SuperiorHealthPlan.com

2016 Provider and Billing Manual
A Medicare Advantage Program
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INTRODUCTION

Welcome to Superior HealthPlan Advantage. Thank you for participating in our network of participating physicians, hospitals and other healthcare professionals.

This Provider Manual is a reference guide for providers and their staff providing services to members who participate in our Medicare Advantage Special Needs Program, Superior HealthPlan Advantage. In addition to the Provider Manual, Superior HealthPlan provides additional reference materials and policy updates on its website at www.SuperiorHealthPlan.com.

OVERVIEW

Superior HealthPlan Advantage is a licensed Health Maintenance Organization (HMO) contracted with the Centers for Medicare and Medicaid Services (CMS) to provide medical and behavioral health services to members who have both Medicare and Medicaid also known as dual-eligible.

Superior HealthPlan Advantage is designed to achieve four main objectives:

- Full partnership between the member, their physician and their Superior HealthPlan Advantage Case Manager;
- Integrated case management (medical, social, behavioral health, and pharmacy);
- Improved provider and member satisfaction; and
- Quality of life and healthy outcomes.

All of our programs, policies, and procedures are designed with these objectives in mind. These objectives mirror and support the objective of CMS and State guidelines to provide covered healthcare services to low-income, elderly and physically disabled members.

Superior HealthPlan Advantage takes the privacy and confidentiality of our member’s health information seriously. We have processes, policies, and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and CMS regulations. The services provided by the contracted Superior HealthPlan Advantage network providers are a critical component in terms of meeting the objectives above. Our goal is to reinforce the relationship between our members and their primary care physician (PCP). We want our members to benefit from their PCP having the opportunity to deliver high quality care using contracted hospitals and specialists. The PCP is responsible for coordinating our member’s health services, maintaining a complete medical record for each member under their care, and ensuring continuity of care. The PCP advises the Member about their health status, medical treatment options, which include the benefits, consequences of treatment or non-treatment, and the associated risks. Members are expected to share their preferences about current and future treatment decisions with their PCP.

Superior HealthPlan Advantage appreciates your partnership in achieving these objectives.
KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following table includes several important telephone and fax numbers available to providers and their office staff. When calling, it is helpful to have the following information available.

1. The provider’s National Provider Identifier (NPI) number.
2. The practice Tax Identification (ID) Number.
3. The member’s ID number.

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<tr>
<td>Superior HealthPlan</td>
<td>1-877-391-5921</td>
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<th>Department</th>
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<td>Provider Services</td>
<td>1-877-391-5921</td>
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<tr>
<td>Member Services</td>
<td>1-877-935-8023</td>
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<tr>
<td>Medical Management Inpatient</td>
<td>1-800-218-7508</td>
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<td>and Outpatient Prior Authorization</td>
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<tr>
<td>Concurrent Review/Clinical Information</td>
<td>1-800-218-7508</td>
<td>1-877-258-6960</td>
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<td>Admission/Census Reports/Facesheets</td>
<td>1-800-218-7508</td>
<td>1-877-258-6960</td>
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<td>Care Management</td>
<td>1-866-615-9399 ext. 42352</td>
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<td>Behavioral Health Prior Authorization</td>
<td>1-800-466-4089</td>
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<td>24/7 Nurse Advice Line</td>
<td>1-855-696-2515</td>
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<td>Argus Pharmacy Services Claims</td>
<td>1-877-935-8021</td>
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<td>U.S. Script (Prescribers)</td>
<td>1-866-399-0928</td>
<td>1-877-941-0480</td>
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<td>NIA</td>
<td>1-800-642-7554</td>
<td></td>
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<td>AECC Total Vision Health Plan of Texas, Inc. (vision)</td>
<td>1-888-756-8768</td>
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<td>Interpreter Services</td>
<td>1-877-935-8023</td>
<td></td>
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<td>To report suspected fraud, waste and abuse</td>
<td>1-866-685-8664</td>
<td></td>
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<td>EDI Claims Assistance</td>
<td>1-800-225-2573 ext. 6075525</td>
<td>e-mail: <a href="mailto:EDIBA@centene.com">EDIBA@centene.com</a></td>
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ENROLLMENT

Superior HealthPlan Advantage is a Medicare Advantage Special Needs Plan (SNP), which means its benefits are designed for people with special health care needs. SNP works to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. Superior HealthPlan Advantage plan is designed specifically for dual eligible members, who have Medicare and who are entitled to assistance from Medicaid.

Dual eligible Superior HealthPlan Advantage members are permitted to enroll or disenroll on a monthly basis. Any changes will be effective the first (1st) day of the month following the request for change.

MEDICARE REGULATORY REQUIREMENTS

As a Medicare contracted provider, you are required to follow a number of Medicare regulations and CMS requirements. Some of these requirements are found in your Provider Agreement while others have been described throughout this manual. A general list of the requirements can be reviewed below:

- Providers may not discriminate against Medicare members in any way based on the health status of the member.
- Providers must ensure that members have adequate access to covered health services.
- Providers may not impose cost sharing on members for influenza vaccinations or pneumococcal vaccinations.
- Providers must allow members to directly access mammography screening and influenza vaccinations.
- Providers must provide female members with direct access to women’s health specialists for routine and preventive healthcare.
- Providers must comply with Plan processes to identify, access, and establish treatment for complex and serious medical conditions.
- Superior HealthPlan Advantage will provide you with at least sixty (60) days written notice of termination if electing to terminate our agreement without cause, or as described in you Participation Agreement if greater than sixty (60) days. Providers agree to notify Superior HealthPlan Advantage according to the terms outlined in the Participation Agreement.
- Providers will ensure that their hours of operation are convenient to the member and do not discriminate against the member for any reason. Providers will ensure necessary services are available to members twenty-four (24) hours a day, seven (7) days a week and provide backup coverage during their absence.
- Marketing materials must adhere to CMS guidelines and regulations and cannot be distributed to Superior HealthPlan Advantage members without CMS approvals of the materials and forms.
- Services must be provided to members in a culturally competent manner, including members with limited reading skills, limited English proficiency, hearing or vision impairments and diverse cultural and ethnic backgrounds.
- Providers will work with Superior HealthPlan Advantage procedures to inform our members of healthcare needs that require follow-up and provide necessary training in self-care management.
- Providers will document in a prominent part of the member’s medical record whether the member has executed an Advance Directive.
• Providers must provide services in a manner consistent with professionally recognized standards of care.
• Providers must cooperate with Superior HealthPlan Advantage to disclose to CMS all information necessary to evaluate and administer the program, and all information CMS may need to permit members to make an informed choice about their Medicare health insurance coverage.
• Providers must cooperate with Superior HealthPlan Advantage in notifying members of provider contract terminations.
• Providers must cooperate with the activities of any CMS approved independent quality review or improvement organization.
• Providers must comply with any Superior HealthPlan Advantage medical policies, Quality Improvement (QI) programs and medical management procedures.
• Providers will cooperate with Superior HealthPlan Advantage in disclosing quality and performance indicators to CMS.
• Providers must cooperate with Superior HealthPlan Advantage procedures for handling grievances, appeals, and expedited appeals.
• Before providing a service, providers must fully disclose to all members services not covered by Superior HealthPlan Advantage. The member must sign an agreement of this understanding. If the member does not, the claim may be denied and the provider will be liable for the cost of the service.
• Providers must allow CMS or its designee access to records related to Superior HealthPlan Advantage services for a period of ten (10) years following termination of this agreement.
• Provider must comply with all CMS requirements regarding the accuracy and confidentiality of medical records.
• Provider shall provide services in accordance with Superior HealthPlan Advantage policy: (a) to all members, for the duration of the Superior HealthPlan Advantage contract period with CMS, and (b) to members who are hospitalized on the date the CMS contract with Superior HealthPlan Advantage terminates or in the event of an insolvency through discharge.
• Provider shall disclose to Advantage all offshore contractor information with an attestation for each such offshore contractor in a format required or permitted by CMS.

SECURE WEB PORTAL

Superior HealthPlan Advantage offers a robust Secure Web Portal with functionality that will be critical to serving members and to ease administration for the Superior HealthPlan Advantage product for providers. Each participating provider’s dedicated Provider Relations Specialist will be able to assist and provide education regarding this functionality. The Portal can be accessed at www.SuperiorHealthPlan.com.

Functionality

All users of the Secure Web Portal must complete a registration process. If you are already a registered user on the Superior HealthPlan Provider Portal, a separate registration is not needed.

Once registered, providers may:

• Verify eligibility.
• View the specific benefits for a member.
• View benefit details including member cost share amounts for medical, Pharmacy, dental, and vision services.

• View demographic information for the providers associated with the registered TIN such as: office location, office hours and associated providers.

• Update demographic information such as address, office hours, etc.

• View and print patient lists. This patient list will indicate the member’s name, member ID number, date of birth and the product in which they are enrolled.

• Submit authorizations and view the status of authorizations that have been submitted for members.

• View claims and the claim status.

• Submit individual claims, batch claims or batch claims via an 837 file.

• View and download Explanations of Payment (EOP).

• View a member’s health record including physician, outpatient hospital, and therapy visits, medications and immunizations.

• View gaps in care specific to a Member including preventive care or services needed for chronic conditions.

• Send secure messages to Superior HealthPlan Advantage staff.

PROVIDER ADMINISTRATION AND ROLE OF THE PROVIDER

Credentialing and Re-credentialing

The credentialing and re-credentialing process exists to verify that participating providers meet the criteria established by Superior HealthPlan Advantage as well as applicable government regulations and standards of accrediting agencies.

If a provider already participates with Superior HealthPlan in the Medicaid product, the provider will not be separately credentialed for the Advantage product.

Note: In order to maintain a current provider profile, practitioners/providers are required to notify Superior HealthPlan Advantage of any relevant changes to their credentialing information in a timely manner but no later than ten (10) days from the date of the change.

Whether a State utilizes a standardized credentialing form or a provider has registered their credentialing information on the Council for Affordable Quality Health (CAQH) website, the following information must be on file:

• A valid NPI.

• Complete, correct, signed and dated application.

• Attestation of historical loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions.

• Attestation to lack of current substance and/or alcohol abuse.

• Attestation to mental and physical competence to perform the essential duties of the profession.

• Attestation to the correctness/completeness of the application.
• Signed and dated Release of Information form.

• Current unrestricted license in the state where the practice is located.

• Current valid and applicable Federal Drug Enforcement Administration (DEA) certificate and State Department of Public Safety (DPS) certificate.

• Current liability insurance in compliance with minimum limits set by Superior HealthPlan’s Provider Agreement.

• Proof of highest level of education. For physicians, proof of graduation from an accredited medical school or school of osteopathy, proof of completion of an accredited residency program, or proof of Board Certification. *Note: Verification of completion of a fellowship does not meet this requirement.*

• Current admitting privileges in good standing at an in-network/inpatient facility or written documentation from a physician/group of physicians, who participate with Superior HealthPlan Advantage, stating that they will assume the inpatient care of all of the provider’s plan members who require admission and that they will do so at a participating facility.

• If a provider is a foreign medical graduate, then an Education Certificate Foreign Medical Graduate (ECFMG) certification or equivalent is required.

• History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the provider for the past five (5) years or any cases that are pending professional liability actions. When reviewing this history, the Credentials Committee will consider the frequency of case(s) as well as the outcome of the case(s).

• Disclosure of ownership or financial interest statement.

• Work history for the previous five (5) years. Any gap greater than six (6) months must be explained by the provider to the Credentials Committee for approval.

• Sign and date the Attestation Form within one hundred and eighty (180) days prior to credentialing decision and Texas Department of Insurance’s credentialing application timeframe.

• Contains primary or secondary source verification information that is active upon the credentialing decision.

• Contains information that the provider has been excluded from participating in the Medicare/Medicaid program.

• A current Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable.

Superior HealthPlan Advantage will verify the following information submitted for credentialing and re-credentialing through primary sources:

• License through appropriate licensing agency.

• Board certification, or residency training, or professional education, where applicable

• Malpractice claims and license agency actions through the National Practitioner Data Bank (NPDB).

• Hospital privileges in good standing or alternate admitting arrangements, where applicable.

• Federal sanction activity including Medicare/Medicaid services (Office of Inspector General (OIG)).

*Note: For providers, hospitals and ancillary facilities, a completed Facility/Provider – Initial and Re-credentialing Application and all supporting documentation as identified in the application must be received with the signed, completed application.*
Once the application is completed, the Credentialing Committee will usually render a decision on acceptance following its next regularly scheduled meeting.

Providers must be credentialed prior to accepting or treating members. Primary care providers cannot accept member assignments until they are fully credentialed.

**Credentials Committee**

The Credentials Committee, including the Medical Director or his/her physician designee, has the responsibility to establish and adopt necessary criteria for participation, termination and direction of the credentialing procedures, including participation, denial, and termination. Committee meetings are held at least monthly and more often as deemed necessary.

*Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site reviews are performed at provider offices and facilities when the member complaint threshold of two (2) complaints in six (6) months is met. A site review evaluates:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Adequacy of medical/treatment record keeping

**Re-credentialing**

Superior HealthPlan Advantage conducts provider re-credentialing at least every thirty-six (36) months from the date of the initial credentialing decision and most recent re-credentialing decision. The purpose of this process is to identify any changes in the provider’s licensure, sanctions, certification, competence, or health status which may affect the provider’s ability to perform services under the contract. This process includes all providers, facilities and ancillary providers previously credentialed and currently participating in the network.

In between credentialing cycles, Superior HealthPlan Advantage conducts provider performance monitoring activities on all network providers. This monthly inquiry is designed to monitor any new adverse actions taken by regulatory bodies against providers in between credentialing cycles. Additionally, Superior HealthPlan Advantage reviews monthly reports released by the Office of Inspector General to identify any network providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid.

A provider’s agreement may be terminated if at any time it is determined by the Superior HealthPlan Advantage Credentials Committee that credentialing requirements or standards are no longer being met.

**Practitioner Right to Review and Correct Information**

All providers participating within the network have the right to review information obtained by Superior HealthPlan Advantage to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank, CAQH, malpractice insurance carriers and State licensing
agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to correct any erroneous information submitted by another party such as information received from other references, personal recommendations, or that is peer review protected. In the event the provider believes any of the information used in the credentialing or re-credentialing process is erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by the provider, then the provider may submit a request to the Credentialing Department to request a release of what was submitted. Upon receipt of this information, the provider will have thirty (30) days from the initial notification to provide a written explanation detailing the error or the difference in information to the Credentials Committee. The Credentials Committee will then include this information as part of the credentialing or re-credentialing process.

**Practitioner Right to Be Informed of Application Status**

All providers who have submitted an application to join have the right to be informed of the status of their application upon request. To obtain application status, the provider should contact the Provider Services Department at 1-800-218-7453.

**Practitioner Right to Appeal Adverse Re-credentialing Determinations**

Applicants who are existing providers and who are declined continued participation due to adverse re-credentialing determinations (for reasons such as appropriateness of care or liability claims issues have the right to request an appeal of the decision. Requests for an appeal must be made in writing within thirty (30) days of the date of the notice.

New applicants who are declined participation may request a reconsideration within thirty (30) days from the date of the notice. All written requests should include additional supporting documentation in favor of the applicant’s appeal or reconsideration for participation in the network. Reconsiderations will be reviewed by the Credentials Committee at the next regularly scheduled meeting and/or no later than sixty (60) days form the receipt of the additional documentation.

**PROVIDER RELATIONS**

**Primary Care Providers**

The Primary Care Provider (PCP) is the cornerstone of Superior HealthPlan Advantage’s delivery model. The 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. The PCP is responsible for providing all primary care services for Superior HealthPlan Advantage’s members including but 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.

Our case managers will partner with the PCP not only to ensure the member receives any necessary care but to also assist the PCP in providing a “medical home” for the patient.

All PCP’s may reserve the right to state the number of patients they are willing to accept into their practice. Since assignment is based on the member’s choice, Superior HealthPlan Advantage does not guarantee a PCP will receive a set number of patients. A PCP must contact their Provider Relations Specialist if they choose to change their panel size or close their panel and only accept established patients. If Superior HealthPlan Advantage determines a PCP fails to maintain quality, accessible care, then Superior HealthPlan Advantage reserves the right to close the PCP panel if necessary and re-assign members to a new PCP.

Specialist as the Primary Care Provider

Members with disabilities, special health care needs, and chronic or complex conditions have the right to designate a specialist as the Primary Care Provider. A specialist may serve as a PCP only under certain circumstances and with approval of a Superior HealthPlan Advantage Provider. In order for a specialist to serve as a PCP, the specialist must:

• Meet Superior requirements for PCP participation, including credentialing; and
• Contract with Superior as a PCP.

All requests for a specialist to serve as a PCP must be submitted to Superior on the Request for Specialist PCP Form. 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; and
• A statement signed by the specialist that he or she is willing to accept responsibility for the coordination of all of the Member’s needs.

Superior HealthPlan Advantage will approve or deny the request for a specialist to serve as a PCP and provide notification of the decision to the Member no later than thirty (30) days after receiving the request. The effective date of the designation of a specialist as a Member’s PCP may be applied retroactively.

If the request is denied, Superior HealthPlan Advantage will provide a written notification to the Member, which will include the reasons for the denial. The Member may file an appeal as a result of the decision to deny the request for their specialist as a PCP. The Member Advocate is available to assist the member with their appeal.

Specialty Care Physicians

The Specialty Care Physician or Specialist agrees to partner with the member’s PCP and Case Manager to deliver care. A key component of the specialist’s responsibility is to maintain ongoing communication with the member’s PCP. Most visits to specialists 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 Superior HealthPlan Advantage. Specialists can elect to limit their practice to established patients only upon request to their Provider Relations Specialist.

Female members can self-refer to an Obstetrics and Gynecologist (OB/GYN) for their annual well-woman checkup or for care related to pregnancy.

Specialty Care Physicians include, but are not limited to:

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

**Hospitals**

Superior HealthPlan Advantage has contracted with several hospitals in multiple counties; however, any facility can be used in the case of an emergency. Superior HealthPlan Advantage also contracts with other facilities such as rehabilitation facilities and ambulatory surgery centers to expand access to our members for emergencies. It is important that our contracted providers have privileges at a contracted facility or have an agreement with a hospitalist group to care for their member when hospitalized. Please see the Provider Directory for a list of contracted hospitals in each county.

**Ancillary Providers**

Ancillary providers cover a wide range of services from therapy services to laboratory. The following is a sample of ancillary providers:

- Durable Medical Equipment
- Hospice Care
- Home Health
- Laboratory
- Prosthetics and Orthotics
• Radiology
• Therapy (Physical, Occupational, Speech)

**APPOINTMENT AVAILABILITY**

The following standards are established regarding appointment availability:

- **Emergency services** must be provided upon the member visit to the service delivery site, including at non-network and out-of-area facilities;
- **Urgent care**, including urgent specialty care, must be provided within twenty-four (24) hours;
- **Non-Urgent** but in need of attention within one (1) week;
- **Routine primary care** must be provided within thirty (30) days;
- **Initial outpatient behavioral health visits** must be provided within fourteen (14) days;
- PCPs must make **referrals for specialty care** on a timely basis, based on the urgency of the member’s medical condition, but no later than three (3) weeks of request;
- **Prenatal care** must be provided within fourteen (14) days, except for high-risk pregnancies within five (5) days, or immediately, if an emergency exists; and
- **Preventive health services for adults** must be offered within ninety (90) days.

*Note: Providers are prohibited from restricting or limiting their office hours for individuals who have Medicaid or Medicare coverage.*

**Telephone Arrangements**

Providers must be accessible to Members twenty-four (24) hours a day, seven (7) days a week.

- **After hours services**
  - Answering services must meet language requirements.
  - Should be able to reach the PCP or other designated medical provider.
  - All calls need to be returned within thirty (30) minutes.

- **Answering Machine**
  - Should be on after business hours.
  - Should direct members to call another number to reach the PCP or other designated medical provider.
  - A live person should be available to answer the designated phone number; another recording is not acceptable.

- **Transferred phone call**
  - Calls can be transferred to another location where a live person will be able to assist and can contact the PCP or another designated medical provider.
  - All calls need to be returned within thirty (30) minutes.

Providers are required to develop and use telephone protocol for all of the following situations:
• Answering the member’s telephone inquiries on a timely basis.
• Prioritizing appointments.
• Scheduling a series of appointments and follow-up appointments as needed by a member.
• Identifying and rescheduling broken and no-show appointments.
• Identifying special member needs while scheduling an appointment, e.g., wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally deficient.
• 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 member’s medical record.

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

Provider Training

Superior HealthPlan Advantage provides training on a wide variety of topics related to Billing to Cultural Competency and Literacy. For additional training topics offered by Superior HealthPlan Advantage, visit www.SuperiorHealthPlan.com under Provider Resources reference Training and Manuals. Superior HealthPlan Advantage training includes training modules that providers can access at their convenience.

Formal Training is offered both locally and via webinar. The Training Calendar, also accessible at www.SuperiorHealthPlan.com, details the type of training, location and RSVP information for each event. Providers can also contact their local Provider Relations Representatives to obtain personalized training on any of the training modules we offer or to help with questions.

Training Requirements

Information on training opportunities will be posted on our website at www.SuperiorHealthPlan.com. The following training courses are required by CMS as well as Superior HealthPlan Advantage.

• Annual Waste, Abuse and Fraud Training within ninety (90) days of contracting and annually thereafter;
• Annual Compliance Training within ninety (90) days of contracting and annually thereafter;
• Annual Model of Care Training within ninety (90) days of contracting and annually thereafter;
• Cultural Competency; and
• Other State Required Training.
SUPERIOR HEALTHPLAN ADVANTAGE BENEFITS

All services are subject to benefit coverage, limitations and exclusions as described in the applicable Superior HealthPlan Advantage coverage guidelines. The table below lists the covered services for members. Note: This is not an exhaustive list and is provided herein for quick reference only. Please visit our Secure Provider Portal at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com) or contact Provider Services at 1-800-218-7453 with any questions you may have regarding benefits.

<table>
<thead>
<tr>
<th>Superior HealthPlan Advantage (HMO SNP)</th>
<th>CY 2015 Brief Benefit Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Premium</td>
<td>$0</td>
</tr>
<tr>
<td>Maximum Out Of Pocket</td>
<td>$3,400</td>
</tr>
<tr>
<td>Includes Part D</td>
<td>Yes – See Below</td>
</tr>
<tr>
<td>Part B Deductible (see below for services that apply to the Part B Deductible)</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient Mental Health Care</td>
<td>$0</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>$0</td>
</tr>
<tr>
<td>Home Health</td>
<td>$0 copay for Medicare-covered home health visits</td>
</tr>
<tr>
<td>Hospice</td>
<td>Must enroll in a Medicare-certified Hospice program. Hospice services and Part A and Part B services related to the terminal condition are paid for by Original Medicare, not Superior HealthPlan Advantage plan. See Evidence Of Coverage for additional details</td>
</tr>
<tr>
<td>Doctor Visits</td>
<td>Primary care provider visit: $0 copay Specialist visit: $0 copay</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>$0 of the cost for each Medicare-covered chiropractic visit</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>$0 of the cost for each Medicare-covered podiatry visit</td>
</tr>
</tbody>
</table>
| Outpatient Mental Health Care, including Partial Hospitalization Program | $0 copay for:  
  - each Medicare-covered individual therapy visit  
  - each Medicare-covered group therapy visit  
  - Medicare-covered partial Hospitalization program services |
| Outpatient Substance Abuse Care        | $0 copay for:  
  - each Medicare-covered individual Substance Abuse Outpatient treatment visit  
  - each Medicare-covered group Substance Abuse Outpatient treatment visit |
## Superior HealthPlan Advantage (HMO SNP)

### CY 2015 Brief Benefit Overview

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Hospital Services</strong></td>
<td>$0 copay for each Ambulatory Surgical Center visit $0 copay for each Outpatient facility visit</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>$0 copay for Medicare-covered Ambulance benefits</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>$0 copay for Medicare-covered Emergency Room visits</td>
</tr>
<tr>
<td><strong>Urgently Needed Care</strong></td>
<td>$0 copay for Medicare-covered Urgently Needed Care visits</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitation Services</strong></td>
<td>$0 copay for: [• Medicare-covered Occupational Therapy visits [• Medicare-covered Physical Therapy and/or Speech and Language Pathology visits [• Medicare-covered Cardiac Rehab services (for a maximum of two (2) one (1) hour sessions per day for up to thirty-six (36) sessions up to thirty-six (36) weeks) [• Medicare-covered Pulmonary rehab services</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>$0 copay for Medicare-covered durable medical equipment</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>$0 copay: [• Medicare-covered Prosthetic Devices [• Medicare-covered medical supplies related to Prosthetics, Splints and other devices</td>
</tr>
<tr>
<td><strong>Diabetes Program and Supplies</strong></td>
<td>$0 copay for: [• Medicare-covered Diabetes self-management training [• Medicare-covered Diabetes monitoring supplies [• Medicare-covered Therapeutic shoes or inserts</td>
</tr>
<tr>
<td><strong>Diagnostic Tests, X-rays, Lab Services, and Radiology Services</strong></td>
<td>$0 copay for: [• Medicare-covered lab services [• Medicare-covered diagnostic procedures &amp; tests [• Medicare-covered X-rays [• Medicare-covered diagnostic radiology services (not including x-rays) [• Medicare-covered therapeutic radiology services</td>
</tr>
<tr>
<td><strong>Cardiac &amp; Pulmonary Rehabilitation Services</strong></td>
<td>$0 copay for: [• Medicare-covered cardiac rehabilitation services [• Medicare-covered intensive cardiac rehabilitation services [• Medicare-covered pulmonary rehabilitation services</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>$0 copay for: [All preventive services covered under Original Medicare at zero (0) cost-sharing Plan covers a physical exam annually</td>
</tr>
</tbody>
</table>

January 12, 2016 20
## Superior HealthPlan Advantage (HMO SNP)

### CY 2015 Brief Benefit Overview

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Kidney Disease & Conditions** | $0 copay for Medicare-covered renal dialysis  
$0 copay for Medicare-covered kidney disease education services |
| **Outpatient Prescription Drugs** | $0 copay for Medicare-covered Part B chemotherapy drugs and other Part B drugs |
| **Dental Services**            | $0 copay for the following preventive dental benefits:                     |
|                                | - Two (2) oral exams                                                        |
|                                | - One (1) dental x-ray                                                      |
|                                | - Two (2) fluoride treatments                                               |
|                                | $0 copay for                                                                    |
|                                | - Medicare-covered Dental Benefits                                           |
|                                | - Plan offers additional Supplemental Comprehensive Dental Benefits          |
|                                | - $350 Plan coverage limit for Comprehensive Dental Benefits                 |
|                                | Comprehensive Benefits for Diagnostic Services, Restorative Services,        |
|                                | Endodontics/Periodontics/Extractions, Prosthodontics (Dentures), Other Oral/Maxillofacial Surgery, and Other Services |
| **Hearing Services**           | Exam to diagnose and treat hearing and balance issues:  
$0 copay Routine Hearing Exam (for up to one (1) every year):  
$0 copay Hearing Aid fitting/evaluation (for up to one (1) every year):  
$0 copay One (1) Hearing aid:  
$500 every year for hearing aids. |
| **Vision Services**            | Exam to diagnose and treat diseases and conditions of the eye                |
|                                | (including yearly glaucoma screening): $0 copay                           |
|                                | Routine Eye Exam (for up to 1 every year): $0 copay                        |
|                                | Contact Lenses: $0 copay Eyeglasses (frames and lenses): $0 copay           |
|                                | $0 copay Eyeglasses or Contact Lenses after cataract surgery: $0 copay      |
|                                | $200 every year for Contact Lenses and Eyeglasses (frames and lenses).       |
| **Wellness Education and other Supplemental Benefits & Services** | *Health Club membership: (Silver Sneakers)                          |
|                                | *Nursing Hotline                                                            |
| **Over-The-Counter (OTC) Items** | $0 copay for covered OTC items, up to $100 per calendar quarter. Unused     |
|                                | amounts do not carry over from one quarter to the next.                      |
| **Transportation**             | $0 copay for up to thirty (30) one way trips to plan-approved locations     |
|                                | every year.                                                                 |
| **Acupuncture & Other Alternative Therapies** | Not Covered                                                                  |
# Superior HealthPlan Advantage (HMO SNP)

## CY 2015 Brief Benefit Overview

### Part D Prescription Drug Coverage

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Tier 1 – One month supply Generic</td>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 2 – One month supply Preferred Brand</td>
<td>$0 copay, $3.60 or $6.60 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3 – One month supply Non-Preferred Brand</td>
<td>$0 copay, $3.60 or $6.60 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 4 – One month supply Injectable</td>
<td>$0 copay, $3.60 or $6.60 copay</td>
<td></td>
</tr>
</tbody>
</table>

The following is a partial list of services not covered under Parts A and B; however, these services may be covered under a supplemental benefit:

- Acupuncture
- Hearing Aids
- Cosmetic Surgery
- Healthcare while traveling outside of the United States
- Routine Foot Care
- Routine Dental Care
- Routine Eye Care Custodial Care

## VERIFYING MEMBER BENEFITS, ELIGIBILITY, AND COST SHARES

It is imperative that providers verify benefits, eligibility, and cost shares each time a Superior HealthPlan Advantage member is scheduled to receive services. All members will receive a Superior HealthPlan Advantage member identification (ID) card.
Member Identification Card

Below is a sample member identification card.

