Ambetter from Superior HealthPlan

Agenda

1) Ambetter Overview
2) Provider Portal
3) Verification of Eligibility, Benefits and Cost Shares
4) Specialty Referrals
5) Prior Authorization
6) Claim Submission / Payment
7) Complaints/Grievances and Appeals
8) Specialty Companies/Vendors
9) Public Website / Provider Tool Kit
10) Contact Information

The Affordable Care Act

The Affordable Care Act

Key objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Changes already in place (pre 2014):

- Dependent coverage to age 26 (without being a full time student)
- No denials based on pre-existing conditions
- No lifetime maximum benefits

Latest addition to complete the essential benefits package:

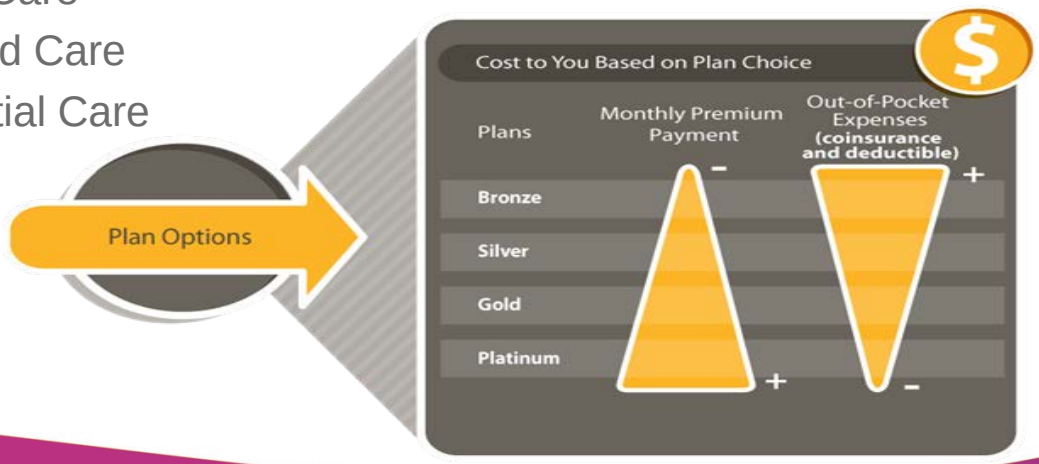
- Preventative care covered at 100% with no deductibles or co-pays

The 10 Essential Health Benefits

1) Preventive and Wellness Services
2) Maternity and Newborn Care
3) Pediatric Services including Pediatric Vision
4) Outpatient or Ambulatory Services
5) Laboratory Services
6) Various Therapies (such as physical therapy and devices)
7) Hospitalization
8) Emergency Services
9) Mental Health and Substance Use Services (both inpatient and outpatient)
10) Prescription Drugs

Overview of Benefit Structure

- Essential Health Benefits (EHBs) are the same with every plan. Every health plan will cover the minimum, comprehensive benefits as outlined in the Affordable Care Act.
- Plans vary based on the individual liability limits or cost share expenses to the member.
- Under the Affordable Care Act (ACA), “Metal Tiers” are used to categorize these limits. Each plan offered on the Health Insurance Marketplace (or Exchange) will be categorized within one of these metal tiers: Platinum, Gold, Silver, and Bronze.
- Metal tiers for Ambetter are named:
  - ✓ Gold = Ambetter Secure Care
  - ✓ Silver = Ambetter Balanced Care
  - ✓ Bronze = Ambetter Essential Care



Affordable Care Act Patient Questions?

Are your patients asking you for information on the Affordable Care Act?

Refer them to the government website: https://www.healthcare.gov/

What is Healthcare.gov?

Healthcare.gov is an online marketplace for purchasing health insurance. Potential members can:

- Register
- Determine eligibility for all health insurance programs under the exchange
- Shop for plans
- Enroll in a plan

- Exchanges may be State-based or federally facilitated or State Partnership – Texas is a Federally Facilitated Marketplace

The Health Insurance Marketplace is the only way to purchase insurance AND receive subsidies.

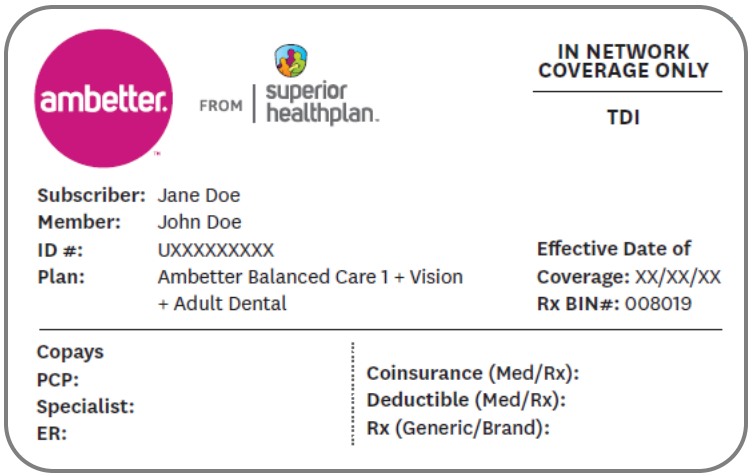
What you need to know

Ambetter from Superior HealthPlan

Ambetter from Superior HealthPlan is a commercial HMO product in the Texas Health Insurance Marketplace.

- Patients must choose a Primary Care Provider (PCP).
- Authorizations are required for certain services.
- All out of network services require prior authorizations (unless emergency - matter of life or limb).

Member ID Card


ambetter. FROM superior healthplan.

IN NETWORK COVERAGE ONLY

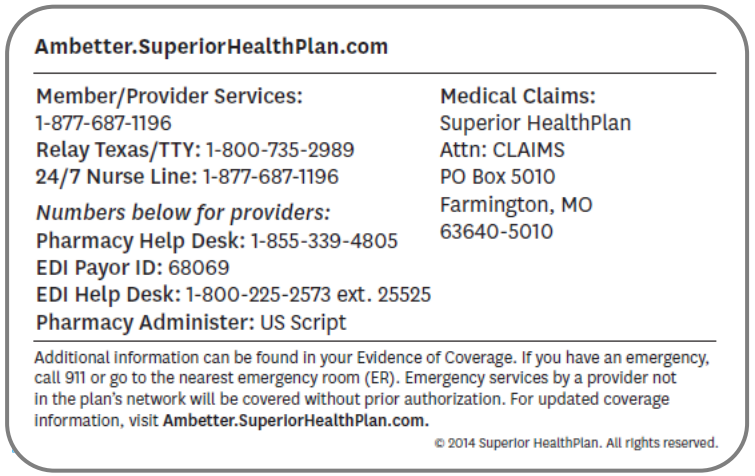
TDI

Subscriber: Jane Doe
Member: John Doe
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

Numbers below for providers:
Pharmacy Help Desk: 1-855-339-4805
EDI Payor ID: 68069
EDI Help Desk: 1-800-225-2573 ext. 25525
Pharmacy Administer: 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 by a provider not in the plan's network will be covered without prior authorization. For updated coverage information, visit **Ambetter.SuperiorHealthPlan.com.**

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

Verification of Eligibility, Benefits and Cost Sharing

Ways to Verify

Eligibility, Benefits and Cost Sharing 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 HealthPlan secure portal, you do NOT need a separate registration.

2. Call Provider Service at: 1-877-687-1196
   - Provider services is available to assist you M-F 8:00 AM – 6:00 PM CST.

3. 24/7 Interactive Voice Response system: 1-877-687-1196
   - IVR Quick Nav. Tips:
     - ✓ Press 1: to check member eligibility or hear benefit and co pay information
     - ✓ Press 2: for claims information and processing
     - ✓ Press 3: to submit or check on authorizations
     - ✓ Press 4: for Behavioral Health Services
     - ✓ Press 5: if you are calling for any other reason

Non Payment of Premium

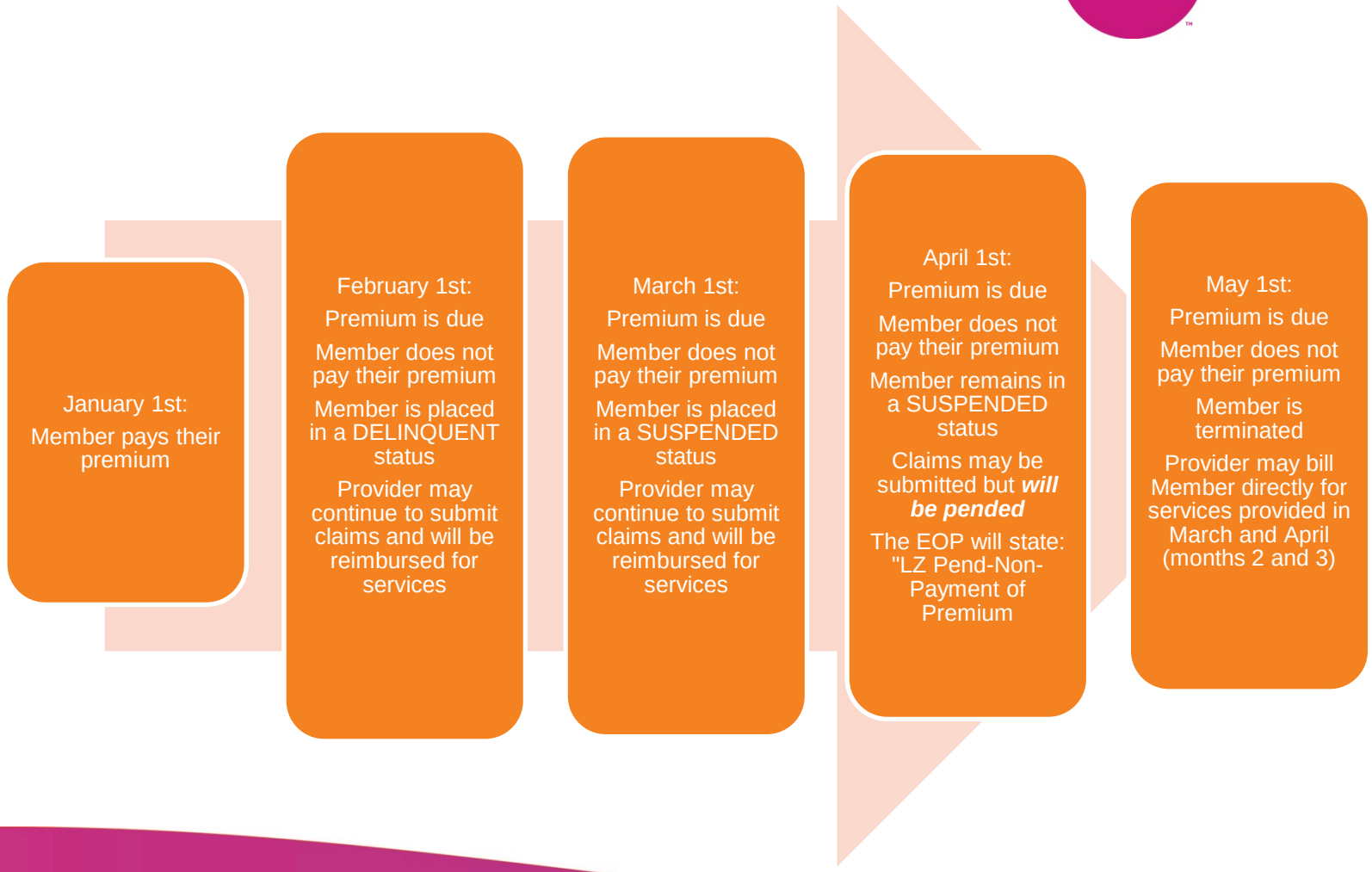
What happens if a member fails to pay their premium?

