Behavioral Health Billing Clinic

STAR, STAR Health, STAR Kids, STAR+PLUS (non-nursing facility) and CHIP

Provider Training

Introductions and Agenda

- Benefits and Services
- Verifying Eligibility
- Authorization, Tools, and Appeals
- Claims Submissions by Provider Type
- Trauma-Informed Care
  Alternative Payment Model
- Turning Point Health Solutions
- Ontrak Program
- Health Passport
- CANS 2.0
- MHR and MHTCM
- Behavioral Health Claims
- Telemedicine and Telehealth
- Electronic Payments and Remittance
- Fraud, Waste, and Abuse
- Superior HealthPlan Departments
- Provider Resources
- Provider Responsibilities
- Pharmacy Benefits
- Secure Provider Portal and Website
- Quality Improvement
- Questions and Answers

Benefits and Services

Behavioral Health Benefits

- Traditional Day and Outpatient Services
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Medication Management Therapy
  - Individual, Group and Family Therapy
- Inpatient Mental Health Services
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation
- Substance Use Disorder Treatment
  - Individual and Group Therapy
  - Residential Treatment
  - Residential Detox
  - Outpatient services
- Enhanced Services
  - Targeted Case Management and Mental Health Rehabilitative Services
- Telemedicine and Telehealth
- Pharmacy Benefits – Prescription Drugs

Please Note: The behavioral health benefits referenced above are not an all-inclusive list, and not available for all products.

Verifying Eligibility

Verify Eligibility

- Texas Medicaid Benefit Card (TMBC) (STAR Only)
  - TexMedConnect - www.TMHP.com/pages/edi/edi_texmedconnect.aspx.
- Viewing the member's Superior issued ID card (Member ID card is not a guarantee of enrollment or payment).
- Secure Provider Portal: Provider.SuperiorHealthPlan.com.
- Contact Member Services:
  - STAR, CHIP: 1-800-783-5386
  - STAR Health: 1-866-912-6283
  - STAR Kids: 1-844-590-4883
  - STAR+PLUS: 1-877-277-9772
- Verify eligibility the first of each month using the provider portal or by contacting Member Services.

Authorization, Tool and Appeals

Behavioral Health Authorizations

- Inpatient Hospitalization
- Psychological Testing
- Partial Hospitalization Program (PHP) Mental Health (MH) and Substance Use Disorder (SUD)
- Intensive Outpatient Program (IOP) MH and SUD
- Residential Treatment for MH (CHIP Only)
- SUD Residential Treatment
- Information on specific authorization requirements for each services as well as frequency limitations can be found on our Behavioral Health Quick Reference Guide, found on Superior's Behavioral Health webpage: SuperiorHealthPlan.com/ProviderBehavioralHealth
- Checklists are also available on the How To section on SuperiorHealthPlan.com/ProviderTrainings.

Behavioral Health Authorizations

- Providers can submit authorizations via:
  - Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - Phone: 1-844-744-5315
  - Fax:
    - Inpatient: 1-800-732-7562
    - Outpatient: 1-866-570-7517

- Providers can determine if authorization is needed by submitting the code through the Pre-Auth Needed Tool: SuperiorHealthPlan.com/PriorAuth

MHR/TCM Services Authorizations

- Authorization is not required for MHR/TCM.
- The participating entity must complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and will submit to Superior.
  - The form is found on SuperiorHealthPlan.com/ProviderForms.
- Providers must submit an annual attestation complying with all requirements of the SB58 Attestation form in order to be reimbursed for services.
- Superior conducts quarterly retrospective reviews for LMHAs and multi-specialty groups delivering MHR/TCM services.
  - This review is conducted to ensure providers of these services meet all training requirements and use the Department of State Health Services (DSHS) Resilience and Recovery Utilization Management Guidelines (RRUMG)

Medical Management Authorizations

All out of network services require an authorization.

- Emergent and urgent services provided by an out-of-network provider do not require prior authorization.

Initiate authorizations 5 Business Days in advance for non-emergency services.

If clinical information is requested by Medical Management, submit by fax or through Superior's Secure Provider Portal:

- Provider.SuperiorHealthPlan.com
- Fax:
  - Inpatient: 1-800-732-7562
  - Outpatient: 1-866-570-7517

Authorization TAT Requirements

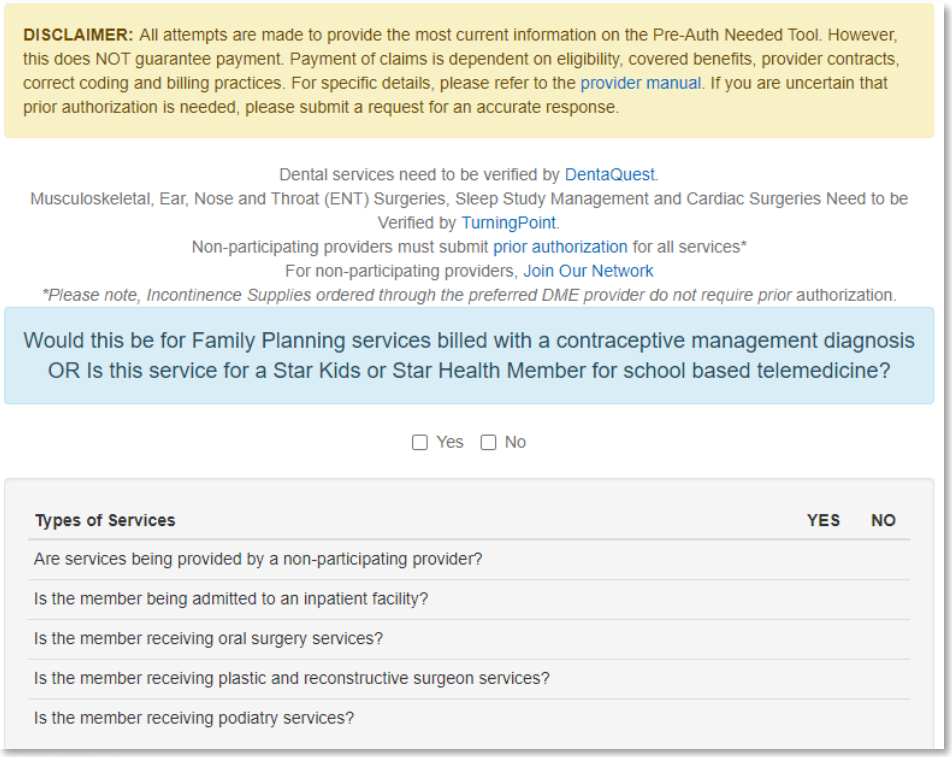
Program	Authorization Type	TAT
Medicaid	Outpatient	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
Medicaid	Urgent	3 Business Days
Medicaid and CHIP	Inpatient	1 Business Day

Authorization TAT Requirements

Authorization Type	TAT
Concurrent Review – The process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission.	• For Medicaid and CHIP, all urgent requests must be reviewed the same day, or within 1 Business Day of notification of admission, or within 1 Business Day of next review date. • Timeframe should not exceed 72 hours or 3 Calendar Days.
Retrospective Review – A form of utilization review for health-care services that have been provided to a member.	If discharge can be confirmed at the time of the initial request/notification of the admission, post-service review timeframes may be applied. A medical necessity determination and written notification is made within 30 Calendar Days from the date of the request.

Medicaid Pre-Authorization Tool

Providers can determine if a prior authorization is required by using the Pre-Auth Needed Tool on the Superior website, answering a series of questions and searching by procedure codes: SuperiorHealthPlan.com/PriorAuth.



DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Dental services need to be verified by DentaQuest.
Musculoskeletal, Ear, Nose and Throat (ENT) Surgeries, Sleep Study Management and Cardiac Surgeries Need to be Verified by TurningPoint.
Non-participating providers must submit prior authorization for all services*
For non-participating providers, Join Our Network
Please note, Incontinence Supplies ordered through the preferred DME provider do not require prior authorization.

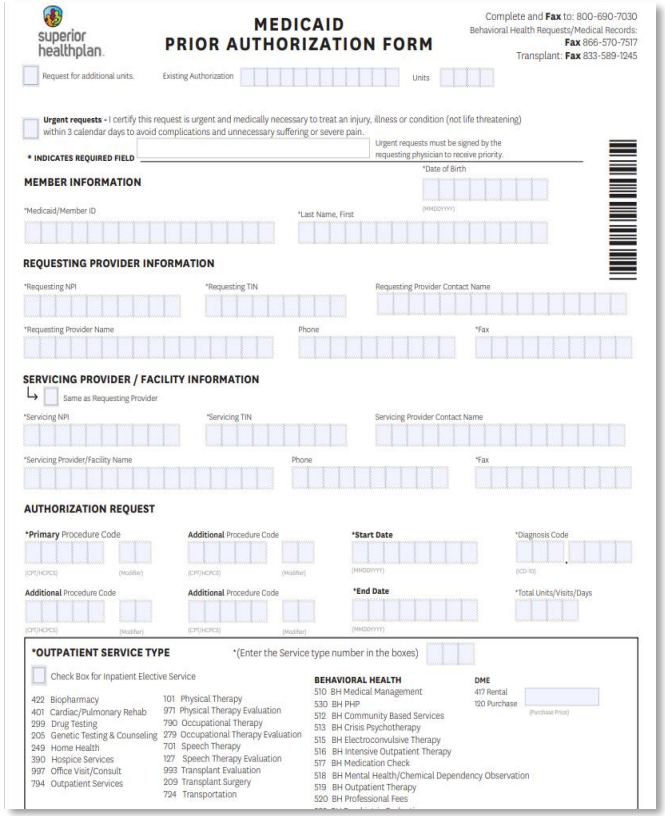
Would this be for Family Planning services billed with a contraceptive management diagnosis OR Is this service for a Star Kids or Star Health Member for school based telemedicine?

