Ambetter from Superior HealthPlan

1/14/2016

This document does not meet accessibility standards. If you have questions about the information contained within, please contact Provider Services at 1-877-687-1196 (Relay Texas/TTY 1-800-735-2989).

Agenda

1. Overview of the Affordable Care Act
2. The Health Insurance Marketplace
3. Verification of Eligibility, Benefits and Cost Shares
4. Specialty Referrals
5. Prior Authorization
6. Claim Submission
7. Claim Payment
8. Complaints/Appeals
9. Specialty Companies/Vendors
10. Public Website
11. Provider Toolkit
12. Contact Information

The Affordable Care Act

Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Coverage:

- Dependent coverage to age 26
- Pre-existing condition insurance plan (high risk pools)
- No lifetime maximum benefits
- Preventive care covered at 100% with no deductible or co-pays
- Insurer minimum loss ratio (80% for individual coverage)

The Affordable Care Act

The ACA reformed commercial insurance through Marketplaces (also known as Exchanges)

- No more underwriting – guaranteed issue
- Tax penalties for not purchasing insurance
- Minimum standards for coverage: benefits and cost sharing limits
- Subsidies for lower incomes (100%-138% Federal Poverty Level)

Health Insurance Marketplace

Online marketplaces for purchasing health insurance

Potential members can:

- Register for an account.
- Determine eligibility for all health insurance programs (including Medicaid).
- Shop for plans.
- Enroll in a plan.

The Health Insurance Marketplace is the only way to purchase insurance and receive subsidies. Exchanges may be State-based, federally facilitated or State partnership. Texas is a Federally Facilitated Marketplace.

If your patients are asking you for information about the Affordable Care Act, refer them to the government website: **www.healthcare.gov.**

Health Insurance Marketplace

Subsidies are provided in two forms:

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

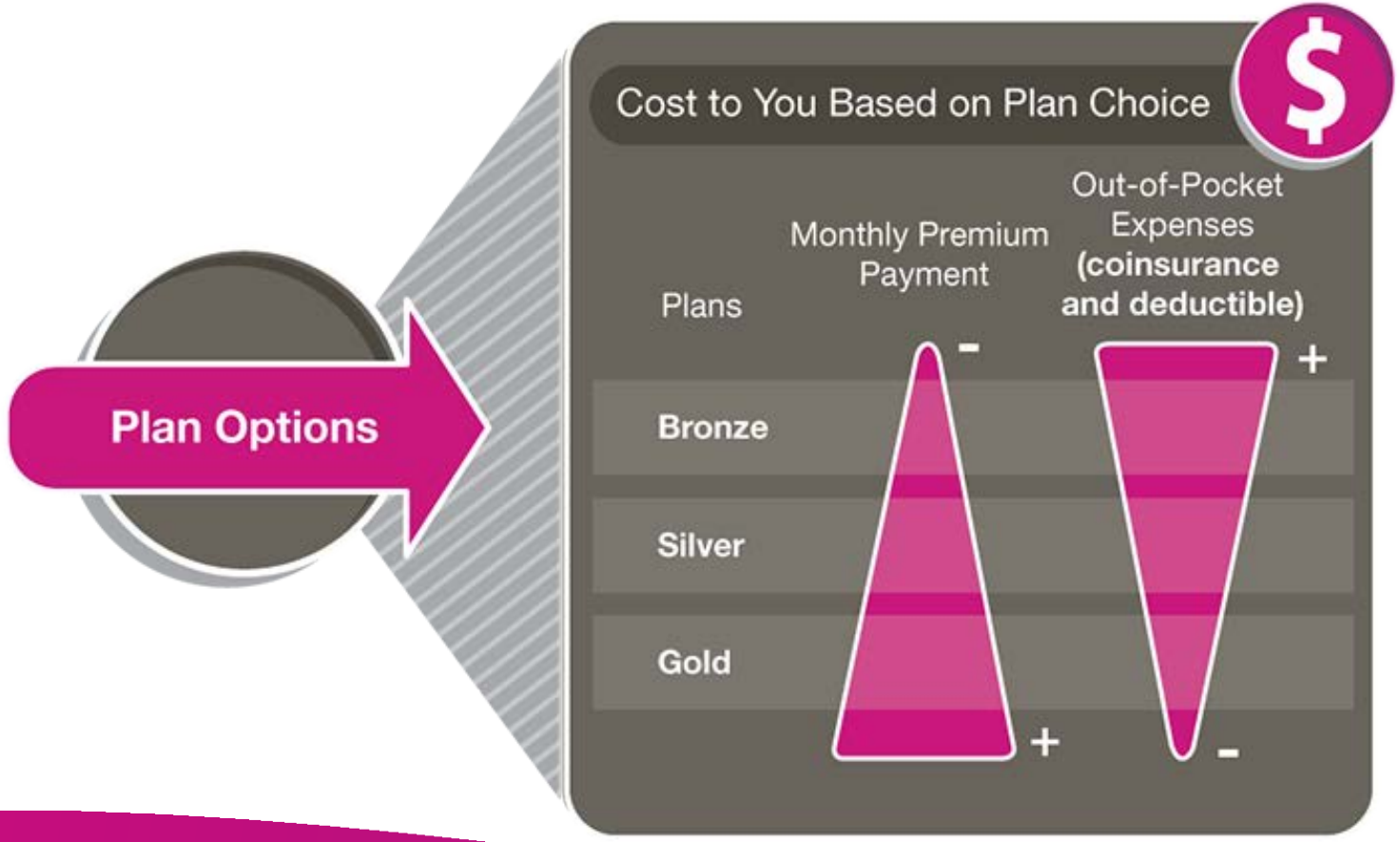
All Benefit Plans have cost shares in the form of copays, coinsurance and deductibles.