![Sample Member Identification Card]

Note: Presentation of a member ID card is not a guarantee of eligibility. Providers must always verify eligibility on the same day services are required.

Preferred Method to Verify Benefits, Eligibility, and Cost Shares

To verify member benefits, eligibility, and cost share information, the preferred method is the Superior HealthPlan Advantage Secure Provider Portal found at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com). By using the Portal, any registered provider can quickly verify member eligibility, benefits and cost share information. Eligibility and cost share information loaded onto this website is obtained from and reflective of all changes made within the last twenty-four (24) hours. The eligibility search can be performed using the date of service, member name and date of birth or the member ID number and date of birth.

![Provider Portal Screenshot]

Other Methods to Verify Benefits, Eligibility and Cost Shares

<table>
<thead>
<tr>
<th>24/7 Toll Fee Interactive Voice Response (IVR) Line at 1-800-218-7453</th>
<th>The automated system will prompt you to enter the member ID number and the month of service to verify eligibility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Services at 1-800-218-7453</td>
<td>If you cannot confirm a member’s eligibility using the Secure Provider Portal or the 24/7 IVR line, please call Provider Services. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility before rendering services. Provider Services will require the member name or member ID number and date of birth to verify eligibility.</td>
</tr>
</tbody>
</table>
MEDICAL MANAGEMENT

Model of Care

The Model of Care defines the care management framework, procedures and operational systems that provide access, coordination and structure needed to provide services and care to Superior HealthPlan Advantage members.

Purpose

To improve quality, reduce costs, and improve the member experience:

- Ensure members have full access to the services they are entitled.
- Improve the coordination between the Federal government and state requirements.
- Develop innovative care coordination and integration models.
- Eliminate financial misalignments that lead to poor quality and cost shifting.

Model of Care Elements include:

- Description of the Member Population;
- Care Coordination;
- Provider Network; and
- Quality Measurements and Performance Improvement.

Model of Care Process

- Every dual eligible member has a comprehensive Health Risk Assessment (HRA) completed within ninety (90) days of enrollment, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member’s medical, psychosocial, cognitive, and functional needs as well as the medical and behavioral health history.
- Members are then triaged by the Superior HealthPlan Advantage case management program for follow up.

Individualized Care Plan

The Individualized Care Plan is developed in collaboration with the member; the member’s authorized representative, authorized family members, managing physician and other members of the health care team including the Interdisciplinary Care Team (ICT). The Individualized Care plan includes:

- Problems, Interventions and Goals;
- Specific services and benefits to be provided; and
- Measureable Outcomes.

Members receive monitoring, service referrals, and condition specific education. Case Manager’s and PCP’s work closely together with the member and their family to prepare, implement and evaluate the Individualized Care Plan (ICP). Superior HealthPlan Advantage disseminates evidence-based clinical guidelines and conducts studies to:
- Measure member outcomes;
- Monitor quality of care; and
- Evaluate the effectiveness of the Model of Care (MOC).

**Interdisciplinary Care Team (ICT)**

The Superior HealthPlan Advantage Case Managers will coordinate the member’s care with the Interdisciplinary Care Team (ICT). The ICT is generally comprised of multidisciplinary clinical and nonclinical staff chosen by the member. Our integrated care management approach allows non-medical personnel to perform non-clinical based health service coordination and clerical functions, and permits the licensed professional staff to focus on the more complex and clinically based service coordination needs. The purpose of the ICT is to coordinate the plan of care with the member. Our program is member centric with the PCP being the primary ICT point of contact. Provider responsibilities include:

- Accepting invitations to attend member’s ICT meetings whenever possible.
- Maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member’s medical record when received.

**Collaborating and actively communicating with:**

- Superior HealthPlan Advantage Case Managers
- Members of the Interdisciplinary Care Team (ICT)
- Members and Caregivers
- Inpatient Care that includes case managers that coordinate with facilities to assist members with coordinating an appropriate discharge plan meeting the member’s needs. Superior HealthPlan Advantage will then notify the PCP of the transition of care and anticipated discharge date to ensure members receive the appropriate follow-up care.
- Managing transition of care for discharged members may include but is not limited to face-to-face or telephonic contact with the member or their representative in the hospital prior to discharge to discuss the discharge plan.
- Provider responsibilities include accepting ICT meeting invitations on members when possible, maintaining copies of the ICP, ICT worksheets and transition of care notifications in the member’s medical record, and collaborating with Superior HealthPlan Advantage case managers, ICT, and members or caregivers.
- All internal and external ICT members will be trained annually on the current Model of Care.

**Utilization Management**

The Utilization Management Program’s goals are to provide covered services that are medically necessary, appropriate to the member’s condition, rendered in the appropriate setting and meet nationally recognized standards of care.

**National Coverage Determinations (NCDs)**

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals. Key manuals for coverage include the: a) Medicare National Coverage Determinations Manual; b) Medicare Program Integrity Manual; and c) Medicare Benefit Policy Manual. CMS updates program manuals through
program transmittals and also sends updated information via articles through the Medicare Learning Network located in the Outreach & Education section of the CMS website.

**Local Coverage Determinations (LCDs)**

CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue LCDs to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

**Prior authorization/Preservice Organization Determinations**

- Superior HealthPlan Advantage providers can submit organization determination requests by web, mail, phone or fax. Superior HealthPlan Advantage requires prior authorization for:
  - Elective inpatient admissions. All unplanned inpatient admissions require notification within one (1) business day of admission;
  - All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis); and
  - Service requests identified in the Medicare authorization guidelines available on the Secure Provider Portal.

For initial and continuation of services, Superior HealthPlan Advantage has appropriate review criteria for authorization reviews and organization determinations, which include, but are not limited to: Medicare National and Local Coverage Determinations (NCD, LCD); when appropriate determination rendered by Superior HealthPlan Advantage Medical Director; Nationally Recognized Medical Necessity Criteria, Superior HealthPlan Advantage (e.g. InterQual, and Health Plan clinical policies).

The organization determination process provides authorization numbers, effective dates for the authorization and specifies the services being authorized. The requesting provider and member are notified via telephone, fax or mail, of the authorization determination. In the event of an adverse determination, we will notify the member and the member’s representative and/or provider, as appropriate.

**Standard Organization Determinations**

Standard organization determinations are made as expeditiously as the member’s health condition requires, but no later than fourteen (14) calendar days after we receive the request for service. An extension may be granted for fourteen (14) additional calendar days if the member requests an extension, or if we justify the need for additional information and documents that the delay is in the best interest of the member.

**Expedited Organization Determinations**

Expedited organization determinations are requests that the member or his or her provider believes that waiting for a decision under the standard timeframe could place the member’s life, health or ability to regain maximum function in serious jeopardy. The determination will be made as expeditiously as the member’s health condition requires, but no later than seventy-two (72) hours after receiving the member’s or provider’s request. An extension may be granted for fourteen (14) additional calendar days if the member requests an extension, or if we justify a need for additional information and documents how the delay is in the best interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received.
Timeframes for Prior Authorization Requests and Notifications

The following timeframes are required for prior authorization and notification:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective/scheduled admissions</td>
<td>Required five (5) business days prior to the scheduled admission date</td>
</tr>
<tr>
<td>Emergent inpatient admissions</td>
<td>Notification required within one (1) business day</td>
</tr>
<tr>
<td>Emergency room and post stabilization, urgent care and crisis intervention</td>
<td>Notification requested within one (1) business day</td>
</tr>
</tbody>
</table>

Services Requiring Prior Authorization

Please visit the Superior HealthPlan Advantage website at www.SuperiorHealthPlan.com and use the Pre-Auth Screen Tool or contact the Authorization Department with questions. Failure to obtain the required prior authorization or pre-certification may result in a denied claim or reduction in payment. **Note:** *All out of network services require prior authorization excluding emergency room services and dialysis.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Out Of Network Services require Prior Authorization except emergency care, out-of-area urgent care, or out-of-area dialysis</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>• Fixed-wing aircraft</td>
</tr>
<tr>
<td></td>
<td>• Non-emergent Transportation</td>
</tr>
<tr>
<td>Behavioral Health Services includes Substance Use Disorder</td>
<td>• Inpatient Psychiatric</td>
</tr>
<tr>
<td></td>
<td>• Partial hospitalization</td>
</tr>
<tr>
<td></td>
<td>• Intensive Outpatient Therapy</td>
</tr>
<tr>
<td></td>
<td>• Psychological Testing</td>
</tr>
<tr>
<td></td>
<td>• Neuropsychological Testing</td>
</tr>
<tr>
<td></td>
<td>• Electroconvulsive Therapy (ECT)</td>
</tr>
<tr>
<td></td>
<td>• Substance Use Disorder Treatment/Rehabilitation</td>
</tr>
<tr>
<td>Clinical Trials-Notification Only</td>
<td>Please notify us of the Medicare Approved Clinical Trial by phone or fax at the numbers above.</td>
</tr>
<tr>
<td>Cosmetic Procedures</td>
<td>Includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. (Medicare Definition)</td>
</tr>
<tr>
<td>Drug Testing (effective 11/01/2014)</td>
<td>Prior Authorization required for all quantitative tests for drugs of abuse, except for those conducted in the emergency room, inpatient hospital, or urgent care locations or those conducted in children less than six (6) years old.</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Durable Medical Equipment (DME)** | Includes but not limited to:  
• Custom Wheelchairs  
• Power Wheelchairs  
• BIPAP  
• CPAP  
• Hospital Bed/Mattress  
• Lift Devices including Hoyer  
• Infusion Pumps  
• Oxygen  
• TENS Units  
• Ventilators  
• Wound Vacuum (Negative Pressure) Devices  
• Bone growth stimulator  
• Vagus nerve stimulator  
To determine if other DME codes require prior authorization, please refer to: [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com) |
| **Experimental/Investigational Services** | Any item or service potentially considered investigational or experimental must be authorized in advance. |
| **Genetic Counseling and Testing** | Genetic testing is a type of medical test that identifies changes in chromosomes, genes, or proteins. |
| **Home Health Services** |  
• Home IV Infusion  
• Occupational Therapy  
• Physical Therapy  
• Speech Therapy  
• Skilled Nursing Visits  
• Social Work Visits |
| **Hospice** | Please notify us of outpatient or inpatient hospice by phone or fax at the numbers above. |
| **Infertility** | Includes the following:  
• Drug Therapy  
• Testing  
• Treatment |
| **Inpatient Admission: Elective or Scheduled** |  
• Acute Inpatient Hospital  
• Inpatient Rehabilitation Hospital  
• Long Term Acute Care Hospital (LTAC)  
• Skilled Nursing Facility (SNF) |
<p>| <strong>Orthotics/Prosthetics</strong> | To determine if Orthotic and Prosthetic codes require prior authorization, please refer to: <a href="http://www.SuperiorHealthPlan.com">www.SuperiorHealthPlan.com</a> |
| <strong>Observation Stay</strong> | Prior Authorization required if &gt; twenty-four (24) hours |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| Outpatient therapy performed at free standing facility or outpatient hospital | - Occupational Therapy (OT)  
- Physical Therapy (PT)  
- Speech-Language Therapy (ST)  
- Pulmonary Rehab Therapy  
*Medicare has $1,900 cap for PT & ST combined, and $1,900 cap for OT, per calendar year* |
| Pain Management                                  | - Facet Injections  
- Trigger Point Injections  
- Epidural Injections |
| Medicare Part B Drugs                            | Please see Medicare Part B Prior Authorization List           |
| Radiation Therapy (effective 01/01/2015)         | Includes but not limited to:  
- Stereotactic Radiotherapy  
- Intensity modulated radiotherapy (IMRT)  
- Proton Beam Therapy  
- Neutron Beam Therapy |
| Radiology                                        | TX, GA, OH, FL: Visit [www.radmd.com](http://www.radmd.com)  
- MRI  
- PET  
- MRA  
- CT  
- Cardiac Imaging: TEXAS only |
| Sleep Studies                                    | - Surgery  
- Treatment |
| Surgeries, regardless of place of service        | - Abortion  
- Bariatric Surgery  
- Blepharoplasty  
- Breast Augmentation (except following mastectomy)  
- Breast Reduction  
- Cochlear Implant  
- Excision of Lesion  
- Facial Osteotomy  
- Hysterectomy  
- Mastectomy for Gynecomastia  
- Oral Surgery – Temporomandibular Joint Surgery  
- Otoplasty  
- Reconstructive and Plastic Surgery  
- Rhinoplasty  
- Sacral Nerve Neuromodulation |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Surgeries, regardless of place of service continued** | • Scar Revision  
• Septoplasty  
• Spinal surgeries including fusion, stabilization, discectomy  
• Uvulopalatopharyngoplasty/Uvulopharyngoplasty  
• Veins (ablation, ligation, stripping, sclerotherapy) |
| **Transplants** | • All transplant evaluations and procedures, including but not limited to evaluation, transplant consult visits, HLA typing, donor search, and transplant procedure. |

**Procedure for Requesting Prior Authorizations**

**Medical**

The preferred method for submitting authorization requests is through the Secure Provider Portal at [http://superiorhealthplan.com/](http://superiorhealthplan.com/). The provider must be a registered user on the Secure Provider Portal.  
*Note: If a provider has already registered for the Secure Provider Portal for another Superior HealthPlan product, then that registration will also grant the provider access to Superior HealthPlan Advantage. If the provider has not already registered as a user on the Secure Provider Portal and needs assistance or training on submitting prior authorizations, the provider should contact his or her dedicated Provider Relations Specialist.*

Other methods of submitting the prior authorization requests are as follows:

- Phone the Medical Management Department at 1-800-218-7508.

Please contact our 24/7 Nurse Advice Line at 1-855-696-2515 for after hour urgent admissions, inpatient notifications or requests.
Behavioral
The required method for prior authorization of inpatient admissions is to contact the health plan telephonically. Outpatient authorizations may be submitted via the Secure Provider Portal or by fax.

Medical and Behavioral
The requesting or rendering provider must provide the following information to request authorization (regardless of the method utilized):

- Member’s name, date of birth and ID number;
- Provider’s NPI number, taxonomy code, name and telephone number;
- Facility name if the request is for an inpatient admission or outpatient facility services;
- Provider location if the request is for an ambulatory or office procedure;
- The procedure code(s): Note: If the procedure codes submitted at the time of authorization differ from the services actually performed, it is recommended that within seventy-two (72) hours or prior to the time the claim is submitted that you phone Medical Management at 1-800-218-7508 to update the authorization. Otherwise, this may result in claim denials;
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed);
- Admission date or proposed surgery date, if the request is for a surgical procedure;
- Discharge plans; and
- For obstetrical admissions, the date and method of delivery, estimated date of confinement and information related to the newborn or neonate.

Behavioral Health Services
Superior HealthPlan Advantage has delegated the management of covered mental health and substance use disorder services to Cenpatico. If you provide behavioral health services, please refer to your contract with Cenpatico for specific information related to covered services and authorization requirements. Additional information regarding Behavioral Health services can be found in other sections of this Manual.

Pharmacy
The covered pharmacy services for Superior HealthPlan Advantage Members vary based on the plan benefits. Information regarding the member’s pharmacy coverage can be found via the Secure Provider Portal. Additional resources available on the website include the Superior HealthPlan Advantage Formulary, the Argus (Pharmacy Benefit Manager) Provider Manual and Medication Request and Exception Request forms.

The Superior HealthPlan Advantage formulary is designed to assist contracted healthcare prescribers with selecting the most clinically and cost-effective medications available. The formulary provides instruction on the following:

- Which drugs are covered, including restrictions and limitations;
- The Pharmacy Management Program requirements and procedures;
- An explanation of limits and quotas;
• How prescribing Providers can make an exception request; and
• How Superior HealthPlan Advantage conducts generic substitution, therapeutic interchange and step-therapy.

The Superior HealthPlan Advantage formulary does not:

• Require or prohibit the prescribing or dispensing of any medication;
• Substitute for the professional judgment of the provider or pharmacist; and
• Relieve the provider or pharmacist of any obligation to the member.

The Superior HealthPlan Advantage formulary will be approved initially by the Superior HealthPlan Advantage Pharmacy and Therapeutics Committee (P & T), led by a Pharmacist and Medical Director, with support from community-based primary care providers and specialists. Once established, the Formulary will be maintained by the P & T Committee, using quarterly meetings, to ensure that Superior HealthPlan Advantage members receive the most appropriate medications. The Superior HealthPlan Advantage formulary contains those medications that the P & T Committee has chosen based on their safety and effectiveness. If a provider feels that a certain medication merits an addition to the list, the formulary Change Request policy can be used as a method to address the request. The Superior HealthPlan Advantage P & T Committee would review the request, along with supporting clinical data, to determine if the drug meets the safety and efficacy standards established by the Committee. Copies of the formulary are available on our website, www.SuperiorHealthPlan.com. Providers may also call Provider Services for hard copies of the formulary.

The majority of prescriptions will be covered based on the Medicare formulary. In addition, Superior HealthPlan Advantage will assist with the following:

• Transitions of prescription drugs
• Quality Assurance
• Utilization Management (Prior Authorization Requirements)
• Exceptions and Appeals
• Locate a pharmacy near you
• Information about any formulary changes
• Out Of Network Coverage

Transition Policy

Under certain circumstances Superior HealthPlan Advantage can offer a temporary supply of a drug if the drug is not on the formulary or is restricted in some way. To be eligible for a temporary supply, members must meet the requirements below:

1. The drug the member has been taking is no longer on the Superior HealthPlan Advantage formulary or — the drug is now restricted in some way.
2. The member must be in one of the situations described below:
   - For those members who were enrolled with Superior HealthPlan Advantage last year and are not in a long-term care facility, Superior HealthPlan Advantage will cover a temporary supply of the drug one time only during the first ninety (90) days enrolled in Superior HealthPlan Advantage of the calendar year. This temporary supply will be for a
maximum of a thirty (30) day supply, or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to Superior HealthPlan Advantage and are not in a long-term care facility,** Superior HealthPlan Advantage will cover a temporary supply of the drug one time only during the first ninety (90) days of membership in Superior HealthPlan Advantage. This temporary supply will be for a maximum of a thirty (30) day supply or less if the prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those who are new Superior HealthPlan Advantage members, and are residents in a long-term care facility,** Superior HealthPlan Advantage will cover a temporary supply of the drug during the first ninety (90) days of membership in Superior HealthPlan Advantage. The first supply will be for a maximum of a thirty-one (31) day supply or less if the prescription is written for fewer days. If needed, we will cover additional refills during the first ninety (90) days in Superior HealthPlan Advantage up to a maximum of ninety-one (91) to ninety-eight (98) day supply.

- **For those who have been a member of Superior HealthPlan Advantage for more than ninety (90) days, are a resident of a long-term care facility and need a supply right away; Superior HealthPlan Advantage will cover one thirty-one (31) day supply or less if the prescription is written for fewer days. This is in addition to the above long-term care transition supply. An exception or prior authorization should also be requested at the time the prescription is filled.**

### Prior Authorization Requirements

Superior HealthPlan Advantage has a team of providers and pharmacists that create tools to help provide quality coverage to Superior HealthPlan Advantage members. The tools include but are not limited to: prior authorization criteria’ clinical edits and quantity limits. Some examples include:

- **Age Limits:** Some drugs require a prior authorization if the member’s age does not meet the manufacturer, Food and Drug Administration (FDA), or clinical recommendations.

- **Quantity Limits:** For certain drugs, Superior HealthPlan Advantage limits the amount of the drug Superior HealthPlan Advantage will cover per prescription or for a defined period of time.

- **Prior Authorization:** Superior HealthPlan Advantage requires prior authorization for certain drugs. Note: Prior Authorization may be required for drugs that are on the formulary or drugs that are not on the formulary and were approved for coverage through our exceptions process. This means that approval will be required before prescription can be filled. If approval is not obtained, Superior HealthPlan Advantage may not cover the drug.

- **Generic Substitution:** When there is a generic version of a brand-name drug available, Superior HealthPlan Advantage network pharmacies will automatically give the generic version, unless the brand-name drug was requested. If the brand-name drug is not on the formulary an exception request may be required for coverage. If the brand-name drug is approved, the member may be responsible for a higher co-pay.

Superior HealthPlan Advantage can make an exception to our coverage rules, please refer to the Comprehensive Formulary. When requesting a utilization restriction exception, submit a supporting statement along with a completed Request for Medicare Prescription Drug Coverage Determination form which can be found at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com). In order to ensure members receive prompt attention to the coverage exception request, providers must use the Medicare specific Superior HealthPlan Advantage form and fax it to the number identified on the form. Generally, Superior HealthPlan Advantage must make a decision within seventy-two (72) hours of getting the supporting statement. Providers can request an expedited exception if the member’s health could be seriously harmed by waiting up to seventy-two (72) hours for a decision. If the request to expedite is granted,
Superior HealthPlan Advantage must provide a decision no later than twenty-four (24) hours after receiving the prescriber’s or prescribing provider’s supporting statement.

**Second Opinion**

Members or a healthcare professional with the member’s consent may request and receive a second opinion from a qualified professional within the Superior HealthPlan Advantage network. If there is not an appropriate provider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider only upon receiving a prior authorization from the Superior HealthPlan Advantage Utilization Management Department.

**Women’s Health Care**

Female members may see a network provider, who is contracted with Superior HealthPlan Advantage to provide women’s health care services directly, without prior authorization for:

- Medically necessary maternity care
- Covered reproductive health services;
- Preventive care (well care) and general examinations particular to women;
- Gynecological care; and
- Follow-up visits for the above services.

If the member’s women’s health care provider diagnoses a condition that requires a prior authorization to other specialists or hospitalization, prior authorization must be obtained in accordance with Superior HealthPlan Advantage’s prior authorization requirements.

**Utilization Determination Timeframes**

Utilization management decision making is based on appropriateness of care and service and the covered benefits of the plan. Superior HealthPlan Advantage does not reward providers or other individuals for issuing denials of authorization.

Authorization decisions are made as expeditiously as possible. Below are the specific timeframes utilized by Superior HealthPlan Advantage. In some cases it may be necessary for an extension to extend the timeframe below. You will be notified if an extension is necessary. Please contact Superior HealthPlan Advantage if you would like a copy of the policy for utilization management timeframes.

**Level of Urgency**

<table>
<thead>
<tr>
<th>Type</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expedited</td>
<td>As soon as medically required within seventy-two (72) hours of request including weekends and holidays.</td>
</tr>
<tr>
<td>Expedited Extension</td>
<td>Determination will be extended up to fourteen (14) additional calendar days if an extension is requested</td>
</tr>
<tr>
<td>Standard</td>
<td>As soon as medically indicated maximum fourteen (14) calendar days from receipt of request</td>
</tr>
<tr>
<td>Standard Extension</td>
<td>Determination will be extended up to fourteen (14) additional calendar days if</td>
</tr>
<tr>
<td>Type</td>
<td>Timeframe</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Concurrent</td>
<td>As soon as medically indicated usually within one (1) business day of request depending on the Plan’s policy</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Within thirty (30) calendar days of receipt of post service request</td>
</tr>
</tbody>
</table>

**Retrospective Review**

Retrospective Review is an initial review of services after services have been provided to a member. This may occur when authorization or timely notification to Superior HealthPlan Advantage was not obtained due to extenuating circumstances such as member was unconscious at presentation, member did not have their Superior HealthPlan Advantage ID card or otherwise indicated other coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service. Requests for Retrospective Review must be submitted promptly.

**Medically Necessary**

The fact that a provider may prescribe, authorize, or direct a service does not itself make it medically necessary or covered by the contract. Medical necessity criteria for covered services will be furnished to a member or provider within thirty (30) days of a request.

Medical necessity determinations will be made in a timely manner by thorough review from Superior HealthPlan Advantage clinical staff. Determinations will be made utilizing guidelines based care, appropriate utilization management policies, and by applying clinical judgment and experience. Medical policies are developed through periodic review of generally accepted standards of medical practice and updated at least on an annual basis. Current medical policies are available on our website.

Medically necessary services are generally accepted medical practices provided in light of conditions present at the time of treatment. These include services which are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member’s medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate, and cost-effective setting give the nature of the diagnosis and severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the healthcare provider or hospital.

In the event that a member may not agree with the medical necessity determination, a member has the opportunity to appeal the decision. Please refer to the “Grievance Process” section of the provider manual.
Emergency Medical Condition

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Utilization Review Criteria

Superior HealthPlan Advantage has adopted the following utilization review criteria to determine whether services are medically necessary services for purposes of plan benefits:

- National Coverage Determinations (NCD)
- Local Coverage Determinations (LCD)
- InterQual®
- Health Plan Clinical Policy

Superior HealthPlan Advantage’s Medical Director reviews, or other health care professionals that have appropriate clinical expertise in treating the member’s condition or disease review, all potential adverse determinations and will make a decision in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from NCD, LCD, InterQual®, or other criteria as mentioned above. Superior HealthPlan Advantage’s Clinical Policies are posted at www.SuperiorHealthPlan.com. Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 1-800-218-7508. Providers have the opportunity to discuss any adverse decisions with a Superior HealthPlan Advantage physician or other appropriate reviewer at the time of the notification to the requesting provider of an adverse determination. The Superior HealthPlan Advantage Medical Director may be contacted by calling 1-800-218-7508. A Superior HealthPlan Advantage Care Manager may also coordinate communication between the Medical Director and the requesting provider.

Utilization management decision making is based on appropriateness of care and service and the existence of coverage. Superior HealthPlan Advantage does not reward providers or other individuals for issuing denials of authorizations.

Care Management

Medical Care Management is a collaborative process which assesses plans, implements, coordinates, monitors and evaluates options and services to meet an individual’s health needs, using communication and available resources to promote quality, cost effective outcomes. Service or Care Coordination and Care Management are member-centered, goal-oriented, culturally relevant and logically managed processes to help ensure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

An initial Health Risk Assessment (HRA) will be completed by phone or in person within ninety (90) days of the member’s enrollment date. The HRA will be the basis of the Care Plan and will be available for your review via the Secure Provider Portal. Superior HealthPlan Advantage’s Care Management teams
support providers by tracking compliance with the Care Management plan, and facilitating communication between the PCP, member, managing physician, and the Care Management team. The Care Manager also facilitates referrals and links to community providers, such as local health departments and school-based clinics. The managing provider maintains responsibility for the member’s ongoing care needs. The Superior HealthPlan Advantage Care Manager will contact the PCP, and/or, managing physician provider if the member is not following the plan of care or requires additional services.

