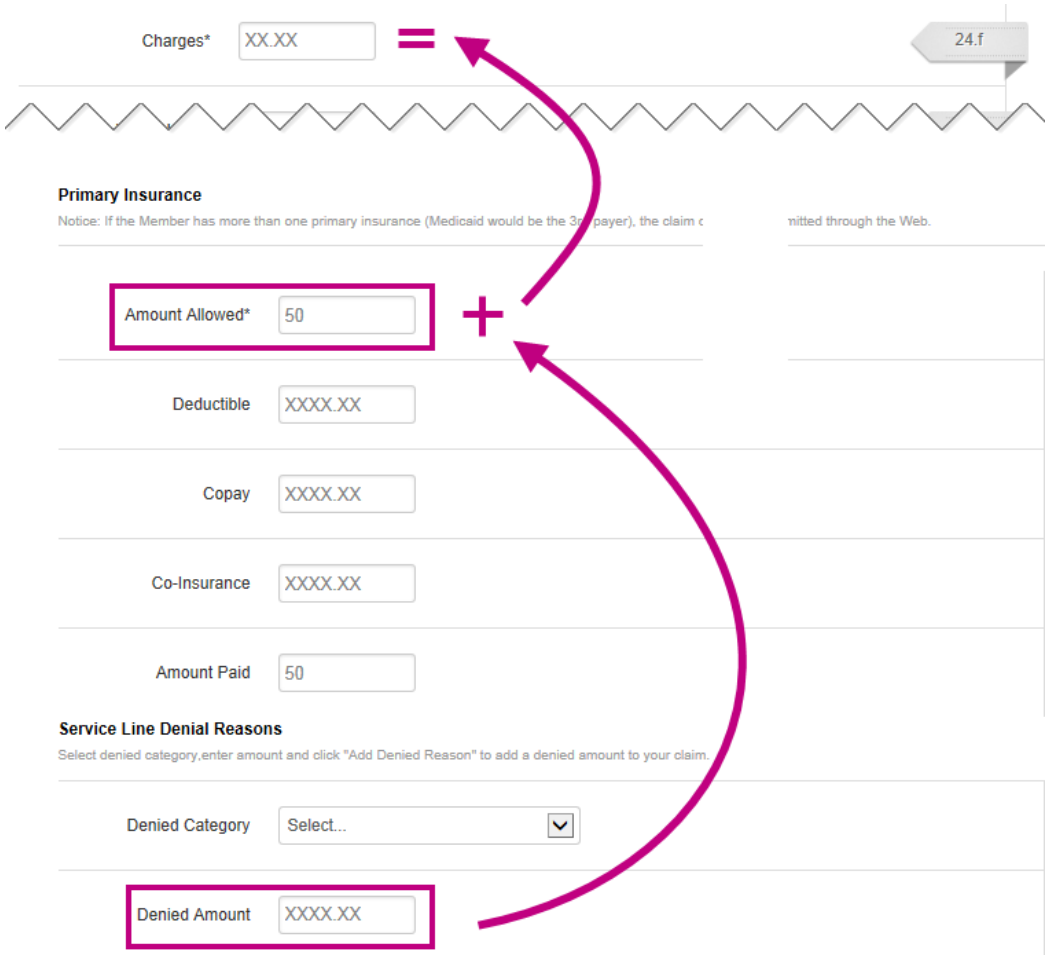


Service Line Denial Reasons are used to indicate instances where the **Amount Allowed** is less than the **Charges**. These can be indicated using the drop down menu and entering the denied amount.

Add Denied Reason must be clicked to include the **Denied Category** and **Denied Amount**.

A new line will be created when the **Denied Category** has been successfully added to the service line.