☐ Yes ☐ No

Types of Services	YES	NO
Are services being provided by a non-participating provider?		
Is the member being admitted to an inpatient facility?		
Is the member receiving oral surgery services?		
Is the member receiving plastic and reconstructive surgeon services?		
Is the member receiving podiatry services?		

Prior Authorization Form

- Prior authorizations can also be submitted at Provider.SuperiorHealthPlan.com.
- Medicaid Authorization Forms and the Texas Standard Prior Authorization Request Form are located on: SuperiorHealthPlan.com/ProviderForms



superior healthplan

MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records: **Fax** 866-570-7517
Transplant: **Fax** 833-589-1245

Request for additional units. Existing Authorization Units

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

Urgent requests must be signed by the requesting physician to receive priority.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Medicaid/Member ID *Last Name, First *Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI *Requesting TIN Requesting Provider Contact Name

*Requesting Provider Name Phone *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI *Servicing TIN Servicing Provider Contact Name

*Servicing Provider/Facility Name Phone *Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date** (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***End Date** (MMDDYYYY)

*Total Units/Visits/Days

***OUTPATIENT SERVICE TYPE** *(Enter the Service type number in the boxes)

Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
299 Drug Testing
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services
101 Physical Therapy
971 Physical Therapy Evaluation
790 Occupational Therapy
279 Occupational Therapy Evaluation
701 Speech Therapy
127 Speech Therapy Evaluation
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
517 BH Medication Check
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees

DME
417 Rental
120 Purchase (Purchase Price)

Medical Management Denials

- Type of Denial
  - Adverse Determination (Medical Necessity) Denial - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
    - Medical necessity is defined as health services that are reasonably necessary to:
      - Prevent illness or medical conditions.
      - Provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, or limitations in function.
  - Contractual (Administrative) Denials (non-clinical reasons)
    - Failure to obtain prior authorization
    - Failure to notify Superior of a hospital admission within stated timeframes
  - Non-Covered Benefit Denial
    - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by HHSC.
    - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by HHSC (Non-covered Benefit)

Appealing Medical Management Denials

- Communication of Denials
  - Denial letters will be sent to member, requesting provider and servicing provider to include:
    - The clinical basis for the denial
    - Criteria used to make the medical necessity decision
    - Member appeal/complaint, external review (CHIP) or fair hearing rights (Medicaid) fully explained
- The provider may request an appeals on behalf of the member.
  - Mail: Superior HealthPlan
    Attn: Appeal Coordinator
    5900 E. Ben White Blvd.
    Austin, TX 78741
  - Fax: 1-866-918-2266

Peer-to-Peer Options

- Peer-to-Peer Review
  - When medical necessity cannot be established, a peer-to-peer review is offered for outpatient prior authorization services. A peer-to-peer discussion is available to the ordering physician, nurse practitioner, or physician assistant during the prior authorization denial process regarding medical necessity.
    - Peer-to-peer discussion is not offered on appeal for Medicaid products
- Pre-Denial Peer-to-Peer
  - A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination for outpatient services.
- Post-Denial Peer-to-Peer
  - An opportunity to discuss is available to the member's requesting or servicing provider after the adverse determination has been rendered for both inpatient and outpatient services. This is like a case consultation and will not result in an overturn since this is not an appeal.
- To schedule a pre or post denial discussion with the Medical Director who has reviewed the case or made the denial determination, call Medical Management at 1-877-398-9461, option 3.

Medical Necessity Internal Appeals

- Standard Member Appeals
  - A Medicaid internal health plan appeal can be submitted orally or in writing and must be requested within **60 Days** of receipt of the Adverse Benefit Determination letter.
  - The appeal will be acknowledged within 5 Business Days of receipt, and the entire appeal process completed within 30 Days of receipt of the request for appeal.
  - Medicaid members, or their authorized representative, may request an extension of the appeal time frame, for an additional 14 Days, or if there is a need for additional information and if the delay is in the best interest of the member.
  - A physician who was not involved in the initial Adverse Benefit Determination, and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the appeal.
  - An appeal resolution letter is mailed within 30 Days of receiving the appeal request.

Medical Necessity Internal Appeals

- Expedited Member Appeals
  - A Medicaid member, a member's authorized representative, or the member's physician or other health care provider may request an expedited appeal of an Adverse Benefit Determination if waiting 30 Days for a standard resolution could seriously jeopardize the member's life or health.
    - Superior's Medical Management will review the request for expedited review.
  - If the Medical Director determines expediting the review is not medically necessary, the appeal will be processed within the standard appeal timeframe of 30 Days.
  - If the Medical Director determines expediting the review is medically necessary, an expedited appeal is resolved no later than 72 hours from receipt of the appeal request. Verbal notification is provided to the appeal requestor (member or provider) on the day of the decision.
    - Written notification is sent to the member and/or member's representative within one Business Day of the decision.

External Appeal Rights

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for Superior service denials and reductions.
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 Days of Superior's appeal decision letter.
- If requested, the External Medical Review through an IRO is completed before a State Fair Hearing.
- There are two types of EMR requests – standard and expedited:
  - Standard EMR Request – IRO Review is completed no later than 10 Days following receipt of Superior's records related to the service denial or reduction determination.
  - Expedited EMR Request – IRO review is completed the next Business Day following receipt of the Superior's record for urgent requests.

External Appeal Rights

- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services: Upheld, Partially Overturned or Fully Overturned.
- The IRO will send written notification of its EMR decision to the member, the member's authorized representative or member's LAR (if applicable), Superior and the HHSC EMR Intake Team.
- Superior will implement any partial or full overturn by the IRO within 72 hours.
- Withdrawal of EMR or State Fair Hearing Requests:
  - EMR – The member, the member's authorized representative, or the member's LAR must initiate an EMR withdrawal request to Superior before the IRO Review is initiated.
  - State Fair Hearing – If the EMR decision is to overturn Superior's adverse determination, the State Fair Hearing will proceed unless the member or member's representative withdraws the request. If the request is not withdrawn, regardless of the EMR decision, the member, the member's authorized representative or the member's LAR is required to attend the State Fair Hearing.
- A recording of the HHSC EMR Provider Training is available to providers.

Claim Submissions

Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - View a list of Superior's Trading Partners: SuperiorHealthPlan.com/Billing
  - Payer ID 68068
- Paper Claims - Initial
  - Superior HealthPlan
    Behavioral Health Claims
    P.O. Box 6300
    Farmington, MO 63640-6806
- Paper Claims - Requests for Corrections, Reconsideration* and Claim Disputes*
  - Superior HealthPlan Behavioral Health Appeals
    P.O. Box 6000
    Farmington, MO 63640-3809

**Must reference the original claim number in the correct field on the claim form.*

Claims Filing

- Claims must be filed within 95 Days from the Date of Service (DOS).
- A provider may submit a corrected claim or claim appeal within 120 Days from the date of Explanation of Payment (EOP) or denial is issued.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be completed in accordance with TMHP billing guidelines.
- Filed on a red CMS 1500 or UB04 form.
- Filed electronically through clearinghouse.
- Filed directly through web portal.
- 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.
- Billing Provider: Billing NPI in box 33a and Billing Taxonomy number in 33(b).

Clean Claims

- Clean claims will be processed within 30 Days.
- For electronic pharmacy claim submissions, claims will be paid in 18 Days.
- Once a clean claim is received, Superior will either pay the total amount of the claim or part of the claim in accordance with the contract, or deny the entire claim or part of the claim, and notify the provider why the claim will not be paid within the 30-Day claim payment period.
- Each claim payment check will be accompanied by an Explanation of Payment (EOP), which itemizes your charges for that reimbursement and the amount of your check from Superior.
- Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Superior, or the date of electronic transmission if payment is made electronically.

Clean Claim Requirements

- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS-1450/UB-04 or CMS 1500 forms.
  - NPI of a referring or ordering physician on a claim.
  - Appropriate two-digit location code must be listed.
  - Appropriate modifiers must be billed when applicable.
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician.
    - ZZ qualifier for CMS 1500 or B3 qualifier for UB04 to indicate taxonomy.
- For additional information on the clean claim requirements, review the Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual Provider Manual at SuperiorHealthPlan.com/ProviderManuals.