- Some members will qualify for assistance with their cost shares based on their income level.
- This assistance would be paid directly from the government to the member's health plan.

Essential Health Benefits (EHBs)

- Emergency Services
- Hospitalization
- Laboratory Services
- Maternity and Newborn Care
- Mental Health and Substance Use Services (both inpatient and outpatient)
- Outpatient and Ambulatory Services
- Pediatric Services including Pediatric Vision
- Prescription Drugs
- Preventive and Wellness Services
- Various Therapies (such as physical therapy and devices)

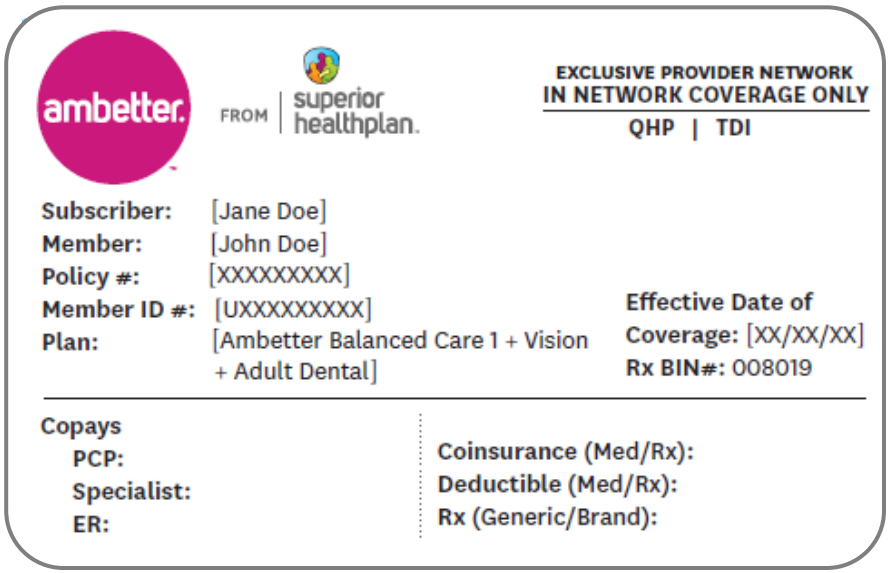
Plan Options



What you need to know

Verification of Eligibility, Benefits and Cost Share

Member ID Card:



ambetter. FROM superior healthplan.

EXCLUSIVE PROVIDER NETWORK
IN NETWORK COVERAGE ONLY
QHP | TDI

Subscriber: [Jane Doe]
Member: [John Doe]
Policy #: [XXXXXXXXX]
Member ID #: [UXXXXXXXXX]
Plan: [Ambetter Balanced Care 1 + Vision + Adult Dental]

Effective Date of Coverage: [XX/XX/XX]
Rx BIN#: 008019

Copays
PCP:
Specialist:
ER:

Coinsurance (Med/Rx):
Deductible (Med/Rx):
Rx (Generic/Brand):

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]
Pharmacy Help Desk: [1-877-687-1196]

Numbers below for providers:
EDI Payor ID: 68069
EDI Help Desk: [Ambetter.SuperiorHealthPlan.com]
Pharmacy Help Desk: [1-855-339-4805]
Pharmacy Administrator: US Script

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

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.SuperiorHealthPlan.com.

AMB15-TX-C-00032

Possession of an ID Card is not a guarantee of eligibility and benefits.

Verification of Eligibility, Benefits and Cost Share

Eligibility, Benefits and Cost Shares can be verified in 3 ways:

1. The Ambetter Secure Provider Portal found at: Ambetter.SuperiorHealthPlan.com.
   - If you are already a registered user of the Superior Secure Portal, you do not need a separate registration.

2. 24/7 Interactive Voice Response system
   - Enter the Member ID Number and the month of service to check eligibility.

