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STAR+PLUS Medicare-Medicaid Dual Demonstration (STAR+PLUS MMP)

Comprehensive Provider Training

Agenda

- What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?
- Who is Superior HealthPlan?
- Role of the Provider
- Service Coordination
- Eligibility, Referrals, and Authorizations
- Pharmacy
- Compliance
- Cultural Competency and Disability Sensitivity
- Model of Care
- Quality Improvement Program
- Claims Submissions
- Superior HealthPlan Departments
- Secure Provider – Submitting Claims
- Questions and Answers

What is the STAR+PLUS Medicare-Medicaid Plan (MMP)?

STAR+PLUS MMP: Goals

- Ensure one health plan be responsible for both Medicare and Medicaid services.
- Achieve cost savings for the state and federal government through improvements in care and coordination.
- Utilize Service Managers for targeted member outreach and care coordination.

STAR+PLUS MMP: Benefits

Every STAR+PLUS MMP member will be offered the following, but are not limited to:

- Ambulance service
- Behavioral health services
- Doctor and clinic visits
- Family planning services
- 24-hour emergency care
- Hospital care
- Lab and X-ray services
- Organ and tissue transplants
- Hearing tests and aids
- Home health services
- Add-on services

Note: All services are subject to benefit coverage, limitations and exclusions. Acute care services fall under the member's Medicare coverage.

Enrollment

- Individuals who meet all of the following criteria will be eligible for STAR+PLUS MMP:
  - 21 years of age or older at the time of enrollment
  - Get Medicare Part A, B and D and are receiving full Medicaid benefits
  - Be enrolled in the Medicaid STAR+PLUS program for at least 30 days, which services members who have disabilities and those who meet a nursing facility-level of care and get STAR+PLUS home and community-based waiver services.
  - Reside in Bexar, Dallas or Hidalgo Counties (Note: the MMP program is available in 6 counties; these are the 3 which Superior services.)

- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions, and individuals with developmental disabilities who 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), or
  - Texas Home Living (TxHmL).

Enrollment

- Enrollment for eligible individuals into STAR+PLUS MMP may be conducted (when no active choice has otherwise been made) using a seamless, passive enrollment process that provides the opportunity for individuals to make a voluntary choice to enroll or disenroll from STAR+PLUS MMP at any time.
- Under passive enrollment, eligible individuals will be notified of plan selection and of their right to select among other contracted STAR+PLUS MMPs no less than 60 days prior to the effective date of enrollment, and will have the opportunity to opt-out until the last day of the month prior to the effective date of enrollment.
- Disenrollment from STAR+PLUS MMP Managed Care Organizations (MCO) and enrollment from one STAR+PLUS MMP MCO to a different STAR+PLUS MMP MCO will be allowed on a month-to-month basis any time during the year.

Disenrollment

- **Voluntary Disenrollment**
  - Members can elect to disenroll from Superior's STAR+PLUS MMP at any time and enroll in another STAR+PLUS MMP, a STAR+PLUS MCO, a Medicare Advantage plan, PACE; or may elect to receive services through Medicare fee-for-service (FFS) and a prescription drug plan, and to receive Medicaid services in accordance with the Texas State Plan and any waiver programs (if eligible). This will become effective on the first day of the following month.
- **Discretionary Involuntary Disenrollment**
  - STAR+PLUS MMP providers may submit a written request, accompanied by the required supporting documentation to Superior's Compliance department.

Disenrollment

- **Required Involuntary Disenrollment**
  - Texas and Centers for Medicare and Medicaid Services (CMS) shall terminate a member's enrollment in the STAR+PLUS MMP if, for example*:
    - The member loses entitlement to either Medicare Part A or Part B.
    - The member dies.
    - MMP's contract with CMS is terminated or reduces its service area to exclude member's in those areas.

*This is not an all-inclusive list. For a full list, see our Provider Manual at www.SuperiorHealthPlan.com/content/dam/centene/Superior/Provider/PDFs/SHP_20184631-STAR+Plus-MMP-Provider-Manual-06112019.pdf.

Who is Superior HealthPlan?

Superior HealthPlan

- Contracted with Texas Health and Human Services (HHS) since December 1999.
- Contracted with CMS for Medicare since January 2009.
- Superior HealthPlan provides programs across the state of Texas. These programs include:
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - CHIP
  - Allwell from Superior Health Plan (Medicare Advantage HMO and HMO SNP)
  - Ambetter from Superior HealthPlan (Health Insurance Marketplace)
- Superior HealthPlan, a Centene Corporation subsidiary, manages health care for over one million members across Texas.

Role of the Provider

Primary Care Providers

The Primary Care Provider (PCP) serves as the “medical home” for the member. The “medical home” concept should assist in establishing a patient-provider relationship and ultimately better health outcomes.

Responsibilities include but are not limited to:

- Supervision, coordination, and provision of care to each assigned member.
- Initiation of referrals for medically-necessary specialty care.
- Maintaining continuity of care for each assigned member.
- Maintaining the member’s medical record, including documentation for all services provided to the member by the PCP, as well as any specialists, behavioral health or other referral services.
- Screening for behavioral health needs at each visit and when appropriate, initiate a behavioral health referral.

Primary Care Providers

PCPs should speak to all their members annually about:

- Reducing the risk of falling.
- Improving bladder control.
- Improving or maintaining mental health.
- Improving or maintaining physical health.
- A review of the member's medication(s).

Specialist as the PCP

Members with disabilities, special health care needs, and chronic or complex conditions have the right to designate a specialist as their PCP. A specialist may serve as a PCP only under certain circumstances and with approval of Superior's Chief Medical Officer.

To be eligible to serve as a PCP, the specialist must:

- Meet Superior's requirements for PCP participation, including credentialing.
- Contract with Superior as a PCP.
- All requests for a specialist to serve as a PCP must be submitted to Superior. The request should contain the following information:
  - Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
  - A statement signed by the specialist that he/she is willing to accept responsibility for the coordination of all of the member's health-care needs.
  - Signature of the member on the completed "Specialist as PCP Request" Form.

Superior will approve or deny the request and provide written notification (including denial reason) of the decision to the member no later than 30 days after receiving the request. If denied, the member may file a complaint.

Specialty Care Physicians

- Agrees to partner with the member's PCP and Service Coordinator to deliver care.
- Maintain ongoing communication with the member's PCP.
- Most visits to Specialist do not require a prior authorization.
- Most Specialists will require a written referral from the member's PCP; however the referral is not required for the claim to be reimbursed by STAR+PLUS MMP.
- Female members can self-refer to an OB/GYN for their annual well-woman checkup or for care related to pregnancy.
- Specialists can elect to limit their practice to established patients only upon request to their Account Manager.

Specialty Care Physicians

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Specialty Care Physicians include, but are not limited to:

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

For a list of services that require authorization, visit www.SuperiorHealthPlan.com.

Referrals

PCPs refer members to a Specialist when the medical need is beyond their scope.

- PCP must initiate the referral to an in-network specialist.
- Specialists may **NOT** refer to another Specialist (only via PCP).
- If you need to refer to an out of network Specialist, please obtain an authorization for the Specialist or advise the Specialist(s) to obtain a prior authorization.

Appointment Availability

A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week.

The following standards are established regarding appointment availability:

- **Emergent:** Seen **same day/immediately** upon arrival
- **Urgent Care:** Seen within **24 hours**
- **Urgent Behavioral/Specialty Care:** Seen within **24 hours**
- **Routine Primary Care:** Within **14 days**
- **Preventative Adult Health Care:** Within **90 days**

Appointment Availability

The following standards are established regarding appointment availability:

- **Initial Outpatient Behavioral Visits:** Within **14 days**
- **Referrals to Specialty Care:** No later than **5 days** dependent on medical condition
- **Prenatal Care:** Within **14 days**
- **Prenatal Care – High Risk or Third Trimester (New Patient):** Within **5 days**
  - If an emergency, then **immediately**

Note: Providers are prohibited from restricting or limiting their office hours for Medicaid or Medicare members.

After-hours Protocol

Providers are required to develop and use telephone protocol for all of the following situations:

- Answering the enrollee telephone inquiries on a timely basis.
- Prioritizing appointments.
- Scheduling a series of appointments and follow-up appointments as needed by an enrollee.
- Identifying and rescheduling broken and no-show appointments.
- Identifying special enrollee needs while scheduling an appointment, e.g. wheelchair and interpretive linguistic needs for non-compliant individuals who are mentally-deficient.
- Response time for telephone call-back waiting times:
  - After hours telephone care for non-emergent, symptomatic issues: **within 30 to 45 minutes**.
  - Non-symptomatic concerns: **same day**
  - Crisis situations: within 15 minutes

After-hours Protocol

- Scheduling continuous availability and accessibility of professional, allied and supportive medical/dental personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider's absence.

- After-hours calls should be documented in a written format in either an after-hour call log or some other method, and transferred to the patient's medical record.

- Superior will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement Program.

Please note: If after-hours urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care or emergency center to notify the facility.

Behavioral Health Providers

The behavioral health provider serves certain members participating in the STAR+PLUS MMP program that have mental illness through targeted case management and mental health rehabilitative services.

Behavioral health providers are required to provide covered health services to members within the scope of their Superior agreement and specialty license.

For Enrollees with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), Mental Health Rehabilitative Services and Mental Health Targeted Case Management must be available to eligible enrollees. The STAR+PLUS MMP must maintain a qualified network of entities, such as Local Mental Health Authorities (LMHAs) and multi-specialty groups, that employ providers of these services. Mental Health Rehabilitative services include the following:

- Adult Day Program
- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

Self-Directed Care

Superior STAR+PLUS MMP providers that offer Primary Home Care (PHC)/Personal Assistance Services (PAS) in-home or out-of-home respite, nursing, physical therapy (PT), occupational therapy (OT) and/or speech therapy (ST), have 3 options available for self-directed care.

1. **Consumer-Directed Services** - The member or the member's legally authorized representative (LAR) is the employer of record and retains control over the hiring, management and termination of an individual providing the services.
   - The enrollee uses a Financial Management Services Agency (FMSA) to handle the employer-related administrative functions such as payroll, substitute (back-up) and filing tax-related reports.
2. **Service Responsibility Option** - The member or the member's LAR is actively involved in choosing the member's provider but is not the employer of record.
   - The Home and Community Support Services agency (HCSSA) in the STAR+PLUS MMP provider network is the employer of record for the personal attendant employee and respite provider.
3. **Agency Model** - STAR+PLUS MMP contracts with a Home and Community Support Services agency (HCSSA) or a certified Home and Community-based Services or Texas Home Living Agency for the delivery of services.
   - The HCSSA is the employer of record and establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports.

Community First Choice

- Community First Choice (CFC) provides Community-Based Long-Term Services and Supports (LTSS) to eligible enrollees who are elderly and to individuals with physical or cognitive disabilities as an alternative to living in an institution.
- To be eligible for CFC services, an enrollee must meet income and resource requirements for Medicaid under the state plan and receive a determination from HHSC that the enrollee meets level of care (LOC) requirements for:
  - Nursing Facility care.
  - An intermediate care facility.
  - An institution for mental diseases.

Service Coordination

Service Coordination Team

Service Coordination Teams will:

- Identify and engage high-risk and non-compliant members.
- Identify barriers to compliance with treatment plans and goals.
- Facilitate communication across medical/behavioral health specialties.
- Coordinate services, including transportation and referrals.
- Facilitate communication regarding medication adherence.
- Work closely with the Superior Pharmacy team to provide member education.

