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Nursing Facility Provider Training

Last updated October 2019

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Agenda

By the end of this presentation, you will be able to:

- Identify who Superior HealthPlan is and our various departments.
- Explain the difference between Unit Rate and Add-on Services.
- Understand Service Coordination and how they will work with the Nursing Facility staff.
- Obtain authorizations and file claims with Superior.

Who is Superior HealthPlan?

- Superior HealthPlan is a subsidiary of Centene Corporation located in St. Louis, MO.
- Superior has held a contract with Texas Health and Human Services Commission (HHSC) since December 1999.
- Superior provides programs in various counties across the State of Texas. These programs include STAR, STAR Health (Foster Care), STAR Kids, STAR+PLUS and CHIP. As well as, Allwell from Superior HealthPlan, Ambetter from Superior HealthPlan and STAR+PLUS Medicare-Medicaid Plan (MMP).
- Superior manages health care for over 1,000,000 members across Texas.

Nursing Facility Members – STAR+PLUS

Mandatory Members

Adults age 21 and older who:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid-eligible because they are in a Social Security exclusion program. These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS waiver eligibility.
- Dual eligible individuals who are 21 and over covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a Nursing Facility.

Voluntary Members

- Nursing Facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing Facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE).

Eligibility

- STAR+PLUS members are always enrolled and disenrolled at the beginning of each month. The period begins on the 1st of each month.
- Nursing facilities should verify member eligibility at the start of each month and before providing services.
- Nursing facilities can verify the member's Resource Utilization Group (RUG) level using Superior's Secure Provider Portal.
- How can eligibility be verified?
  - Superior HealthPlan Identification Card
  - Superior HealthPlan Secure Provider Portal at Provider.SuperiorHealthPlan.com
  - Call the Member Hotline at:
    - STAR+PLUS – 1-877-277-9772
    - STAR+PLUS MMP - 1-866-896-1844

Nursing Facility Members – STAR+PLUS MMP

STAR+PLUS MMP Population:

- Individuals who are age 21 and older
- Receiving Medicare part A, B and D
- Receive full Medicaid Benefits and are in a STAR+PLUS Program
- Do not reside in an Intermediate Care Facility or get services through one of these waivers:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HSC)
  - Texas Home Living Program (TxHmL)
- Members enrolled in the MMP Dual Demonstration
- Superior's STAR+PLUS MMP program is available in Bexar, Dallas, and Hidalgo County

Opt-out/Passive Enrollment – STAR+PLUS MMP

- Centers for Medicare and Medicaid Services (CMS)-HHSC may conduct passive enrollment to assign eligible beneficiaries who do not select a health plan, opt-out or disenroll from the demonstration.

- Eligible beneficiaries who have Third Party Health Insurance will not be passively enrolled in the demonstration.

- Passive enrollment is effective no sooner than 60 calendar days after beneficiary notification of plan selection and the right to select a different STAR+PLUS MMP, or with the option to opt out until the last day of the month prior to the enrollment effective date.

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Services, Benefits and Prior Authorizations

Nursing Facility Unit Rate

- The Nursing Facility Unit Rate means the types of services included in the HHSC daily rate for nursing facility providers, such as:
  - Room and board
  - Medical supplies and equipment
  - Personal needs items
  - Social services
  - Over-the-counter drugs

- The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. The Nursing Facility Unit Rate excludes nursing facility add-on services.
  - *Please Note: HHSC will authorize the daily rate. HHSC will authorize and make the medical necessity determinations. Superior will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Questions call THMP at 1-800-626-4117 Option 2.*

Nursing Facility Add-on Services

- Nursing Facility Add-on Services mean the types of services that are provided in the facility setting by the provider or another network provider and are outside of the Nursing Facility Unit Rate.

- Add-on Services include but are not limited to:
  - Emergency dental services
  - Physician-ordered rehabilitative services (PT, OT, ST)
  - Customized Power Wheel Chairs (CPWC)
  - Augmentative Communication Device (ACD)
  - Ventilator care*
  - Tracheostomy care*

- All add-on services require a prior authorizations with the exception* of Ventilator and Tracheostomy care, unless the authorization request is for supplemental payment for members 21 years of age and older.

Applied Income

- Applied Income (AI) means the portion of the earned and unearned income of the STAR+PLUS member, or if applicable the member and their spouse, that is paid under the Medicaid program to a nursing facility.
- It is the responsibility of the nursing facility to make reasonable efforts to collect AI, document those efforts and notify Superior's Service Coordinator when two unsuccessful attempts in one month have been made to collect AI.
- The Service Coordinator will also ensure that the member and their family understand that if the AI remains unpaid, then the member may not be allowed to stay at the facility.
  - Superior's Service Coordinator will assist the nursing facility with the collection of AI from the member.