3. Contact Provider Services at: 1-877-687-1196.
   - Provider Services is available to assist you Mon.-Fri. 8:00 a.m. – 6:00 p.m. CT.

Secure Provider Portal

Sign up for a secure web portal account to gain access to helpful information and interactive tools.

Visit Ambetter.SuperiorHealthPlan.com. Click the LOGIN button to get started.

- Authorizations
- Check eligibility and view member roster
- Claims
- Explanation of Payment (EOP)
- Member benefits, health records, and gaps in care
- PCP's can view and print Patient Lists
- Secure messaging
- Update provider demographic information (address, officer, etc.)

Non-Payment of Premium

What happens if a Member fails to pay their premium?

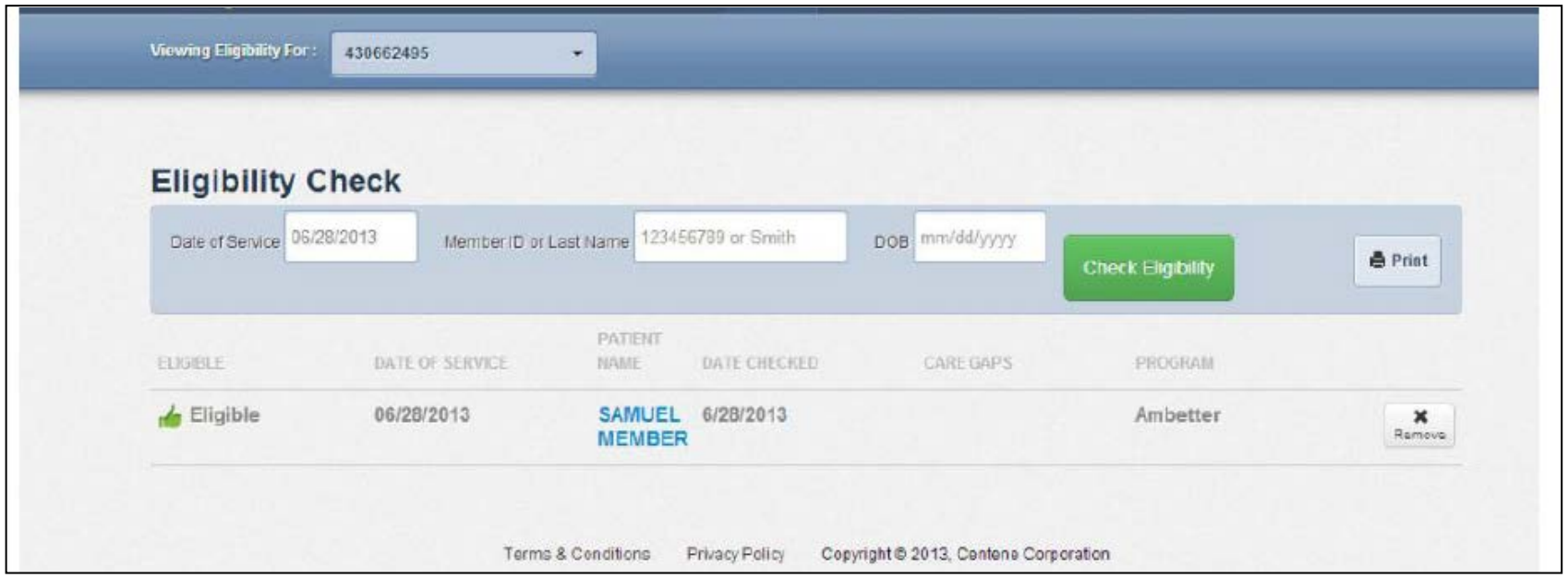
A provision of the Affordable Care Act requires that Ambetter allow members receiving APTC subsidies a three month grace period to pay premiums before coverage is terminated.

When providers are verifying eligibility through the Secure Web Portal, the following results may appear:

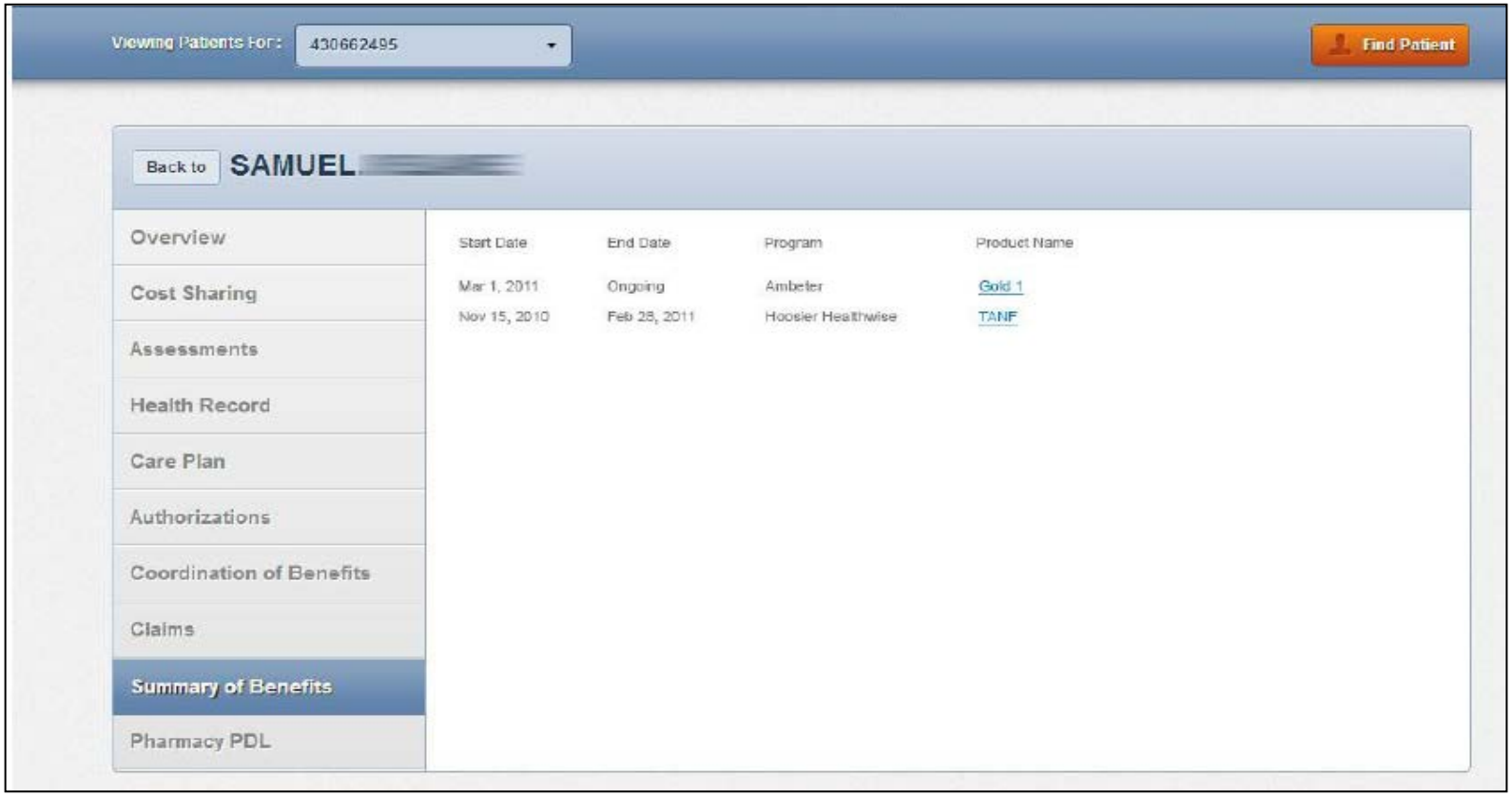
- **Month 1**: Non-payment of premium
  - The member will be confirmed as enrolled and eligible.

- **Months 2 & 3**: Non-payment of premium
  - Same as Month 1 Non-payment of premium
  - An additional alert message will be returned indicating non-payment of premium.