Service Coordination

- A special kind of care management used to coordinate all aspects of care for a member.
- Utilizes a multidisciplinary approach to meet the members' needs, including behavioral health referrals and non-clinical social support.
- Members and their respective Nursing Facilities will be assigned the same Service Coordinator.
- Coordinator's names are found on the Secure Provider Portal or at www.SuperiorHealthPlan.com.

Interdisciplinary Care Team (ICT)

- The purpose of the ICT is to collaborate with the member, his or her Providers/Specialists, and other health-care professionals to ensure appropriate services are in place and to identify alternative solutions to barriers identified in a member's care plan.

- Superior's program is member-centric with the PCP being the primary ICT point of contact. Superior staff works with all members of the ICT in coordinating the plan of care for the member.

Interdisciplinary Care Team (ICT)

- As part of the ICT process, providers are responsible for:
  - Accepting invitations to attend member's ICT meetings.
  - Maintaining copies of the Individualized Care Plan (ICP), ICT worksheets and transition of care notifications in the member's medical record.
  - Collaborating and actively communicating with care managers the ICT, members and caregivers.
- Superior Care Managers work with the member to encourage self-management of his or her condition, as well as communicate the member's progress toward these goals to the other members of the ICT.

Interdisciplinary Care Team

The ICT will be led by a Care Coordinator, and at a minimum is comprised of the following core members:

- Member and/or authorized representative
- PCP
- Family and/or caregiver, if approved by the member
- Care coordinator(s) (Service Coordinator, Behavioral Health Care Manager)
- Specialist (if serving as member's PCP)

Responsibility of the ITC

- Analyze and incorporate the results of the initial and annual health risk assessment into the individualized care plan.
- Coordinate the medical, cognitive, psychosocial and functional needs of members.
- The development and implementation of individualized care plan with the member's participation as feasible.
- Conduct ICT meetings according to the member's condition. These meetings may be held face-to-face, via conference call or web-based interface.

Care Coordination

- Superior and its providers partner to identify and manage services for all members, including persons with disabilities, chronic or complex conditions.
- This includes development of a plan of care to meet the needs of the member.
- The plan of care is based on health needs, the member's providers and Specialists recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs.

Behavioral Health and Physical Health Services Coordination

- Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success.
- Providers are required to obtain a consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider and the member's physical health provider.
  - If the member refuses to release the information, he or she should indicate his or her refusal on the release form. Providers must document the reasons for declination in the medical record.

Behavioral Health and Physical Health Services Coordination

PCPs are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must minimally include:
  - Behavioral health medications prescribed.
  - Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.
- Administer a screening tool at intake, and at least annually thereafter, to identify members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider that referred the member. Make referrals to behavioral health providers when the required Texas Health Steps screen reveals the need for a mental health, substance abuse and/or developmental disability assessment.

Note: Behavioral health providers are required to refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.

Eligibility, Referrals and Authorizations

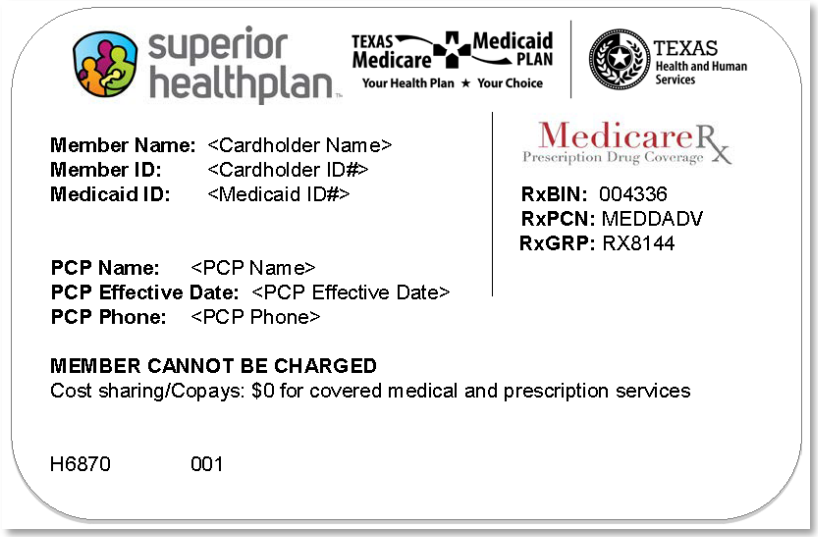
Verifying Eligibility

You can verify eligibility by:

- Visiting the Secure Provider Portal at www.Provider.SuperiorHealthPlan.com.
- Contacting Superior's Member Services Department at:

  1-866-896-1844, Monday - Friday from 8:00 a.m. - 8:00 p.m.
- Visiting TexMedConnect: www.tmhp.com.
- Reviewing member's issued Plan ID card (Member ID card is not a guarantee of enrollment or payment).

Member ID Card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TEXAS Medicare Medicaid PLAN
Your Health Plan ★ Your Choice

TEXAS Health and Human Services

Member Name: <Cardholder Name>
Member ID: <Cardholder ID#>
Medicaid ID: <Medicaid ID#>

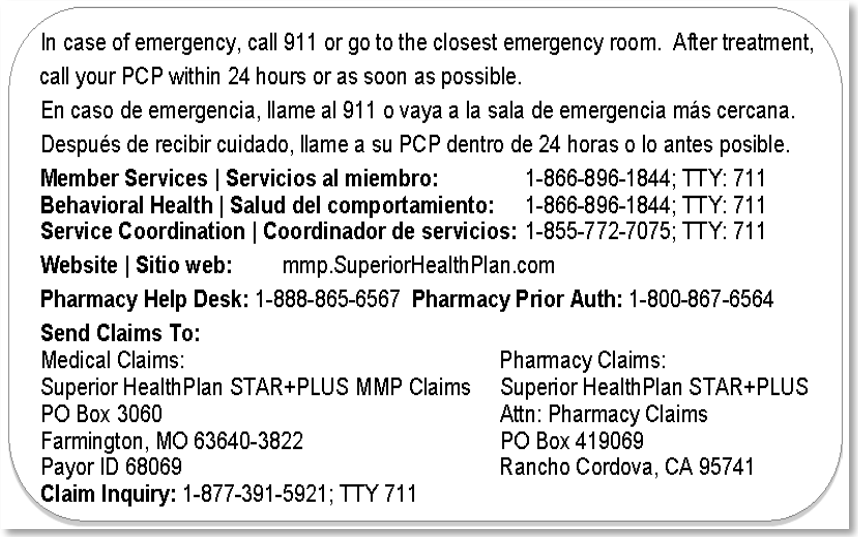
MedicareRx
Prescription Drug Coverage

RxBIN: 004336
RxPCN: MEDDADV
RxGRP: RX8144

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

MEMBER CANNOT BE CHARGED
Cost sharing/Copays: $0 for covered medical and prescription services

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 | 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: 1-855-772-7075; TTY: 711
Website | Sitio web: mmp.SuperiorHealthPlan.com
Pharmacy Help Desk: 1-888-865-6567 **Pharmacy Prior Auth:** 1-800-867-6564

Send Claims To:

Medical Claims:
Superior HealthPlan STAR+PLUS MMP Claims
PO Box 3060
Farmington, MO 63640-3822
Payor ID 68069

Pharmacy Claims:
Superior HealthPlan STAR+PLUS
Attn: Pharmacy Claims
PO Box 419069
Rancho Cordova, CA 95741

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

Available in Bexar, Dallas and Hidalgo counties for Superior members only.

Self-Referral

Superior STAR+PLUS MMP members can self-refer for the following services:

- Family planning
- Care management for pregnant women
- Vision
- True emergency services
- Behavioral health (Behavioral health-related services may be provided by the PCP if it is within their scope.)
- Well woman annual examinations
- OB care

Prior Authorization – Acute Care Process

Procedures and/or services that require authorization can be found at www.SuperiorHealthPlan.com.

	Timeframes
Expedited Authorization/ Concurrent Hospital	1 business day after receipt of the request
Standard Authorization	3 business days of receipt of the request
Retrospective Review	30 calendar days

Prior Authorization – Acute Care Services

For a full list of acute services that require prior authorization, please visit: www.SuperiorHealthPlan.com/providers/preauth-check/mmp-pre-auth.html.

Acute Care
Prior Authorization Process

Authorizations for these services are requested from the Prior Authorization department. This can be done in one of three ways:

1. Calling the Prior Auth Hotline at 1-800-218-7508.

2. Submitting via the secure web portal at Provider.SuperiorHealthPlan.com.

3. Faxing the STAR+PLUS MMP Prior Auth Form found at www.SuperiorHealthPlan.com under Provider Resources/Forms to:
   - **Inpatient:** 1-877-259-6960
   - **Outpatient:** 1-877-808-9368

Behavioral Health Authorizations

- Superior issues authorizations for behavioral health services.
- For Superior authorization inquiries:
  - Call: 1-844-744-5315
  - Fax: 1-855-772-7079
  - Visit: Provider.SuperiorHealthPlan.com

Radiology Authorizations

Prior authorization is required for the following outpatient radiology procedures through National Imaging Associates (NIA):

- CT/CA
- MRI/MRA
- PET Scan
- CCTA
- Nuclear Cardiology/MPI
- Stress Echo

To submit authorizations and/or access the status of an authorization:

- Access www.radmd.com; or
- Call 1-800-642-7554.

TurningPoint HealthCare Solutions

- Effective November 15, 2019, Superior HealthPlan will be working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint will be responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal surgical procedures.
- This new process applies to: STAR, STAR Health, STAR Kids, STAR+PLUS, CHIP, Allwell and Ambetter.
- Physicians will begin submitting requests to TurningPoint for prior authorization beginning on November 1, 2019 for dates of service on or after November 15, 2019.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under Billing Resources at www.SuperiorHealthPlan.com/providers/resources.html.

TurningPoint HealthCare Solutions

Prior authorization will be required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Knee Arthroplasty and Arthroscopy	Spinal Fusion Surgeries
Uni/Bi-compartmental Knee Replacement	Cervical
Hip Arthroplasty and Arthroscopy	Lumbar
Acromioplasty and Rotator Cuff Repair	Thoracic
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Osteochondral Defect Repair	Laminectomy/Discectomy

**This is not an all-inclusive list. For a detailed list of impacted Current Procedural Terminology (CPT) codes, visit TurningPoint's Web Portal or www.SuperiorHealthPlan.com/providers/preauth-check.html.*

TurningPoint HealthCare Solutions

- Emergency-related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services from the previous slide should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
  - Web Portal Intake: http://www.myturningpoint-healthcare.com
  - Telephonic Intake: 469-310-3104
    855-336-4391
  - Facsimile Intake: 214-306-9323

Ophthalmology for Medical Eye Care Services – Effective January 1, 2020

- Effective for service dates beginning January 1, 2020, Superior HealthPlan will assume the management of medical eye care services delivered by ophthalmologists for all Superior members.
- Envolve Vision will continue to manage routine eye care services and full-scope of licensure optometric services for Superior HealthPlan.

Ophthalmology for Medical Eye Care Services – Effective January 1, 2020

Beginning January 1, 2020, Superior will manage all functions for ophthalmologists providing medical eye care services, including but not limited to:

- Claim Processing and Appeals
- Contracting/Credentialing
- Prior Authorization
- Retrospective Utilization Review
- Medical Necessity Appeals
- Provider Complaints Related to Medical Eye Care Services
- Provider Relations/Account Management
- Provider Services
- Provider Web Portal

For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool: www.SuperiorHealthPlan.com/providers/preauth-check.html.

