Welcome To Ambetter from Superior HealthPlan

Your Partner In Better Healthcare

2024 Provider Orientation

AGENDA

OVERVIEW

- Who We Are
- Affordable Care Act
- The Health Insurance Marketplace
- Our Networks

WHAT YOU NEED TO KNOW

- Key Contact Information
- Provider Manual
- Provider Engagement
- Public Website and Secure Portal
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Claims, Billing and Payments
- Complaints, Grievances and Appeals
- Specialty Companies and Vendors

QUESTIONS & ANSWERS

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2024 Provider Orientation

OVERVIEW

WE ARE AMBETTER

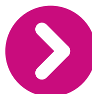
We provide market-leading, affordable health insurance on the marketplace.

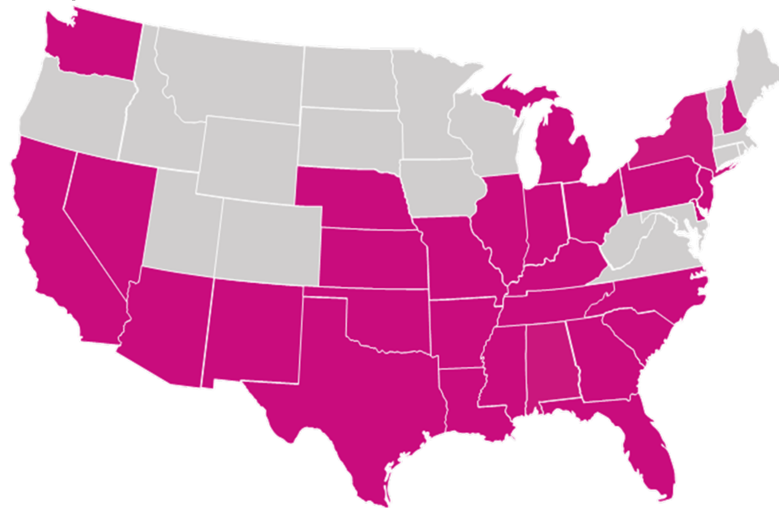
#1 carrier
on the health insurance marketplace

2014
year that Ambetter began

3.3M+
members insured

29
states





LOCAL APPROACH TO CARE

Ambetter delivers high quality, locally-based healthcare services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.

We target a focused demographic.

We target lower income, underinsured and uninsured

PARTNERSHIP

- The **Ambetter plan design philosophy** is to provide affordable care to individuals or families that need to purchase healthcare coverage on their own.

- **Our products** focus on various cost shares — many with low or no copay amounts — to meet the budget and utilization needs of these consumers. This gives our members the peace of mind that they have full comprehensive medical coverage.

- Additionally, the **emphasis on reducing barriers and improving access to care** mitigates the risk of individuals showing up without insurance (uncompensated care). Ambetter's generous cost-sharing initiatives lower patient financial responsibility while also reducing the amount that providers need to collect at time of service.

- Most importantly, Ambetter plans encourage members to establish relationships with their primary care providers to **achieve favorable health outcomes**.

We are proud to be your partner.

AFFORDABLE CARE ACT

AFFORDABLE CARE ACT (ACA):
Key Objectives

- Increase access to quality health insurance
- Improve affordability

ADDITIONAL PARAMETERS:

- Dependent coverage to age 26
- No lifetime maximum benefits
- Preventative care covered at 100%
- Insurer minimum loss ratio (80%* for individual coverage)

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AFFORDABLE CARE ACT

REFORM THE COMMERCIAL INSURANCE MARKET – MARKETPLACE OR EXCHANGES

- No more underwriting – guaranteed issue.
- There is no longer a federal tax penalty associated with not having minimum essential coverage*.
- Minimum standards for coverage: benefits and cost sharing limits.
- The ACA created premium tax credits (also known as subsidies) and Cost-Sharing Reductions (CSR) to help reduce costs for eligible consumers who buy a plan through the Marketplace.
- Subsidies may be available to eligible individuals/families who have a household income between 100 and 400 percent of the Federal Poverty Level (FPL), based on the taxpayer's family size.
    - Currently, the subsidy cap has been eliminated through Plan Year 2025, but that may be extended.
- CSRs are available to eligible individuals/families who have a household income between 100 and 250 percent of the FPL, based on the taxpayer's family size.

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**States may enact tax penalties for not purchasing insurance*

HEALTH INSURANCE MARKETPLACE

The Health Insurance Marketplace is a service available in every state that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace for most states, but some states run their own Marketplaces.

The Health Insurance Marketplace provides health plan shopping and enrollment services through websites, call centers, and in-person help. Visit HealthCare.gov for more information.

Potential members can:

- Register for the exchange
- Determine eligibility for all health insurance programs (including Medicaid)
- Shop for plans
- Enroll in a plan
- Exchanges may be state-based, federally facilitated, or a federal-state hybrid — **Texas *is a federally facilitated Marketplace***

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.

HEALTH INSURANCE MARKETPLACE

FINANCIAL COMES IN THE FORM OF:

- Advanced Premium Tax Credits (APTC)
- Cost-Sharing Reductions (CSR)

ALL BENEFIT PLANS HAVE COST SHARES IN THE FORM OF COPAYS, COINSURANCE AND DEDUCTIBLES

- Some members qualify for assistance with their cost shares based on income level

The Health Insurance Marketplace is the ONLY WAY to purchase insurance and receive subsidies.

2024 Provider Orientation

OUR NETWORKS

- Ambetter offers a robust suite of innovative networks that give members more coverage options to fit their needs and budget.
- By offering increased product options, Ambetter also benefits providers by giving them exclusive access
to new patient populations.
- Each Ambetter network is designed to offer members a unique type of coverage option specific to their state. This means that member plans and benefits can vary, and there may be referral or prior authorization requirements for certain types of care to be covered.
- As a provider, it is important you confirm which network and plan a member is in before extending care. This information is located on the member’s ID card and can also be confirmed when verifying the member’s eligibility.

OUR NETWORKS

AMBETTER HEALTH SILVER AND GOLD

- The Ambetter Health Silver and Gold network is our broadest network of healthcare providers and hospitals offering affordable care to individuals or families that need to purchase healthcare coverage on their own.
- Ambetter Health Silver Care plans provide the best value and most balance between monthly premiums and out-of-pocket costs.
- Ambetter Health Gold offers peace of mind for all healthcare needs. Members can expect higher monthly premiums to limit out-of-pocket expenses later.