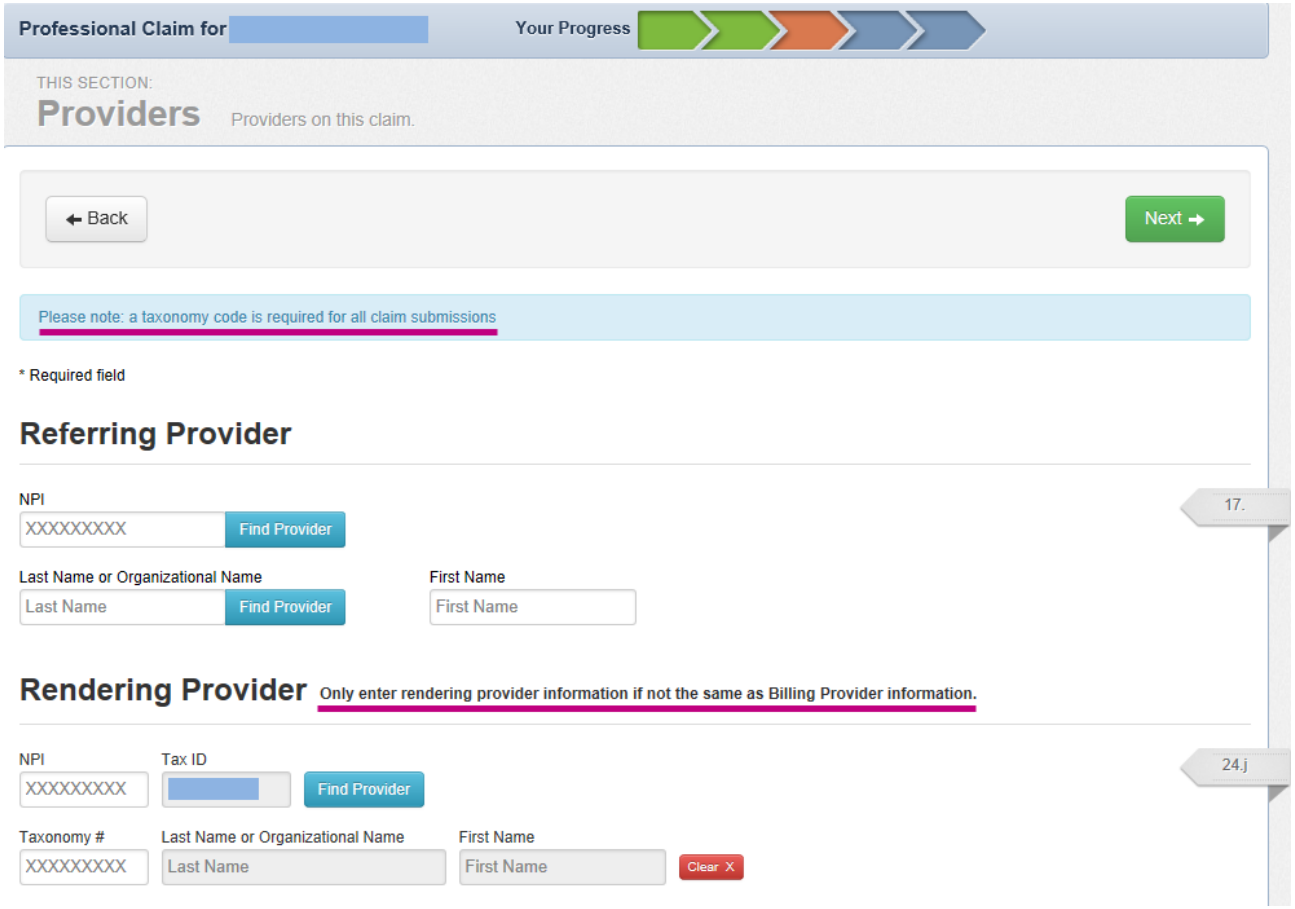
Coordination of Benefits



Final Calculations: Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

Denied Category** and **Denied Amount** are not required and can be left blank when appropriate

