



Ambetter from Superior HealthPlan

Provider Training

1/19/2023

Agenda



- Overview
- Overall: Ambetter Health Plans
- Verification of Eligibility, Benefits and Cost Shares
- Referrals
- Prior Authorization
- Complaints and Appeals
- Claims
- Provider Resources
- Quality Improvement
- Helpful Websites
- Our Vendor Partners
- Questions



Overview

Who We Are



- Ambetter from Superior HealthPlan (Ambetter Health) provides market-leading, affordable health insurance on the Health Insurance Marketplace.
- We target a focused demographic – lower income, underinsured and uninsured.
- Ambetter Health delivers high quality, locally-based health-care services to its members, with our providers benefiting from enhanced collaboration and strategic care coordination programs.
- Ambetter Health is the number one carrier on the health insurance marketplace.

We Are Proud to be Your Partner



- The Ambetter Health 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 Health’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 Health plans encourage members to establish relationships with their primary care providers to achieve favorable health outcomes.

The Affordable Care Act



Key Objectives of the Affordable Care Act (ACA):

- Increase access to quality health insurance
- Improve affordability

Additional Parameters:

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

The Affordable Care Act



Reform the commercial insurance market – Marketplace or Exchanges:

- No more underwriting – guaranteed issue
- Minimum standards for coverage:
 - Benefits and cost sharing limits
- Subsidies for lower incomes (100% - 138% FPL)
- Learn more at www.healthcare.gov/

Health Insurance Marketplace



Subsidies come in the form of:

- 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 Ambetter Health.



Ambetter Health Plans

Network Built to Offer More



- Ambetter Health now 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 Health also benefits providers by giving them exclusive access to new patient populations.
- Each Ambetter Health network is designed to offer members a unique type of coverage option.
 - Member plans and benefits can vary and there may be referral 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 allocated on the member's ID card and can also be confirmed when verifying the member's eligibility.



Ambetter Health – Silver and Gold

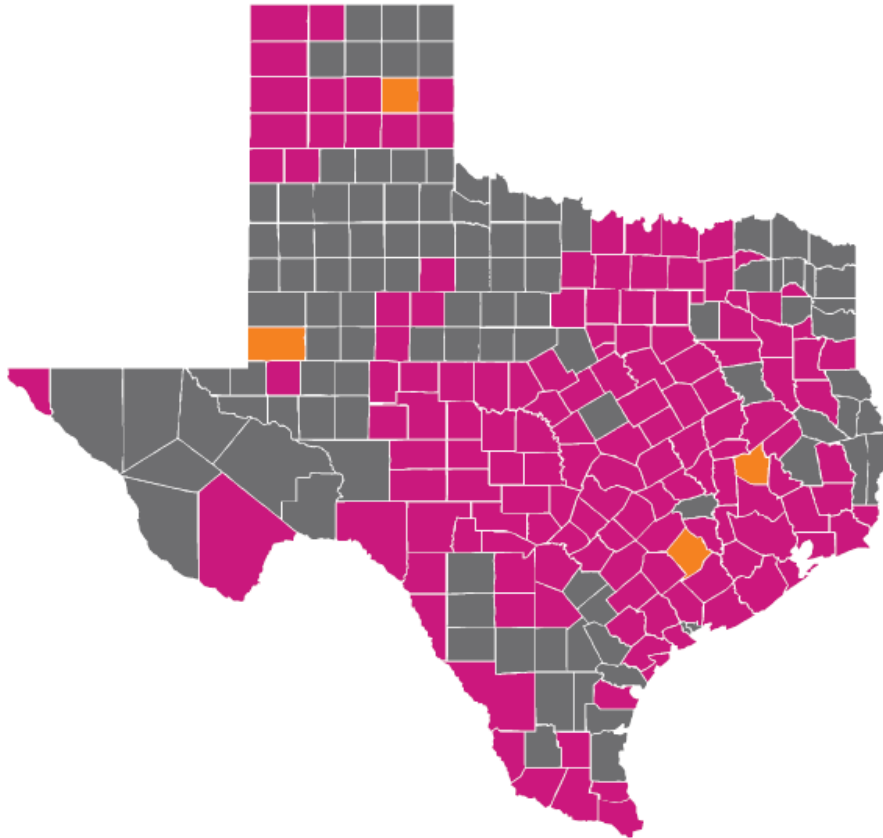
Formerly Essential/Balanced/Secure

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.

Ambetter Health 2023 – Silver and Gold



Existing Counties:

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, 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, 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, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, Zapata

2023 Expansion Counties

Andrews, Colorado, Gray and Walker

Health Insurance Marketplace





PCP Selection and Panel Status:

- 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.

