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# Nursing Facility Provider Training

(includes STAR+PLUS Medicare-Medicaid Plan)

# Nursing Facility Services

Beginning March 1, 2015, Nursing Facilities services will be a statewide covered benefit of the STAR+PLUS program managed by Superior HealthPlan. The following will apply:

**DADS will**:

- Maintain nursing facility licensing and certification responsibilities
- Maintain the Minimum Data Set (MDS) function
- Continue Trust Fund Monitoring
- Continue its Regulatory Services Division

**Nursing Facilities will:**

- Complete and submit the MDS forms
- Complete and transmit the 3618s and 3619s

**Superior will:**

- Contract directly with the Nursing Facility
- Authorize add-on services
- Process claims for reimbursement

# Agenda

By the end of this presentation, you will be able to:

- Identify who Superior HealthPlan is and our various departments
- Explain the difference between Unit Rate and Add-on Services
- Understand Service Coordination and how they will work with the Nursing Facility staff
- Obtain authorizations and file claims with Superior HealthPlan

# Who is Superior HealthPlan?

- Superior HealthPlan is a subsidiary of Centene Corporation located in St. Louis, MO.
- Superior HealthPlan has held a contract with HHSC since December 1999.
- Superior HealthPlan provides programs in various counties across the State of Texas. These programs include STAR, STAR+PLUS, CHIP, STAR Health (Foster Care), Medicare Advantage, Ambetter by Superior HealthPlan and STAR+PLUS Medicare-Medicaid Plan.
- Superior HealthPlan manages healthcare for over 900,000 Members across Texas.

# Contract with Superior HealthPlan

- Nursing Facilities who offer services to our Members should be contracted with Superior HealthPlan.
- To get contracted, you must contact our Network Development department and request a contract.
- Visit www.superiorhealthplan.com, select “For Providers” and then “Network Participation”.
- Follow the instructions to submit a request.
- For help, call 1-877-615-9399 x-22354

# Nursing Facility Members

**Mandatory Population**

Adults age 21 and older who:

- Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income
- Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program)

**Excluded Population**

- Children and young adults under age 21 receiving SSI or SSI-related services living in a STAR+PLUS service area may choose to enroll in STAR+PLUS or remain in traditional Medicaid
- Residents in the Truman W. Smith Children's Care Center and residents of the State's Veteran's home

# Nursing Facility Members

**STAR+PLUS Medicare-Medicaid Plan (MMP) Population:**

- Individuals who are age 21 and older,
- Receiving Medicare part A, B and D,
- Receive full Medicaid Benefits and are in a STAR+PLUS Program,
- Do not reside in an Intermediate Care Facility or get services through one of these waivers:
  - Community Living Assistance and Support Services (CLASS),
  - Deaf Blind with Multiple Disabilities Program (DBMD),
  - Home and Community-based Services (HSC), or
  - Texas Home Living Program (TxHmL).
- Members enrolled in the MMP Dual Demonstration,
- Superior's STAR+PLUS MMP program is available in Bexar, Dallas, and Hidalgo County.

# Eligibility

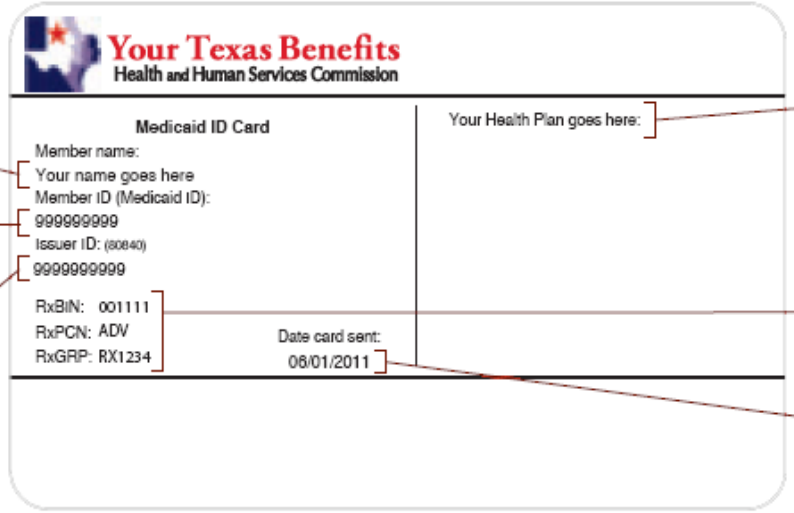
STAR+PLUS Members are always enrolled and disenrolled at the beginning of each month.  The period begins on the 1st of each month.

Nursing Facilities should verify Member eligibility at the start of each month and **before** providing services.

How can eligibility be verified?

- Texas Medicaid “Your Texas Benefits” Card
- ***Preferred***-Superior HealthPlan Identification Card
- ***Preferred***-Superior HealthPlan secure provider web portal at: www.superiorhealthplan.com

***Preferred***-Call the Member Hotline at 1-877-277-9772




This is where your name appears.

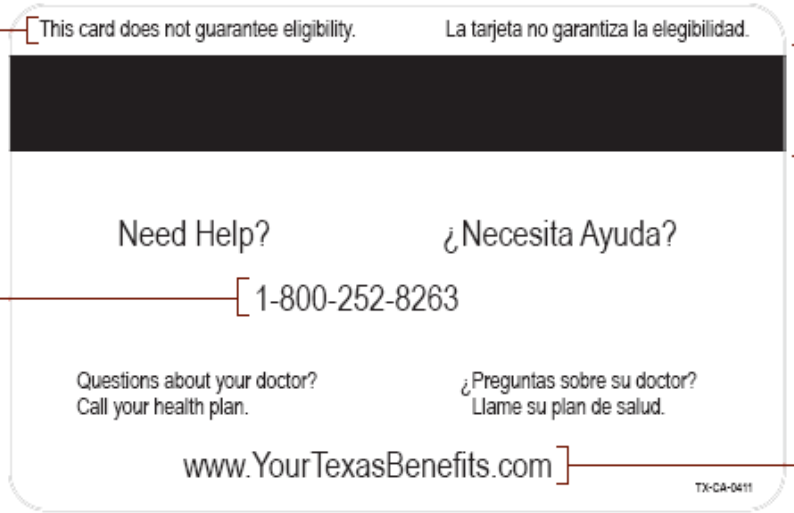
This is your Medicaid ID number.

This is HHSC's agency ID number. Doctors and other providers need this number.

If you have a health plan, its name and phone number will be listed here. Call this number if you have questions about your doctor or services.

Drug stores use these numbers.

This is the date your card was sent to you.



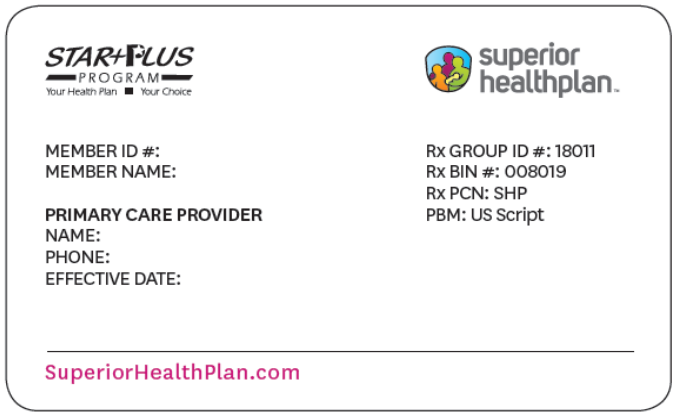

This message is for doctors and other providers. This means they need to make sure you are still in the Medicaid program.

This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.

Call this number if you need help using this card.

Go to this website to learn more about this card.

# Superior STAR+PLUS ID Card


STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

superior healthplan

MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com


Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-800-466-4089

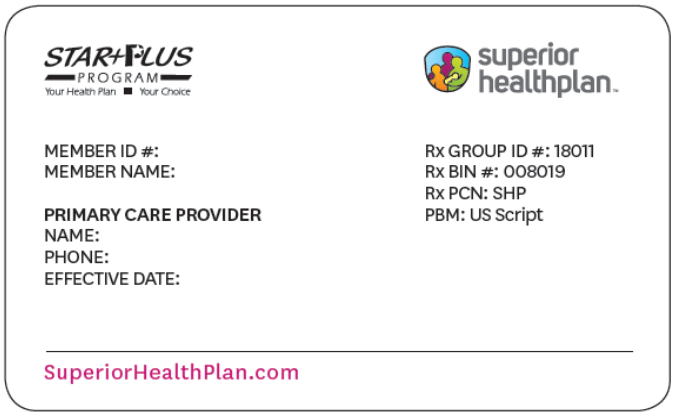
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

Servicios para Miembros: 1-866-516-4501
Disponible 24 horas al día/7 días de la semana
Coordinandora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-800-466-4089

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que tambien éstan eligibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

- Members enrolled in STAR+PLUS only and who receive Medicaid only will show their PCP listed.
- Members enrolled in STAR+PLUS only and who receive Medicare and Medicaid will not list a PCP and will show “LTC benefits only” in the Primary Care Provider field.

# Superior STAR+PLUS ID Card Dallas Only


STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

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MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com


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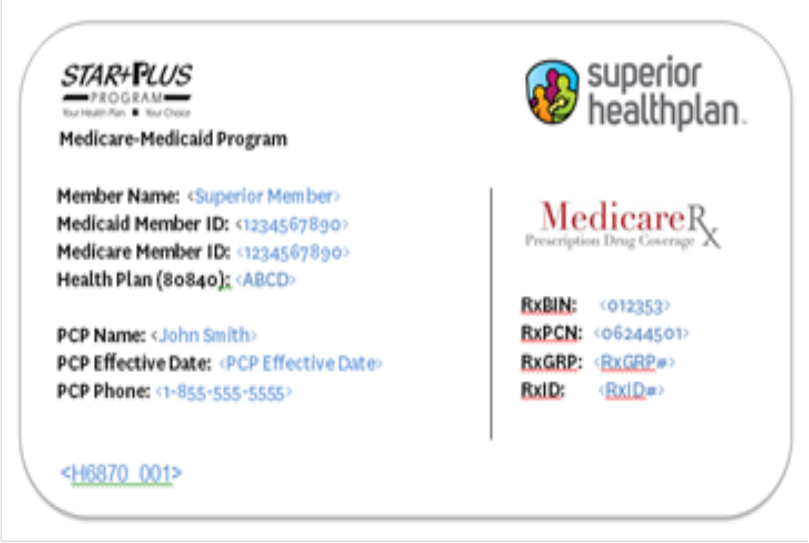
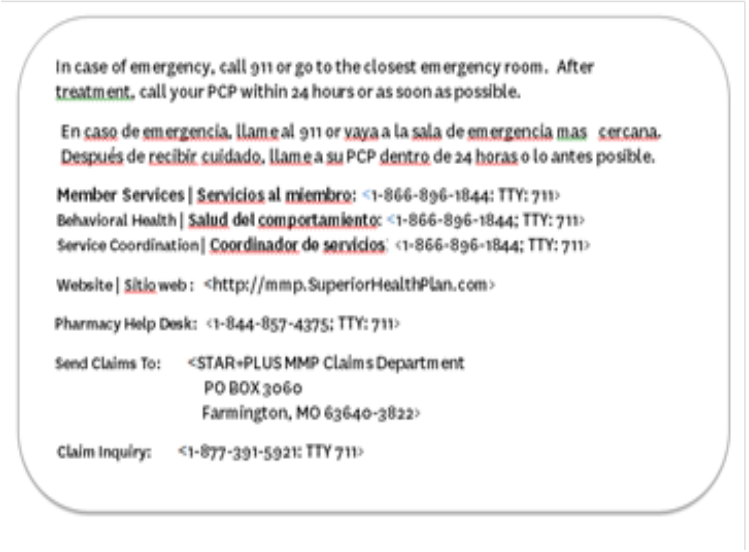
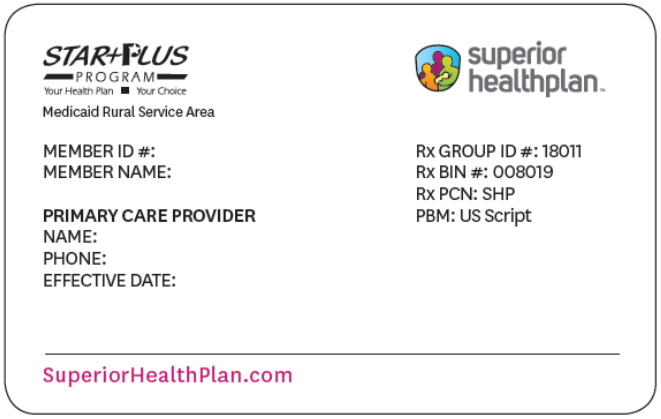
# Superior STAR+PLUS MMP ID Card




Available in Bexar, Dallas and Hidalgo counties only

# Superior STAR+PLUS ID Card Medicaid Rural Service Area


STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice

Medicaid Rural Service Area

MEMBER ID #:
MEMBER NAME:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

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Rx GROUP ID #: 18011
Rx BIN #: 008019
Rx PCN: SHP
PBM: US Script

SuperiorHealthPlan.com


Member Services: 1-866-516-4501
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
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In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

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- Members enrolled in STAR+PLUS only and who receive Medicaid only will show their PCP listed.
- Members enrolled in STAR+PLUS only and who receive Medicare and Medicaid will not list a PCP and will show “LTC benefits only” in the Primary Care Provider field.

# What is managed care?

HHSC contracts with managed care organizations (MCO)/companies who are licensed by the Texas Department of Insurance to provide the services specified.

HHSC pays the MCO a monthly amount to coordinate health services for Medicaid clients enrolled in their health plan.

HHSC designs the benefit package and describes what services will be covered in the program.  MCOs can offer additional benefits, referred to as value added services, but has to offer the full scope of services outlined in their contract with HHSC.

The health plans contract directly with doctors, hospitals and many other health care and service providers to create comprehensive provider networks.

# What is STAR+PLUS?

The program is designed to integrate the delivery of acute care and long-term services and supports (LTSS) through a managed care system, combining traditional health care (doctors visits) with long-term services and support, such as providing help in the home with daily living activities, home modifications and personal assistance.