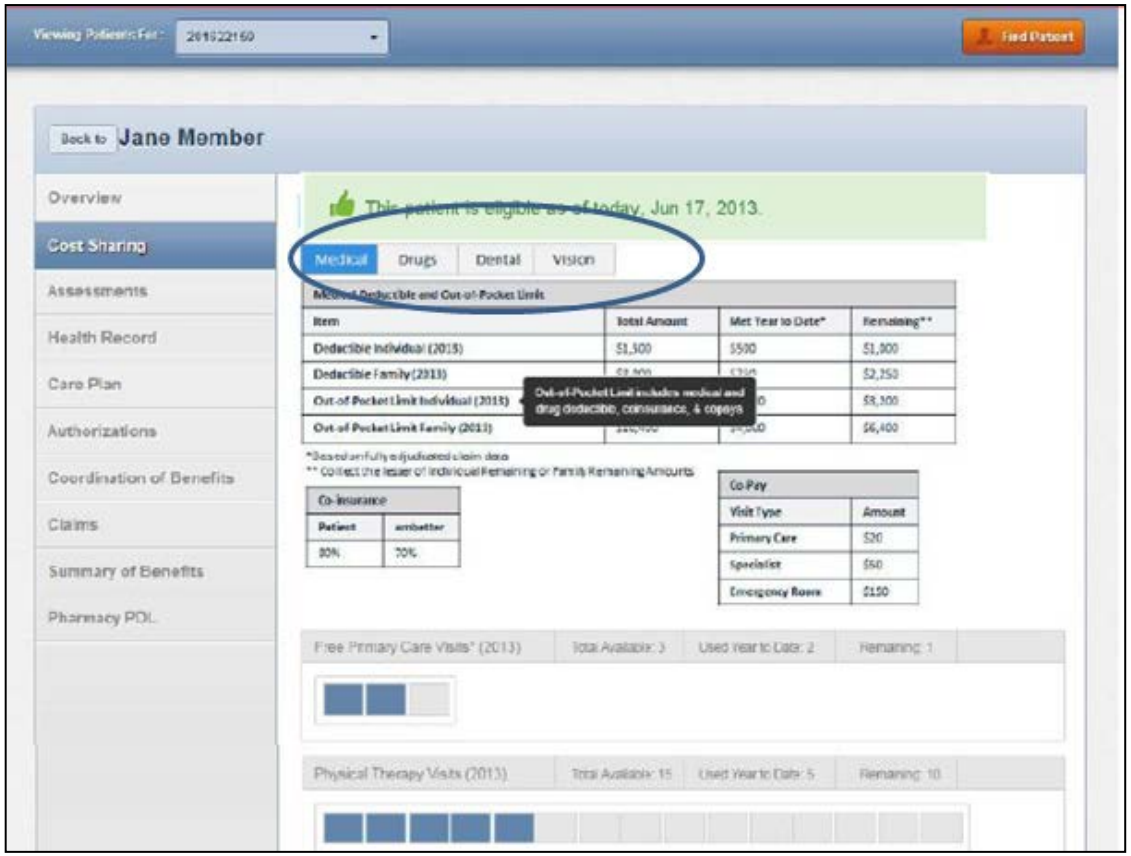
Verification of Eligibility



Verification of Benefits



Verification of Cost Shares



Specialty Referrals

- Members are encouraged to first seek care or consultation with their Primary Care Provider.
- When 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.

Prior Authorization

Procedures / Services Requiring Authorization

- Bariatric Surgery
- Experimental or Investigational
- High Tech Imaging (i.e. CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
- Pain Management
- Potentially Cosmetic

All Out-of-Network (Non-Par) services require prior authorization excluding emergency services.

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department at 1-877-687-1196.

Prior Authorization

Inpatient Authorization

- All services performed in out-of-network facilities
- Behavioral Health/Substance Use Disorder
- Hospice care
- Medical admissions
- Newborn deliveries must include birth outcomes
- Observation stays exceeding 23 hours require Inpatient Authorization
- Partial Inpatient, PRTF, and/or Intensive Outpatient Programs
- Rehabilitation facilities
- Surgical admissions
- Transplants including evaluations
- Urgent/Emergent Admissions

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department at 1-877-687-1196.

Prior Authorization

Ancillary Services

- Durable Medical Equipment (DME)
- Genetic Testing
- Hearing Aid Devices including cochlear implants
- Home health care services: Home infusion, Skilled nursing, and Therapy
- Non-emergent transport including fixed wing airplane and ambulance
- Orthotics/Prosthetics
- Quantitative Urine Drug Screen
- Therapy (Occupational, Physical and Speech)

This is not meant as an all-inclusive list. Please visit the Ambetter website at Ambetter.SuperiorHealthPlan.com and use the Pre-Screen Tool, or call Provider Services Authorization Department at 1-877-687-1196.