A provision of the Affordable Care Act requires that Ambetter allow members receiving 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 of non-payment of premium, the member will be confirmed as enrolled and eligible.
- Months 2-3 of non-payment, the member will be confirmed as enrolled and eligible however an additional alert message will be returned indicating nonpayment of premium.

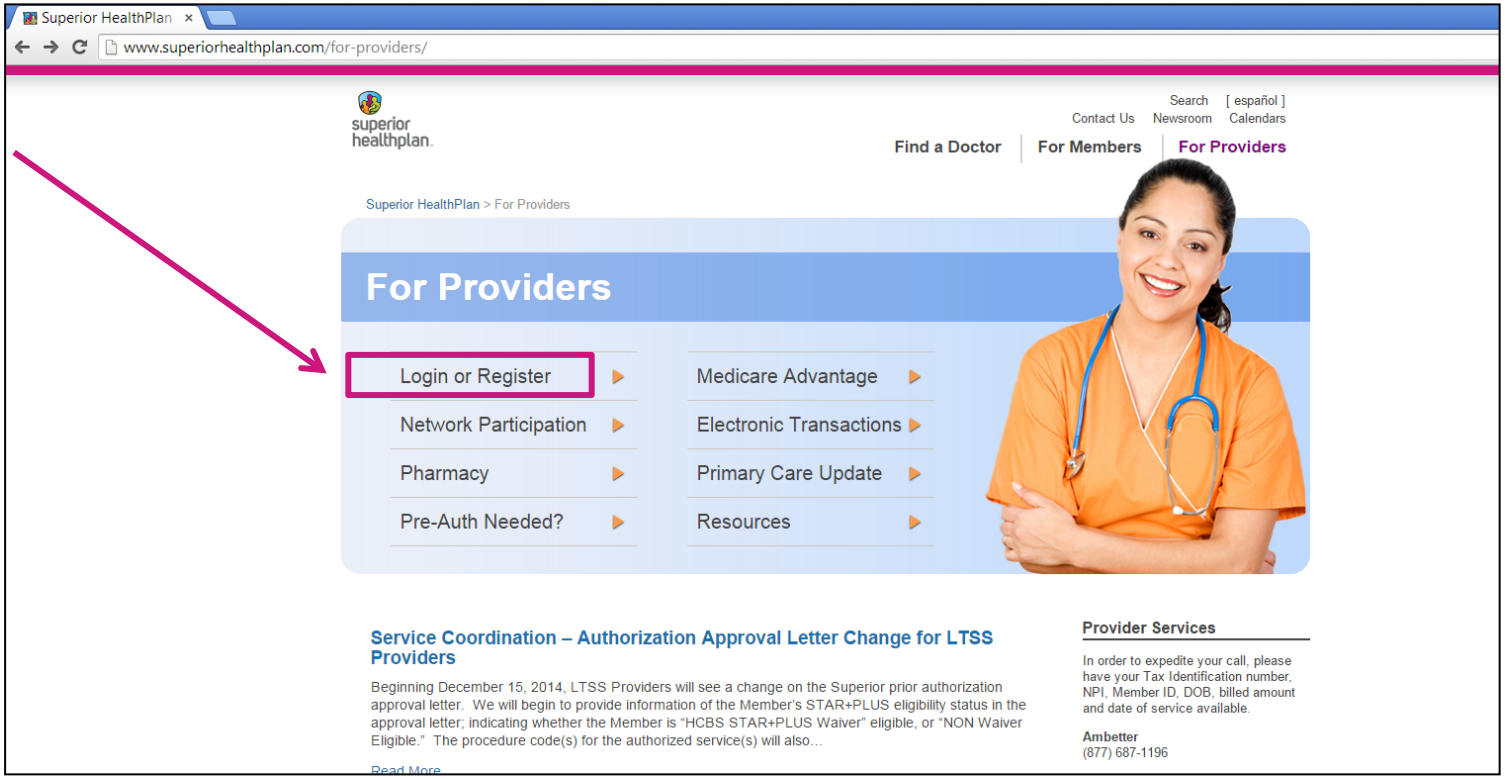