Members, their families and Providers work together to coordinate Member's health care, long-term care and community support services.

The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a Member.

# What is STAR+PLUS MMP?

- STAR+PLUS MMP is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid.
- Services will include all Medicare benefits, including parts A, B, and D; and Medicaid benefits, including long term supports & services and flexible benefits/value added benefits. STAR+PLUS MMP is an opt-in/opt-out program.
- STAR+PLUS MMP will begin on March 1, 2015. NF residents will begin passive enrollment in August 2015.
- Superior will offer STAR+PLUS MMP in Bexar, Dallas and Hidalgo County.

# Service Coordination-
# The cornerstone of STAR+PLUS

- Is a special kind of care management used to coordinate all aspects of care for a Member.
- Utilizes a multidisciplinary approach in meeting Members' needs.
- Is available to all STAR+PLUS and STAR+PLUS MMP Members.
- Nursing Facilities and their Superior residents will be assigned the same Superior Service Coordinator.
- Service Coordinators participate with the Member, their family or representative, the Nursing Facility staff, and other members of the interdisciplinary team to provide input for the development of the Nursing Facility plan of care.

# Service Coordinator & Nursing Facility Staff

The Service Coordinator (SC) will partners with the Nursing Facility staff to ensure members' care is holistically integrated and coordinated.

**Service Coordinators will:**

- Quarterly Member visits (may be less for Hospice residents)
- Participate in Nursing Facility care planning meetings
- Assist with the collection of applied income, when necessary
- Perform initial Member assessments within 30 days of notification, then at 90 days and quarterly thereafter to develop a plan of care for the Member to transition back into the community.
- Comprehensively reviewing the member's service plan, including the NF plan of care, at least annually, or when there is a significant change in condition.

**This is not an all inclusive list.**

**For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.**

# Service Coordinator & Nursing Facility Staff

**Nursing Facility staff will:**

- Invite the SC to provide input for the development of the NF care plan
- Provide SC access to the facility, staff, and Member's medical information and records.
- Notify the SC within one business day of admission or discharge to a hospital or other acute facility, skilled bed, long-term services and supports provider, non-contracted bed, or another nursing or long-term care facility.
- Notify the SC within one business day of an adverse change in a member's physical or mental condition or environment that potentially leads to hospitalization.
- Notify the SC within one business day of an emergency room visit by a Member.
- Notifying the SC within 72 hours of a member's death.

**This is not an all inclusive list.**

**For a complete list of responsibility, please refer to the Nursing Facility Provider Manual.**

# Service Coordinator & Nursing Facility Staff

- To notify Superior's Service Coordinator, Nursing Facility staff must fill out the applicable areas of the Service Coordination Notification Form and fax it to the attention of your Service Coordinator at:
  1-888-209-4584.
- You can find a copy of this form on our website or contact your Service Coordinator or Provider Relations Specialist.
- Questions about Service Coordination, call them at:
  1-877-277-9772.

# How were Members enrolled?

- In November 2014, Nursing Facility residents received both introduction letters and enrollment packets from the State's enrollment broker, Maximus.
- The packets included a welcome letter informing them of the change to STAR+PLUS, a yellow comparison chart that provided information of any value added services offered by each plan, an enrollment form, Provider Directory and an FAQ document to help answer their questions.
- Candidates were asked to make a selection by either mailing the form back, calling Maximus or visiting the website by February 11, 2015.
- If a candidate does not make their selection, they will be automatically enrolled into a health plan by Maximus and follow the HHSC default methodology.

# How were NF residents enrolled into STAR+PLUS MMP?

| Intro letter | 60 day reminder | 30 day reminder | Enrollment Start Date | Population |
|---|---|---|---|---|
| May 2015 | June 1, 2015 | July 1, 2015 | August 1, 2015 | Nursing Facility residents in Bexar & El Paso Counties |
| June 2015 | July 1, 2015 | August 1, 2015 | September 1, 2015 | Nursing Facility residents in Harris County |
| July 2015 | August 1, 2015 | September 1, 2015 | October 1, 2015 | Nursing Facility residents in Hidalgo, Dallas, and Tarrant counties |

- Passive Enrollment begins March 1. This is open to any eligible client who opts-in.
- Nursing Facility residents in Bexar County will begin phasing in starting August 1 and all residents that are eligible for STAR+PLUS MMP to be in the program by October 1, 2015.
- **Note:** Members are encouraged to select their own PCP, and are able to call in to Member Services and change their PCP assignment at any time. PCP assignments are effective the first of the month after they are received. The enrollment broker will not be selecting PCPs for STAR+PLUS MMP Members.
- Reminder: Superior will offer STAR+PLUS MMP in Bexar, Dallas and Hidalgo County.

# After a plan is selected...

Once a plan is selected, the state enrollment broker will send an enrollment file to the selected plan at the end of February for March's enrollment. The file will list all of the Members that are enrolled on March 1, 2015.

At the end of each month, the state enrollment broker, Maximus, sends an enrollment file to each plan of all of the members enrolled with the plan the first of the following month.

**Members can switch plans anytime**. The change takes 15-45 days and are made through Maximus.

# *Services, Benefits and Prior Authorizations*

# Nursing Facility Unit Rate

The Nursing Facility Unit Rate means the types of services included in the DADS daily rate for nursing facility providers, such as:

- room and board
- medical supplies and equipment
- personal needs items
- social services
- over –the-counter drugs

The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. The Nursing Facility Unit Rate excludes Nursing Facility add-on services.

**Note: HHSC will authorize the daily rate. DADS will authorize and make the medical necessity determinations. Superior will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Questions call THMP at 1-800-626-4117 Option 2.**

# Applied Income

- Applied Income (AI) means the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and their spouse, that is paid under the Medicaid program to a Nursing Facility.
- It is the **responsibility** of the Nursing Facility to make reasonable efforts to collect AI, document those efforts and notify Superior's Service Coordinator when two unsuccessful attempts in one month have been made to collect AI.
- Superior's Service Coordinator will assist with the collection of AI from the Member.

# Additional Benefits

- **Prescriptions**
  - All STAR+PLUS (non-duals) Members receive unlimited prescriptions.

    **Note:** Members who receive Medicare as their primary insurance will continue to receive their prescriptions through their Medicare Part D.
- **Value Added Services/Flexible Benefits**
  - Superior offers added benefits beyond the traditional Medicaid benefits. For a complete listing, refer to the STAR+PLUS Nursing Facility Member Handbook or visit www.superiorhealthplan.com.

# Nursing Facility Add-on Services

Nursing Facility Add-on Services mean the types of services that are provided in the Facility setting by the Provider or another network provider and are outside of the Nursing Facility Unit Rate.

Add-on Services include but are not limited to:

- Emergency dental services
- Physician-ordered rehabilitative services (PT, OT, ST)
- Customized power wheel chairs (CPWC)
- Augmentative communication device (ACD)
- Ventilator care*
- Tracheostomy care*

**Note: All add-on services require a prior authorizations with the exception of Ventilator and Tracheostomy care unless authorization request is for supplemental payment for Members 21 years of age and older only.**

# Acute Care Services (non-duals only)

Some common acute care services that require authorization are:

- Hearing Aids
- Orthotics/Prosthetics
- Non-emergent ambulance transportation

For a full list of acute care services that require authorization, you can:

1. You can also call the Prior Authorization Department at 1-800-218-7508, Monday through Friday, 8:00am-5:00pm local time and speak to a live agent.

# Non-emergent Ambulance Transport

Superior is required to cover medically necessary non-emergency ambulance services when medically necessary and when ordered by a physician.

Non-emergency transport by ambulance can be provided:

- to or from a scheduled medical appointment.
- to or from a licensed facility for treatment.
- to a member’s home after discharge when there is a medical condition such that the use of an ambulance is the only appropriate means of transportation.

# Non-emergent Ambulance Transport

All non-emergency ambulance transports require prior authorization.

**How can you find a participating ambulance provider?**

- In-network ambulance providers can be found at http://apps.superiorhealthplan.com/findadoc/legacy/selectProduct?busLine=TX and by using the Specialty search field.

**How can you get a prior authorization?**

- Calling the Medical Management Department at 1-800-218-7508.
- Faxing a request for prior authorization to 1-800-690-7030.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through our secure web portal at www.SuperiorHealthPlan.com.

# Non-emergent Ambulance Transport

## Authorization Tips

Nursing facility providers must follow the steps below:

- A physician or physician extender writes an order for non-emergency transport.
- NF staff should contact Superior HealthPlan's member services line, utilization management department, or the assigned Service Coordinator to find an ambulance company that is in-network.
- The NF staff contacts the ambulance company to get their necessary information to complete the prior authorization form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI, and other business information.
- The ambulance provider will document the request was initiated by the NF staff and include name, time, and date.
- The NF must sign and submit the form to Superior for review along with documentation to support medical necessity.
- The ambulance company and NF will coordinate the scheduling of the appointment.

# Non-emergent Ambulance Transport

**Approvals**

- Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider.
- The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied.

# Non-emergent Ambulance Transport

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**Denials**

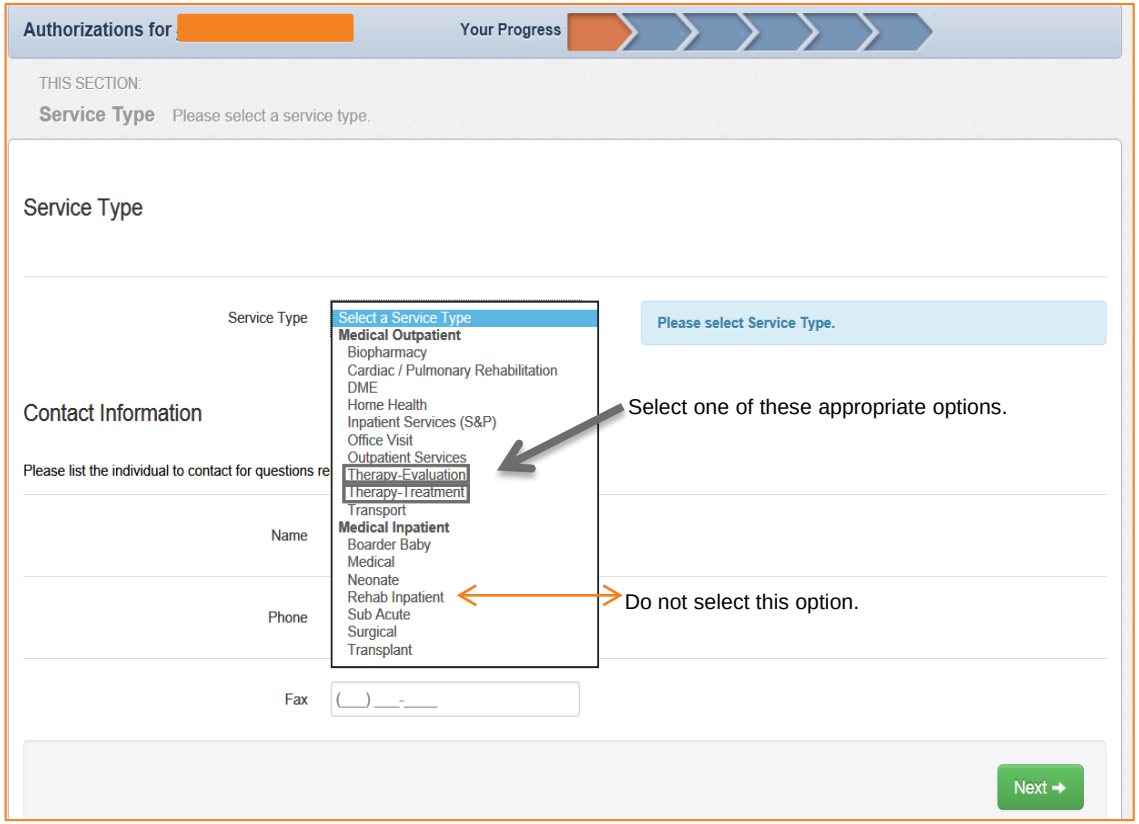
- Any service denied will have standard appeal rights for denials of medical necessity.
- Providers may follow the standard provider appeal process.
- Members may also file an appeal.

# Add-on and Acute Care Services Authorization Process

- STAR+PLUS Medicaid Only:
  - Call the Prior Authorization Hotline at 1-800-218-7508,
  - Submit via the secure web portal at www.superiorhealthplan.com, or
  - Fax the Prior Authorization Form to 1-800-690-7030
- Dual-Eligible Members (non-STAR+PLUS MMP):
  - Contact the Member's Medicare carrier
- STAR+PLUS MMP
  - Call the Prior Authorization Hotline at 1-800-218-7508,
  - Submit via the secure web portal at www.superiorhealthplan.com, or
  - Fax the Prior Authorization Form to
    - Inpatient: 1-877-259-6960
    - Outpatient: 1-877-808-9368

# Physician-ordered Rehabilitative Services (PT, OT, ST) Authorization Process

- **Select 'Medical Outpatient'** then **'Therapy'** as the Service Type.
- Do not select 'Rehab Inpatient' as the Service Type.
- Authorization requests must be submitted for each type of therapy (i.e. physical, speech, or occupational).



# *Claims Submissions*

# What does Superior Pay for?

**DUALS**

These are members who receive both Medicare and Medicaid. Members may select a managed care Medicare plan and have Superior as their STAR+PLUS Medicaid plan.

- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services), skilled nursing facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the RUG.
- STAR+PLUS (Superior) covers Vent and Trach add-on services, is the primary payor for the *co-insurance* for the SNF Unit Rate for days 21 – 100 (if the stay meets qualifying hospital stay criteria and skillable needs) and add-on services, and is the primary payor for the NF Unit Rate starting day 101.

**NON-DUALS**

Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.

- Covers acute care, add-on services and the NF Unit Rate.