Medical Necessity Denials

- When medical necessity cannot be established, a peer to peer conversation may be requested.
- If it is not established, denial letters will be sent to both the member and the provider.
- The clinical basis for the denial will be indicated.
- Appeal rights will be fully explained.

Medical Necessity Timeframes

Providers or members have 60 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal.

- 120 calendar days from the date of notification of adverse determination to file a Fair Hearing.
  - Non-covered benefit denial also has Fair Hearing rights.
- Superior HealthPlan will review and respond to the appeal within 30 calendar days.

Expedited Timeframes

- **Expedited Appeals**
  - Inpatient (IP) expedited are processed within 1 business day of appeal request.
  - All other expedited appeals are completed within 3 calendar days.

- **Expedited Appeals Criteria**
  - Will it cause severe pain if not processed within a 30-day time frame?
  - Is it life/limb threatening if not processed within a 30-day time frame?
  - Reviewed by a Medical Director.

Other Appeals

- **Medicaid Fair Hearing Process** – Members may appeal to the HHS Appeals Division for Medicaid-based adverse determinations. These appeals must be made in writing via mail, fax or hand-delivery of electronic transmission.
  - Appeals must be filed within 120 days of the notice of action.
  - Expedited appeals will be resolved within 72 hours. Non-expedited appeals will be decided within 90 calendar days from the date it was filed.
- **CMS Independent Review Entity (IRE)** – If the internal review is not decided fully in the member's favor, Superior will automatically forward the case for Medicare services to the IRE.
  - The IRE will notify the member and the provider within 30 calendar days of their decision (expedited will be sent within 72 hours of receipt).

Other Appeals

- **Hospital Discharge Appeals** - Members have the right to request an expedited discharge appeal review by a Quality Improvement Organization (QIO).
  - The QIO will have 1 business day to make its decision after receiving the request along with all information (e.g. medical records) to make its decision.

Pharmacy

Envolve Pharmacy Solutions

- Envolve Pharmacy Solutions (formerly, U.S. Script) is the Pharmacy Benefit Manager (PBM) for Superior HealthPlan.
- Envolve is responsible for payment of pharmacy claims via the CVS Caremark claims platform.
- Envolve works with Superior HealthPlan Pharmacy and Centene Corporation to provide and maintain our network of participating pharmacies in Texas.
- Some drugs have coverage rules, restrictions, or limitations. These drugs have additional requirements before getting the drug. Limitation examples include, but are not limited to, Prior Authorization (PA), Quantity Limitation (QL), and Step Therapy (ST).
- If a drug is not covered or there are restrictions or limits on a drug, a request for coverage determination may be done. Envolve is responsible for the review of coverage determinations.

Medicare Pharmacy Services:
Allows the provider to speak with a Pharmacy Tech, Manager or Pharmacist. Call Envolve at 1-800-867-6564, Monday – Friday, 5 a.m. – 6 p.m, PST.

Superior HealthPlan Formulary

- Covered drugs include Medicare Part D drugs and some Medicaid-covered prescription and over-the-counter drugs and items. A full list of covered items can be found in the formulary: MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/coverage-determinations-exceptions.html.
- Drug Tiers
  - **Tier 1:** Generic
  - **Tier 2:** Preferred Brand Name
  - **Tier 3:** Non-Medicare prescription or over-the-counter drugs
  - Copays for all tiers are $0.
- Unlimited number of monthly prescriptions.

Superior HealthPlan Formulary

- Most drugs are covered under Part D, but there are some drugs that can be covered under both part B or Part D depending on what the drug is used for and how it is administered.
- These drugs may need prior authorization to decide if it should be covered under Medicare Part B or Part D.
  - Some antigens
  - Injectable osteoporosis drugs
  - Erythropoiesis-stimulating agents
  - Hemophilia clotting factors
  - Injectable and infused drugs
  - Transplant / Immunosuppressive drugs, dependent on transplant status
  - Some oral cancer/oral anti-nausea drugs
  - Inhalation drugs
  - Oral End-Stage Renal Disease (ESRD) drugs
  - Drugs used with an item of durable medical equipment (DME)
  - Shots (vaccinations)

Superior HealthPlan Formulary

By law, certain categories of drugs are **not** covered under Medicare Part B **or** Medicare Part D:

- Non-prescription (over the counter drugs)
- Drugs used to promote fertility
- Drugs used to relieve cough or cold symptoms
- Drugs used for cosmetic purposes
- Drugs used to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations when medically necessary
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss or weight gain

Note: Some of these drugs may be covered under the Medicaid coverage portion of the plan (Tier 3). The medication must also be covered by the TX Vendor Drug Program (TXVDP). Please refer to our formulary for more information on covered drugs.

Superior HealthPlan Formulary

- Most maintenance medications can be dispensed as a 90-day supply at no extra cost to the member.
- Members have two options for 90-day supplies: mail order or retail/pharmacy.
- Prescribing a 90-day supply may encourage members to be consistent in taking medications, which will help to improve medication adherence and lead to better overall health.
- Visit MMP.SuperiorHealthPlan.com for a link to the most up-to-date formulary.

Transition Fill Policy

- A transition fill is a temporary supply of medication.
- New plan members can receive a one-time 30-day transitional fill for a non-formulary drug or a drug requiring coverage determination within the first 90 days of their membership.
- This policy also applies to current members if any of their current drugs are placed on the excluded list beginning in January of the following year.
- The transition period allows the member and doctor to either change the drug to one on the formulary or to file an exception to request that the drug be covered.

Transition Fill Policy

- When members are transitioning from one care setting to another, they may also be entitled to transition fills – i.e. hospital to Skilled Nursing Facility (SNF), or home.
- Certain additional allowances are made for LTSS patients.
- Applies only to Medicare Party D drugs (Tier 1 and Tier 2).
- Refer to our website for additional information: MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/drug-transition-policy.html.

72-Hour Emergency Supply

- A 72-hour emergency supply of a Tier 3 (non-preferred) prescribed drug must be provided when a medication is needed without delay and prior authorization is not available.

- To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit pharmacy benefit claims electronically through the PBM claims adjudication system.

- For Pharmacy claims questions, call the CVS Caremark Pharmacy Help Desk at 1-888-865-6567.

E-prescribing

- E-prescribing is a process allowing prescribers the ability to send prescriptions directly to a pharmacy from the point of care.
- E-prescribing has been shown to reduce errors. Many of our network pharmacies are capable of receiving and processing E-prescriptions.

Note: Please indicate your e-prescribing capability on your demographic form.

Pharmacy Prior Authorization

- For Prior Authorization, Step Therapy and Quantity Limits, visit: MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/prior-auth.html.
- Coverage determination forms can be found online at: MMP.SuperiorHealthPlan.com/mmp/prescription-drug-part-d/coverage-determinations-exceptions.html.

Pharmacy Prior Authorization

- Contact Information:
  - CVS Caremark/Envolve Pharmacy Resolution Help Desk: 1-800-867-6564
  - CVS Caremark Home Delivery: 1-888-624-1139 (TTY 711)
  - Homescripts: 1-888-239-7690
  - Coverage determination/Prior Authorization:
    - Phone: 1-800-867-6564
    - Fax: 1-877-941-0480
  - Address:

    Medicare Part D Prior Authorization Department

    P.O. Box 419069

    Rancho Cordova, CA 95741

Compliance

Fraud, Waste and Abuse: Definitions

Understanding the terms:

- **Fraud**
  - Intentional deception or misrepresentation to obtain the money or property of a health-care benefit program (by means of false or fraudulent pretenses, representations, or promises).

- **Waste**
  - The over-utilization of services or other practices that result in unnecessary costs.

- **Abuse**
  - Obtaining payment for items or services when there is no legal entitlement to that payment, but without knowing and/or intentional misrepresentation of facts to obtain payments.

Fraud, Waste, and Abuse: Reporting

Everyone is responsible for reporting suspected fraud, waste and abuse. You can report to:

- Medicare: 1-800-Medicare
- Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
- Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
- Superior HealthPlan Fraud Hotline: 1-866-685-8664

Health Insurance Portability and Accountability Act (HIPAA)

Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for:

- Electronic health care transactions and code sets.
- Unique health identifiers.
- Security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

A significant component of the rules is the standards applied to protect health information and privacy.

Privacy Regulations

The privacy rules regulate who has access to a member's/patient's personally identifiable health information (PHI), whether in written, verbal or electronic form.

The regulation affords individuals the right to keep their PHI confidential and even from being disclosed.

In compliance with this privacy regulations, Superior provides each Superior member with a privacy notice. The notice describes:

- How Superior can use or share a member's health records.
- How the member can get access to his or her information.
- Their privacy rights and how their rights can be exercised.

HIPAA Resources

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules.

A summary of the HIPAA Administrative Simplification Rules can be found at: https://www.hhs.gov/hipaa/for-professionals/index.html.

Cultural Competency and Disability Sensitivity

What is Cultural Competency?

- A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups, and the sensitivity to know how these differences influence relations with members.
- Complimentary behaviors, attitudes, and policies that help professionals work effectively with people of different cultures.

How to Become a Culturally Competent Provider

- **Value Diversity and Acceptance of Differences**
  - How does the member define health and family? Consider each person as an individual, as well as a product of his or her country, religion, ethnic background, language and family system.

- **Self-Awareness**
  - How does our own culture influence how we act and think?
  - Do not place everyone in a particular ethnic group in the same category.

How to Become a Culturally Competent Provider

- **Consciousness of the impact of culture when we interact**
  - Respect cultural differences regarding physical distance and contact, eye contact, and rate and volume of voice.
  - Misinterpretations or misjudgments may occur.

- **Knowledge of member's culture**
  - Become familiar with aspects of culture.
  - Understand the linguistic, economic and social barriers that members from different cultures face which may prevent access to healthcare and social services.
  - Make reasonable attempts to collect race- and language-specific member information.

How to Become a Culturally Competent Provider

- **Adaptation of Skills**
  - Provide services that reflect an understanding of diversity between and within cultures.
  - Understand that members from different cultures consider and use alternatives to Western health care.
  - Consider the member and his or her family's background in determining what services are appropriate.
  - Consider the member and his or her family's perception of aging and caring for the elderly.
  - Treatment plans are developed with consideration of the member's race, country or origin, native language, social class, religion, mental or physical abilities, age, gender and/or sexual orientation.

Tips for Successful Cross-Cultural Communication

- Let the person see your lips as you speak.
- Be careful with your pronunciation.
- Project a friendly demeanor/attitude.
- Stick to the main point.
- Be aware of your assumptions.
- Emphasize or repeat key words.
- Don’t rush the person.
- Control your vocabulary; avoid jargon, slang, and difficult words.
- Listen carefully.
- Make your statement in a variety of ways to increase the chance of getting the thought across.
- Speak clearly but not more loudly.
- Write down key information for him or her to refer to later.

Interpreter Services

Members understand that they have access to medical interpreters, signers and teletypewriter (TTY) services to facilitate communication with no cost to them.

To arrange interpreter/translation services:

- Contact Member Services at:
  - 1-866-896-1844 / (TDD/TTY) 1-800-735-2989 or 7-1-1
    - As soon as possible, or at least 2 business days before the appointment.

Tips for Working with Interpreters

- Family and friends are not the same as a professional interpreter.
- Allow enough time for appointments involving interpreters.
- Speak directly to the member and not to the interpreter.
- Avoid jargon and technical terms.
- Keep your sentences short, pausing to allow for interpretation.
- Ask only 1 question at a time.
- Be prepared to repeat yourself in different words if your message is not understood.
- Check to make sure that your message is understood.