Ambetter Health Silver and Gold



Member ID Card:

		EXCLUSIVE PROVIDER ORGANIZATION QHP TDI	
Subscriber: [Jane Doe] Member: [John Doe]	Policy #: [XXXXXXXX] Member ID #: [XXXXXXXXXXXXXX] Effective Date: [00/00/00]		
 [Ambetter.com/copays]		PCP: [\$10 coin. after ded.] Specialist: [\$25 coin. after ded.] Rx (Generic/Brand): [\$5/\$25 after Rx ded.] Urgent Care: [20% coin. after ded.] ER: [\$250 copay after ded.] Max Out-of-Pocket: [\$25,000]	
Plan: [Plan name] [Line 2 if needed] [Network Name] Network Coverage Only		RXBIN: [004336] RXPCN: [ADV] RXGROUP: [RX5447]	
REFERRAL FROM PCP [NOT] REQUIRED FOR SPECIALIST			

[Ambetter.SuperiorHealthPlan.com]

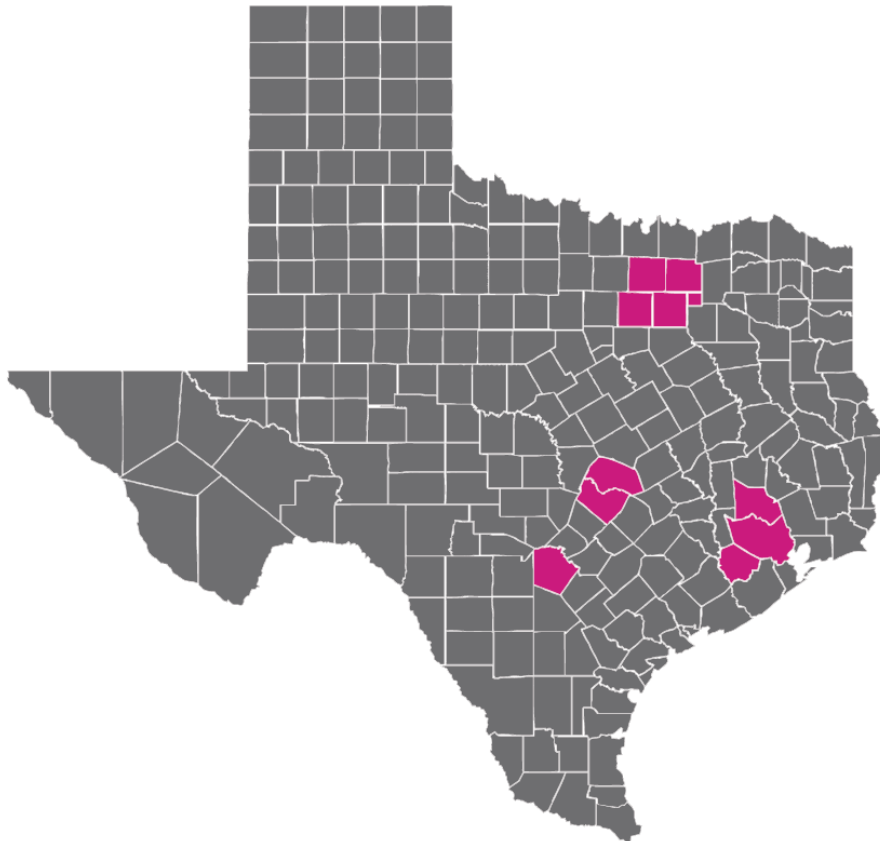
Member/Provider Services: [1-877-687-1196 (Relay Texas/TTY: 1-800-735-2989)] 24/7 Nurse Line: [1-877-687-1196]	Medical Claims Address: [Superior HealthPlan Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010]
Numbers below for providers: Pharmacy Benefit Manager: CVS Health Pharmacy Help Desk: [1-844-276-1395] EDI Payor ID: 68069 [Envolv Vision: [1-866-753-5779]] [Envolv Dental Powered by United Concordia: [1-833-260-3625]]	
<small>[Additional information can be found in your Major Medical Expense Policy. 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; however, it may change the member's responsibility. 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.]</small>	
<small>[AMB22-TX-C-00013]</small>	<small>[Ambetter from Superior HealthPlan is underwritten by Celtic Insurance Company. © 2022 Celtic Insurance Company. All rights reserved.]</small>

Note: Possession of an ID Card does not guarantee eligibility and benefits.



Ambetter Health – Value

Ambetter Health 2023 – Value






2023 Counties:

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


Ambetter Health Value ID Card



Member ID Card:

 FROM  superior healthplan.		HEALTH MAINTENANCE ORGANIZATION QHP TDI	
Subscriber: [Jane Doe] Member: [John Doe]	Policy #: [XXXXXXXXXX] Member ID #: [XXXXXXXXXXXXXX] Effective Date: [00/00/00]		
VALUE	 [Ambetter.com/copays]	PCP: [\$10 coin. after ded.] Specialist: [\$25 coin. after ded.] Rx (Generic/Brand): [\$5/\$25 after Rx ded.] Urgent Care: [20% coin. after ded.] ER: [\$250 copay after ded.] Max Out-of-Pocket: [\$25,000]	
	Plan: [Plan name] [Line 2 if needed] [Network Name] Network Coverage Only	RXBIN: [004336] RXPCN: [ADV] RXGROUP: [RX5447]	
REFERRAL FROM PCP REQUIRED FOR SPECIALIST			

