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Medicare Advantage

Medicare Advantage

Provider Orientation

Agenda



- Plan Overview
- Membership, Services and Additional Benefits
- Providers and Authorizations
- Preventive Care and Screenings
- Model of Care (MMP and D-SNP only)
- Medicare STAR Ratings
- Web-Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer & Electronic Medical Records
- Advance Directives
- Fraud, Waste and Abuse
- CMS Mandatory Trainings



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Plan Overview

Overview: Medicare Advantage Plans



- Superior HealthPlan Medicare Advantage provides complete continuity of care. This includes:
 - Integrated coordination care
 - Care management
 - Co-location of behavioral health expertise
 - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM)
 - Additional services specific to the beneficiary needs
- Our approach to care management facilitates the integration of community resources, health education and disease management.
 - It promotes access to care as the beneficiaries are served through a multidisciplinary team including RN, Social Workers, Pharmacy Technicians and Behavioral Health Case Managers all co-located in a single, locally based unit.

Medicare Advantage Prescription Drug Plan (MAPD)



For the first time, Superior is offering non-dual SNP HMO plans in 2017. These HMO plans will cover all Medicare-required services along with a prescription drug benefit. HMO plans (unlike D-SNP and MMP) do not require you to have Medicaid to enroll.

- Most Medicare Advantage plans (sometimes referred to as "Part C") include the Part D prescription drug benefit plan, and are known as a Medicare Advantage Prescription Drug (MAPD) plan.
- Superior HealthPlan offers the MAPD program in ***Bexar, Cameron, Collin, Dallas, Denton, El Paso, Hidalgo, Nueces, Smith counties only.***
- MAPD plans cover the most commonly prescribed drugs. However, each specific Part D plan may determine which drugs are covered.
- The covered drugs are included in the plan's formulary, or list of drugs:
 - <https://www.silverscript.com/learn/drug-list-formulary.aspx>

Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP)



- A Dual-Eligible Special Needs Plan (D-SNP) is a plan for individuals with specific conditions or financial needs who are eligible for both Medicare and medical assistance from Texas Medicaid.
- Superior HealthPlan offers a D-SNP program in ***Bexar, Collin, Dallas, Nueces and Rockwall counties only.***
- For D-SNP members, Medicare is always the primary payor and Medicaid is secondary payor.
- D-SNP members may have both Superior Medicare and Superior Medicaid but not always, so it is important to verify coverage prior to servicing the member. You may see members with Superior Medicare where their Medicaid is under another health plan or traditional Fee-For-Service (FFS) Medicaid or vice versa.

Medicare-Medicaid Plan (MMP)



- STAR+PLUS MMP blends Medicare and Texas Medicaid benefits into one plan.
- Superior HealthPlan offers STAR+PLUS MMP in ***Bexar, Dallas and Hidalgo counties only.***
- In this program, Superior covers:
 - All Medicare benefits, including parts A, B and D
 - Medicaid benefits, including Long Term Services and Supports (LTSS)
 - Add-on Services
 - Flexible Benefits



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Membership, Benefits and Additional Services

Membership



- Medicare beneficiaries have the option to stay in the original Fee-For-Service Medicare plan or choose a Medicare health plan, such as Superior HealthPlan Medicare Advantage.
- Advantage members may change PCPs at any time.
- Providers should verify eligibility before every visit by using one of the options below:
 - Website: www.SuperiorHealthPlan.com
 - 24/7 Interactive Voice Response Line: 1-800-218-7453
 - Provider Services: 1-877-391-5921
 - TTY: 1-800-735-2989

Membership (continued)

D-SNP ID Card



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

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

Medicare^{Rx}
Prescription Drug Coverage

CMS: H5294-001

RxBIN: 12353
RxPCN: 6244500

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

Providers: This card does not guarantee eligibility or authorization. For eligibility, call 1-877-935-8023.

For prior auth or case management referral, call 1-800-218-7508.

For questions, pharmacists can call 1-888-210-3879.

For pharmacy prior auth, call 1-866-399-0928.