# Nursing Facility Unit Rate

- **Preferred** Way to Submit Claims – Superior's Web Portal, as claims will be received immediately by Superior.
- Nursing Facilities can also submit claims through TMHP's portal, which will redirect to Superior.
- HHSC will set the prevailing rate for the date of service as found on their website.
- Nursing Facilities have within **365** days to submit the claims from the date of service.
- Superior will follow the clean claim criteria used by DADS.
- Superior HealthPlan has **10** days to pay clean claims from the date of submission.
- All rate adjustments will be processed no later than 30 days after the receipt of the HHSC rate notification.

# Add-on Services

- **Preferred** Way to Submit Claims – Superior's Web Portal, as claims will be received immediately by Superior.
- Nursing Facilities can also submit claims through TMHP's portal, which will redirect to Superior.
- Nursing Facilities have to submit the claims within **95** days from the date of service.
- Superior will follow the clean claim criteria used by DADS.
- Superior HealthPlan has **30** days to pay clean claims from the date of submission.
- Nursing Facilities may submit claims for NF add-on physician-ordered therapies on behalf of employed or contracted therapy providers.
- Add-on Therapy claims must be submitted separately from the NF Unit Rate Claims.
- DME add-on providers must submit claims directly to Superior. Emergency Dental claims must be submitted to dental carrier.

# Acute Care & Add-on Services

- **Preferred** Way to Submit Claims – Superior's Web Portal, as claims will be received immediately by Superior.
- Acute Care-Providers have **95** days from the date of service to submit their claims.
- Superior will follow the clean claim criteria as set by TMHP billing guidelines.
- Superior HealthPlan has **30** days to pay clean claims from the date of submission.
- Alternative ways of filing acute care claims include: Through a clearinghouse or on the red and white paper claim.
  - For a list of preferred clearing houses, visit our website.
  - For 1st time paper claims, mail them to:
    - Superior HealthPlan
      Attn: Claims
      **P.O. Box 3003**
      Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.

# Bill Code Crosswalk

- Details on required coding for claims submission can be found on the LTC Bill Code Crosswalk.
- This document updates periodically. For the most current LTC Bill Code Crosswalk visit:
  https://hhs.texas.gov/sites/hhs/files/documents/services/health/medicaid-chip/programs/carved-in-carved-out-services.pdf

# Nursing Facility Billing Reminders

- Nursing Facility identification requirements remain in effect
  - Nursing Facilities must be contracted, certified, and licensed by DADS to submit claims.
  - You must use your valid DADS contract number, vendor number and NPI for both contracting with Superior and on the claims when billing Superior.
  - If they differ from what is on record at DADS, your claims my result in denials as Superior cannot pay your claim until this information is corrected.
- Valid Attending Provider NPI, TIN and Principle Diagnosis Code are required when submitting claims
  - Entry of invalid format for the National Provider Identifier (NPI), Tax Identification Number (TIN), or Principle Diagnosis Code on a claim may result in rejection or denial from Superior.
- Questions for TexMedConnect Portal Contact:
  - 1-800-626-4117, Option 1

# Auto Adjusted Claims

- There may be occasions in which a claim which is in a paid status may require a payment adjustment of the **daily unit rate**. Superior will be informed of the need to re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are **automatic** and Nursing Facilities are not required to take any action.
- Some of the reasons a claim may require an adjustment are due to changes in:
  - Nursing Facility Daily Rates
  - Provider Contracts
  - Service Authorizations
  - Applied Income
  - Level of Service (RUG)
- In each of these instances, Superior will automatically re-adjudicate claims affected by the change. Payment on adjusted claims will be made within **30** days from receipt of the adjustment reason.

# Claim Adjustments, Disputes & Reconsiderations

If a provider wants to adjust/correct a claim or submit a claim appeal, these must be received within **120** days from the date of notification or denial.

- **Adjusted or Corrected Claim** – The Provider is changing the original claim. Correction to a prior- 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.

Both can be submitted via the web portal or through paper. Paper claims require a Superior Corrected Claim or Claim Appeal form. Find them under Resources at www.SuperiorHealthPlan.com.

# Corrected Claims Filing

- Must reference original claim # from EOP
- Must be submitted within 120 days of adjudication paid date
- Resubmission of claims can be done via your clearinghouse or through Superior's web portal.
  - To send both individual and batch claim adjustments via a clearinghouse, you must provide the following information to your billing company: the CLM05-3 must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject)
  - For batch adjustments, upload this file to your clearinghouse or through Superior's web portal
  - To send individual claim adjustments through the web portal, log-in to your account, select claim and then the Correct Claim button
- Corrected or adjusted paper claims can also be submitted to:

Superior HealthPlan
Attn: Claims
**P.O. Box 3003**
Farmington, MO 63640-3803

Superior HealthPlan STAR+PLUS MMP
Attn: Claims:
**P.O. Box 4000**
Farmington, MO 63640-4000

# Corrected Claims Filing

- There may be occasions in which a Nursing Facility will need to resubmit/submit a corrected claim, if they billed incorrectly. These claims will not auto adjust. Nursing Facilities should submit a corrected claim, if:
  - Billed across multiple months i.e. 2/15-3/15
  - Billed for days spans that include unauthorized days, i.e. SAS approves 3/5-3/31 provider bills 3/1-3/31
  - Billed for days when the member is in an acute care facility
  - Billed for days that span across multiple years i.e. 12/31/2015 - 1/5/2016
  - Billed for Medicare coinsurance days when non-Medicare days are authorized
  - Billed for non-Medicare days when only Medicare coinsurance days are authorized

# Appealing Denied Claims

- Submit appeal within 120 days from the date of adjudication or denial.
- Claims appeals may be submitted one of two ways:
  - In writing:

    Superior HealthPlan
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800

    Superior HealthPlan STAR+PLUS MMP
    Attn: Claims Appeals
    P.O. Box **4000**
    Farmington, MO 63640-4000

  - Or through the secure web portal.
    - At this time, batch adjustments are not an option via the SHP secure portal
- Attach & complete the claim appeal form from the website.
- Include sufficient documentation to support appeal.
- Include copy of UB04 or CMS1500 (corrected or original) or EOP copy with claim # identified.

# Appeals Documentation

Examples of supporting documentation may include but are not limited to:

- A copy of the SHP 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, 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

# Coordination of Benefits

- Any other insurance, including Medicare, is always primary to Medicaid coverage.
- If a Member has other insurance, you must submit your claim to the primary insurance for consideration first.
- For duals, if the Member is admitted under the 3-day hospital stay criteria and has a skillable need then days 0-20 are billed directly to Medicare (or to Superior if the member is enrolled in STAR+PLUS MMP), use Revenue Code 100. Then, bill with Revenue Code 101 for days 21 – 100. Starting day 101, the claim should be billed with Revenue Code 100.
- For Superior payment consideration, file the claim with a copy of the EOB, EOP or rejection letter from the other insurance.

# Coordination of Benefits

- If this information is not sent with an initial claim filed for a Member with other insurance, the claim will pend and/or deny until this information is received.

- Preferred way to submit is through Superior's web portal. You cannot send through TMHP's web portal. It does not allow for attachments. You may also submit via a paper claim to Superior.

**Note: If a Member has more than one primary insurance, then Medicaid would be the third payor. These claims must be submitted on paper.**

# *Secure Provider Web Portal - Submitting Claims*

# Superior Web Portal & Website

Superior HealthPlan is committed to providing you with all of the tools, resources and support you need to be make your business transactions with Superior as smooth as possible. One of the most valuable tools is our web portal. Once you are registered you get access to the full site.

Secure site:

- It is secure.
- It provides up-to-date member eligibility and Service Coordinator assignment.
- It has a secure claim submission portal you can submit claims for FREE!
- It provides a claim wizard tool that walks you through filling in a claim to submit on-line.
- It provides claim status and payment information.
- It allows you to check the status of an authorization.

Public Site:

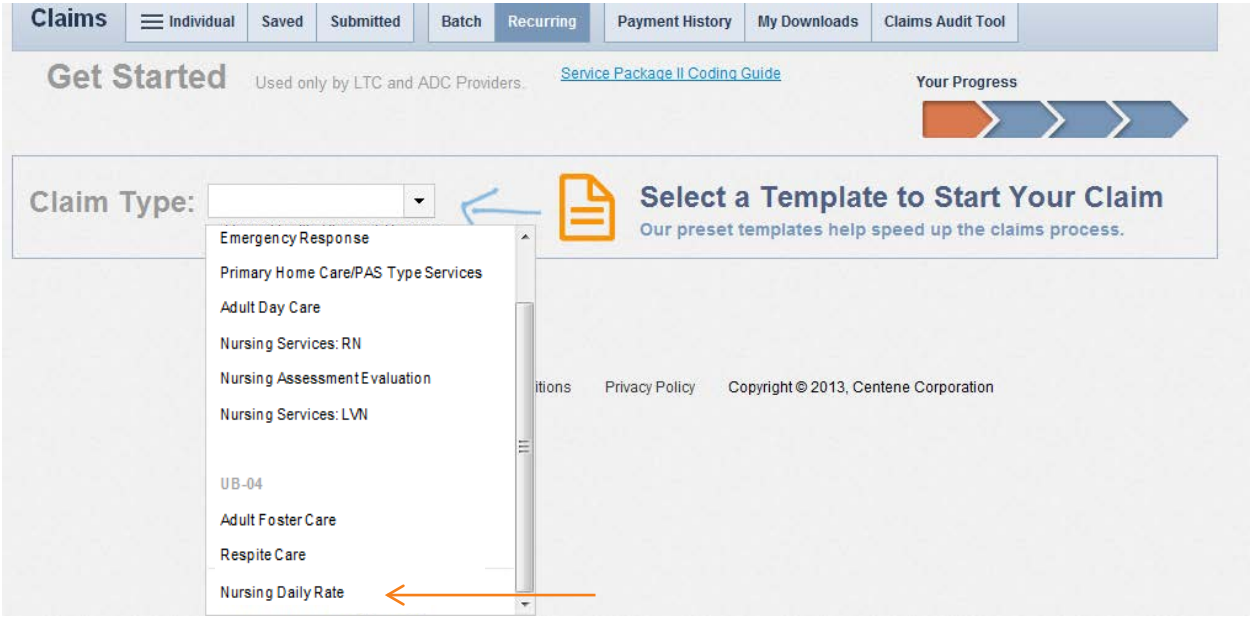
- It contains our Provider Directory and on-line lookup.
- It has a map where you could easily identify the office of the field Provider Network Specialist assigned to you.
- It contains an archive of newsletters, bulletins, the Provider Manual, and link to important sites to keep you up to date on any new changes that may affect you.

# Registration

https://provider.Superiorhealthplan.com/sso/login

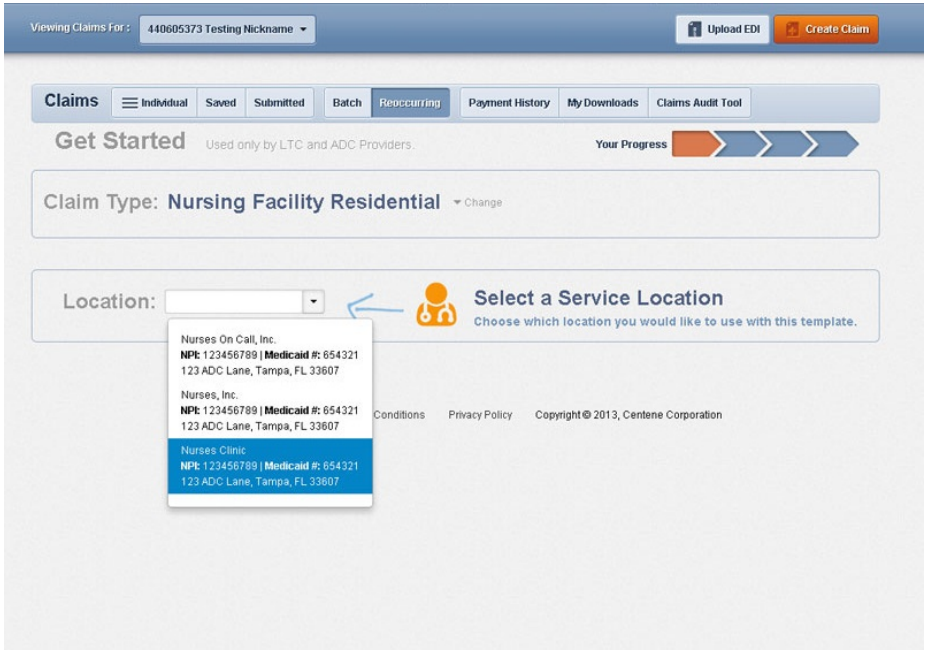
- A user account is required to access the Provider Secure area.
- If you do not have a user account, click **Register** to complete the 4-step registration process.

