Behavioral Health

Provider Training

11/8/2017

Agenda

- Benefits and Services
- Authorization Process
- Pharmacy Benefits and Transportation
- Quality Improvement
- Fraud, Waste and Abuse
- Claims Filing and Payment
- Secure Provider Portal
- Superior HealthPlan Departments

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Benefits and Services

11/8/2017

Behavioral Health Benefits

- Traditional & Day Treatment Outpatient Services
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Medication Management Therapy
  - Individual, Group and Family Therapy
- Inpatient Mental Health Services
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation
- Substance Use Disorder Treatment
  - Individual and Group Therapy
  - Residential Treatment
  - Outpatient services
- Enhanced Services
  - Targeted Case Management or Rehabilitative Services
- Telemedicine
- Pharmacy Benefits - Prescription Drugs
  - Pharmacy Benefit Manager (PBM) = Envolve Pharmacy Solutions

Please Note: The behavioral health benefits referenced above are not available for all products.

Service Coordinators

- Available to members receiving behavioral and/or physical health services, depending on the level of service coordination assigned.
- Perform in-home assessments with members for Long-Term Services and Supports (LTSS) to ensure members are able to live a healthy life in the setting of their choice.
- Coordinate referrals to other programs like Disease Management and Case Management, if necessary.
- Assist with coordinating care and follow-up with members.
- Visit or touch-base telephonically with members at least 2 times a year.

STAR and STAR MRSA

Who is covered in Texas?

- Families, children and pregnant women
  - Based on income level, age, family income and resources/assets.
- Newborns
  - Born to mothers who are Medicaid-certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday.
- Cash assistance recipients
  - Based on receipt of Temporary Assistance for Needy Families (TANF) and dependent on age.
- Supplemental Security Income (SSI) recipients
  - Must join if 21 years old and older and live in the Medicaid Rural Service Area (MRSA).
  - May join if 20 years old and under.

STAR Health

- STAR Health is Medicaid for children who receive Medicaid coverage through the Texas Department of Family and Protective Services (DFPS). STAR Health also is for young adults who were previously in foster care and are either:
  - Former Foster Care Children's Medicaid
  - Medicaid for Transitioning Youth
- Young adults who are in the Former Foster Care in Higher Education program also get services through STAR Health.
- Superior contracts with the Texas Health and Human Services (HHS) to provide services to STAR Health members state-wide as a single provider program.

STAR Health

- Children and young adults:
  - In foster care
  - In kinship care
  - Who choose to remain in a paid foster care placement (through the month of their 22nd birthday)
  - Who aged out of foster care at age 18 (through the month of their 21st birthday)

STAR Health

- Texas provides Medicaid benefits to adults under age 26 who were receiving Medicaid when they aged out of foster care at age 18 or older. This program is called the Former Foster Care Children (FFCC) program.
- To get benefits with the FFCC program, they must:
  - Have been in foster care on their 18th birthday
  - Be 18-25 years old
  - Have been a Medicaid recipient when they left foster care
  - Be a U.S. citizen or legal immigrant

STAR Health

- FFCC members will receive health-care benefits in two separate programs based on their age:
  - Members who are 18-20 years old will continue to get their benefits in the STAR Health program unless they want to change to a STAR plan.
  - Members who are 21-25 years old will get their Medicaid benefits through a STAR plan of their choice.

Please note: There are no income, asset or educational requirements to qualify for the FFCC program.

STAR+PLUS

- The STAR+PLUS program is designed to integrate the delivery of acute care and LTSS through a managed care system, combining traditional health care (doctors visits) with LTSS, such as providing help in the home with:
  - Daily living activities, home modifications and personal assistance
- Members, their families and providers work together to coordinate member's health care, long-term care and community support services.
- The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a member.

STAR+PLUS

- Mandatory Population
  - Adults 21 years old and older who:
    - Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income.
    - Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program).