PCP SELECTION

- Ambetter Health emphasizes to members the importance of establishing a medical home (better care, greater appointment availability, consistent care, etc.). Part of that is the selection of a Primary Care Provider (PCP).
- While Silver and Gold members may see any provider they choose, Ambetter Health encourages providers to emphasize the importance of the medical home relationship to members.
- PCPs can still administer service if the member is not assigned to them and may wish to have member assigned to them for future care.
- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done through the Secure Provider Portal.

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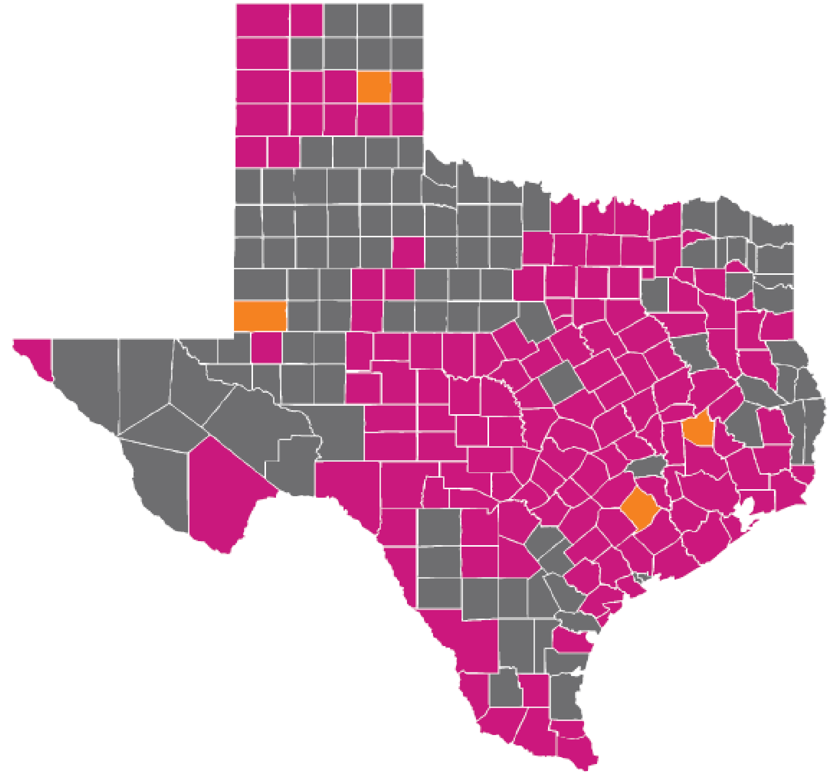
AMBETTER HEALTH 2024 SILVER AND GOLD

Counties:

- Andrews, Aransas, Armstrong, Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Brewster, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Castro, Chambers, Cherokee, Coke, Coleman, Collin, Collingsworth, Colorado, Comal, Comanche, Concho, Cooke, Dallam, Dallas, Deaf Smith, Delta, Denton, DeWitt, Donley, Ector, Edwards, El Paso, Ellis, Falls, Fannin, Fayette, Fisher, Fort Bend, Freestone, Frio, Galveston, Gillespie, Goliad, Gonzales, Gray, Grayson, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hartley, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Hunt, Irion, Jack, Jackson, Jefferson, Johnson, Kendall, Kerr, Kimble, Kinney, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Llano, Madison, Mason, Matagorda, Maverick, McCulloch, McLennan, Medina, Menard, Milam, Mills, Mitchell, Montague, Montgomery, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Parmer, Potter, Rains, Randall, Real, Refugio, Robertson, Rockwall, Runnels, Rusk, San Jacinto, San Saba, Schleicher, Scurry, Sherman, Smith, Somervell, Starr, Sterling, Stonewall, Sutton, Tarrant, Tom Green, Travis, Trinity, Tyler, Val Verde, Van Zandt, Victoria, Walker, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, Zapata



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AMBETTER VALUE

- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
  - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson.
- The Ambetter Health Value plan design differs in the following:
  - New for 2024, members will be assigned a PCP at the practitioner level.
  - Any specialty care rendered by a specialist outside of the PCP's group will require a referral prior to services being rendered to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Radiology, Durable Medical Equipment, Ambulance and Anesthesia.
  - The above provider or facility types will still be required to be in-network* and prior authorization requirements will continue to apply, as applicable.

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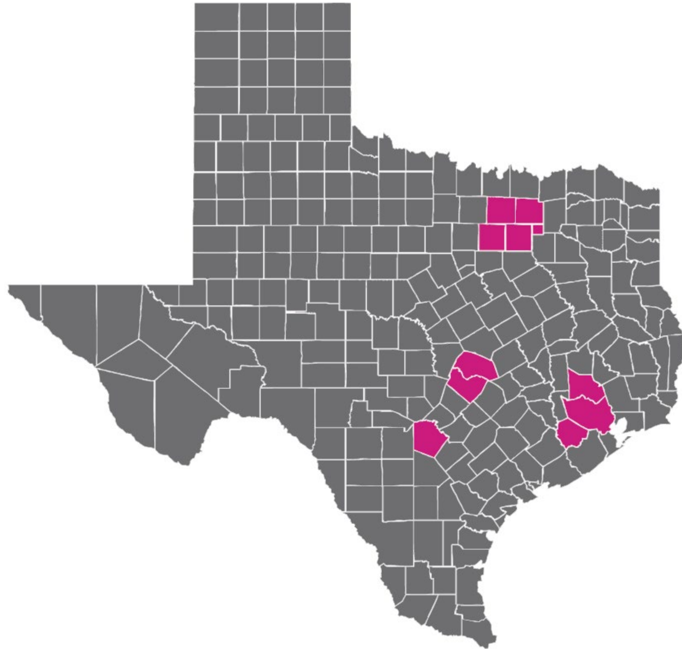
AMBETTER HEALTH 2024 VALUE



Counties:

- Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson

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AMBETTER VIRTUAL ACCESS

- Ambetter Virtual Access supports the changing dynamics of how providers deliver care, and how members seek care, which increases access to primary and urgent care services in an agile way.
- Ambetter Virtual Primary Care is relationship-based care with a consistent provider delivered virtually
  Available exclusively to Ambetter Virtual Access (AVA) members.
- Ambetter Virtual Access most closely mirrors the network offered within Silver and Gold.
  - There are a few exceptions most noticeably within our Hospital systems network.
- The Ambetter Virtual Access plan design differs in the following:
  - Teladoc is the preferred PCP group to which members will automatically be assigned.
    - Members under the age of 18 are the exception as they will be assigned to a local PCP.
  - Members utilize Teladoc's application that can be downloaded on a phone or table or by visiting Teladoc.com/AmbetterVirtualAccess/.
  - Teladoc (or local PCP) will be responsible to submit a referral to Ambetter in order for any specialty care provider to render services to our members.

