



superior
healthplan™

Nursing Facility Provider Training

Last updated February 2022

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 (HHS) 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, Wellcare By Allwell, 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) 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.



Services, Benefits and Prior Authorizations

Nursing Facility Unit Rate



- The Nursing Facility Unit Rate means the types of services included in the HHS 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: HHS will authorize the daily rate. HHS 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, Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)
 - Customized Power Wheel Chairs (CPWC)
 - Augmentative Communication Device (ACD)
 - Non-Emergent Medical Transportation
 - Ventilator care*
 - Tracheostomy care*
- All add-on services require a prior authorization 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.

STAR+PLUS Non-Urgent Transportation



- Superior's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- For nursing facility members, this program is only available for dialysis appointments.
- Superior's Medical Ride Program may also reimburse mileage for the client, a caregiver/medical consenter, friend or someone else to take the client to healthcare services if the trip is scheduled in advance and the driver abides by the program's guidelines.
- Transportation services are provided by SafeRide.
- Appointments must be made at least two business days in advance and can be requested Monday through Friday, 8:00 a.m. – 5:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).
- For questions, concerns or complaints about SafeRide, Superior medical providers and nursing facilities can contact 1-855-932-2322 (Monday through Friday, 8:00am – 6:00pm CST) for assistance.

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](https://Provider.SuperiorHealthPlan.com)
 - 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](https://Provider.SuperiorHealthPlan.com)
 - 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]).

A screenshot of a web-based authorization form. The form is divided into two main sections: "Authorization For" and "Enter Authorization". The "Authorization For" section contains patient information (GLAESER, JENSON, DOB: 02/25/2019, MEDICAID NBR: 731635819) and three text boxes with instructions. The "Enter Authorization" section has a "1. PROVIDER REQUEST" step with a "Urgent Request" checkbox and a "Select a Service Type" dropdown menu. The dropdown menu is open, showing a list of service types, with "Therapy-Evaluation" and "Therapy-Treatment" highlighted. The "2. SERVICE LINE" and "3. FINISH UP" steps are also visible.

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 Claims Filing



- 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 the Texas Medicaid & Healthcare Partnership (TMHP) portal, which will redirect to Superior.
- HHS 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 HHS 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 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 HHS to submit claims.
 - You must use your valid HHS 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 HHS, 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 skilable 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 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.

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



- 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.

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, Texas Medicaid Benefit 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 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 **Create New Account** to complete the registration process.



Create Your Account

Let's get started - creating an account is quick and easy.

Email

First Name

Last Name

Language Preference

English



Password



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.

A screenshot of the Superior Healthplan web interface. At the top, there's a header with "Viewing Patients For:" followed by a dropdown menu showing "Medicaid / CHIP" and a "Find Patient" button. Below this is a "Reports" section with a "Reports" button. A red arrow points to the "Medicaid Recertification Report" link in the list of reports. The list also includes "Community Physicians of Superior Health Plan Headquartered in Austin, Texas" and "Family Practice All Provider Scorecard".

GROUP NAME	DOCUMENT TITLE	DOCUMENT NAME	REPORT DATE
	Medicaid Recertification Report	Medicaid_Recert_Report_001049003.xls	2018-02-28
Community Physicians of Superior Health Plan Headquartered in Austin, Texas	Family Practice All Provider Scorecard	TEST_JG_REALLY_LONG_FILE_NAME_EXAMPLE_ALL.pdf	2014-01-21

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.
- Work with the nursing facility discharge planning staff to plan discharge and transition from the nursing facility.

Service Coordinator and Nursing Facility Staff



- The Service Coordinator will partner 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 of any discharge plans or requests
 - 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:
 - 1-877-277-9772

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
 - 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
