STAR+PLUS Long-Term Services and Supports (LTSS) Billing Clinic

Provider Training

Introductions and Agenda

- Introduction to Superior HealthPlan
- Verifying Eligibility
- Service Coordination
- Prior Authorizations
- Electronic Visit Verification
- Adult Foster Care and Assisted Living/Residential Care
- Daily Activity and Health Services
- Emergency Response Services and Home Delivered Meals
- Personal Attendant Services and Home Health
- Respite Care
- Claims Submission and Payment Options
- Superior's Secure Provider Portal
- Superior HealthPlan Departments
- Questions and Answers

Who is Superior HealthPlan?

- Only health plan with statewide Health Maintenance Organization (HMO) license.
  - An HMO is an organization that provides or arranges managed care for health insurance.
- First health plan with child welfare experience nationally.
  - Superior has been the only provider of health insurance for youth in Texas foster care (STAR Health) since 2008. STAR Health has helped set a framework for foster care programs at other health plans in the U.S.
- Leader in Pay for Performance programs.
  - Pay for Performance (P4P) gives financial incentives to providers to improve health outcomes.
- Large provider network.
  - Superior has 61,000+ providers across Texas. This includes doctors, specialists, clinics and hospitals.

NCQA Accreditation

- National Committee for Quality Assurance (NCQA) awards accreditation to participating health plans.
  - NCQA is a private, non-profit organization. It was founded in 1990 to help improve health-care quality.
  - NCQA Accreditation ratings are based on Health Effectiveness Data and Information Set (HEDIS) scores, Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores and NCQA Accreditation standard scores.

What is STAR+PLUS?

- The STAR+PLUS 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 LTSS, 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 include all Medicare benefits, including parts A, B and D, and Medicaid benefits, including LTSS and flexible benefits/value added benefits.
- STAR+PLUS MMP is an opt-in/opt-out program.
- STAR+PLUS MMP started on March 1, 2015.
- Superior offers STAR+PLUS MMP in Bexar, Dallas and Hidalgo counties.

What is LTSS?

- Personal Attendant Services (PAS)
- Day Activity and Health Services (DAHS)
- STAR+PLUS Waiver Services
  - Adaptive aids
  - Adult foster care
  - Consumer directed services
  - Durable Medical Equipment (DME)
  - Emergency response system
  - Home delivered meals
  - Medical supplies
  - Minor home modification
  - Physical, occupational and speech therapy
  - Residential care/assisted living
  - Skilled nursing
  - Transition assistance services

What is Community First Choice (CFC)?

- CFC is part of Senate Bill 7 from the 2013 Texas Legislature requiring Health and Human Services (HHS) to put in place a cost-effective option for attendant and habilitation services for people with disabilities.
- CFC services are available for STAR+PLUS members who:
  - Need help with activities of daily living (dressing, bathing, eating, etc.).
  - Need an institutional level of care (Intermediate Care Facility for Individuals with an Intellectual Disability or Related conditions [ICF/IID], Nursing Facility [NF] or Institution for Mental Disease [IMD]).
  - Currently receive Personal Attendant Services (PAS).
  - Are individuals on the waiver interest list or are already getting services through a 1915 (c) waiver.
- CFC will include PAS, Habilitation, Emergency Response Services and Support Management.