All Superior HealthPlan Advantage members with identified needs are assessed for Care Management enrollment. Members with needs may be identified via clinical rounds, referrals from other Superior HealthPlan Advantage staff members, hospital census, direct referral from providers, self-referral or referral from other providers.

Care Management Process
Superior HealthPlan Advantage’s Care Management for high risk, complex or catastrophic conditions contains the following key elements:

- Screen and identify members who potentially meet the criteria for Care Management.
- Assess the member’s risk factors to determine the need for Care Management.
- Notify the member and their PCP of the member’s enrollment in Superior HealthPlan Advantage’s Care Management program.
- Develop and implement a treatment plan that accommodates the specific cultural and linguistic needs of the member.
- Establish treatment objectives and monitor outcomes.
- Refer and assist the member in ensuring timely access to providers.
- Coordinate medical, residential, social and other support services.
- Monitor care/services.
- Revise the treatment plan as necessary.
- Assess the member’s satisfaction with Complex Care Management services.
- Track plan outcomes.
- Follow-up post discharge from Care Management.
- Providers are asked to contact a Superior HealthPlan Advantage Care Manager to refer a member identified in need of Care Management intervention.

ENCOUNTERS AND CLAIMS

Encounter Reporting

What is an Encounter versus a Claim?

An encounter is a claim which is paid at zero ($0) dollars as a result of the Provider being pre-paid or capitated for the services he/she provided Superior HealthPlan Advantage members. For example, if you are the PCP for Superior HealthPlan Advantage member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero ($0) dollar amounts. It is mandatory that your office submits encounter data.
Superior HealthPlan Advantage utilizes the encounter reporting to evaluate all aspects of quality and utilization management, which is also required by CMS. Encounters do not generate an EOP.

A claim is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be generated and mailed to the provider who submitted the original claim. Providers are required to submit either an encounter or a claim for each service that is rendered to a Superior HealthPlan Advantage member.

**CLAIMS**

In general, Superior HealthPlan Advantage follows the Center for Medicare and Medicaid Services (CMS) billing requirements for paper, electronic data interchange (EDI), and secure web-submitted claims. Superior HealthPlan Advantage is required by state and federal regulations to capture specific data regarding services rendered to its members. The provider must adhere to all billing requirements in order to ensure timely processing of claims and to avoid unnecessary upfront rejections or denials on the explanation of payment which occurs when a claim is not submitted correctly. *Note: Claims will be rejected or denied if not submitted correctly.*

**Verification Procedures**

All claims filed with Superior HealthPlan Advantage are subject to verification procedures. These may include, but are not limited to, verification of the following:

- All required fields are completed on an original CMS 1500 Claim Form, CMS 1450 (UB-04) Claim Form, EDI, an electronic claim format, or claims submitted on our Secure Provider Portal, individually or batch.
- All claim submissions will be subject to 5010 validation procedures based on CMS Industry Standards.
- Claims must contain the CLIA number when CLIA waived or CLIA certified services are provided. Paper claims must include the CLIA certification in Box 23 when CLIA waived or CLIA certified services are billed. For EDI submitted claims, the CLIA certification number must be placed in: X12N 837 (5010 HIPAA version) loop 2300 (single submission) REF segment with X4 qualifier or X12N 837 (5010 HIPAA version) loop 2400 REF segment with X4 qualifier, (both laboratory services for which CLIA certification is required and non-CLIA covered laboratory tests).
- All Diagnosis, Procedure, Modifier, Location (Place of Service), Revenue, Type of Admission, and Source of Admission Codes are valid for:
  - Date of Service,
  - Provider Type and/or provider specialty billing,
  - Age and/or sex for the date of service billed, and
  - Bill type.
- All Diagnosis Codes are to their highest number of digits available.
- National Drug Code (NDC) is billed in the appropriate field on all claim forms when applicable. This includes the quantity and type. Type is limited to the list below:
  - F2 – International Unit
  - GR – Gram
– ME – Milligram
– ML – Milliliter
– UN - Unit

- Principal diagnosis billed reflects an allowed principal diagnosis as defined in the volume of ICD-9-CM and/or ICD-10-CM for the date of service billed.
- For a CMS 1500 Claim Form, this criteria reviews all procedure codes billed and the diagnosis. If a procedure identifies the diagnosis as primary, and that code is not valid as a primary diagnosis code, that service line will deny.
- All inpatient facilities are required to submit a Present on Admission (POA) Indicator. Claims will be denied (or rejected) if the POA indicator is missing. Please reference the CMS Billing Guidelines regarding POA for more information and for excluded facility types. Valid 5010 POA codes are:
  - N – No
  - U – Unknown
  - W – Not Applicable
  - Y - Yes

- Member is eligible for services under Superior HealthPlan Advantage during the time period in which services were provided.
- Services that were provided by a participating provider, or if provided by an “out of network” provider, authorization has been received to provide services to the eligible member. Note: This excludes services by an “out of network” provider for an emergency medical condition; however, authorization requirements apply for post-stabilization services.
- An authorization has been given for services that require prior authorization by Superior HealthPlan Advantage.
- Third party coverage has been clearly identified and appropriate COB information has been included with the claim submission.

Claims eligible for payment must meet the following requirements:
- The member is effective on the date of service.
- The service provided is a covered benefit under the member’s contract on the date of service and prior authorization processes were followed.
- Payment for services is contingent upon compliance with Superior HealthPlan Advantage referral and prior authorization policies and procedures.

Clean Claim Definition
A clean claim is a claim that does not require external investigation or development to obtain information not available on the claim form or on record in the health plan’s systems in order to adjudicate the claim.

Non-Clean Claim Definition
Any claim that does not meet the definition of a clean claim is considered a non-clean claim. Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.
Upfront Rejections versus Denials

Upfront Rejection
An upfront rejection is defined as an unclean claim that contains invalid or missing data elements required for acceptance of the claim into the claim processing system. These data elements are identified in the Companion Guide located in the Appendix of this Manual. A list of common upfront rejections can be found in Appendix I of this Manual. Upfront rejections will not enter our claims adjudication system, so there will be no Explanation of Payment (EOP) for these claims. The provider will receive a letter or a rejection report if the claim was submitted electronically.

Denial
If all edits pass and the claim is accepted, the claim will be entered into the system for processing. A denial is defined as a claim that has passed edits and is entered into the system; however, the claim has been billed with invalid or inappropriate information causing the claim to deny. An EOP will be sent to the provider that includes the denial reason. A list of common delays and denials can be found listed below with explanations in Appendix II.

Timely Filing
Participating providers must submit first time claims within ninety-five (95) days of the date of service. Claims received outside of this timeframe will be denied for untimely submission. All Corrected Claims, Requests for Reconsideration or Claim Disputes must 1) comply with the timeframe specified in the provider contract or 2) must be received within one-hundred twenty (120) from the date the explanation of payment or denial is issued, whichever comes first.

Who Can File Claims?
All providers who have rendered services for Superior HealthPlan Advantage members can file claims. It is important that providers ensure Superior HealthPlan Advantage has accurate and complete billing information on file. Please confirm with the Provider Services department or your dedicated Provider Relations Specialist that the following information is current in our files:

- Provider Name (as noted on current Form W-9)
- National Provider Identifier (NPI)
- Group National Provider Identifier (NPI) (if applicable)
- Tax Identification Number (TIN)
- Taxonomy code (This is a required field when submitting a claim)
- Physical location address (as noted on current W-9 form)
- Billing name and address (as noted on current W-9 form)

We recommend that providers notify Superior HealthPlan Advantage sixty (60) days in advance of changes pertaining to billing information. If the billing information change affects the address to which the end of the year 1099 IRS form will be mailed, a new Form W-9 will be required. Changes to a provider’s TIN and/or address are not acceptable when conveyed via a claim form.
Electronic Claims Submission

Providers are encouraged to submit clean claims and encounter data electronically. Superior HealthPlan Advantage can receive an ANSI X12N 837 professional, institution, or encounter transaction. In addition, we can generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP) and deliver it securely to providers electronically or in paper format. For more information on electronic claims and encounter data filing and the Clearinghouses Superior HealthPlan Advantage has partnered with, contact:

Superior HealthPlan Advantage

c/o Centene EDI Department
1-800-225-2573, extension 6075525
or by e-mail at: EDIBA@centene.com

Providers who bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers who bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are also responsible for correcting any errors and resubmitting the affiliated claims and encounters.

Superior HealthPlan Advantage has the ability to receive coordination of benefits (COB or secondary) claims electronically. Superior HealthPlan Advantage follows the 5010 X12 HIPAA Companion Guides for requirements on submission of Coordination of Benefits data.

The Superior HealthPlan Advantage Payer ID is 68069. For a list of the Clearinghouses that we currently work with, please visit our website at www.SuperiorHealthPlan.com.

Specific Data Record Requirements

Claims transmitted electronically must contain all of the required data of the X12 5010 Companion Guides. Please contact the Clearinghouse you intend to use and ask if they require additional data record requirements.

Electronic Claim Flow Description & Important General Information

In order to send claims electronically to Superior HealthPlan Advantage, all EDI claims must first be forwarded to one of Superior HealthPlan Advantage’s Clearinghouses. This can be completed via a direct submission to a Clearinghouse or through another EDI Clearinghouse.

Once the Clearinghouse receives the transmitted claims, they are validated against their proprietary specifications and plan specific requirements. Claims not meeting the requirements are immediately rejected and sent back to the sender via a Clearinghouse error report. It is very important to review this error report daily to identify any claims that were not transmitted to Superior HealthPlan Advantage. The name of this report can vary based upon the provider’s contract with their intermediate EDI Clearinghouse. Accepted claims are passed to Superior HealthPlan Advantage and the Clearinghouse returns an “acceptance” report to the sender immediately.

Claims forwarded to Superior HealthPlan Advantage by a Clearinghouse are validated against provider and member eligibility records. Claims that do not meet provider and/or member eligibility requirements will result in an upfront rejection that will be returned on a daily basis to the Clearinghouse. The Clearinghouse in turn forwards the upfront rejection back to its trading partner, the intermediate EDI Clearinghouse or provider. It is very important to review this report daily. If the report shows rejected
claims, these claims must be reviewed and corrected timely. Claims passing eligibility requirements are then passed to the claim processing queues.

Providers are responsible for verification of EDI claim receipts. Acknowledgements for accepted or rejected claims received from the Clearinghouse must be reviewed and validated against transmittal records on a daily basis.

Since the Clearinghouse returns acceptance reports directly to the sender, submitted claims not accepted by the Clearinghouse are not transmitted to Superior HealthPlan Advantage.

If you would like assistance in resolving submission issues reflected on either the acceptance or claim status reports, please contact your Clearinghouse or vendor Customer Service department.

Rejected electronic claims may be resubmitted electronically once an error has been corrected. Please be sure to clearly mark your claim as a corrected claim per the instruction provided in the corrected claim section.

**Invalid Electronic Claim Record Upfront Rejections/Denials**

All claim records sent to Superior HealthPlan Advantage must first pass the Clearinghouse proprietary edits and plan specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected without being recognized as received by Superior HealthPlan Advantage. In this case, the claim must be corrected and resubmitted within the required filing deadline as previously mentioned in the Timely Filing Section of this Manual. It is important that you review the acceptance or claim status reports received from the Clearinghouse in order to identify and resubmit these claims accurately.

Questions regarding electronically submitted claims should be directed to our EDI BA Support at 1-800-225-2573 Ext. 6075525, or via e-mail at EDIBA@centene.com. If you are prompted to leave a voice mail, you will receive a return call within twenty-four (24) business hours.

The full Companion Guides can be located on the Executive Office of Health and Human Services (EOHHS) on the state specific website.

**Specific Electronic Edit Requirements – 5010 Information**

- Institutional Claims – 837Iv5010 Edits
- Professional Claims – 837Pv5010 Edits

**Corrected EDI Claims**

- CLM05-3 Required 7 or 8.
- IN 2300 Loop/REF segment is F8; Ref 02 must input original claim number assigned.
  - Failure to include the original claim number will result in upfront rejection of the adjustment (error code 76).

**Exclusions**

The following inpatient and outpatient claim times are excluded from EDI submission options and must be filed on paper:
• Claim records requiring supportive documentation or attachments i.e. consent forms. Note: COB claims can be filed electronically.

• Medical records to support billing miscellaneous codes.

• Claims for services that are reimbursed based on purchase price, including custom DME and prosthetics. The provider is required to submit the invoice with the claim.

• Claims for services requiring clinical review such as a complicated or unusual procedure. The provider is required to submit medical records with the claim.

• Claim for services requiring documentation and a Certificate of Medical Necessity such as oxygen and motorized wheelchairs.

**Electronic Billing Inquiries**

Please direct inquiries as follows:

<table>
<thead>
<tr>
<th>Action</th>
<th>Contact</th>
</tr>
</thead>
</table>
| Submitting Claims through Clearinghouses |  • Allscripts/Payerpath  
| Superior HealthPlan Advantage Payer ID |  • Availity  
| number for all Clearinghouses (Medical and |  • Capario  
| Cenpatico) is 68069 |  • Claim Remedi  
| |  • Claims source  
| |  • CPSI  
| |  • DeKalb  
| |  • Emdeon  
| |  • First Health Care  
| |  • Gateway EDI  
| |  • GHNonline  
| |  • IGI  
| |  • MDonLine  
| |  • Physicians CC  
| |  • Practice Insight  
| |  • Relay/Mckesson  
| |  • Smart Data  
| |  • SSI  
| |  • Trizetto Provider Solutions, LLC  
| |  • Viatrack |
| General EDI Questions | Contact EDI Support at 1-800-225-2573 Ext. 6075525 or (314) 505-6525 or via e-mail at EDIBA@Centene.com |
| Claims Transmission Report Questions | Contact your Clearinghouse technical support area. |
| Claim Transmission Questions such as has my claim been received or rejected?) | Contact EDI Support at 1-800-225-2573 Ext. 6075525 or via e-mail at EDIBA@Centene.com |
| Remittance Advice Questions | Contact Provider Services or the Secure Provider Portal. |
| Provider Payee, UPIN, Tax ID, Payment Address Changes | Notify Provider Service in writing and include a Form W9. |
Important Steps to a Successful Submission of EDI Claims:

1. Select a Clearinghouse to utilize.
2. Contact the Clearinghouse regarding what data records are required.
3. Verify with Provider Services that the Provider is set up in the Superior HealthPlan Advantage system prior to submitting EDI claims.
4. You will receive two (2) reports from the Clearinghouse. Always review these reports daily. The first report will show the claims that were accepted by the Clearinghouse and transmitted to Superior HealthPlan Advantage as these claims did not meet the Clearinghouse requirements. The second report will be a claim status report that shows accepted and rejected claims by Superior HealthPlan Advantage. Always review the acceptance and claims stats report for rejected claims. If rejections are noted, correct and resubmit the claims.
5. Most importantly, all claims must be submitted with providers identifying the appropriate coding. See the CMS 1500 (02/12) and CMS 1450 (UB-04) Claims Forms instructions and claim form for details.

Online Claim Submission

For providers who have internet access and choose not to submit claims via EDI or paper, Superior HealthPlan Advantage has made it easy and convenient to submit claims directly to Superior HealthPlan Advantage on the Secure Provider Portal at www.SuperiorHealthPlan.com.

You must request access to our secure site by registering for a username and password. If you have technical support questions, please contact Provider Services.

Once a provider has access to the Secure Provider Portal, the provider may file first time claims individually or submit first time batch claims. Providers will also have the capability to find, view, and correct any previously processed claims. Detailed instructions for submitting claims via Secure Provider Portal are also stored on our website. Providers must login to the secure site to access this manual.

Paper Claim Submission

The mailing address for first time Claims, Corrected Claims and Requests for Reconsideration:

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

Superior HealthPlan Advantage encourages all providers to submit claims electronically. The Companion Guides for electronic billing are available in the Appendix section of this Manual. Note: Paper submissions are subject to the same edits as electronic and web submissions.

All paper claims sent to the claims office must first pass specific edits prior to acceptance. Claim records that do not pass these edits are invalid and will be rejected or denied. If a paper claim has been rejected, Provider should submit the rejection letter with the corrected claim.

Acceptable Forms

Superior HealthPlan Advantage only accepts the CMS 1500 (02/12) and CMS 1450 (UB-04) paper claims forms. Other claim form types will result in an upfront rejection and returned to the provider for correction.
Professional providers and medical suppliers complete the CMS 1500 (02/12) Claim Form and institutional providers complete the CMS 1450 (UB-04) Claim Form. Superior HealthPlan Advantage does not supply claim forms to providers. Providers should purchase these from a supplier of their choice. All paper claim forms must be typed with either ten (10) or twelve (12) Times New Roman font, and on the required original red and white version to ensure clean acceptance and processing. Black and white forms or handwritten forms will be upfront rejected and returned to provider. To reduce document handling time, do not use highlights, italics, bold text or staples for multiple page submissions. If you have questions regarding what type of form to complete, please contact Provider Services.

Important Steps to Successful Submission of Paper Claims:

1. Complete all required fields on an original, red CMS 1500 (Version 02/12) or CMS 1450 (UB-04) Claim Form. Note: Non-red and handwritten claim forms will be rejected back to the provider.

2. Ensure all Diagnosis Codes, Procedure Codes, Modifier, Location (Place of Service); Type of Bill, Type of Admission, and Source of Admission Codes are valid for the date of service.

3. Ensure all Diagnosis and Procedure Codes are appropriate for the age and/or sex of the member.

4. Ensure all Diagnosis Codes are coded to their highest number of digits available.

5. Ensure the member is eligible for services during the time period in which services were provided.

6. Ensure that services were provided by a participating provider or that the “out-of-network” provider has received authorization to provide services to the eligible member.

7. Ensure an authorization has been given for services that require prior authorization by Superior HealthPlan Advantage.

Claims missing the necessary requirements are not considered “clean claims” and will be returned to providers with a written notice describing the reason for return.

Corrected Claims, Requests for Reconsideration or Claim Disputes

All requests for Corrected Claims, Request for Reconsiderations or Claim Disputes must 1) comply with the timeframe specified in the provider contract or 2) must be received within one hundred and twenty (120) days from the date of explanation of payment or denial is issued. Prior processing will be upheld for corrected claims or provider claim Requests for Reconsideration or Disputes received outside of the one hundred and twenty (120) days unless a qualifying circumstance is offered and appropriate documentation is provided to support the qualifying circumstance. Qualifying circumstances include:

- A catastrophic event that substantially interferes with normal business operation of the provider, or damage or destruction of the provider’s business office or records by a natural disaster, mechanical, administrative delays or errors by Superior HealthPlan Advantage or the Federal and/or State regulatory body.

- The member was eligible; however, the provider was not aware that the member was eligible for services at the time services were rendered. Consideration is granted in this situation only if all of the following conditions are met:
  - The provider’s records document that the member refused or was physically unable to provide his or her ID card or information.
  - The provider can substantiate that he or she continually pursued reimbursement from the patient until eligibility was discovered.
  - The provider has not filed a claim for this member prior to the filing of the claim under review.
Below are relevant definitions.

- Corrected claim – A provider is CHANGING the original claim.
- Request for Reconsideration – Provider disagrees with the original claim outcome such as the payment amount and/or the denial reason, etc.
- Claim Dispute/Appeal – Provider disagrees with the outcome of the Request for Reconsideration.

Corrected Claims

Corrected claims must clearly indicate they are corrected in one of the following ways:

- Submit a corrected claim via the Secure Provider Portal - Follow the instructions on the portal for submitting a correction.
- Submit a corrected claim electronically via a Clearinghouse.
  - Institutional Claims (UB): Field CLM05-3=7 and Ref*8 = Original Claim Number
  - Professional Claims (CMS): Field CLM05-3=7 and REF*8 = Original Claim Number
- Submit a corrected paper claim to:

  Superior HealthPlan Advantage  
  Corrections, Reconsiderations or Appeals  
  PO BOX 3060  
  Farmington, MO 63640-3060

- The original claim number must be typed in field 22 (CMS 1500) and in field 64 (UB-04) with the corresponding frequency codes in field 22 of the CMS 1500 and in field 4 of the UB-04 form.
- Corrected claims must be submitted on standard red and white forms. Handwritten corrected claims will result in an upfront rejection.

Request for Reconsideration

A Request for Reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally, medical records are not required for a Request for Reconsideration. However, if the Request for Reconsideration is related to a code audit, code edit or authorization denial, medical records must accompany the Request for Reconsideration. If the medical records are not received, the original denial will be upheld.

Reconsiderations may be submitted in the following ways:

1. **Form**: The preferred method for form submission is that providers utilize the Request for Reconsideration form found on the Superior HealthPlan Advantage website.

2. **Phone call to Provider Services**: This method may be utilized for Requests for Reconsideration that do not require submission of supporting or additional information. This may be used when a provider may believe a particular service should be reimbursed at a particular rate; however, the payment amount did not reflect that particular rate.

3. **Written Letter**: Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient identifying information such as the member name, member ID number, date of service, total charges, provider name, original EOP, and/or the original claim number found in box 22 on a CMS 1500 form or field 64 on a UB-04 form.
Requests for reconsideration and any applicable attachments must be mailed to:

**Superior HealthPlan Advantage**  
Corrections, Reconsiderations or Appeals  
PO BOX 3060  
Farmington, MO 63640-3060

**Claim Dispute or Appeals**

A claim dispute or appeal should be used only when a provider has received an unsatisfactory response to a Request for Reconsideration.

A claim dispute or appeal must be submitted on a claim dispute or appeal form found on our website. The claim dispute/appeal form must be completed in its entirety. The completed claim dispute or appeal form may be mailed to:

**Superior HealthPlan Advantage**  
Corrections, Reconsiderations or Appeals  
PO BOX 3060  
Farmington, MO 63640-3060

If the Corrected Claim, the Request for Reconsideration or the Claim Dispute results in an adjusted claim, the provider will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and steps for escalated reconsideration.

Superior HealthPlan Advantage shall process, and finalize all Corrected Claims, Requests for Reconsideration and disputed claims to a paid or denied status in accordance with law and regulation.

**Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)**

Superior HealthPlan Advantage partners with specific vendors to provide an innovative web based solution for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs). This service is provided at no cost to providers and requires online enrollment. Providers are able to enroll after they have received their completed contract or submitted a claim. Please visit the Superior HealthPlan Advantage website for information about EFT and ERA or contact Provider Services.

Benefits include:

- **Elimination of paper checks** - all deposits transmitted via EFT to the designated bank account
- Convenient payments & retrieval of remittance information
- Electronic remittance advices presented online
- HIPAA 835 electronic remittance files for download directly to a HIPAA-Compliant Practice Management for Patient Accounting System
- **Reduce accounting expenses** – Electronic remittance advices can be imported directly into practice management or patient accounting system which eliminates the need for manual re-keying.
- **Improve cash flow** – Electronic payments can result in faster payments and improved cash flow.
- **Maintain control over bank accounts** - Providers have *total* control over the destination of claim payment funds. Multiple practices and accounts are supported.

- **Match payments to advices quickly** – Providers can associate electronic payments with electronic remittance advices quickly and easily.

- **Manage multiple Payers** – Reuse enrollment information to connect with multiple payers assign different payers to different bank accounts, as desired.

For more information, please visit Superior HealthPlan Advantage Provider home page at [SuperiorHealthPlan.com](http://SuperiorHealthPlan.com). If further assistance is needed, please contact our Provider Services department at 1-800-218-7453.

### Risk Adjustment and Correct Coding

Risk adjustment is a critical and a requirement defined in CFR42 (Section 42 of the Code of Federal Regulations) and the Medicare Modernization Act. It helps to ensure the long-term success of the Medicare Advantage program. Accurate calculation of risk adjustment requires accuracy, documentation completeness, and specificity in diagnostic coding. Providers should, at all times, document and code according to CMS regulations and follow all applicable coding guidelines for ICD-9 CM, CPT, DSM-IV, and Health Care Common Procedure Coding System (HCPCs) code sets. Services rendered after October 1, 2015 are required, per CMS, to be billed using ICD-10 and DSM-V coding guidelines. Providers should note the following guidelines:

- Code all diagnoses to the highest level of specificity using the fourth (4th) and fifth (5th) digits, when applicable and defensible through chart audits and medical assessments.

- Code all documented conditions that co-exist at the time of the encounter and/or visit, and require or affect patient care, treatment, or management.

- Ensure that medical record documentation is clear, concise, consistent, complete and legible and meets CMS signature guidelines and that each encounter stands alone.

- Submit claims and encounter information according to the requirements specified in the Provider Contract or this Provider Manual.

- Alert Superior HealthPlan Advantage of any erroneous data submitted and follows Superior HealthPlan Advantage’s policies to correct errors as set forth in the Provider Contract or this Provider Manual.

- Provide ongoing training to your staff regarding appropriate use of ICD coding for reporting diagnoses.

### Coding Of Claims/ Billing Codes

Superior HealthPlan Advantage requires claims to be submitted using codes from the current version of ICD-9-CM/ ICD-10-CM (effective 10-01-15), ASA, DRG, CPT, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with Federal and State regulations as necessary. Below are some code related reasons a claim may reject or deny:

- The code billed is missing, invalid, or deleted at the time of services.

- The code is inappropriate for the age or sex of the member.

- The diagnosis is code missing the fourth (4th) and fifth (5th) digit as appropriate (ICD-9).

- The procedure code is pointing to a diagnosis that is not appropriate to be billed as primary.
- The code billed is inappropriate for the location or specialty billed.
- The code billed is part of a more comprehensive code billed on same date of service.

Written descriptions, itemized statements, and invoices may be required for non-specific types of claims or at the request of Superior HealthPlan Advantage.

Newborn services provided in the hospital will be reimbursed separately from the mother's hospital stay. Separate claims should be submitted for the mother and her newborn.

Billing from independent provider-based Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) for covered RHC/FQHC services furnished to members should be made with specificity regarding diagnosis codes and procedure code or modifier combinations.

Code all documented conditions that coexist at the time of the encounter or visit that affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

For more information regarding billing codes, coding, and code auditing or editing, please contact Superior HealthPlan Advantage Provider Services.

**Code Auditing and Editing**

Superior HealthPlan Advantage uses HIPAA compliant code auditing software to assist in improving accuracy and efficiency in claims processing, payment, and reporting. The software will detect, correct, and document coding errors on provider claims submissions prior to payment. The software analyzes CPT, HCPCS, Diagnosis codes and modifiers against correct coding principles established by the AMA and CMS. Moreover, the software contains additional edit logic that is sourced from medical and provider societies for billing rules for their membership on correct coding principles. These policies are based on correct coding principles established by the AMA and CMS clinical policies for correct coding. Claims billed in a manner that do not adhere to the standards of the code auditing software will be denied or pended for further review by a coding analyst.

The code auditing software contains a comprehensive set of rules addressing coding inaccuracies such as: unbundling, fragmentation, up-coding, duplication, invalid codes, and mutually exclusive procedures. The software offers a wide variety of edits that are based on:

- **American Medical Association (AMA)** is software that utilizes the CPT Manuals, CPT Assistant, CPT Insider’s View, the AMA website, and other sources.
- **Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI)**, which includes column 1 and column 2, are mutually exclusive and have an outpatient code editor (OCE edits). In addition to using the AMA’s CPT Manual, the NCCI coding policies are based on national and local policies and edits, coding guidelines developed by national societies, and analysis of standard medical and surgical practices and a review of current coding practices.
- **Public-domain specialty society guidance (i.e., American College of Surgeons, American College of Radiology, American Academy of Orthopedic Surgeons).**
- **Clinical consultants** who research, document, and provide edit recommendations based on the most common clinical scenario.
In addition to nationally-recognized coding guidelines, the software has added flexibility to its rule engine to allow business rules that are unique to the needs of individual product lines.