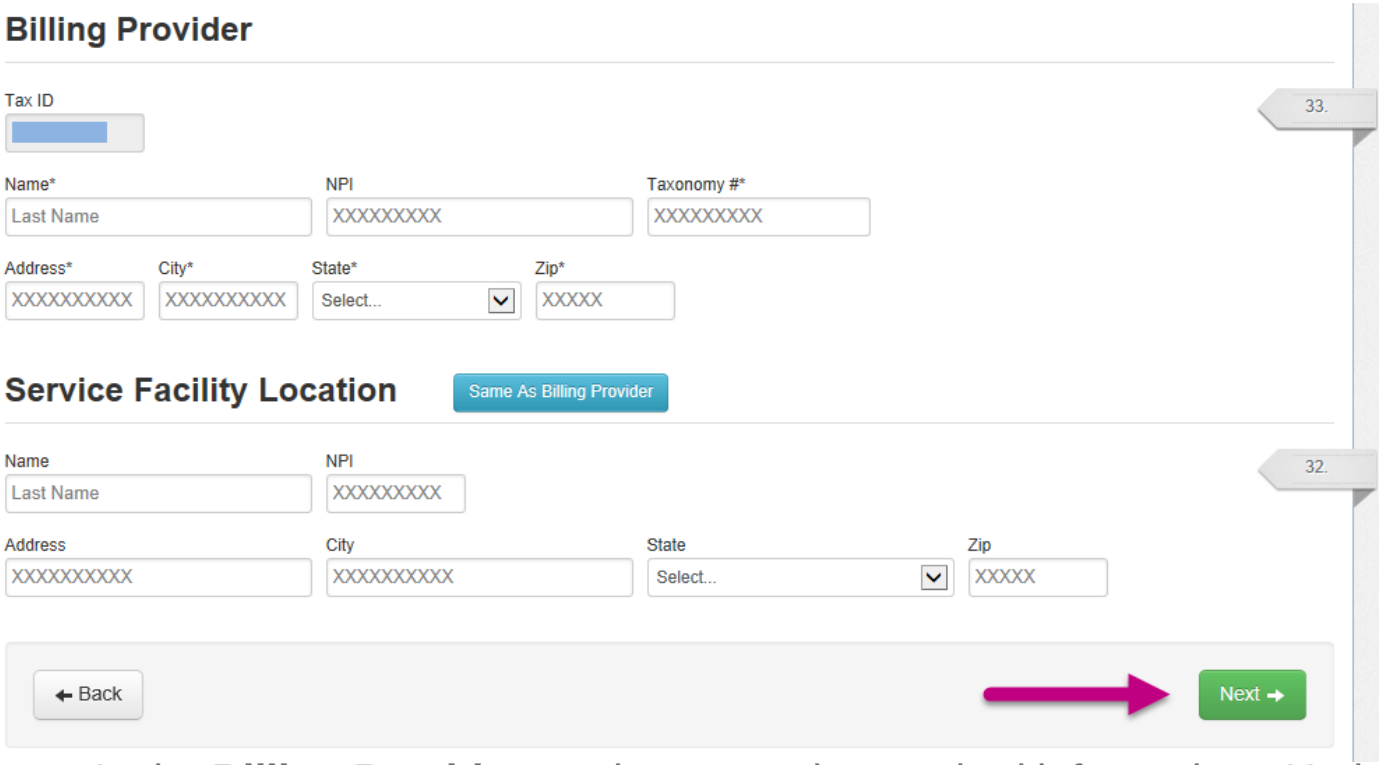
Referring and Rendering Provider



Enter pertinent provider information for **Referring** and **Rendering Provider**.