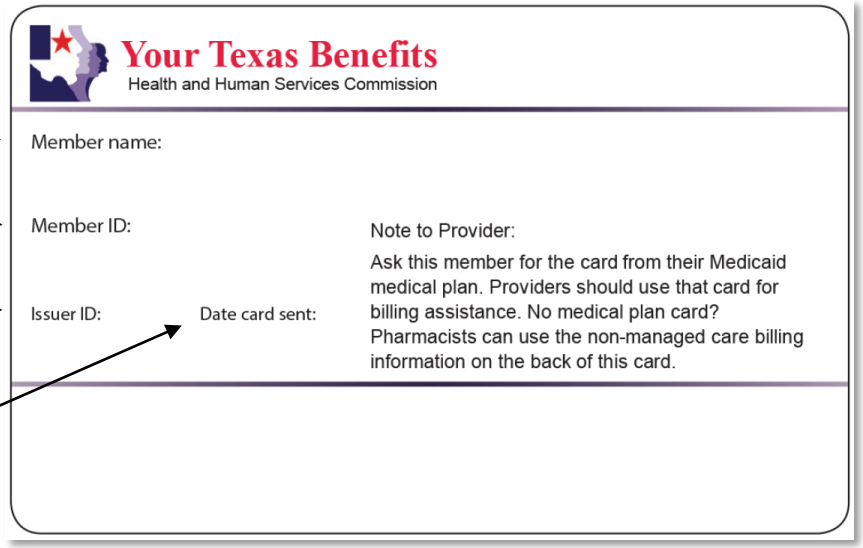
Verifying Eligibility

Verify Eligibility

- Superior Identification Card
- Superior Secure Provider Portal
  www.Provider.SuperiorHealthPlan.com
- Superior STAR+PLUS Member Services: 1-877-277-9772
- Superior STAR+PLUS Medicare-Medicaid Plan (MMP) Card
- Texas Medicaid Benefits Card
- TexMedConnect –
  http://www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx
- Maximus Enrollment Broker: 1-800-964-2777

Note: It is recommended to verify eligibility the 1st of each month using Superior's website or by contacting Member Services.

Superior Member ID Cards

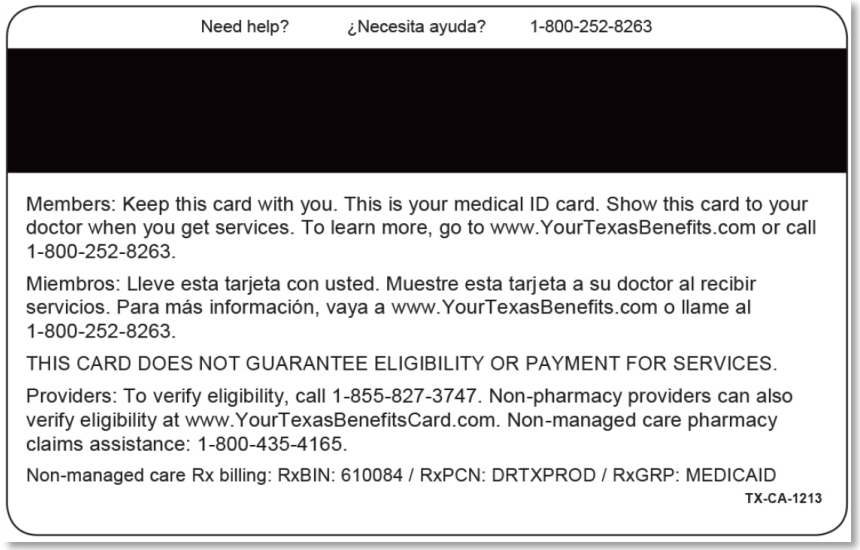


This is where your name appears.

This is your Medicaid ID number.

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

This is the date the card was sent to you.



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

Go to this website or call this number to learn more about this card.

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

STAR+PLUS Member ID Cards

STAR+PLUS MMP ID Card

Service Coordination

Service Coordination

- Single point of contact for the member.
- Review assessments and develop plan of care utilizing input from member, family and providers.
- Coordinate with the member's Primary Care Physician (PCP), specialist and LTSS providers to ensure the member's health and safety needs are met in the least restrictive setting.
- Refer member to support services such as disease management and community resources.

Service Coordination

- Utilizes a multidisciplinary approach in meeting members' medical and behavioral health needs.
- Conducts mandatory telephonic or face-to-face contacts.
- Processes prior authorization requests.

Locating a Member's Service Coordinator

- Members and providers will be able to access the name and phone number of the assigned Service Coordinator through the Secure Member and Secure Provider Portals.
- When providers access eligibility on a specific member, the assigned Service Coordinator and phone number is displayed on the **Eligibility Overview** page, under **Care Gaps**.
- Call Service Coordination at 1-877-277-9772.