Prior Authorization Request Timeframes

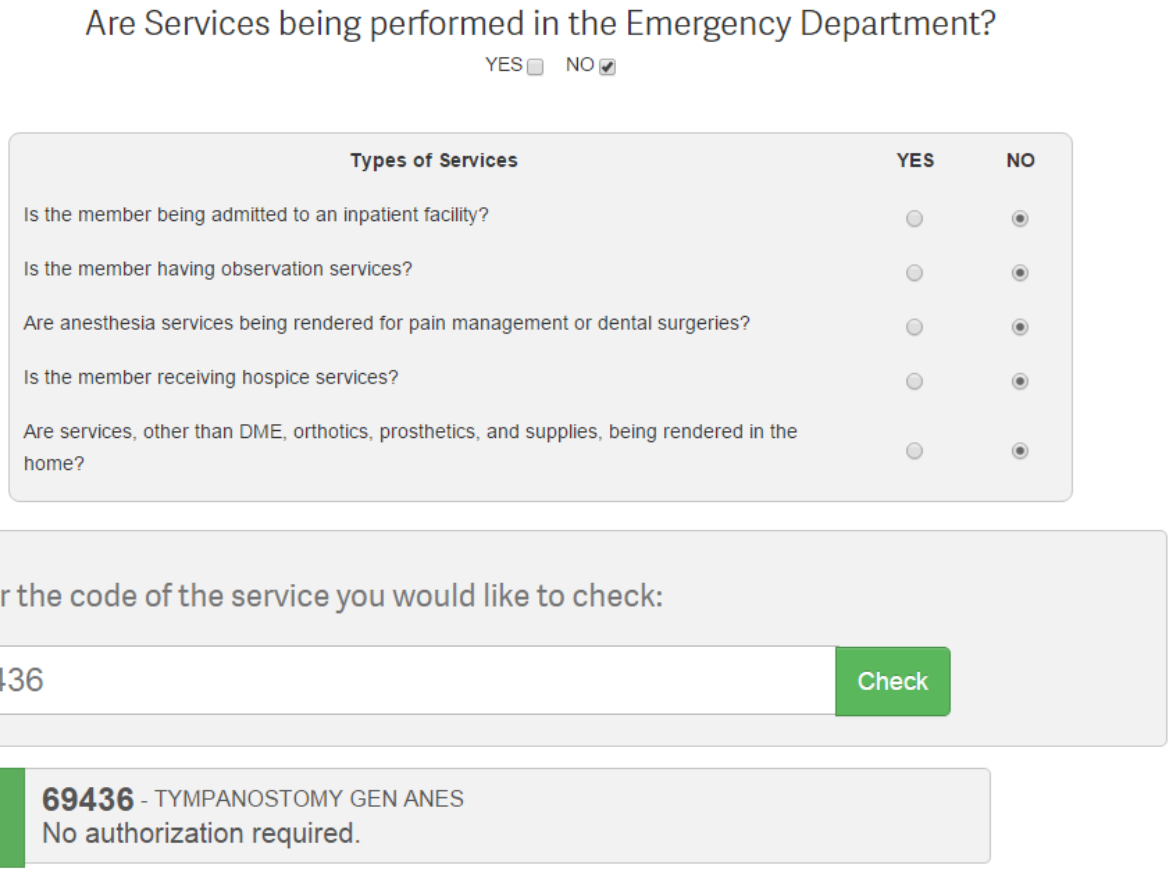
Service Type	Timeframe
Scheduled inpatient admissions	**5 business days** prior to the scheduled admission date
Elective outpatient services	**5 business days** prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within **1 business day**
Observation – greater than 23 hours	Requires inpatient prior authorization within **1 business day**
Emergency room and post stabilization, urgent care and crisis intervention	Notification within **1 business day**
Maternity admissions	Notification within **1 business day**
Newborn admissions	Notification within **1 business day**
NICU admissions	Notification within **1 business day**
Outpatient Dialysis	Notification within **1 business day**

Utilization Determination Timeframes

Type	Timeframe
Prospective/Urgent	Three (3) Calendar days
Prospective/Non-Urgent	Three (3) Calendar days
Emergency Services	60 minutes
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day)
Retrospective	Thirty (30) calendar days

Prior Authorization

Pre-Authorization Needed Tool:



Prior Authorization

Prior Authorization can be requested in 3 ways:

1. The Ambetter Secure Portal found at Ambetter.SuperiorHealthPlan.com
   - If you are already a registered user of the Superior HealthPlan portal, you do not need a separate registration.

2. Fax Requests to: 1-855-537-3447
   - The fax authorization forms are located on our website at Ambetter.SuperiorHealthPlan.com.

3. Call for Prior Authorization at 1-877-687-1196.

Prior Authorization

Prior Authorization will be granted at the CPT code level.

1. If a claim is submitted that contains CPT codes that were not authorized, the services will be denied.
    - If during the procedure additional procedures are performed, in order to avoid a claim denial, the provider must contact the health plan to update the authorization. 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 be denied.

2. Ambetter will update authorizations but will not retro-authorize services. The claim will be denied for lack of authorization. If there are extenuating circumstances that led to the lack of authorization, the claim may be submitted for a reconsideration or a claim dispute.

Claim Submission

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 3 ways:

1. The Secure Web Portal located at Ambetter.SuperiorHealthPlan.com
2. Electronic Clearinghouse
   - Payor ID 68069
   - Clearinghouses currently utilized by Ambetter from Superior HealthPlan will continue to be utilized
   - For a listing of our the Clearinghouses, please visit out website at Ambetter.SuperiorHealthPlan.com
3. Paper claims may be submitted to:

   Ambetter from Superior HealthPlan
   P.O. Box 5010
   Farmington, MO 64640-5010

Claim Submission

Request for Adjustment or Claim Appeals

- 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.

- Claim Appeals may be mailed to:

  Ambetter from Superior HealthPlan
  Claims Disputes/Appeals
  P.O. Box 5010
  Farmington, MO 63640-5010

Claim Submission

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.
- The completed Claim Dispute form may be mailed to:
  Ambetter from Superior HealthPlan
  Claim Disputes/Appeals
  P.O. Box 5000
  Farmington, MO 63640-5000

Claim Submission

Member in Suspended Status

- A provision of the ACA allows members who are receiving Advanced Premium Tax Credits (APTCs) a 3 month grace period for paying claims.
- 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.
- If the member subsequently pays their premium and is removed from a suspended status, claims will be adjudicated by Ambetter.
- If the member fails to pay their premium during the grace period, any claims paid will be subject to recoupment.
- If the member does not pay their premium and is terminated from their Ambetter plan, providers may bill the member for their full billed charges.