Paper Claims Filing

- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS-1450/UB-04 or CMS 1500 red form (not a copy).
    - Handwritten claim forms are no longer accepted.
  - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

Electronic Claims Filing

Superior will not pay any claim submitted by a provider, if the provider:

- Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- Is on payment hold under the authority of HHSC or its authorized agent(s).
- Has provided neonatal services provided on or after September 1, 2013, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2013, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

**In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.*

Identifying a Claim Number

- Superior assigns claim numbers for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.
- When calling Provider Services, please have the following ready to expedite handling:
  - Claim Number (can be found on the Secure Provider Portal)
  - Electronic Data Interchange (EDI) Rejection/Acceptance reports
  - Rejection letters
  - EOP

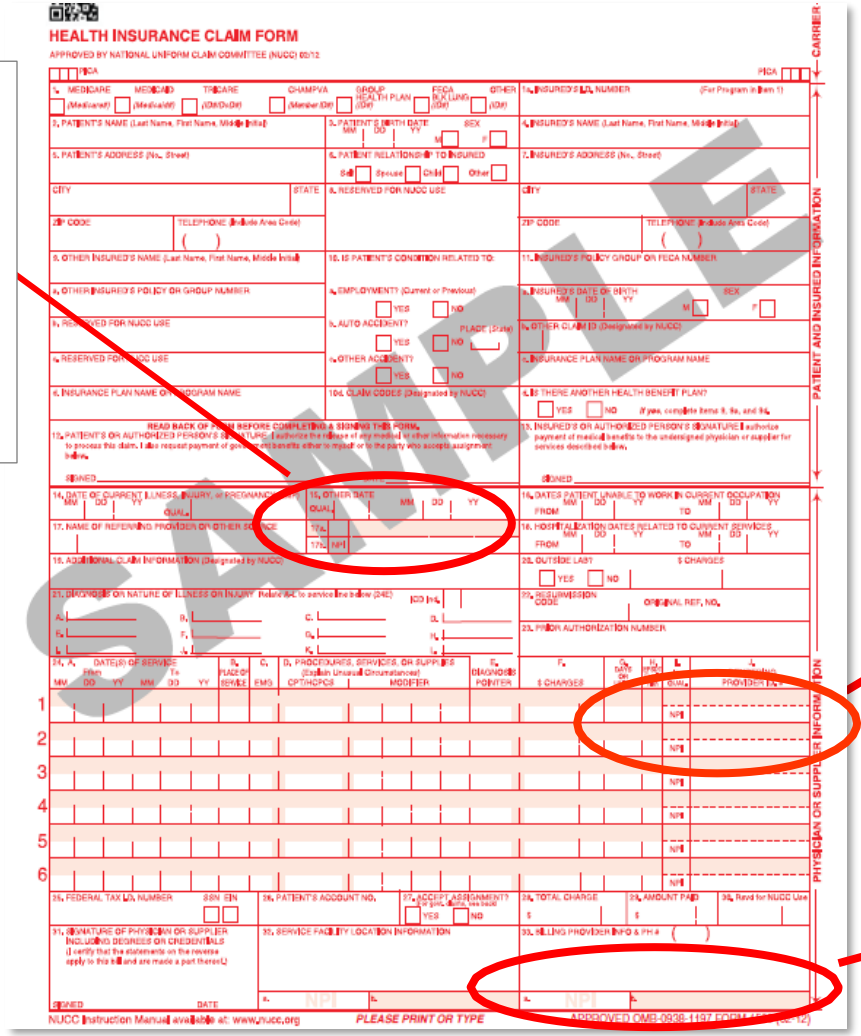
Note: Remember that rejected claims have never made it through Superior's claims system for processing. All rejected claims must be corrected and resubmitted within 95 Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.

CMS 1500 Form

Referring Provider: [C]

17 Name of the referring provider

17b NPI



Rendering Provider: [R]

Place your NPI (National Provider Identifier #) in box 24J (unshaded) and Taxonomy Code in box 24J (shaded).

These are required fields when billing Superior claims.

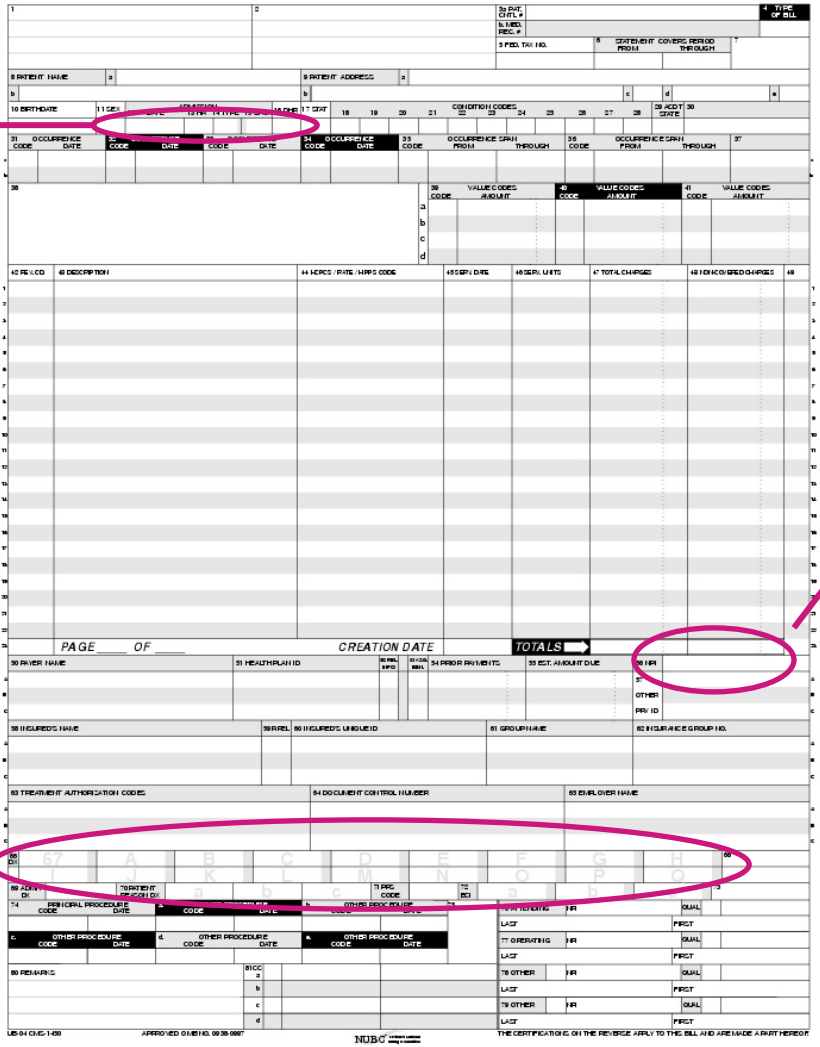
If you do not have an NPI, place your API (Atypical Provider Identifier #/LTSS #) in Box 33b.

Billing Provider: [R]

Billing NPI # in box 33a and Billing Taxonomy # (or API # if no NPI) in 33b.

UB-04 Requirements

Admission Information



Billing Provider NPI

Diagnosis code(s) and POA indicator(s)

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 Days from the date of adjudication or denial.
  - Adjusted or Corrected Claim: The provider is changing the original claim.
  - Correction to a Prior Claim: Finalized claim that was in need of correction as a result of a denied or paid claim.
  - Claim Appeals: Often require additional information from the provider.
    - Request for Reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - Claim Dispute: Provider disagrees with the outcome of the request for reconsideration.
- Claim Adjustments/Corrections and Submissions can be processed through the Provider Portal or a paper claim.
  - Paper claims require a Superior Corrected Claim or Claim Appeal form.
    - Claim forms can be found at SuperiorHealthPlan.com/ProviderForms.

Corrected Claims Filing

- A corrected claim is a correction or a change of information to a previously finalized clean claim in which additional information from the provider is required to perform the adjustment.
- Corrections can be made to, but are not limited to:
  - Patient Control Number (PCN)
  - Date of Birth (DOB)
  - Date of Onset
  - Place of Service (POS)
  - Present on Admission (POA)
  - Quantity Billed
  - Prior Authorization Number (PAN)
  - Beginning DOS
  - Ending DOS or Discharge Date

Corrected Claims Filing

- Must reference original claim number on EOP within 120 Days of adjudication date.
- Can be submitted electronically, through your clearinghouse/EDI software or through Superior's Provider Portal.
- Corrected or adjusted paper claims can also be submitted with a corrected claim form attached and sent to:

  Superior HealthPlan
  Attn: Behavioral Health Claims
  P.O. Box 6000
  Farmington, MO 63640-3809

Claims Appeal Form

- A claims appeal is a request for reconsideration of a claim for anything other than medical necessity and/or any request that would require review of medical records to make a determination.
- Submit appeal within 120 Days from the date of adjudication or denial.
  - Can be submitted in writing or electronically through Provider.SuperiorHealthPlan.com.
- Claim appeals in writing should be submitted to:
  - Superior HealthPlan Behavioral Health Appeals
    P.O. Box 6000
    Farmington, MO 63640-6806

Appeals Documentation

- Examples of supporting documentation may include, but are not limited to:
  - A copy of Superior's EOP (required)
  - A letter from the provider stating why they feel the claim payment is incorrect (required)
  - A copy of the original claim
  - An EOP from another insurance company
  - Documentation of eligibility verification such as copy of ID card, TMBC, Texas Medicaid and Healthcare Partnership (TMHP) documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing
  - Centene EDI acceptance reports showing the claim was accepted by Superior
  - Prior authorization number and/or form or fax

Withdrawal Management and Treatment Services Billing Guidelines

- Superior appreciates the provisioning of Withdrawal Management and Treatment Services through our network providers and encourages the delivery of all associated medically necessary and clinically appropriate facility and professional services for Medicaid.