# Create Recurring UB-04 Claims



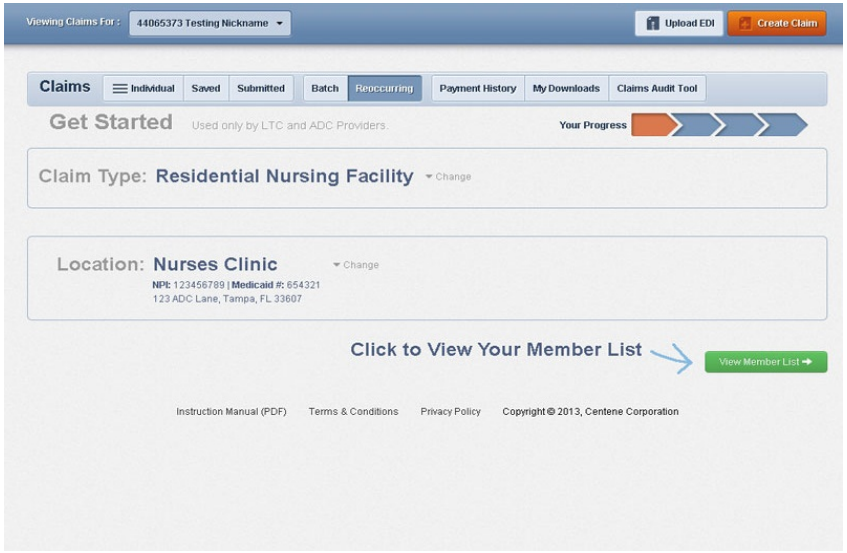

Select Nursing Daily Rate

# Create Recurring UB-04 Claims

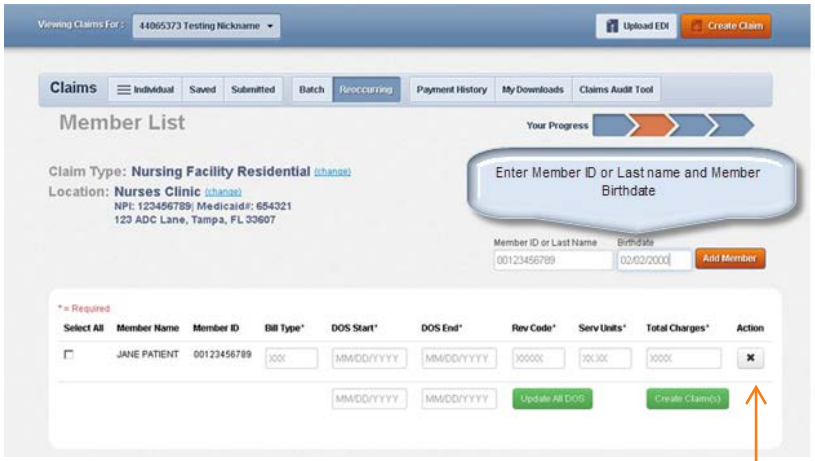



Select Your Service Location

# Create Recurring UB-04 Claims

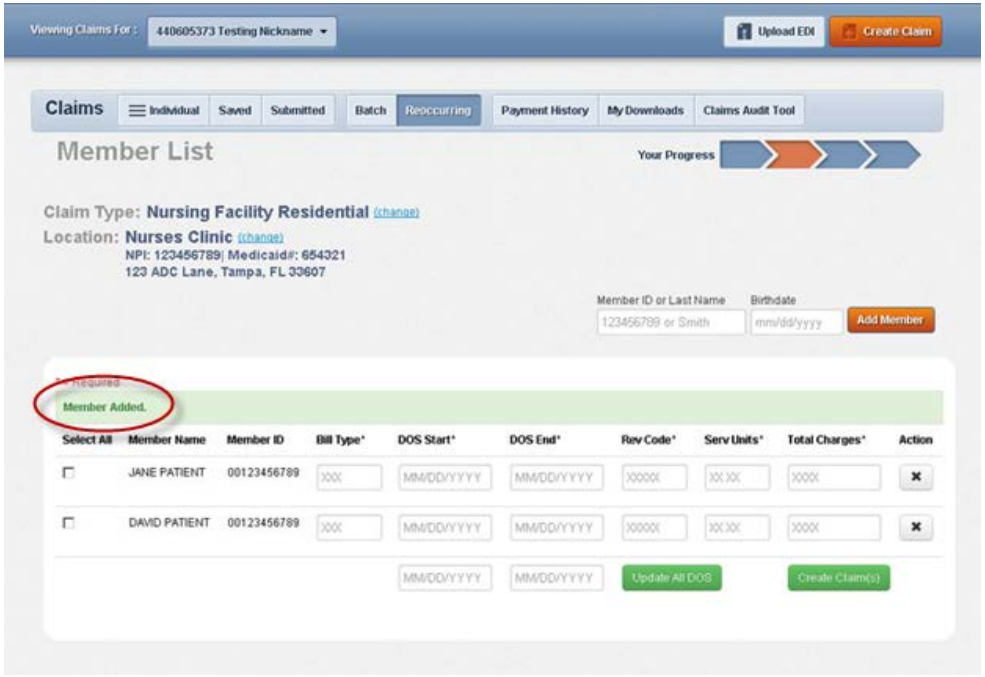



- Click on View Your Member List. Member Lists only need to be created once during your first time using the Multiple Claims Wizard.
- Enter Member ID or Last Name and Birthdate. Member ID is the Medicaid ID on the Member ID card.



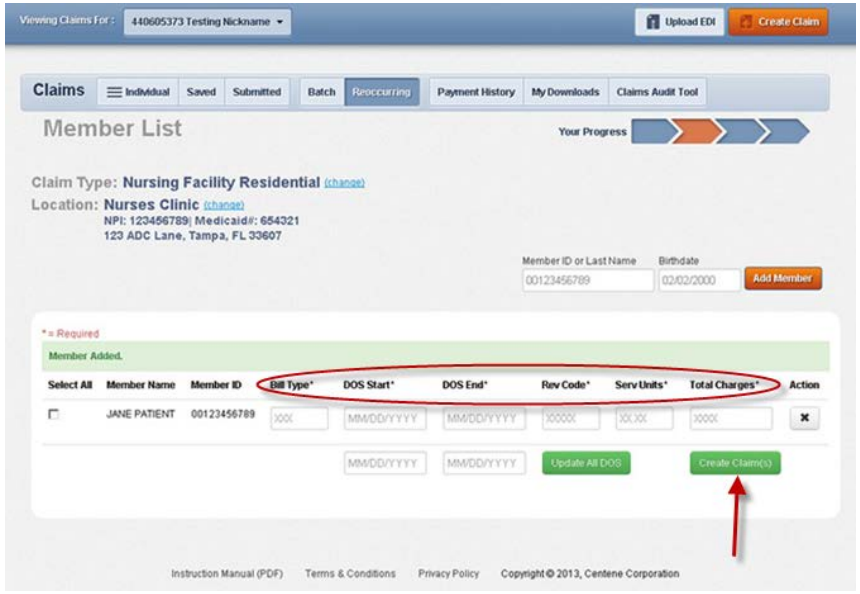

Delete

# Create Recurring UB-04 Claims




- Once Members are added, you'll be alerted with a Members Added remark at the top of the list.
- Members are listed in alphabetic order by last name.
- If you can't find a Member, check that the ID and birthdate were entered correctly.

# Create Recurring UB-04 Claims



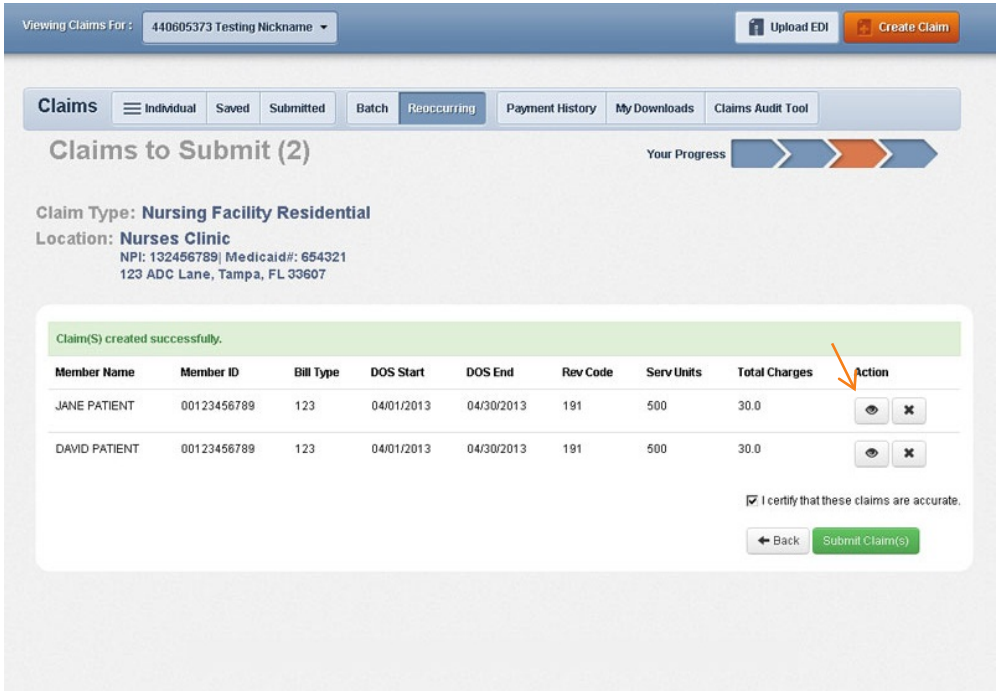

Create claim(s) by selecting the appropriate member(s) from Member List.

For each member selected enter the:

- Bill Type
- First date of service (DOS Start)
- Last date of service (DOS End)
- Rev Code (Revenue Code)
- Serv Units (days or service units)
  - Note: Serv Units must match the total number of days
- Total Charges

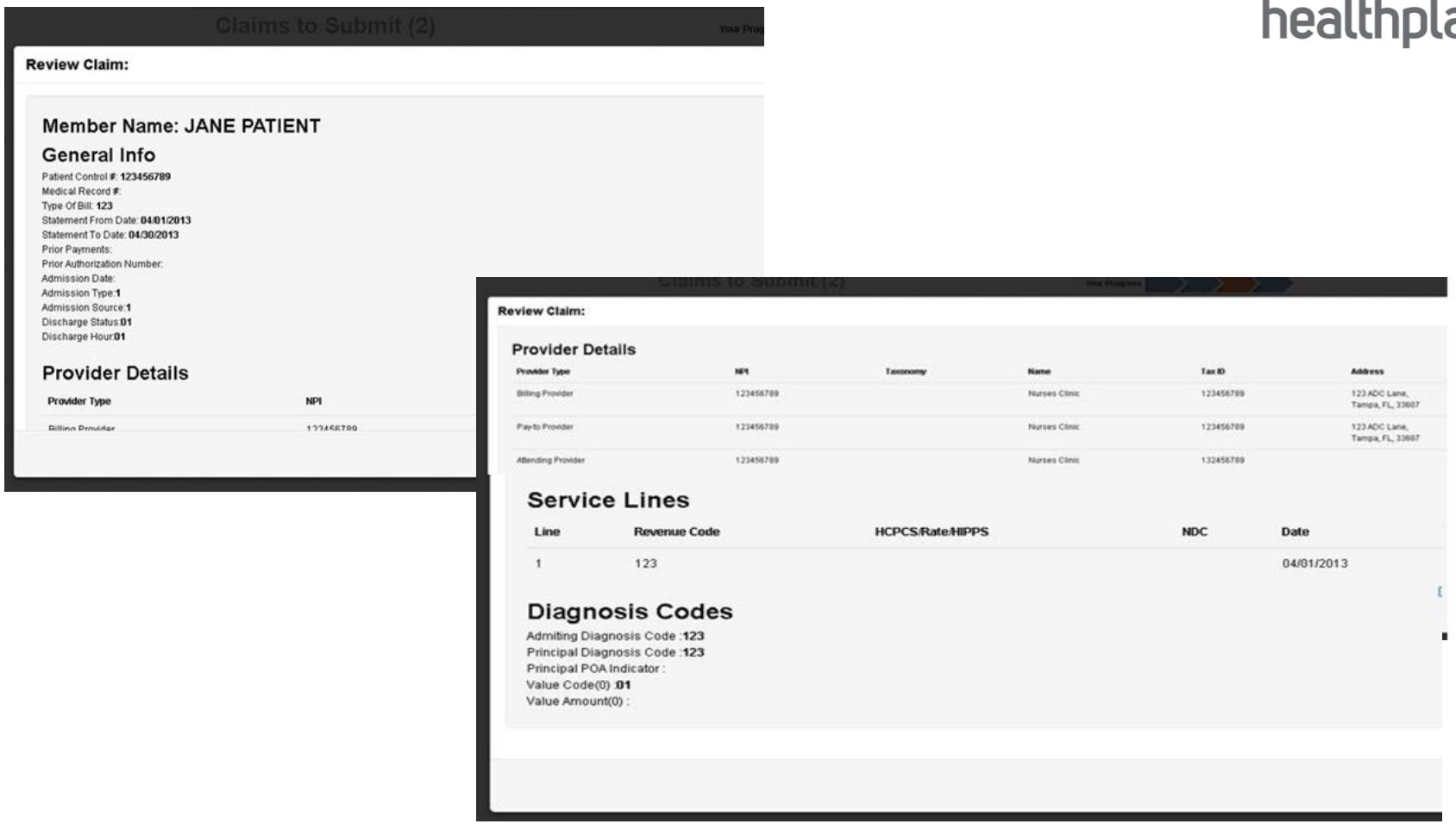
After entering all the required information, click Create Claim(s). Click on X under Action to delete the claim.

# Create Recurring UB-04 Claims

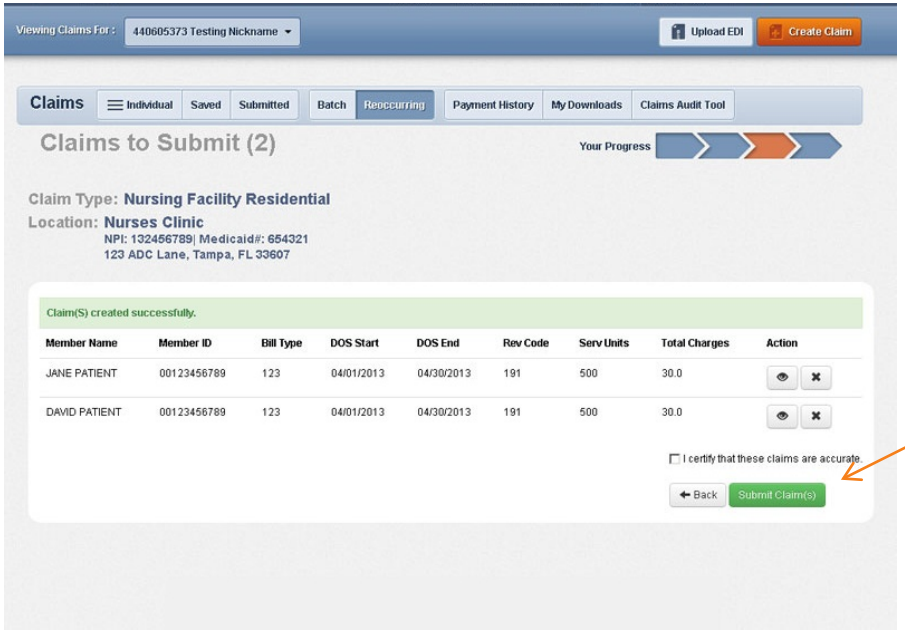


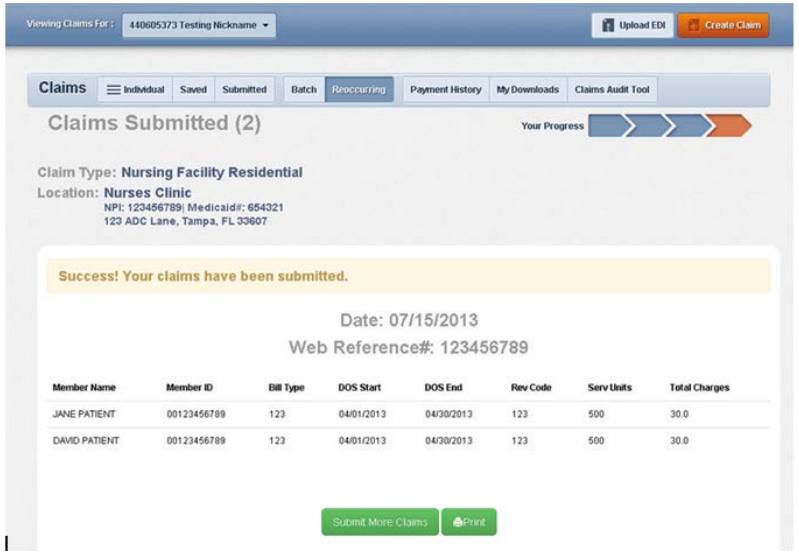

- You can review claims prior to submitting.
- To review click on the eye. You can review the claim or change some of the fields pre-coded for you. Some fields may not allow you to edit. If those fields need to be changed you will need to delete the claim and start over.
- You can click on the X to delete claim.