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AMBETTER VIRTUAL ACCESS

- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Durable Medical Equipment, Ambulance, Radiology and Anesthesia.
  - The above provider or facility types will still be required to be in-network (except for emergent services) and prior authorization requirements will continue to apply as applicable.
- The network centers on an online, easily accessible medical home offering, with key features such as:
  - Creates a patient-centered care plan within the app.
  - Easy to access, member-friendly reminders for follow-ups, picking up prescriptions, etc.
  - Full incorporation of virtual behavioral health providers.
- In Texas, members will be enrolled in plans that require referrals. It is possible that providers may see Virtual Access members from other states with a different referral requirement.
  - Always check the member’s ID card to determine if a referral is or is not required.

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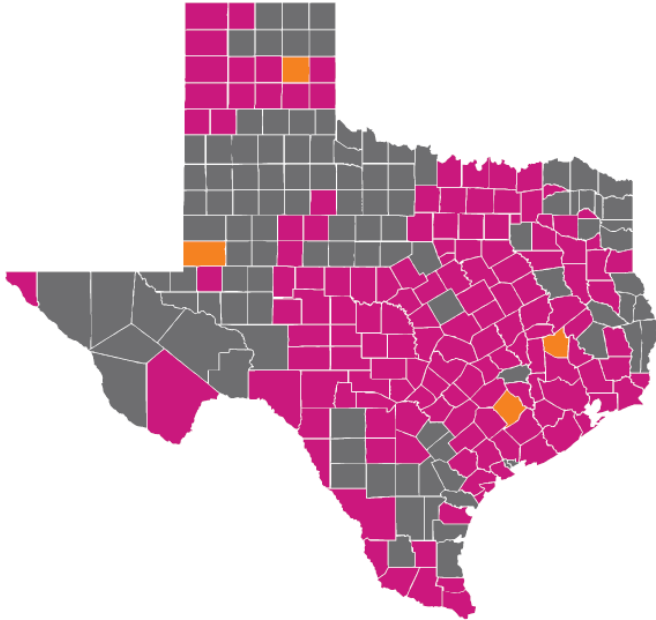
AMBETTER VIRTUAL ACCESS 2024



Counties:

- Andrews, Aransas, Armstrong, Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Brewster, Brooks, Brown, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Castro, Chambers, Cherokee, Coke, Coleman, Collin, Collingsworth, Colorado, Comal, Comanche, Concho, Cooke, Dallam, Dallas, Deaf Smith, Delta, Denton, DeWitt, Donley, Ector, Edwards, El Paso, Ellis, Falls, Fannin, Fayette, Fisher, Fort Bend, Freestone, Frio, Galveston, Gillespie, Goliad, Gonzales, Gray, Grayson, Gregg, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hartley, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Hunt, Irion, Jack, Jackson, Jefferson, Johnson, Kendall, Kerr, Kimble, Kinney, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Llano, Madison, Mason, Matagorda, Maverick, McCulloch, McLennan, Medina, Menard, Milam, Mills, Mitchell, Montague, Montgomery, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Parmer, Potter, Rains, Randall, Real, Refugio, Robertson, Rockwall, Runnels, Rusk, San Jacinto, San Saba, Schleicher, Scurry, Sherman, Smith, Somervell, Starr, Sterling, Stonewall, Sutton, Tarrant, Tom Green, Travis, Trinity, Tyler, Val Verde, Van Zandt, Victoria, Walker, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, Zapata

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HOW TO IDENTIFY A MEMBER'S NETWORK

All members receive an Ambetter member identification card. The ID card includes new information that includes:

- The **Ambetter Plan** the member has selected.
- The **Provider Network** the member belongs to.
- **Referral requirements** based on the member's plan selection.

Note: *Presentation of a member ID card is not a guarantee of eligibility. Providers must verify eligibility on the same day services are rendered.*

2024 Provider Orientation

WHAT YOU NEED TO KNOW

KEY CONTACT INFORMATION

Ambetter from Superior HealthPlan

PHONE
1-877-687-1196

WEB
Ambetter.SuperiorHealthPlan.com

PORTAL
Provider.SuperiorHealthPlan.com

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AMBETTER PROVIDER MANUAL

THE PROVIDER MANUAL IS YOUR COMPREHENSIVE GUIDE TO DOING BUSINESS WITH AMBETTER FROM SUPERIOR HEALTHPLAN.

The manual includes a wide-range of important information relevant to providers doing business with Ambetter. Key information includes:

- Network information
- Billing guidelines
- Claims information
- Regulatory information
- Key contact list
- Quality initiatives

The Provider Manual can be found in the Provider section of the Ambetter website at **Ambetter.SuperiorHealthPlan.com**.

PROVIDER SERVICES

The **Ambetter from Superior HealthPlan** Provider Services team includes trained staff available to respond quickly and efficiently to all provider inquiries, or requests, including:

- Credentialing/Network status
- Claims
- Request for adding/deleting physicians to an existing group

By calling Provider Services at 1-877-687-1196 providers are able to access real time assistance for all their service needs.