Prior Authorizations

LTSS Authorizations

- Personal Attendant Services (PAS)
- Day Activity and Health Services (DAHS)
- STAR+PLUS Waiver Services
  - Adaptive aids
  - Adult foster care
  - Consumer directed services
  - Durable Medical Equipment (DME)
  - Emergency response system
  - Home delivered meals
  - Medical supplies
  - Minor home modification
  - Physical, occupational, speech therapy (PT/OT/ST)
  - Residential care/assisted living
  - Skilled Nursing
  - Transition assistance services

Services Requiring Prior Authorizations

- DAHS, assisted living, respite, PAS/PHC, home health, home delivered meals, adult foster care, emergency response services, consumer directed services and minor home modifications
- DME
  - Non waiver items below $500 generally will not require prior authorization.
    - Please note: providers should verify if prior authorization is required by visiting Superior's Prior Authorization Tool at www.SuperiorHealthPlan.com/providers/preauth-check.html.
  - If waiver-specific DME item, then prior authorization is required.
- Skilled Nursing, PT/OT/ST – except at initial evaluation

Please note: Refer to the Provider Manual for complete guidelines.

Durable Medical Equipment (DME)

- Effective October 1, 2017, Superior began using Medline as the preferred supplier for DME for specific DME supplies for STAR, STAR Health, STAR+PLUS and CHIP members.
  - Download the list of DME supplies available through Medline without a prior authorization by visiting www.SuperiorHealthPlan.com/newsroom/important-updates-for-dme-supplies.html.
- Superior members may choose to fill their medical prescription with another DME supplier in the Superior network.
  - Members may opt out of using Medline for any reason by completing the DME Preferred Provider Opt-Out form.
  - Opt-out forms should be faxed to 1-844-755-9363 by the member's medical supply provider.
  - *Please note: The form must indicate the supplier the member wishes to use.*
- For questions regarding this change, please contact Provider Services at 1-877-391-5921.

How do I authorize LTSS or CFC?

- All authorizations for LTSS and CFC are obtained through the Service Coordination department.
- The name of each member's Service Coordinator can be viewed once a member's eligibility is confirmed through the Secure Provider Portal.
- Call 1-877-277-9772 to speak to a Service Coordinator, obtain prior authorization and to check the status of an authorization.

Authorization Timeframes

PAS / DAHS Timeframes

- Within 14 days after the member has requested services.
- Upon receiving PSON or DAHS forms.
  - We provide a 30 day authorizations to allow for DAHS required documents to be submitted.
- Once all documents are submitted and approved, a date span for the authorization is given.

Waiver Services Timeframe

Waiver Services

- 60 days to complete process
  - Including Waiver Assessment, Individual Service Plan (ISP) submission to HHS and HHS approval.
  - The waiver start date is the first day of the following month.

Renewals

- PAS / DAHS
  - 14 days to complete process.
- Waiver Services
  - 90 days prior to ISP expiring, Superior begins the assessment.

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Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Attendants providing covered services to an individual or health plan member must use the selected HHS-approved EVV system to record visit arrival and departure times.
- The provider agency will use the time recorded in the EVV system to determine billable units/hours before requesting payment.
- The computer-based system
  - Electronically verifies the occurrence of authorized personal attendant service visits.
  - Electronically documents the precise time a service delivery visit begins and ends.

Programs Requiring EVV

- STAR Health:
  - Personal Care Services (PCS)
  - Community First Choice (CFC)-PAS and Habilitation (HAB)
  - In-home respite services
  - Flexible family support services
- STAR Kids:
  - Personal Care Services (PCS)
  - In-home respite services
  - Flexible family support services
  - Community First Choice (CFC)-PAS and Habilitation (HAB)
- STAR+PLUS:
  - Personal Attendant Services (PAS)
  - Personal Care Services (PCS)
  - In-home respite services
  - Community First Choice (CFC)-PAS and Habilitation (HAB)
  - Protective Supervision

EVV Claims

- Providers will verify times of service using the vendor-specified submission procedure.
- Provider claims are processed in accordance with EVV data prior to adjudication.
- Superior will only pay for verified units of service aligned with EVV data.
- To avoid denials, claims for multiple dates of service should be billed on a separate line for each day with the number of units per day.

EVV Changes Effective September 1, 2019

- Effective September 1, 2019, EVV relevant claims must be billed to Texas Medicaid and Healthcare Partnership (TMHP) and will be subject to the EVV claims matching process.
- For STAR+PLUS, PAS and In-Home Respite increments will change from 1 hour to 15 minute units.
  - Please refer to the LTSS billing matrix for further clarification.
- Healthcare Common Procedure Coding System (HCPCS) , modifiers, and units must be an exact match for the aggregator to advise Superior in processing EVV-related claims.
  - If modifiers and units do not match, the claim will be denied. Additionally, claims submitted using date spans will be denied.
- TMHP will compare EVV data prior to Superior's claim adjudication process.
- Providers will be required to resubmit any denials to TMHP.