Claim Submission

Member in Suspended Status – Example

- **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.

Note: Claims for members in a suspended status are not considered “clean claims.
When checking Eligibility, the Secure Portal will indicate that the member is in a suspended status.

Grace Period Flow

January 1st:

Member pays their premium

February 1st:

Premium is due
Member does not pay their premium

Member is placed in a DELINQUENT status

Provider may continue to submit claims and will be reimbursed for services

March 1st:

Premium is due
Member does not pay their premium

Member is placed in a SUSPENDED status

Provider may continue to submit claims and will be reimbursed for services

April 1st:

Premium is due
Member does not pay their premium

Member remains in a SUSPENDED status

Claims may be submitted but ***will be pended***
The EOP will state: "LZ Pend-Non-Payment of Premium

May 1st:

Premium is due
Member does not pay their premium

Member is terminated
Provider may bill Member directly for services provided in March and April (months 2 and 3)

Claim Submission

Other helpful information

Rendering Taxonomy Code:

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

Clinical Lab Improvement Act (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.

Claim Submission

Billing the Member:

- Copays, Coinsurance, and any unpaid portion of the Deductible may be collected at the time of service.
- The Secure Web Portal will indicate the amount of the deductible that has been met.
- 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.

Preventive Visits

My Health Pay Rewards Logic

	Reward Type	Provider Limits	Logic	Codes
Well Visit	**Annual Adult Well Visit**	PCP or OBGYN	One Per Year	**Proc Codes**: 99385-87, 99395-97, or **Diag Codes**: Z0000, Z005, Z008,Z021, Z023, Z0289, or **HCPCS Codes**: G0344, G0402, G0438-39
	Annual Childhood Well Visit (over age 3)	PCP or OBGYN	One Per Year	**Proc Codes**: 99382-85, 99392-95 or **Diag Codes**: Z0000, Z005, Z008,Z00129, Z021, Z023, Z0289, or **HCPCS Codes**: G0438-39
	Well Child Visits (under age 3)	PCP only	Max of 6 from birth to age 1 Max of 3 between age 1 and 2 Max of 2 between age 2 and 3	**Proc Codes**: 99381-82, 99391-92 or **Diag Codes**: Z0000, Z005, Z008,Z00129, Z021, Z023, Z0289, or **HCPCS Codes**: G0438-39
	Well Child Visits (under 15 mos)	PCP only	Reward if 6 visits occur prior to the age of 15 months	**Proc Codes**: 99381-85, 99391-95, 99461 or **Diag Codes**: Z0000, Z005, Z008,Z00129, Z021, Z023, Z0289, or **HCPCS Codes**: G0438-39
	Well Child Visits (ages 3 to 6)	PCP only	One Per Year	**Proc Codes**: 99381-85, 993691-95, 99461 or **Diag Codes**: Z0000, Z005, Z008, Z00110, Z00111, Z00129, Z021, Z023, Z0289, or **HCPCS Codes**: G0438-39
	Adolescent Well Care	PCP or OBGYN	One Per Year	**Proc Codes**: 99381-85, 99391-95, 99461 or **Diag Codes**: Z0000, Z005, Z008, Z00110, Z00111, Z00129, Z021, Z023, Z0289, or **HCPCS Codes**: G0438-39
Flu Shot	**Flu Shots (all)**	Any	One Per Flu Season (October through April)	**Proc Codes**: 90654-90664, G0008, Q2035-Q2039

Claim Payment

PaySpan

- Ambetter partners with PaySpan for Electronic Remittance Advice (ERA) and Electronic Funds Transfer.
- If you currently utilize PaySpan, you will need to register specifically for the Ambetter product.
- **To register for PaySpan:**
  Call 1-877-331-7154 or visit www.payspanhealth.com.

Complaints

Claims

- A provider must exhaust the Claims Reconsideration and Claims Dispute process before filing a Complaint/Grievance or Appeal.

Complaint

- Must be filed within 30 calendar days of the last claim disposition.
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days.

Appeals

Appeals

- Appeals are reserved for Medical Necessity determinations.
- For Claims Appeals/Reconsiderations follow the Claim Reconsideration and Claim Dispute process.

Medical Necessity

- 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 72 hours from the date of receipt.

Appeals

- 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.

- Ambetter will not take any retaliation against a Member for filing a complaint.