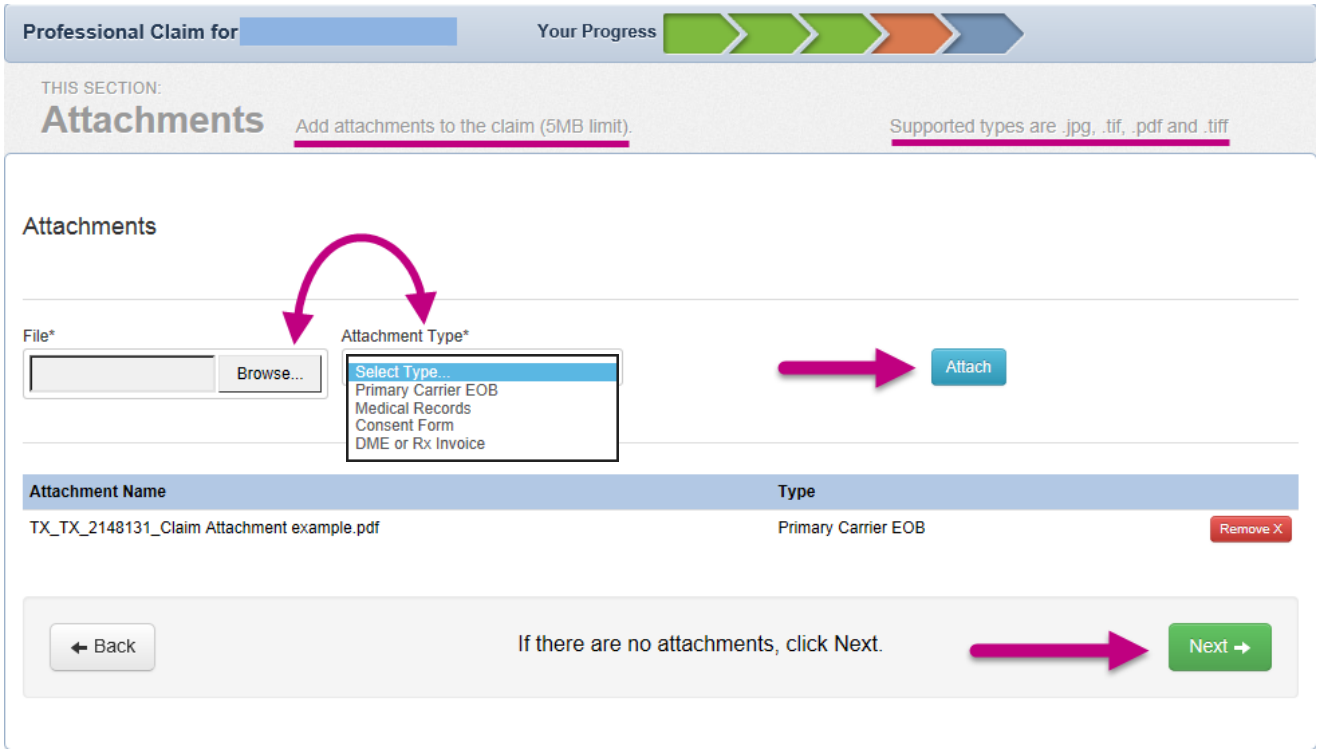
Only enter **Rendering Provider** information if it is not the same as **Billing Provider** information

Billing Provider Section



- In the **Billing Provider** section, enter the required information. Under Service Facility Location, enter the necessary information or click **Same as Billing Provider** to automatically copy the billing provider information into the service facility fields.