CDS EVV – Effective January 1, 2021

- Effective January 1, 2021, Financial Management Services Agency (FMSA) will be required to use EVV for Consumer Directed Services (CDS).
- It is the responsibility of the FMSA to select an EVV vendor to collect and transmit EVV visit data.
- The EVV vendors will be able to provide training to CDS employers and FMSAs.
- CDS employers are responsible for training their attendants on how to clock in/out of the EVV system.

CDS EVV – Billing After January 1, 2021

- CDS claims billed with dates of service on or after January 1, 2021 must be submitted to TMHP and will be subject to the EVV claims matching process.
- CDS claims must match EVV transaction data, including:
  - National Provider Identifier (NPI or Atypical Provider Identifier (API)
  - Date of Service
  - Medicaid ID
  - HCPCS Codes
  - Modifier(s), if applicable
- All CDS claims line items billed without matching EVV visit transactions will result in denials.
- Claims must be billed with units; however, the units will not be used for matching.
- CDS employers will use the EVV Vendor System to view EVV data and reports.
  - CDS employers will not use the EVV portal.

Adult Foster Care (AFC) and Assisted Living/ Residential Care

Authorization Specifics

- Services are initiated as the need is identified by the following avenues:
  - The member's Service Coordinator
  - The provider, hospital or Nursing Facility discharge planner
  - Medical Necessity Level of Care Assessment (waiver specific)
- To initiate prior authorization requests or any changes to an authorization, providers may call the Service Coordination department or fax a 2067 Form.
  - 2067 Form: https://hhs.texas.gov/node/18108
  - Fax Numbers:
    - STAR+PLUS and STAR MRSA 1-866-895-7856
    - STAR+PLUS MMP 1-855-277-5700
- Any applicable copay is determined by the STAR+PLUS Support Unit and provided to Superior. The provider is responsible to collect room and board and copays from the member or their representative.

Billing Requirements

All claims must be billed with appropriate modifiers as found on the LTSS Billing Matrix. The authorization will also include procedure codes and if the member is waiver of non-waiver. Do not deduct room and board or applicable copay from claims. Copay is deducted from the claim upon adjudication.

- Place of Service Codes:
  - AFC: 12
  - Assisted Living/Residential Care: 13
- Procedure Codes:
  - AFC: S5140
  - Assisted Living/Residential Care: T2031
- Taxonomy Codes:
  - AFC: 311ZA0620X: Adult Foster Care
  - Assisted Living/Residential Care: 310400000X
- Units = 1 Day

Note: If provider bills less than contracted amount, the claim will be eligible for reimbursement at the lesser of billed charges.

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Day Activity and Health Services (DAHS)

Authorization Specifics

- A new Individual Service Plan (ISP) is necessary for individuals who need initial prior approval for DAHS services or who are being transferred to a new DAHS facility.
- Updates are made when there is a change to the individual's treatment, monitoring and intervention occurs, or nursing service needs changed based on new or supplemental physician's orders.

Authorization Specifics

- Providers may call the Superior Service Coordination department or fax a 2067 Form to request initial approval of DAHS services.
- Additionally, the following HHS forms can be used at:
  - Initial and renewal requests & facility transfer.
  - Health assessments.
    - Form 3050
    - Form 3055
- For more information visit: https://hhs.texas.gov/laws-regulations/handbooks/day-activity-and-health-services-provider-manual/dahs-forms.

Authorization Specifics

An alternative to the forms is submitting all the following criteria that is either current or no older than 3 months:

- Active medical diagnosis
- Current list of medications
- Description of member's personal care requirements
- Indication of dietary needs (special requirements)
- Complete vital signs at time of assessment
- Physician's orders requesting the service
- Functional disability related to the medical diagnosis
- Therapeutic benefit potential from attending DAHS
- Interventions being performed by nurse at the DAHS facility for the member

Billing Requirements

- Place of Service Codes:
  - 99
- Procedure Codes:
  - DAHS: S5101
- Taxonomy Codes:
  - 261QA0600X
- Units:
  - 1 unit = 3 to 6 hours
  - 2 units = Over 6 hours

Note: If provider bills less than contracted amount, the claim will be eligible for reimbursement at the lesser of billed charges.