Grace Period Flow



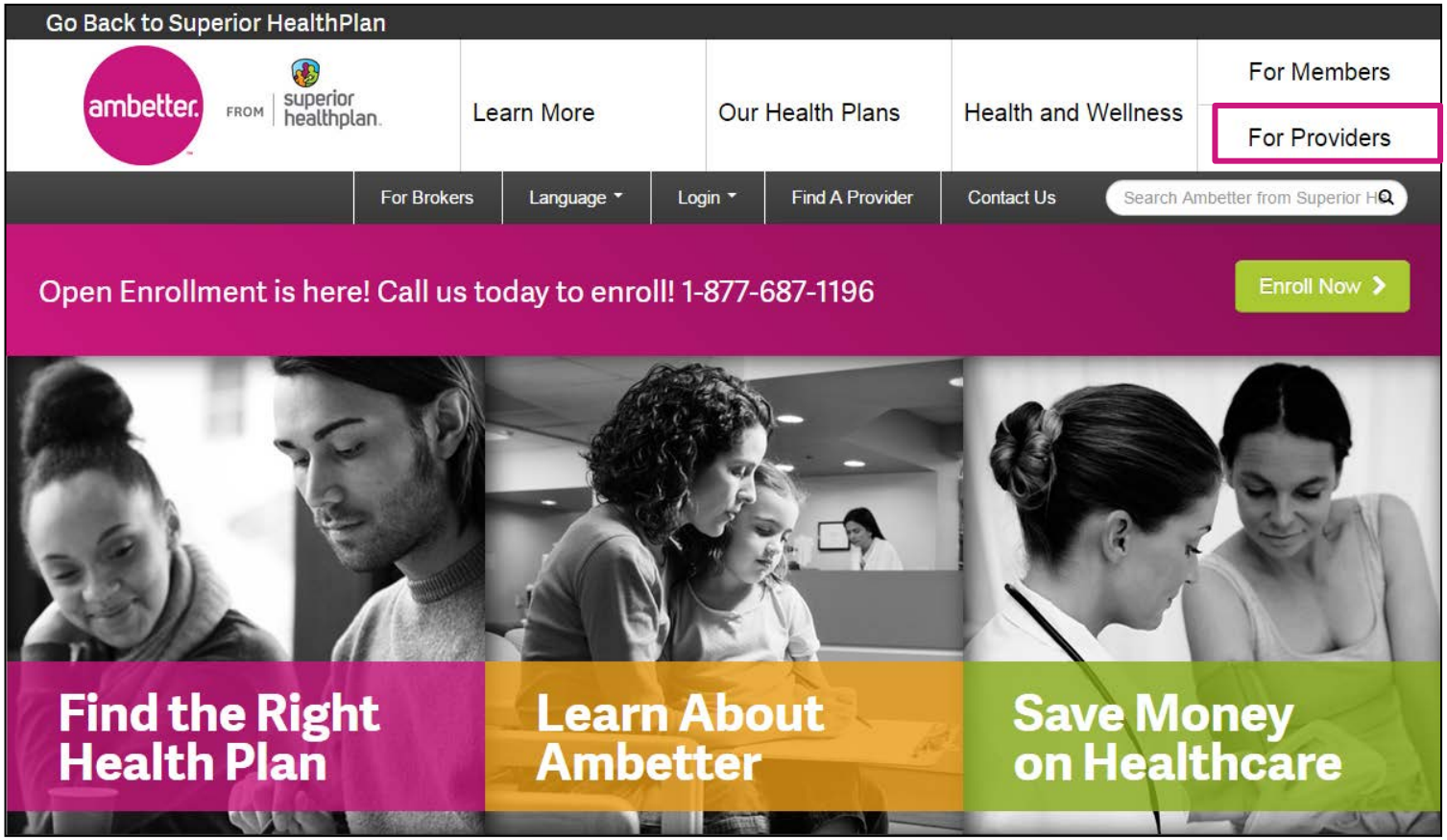
Secure Provider Portal

Provider Portal

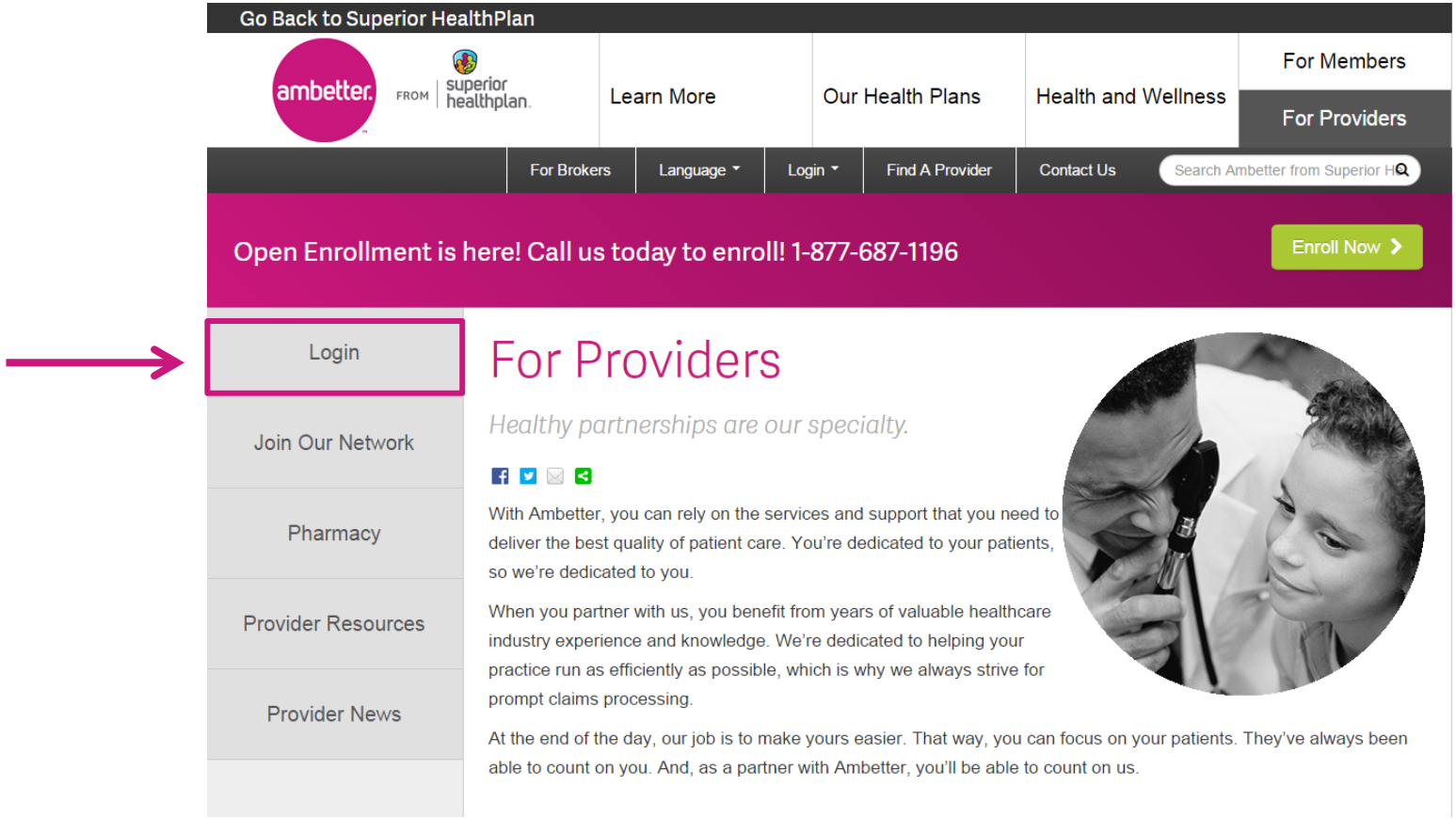
To Login or Register



Provider Portal

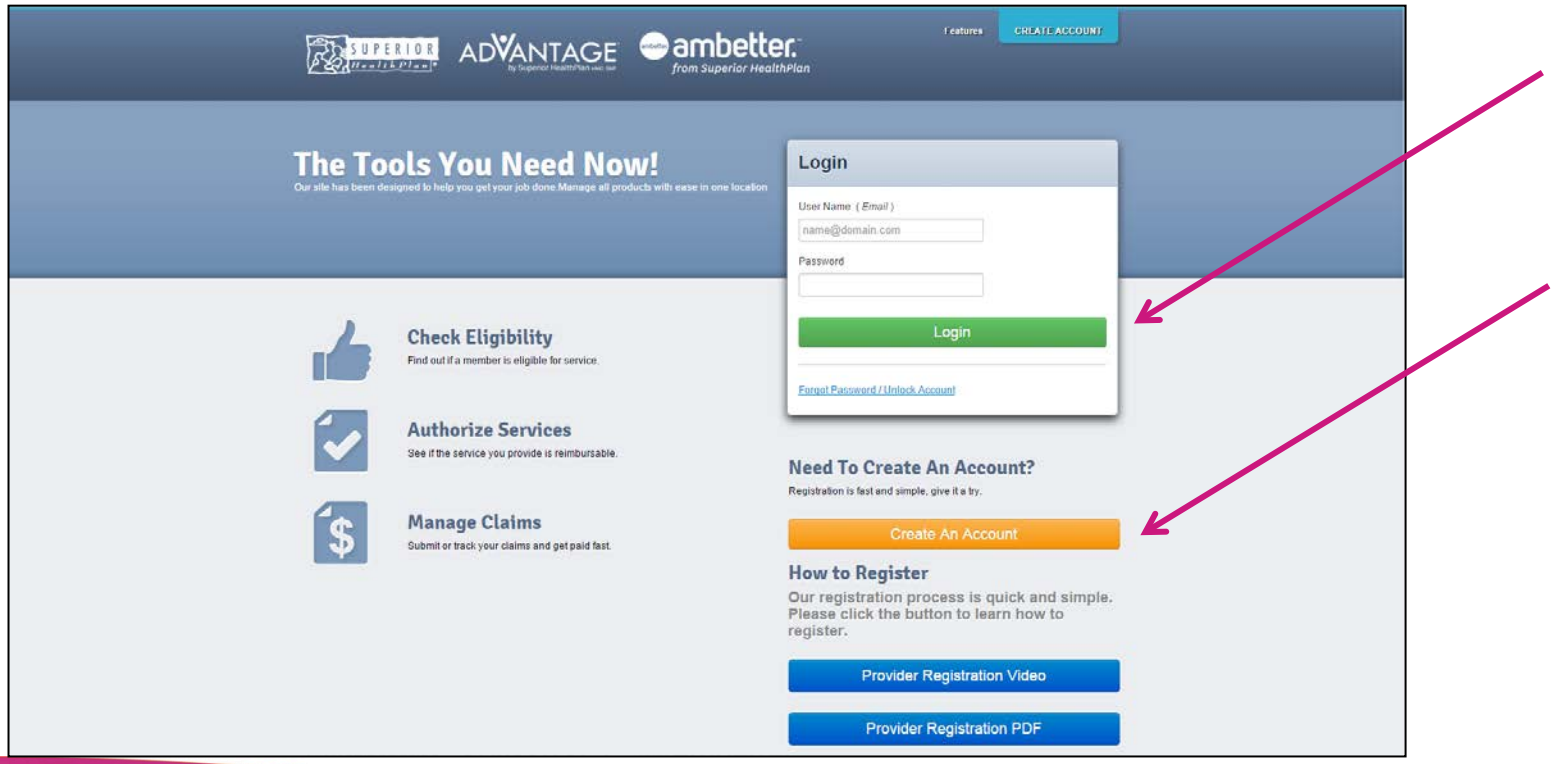


Provider Portal



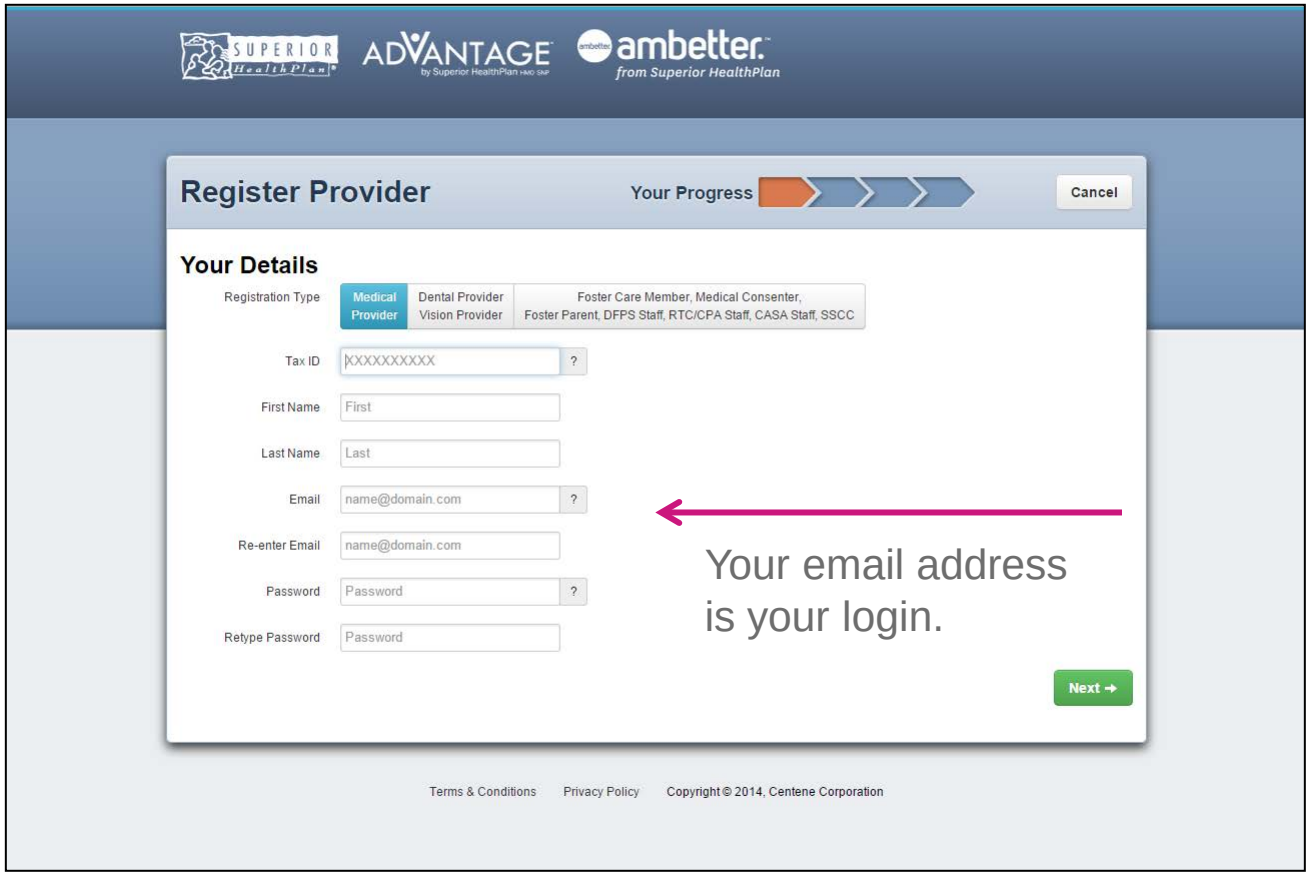
To Login or Register

Choose “Create An Account” if this is your first time to the portal.
Choose “Login” if you are a returning user.