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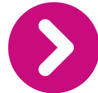
ACCOUNT MANAGEMENT

- As an **Ambetter** provider, you will have a dedicated Account Manager available to assist you.
- Our Account Managers serve as the primary liaisons between our health plan and the provider network.
- Your Account Manager is here to help you operate your practice and address needs, such as:



- ✓ **Inquiries related to administrative policies, procedures, and operational issues**
- ✓ **Contract clarification**
- ✓ **Membership/provider roster questions**
- ✓ **Secure Portal registration and PaySpan**
- ✓ **Provider education**
- ✓ **Demographic information updates**
- ✓ **Initiate credentialing of a new practitioner**

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PUBLIC WEBSITE AND SECURE PORTAL

Ambetter.SuperiorHealthPlan.com

Our Health Plans | Join Ambetter Health | For Members | For Providers | For Brokers | Shop Our Plans

Open Enrollment starts Nov. 1!

Get the quality, affordable healthcare coverage you deserve with America's #1 Marketplace health insurance*.

Learn More

AMBETTER PUBLIC WEBSITE

WHAT'S ON THE PUBLIC WEBSITE?

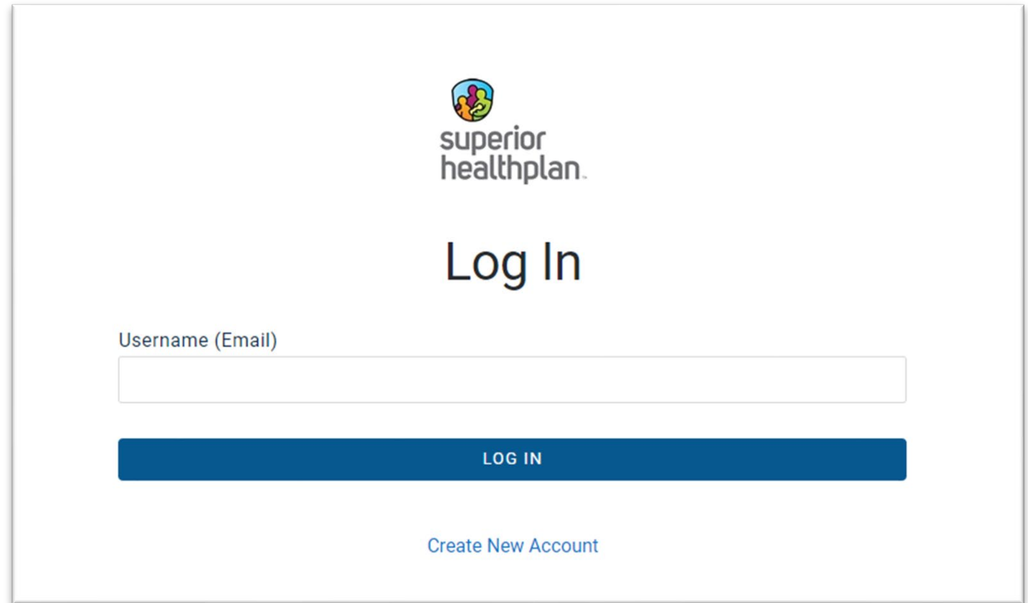
- Provider Manual
- Quick Reference Guides
- Important Forms (Notification of Pregnancy, Prior Authorization Fax forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- Trainings

AMBETTER PUBLIC WEBSITE

REGISTRATION IS FREE AND EASY!

Contact your Account Manager to get started!

Provider.SuperiorHealthPlan.com



SECURE PROVIDER PORTAL

SECURE PROVIDER PORTAL

WHAT'S ON THE SECURE PROVIDER PORTAL?

- Member eligibility and benefits
- Patient listings
- Health records and care gap information
- Authorizations
- Claims submissions and status
- Corrected claims and adjustments
- Payment history
- Monthly PCP cost reports
- Provider analytics reports
- PCP Referrals for Value and Virtual plans

PCP REPORTS INCLUDE:

- Patient List with HEDIS Care Gaps
- Emergency Room Utilization
- Rx Claims Report
- High-Cost Claims

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VERIFICATION OF ELIGIBILITY, BENEFITS AND COST SHARES

MEMBER ID CARD

Provider Services Contact Information

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HEALTH MAINTENANCE ORGANIZATION
QHP | TDI

Subscriber: [Jane Doe]
Member: [John Doe]

Policy #: [XXXXXXXXX]
Member ID #: [XXXXXXXXXXXXX]
Effective Date: [00/00/00]

VALUE

AmbetterHealth.com/copays

PCP: [$10 copay after ded. [($600)]]
Specialist: [$25 coin. after ded. [($600)]]
Rx (Generic/Brand): [$5/$25 after Rx ded. [($600)]]
Urgent Care: [20% coin. after ded. [($600)]]
ER: [$250 copay after ded. [($600)]]
Max Out-of-Pocket: [$25,000]

Plan: [Plan name]
ine 2 if needed]
etwork Name] Network Coverage Only

RXBIN: 003858
RXPCN: A4
RXGROUP: 2DSA

REFERRAL REQUIRED

Ambetter.SuperiorHealthPlan.com

Member/Provider Services: 1-877-687-1196
(Relay Texas/TTY 1-800-735-2989)
24/7 Nurse Line: 1-877-687-1196

Numbers below for providers:
Pharmacy Benefit Manager: Express Scripts
Pharmacist Only: 1-833-750-4268
EDI Payor ID: 68069
[Envolve Vision: 1-8 53-5779]
[Envolve Dental Pow ed by United Concordia: 1-833-260-3625]

Medical Claims Address:
Superior HealthPlan
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

EXPRESS SCRIPTS

Pharmacy Benefit Information

AMB23-TX-C-00046

Ambetter from Superior HealthPlan is underwritten by Celtic Insurance Company, which is a Qualified Health Plan issuer in the Texas Health Insurance Marketplace. This is a solicitation for insurance. © 2023 Celtic Insurance Company. All rights reserved.

Plans can include:

- Ambetter Gold / Silver
- VALUE
- Ambetter Virtual Access

Certain plans may have a referral requirement. Please note:

1. Referral from PCP is required to see a specialist. Auth may be required.
2. Referral from PCP is **not** required to see a specialist. Auth may be required.

Navigating the Member ID Card

PROVIDER MUST VERIFY MEMBER ELIGIBILITY

- Every time a member schedules an appointment.
- When the member arrives for the appointment.

PANEL STATUS

- PCPs should confirm that a member is assigned to their patient panel.
  - This can be done via our Secure Provider Portal.
- Value members PCP will be listed as “Ambetter Value Medical Group” or “Ambetter Value CH Provider Partner.”