STAR+PLUS
Additional Benefits

- Superior offers added benefits beyond the traditional Medicare and Medicaid benefits. These include, but are not limited to:
  - Extra vision services
  - Extra foot doctor (podiatry) services
  - Gift cards for completing exams and screenings
  - A welcome kit when a member is placed in a nursing facility

Please Note: additional benefits vary by the service delivery area.

Non-emergent Ambulance Transport

- The nursing facility is responsible for providing normal transportation for the recipient to medical services outside the facility. The attending physician must have ordered the medical services.
- Normal transportation is to and from the medical care provider of the recipient's choice, who is generally available and used by recipients of the locality for medical care included under the Texas Medical Assistance Program.
- Transportation charges, including non-emergency, routine ambulance services, involved in the certification or recertification of a recipient are the responsibility of the nursing facility.
- The facility may not use the state's medical transportation program except to transport recipients for renal dialysis treatments.

Non-emergent Ambulance Transport

- Charges for the following medically necessary ambulance services, when provided by a Medicaid-enrolled provider, are not the responsibility of the nursing facility, but are payable by Superior as a Medicaid benefit:
  - Emergency transport
  - Nonemergency transport, under the following conditions:
    - The member is severely disabled, which is defined as a condition which limits mobility and requires confinement to bed at all times, prevents sitting unassisted at all times, or requires the monitoring of life support systems, including oxygen or intravenous infusion.
    - The severely disabled recipient cannot be transported by any means other than an ambulance without endangering the health or safety of the member.
    - The nonemergency ambulance transportation of the severely disabled recipient is to or from a scheduled medical appointment and authorization has been received from Superior.
      - If payment under the medical assistance program is denied because the facility failed to obtain prior authorization, the facility must pay for the service if presented a copy of the bill for which payment was denied.

Non-emergent Ambulance Transport

- Authorization requirements:
  - All non-emergency ambulance transports require prior authorization, including:
    - All facility-to-facility transports.
    - All out of state transports.
    - All air, ground and water transports.
- Finding a participating ambulance provider:
  - In-network ambulance providers can be found at ProviderSearch.SuperiorHealthPlan.com and by using the Specialty search field.
- Requesting prior authorization:
  - Call the Medical Management Department at 1-800-218-7508.
  - Fax a request for prior authorization to 1-800-690-7030.
  - Fax clinical information establishing medical necessity to 1-800-690-7030.
  - Submitting the request and clinical information through our secure web portal at www.SuperiorHealthPlan.com.

Non-emergent Ambulance Transport

- Authorization Tips
  - Nursing facility providers must follow the steps below:
    - A physician or physician extender writes an order for non-emergency transport.
    - Nursing facility staff should contact Superior's member services line, utilization management department, or the assigned Service Coordinator to find an ambulance company that is in-network.
    - The nursing facility staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI and other business information.
    - The ambulance provider will document the request was initiated by the nursing facility staff and include name, time and date.
    - The nursing facility must sign and submit the form to Superior for review along with documentation to support medical necessity.
    - The ambulance company and nursing facility will coordinate the scheduling of the appointment.

Non-emergent Ambulance Transport

- Approvals
  - Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider.
  - The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied.
- Denials
  - Any service denied will have standard appeal rights for denials of medical necessity.
  - Providers may follow the standard provider appeal process.
  - Members may also file an appeal.

Add-on and Acute Care Services Authorization

- STAR+PLUS (Medicaid only):
  - Call the Prior Authorization Hotline at 1-800-218-7508,
  - Submit through the Secure Provider Portal at Provider.SuperiorHealthPlan
  - Fax the Prior Authorization Form to 1-800-690-7030
- Dual-Eligible members (non-STAR+PLUS MMP):
  - Contact the Member's Medicare carrier
- STAR+PLUS MMP
  - Call the Prior Authorization Hotline at 1-800-218-7508
  - Submit through the Secure Provider Portal at Provider.SuperiorHealthPlan
  - Fax the Prior Authorization Form to:
    - Inpatient: 1-877-259-6960
    - Outpatient: 1-877-808-9368

Physician-ordered Rehabilitative Services (PT, OT, ST)

- Authorization Process
  - Select **Medical Outpatient** then **Therapy** as the Service Type.
  - Do not select **Rehab Inpatient** as the Service Type.
  - Authorization requests must be submitted for each type of therapy (i.e. physical [PT], speech [ST] or occupational [OT]).

