



By



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Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

Effective January 1, 2026, in Dallas
and Hidalgo Counties

Agenda



- Wellcare By Superior HealthPlan
- Eligibility
- Provider Roles and Responsibilities
- Member Benefit and Covered Services
- Prior Authorization, Notification and Referrals
- Service Coordination
- Claims and Payment Processing
- Electronic Visit Verification
- Appeals
- Pharmacy
- Secure Provider Portal
- Model of Care
- Network Partners
- Advance Directives
- Fraud, Waste and Abuse
- Partnering with Wellcare By Superior HealthPlan

Wellcare By Superior HealthPlan



Wellcare By Superior HealthPlan Duals FIDE SNP – Integrated Care for Dual Eligible Members



- Effective January 1, 2026, the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) will launch in Dallas and Hidalgo Counties.
- These plans combine Medicare (Wellcare By Allwell) and Medicaid (Superior HealthPlan) benefits, offering comprehensive coverage and additional services for people with specific health needs or disabilities.
- Care Coordination is a key focus of the FIDE plan, offering unified case management and service coordination under one team to support complex-care Members.
 - Each Member will have one assigned Service Coordinator.

Wellcare By Superior HealthPlan Duals FIDE SNP – Integrated Care for Dual Eligible Members

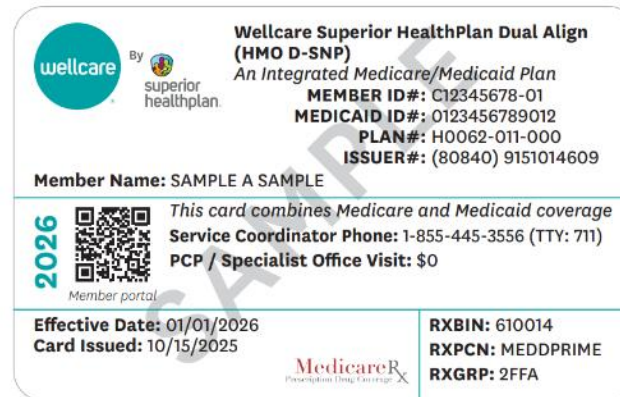


- Members will have Medicare and Medicaid coverage under one integrated plan.
- Medicare covers:
 - Inpatient services such as hospital visits and short-term skilled nursing facilities
 - Outpatient services such as doctor visits, diagnostics tests, and home health care
 - Prescription drugs
 - Other supplemental benefits may also be covered
- Medicaid covers:
 - Long-term nursing home expenses, personal care in home, and other support services
 - Behavioral health coverage above and beyond Medicare
 - May also cover cost shares for services not fully covered by Medicare and Part B premiums

Wellcare By Superior HealthPlan Duals FIDE SNP – Integrated Care for Dual Eligible Members



- Members receive one ID card, one care team, and one Provider network.
 - The Member ID cards will show the plan name as Wellcare Superior HealthPlan Dual Align (HMO-DSNP).



- This program focuses on improved care coordination, streamlined authorizations, and reduced administrative burden.

What is an AIP?

- Superior's FIDE SNP program is also an Applicable Integrated Plan (AIP).
 - This requires exclusively aligned enrollment, i.e., Members enrolled in a DSNP must be within the same organization.
 - AIPs streamline the insurance experience for both members and providers.
 - AIPs also require a unified appeals and grievances process for Medicare and Medicaid.
- Please note, not all dual eligible members will be through an AIP. Some members may be covered by standalone Medicare and Medicaid products.
- Please ensure to verify eligibility and coverage prior to rendering services.
- For additional information on the different plans, please access the **Wellcare D-SNPs Key Differences Guide (PDF)** in the *Quick Reference Guides* section of [Superior's Wellcare webpage](#).



Deeming Period



- CMS requires FIDE SNP plans to provide a member a period of up to six months to allow those FIDE SNP members who have lost Medicaid eligibility or had a change in status an opportunity to regain their eligibility.
 - This period is called the “Deeming Period.”
- Wellcare By Superior HealthPlan has a **six-month** Deeming Period for our FIDE SNP plans.
- During this time, the member is **not eligible** for Medicaid benefit coverage; however, for members in our Wellcare By Superior HealthPlan plan, we will continue to cover the cost share for the duration of the deeming period.