STAR Kids

- STAR Kids provides Medicaid benefits to individuals with disabilities, which include children and young adults age 20 and younger who receive:
  - Social Security Income (SSI) and SSI-related Medicaid.
  - SSI and Medicare.
  - Medically Dependent Children (MDCP) waiver services.
  - State plan services and coordination only for:
    - Youth Empowerment Services (YES) waiver services.
    - IDD waiver services (e.g., CLASS, DBMD, HCBS, TxHmL).
    - Those who reside in community-based ICF-IID or in Nursing Facilities (NF).

CHIP

- Children who are under 19 years old and whose family's income is below 200% of the Federal Poverty Level (FPL) are eligible, if they do not qualify for Medicaid coverage.
- CHIP members are allowed to change health plans within 90 days of enrollment, and at least every 12 months thereafter during the re-enrollment period for any reason.
- CHIP members must re-apply yearly on their original enrollment date.

STAR+PLUS MMP

- The Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) program combines Medicare and Medicaid services into one product. This means providers and members will work with Superior for all health-related services including authorizations and claim payments.
- Dual Eligibility: Who Qualifies?
  - Medicare Part A, and/or Medicare Part B and Full Medicaid (STAR+PLUS).
  - Enrollees must live in Bexar, Dallas and Hidalgo counties.
- Coordination of Care:
  - Provide all Medicare Part A & Part B benefits, and may include Part D and STAR+PLUS Medicaid.
  - Find the appropriate providers in the appropriate geographic locations.
  - Educate the providers about coverage & encouraging them to participate in the Care Plan.

Allwell (Medicare)

- Allwell from Superior HealthPlan (HMO and HMO SNP) is a Medicare federal health insurance program for people ages 65 (under 65 with qualifying disabilities).
- Eligibility: Who Qualifies?
  - **HMO**: Individuals enrolled in Medicare only.
  - **HMO SNP**: Individuals who qualify for Medicaid coverage through the state of Texas and are eligible for Medicare.
  - Enrollees must also live in the following counties:
    - **HMO**: Bexar, Cameron, Collin, Dallas, Denton, El Paso, Hidalgo, Nueces, Smith and Tarrant
    - **HMO SNP**: Bexar, Cameron, Collin, Dallas, Hidalgo, Nueces, Rockwall and Tarrant

Allwell (Medicare)

- Allwell provides complete continuity of care. This includes:
  - Integrated coordination of care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM)
  - Additional services specific to the member's needs
- Superior's 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 Registered Nurses (RN), social workers, pharmacy technicians and behavioral health case managers all co-located in a single, locally based unit.

Ambetter

- Ambetter from Superior HealthPlan is a commercial HMO product in the Texas Health Insurance Marketplace. Licensed in 41 counties within the Texas market. Potential members should visit Healthcare.gov in order to:
  - Register
  - Determine eligibility for all health insurance programs under the exchange
  - Shop for plans
  - Enroll in a plan
- Overview of Benefit Structure
  - Essential Health Benefits (EHBs) are the same with every plan. Every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act (ACA).
  - Plans vary based on the individual liability limits or cost share expenses to the member.
  - Under the ACA, “Mental Tiers” are used to categorize these limits. Each plan offered on the Health Insurance Marketplace (Exchange) will be categorized within one of these metal tiers: Gold, Silver, and Bronze.

Authorization Process

11/8/2017

Prior Authorizations (PA)

- Acute care authorization process
- Notification of admissions
- Therapy authorizations
  - Initial evaluation and re-evaluation
  - Initial and ongoing treatment services
  - Early Childhood Intervention (ECI)
- Alberto N. process
- LTSS authorization process
- Behavioral health authorizations

Acute Care Services Requiring Prior Authorization

- Some common acute services that require authorization are:
  - DME items with a purchase price > $500
  - Enteral nutrition
  - Home Health/Skilled Nursing/Private Duty Nursing
  - Hearing aids
  - Orthotics/prosthetics
  - Non-emergent ambulance transportation
  - Therapy-physical, occupational and speech
  - Incontinence supplies

- For a full list of acute services that require authorization, you can:
  - Look up Superior's most current prior authorization list found at www.SuperiorHealthPlan.com/for-providers/provider-resources/.
  - You can also call the Prior Authorization department at 1-800-218-7508, Monday through Friday, 8:00 am-5:00 pm (CST) and speak to a live agent.