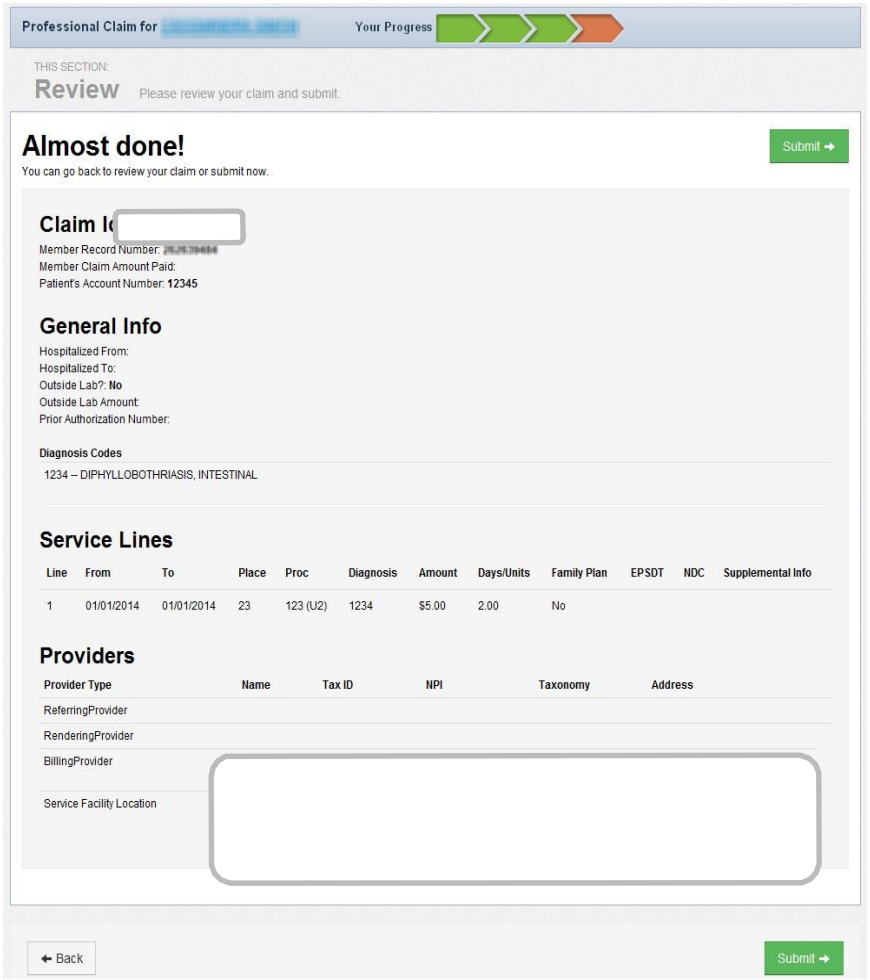
Attachments



There is an attachment upload limit of 5MB

Add attachments, if applicable. **Browse** for the document, select an **Attachment Type**, and then **Attach**. If there are no attachments, click **Next**.

Review & Submit



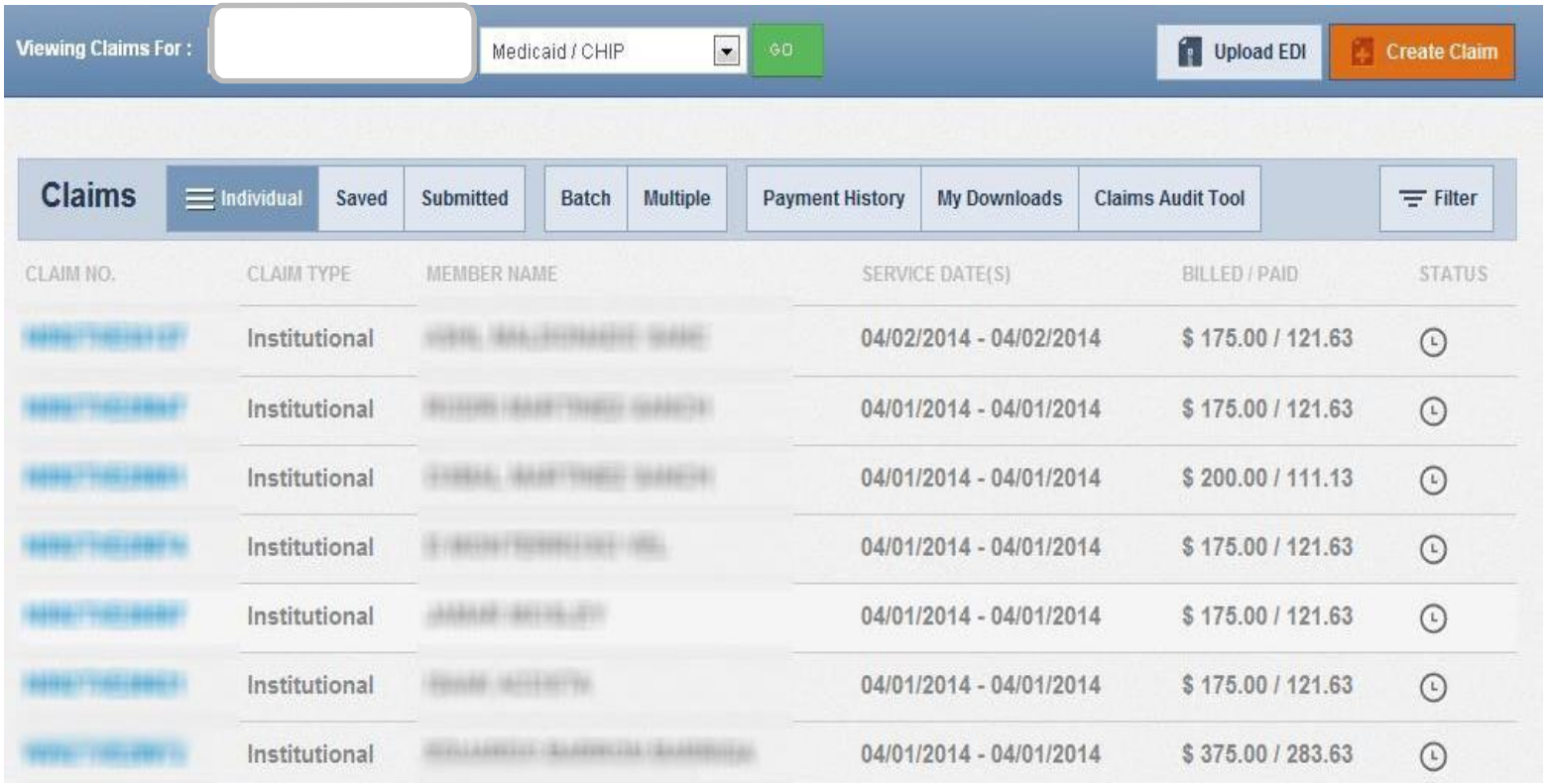
Review to ensure that all information is correct.