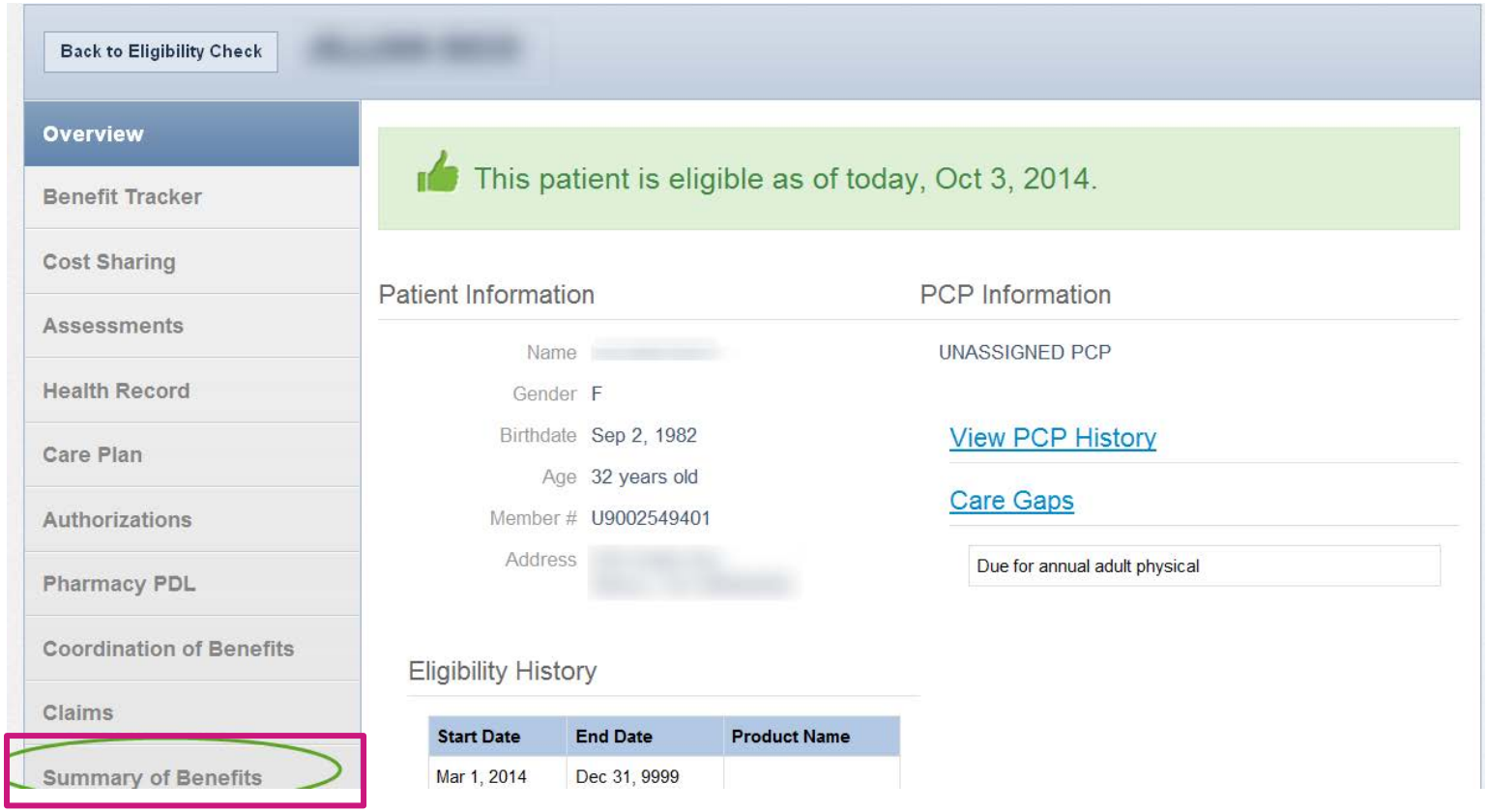
Begin Your Registration

The process could take up to 48 hours for approval.



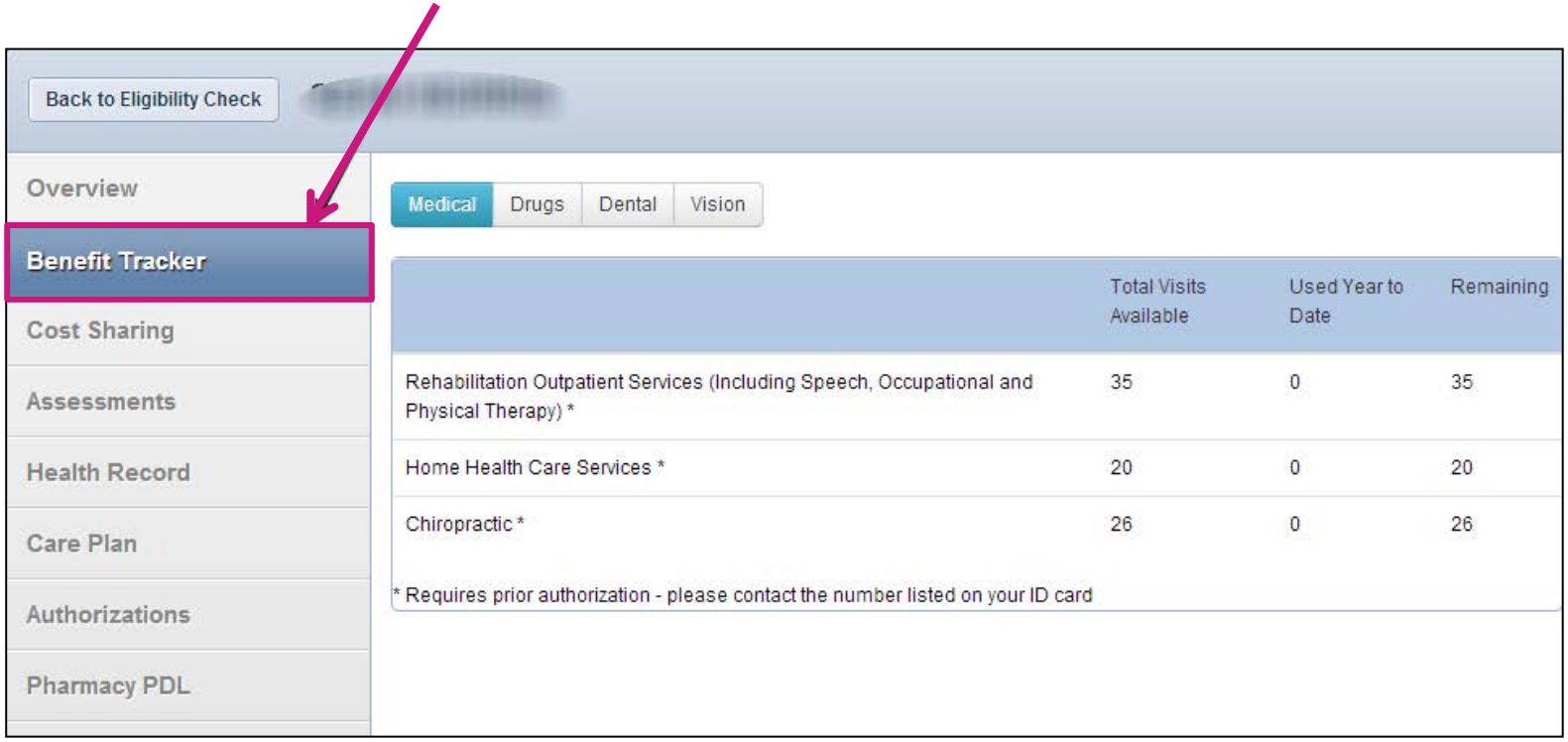
Provider Portal Sample

Verification of Benefits page



Benefit Limitation Tracking

Tracker shows total visits, used, and remaining allowed.



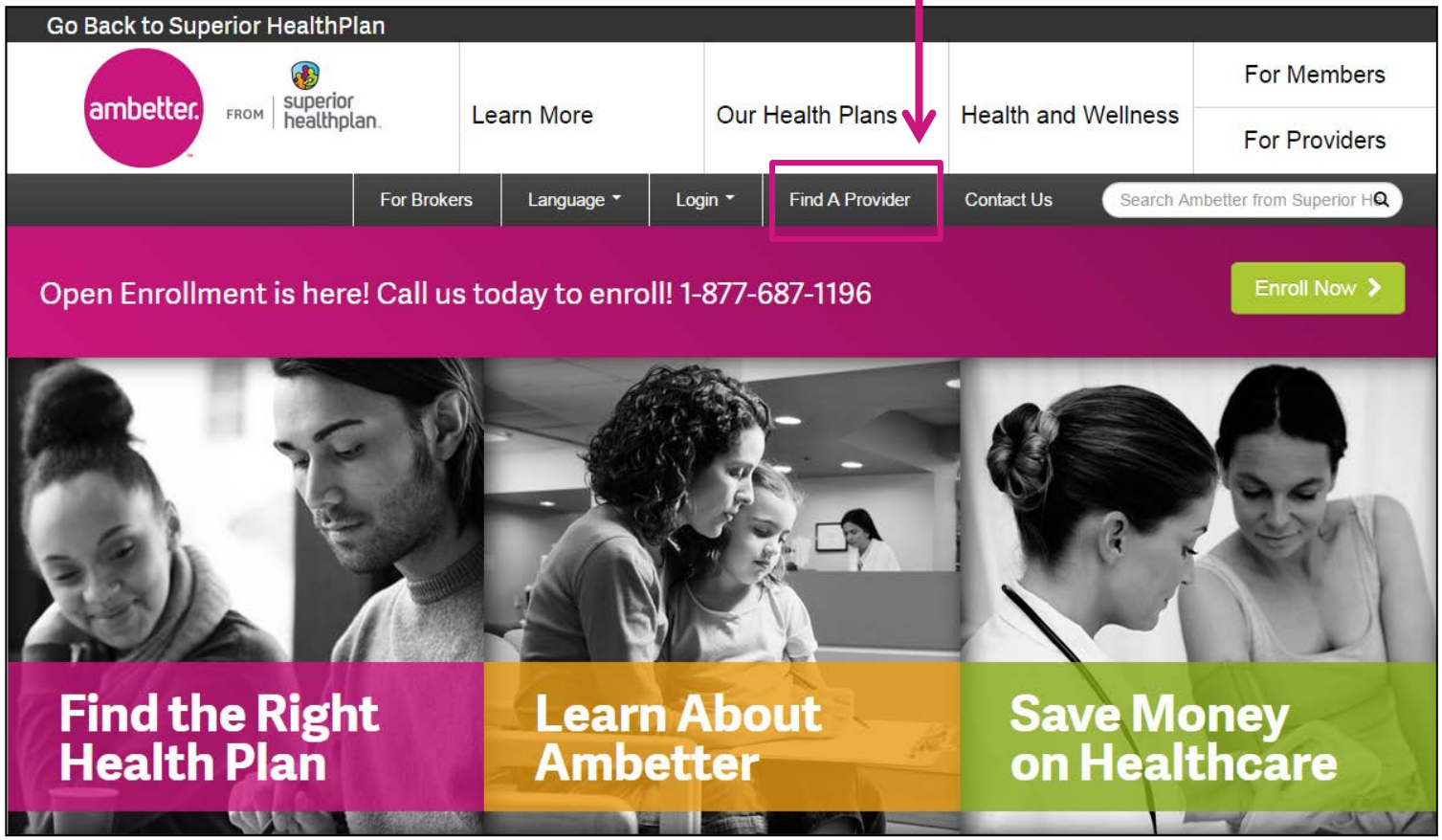
"Used Year to Date" is updated nightly based on claims processed.