- Withdrawal Management and Treatment Services require prior authorization through Superior before provisioning these services. In addition, guidelines for billing and related reimbursement for these services are detailed in the following slides. Claims must be billed in compliance with these guidelines to be eligible for reimbursement.

Substance Abuse Disorder Treatment

- PHP and IOP services must be specified in your provider contract by revenue code.
- Treatment for substance use disorder is a benefit of Texas Medicaid for persons who meet the criteria for a substance related disorder, as outlined in the current edition of the American Psychiatric Association's DSM. Initial evaluation and specialty follow-up evaluation as needed.
- SUD services may include individual, group and/or family treatment services, withdrawal management services, residential treatment services, medication assisted treatment and evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.
- Facility must be a Licensed Chemical Dependency Treatment Center (CDTF) per HHSC requirements for PAR providers.
- Levels of Service: This would be based on the members condition and the needed level of care.

Outpatient Withdrawal Management Services

- Outpatient Withdrawal Management Services:
  - HCPC H0016 – Alcohol and/or drug services; medical/somatic – medical intervention in ambulatory setting
    - Eligible for billing and reimbursement as a stand-alone code
    - Limited to once per day per patient, any provider
  - HCPC H0050 – Alcohol and/or drug services, brief intervention, per 15 minutes
  - HCPC S9445 – Patient education, not otherwise classified, non-physician provider, individual, per session
    - Must be billed with H0016 to be considered for reimbursement
    - Limited to once per day per patient, any provider
    - Eligible for reimbursement on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the person's treatment plan

Outpatient Withdrawal Management Services

- Outpatient Treatment Services
  - HCPC H0004 – Behavioral health counseling and therapy, per 15 minutes
  - HCPC H0005 – Alcohol and/or drug services; group counseling by a clinician
- Limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a Chemical Dependency Treatment Facilities (CDTF)
- Denied if billed on the same date of service as residential withdrawal management
  - Procedure codes H0012, H0031, H0047, S9445, T1007
- Denied if billed on the same date of service as residential treatment
  - Procedure code H2035

Residential Withdrawal Management Services

- Residential Withdrawal Management:
  - HCPC H0012 – Residential sub-acute detoxification for alcohol and/or drug services
    - Eligible for billing and reimbursement as a stand-alone code
    - Limited to once per day per patient, any provider
- The following services must be billed with H0012 to be considered for reimbursement and are limited to once per day per patient, any provider:
  - HCPC H0031 – Mental health assessment by non-physician
  - HCPC S9445 – Patient education, not otherwise classified, non-physician provider, individual, per session
  - HCPC T1007 – Alcohol and/or substance abuse services, treatment plan development and/or modification
  - HCPC H0047 – Room and board for residential treatment services

Residential Treatment Services

- Residential treatment programs provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive substance use disorder treatment with attention to co-occurring conditions, as appropriate. The frequency and duration of services should be based on meeting the person's needs and achieving the person's treatment goals.
- HCPC H2035 – Residential Treatment Services
  - Limited to once per day per patient, any provider
  - Under age 21 may exceed benefit limit
  - Facility must be a SUD facility per HHSC requirements
  - Requires Authorization for Par and Non-Par Providers
    - May authorize up to 35 days per episode of care, not to exceed 70 days per rolling six months.
- Residential Treatment Services are to be billed as outpatient.

Inpatient Facility

- Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service Medicaid or managed care.
- Inpatient facility services include but are not limited to:
  - Partial Hospitalization Program (PHP) – Provider's contract must outline codes and pricing
  - Intensive Outpatient Program (IOP) – Provider's contract must outline codes and pricing
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation
- May require authorization
  - To facilitate the retrospective review, clinical documentation to support the medical necessity of the inpatient admission must be submitted with the claim for the inpatient stay.
  - Notification of admission is still required at the time of admission.
    - Lack of notification may result in a contractual denial for failure to comply
  - Observation does not require authorization

Revenue Code	Definition
0124	Psychiatric
0126	Detoxification

Common Claim Denials for Substance Use Disorder

Denial Code	Definition
EXA1	No authorization on file that matches service(s) billed
EX29	The time limit for filing has expired
EXMt	Not Medically Necessary Services
EXNu	Did not use authorized provider-non par
EXNP	Authorization requested for non-plan provider
EXMA	Provider NPI, Tax ID, and or Taxonomy not on State File
EX46	Services is not a covered benefit of Texas Medicaid

Common Claim Denials for Residential Treatment Centers

Denial Code	Definition
EXA1	No authorization on file that matches service(s) billed
EXQV	Code not Payable without Primary Procedure code
EXIM	Resubmit with correct Modifier
EXE3	Modifier Missing or Invalid
EX29	The time limit for filing has expired

For additional information on billing guidelines for Withdrawal Management and Treatment Services, visit:
Behavioral Health Providers: Service and Claim Billing Guidelines for Withdrawal Management and Treatment Services

Common Denials for Inpatient Facility

Denial Code	Definition
EXA1	No Authorization on file that matches service(s) billed
EX29	The time limit for filing a claim has expired
EXBG	Type of Bill missing or Incorrect on claim, please resubmit
EXCd	Medicare coverage rules not followed therefore services not eligible
EXMA	Provider NPI, Tax ID, and or Taxonomy not on State File
EXNB	Service not covered, provider responsibility, do not bill member
EXHP	No Authorization on file that matches service(s) billed
EXVV	Missing or Invalid POA
EXDZ	Service has exceeded the Authorized Limit
EXL6	Bill Primary Insurer 1st resubmit with EOB

Trauma-Informed Care Alternative Payment Model

Trauma-Informed Care Alternative Payment Model

- Superior has an Alternative Payment Model (APM) for behavioral health therapy providers serving STAR Health members. When a provider uses an approved evidenced-based, trauma-informed care modality to treat trauma-related behavioral health symptoms and issues, they can receive an additional 10% payment to their submitted claim.

- Additional information on this program can be found online at: STAR Health Trauma-Informed Care Alternative Payment Model

- Please submit your certifications to ProviderCertifications@SuperiorHealthPlan.com.
  - Certifications are only valid for a set period of time from the issue date and must be renewed and resubmitted periodically.

Trauma-Informed Care Alternative Payment Model

There are 5 therapy modalities that will be recognized for this APM:

1. **Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)** – Recognized as evidence-based and validated for use with children and adolescents.
   - Certification is valid for 5 years
2. **Eye Movement Desensitization and Reprocessing (EMDR)** – Recognized as evidence-based, validated for use with adults.
   - This certificate is a lifelong certificate and will not need to be resubmitted
3. **Cognitive Processing Therapy (CPT)** – Recognized as evidence-based, primarily focused on adults.
   - Certification is valid for 3 years
4. **Prolonged Exposure (PE)** – Recognized as evidence-based, validated for adolescents (PE-A) and adults
   - This certificate is a lifelong certificate and will not need to be resubmitted
5. **Parent Child Interaction Therapy (PCIT)** – Recognized as evidence-based, validated for children ages 2-7.
   - This certificate is a lifelong certificate and will not need to be resubmitted

Trauma-Informed Care Alternative Payment Model

The requirements for participating are as follows:

1. Submit a training certificate for one or more of the modalities listed below. Certificates can be submitted to ProviderCertifications@SuperiorHealthPlan.com.
2. When submitting claims to Superior for the therapy modalities, use the identified billing modifier to indicate which modality was used.

    - U1 = Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
    - U2 = Eye Movement Desensitization and Reprocessing (EMDR)
    - U3 = Cognitive Processing Therapy (CPT)
    - U4 = Prolonged Exposure (PE)
    - U5 = Parent Child Interaction Therapy (PCIT)

3. Complete a baseline screening at the beginning of treatment. Follow-up screenings should be conducted every 90 Calendar Days, or at the conclusion of treatment (whichever comes first). There are 2 screenings available within Superior's Health Passport for this purpose. For children and adolescents, use the Child and Adolescent Trauma Screen (CATS). For adults, use the Trauma Screening Questionnaire (TSQ). Document in the patient's medical chart that an evidenced-based approach to trauma is being used.

Turning Point Program

Turning Point Program

- A Psychiatric Hospital Diversion Program for Children and Youth in STAR Health.
- **Benefits of this new program include:**
  - Access to a 24-hour crisis information line.
  - Mental health assessment.
  - Counseling.
  - Family supports and skills building.
  - Alternate care setting for youth who qualify.
  - Crisis support and intervention planning.
- In order for children and youth in STAR Health who live outside of the Dallas/Fort Worth area to participate in Turning Point they must:
  - Have a caregiver willing to virtually participate in their treatment
  - Have a caregiver willing to transport them to and from the program location.
  - Be able and willing to travel.
- **To learn more about Turning Point, call the number below:**
  - **Dallas/Fort Worth:** 1-817-909-1171
  - More information is also available online at www.ACHservices.org
  - Download a PDF of the Turning Point Flyer (PDF).