Non-participating providers must obtain prior auth on all services, except for emergency care. Call 1-800-218-7508 for prior auth.

Claims submissions:

Superior HealthPlan Advantage (HMO SNP)
P.O. Box 3060, Farmington, MO 63640-3822

Membership (continued)

MAPD ID Card



Superior Healthplan Medicare Advantage (HMO)

A Medicare Advantage Prescription Drug Plan

Name: John Doe
Member ID: C11111111-00

Rx Claims Processor: CVS Caremark
RxBIN: 004336
RxPCN: MEDDADV
RxGroup: RX8905



CMS H0062 001

Medical Group/Primary Care Provider (PCP):

Dr. James Smith 1-888-888-8888

Member questions: 1-844-796-6811 or TTY: 711 or access our website at <http://advantage.superiorhealthplan.com>

24-hr Nurse Advice Line: 1-855-696-2515 or TTY: 711

Provider Inquiries: 1-844-796-6811 or TTY: 711

Pharmacist Inquiries: 1-888-865-6567

Pharmacy Prior Authorization: 1-844-796-6811

Submit Medical Claims to:

EDI Payor ID: 68069
Superior Healthplan
Medicare Advantage
P.O. Box 3060 Farmington,
MO 63640-3822

Submit Part D Drug Claims to:

Superior Healthplan Medicare Advantage
PO Box 419069
Rancho Cordova, CA 95741-9069

Membership (continued)

MMP ID Card



MedicareRx
Prescription Drug Coverage

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Health Plan (80840): <Card Issuer Identifier>
Medicaid ID: <Medicaid ID#>

PCP Name: <PCP Name>
PCP Effective Date: <PCP Effective Date>
PCP Phone: <PCP Phone>

RxBIN: <RxBIN#>
RxPCN: <RxPCN#>
RxGRP: <RxGRP#>
RxID: <RxID#>

H6870 001

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

En caso de emergencia, llame al 911 o vaya a la sala de emergencia más cercana. Después de recibir cuidado, llame a su PCP dentro de 24 horas o lo antes posible.

Member Services³ | Servicios al miembro: <1-866-896-1844; TTY: 711>

Behavioral Health | Salud del comportamiento: <1-866-896-1844; TTY: 711>

Service Coordination | Coordinador de servicios: <1-866-896-1844; TTY: 711>

Website | Sitio web: <<http://mmp.SuperiorHealthPlan.com>>

Pharmacy Help Desk: <1-844-857-4375; TTY 711>

Send Claims To:

<Superior HealthPlan STAR+PLUS MMP Claims Dept.
PO Box 3060
Farmington, MO 63640-3822
Payor ID 68069>

Claim Inquiry: <1-877-391-5921; TTY 711>

Plan Coverage



Medicare Advantage covers:

- All Part A and Part B benefits by Medicare.
- Part B drugs – such as chemotherapy drugs.
- Part D drugs – no deductible at network retail pharmacies or mail order.
- Additional benefits and services such as wellness programs, over-the-counter items and mental health services. For a summary of plan benefits, visit:
 - <https://Advantage.SuperiorHealthPlan.com/learn-about-our-plans.html>

Covered Services



Covered Services include, but are not limited to:

- Hospital Inpatient/Outpatient
- Physician
- Prescribed Medicines
- Lab and X-Ray
- Transportation*
- Dental*
- Vision
- Hearing
- Behavioral Health
- Medical Equipment & Supplies
- Wellness Programs
- Therapy
- Ambulance
- Podiatry

**Specific counties only.*

Additional Benefits



- **Additional benefits include:**
 - Non-Emergency Transportation
 - Fitness Program
 - 24/7 Nurse Advice Line
 - Multi-language Interpreter Services
 - Over-The-Counter Items
- **For a summary of specific plan benefits, visit:**
<https://Advantage.SuperiorHealthPlan.com/learn-about-our-plans.html>