Deeming Scenarios



Scenario	Medicare Eligibility	Medicaid Eligibility	Claim / Cost-Share
<p>D-SNP Member loses Medicaid...</p> <p>Regains their eligibility within Deeming Period</p>	<ul style="list-style-type: none"> Active throughout Deeming period 	<ul style="list-style-type: none"> Termed during Deeming Reinstated based on State file, with effective date as 1st of the following month 	<ul style="list-style-type: none"> Medicaid claim denied for no eligibility during Deeming Medicare cost share is covered Full Medicare allowable paid
<p>D-SNP Member loses Medicaid...</p> <p>Does NOT regain their eligibility</p>	<ul style="list-style-type: none"> Active throughout Deeming Involuntary disenrollment after Deeming Period ends 	<ul style="list-style-type: none"> Termed during Deeming and Member remains termed 	<ul style="list-style-type: none"> Medicaid claim denied for no eligibility during Deeming Medicare cost share is covered Full Medicare allowable paid
<p>D-SNP Member moves from Full Dual to Partial Dual...</p> <p>Does NOT regain their Full Dual eligibility</p>	<ul style="list-style-type: none"> Active throughout Deeming Involuntary disenrollment after Deeming period ends or until Member signs up with other DSNP options available to partial dual eligible plan (whichever is sooner) 	<ul style="list-style-type: none"> Medicaid record is not termed 	<ul style="list-style-type: none"> Medicaid claim denied for no eligibility during Deeming Medicare cost share is covered Full Medicare allowable paid

Eligibility



Member Eligibility



To enroll in a Wellcare By Superior HealthPlan, individuals must:

- Permanently reside in the Wellcare By Superior HealthPlan service areas (incarcerated individuals are not considered living in the service area, even if they are physically located in it)
- Have both Medicare Part A and Medicare Part B
- Be a U.S. citizen or lawfully present in the United States
- Be 21 years of age or older
- Are currently eligible for STAR+PLUS and at least one of the following:
 - Have a physical or mental disability and qualify for Supplemental Security Income (SSI)
 - Qualify for STAR+PLUS because they receive Home and Community-Based Services (HCBS)

About Dual-Eligible Members



- Dual-eligible members may be more vulnerable and have more complex care needs than members who are enrolled in only Medicare or Medicaid.
- Factors that can lead to dual-eligibility include:
 - Demographic data including age
 - Income level
 - Disability status
 - Diagnosed clinical conditions
 - Social determinants of health
- Awareness of which factors apply to your dual-eligible patients is critical to understanding their care needs.

Provider Role and Responsibilities



Primary Care Provider Responsibilities



- Serve as a “Medical Home.”
- Responsible for the coordination of care and referrals to specialists that are within the Wellcare By Superior HealthPlan network.
- Verify Member eligibility and prior authorization approval prior to rendering services.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.
- After-hours calls should be documented in an after-hour call log and transferred to the member’s medical record.
- Cooperate with all Quality Improvement activities.
- See members for initial office visit and assessment within 90 Calendar Days of enrollment into plan.

Clinical Best Practices



- Engage the patient
 - Outreach to members without visit, or in need of follow-up care
 - Encourage regular preventive care
 - Initiate needed screenings and routine monitoring
 - Keep track of medication adherence
- Take advantage of value-added services such as:
 - Dental/vision coverage
 - Hearing exams/hearing aids
 - Transportation benefits
 - Telehealth
 - Fitness programs
 - Meal programs
 - In-home support

Interdisciplinary Care Team



- The purpose of the Interdisciplinary Care Team (ICT) is to collaborate with the member and their support team (PCP, Specialists, etc.) to ensure care is coordinated, person-centered, and aligned with the member's unique goals, preferences, and needs.
- As part of the ICT process, providers are responsible for:
 - Accepting invitations to attend member's ICT.
 - 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 Service Coordinator, the ICT, members and caregivers.
- Wellcare By Superior HealthPlan's Service Coordinators (SCs) work with the member to encourage self-management of their condition and communicate the member's progress toward these goals to the other members of the ICT.

Interdisciplinary Care Team



- The ICT is comprised of the following core members:
 - Member an/or authorized representative
 - PCP
 - Family and/or caregiver, if approved by the member
 - Service Coordinator
 - Specialist if member has needs outside of the PCP
 - Community Resources



Responsibilities of the ICT



- 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 the member.
- The development and implementation of ICP 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.

Coordination of Care Between Medical and Behavioral Health Providers



- Communication between Behavioral Health providers and PCP is critical to maintain continuity of care, member safety, and member well-being.
- PCPs and Behavioral Health Providers may offer services within their licensed scope of practice.
- Behavioral Health Providers must use the latest Diagnostic and Statistical Manual of Mental Disorders (DSM) for assessments and document diagnoses and outcomes in the member's medical record.
- Behavioral Health Providers are encouraged to submit, with the member's or the member's legal guardian's consent, an initial and quarterly summary report of the member's behavioral health status to the PCP.
 - Communication with the PCP should occur more frequently if clinically indicated.
- If a member's medical or behavioral condition changes, Wellcare By Superior HealthPlan expects that both PCPs and Behavioral Health Providers will communicate those changes to each other, especially if there are any changes in medications that need to be discussed and coordinated between providers.