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Emergency Response Services (ERS) and Home Delivered Meals (HDM)

Authorization Specifics

- Services for members are initiated as the need is identified through the following avenues:
  - The member's Service Coordinator
  - The provider, hospital or Nursing Facility discharge planner
  - Medical Necessity Level of Care Assessment (waiver specific)
- To initiate pre-authorization requests, or to implement any change to an authorization, providers may call the Service Coordination department or fax a 2067 form.
- ERS and HDM are a STAR+PLUS waiver benefit but may be approved by a Service Coordinator for non-waiver members.

Billing Requirements

- Place of Service Code:
  - 12
- Procedure Codes:
  - ERS: S5161
  - ERS Installation and Testing: S5160
  - HDM: S5170 (Monthly service)
- Taxonomy Codes:
  - ERS: 333300000X
  - HDM: 332U00000X
- Units:
  - 1 unit = 1 month for ERS
  - 1 unit = 1 unit per service for installation and testing ERS
  - 1 unit = 1 meal for HDM

Note: If a provider bills less than contracted amount, the claim will be eligible for reimbursement at the lesser of billed charges.

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Personal Attendant Services (PAS) and Home Health (HH)

Authorization Specifics - PAS

- Providers may call the Service Coordination department at 1-877-277-9772 or fax a 2067 form to request initial approval or changes to PAS.
  - Dedicated Service Coordination teams are located in each Service Delivery Area (SDA).
- PAS are reviewed annually by the Service Coordinator or when a change has been indicated.
- PAS are initiated as service need is identified by the member's Service Coordinator, provider, hospital or a nursing home discharge, or the results from Needs Assessment Questionnaire and Task/Hour Guide (Form 2060).
- LTSS skilled nursing for STAR+PLUS waiver members are added into the service plan after an assessment is completed on the member and specified for the period of the ISP.

Authorization Specifics - HH

- Acute Care Services are driven by physician orders for a specified period of time.
- Continuation of service authorization is driven by the plan of care and reviewed against Superior's medical necessity criteria.
- Non-LTSS authorization requests should be faxed to the Prior Authorization department at 1-800-690-7030.
- Home Health services can be initiated by Superior through the PCP, hospital, nursing facility discharge planner or health risk assessments, etc.

Billing Requirements

- Place of Service Code:
  - 12
- Procedure Codes:
  - S5125: PAS Authorization will include if the member is waiver or non-waiver.
  - G0299, G0300: Skilled nursing services defined as acute care (e.g. IV infusion, wound care).
    - This benefit is for all members.
  - S9123 & S9124: Skilled services that are more long term in nature (e.g. med box fills). Use the code appropriate to licensure.
    - This code is specific to for Waiver members. If long term nursing is required for a non-waiver member an Upgrade Assessment for waiver should be requested.
    - *Please note: to receive specialized RN/LVN rates, provider must have an agreement on file for the higher rates.*
  - Modifiers are typically required for all “S” procedure codes.

Billing Requirements (continued)

- Taxonomy Codes:
  - PAS: 3747P1801X
  - Nursing Services Taxonomy: 251J00000X
- Units (PAS):
  - 1 unit = 1 hour

*Note: Claims submitted for PAS that are incorrectly billed using the taxonomy code associated to Home Health Services 251E0000X will **deny** EX9L: Taxonomy does not match service provided.*

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Respite Care

Authorization Specifics

- Respite Care can be provided:
  - In the member's home.
  - At a Nursing Facility.
  - At an Assisted Living Facility.
- Services are typically initiated as the need is identified by the member or member's caregiver.
- To initiate pre-authorization requests or any changes to an authorization:
  - Providers may call the Service Coordination department or fax a 2067 form.
  - Members may call the Service Coordination department.

Billing Requirements

- In-Home Respite Care
- Out-of-Home Respite Care:
  - Assisted Living/Residential Care
  - Adult Foster Care
  - Nursing Facility
- Procedure Code:
  - S5151
- Providers must bill with the appropriate Taxonomy Code for their provider type for respite care.

