Superior HealthPlan STAR+PLUS

Provider Training (non-Nursing Facility Residents)

Who is Superior HealthPlan?

- Superior HealthPlan is a subsidiary of Centene Corporation located in St. Louis, MO.
- Superior HealthPlan has held a contract with HHSC since December 1999.
- Superior HealthPlan provides programs in various counties across the State of Texas. These programs include STAR, STAR+PLUS, CHIP, STAR Health (Foster Care), Medicare Advantage, Ambetter by Superior HealthPlan and STAR+PLUS Medicare-Medicaid Plan (beginning March 1, 2015).
- Superior HealthPlan manages healthcare for over 900,000 Members across Texas.

Contract with Superior

- Providers who offer services to our Members should be contracted with Superior HealthPlan.

- To get contracted, you must contact our Network Development department and request a contract. You can do that by:
  - Calling - 1-866-615-9399 x 22534
  - Emailing - shp-networkdevelopment@centene.com
  - Visiting - www.superiorhealthplan.com

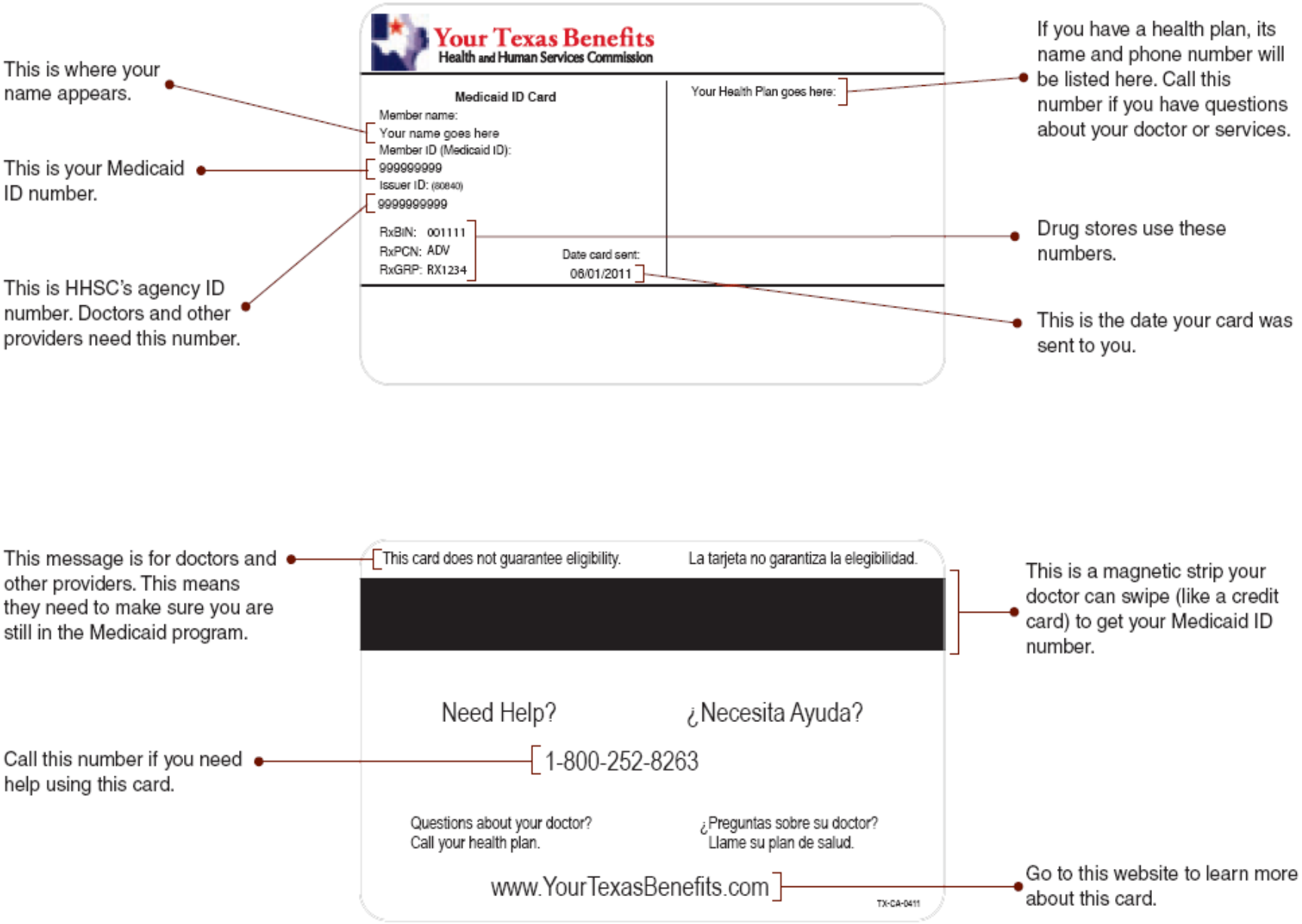
How do you know if a Member is eligible and enrolled with Superior?