Appointment Availability Standards

PRIMARY CARE AND SPECIALIST

Type of Appointment	Access Standard
Urgent	Within 24 hours
Non-Urgent	Within 7 Business Days
Regular/Routine Services	Within 30 Business Days
After-Hours Care	24 hours/day, 7 days/week
Appointment Wait Time	Not to exceed 15 minutes

BEHAVIORAL HEALTH

Type of Appointment	Access Standard
Non-Life-Threatening Emergency	Within 6 hours
Urgent Care	Within 48 hours
Post-Inpatient Discharge	Within 7 Business Days
Initial Routine Care	Within 10 Business Days
Routine Care Follow-Up	Within 30 Calendar Days



Provider Directory Updates



- Having access to accurate provider demographic information is vitally important to Wellcare By Superior HealthPlan members to ensure they can obtain the care needed.
- Make sure your demographic information is up-to-date.
 - Notify Superior of any changes (ex. service locations or telephone number updates), including if you can no longer accept new patients or if you are leaving the network.
- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 - Login to Wellcare By Superior HealthPlan’s [Secure Provider Portal](#)
 - From the main tool bar, select “Account Details”
 - Select the Provider whose data you want to update
 - Choose the appropriate service location
 - Make appropriate edits and click “Save”

Member Benefits and Covered Services



Member Benefits and Covered Services



- Wellcare By Superior HealthPlan offers a comprehensive benefit package to members who are eligible for Medicare and full Medicaid benefits.
- Wellcare By Superior HealthPlan integrates Medicare and Medicaid benefits, including Long-Term Services and Supports (LTSS), behavioral health, and preventive care.
- Covered services are based on medical necessity and must meet professionally accepted standards of care.
- Covered services include, but are not limited to:

Primary and Specialty Care	Dental Services	Skilled Nursing Facility Care	Hearing Services
Hospital Services	Behavioral Health Services	Prescription Drugs	Emergency and Urgent Care
Home Health and Personal Care Services	Physical, Speech and Occupational Therapies	DME and Medical Supplies	Care Coordination and Case Management
Family Planning	Podiatry and Chiropractic Care	Transportation Services	Preventive Services
Vision Services	Long-Term Services and Supports	Home and Community-Based Services	Second Medical Opinions

Long-Term Services and Supports



- LTSS benefits include, but are not limited to:
 - Personal Assistance Services (PAS)
 - Day Activity and Health Services (DAHS)
 - Home and Community Based Services (HCBS) include, but are not limited to:

Adaptive Aids and Medical Supplies	Emergency Response Services	Mental Health Rehabilitation Services	Respite Care Services
Adult Foster Care	Employment Assistance	Mental Health Targeted Case Management	Supported Employment
Assisted Living Facility	Financial Management Services	Minor Home Modifications	Transitional Assistance Services
Dental Services	Home Delivered Meals	Personal Assistance Services	Supplemental Transition Services

- All LTSS services require prior authorizations.
 - All requests should be faxed to the LTSS Service Coordination Department at [1-866-895-7856](tel:1-866-895-7856).

Behavioral Health



- Wellcare By Superior HealthPlan is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance use disorder Providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals, and Local Mental Health Authority (LMHA) facilities.
- Behavioral Health and Substance Use Disorder benefits include, but are not limited to:
 - Individual, group, and family therapy
 - Psychiatric evaluations and medication management
 - Care coordination and case management
 - Group or individual counseling by a qualified clinician
 - Treatment of drug abuse Subacute detoxification in a residential addiction program
 - Opioid Treatment Program (OTP) services

Please Note: Some behavioral health services may require Prior Authorization.

Value-Added Services



- Wellcare By Superior HealthPlan members also have access to other services in addition to Medicaid-covered benefits and services, depending on their health needs.
- These Value-Added Services include:
 - Online mental health resources
 - Emergency response services that ensure members have access to emergency help while home alone
 - Access to household, personal care and oral care items
 - Access to dental services such as exams, cleanings and x-rays
 - Extra vision services to help cover the cost of eyeglasses
 - Home delivered meals following discharge from a hospital or nursing facility
 - Respite care services to help while a member’s family or other unpaid caregiver is taking a break
 - Short-term phone help offering a phone and minutes
 - 24-Hour Nurse Advice Line