Community First Choice (CFC)

- CFC will include PAS, Habilitation, Emergency Response Services and Support Management (non-billable).
- CFC assessments will be conducted by Superior.
- If the PCP determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination and request an assessment.
- CFC services should be billed directly to Superior on paper, or through the Secure Provider Portal or clearinghouse. Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the HHS STAR+PLUS Handbook.

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Claims Submission and Payment Options

Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS).
- Filed on CMS 1450/UB-04 or CMS 1500 (HCFA).
- Filed electronically through clearinghouse or the Secure Provider Portal at www.Provider.SuperiorHealthPlan.com.
- If filing by paper claim, mail to:

Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

Initial Submission

- Claims must be completed in accordance with TMHP billing guidelines
- Use appropriate modifiers and procedure codes from the LTSS Billing Matrix: https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook/appendices/appendix-xvi-long-term-services-supports-codes-modifiers.
- All member and provider information must be completed.
- Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved.

Identifying a Claim Number

- Superior 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 the claim number ready for expedited handling.
  - Electronic data interchange (EDI) Rejection/Acceptance reports
  - Rejection Letters*
  - Secure Provider Portal
  - 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.*

How to Submit a Claim

There are 2 ways to submit claims to Superior:

1. Electronic:
   - Secure Provider Portal or EDI through a clearinghouse.
   - If the submission is electronic, the response to the submission is viewable through an EDI rejection/acceptance report, rejection letters, Secure Provider Portal and EOPs.
2. Paper:
   - Mailed to Superior's processing center.
   - If the submission is paper, the response to the submission is viewable through rejection letters, Secure Provider 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?

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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]H

Patient Name: [redacted]

Control Number: N125TXP02973

Service Provider: [redacted]

Group:

ID: [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 through Secure Provider Portal (EOP)

Electronic Claim Filing Tips

- If the clearinghouse does not have Superior's **Payer ID 68069**, they may drop the claim to paper.
- If a provider uses EDI software but it is not setup with a clearinghouse, they must bill Superior through paper claims or through the Secure Provider Portal until the provider has established a relationship with a clearinghouse listed on Superior's website.
- To send claim adjustments through EDI, the CLM05 -3 "Claim Frequency Type Code" must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
- Claims can also be submitted through the Secure Provider Portal. Claims submitted through the portal are considered electronic claims.

EDI: Payer ID by Product

STAR+PLUS and STAR+PLUS Medicare-Medicaid Plan (MMP)

- Medical Claims - 68069
- Behavioral Health Claims - 68068

EDI: Current Trading Partners List

- Allscripts/Payerpath
- Availity
- Capario
- Claim Remedi
- Claimsource
- CPSI
- DeKalb
- Emdeon
- First Health Care
- GHNonline
- IGI
- MD On-Line
- Physicians CC
- Practice Insight
- Relay/ McKesson
- Smarta Data
- SSI
- Trizetto Provider Solutions, LLC.
- Viatrack

Telephone: 1-800-225-2573 x 25525
Email: ediba@centene.com
Web Info:
www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html

Paper Claim Filing Tips

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To assist the mail center in improving the speed and accuracy to complete scanning, 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 or CMS 1500 red form (not a copy).
- Handwritten claim forms are no longer accepted.

Billing Tip Reminders

- National Provider Identifier (NPI) of rendering provider.
- Appropriate 2 digit location code must be listed.
- ZZ qualifier to indicate taxonomy (24 J shaded/33b) when you are billing with your NPI number.
- Ensure appropriate modifiers have been entered.
- Taxonomy codes are required on encounter submissions effective for the rendering and billing providers.
- Ensure the EVV data matches the units/hours on the claim.
- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS 1450 or CMS 1500 forms.