People with Disabilities

The Americans with Disabilities Act (ADA) defines a person with a disability as:

- A person who has a physical or mental impairment that substantially limits one or more major life activities.
  - This includes people who have a record of an impairment, even if they do not currently have a disability.
  - It also includes individuals who do not have a disability, but are regarded as having a disability.

Accommodating Patients with Disabilities

Physical Accessibility Guidelines:

- Parking: Adequate, marked accessible parking.
- Route: Access into the facility is stable, firm and slip resistant.
- Entry: Zero steps into the building/office, entry doors at least 34” wide, entry door with easy assist system, elevators located on the accessible route with Braille symbols and also audible signals for up and down directions.
- Restrooms: Large enough to accommodate a person with a wheelchair/scooter, entry doors at least 36” wide and easy to open, grab bars behind and to the wall side of the toilet, soap and towel dispenses 48” or less from the floor.
- Exam Room: On the accessible route with an entry door at least a 32” clear opening.

Accommodating Patients with Disabilities

Effective Communication

- Use of auxiliary aids and services such as qualified readers and/or interpreters, audio recordings, relay service, Braille, assistive listening devices, large print, captioning.

Accessible Medical Equipment

- Height adjustable exam tables.
- Hoyer-type lift available to transfer a patient onto an exam table.
- Wheelchair accessible weight scales.
- Moveable exam chairs.

Be Prepared – Know Your Patients!

- When scheduling the appointment, ask about accommodations that may be required.
- Record information in patient's charts or electronic health records.
- If making referrals to other providers that the patient may not have previously seen, communicate with the receiving provider regarding the necessary accommodations.

Medical vs. Independent Living Model

Medical Model	Independent Living Model
Decisions made by rehabilitation professional	Decisions made by the individual
Focus is on problems or deficiencies/disability	Focus is on social and attitudinal barriers
Having a disability is perceived as being unnatural and a tragedy	Having a disability is a natural, common experience in life

Person First Language

A person is not defined by his or her disability. Be conscious of how you address or refer to patients under your care.

Avoid	Instead, use
Handicap/Handicapped	Accessible Parking/Accessible Seating
Handicapped parking/seating	Accessible Parking/Accessible Seating
Stricken/Victim/Suffering from	Had or has a Disability
Retard/Mongoloid	Cognitive or Intellectual Impairment
Wheelchair bound/confined	Uses a wheelchair
Dumb/Deaf/Mute	Person with a Communication Disorder
The Deaf	A person who is Deaf
The Blind	A person/people who are blind

Disability Etiquette – Tips to Remember

Mobility Impairments	Don't push or touch someone's wheelchair. Don't lean on the chair. When possible, bring yourself down to their level to speak to them.
Visually Impaired	Identify yourself. Do not speak or touch a guide dog, who is working.
Deaf or Hard of Hearing	Speak directly to the person, not the interpreter. Do not assume they can read your lips. Do not chew gum, wear sunglasses or otherwise obscure your face.
Speech Disorders	Don't finish the person's sentences. Ask the person to repeat or you can repeat to make sure you understood.
Seizure Disorders	Do not interfere with the seizure; protect their head during the event. Do not assume they need you to call 911.
(MCS) Respiratory Disorders	Do not wear perfumes. Do not use sprays or chemicals. Maintain good ventilation.
Developmental Disabilities	Speak clearly using simple words. Do not use baby talk or talk down to the person. Do not assume they cannot make their own decisions unless you have been told otherwise.

Tips to Remember

Providers need to make reasonable accommodations for members, including but are not limited to:

- Providing large print (at least 16-point font) versions of all written materials to individuals with visual impairments.
- Ensuring that all written materials are available in formats compatible with optical recognition software.
- Reading notices and other written materials to patients upon request.
- Assisting patients with filling out forms over the telephone.
- Ensuring effective communication to and from individuals with disabilities through email, telephone, personal assistance and other electronic means.
- Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for persons who are Deaf.
- Providing individualized forms of assistance.

Model of Care

Model of Care: Goal

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

- 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 healthcare 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

Model of Care elements:

- Description of the STAR+PLUS MMP population
- Care coordination and care transitions protocol
- Provider network
- Quality measurements and performance improvement

Model of Care Process

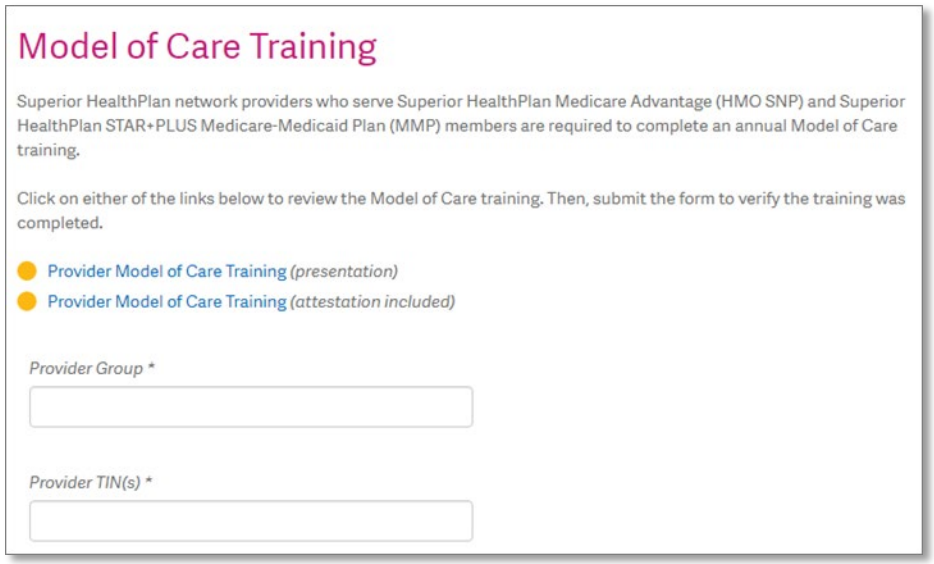
- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and, at a minimum, annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Service Coordination Program for follow-up.

Model of Care Process

- Superior values its partnership with network physicians and providers.
- The Model of Care requires that Superior and providers collaborate to benefit members by:
  - Enhancing communication between members, physicians, providers and STAR+PLUS MMP.
  - 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

- Model of Care information is available at: www.SuperiorHealthPlan.com/providers/training-manuals/model-of-care-form.html.
- Model of Care training is a CMS requirement for newly-contracted Medicare providers within 30 days of execution of their contract.
- The Model of Care training must be completed by each participating provider annually, during each calendar year.



Model of Care Training

Superior HealthPlan network providers who serve Superior HealthPlan Medicare Advantage (HMO SNP) and Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) members are required to complete an annual Model of Care training.

Click on either of the links below to review the Model of Care training. Then, submit the form to verify the training was completed.

- Provider Model of Care Training *(presentation)*
- Provider Model of Care Training *(attestation included)*

*Provider Group **

*Provider TIN(s) **

Quality Improvement Program

Quality Improvement

Quality Assessment and Performance Improvement (QAPI)

- Monitors quality of services and care provided to members:
  - Appointment availability audits
  - After-hours access

- Providers Participate in QAPI by:
  - Volunteering for Quality Improvement Committees
  - Responding to surveys and requests for information
  - Vocalizing opinions

- Quality Improvement Committee:
  - 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

Office Site Survey

Superior conducts site visits to the provider's/practitioner's office to investigate member complaints related to physical accessibility, physical appearance, etc.

Site visits conducted by Superior Representatives include but are not limited to:

- Staff information.
- Access for persons who are disabled.
- Licensure.
- Office policies/general information, in particular, verifying that a confidentiality policy is in place and maintained.
- Cultural competence.
- Physical accessibility (access, office hours, wait time, preventive health appointment).
- Physical appearance.
- Availability of emergency equipment.
- Medication administration/dispensing/storage of drug samples.
- Adequacy of medical records keeping practices.

Abuse, Neglect and Exploitation (ANE)

- Abuse:
  - Intentional mental, emotional, physical or sexual injury to a child with disabilities, or failure to prevent such injury.
- Neglect:
  - Failure to provide a child with food, clothing, shelter and/or medical care, and/or leaving a child in a situation where the child is at risk of harm. Children with disabilities results in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care and personal hygiene.
- Exploitation:
  - Misuse of a child with disabilities for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account, and taking property and other resources.

How to Report ANE

Providers must report any allegation or suspicion of ANE to the appropriate entity:

- Department of Family and Protective Services (DFPS)
  - To report a child who has a disability, receiving services from:
    - Home and Community Support Services Agencies (HCSSAs).
    - An unlicensed foster care provider with 3 or fewer beds.
    - A child with disability or child residing in or receiving services from local authority, local mental health authority (LMHAs), community center or mental health facility operated by the Department of State Health Services (DSHS).
    - A child with disability receiving services through the Consumer Directed Services option.
  - Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free at 1-800-252-5400.

How to Report ANE

- HHS
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities
    - Assisted living facilities
    - HCSSAs – also required to report any HCSSA allegation to DFPS
    - Day care centers
    - Licensed foster care providers
    - Phone: 1-800-647-7418
- Local Law Enforcement:
  - If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.

Claims Submissions

Claims Filing: Important Definitions

- Clean Claim – A claim for services rendered to a member with the data necessary for Superior to adjudicate and accurately report the claim.
- Adjusted or corrected claim – A provider is changing the original claim.
- 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.

Note: Effective January 1, 2020, medical eye services provided by an ophthalmologist will be submitted to Superior HealthPlan for processing.

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 HealthPlan 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: www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html.
  - For first-time claims, mail them to:
    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims
    P. O. Box 3060, Farmington, MO 63640-3822
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) (or Atypical ID) are all required when billing Superior claims.

Corrected Claims Filing

- Must reference original claim number from explanation of payment (EOP).
- Must be submitted within 120 days of adjudication paid date.
- Resubmission of claims can be done via your clearinghouse or through Superior's 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" and 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 web portal.
  - To send individual claim adjustments through the web portal, log-in to your account, select claim and then the Correct Claim button.

Corrected Claims Filing

- Corrected or adjusted paper claims can also be submitted to:

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

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 HealthPlan STAR+PLUS MMP
    Attn: Claims
    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 website.
- 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 HealthPlan 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, Texas Medicaid Benefit Card (TMBC), TMHP documentation, call log, etc.
- Overnight or certified mail receipt as proof of timely filing.
- Centene electronic data interchange (EDI) acceptance reports showing the claim was accepted by Superior.
- Prior authorization number and/or form or fax.

Billing the Member

It is imperative that providers verify benefits, eligibility and cost shares each time a Superior member is scheduled to receive services.

- Providers may NOT balance bill members for covered services.
- Superior reimburses only those services that are medically necessary and a covered benefit; an EOP is provided that will detail reimbursement for each claim submitted.
- Additional details can be found in your provider contract with Superior HealthPlan.

Superior HealthPlan Departments

Provider Complaints

Superior offers a number of ways to file a complaint.

- Visiting www.SuperiorHealthPlan.com/contact-us/complaint-form-information.
- Faxing or mailing a complaint form to Superior. The link to the printable complaint form is available at: www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.
  - Mail: Superior HealthPlan
    ATTN: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
  - Fax: 1-866-683-5369
- Calling the provider hotline at 1-877-391-5921.

Provider Services

The 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.

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

- You can contact Provider Services Monday through Friday, 8:00 a.m. to 5:00 p.m. local time, at 1-877-391-5921.

Account Management

Account Managers are here to assist you with:

- Face-to-face orientations.
- Face-to-face provider portal training.
- Office visits to review ongoing claim trends.
- Provider trainings.