[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]	Medical Claims Address: [Superior HealthPlan Attn: CLAIMS PO Box 5010 Farmington, MO 63640-5010]
Numbers below for providers: Pharmacy Benefit Manager: CVS Health Pharmacy Help Desk: [1-844-276-1395] EDI Payor ID: 68069	
<small>[Additional information can be found in your Major Medical Expense Policy. 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; however, it may change the member's responsibility. 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.]</small>	
<small>[AMB22-TX-C-00013]</small>	<small>[Ambetter from Superior HealthPlan is underwritten by Superior HealthPlan, Inc. © 2022 Superior HealthPlan, Inc. All rights reserved.]</small>

Note: Possession of an ID Card does not guarantee eligibility and benefits.

Ambetter Health – Value

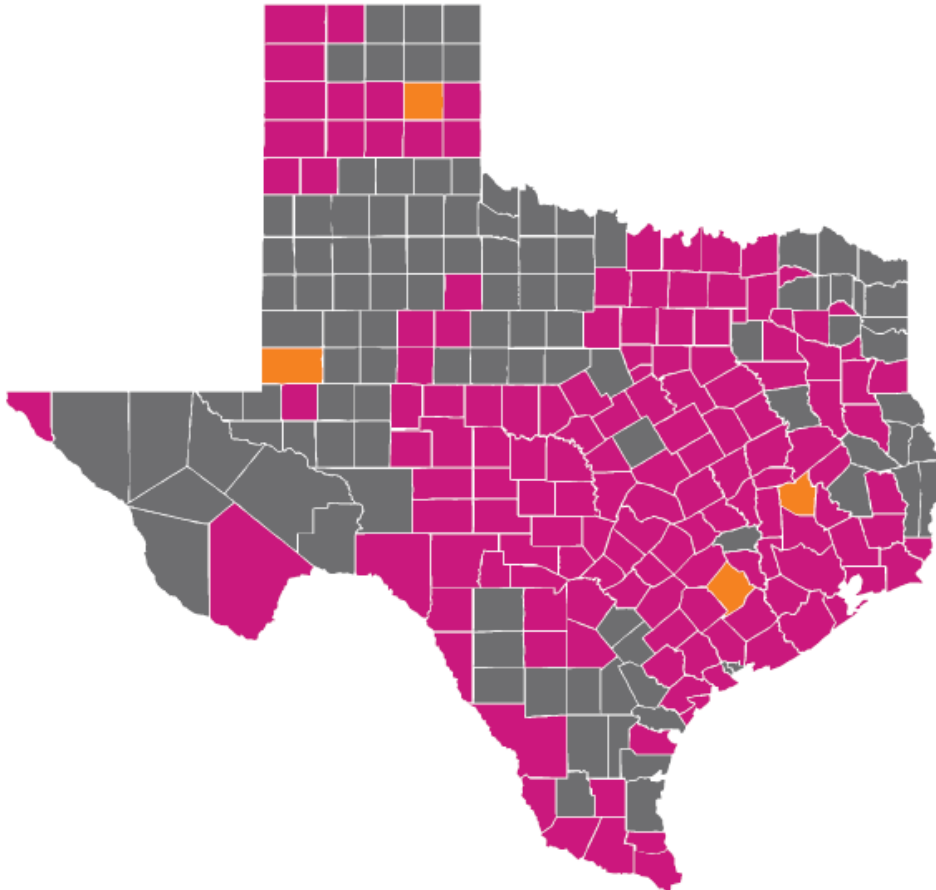


- Ambetter Health Value uses a tailored network approach to offer Ambetter Health’s robust benefits at budget-family premiums to members.
- Value has a more restrictive, yet inclusive and adequate network being offered within a limited set of counties:
 - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson.
- The Ambetter Health Value plan design differs in the following:
 - Preferred PCP groups which members will be able to utilize as a medical home.
 - ID Cards will display “**Ambetter Value Medical Group**” or “**Ambetter Value CH Provider Partner**”.
 - Any specialty care rendered by a specialist outside of the preferred PCP groups 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.