Non-Emergency Transportation



- Wellcare By Superior HealthPlan ensures that Non-Emergency Medical Transportation (NEMT) services are readily available and accessible for members.
- This service supports access to medical appointments, examinations, and treatments as determined necessary by the member's PCP.
- NEMT is available to support members' access to medically necessary care.
- Covered services include, but not limited to:
 - End Stage Renal Disease treatment (hemodialysis)
 - Prenatal and preventive care
 - Mental health services
 - Prescription pickup
 - Durable Medical Equipment (DME) supplies

Accessing NEMT Services



- Wellcare By Superior HealthPlan partners with a transportation agency that maintains a provider network capable of servicing the entire geographic area in which members reside.
- To schedule non-emergent transportation, the member or their provider may call:
 - Transportation Vendor: [1-866-393-2166](tel:1-866-393-2166)
 - Member Services: [1-855-445-3556](tel:1-855-445-3556)
- The non-emergent transportation vendor will provide services for the following individuals:
 - Members: All Wellcare By Superior HealthPlan members for covered outpatient services.
 - Parents or Legal Guardians: May accompany legally incapacitated members to appointments.
 - Other Family Members: Transportation for additional individuals (e.g., siblings) may be permitted, depending on circumstances and vendor policies.
- Transportation is provided to and from participating providers. In cases where medically necessary services are only available from a non-participating provider, transportation may be arranged, as directed by Wellcare By Superior HealthPlan.

Prior Authorization, Notification and Referrals



Prior Authorization



- A prior authorization is a formal medical necessity determination request submitted to Wellcare By Superior HealthPlan by a provider prior to a service being rendered.
- Prior authorization may be obtained by the member's PCP or by a treating specialist or facility to which they were referred.
- Providers will only need to submit one authorization or clinical appeal and will receive a single decision.
- Wellcare By Superior HealthPlan will issue a decision to the provider and member/member's representative within the following timeframes, as required by CMS guidelines:
 - Expedited Request: within 72 hours.
 - Standard Part B Request: within 7 Calendar Days.
 - Standard Pre-Service Request: within 7 Calendar Days.
 - Standard Post-Service Request: within 30 Calendar Days.

Submitting Prior Authorization



- Providers may submit requests for authorization by:
 - Submitting an authorization request is through Wellcare By Superior HealthPlan’s [Secure Provider Portal](#)*.
 - Faxing a properly completed Inpatient, Outpatient, Durable Medical Equipment (DME) and Orthotic and Prosthetic, or Home Health and Skilled Therapy Services Authorization Request Form to the appropriate number below. The forms can be found on the *Medicaid Prior Authorization Forms* section of [Superior's Forms webpage](#).
 - Medical: 1-877-808-9362
 - Behavioral Health Inpatient: 1-866-535-6974 (Inpatient)
 - Behavioral Health Outpatient: 1-855-772-7079 (Outpatient)
 - Calling [1-855-445-3572](#) for inpatient notifications and urgent outpatient services.
- Failure to obtain prior authorization when one is required will result in an administrative denial.
- Outreach will be made to the appropriate provider for all requests with incomplete or insufficient documentation.

**Preferred and fastest method*

Inpatient Notification Requirements



- Providers, including facilities, must notify Wellcare By Superior HealthPlan of all emergent admissions no later than the close of the next Business Day.
- Prior authorization is not required for emergency services, urgent care services and post-stabilization services.
- All non-emergency, elective inpatient admissions require a prior authorization.
- Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, behavioral health and all other inpatient facility type require notification.
- Failure to notify an emergent inpatient admission by the next Business Day will result in a late notification denial, unless otherwise stated within a contract with Wellcare By Superior HealthPlan.
- Notifications for inpatient admissions may be completed by contacting Provider Services at [1-855-445-3572](tel:1-855-445-3572).

Medical Necessity Determination



- When medical necessity cannot be established, a peer-to-peer conversation is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.
- Providers can contact Wellcare By Superior HealthPlan at [1-855-445-3572](tel:1-855-445-3572) to request a peer-to-peer discussion to address the denial decision letter.

Referrals



- Referrals to out of network specialists may be considered when:
 - An appropriate in-network specialist is not available, or
 - When a second opinion is requested following consultation or treatment by an in-network specialist.
- Referrals to a health care public entity can be requested through the [Secure Provider Portal](#) or by calling Provider Services at [1-855-445-3572](tel:1-855-445-3572).
- Members may self-refer for:
 - Family Planning services, including any medically approved method used to voluntarily prevent or delay pregnancy or detect and treat Sexually Transmitted Diseases (STDs).
 - Women’s Health services such as routine annual exams, preventive screenings, prenatal or perinatal care provide by an in-network OB/GYN.