LTSS Require Authorizations

- All Long Term Services & Supports (LTSS) require authorization:
  - Personal Attendant Services (PAS)
  - Day Activity & Health Services (DAHS) (available for > 18 years)
  - Medically Dependent Children's Program (MDCP) - Employment assistance/supported employment
  - Cognitive Rehabilitative Therapy
  - Community First Choice (CFC)
  - Private Duty Nursing (PDN)
  - Personal Care Services (PCS)

MRI/MRA, CT/CTA, CCTA, Stress Echo, Nuclear & PET Scans

- Require authorization.
- PCP is responsible for obtaining authorization.
- All other radiology procedures do not require authorization.
- Inpatient and ER procedures do not require authorization.
- Servicing providers may request authorization by:
  - Accessing www.radmd.com
  - Utilizing the toll free number: 1-800-648-7554
- Servicing providers and imaging facilities may access status of authorizations by:
  - Accessing www.radmd.com
  - Accessing Integrated Voice Response (IVR) through a toll free number 1-800-642-7554. To check on the status of an authorization press 1, 1, then enter or speak the tracking number.

Behavioral Health Authorizations

- Psychological testing
  - STAR Health members are allowed 8 units per year without an authorization.
- Partial Hospitalization Program (PHP) Mental Health (MH) and Chemical Dependency (CD)
- Intensive Outpatient Program (IOP) MH and CD
- Residential Treatment for MH and CD
- Substance Use Disorder Residential
- Targeted Case Management
- Psychosocial Rehabilitation Services

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Pharmacy Benefits and Transportation

11/8/2017

Pharmacy Benefits

- Pharmacy Benefit Manager (PBM),
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
  - Responsible for PA of prescriptions, as applicable.
- Providers should reference the Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL) for Medicaid products.

Specialty Drugs

- Medications on the HHS specialty drug list may be obtained from AcariaHealth or CVS Caremark if not under limited drug distribution.
- Contact Information:
  - Phone: 1-855-535-1815
  - Fax: 1-877-541-1503
  - Web: www.AcariaHealth.com

How to Access the Formulary/PDL

- Superior utilizes the VDP formulary which is available on smart phones, tablets or similar technology on the web at: www.Epocrates.com.
- The VDP Website for PDL and clinical PA criteria: www.TXVendorDrug.com.
- Texas PDL/PA Criteria to be used for Superior Members: www.TXVendordrug.com/formulary/formulary-search.

Pharmacy Contact Information – Superior HealthPlan

- Assists with questions, concerns from prescribers and members.
  - Phone: 1-800-218-7453 ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: www.SuperiorHealthPlan.com/contact-us
- In-Clinic Rx administration (Superior PA department).
  - PA Requests Phone: 1-800-218-7453 ext. 22272
  - PA Requests Fax: 1-866-683-5631
- Appeal (Superior Appeal department).
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453 ext. 22168

HHS Medical Transportation Program (MTP)

- MTP serves Medicaid members who have no other means of transportation for non-emergent medical, behavioral, dental or vision appointments.
- Request MTP by calling: 1-877-633-8747.
  - Available Monday - Friday from 8:00 a.m. to 5:00 p.m.
  - The member, regardless of the SDA, needs to call MTP at least 48 hours in advance in order to schedule services.
  - Member must have doctor's name, address, phone number, date, time and reason for visit. Appointments can't be set more than two weeks in advance.
  - Members can call Superior Member Services for assistance with MTP coordination.
- May also reimburse mileage for the client, a caregiver/medical consenter, friend or someone else to take the client to health-care services if the trip is scheduled in advance and the driver abides by the MTP guidelines.