Pharmacy Formulary



- The Advantage formulary is available at:
 - <https://Advantage.SuperiorHealthPlan.com/prescription-drugs-formulary/formulary.html>
- Please refer to the formulary for specific types of exceptions
- When requesting a formulary exception, a Request For Medicare Prescription Drug Coverage Determination form must be submitted:
 - <https://Advantage.SuperiorHealthPlan.com/prescription-drugs-formulary/coverage-determinations.html>
 - The completed form can be faxed to Envolve Pharmacy Solutions at: 1-800-977-8226



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Providers and Authorization

Primary Care Providers



PCPs serve as a “medical home” and provide the following:

- Sufficient facilities and personnel
- Covered services as needed
 - 24-hours a day, 365 days a year
- Coordination of medical services and specialist referrals
- After-hours accessibility using one of the following methods:
 - Answering service
 - Call center system connecting to a live person
 - Recording directing member to a covering practitioner
 - Live individual who will contact a PCP

Utilization Management



Authorization must be obtained prior to the delivery of certain elective and scheduled services. The preferred method for submitting authorization requests is through the Secure Provider Portal at:

Provider.SuperiorHealthPlan.com

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorizations



Prior authorization is required for:

- Inpatient admissions, including observation
- Home health services
- Ancillary services
- Radiology (MRI, MRA, PET, CT)
- Pain management programs
- Outpatient therapy and rehab (OT,PT,ST)
- Transplants
- Surgeries
- Durable Medical Equipment (DME)
- Part B drugs

INPATIENT MEDICARE AUTHORIZATION FORM

Complete and Fax to:
1-877-259-6960

Standard (Prior Approval Admission Requests) - Determination within 14 Days from receipt of all necessary information.

 Expedited (Prior Approval Admission Requests) - Determination within 72 hours of receipt of all necessary information.

 Concurrent (All Inpatient stays including patients already admitted, ER patients with admit orders and direct admits) - Determination within 1 business day of receipt of all necessary information.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

Member ID * Last Name, First Date of Birth *

REQUESTING PROVIDER INFORMATION

Requesting NPI * Requesting TIN * Requesting Provider Contact Name

Requesting Provider Name Phone Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI * Servicing TIN * Servicing Provider Contact Name

Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST ICD-9 ICD-10

Primary Procedure Code Additional Procedure Code Start Date OR Admission Date * Diagnosis Code *

Additional Procedure Code Additional Procedure Code Discharge Date (if applicable) (otherwise Length of Stay will be based on Medical Necessity) Additional Diagnosis Code

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

970 Inpatient Medical	121 Long Term Acute Care
411 Inpatient Surgery	
402 Skilled Nursing Facility	Transplant
	209 Surgery
Inpatient Rehab	
479 Inpatient Hospital	Delivery
220 Free Standing Facility	720 Vaginal (2 Days)
	779 C-Section (4 Days)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan benefit and medically necessary with prior authorization as per plan policy and procedure.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this message in error, please notify us immediately and destroy this document.

SHP_2015289H Rev 10/24/2014 TX-PAF-0768

Out-of-Network Coverage



Plan authorization is required for out-of-network services, except:

- Emergency care.
- Urgently needed care when the network provider is not available (usually due to out-of-area).
- Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.

Medical Necessity Determination



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



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Preventive Care & Screening Tests

Preventive Care



- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- **Initial Preventive Physical Exam – Welcome to Medicare:**
Measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements. Also includes an electrocardiogram, education and counseling. Does not include lab tests. Limited to one per lifetime.
- **Annual Wellness Visit:**
Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care



- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Counseling
- Blood Pressure Screening
- BMI, Functional Status
- Bone mass measurement
- Breast Cancer Screening (mammogram)
- Cardiovascular Disease (behavioral therapy)
- Cardiovascular Screenings
- Cervical and Vaginal Cancer Screenings
- Colonoscopy
- Colorectal Cancer Screenings
- Depression Screening
- Diabetes Screenings
- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- HIV screening
- Medical Nutrition Therapy Services
- Medication Review
- Obesity Screening and Counseling
- Pain Assessment
- Prostate Cancer Screenings (PSA)
- Sexually Transmitted Infections Screening and Counseling
- Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots



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Model of Care (D-SNP and MMP Only)

Model of Care (D-SNP and MMP Only)



The Model of Care is Superior's plan for delivering our integrated care management program for members with special needs. The goals of the Model of Care are to:

- Improve access to medical, mental health and social services.
- Improve access to affordable care.
- Improve coordination of care through an identified point of contact.
- Improve transitions of care across health-care settings and providers.
- Improve access to preventive health services.
- Assure appropriate utilization of services.
- Assure cost-effective service delivery.
- Improve beneficiary health outcomes.

Model of Care (D-SNP and MMP Only)



Model of Care elements are:

- Description of the SNP Population
- Care Coordination and Care Transitions Protocol
- Provider Network
- Quality Measurements and Performance Improvement

Model of Care Process (D-SNP and MMP Only)



- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and, at a minimum, annually, 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, and medical and behavioral health history.
- Members are then triaged to the appropriate Superior Case Management Program for follow up.

Model of Care Process (D-SNP and MMP Only)



- Superior values our partnership with our physicians and providers.
- The Model of Care requires collaboration with Superior and providers to work together to benefit our members by:
 - Enhancing communication between members, physicians, providers and Superior.
 - Taking an interdisciplinary approach with regard to the member's special needs.
 - Providing comprehensive coordination with all care partners.
 - Supporting the member's preferences in the Model of Care.
 - Reinforcing the member's connection with their medical home.

Model of Care Information (D-SNP and MMP Only)



Model of Care information is available on:

<https://www.SuperiorHealthPlan.com/providers/training-manuals/model-of-care-form.html>

Note: The Model of Care Training must be completed by providers annually, during each calendar year.

A screenshot of the Superior HealthPlan website showing the "Model of Care Provider Training" form. The page header includes the Superior HealthPlan logo, a search bar with "[español]" next to it, and links for "Contact Us", "Newsroom", and "Calendars". Below the header are navigation links: "Find a Doctor", "For Members", and "For Providers". The main heading is "Model of Care Provider Training". The text below the heading states: "All Superior HealthPlan network providers are required to complete an annual Model of Care training. Click on the link below to review the Model of Care training presentation. Then, submit the form to verify the training was completed." There are two links: "Provider Model of Care Training" and "Provider Model of Care Training Manual (attestation included)". The form title is "Provider Model of Care Training Confirmation". The form fields include: "Provider Group *" with a text input box; "Provider TIN(s) *" with a text input box; a note: "Please provide any additional TINs that should be represented on this form."; "TIN 2" with a text input box; "TIN 3" with a text input box; "TIN 4" with a text input box; and "TIN 5" with a text input box.



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Medicare Star Ratings

Medicare Star Ratings



What Are CMS Star Ratings?

- The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health-care system. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (D-SNP and MAPD).
- The ratings are posted on the CMS consumer website, www.Medicare.gov, to give beneficiaries help in choosing an MA and MAPD plan offered in their area. The Star Rating Program is designed to promote improvement in quality and recognize Primary Care Providers for demonstrating an increase in performance measures over a defined period of time.

Medicare Star Ratings



CMS's Star Rating Program is based on measures in 5 different domains:

1. Staying healthy: screenings, tests and vaccines
2. Managing chronic (long-term) conditions
3. Member experience with the health plan
4. Member complaints, problems getting services and improvement in the health plan's performance
5. Health plan customer service

How Can Providers Improve Star Ratings?



- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Manage chronic conditions, such as hypertension and diabetes including medication adherence.
- Continue to talk to patients and document interventions regarding topics such as fall prevention, bladder control and the importance of physical activity and emotional health and wellbeing (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Follow up with patients regarding their test results (CAHPS).