- STAR+PLUS Members are always enrolled and disenrolled at the beginning of each month. The period begins on the 1st of each month.
- Providers should verify Member eligibility at the start of each month and **before** providing services.

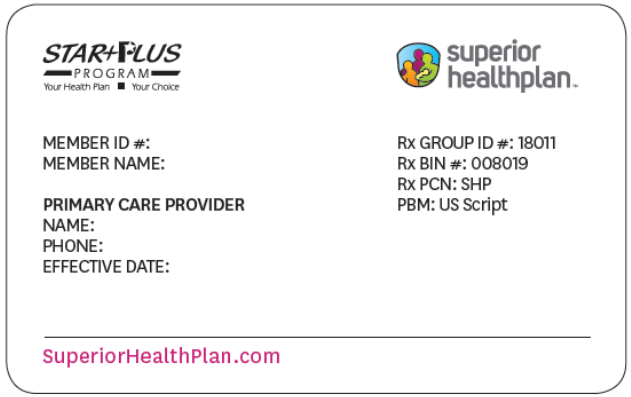
- How can eligibility be verified?

- Texas Medicaid “Your Texas Benefits” Card
- ***Preferred***-Superior HealthPlan Identification Card
- ***Preferred***-Superior HealthPlan secure provider web portal at: www.superiorhealthplan.com

- ***Preferred***-Call the Member Hotline at 1.866.516.4501 available 24/7. You can navigate the Interactive Voice Response System or reach a live agent during normal business hours, Monday through Friday 8:00am to 5:00pm local time.


This is where your name appears.
This is your Medicaid ID number.
This is HHSC's agency ID number. Doctors and other providers need this number.
Your Texas Benefits
Health and Human Services Commission
Medicaid ID Card
Member name:
Your name goes here
Member ID (Medicaid ID):
999999999
Issuer ID: (80840)
9999999999
RxBIN: 001111
RxPCN: ADV
RxGRP: RX1234
Your Health Plan goes here:
Date card sent:
06/01/2011
If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.
Drug stores use these numbers.
This is the date your card was sent to you.
This message is for doctors and other providers. This means they need to make sure you are still in the Medicaid program.
This card does not guarantee eligibility.
La tarjeta no garantiza la elegibilidad.
This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.
Need Help?
¿Necesita Ayuda?
Call this number if you need help using this card.
1-800-252-8263
Questions about your doctor?
Call your health plan.
¿Preguntas sobre su doctor?
Llame su plan de salud.
www.YourTexasBenefits.com
TX-CA-0411
Go to this website to learn more about this card.

Superior STAR+PLUS ID Card


STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

superior healthplan

MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com


Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-800-466-4089

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. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

Servicios para Miembros: 1-866-516-4501
Disponible 24 horas al día/7 días de la semana
Coordinandora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-800-466-4089

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que tambien éstan eligibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

- Members enrolled in STAR+PLUS only and who receive Medicaid only will show their PCP listed.
- Members enrolled in STAR+PLUS only and who receive Medicare and Medicaid will not list a PCP and will show “LTC benefits only” in the Primary Care Provider field.