Out-of-Network Coverage



- Prior authorization is required for all out-of-network services, except:
 - Emergency care
 - Urgently needed care when the network provider is unavailable (usually due to out-of-area)
 - Kidney dialysis at Medicare-certified dialysis centers, when the member is temporarily out of the service area

Service Coordination

Service Coordination



The Wellcare By Superior HealthPlan Service Coordinator provides a specialized level of care management services that includes, but is not limited to:

- Conduct mandatory telephonic or face-to-face contacts and assessments.
 - Identification of medical, psychosocial, cognitive, functional and social determinate needs, and medical and behavioral health history for members.
 - Development of a Service Plan of Care as appropriate to address identified needs.
 - Provide the Service Plan to the member and the member’s authorized representatives and providers in the language and format requested.
 - Note: Providers can access Service Plans and ISP documents on the [Secure Provider Portal](#) using the Assessment tab.

Service Coordination services provided to members are:

- Coordinate with the member’s PCP, Specialist, and LTSS Providers to ensure the member’s health and safety needs are met in the least restrictive setting.
- Refer members to support services, such as disease management and community resources.
- Authorize LTSS services.
- Host ICT meetings

Service Coordination



- Service Coordinators may contact Providers to:
- Participate in the member Integrated Care Team (ICT) meeting.
- Coordinate or update a member's plan of care.
- Confirm diagnoses or test results.
- Identify care gaps or non-compliance issues.
- Address behavioral health needs or social determinants of health.
- Referrals to Service Coordination may be submitted via the [Secure Provider Portal](#) using the "Notify CM" button, or by calling [1-855-445-3572](tel:1-855-445-3572).

Claims and Payment Processing



Claims Filing Requirements



- Providers will only need to submit one claim through Wellcare By Superior HealthPlan for Medicare and Medicaid services.
- Providers have 95 Calendar Days from the Date of Service to submit first time claims.
 - Providers will receive a single EOP with details outlined for both Medicare and Medicaid payments.
- Corrected claims and appeals must be submitted within 180 Calendar Days from the adjudication date.
- Claims can be submitted online, through a clearinghouse, or by mail.
 - Providers can use Wellcare By Superior HealthPlan’s [secure provider portal](#) or [Availity Essentials](#) to submit claims, check claims status, submit authorizations and verify eligibility and benefits.
 - If your organization is new to Availity, start by registering with Availity today using [Availity's Multi-Payer Portal Registration](#).
 - Payor ID: 68069
 - Mail:
 - Attn: Claims
 - P.O. Box 9700
 - Farmington, MO 63640-0700

Claims Payment



- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment, or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may **not** bill members for services when the provider fails to obtain authorization, and the claim is denied.
- Billing by Payor Type:

Payor Type	Claim Form	Reimbursement Method
Wellcare By Superior HealthPlan Medicare Primary	UB-04	Paid at CMS Federal Encounter Rate or Fee Schedule based on services rendered
Wellcare By Superior HealthPlan Medicaid Primary	UB-04	Paid based on the Texas Medicaid Provider fee schedule
Dual-Eligible Members	UB-04	Medicare pays primary claim; Medicaid processes coinsurance and remaining balance, as applicable

Balance Billing



- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, coinsurance, and copayments.
- Balance billing a member for covered services is prohibited, except for the member's applicable member Liability towards covered Medicaid services, such as Nursing Facility.
- Members are not responsible for co-pays for Medicare or Medicaid covered services.
 - Members may have co-pays on certain prescriptions, based on tiering.
- Additional details can be found in your Wellcare By Superior HealthPlan contract.

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)



- Electronic payments can mean faster payments, leading to improvements in cash flow.
- Eliminate re-keying of remittance data.
- Match payments to statements quickly.
- Providers can quickly connect with any payers that are using PaySpan Health to settle claims.
- Providers already registered with Payspan/Zelis must add the Duals line of business to their TIN to begin receiving payments.
 - If you are new to Payspan/Zelis, access registration details on the [PaySpan website](#).

Electronic Visit Verification



Electronic Visit Verification (EVV)



- EVV is a system that records when, where, and what services were provided during certain Medicaid visits, using HHSC-approved methods to clock in and out.
- EVV requirements for STAR+PLUS services remain in effect and apply to services rendered for members enrolled in Wellcare By Superior HealthPlan.
 - Providers must submit claims with EVV required services directly to Texas Medicaid & Healthcare Partnership (TMHP) for EVV claims matching.
- EVV is required for certain in-home and community-based services, including:
 - Community First Choice (CFC) Personal Assistance Services (PAS)
 - CFC Habilitation (HAB)
 - In-Home Respite
- For dates of service 1/1/2026 and after, providers will enter new or existing authorizations in the EVV system for applicable services for members enrolled in Wellcare By Superior HealthPlan.
- Providers may refer to the EVV service tables for a list of all applicable EVV services.
 - [Personal Care Services Required to Use EVV \(PDF\)](#)
 - [Home Health Care Services Required to Use EVV \(PDF\)](#)