The following provides conditions where the software will make a change on submitted codes:

**Unbundling of Service** - identifies services that have been unbundled.

*Example: Unbundling lab panel. If component lab codes are billed on a claim along with a more comprehensive lab panel code that more accurately represents the service performed, the software will bundle the component codes into the more comprehensive panel code. The software will also deny multiple claim lines and replace those lines with a single, more comprehensive panel code when the panel code is not already present on the claim.*

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>80053</td>
<td>Comprehensive Metabolic Panel</td>
<td>Disallow</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC, Automated and automated differential WBC count</td>
<td>Disallow</td>
</tr>
<tr>
<td>84443</td>
<td>Thyroid Stimulating Hormone</td>
<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:** 80053, 85025, and 84443 are included in the lab panel code 80050; therefore, they are not separately reimbursable. Those claims lines containing the component codes are denied and only the comprehensive lab panel code is reimbursed.

<table>
<thead>
<tr>
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<td>Disallow</td>
</tr>
<tr>
<td>80050</td>
<td>General Health Panel</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:** 80053, 85025, and 84443 are included in the lab panel code 80050; therefore, they are not separately reimbursable. Those claim lines containing the component codes are denied, and CPT code 80050 is added to a new service line and recommended for reimbursement.

**Bilateral** - Identical procedures performed on bilateral anatomical site during same operative session.

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>69436</td>
<td>Tympanostomy</td>
<td>Allow</td>
</tr>
<tr>
<td>69436 50</td>
<td>Tympanostomy billed with modifier 50 (bilateral procedure)</td>
<td>Reduce payment</td>
</tr>
</tbody>
</table>

**Duplicate Services** - Submission of same procedure more than once on the same date of service that cannot be, or normally not, performed more than once on the same day.
Example: Excluding a Duplicate CPT

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey, study</td>
<td>Allow</td>
</tr>
<tr>
<td></td>
<td>anteroposterior &amp; lateral</td>
<td></td>
</tr>
<tr>
<td>72010</td>
<td>Radiologic exam, spine, entire, survey, study</td>
<td>Disallow</td>
</tr>
<tr>
<td></td>
<td>anteroposterior &amp; lateral</td>
<td></td>
</tr>
</tbody>
</table>

Explanation:

- Procedure 72010 includes radiologic examination of the lateral and anteroposterior views of the entire spine that allow views of the upper cervical vertebrae, the lower cervical vertebrae, the thoracic vertebrae, the lumbar vertebrae, the sacrum, and the coccyx.
- It is clinically unlikely that this procedure would be performed twice on the same date of service.

Evaluation and Management Services (E/M) - Submission of E/M services either within a global surgery period or on the same date of service as another E/M service.

Global Surgery -

Procedures that are assigned a ninety (90) day global surgery period are designated as major surgical procedures. Those assigned a ten (10) day or zero (0) day global surgery period are designated as minor surgical procedures.

- Evaluation and management services submitted with major surgical procedures (90) day and minor surgical procedures (10) day, are not recommended for separate reporting because they are part of the global services.
- Evaluation and management services submitted with minor surgical procedures (0) day, are not recommended for separate reporting or reimbursement because these services are part of the global services.

Example: Global Surgery Period

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>27447</td>
<td>Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty).</td>
<td>Allow</td>
</tr>
<tr>
<td>DOS=05/20/09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling &amp; coordination of care with other Providers or agencies are provided consistent with nature of problem(s) &amp; patient’s &amp;/or family’s needs. Problem(s) are low to moderate severity. Typically fifteen (15) minutes are spent face-to-face with the patient &amp;/or family.</td>
<td>Disallow</td>
</tr>
<tr>
<td>DOS=06/02/09</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Explanation:

- Procedure Code 27447 has a global surgery period of ninety (90) days.
- Procedure Code 99213 is submitted with a date of service that is within the ninety (90) day global period.
- When a substantial diagnostic or therapeutic procedure is performed, the evaluation and management service is included in the global surgical period.

Example: E/M with Minor Surgical Procedures

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to ten (10%) percent of body surface.</td>
<td>Allow</td>
</tr>
<tr>
<td>DOS=01/23/10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an EST patient, which requires at least two (2) of these three (3) key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling &amp; coordination of care with other providers or agencies are provided consistent nature of problem(s) &amp; patient's &amp;/or family's needs. Problem(s) are low to moderate severity. Typically fifteen (15) minutes are spent face-to-face with patient &amp;/or family.</td>
<td>Disallow</td>
</tr>
<tr>
<td>DOS=01/23/10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Explanation:

- Procedure 11000 (0 day global surgery period) is identified as a minor procedure.
- Procedure 99213 is submitted with the same date of service.
- When a minor procedure is performed, the evaluation and management service is considered part of the global service.

Same Date of Service

One evaluation and management service is recommended for reporting on a single date of service.

Example: Same Date of Service

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two (2) of these three (3) key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent nature of problem(s) and patient's and/or family's needs. Usually, problem(s) are moderate to high severity. Typically forty (40) minutes are spent face-to-face with patient and/or family.</td>
<td>Allow</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, which requires these three (3) key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Counseling or coordination of care with other Providers or agencies are provided consistent with nature of problem(s) and patient's/family's needs. Presenting problem(s) are low severity. Typically thirty (30) minutes are spent face-to-face with patient and/or family.</td>
<td>Disallow</td>
</tr>
</tbody>
</table>
• Procedure 99215 is used to report an evaluation and management service provided to an established patient during a visit.
• Procedure 99242 is used to report an office consultation for a new or established patient.
• Separate reporting of an evaluation and management service with an office consultation by a single provider indicates a duplicate submission of services. Interventions provided during an evaluation and management service typically include the components of an office consultation.

Please note the following:

**Modifier – 24** is used to report an unrelated E/M service by the same provider during a post-operative period.

**Modifier – 25** is used to report a significant separately identifiable E/M service by the same provider or other qualified health care professional on the same day of a procedure. The E/M service will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines are utilized to determine whether or not a modifier 25 was used appropriately:

• If the E/M service is the first time a provider has seen the member or evaluated a major condition;
• A diagnosis on the claim indicates that a separate medical condition was treated in addition to the procedure that was performed;
• The member’s condition is worsening as evidenced by diagnostic procedures being performed on or around the date of services; and
• If a provider bills supplies or equipment, on or around the same date, that are unrelated to the procedure performed but would have required E/M services to determine the patient’s need.

Providers should assign all applicable diagnosis code(s) that indicate the need for additional E/M services. E/M codes appended with a modifier 25 will not automatically be reimbursed. Medical records will be required to support the billing of the modifier.

**Modifier- 50** is used to indicate a procedure performed on bilateral anatomical sites and applied to a surgical, radiological or diagnostic procedure.

**Modifier – 59** is used to report distinct procedures or services not normally reported together but appropriately billable under the circumstances. Procedures or services reported with modifier 59 will be reviewed through the code edit and audit process and may require the submission of medical records. The following guidelines will be utilized to determine if a modifier 59 was used correctly:

• The diagnosis codes on the claim indicate multiple conditions or sites were treated or are likely to be treated.
• Claim history for the patient indicates that diagnostic testing was performed on multiple body sites or areas which would result in procedures being performed on multiple body areas and sites.

Providers should assign to the claim all applicable diagnosis and procedure codes and utilize all applicable anatomical modifiers designating which areas of the body were treated. Procedures or services appended with a modifier 59 will not automatically be reimbursed. Medical records will be needed to support the billing of the modifier.

**Modifier- 79** is used to report an unrelated procedure or service by the same provider or other qualified health care professional during the post-operative period.
Modifiers- Codes added to the main procedure code to indicate the service has been altered by a specific circumstance:

**Modifier- 26 (Professional Component)**

**Definition:** Modifier- 26 identifies the professional component of a test or study.

- If modifier – 26 is not valid for the submitted procedure code, the procedure code is not recommended for separating reporting.
- When a claim line is submitted without the modifier – 26 in a facility setting (i.e. POS 21, 22, 23, 34), the rule will replace the service line with a new line with the same Procedure Code and the modifier – 26 appended.

**Example:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>78278</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Disallow</td>
</tr>
<tr>
<td>78278-26</td>
<td>Acute gastrointestinal blood loss imaging</td>
<td>Allow</td>
</tr>
</tbody>
</table>

**Explanation:**

- Procedure code 78278 is valid with modifier – 26.
- Modifier – 26 will be added to procedure code 78278 when submitted without a modifier – 26.

**Modifier – 80 and -82 (Assistant Surgeon)**

**Definition:** This edit identifies claim lines containing Procedure Codes billed with an assistant surgeon modifier that typically do not require as assistant surgeon.

Many surgical procedures require aid in prepping and draping the patient, monitoring visualization, keeping the wound clear of blood, holding and positioning the patient, and assisting with wound closure and/or casting, if required. This assistance does not require the expertise of a surgeon. A qualified nurse, orthopedic technician, or resident physician can provide the necessary assistance.

**Explanation:**

- Procedure Code 42820 is not recommended for assistant surgeon reporting because a skilled nurse or surgical technician can function as the assistant in the performance of this procedure.

**Other Edits**

The following provides examples of other types of edits that will be used during the adjudication process:

- Validity edits are due to invalid data submitted. For example,
  - ICD-CM diagnosis codes – Wrong codes;
  - HCPCS procedure codes without Revenue codes (for APC);
  - Invalid age – Inappropriate procedures for the age of the member
– Invalid sex – Inappropriate procedure for the gender of the member; and
– Diagnosis/procedure and age or sex conflicts – Inappropriate procedure for the age and gender of the member

• Volume/unit edits—Medically Unlikely Edits – *Note: The code audit and edit process will review the number of doses billed for allergen immunotherapy.* This is based upon Chapter 15 of the Medicare Benefits Policy Manual.

• Claim lacks required device or procedure code.
• Specific nuclear medicine services on claims that do not contain specific radiopharmaceuticals.
• National Correct Coding Initiative (CCI) Edits
• Outpatient Code Editor (OCE) Edits

Claim Reconsiderations Related to Code Auditing and Editing

If a provider disagrees with a code audit or edit and request claim reconsideration, medical documentation and record related to the reconsideration is required. If medical documentation is not received, the original code audit or edit will be upheld.

CPT Category II Codes

CPT Category II Codes are supplemental tracking codes developed to assist in the collection and reporting of information regarding performance measurement which includes HEDIS. Submission of CPT Category II Codes allows data to be captured at the time of service and may reduce the need for retrospective medical record review.

Uses of these codes are optional and are not required for correct coding. They may not be used as a substitute for Category I Codes. However, as noted above, submission of these codes can minimize the administrative burden on providers and health plans by greatly decreasing the need for medical record review.

Code Editing Assistant

A web-based code auditing reference tool designed to “mirror” how the code auditing product(s) evaluate code and code combinations during the auditing of claims. The tool is available for providers who are registered on Superior HealthPlan Advantage Secure Provider Portal. Providers can access the tool in the Secure Provider Portal by referencing Claims Module then clicking “Claim Auditing Tool”.

This tool offers many benefits:

• *Prospectively* access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
• *Proactively* determine the appropriate code or code combination representing the service for accurate billing purposes

The tool will review what was entered and will determine if the code or code combinations are correct based on the age, sex, location, modifier if applicable, or other code(s) entered.

The Code Editing Assistant is intended for use as a “what if” or hypothetical reference tool. It is meant to apply coding logic only. *Note: The tool does not take into consideration historical claims information which may have been used to determine an edit. The tool assumes all CPT codes are billed on a single claim.*
The tool will not take into consideration individual fee schedule reimbursement, authorization requirements, or other coverage considerations. The tool is a guideline and the results displayed do not guarantee how the claim will be processed.

**Clinical Lab Improvement Act (CLIA) Billing Instructions**

CLIA numbers are required for CMS 1500 claims where CLIA Certified or CLIA waived services are billed. If the CLIA number is not present, the claim will result in an upfront rejection. Below are billing instructions on how and/or where to provide the CLIA certification or waiver number on the following claim type submissions:

**Paper Claims**

If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided in Box 23.

*Note: As it would any laboratory service, an independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service. The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two (2) separate claims, one (1) claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one (1) laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred unless one or more of the reference laboratories are separately billing. When the referring laboratory is the billing laboratory, the reference laboratory’s name, address, and zip code shall be reported in item 32 on the CMS-1500 claim form to show where the service or test was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.*

**EDI**

If a single claim is submitted for those laboratory services for which CLIA certification or waiver is required, report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

-Or-

If a claim is submitted with both laboratory services for which CLIA certification or waiver is required and non-CLIA covered laboratory test, in the 2400 loop for the appropriate line report the CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4

*Note: The billing laboratory submits, on the same claim, tests referred to another referral or rendered laboratory, with modifier 90 reported on the line item and reports the referral laboratory’s CLIA certification or waiver number in: X12N 837 (HIPAA version) loop 2400, REF02. REF01 = X4*

Please refer to the 5010 implementation guides for the appropriate loops to enter the CLIA number. If a particular claim has services requiring an authorization number and CLIA services, only the CLIA number must be provided.
Web

Complete Box 23 with CLIA certification or waiver number as the prior authorization number for those laboratory services for which CLIA certification or waiver is required.

Note: As it would any laboratory service, an independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service. The line item services must be submitted with a modifier 90. An independent clinical laboratory that submits claims in paper format may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two (2) separate claims, one (1) claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred unless one or more of the reference laboratories are separately billing. When the referring laboratory is the billing laboratory, the reference laboratory’s name, address, and zip code shall be reported in item 32 on the CMS-1500 claim form to show where the service or test was actually performed. The NPI shall be reported in item 32a. Also, the CLIA certification or waiver number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form.

Third Party Liability

Third Party Liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker’s compensation) or program that is or may be liable to pay all or part of the health care expenses of the member.

If Third Party Liability coverage is determined after services are rendered, Superior HealthPlan Advantage will coordinate with the provider to pay any claims that may have been denied for payment due to Third Party Liability.

BILLING THE MEMBER

Failure to Obtain Authorization

Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by Superior HealthPlan Advantage.

No Balance Billing

Providers may not seek payment from Superior HealthPlan Advantage members for the difference between the billed charges and the contracted rate paid by Superior HealthPlan Advantage.

Non-Covered Services

Contracted providers may only bill Superior HealthPlan Advantage members for non-covered services. If the member and provider both sign an agreement outlining the member’s responsibility to pay prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- the specific service(s) to be provided;
• a statement that the service is not covered by Superior HealthPlan Advantage;
• a statement that the member chooses to receive and pay for the specific service; and
• the member is not obligated to pay for the service if it is later found that service was covered by Superior HealthPlan Advantage at the time it was provided, even if Superior HealthPlan Advantage did not pay the provider for the service because the provider did not comply with Superior HealthPlan Advantage requirements.

MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Providers must comply with the rights of members as set forth below.

1. To participate with providers in making decisions about his/her health care. This includes working on any treatment plans and making care decisions. The member should know any possible risks, problems related to recovery, and the likelihood of success. The member shall not have any treatment without consent freely given by the member or the member’s legally authorized surrogate decision-maker. The member must be informed of their care options.

2. To know who is approving and who is performing the procedures or treatment. All likely treatments and the nature of the problem should be explained clearly.

3. To receive the benefits for which the member has coverage.

4. To be treated with respect and dignity.

5. To privacy of their personal health information, consistent with state and federal laws, and Superior HealthPlan Advantage policies.

6. To receive information or make recommendations, including changes, about Superior HealthPlan Advantage’s organization and services, the Superior HealthPlan Advantage network of providers, and member rights and responsibilities.

7. To candidly discuss with their providers appropriate and medically necessary care for their condition, including new uses of technology, regardless of cost or benefit coverage. This includes information from the member’s primary care physician about what might be wrong to the level known, treatment and any known likely results. The provider must tell the member about treatments that may or may not be covered by the plan, regardless of the cost. The member has a right to know about any costs they will need to pay. The member should be informed in a way that the member can understand. When it is not appropriate to give the member information for medical reasons, the information can be given to a legally authorized person. The provider will ask for the member’s approval for treatment unless there is an emergency and the member’s life and health are in serious danger.

8. To make recommendations regarding the Superior HealthPlan Advantage member’s rights, responsibilities and policies.

9. To voice complaints or appeals about: Superior HealthPlan Advantage, any benefit or coverage decisions Superior HealthPlan Advantage makes, Superior HealthPlan Advantage coverage, or the care provided.

10. To refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by the provider(s) of the medical consequences.

11. To see their medical records.

12. To be kept informed of covered and non-covered services, program changes, how to access services, primary care physician assignment, providers, advance directive information, referrals and authorizations, benefit denials, member rights and responsibilities, and other Superior
HealthPlan Advantage rules and guidelines. Superior HealthPlan Advantage will notify members before the effective date of the modifications. Such notices shall include the following:

- Any changes in clinical review criteria.
- A statement of the effect of such changes on the personal liability of the member for the cost of any such changes.

13. To have access to a current list of network providers. Additionally, a member may access information on network providers’ education, training, and practice.

14. To select a health plan or switch health plans, within the guidelines, without any threats or harassment.

15. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual preference, national origin or religion.

16. To access medically necessary urgent and emergency services twenty-four (24) hours a day and seven (7) days a week.

17. To receive information in a different format in compliance with the Americans with Disabilities Act, if the member has a disability.

18. To refuse treatment to the extent the law allows. The member is responsible for their actions if treatment is refused or if the provider’s instructions are not followed. The member should discuss all concerns about treatment with their primary care physician or other provider. The primary care physician or other provider must discuss different treatment plans with the member. The member must make the final decision.

19. To select a primary care physician within the network. The member has the right to change their primary care physician or request information on network providers close to their home or work.

20. To know the name and job title of people providing care to the member. The member also has the right to know which provider is their primary care physician.

21. To have access to an interpreter when the member does not speak or understand the language of the area.

22. To a second opinion by a network provider, at no cost to the member, if the member believes that the network provider is not authorizing the requested care, or if the member wants more information about their treatment.

23. To execute an advance directive for health care decisions. An advance directive will assist the Primary Care Provider and other providers in understanding the member’s wishes about the member’s health care. The advance directive will not take away the member’s right to make their own decisions. Examples of advance directives include:

- Living Will.
- Health Care Power of Attorney.
- “Do Not Resuscitate” Orders.

24. Members also have the right to refuse to make advance directives. Members may not be discriminated against for not having an advance directive.

**Member Responsibilities**

1. To read their Superior HealthPlan Advantage Contract in its entirety.

2. To treat all health care professionals and staff with courtesy and respect.

3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health. The member should make it
known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider so they understand the care they are receiving.

4. To review and understand the information they receive about Superior HealthPlan Advantage. The member needs to know the proper use of covered services.

5. To show their I.D. card and keep scheduled appointments with their provider and call the provider’s office during office hours whenever possible, if the member has a delay or cancellation.

6. To know the name of their assigned primary care physician. The member should establish a relationship with their primary care physician. The member may change their primary care physician verbally or in writing by contacting the Superior HealthPlan Advantage Member Services Department at 1-877-935-8023.

7. To read and understand to the best of their ability all materials concerning their health benefits or to ask for assistance if they need it.

8. To understand their health problems and participate, along with their health care providers in developing mutually agreed upon treatment goals to the degree possible.

9. To supply, to the extent possible, information that Superior HealthPlan Advantage and/or their providers need in order to provide care.

10. To follow the treatment plans and instructions for care that they have agreed on with their health care providers.

11. To understand their health problems and tell their health care providers if they do not understand their treatment plan or what is expected of them. The member should work with their primary care physician to develop mutually agreed upon treatment goals. If the member does not follow the treatment plan, the member has the right to be advised of the likely results of their decision.

12. To follow all health benefit plan guidelines, provisions, policies and procedures.

13. To use any emergency room only when they think they have a medical emergency. For all other healthcare services, the member should call their primary care physician.

14. To give all information about any other medical coverage they have at the time of enrollment. If, at any time, the member gains other medical coverage besides Superior HealthPlan Advantage coverage, the member must provide this information to Superior HealthPlan Advantage.

15. To pay their monthly premium, all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

PROVIDER RIGHTS AND RESPONSIBILITIES

Provider Rights

1. To be treated by their patients, who are Superior HealthPlan Advantage members, and other healthcare workers with dignity and respect.

2. To receive accurate and complete information and medical histories for members’ care.

3. To have their patients, who are Superior HealthPlan Advantage members, act in a way that supports the care given to other patients and that helps keep the doctor’s office, hospital, or other offices running smoothly.

4. To expect other network providers to act as partners in members’ treatment plans.

5. To expect members to follow their health care instructions and directions such as taking the right amount of medication at the right times.

6. To make a complaint or file an appeal against Superior HealthPlan Advantage and/or a member.
7. To file a grievance on behalf of a member, with the member’s consent.

8. To have access to information about Superior HealthPlan Advantage quality improvement programs, including program goals, processes, and outcomes that relate to member care and services.

9. To contact Provider Services with any questions, comments, or problems.

10. To collaborate with other health care professionals who are involved in the care of members.

11. To not be excluded, penalized, or terminated from participating with Superior HealthPlan Advantage for having developed or accumulated a substantial number of patients in Superior HealthPlan Advantage with high cost medical conditions.

12. To collect member cost shares at the time of the service.

**Provider Responsibilities**

Providers must comply with each of the items listed below.

1. To help or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
   - Recommend new or experimental treatments.
   - Provide information regarding the nature of treatment options.
   - Provide information about the availability of alternative treatment options, therapies, consultations, or tests, including those that may be self-administered.
   - Be informed of risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options.

2. To treat members with fairness, dignity, and respect.

3. To not discriminate against members on the basis of race, color, national origin, limited language proficiency, religion, age, health status, existence of a pre-existing mental or physical disability/condition including pregnancy and/or hospitalization, the expectation for frequent or high cost care.

4. To maintain the confidentiality of members’ personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.

5. To give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider’s practice and scope of service.

6. To provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA.

7. To allow members to request restriction on the use and disclosure of their personal health information.

8. To provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.

9. To provide clear and complete information to members - in a language they can understand - about their health condition and treatment, regardless of cost or benefit coverage, and allow member participation in the decision-making process.

10. To tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment.

11. To allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.
12. To respect members’ advance directives and include these documents in their medical record.
13. To allow members to appoint a parent guardian, family member, or other representative if they can’t fully participate in their treatment decisions.
14. To allow members to obtain a second opinion, and answer members’ questions about how to access health care services appropriately.
15. To follow all state and federal laws and regulations related to patient care and rights.
16. To participate in Superior HealthPlan Advantage data collection initiatives, such as HEDIS and other contractual or regulatory programs.
17. To review clinical practice guidelines distributed by Superior HealthPlan Advantage.
18. To comply with the Superior HealthPlan Advantage Medical Management program as outlined herein.
19. To disclose overpayments or improper payments to Superior HealthPlan Advantage.
20. To provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status.
21. To obtain and report to Superior HealthPlan Advantage information regarding other insurance coverage the member has or may have.
22. To give Superior HealthPlan Advantage timely, written notice if the provider is leaving or closing a practice.
23. If appropriate, to contact Superior HealthPlan Advantage to verify member eligibility and benefits.
24. To invite member participation in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals.
25. To provide members with information regarding office location, hours of operation, accessibility, and translation services.
26. To object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds.
27. To provide hours of operation to Superior HealthPlan Advantage members that are no less than those offered to other Medicare patients.

CULTURAL COMPETENCY

Superior HealthPlan Advantage views Cultural Competency as the measure of a person or organization’s willingness and ability to learn about, understand and provide excellent customer service across all segments of the population. It is the active implementation of a system wide philosophy that values differences among individuals and is responsive to diversity at all levels in the community and within an organization and at all service levels the organization engages in outside of the organization. A sincere and successful Cultural Competency program is evolutionary and ever-changing to address the continual changes occurring within communities and families. In the context of health care delivery, Cultural Competency is the promotion of sensitivity to the needs of patients who are members of various racial, religious, age, gender and/or ethnic groups and accommodating the patient’s culturally-based attitudes, beliefs and needs within the framework of access to health care services and the development of diagnostic and treatment plans and communication methods in order to fully support the delivery of competent care to the patient. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.
Superior HealthPlan Advantage is committed to the development, strengthening and sustaining of healthy provider and member relationships. Members are entitled to dignified appropriate care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment reducing effectiveness of the entire healthcare process. Superior HealthPlan Advantage offers training and resources to providers and their staff that they can use to develop their skills and office culture. (Please refer to Provider Training for more details.

As part of Superior HealthPlan Advantage’s Cultural Competency Program, providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Medical care is provided with consideration of the members’ primary language, race and/or ethnicity as it relates to the members’ health or illness.
- Office staff routinely interacting with members has been given the opportunity to participate in, and have participated in, cultural competency training.
- Office staff responsible for data collection makes reasonable attempts to collect race and language specific information for each member. Staff will also explain race categories to a member in order to assist the member in accurately identifying their race or ethnicity.
- Treatment plans are developed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member’s perspective on health care.
- Office sites have posted and printed materials in English and Spanish or any other non-English language which may be prevalent in the applicable geographic area.
- An appropriate mechanism is established to fulfill the provider’s obligations under the Americans with Disabilities Act including that all facilities providing services to members must be accessible to persons with disabilities. Additionally, no member with a disability may be excluded from participation in or be denied the benefits of services, programs or activities of a public facility, or be subjected to discrimination by any such facility.

Superior HealthPlan Advantage considers mainstreaming of members an important component of the delivery of care and expects providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a member a covered service or availability of a facility.
- Providing a Superior HealthPlan Advantage member a covered service that is different in time or location than to other “public” or private pay members. Some examples include separate waiting rooms and delayed appointment times.

There are other numerous resources available to physicians, nurses, and those working in the medical field.

The following are some of the resources available:

- On the Office of Minority Health’s website, you will find “A Physician’s Practical Guide to Culturally Competent Care.” By taking this course online, you can earn up to nine CME credits, or
nine contact hours for free. The course may be found at:

- Think Cultural Health’s website includes classes, guides and tools to assist you in providing culturally competent care. The website is: http://www.thinkculturalhealth.hhs.gov/
- The Health Care Literacy website which offers a toolkit as a way for primary care practices to assess their services for health literacy considerations, raise awareness of their entire staff, and work on specific areas. The toolkit can be found at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

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 as soon as possible, or at least two (2) business days before the appointment. All Providers (Medical, Behavioral, LTSS, Pharmacy, etc...) can call Member Services at 1-877-935-8023 or TTY 1-800-735-2989 to help arrange translation services.

Americans with Disabilities Act

Superior HealthPlan Advantage strives to assist providers in meeting the requirements in Title II and Title III of the ADA and Section 504 which requires that medical care providers provide individuals:

- Full and equal access to healthcare services and facilities; and
- Reasonable modifications to policies, practices, and procedures when necessary to make healthcare available to individuals with disabilities, unless the modifications would fundamentally alter the nature of the services.

The term "disability", with respect to an individual, means -

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- A record of such an impairment; or
- Being regarded as having such impairment.

If an individual meets any one of these three tests, then he or she is considered to be an individual with a disability for purposes of coverage under the Americans with Disabilities Act.

General Requirements

§ 35.130 General prohibitions against discrimination.

(1) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.

(2) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability:
i. Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

ii. Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

iii. Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others;

iv. Provide different or separate aids, benefits, or services to individuals with disabilities or to any class of individuals with disabilities than is provided to others unless such action is necessary to provide qualified individuals with disabilities with aids, benefits, or services that are as effective as those provided to others;

v. Aid or perpetuate discrimination against a qualified individual with a disability by providing significant assistance to an agency, organization, or person that discriminates on the basis of disability in providing any aid, benefit, or service to beneficiaries of the public entity's program;

vi. Deny a qualified individual with a disability the opportunity to participate as a member of planning or advisory boards; and

vii. Otherwise limit a qualified individual with a disability in the enjoyment of any right, privilege, Superior HealthPlan Advantage, or opportunity enjoyed by others receiving the aid, benefit, or service.

(3) A public entity may not deny a qualified individual with a disability the opportunity to participate in services, programs, or activities that are not separate or different, despite the existence of permissibly separate or different programs or activities.