Ambetter Virtual Access

Ambetter 2023 - Virtual



2023 Counties:

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, 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, 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, Runnels, Rockwall, 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, Waller, Webb, Wharton, Wheeler, Willacy, Williamson, Wise, Wood, Zapata

2023 Expansion Counties

Andrews, Colorado, Gray and Walker

Ambetter Virtual ID Card



Member ID Card:

		HEALTH MAINTENANCE ORGANIZATION QHP TDI	
Subscriber: [Jane Doe] Member: [John Doe]		Policy #: [XXXXXXXX] Member ID #: [XXXXXXXXXXXXXX] Effective Date: [00/00/00]	
VIRTUAL ACCESS	 [Ambetter.com/copays]	Virtual PCP: [\$10 coin. after ded.] Specialist: [\$25 coin. after ded.] Rx (Generic/Brand): [\$5/\$25 after Rx ded.] Urgent Care: [20% coin. after ded.] ER: [\$250 copay after ded.] Max Out-of-Pocket: [\$25,000]	
		Plan: [Plan name] [Line 2 if needed] [Network Name] Network Coverage Only	RXBIN: [004336] RXPCN: [ADV] RXGROUP: [RX5447]
REFERRAL FROM PCP REQUIRED FOR SPECIALIST			

[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]

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

Numbers below for providers:

Pharmacy Benefit Manager: CVS Health
Pharmacy Help Desk: [1-844-276-1395]
EDI Payor ID: 68069



[Additional information can be found in your Major Medical Expense Policy. 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; however, it may change the member's responsibility. 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.]

[AMB22-TX-C-00013]

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Note: Possession of an ID Card does not guarantee eligibility and benefits.

Ambetter Virtual Access



- Ambetter Virtual Access leans into the changing dynamics of how providers are delivering care, and how members are seeking care, increasing access to primary and urgent care services in a nimble way.
- 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.
 - Beginning in 2023 members will be utilizing a new Teladoc 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.

Ambetter Virtual



- 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* 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.



Verification of Eligibility, Benefits and Cost Shares

Verification of Eligibility, Benefits and Cost Shares



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

1. Visit the Secure Provider Portal found at Provider.SuperiorHealthPlan.com.
 - If you are already a registered user of the Secure Provider Portal, you do not need a separate registration.
2. Utilize the 24/7 Interactive Voice Response system at 1-800-964-2777.
 - Enter the Member ID Number and the month of service to check eligibility.
3. Contact Provider Services at 1-877-687-1196.
 - Available Monday – Friday, 8:00 a.m. – 6:00 p.m. CST.

Verification of Eligibility, Benefits and Cost Shares



Providers **MUST** verify member eligibility

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

Panel Status

- Primary Care Physicians (PCPs) should confirm that a member is assigned to their patient panel.
 - This can be done through the Secure Provider Portal.
- Value members PCP will be listed as “Ambetter Value Medical Group” or “Ambetter Value CH Provider Partner.”

Verification of Eligibility




ambetter.™

Eligibility Patients Authorizations Claims Messaging Help

Viewing Eligibility For : TIN [] Plan Type [Ambetter] **GO**

Eligibility Check

Date of Service [10/05/2020] Member ID or Last Name [123456789 or Smith] DOB [mm/dd/yyyy] **Check Eligibility** **Print**

ELIGIBLE	DATE OF SERVICE	PATIENT NAME	DATE CHECKED	CARE GAPS	LOG ER VISIT
	10/05/2020	AARON DOE >View details	10/05/2020	No flu vaccine in past 12 months.	ER Visit? Remove

Verification of Benefits



Back to Eligibility Check

- Overview
- Cost Sharing
 - [Schedule of Benefits](#)
 - [Summary of Benefits and coverage](#)
- 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

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

Verification of Cost Shares



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

Note: There are separate tabs for Medical and Drug expenditure.

Back to Eligibility Check AARON DOE

Overview **Medical** Drugs [Print Cost Sharing](#)

Cost Sharing

Benefit Tracker

Assessments

Health Record

Authorizations

Pharmacy PDL

Referrals

Coordination of Benefits

Claims

Summary of Benefits

Medical

👍 This patient is eligible as of today, Oct 5, 2020. The premium paid through date is Oct 31, 2020 and the claims paid through date is Dec 31, 2020.

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	\$0.00	\$0.00	\$0.00
Person	\$0.00	\$0.00	\$0.00

Co-insurance
The portion of your medical bill you pay, for certain services, after you meet your deductible. Think of coinsurance as splitting your healthcare costs with your insurance company.

Once you have reached your deductible, your share of the cost for a covered health care service will be 25% of the allowed amount for the service