EVV Claims



- Units should be billed using the rounded “Pay Hours” calculated in the EVV vendor system.
 - Example: If a client was services for 48 minutes, this should be rounded down to 45 minutes, and .75 units should be billed.
 - If a client was serviced for 52 minutes, this would be rounded up to 1 hour and a full unit should be billed for the visit.
- All unit increments should be billed in the following format after rounding:

Service Time	Units
60 minutes	1
45 minutes	.75
30 minutes	.50
15 minutes	.25
0 minutes	0

EVV Claims



- The EVV Aggregator conducts validation on data from the EVV visit transaction verifying the data on the billed claim matches the visit data in the EVV portal before forwarding the claim to Wellcare By Superior HealthPlan for adjudication.
- To prevent claim denials, providers and FMSAs should verify the EVV visit transaction is accepted before billing.
- When billing claims, Providers and FMSAs must verify the data elements billed match the data listed in the EVV portal.
- Only EVV claims with claim line items displaying a match result code of EVV01, listed in the EVV Portal, may be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.

Appeals

Appeals



- An appeal is a formal request from the member, their authorized representative, or provider to review a decision made by Wellcare By Superior HealthPlan to deny, reduce, delay, or terminate a requested service or payment.
 - Examples include:
 - Denial of a service based on medical necessity.
 - Denial of payment for a service already received.
 - Termination or reduction of a previously authorized service.
- Members have the right to appeal an adverse benefit determination.
- For non-urgent appeals, members have 65 Calendar Days to file an appeal from the date of the denied service.
- For urgent appeals, in which the member's life or health is in jeopardy or the member is in severe pain, the member or the provider must call Member Services at [1-855-445-3556](tel:1-855-445-3556).

Appeals



- A Provider or other authorized representative of the member such as family member, friend, or attorney may file an appeal on the member's behalf with the member's written permission.
- Appeals are reviewed by a qualified clinical peer reviewer holding the same or similar specialty as the treating provider.
- Wellcare By Superior HealthPlan will provide written notification of the appeal decision to the member, the Primary Care Provider (PCP), and any other provider directly involved in the appeal.

External Review of an Appeal



- Members have the right to request a determination from the Insurance Director or his/her designee, or by an independent review organization under the Member's Right to Independent Review Act.
- Members must first exhaust the internal appeal process through the health plan before filing a request for an external review with the Texas Department of Insurance (TDI).
- An expedited external appeal may be submitted by the member and/or the member's authorized representative within 10 Calendar Days after the member receives an adverse determination from the health plan only if the following are met:
 - A Provider must substantiate, either orally or in writing, that the standard timeframe for review of the grievance/appeal would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function; and
 - The member has already filed a request for an expedited internal appeal with the health plan.
- To request an external review, visit [HHS-Administered Federal External Review Process website](#).

Post-Service Provider Appeals



- A Post-Service Provider Appeal is an appeal of services that were denied or reduced because they did not meet a specific criteria, policy or guideline and have a denied authorization on file.
- Wellcare By Superior HealthPlan offers a post-service claim appeal process for disputes related to denial of payment for services rendered to our members.
- This process is available to all providers, regardless of whether they are in or out of network.
- Providers must submit an administrative appeal explaining the circumstances and why the provider feels an exception is warranted in that specific case.
- Appeals can be submitted through the [Secure Provider Portal](#) or by fax or mail.
- Appeals must be submitted within 180 Calendar Days from the date of the EOP.

Pharmacy

Pharmacy Benefits



- Wellcare By Superior HealthPlan utilizes a Pharmacy Benefit Manager (PBM) to administer member pharmacy benefits.
- The PBM provides Wellcare By Superior HealthPlan with a pharmacy network, pharmacy claims management, and adjudication services.
- We utilize the Medicaid Formulary and the Preferred Drug List (PDL) to determine whether a prior authorization is required.
 - If a specific medication is not listed on the Formulary or PDL and is deemed medically necessary for a member, a medical necessity exception may be requested through the prior authorization (PA) process.
- The formulary includes drugs covered under Medicare Part D, some prescription and over-the-counter (OTC) drugs, and products covered under STAR+PLUS Medicaid. The formulary is available on [Wellcare's List of Drugs \(Formulary\) webpage](#). Use the **Drug Search Tool** to search the most recently available PDL.