(4) A public entity may not, directly or through contractual or other arrangements, utilize criteria or methods of administration:

i. That have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of disability;

ii. That have the purpose or effect of defeating;

iii. substantially impairing accomplishment of the objectives of the public entity's program with respect to individuals with disabilities; or

iv. That perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State.

(5) A public entity may not, in determining the site or location of a facility, make selections:

i. That have the effect of excluding individuals with disabilities from, denying them the benefits of, or otherwise subjecting them to discrimination; or

ii. That have the purpose or effect of defeating or substantially impairing the accomplishment of the objectives of the service, program, or activity with respect to individuals with disabilities.

(6) A public entity, in the selection of procurement contractors, may not use criteria that subject qualified individuals with disabilities to discrimination on the basis of disability.

(7) A public entity may not administer a licensing or certification program in a manner that subjects qualified individuals with disabilities to discrimination on the basis of disability, nor may a public entity establish requirements for the programs or activities of licensees or certified entities that subject qualified
individuals with disabilities to discrimination on the basis of disability. The programs or activities of entities that are licensed or certified by a public entity are not, themselves, covered by this part.

(8) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

(9) A public entity shall not impose or apply eligibility criteria that screen out or tend to screen out an individual with a disability or any class of individuals with disabilities from fully and equally enjoying any service, program, or activity, unless such criteria can be shown to be necessary for the provision of the service, program, or activity being offered.

(10) Nothing in this part prohibits a public entity from providing benefits, services, or Superior HealthPlan Advantage to individuals with disabilities, or to a particular class of individuals with disabilities beyond those required by this part.

(11) A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

(12) Nothing in this part shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit provided under the ADA or this part which such individual chooses not to accept.

(13) Nothing in the Act or this part authorizes the representative or guardian of an individual with a disability to decline food, water, medical treatment, or medical services for that individual.

(14) A public entity may not place a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids or program accessibility, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part.

(15) A public entity shall not exclude or otherwise deny equal services, programs, or activities to an individual or entity because of the known disability of an individual with whom the individual or entity is known to have a relationship or association.

MEMBER GRIEVANCES AND APPEALS

Grievances

Members must follow the complaint or dispute (grievance) process as listed below when a member is dissatisfied with the manner in which Superior HealthPlan Advantage or a delegated entity provides healthcare services. Grievances may include:

- Timeliness
- Appropriateness
- Access to provided health services
- Setting of health services
- Procedures
Members or their representatives may submit a grievance verbally or in writing via phone, mail, facsimile, electronic mail or in person within sixty (60) calendar days after the event. If the grievance meets the necessary criteria, a resolution is delivered to the member as expeditiously as the member’s case requires, based on health status, but no later than twenty-four (24) hours for expedited grievances and thirty (30) calendar days. Extensions of up to fourteen (14) calendar days can be granted for standard grievances; if the member requests the extension or if Superior HealthPlan Advantage justifies the need for additional information and the delay is in the best interest of the member.

Appeals

Members or their representatives may file a formal appeal if they are dissatisfied with a medical care or drug coverage decision made by Superior HealthPlan Advantage. Appeals must be submitted within sixty (60) days of the decision. Expedited determinations will be made on medical care or drug coverage not yet received if standard deadlines can cause serious harm to the member’s health. Written appeals must be mailed to:

Superior HealthPlan Advantage  
Attn: Appeals and Grievances  
P. O. Box 3060  
Farmington, MO 63640

For process or status questions, members or their representatives may contact Member Services at 1-877-935-8023.

PROVIDER COMPLAINT PROCESS

Provider Complaint/Grievance and Appeal Process

Claim Complaints must follow the Dispute Process and then Complaint Process below. Medical necessity and authorization denial complaints are handled in the Appeals Process below. Please note that claim payments are not appealable. These must be handled via the Claim Dispute and Complaint Process. Claim Disputes may be mailed to:

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

Complaint or Grievance

A Complaint or Grievance is a verbal or written expression by a provider which indicates dissatisfaction or dispute with Superior HealthPlan Advantage’s policies, procedures, or any aspect of Superior HealthPlan Advantage’s functions. Superior HealthPlan Advantage logs and tracks all complaints or grievances whether received verbally or in writing. A provider has thirty (30) calendar days from the date of the incident such as the original Explanation of Payment date, to file a complaint or grievance. After a complete review of the complaint/grievance, Superior HealthPlan Advantage shall provide a written notice to the provider within thirty (30) calendar days from the received date of Superior HealthPlan Advantage’s
decision. Prior to filing a Complaint, if the complaint or grievance is related to claims payment, the provider must follow the process for Claim Reconsideration or Claim Dispute as noted in the Claims Section of this Provider Manual.

Authorization and Coverage Complaints

Authorization and Coverage Complaints must follow the Appeal process below.

An Appeal is the mechanism which allows providers the right to appeal actions of Superior HealthPlan Advantage such as a prior authorization denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by Superior HealthPlan Advantage. A provider has thirty (30) calendar days from Superior HealthPlan Advantage’s notice of action to file the appeal. Superior HealthPlan Advantage shall acknowledge receipt of each appeal within ten (10) business days after receiving an appeal. Superior HealthPlan Advantage shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member’s health condition requires, but shall not exceed thirty (30) calendar days from the date Superior HealthPlan Advantage receives the appeal. Superior HealthPlan Advantage may extend the timeframe for resolution of the appeal up to fourteen (14) calendar days if the member requests the extension or Superior HealthPlan Advantage demonstrates that there is need for additional information and how the delay is in the member’s best interest. For any extension not requested by the member, Superior HealthPlan Advantage shall provide written notice to the member for the delay.

Expedited appeals may be filed with Superior HealthPlan Advantage if the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. No punitive action will be taken against a provider that requests an expedited resolution or supports a member’s appeal. In instances where the member’s request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

Decisions for expedited appeals are issued as expeditiously as the member’s health condition requires, not exceeding seventy-two (72) hours from the initial receipt of the appeal. Superior HealthPlan Advantage may extend this timeframe by up to an additional fourteen (14) calendar days if the member requests the extension or if Superior HealthPlan Advantage provides satisfactory evidence that a delay in rendering the decision is in the member’s best interest. Providers may also invoke any remedies as determined in the Participating Provider Agreement.

Ombudsman Services

The Mission of the Ombudsman is to serve as an impartial and confidential resource, assisting our clients with health and human services-related complaints and issues. The Health and Human Services Commission’s Office of the Ombudsman helps people when the agency’s normal complaint process cannot or does not satisfactorily resolve the issue. The Office of the Ombudsman’s services includes:

- Conducts independent reviews of complaints concerning agency policies or practices.
- Ensures policies and practices are consistent with the goals of the Texas Health and Human Services Commission.
- Ensures individuals are treated fairly, respectfully and with dignity.
- Makes referrals to other agencies as appropriate.
QUALITY IMPROVEMENT PLAN

Overview

Superior HealthPlan Advantage's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality improvement initiatives using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system incorporates a continuous cycle for assessing the level of care and service form members through initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. Superior HealthPlan Advantage requires all practitioners and providers to cooperate with all QI activities, as well as to allow Superior HealthPlan Advantage to use practitioner and/or provider performance data to ensure success of the QI program.

Superior HealthPlan Advantage will arrange for the delivery of appropriate care with the primary goal being to improve the health status of its members. Where the member’s condition is not amenable to improvement, Superior HealthPlan Advantage will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Superior HealthPlan Advantage QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

QAPI Program Structure

The Superior HealthPlan Advantage Board of Directors (BOD) has the ultimate oversight for the care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to:

- Enhance and improve quality of care;
- Provide oversight and direction regarding policies, procedures, and protocols for member care and services; and
- Offer guidelines based on recommendations for appropriateness of care and services.

This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems; the identification of opportunities to improve member outcomes; and the education of members, providers and staff regarding the QI, UM, and Credentialing and Re-credentialing programs.

The following sub-committees report directly to the QIC:

January 12, 2016

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Providers can contact the Office of the Ombudsman at 1-877-787-8999 for help with any of the issues as defined above www.hhsc.state.tx.us/ombudsman/.
Provider Involvement

Superior HealthPlan Advantage recognizes the integral role that provider involvement plays in the success of its QAPI Program. Provider involvement in various levels of the process is highly encouraged through provider representation. Superior HealthPlan Advantage promotes PCP, behavioral health, specialty, and OB/GYN representation on key quality committees such as, but not limited to, the QIC, Credentials Committee, and select ad-hoc committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the level of clinical care and the level of service provided to Superior HealthPlan Advantage members. The Superior HealthPlan Advantage QAPI Program incorporates all demographic groups and ages, benefit packages, care settings, providers, and services in quality improvement activities. This includes services for the following: preventive care, primary care, specialty care, acute care, short-term care, long-term care, ancillary services, and operations, among others.

Superior HealthPlan Advantage’s primary QAPI Program goal is to improve members’ health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the care and services delivered.

To that end, the Superior HealthPlan Advantage QAPI Program monitors the following:

- Acute and chronic care management
- Behavioral health care
- Compliance with member confidentiality laws and regulations
- Compliance with preventive health guidelines and practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department entity oversight
- Department performance and service
- Employee and provider cultural competency
- Fraud and abuse detection and prevention
- Information management
- Marketing practices
- Member enrollment and disenrollment
- Member grievance system
• Member satisfaction
• Member services
• Network performance
• Organizational structure
• Patient safety including hospitals, ambulatory care centers and office-based surgery sites to endorse and adopt procedures for verifying correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol TM developed by The Joint Commission
• Primary care provider changes
• Pharmacy
• Provider and plan accessibility
• Provider availability
• Provider complaint system
• Provider network adequacy and capacity
• Provider satisfaction
• Provider services
• Quality management
• Records management
• Selection and retention of providers (credentialing and re-credentialing)
• Utilization management, including under and over utilization

Practice Guidelines
Superior HealthPlan Advantage, whenever possible, adopts preventive and clinical practice guidelines (CPG) from recognized sources, for the provision of acute, chronic and behavioral health services relevant to the populations served. Guidelines will be presented to the Quality Improvement Committee (QIC) for appropriate provider review and adoption. Guidelines will be updated at least every two (2) years or upon significant new scientific evidence or changes in national standards.

Superior HealthPlan Advantage adopts clinical practice guidelines for at least two (2) non-preventive acute or chronic medical conditions. Centene also adopts at least two (2) behavioral health conditions, preventive or non-preventive, relevant to the population. At least two (2) of the adopted CPGs directly correspond with two (2) disease management programs offered by Superior HealthPlan Advantage. Guidelines will be based on health needs of population and/or opportunities for improvement as identified through the QAPI program.

Clinical Practice guidelines (CPG) may include, but are not limited to:

• Asthma Guidelines
• Diabetes Care Guidelines
• Sickle Cell Guidelines
Centene also adopts applicable preventive health guidelines. Preventive Health guidelines may include, but are not limited to:

- Adult Preventive Health Guidelines
- Immunization Guidelines

Copies of these guidelines are available on our website at [www.SuperiorHealthPlan.com](http://www.SuperiorHealthPlan.com). All guidelines are reviewed annually for updating and/or when new scientific evidence or national standards are published. Superior HealthPlan Advantage’s QAPI program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Superior HealthPlan Advantage’s QIC bi-annually.
- Adopted guidelines are evidence-based and include preventive health services.
- Guidelines are reviewed on an annual basis and updated accordingly no less than bi-annually.
- Guidelines are disseminated to Providers in a timely manner via the following appropriate communication settings:
  - Provider orientations and other group sessions
  - Provider e-newsletters
  - Online via the HEDIS Resource Page
  - Online via the Secure Provider Portal
  - Targeted mailings

Guidelines are posted on Superior HealthPlan Advantage’s website or paper copies are available upon request by contacting Superior HealthPlan Advantage’s QI Department.

**Patient Safety and Level of Care**

Patient Safety is a key focus of the Superior HealthPlan Advantage QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual level of care events. A potential level of care issue is any alleged act or behavior that may be detrimental to the level or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. Superior HealthPlan Advantage employees including medical management staff, member services staff, provider services, complaint coordinators, etc., panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential level of care issues. Adverse events may also be identified through claims based reporting and analyses. Potential level of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential level of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

**Performance Improvement Process**

The Superior HealthPlan Advantage QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care appropriate industry standards. The QIC adopts traditional quality risk, or utilization management approaches to identify problems, issues and trends with the objective of developing improvement opportunities. Most often, initiatives are selected based on data that indicates
the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or service standards.

Performance improvement projects, focus studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and level of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow Superior HealthPlan Advantage to monitor improvement over time.

Annually, Superior HealthPlan Advantage develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The Work Plan integrates QIC activities, reporting and studies from all areas of the organization clinical and service and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Superior HealthPlan Advantage communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the member newsletter, provider newsletter and the Superior HealthPlan Advantage website at www.SuperiorHealthPlan.com.

At any time, Superior HealthPlan Advantage providers may request additional information on the health plan programs including a description of the QAPI Program and a report on Superior HealthPlan Advantage’s progress in meeting the QAPI Program goals by contacting the Quality Improvement department.

Additionally, Superior HealthPlan Advantage develops and implements chronic care improvement programs and quality improvement projects required by CMS. Superior HealthPlan Advantage encourages all providers to participate in these initiatives.

**Office Site Surveys**

Superior HealthPlan Advantage conducts site visits to the provider’s office to investigate member complaints related to physical accessibility, physical appearance, and adequacy of exam room and waiting room space. Site visits can also be conducted as part of the credentialing process, or as part of standard audits to ensure standards are being met. Standards are determined based on NCQA guidelines, State and Federal regulations. Site visits conducted by Superior HealthPlan Advantage Representatives include at a minimum:

- 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
- Adequacy of waiting and examining room space
• Scheduling/appointment availability, including office protocols/policies
• Availability of emergency equipment
• Clinical lab (CLIA) standards
• Medication administration/dispensing/storage of drug samples
• Adequacy of medical records keeping practices

MEDICARE STAR RATINGS

The Centers for Medicare and Medicaid Services (CMS) developed the Medicare Star Ratings in order to provide information to consumers about Medicare Superior HealthPlan Advantage Health Plans and to reward top-performing health plans. CMS rates the quality of service and care provided by Medicare Superior HealthPlan Advantage Health Plans based upon a five-star rating scale. This scale is comprised of: Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, and the Medicare Health Outcomes Survey (HOS).

How can providers help to improve Star Ratings?

• Continue to encourage patients to obtain preventive screenings annually or when recommended.
• Continue to talk to your patients and document interventions regarding topics such as: fall prevention; bladder control; and the importance of physical activity.
• Create office practices to identify noncompliant patients at the time of their appointment.
• Submit complete and correct encounters/claims with appropriate codes and properly document medical chart for all members.
• Review the gap in care files listing members with open gaps which are available on our Secure Provider Portal.
• Identify opportunities for you or your office to have an impact.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences.

As Federal and State governments move toward a health care industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider. CMS utilizes HEDIS rates to evaluate the effectiveness of a managed care plan’s ability to demonstrate an improvement in preventive health outreach to its members.

HEDIS Rate Calculations

HEDIS rates are calculated in two (2) ways: administrative data or hybrid data. Administrative data consists of claim and encounter data submitted to the health plan. Measures typically calculated using administrative data include Breast Cancer Screening (routine mammography), Colorectal Cancer Screening (colonoscopy, sigmoidoscopy or FOBT), Use of Disease Modifying Anti-Rheumatic Drugs for
Members with Rheumatoid Arthritis, Osteoporosis Management in Women Who Had a Fracture, Access to PCP Services, and Utilization of Acute and Mental Health Services.

Hybrid data consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of medical records to extract data regarding services rendered but not reported to the health plan through claims or encounter data. Accurate and timely claims and encounter data and submission using appropriate CPT, ICD-10 and HCPCS codes can reduce the necessity of medical record reviews. Examples of HEDIS measures typically requiring medical record review include: Adult BMI Assessment, Comprehensive Diabetes Care screenings and results including HbA1c, nephropathy, dilated retinal eye exams, and blood pressures, and Controlled Blood Pressure blood pressure results <140/90 for members with high blood pressure).

Who conducts Medical Record Reviews (MRR) for HEDIS?

Superior HealthPlan Advantage may contract with an independent national Medical Record Review (MRR) vendor to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted March through May each year. Prompt cooperation with the MRR process is greatly needed and appreciated.

As a reminder, sharing of protected health information (PHI) that is used or disclosed for purposes of treatment, payment or health care operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Superior HealthPlan Advantage that allows them to collect PHI on our behalf.

How can providers improve their HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claims and encounter data for each and every service rendered. All providers must bill or submit encounter data for services delivered, regardless of their contract status with Superior HealthPlan Advantage Claims and encounter data is the most efficient way to report HEDIS.
- Submit claims and encounter data correctly, accurately, and on time. If services rendered are not filed or billed accurately, they cannot be captured and included in the scoring calculation. Accurate and timely submission of claims and encounter data will reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided. Keep accurate chart or medical record documentation of each member service and document conversation or services.
- Submit claims and encounter data using CPT codes related to HEDIS measures such as diabetes, eye exam, and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at SHPHEDIS@centene.com.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well the plan is meeting the members’ expectations.
Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability. CAHPS survey material that may reflect on the service of providers includes:

- Whether the member received an annual flu vaccine;
- Whether members perceive they are getting needed care including specialist and prescriptions; and
- How quickly members were able to get appointments and care

**Medicare Health Outcomes Survey (HOS)**

The Medicare HOS is a patient-reported outcomes measure used in Medicare managed care. The goal of the Medicare HOS is to gather data to help target quality improvement activities and resources; monitoring health plan performance and rewarding top-performing health plans; and helping Medicare beneficiaries make informed health care choices. Superior HealthPlan Advantage must participate in the Medicare Health Outcomes Survey. HOS questions that may reflect on the service of providers includes:

- Whether the member perceives their physical or mental health is maintained or improving.
- Whether the member has seen their provider and discussed starting, increasing, or maintaining their level of physical activity.
- If provider has discussed fall risks and bladder control with the member.

**REGULATORY MATTERS**

**Medical Records**

Superior HealthPlan Advantage providers must keep accurate and complete patient medical records which are consistent with 42 CFR §456 and National Committee for Quality Assurance (NCQA) standards as well as financial and other records pertinent to Superior HealthPlan Advantage members. Such records will enable providers to render the most appropriate level of health care service to members. They will also enable Superior HealthPlan Advantage to review the level and appropriateness of the services rendered. To ensure the member’s privacy, medical records should be kept in a secure location. Superior HealthPlan Advantage requires providers to maintain all records for members for at least ten (10) years after the final date of service, unless a longer period is required by applicable state law.

**Required Information**

To be considered a complete and comprehensive medical record, the member’s medical record file should include at a minimum: provider notes regarding examinations, office visits, referrals made, tests ordered, and results of diagnostic tests ordered (i.e. x-rays, laboratory tests). Medical records should be accessible at the site of the member’s participating primary care physician or provider. All medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, should be documented and prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.
Providers must maintain complete medical records for members in accordance with the standards set forth below.

- Written policy regarding confidentiality and safeguarding of member information; records are protected through secure storage with limited access.
- Records are organized, consistent and easily retrieved at the time of each visit. Written procedure for release of information and obtaining consent for treatment.
- Each page in the record contains the patient’s name or ID number.
- Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.
- All entries in the medical record contain author identification, are legible (to someone other than the writer), in ink and dated.
- The history and physical exam records appropriate subjective and objective information for presenting complaints.
- Problem List documenting significant illnesses, behavioral health and/or medical conditions; unresolved problems from previous office visits are addressed in subsequent visits.
- Medication List includes instructions to member regarding dosage, initial date of prescription, and number of refills.
- Medical allergies and adverse reactions are prominently documented in a uniformed location in the medical record; if no known allergies, NKA or NKDA is documented.
- An immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive services or risk screening are offered in accordance with Plan’s established practice guidelines.
- Past medical history for patients seen three or more times is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (eighteen (18) years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.
- Consultation lab or imaging reports and other studies are ordered, as appropriate. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries are initialed by the ordering provider or other documentation of review to signify review.
- All working diagnoses and treatment plans are consistent with findings. Ancillary tests and/or services diagnostic and therapeutic ordered by provider are documented; encounter forms or notes include follow-up care, calls, or visits., with specific time of return noted in weeks, months, or PRN, and include follow up of outcomes and summaries of treatment rendered elsewhere.
- No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
- Health teaching and/or counseling is documented. If a consultation is requested, there is a note from the consultant in the record.
- For members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use for Members seen three or more times substance abuse history should be queried.
• Documentation of failure to keep an appointment.

• Evidence that an Advance Directive has been discussed with adults eighteen (18) years of age and older.

Additional Behavioral Health Documentation Standards:

• For members receiving behavioral health treatment, documentation is to include "at risk" factors danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history.

• For members receiving behavioral health treatment, an assessment is done with each visit relating to client status or symptoms to treatment process. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.

• For members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in therapy sessions, when appropriate.

Medical Records Release

All member medical records are confidential and must not be released without the written authorization of the member or their parent or legal guardian, in accordance with state and federal law and regulation. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

All release of specific clinical or medical records for Substance Use Disorders must meet Federal guidelines at 42 CFR, part 2 and any applicable State Laws.

Medical Records Transfer for New Members

All PCPs are required to document in the member’s medical record attempts to obtain historical medical records for all newly assigned Superior HealthPlan Advantage members. If the member or member’s parent or legal guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

Superior HealthPlan Advantage will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over or under utilization of services, as well as the outcome of such services, is also subject to review and assessment during a medical record audit. Superior HealthPlan Advantage will provide written notice prior to conducting a medical record review.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of Federal and/or State laws.

These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol or substance abuse treatment and communicable disease records.

For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when
permitted under the law (i.e. for treatment, payment and operations activities, including care management and coordination).

However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or “Part 2”). These records generally may not be released without consent from the individual whose information is subject to the release.

Still other laws at the State level place further restrictions on the release of certain information such as mental health, communicable disease, etc.

For more information about any of these laws, refer to the following:

- **HIPAA** - please visit the Centers for Medicare & Medicaid Services (CMS) website at: [www.cms.hhs.gov](http://www.cms.hhs.gov) and then select “Regulations and Guidance” and “HIPAA – General Information”;
- **Part 2 regulations** - please visit the Substance Abuse and Mental Health Services Administration (within the U.S. Department of Health and Human Services) at: [www.samhsa.gov](http://www.samhsa.gov); and
- **State laws** - consult applicable statutes to determine how they may impact the release of information on patients whose care you provide.

Contracted providers within the Superior HealthPlan Advantage network are independently obligated to know, understand and comply with these laws.

Superior HealthPlan Advantage takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or State confidentiality and privacy laws.

**Health Insurance Portability and Accountability Act**

To improve the efficiency and effectiveness of the health care system, the 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, and 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.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards.
- Employer identifier standard.
- National Provider identifier standard.

Privacy Regulations
The Privacy rules regulate who has access to a member's personally identifiable health information (PHI) whether in written, verbal or electronic form. In addition, this regulation affords individuals the right to keep their PHI confidential, and in some instances, from being disclosed.

In compliance with the privacy regulations, Superior HealthPlan Advantage has provided each Superior HealthPlan Advantage member with a privacy notice, which describes how Superior HealthPlan Advantage can use or share a member's health records and how the Member can get access to the information. In addition, the Member Privacy Notice informs the member of their health care privacy rights and explains how these rights can be exercised. Copies of Superior’s Member Privacy Notices can be found at www.SuperiorHealthPlan.com.

1. As a provider, if you have any questions about Superior HealthPlan Advantage’s privacy practices, contact Superior’s compliance officer at 1-800-218-7453.

2. Members should be directed to Superior HealthPlan Advantage’s Member Services department with any questions about the privacy regulations. Member Services can be reached at 1-866-516-4501.

The Security Rule
The HIPAA Security Rule establishes national standards to protect individuals’ electronic personal health information that is created, received, used, or maintained by Superior HealthPlan Advantage. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information. The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

The Breach Notification Rule
On January 25, 2013, the Office for Civil Rights (OCR) of the United States Department of Health and Human Services (HHS) published in the Federal Register a final omnibus rule that revises certain rules promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These revised rules were issued pursuant to changes enacted by Congress in the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Genetic Information Nondiscrimination (GINA) Act of 2008. Effective March 23, 2013, the Final Rule implements section 13402 of the HITECH Act by requiring various notifications following a breach of unsecured protected health information.

The Final Rule eliminates the significant risk of harm standard from the Interim Rule for determining whether a breach has occurred. Covered entities and business associates must ensure compliance with regulatory definitions relating to breach notifications.

Transactions and Code Sets Regulations
Transactions are activities involving the transfer of health care information for specific purposes. Under HIPAA, if Superior HealthPlan Advantage or a health care provider engages in one of the identified transactions, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The Standards for Electronic Transactions and Code Sets, published August 17, 2000 and since modified, adopted standards for several transactions, including claims and encounter information, payment and claims status. Any health care provider that conducts a standard transaction also must comply with the Privacy Rule.
Version 5010 refers to the revised set of HIPAA electronic transaction standards adopted to replace the current standards. Every standard has been updated, including claims, eligibility and referral authorizations.

All HIPAA covered entities must be using version 5010 as of January 1, 2012. Any electronic transaction for which a standard has been adopted must have been submitted using version 5010 on or after January 1, 2012.

**HIPAA Required Code Sets**

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding. Only national standard codes can be used for electronic claims and/or authorization of services.

Nationally recognized code sets include:

1. Health Care Common Procedure Coding System (HCPCS) - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.

2. Current Procedure Terminology (CPT) codes - The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the AMA.

3. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 and 2 (diagnosis codes) - These are maintained by the National Center for Health Statistics and Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

4. International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) - Those are maintained by CMS.

5. International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM - This is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 and 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, Volume 3, and two parts:
   - Part 1: ICD-10-CM for diagnosis coding. ICD-10-CM is for use in all U.S. Health care settings. Diagnosis coding under ICD-10-CM uses three (3) to seven (7) digits instead of the three (3) to five (5) digits used with ICD-9-CM, but the format of the code sets is similar.
   - Part 2: ICD-10-PCS for inpatient procedure coding. ICD-10-PCS is for use in U.S. Inpatient hospital settings only. ICD-10-PCS uses seven (7) alphanumeric digits instead of the three (3) or four (4) numeric digits used under ICD-9-CM procedure coding.

The transition to ICD-10 is occurring because ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures. ICD-9 is thirty (30) years old, has outdated terms, and is inconsistent with current medical practice. Also, the structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims. Everyone covered by HIPAA who transmits electronic claims must also switch to Version 5010 transaction standards. The change to ICD-10 does not affect CPT coding for outpatient procedures.

6. National Drug Code (NDC) - The NDC is a code that identifies the vendor (manufacturer), product and package size of all medications recognized by the Federal Drug Administration (FDA). To
access the complete NDC code set, see www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm.

**HIPAA Regulated Transactions**

Below are the ten (10) electronic standardized transactions that are mandated by the HIPAA legislation.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Transaction Name</td>
</tr>
<tr>
<td>2.</td>
<td>HIPAA Transaction Number</td>
</tr>
<tr>
<td>3.</td>
<td>Claims and encounters</td>
</tr>
<tr>
<td>4.</td>
<td>Enrollment and disenrollment</td>
</tr>
<tr>
<td>5.</td>
<td>Health plan eligibility solicitations and response</td>
</tr>
<tr>
<td>6.</td>
<td>Payment and remittance advice</td>
</tr>
<tr>
<td>7.</td>
<td>Premium payment</td>
</tr>
<tr>
<td>8.</td>
<td>Claim status solicitation and response</td>
</tr>
<tr>
<td>9.</td>
<td>Coordination of benefits</td>
</tr>
<tr>
<td>10.</td>
<td>Referral and authorization</td>
</tr>
</tbody>
</table>

Though it is standard operating process, Superior HealthPlan Advantage does not currently utilize all standard transaction sets. Functionality equivalent to that which is offered by these transaction sets is made is available to Superior HealthPlan Advantage’s Members and Providers via various alternative capabilities such as online tools. Superior HealthPlan Advantage currently offers an alternative through the Secure Provider Portal, for the following transactions:

- ASC X12 270 Eligibility Status Inquiry.
- ASC X12 271 Eligibility Status Response.
- ASC X12 276 Claim Status Inquiry.
- ASC X12 277 Claim Status Response.
- ASC X12 278 Referral Certification and Response.