Authorization For

GLAESER, JENSON DOB: 02/25/2019 | MEDICAID NBR: 731635819

By checking the Urgent Request box, I certify that this is an urgent request for a medically necessary treatment for an injury, illness, or another type of condition (usually not life threatening), which must be treated within 48 hours.

After hours emergent and urgent admissions, inpatient notifications or requests will need to be provided telephonically. Electronic requests will not be monitored after hours and will be responded to on the next business day. Please contact our NurseWise line at 800-783-5386 (Option 7) for after-hours urgent admission, inpatient notifications or requests.

Please select Service Type.

Enter Authorization

1. PROVIDER REQUEST

Urgent Request

Select a Service Type
Medical Outpatient
Biopharmacy
Cardiac / Pulmonary Rehabilitation
DME
Drug Testing
Genetic Testing & Counseling
Home Health
Office Visit
Outpatient Services
Therapy-Evaluation
Therapy-Treatment
Transport
Medical Inpatient
Boarder Baby
Medical
Neonate
Rehab Inpatient
Sub Acute
Surgical Inpatient
Transplant

2. SERVICE LINE

3. FINISH UP

Change of Ownership

Change of Ownership

- If a nursing facility undergoes a Change of Ownership (CHOW), the following form must be completed and submitted to Superior IN ADVANCE of the CHOW, including the effective date of the change:
  - www.SuperiorHealthPlan.com/providers/become-a-provider/change-of-ownership.html
- When undergoing a CHOW, the nursing facility will be loaded with the new Tax ID as non-par in the system until credentialing is complete.
- Nursing facilities will still be completely reimbursed.
- The effective date the facilities receives for the new ownership will be prospective (i.e. it will not align with the CHOW effective date assigned by the State).

Claims Submissions

Nursing Facility Unit Rate

- Preferred way to submit claims – Superior's Secure Provider Portal, as claims will be received immediately by Superior.
- Nursing facilities can also submit claims through TMHP's portal, which will redirect to Superior.
- HHSC will set the prevailing rate for the date of service as found on their website.
- Nursing facilities have **365** days from the date of service to submit claims.
- Superior has **10** days to pay clean claims from the date of submission.
- All rate adjustments will be processed no later than 30 days after the receipt of the HHSC rate notification.

Add-on Services

- Preferred way to submit claims – Superior's Secure Provider Portal, as claims will be received immediately by Superior.
- Nursing facilities can also submit claims through TMHP's portal, which will redirect to Superior.
- Nursing facilities have to submit the claims within **95** days from the date of service.
- Superior has **30** days to pay clean claims from the date of submission.
- Nursing facilities may submit claims for nursing facility add-on physician-ordered therapies on behalf of employed or contracted therapy providers.
- Add-on therapy claims must be submitted separately from the Nursing Facility Unit Rate Claims.
- Providers must submit claims directly to Superior for Durable Medical Equipment (DME) add-on services.
- Emergency Dental claims must be submitted to dental carrier.

Acute Care and Add-on Services

- Preferred way to submit claims – Superior's Secure Provider Portal, as claims will be received immediately by Superior.
- Acute care providers have **95** days from the date of service to submit their claims.
- Superior will follow the clean claim criteria as set by TMHP billing guidelines.
- Superior has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing claims for add-on services include filing through a clearinghouse or on the red and white paper claim.
  - For a list of preferred clearing houses, visit our website.
  - For 1st time paper claims, mail them to:

    Superior HealthPlan
    Attn: Claims
    P.O. Box 3003
    Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Nursing Facility Billing Reminders

- The following nursing facility identification requirements remain in effect:
  - Nursing Facilities must be contracted, certified and licensed by HHSC to submit claims.
  - You must use your valid HHSC contract number, vendor number and NPI for both contracting with Superior and on the claims when billing Superior.
  - If they differ from what is on record at HHSC, your claims may result in denials as Superior cannot pay your claim until this information is corrected.
- Valid Attending Provider National Provider Identifier (NPI), Tax Identification Number (TIN) and Principle Diagnosis Code are required when submitting claims
  - Entry of invalid format for the NPI, TIN, or Principle Diagnosis Code on a claim may result in rejection or denial from Superior.
- Questions for TexMedConnect Portal Contact:
  - 1-800-626-4117, Option 1

Billing – STAR+PLUS

DUALS

These are members who receive both Medicare and Medicaid. Members may select a managed care Medicare plan and have Superior as their STAR+PLUS Medicaid plan.

- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services), Skilled Nursing Facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the RUG.

- Superior STAR+PLUS covers Vent and Trach add-on services, and is the primary payor for the *co-insurance* for the SNF Unit Rate for days 21-100 (if the stay meets qualifying hospital stay criteria and skillable needs) and add-on services, and is the primary payor for the NF Unit Rate starting day 101.

NON-DUALS

Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.

- Covers acute care, add-on services and the NF Unit Rate.

Billing – STAR+PLUS MMP

- Superior STAR+PLUS MMP reimburses providers for acute care services, including behavioral health as well as the approved Skilled Nursing Facility (SNF) amounts.
- For SNF claims, providers must file 2 claims:
  - One claim with the standard Medicare revenue code.
  - A second claim for the Medicaid coinsurance revenue code 101.
- The Superior Medicare Explanation of Payment (EOP) is not required to be filed with the coinsurance claim.
- The claims must be filed within 365 days after the date of service or 95 days after the date on the EOP from the Medicare payment.

Auto Adjusted Claims

- Some of the reasons a claim may require an adjustment are due to changes in:
  - Nursing facility daily rates
  - Provider contracts
  - Service authorizations
  - Applied income
  - Level of service (RUG)
- In each of these instances, Superior will automatically re-adjudicate claims affected by the change. Payment will be made within **30** days from receipt of the adjustment reason.
- There will be times when a claim gets adjusted and the claim denies. In these cases, the provider will need to submit a corrected claim. These will not be automatically adjusted.

STAR+PLUS Acute Care and Add-on Services

- Preferred way to submit claims – Superior's Secure Provider Portal, as claims will be received immediately by Superior.
- Acute Care providers have **95** days from the date of service to submit their claims.
- Superior will follow the clean claim criteria as set by TMHP billing guidelines.
- Superior has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing acute care claims include: Through a clearinghouse or on the red and white paper claim.
  - For a list of preferred clearing houses, visit our website.
  - For 1st time paper claims, mail them to:
    - Superior HealthPlan
Attn: Claims
P.O. Box 3003
Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

Claim Adjustments, Disputes & Reconsiderations

- If a provider wants to adjust/correct a claim or submit a claim appeal, it must be received within **120** days from the date of notification or denial.
  - Adjusted or Corrected Claim – The provider is changing the original claim. Correction to a prior-finalized claim that was in need of correction as a result of a denied or paid claim.
  - Claim Appeals – Often require additional information from the provider.
    - **Request for Reconsideration**: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - **Claim Dispute:** Provider disagrees with the outcome of the Request for Reconsideration.
- Both can be submitted via the Secure Provider Portal or through paper. Paper claims require a Superior Corrected Claim or Claim Appeal form, found at www.SuperiorHealthPlan.com/providers/resources/forms.html

Corrected Claims Filing

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

Superior HealthPlan
Attn: Claims
P.O. Box 3003
Farmington, MO 63640-3803

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

Corrected Claims Filing

- There may be occasions in which a nursing facility will need to submit a corrected claim, if they billed incorrectly. These claims will not auto adjust. Nursing facilities should submit a corrected claim, if:
  - Billed across multiple months i.e. 2/15-3/15.
  - Billed for days spans that include unauthorized days, i.e. SAS approves 3/5-3/31 provider bills 3/1-3/31.
  - Billed for days when the member is in an acute care facility.
  - Billed for days that span across multiple years i.e. 12/31/2015 - 1/5/2016.
  - Billed for Medicare coinsurance days when non-Medicare days are authorized.
  - Billed for non-Medicare days when only Medicare coinsurance days are authorized.
  - Billed with different RUG/service levels. Claims must only be billed for one RUG/service level.

Appealing Denied Claims

- Submit appeal within 120 days from the date of adjudication or denial.
- Claims appeals may be submitted one of two ways:
  - In writing:

    Superior Health Plan
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800

    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims Appeals
    P.O. Box 4000
    Farmington, MO 63640-4000
  - Or through the Secure Provider Portal:
    - At this time, batch adjustments are not an option via the portal
- Attach and complete the claim appeal form from the SuperiorHealthPlan.com.
- Include sufficient documentation to support appeal.
- Include copy of UB04 or CMS1500 (corrected or original) or EOP copy with claim number identified.