Specialty Companies/Vendors

Service	Specialty Company/Vendor	Contact Information
Behavioral Health Payor ID - 68069	Cenpatico Behavioral Health	1-877-687-1196 www.cenpatico.com
Pharmacy Services BIN # 008019	US Script	1-866-768-0468 www.usscript.com
High Tech Radiology Imaging Services	National Imaging Associates	1-800-424-4916 www.radmd.com
Vision Services Payor ID - 56190	Total Vision Health Plan	1-866-753-5779 www.opticare.com

Health Information System (HIS)

- Improve performance and manage costs with this user-friendly, no-cost dashboard.
- Access data about the quality and access to care within your practice.
- Track incentive-based programs.
- Monitor patient's profile for ER visits.

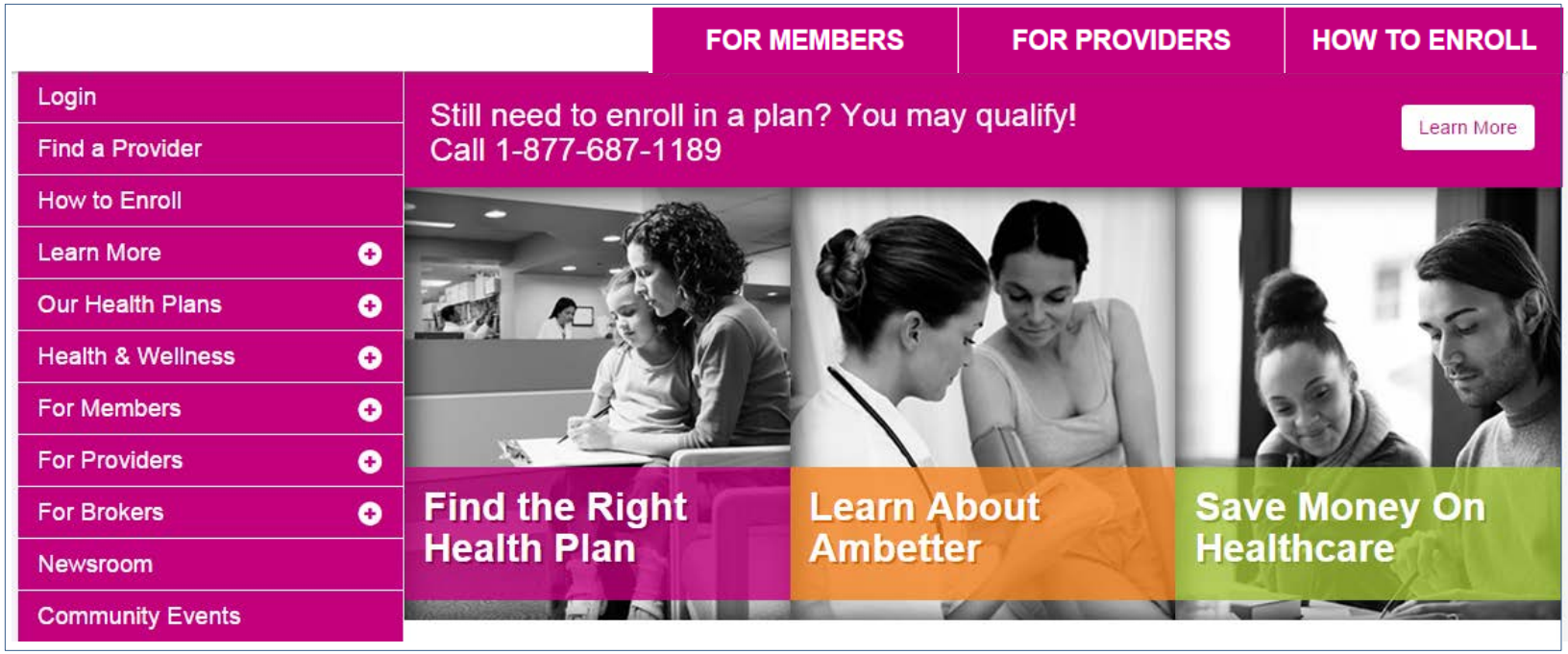
General Information:

- Superior HealthPlan Provider Services: 1-877-391-5921
- Reference materials: SuperiorHealthPlan.com/for-providers/provider-resources/

Public Website

Accessing the Public Website for Ambetter:

- Go to Ambetter.SuperHealthPlan.com



Public Website

Information contained on our Website:

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

Provider Tool Kit

Information included in the Tool Kit:

- Welcome Letter
- Ambetter Provider Introductory Brochure
- Frequently Asked Questions
- Secure Portal Setup
- Electronic Funds Transfer Setup
- Prior Authorization Guide
- Quick Reference Guide
- Provider Office Window Decal
- PaySpan Setup

The following items will be provided for your patients:

- Ambetter Consumer Introductory Brochure
- Quick Guide Education Cards

Contact Information

Ambetter from Superior HealthPlan

Phone: 1-877-687-1196

Relay Texas/TTY: 711

Ambetter.SuperiorHealthPlan.com

Questions?