For more information on conducting these transactions electronically, contact the EDI Department at 1-800-225-2573 ext. 6075525 or by email at EDIBA@centene.com.

**National Provider Identifier**

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care Providers and all health plans and health care Clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy Provider identifiers in all electronic HIPAA standards transactions. However, some LTSS Providers are considered “Atypical Providers” because they render non-health or non-medical services to STAR+PLUS Members. These providers bill using their Atypical ID (LTSS #) in the Non-NPI Provider ID field of the claim form.

As outlined in the Federal regulation, covered Providers must also share their NPI with other Providers, health plans, Clearinghouses, and any entity that may need it for billing purposes.
Please contact the Superior HealthPlan Advantage Compliance Officer by phone at 1-800-218-7453 or in writing (refer to address below) with any questions about our privacy practices.

Superior HealthPlan Advantage
2100 South IH-35, Suite 200
Austin, TX 78704

Waste, Fraud, and Abuse

Superior HealthPlan Advantage takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a waste, abuse and fraud (WAF) program that complies with the federal and state laws. Superior HealthPlan Advantage, in conjunction with its parent company, Centene, operates a waste, abuse and fraud unit. Superior HealthPlan Advantage routinely conducts audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system, please review the Billing and Claims section of this Manual. The Centene Special Investigation Unit (SIU) performs retrospective audits which, in some cases, may result in taking actions against providers who commit waste, abuse, and/or fraud.

These actions include but are not limited to:

- Remedial education and training to prevent the billing irregularity;
- More stringent utilization review;
- Recoupment of previously paid monies;
- Termination of provider agreement or other contractual arrangement;
- Civil and/or criminal prosecution; and
- Any other remedies available to rectify.

Some of the most common WAF practices include:

- Unbundling of codes;
- Up-coding services;
- Add-on codes billed without primary CPT;
- Diagnosis and/or procedure code not consistent with the member’s age/gender;
- Use of exclusion codes;
- Excessive use of units;
- Misuse of benefits; and
- Claims for services not rendered.

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential WAF hotline at 1-866-685-8664. Superior HealthPlan Advantage takes all reports of potential waste, abuse or fraud very seriously and investigates all reported issues.
OIG/GSA Exclusion—As a provider in our network, the plan's expectation is that you will check the exclusion list as outlined below for all your staff, volunteers, temporary employees, consultants, Board of Directors, and any contractors that would meet the requirements as outlined in The Act §1862(e)(1)(B), 42 C.F.R. §§ 422.503(b)(4)(vi)(F), 422.752(a)(8), 423.504(b)(4)(vi)(F), 423.752(a)(6), 1001.1901.

Note: Providers' implementation of Waste, Abuse and Fraud safeguards to identify excluded providers and entities.

Medicare payment may not be made for items or services furnished or prescribed by an excluded provider or entity. Plans shall not use federal funds to pay for services, equipment or drugs prescribed or provided by a provider, supplier, employee or FDR excluded by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) or the General Services Administration (GSA). Superior HealthPlan Advantage will review the DHHS OIG List of Excluded Individuals and Entities (LEIE list) and the GSA Excluded Parties List (EPLS) prior to hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or First Tier, Downstream or Related entities (FDR), and monthly thereafter.

If anyone is identified, providers are required to notify Superior HealthPlan Advantage immediately so that if needed Superior HealthPlan Advantage can take appropriate action. Providers may contact the Superior HealthPlan Advantage Compliance officer at Superior HealthPlan Advantage.

WAF Program Compliance Authority and Responsibility

The Superior HealthPlan Advantage Vice President of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. Superior HealthPlan Advantage is committed to identifying, investigating, sanctioning and prosecuting suspected waste, abuse and fraud.

The Superior HealthPlan Advantage provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

False Claims Act

The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval;
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim;
- Conspiring to commit any violation of the False Claims Act;
- Falsely certifying the type or amount of property to be used by the Government;
- Certifying receipt of property on a document without completely knowing that the information is true;
- Knowingly buying Government property from an unauthorized officer of the Government; and
- Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims Act, please visit www.cms.hhs.gov.

January 12, 2016
Physician Incentive Programs

On an annual basis and in accordance with Federal Regulations, Superior HealthPlan Advantage must disclose to the Centers for Medicare and Medicaid Services, any Physician Incentive Programs that could potentially influence a provider’s care decisions. The information that must be disclosed includes the following:

- Effective date of the Physician Incentive Program;
- Type of Incentive Arrangement;
- Amount and type of stoploss protection;
- Patient panel size;
- Description of the pooling method, if applicable;
- For capitation arrangements, provide the amount of the capitation payment that is broken down by percentage for primary care, referral and other services;
- The calculation of substantial financial risk (SFR);
- Whether Superior HealthPlan Advantage does or does not have a Physician Incentive Program; and
- The name, address and other contact information of the person at Superior HealthPlan Advantage who may be contacted with questions regarding Physician Incentive Programs.

Physician Incentive Programs may not include any direct or indirect payments to providers/provider groups that create inducements to limit or reduce the provision of necessary services. In addition, Physician Incentive Programs that place providers/provider groups at SFR may not operate unless there is adequate stoploss protection, member satisfaction surveys and satisfaction of disclosure requirements satisfying the Physician Incentive Program regulations.

Substantial financial risk occurs when the incentive arrangement places the provider/provider group at risk beyond the risk threshold which is the maximum risk if the risk is based upon the use or cost of referral services. The risk threshold is set at twenty-five percent (25%) and does not include amounts based solely on factors other than a provider/provider group’s referral levels. Bonuses, capitation, and referrals may be considered incentive arrangements that result in SFR.

If you have questions regarding the Physician Incentive Program Regulations, please contact your Provider Relations Specialist.

First-Tier and Downstream Providers

Through written agreement, Superior HealthPlan Advantage may delegate certain functions or responsibilities in accordance with CMS regulations 42 CFR § 438.230 to First-Tier, downstream, and delegated entities. These functions and responsibilities include but are not limited to, contract administration and management, claims submission, claims payment, credentialing and re-credentialing, network management, and provider training. Superior HealthPlan Advantage oversees and is accountable for these responsibilities specified in the written agreement and will impose sanctions or revoke delegation if the entities’ performance is inadequate. Superior HealthPlan Advantage will ensure written agreements which specify these responsibilities by Superior HealthPlan Advantage and the delegated entity are clear and concise. Agreements will be kept on file by Superior HealthPlan Advantage for reference.
APPENDIX

Appendix I: Common Causes for Upfront Rejections

Common causes for upfront rejections include but are not limited to:

- Unreadable Information - The ink is faded, too light, or too bold bleeding into other characters or beyond the box or the font is too small.
- Member Date of Birth is missing.
- Member Name or Identification Number is missing.
- Provider Name, Taxpayer Identification Number (TIN), or National provider Identification (NPI) Number is missing.
- Attending Provider information missing from Loop 2310A on Institutional claims when CLM05-1 (Bill Type) is 11, 12, 21, 22, or 72 or missing from box 48 on the paper UB claim form.
- Date of Service is not prior to the received date of the claim (future date of service).
- Date of Service or Date Span is missing from required fields. Example: “Statement From” or “Service From” dates.
- Type of Bill is invalid.
- Diagnosis Code is missing, invalid, or incomplete.
- Service Line Detail is missing.
- Date of Service is prior to member’s effective date.
- Admission Type is missing (Inpatient Facility Claims – UB-04, field 14).
- Patient Status is missing (Inpatient Facility Claims – UB-04, field 17).
- Occurrence Code/Date is missing or invalid.
- Revenue Code is missing or invalid.
- CPT/Procedure Code is missing or invalid.
- A missing CLIA Number in Box 23 or a CMS 1500 for CLIA or CLIA waived service
- Incorrect Form Type used.

Appendix II: Common Cause of Claims Processing Delays and Denials

- Procedure or Modifier Codes entered are invalid or missing.
- This includes GN, GO, or GP modifier for therapy services.
- Diagnosis Code is missing the fourth (4th) or fifth (5th) digit.
- DRG code is missing or invalid.
- Explanation of Benefits (EOB) from the primary insurer is missing or incomplete.
- Third Party Liability (TPL) information is missing or incomplete.
- Member ID is invalid.
- Place of Service Code is invalid.
• Provider TIN and NPI do not match.
• Revenue Code is invalid.
• Dates of Service span do not match the listed days/units.
• Tax Identification Number (TIN) is invalid.

Appendix III: Common EOP Denial Codes and Descriptions

See the bottom of your paper EOP for the updated and complete description of all explanation codes associated with your claims. Electronic Explanations of Payment will use standard HIPAA denial codes.

<table>
<thead>
<tr>
<th>EX Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>0B</td>
<td>ADJUST: CLAIM TO BE REPROCESSED/ CORRECTED UNDER NEW CLAIM NUMBER</td>
</tr>
<tr>
<td>0I</td>
<td>ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER</td>
</tr>
<tr>
<td>1D</td>
<td>DENY: DISCHARGE STATUS INVALID FOR TYPE OF BILL</td>
</tr>
<tr>
<td>52</td>
<td>DENY - PAYMENT INCLUDED IN ALLOWANCE FOR ANOTHER PROCEDURE</td>
</tr>
<tr>
<td>57</td>
<td>DENY - AUTHORIZATION LIMITATION EXCEEDED</td>
</tr>
<tr>
<td>64</td>
<td>DENY - PROCEDURE INCONSISTENT WITH DIAGNOSIS</td>
</tr>
<tr>
<td>65</td>
<td>DENY - MISSING OR INVALID INFORMATION</td>
</tr>
<tr>
<td>71</td>
<td>DENY - MEMBER NOT ELIGIBLE ON DATE OF SERVICE</td>
</tr>
<tr>
<td>76</td>
<td>DENY - MAXIMUM BENEFIT HAS BEEN PAID</td>
</tr>
<tr>
<td>78</td>
<td>DENY: INVALID OR MISSING PLACE OF SERVICE LOCATION</td>
</tr>
<tr>
<td>82</td>
<td>DENY - NON COVERED SERVICES</td>
</tr>
<tr>
<td>83</td>
<td>DENY - DUPLICATE OF PREVIOUS SUBMITTED CLAIM</td>
</tr>
<tr>
<td>A1</td>
<td>APC - OCE LINE ITEM REJECTION</td>
</tr>
<tr>
<td>A2</td>
<td>APC - OCE LINE ITEM DENIAL</td>
</tr>
<tr>
<td>A4</td>
<td>APC - OCE CLAIM LEVEL RETURN TO PROVIDER (RTP)</td>
</tr>
<tr>
<td>A5</td>
<td>APC - OCE CLAIM LEVEL REJECTION</td>
</tr>
<tr>
<td>AN</td>
<td>DENY - SERVICE DENIED FOR NO AUTHORIZATION ON FILE</td>
</tr>
<tr>
<td>BT</td>
<td>DENY: TYPE OF BILL INVALID</td>
</tr>
<tr>
<td>C5</td>
<td>DENY: CODE REPLACED BASED ON CODE AUDITING</td>
</tr>
<tr>
<td>dh</td>
<td>DENY - NON-EMERGENCY OUT OF AREA SERVICES ARE NOT COVERED</td>
</tr>
<tr>
<td>DZ</td>
<td>DENY: RESUBMIT WITH CORRECTED COUNT</td>
</tr>
<tr>
<td>EB</td>
<td>DENIED BY MEDICAL SERVICES</td>
</tr>
<tr>
<td>EC</td>
<td>DENY: DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT</td>
</tr>
<tr>
<td>Es</td>
<td>INVALID OR MISSING REQUIRED ESRD OR HHA CLAIMS DATA</td>
</tr>
<tr>
<td>FT</td>
<td>INVALID FORM TYPE FOR PROCEDURE(S) SUBMITTED</td>
</tr>
<tr>
<td>EX Code</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>Hn</td>
<td>HHA GROUPER INVALID OR NO TREATMENT AUTHORIZATION CODE PROVIDED</td>
</tr>
<tr>
<td>Jq</td>
<td>ORIGINAL CHECK NOT CASHED-PAY TO/ADDRESS VERIFICATION NEEDED</td>
</tr>
<tr>
<td>MR</td>
<td>MODIFIER REQUIRED FOR PROCEDURE</td>
</tr>
<tr>
<td>NN</td>
<td>MODIFIER NOT REQUIRED FOR THIS PROCEDURE</td>
</tr>
<tr>
<td>NV</td>
<td>DENY: PLEASE RESUBMIT WITH INVOICE FOR SERVICES RENDERED</td>
</tr>
<tr>
<td>PM</td>
<td>DENY - INVALID PROCEDURE MODIFIER COMBINATION SUBMITTED</td>
</tr>
<tr>
<td>QR</td>
<td>DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT</td>
</tr>
<tr>
<td>S9</td>
<td>DENY - CODE BILLED IS NOT COVERED FOR PROVIDER TYPE</td>
</tr>
<tr>
<td>TF</td>
<td>DENY - FILING LIMIT EXCEEDED</td>
</tr>
<tr>
<td>x2</td>
<td>SERVICE(S) OR SUPPLIES DURING GLOBAL SURGICAL PERIOD</td>
</tr>
<tr>
<td>x3</td>
<td>PROCEDURE CODE UNBUNDLED FROM GLOBAL PROCEDURE CODE</td>
</tr>
<tr>
<td>x8</td>
<td>MODIFIER INVALID FOR PROCEDURE OR MODIFIER NOT REPORTED</td>
</tr>
<tr>
<td>ya</td>
<td>DENY: DENIED AFTER REVIEW OF PATIENT S CLAIM HISTORY</td>
</tr>
<tr>
<td>ye</td>
<td>CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS</td>
</tr>
<tr>
<td>YO</td>
<td>DENY: ADD ON CODE BILLED WITHOUT PRIMARY PROCEDURE</td>
</tr>
<tr>
<td>ZW</td>
<td>AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS</td>
</tr>
</tbody>
</table>

Appendix IV: Instructions for Supplemental Information

(CMS- 1500 02/12) FORM, SHADED FIELD 24A-G

The following types of supplemental information are accepted in a shaded claim line of the CMS 1500 (02/12) Claim Form field 24-A-G:

- National Drug Code (NDC)
- Narrative description of unspecified/miscellaneous/unlisted codes
- Contract Rate

The following qualifiers are to be used when reporting these services:

- ZZ Narrative description of unspecified/miscellaneous/unlisted codes
- N4 National Drug Code (NDC)
- CTR Contract Rate

If required to report other supplemental information not listed above, follow payer instructions for the use of a qualifier for the information being reported. When reporting a service that does not have a qualifier, enter two (2) blank spaces before entering the information.
To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number, code, and information. Do not enter hyphens or spaces within the number and code.

More than one (1) supplemental item can be reported in the shaded lines of item number 24. Enter the first (1st) qualifier and number, code, and information at 24A. After the first item, enter three (3) blank spaces and then the next qualifier and number, code, and information.

For reporting dollar amounts in the shaded area, always enter the dollar amount, a decimal point, and the cents. Use 00 for cents if the amount is a whole number. Do not use commas. Do not enter dollars signs (ex. 1000.00; 123.45).

Additional Information for Reporting NDC:

When adding supplemental information for NDC, enter the information in the following order:

- Qualifier
- NDC Code
- One space
- Unit/basis of measurement qualifier
  - F2- International Unit
  - ME – Milligram
  - UN – Unit
  - GR – Gram
  - ML - Milliliter
- Quantity
  - The number of digits for the quantity is limited to eight digits before the decimal and three digits after the decimal (ex. 99999999.999).
  - When entering a whole number, do not use a decimal (ex. 2).
  - Do not use commas.

Unspecified/Miscellaneous/Unlisted Codes

NDC Codes

January 12, 2016 89
Appendix V: Common HIPAA Compliant EDI Rejection Codes

These codes on the follow page are the Standard National Rejection Codes for EDI submissions. All errors indicated for the code must be corrected before the claim is resubmitted.

<table>
<thead>
<tr>
<th>ERROR_ID</th>
<th>ERROR_DESC</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Invalid Mbr DOB</td>
</tr>
<tr>
<td>02</td>
<td>Invalid Mbr</td>
</tr>
<tr>
<td>06</td>
<td>Invalid Prv</td>
</tr>
<tr>
<td>07</td>
<td>Invalid Mbr DOB &amp; Prv</td>
</tr>
<tr>
<td>08</td>
<td>Invalid Mbr &amp; Prv</td>
</tr>
<tr>
<td>09</td>
<td>Mbr not valid at DOS</td>
</tr>
<tr>
<td>10</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS</td>
</tr>
<tr>
<td>12</td>
<td>Prv not valid at DOS</td>
</tr>
<tr>
<td>13</td>
<td>Invalid Mbr DOB; Prv not valid at DOS</td>
</tr>
<tr>
<td>14</td>
<td>Invalid Mbr; Prv not valid at DOS</td>
</tr>
<tr>
<td>15</td>
<td>Mbr not valid at DOS; Invalid Prv</td>
</tr>
<tr>
<td>16</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv</td>
</tr>
<tr>
<td>17</td>
<td>Invalid Diag</td>
</tr>
<tr>
<td>18</td>
<td>Invalid Mbr DOB; Invalid Diag</td>
</tr>
<tr>
<td>19</td>
<td>Invalid Mbr; Invalid Diag</td>
</tr>
<tr>
<td>21</td>
<td>Mbr not valid at DOS; Prv not valid at DOS</td>
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<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS</td>
</tr>
<tr>
<td>23</td>
<td>Invalid Prv; Invalid Diag</td>
</tr>
<tr>
<td>24</td>
<td>Invalid Mbr DOB; Invalid Prv; Invalid Diag</td>
</tr>
<tr>
<td>25</td>
<td>Invalid Mbr; Invalid Prv; Invalid Diag</td>
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<tr>
<td>26</td>
<td>Mbr not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>27</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>ERROR_ID</td>
<td>ERROR_DESC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>29</td>
<td>Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>30</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>31</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>32</td>
<td>Mbr not valid at DOS; Prv not valid; Invalid Diag</td>
</tr>
<tr>
<td>33</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid; Invalid Diag</td>
</tr>
<tr>
<td>34</td>
<td>Invalid Proc</td>
</tr>
<tr>
<td>35</td>
<td>Invalid DOB; Invalid Proc</td>
</tr>
<tr>
<td>36</td>
<td>Invalid Mbr; Invalid Proc</td>
</tr>
<tr>
<td>37</td>
<td>Invalid or future date</td>
</tr>
<tr>
<td>38</td>
<td>Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>39</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag</td>
</tr>
<tr>
<td>40</td>
<td>Invalid Prv; Invalid Proc</td>
</tr>
<tr>
<td>41</td>
<td>Invalid Prv; Invalid Proc; Invalid Mbr DOB</td>
</tr>
<tr>
<td>42</td>
<td>Invalid Mbr; Invalid Prv; Invalid Proc</td>
</tr>
<tr>
<td>43</td>
<td>Mbr not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>44</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>46</td>
<td>Prv not valid at DOS; Invalid Proc</td>
</tr>
<tr>
<td>48</td>
<td>Invalid Mbr; Prv not valid at DOS, Invalid Proc</td>
</tr>
<tr>
<td>49</td>
<td>Invalid Proc; Invalid Prv; Mbr not valid at DOS</td>
</tr>
<tr>
<td>51</td>
<td>Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>52</td>
<td>Invalid Mbr DOB; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>53</td>
<td>Invalid Mbr; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>55</td>
<td>Mbr not valid at DOS; Prv not valid at DOS, Invalid Proc</td>
</tr>
<tr>
<td>57</td>
<td>Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>58</td>
<td>Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>59</td>
<td>Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>60</td>
<td>Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>61</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>63</td>
<td>Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>64</td>
<td>Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>65</td>
<td>Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>66</td>
<td>Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>67</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>ERROR_ID</td>
<td>ERROR_DESC</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>72</td>
<td>Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>73</td>
<td>Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc</td>
</tr>
<tr>
<td>74</td>
<td>Reject. DOS prior to 6/1/2006; OR Invalid DOS</td>
</tr>
<tr>
<td>75</td>
<td>Invalid Unit</td>
</tr>
<tr>
<td>76</td>
<td>Original claim number required</td>
</tr>
<tr>
<td>77</td>
<td>INVALID CLAIM TYPE</td>
</tr>
<tr>
<td>81</td>
<td>Invalid Unit; Invalid Prv</td>
</tr>
<tr>
<td>83</td>
<td>Invalid Unit; Invalid Mbr &amp; Prv</td>
</tr>
<tr>
<td>89</td>
<td>Invalid Prv; Mbr not valid at DOS; Invalid DOS</td>
</tr>
<tr>
<td>A2</td>
<td>DIAGNOSIS POINTER INVALID</td>
</tr>
<tr>
<td>A3</td>
<td>CLAIM EXCEEDED THE MAXIMUM 97 SERVICE LINE LIMIT</td>
</tr>
<tr>
<td>B1</td>
<td>Rendering and Billing NPI are not tied on state file</td>
</tr>
<tr>
<td>B2</td>
<td>Not enrolled with MHS and/or State with rendering NPI/TIN on DOS. Enroll with MHS and resubmit claim</td>
</tr>
<tr>
<td>B5</td>
<td>Missing/incomplete/invalid CLIA certification number</td>
</tr>
<tr>
<td>H1</td>
<td>ICD9 is mandated for this date of service.</td>
</tr>
<tr>
<td>H2</td>
<td>Incorrect use of the ICD9/ICD10 codes.</td>
</tr>
<tr>
<td>HP</td>
<td>ICD10 is mandated for this date of service.</td>
</tr>
<tr>
<td>ZZ</td>
<td>Claim not processed</td>
</tr>
</tbody>
</table>

**Appendix VI: Claim Form Instructions**


Required (R) fields must be completed on all claims. Conditional (C) fields must be completed if the information applies to the situation or the service provided.

*Note: Claims with missing or invalid Required (R) field information will be rejected or denied*

**Completing a CMS 1500 Claim Form**

Updated format (Form 1500 (02-12)) can be accepted as of January 1, 2014, and is required after October 1, 2014.
Please see the following example of a CMS 1500 form.

### CMS 1500 Claim Form

![CMS 1500 Claim Form Example](image-url)
## Claim Form Instructions

<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>INSURANCE PROGRAM IDENTIFICATION</td>
<td>Check only the type of health coverage applicable to the claim. This field indicated the payer to whom the claim is being field. Enter “X” in the box noted “Other”</td>
<td>R</td>
</tr>
<tr>
<td>1a</td>
<td>INSURED’S I.D. NUMBER</td>
<td>The nine (9) digit identification number on the member’s I.D. Card</td>
<td>R</td>
</tr>
<tr>
<td>2</td>
<td>PATIENTS NAME (Last Name, First Name, Middle Initial)</td>
<td>Enter the patient’s name as it appears on the member’s I.D. card. Do not use nicknames.</td>
<td>R</td>
</tr>
<tr>
<td>3</td>
<td>PATIENT’S BIRTH DATE/SEX</td>
<td>Enter the patient’s eight (8) digit date of (MM/DD/YYYY) and mark the appropriate box to indicate the patient’s sex/gender. M= Male     F= Female</td>
<td>R</td>
</tr>
<tr>
<td>4</td>
<td>INSURED’S NAME</td>
<td>Enter the patient’s name as it appears on the member’s I.D. Card</td>
<td>C</td>
</tr>
</tbody>
</table>
| 5       | PATIENT’S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code) | Enter the patient’s complete address and telephone number including area code on the appropriate line.  
First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101).  
Second line – In the designated block, enter the city and state.  
Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414).  
Note: Patient’s Telephone does not exist in the electronic 837 Professional 4010A1. | C                       |
| 6       | PATIENT’S RELATION TO INSURED                          | Always mark to indicate self.                                                          | C                       |
| 7       | INSURED’S ADDRESS (Number, Street, City, State, Zip Code) Telephone (include area code) | Enter the patient’s complete address and telephone number including area code on the appropriate line.  
First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). | C                       |
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9</td>
<td>OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)</td>
<td>Refers to someone other than the patient. REQUIRED if patient is covered by another insurance plan. Enter the complete name of the insured.</td>
<td>C</td>
</tr>
<tr>
<td>9a</td>
<td>*OTHER INSURED’S POLICY OR GROUP NUMBER</td>
<td>REQUIRED if field 9 is completed. Enter the policy of group number of the other insurance plan.</td>
<td>C</td>
</tr>
<tr>
<td>9b</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9c</td>
<td>RESERVED FOR NUCC USE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>9d</td>
<td>INSURANCE PLAN NAME OR PROGRAM NAME</td>
<td>REQUIRED if field 9 is completed. Enter the other insured’s (name of person listed in field 9) insurance plan or program name.</td>
<td>C</td>
</tr>
<tr>
<td>10a,b,c</td>
<td>IS PATIENT’S CONDITION RELATED TO</td>
<td>Enter a Yes or No for each category/line (a, b, and c). Do not enter a Yes and No in the same category/line. When marked Yes, primary insurance information must then be shown in Item Number 11.</td>
<td>R</td>
</tr>
<tr>
<td>10d</td>
<td>CLAIM CODES (Designated by NUCC)</td>
<td>When reporting more than one code, enter three blank spaces and then the next code.</td>
<td>C</td>
</tr>
<tr>
<td>11</td>
<td>INSURED POLICY OR FECA NUMBER</td>
<td>REQUIRED when other insurance is available. Enter the policy, group, or FECA number of the other insurance. If Item Number 10abc is marked Y, this field should be populated.</td>
<td>C</td>
</tr>
<tr>
<td>11a</td>
<td>INSURED’S DATE OF BIRTH / SEX</td>
<td>Enter the 8-digit date of birth (MM DD YYYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>11b</td>
<td>OTHER CLAIM ID (Designated by NUCC)</td>
<td>The following qualifier and accompanying identifier has been designated for use:</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Y4 Property Casualty Claim Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FOR WORKERS’ COMPENSATION OR PROPERTY &amp; CASUALTY: Required if known. Enter the claim number assigned by the payer.</td>
<td></td>
</tr>
<tr>
<td>11c</td>
<td>INSURANCE PLAN NAME OR PROGRAM NUMBER</td>
<td>Enter name of the insurance health plan or program.</td>
<td>C</td>
</tr>
<tr>
<td>11d</td>
<td>IS THERE ANOTHER HEALTH BENEFIT PLAN</td>
<td>Mark Yes or No. If Yes, complete field’s 9a-d and 11c.</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Enter “Signature on File”, “SOF”, or the actual legal signature. The provider must have the member’s or legal guardian’s signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.</td>
<td>C</td>
</tr>
<tr>
<td>13</td>
<td>INSURED’S OR AUTHORIZED PERSON’S SIGNATURE</td>
<td>Obtain signature if appropriate.</td>
<td>Not Required</td>
</tr>
<tr>
<td>14</td>
<td>DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR Pregnancy (LMP)</td>
<td>Enter the 6-digit (MM</td>
<td>DD</td>
</tr>
<tr>
<td>15</td>
<td>IF PATIENT HAS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE</td>
<td>Enter another date related to the patient’s condition or treatment. Enter the date in the 6-digit (MM</td>
<td>DD</td>
</tr>
<tr>
<td>16</td>
<td>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>17</td>
<td>NAME OF REFERRING PHYSICIAN OR OTHER SOURCE</td>
<td>Enter the name of the referring physician or professional (first name, middle initial, last name, and credentials).</td>
<td>C</td>
</tr>
<tr>
<td>17a</td>
<td>ID NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. Use ZZ qualifier for Taxonomy code</td>
<td>C</td>
</tr>
<tr>
<td>17b</td>
<td>NPI NUMBER OF REFERRING PHYSICIAN</td>
<td>Required if field 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.</td>
<td>C</td>
</tr>
<tr>
<td>18</td>
<td>HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>19</td>
<td>RESERVED FOR LOCAL USE – NEW FORM: ADDITIONAL CLAIM INFORMATION</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>20</td>
<td>OUTSIDE LAB / CHARGES</td>
<td></td>
<td>C</td>
</tr>
<tr>
<td>21</td>
<td>DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS A-L TO ITEM 24E BY LINE). NEW FORM ALL...</td>
<td>Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-9-CM or ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Note: Claims missing or with invalid diagnosis codes will be rejected or denied for payment.</td>
<td>R</td>
</tr>
<tr>
<td>22</td>
<td>RESUBMISSION CODE / ORIGINAL REF.NO.</td>
<td>For re-submissions or adjustments, enter the original claim number of the original claim. New form – for resubmissions only: 7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| 23 | PRIOR AUTHORIZATION NUMBER or CLIA NUMBER | Enter the authorization or referral number. Refer to the Provider Manual for information on services requiring referral and/or prior authorization. CLIA number for CLIA waived or CLIA certified laboratory services. | If auth = C  
If CLIA = R  
(If both, always submit the CLIA number) |
<p>| | | | |
| | | | |
| 24a-j | General Information | Box 24 contains six (6) claim lines. Each claim line is split horizontally into shaded and un-shaded areas. Within each un-shaded area of a claim line there are ten (10) individual fields labeled A-J. Within each shaded area of a claim line there are four (4) individual fields labeled 24A-24G, 24H, 24J, and 24Jb. Fields 24A through 24G are a continuous field for the entry of supplemental information. Instructions are provided for shaded and un-shaded fields. The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, and Provider Number. Shaded boxes 24 a-g is for line item supplemental information and provides a continuous line that accepts up to 61 characters. Refer to the instructions listed below for information on how to complete. The un-shaded area of a claim line is for the entry of claim line item detail. | |
| 24 A-G | Shaded SUPPLEMENTAL INFORMATION | The shaded top portion of each service claim line is used to report supplemental information for: NDC Narrative description of unspecified codes Contract Rate For detailed instructions and qualifiers refer to Appendix IV of this guide. | C |
| 24A | Unshaded DATE(S) OF SERVICE | Enter the date the service listed in field 24D was performed (MM/DD/YYYY). If there is only one date, enter that date in the &quot;From&quot; field. The &quot;To&quot; field may be left blank or populated with the &quot;From&quot; date. If identical services (identical CPT/HCPC code(s)) were performed each date must be entered on a separate line. | R |
| 24B | Unshaded PLACE OF SERVICE | Enter the appropriate two (2) digit CMS Standard Place of Service (POS) Code. A list of current POS Codes may be found on the CMS website. | R |
| 24C | Unshaded EMG | Enter Y (Yes) or N (No) to indicate if the service was an emergency. | Not Required |
| 24D | Unshaded PROCEDURES, SERVICES OR SUPPLIES CPT/HCPCS MODIFIER | Enter the five (5) digit CPT or HCPC code and two (2) character modifier, if applicable. Only one CPT or HCPC and up to four (4) modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment. | R |</p>
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 E</td>
<td>DIAGNOSIS CODE</td>
<td>Only the first (1st) modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the Procedure Code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim.</td>
<td>R</td>
</tr>
<tr>
<td>24 F</td>
<td>CHARGES</td>
<td>In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-9-CM (or ICD-10-CM, once mandated) diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E. Do not use commas between the diagnosis pointer numbers. Diagnosis Codes must be valid ICD-9/10 Codes for the date of service or the claim will be rejected/denied.</td>
<td>R</td>
</tr>
<tr>
<td>24 G</td>
<td>DAYS OR UNITS</td>
<td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight (8) characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>R</td>
</tr>
<tr>
<td>24 H</td>
<td>EPSDT (Family Planning)</td>
<td>Leave blank or enter “Y” if the services were performed as a result of an EPSDT referral.</td>
<td>C</td>
</tr>
<tr>
<td>24 I</td>
<td>ID QUALIFIER</td>
<td>Enter the appropriate qualifier for EPSDT visit.</td>
<td>C</td>
</tr>
<tr>
<td>24 J</td>
<td>NON-NPI PROVIDER ID#</td>
<td>Use ZZ qualifier for Taxonomy Use 1D qualifier for ID, if an Atypical Provider.</td>
<td>R</td>
</tr>
</tbody>
</table>