How Can Providers Improve Star Ratings? *(continued)*



- Submit complete and correct encounters/claims with appropriate codes and properly document medical charts for all members, including availability of medical records for chart abstractions.
- Review the gap in care files listing members with open gaps which are available on our secure provider portal.
- Review medication and follow up with members within 14 days post hospitalization.
- Identify opportunities for you or your office to have an impact on your patient's health and well-being.
- Make appointments available to patients and reduce wait times (CAHPS).



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Web-Based Tools

SuperiorHealthPlan.com

Superior Website



Through the Superior website (non-secure portal), providers can access:

- Billing Manuals
- Forms
- HEDIS Quick Reference Guides
- Provider News
- Pre-Auth Needed? Tool
- Provider Resources

Superior Secure Provider Portal

Provider.SuperiorHealthPlan.com



On the Secure Provider Portal, providers can access:

- Authorizations
- Claims
 - Download Payments History
 - Processing Status
 - Submission / Adjustments
 - Clean Claim Connection – Claim Auditing Software
- Health Records
 - Care Gaps*
- Patient Listings* and Member Eligibility

**Available for PCPs only.*

Primary Care Provider Reports



Patient List – Located on Provider.SuperiorHealthPlan.com.

- Includes member's name, ID number, date of birth and telephone number. The Patient List is available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender and address.

The screenshot shows a web interface for a "Patient List" as of 10/08/2014. The interface includes a "Download" button, a "Filter" search box, and a "Cost Reports" menu icon. The table below lists member information with columns for Eligible status, Member Name, Member #, Date of Birth, and Phone Number.

ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	775.867.2818
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	775.867.2818
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	775.867.2818
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	775.867.2818
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	865.760.2818
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	
✔	MEMBER NAME	MEMBER #	DATE OF BIRTH	

Updating Your Data



- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 1. Log in to the Secure Provider Portal.
 2. From the main tool bar select “Account Details.”
 3. Select the provider whose data you want to update.
 4. Choose the appropriate service location.
 5. Make appropriate edits and save.



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Network Partners

Partners and Vendors



- Pharmacy Benefit Manager: Envolve Pharmacy Solutions
Phone: 1-866-399-0928
Fax (PA Requests): 1-866-399-0929
- Behavioral Health: Cenpatico
www.cenpatico.com
- Vision Benefits: Envolve Vision Services
Phone: 1-888-756-8768
www.envolvevision.com
- Non-emergent, Outpatient High Tech Imaging: National Imaging Associates (NIA)
Phone: 1-800-642-7554
www.RadMD.com

Lab and DME Partners



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Lab

Bio Reference

Sequenome Center

MD Labs

Lab Corp

Quest

DME

American Home Patient

Apria

Breg

CCS Medical

Critical Signal Technologies

DJO

EBI

Edge Park

J&B Medical

KCI

Lincare

Hanger Prosthetics and Orthotics

National Seating & Mobility

Numotion

St. Louis Medical

AcariaHealth - Specialty Pharmacy



AcariaHealth is a national, comprehensive specialty pharmacy providing services in all specialty disease states including:

- Cystic Fibrosis
- Hemophilia
- Hepatitis C
- Multiple Sclerosis
- Oncology
- Rheumatoid Arthritis

Most biopharmaceuticals and injectables require prior authorization at:

customercare@acariahealth.com



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Billing Overview

Electronic Claims Transmission



Six Clearinghouses for Electronic Data Interchange (EDI) submission:

- Faster processing turn around time than paper submission.
 - Emdeon – Payer ID 68069
 - Gateway
 - Availity/THIN
 - SSI
 - Medavant
 - Smart Data Solution

EDI Support



- Companion guides for EDI billing requirements and loop segments can be found on the following website:
www.SuperiorHealthPlan.com
- For more information, email:
EDIBA@centene.com

Claims Filing Timelines



- Medicare Advantage claims should be mailed to the following billing address:
Superior HealthPlan Advantage
P. O. Box 3060
Farmington, MO 63640-3822
- Participating providers have 95 days from the date of service to submit a timely claim.
- All requests for reconsideration or claim disputes must be received within 120 days from last timely processed claim.