ELIGIBILITY, BENEFITS AND COST SHARE

ELIGIBILITY, BENEFITS AND COST SHARES CAN BE VERIFIED IN THREE WAYS:

- ✓ **The Ambetter Secure Portal: Provider.SuperiorHealthPlan.com**

  If you are already a registered user of Superior HealthPlan's secure portal, you do NOT need a separate registration!

- ✓ **24/7 Interactive Voice Response System**

  Enter the Member ID Number and the month of service to check eligibility.

- ✓ **Contact Provider Services: 1-877-687-1196**

Verification of Eligibility, Benefits and Cost Share

VERIFICATION OF ELIGIBILITY ON THE PORTAL

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Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging | Help

Viewing Eligibility For : TIN | Plan Type: Ambetter | GO

Required Action! Providers seeing members enrolled in Ambetter VALUE or VIRTUAL ACCESS products will need to ensure that PCP Referrals are created prior to providing care. Providers who are outside of the members Primary Provider Group will require a referral for services to be covered. Claims will deny if the referral is not in place.

Eligibility Check

Date of Service: 01/10/2024 (mm/dd/yyyy)

Member ID or Last Name: 123456789 or Smith

Date Of Birth: (mm/dd/yyyy)

Check Eligibility | Print

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	STATE	NETWORK	REFERRAL REQUIRED	RECENT ADT	CARE GAPS	LOG ER VISIT	
	01/10/2024	>View details	01/10/2024	TX	AMBETTER CORE	NO	NO	Non-compliant for annual well visit.	ER Visit?	Remove

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VERIFICATION OF COST SHARES ON THE PORTAL

- To verify how much remains of a member's deductible, visit the **Cost Sharing** tab in their profile.

ambetter | Manage Practice | Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging

Viewing Patients For : TIN | Plan Type: Ambetter | GO | Find Patient

Back to Patient List | Smith

- Overview
- Cost Sharing
- Benefits Usage
- Assessments
- Health Record
- ADT
- Care Plan
- Authorizations
- Pharmacy PDL
- Care Management Referrals
- PCP Referrals
- Coordination of Benefits
- Claims
- Benefit Documents
- Document Resource Center
- Notes

Print Cost Sharing

This patient is eligible as of today, Aug 18, 2023. The premium paid through date is Aug 31, 2023 and the claims paid through date is Aug 31, 2023.

Deductible

The fixed amount of money that you are responsible for paying before your insurance starts to pay. Whether or not you meet your deductible depends on how much healthcare you need throughout the year.

Type	Total Amount	Meet Year To Date*	Remaining
Family	$15,000.00	$0.00	$15,000.00
Person	$7,500.00	$0.00	$7,500.00

Co-insurance and Copayment information are contained in Schedule of Benefits.

Schedule of Benefits

Out-Of-Pocket Limit

The total amount you will spend for healthcare, after which the insurance company pays for all your medical care until the year ends.

Type	Total Amount	Meet Year To Date*	Remaining
Family	$18,000.00	$163.81	$17,836.19
Person	$9,000.00	$163.81	$8,836.19

* These values will start at zero on January 1st. The following counts towards your deductible: medical costs, physician services, hospital services, EHB covered services, including pediatric, vision and mental health services, drug benefits.

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VERIFICATION OF BENEFITS ON THE PORTAL

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Manage Practice | Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging

Viewing Patients For : TIN | Plan Type: Ambetter | GO | Find Patient

Back to Patient List | Smith

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- Benefit Documents
- Document Resource Center
- Notes

Schedule of Benefits

Summary of Benefits and coverage

For additional Benefit Coverage information go to AmbetterHealth.com or call provider services

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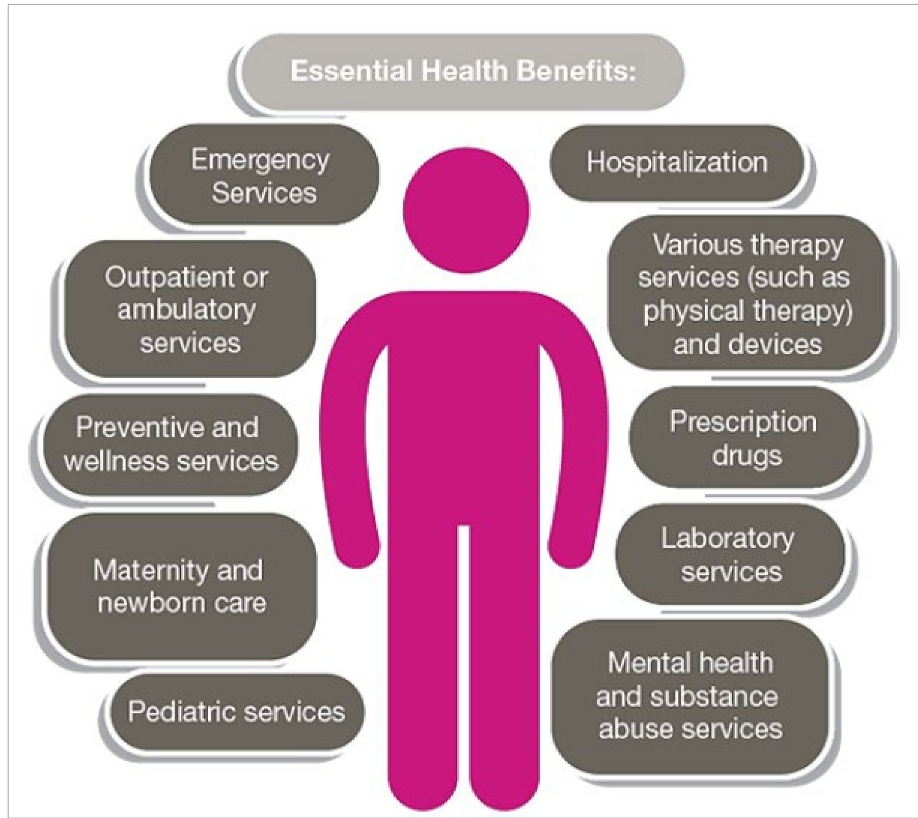
ESSENTIAL HEALTH BENEFITS



- Essential Health Benefits are offered within each Ambetter Health plan.