Referrals & Authorizations

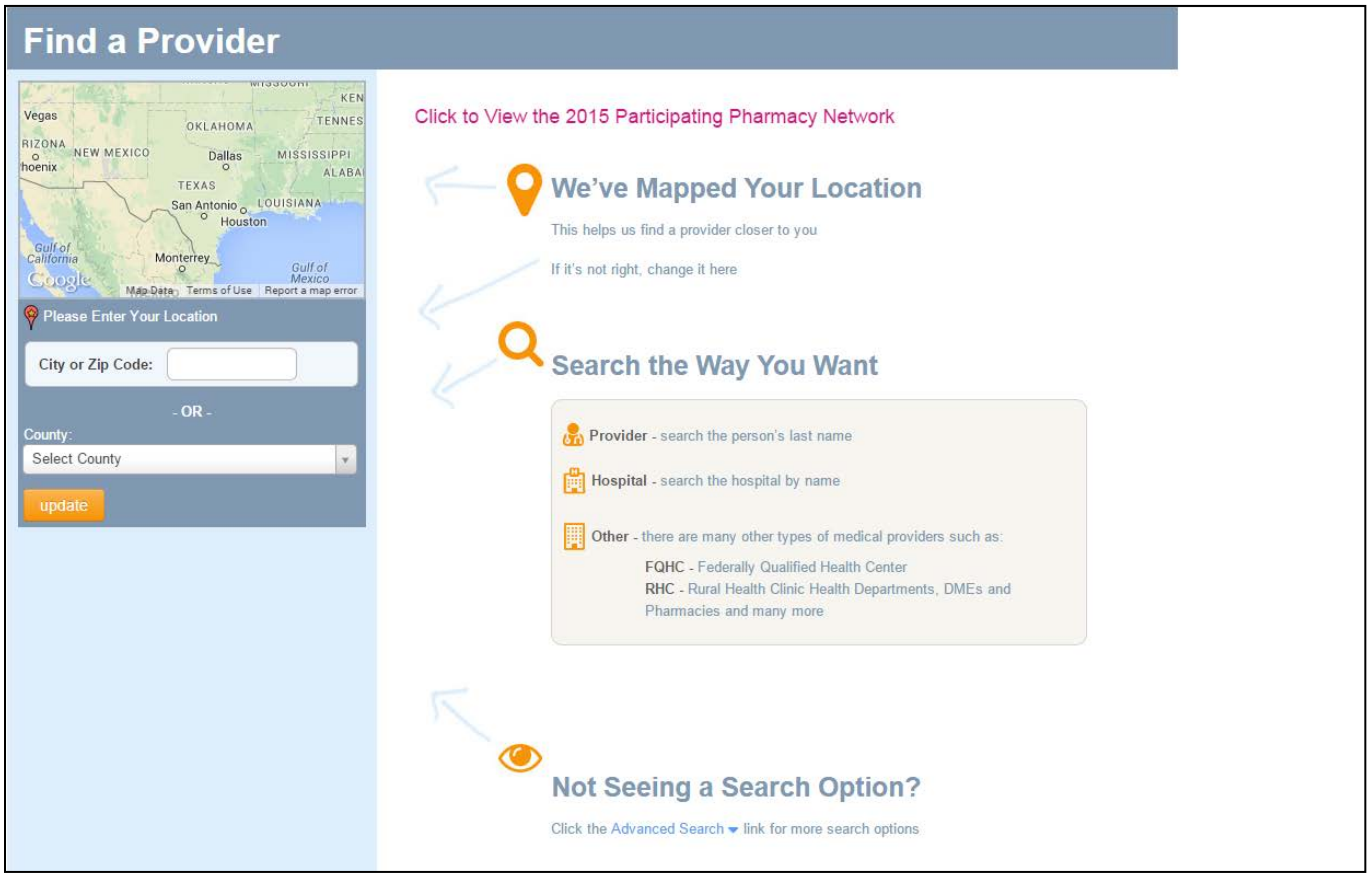
Specialty Referrals

- Ambetter from Superior HealthPlan is an HMO Benefit Plan.
- Members enrolled in Ambetter must use in-network participating providers, except in the case of emergency services.
- If an out-of-network provider is used (except in the case of emergency services), the member will be 100% responsible for all charges.
- Members and providers can find other participating providers by visiting www.Ambetter.SuperiorHealthPlan.com and clicking on Find a Provider.

Specialty Referrals



Specialty Referrals



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.
- The referring provider should be listed in the appropriate block on the claim form (if applicable).

Prior Authorization

Procedures / Services*

- Potentially cosmetic
- Experimental or investigational
- High tech imaging, i.e., CT, MRI, PET (*facilitated by NIA)*
- Infertility
- Obstetrical ultrasound – two allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists. For urgent/emergent ultrasounds, treat using best clinical judgment and this will be reviewed retrospectively.
- Pain management – must have prior auth except if performed on the same day as surgery.

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 with questions at 1-877-687-1196.

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

Prior Authorization

Inpatient Authorization

- 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

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

- Observation stays exceeding 23 hours require inpatient authorization. Observation stays 23 hours or less require notification to Ambetter from Superior HealthPlan.
- Urgent/Emergent Admissions
  - ✓ Within ***1 business day*** following the date of admission.
  - ✓ Newborn deliveries must include birth outcome.
- Partial inpatient, PRTF and/or intensive outpatient programs

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 with questions at 1-877-687-1196.

Prior Authorization

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- DME
- Home health care services including:
  - Home infusion and therapy
  - Hospice
  - Furnished medical supplies & DME
- Orthotics/Prosthetics
- Hearing aid devices including cochlear implants
- Genetic testing
- Quantitative urine drug screen – Except for urgent care, ER and inpatient place of service.
- Therapy, including Occupational, Physical, Speech – each has benefit limits. Once member uses the benefit limit, no additional coverage is available.

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 with questions at 1-877-687-1196.

Prior Authorization Request Timeframes

Service Type	Timeframe
Elective/Scheduled Admissions	**5 business days** prior to the scheduled admission date
Emergent inpatient admissions	Notification 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

Prior Authorization Type	Timeframe
Prospective/Urgent	Three (3) calendar days of receipt of request.
Prospective/Non-Urgent	Three (3) calendar days of receipt of the request.
Concurrent/Urgent	Twenty-four (24) hours (1 calendar day) of request, followed by a letter within 3 working days.
Concurrent/Non-Urgent	Two (2) business days of request. Three (3) business days for an adverse determination

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.

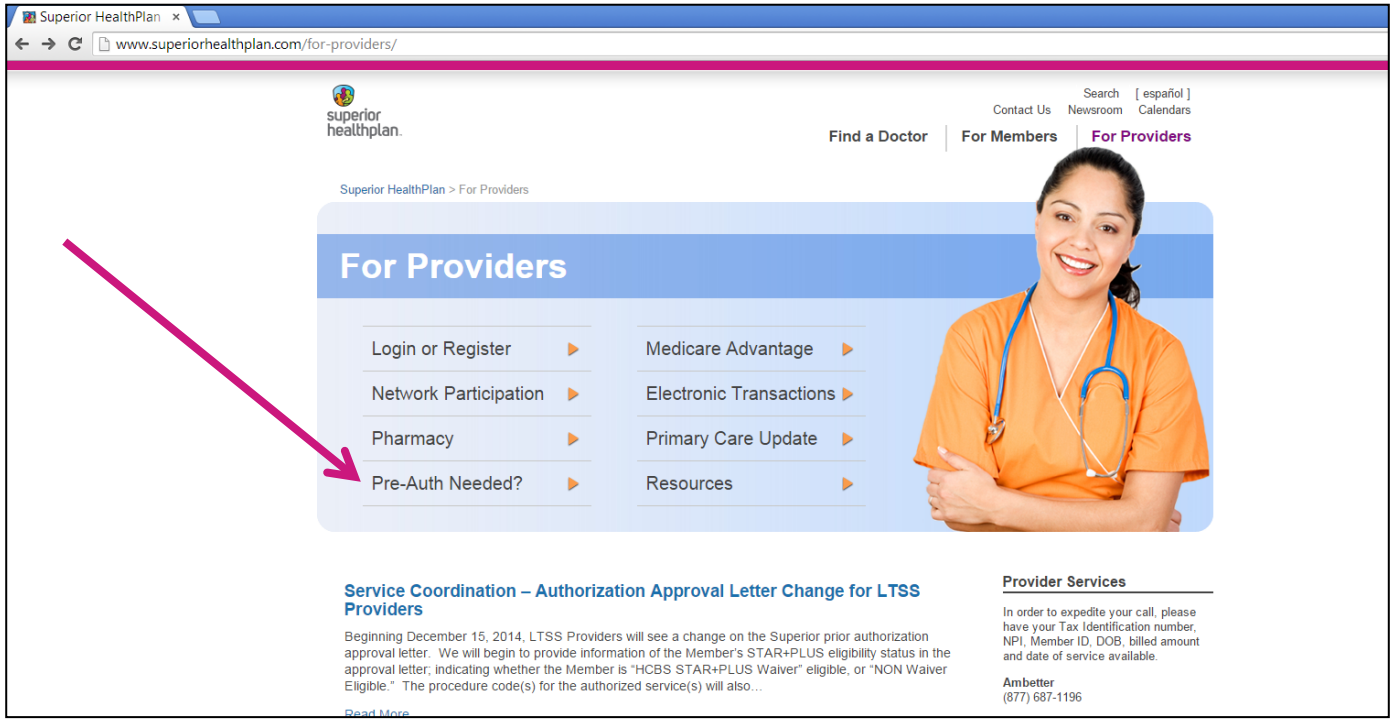
- If a claim is submitted that contains CPT codes that were not authorized and were not submitted for update, the services will be denied.