- If information is incorrect, click **Previous Step** to move to the section that needs changes and change the information within the section
- If all information is correct, click **Submit Claim** and the claim will be transmitted. A "Claim Submitted" confirmation will be displayed

Claim Submitted Successfully!

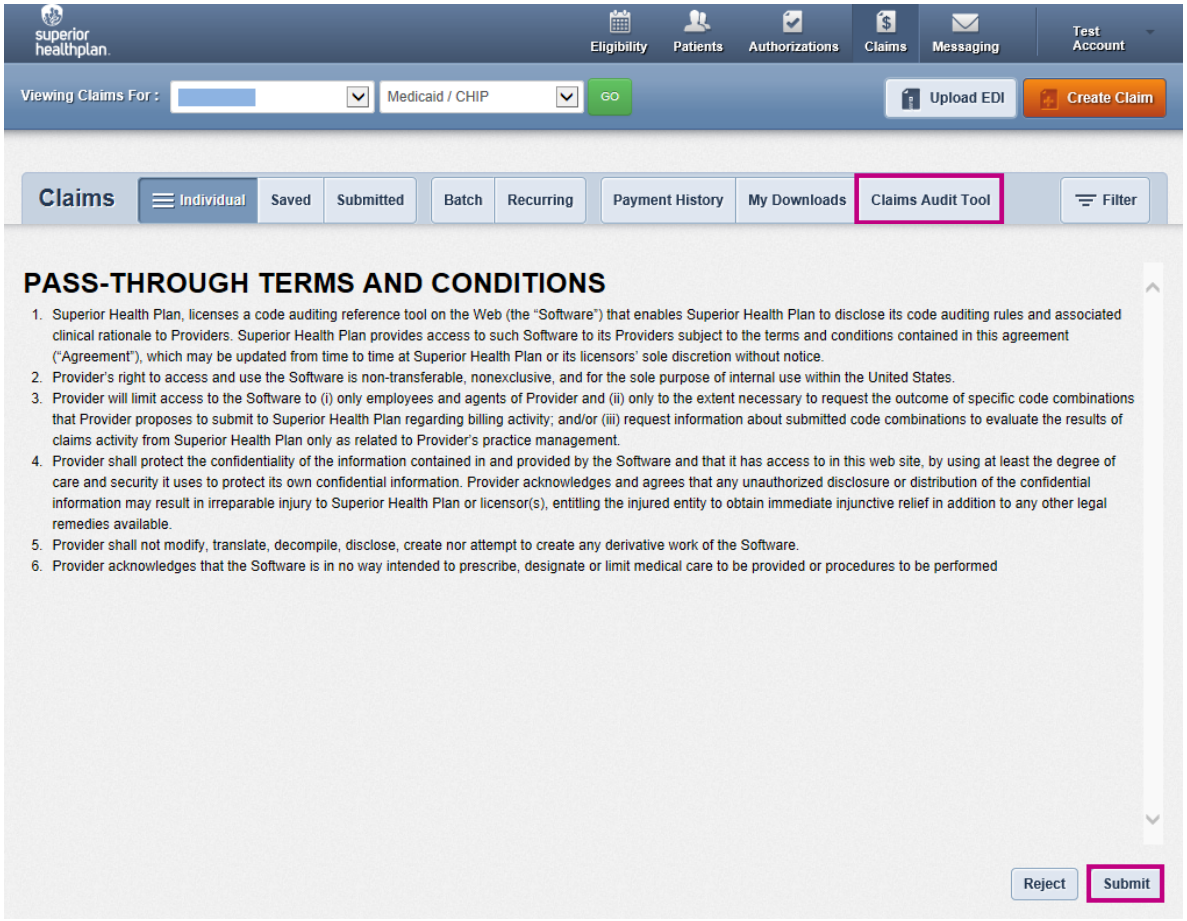
Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Provider Services Representative.