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OTHER BENEFITS

- My Health Pays Rewards
- Health Management programs
- Optional Dental and Vision
- Start Smart for Your Baby
- Your Better Health Center
- Virtual 24/7 Care
    - This is one-time, episodic care, available 24/7, and delivered virtually

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2024 Provider Orientation

REFERRALS

AMBETTER PCP REFERRAL REQUIREMENTS

- Some Ambetter plans have referral requirements.
- For services to be covered under these plans, they must be provided by or referred by a PCP.
- If a referral is not initiated, services performed outside of the member's assigned provider or primary care group will be denied.
- Prior authorization requirements will also apply, as necessary.
- Referral requirements are reiterated throughout the Ambetter Guide and member plan materials to ensure members understand the rules associated with their plan.
- Referring providers can use our Secure Provider Portal to initiate referrals on behalf of members.

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EXCEPTIONS TO REFERRAL REQUIREMENTS

THE FOLLOWING SERVICES ARE EXEMPT FROM REFERRAL REQUIREMENTS:

- Emergency or urgent care services
- In-network mental, behavioral health and substance abuse disorder services
- Obstetrical or gynecological services
- Labs, X-Ray/Imaging, Anesthesiology

Prior authorization requirements will also apply, as necessary.

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AMBETTER REFERRAL REQUIREMENTS

Silver and Gold

- Members are educated to seek care or consultation with their PCP first.
- Medically necessary care is needed beyond the scope of what a PCP provides, PCPs should initiate and coordinate the care members receive from specialist providers.
- Paper referrals are not required for members to seek care with in-network specialists.

Virtual

- Teladoc (or local PCP) will be responsible to submit a referral to Ambetter Health in order for any specialty care provider to render services to our members.

Value

- Any specialty care rendered by a specialist outside of the preferred physician group will require a referral prior to services being rendered to our members.

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MAKING A REFERRAL: SECURE PROVIDER PORTAL

ONCE YOU IDENTIFY THE SPECIALIST'S NAME AND NPI, SUBMIT THE INFORMATION ON THIS SCREEN.

1. Click on "**PCP Referrals**" tab at the top of the screen.
2. Click the "**Create Referral**" button.
3. Complete the fields on the PCP Referral form.

Tip: Please utilize the Helpful Information section for assistance / guidance.

Create Referral

Patient Name Smith
Birth Date
Plan Ambetter Value
Member ID
Primary Provider Group

Referral Date

Select a Start Date to determine the type of referral required.
*All fields required except Notes and Attachments

Start Date * 08/18/2023
End Date * 11/16/2023

Helpful Information:
If you need to find a provider for your referral, please use the Ambetter Guide.

No referral necessary for the following Specialties:

- Anesthesiology
- Behavioral Health/Substance Use Disorder
- Labs
- Obstetrics and Gynecology
- Radiology (X-ray, Imaging)
- Urgent or Emergent Services

Referring Provider
ENTER NAME OR NPI * SEARCH
Name
TIN NPI
Phone

Referral Type & Visits
Select Referral Type * Consult & Treatment
Visits * 1

Referred To Provider
ENTER NAME OR NPI * SEARCH
Name
TIN NPI
Phone

Referred To Provider's Specialty
Select Specialty *

Notes(optional)
Enter some notes here...
0/400

ATTACHMENTS
Drag & Drop Files
Or Select Files From Your Computer
Upload PDF or Word Doc
5 KB minimum and 25 MB maximum per file

Note: Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual.

CANCEL NEXT

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RECEIVING A REFERRAL

1. Once you receive a referral for care from the member's PCP, the member will schedule an appointment with you.
2. Log in to the Secure Provider Portal.
3. Navigate to 'Referrals' tab at the top.
4. Click on 'Referrals Received' to see the referral tracking table.
5. When you are ready to submit a claim for the referred service, reference this table for the referral ID/REF#.
6. Submit claims form with the REF# in **Box 23**.
7. Claim form **MUST** include a REF# if a referral is required for the service. **If no REF# is submitted, the claim will be denied.**

ambetter | Manage Practice | Eligibility | Patients | PCP Referrals | Authorizations | Claims | Messaging

Viewing Referrals For : TIN | Plan Type: Ambetter | GO | Create Referral

PCP Referrals

What's New: Filter Referrals
You can now filter primary care provider referrals by typing a keyword for Plans, Referral IDs, Status types, Specialties, and Dates. To select specific attributes, including Member Last Name, please use the Filter tool.

PCP Referrals Received | PCP Referrals Made

Filter | Filter By Keywords

Submitted	Referral ID	Member Name	Plan	Specialty	Visits Left	Start - End Dates	Status
07/20/2023	REFC5		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	07/20/2023 - 10/18/2023	Active
06/30/2023	REF35		Ambetter Value	Obstetrics & Gynecology 12 Allowed Visits	12	06/30/2023 - 09/28/2023	Active
05/02/2023	REF05		Ambetter Value	Obstetrics & Gynecology: Gynecology 6 Allowed Visits	6	05/02/2023 - 07/31/2023	Expired
03/30/2023	REF64		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/30/2023 - 06/28/2023	Expired
03/27/2023	REFD2		Ambetter Value	General Acute Care Hospital 6 Allowed Visits	6	03/27/2023 - 06/25/2023	Expired
03/24/2023	REF18		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/24/2023 - 06/22/2023	Expired
03/22/2023	REF61		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	03/22/2023 - 06/20/2023	Expired
03/07/2023	REF98D0E0966		Ambetter Value	Obstetrics & Gynecology: Gynecology 6 Allowed Visits	6	03/07/2023 - 06/05/2023	Expired
02/23/2023	REF8E0AC478B		Ambetter Value	Obstetrics & Gynecology 6 Allowed Visits	6	02/23/2023 - 05/24/2023	Expired

DOWNLOAD

Rows per page: 10 | 1–9 of 9

'Visits Left' is based on claims processing starting on 1/1/2023. If Ambetter has not received a claim for a date of service, it will not be included in the counts above.