Appeals Documentation

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

Overpayments, Refunds and Recoupments

- If a provider identifies an overpayment, or receives payment from another payer, Superior must be notified within 30 days of discovery. The provider has the option to refund the overpayment or they can request for Superior to recoup the funds.
  - The notification can be submitted several ways:
    - 'Contact Us' form on the Superior website
    - Email: Provider_Operations@centene.com
    - Mail: Superior HealthPlan
      P.O. Box 3003
      Farmington, MO 63640-3803
- If a recoup is requested, the erroneous payment(s) will be reversed by Superior within 30-60 days. The reversal of the payment will be reflected on the provider's EOP.
- If the provider opts to submit a refund, they should send a copy of the EOP along with the refund check to:

  Superior HealthPlan
  P.O. Box 664007
  Dallas, TX 75266-4007

Secure Provider Portal - Submitting Claims

Superior Secure Provider Portal

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

- Secure site:
  - It is secure.
  - It provides up-to-date member eligibility and Service Coordinator assignment.
  - It has a secure claim submission portal you can submit claims for free.
  - It provides a claim wizard tool that walks you through filling in a claim to submit on-line.
  - It provides claim status and payment information.
  - It allows you to check the status of an authorization.
- Public Site:
  - It contains our Provider Directory and on-line lookup.
  - It has a map where you could easily identify the office of the field Account Manager assigned to you.
  - It contains an archive of newsletters, bulletins, the Provider Manual, and link to important sites to keep you up to date on any new changes that may affect you.

Registration

- To register for Superior's Secure Provider Portal, please visit: https://Provider.Superiorhealthplan.com/sso/login
- A user account is required to access the Provider Secure area.
- If you do not have a user account, click **Register** to complete the 4-step registration process.

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Register Provider Your Progress Cancel

Your Details

Registration Type: Medical Provider Behavioral Provider | Dental Provider Vision Provider | Foster Care Member, Medical Consenter, Foster Parent, DFPS Staff, RTC/CPA Staff, CASA Staff, SSCC

Tax ID ?

First Name: First

Last Name: Last

Email: name@domain.com ?

Re-enter Email: name@domain.com

Password: Password ?

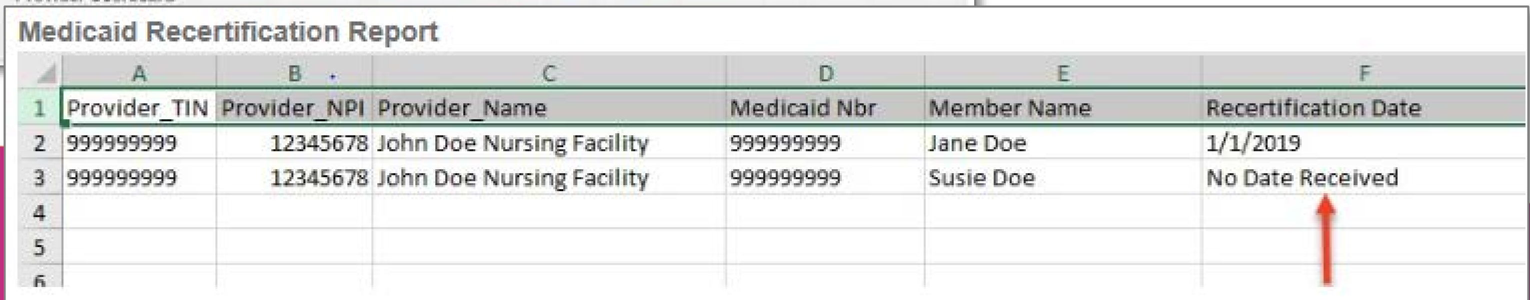
Retype Password: Password

Next

Terms and Conditions Privacy Policy Copyright © 2018, Centene Corporation

Medicaid Recertification Date

- The **Medicaid Recertification Report** can be found under **Reports** at Provider.SuperiorHealthPlan.com.
- This report allows you to work with Superior members to ensure they are recertified prior to their expiration date, preventing any unnecessary lapse in coverage.
- If no recertification date is provided, **No Date Received** will be listed under **Report Date**.
- Updates to the report will be made within the first week of every month.