To view a map than can assist you with identifying the field office you can call to get in touch with your Account Manager, visit www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html.

Network Development

A centralized dedicated 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 Health, Superior HealthPlan Advantage) to existing Superior contracts.
- Checking status of submission of any contract requests.

Contract Packets can be requested online:

- Visit www.SuperiorHealthPlan.com, select link “For Providers” and then “Network Request or Update”. Follow the instructions to submit a request.

Secure Provider Portal - Submitting Claims

Provider Portal and Website

Superior HealthPlan 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 gain access to the full site.

- Secure Provider Portal:
  - Up-to-date member eligibility and Service Coordinator assignment.
  - Claim submission portal where you can submit claims for free.
  - A claim wizard tool that walks you through filling in a claim to submit online.
  - Claim status and payment information.
  - Check the status of an authorization.

- Public Site:
  - View our Provider Directory and online lookup.
  - Locate the field office number of your Account Manager.
  - Review current and archives of newsletters, bulletins, the Provider Manual and links to important sites to keep you up-to-date on any new changes that may affect you.

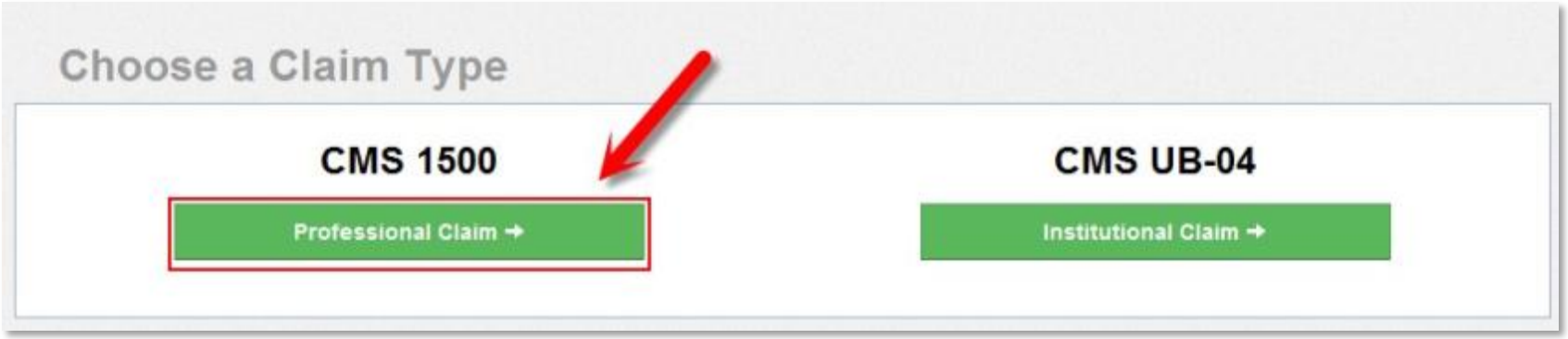
Registration

To register, visit Provider.SuperiorHealthPlan.com/sso/login.

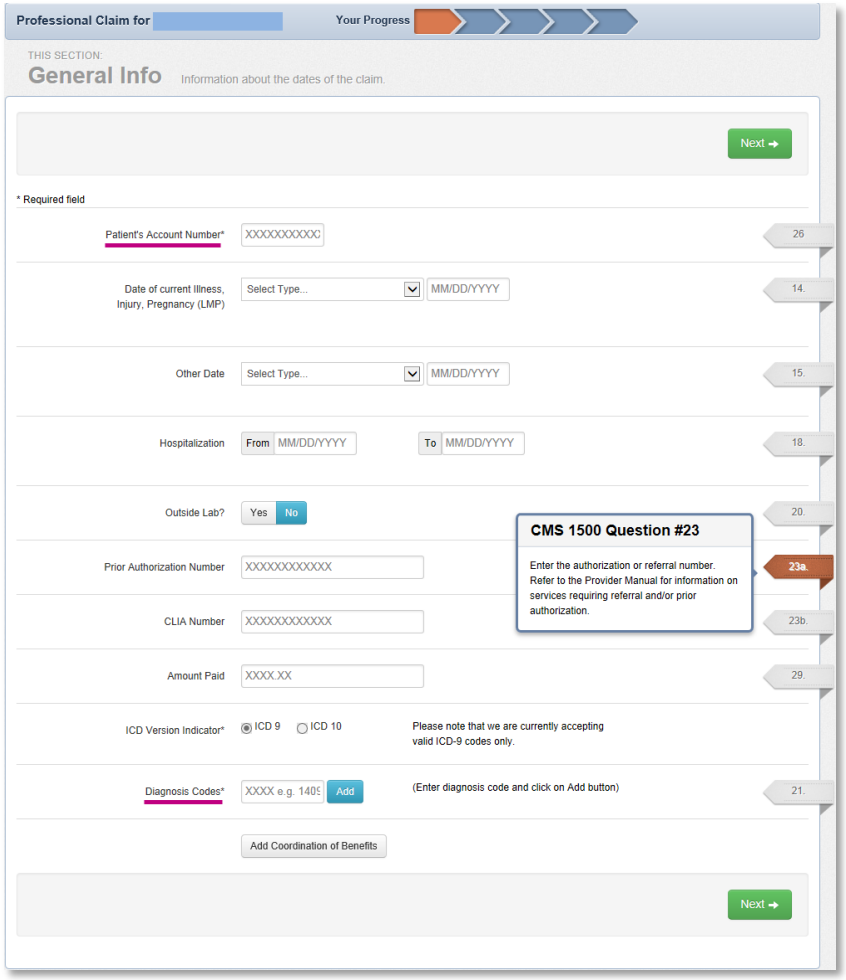
- A user account is required to access the provider secure area.
- If you do not have a user account, click **Register** to complete the 4-step registration process.

Create Professional Claims

- Choose a Claim Type.
- Select **Professional Claim.**



General Information



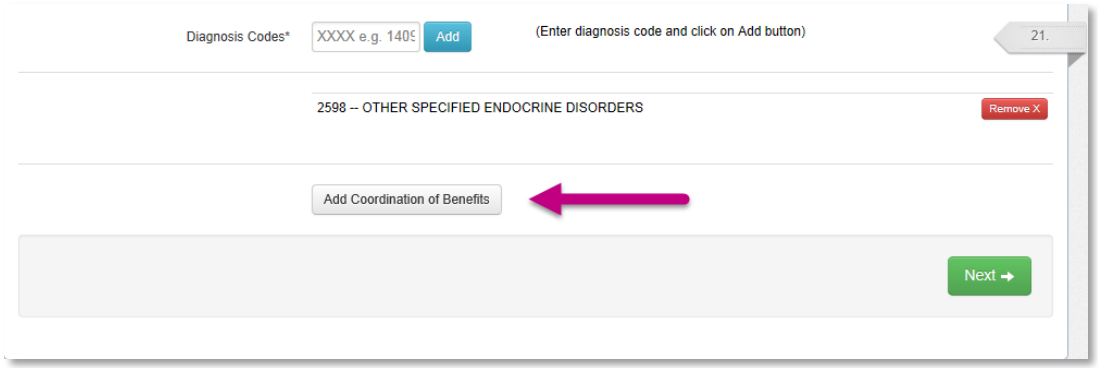
Required Fields:

- ✓ **Patient Account Number**
- ✓ **Diagnosis Codes**

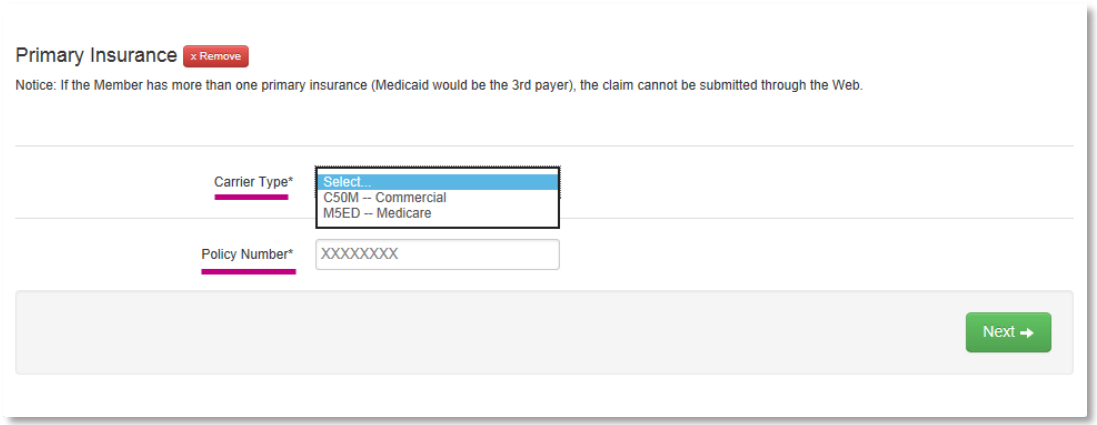
Enter other pertinent information for the claim as necessary.

Use any of the field tabs to get details for what information should be entered.

Coordination of Benefits



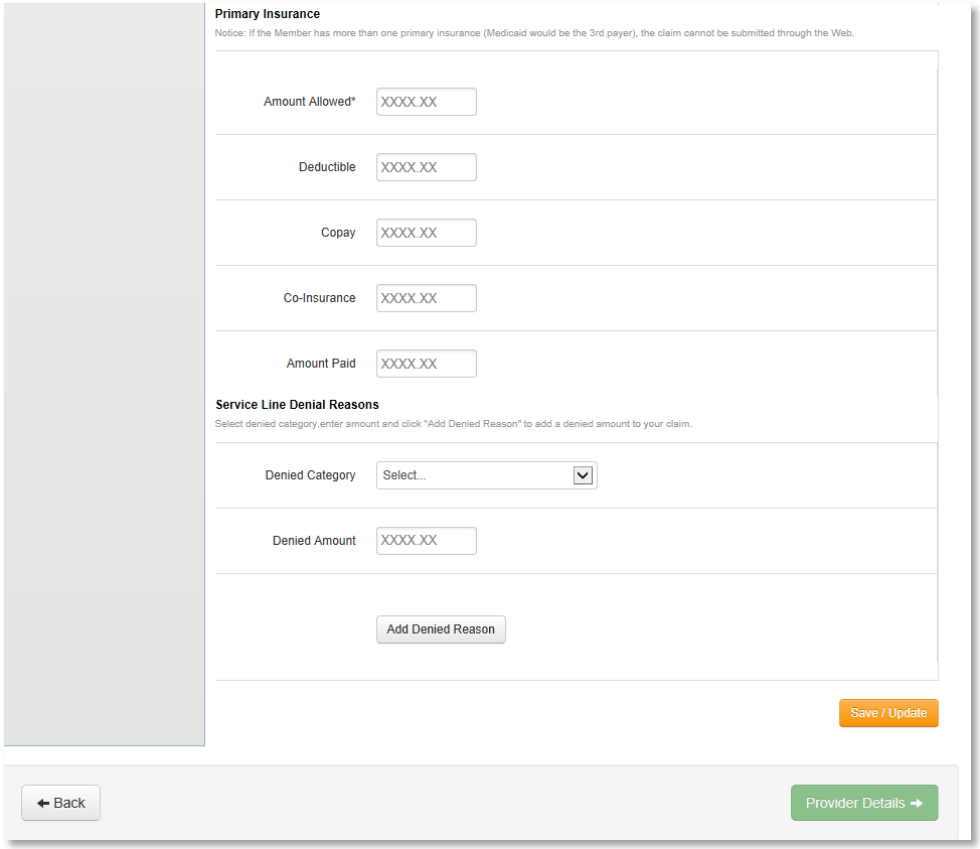
Use the **Add Coordination of Benefits** button to include primary insurance information, when applicable.