Co-payment

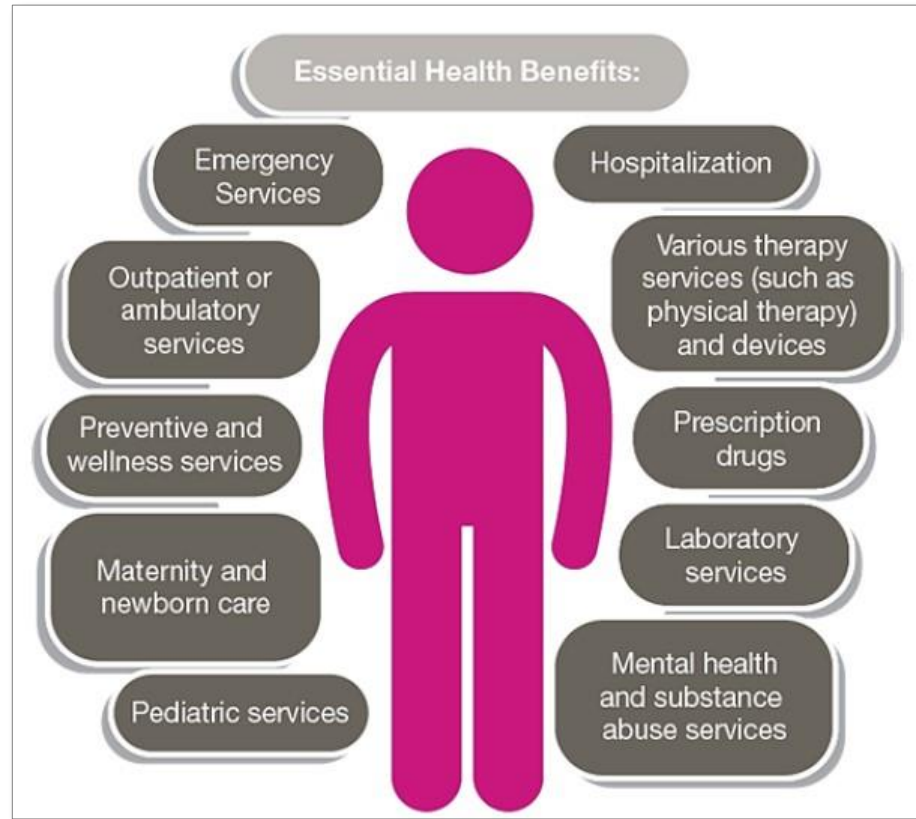
Drug Type	Your Cost
Primary Care	No charge
Specialist	\$5 Copay
Emergency Room	25% Coinsurance

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	\$2,100.00	\$0.00	\$2,100.00
Person	\$1,050.00	\$0.00	\$1,050.00


* 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.

Essential Health Benefits



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

Other Benefits



Start Smart for Your
Baby®


 **Prescription Coverage**
Ambetter covers a wide range of prescriptions, so your patients can count on care when they need it most.

 **Care Management and Disease Management**
Our care managers work closely with you to make sure your patients have access to the care and support services they need as part of your treatment plan.

 **24/7 Nurse Advice Line**
Your patients have nonstop access to our medical advice line for answers to all of their health questions.

 **Myhealthpays® Rewards Program**
By staying up-to-date with regular preventive care, your patients can earn rewards, which can be used to help pay for health-related costs and more.

 **Ambetter Telehealth**
Your patients have convenient, 24-hour phone or video access to healthcare providers for non-emergency health issues through Ambetter Telehealth.



Your Better Health
Center



Referrals

Ambetter Health Referral Requirements



- Some Ambetter Health 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 access experiences to ensure members understand the rules associated with their plan.
- Referring providers can use the Secure Provider Portal to initiate referrals on behalf of members.

Specialty Referrals



- 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.

Specialty Referrals



- The method for submitting PCP referrals is through the [Secure Provider Portal](#).
 - The provider must be a registered user on the Secure Provider Portal.
- If a provider is already registered for the Secure Provider Portal under another products, that registration will grant the provider access to Ambetter Health.
 - If the provider is not already a registered user and needs assistance or training on submitting prior authorizations, the provider should contact their local Account Manager.
- The requesting or rendering provider must provide the following information to request PCP referrals:
 - Referral Number will be auto-assigned by the system. Specialists will need to include that Referral Number on claims submitted under the referral.
 - Submission Date
 - Member's Assigned Medical Provider Group
 - Referring Provider
 - Provider Name, NPI, TIN
 - Medical Group Number
 - Specialty
 - Referred Provider
 - MUST be within the Ambetter Health Guide for the product/network member belongs to. Find the guide here: [Guide.AmbetterHealth.com](https://www.ambetterhealth.com/guide)
 - Provider Specialty Type
 - Provider Name, NPI, TIN
 - Medical Group or TIN
 - Service
 - Specialty Type
 - Referral Date Range start
 - Referral Date Range End
 - Referral Type (Consult vs. Treatment)
 - Number of Visits referred for
 - Notes

Making a Referral



1. Click on the **Referrals** tab on the main toolbar.
2. Click the **Create Referral** button.
3. Enter the **NPI** into the **Referred to Provider** field to find the provider you are referring to.
4. Complete the remaining fields in the PCP referral form.

A screenshot of a web-based referral form. The form is organized into several sections:

- Dates:** Contains two date pickers. The "Start Date" is set to 11/10/2022 and the "End Date" is set to 12/31/2022. Each date has an information icon to its right.
- Referring Provider:** A search section with a text input field labeled "ENTER NAME OR NPI" and a magnifying glass icon. Below the input are labels for "Name", "TIN", and "Phone", with an "NPI" label positioned to the right of the "TIN" label.
- Referral Type & Visits:** A section with a "Select Referral Type" dropdown menu and a "Visits" input field containing the number "1".
- Referred To Provider:** Another search section identical in layout to the "Referring Provider" section, with labels for "Name", "TIN", and "Phone", and an "NPI" label.
- Referred To Provider's Specialty:** A section with a "Select Specialty" dropdown menu.
- Notes(optional):** A section at the bottom with a text input field containing the placeholder text "Enter some notes here..."