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Quality Improvement

11/8/2017

Quality Improvement

Working with our provider community:

- Manage and review annual The Healthcare Effectiveness Data and Information Set (HEDIS) rates to identify interventions to improve HEDIS scores.
- Maintain compliance with quality related areas of HHSC regulations.
- Generates, distributes and analyzes selected provider profiles.
- Coordinates office site visits related to complaints regarding physical appearance, physical accessibility, adequacy of wait time and adequacy of treatment record.
- Conducts provider satisfaction surveys annually.
- Review, investigates and analyzes quality of care concerns (member complaints).

Quality Improvement

Quality Assessment and Performance Improvement (QAPI):

- Monitors quality of services and care provided to members through:
  - Appointment availability audits
  - After-hours access audits
  - Tracking/ trending of complaints
- Providers participate in QAPI by:
  - Volunteering for Quality Improvement Committees
  - Responding to surveys and requests for information
  - Vocalizing opinions
- Quality Improvement Committee (QIC)
  - Comprised of contracted providers from different regions and specialties
  - Appointed by Superior's Chief Medical Director
  - Serves as Peer Review Committee
  - Advises on proposed quality improvement activities and projects
  - Evaluates, reviews and approves clinical practice and preventative health-care guidelines

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Fraud, Waste and Abuse

11/8/2017

Fraud, Waste and Abuse

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
  - Visit https://oig.hhsc.state.tx.us and select “Click Here to report fraud, waste and abuse” to complete the online form.
  - Contact Superior’s Corporate Special Investigative Unit directly at:

    Centene Corporation
    Superior HealthPlan Fraud and Abuse Unit
    7700 Forsyth Boulevard
    Clayton, MO 63105
    1-866-685-8664

- Examples of Fraud, Waste and Abuse include:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid of CHIP ID

Health Insurance Portability and Accountability Act

- Regulates who has access to a member's Protected Health Information (PHI).
- Individuals have the right to keep their PHI confidential.
- Superior has provided each member with a privacy notice.
- For questions about Superior's privacy practices, contact Superior's compliance officer by:
  - Calling: 1-800-218-7453
  - Emailing: Superior.Compliance@SuperiorHealthPlan.com

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Claims Filing and Payment

11/8/2017

Claims Filing

- Claims must be filed within 95 days from the Date of Service (DOS).
- A provider may submit a corrected claim or claim appeal within 120 days from the date of Explanation of Payment (EOP) or denial is issued.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be completed in accordance with TMHP billing guidelines.
- Filed on a red CMS 1500 or UB04 form.
- Filed electronically through clearinghouse.
- Filed directly through web portal.
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com/sso/login
- Electronic Claims:
  - Visit the web for a list of our Trading Partners: www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
  - Superior Emdeon ID 68068
- Paper Claims - Initial and Corrected*
  - Superior HealthPlan, P.O. Box 6300, Farmington, MO 63640-6806
- Paper Claims - Requests for Reconsideration* and Claim Disputes*
  - Superior HealthPlan, P.O. Box 6000, Farmington, MO 63640-3809