Checking Claim Status



Claims status could be viewed on claims that have been sent EDI, Paper or Web portal

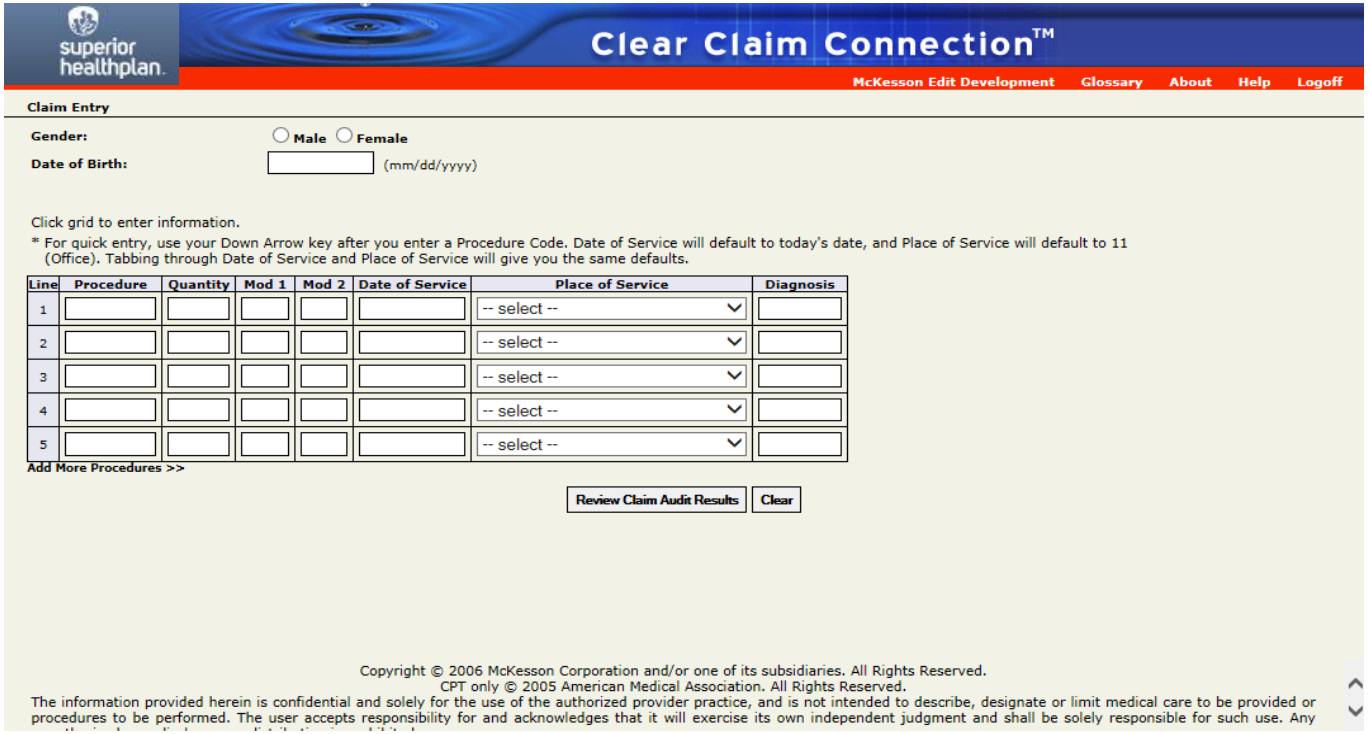
Claims Audit Tool



Select the **Claims Audit Tool**.

Click **Submit** to enter the **Clear Claim Connection** page.

Claims Audit Tool



Test claim coding by entering core information to be audited before submitting the live claim.

QUESTIONS?

Let us know what we can do to help.

Thank you for attending!