# Create Recurring UB-04 Claims



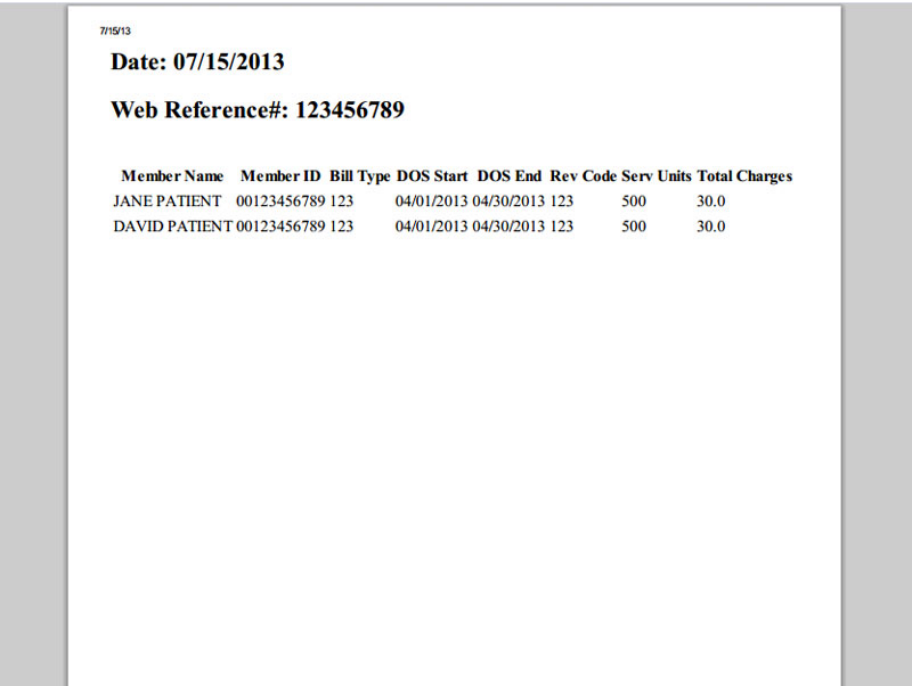
# Create Recurring UB-04 Claims




After all the claims have been reviewed for accuracy, select “I certify that these claims are accurate” and click Submit Claims.

# Create Recurring UB-04 Claims



7/15/13

**Date: 07/15/2013**

**Web Reference#: 123456789**

| Member Name | Member ID | Bill Type | DOS Start | DOS End | Rev Code | Serv Units | Total Charges |
|---|---|---|---|---|---|---|---|
| JANE PATIENT | 00123456789 | 123 | 04/01/2013 | 04/30/2013 | 123 | 500 | 30.0 |
| DAVID PATIENT | 00123456789 | 123 | 04/01/2013 | 04/30/2013 | 123 | 500 | 30.0 |

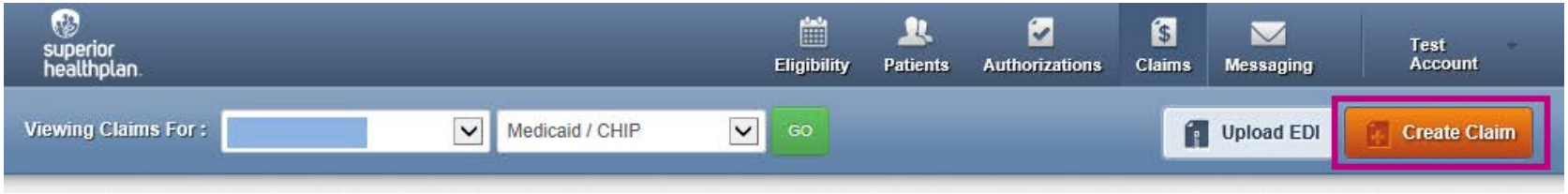
- Click Print to print a copy of the claims submitted including the Web Reference#.
- Click Submit More Claims to request a new template or move on to other functions.

# Create Professional Claims

From the navigation menu select:

Claims at the top of the landing page

Then select Create Claim



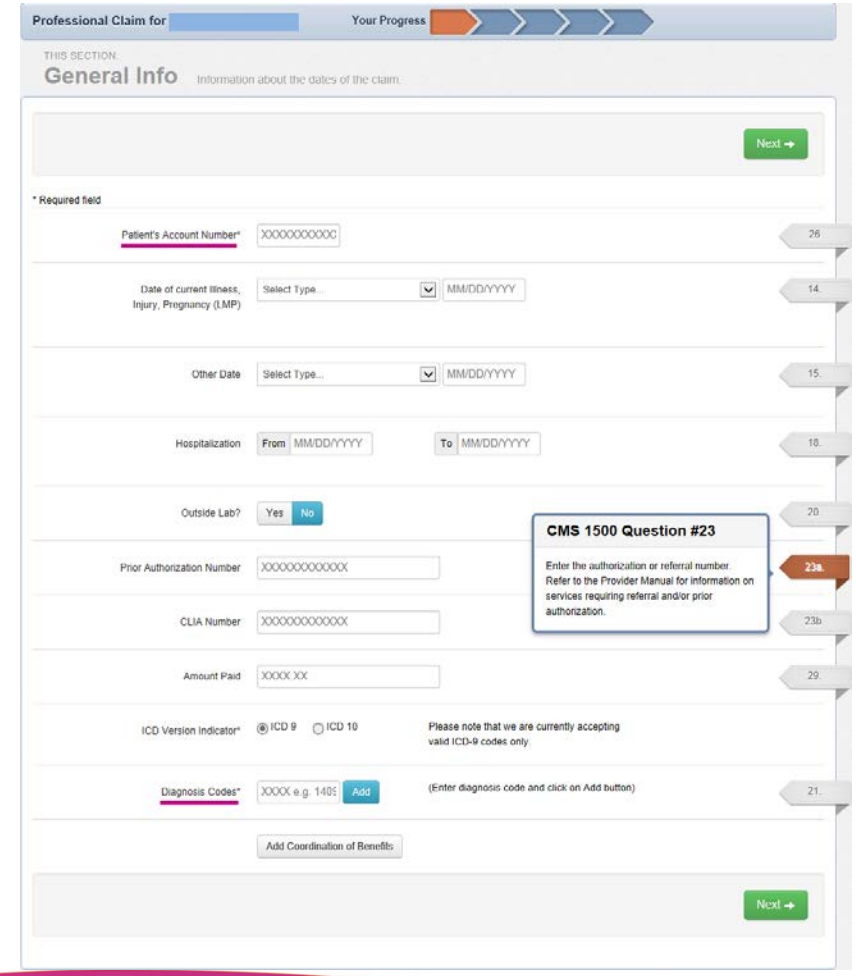
# Create Professional Claims


- Enter the **Member's Medicaid ID** or **Last Name** and **Birthdate**
- Click the **Find** button

# Create Professional Claims

- Choose a Claim Type
- Select **Professional Claim**

# General Information



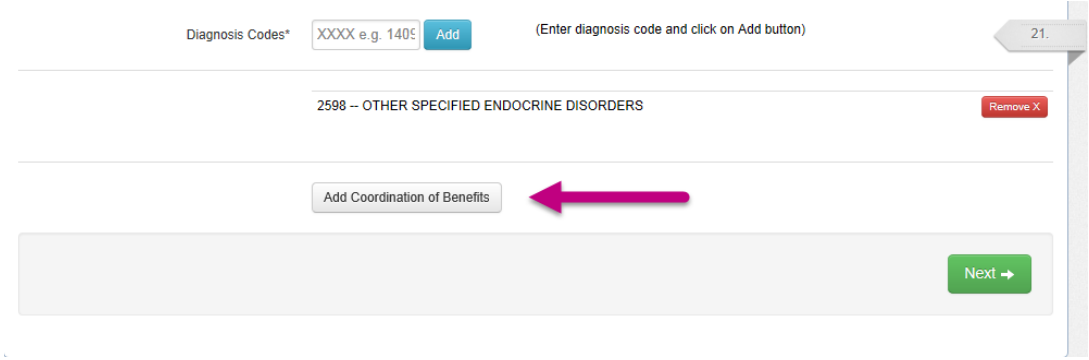

Required Fields:

- ✓ **Patient Account Number**
- ✓ **Diagnosis Codes**

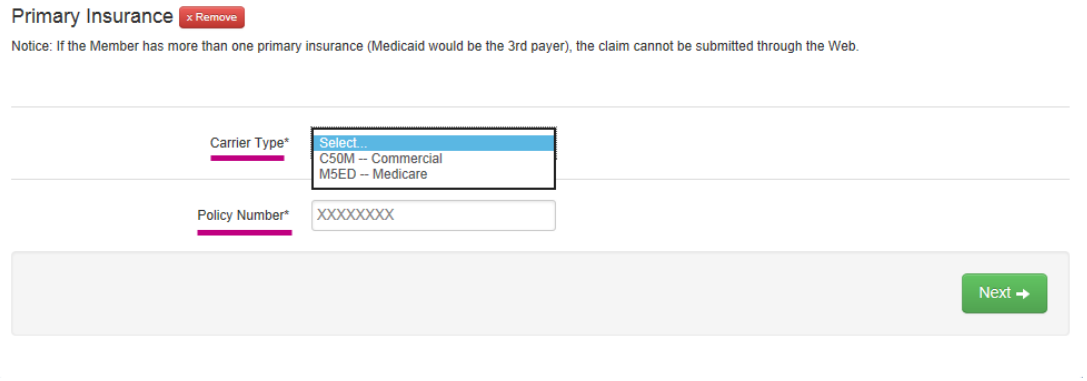
Enter other pertinent information for the claim as necessary.

Use any of the field tabs to get details for what information should be entered.

# Coordination of Benefits



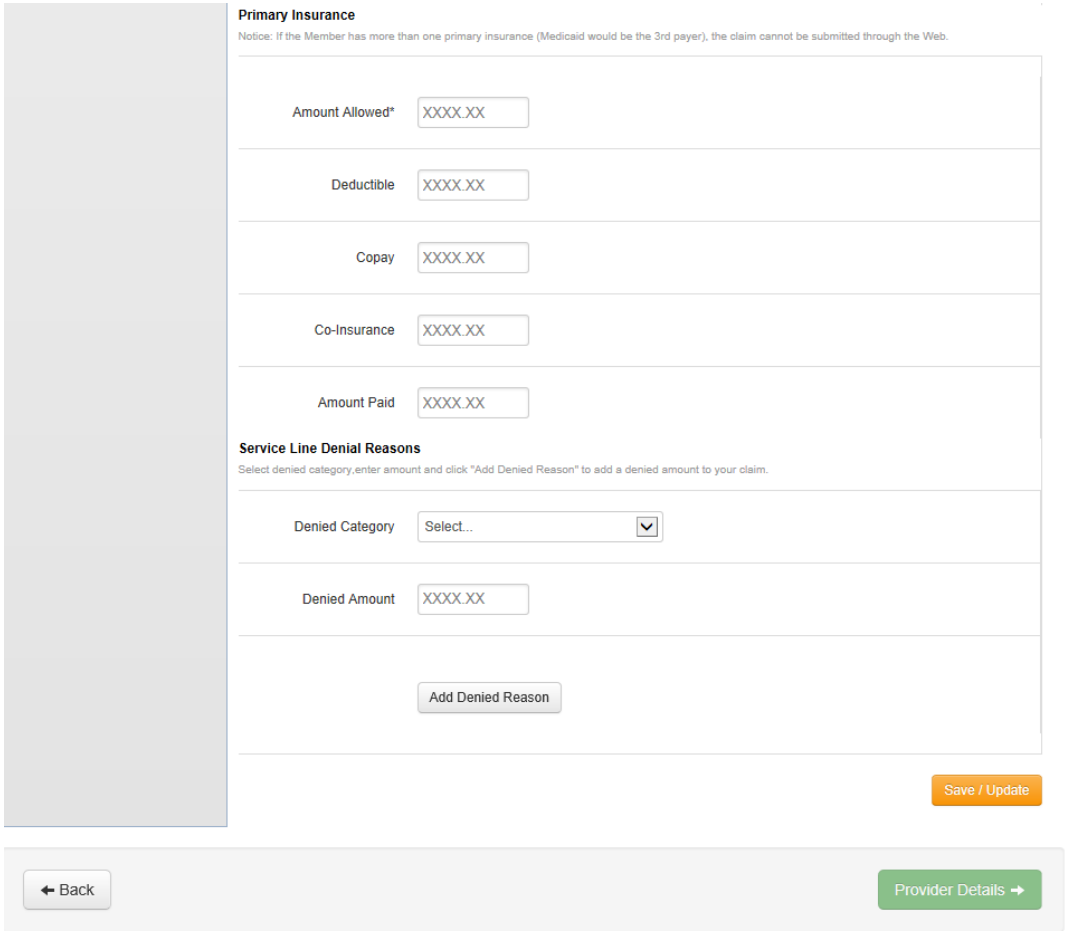

Use the **Add Coordination of Benefits** button to include primary insurance information when applicable.