CMS 1500 (HCFA) Form Tips

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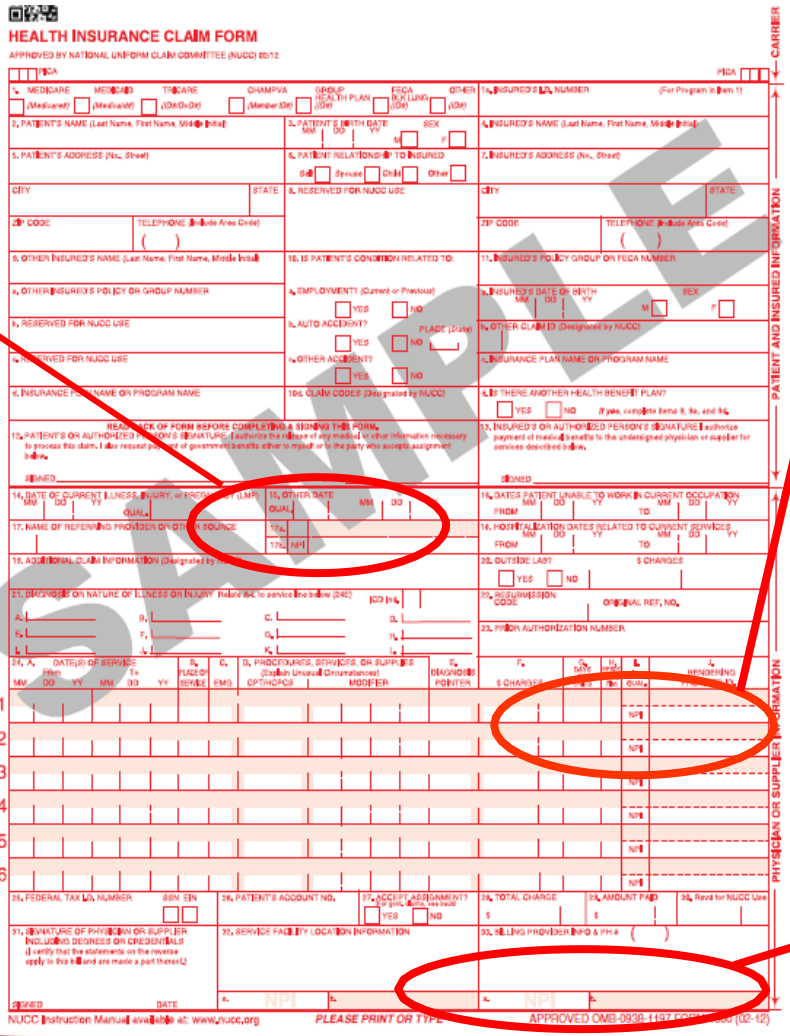
Referring Provider: [C]
17 Name of the referring provider and 17b NPI



Rendering Provider: [R]
Place your NPI in box 24J (Unshaded) and Taxonomy Code with a ZZ Modifier in box 24J (shaded). **These are required fields when billing Superior claims**.

If you do not have an NPI, place your API (atypical provider number/LTSS number) in Box 33b

Billing Provider: [R]
33a Billing NPI number

33b Billing Taxonomy number (or API if no NPI)

Authorization and Billing Tips

- Avoid denials: Remember to use the right Tax ID LTSS number when requesting authorizations.
- If the authorization denies because it was billed with a different combination than was authorized, providers can appeal by:
  - Rebilling with correct combination.
  - Requesting reconsideration by providing the authorization number you did obtain and ask it be assigned to the correct combination.

Recurring Bills Reminder

- Superior may issue authorizations that extend to multiple dates of service.
- In order for the claim to process correctly, dates of services billed on a claim must be covered under a single authorization.
- Bill must be reflect the services under the authorization - including billing period.
- One claim per authorization period.

Recurring Bills Reminder

- Superior frequently issues authorizations that span over multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under one single authorization.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Adjustments, Reconsiderations and Disputes

- All claim adjustments (corrected claims), requests for reconsideration or disputes 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
- Visit www.SuperiorHealthPlan.com for easy-to-fill Corrected Claim or Claim Appeal forms.

Corrected Claim Filing Tips

- Must reference original claim number from EOP.
- Must be submitted within 120 days of adjudication paid date.
- Resubmission of claims can be done through a clearinghouse or through Superior's Secure Provider Portal.
  - To send both individual and batch claim adjustments through 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 a clearinghouse or through the Secure Provider Portal.
  - To send individual claim adjustments through the 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

Appealing Denied Claims

- Submit appeal within 120 days from the date of adjudication or denial.
- Claims appeals may be submitted:
  - In writing:
    Superior HealthPlan
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800
  - Through the Secure Provider Portal.
    - At this time, batch adjustments are not an option through the portal.
- Attach and complete the Claim Appeal form from www.SuperiorHealthPlan.com.
- Include sufficient documentation to support appeal.
- Submissions must include an attachment outlining the reason for the appeal.
- Include copy of CMS 1450 or CMS 1500 (corrected or original) or EOP copy with claim number identified.