Emergency Prescription Supply



- A pharmacy may dispense a 72-hour (3-day) supply of medication to any member awaiting a prior authorization or medical necessity determination, if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- If the prescribing provider cannot be reached or is unable to request an authorization, the pharmacy may dispense an emergency 72-hour prescription if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

Secure Provider Portal



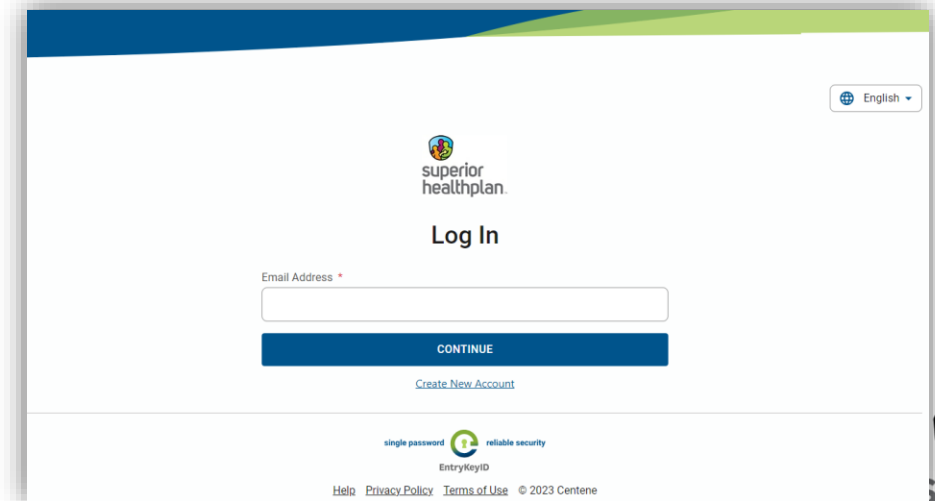
Wellcare By Superior HealthPlan's Secure Provider Portal

FUNCTIONS OF THE SECURE PROVIDER PORTAL

- Member eligibility and patient lists
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- PCP reports

REGISTRATION

- Visit the [Secure Provider Portal](#) to register or contact your local Provider Representative. To access their contact information visit, [Find My Provider Representative](#).



The screenshot shows the login page for the Superior HealthPlan Secure Provider Portal. At the top right, there is a language selection dropdown menu set to "English". The Superior HealthPlan logo is centered at the top. Below the logo, the text "Log In" is displayed. Underneath, there is a text input field labeled "Email Address *". Below the input field is a blue "CONTINUE" button. A link for "Create New Account" is located below the button. At the bottom of the page, there is a footer with the text "single password reliable security EntryKeyID" and a small logo. The footer also includes links for "Help", "Privacy Policy", and "Terms of Use", along with the copyright notice "© 2023 Centene".



Availity Essentials



- For Providers new to Availity Essentials, getting their Essentials account is the first step toward working on Availity.
- The Provider organization's designated Availity administrator is the person responsible for registering their practice in Essentials, managing user accounts, and should have legal authority to sign agreements for their organization.
- Administrators can register with Availity Essentials here:
 - [Availity Essentials website](#)
 - Providers needing additional assistance with registration can call Availity Client Services at **1-800-AVAILITY (1-800-282-4548)**, Monday through Friday, 8 a.m. – 8 p.m. EST.
- For general questions, providers can reach local Provider Representative. To access their contact information visit, [Find My Provider Representative](#).

Model of Care



Model of Care



Wellcare By Superior HealthPlan's Model of Care plan delivers our integrated care management program for members with special needs.

The goals of our 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 Elements:

- Description of the SNP population
- Care coordination and care transitions protocol
- Provider network
- Quality measurement

Model of Care Process



- We contact every Member to evaluate their health status with a comprehensive Health Risk Assessment (HRA) within 90 Calendar Days of enrollment, and at a minimum annually, or more frequently with any significant change in condition or health risk level.
- The HRA collects information about the member's medical, psychosocial, cognitive, functional and social determinate needs, and medical and behavioral health history. The HRA is scored for risks to assist with triage.
- Members HRA risk level helps to determine the appropriate level of care management and composition of an Interdisciplinary Care Team (ICT).
- At a minimum, every member is provided an annual Individualized Care Plan (ICP) outlining health goals and interventions.
- Each member receives an annual in-person or virtual face-to-face encounter with a Provider or Service Coordinator for the purpose of delivering health care, care management, or care coordination services.

Model of Care Process



- Wellcare By Superior HealthPlan values our partnership with our Providers.
- The Model of Care requires all of us to work together to benefit our members by:
 - Enhanced communication between members, Providers, and Wellcare.
 - Interdisciplinary approach to the member's special needs.
 - Comprehensive coordination with all care partners.
 - Support for the member's preferences in the Model of Care.
 - Reinforcement of the member's connection with their medical home.
- Model of Care training is a CMS requirement for any provider that treats SNP members to be completed annually.
- Newly contracted Medicare Providers should complete within 30 Calendar Days of execution of contract.
- Model of Care information is available on [Superior's Model of Care Training webpage](#).