**Must reference the original claim number in the correct field on the claim form.*

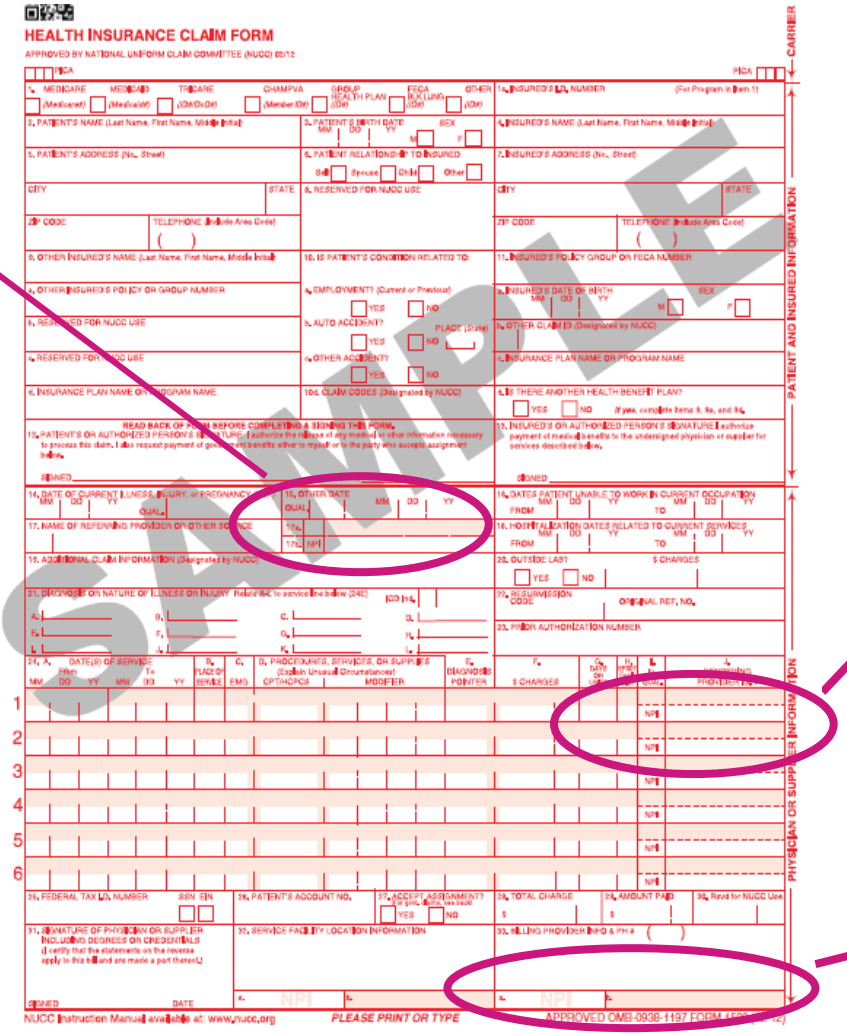
Claims Filing: Deadlines

- First Time Claim Submission
  - 95 days from date of service
- Adjusted or Corrected Claims
  - 120 days from the date of Explanation of Payment or denial is issued
- Claim Reconsiderations and Disputes
  - 120 days from the date of Explanation of Payment or denial is issued

CMS 1500 Requirements

If Populated:

17a NPI # and
Taxonomy #



NPI # and Taxonomy # in box 24J is required when billing Superior claims

Billing NPI# in box 33a and Taxonomy # in 33b

Identifying a Claim Number from Superior

- Superior assigns claim numbers for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication. It can be found in the following:
  - EDI rejection/acceptance reports
  - Rejection letters*
  - Secure Provider Portal
  - EOP
- When calling into Provider Services, please have your claim number ready for expedited handling.

**Remember that rejected claims have never made it through Superior's claims system for processing. The claim number that is provided on the Rejection Letter is a claim image number that helps us retrieve a scanned image of the rejected claim.*

Where do I find a Claim Number?