- If during the procedure additional procedures are performed, contact the health plan within 72 hours of the procedure to update the authorization. Update must be made prior to claim submission or the claim will deny.

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

Prior Authorization Pre-Screen Tool

Access from www.SuperiorHealthPlan.com



Prior Authorization Pre-Screen Tool

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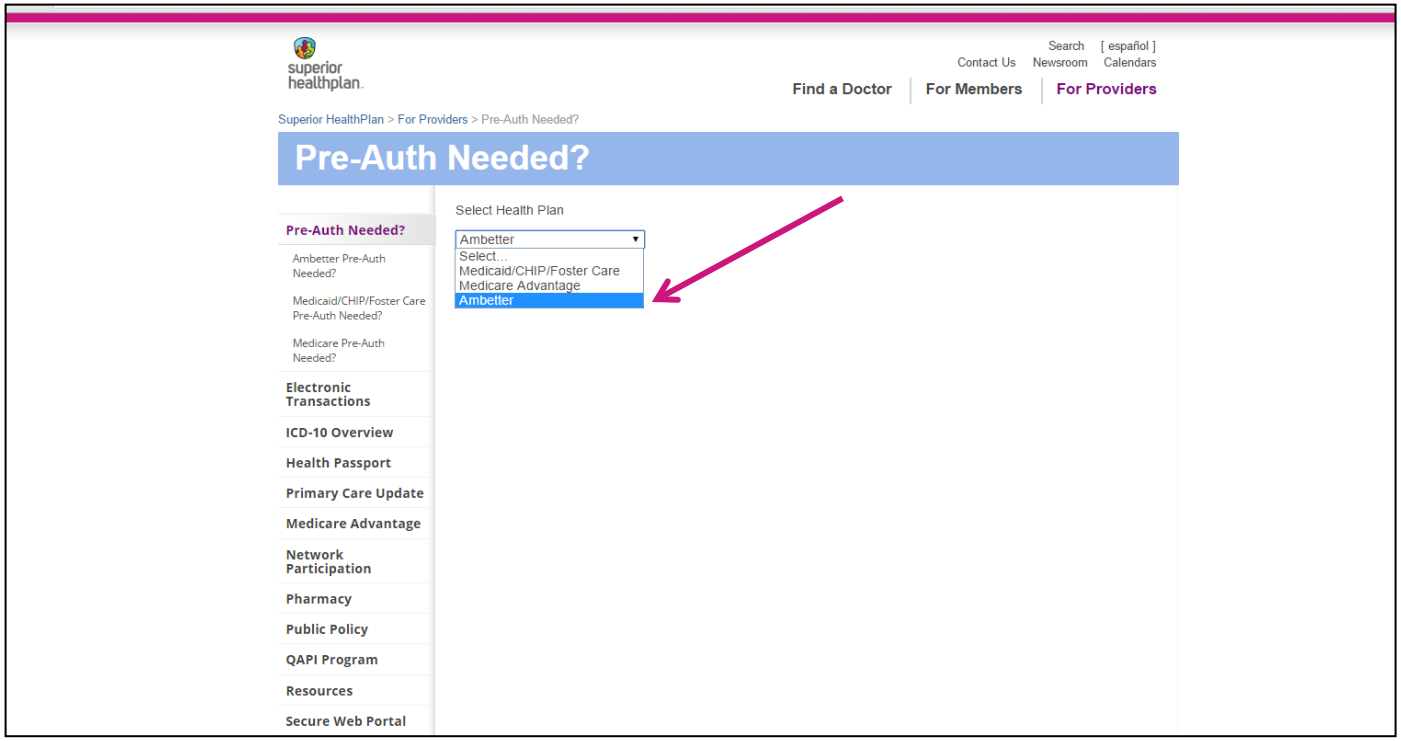

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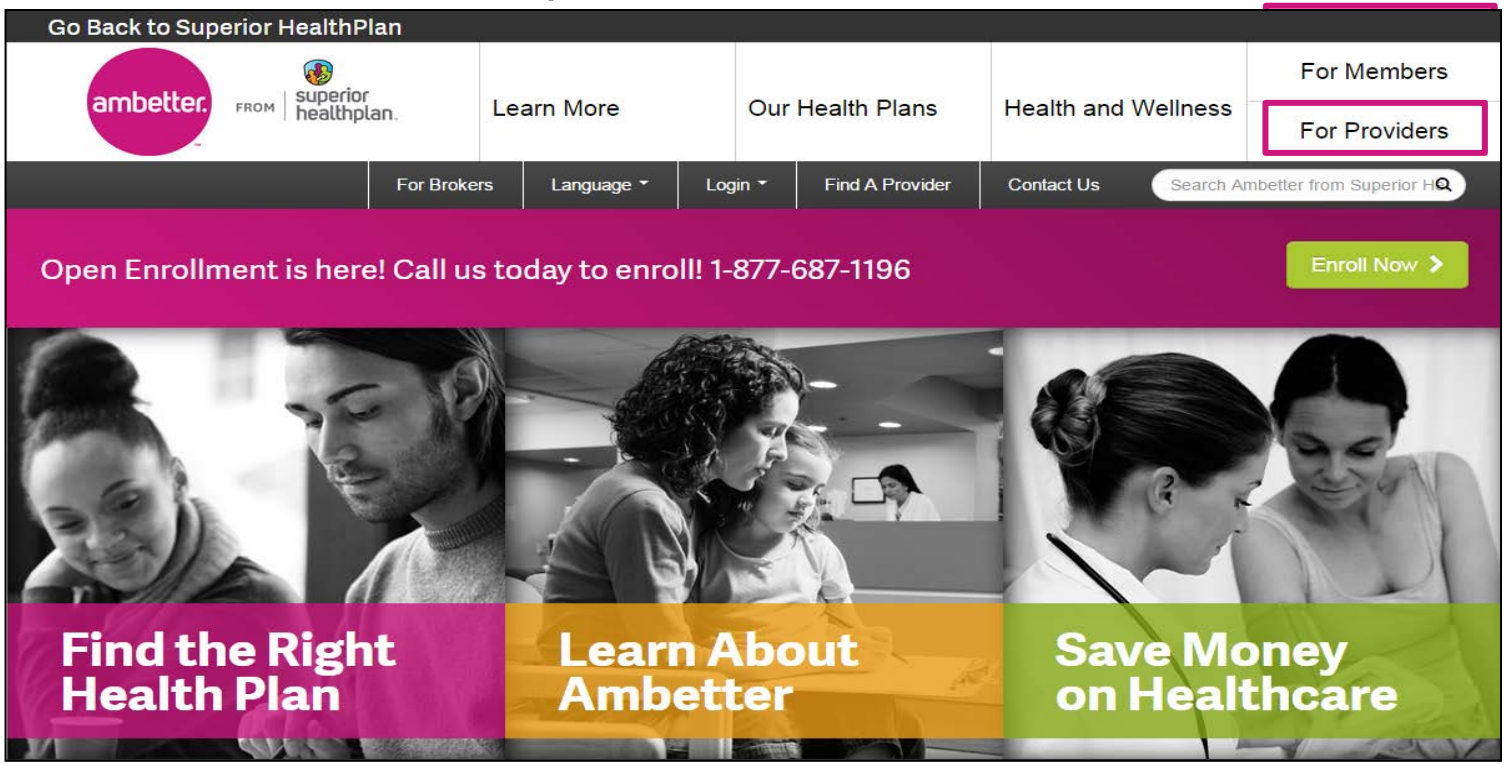

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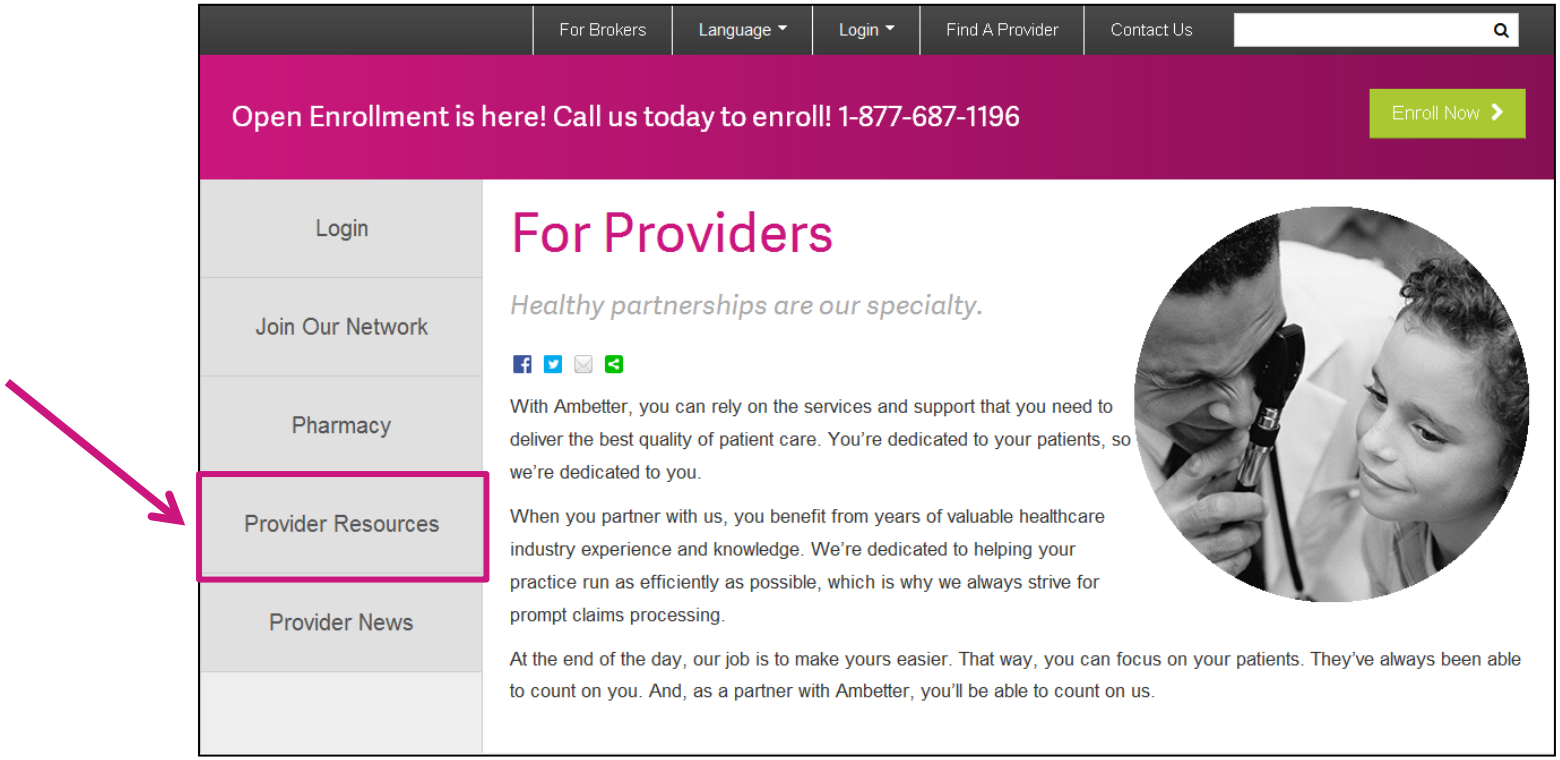