Ontrak Program

Ontrak Billing Reminders

- Ontrak program service claims for Superior members must be submitted to Superior for processing.
- In order to receive the specialized rate for these services, providers must submit claims with modifier X2, along with the modifier that identifies the provider type rendering the services for each Ontrak procedure code submitted.
- Provider type modifiers include:

Description	Modifier
Clinical Psychologist	AH
Post-Doc	UB
LPA/LPC/LMFT/LCSW	UC
PLP	U9

Ontrak Billing Reminders

Medical Provider Services

Type of Service	CPT Code
Medical Evaluation – New Patient	99203
Medical Office Visit – Established Patient	99213
Suboxone – Initial Evaluation	90792
Suboxone – Follow up	99214

Psychosocial Provider Services (Licensed Psychologist/Doctoral and Master's Level)

Type of Service	CPT Code
Psychiatric Diagnostic Interview	90791
Psychosocial Evaluation	90834

To find information about Ontrak Services, visit: https://ontrakhealth.com/

Health Passport

Health Passport

- Health Passport is a secure web-based application built using core clinical and claims information to deliver relevant health-care information when and where it is needed for the STAR Health population.
- Medical Consenters, health care providers, Department of Family and Protective Services (DFPS) caseworkers and STAR Health staff may have access to the information.
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination
  - Eliminate waste
  - Reduce errors
- To log on to Health Passport, visit Provider.SuperiorHealthPlan.com.
- For additional information, visit FosterCareTX.com/For-Providers/Health-Passport.html.

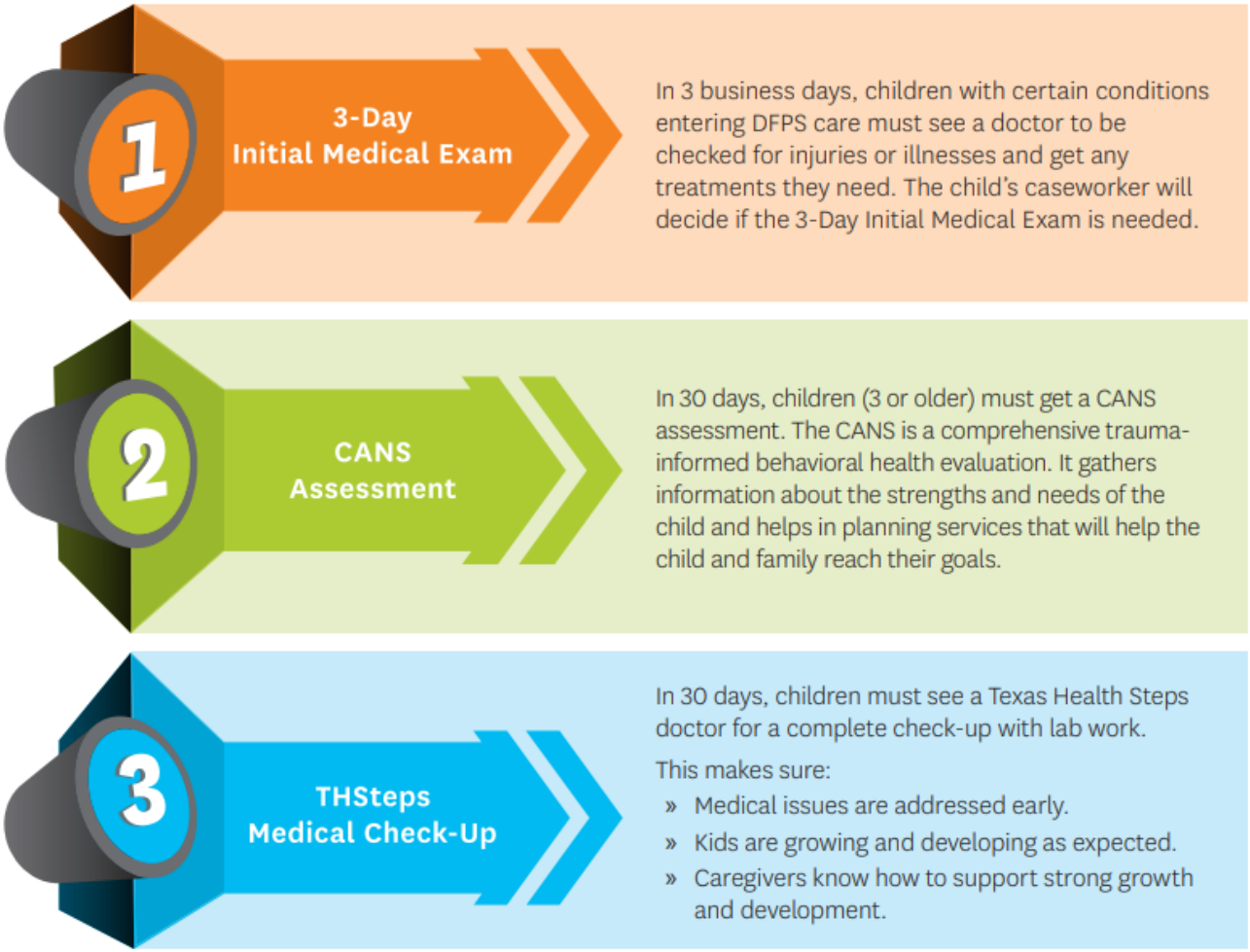
Health Passport Contractual Requirement

- It is a contractual requirement for behavioral health providers treating STAR Health members to document outcome measurement scores in Health Passport. The following information must be documented within Health Passport:
  - Primary and secondary (if present) diagnosis
  - Assessment information
  - Brief narrative summary of clinical visits and progress
  - Scores on each outcome rating form(s)
  - Referrals to other providers or community resources
  - Evaluations of each member's progress at intake, monthly and at termination of the Health Care Service Plan (HCSP) or as significant changes are made in the treatment plan
  - Any other relevant care information
- Behavioral health providers must submit an initial and monthly narrative summary report of a member's behavioral health status for inclusion in Health Passport.
- Additional information on this requirement can be found in our provider manual or at https://www.superiorhealthplan.com/newsroom/health-passport-requirement-for-bh-providers.html

CANS 2.0

Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 2.0 (Child Welfare) Assessment

3 in 30 and CANS 2.0



Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 2.0 (Child Welfare) Assessment

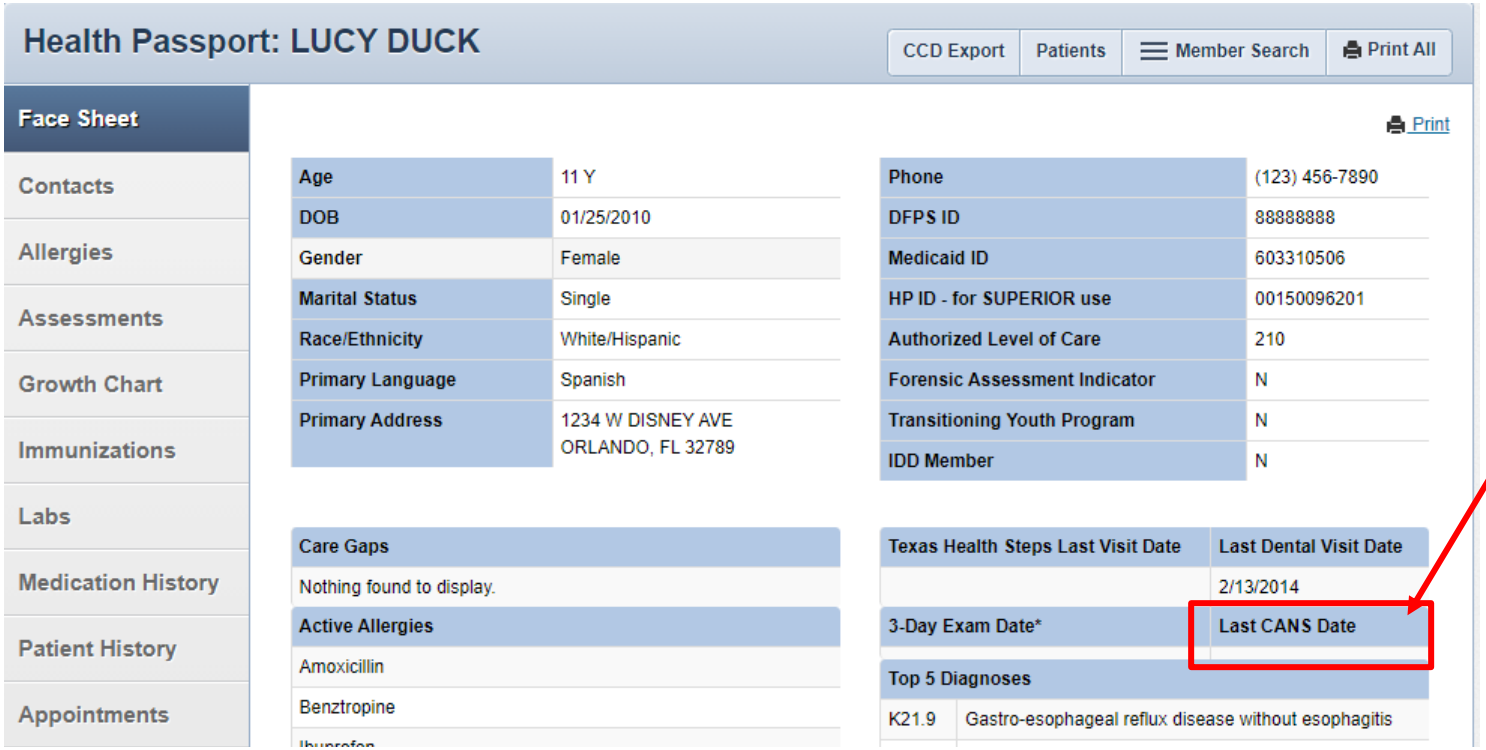
- Multi-purpose tool developed with the primary objectives of permanency, safety and improved quality of life for youth in foster care.
- Completed by a licensed clinician who is certified to administer the tool.
- Children who are 3-17 years of age at the time of removal are required to have a CANS assessment **within 30 days** of entering foster care.
- Children who turn 3 while in care are required to have a CANS within 30 days of their 3rd birthday.
- CANS 2.0 re-assessments are required annually while an eligible child remains in foster care.
- Certified providers can be reimbursed for completion of the CANS 2.0 assessment.
  - CPT 90791 and modifier TJ
- Additional information can be found online at Superior's Foster Care Resources webpage.
- Clinical policy is available at SuperiorHealthPlan.com/Policies.

