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*Medicare Advantage*

# Medicare Advantage

*Provider Orientation*

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# 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

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# 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 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

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# 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](http://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



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**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**<sup>Rx</sup>  
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)**



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### **A Medicare Advantage Prescription Drug Plan**

Name: John Doe  
Member ID: C11111111-00

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

**MedicareRx**  
Prescription Drug Coverage

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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



**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 Services<sup>3</sup> | 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 – available at network retail pharmacies or mail order (deductibles may apply).
- 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 may 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>

*\*Specific counties only.*

# 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

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# 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](https://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



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**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 ★  Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity   
 (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (MM/DD/YYYY) (S/D-g/ICD-10)  
 Additional Procedure Code  Additional Procedure Code  Additional Diagnosis Code   
 (CPT/HCPCS) (Modifier) (CPT/HCPCS) (Modifier) (S/D-g/ICD-10)

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

970 Inpatient Medical	121 Long Term Acute Care
411 Inpatient Surgery	<b>Transplant</b>
402 Skilled Nursing Facility	209 Surgery
<b>Inpatient Rehab</b>	<b>Delivery</b>
479 Inpatient Hospital	720 Vaginal (2 Days)
220 Free Standing Facility	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 transmittal 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

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# 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)

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## 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 "Model of Care Provider Training" form on the Superior HealthPlan website. The page has a white background with a pink header bar. The header bar contains the Superior HealthPlan logo on the left, and navigation links "Find a Doctor", "For Members", and "For Providers" in the center. On the right, there are links for "Search", "[ español ]", "Contact Us", "Newsroom", and "Calendars". Below the header bar, the breadcrumb "Superior HealthPlan > Model of Care Provider Training" is visible. The main title "Model of Care Provider Training" is in large, bold, pink letters. Below the title, a paragraph 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 blue links: "Provider Model of Care Training" and "Provider Model of Care Training Manual (attestation included)". Below these is the section "Provider Model of Care Training Confirmation". It contains a form with the following fields: "Provider Group \*" (text box), "Provider TIN(s) \*" (text box), and a section for additional TINs. The additional TINs section is titled "Please provide any additional TINs that should be represented on this form." and includes five rows, each with a label (TIN 2, TIN 3, TIN 4, TIN 5) and a text box.



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# Medicare Star Ratings

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# 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](http://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

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# 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](http://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](https://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.

Patient List as of 10/08/2014 →					Download	Filter	Cost Reports
ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER			
✓	ABRAHAM, JACOB	000000001	01/01/2014				
✓	ABRAHAM, JACOB	000000002	01/01/2014				
✓	ABRAHAM, JACOB	000000003	01/01/2014				
✓	ABRAHAM, JACOB	000000004	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000005	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000006	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000007	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000008	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000009	01/01/2014	(770) 457-1234			
✓	ABRAHAM, JACOB	000000010	01/01/2014	(770) 457-1234			



## 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

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# 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](http://www.cenpatico.com)
- Vision Benefits: Envolve Vision Services  
Phone: 1-888-756-8768  
[www.envolvevision.com](http://www.envolvevision.com)
- Non-emergent, Outpatient High Tech Imaging: National Imaging Associates (NIA)  
Phone: 1-800-642-7554  
[www.RadMD.com](http://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](mailto:customercare@acariahealth.com)



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# Billing Overview

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# 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](http://www.SuperiorHealthPlan.com)
- For more information, email:  
[EDIBA@centene.com](mailto: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)

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## 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](http://www.PayspanHealth.com)

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# Meaningful Use – Electronic Medical Records

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# 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

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# 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

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# 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

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# 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, specifically the Medicare Learning Network (MLN) Provider Compliance page. The page has a blue header with the CMS.gov logo and navigation links. A yellow navigation bar contains links for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations &amp; Guidance, Research, Statistics, Data &amp; Systems, and Outreach &amp; Education. The main content area is titled "MLN Provider Compliance" and features the MLN logo. It includes a "Fast Fact" section with text about medical review contractors and electronic medical records. Below this is a "Downloads" section with links to various educational products like "Medicaid Program Integrity: Safeguarding Your Medical Identity" and "Medicare Parts C and D Fraud, Waste, and Abuse Training".

# Questions and Answers