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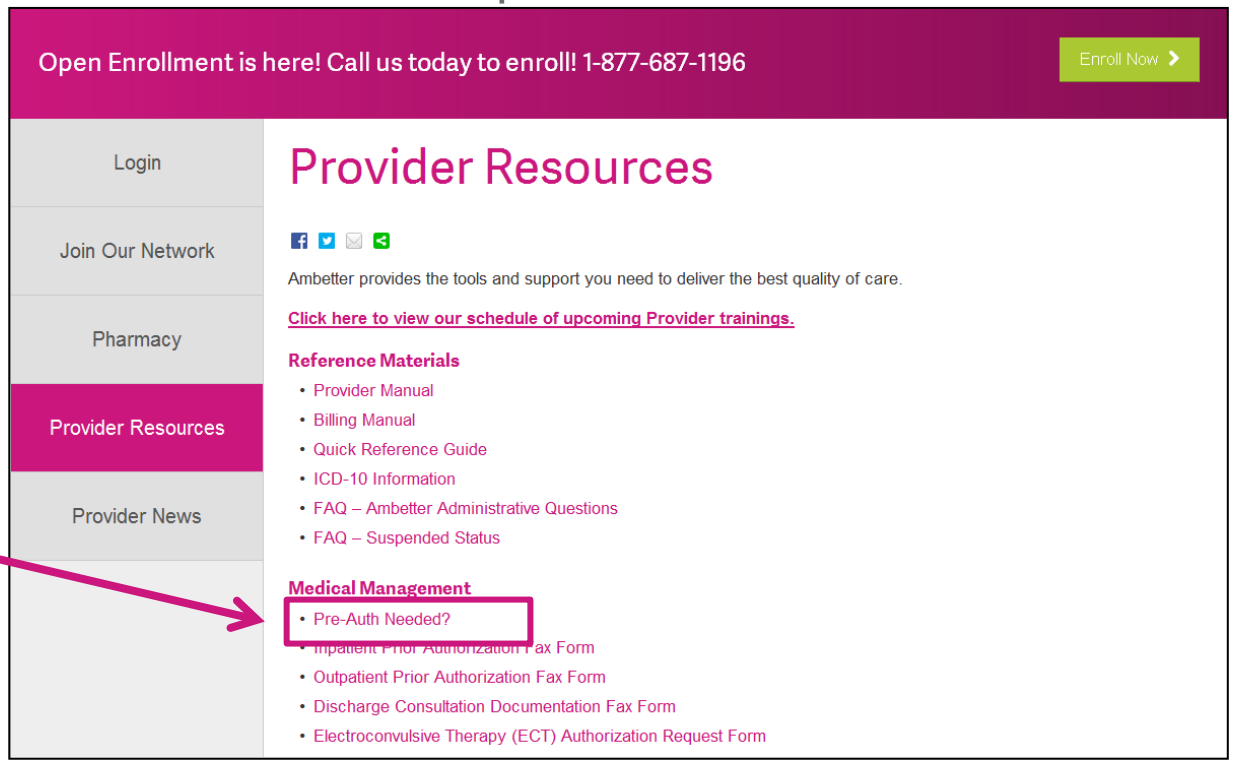

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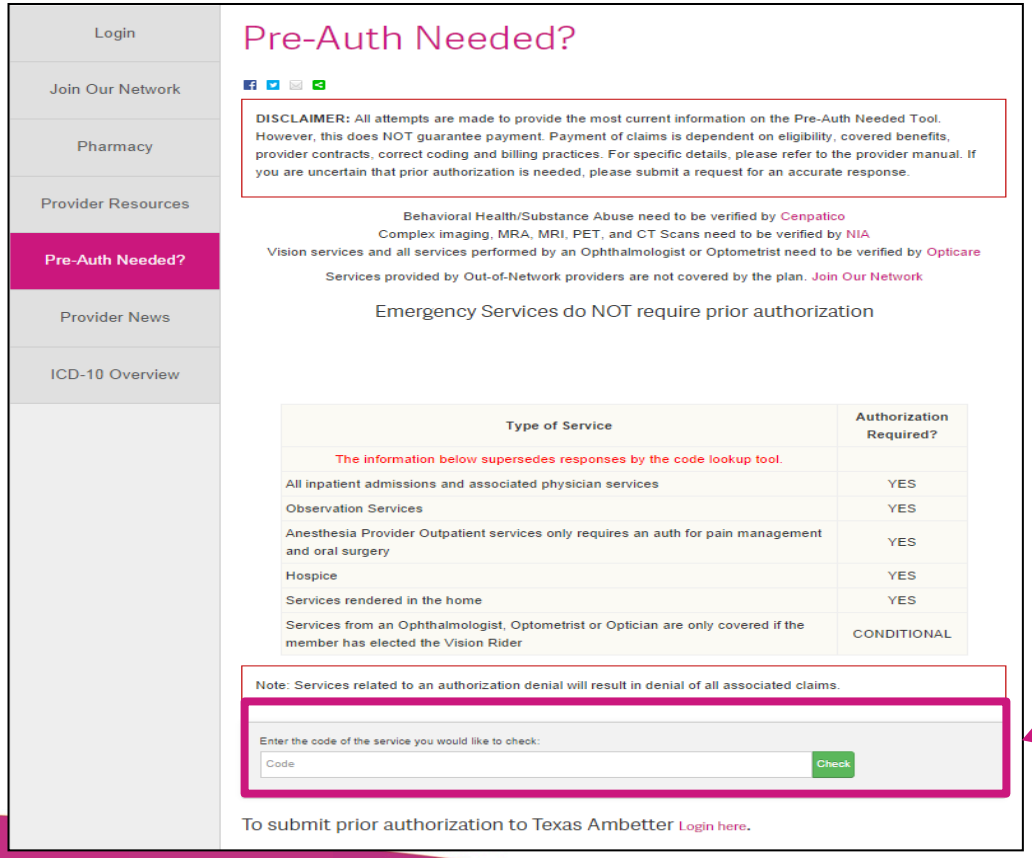


Claim Processes

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 clearinghouses, please visit our website at: http://www.superiorhealthplan.com/for-providers/electronic-transactions/

3. Paper claims may be submitted to:

Ambetter from Superior HealthPlan
PO Box 5010
Farmington, MO 63640-5010

Claim Submission

Other helpful information

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.

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

Rendering Provider 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.

Scenario One: Rendering NPI and Billing BPI are the same

Required Data	Paper CMS 1500	Electronic Submission	
Applicable NPI	Box 33a	2010AA	NM109
Applicable Taxonomy utilizing the "ZZ" Qualifier	Box 33b	2000A 2010AA	PRV03 REF01 REF02