Claims Payment



- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may NOT bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance and copayments.
- Providers may not balance bill members for any differential.

Coding Auditing & Editing



Superior uses code editing software based on edits from:

- American Medical Association (AMA)
- Specialty society guidance
- Clinical consultants
- Centers for Medicare & Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI)

Software audits for coding inaccuracies, including:

- Unbundling
- Upcoding
- Invalid codes

Claims Reconsideration & Disputes



- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Submit reconsiderations or disputes to:
 - Superior HealthPlan Advantage
 - Attn: Corrections, Reconsiderations or Appeals
 - P. O. Box 4000
 - Farmington, MO 63640-4000



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Electronic Funds Transfer (EFT) & Electronic Remittance Advice (ERA)

EFT/ERA



Electronic payment benefits include:

- Obtaining faster payments, leading to improvements in cash flow.
- Eliminating re-keying of remittance data.
- Matching payments to statements promptly.
- Connecting quickly with any payers that are using Payspan to settle claims.
- Accessing payment services for free: www.PayspanHealth.com

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Meaningful Use – Electronic Medical Records

Meaningful Use



- Electronic Health Records/Electronic Medical Records (EHR/EMR) allows health-care professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
 - Complete and accurate information
 - Better access to information
 - Patient empowerment

Note: Incentive programs may be available.



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Advance Directives

Advance Medical Directives



- An advance directive helps the Primary Care Provider understand the member's wishes about their health care in the event they are unable to make decisions on their own behalf.
Examples include:
 - Living Will
 - Health Care Power of Attorney
 - “Do Not Resuscitate” Orders
- Member's medical records must be documented to indicate whether an advance directive has been executed.
- Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions about medical care.



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Fraud, Waste and Abuse

Fraud, Waste and Abuse



Superior follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report and correct fraud, waste and abuse:

- Preventing fraud through effective enrollment and education of physicians, providers, suppliers and beneficiaries.
- Detection through data analytics and medical records review.
- Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
- Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review and corrective action plan.

Fraud, Waste and Abuse



Superior performs front and back-end audits to ensure compliance with billing regulations.

Most common errors:

- Use of incorrect billing code
- Not following the service authorization
- Procedure code not being consistent with provided service
- Excessive use of units not authorized by the case manager
- Lending of insurance card

Benefits of stopping Fraud, Waste and Abuse:

- Improves patient care
- Helps save dollars and identify recoupments
- Decreases wasteful medical expenses

Fraud, Waste and Abuse



Superior expects all providers, contractors and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:

- Federal and State False Claims Act
- Qui Tam Provision (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act (SSI)
- US Criminal Codes

Fraud, Waste and Abuse



Effective January 1, 2016:

- First-Tier, Downstream and Related Entities (FDR), as well as delegated entities, will be required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter.
- Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan.

Medicare Reporting



Potential fraud, waste or abuse may be reported by calling:

- Superior's Fraud, Waste and Abuse Hotline: 1-866-685-8664
- Superior's Compliance Officer: 1-800-218-7453

To report suspected fraud, waste or abuse in the Medicare program, please use one of the following avenues:

- Office of Inspector General (OIG): 1-800-436-6148
- Medicare: 1-800-Medicare



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CMS Mandatory Trainings

General Compliance & Medicare Fraud, Waste and Abuse Training



- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Superior.

A screenshot of the CMS.gov website. The page title is "MLN Provider Compliance". The navigation bar includes "Home", "About CMS", "Newsroom", "FAQs", "Archive", "Share", "Help", and "Print". Below the navigation bar is a search bar with the text "Learn about your healthcare options". The main content area is titled "MLN Provider Compliance" and features a "Fast Fact" section. The "Fast Fact" section contains text about medical review contractors and electronic medical records. Below the "Fast Fact" section is a "Downloads" section with links to "Medicaid Program Integrity: Safeguarding Your Medical Identity Educational Products [PDF - 193KB]", "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training [PDF - 131KB]", and "View previous fast facts".

Questions and Answers



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