**Typical Providers:**
Enter the Provider taxonomy code that corresponds to the qualifier entered in field 24I shaded. Use ZZ qualifier for Taxonomy Code.

**Atypical Providers:**
Enter the Provider ID number.
<table>
<thead>
<tr>
<th>Field #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 J</td>
<td>NPI PROVIDER ID</td>
<td>Typical Providers ONLY: Enter the ten (10) character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider’s ten (10) character NPI ID may be entered. Enter the billing NPI if services are not provided by an individual (e.g., DME, Independent Lab, Home Health, RHC/FQHC General Medical Exam, etc.).</td>
<td>R</td>
</tr>
<tr>
<td>25</td>
<td>FEDERAL TAX I.D. NUMBER</td>
<td>Enter the provider or supplier nine (9) digit Federal Tax ID number and mark the box labeled EIN</td>
<td>R</td>
</tr>
<tr>
<td>26</td>
<td>PATIENT’S ACCOUNT NO.</td>
<td>Enter the provider’s billing account number</td>
<td>C</td>
</tr>
<tr>
<td>27</td>
<td>ACCEPT ASSIGNMENT?</td>
<td>Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a member using state funds indicates the provider accepts assignment. Refer to the back of the CMS 1500 (02-12) Claim Form for the section pertaining to Payments</td>
<td>C</td>
</tr>
<tr>
<td>28</td>
<td>TOTAL CHARGES</td>
<td>Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight (8) characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>R</td>
</tr>
<tr>
<td>29</td>
<td>AMOUNT PAID</td>
<td>REQUIRED when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing when Superior HealthPlan Advantage is listed as secondary or tertiary. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>C</td>
</tr>
<tr>
<td>30</td>
<td>BALANCE DUE</td>
<td>REQUIRED when field 29 is completed. Enter the balance due (total charges minus the amount of payment received from the primary payer). Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199999.99). Do not use commas. Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>C</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>31</td>
<td>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td>If there is a signature waiver on file, you may stamp, print, or computer-generate the signature; otherwise, the provider or provider's authorized representative MUST sign the form. If signature is missing or invalid the claim will be returned unprocessed. <em>Note: Does not exist in the electronic 837P.</em></td>
<td>R</td>
</tr>
<tr>
<td>32</td>
<td>SERVICE FACILITY LOCATION INFORMATION</td>
<td>REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. Box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen.</td>
<td>C</td>
</tr>
<tr>
<td>32a</td>
<td>NPI – SERVICES RENDERED</td>
<td>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the ten (10) character NPI ID of the facility where services were rendered.</td>
<td>C</td>
</tr>
<tr>
<td>32b</td>
<td>OTHER PROVIDER ID</td>
<td>REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Typical Providers Enter the two (2) character qualifier ZZ followed by the Taxonomy Code (no spaces). Atypical Providers Enter the 2-character qualifier 1D (no spaces).</td>
<td>C</td>
</tr>
<tr>
<td>33</td>
<td>BILLING PROVIDER INFO &amp; PH#</td>
<td>Enter the billing provider's complete name, address (include the zip + 4 code), and phone number. First line -Enter the business/facility/practice name. Second line -Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line -In the designated block, enter the city and state.</td>
<td>R</td>
</tr>
<tr>
<td>Field #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
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<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fourth line- Enter the zip code and phone number. When entering a nine (9) digit zip code (zip+ 4 code), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (555)555-5555). Note: The nine (9) digit zip code (zip + 4 code) is a requirement for paper and EDI claim submission.</td>
<td></td>
</tr>
<tr>
<td>33a</td>
<td>GROUP BILLING NPI</td>
<td>Typical Providers ONLY: REQUIRED if the location where services were rendered is different from the billing address listed in field 33. Enter the ten (10) character NPI ID.</td>
<td>R</td>
</tr>
<tr>
<td>33b</td>
<td>GROUP BILLING OTHERS ID</td>
<td>Enter as designated below the Billing Group taxonomy code. Typical Providers: Enter the Provider Taxonomy Code. Use ZZ qualifier. Atypical Providers: Enter the Provider ID number.</td>
<td>R</td>
</tr>
</tbody>
</table>

**Completing A UB-04 Claim Form**

A UB-04 is the only acceptable claim form for submitting inpatient or outpatient Hospital claim charges for reimbursement by Superior HealthPlan Advantage. In addition, a UB-04 is required for Comprehensive Outpatient Rehabilitation Facilities (CORF), Home Health Agencies, nursing home admissions, inpatient hospice services, and dialysis services. Incomplete or inaccurate information will result in the claim or encounter being rejected for correction.

**UB-04 Hospital Outpatient Claims/Ambulatory Surgery**

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.
- Please refer to your provider contract with Superior HealthPlan Advantage or research the Uniform Billing Editor for Revenue Codes that do not require a CPT Code.
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
</table>
| 1       | UNLABELED FIELD           | LINE 1: Enter the complete provider name.  
LINE 2: Enter the complete mailing address.  
LINE 3: Enter the City, State, and Zip +4 codes (include hyphen). NOTE: The 9 digit zip (zip +4 codes) is a requirement for paper and EDI claims.  
LINE 4: Enter the area code and phone number.                                                                                      | R                      |
| 2       | UNLABELED FIELD           | Enter the Pay- to Name and Address                                                                                                                                                                                      | Not Required           |
| 3a      | PATIENT CONTROL NO.       | Enter the facility patient account/control number.                                                                                                                                                                      | Not Required           |
| 3b      | MEDICAL RECORD NUMBER     | Enter the facility patient medical or health record number.                                                                                                                                                            | R                      |
| 4       | TYPE OF BILL              | Enter the appropriate Type of Bill (TOB) Code as specified by the NUBC UB-04 Uniform Billing Manual minus the leading "0" (zero). A leading "0" is not needed. Digits should be reflected as follows:  
1st Digit – Indicating the type of facility.  
2nd Digit – Indicating the type of care.  
3rd Digit- Indicating the bill sequence (Frequency code).                                                                                       | R                      |
| 5       | FED. TAX NO               | Enter the 9 digit number assigned by the federal government for tax reporting purposes.                                                                                                                                  | R                      |
| 6       | STATEMENT COVERS PERIOD FROM/THROUGH | Enter begin and end, or admission and discharge dates, for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology, and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MMDDYY). | R                      |
| 7       | UNLABELED FIELD           | Not used                                                                                                                                                                                                               | Not Required           |
| 8a-8b   | PATIENT NAME              | 8a – Enter the first nine (9) digits of the identification number on the member’s I.D. card  
8b – enter the patient’s last name, first name, and middle initial as it appears on the ID card. Use a comma or space to separate the last and first names.  
Titles: (Mr., Mrs., etc.) should not be reported in this                                                                                     | Not Required R         |
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>field.</td>
<td>Prefix: No space should be left after the prefix of a name (e.g. McKendrick. H) Hyphenated names: Both names should be capitalized and separated by a hyphen (no space) Suffix: a space should separate a last name and suffix. Enter the patient’s complete mailing address of the patient.</td>
<td>R (except line 9e)</td>
</tr>
<tr>
<td>9</td>
<td>PATIENT ADDRESS</td>
<td>Enter the patient’s complete mailing address of the patient. Line a: Street address Line b: City Line c: State Line d: Zip code Line e: country Code (NOT REQUIRED)</td>
<td>R</td>
</tr>
<tr>
<td>10</td>
<td>BIRTHDATE</td>
<td>Enter the patient’s date of birth (MMDDYYYY)</td>
<td>R</td>
</tr>
<tr>
<td>11</td>
<td>SEX</td>
<td>Enter the patient’s sex. Only M or F is accepted.</td>
<td>R</td>
</tr>
<tr>
<td>12</td>
<td>ADMISSION DATE</td>
<td>Enter the date of admission for inpatient claims and date of service for outpatient claims. Enter the time using two (2) digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services.</td>
<td>R</td>
</tr>
<tr>
<td>13</td>
<td>ADMISSION HOUR</td>
<td>0012:00 midnight to 12:59 12:00 noon to 12:59 01-01:00 to 01:59 13-01:00 to 01:59 02-02:00 to 02:59 14-02:00 to 02:59 03-03:00 to 03:39 15-03:00 to 03:59 04-04:00 to 04:59 16-04:00 to 04:59 05-05:00:00 to 05:59 17-05:00:00 to 05:59 06-06:00 to 06:59 18-06:00 to 06:59 07-07:00 to 07:59 19-07:00 to 07:59 08-08:00 to 08:59 20-08:00 to 08:59 09-09:00 to 09:59 21-09:00 to 09:59 10-10:00 to 10:59 22-10:00 to 10:59 11-11:00 to 11:59 23-11:00 to 11:59</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>14</td>
<td>ADMISSION TYPE</td>
<td>Require for inpatient and outpatient admissions (Enter the one (1) digit code indicating the type of the admission using the appropriate following codes: 1 Emergency, 2 Urgent, 3 Elective, 4 Newborn, 5 Trauma)</td>
<td>R</td>
</tr>
</tbody>
</table>
| 15      | ADMISSION SOURCE       | Required for inpatient and outpatient admissions. Enter the one (1) digit code indicating the source of the admission or outpatient service using one of the following codes.  
  For Type of admission 1,2,3, or 5: 1 Physician Referral, 2 Clinic Referral, 3 Health Maintenance Referral (HMO), 4 Transfer from a hospital, 5 Transfer from Skilled Nursing Facility, 6 Transfer from another health care facility, 7 Emergency Room, 8 Court/Law Enforcement, 9 Information not available  
  For Type of admission 4 (newborn): 1 Normal Delivery, 2 Premature Delivery, 3 Sick Baby, 4 Extramural Birth, 5 Information not available | R                      |
| 16      | DISCHARGE HOUR         | Enter the time using two (2) digit military times (00-23) for the time of the inpatient or outpatient discharge.  
  0012:00 midnight to 12:59 12-12:00 noon to 12:59  
  01-01:00 to 01:59 13-01:00 to 01:59  
  02-02:00 to 02:59 14-02:00 to 02:59  
  03-03:00 to 03:39 15-03:00 to 03:59  
  04-04:00 to 04:59 16-04:00 to 04:59  
  05-05:00:00 to 05:59 17-05:00:00 to 05:59  
  06-06:00:00 to 06:59 18-06:00:00 to 06:59 | C                      |
<table>
<thead>
<tr>
<th>FIELD #</th>
<th>Field Description</th>
<th>Instruction or Comments</th>
<th>Required or Conditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>07-07:00 to 07:59</td>
<td>19-07:00 to 07:59</td>
<td>08-08:00 to 08:59 20-08:00 to 08:59</td>
<td>09-09:00 to 09:59 21-09:00 to 09:59</td>
</tr>
<tr>
<td>10-10:00 to 10:59</td>
<td>22-10:00 to 10:59</td>
<td>11-11:00 to 11:59 23-11:00 to 11:59</td>
<td>Required or Conditional for inpatient and outpatient claims. Enter the two (2) digit disposition of the patient as of the “through” date for the billing period listed in field 6 using one of the following codes:</td>
</tr>
<tr>
<td>01 Routine Discharge</td>
<td>02 Discharged to another short-term general hospital</td>
<td>03 Discharged to SNF</td>
<td>04 Discharged to ICF</td>
</tr>
<tr>
<td>05 Discharged to another type of institution</td>
<td>06 Discharged to care of home health service Organization</td>
<td>07 Left against medical advice</td>
<td>08 Discharged/transferred to home under care of a Home IV provider</td>
</tr>
<tr>
<td>09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims)</td>
<td>20 Expired or did not recover</td>
<td>30 Still patient (To be used only when the client has been in the facility for 30 consecutive days if payment is based on DRG)</td>
<td>40 Expired at home (hospice use only)</td>
</tr>
<tr>
<td>41 Expired in a medical facility (hospice use only)</td>
<td>42 Expired—place unknown (hospice use only)</td>
<td>43 Discharged/Transferred to a federal hospital (such as a Veteran’s Administration [VA] hospital)</td>
<td>50 Hospice—Home</td>
</tr>
<tr>
<td>51 Hospice—Medical Facility</td>
<td>61 Discharged/Transferred within this institution to a hospital-based Medicare approved swing bed</td>
<td>62 Discharged/Transferred to an Inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital</td>
<td>63 Discharged/Transferred to a Medicare certified long-term care hospital (LTCH)</td>
</tr>
<tr>
<td>64 Discharged/Transferred to a nursing facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
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</tr>
<tr>
<td></td>
<td>certified under Medicaid but not certified under Medicare</td>
<td>65 Discharged/ Transferred to a Psychiatric hospital or psychiatric distinct part unit of a hospital; 66 Discharged/transferred to a critical access hospital (CAH)</td>
<td></td>
</tr>
<tr>
<td>18-28</td>
<td>CONDITION CODES</td>
<td>Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual.</td>
<td>C</td>
</tr>
<tr>
<td>29</td>
<td>ACCIDENT STATE</td>
<td>Not Required</td>
<td>Not Required</td>
</tr>
<tr>
<td>30</td>
<td>UNLABELED FIELD</td>
<td>NOT USED</td>
<td>Not required</td>
</tr>
<tr>
<td>31-34 a-b</td>
<td>OCCURRENCE CODE and OCCURRENCE DATE</td>
<td>Occurrence Code: Required when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</td>
<td>C</td>
</tr>
<tr>
<td>35-36 a-b</td>
<td>OCCURRENCE SPAN CODE and OCCURRENCE DATE</td>
<td>Occurrence Span Code: Required when applicable. Occurrence Codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows for entry of a 2-character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span code is present on the same line (35a-36a). Enter the date for the associated Occurrence Code in MMDDYYYY format.</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>37</td>
<td>(UNLABELED FIELD)</td>
<td>REQUIRED for re-submissions or adjustments. Enter the DCN (Document Control Number) of the original claim.</td>
<td>C</td>
</tr>
<tr>
<td>38</td>
<td>RESPONSIBLE PARTY NAME AND ADDRESS</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>39-41 a-d</td>
<td>VALUE CODES CODES and AMOUNTS</td>
<td>Code: <em>Required</em> when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows for entry of a two (2) character code. Codes should be entered in alphanumerical sequence (numbered codes precede alphanumerical codes). Up to twelve (12) codes can be entered. All &quot;a&quot; fields must be completed before using &quot;b&quot; fields, all &quot;b&quot; fields before using &quot;c&quot; fields, and all &quot;c&quot; fields before using &quot;d&quot; fields. For a list of codes and additional instructions refer to the NUBC UB-04 Uniform Billing Manual. Amount: <em>Required</em> when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999,99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td>
<td>C</td>
</tr>
<tr>
<td>General Information Fields 42-47</td>
<td>SERVICE LINE DETAIL</td>
<td>The following UB-04 fields – 42-47: Have a total of 22 service lines for claim detail information. Fields 42, 43, 45, 47, 48 include separate instructions for the completion of lines 1-22 and line 23.</td>
<td></td>
</tr>
<tr>
<td>42 Line 1-22</td>
<td>REV CD</td>
<td>Enter the appropriate revenue codes itemizing accommodations, services, and items furnished to the patient. Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.</td>
<td>R</td>
</tr>
<tr>
<td>42 Line 23</td>
<td>Rev CD</td>
<td>Enter 0001 for total charges.</td>
<td>R</td>
</tr>
<tr>
<td>43 Line 1-22</td>
<td>DESCRIPTION</td>
<td>Enter a brief description that corresponds to the revenue code entered in the service line of field 42.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
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<td>------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>43</td>
<td>PAGE ___ OF ___</td>
<td>Enter the number of pages. Indicate the page sequence in the “PAGE” field and the total number of pages in the “OF” field. If only one claim form is submitted, enter a “1” in both fields (i.e. PAGE “1” OF “1”). (Limited to 4 pages per claim)</td>
<td>C</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/RATES</td>
<td>Required for outpatient claims when an appropriate CPT/HCPCS Code exists for the service line revenue code billed. The field allows up to nine (9) characters. Only one (1) CPT/HCPC and up to two (2) modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes, or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider contract.</td>
<td>C</td>
</tr>
<tr>
<td>45</td>
<td>SERVICE DATE</td>
<td>Required on all outpatient claims. Enter the date of service for each service line billed. (MMDDYY) Multiple dates of service may not be combined for outpatient claims</td>
<td>C</td>
</tr>
<tr>
<td>46</td>
<td>CREATION DATE</td>
<td>Enter the date the bill was created or prepared for submission on all pages submitted (MMDDYY).</td>
<td>R</td>
</tr>
<tr>
<td>47</td>
<td>SERVICE UNITS</td>
<td>Enter the number of units, days, or visits for the service. A value of at least “1” must be entered. For inpatient room charges, enter the number of days for each accommodation listed.</td>
<td>R</td>
</tr>
<tr>
<td>48</td>
<td>TOTAL CHARGES</td>
<td>Enter the total charge for each service line.</td>
<td>R</td>
</tr>
<tr>
<td>49</td>
<td>TOTALS</td>
<td>Enter the total charges for all service lines.</td>
<td>R</td>
</tr>
<tr>
<td>50</td>
<td>NON-COVERED</td>
<td>Enter the non-covered charges included in field 47 for the Revenue Code listed in field 42 of the service line. Do not list negative amounts.</td>
<td>C</td>
</tr>
<tr>
<td>51</td>
<td>TOTALS</td>
<td>Enter the total non-covered charges for all service lines.</td>
<td>C</td>
</tr>
<tr>
<td>(UNLABELED FIELD)</td>
<td>Not Used</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>50 A-C</td>
<td>PAYER</td>
<td>Enter the name of each Payer from which reimbursement is being sought in the order of the Payer liability. Line A refers to the primary payer; B, secondary; and C, tertiary</td>
<td>R</td>
</tr>
<tr>
<td>51 A-C</td>
<td>HEALTH PLAN</td>
<td>Not Required</td>
<td></td>
</tr>
<tr>
<td>IDENTIFICATION NUMBER</td>
<td>Not Required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>52 A-C</td>
<td>REL INFO</td>
<td>REQUIRED for each line (A, B, C) completed in field 50. Release of Information Certification Indicator. Enter “Y” (yes) or “N” (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain “Y”.</td>
<td>R</td>
</tr>
<tr>
<td>53</td>
<td>ASG. BEN.</td>
<td>Enter “Y” (yes) or ‘N’ (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.</td>
<td>R</td>
</tr>
<tr>
<td>54</td>
<td>PRIOR PAYMENTS</td>
<td>Enter the amount received from the primary payer on the appropriate line when Superior HealthPlan Advantage is listed as secondary or tertiary.</td>
<td>C</td>
</tr>
<tr>
<td>55</td>
<td>EST. AMOUNT DUE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>56</td>
<td>NATIONAL PROVIDER IDENTIFIER OR PROVIDER ID</td>
<td>Required: Enter Providers 10-character NPI ID.</td>
<td>R</td>
</tr>
<tr>
<td>57</td>
<td>OTHER PROVIDER ID</td>
<td>Enter the numeric provider identification number.</td>
<td>R</td>
</tr>
<tr>
<td>58</td>
<td>INSURED’S NAME</td>
<td>For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient’s name. Enter the name as last name, first name, middle initial.</td>
<td>R</td>
</tr>
<tr>
<td>59</td>
<td>PATIENT RELATIONSHIP</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>60</td>
<td>INSURED’S UNIQUE ID</td>
<td>REQUIRED: Enter the patient’s Insurance ID exactly as it appears on the patient’s ID card. Enter the Insurance ID in the order of liability listed in field 50.</td>
<td>R</td>
</tr>
<tr>
<td>61</td>
<td>GROUP NAME</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>62</td>
<td>INSURANCE GROUP NO.</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Enter the Prior Authorization or referral when services require pre-certification.</td>
<td>C</td>
</tr>
<tr>
<td>64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>Enter the twelve (12) character original claim number of the paid/denied claim when submitting a replacement or void on the corresponding A, B, C line reflecting Superior HealthPlan Advantage Health Plan from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of “7” (Replacement of Prior Claim) or Type of Bill Frequency of “8” (Void/Cancel of Prior</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
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<td>---------</td>
<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Claim).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Please refer to reconsider/corrected claims section.</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>EMPLOYER NAME</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>66</td>
<td>DX VERSION QUALIFIER</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>67</td>
<td>PRINCIPAL DIAGNOSIS CODE</td>
<td>Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-9/10-CM Volume 1&amp; 3 for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>67 A-Q</td>
<td>OTHER DIAGNOSIS CODE</td>
<td>Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-9/10-CM Volume 1&amp; 3 for the date of service. Diagnosis codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. Note: Claims with incomplete or invalid diagnosis codes will be denied.</td>
<td>C</td>
</tr>
<tr>
<td>68</td>
<td>PRESENT ON ADMISSION INDICATOR</td>
<td>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1&amp; 3 for the date of service.</td>
<td>R</td>
</tr>
<tr>
<td>69</td>
<td>ADMITTING DIAGNOSIS CODE</td>
<td>Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update of ICD-9/10-CM Volume 1&amp; 3 for the date of service. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest level of specificity – 4th or “5” digit. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>70</td>
<td>PATIENT REASON CODE</td>
<td>Enter the ICD-9/10-CM Code that reflects the patient’s reason for visit at the time of outpatient registration. Field 70a requires entry, fields 70b-70c are conditional. Diagnosis Codes submitted must be valid ICD-9/10 Codes for the date of service and carried out to its highest digit – 4th or “5”. “E” codes and most “V” codes are NOT acceptable as a primary diagnosis. Note: Claims with missing or invalid diagnosis codes will be denied.</td>
<td>R</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>71</td>
<td>PPS/DRG CODE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>72</td>
<td>EXTERNAL CAUSE CODE</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>73</td>
<td>UNLABELED</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>74</td>
<td>PRINCIPAL PROCEDURE CODE/DATE</td>
<td>CODE: Enter the ICD-9/10 Procedure Code that identifies the principal/primary procedure performed. Do not enter the decimal between the second (2nd) or third (3rd) digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).</td>
<td>C</td>
</tr>
<tr>
<td>74 a-e</td>
<td>OTHER PROCEDURE CODE DATE</td>
<td>Required on inpatient claims when a procedure is performed during the date span of the bill. CODE: Enter the ICD-9 procedure code(s) that identify significant a procedure(s) performed other than the principal/primary procedure. Up to five ICD-9 Procedure Codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code, it is implied. DATE: Enter the date the principal procedure was performed (MMDDYY).</td>
<td>C</td>
</tr>
<tr>
<td>75</td>
<td>UNLABELED</td>
<td></td>
<td>Not Required</td>
</tr>
<tr>
<td>76</td>
<td>ATTENDING PHYSICIAN</td>
<td>Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID number: 0B – State License #. 1G – Provider UPIN. G2 – Provider Commercial #. B3 – Taxonomy Code. LAST: Enter the attending physician’s last name. FIRST: Enter the attending physician’s first name.</td>
<td>R</td>
</tr>
<tr>
<td>77</td>
<td>OPERATING PHYSICIAN</td>
<td>Required when a surgical procedure is performed. Enter the NPI and name of the physician in charge of the patient care. NPI: Enter the attending physician 10-character NPI ID Taxonomy Code: Enter valid taxonomy code. QUAL: Enter one of the following qualifier and ID</td>
<td>C</td>
</tr>
<tr>
<td>FIELD #</td>
<td>Field Description</td>
<td>Instruction or Comments</td>
<td>Required or Conditional</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>number:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0B – State License #.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1G – Provider UPIN.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>G2 – Provider Commercial #.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>B3 – Taxonomy Code.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>LAST: Enter the attending provider’s last name.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>FIRST: Enter the attending physician’s first name.</td>
<td></td>
</tr>
<tr>
<td>78 &amp; 79</td>
<td>OTHER PHYSICIAN</td>
<td>Enter the Provider Type qualifier, NPI, and name of the physician in charge of the patient care.</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Blank Field): Enter one of the following Provider Type Qualifiers:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DN – Referring Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>ZZ – Other Operating MD</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>82 – Rendering Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NPI: Enter the other physician 10-character NPI ID.</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>REMARKS</td>
<td>QUAL: Enter one of the following qualifier and ID number:</td>
<td></td>
</tr>
<tr>
<td>81</td>
<td>CC</td>
<td>A: Taxonomy of billing provider. Use B3 qualifier.</td>
<td>R</td>
</tr>
<tr>
<td>82</td>
<td>Attending Physician</td>
<td>Enter name or 7 digit provider number of ordering physician</td>
<td>R</td>
</tr>
</tbody>
</table>
Appendix VII: Billing Tips and Reminders

Adult Day Health Care

- Must be billed on a CMS 1500 Claim Form.
- Must be billed in location 99.