Claim Submission

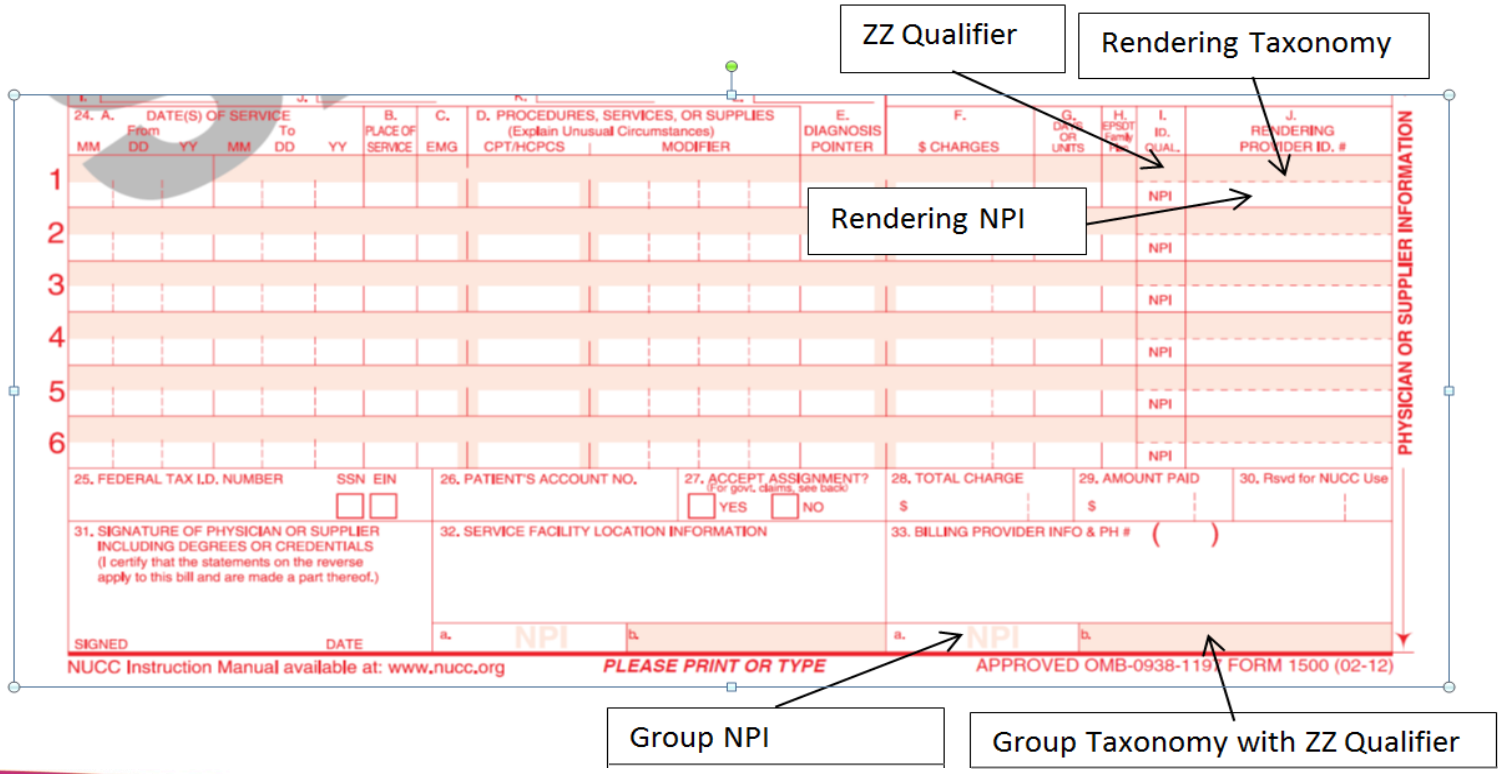
Rendering Provider Taxonomy Code

Scenario Two: Rendering NPI is different than Billing NPI

Required Data	Paper CMS 1500	Electronic Submission	
		Loop ID	Segment/Data Element
Rendering NPI	Unshaded portion of box 24J	2310B 2420A	NM109 NM109
Taxonomy Qualifier “ZZ”	Shaded portion of box 24 I	2310B 2420A	PRV02 REF01 PRV02 REF01
Rendering Provider Taxonomy Number	Shaded portion of box 24J	2310B 2420A	PRV03 REF02 PRV03 REF02
Group NPI	Box 33a	2010AA	NM109
Group Taxonomy utilizing the “ZZ” Qualifier	Box 33b	2000A 2010AA	PRV03 REF01 REF02

Claim Submission

Rendering Provider Taxonomy Code - CMS 1500 Example

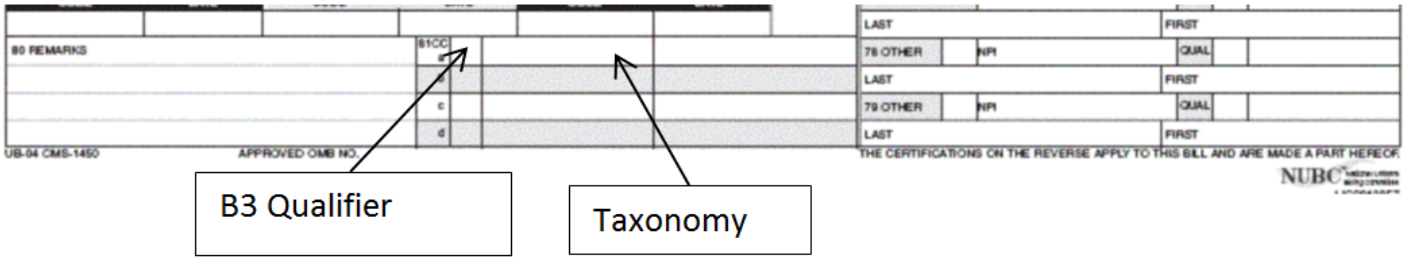


Claim Submission

Rendering Provider Taxonomy Code - UB04 Example

Required Data	Paper UB 04	Electronic Submission
Taxonomy Code with B3 Qualifier	Box 81 CC	Billing Level 2000A Loop and PRVR segment

Below is an example of the UB 04 form



Claim Submission

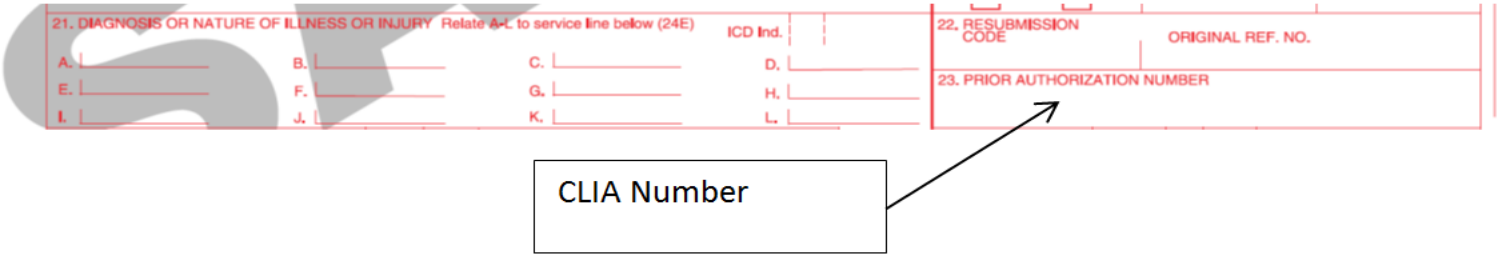
CLIA Number

- If the claim contains CLIA certified or CLIA waived services, the CLIA number must be entered in Box 23 of a CMS 1500 paper claim form, or in the appropriate loop for EDI claims.

- CLIA number is not required on UB04 submissions.

- Claims will be rejected if the CLIA number is not on the claim.

CLIA Number – CMS 1500 Example



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.

Preventative Visits

HEDIS Measures

My Health Pays Reward Logic				
	REWARD_TYPE	Provider limits	Logic	Codes
Well Visit	Annual Adult Well Visit	PCP or OBGYN	one per year	Proc codes: 99385, 99386, 99387, 99395, 99396, 99397 or Diag Code: V700, V703, V705, V706, V708, V709 or HCPCS code: G0344, G0402, G0438, G0439
	Annual Childhood Well Visit over age 3	PCP or OBGYN	one per year	Proc codes: 99382, 99383, 99384, 99385 ,99392, 99393, 99394, 99395 or Diag Code: V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits under age 3	PCP only	Max of 6 from birth to age 1; Max of 3 between age 1 and age 2; Max of 2 between age 2 and age 3	Proc codes: 99381, 99382, 99391, 99392 or Diag Code: V202, V203x, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits under 15 months	PCP only	Reward if 6 visits occur prior to the age of 15 months	Proc codes: 99381, 99382, 99383,99384, 99385, 99391, 99392, 99393,99394,99395, 99461 or Diag Code: V202, V203x, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Well Child Visits age 3,4,5,6	PCP only	one per year	Proc codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461, or Diag Code: V20.3, V20.31, V20.32, V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
	Adolescent Well Care	PCP or OBGYN	one per year	Proc codes: 99381, 99382, 99383, 99384, 99385 ,99391, 99392, 99393, 99394, 99395, 99461 or Diag Code: V20.3, V20.31, V20.32, V202, V700, V703, V705, V706, V708, V709 or HCPCS code G0438, G0439
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 for other Superior products, you will be auto-enrolled in PaySpan for the Ambetter product.
- **If you do not currently use PaySpan:** To register, call 1-877-331-7154 or visit www.payspanhealth.com

Claim Reconsiderations, Disputes and Appeals

Claim Reconsiderations

Claim Reconsiderations Process

- A claim reconsideration is 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 day**s of the Explanation of Payment.

- Claim Reconsiderations may be mailed to:

Ambetter from Superior HealthPlan
Claims Reconsiderations
PO Box 5010
Farmington, MO 63640-5010

Claims Disputes

Claim Disputes Process

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

Ambetter from Superior HealthPlan

Claim Disputes

PO Box 5000

Farmington, MO 63640-5000

Complaints/Grievances/ Appeals

Claims

- A provider must exhaust the claims reconsideration and claims dispute process before filing a Complaint/Grievance.

Complaints/Grievances

- Must be filed within **30 calendar days** of the Notice of Action (denial letter).
- Upon receipt of complete information to evaluate the request, Ambetter will provide a written response within 30 calendar days.

Complaints/Grievances/ Appeals

Appeals

- For claims processing issues follow the claim reconsideration, claim dispute and complaint/grievance process. Appeals are reserved for medical necessity determinations.

Medical Necessity

- Must be filed within **180 calendar days** from the Notice of Action (denial).
- Ambetter shall acknowledge receipt within 10 business 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 24 hours.

Complaints/Grievances/ Appeals

- Members may designate providers 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.

- Full details of the claim reconsideration, claim dispute, complaints/grievances and appeals processes can be found in our Provider Manual at:

Ambetter.SuperiorHealthPlan.com

Additional Information

Specialty Companies/Vendors

Behavioral Health – Cenpatico www.cenpatico.com Phone: 1-877-687-1196 – Payor ID 68069	**Dental Services – DentaQuest** www.dentaquest.com Phone: 1-888-308-4766 – Payor ID CX014
High Tech Radiology Imaging Services – NIA www.radmd.com Phone: 1-800-424-4916	**Pharmacy Services – US Script** www.usscript.com Phone: 1-866-768-0468 – BIN # 008019
Vision Services – Total Vision Health Plan www.opticare.com Phone: 1-866-753-5779 – Payor ID 56190	**24 hours Nurse Advice Line - Nurse Response** http://www.nurseresponse.com/ Phone: 1-877-687-1196

Online Provider Resources

Information contained on our website:

- Provider Manual
- Billing Manual
- Quick Reference Guides
- Forms - Prior Authorization Fax forms, Claim Dispute Forms, etc.
- The Prior Authorization Pre-Screen Tool
- The Pharmacy Preferred Drug Listing
- Find a Provider Tool
- HEDIS Guides
- FAQ’s – ACA, Suspended Status, and Administrative Questions

Provider Toolkit

- Ambetter Provider Introductory Brochure
- Provider Quick Reference Guide
- FAQ
- PaySpan Quick Reference Guide
- Secure Website Portal Flyer
- Window Decal

Contact Information

Ambetter from Superior HealthPlan

Phone: 1-877-687-1196

TDD/TTY:1-800-735-2989

Ambetter.SuperiorHealthPlan.com

Questions?