Receiving a Referral



1. Once referred to you for care outside of their PCP, a member will set up an appointment.
2. Log in to the Secure Provider Portal.
3. Navigate to the **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/Reference Number**.
6. Submit claims with the reference number in **Box 23**.
7. Claims **MUST** include a reference number if a referral is required for the service.
 - If no reference number is submitted, the claim will be denied.

Referrals						
Referrals Received			Referrals Made			
Submitted	Referral ID	Status	Member Name	Plan	Start - End Dates	Specialty
07/18/2022	REF23456789	Open	Philip Alpha	Ambetter Virtual	07/20/2022 - 12/31/2022	Oncology
07/17/2022	REF34567890	Closed	Jennifer Superlonglastname	Ambetter Value	07/20/2022 - 07/25/2022	Surgery
06/10/2022	REF45678901	Closed	U Thant	Ambetter Value	06/12/2022 - 08/12/2022	Neuromusculosk Medicine
05/16/2022	REF56789012	Cancelled	Yun-A O	Ambetter Value	05/20/2022 - 10/20/2022	Pediatric Otolaryngology
05/01/2022	REF67890123	Inactive	Barbara Gordon	Ambetter Virtual	05/01/2022 - 06/01/2022	Physical Therapi Geriatrics

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Prior Authorization

Prior Authorization



Procedures / Services*:

- Potentially Cosmetic
- Experimental or Investigational
- High-Tech Imaging (i.e., CT, MRI, PET)
- Infertility
- Obstetrical Ultrasound
 - One allowed in a nine month period. Any additional ultrasounds will require prior authorization (unless rendered by a Perinatologist).
 - For urgent/emergent ultrasounds, treat using best clinical judgment and authorizations will be reviewed retrospectively.
- Pain Management
- Therapy services

**Please note: This is not meant to be an all-inclusive list and exclusions apply.*

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
- Observation stays exceeding 23 hours require Inpatient Authorization.
- Urgent/Emergent Admissions
 - Within one Business Day following the date of admission
 - Newborn deliveries must include birth outcomes
- Partial Inpatient, Psychiatric Residential Treatment Facility (PRTF) and/or Intensive Outpatient Programs

**Please note: This is not meant to be an all-inclusive list and exclusions apply.*

Prior Authorization



Ancillary Services*:

- Durable Medical Equipment (DME)
- Hearing Aid Devices (including cochlear implants)
- Genetic Testing
- Non-Emergency Transportation
- Quantitative Urine Drug Screen
- Orthotics/Prosthetics
- Home Health Care Services (including Home Infusion Skilled Nursing and Therapy)
 - Home Health Services
 - Adult Medical Day Care
 - Hospice
 - Furnished Medical Supplies and DME
 - Occupational Therapy
 - Physical Therapy
 - Speech Therapy

**Please note: This is not meant to be an all-inclusive list and exclusions apply.*

Prior Authorization



Service Type*	Timeframe
Elective Admissions	Prior Authorization required 5 Business Days prior to the scheduled admission date.
Outpatient services that require prior auth	Prior Authorization required 5 Business Days prior to the elective outpatient admission date.
Non-Elective (emergent) inpatient admissions	Notification within 1 Business Day of admission.
Newborn admissions	Notification within 1 Business Day.
Inpatient admission facility transfers or change in level of care	Notification within 1 Business Day.
Organ transplant initial evaluation	Prior authorization required at least 30 Days prior to the initial evaluation for organ transplant services.
Clinical trials services	Prior Authorization required at least 30 Days prior to receiving clinical trial services.

** This is not meant to be an all-inclusive list.*

Utilization Determination Timeframes



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

** This is not meant to be an all-inclusive list.*

Pre-Auth Needed Tool



- Use the Pre-Auth Needed Tool to quickly determine if a service or procedure requires prior authorization.
- Can be found at: Ambetter.SuperiorHealthPlan.com/Provider-Resources/Manuals-and-Forms/Pre-Auth.html

Are Services being performed in the Emergency Department?

Yes No

Types of Services	YES	NO
Are the services being performed or ordered by a non-participating provider?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member being admitted to an inpatient facility?	<input type="radio"/>	<input checked="" type="radio"/>
Are anesthesia services being rendered for pain management or dental surgeries?	<input type="radio"/>	<input checked="" type="radio"/>
Is the member receiving hospice services?	<input type="radio"/>	<input checked="" type="radio"/>

Enter the code of the service you would like to check:

69436

Y **69436** - TYMPANOSTOMY GEN ANES
Yes
TurningPoint Health Solutions, LLC will administer prior authorization for Ear, Nose and Throat (ENT) surgeries, sleep study management and cardiac surgeries.

To submit a prior authorization [Login Here](#).