CANS/ANSA vs. CANS 2.0

- The Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 2.0 (child welfare) assessment for children placed in foster care is required within 30 Days from when they entered DFPS conservatorship and an annual assessment thereafter.
- The CANS 2.0 assessment is not the same as the CANS assessment facilitated by LMHAs for utilization of MHR/TCM services. The CANS 2.0 must include a trauma screening and interviews with individuals having knowledge of the child's needs.
  - The CANS 2.0 is a reimbursable service for STAR Health members and helps to determine interventions and needs for foster care.
  - The CANS/ANSA is the uniform assessment that MHR/TCM provider must do to complete review for services; however, it is not reimbursable.
- Providers are required to become trained and certified in order to administer the CANS assessment.

Checking CANS 2.0 Status

Providers can log into Health Passport to verify when the last CANS assessment was completed for a STAR Health member. Health Passport also indicates the PID number needed to submit an assessment through eCANS.



Becoming a CANS 2.0 Provider

- To become a CANS-certified provider:
  1. Access the CANS training at www.schoox.com/academy/CANSAcademy/register. The Texas Comprehensive 2.0 (Child Welfare) is the appropriate version to complete the required certification.
     - The training cost is $15.
     - Discount coupon codes can be requested for groups of 5 or more by emailing ecans.support@uky.edu.
  2. Complete the entire training to receive certification.
  3. Submit the CANS 2.0 certificate to TXCANS@SuperiorHealthPlan.com
     - Please include your National Provider Identifier (NPI) in the email.

MHR and MHTCM

Mental Health Rehabilitation (MHR) and Mental Health Targeted Case Management (TCM)

MHR and TCM Services – LMHA and Non LMHA Groups

- Mental Health Rehabilitation (MHR) – Includes services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.

- Mental Health Targeted Case Management (TCM) – Services are furnished to assist persons in gaining access to needed medical, social/behavioral, education and other services and supports.

- Billing for MHR/TCM services is limited to Local Mental Health Authorities (LMHA) or Non-LMHA groups who have completed all of the required trainings, and are fully attested with Superior.

LMHA and Non LMHA Groups Contract Requirements

- Providers are required to attest annually to the following prior to delivering MHR/TCM services
  - Participating providers are trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) assessment tools, and agree to use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system.
  - The participating provider has completed all training requirements outlined in the Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual (UMCM) Chapter 15.3 before delivering any MHR and Mental Health TCM Services. To review these requirements, please visit HHSC Mental Health Targeted Case Management.
  - The participating entity will complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and will submit to Superior.

LMHA and Non LMHA Groups Contract Requirements

- MHR/TCM Attestation, continued
  - The participating entity will provide Mental Health Rehabilitative Services and TCM using the DSHS TRR UM Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.
  - The participating entity has the ability to provide covered persons with the full array of TRR services either directly or through sub-contract.
  - The participating entity is familiar with the HHSC cost reporting process and will participate in this process.
- Please note: This is included in the Attestation Form providers must submit annually. The Mental Health Rehabilitation and Targeted Case Management Annual Attestation form can be found under the Credentialing section on SuperiorHealthPlan.com/ProviderForms

MHR Billing Codes and Modifiers

MHR Service	HCPC Code
Day Program for Acute Needs	H2012
Medication Training and Support	H0034
Crisis Intervention	H2011
Skills Training and Development	H2014
Psychosocial Rehabilitative Services	H2017

Service Description	Modifier
Group Services for Adults	HQ
Group Services for Child/Youth	HA/HQ
Individual Services for Child/Youth	HA
Individual Services Provided by RN	TD
Group Services Provided by RN	HQ/TD
Individual Crisis Services	ET

MHTCM Billing Codes and Modifiers

- MHTCM Services must be billed using procedure code T1017.
- T1017 must be billed with the appropriate modifiers. To ensure timely and appropriate reimbursement, modifier TF or TG must be placed in the first position.
- Intensive Case Management and Routine Case Management are benefits for child and adolescent members who are 20 years of age and younger.
  - These services cannot be billed for the same date of service.
- Routine Case Management is a benefit for adult members 21 years of age and older.

Modifier	Modifier Description	Modifier Position	Eligible Population
TF	Routine Case Management	Primary	Children / Adolescents / Adults
TG	Intensive Case Management	Primary	Children / Adolescents
HA	Child / Adolescent Program	Secondary	Children / Adolescents
HZ	Funded by Criminal Justice Agency	N/A	N/A

MHR / TCM Billing Reminders

- Multiple claims for the same service to the same member can be processed for both MR and TCM.
- Superior does not require providers to submit a Medicare or private insurance denial for services that are never covered and/or paid by Medicare or private insurance, including Targeted Case Management and Rehabilitative Services.
  - Exception: For dual-eligible individuals, providers will not bill Superior, as services for these individuals will be billed through TMHP.
- For MHR and MHTCM, Superior does not require the name of a rendering provider on claims submitted to the MCO if that provider is not a type that enrolls in Medicaid (CSSPs, Peer Providers, Family Partners, and some QMHPs).
  - A rendering provider number is only required if the individual delivering the service is licensed and has a Medicaid provider number.

MHR/TCM Billing Reminders

- Claims must be submitted with the diagnosis codes outlined in the TMHP Behavioral Health Provider manual.
- Participating Local Mental Health Authority (LMHA) facilities must submit a rendering provider roster to Superior to add both licensed and non-licensed providers to their current contract.
  - Rosters can be submitted to lmha.load@superiorhealthplan.com
- Non-LMHA multi-specialty groups must submit additions to their group through the Add a Provider to an Existing Group Contract form, located on Superior's Network Request or Update page: SuperiorHealthPlan.com/JoinOurNetwork
- MHR/TCM Group providers must also submit the Group National Provider Identifier Demographic Form located under the Credentialing section on SuperiorHealthPlan.com/ProviderForms
- Attestations are required to be submitted annually.
  - Please ensure attestations are sent in timely in order to avoid claim denials.

Behavioral Health Claims

Psychologist Delegated Services

- Psychological services provided by a Licensed Psychological Associate (LPA), Provisionally Licensed Psychologist (PLP), psychology intern or post-doctoral fellow must be billed under the supervising psychologist's Medicaid provider identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.
- Services provided by a psychologist, Licensed Psychological Associate (LPA), Provisionally Licensed Psychologist (PLP), psychology intern or post-doctoral fellow must be billed with a modifier on each claim detail line.
- Superior requires provider to submit claims for psychological delegated services with the modifier identifying the provider type rendering the service billed.

Psychologist Delegated Services	Modifier
Clinical Psychologist	AH
Pre-Doctoral Psychology Intern or Post-Doctoral Psychology Fellow	UB
License Psychological Associate	UC
Provisionally Licensed Psychologist	U9

Psychologist Delegated Services

- Services performed by a LPA or PLP will be reimbursed at 70% of the psychologist rate. Services performed by the psychology intern or post-doctoral fellow will be reimbursed at 50% of the psychologist rate.

- The Licensed Clinical Social Worker (LCSW), Marriage and Family Therapists (MFT), Licensed Professional Counselor (LPC), Advanced Practice Registered Nurse (APRN) or Physician's Assistant (PA) performing the mental health service may bill for the performed services.

- The LCSW, MFT, LPC, APRN or PA must not bill for services performed by people under his or her supervision.

Twelve Hour System Limitation

- The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of persons seen for outpatient mental health services:
  - Psychologist
  - APRN
  - PA
  - LCSW
  - LMFT
  - LPC
- Court-ordered and DFPS-directed services are not subject to the 12-hour per provider, per day system limitation when billed with modifier H9.
- Physicians are not subject to the 12-hour system limitation since they can delegate and may submit claims in excess of 12 hours per day.
- Psychologists can delegate to multiple LPAs, PLPs, interns, or post-doctoral fellows
  - Delegated services are not subject to the 12-hour system limitation.