New fields will appear to enter the **Carrier Type** and the **Primary Insurance Policy Number**.

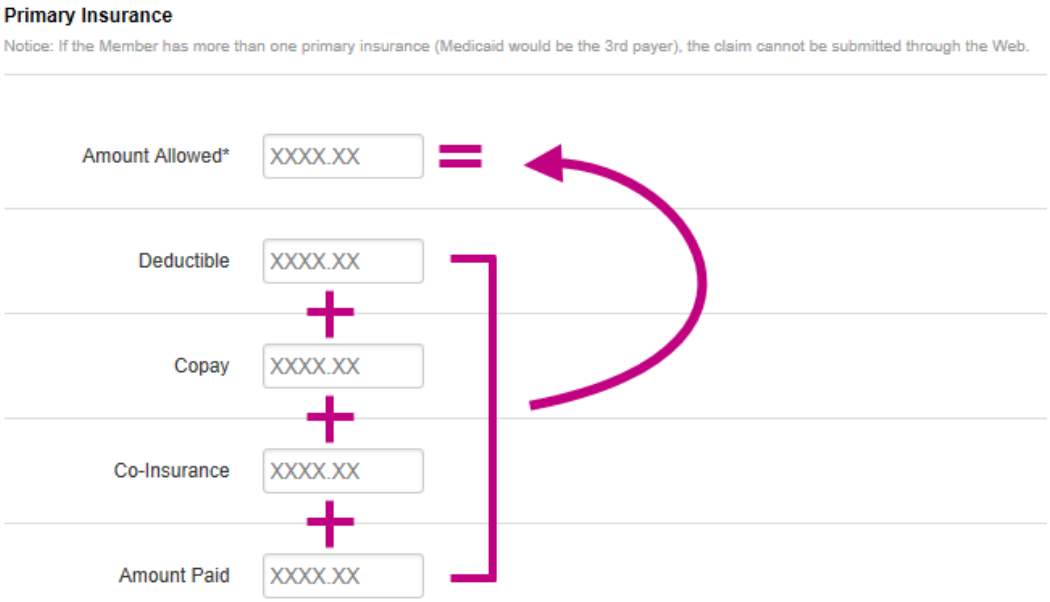
***If the member has more than one primary insurance (Medicaid would be the 3rd payer) the claim cannot be submitted via the Web***

# Coordination of Benefits




The **Primary Insurance** and **Service Line Denial Reasons** fields will be present when Coordination of Benefits is selected at step one. Complete based on the primary insurance EOP.

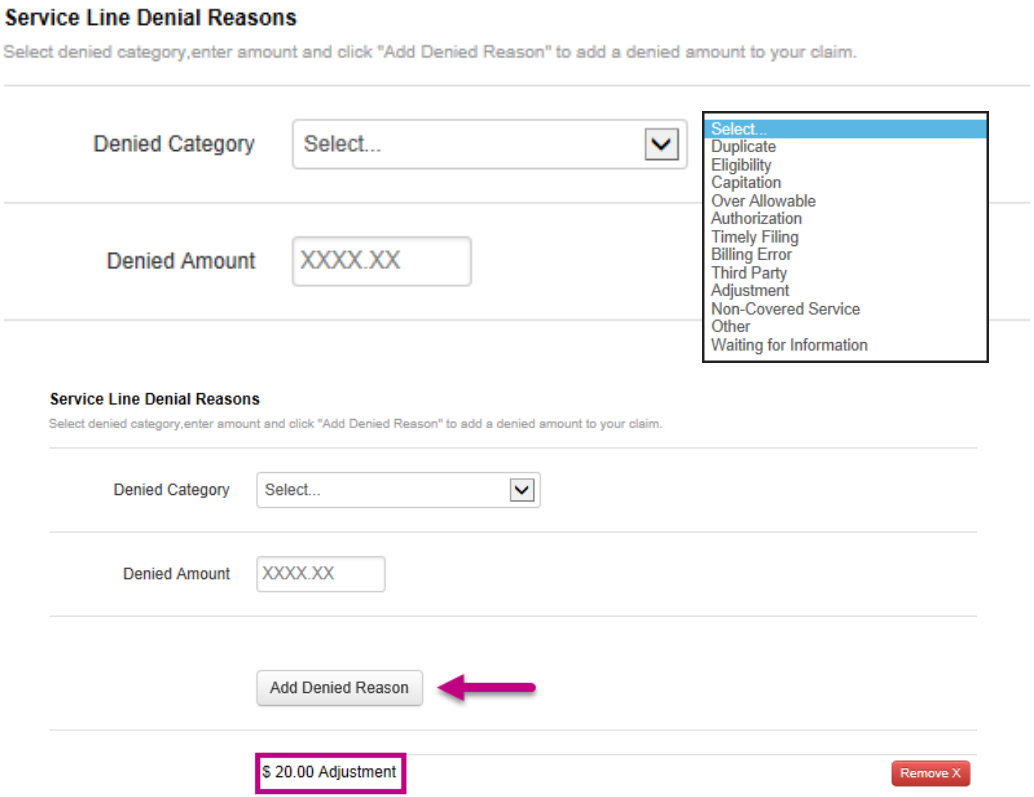
# Coordination of Benefits




The **Primary Insurance** fields perform a calculation to help ensure accuracy when billing.

**Deductible + Copay + Co-Insurance + Amount Paid = Amount Allowable**

# Coordination of Benefits

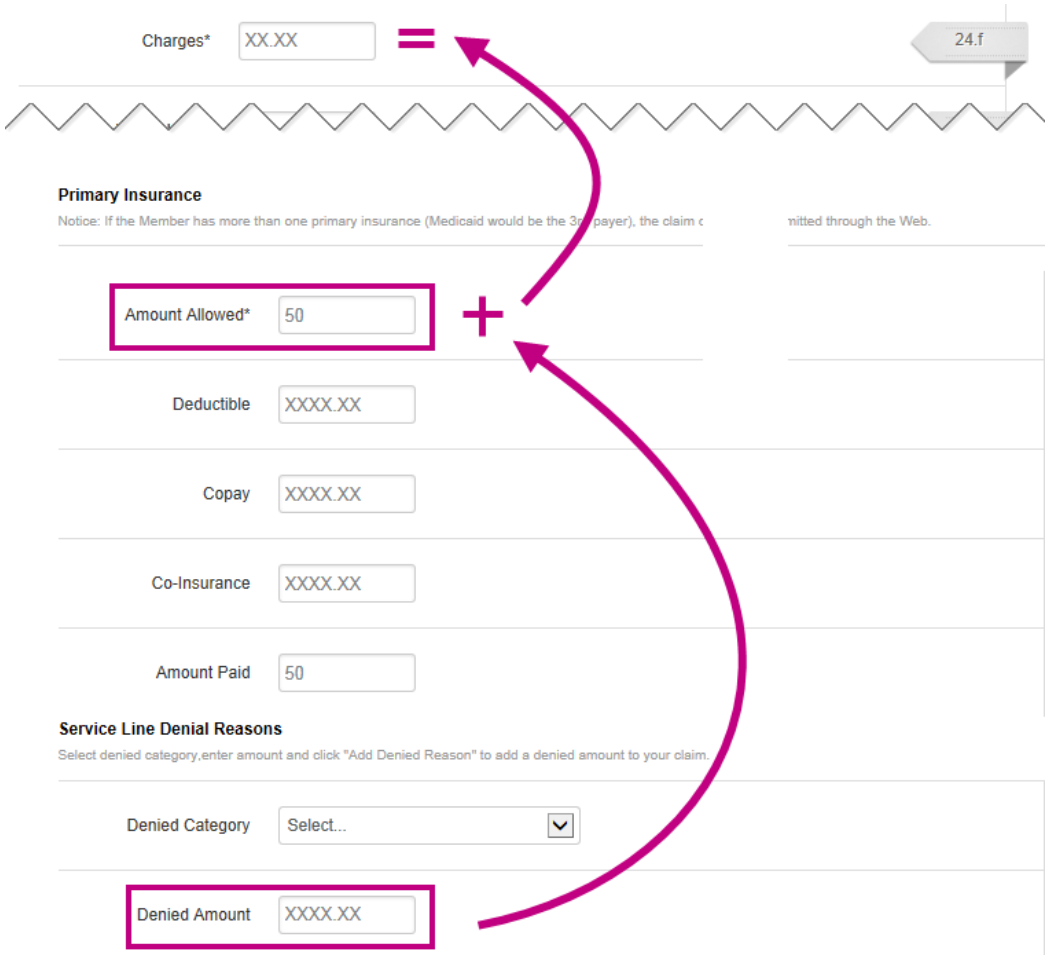



**Service Line Denial Reasons** are used to indicate instances where the **Amount Allowed** is less than the **Charges**. These can be indicated using the drop down menu and entering the denied amount.

**Add Denied Reason** must be clicked to include the **Denied Category** and **Denied Amount**.

A new line will be created when the **Denied Category** has been successfully added to the service line.

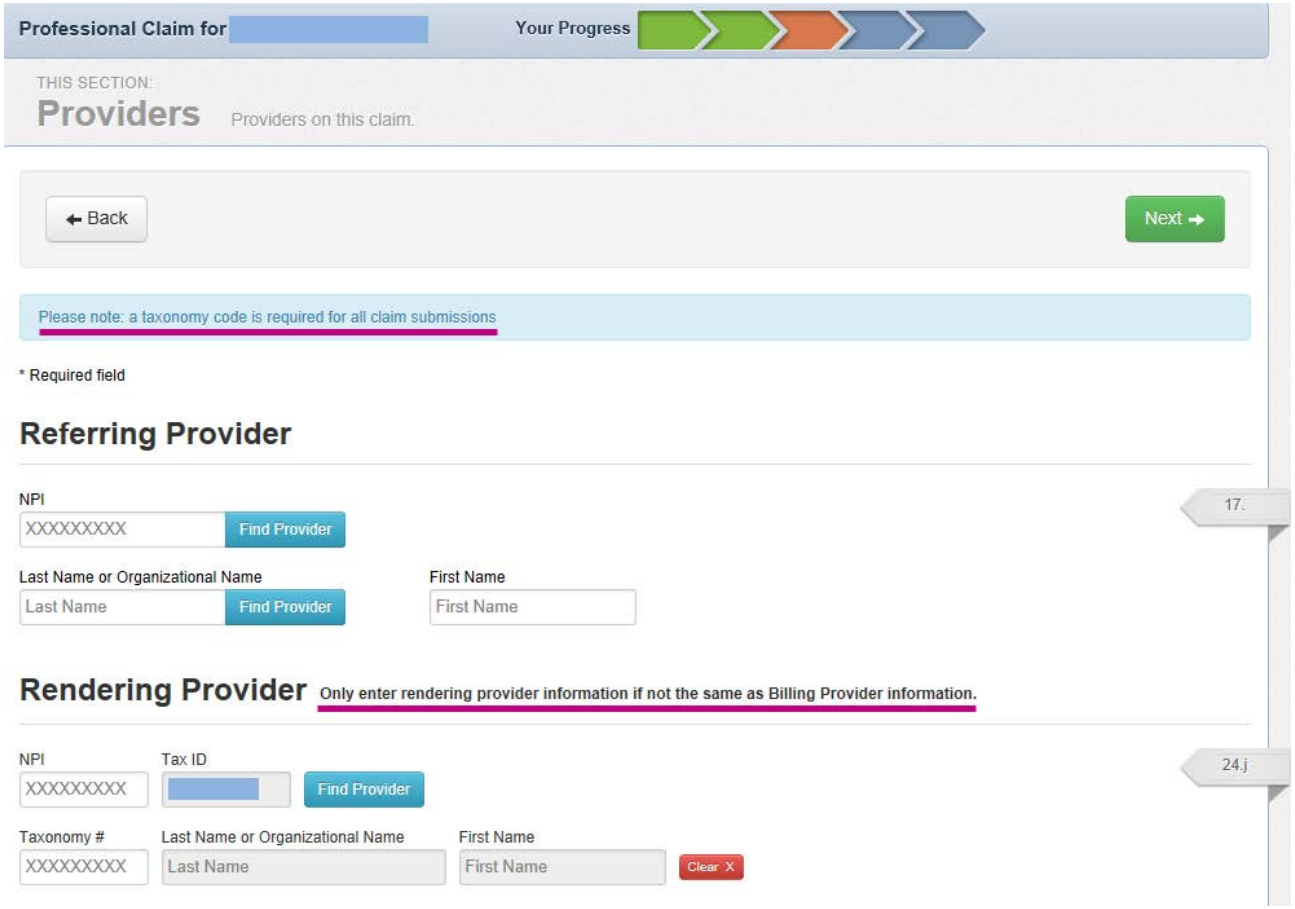
# Coordination of Benefits




Final Calculations: Total of the **Amount Allowed** and **Denied Amount** must equal the **Charges**.