Prior Authorization



Prior Authorization can be requested in 3 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.

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, the services will be denied.
- If additional procedures are performed during the procedure, the provider must contact Ambetter Health 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 Health 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.

House Bill 3459



- 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.



Complaint Process

Provider Complaints



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 claim within 5 Business Days.
- Following the investigation of the complaint, a written complaint resolution will be sent to the provider within 30 Calendar Days from the received date of the complaint.
 - 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.
- For denials or reconsiderations of processed claims, a provider should follow the Claims Appeal/Reconsideration and Claims Dispute process.

Appeals of Adverse Determination



- Members may designate providers to act as their representative for filing appeals related to adverse determinations
- Must be filed within 180 Calendar Days from the notice of adverse determination.
- Ambetter Health will acknowledge receipt within 5 Business Days of receiving the appeal.
- Ambetter Health will resolve each appeal and provide written notice as expeditiously as the member's health condition requires, but not to exceed 30 Calendar Days.
- An expedited appeal is available for denials of emergency care, continued stays for hospitalized members, or prescription drugs or intravenous infusions for which a member is receiving benefits; adverse determinations of a step-therapy protocol; or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.
- An expedited appeal review is completed based on the immediacy of the condition, procedure, or treatment, but no later than one working day from the date all information necessary to complete the appeal is received.



Claims

Claims



Clean Claim:

- A 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.

Exceptions:

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

Claim Submission



The timely filing deadline for initial claims is 95 Days from the date of service or date of discharge.

Claims may be submitted in 3 ways:

1. On the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
2. Through an Electronic Clearinghouse:
 - Payor ID 68069.
 - Clearinghouses currently utilized by Ambetter Health will continue to be utilized.
 - For a list of our Clearinghouses, please visit our website at Ambetter.SuperiorHealthPlan.com.
3. By mail, paper claims may be submitted to:
Ambetter Health
P.O. Box 5010
Farmington, MO 63640-5010

Claim Submission



Claim Reconsiderations:

- 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 Reconsiderations may be mailed to:
P.O. Box 5010
Farmington, MO 63640-5010

Providers can also use the Reconsider Claim button on the Claim Details screen within the portal.

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/Provider-Resources/Manuals-and-Forms.html.
- The completed Claim Dispute form may be mailed to:
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 premiums.
- While the member is in a suspended status, claims will be pended.
 - After 30 Days, the member is placed in a suspended status. The Explanation of Payment will indicate LZ Pend: Non-Payment of Premium.
 - **Note:** While the member is in a suspended status, claims will be paid for the first 60 Days. Claims will be denied Days 61-90.
- When the premium is paid by the member, the claims will be released and adjudicated.
- If the member does not pay the premium, the provider may bill the member directly for services.

Claim Submission



Member in Suspended Status (APTC 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: When checking Eligibility, the Secure Provider Portal will indicate that the member is in a Suspended Status. Claims for members in a Suspended Status are not considered “clean claims.”

Claim Submission



Member in Suspended Status (Non-APTC Example)

- January 1st
 - Member pays premium.
- February 1st
 - Premium due - member does not pay.
- March 1st
 - Member placed in Suspended Status.
- April 1st
 - If premium remains unpaid, member is terminated. Provider may bill member directly for services rendered.

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

Claim Submission



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 Payment



PaySpan:

- Ambetter Health 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 Health product.
- To register for PaySpan:
 - Call 1-877-331-7154 or visit www.PaySpanHealth.com.
 - You will need your National Provider Identifier (NPI) and Provider Tax ID Number (TIN) or Employer Identification Number (EIN).

Billing the Member



- Copays, coinsurance and any unpaid portion of the deductible may be collected at the time of service.
- The Secure Provider 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.

Ophthalmology for Medical Eye Care Services



- Ambetter Health manages all functions for ophthalmologists providing medical eye care services, including but not limited to:
 - Claim Processing and Appeals
 - Contracting/Credentialing
 - Prior Authorization
 - Retrospective Utilization Review
 - Medical Necessity Appeals
 - Provider Complaints Related to Medical Eye Care Services
 - Provider Relations/Account Management
 - Provider Services
 - Provider Web Portal
- Envision Vision continues to manage routine eye care services and full-scope of licensure optometric services for Ambetter Health.
- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool: [SuperiorHealthPlan.com/PriorAuth](https://www.superiorhealthplan.com/priorauth).



Provider Resources

Provider Services



The Provider Services department is available to respond quickly and efficiently to all provider inquiries or requests including, but **not limited to**:

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

Providers are able to access real time assistance for their service needs, Monday – Friday, 8:00 a.m. – 6:00 p.m. CST, by calling Provider Services at 1-877-687-1196.