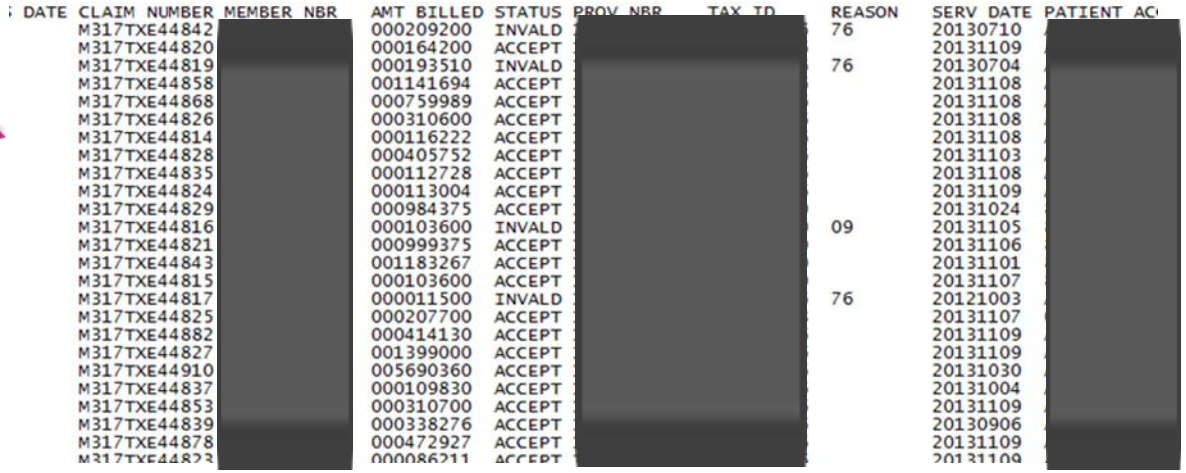
- There are two ways of submitting your claims to Superior:
  - Electronic: Secure Provider Portal or EDI via a clearing house.
    - Your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior Secure Provider Portal and EOPs.
  - Paper: Mailed to our processing center
    - Your response to your submission is viewable via rejection letters, Superior Secure Provider Portal and EOPs.

Please note: On all correspondence, please reference either the 'Claim Number' / 'Control Number'.

Where do I find a Claim Number?

Examples:

EDI Reports



DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842	[redacted]	000209200	INVALD	[redacted]		76	20130710	[redacted]
	M317TXE44820		000164200	ACCEPT				20131109	
	M317TXE44819		000193510	INVALD			76	20130704	
	M317TXE44858		001141694	ACCEPT				20131108	
	M317TXE44868		000759989	ACCEPT				20131108	
	M317TXE44826		000310600	ACCEPT				20131108	
	M317TXE44814		000116222	ACCEPT				20131108	
	M317TXE44828		000405752	ACCEPT				20131103	
	M317TXE44835		000112728	ACCEPT				20131108	
	M317TXE44824		000113004	ACCEPT				20131109	
	M317TXE44829		000984375	ACCEPT				20131024	
	M317TXE44816		000103600	INVALD			09	20131105	
	M317TXE44821		000999375	ACCEPT				20131106	
	M317TXE44843		001183267	ACCEPT				20131101	
	M317TXE44815		000103600	ACCEPT				20131107	
	M317TXE44817		000011500	INVALD			76	20121003	
	M317TXE44825		000207700	ACCEPT				20131107	
	M317TXE44882		000414130	ACCEPT				20131109	
	M317TXE44827		001399000	ACCEPT				20131109	
	M317TXE44910		005690360	ACCEPT				20131030	
	M317TXE44837		000109830	ACCEPT				20131004	
	M317TXE44853		000310700	ACCEPT				20131109	
	M317TXE44839		000338276	ACCEPT				20130906	
	M317TXE44878		000472927	ACCEPT				20131109	
	M317TXE44823		000086211	ACCEPT				20131109	

Explanation of Payment Details

Check/Trace Number:0000000000 Check Date:05/16/2014

Insured Name: [redacted]
Patient Name: [redacted]
Control Number: [redacted]
Service Provider: [redacted]

Group:
ID: [redacted]
Account: [redacted]
NPI: [redacted]

View Service Line Details

Serv	Date	Diag#/ Drug#	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	09/16/2013	2920	270		0/1	51.71	10.34	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00
20	09/16/2013	2920	272		0/1	9.17	1.83	0.00/0.00	0.00	0.00/0 00	0 00/0.00	0.00	0.00	MX	0.00

Payment History via Secure Provider Portal (EOP)

Common Billing Errors

- Member date of birth or name not matching ID card/member record.
- Code combinations not appropriate for demographic of patient.
- Not filed timely.
- No itemized bill provided when required.
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate.
- Illegible paper claim.