New fields will appear to enter the **Carrier Type** and the **Primary Insurance Policy Number**.

Please note: If the member has more than one primary insurance (Medicaid would be the third payer), the claim cannot be submitted online.

Coordination of Benefits

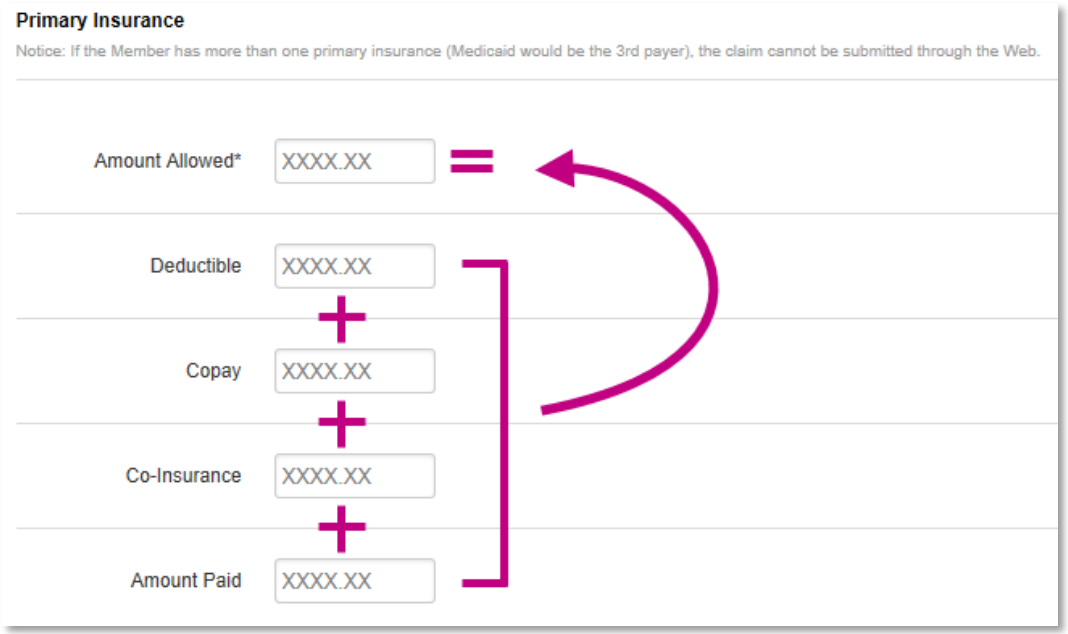


The **Primary Insurance** and **Service Line Denial Reasons** fields will be present when Coordination of Benefits is selected at step one. Complete based on the primary insurance EOP.

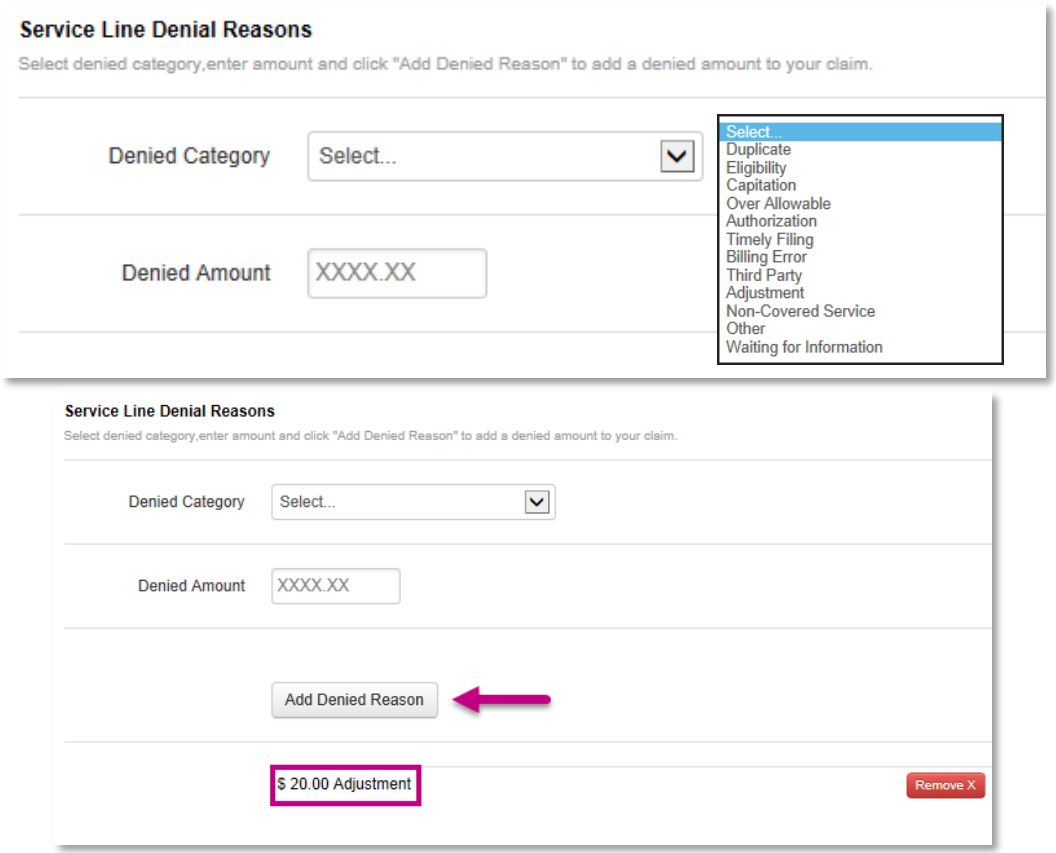
Coordination of Benefits

The **Primary Insurance** fields perform a calculation to help ensure accuracy when billing.

Deductible + Copay + Co-Insurance + Amount Paid = Amount Allowable



Coordination of Benefits

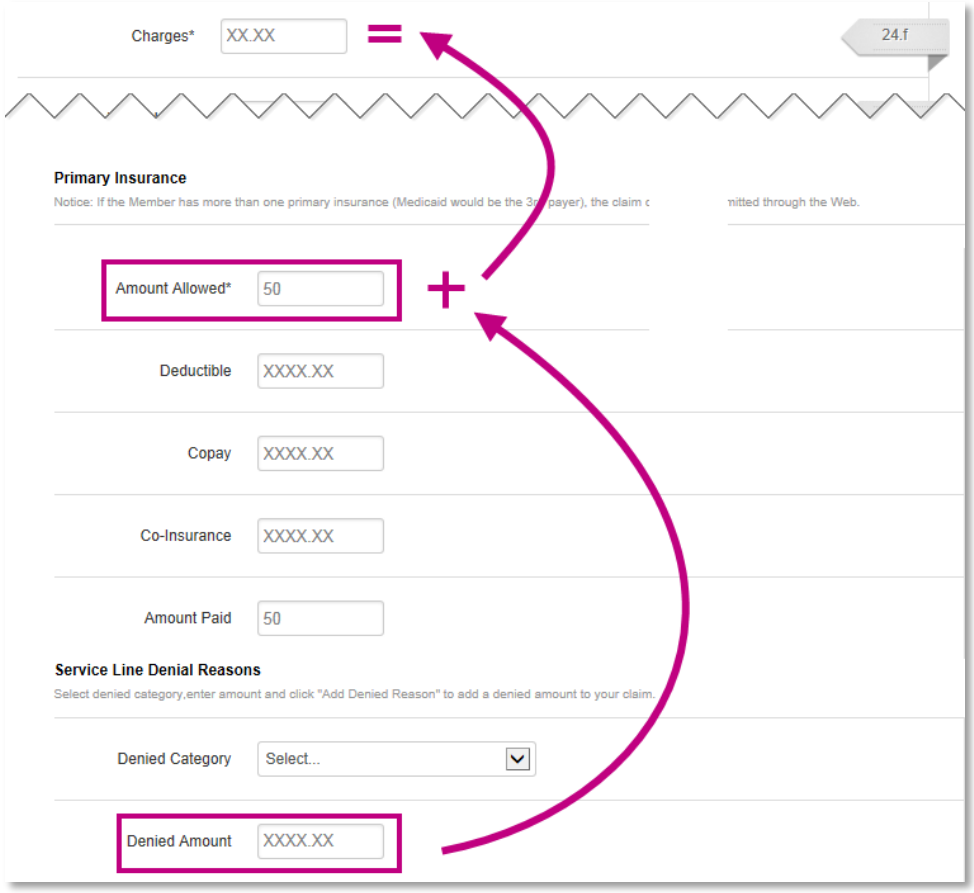


Service Line Denial Reasons are used to indicate instances where the **Amount Allowed** is less than the **Charges**. These can be indicated using the drop down menu and entering the denied amount.

Add Denied Reason must be clicked to include the **Denied Category** and **Denied Amount**.

A new line will be created when the **Denied Category** has been successfully added to the service line.

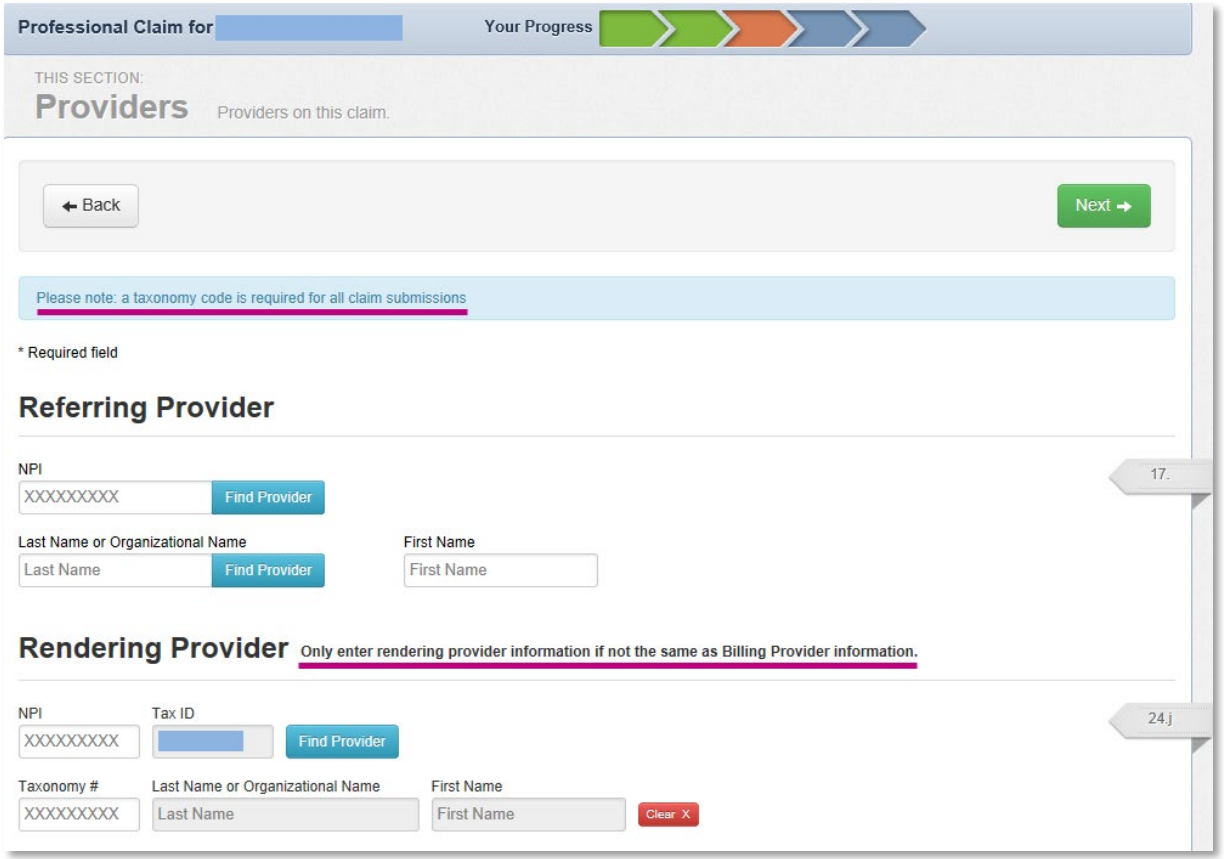
Coordination of Benefits



Final Calculations: Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

*Please note: **Denied Category** and **Denied Amount** are not required and can be left blank when appropriate.*