Status Type Explanation

ACTIVE: The referral is still within the start date and end date
EXPIRED: The end date for the referral has passed
CANCELLED: The referral has been cancelled by the referring provider
CLOSED: The referral number was submitted with a claim

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2024 Provider Orientation

PRIOR AUTHORIZATION

HOW TO SECURE A PRIOR AUTHORIZATION

NEED PRIOR AUTHORIZATION?
It can be requested in the following ways:

1. On the Secure Provider Portal at Provider.SuperiorHealthPlan.com
   - If you are already a registered user of the Secure Provider Portal, you do not need a separate registration
2. Fax requests to:
   - Outpatient: 1-855-537-3447 (Medical) or 1-844-307-4442 (Behavioral)
   - Inpatient: 1-866-838-7615 (Medical) or 1-866-900-6918 (Behavioral)
     - The fax authorization forms are located at Ambetter.SuperiorHealthPlan.com/Provider-Resources/Manuals-and-Forms.html
3. Call for Prior Authorization at 1-877-687-1196

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PROCEDURES / SERVICES THAT REQUIRE PRIOR AUTHORIZATION INCLUDE*:

- Potentially cosmetic
- Experimental or investigational
- High-tech imaging (e.g. CT, MRI, PET)
- Infertility
- Pain Management

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

REQUIREMENTS

INPATIENT AUTHORIZATION IS NEEDED FOR THE FOLLOWING:

All elective/scheduled admission notifications requested at least 5 Business Days prior to the scheduled date of admit including:

- All services performed in out-of-network facilities
- Behavioral health/substance use
- Hospice care
- Rehabilitation facilities
- Transplants, including evaluation

- Observation stays more than 23 hours require Inpatient Authorization
- Urgent/Emergent Admissions
  - Within 1 Business Day following the date of admission
  - Newborn deliveries must include birth outcomes
- Partial Inpatient, PRTF and/or Intensive Outpatient Programs (IOP)

REQUIREMENTS

ANCILLARY SERVICES THAT REQUIRE PRIOR AUTHORIZATION INCLUDE*:

- Air ambulance transport (non-emergent fixed-wing airplane)
- Durable medical equipment (DME)
- Home health care services, including:
  - Home infusion
  - Skilled nursing
  - Therapy
  - Private duty nursing
  - Adult medical day care
  - Hospice
  - Furnished medical supplies and DME

**This list is not all-inclusive. Use the Pre-Auth Needed Tool to check if a specific service or procedure requires prior authorization.*

REQUIREMENTS

TIMEFRAMES

Service Type	Timeframe
Scheduled admissions	Prior Authorization required 5 Business DAYS prior to the scheduled admission date
Elective outpatient services	Prior Authorization required 5 Business DAYS prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 1 business day
Observation – 48 hours or less	Notification within one Business Day for non-participating providers
Observation – greater than 48 hours	Requires inpatient prior authorization within 1 Business Day
Emergency room and post stabilization, urgent care and crisis intervention	No prior authorization required
Maternity admissions	Notification within 1 Business Day
Newborn admissions	Notification within 1 Business Day
Neonatal Intensive Care Unit (NICU) admissions	Notification within 1 Business Day
Outpatient Dialysis	Notification within 3 Calendar Days

Prior Authorization Timeframes

Type	Timeframe
Prospective/Urgent	3 Calendar Days
Prospective/Non-Urgent	3 Calendar Days
Concurrent/Urgent	24 Hours
Retrospective	30 Calendar Days

PRIOR AUTHORIZATION WILL BE GRANTED AT THE CPT CODE LEVEL

- If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
- If additional procedures are performed during the procedure, the provider **must** contact the health plan to update the authorization in order to avoid a claim denial.
- It is recommended that this be done within 72 hours of the procedure. However, it **must** be done prior to claim submission or the claim will deny.
- Ambetter will update authorizations but will **not** retro-authorize services.
  - The claim will deny for lack of authorization.
  - If there are extenuating circumstances that led to the lack of authorization, the claim may be appealed.

CORRECT CODING

Preauthorization Exemptions

- Providers will be exempt for six months from obtaining prior authorizations for specific services in which, during the review period, if they received 90% medical necessity approval, with a minimum of 5 requests per service/procedure code/prescription.
  - Concurrent Inpatient review services are excluded from preauthorization exemption.
  - Prescription, outpatient and elective inpatient procedures are subject to review for prior authorization exemption.
- January and June of each year we are able to review between 5 and 20 medical records for claims received and may rescind prior authorization exclusion if:
  - 90% of medical necessity criteria are not met for the sample size.
  - Providers may request an independent review from an IRO if they disagree with Ambetter Health's decision.
- Out-of-network providers will still require prior authorization unless the provider is exempt for the service/procedure code/prescription.

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2024 Provider Orientation

CLAIMS, BILLING AND PAYMENTS

CLAIMS

WHAT IS A CLEAN CLAIM?

- A clean claim that is received for adjudication in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required documentation, or particular circumstance requiring special treatment that prevents timely payment.

ARE THERE ANY EXCEPTIONS?

- A claim for which fraud is suspected
- A claim for which a third-party resource should be responsible

HOW TO SUBMIT A CLAIM

The timely filing deadline for initial claims is 95 days from the date of service, or date of primary payment, when Ambetter is secondary.

CLAIMS MAY BE SUBMITTED IN THREE WAYS:

1. **The Secure Provider Portal**
   - Provider.SuperiorHealthPlan.com

2. **Electronic Clearinghouse**
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter will continue to be utilized
   - For a listing of our clearinghouses, visit our website at Ambetter.SuperiorHealthPlan.com

3. **Mail**
   - Ambetter
     P.O. Box 5010
     Farmington, MO 64640-5010

CLAIM RECONSIDERATIONS AND DISPUTES

CLAIM RECONSIDERATIONS

- For reconsideration requests, providers can use the **Reconsider Claim** button on the Claim Details screen within the Secure Provider Portal.
- A written request from a provider about a disagreement in the manner in which a claim was processed. No specific form is required.
- Must be submitted within 120 days of the explanation of payment.
- Mail claim reconsiderations to:

  Ambetter from Superior HealthPlan
  Attn: Level I – Request for Reconsideration
  PO Box 5010
  Farmington, MO 63640-5010

CLAIM DISPUTES

- Must be submitted within 120 days of the Explanation of Payment
- A Claim Dispute form can be found on our website at Ambetter.SuperiorHealthPlan.com
- Mail completed Claim Dispute form to:

  Ambetter from Superior HealthPlan
  Attn: Level II – Claim Dispute
  PO Box 5010
  Farmington, MO 63640-5010

CLAIM SUBMISSION SUSPENDED STATUS

WHAT IF A MEMBER IS IN SUSPENDED STATUS?