Network Partners



- Evolut is contracted with Superior to perform utilization review for:
 - High-Tech Imaging Services
 - Interventional Pain Management (IPM)
 - Physical Occupational and Speech Therapy
 - Musculoskeletal surgical procedures
 - Interventional Cardiology
- For IPM, a separate prior authorization number is required for each procedure ordered.
- The ordering physician is responsible for obtaining authorizations.
- Emergency room and inpatient procedures do not require authorization; however, prior authorization and/or notification of admission is still required through Superior.
 - Observation Imaging Services also do not require authorization
- To obtain authorization through Evolut, visit the [Evolut website](#).
- Claims should still be submitted to Superior for processing.

TurningPoint Healthcare Solutions



- Wellcare By Superior HealthPlan partners with TurningPoint Healthcare Solutions to process prior authorization requests for medical necessity and appropriate length of stay for ENT surgeries.
- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services 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.
- **TurningPoint's Procedure Coding and Medical Policy Information (PDF)** can be located under *Billing Resources* on Superior's Provider Resources webpage.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
 - Web Portal Intake: TurningPoint Provider Login
 - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
 - Fax Intake: 1-214-306-9323

Other Network Partners



Service	Specialty Company/Vendor	Contact Information
Dental Services	Liberty Dental	1-866-544-4669 Liberty Dental
Hearing Services	TruHearing	1-800-334-1807 TruHearing
Vision Services	Premier Eye Care	1-855-879-1456 Premier Eye Care
Pharmacy Services	Express Scripts	1-833-750-0201 Express Scripts Pharmacy

Advance Directives

Advance Directives



- An advance directive will help the PCP understand the member’s wishes about their healthcare in the event they become unable to make decisions on their own behalf. Examples include:
 - Living will
 - Healthcare power of attorney
 - “Do Not Resuscitate” orders
- Execution of an advance directive must be documented on the member’s medical records.
- Providers must educate staff on issues concerning advance directives and maintain written policies that address a member’s right to make decisions about their own medical care.
 - Providers shall not, as a condition of treatment, require a member to execute or waive an advance directive.

Fraud, Waste and Abuse



Fraud, Waste and Abuse



- Wellcare By Superior HealthPlan follows the four parallel strategies of the Medicare and Medicaid programs to prevent, detect, report, and correct fraud, waste, and abuse:
 - Preventing fraud through effective enrollment and education of physicians, providers, suppliers, and beneficiaries.
 - Detection through data analytics and medical records review.
 - Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
 - Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review, and corrective action plan.

Fraud, Waste and Abuse



- Wellcare By Superior HealthPlan performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:
 - Use of incorrect billing code
 - Not following the service authorization
 - Procedure code not being consistent with provided service
 - Excessive use of units not authorized by the case manager
 - Lending of insurance card
 - Benefits of stopping fraud, waste, and abuse:
 - Improves patient care
 - Helps save dollars and identify recoupments
 - Decreases wasteful medical expenses

Fraud, Waste and Abuse



- Wellcare By Superior HealthPlan expects all of our providers, contractors, and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:
 - Federal and State False Claims Act
 - Qui Tam Provision (Whistleblower)
 - Anti-Kickback Statute
 - Physician Self-Referral Law (Stark Law)
 - Health Insurance Portability and Accountability Act (HIPAA)
 - Social Security Act (SSI)
 - U.S. Criminal Codes
 - To report suspicions of fraud, waste and abuse, call:
 - Fraud, Waste and Abuse Hotline: [1-866-685-8664](tel:1-866-685-8664)
 - Corporate Compliance Officer: [1-800-345-1642](tel:1-800-345-1642)
 - You can also send an email to Special_Investigations_Unit@centene.com.

Partnering with Wellcare By Superior HealthPlan



Partnering for Integrated Member Care



- Verify eligibility and plan type before each visit in the Provider Portal.
- Collaborate with Care Management and Service Coordination teams for high-risk members.
- Attend required Model of Care training sessions (annual requirement).
- Monitor plan bulletins and policy updates through [Superior's Provider News & Information](#).
- Contact Information:
 - Provider Services: [1-855-445-3572](tel:1-855-445-3572)
 - Wellcare By Superior HealthPlan Portal Support Email: TX.WebApplications@SuperiorHealthPlan.com
- Provider Resources can be found on [Superior's Wellcare webpage](#).
- Contact your local Provider Representative for FIDE-related questions. To find their contact information visit [Find My Provider Representative](#).