***Denied Category** and **Denied Amount** are not required and can be left blank when appropriate***

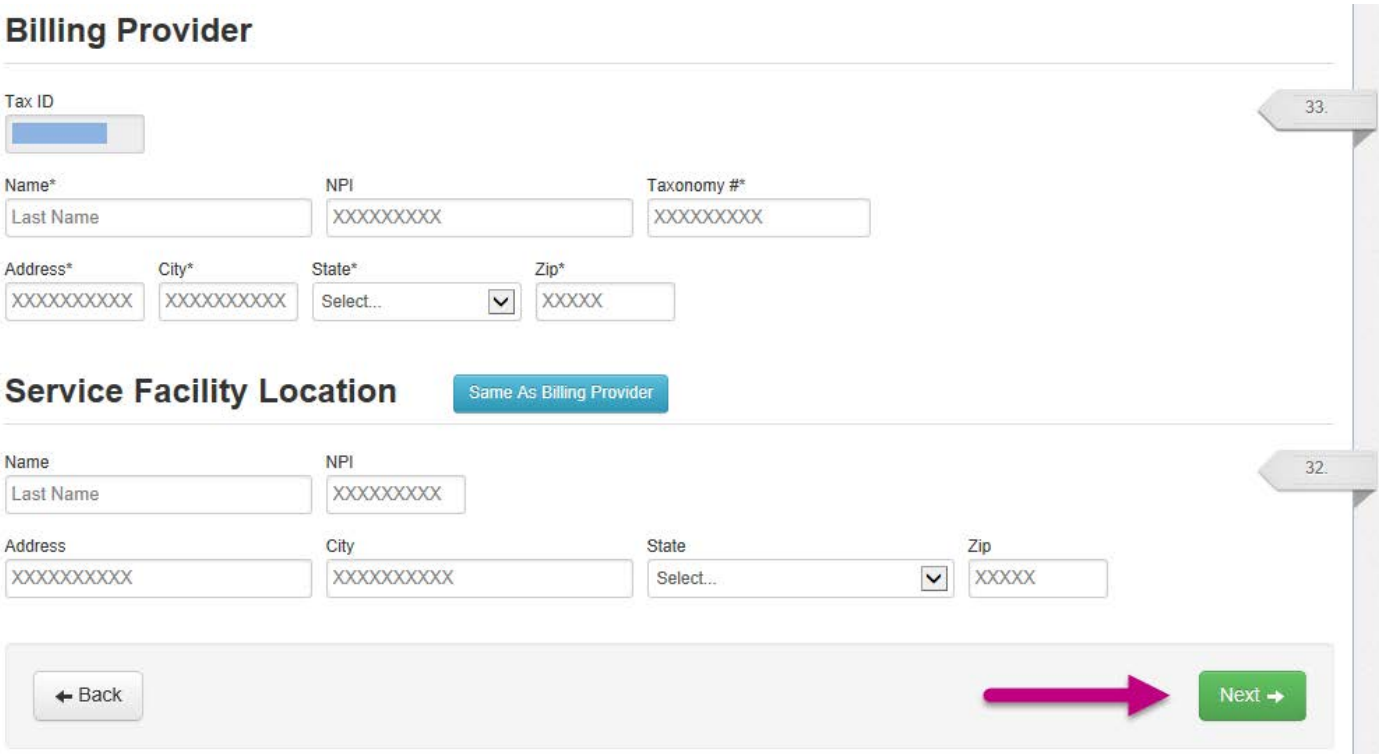
# Referring and Rendering Provider




Enter pertinent provider information for **Referring** and **Rendering Provider**.

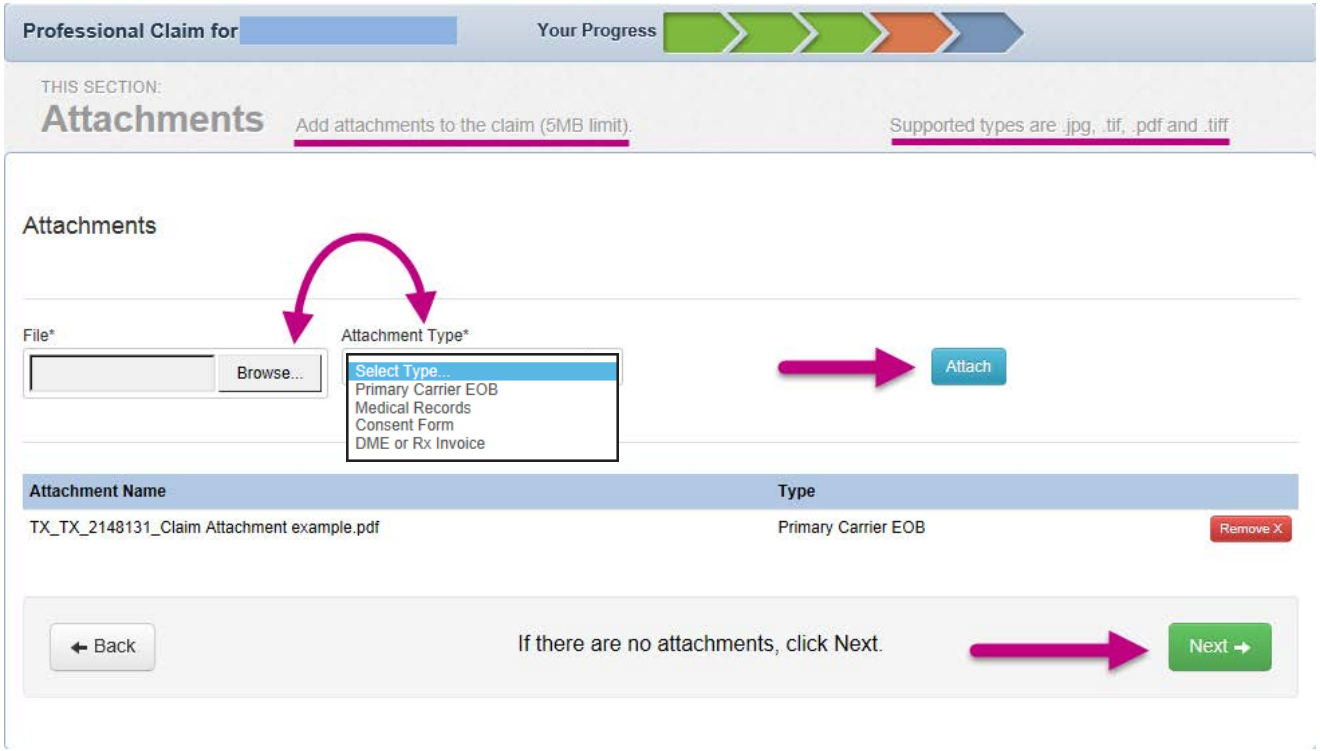
***Only enter **Rendering Provider** information if it is not the same as **Billing Provider** information***

# Billing Provider Section




- In the **Billing Provider** section, enter the required information. Under Service Facility Location, enter the necessary information or click **Same as Billing Provider** to automatically copy the billing provider information into the service facility fields.

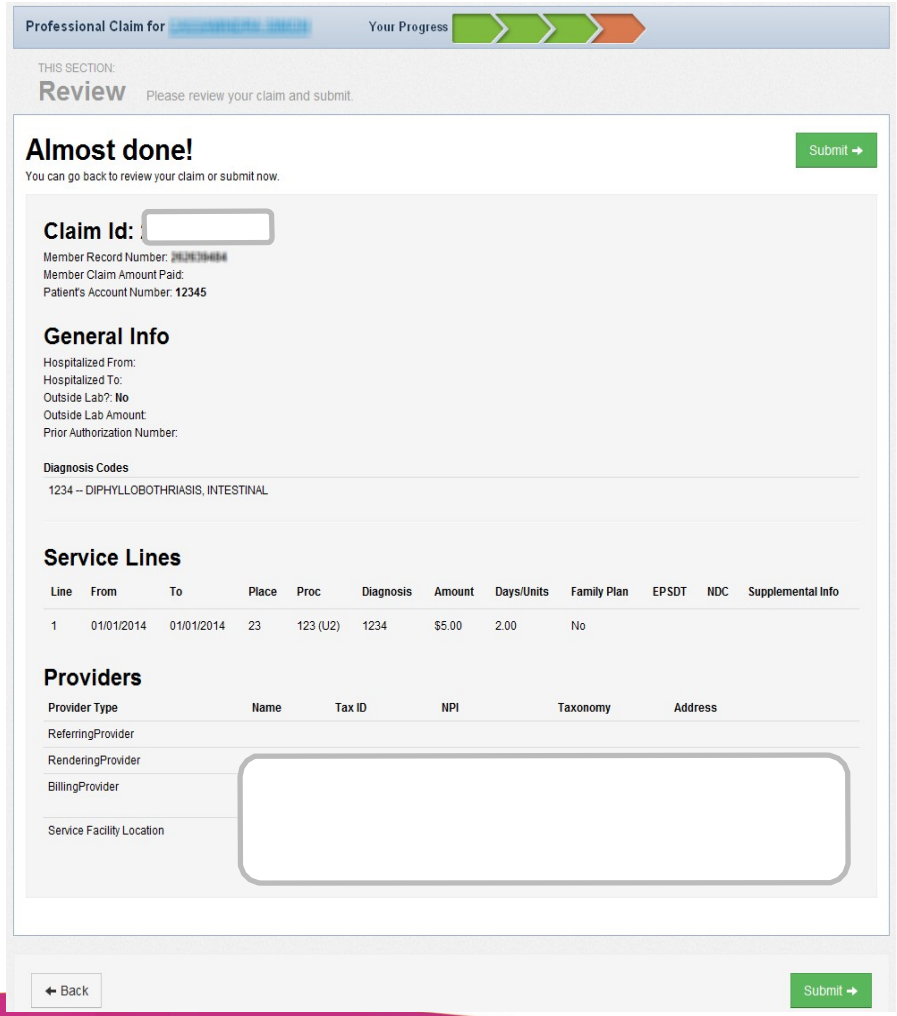
# Attachments




Add attachments, if applicable. **Browse** for the document, select an **Attachment Type**, and then **Attach**. If there are no attachments, click **Next**.

***There is an attachment upload limit of 5MB***

# Review & Submit



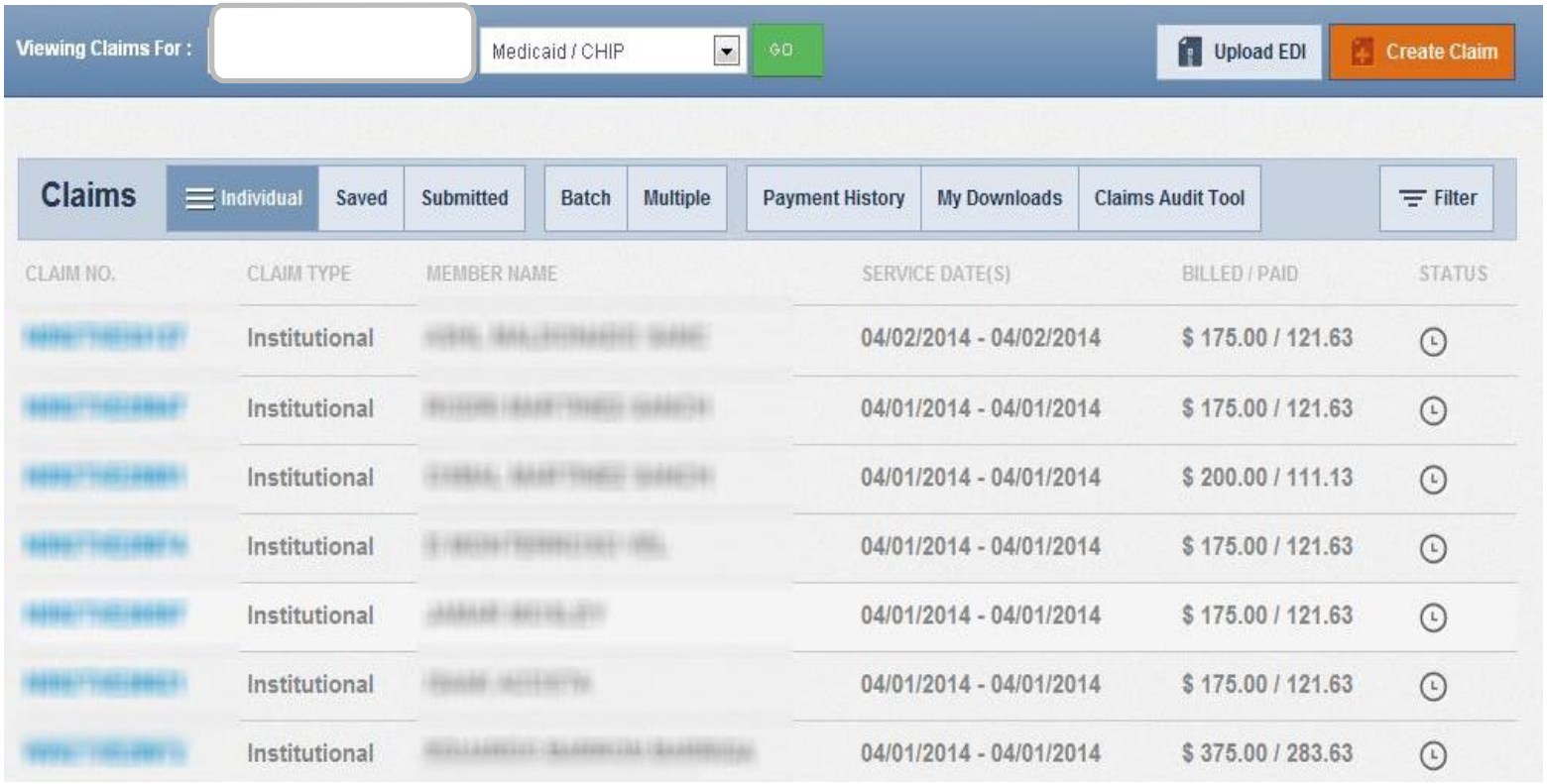

**Review to ensure that all information is correct.**

- If information is incorrect, click **Previous Step** to move to the section that needs changes and change the information within the section
- If all information is correct, click **Submit Claim** and the claim will be transmitted. A "Claim Submitted" confirmation will be displayed