Corrected Claims

- A corrected claim is a correction of information to a previously finalized clean claim.
  - For example – Correcting a member's date of birth, a modifier, Dx code, etc.
  - The original claim number must be billed in field 64 of the UB-04 form or field 22 of the HCFA 1500 form.
  - The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 form or field 22 of the HCFA 1500 form.
  - A corrected claim form, found in the Provider Manual, may be used when submitting a corrected claim.

Claim Appeals

- A claim appeal can be requested when the provider disagrees with the outcome of the original processing of the claim.
  - For example – Claim denied for no authorization, but there was an authorization obtained prior to services.
  - A claims appeal form, found in the Provider Manual, is required when submitting a request for reconsideration.

Claim Appeal Supporting Documents

- Examples of supporting documentation may include but are not limited to:
  - A copy of the Superior EOP (required)
  - A letter from the provider stating why they feel the claim payment is incorrect (required)
  - A copy of the original claim
  - An EOP from another insurance company
  - Documentation of eligibility verification such as copy of ID card, TMBC, TMHP documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing
  - Centene EDI acceptance reports showing the claim was accepted by Superior
  - PA number and/or form or fax

PaySpan Health

- Superior has partnered with PaySpan Health to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs)
  - Online remittance advices (ERAs/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com.
- For further information contact 1-877-331-7154, or email ProviderSupport@PaySpanHealth.com.

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Secure Provider Portal

11/8/2017

Superior's Website & Secure Provider Portal

www.SuperiorHealthPlan.com

Submit:

- Claims
- PA Requests
- Request for EOPs
- Provider Complaints
- Notification of Pregnancy
- COB Claims
- Adjusted Claims

Verify:

- Member Eligibility
- Claim Status

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for additional Provider Resources
- Claim Editing Software

How to Register for the Secure Provider Portal

- Go to Provider.SuperiorHealthPlan.com
- Enter your provider/group name, tax identification number, individual's name entering the form, office phone number and email address.
- Create user name and password.
- Each user within the provider's office must create their own user name and password.
- The provider portal is a free service and providers are not responsible for any charges or fees.

Secure Provider Portal: Eligibility

- Search for eligibility using:
  - Member's date of birth
  - Medicaid/CHIP/DFPS ID number or last name
  - Date of service
- View/Print Patient List
  - Member panel
  - Member care gap alerts
  - Both can be downloaded in Excel or PDF format

Secure Provider Portal: Authorizations

- Create Authorizations
  - Enter the patient's member ID/last name and DOB and click find
  - Populate the six sections of the authorization with the appropriate information starting with the service type section
  - Follow the prompts and complete all required information
  - Attach any required documentation, review and submit
- Check Authorization Status
  - Enter web reference number and click search; please allow at least 24 hours after submission to review status
  - View authorization status, id number, member name, dates of service, type of service and more
  - To view all processed authorizations, click "Processed" and to view any authorizations with errors, click "Errors"

Please note: Authorizations update to the Secure Provider Portal every 24 hours.

Secure Provider Portal: Claims

- Claim Status
  - Claims update to the Secure Provider Portal every 24 hours.
  - Status can be checked for a period of time going back 18 months
- View Web Claims
  - Click on the claims module to view the last three months of submitted claims
- Unsubmitted Claims
  - Incomplete claims or claims that are ready to be submitted can be found under “Saved” claims
- Submitted Claims
  - Status will show “in progress,” “accepted,” “rejected” or “completed”

Secure Provider Portal: Claims

- Create Claims
  - Professional, Institutional, Corrected and Batch
- View Payment History
  - Displays check date, check number and payment amount for a specific timeframe (data available online is limited to 18 months)
- Claim Auditing Tool
  - Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted
  - Proactively determine the appropriate code/code combination representing the service for accurate billing purposes
  - Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received