Account Management



Each provider has an Account Manager assigned to them. This Account Manager serves as the primary liaison between Ambetter Health and our provider network. The Account Management team is responsible for:

- Provider education
- Claims assistance
- Demographic information update
- Provider enrollment status
- Administrative policies, procedures and operational issues
- Contract clarification
- Membership/provider roster questions
- Provider Portal registration and PaySpan



Quality Improvement

Quality Improvement



HEDIS and Risk Adjustment Programs

- Member Gap Forms
 - Provider initiative targeting Ambetter Health members who have a potential gap in their care.
 - Select providers will receive support to close gaps for scheduled members or to reach out and schedule members in order to address care gaps.
 - Forms with care gaps unique to each of the targeted patients will be provided.
- Chart Retrievals
 - Our vendor partners will request charts for chart reviews, including the Risk Adjustment Data Validation Audit, for Ambetter Health members.
 - Charts are targeted based on reported and suspected chronic conditions for a member.
 - Coders then review medical charts to ensure claims data reflects the documented medical record accurately.
- Continuity of Care (CoC)
 - A provider engagement program that ensures that members receive care and treatment for all existing health conditions and not just acute health issues.
 - Providers will have access to Appointment Agendas that outline care gaps.



Helpful Websites

Ambetter Health Website



Ambetter.SuperiorHealthPlan.com



[Our Health Plans](#) [Join Ambetter](#) [For Members](#) [For Providers](#) [For Brokers](#)

[Shop Our Plans](#)

Open Enrollment is here. Sign up for health insurance today.

Let's get you the coverage you need. Ambetter from Superior HealthPlan has you covered with a range of high-quality, affordable plans.

[Get Started](#)



Website Resources



Provider resources available on the Ambetter Health website include, but are not limited to:

- The Provider and Billing Manual
- Quick Reference Guides
- Forms (Prior Authorization Fax forms, Behavioral Health forms, etc.)
- The Pre-Auth Needed Tool
- The Pharmacy Preferred Drug Listing
- Trainings

Secure Provider Portal



Information contained on Provider.SuperiorHealthPlan.com includes, but is not limited to:

- Member Eligibility and Benefits and Patient Listings
- Health Records and Care Gaps
- Authorizations
- Claims Submissions and Status
- Corrected Claims and Adjustments
- Payments History
- Monthly PCP Cost Reports - Generated on a monthly basis and can be exported into a PDF or Excel format. Reports Include:
 - Patient List with HEDIS Care Gaps
 - Emergency Room Utilization
 - Rx Claims Report
 - High Cost Claims

Secure Provider Portal



Registration is free and easy. Visit Provider.SuperiorHealthPlan.com to get started.

A screenshot of the "Create Your Account" registration page. The page has a white background with a blue and green decorative header. At the top center is the superior healthplan. logo. Below the logo is the heading "Create Your Account" in a large, black, sans-serif font. Underneath the heading is the subtext "Let's get started - creating an account is quick and easy." in a smaller, grey font. The registration form consists of four input fields: "Email" (a long text box with a vertical cursor), "First Name" (a text box), "Last Name" (a text box), and "Language Preference" (a text box).



Our Vendor Partners

Specialty Vendors



Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-877-687-1196 RadMD.com
Interventional Pain Management	National Imaging Associates	1-877-687-1196 RadMD.com
Therapy services	National Imaging Associates	1-877-687-1196 RadMD.com
Vision Services	Engolve Vision Services	1-866-753-5779 visionbenefits.engolvehealth.com/
Pharmacy Services	CVS Caremark	1-800-364-6331 CVS Caremark PBM & Mail Order Pharmacy Sign In

Specialty Vendor Contacts



Service	Specialty Company/Vendor	Contact Information
Musculoskeletal Surgical Procedures	TurningPoint HealthCare Solutions	1-469-310-3104 www.myturningpoint-healthcare.com
Cardiac Surgical Procedures	TurningPoint HealthCare Solutions	1-469-310-3104 www.myturningpoint-healthcare.com
Ear, Nose and Throat (ENT) Surgeries and Sleep Study Procedures	TurningPoint HealthCare Solutions	1-469-310-3104 www.myturningpoint-healthcare.com

Specialty Vendor Contacts



- National Imaging Associates
 - Provides specialized utilization management and provider profiling services for radiology and imaging services rendered to Ambetter Health members.
 - NIA also provides services for Interventional Pain Management (IPM) and therapy services.
- Engolve Vision Services
 - Administers fully customizable vision plans to help reduce both provider and member costs while still delivering the highest quality vision benefits available.
 - **Ophthalmologists ONLY:** Claims and authorizations for medical eye services are administered through Ambetter Health.
 - Only routine vision services are administered through Engolve.

Specialty Vendor Contacts



- CVS Caremark
 - Transforms the traditional pharmacy benefit delivery model through innovative, flexible pharmacy solutions, customized care and prescription drug coverage management.
- TurningPoint HealthCare Solutions
 - Processes prior authorization requests for medical necessity and appropriate length of stay (when applicable) for musculoskeletal surgical procedures.
 - TurningPoint also provides services for cardiac surgical procedures, Ear, Nose and Throat (ENT) surgeries and sleep study procedures.



Questions