What is managed care?

- HHSC contracts with managed care organizations (MCO)/companies who are licensed by the Texas Department of Insurance to provide the services specified.
- HHSC pays the MCO a monthly amount to coordinate health services for Medicaid clients enrolled in their health plan.
- HHSC designs the benefit package and describes what services will be covered in the program. MCOs can offer additional benefits, referred to as value added services, but has to offer the full scope of services outlined in their contract with HHSC.
- The health plans contract directly with doctors, hospitals and many other health care and service providers to create comprehensive provider networks.

What is STAR+PLUS?

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

Service Coordination-
The cornerstone of STAR+PLUS

- Is a special kind of care management used to coordinate all aspects of care for a Member.
- Utilizes a multidisciplinary approach in meeting Members' needs.
- Service Coordination is available to all STAR+PLUS Members.
- Members are assigned a Service Coordinator who they can call directly.
- Service Coordinators participate with the Member, their family or representative, and other members of the interdisciplinary team to provide input for the development of the plan of care.

Who enrolls in STAR+PLUS?

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

- **Voluntary Population**
  - Children and young adults under age 21 receiving SSI or SSI-related services living in a STAR+PLUS service area may choose to enroll in STAR+PLUS or remain in traditional Medicaid

What are the LTSS benefits offered in STAR+PLUS?

- Personal Assistance Services (PAS)
- Day Activity and Health Services (DAHS)
- STAR+PLUS HCBS Waiver – those services provided through CBA in traditional Medicaid:
  - Assisted living
  - Adaptive aids
  - Minor home modifications
  - Personal assistance services
  - Respite care
  - Emergency response
  - Transition assistance services
  - Home delivered meals
  - Nursing services
  - Medical supplies
  - Adult foster care
  - Dental
  - Therapies
  - Consumer directed services option
  - Cognitive Rehabilitative Therapy
  - Employment Assistance/Supported Employment

Once a plan is selected...

- The state enrollment broker, Maximus sends an enrollment file to each plan that offers STAR+PLUS. This file includes all of the members enrolled with them for the first of the following month.

- **Please note:** Members can switch plans anytime. The change takes 15-45 days and is made through Maximus.

2014 Recap & What's New?

2014 Benefits Recap Grid

This grid is a quick visual summary of each of the 2014 benefits and services and which program covers them that we introduced last year.

Benefit	Effective Date	STAR	STAR+PLUS	STAR+PLUS Waiver	STAR Health
Cognitive Rehab Therapy	3/6/2014			x	
IDD Waiver	9/1/2014		x		
Mental Health Rehabilitative Services	9/1/2014	x	x	x	x
Employment Assistance	9/1/2014			x	
Supported Employment	9/1/2014			x	
Mental Health Targeted Case Management	9/1/2014	x	x	x	x
Financial Management Services	9/1/2014			x	
Support Consultation	9/1/2014			x	

What has changed?

Nursing Facility Resident Participation

- Starting March 1, 2015, Nursing Facility Residents will be part of the STAR+PLUS program.
- They will be enrolled into a plan in their area based on their selection or via the default metrology conducted by Maximus.
- Residents and Nursing Facilities will be assigned a designated Service Coordinator to ensure that a plan of care is established to meet the residents needs.
- Superior offers a separate Nursing Facility Provider Training. For dates and times, visit www.SuperiorHealthPlan.com.

What has changed?

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Electronic Visit Verification

- Starting April 16, 2015, Personal Care Service (PCS) and Personal Attendant Service (PAS) must electronically verify visits.
- Starting June 1, 2015, Private Duty Nursing (PDN) and Habilitation Providers must electronically verify visit.
- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits.
- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.

What has changed?