Additional Secure Provider Portal Information

- Online Assessment Forms
  - Notification of pregnancy
- Resources
  - Practice guidelines and standards
  - Training and education
- Contact Us (Web Applications Support Desk)
  - Phone: 1-866-895-8443
  - Email: TX.WebApplications@SuperiorHealthPlan.com

Secure Provider Portal Highlights

- Manage all product lines and multiple TINs from one account
  - Office Manager accounts available
- PCP Panel - Texas Health Steps last exam date
  - View the date of the member's last Texas Health Steps exam on file
- Eligibility section for providers
- Authorization detail & history:
  - New display features: Authorization denial reason
- Submit batched, individual or recurring claims
- Download EOPs
- Secure messaging
- Refer members to Case Management
- Review member alerts/care gaps

Secure Provider Portal Highlights

Alerts section indicates whether a member has a potential gap in care.

- Examples of Care Gap Alert categories and descriptions:
  - Adult Preventive
    - No mammogram in most recent 12 month
    - No chlamydia test in past 12 months in patient 16-25 years
    - No PAP in past 12 months
  - Diabetes:
    - DM - Not seen in past six (6) months
    - DM - No retinal eye exam in past 12 months
    - DM - No HbA1C screening in past 12 months
  - Cardiac:
    - CAD - Not seen in past 12 months
    - HTN - Not seen in past 12 months
    - Flu vaccine
    - No flu vaccine in past 12 months
  - Child Preventive:
    - Immunizations not current for age

Superior HealthPlan Departments

11/8/2017

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - Office visits to review quality performance reports
- Superior Account Management offers targeted billing presentations depending on the type of services you provide. For example, we offer general and LTSS billing clinics.

Please note: You can find a map on the Superior HealthPlan website that can assist you with contact information for your Account Manager.

Provider Services

- Provider Services can help you with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims related questions, have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Contact Provider Services, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time:
  - 1-877-391-5921

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Answering questions
    - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
      - STAR/MRSA/CHIP/RSA and Perinate: 1-800-783-5386
      - STAR+PLUS: 1-866-516-4501
      - STAR Kids: 1-844-590-4883
      - STAR Health: 1-866-912-6283
      - STAR+PLUS MMP 1-866-896-1844
      - Medicare Advantage 1-877-935-8023
      - Ambetter 1-877-687-1196

Provider Contracting

- Network Development and Contracting is a centralized team that handles all contracting for new and existing providers to include:
  - New provider contracts
  - Adding providers to existing Superior contracts
  - Adding additional products (i.e. CHIP, STAR, STAR+PLUS) to existing Superior contracts
  - Amendments to existing contracts
- Contract packets can be requested at: www.SuperiorHealthPlan.com/for-providers/join-our-network/

Provider Credentialing

- Initial Credentialing:
  - Complete a TDI credentialing application form for participation
  - Complete an electronic application
  - Provide Council for Affordable Quality Healthcare (CAQH) identification number
  - Email applications to SHP.NetworkDevelopment-Medicaid@SuperiorHealthPlan.com
- Re-credentialing:
  - Completed every three years from date of initial credentialing
  - Applications and notices are mailed at 180, 120, 90 and 30 days out from the last day of the credentialing anniversary month
  - Lack of timely submission can result in members being re-assigned and system termination
  - Email applications to Credentialing@SuperiorHealthPlan.com
  - Failure to respond timely to requests for information or documentation will result in discontinuation of recredentialing and termination of contract.
- All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686, ext. 22281 or Credentialing@SuperiorHealthPlan.com.

Provider Complaints

A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to the Superior. Superior offers a number of ways to file a complaint, as listed below:

- Mail:

  Superior HealthPlan

  ATTN: Complaint Department

  5900 E. Ben White Blvd.

  Austin, Texas 78741

- Fax:

  1-866-683-5369

- Online:

  www.SuperiorHealthPlan.com/providers/resources/complaint-procedures.html

superior healthplan™

Questions and Answers

11/8/2017