Twelve Hour System Limitation

The following table lists the procedure codes for mental health services included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Applied	Procedure Code	Time Applied	Procedure Code	Time Applied
90791	60 minutes	90837	60 minutes	96130	60 minutes
90792	60 minutes	90838*	60 minutes	96131*	60 minutes
90832	30 minutes	90846	50 minutes	96132	60 minutes
90833*	30 minutes	90847	50 minutes	96133*	60 minutes
90834	45 minutes	96116	60 minutes	96136	30 minutes
90836*	45 minutes	96121*	60 minutes	96137*	30 minutes

*Add-on procedure codes indicated with an asterisk must be billed with the appropriate primary procedure code.

FQHC: Medicaid and CHIP Billing Procedures

- In order to receive the full PPS encounter rate, Federally Qualified Health Centers (FQHCs) must bill a T1015 procedure code and all applicable modifiers on the first service line, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge).
- CMS 1500 claim form.
- Bill using location 50.
- Bill with the billing provider's NPI in box 33a and billing provider's taxonomy in box 33b.
  - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission.
- Rendering Provider NPI/taxonomy is required for all services in box 24J.

RHC: Medicaid and CHIP Billing Procedures

- The Rural Health Clinic (RHC) must bill a T1015 procedure code for general medical services.
- A RHC is paid their full encounter rate directly from Superior.
- All services provided at an RHC and billed on a CMS 1500 form must be submitted using location POS code 72. This includes Texas Health Steps/Well visits and Family Planning Services.
- Services rendered at an RHC facility and billed with a location code other than 72 may be denied.
- Providers must use the appropriate modifiers in order to receive payment for services.

Billing Reminders

- All institutional claims must contain Present on Admission (POA) indicators and Superior will utilize the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
  - For per diem hospital payments, Superior utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.
- If a provider bills for procedure codes not identified as valid encounter services (identified specifically in the TMHP manual available at www.TMHP.com), the service will not pay as the services are considered to be informational only.

Billing Reminders - Authorizations

- When calling in to request an authorization, or to notify of a patient admission, please have available the Tax Identification Number (TIN) and NPI or LTSS ID number that will be used to bill your claim. If these numbers are not presented, your request will not be processed.
- The TIN/NPI used to request the authorization must match what is used to bill the claim, or the claim will deny.
- If the claim denies because it was billed with a different TIN/NPI combination than was authorized:
  - Verify that the TIN/NPI combination on the requested authorization matches what was billed.
  - If authorization and claim match, contact Provider Services.
  - If the claim was billed incorrectly, a corrected submission is required.

Billing Reminders - Authorizations

- Superior may issue authorizations that extend to multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under a single authorization.
- Bill must reflect the services under the authorization, including billing period.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Common Billing Errors

- Member date of birth or name not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- No itemized bill provided when required
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate
- Illegible paper claim

Member Balance Billing

- Providers may not bill members directly for covered services for Medicaid or CHIP.
- Superior Medicaid and CHIP Perinate members do not have co-payments. Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (under CHIP Benefits).
- Additional details can be found in your provider contract with Superior and in the Balance Billing: Superior Medicaid and CHIP found under the Billing Resources section at SuperiorHealthPlan.com/ProviderResources.

Telemedicine and Telehealth

What is Telemedicine?

- Telemedicine services are medical services delivered by a physician to a patient at a different physical location. Using telecommunications or information technology, providers are able to see and hear the patient in “real” time.
- Providers must be licensed in Texas or be under the supervision of a provider licensed in Texas. Provider types able to practice telemedicine include:
  - Physicians
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician’s Assistants
  - Certified Nurse Midwives
  - Federally Qualified Health Center (FQHC)
- Providers must use a HIPAA-compliant system for all interactions.

What is Telehealth?

- Telehealth services are behavioral health services provided by licensed or certified providers to a patient at a different physical location other than the health professional using telecommunications or information technology.

- A distant site provider does not need to conduct a physical examination in order for behavioral health services to be rendered.

- The distant site provider is able to conduct a “face-to-face” evaluation via telehealth at an established medical site prior to providing ongoing care. They may also provide treatment for a patient referred by another physician who completed a “face-to-face” evaluation via telemedicine at an established medical site.
  - The Centers for Medicare and Medicaid Services (CMS) define the distant site as the telehealth site where the provider/specialist is seeing the patient at a distance or consulting with a patient’s provider.

What is Telehealth?

- Telehealth is a benefit when provided by these provider types:
  - Early Childhood Intervention (ECI)
  - Licensed Professional Counselor
  - Licensed Marriage and Family Therapists (LMFT)
  - Licensed Clinical Social Workers (LCSW)
  - Psychologist
  - Licensed Psychological Associate
  - Provisionally Licensed Psychologist
  - Licensed Dietitian
  - CCP providers (Occupational Therapist, Speech-language Pathologist)
  - Home Health agency
  - School Health and Related Services (SHARS)
  - FQHC
  - RHC

Covered Benefits of Telemedicine and Telehealth

- Telemedicine and Telehealth may be delivered via:
  - Synchronous audiovisual interaction between the provider and the client in another location using a mobile app or live online video.
  - Asynchronous store and forward technology using:
    - Clinically relevant photographic or video images, including diagnostic images.
    - The patient's medical records (i.e. medical history, lab results and prescriptive histories).
  - Other forms of audiovisual communication that allow the provider to meet the in-person visit standard of care.

Covered Benefits of Telemedicine and Telehealth

- For a list of Current Procedural Terminology (CPT) codes that are covered under telemedicine and telehealth, please see the TMHP Telecommunication Services Handbook at www.TMHP.com.
  - The codes listed must be billed with modifier 95.
  - Procedure codes that indicate remote in the description do not need modifier 95.
  - Procedure codes for behavioral health services are subject to the same benefits and limitations as in-person visits.

- Patient site providers may be reimbursed for Q3014 in a facility setting; however, it is not a benefit of telehealth services.

Covered Benefits of Telemedicine and Telehealth

- Texas Health Steps checkups are not a benefit under telemedicine or telehealth.
- Distant site providers issuing prescriptions must follow the same standards as would be applied during an in-person visit.
- Reimbursement may not be provided for text-only email messages and facsimile transmissions.
  - After the COVID-19 pandemic, Superior will only reimburse for telephone-only services when a HIPAA-compliant platform is used to conduct them.

Electronic Payments and Remittance

Signing up for Electronic Funds Transfer (EFT) and Retrieving your Explanation of Payment (EOP)

PaySpan

- Superior has partnered with PaySpan to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs)
  - Online remittance advices (Electronic Remittance Advice [ERAs]/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at www.PaySpan.com.
- For further information contact 1-877-331-7154, or email ProviderSupport@PayspanHealth.com.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
  - Visit https://oig.hhs.gov/ and select “Click Here to report fraud, waste and abuse” to complete the online form.
  - Contact Superior’s Corporate Special Investigative Unit directly at:

    Centene Corporation
    Superior HealthPlan Fraud and Abuse Unit
    7700 Forsyth Boulevard
    Clayton, MO 63105
    1-866-685-8664

- Examples of fraud, waste and abuse:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid or CHIP ID

Superior HealthPlan Departments

Provider Services

- Provider Services can help you with:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims related questions, please have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Contact Provider Services, Monday through Friday, 8:00 a.m. to 5:00 p.m.* local time:
  - Medicaid/CHIP – 1-877-391-5921

**For STAR Health, office hours are from 8 a.m. to 6 p.m. (local time), Monday through Friday.*

Account Management

Account Management serves as the primary liaison between Superior and our provider network. The Account Management team is responsible for:

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

Behavioral Health providers have a designated team of Account Managers to assist with their inquiries. You may contact them at AM.BH@superiorhealthplan.com.

Provider Contracting

- Network Development and Contracting is a centralized team that handles all contracting for new and existing providers to include:
  - New provider contracts
  - Adding providers to existing Superior contracts
  - Adding additional products to existing Superior contracts
  - Amendments to existing contracts

- Contract packets can be requested at SuperiorHealthPlan.com/JoinOurNetwork

Provider Credentialing

- Initial Credentialing
  - Complete a Texas Department of Insurance (TDI) credentialing application form for participation
  - Complete an electronic application
  - Provide Council for Affordable Quality Healthcare (CAQH) identification number
  - Email applications to SHP.NetworkDevelopment@SuperiorHealthPlan.com.

Provider Credentialing

- Re-credentialing
  - Completed every 3 years from date of initial credentialing.
  - Applications and notices are mailed at 180, 120, 90 and 30 days out from the last day of the credentialing anniversary month.
  - Lack of timely submission can result in members being re-assigned and system termination.
  - Email applications to Credentialing@SuperiorHealthPlan.com.
  - Failure to respond timely to requests for information or documentation will result in discontinuation of re-credentialing and termination of contract.
- All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686 or Credentialing@SuperiorHealthPlan.com.

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Finding additional local community resources
  - Answering questions

- Contact Member Services Monday through Friday:
  - STAR/CHIP – 1-800-783-5386 (8 a.m. to 5 p.m.)
  - STAR Health – 1-866-912-6283 (8 a.m. to 9 p.m.)
  - STAR Kids – 1-844-590-4883 (8 a.m. to 5 p.m.)
  - STAR+PLUS – 1-877-277-9772 (8 a.m. to 5 p.m.)