Electronic Visit Verification

- PAS, PCS, HAB and PDN Providers will verify service times using EVV process.
- EVV vendor will send verification data to Superior.
- Superior will compare provider claims to verification data prior to adjudication.
- Only verified units of service will be paid.
- Superior is offering training on EVV. Check the Provider Calendar at www.SuperiorHealthPlan.com.

What has changed?

Community First Choice (CFC)

- CFC is part of Senate Bill 7 from the 2013 Texas Legislature requiring HHSC to put in place a cost-effective option for attendant and habilitation services for people with disabilities.
- Starting June 1,2015, CFC Services are available for STAR+PLUS Members who:
  - Need help with activities of daily living (dressing, bathing, eating, etc.)
  - Need an institutional level of care (Intermediate Care Facility for Individuals with an Intellectual Disability or Related conditions (ICF/IID), nursing facility (NF) or Institution for Mental Disease (IMD).
  - Currently receive personal attendant services (PAS).
  - Are individuals on the waiver interest list or are already getting services through a 1915 (c) waiver.

What has changed?

Community First Choice (CFC)

- CFC will include PAS, Habilitation, Emergency Response Services, and Support Management.
- CFC assessments will be conducted by Superior HealthPlan.
- If the PCP determines that a Member should receive a CFC service or needs an authorization, PCPs should call Service Coordination at 1-877-277-9772 and request an assessment.
- CFC services should be billed directly to Superior HealthPlan via paper, through the Secure Web Portal or your clearinghouse. Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the Uniformed Manage Care Manual or the STAR+PLUS Handbook.

Prior Authorization Process

Behavioral Health Prior Authorizations

Cenpatico Behavioral Health

Contact Cenpatico for your Superior Members needing prior-authorizations for Behavioral Health Services including Outpatient Treatment Requests (OTR). These require use of an OTR Form. Additional information and copies of the OTR form can be found on their website.

Phone: 1-800-466-4089

Web: www.cenpatico.com

NorthSTAR

For Members enrolled in the Dallas service area, all behavioral health (mental health and drug and alcohol abuse) services are provided through NorthSTAR. You can reach the them at 1-888-800-6799 or refer to the Texas Medicaid Provider Procedures Manual for further coordination.

LTSS Require Authorizations

All Long Term Services & Supports (LTSS) require authorization:

- Personal Attendant Services (PAS)
- Day Activity & Health Services (DAHS)
- Employment Assistance/Supported Employment
- Cognitive Rehabilitative Therapy
- Community First Choice (CFC)

Including STAR+PLUS Waiver Services:

- Personal Attendant Service (PAS)
- Day Activity & Health Services (DAHS)
- Nursing Services (in home)
- Emergency Response Services (ERS)
- Home Delivered Meals (HDM)
- Minor Home Modifications (MHM)
- Assisted Living (AL)
- Transition Assistance Services (TAS)
- Adult Foster Care (AFC)

LTSS Authorization Process

- All authorizations for LTSS are obtained through the Service Coordination Department.
- The name of each Member's Service Coordinator name can be seen when a member's eligibility is confirmed through the Superior HealthPlan web portal.
- Then call **1-877-277-9772** to speak to the specific Service Coordinator.

Acute Care Services
(non-duals only)

Some common acute services that require authorization are:

- DME items with a purchase price > $500
- Enteral nutrition
- Home health/Skilled Nursing/Private Duty Nursing
- Hearing Aids
- Orthotics/Prosthetics
- Non-emergent ambulance transportation
- Therapy-physical, occupational and speech
- Incontinence Supplies

For a full list of acute services that require authorization, you can:

1. Look up Superior's most current Prior Authorization List found at www.superiorhealthplan.com.
2. You can also call the Prior Authorization Department at 1-800-218-7508, Monday through Friday, 8:00am-5:00pm local time and speak to a live agent.

Acute Care Authorization Process

Authorizations for these services are requested from the Prior Authorization Department.

That could 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 www.superiorhealthplan.com.
3. Or by faxing a Prior Auth form to 1-800-690-7030. The form can be found at www.superiorhealthplan.com.