Ambulance

- Must be billed on a CMS 1500 Claim Form.
- Appropriate modifiers must be billed with the Transportation Codes.

Ambulatory Surgery Center (ASC)

- Ambulatory surgery centers must submit charges using the CMS 1500 Claim Form.
- Must be billed in place of service 24.
- Invoice must be billed with Corneal Transplants.
- Most surgical extractions are billable only under the ASC.

Anesthesia

- Bill total number of minutes in field 24G of the CMS 1500 Claim Form and must be submitted with the appropriate modifier.
- Failure to bill total number of minutes may result in incorrect reimbursement or claim denial.
- Appropriate modifiers must be utilized.

APC Billing Rules

- Critical Access Hospitals (CAHs) are required to bill with 13x-14x codes.
- Bill type for APC claims are limited to 13xs-14x range.
- Late charge claims are not allowed. Only replacement claims. Claims with late charges will be denied to be resubmitted.
- Claims spanning two calendar years will be required to be submitted by the provider as one claim.
- CMS Maximum Unit Edits (MUEs) will be applied per line, per claim.
  - Claim lines exceeding the MUE value will be denied.
- Observation: Providers are required to bill HCPCS G0378 along with the revenue code. The Observation G code will allow the case rate. CMS is proposing significant changes to observation rules and payment level for 2014, and this will be updated accordingly.
- Ambulance Claims: Need to be submitted on a CMS 1500 form. Any Ambulance claim submitted on a UB will be denied.
- Revenue codes and HCPCS codes are required for APC claims.

Comprehensive Day Rehab

- Must be billed on a CMS 1500 Claim Form.
• Must be billed in location 99.
• Acceptable modifiers.

**Deliveries**
• Use appropriate value codes as well as birth weight when billing for delivery services.

**DME/Supplies/Prosthetics and Orthotics**
• Must be billed with an appropriate modifier.
• Purchase only services must be billed with modifier NU.
• Rental services must be billed with modifier RR.

**Hearing Aids**
• Must be billed with the appropriate modifier LT or RT.

**Home Health**
• Must be billed on a UB 04.
• Bill type must be 3XX.
• Must be billed in location 12.
• Both Rev and CPT codes are required.
• Each visit must be billed individually on separate service line.

**Long Term Acute Care Facilities (LTACs)**
• Long Term Acute Care Facilities (LTACs) must submit Functional Status Indicators on claim submissions.

**Maternity Services**
• Providers must utilize correct coding for Maternity Services.
• Services provided to Members prior to their Superior HealthPlan Advantage effective date, should be correctly coded and submitted to the payer responsible.
• Services provided to the member on or after their Superior HealthPlan Advantage effective date, should be correctly coded and submitted to Superior HealthPlan Advantage.

**Modifiers**
• Appropriate Use of – 25, 26, TC, 50, GN, GO, GP.
• **25 Modifier** - should be used when a significant and separately identifiable E&M service is performed by the same physician on the same day of another procedure (e.g., 99381 and 99211-25. Modifier 25 is subject to the code edit and audit process. Appending a modifier 25 is not a guarantee of automatic payment and may require the submission of medical records.
• Well-Child and sick visit performed on the same day by the same physician). *Note: 25 modifiers are not appended to non E&M procedure codes, e.g. lab.
• **26 Modifier** – should never be appended to an office visit CPT code.
• Use 26 modifier to indicate that the professional component of a test or study is performed using the 70000 (radiology) or 80000 (pathology) series of CPT codes. Inappropriate use may result in a claim denial/rejection

• **TC Modifier** – used to indicate the technical component of a test or study is performed.

• 50 Modifier – indicates a procedure performed on a bilateral anatomical site
  – Procedure must be billed on a single claim line with the 50 modifier and quantity of one.
  – RT and LT modifiers or quantities greater than one should not be billed when using modifier 50.

• **GN, GO, GP Modifiers** – therapy modifiers required for speech, occupational, and physical therapy.

**Supplies**

• Physicians may bill for supplies and materials in addition to an office visit if these supplies are over and above those usually included with the office visit.

• Supplies such as gowns, drapes, gloves, specula, pelvic supplies, urine cups, swabs, jelly, etc., are included in the office visit and may not be billed separately. Providers may not bill for any reusable supplies.

**Outpatient Hospital Laboratory Services**

• Bill Type 141 – Must be utilized when a non-inpatient or non-outpatient hospital member’s specimen is submitted for analysis to the Hospital Outpatient Laboratory. The Member is not physically present at the hospital.

• Bill Type 131 and Modifier L1 – Must be utilized when the hospital only provides laboratory tests to the Member and the Member does not also receive other hospital outpatient services during the same encounter. Must also be utilized when a hospital provides a laboratory test during the same encounter as other hospital outpatient services that are clinically unrelated to the other hospital outpatient services, and the laboratory test is ordered by a different Provider than the Provider who ordered the other hospital outpatient services provided in the hospital outpatient setting.

• Services not billed following the above guidelines will be denied as EX code AT.

**POA**

• Present on Admission (POA) Indicator is required on all inpatient facility claims
  – Failure to include the POA may result in a claim denial/rejection.

**Rehabilitation Services – Inpatient Services**

• Functional status indicators must be submitted for inpatient Rehabilitation Services.

**Telemedicine**

• Physicians at the distant site may bill for telemedicine services and MUST utilize the appropriate modifier to identify the service was provided via telemedicine.
  – E&M CPT plus the appropriate modifier.
  – Via interactive audio and video tele-communication systems.
Appendix VIII: Reimbursement Policies

As a general rule, Superior HealthPlan Advantage follows Medicare reimbursement policies. Instances that vary from Medicare include:

Physician Rules

Calculating Anesthesia

Anesthesia time is defined as the period during which an anesthesia provider is present with the patient. It starts when the anesthesia provider begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia provider is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Certified Nurse Midwife (CNM) Rules

Payment for CNM services is made at 100% of the contracted rate.

EKG Payment

EKG Interpretation is separately billable and payable from the actual test. However, the first provider to bill receives payment for services.

Physician Site Of Service

Physicians will be paid at Physician rate only at the following Sites of Service: Office, Home, Assisted Living Facility, Mobile unit, walk in retail health clinic, urgent care facility, birthing center, nursing facility, SNFs, independent clinic, FQHC, Intermediate HC Facility, Resident Substance Abuse Facility, Nonresident Substance Abuse Facility, Comprehensive OP Rehab facility, ESRD Facility, State or Local Health Clinic, RHC, Indy lab, Other POS.

Endoscopic Multiple Procedure Rules

When you have two (2) sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608) - identify the primary code within the family, and then apply multiple procedure discounts to the two (2) primary codes. Secondary codes are not paid because you consider the total payment for each set of endoscopies as one service.

When you have two (2) related endoscopies and a third (3rd), unrelated procedure identify the primary code in the related endoscopies. Then apply multiple procedure discounts to the unrelated code and the identified primary code. The secondary code is not paid because you consider the total payment for each set of endoscopies as one (1) service.

Diagnostic Testing Of Implants

Charges and payments for diagnostic testing of implants following surgery is not included in the global fee for surgery and is reimbursable if the testing is outside the global timeframe. If it is inside the global timeframe, it is not reimbursable.
Lesser Of Language
Pay provider lesser of the providers allowable charges or the negotiated rate

Multiple Procedure Rules for Surgery
Payment should be paid at 100%/50%/50%, starting with procedure ranked highest maximum of three (3) procedures.

Procedures 4+ are subject to manual review and payment if appropriate.

Multiple Procedure Ranking Rules
If two (2) or more multiple surgeries are of equal payment value and bill charges do not exceed the payment rate, rank them in descending dollar order billed pay based on multiple procedure discounts.

Multiple Procedure Rules for Radiology
Multiple procedure radiology codes follow Multiple Procedure discount rules: 100%/50%/50%, maximum of three (3) radiology codes.

Physician Assistant (PA) Payment Rules
Physician assistant services are paid at eight percent (8%) of what a physician is paid under the Superior HealthPlan Advantage Physician Fee Schedule.

- PA services furnished during a global surgical period shall be paid eighty-five percent (85%) of what a Provider is paid under the Superior HealthPlan Advantage Physician Fee Schedule.
- PA assistant-at-surgery services at eighty-five percent (85%) of what a provider is paid under the Medicare Physician Fee Schedule. Since providers are paid at sixteen percent (16%) of the surgical payment amount under the Medicare Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is thirteen point six percent (13.6%) of the amount paid to providers. The AS modifier must be used.

Nurse Provider (NP) and Clinical Nurse Specialist (CNS) Payment Rules
In general, NPs and CNSs are paid for covered services at eighty-five percent (85%) of what a physician is paid under the Superior HealthPlan Advantage Physician Fee Schedule.

- NP or CNS assistant-at-surgery services at eighty-five percent (85%) of what a provider is paid under the Superior HealthPlan Advantage Physician Fee Schedule. Since physicians are paid at sixteen percent (16%) of the surgical payment amount under the Superior HealthPlan Advantage Physician Fee Schedule for assistant-at-surgery services, the actual payment amount that PAs receive for assistant-at-surgery services is thirteen point six percent (13.6%) of the amount paid to physicians. The AS modifier must be used.

Surgical Physician Payment Rules
For surgeries billed with either modifier 54, 55, 56, or 78 pay the appropriate percentage of the fee schedule payment as identified by the modifier and procedure code used.
Incomplete Colonoscopy Rule

Incomplete colonoscopies should be billed with CPT 45378 and MOD 53. This will pay twenty-five percent (25%) of the FS rate for the incomplete procedures. The rest of the claim pays according to the FS.

Injection Services

Injection service codes must pay separately if no other physician service is paid and when not billed with office visit. If an office visit is billed, then no injection is payable because it is covered in the office charge.

Unpriced Codes

In the event that the CMS/Medicare RBRVS does not contain a published fee amount, an alternate “gap fill” source is utilized to determine the fee amount. If there is no fee available on the alternate “gap fill” source, Superior HealthPlan Advantage will reimburse forty percent (40%) of billed charges less any applicable copay, coinsurance or deductible, unless contracted differently. Unlisted codes are subject to the code edit and audit process and will require the submission of medical records.

Rental or Purchase Decisions

Rental or purchase decisions are made at the discretion of Medical Management.

Payment for Capped Rental Items during Period of Continuous Use

When no purchase options have been exercised, rental payments may not exceed a period of continuous use of longer than fifteen (15) months. For the month of death or discontinuance of use, contractors pay the full month rental. After fifteen (15) months of rental have been paid, the supplier must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Superior HealthPlan Advantage coverage ceases. For this purpose, unless there is a break in need for at least sixty (60) days, medical necessity is presumed to continue. Any lapse greater than sixty (60) days triggers new medical necessity.

If the beneficiary changes suppliers during or after the fifteen (15) month rental period, this does not result in a new rental episode. The supplier that provides the item in the fifteenth (15th) month of the rental period is responsible for supplying the equipment and for maintenance and servicing after the fifteen (15) month period. If the supplier changes after the tenth (10th) month, there is no purchase option.

Percutaneous Electrical Nerve Stimulator (PENS) Rent Status While Hospitalized

An entire month's rent may not be paid when a patient is hospitalized during the month. The rent will be prorated to allow for the time not hospitalized.

Transcutaneous Electrical Nerve Stimulator (TENS)

In order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular patient, contractors pay ten (10) percent of the purchase price of the item for each of two (2) months. The purchase price and payment for maintenance and servicing are determined under the same rules as any other frequently purchased item. There is a reduction in the allowed amount for purchase due to the two months rental.
Appendix IX: EDI Companion Guide

EDI Companion Guide Overview

The Companion Guide provides Centene trading partners with guidelines for submitting 5010 version of 837 Professional Claims. The Centene Companion Guide documents any assumptions, conventions, or data issues that may be specific to Centene business processes when implementing the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3). As such, this Companion Guide is unique to Centene and its affiliates.

This document does NOT replace the HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) for electronic transactions, nor does it attempt to amend any of the rules therein or impose any mandates on any trading partners of Centene. This document provides information on Centene- specific code handling and situation handling that is within the parameters of the HIPAA administrative Simplification rules.

Readers of this Companion Guide should be acquainted with the HIPAA Technical Reports Type 3, their structure and content. Information contained within the HIPAA TR3s has not been repeated here although the TR3s have been referenced when necessary. The HIPAA ASC X12N 5010A Technical Reports Type 3 (TR3) can be purchased at http://store.x12.org.

The Companion Guide provides supplemental information to the Trading Partner Agreement (TPA) that exists between Centene and its trading partners. Refer to the TPA for guidelines pertaining to Centene legal conditions surrounding the implementations of EDI transactions and code sets. Refer to the Companion Guide for information on Centene business rules or technical requirements regarding the implementation of HIPAA compliant EDI transactions and code sets.

Nothing contained in this guide is intended to amend, revoke, contradict, or otherwise alter the terms and conditions of the Trading Partner Agreement. Note: If there is an inconsistency with the terms of this guide and the terms of the Trading Partner Agreement, the terms of the Trading Partner Agreement shall govern.

Rules of Exchange

The Rules of Exchange section details the responsibilities of trading partners in submitting or receiving electronic transactions with Centene.

Transmission Confirmation

Transmission confirmation may be received through one of two possible transactions: the TA1 Interchange Acknowledgement or the 999 Functional Acknowledgements. A TA1 Acknowledgement is used at the ISA level of the transmission envelope structure, to confirm a positive transmission or indicate an error at the ISA level of the transmission. The 999 Acknowledgement may be used to verify a successful transmission or to indicate various types of errors.

Confirmations of transmissions, in the form of TA1 or 999 transactions, should be received within 24 hours of batch submissions, and usually sooner. Senders of transmissions should check for confirmations within this time frame.

Batch Matching

Senders of batch transmissions should note that transactions are unbundled during processing, and rebundled so that the original bundle is not replicated. Trace numbers or patient account numbers should be used for batch matching or batch balancing.
**TA1 Interchange Acknowledgement**

The TA1 Interchange Acknowledgement provides senders a positive or negative confirmation of the transmission of the ISA/IEA Interchange Control.

**999 Functional Acknowledgement**

The 999 Functional Acknowledgement reports on all Implementation Guide edits from the Functional Group and transaction Sets.

The IK5 segment in the Functional Acknowledgement may contain an A, E, or R. An ‘A’ indicates the entire transaction set was accepted. While an ‘R’ indicates the entire transaction set was rejected. However, an ‘E’ may be used if the transaction set was accepted but within the transaction set there were claims which may have rejected or have a warning message. Rejected claims will be identified with a CTX segment in between the IK3 & IK4 segments.

**277CA Health Care Claim Acknowledgement**

The 277CA Health Care Claim Acknowledgement provides a more detailed explanation of the transaction set. Centene also provides the Pre-Adjudication rejection reason of the claim within the STC12 segment of the 2220D loop. *Note: The STC03 – Action Code will only be a “U” if the claim failed on HIPAA validation errors, NOT Pre-Adjudication errors.*

**Duplicate Batch Check**

To ensure that duplicate transmissions have not been sent, Centene checks five values within the ISA for redundancy:

- ISA06
- ISA08
- ISA09
- ISA10
- ISA13

Collectively, these numbers should be unique for each transmission. A duplicate ISA/IEA receives a TA1 response of “025” (Duplicate Interchange Control Number).

To ensure that Transaction Sets (ST/SE) have not been duplicated within a transmission, Centene checks the ST02 value (the Transaction Set Control Number), which should be a unique ST02 within the Functional Group transmitted. Duplicate Transaction Sets (ST/SE) return a 999 Functional Acknowledgement with an IK502 value of “23” (Transaction Set Control Number not unique within the Functional Group).
New Trading Partners

New trading partners should access https://sites.edifecs.com/index.jsp?centene, register for access, and perform the steps in the Centene trading partner program. The EDI Support Desk (EDIBA@Centene.com) will contact you with additional steps necessary upon completing your registration.
Claims Processing

Acknowledgements
Senders receive four (4) types of acknowledgement transactions: the TA1 transaction to acknowledge the Interchange Control Envelope (ISA/IEA) of a transaction, the 999 transaction to acknowledge the Functional Group (GS/GE) and Transaction Set (ST/SE), the 277CA transaction to acknowledge health care claims, and the Centene Audit Report. At the claim level of a transaction, the only acknowledgement of receipt is the return of the Claim Audit Report and/or a 277CA. Note: Trading Partners will not be provided a 997 once they begin submitting 5010 version of transactions.

Coordination of Benefits (COB) Processing
To ensure the proper processing of claims requiring coordination of benefits, Centene recommends that providers validate the patient’s Membership Number and supplementary or primary carrier information for every claim.

Centene requires that 837I COB be submitted at the Claim level loop (2300). 837P at the Detail level (2400) for all COB transactions.

All Sum of paid amount (AMT02 in loop 2320) and all line adjustment amounts (CAS in 2320 & 2340) must equal the total charge amount (CLM). Additionally, the service charge amount must equal the value of all drug charges (sum of CTP03 and CTP04 in 2410).

If the claim was adjudicated by another payer identified in the 2330B loop the AMT – Payer Paid Amount and AMT – Remaining Patient Liability must be completed.

Primary and secondary coverage for the same claim will not be processed simultaneously. Claims that contain both primary and secondary coverage must be broken down into two (2) claims. File the primary coverage first and submit the secondary coverage after the primary coverage claim has been processed. Submitters can be assured that the primary coverage claim has been processed upon receipt of the EOP or ERA. A secondary coverage claim that is submitted prior to the processing of its preceding primary coverage claim will be denied, based on the need for primary insurance information.

Code Sets
Only standard codes, valid at the time of the date(s) of service, should be used.

Corrections and Reversals
The 837 TR3 defines what values submitters must use to signal to payers that the inbound 837 contains a reversal or correction to a claim that has previously been submitted for processing. For both Professional and Institutional 837 claims, 2300 CLM05-3 (Claim Frequency Code) must contain a value for the National UB Data Element Specification Type List Type of Bill Position 3. Values supported for corrections and reversals are:

- 5 = “Late Charges Only” Claim
- 7 = Replacement of Prior Claim
- 8 = Void/Cancel of Prior Claim

Data Format/Content
Centene accepts all compliant data elements on the 837 Professional Claim. The following points outline consistent data format and content issues that should be followed for submission.
Dates

The following statements apply to any dates within an 837 transaction:

- All dates should be formatted according to Year 2000 compliance, CCYYMMDD, except for ISA segments where the date format is YYMMDD.
- The only values acceptable for “CC” (century) within birthdates are 18, 19, or 20.
- Dates that include hours should use the following format: CCYYMMDDHHMM.
- Use Military format, or numbers from 0 to 23, to indicate hours. For example, an admission date of 201006262115 defines the date and time of June 26, 2010 at 9:15 PM.
- No spaces or character delimiters should be used in presenting dates or times.
- Dates that are logically invalid (e.g. 20011301) are rejected.
- Dates must be valid within the context of the transaction. For example, a patient’s birth date cannot be after the patient’s service date.

Decimals

All percentages should be presented in decimal format. For example, a twelve point five percent (12.5%) value should be presented as .125.

Dollar amounts should be presented with decimals to indicate portions of a dollar; however, no more than two (2) positions should follow the decimal point. Dollar amounts containing more than two (2) positions after the decimal point are rejected.

Monetary and Unit Amount Values

Centene accepts all compliant data elements on the 837 Professional Claim; however, monetary or unit amount values that are in negative numbers are rejected.

Delimiters

Delimiters are characters used to separate data elements within a data string. Delimiters used by Centene are specified in the Interchange Header segment (the ISA level) of a transmission; these include the tilde (~) for segment separation, the asterisk (*) for element separation, and the colon (:) for component separation. Please note that the pipe symbol (|) and or line feed cannot be used as delimiters.

Phone Numbers

Phone numbers should be presented as contiguous number strings, without dashes or parenthesis markers. For example, the phone number (336) 555-1212 should be presented as 3365551212. Area codes should always be included. Centene requires the phone number to be AAABBBCCCC where AAA is the Area code, BBB is the telephone number prefix, and CCCC is the telephone number.

Additional Items

- Centene will not accept more than 97 service lines per claim.
- Centene will not accept negative values in AMT fields.
- Centene will only accept single digit diagnosis pointers in the SV107 of the 837P.
- The Value Added Network Trace Number (2300-REF02) is limited to 20 characters.

Identification Codes and Numbers

General Identifiers

Federal Tax Identifiers

Any Federal Tax Identifier (Employer ID or Social Security Number) used in a transmission should omit dashes or hyphens. Centene sends and receives only numeric values for all tax identifiers.

Sender Identifier

The Sender Identifier is presented at the Interchange Control (ISA06) of a transmission. Centene expects to see the sender's Federal Tax Identifier (ISA05, qualifier 30) for this value. In special circumstances, Centene will accept a "Mutually Defined" (ZZ) value. Senders wishing to submit a ZZ value must confirm this identifier with Centene EDI.

Provider Identifiers

National Provider Identifiers (NPI)

HIPAA regulation mandates that providers use their NPI for electronic claims submission. The NPI is used at the record level of HIPAA transactions; for 837 claims, it is placed in the 2010AA loop. See the 837 Professional Data Element table for specific instructions about where to place the NPI within the 837 Professional file. The table also clarifies what other elements must be submitted when the NPI is used.

Billing provider

The Billing Provider Primary Identifier should be the group or organization ID of the billing entity, filed only at 2010AA. This will be a Type 2 (Group) NPI unless the Billing provider is a sole proprietor and processes all claims and remittances with a Type 1 (Individual) NPI.

Rendering Provider

When providers perform services for a subscriber or patient, the service will need to be reported in the Rendering Provider Loop (2310B or 2420A). You should only use 2420A when it is different than 2310B.

Referring Provider

Centene has no requirement for Referring Provider information beyond that prescribed by the X12 implementation guide (TR3).

Atypical Provider

A typical providers are not always assigned an NPI number, however, if an Atypical provider has been assigned an NPI, then they need to follow the same requirements as a medical provider. An Atypical provider which provides non-medical services is not required to have an NPI number (i.e. carpenters, transportation, etc). Existing Atypical providers need only send the Provider Tax ID in the REF segment of the billing provider loop.
Subscriber Identifiers

Submitters must use the entire identification code as it appears on the subscriber’s card in the 2010BA element.

Claim Identifiers

Centene issues a claim identification number upon receipt of any submitted claim. The ASC X12 Technical Reports (Type 3) may refer to this number as the Internal Control Number (ICN), Document Control Number (DCN), or the Claim Control Number (CCN). It is provided to senders in the Claim Audit Report and in the CLP segment of an 835 transaction. *Note: When submitting a claim adjustment, this number must be submitted in the Original Reference Number (ICN/DCN) segment, 2300, REF02.*

Centene returns the submitter’s Patient Account Number (2300, CLM01) on the Claims Audit Report and the 835 Claim Payment/Advice (CLP01).

Connectivity Media for Batch Transactions

Secure File Transfer

Centene encourages trading partners to consider a secure File Transfer Protocol (FTP) transmission option. Centene offers two (2) options for connectivity via FTP.

- **Method A** – the trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the Centene FTP server.
- **Method B** – The trading partner will push transactions to the Centene FTP server and Centene will push outbound transactions to the trading partner’s FTP server.

Encryption

Centene offers the following methods of encryption SSH/SFTP, FTPS (Auth TLS), FTP w/PGP, HTTPS. *Note: This method only applies with connecting to Centene’s Secure FTP. Centene does not support retrieve files automatically via HTTPS from an external source at this time. If PGP or SSH keys are used they will shared with the trading partner. These are not required for those connecting via SFTP or HTTPS.*

Direct Submission

Centene also offers posting an 837 batch file directly on the Provider Portal website for processing.

Edits and Reports

Incoming claims are reviewed first for HIPAA compliance and then for Centene business rules requirements. The business rules that define these requirements are identified in the 837 Professional Data Element Table below, and are also available as a comprehensive list in the 837 Professional Claims – Centene Business Edits Table. HIPAA TR3 implementation guide errors may be returned on either the TA1 or 999 while Centene business edit errors are returned on the Centene Claims Audit Report.
**Reporting**

The following table indicates which transaction or report to review for problem data found within the 837 Professional Claim Transaction.

<table>
<thead>
<tr>
<th>Transaction Structure Level</th>
<th>Type of Error or Problem</th>
<th>Transaction or Report Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISA/IEA Interchange Control</td>
<td>HIPAA Implementation Guide violations</td>
<td>TA1</td>
</tr>
</tbody>
</table>
| GS/GE Functional Group      | HIPAA Implementation Guide violations | 999  
Centene Claims Audit Report  
(a proprietary confirmation and error report) |
| ST/SE Segment               | Centene Business Edits  
(see audit report rejection reason codes and explanation.) | Centene Claims Audit Report  
(a proprietary confirmation and error report) |
| Detail Segments             | HIPAA Implementation Guide violations and Centene Business Edits. | 277CA |
### 837: Data Element Table

The 837 Data Element Table identifies only those elements within the X12 5010 Technical Report implementation guide that require a comment within the context of Centene business processes. The 837 Data Element Table references the guide by loop name, segment name and identifier, element name and identifier. The Data Element Table also references the Centene Business Edit Code Number if there is an edit applicable to the data element in question. The Centene Business Edit Code numbers appear on the Claims Audit Report, along with a narrative explanation of the edit. For a list of the error messages and their respective code numbers, see ‘Audit Report - Rejection Reason Codes and Explanation’ above.

The Centene business rule comments provided in this table do not identify if elements are required or situational according to the 837 Implementation guides. It is assumed that the user knows the designated usage for the element in question. Not all elements listed in the table below are required, but if they are, the table reflects the values Centene expects to see.

<table>
<thead>
<tr>
<th>Loop ID</th>
<th>Segment Type</th>
<th>Element Designator</th>
<th>Data Element</th>
<th>Centene Business Rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010AA</td>
<td>NM1</td>
<td>Billing Provider Name</td>
<td>NM103-NM105</td>
<td>Name Last</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NM104</td>
<td>Name First</td>
</tr>
<tr>
<td>2010BA</td>
<td>NM1</td>
<td>Subscriber Name</td>
<td>NM103-NM105</td>
<td>Name (Last, First, Middle)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NM109</td>
<td>ID Code</td>
</tr>
<tr>
<td>DMG</td>
<td>Demographic Information</td>
<td>DMG03</td>
<td>Gender Code</td>
<td>Centene will only accept ‘M’, ‘F’, and ‘O’ values.</td>
</tr>
<tr>
<td>2010BB</td>
<td>NM1</td>
<td>Payer Name</td>
<td>NM103-NM105</td>
<td>Name Last</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NM103</td>
<td>Last Name or Organization Name</td>
</tr>
<tr>
<td>2300</td>
<td>REF</td>
<td>Payer Claim Control Number</td>
<td>REF02</td>
<td>Reference Identification Qualifier</td>
</tr>
</tbody>
</table>