Service Coordinators

- Available to members receiving behavioral and/or physical health services, depending on the level of service coordination assigned.
- Perform in-home assessments with members for LTSS to ensure members are able to live a healthy life in the setting of their choice.
- Coordinate referrals to other programs like Disease Management and Case Management, if necessary.
- Assist with coordinating care and follow-up with members.
- Visit or touch-base telephonically with members at least 2 times a year.

Behavioral Health Care Management

- Superior has experienced nurses, licensed clinical counselors and licensed CSWs who can assist members in coordinating all aspects of their care.

- Care Management services are available for any member.

- Levels of care management include:

  - **Care Coordination** – Lowest level, mostly short-term needs, social assistance, stable chronic conditions.
  - **Care Management** – Intermediate needs, may require additional time or resources to ensure member needs are addressed.
  - **Complex Care Management** – Significant illness burden and complexity. These members require longer term, ongoing assistance to address care gaps and service needs.

Provider Complaints

- A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to the Superior. Superior offers a number of ways to file a complaint, as listed below:
  - **Mail:** Superior HealthPlan

    ATTN: Complaint Department

    5900 E. Ben White Blvd.

    Austin, Texas 78741
  - **Fax:** 1-866-683-5369
  - **Online:** Superior HealthPlan Complaint Procedures

Provider Resources

Provider Resources

- Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual found on SuperiorHealthPlan.com/ProviderManuals
- Secure Provider Portal Booklet, found on Provider.SuperiorHealthPlan.com
- Superior's Provider Training Calendar, found on SuperiorHealthPlan.com/ProviderCalendar
- TMHP Fee Schedule
- Texas CANS 2.0 FAQ found on Superior's Foster Care Provider Resources webpage
- Directed Payment Program for Behavioral Health Services FAQ found on SuperiorHealthPlan.com/ProviderBehavioralHealth
- Request for Child Abuse/Neglect Central Registry Check (1600)
- For Dallas/Fort Worth providers, the Turning Point flyer can be found on Superior's Foster Care Behavioral Health webpage.
- Training videos found on SuperiorHealthPlan.com/ProviderTrainings:
  - Superior's Secure Provider Portal - Submitting a Professional Claim
  - Superior's Secure Provider Portal - Submitting a Prior Authorization
- Superior's Foster Care Important Forms webpage
- Clinical Policies can be found on SuperiorHealthPlan.com/Policies

Provider Responsibilities

Behavioral Health Provider Responsibilities

Behavioral health providers are required to:

- Comply with the Psychotropic Medication Utilization Parameters for Foster Care Children
  - For more information, visit: Texas Department of Family and Protective Services (DFPS) Psychotropic Medications webpage
- Expand the use of evidence-based practices, including:
  - Trauma focused cognitive behavioral therapy
  - Cognitive behavioral therapy for sexually abused children
- Provide services to targeted populations, including members with:
  - Abandonment issues
  - Attention Deficit Hyperactivity Disorder
- Provide documentation required for judicial review, including initial assessments and monthly reviews

Behavioral Health Provider Responsibilities

- It is a contractual obligation that all Star Health Foster Care behavioral health providers upload into Health Passport, initial and quarterly monthly (or more frequently if clinically indicated) summary reports of a member's behavioral health status. Notes should include:
  - Member's primary and secondary diagnosis
  - Assessment information
  - brief narrative summary of clinical visits/progress
  - scores on each outcome rating form(s)
  - Referrals and/or community resources provided
  - Any other relevant care information
  - Evaluations of each Member's progress at intake, monthly, and at termination of the HCSP, or as significant changes are made in the treatment plan
- STAR Health providers must upload initial and monthly information into Health Passport either by web or fax. BH providers may use the Superior form or their own form. More specific information may be found in the training listed below.
  - Health Passport training, which includes a refresher of how to view and submit assessments, is available to providers and can be found on SuperiorHealthPlan.com/ProviderCalendar
- BH Providers must comply with all of Superior's policies, procedures, rules and regulations, including those found in the Medicaid Provider Manual found on SuperiorHealthPlan.com/ProviderManuals.

Pharmacy Benefits

Pharmacy Benefits

- Pharmacy Benefit Manager (PBM)
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
- Centene Pharmacy Services (CPS)
  - Responsible for review of prior authorizations for prescriptions, as applicable.
- Superior utilizes the Vendor Drug Program (VDP) formulary and the Preferred Drug List (PDL) to determine whether a prior authorization is required. Authorization requirements may be determined on the PDL.
  - View VDP formulary and PDL here: https://www.txvendordrug.com/formulary
- For more information, please see the Pharmacy Resources Guide and Benefit Overview

How to Access the Formulary/PDL

- Superior utilizes the VDP formulary which is available on smart phones, tablets or similar technology on the web at: www.epocrates.com
- VDP Website for PDL and clinical authorization criteria: www.txvendordrug.com
- Texas clinical prior authorization criteria for Superior members: www.txvendordrug.com/formulary/prior-authorization/preferred-drugs

72-Hour Prescription

- State and Federal law requires that a pharmacy dispense a 72-Hour (3 day) supply of medication to any member awaiting a prior authorization or medical necessity determination.
- If the prescribing provider cannot be reached or is unable to request an authorization, the pharmacy should dispense an emergency 72-Hour prescription.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-Hour emergency supply.

Pharmacy Contact Information

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - Online Form: SuperiorHealthPlan.com/contact-us
- Pharmacy benefit prior authorization requests (PBM)
  - Authorization Requests Phone: 1-866-399-0928
  - Authorization Requests Fax: 1-833-423-2523
- Biopharmacy/Clinician Administered Drugs (CAD) Rx administration (Superior Authorizations Department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superiors Appeals Department)
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168

Secure Provider Portal and Website

Online Tools

Secure Provider Portal and Website

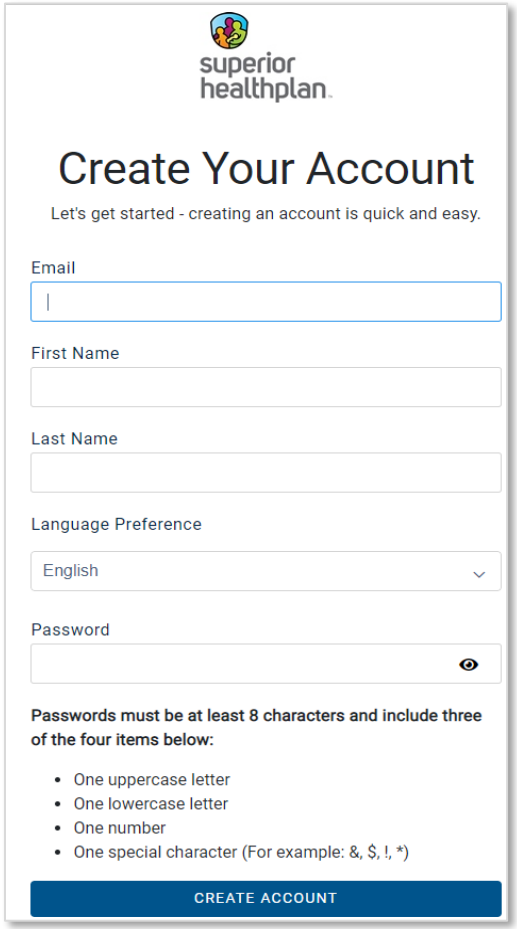
Superior is committed to providing you with all of the tools, resources and support you need to make your business transactions with Superior as smooth as possible.

- One of the most valuable tools is Superior's Secure Provider Portal. Once you are registered you get access to the full site. Features include:
  - View multiple TINs
  - Access daily patient lists from one screen
  - Manage Batch Claims for free
  - Simplify prior authorization process
  - Check patient care gaps
  - Streamline office operations
- To find resources for providers and members visit SuperiorHealthPlan.com. Features include:
  - Provider Directory with online lookup tool
  - Map of Account Managers by region
  - Newsletters, news posts, provider manuals, forms and helpful links

Portal Registration

To register, visit Provider.SuperiorHealthPlan.com.

- A user account is required to access the web portal. If you do not have a user account, click **Create An Account** to complete the registration process.
- Input the information as required and create your password.
- Each user within the provider's office must create their own account.



Quality Improvement

Quality Improvement

- Working with our provider community:
  - Manage and review annual Healthcare Effectiveness Data and Information Set (HEDIS) rates to identify interventions to improve HEDIS scores.
  - Maintain compliance with quality related areas of HHSC regulations.
  - Generate, distribute and analyze selected provider profiles.
  - Coordinate office site visits related to complaints regarding physical appearance, physical accessibility, adequacy of wait time and adequacy of treatment record.
  - Conduct provider satisfaction surveys annually.
  - Review, investigate and analyze quality of care concerns (member complaints).

Quality Improvement

- Quality Assessment and Performance Improvement (QAPI):
  - Monitors quality of services and care provided to members through:
    - Appointment availability audits
    - After-hours access audits
    - Tracking/trending of complaints
  - Providers participate in QAPI by:
    - Volunteering for Quality Improvement Committees
    - Responding to surveys and requests for information
    - Vocalizing opinions
- HEDIS and Risk Adjustment Programs
  - Continuity of Care (CoC)
    - A provider engagement program for PCPs and specialists 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.

Questions and Answers

Thank you for attending!