Claims and Billing

What does Superior pay for?

DUALs

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

- Medicare is the primary payor for **all acute care** services (e.g. PCP, hospital, outpatient services)

- Medicaid Acute Care (TMHP) - Covers **co-insurance, deductible, and some Long Term Care Services** (ex: incontinence supplies).

NOTE: All non-LTSS services must be billed through Medicare as primary payer and TMHP as secondary.

- STAR+PLUS (Superior) – **ONLY** Covers Long Term Support Services (ex: PAS, DAHS, etc.).

What does Superior pay for?

NON-DUALS

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

STAR+PLUS (Superior) covers **BOTH** Acute Care Services and Long Term Support Services.

Exception: For IDD members, Superior pays for acute care services **only.*

How do I file a claim?

1. You can use Superior's web portal. Submitting claims is secure and best part there is no cost to you! Using the portal gets your claim in directly into our system so you get your payment faster.
2. You can use electronic filing through your clearinghouse. Superior supports EDI and works with various vendors. For a full list you can visit: http://www.superiorhealthplan.com/for-providers/electronic-transactions/ Use Payor ID: 68069
3. You can bill on paper and mail your claim(s) to:

Superior HealthPlan
P O Box 3003
Farmington, MO 63640-3803

We encourage all of our providers to file electronically or through our web portal. We also recommend registering for Electronic Funds Transfer (EFT) through PaySpan so you can get your money faster!

Claim Adjustments, Disputes & Reconsiderations

If a provider wants to adjust/correct a claim or submit a claim appeal, these 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 web portal or through a paper claim. Paper claims require a Superior Corrected Claim or Claim Appeal form. Find them under Resources at www.superiorhealthplan.com.

Corrected Claims Filing

- Must reference original claim # from EOP
- Must be submitted within 120 days of adjudication paid date
- Resubmission of claims can be done via your clearinghouse or through Superior's web 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 or adjusted paper claims can also be submitted to:

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

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
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800
  - Or through the secure web portal.
    - At this time, batch adjustments are not an option via the SHP secure portal
- Attach & 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 # identified.

Appeals Documentation

Examples of supporting documentation may include but are not limited to:

- A copy of the SHP EOP (required)
- A letter from the provider stating why they feel the claim payment is incorrect (required)
- A copy of the original claim
- An EOP from another insurance company
- Documentation of eligibility verification such as copy of ID card, TMBC, TMHP documentation, call log, etc.
- Overnight or certified mail receipt as proof of timely filing
- Centene EDI acceptance reports showing the claim was accepted by Superior
- Prior authorization number and/or form or fax

Superior HealthPlan Departments - We Can Help You!

Member Services

The Member Services staff can help you with:

- Verifying eligibility
- Reviewing Member benefits
- Assist with non-compliant Members
- Help find additional local community resources

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

1-866-516-4501

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 Provider Network Specialist

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

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

1-877-391-5921

Field Provider Relations

Field staff are here to assist you with:

- Face-to-face orientations
- Face-to-face web portal training
- Office visits to review ongoing claim trends
- Office visits to review quality performance reports

You can also find a map that can assist you with identifying the field office you can call to get in touch with your Provider Relations Specialist on our website.

Superior Web Portal & 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 web 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 at no cost!
- 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 field office assigned to you to locate your Provider Network Specialist.
- It contains an archive of the Provider Manual, newsletters, bulletins, and links to important sites to keep you up to date on any new changes that may affect you.

Provider Training

Superior HealthPlan offers targeted billing presentations depending on the type of services you provide and bill for. For example, LTSS Billing, Electronic Visit Verification (EVV), and General Billing Clinics. We also offer product specific training on STAR+PLUS MMP and STAR/CHIP.

You can find the schedule on the Provider Trainings Calendar at http://www.superiorhealthplan.com/provider-calendar/.

We encourage you to come join us!

Questions and Answers

Thank you for attending!

superior healthplan™

We are committed to assisting all of our network providers.

Let us know what we can do to help.