Referring and Rendering Provider

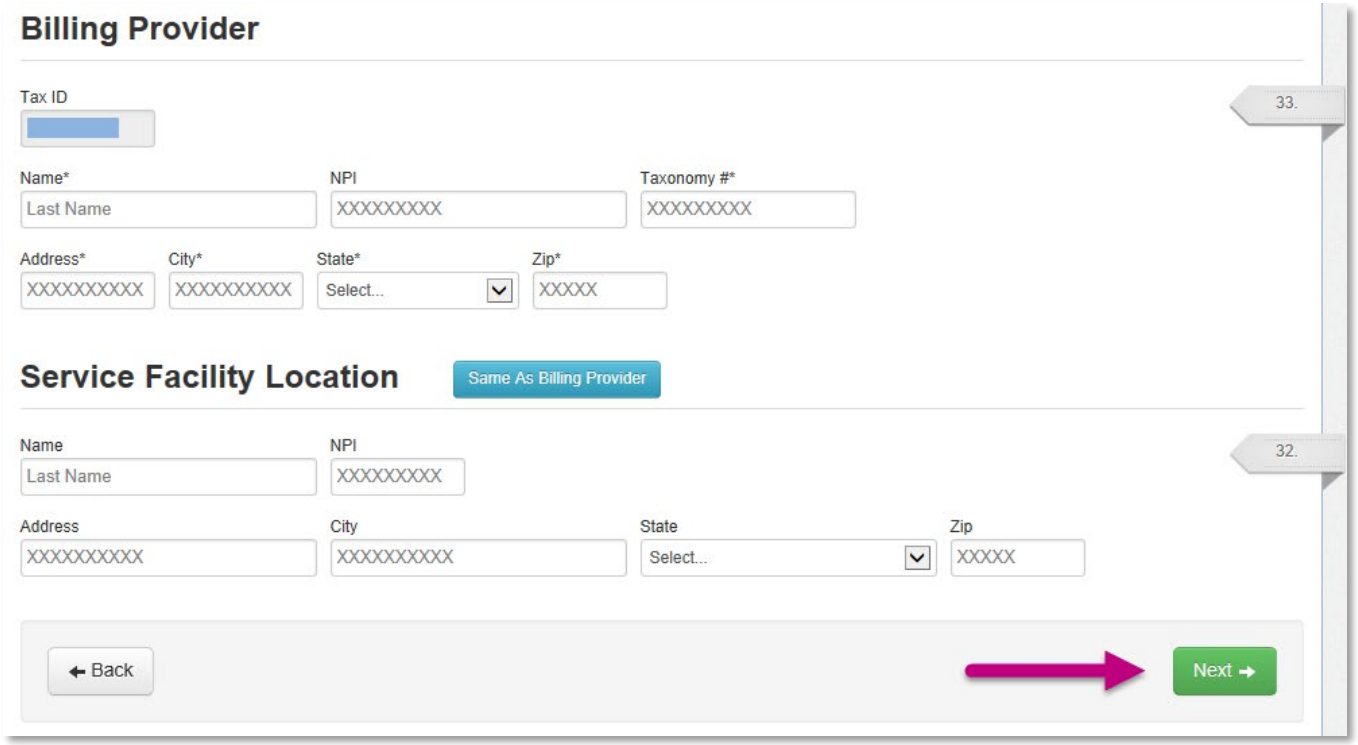


Enter pertinent provider information for **Referring** and **Rendering Provider**.

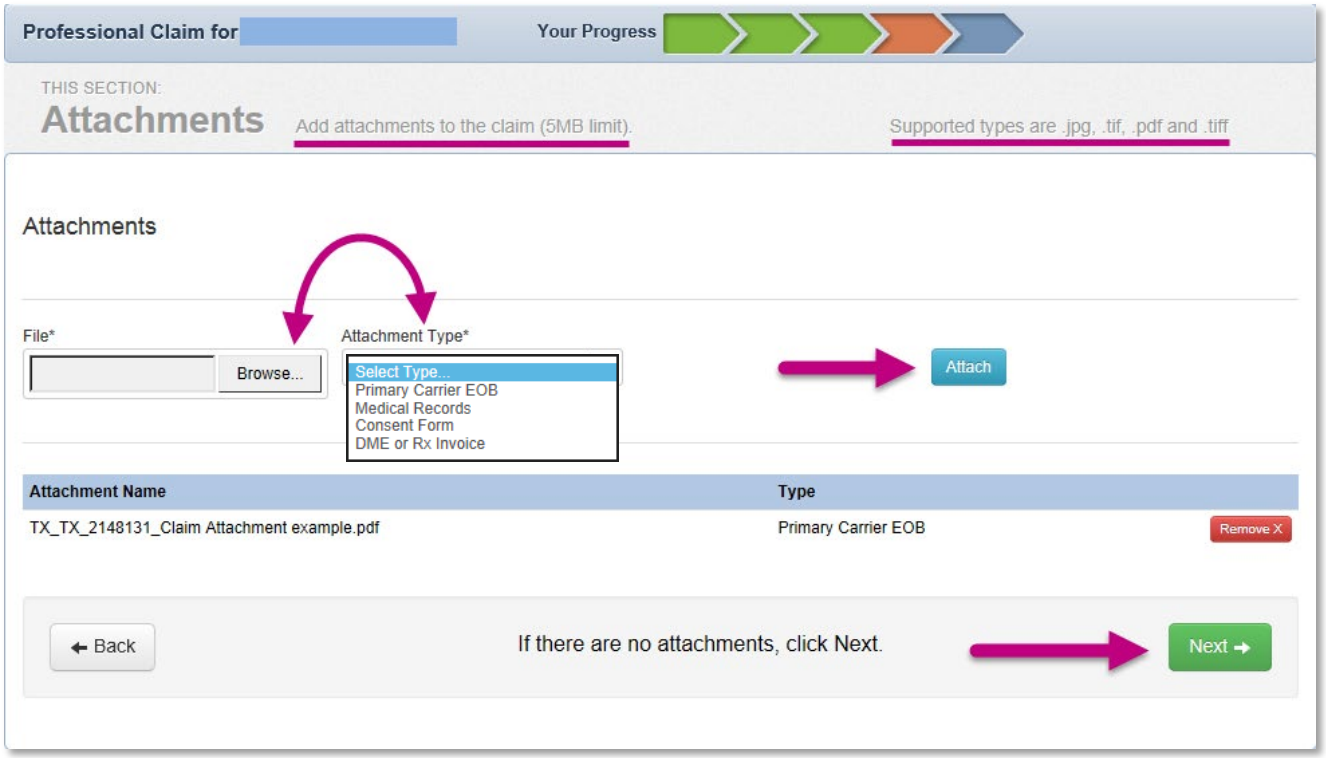
Please note: Only enter **Rendering Provider** information if it is not the same as **Billing Provider** information.

Billing Provider Section

In the **Billing Provider** section, enter the required information. Under **Service Facility Location**, enter the necessary information or click **Same as Billing Provider** to automatically copy the billing provider information into the service facility fields.



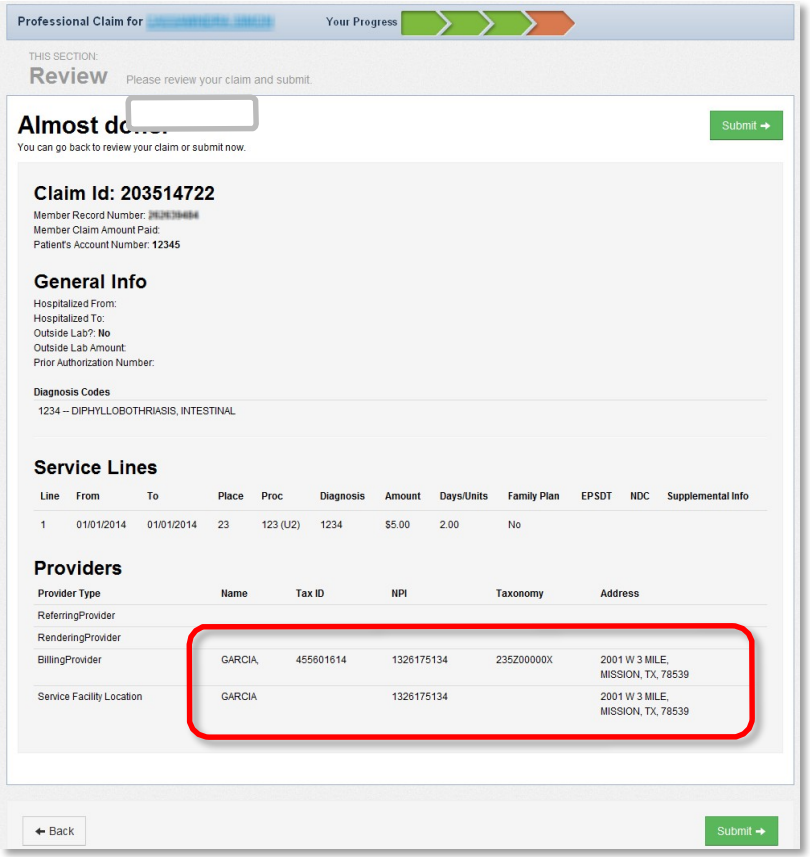
Attachments



Add attachments, if applicable. **Browse** for the document, select an **Attachment Type**, and then **Attach**. If there are no attachments, click **Next**.

Please note: There is an attachment upload limit of 5MB.