# Claim Submitted Successfully!

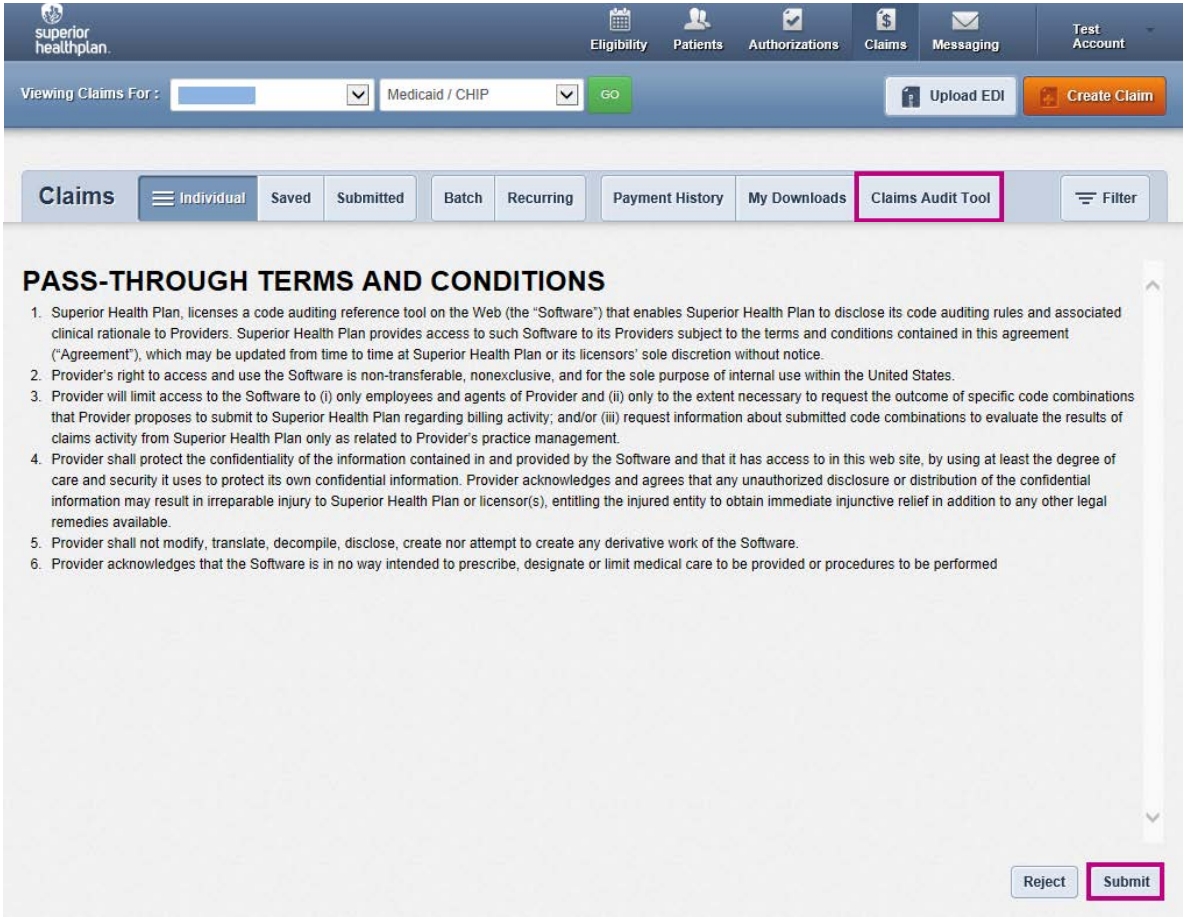

Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Provider Services Representative.

# Checking Claim Status




**Claims status could be viewed on claims that have been sent EDI, Paper or Web portal**

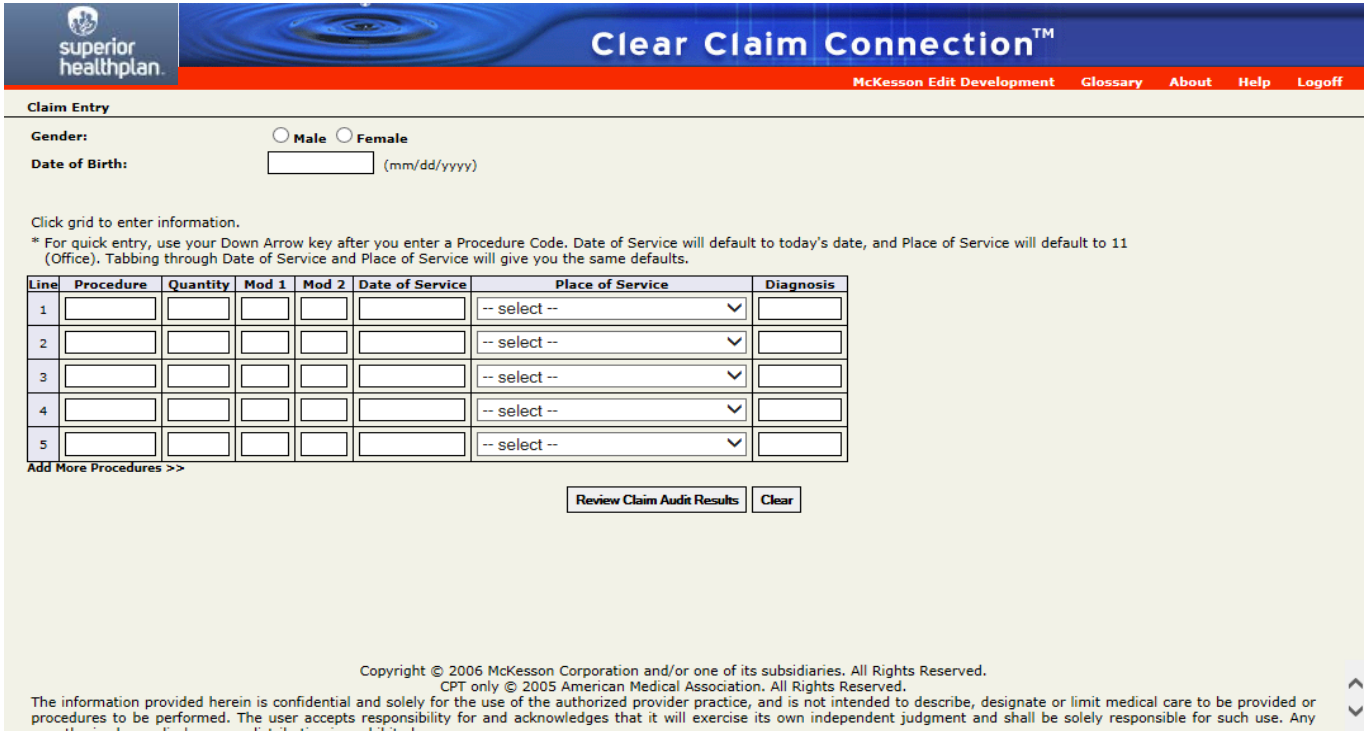
# Claims Audit Tool




Select the **Claims Audit Tool**.

Click **Submit** to enter the **Clear Claim Connection** page.

# Claims Audit Tool




Test claim coding by entering core information to be audited before submitting the live claim.

# *Superior HealthPlan Departments - We Can Help You!*

# Member Services

The Member Services staff can help you with:

- Verifying eligibility
- Reviewing Member benefits
- Assist with non-compliant Members
- Help find additional local community resources

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time at 1-877-277-9772.

# Provider Services

The Provider Services staff can help you with:

- Questions on claim status and payments
- Assisting with claims appeals and corrections
- Finding Superior Network Providers
- Locating your Service Coordinator and Provider Relations Representative

For claims related questions, be sure to have your claim number, TIN, and other pertinent information available as HIPAA validation will occur.

You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

**1-877-391-5921**

# Identifying a Superior Claim Number

Superior HealthPlan assigns claim numbers (aka Claim Control Number or Submission ID) for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.

When calling into Provider Services, please have your claim number ready for expedited handling.

- EDI Rejection/Acceptance reports
- Rejection Letters*
- Web portal
- Explanation of Payments (EOP)

*Remember that rejected claims have never made it through Superior's claims system for processing. The submission ID that is provided on the Rejection Letter is a claim image number that helps us retrieve a scanned image of the rejected claim.

# Where do I find a Claim Number?

There are two ways of submitting your claims to Superior:

- Electronic – Web Portal or EDI via a clearing house
- Paper –Mailed to our processing center

If your submission is electronic your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior Web Portal and EOPs.

If your submission is paper your response to your submission is viewable via rejection letters, Superior Web Portal and EOPs.

**Note: On all correspondence, please reference either the 'Claim Number', 'Control Number', or 'Submission ID'.**

# Where do I find a Claim Number?

superior healthplan

**Examples:**

EDI Reports

| DATE | CLAIM NUMBER | MEMBER NBR | AMT BILLED | STATUS | PROV NBR | TAX ID | REASON | SERV DATE | PATIENT AC |
|---|---|---|---|---|---|---|---|---|---|
| | M317TXE44842 | [redacted] | 000209200 | INVALD | [redacted] | [redacted] | 76 | 20130710 | [redacted] |
| | M317TXE44820 | | 000164200 | ACCEPT | | | | 20131109 | |
| | M317TXE44819 | | 000193510 | INVALD | | | 76 | 20130704 | |
| | M317TXE44858 | | 001141694 | ACCEPT | | | | 20131108 | |
| | M317TXE44868 | | 000759989 | ACCEPT | | | | 20131108 | |
| | M317TXE44826 | | 000310600 | ACCEPT | | | | 20131108 | |
| | M317TXE44814 | | 000116222 | ACCEPT | | | | 20131108 | |
| | M317TXE44828 | | 000405752 | ACCEPT | | | | 20131103 | |
| | M317TXE44835 | | 000112728 | ACCEPT | | | | 20131108 | |
| | M317TXE44824 | | 000113004 | ACCEPT | | | | 20131109 | |
| | M317TXE44829 | | 000984375 | ACCEPT | | | | 20131024 | |
| | M317TXE44816 | | 000103600 | INVALD | | | 09 | 20131105 | |
| | M317TXE44821 | | 000999375 | ACCEPT | | | | 20131106 | |
| | M317TXE44843 | | 001183267 | ACCEPT | | | | 20131101 | |
| | M317TXE44815 | | 000103600 | ACCEPT | | | | 20131107 | |
| | M317TXE44817 | | 000011500 | INVALD | | | 76 | 20121003 | |
| | M317TXE44825 | | 000207700 | ACCEPT | | | | 20131107 | |
| | M317TXE44882 | | 000414130 | ACCEPT | | | | 20131109 | |
| | M317TXE44827 | | 001399000 | ACCEPT | | | | 20131109 | |
| | M317TXE44910 | | 005690360 | ACCEPT | | | | 20131030 | |
| | M317TXE44837 | | 000109830 | ACCEPT | | | | 20131004 | |
| | M317TXE44853 | | 000310700 | ACCEPT | | | | 20131109 | |
| | M317TXE44839 | | 000338276 | ACCEPT | | | | 20130906 | |
| | M317TXE44878 | | 000472927 | ACCEPT | | | | 20131109 | |
| | M317TXE44823 | | 000086211 | ACCEPT | | | | 20131109 | |

**Explanation of Payment Details**

Back to Payments List | Download (Excel Format) | Print

Check/Trace Number:0000000000 Check Date:05/16/2014

Insured [redacted]

Patient [redacted]

Control Number: N125TXP02973

Service Pro[redacted]

Group: [redacted]

Account: AYEU9245

NPI: 1003885641

View Service Line Details

| Serv | Date | Diag#/ Drug# | Proc#/ Proc2 | Mod | Days/ Cnt Qty | Charged | Allowed | Deduct/ Copay | Coinsur | Discount/ Interest | Med Allow/ Med Paid | TPP | Denied | Remit Codes | Payment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | 09/16/2013 | 2920 | 270 | | 0/1 | 51.71 | 10.34 | 0.00/0.00 | 0.00 | 0.00/0.00 | 0.00/0.00 | 0.00 | 0.00 | MX | 0.00 |
| 20 | 09/16/2013 | 2920 | 272 | | 0/1 | 9.17 | 1.83 | 0.00/0.00 | 0.00 | 0.00/0.00 | 0.00/0.00 | 0.00 | 0.00 | MX | 0.00 |

Payment History via Web Portal (EOP)

# Field Provider Relations

Field staff are here to assist you with:

- Face-to-face orientations
- Face-to-face web portal training
- Office visits to review ongoing claim trends
- Office visits to review quality performance reports
- Provider trainings

You can also find a map that can assist you with identifying the field office you can call to get in touch with your Provider Relations Specialist on our website.

# Provider Training

Superior HealthPlan offers targeted billing presentations depending on the type of services you provide and bill for. For example, LTSS Billing, Electronic Visit Verification (EVV), and General Billing Clinics.  We also offer product specific training on STAR+PLUS, MMP and STAR/CHIP.

You can find the schedule for all of the training presentations on our website at www.superiorhealthplan.com in the Provider Resources section.

*We encourage you to come join us!*

# Complaints

Superior requires complaints to be submitted in writing. The website contains a complaint form that can be completed and submitted online or printed, completed and faxed or mailed to Superior for resolution response:

- **Address:**
  Superior HealthPlan
  5900 E. Ben White Blvd.
  Austin, Texas 78741
  ATTN: Complaint Department
- **Fax number:** 1-866-683-5369
- **Website Links:**
  - http://wwwSuperiorHealthPlan.com/contact-us/complaint-hotline/complaint-form/ (submit online)
  - http://www.superiorhealthplan.com/files/2014/10/Provider_Complaint_Form_10282014.pdf(form)

# Compliance

## Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines http://wwwhhs.gov/ocr/privacy.

## Fraud, Abuse and Waste (Claims/Eligibility)

- Providers and Contractors are all required to comply with State and Federal provisions that are set forth.
- To report Fraud, Waste and Abuse, call the numbers listed below:
  - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
  - Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
  - Superior HealthPlan Fraud Hotline: 1-866-685-8664

# *Questions And Answers*

# In conclusion...

We are committed to assisting all of our network providers & Nursing Facilities in making the transition as easy as possible.

By now you are able to:

- Identify who Superior HealthPlan is and our various departments
- Explain the difference between Unit Rate and Add-on Services
- Understand Service Coordination and how the Service Coordinator will work with the Nursing Facility staff
- Obtain authorizations and file claims with Superior HealthPlan

Let us know what we can do to help.

*Thank you for attending!*