- After the first 30 days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
- A provision of the Affordable Care Act (ACA) allows members who are receiving Advanced Premium Tax Credits (APTCs) a three-month grace period for paying claims.
- While the member is in a suspended status, claims will be pended.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the claims will be released, and the provider may bill the member directly for services.

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CLAIM SUBMISSION SUSPENDED STATUS

EXAMPLE TIMELINE OF A MEMBER IN SUSPENDED STATUS

- **January 1st**
  Member pays premium.

- **February 1st**
  Premium due – member does not pay.

- **March 1st**
  Member placed in suspended status.

- **April 1st**
  Member remains in suspended status.

- **May 1st**
  If premium remains unpaid, member is terminated.
  Provider may bill member directly for services rendered.

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HELPFUL INFORMATION ABOUT CLAIMS

MAKE SURE TO INCLUDE THE RENDERING TAXONOMY CODE!

- Claims **must** be submitted with the rendering provider's taxonomy code.
- The claim will deny if the taxonomy code is not present.
- This is necessary in order to accurately adjudicate the claim.

REMINDER: DO NOT FORGET THE CLIA NUMBER!

- If the claim contains CLIA-certified or CLIA-waived services, the CLIA number **must** be entered in **Box 23** of a paper claim form or in the appropriate loop for EDI claims.
- Claims will be rejected if the CLIA number is not on the claim.

BILLING THE MEMBER

COPAYS, CO-INSURANCE AND DEDUCTIBLES

- Copays, co-insurance and any unpaid portion of the deductible may be collected at the time of service.
- Deductible information, including the amount that has been paid toward the deductible so far, can be accessed via the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- If the amount collected from the member is higher than the actual amount owed upon claim adjudication, the provider must reimburse the member within 45 days.

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PAYSPAN®: A FASTER, EASIER WAY TO GET PAID

- Ambetter offers PaySpan® Health, a free solution that helps providers transition into electronic payments and automatic reconciliation
- If you currently utilize PaySpan®, you will need to register specifically for Ambetter
- **Set up your PaySpan® account:**
  - Visit www.payspanhealth.com and click Register
  - You may need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN)

CLAIMS PAYMENTS

2024 Provider Orientation

COMPLAINTS, GRIEVANCES AND APPEALS

COMPLAINTS, GRIEVANCES AND APPEALS

CLAIMS

- A provider must exhaust the claims reconsideration and claims dispute process before filing a complaint/grievance or appeal.

COMPLAINT/GRIEVANCE

- A complaint is a verbal or written expression by a provider, which indicates dissatisfaction or dispute with Ambetter Health's policies, procedures, or any aspect of Ambetter Health's functions.
- A letter will be sent to the provider acknowledging receipt of the complaint within 5 Business Days.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 days.
  - The letter includes the decision/resolution of the complaint, the facts utilized to resolve it and the provider's right to pursue arbitration or file a complaint with TDI if they are not satisfied with the outcome.

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COMPLAINTS, GRIEVANCES AND APPEALS

APPEALS

- For Claims, the Claims Reconsideration, Claims Dispute and Complaint/Grievances process must be exhausted prior to filing an appeal.

MEDICAL NECESSITY

- Must be filed within 180 calendar days from the Notice of Action.
- Ambetter shall acknowledge receipt within 5 days of receiving the appeal.
- Ambetter shall resolve each appeal and provide written notice as expeditiously as the member's health condition requires but not to exceed 30 calendar days.
- Expedited appeals may be filed if the time expended in a standard appeal could seriously jeopardize the member's life or health. The timeframe for a decision for an expedited appeal will not exceed one working day from the date all information necessary to complete the appeal is received.

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COMPLAINTS, GRIEVANCES AND APPEALS

MEMBER REPRESENTATIVES

- Members may designate a provider to act as their representative for filing appeals related to medical necessity.
- Ambetter requires that this designation by the member be made in writing and provided to Ambetter.
- No punitive action will be taken against a provider by Ambetter for acting as a member's representative.

NEED MORE INFORMATION?

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual, located on our website at **Ambetter.SuperiorHealthPlan.com**.

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CULTURAL COMPETENCY

Cultural Sensitivity

- Ambetter Health encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with members, and the health and wellness of the members themselves.
- Providers and their staff should address Medical Consenters, Caregivers, and members with dignity sensitivity and respect.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
  - Knowledge
    - Provider's self-understanding of race, ethnicity and influence.
    - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
  - Skills
    - Ability to communicate effectively with the use of cross-cultural interpreters.
    - Ability to utilize community resources.
  - Attitudes
    - Respect the importance of cultural forces.
    - Respect the importance of spiritual belief.

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Resources

- Complimentary Interpretation Services
  - Ambetter Health offers interpretation services to providers at no cost.
  - To access telephonic interpreters for your members or to schedule an in-person interpreter, please contact Ambetter's Member Services department at 1-877-687-1196.

- Trainings and Information
  - The Culture, Language and Health Literacy website provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions and special populations.
    - https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy
  - EthnoMed is a website containing information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
    - https://ethnomed.org/
  - Superior's Health Equity webpage offers information about cultural and linguistic competency and available language services.
    - https://www.superiorhealthplan.com/providers/resources/quality-improvement/health-equity-program.html

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SPECIALTY SERVICES & VENDORS

Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services, Interventional Pain Management, Therapy Services and Musculoskeletal Services	National Imaging Associates	1-877-687-1196 www.radmd.com
Vision Services	Envolve Vision©	1-866-753-5779 www.envolvevision.com
Dental Services	Envolve Dental©	1-833-260-3625 www.envolvedental.com
Pharmacy Services	Express Scripts	1-833-750-4508 Physician Innovation | Express Scripts (express-scripts.com)

SPECIALTY COMPANIES AND VENDORS

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Questions & Answers