Review and Submit

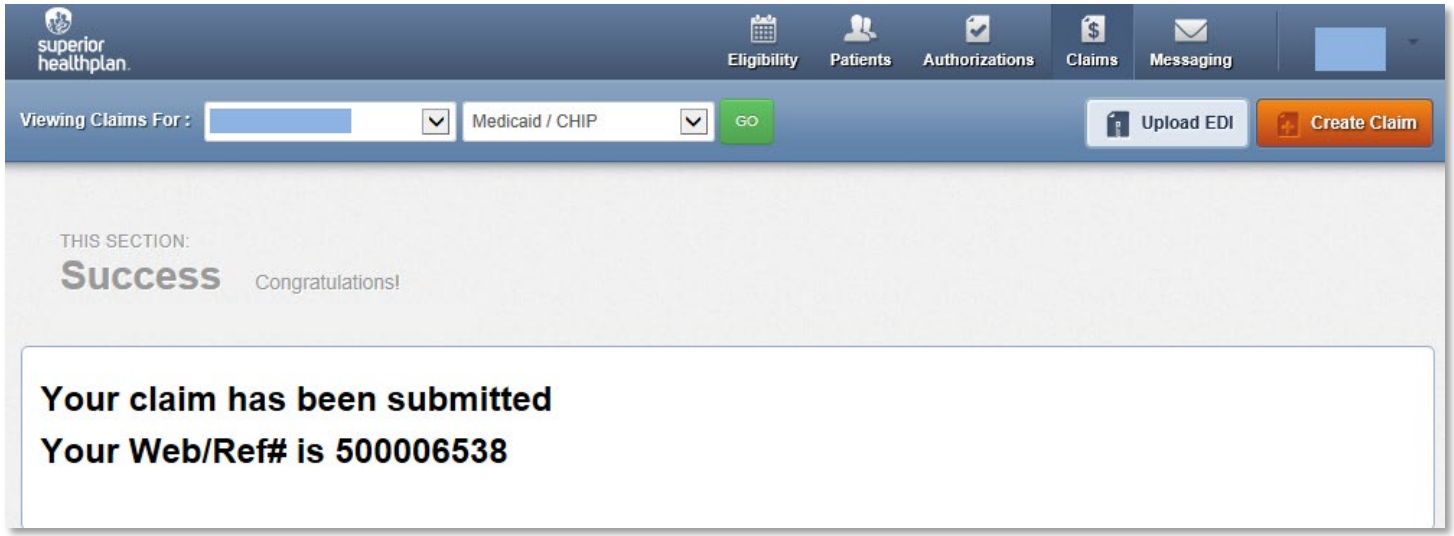


Review to ensure that all information is correct.

- If information is incorrect, click **Previous Step** to move to the section that needs changes and change the information within the section.
- If all information is correct, click **Submit Claim** and the claim will be transmitted. A “Claim Submitted” confirmation will be displayed.

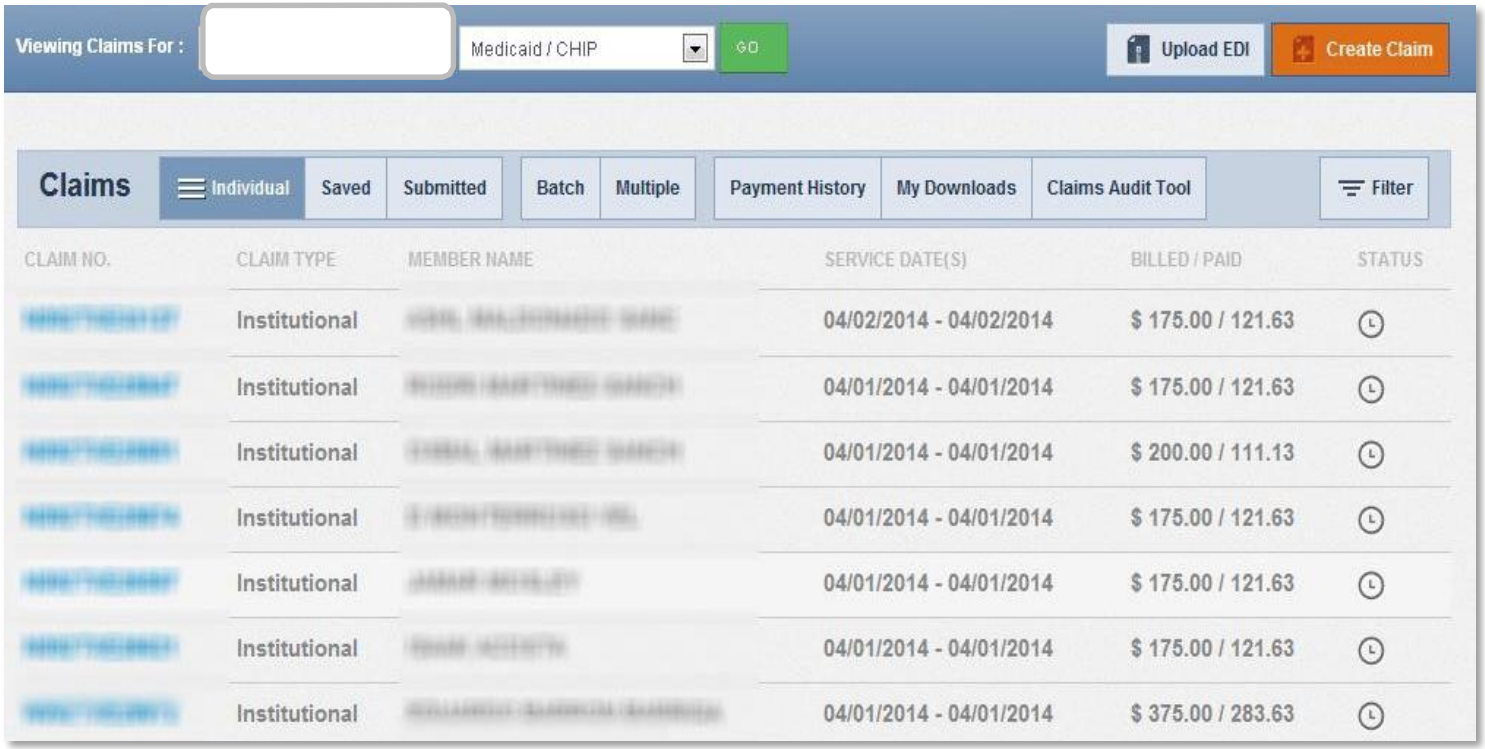
Claim Submitted Successfully!

Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Provider Services Representative.

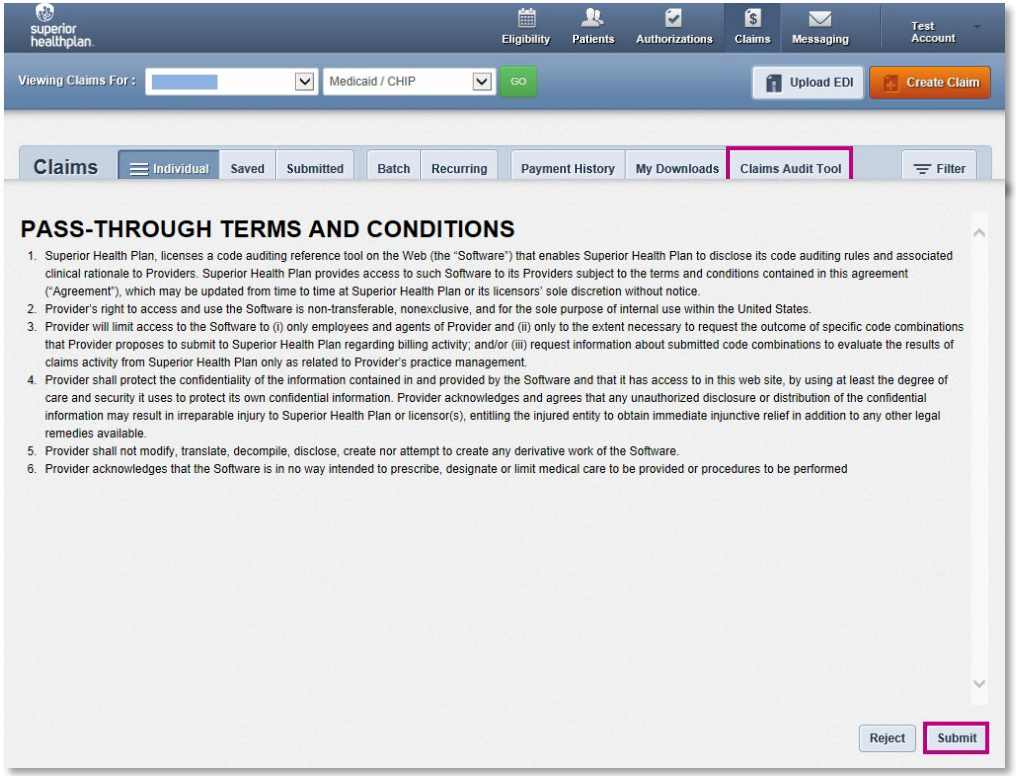


Checking Claim Status

Claims status can be viewed on claims that have been sent EDI, paper or provider portal.



Claims Audit Tool

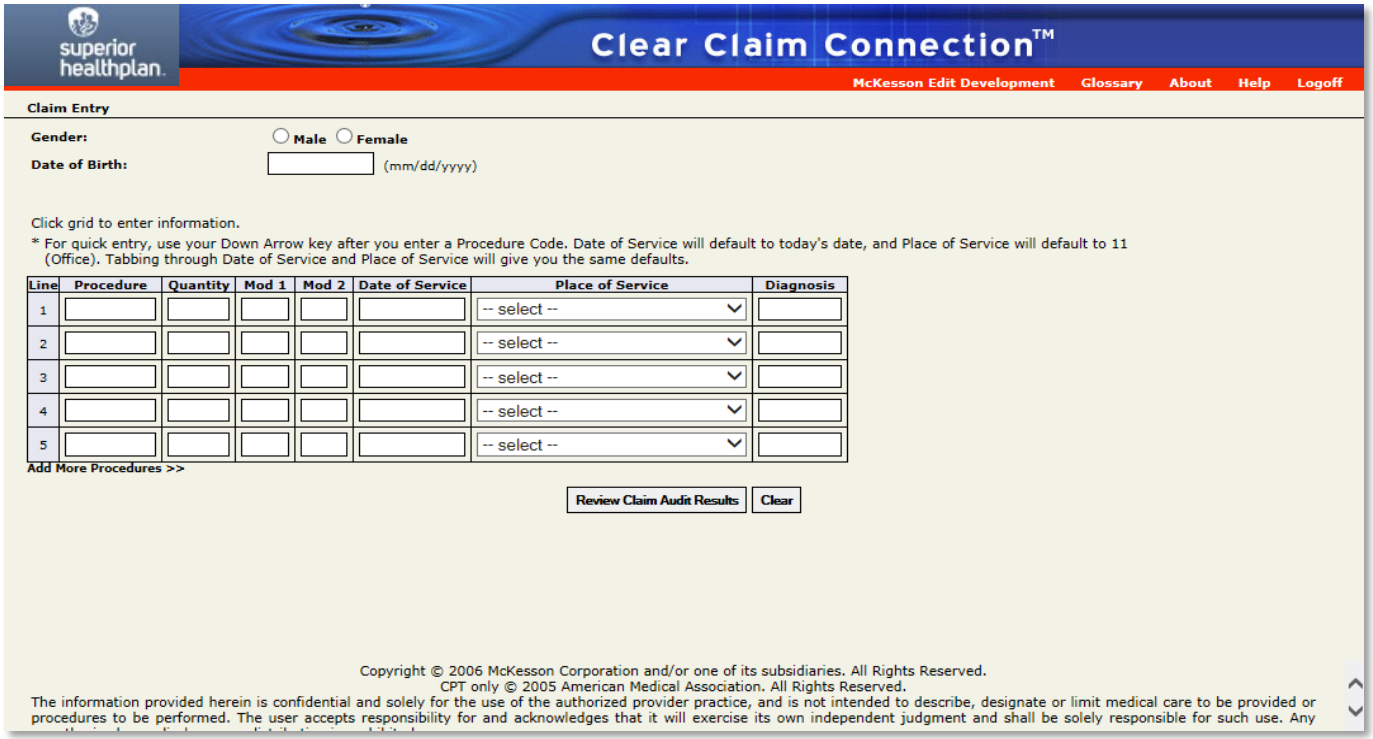


Select the **Claims Audit Tool**.

Click **Submit** to enter the **Clear Claim Connection** page.

Claims Audit Tool

Test claim coding by entering core information to be audited before submitting the live claim.



Questions and Answers

Let us know what we can do to help.
Thank you for attending!