Medicaid Recertification Report

	A	B	C	D	E	F
1	Provider_TIN	Provider_NPI	Provider_Name	Medicaid Nbr	Member Name	Recertification Date
2	999999999	12345678	John Doe Nursing Facility	999999999	Jane Doe	1/1/2019
3	999999999	12345678	John Doe Nursing Facility	999999999	Susie Doe	No Date Received
4						
5						
6						

Superior HealthPlan Departments

Service Coordination

- A special kind of care management used to coordinate all aspects of care for a member.
- Utilizes a multidisciplinary approach in meeting members' needs.
- Is available to all STAR+PLUS and STAR+PLUS MMP members.
- Superior residents will be assigned the same Superior Service Coordinator.
- Service Coordinators participate with the member, their family or representative, the nursing facility staff, and other members of the interdisciplinary team to provide input for the development of the nursing facility plan of care.

Service Coordinator and Nursing Facility Staff

- The Service Coordinator will partners with the Nursing Facility staff to ensure members' care is holistically integrated and coordinated.
- Service Coordinators will:
  - Conduct quarterly member visits (may be less for Hospice residents)
  - Participate in Nursing Facility care planning meetings
  - Assist with issues pertaining to Applied Income
  - Comprehensively review the member's service plan, including the nursing facility plan of care, at least annually, or when there is a significant change in condition.
  - Notify the Nursing Facility within 5 days of a change in their assigned Service Coordinator.

  Please note: This is not an all inclusive list. For a complete list of responsibility, please refer to Superior's Nursing Facility Provider Manual.

Service Coordinator and Nursing Facility Staff

- Nursing Facility staff will:
  - Invite the Service Coordinator to provide input for the development of the nursing facility care plan.
  - Provide Service Coordination access to the facility, staff and member’s medical information and records.
  - Notify the Service Coordinator within 1 business day of admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, non-contracted bed, or another nursing or long-term care facility.
  - Notify the Service Coordinator within 1 business day of an adverse change in a member's physical or mental condition or environment that potentially leads to hospitalization.
  - Notify the Service Coordinator within 1 business day of an emergency room visit by a member.
  - Notifying the Service Coordinator within 72 hours of a member's death.

Please note: This is not an all inclusive list. For a complete list of responsibility, please refer to Superior’s Nursing Facility Provider Manual.

Service Coordinator and Nursing Facility Staff

- To notify Superior's Service Coordinator, Nursing Facility staff must fill out the applicable areas of the Service Coordination Notification Form and fax it to the attention of your Service Coordinator at:
  - 1-855-277-5700
- You can find a copy of this form contact your Service Coordinator or Account Manager or download the form from https://www.SuperiorHealthPlan.com/providers/resources/nursing-facilities.html
- For questions about Service Coordination, please contact:
  - 1-855-772-7075

Member Services

- Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing Member benefits
  - Assist with non-compliant Members
  - Help find additional local community resources

- Member Services is available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time by calling:
  - STAR+PLUS – 1-877-277-9772
  - STAR+PLUS MMP - 1-866-896-1844

Provider Services

- Provider Services staff can help you with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior Network Providers
  - Locating your Service Coordinator and Account Manager
  - Request for negative balance

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

- Provider Services is available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.
  - 1-877-391-5921

Account Management

- Account Managers are here to assist you with:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing claim trends
  - Office visits to review quality performance reports
  - Provider trainings

- To locate your Account Manager, please visit www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html

Provider Training

- Superior offers targeted billing presentations depending on the type of services you provide and bill for. For example, Long-Term Services and Supports (LTSS) billing, Electronic Visit Verification (EVV) and General Billing Clinics. We also offer product specific training on STAR+PLUS, STAR+PLUS MMP and STAR/CHIP.
- You can find the schedule for all of the training presentations on our website at: https://www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html
- We encourage you to come join us!

Complaints

- Nursing facilities can submit complaints either orally or in writing. The website contains a complaint form that can be completed and submitted online or printed, completed and faxed or mailed to Superior for resolution response:
  - Address:
    Superior HealthPlan
    ATTN: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
- Fax number: 1-866-683-5369
- To access the complaint form, visit:
  - https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html

Compliance

- Health Insurance Portability Accountability Act (HIPAA) of 1996
  - Providers and contractors are required to comply with HIPAA guidelines http://www.hhs.gov/ocr/privacy.
- Fraud, Abuse and Waste (Claims/Eligibility)
  - Providers and contractors are all required to comply with State and Federal provisions that are set forth.
  - To report Fraud, Waste and Abuse, call the numbers listed below:
    - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-269-0271
    - Texas Attorney General Medicaid Fraud Control Hotline: 1-800-252-8011
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664
    - Providers may also email the Superior Compliance team to report suspected Fraud, Waste and Abuse: Superior.Compliance@Superiorhealthplan.com

Questions and Answers