Appeals Documentation

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

- A copy of the Superior 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, Texas Medicaid Benefits 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

Claims Filing Addresses for STAR+PLUS MMP Members

Addresses are different for MMP members.

- Initial claim submission, Adjusted/Corrected Claims, reconsiderations and disputes by paper:

  Superior HealthPlan STAR+PLUS MMP
  P. O. Box 3060
  Farmington, MO 63640-3822

- Providers can file through the Secure Provider Portal or their clearinghouse for Initial and Adjusted/Corrected Claims.

LTSS Billing Codes

Adult Foster Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5140	99	U3			Adult Foster Care -- Level 1 (one day)	1 day = 1 unit
S5140	99	U4			Adult Foster Care -- Level 2 (one day)	1 day = 1 unit
S5140	99	U5			Adult Foster Care -- Level 3 (one day)	1 day = 1 unit
S5140	99	U6			Adult Foster Care Provider Agency -- Level 1 (one day)	1 day = 1 unit
S5140	99	U7			Adult Foster Care Provider Agency-- Level 2 (one day)	1 day = 1 unit
S5140	99	U8			Adult Foster Care Provider Agency -- Level 3 (one day)	1 day = 1 unit

LTSS Billing Codes

Attendant Care and Habilitation (CFC-HAB)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	U9				CFC Attendant care and habilitation, Agency model	15 mins = 1 unit
T1019	U2				CFC Attendant care and habilitation, SRO model	15 mins = 1 unit
T1019	U4				CFC Attendant care and habilitation, CDS model	15 mins = 1 unit

Community First Choice Attendant Care Only (CFC-PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	UD				CFC PCS Attendant care only – Agency Model	15 mins = 1 unit
T1019	U1				CFC PCS Attendant care only – SRO Model	15 mins = 1 unit
T1019	U3				CFC PCS Attendant care only - CDS Model	15 mins = 1 unit

LTSS Billing Codes

Day Activities and Health Services (DAHS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5101					Day Activities and Health Services (DAHS) 3 to 6 hours	3-6 hours = 1 unit
S5101					DAHS over 6 hours	Over 6 hours = 2 units

Emergency Response

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5161	U3	U3			Emergency Response Services (Monthly) (SPW)	1 month = 1 unit
S5161	U3	U3	U3		Emergency Response Services (Monthly) (SPW) (CFC)	1 month = 1 unit
S5161	U7	U7			Emergency Response Services (Monthly) (Non-SPW)	1 month = 1 unit
S5161	U7	U7	U7		Emergency Response Services (Monthly) (Non-SPW) (CFC)	1 month = 1 unit
S5160					Emergency Response Services (Installation and Testing)	1 unit per service

LTSS Billing Codes

Employment Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2025	U3	U3			Supportive Employment (SPW)	1 hour = 1 unit
H2025	U3	99	99	UC	Supportive Employment (CDS) (SPW)	1 hour = 1 unit
H2025	U3	99	99	US	Supportive Employment (SRO) (SPW)	1 hour = 1 unit
H2023	U3	U3			Employment Assistance (SPW)	1 hour = 1 unit
H2023	U3	99	99	UC	Employment Assistance (CDS) (SPW)	1 hour = 1 unit
H2023	U3	99	99	US	Employment Assistance (SRO) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Financial Management Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2040	U3				Consumer Directed Services Agency (SPW)	Monthly Fee
T2040	U7				Consumer Directed Services Agency (non-SPW)	Monthly Fee

LTSS Billing Codes

Habilitation (HAB)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2021	U7	U7	U7		Habilitation Agency Model (Non-SPW) (CFC)	1 hour = 1 unit
T2021	U3	U3	U3		Habilitation Agency Model (SPW) (CFC)	1 hour = 1 unit
T2021	U7	U7	U7	UC	Habilitation Consumer Directed Services (Non-SPW) (CFC)	1 hour = 1 unit
T2021	U3	U3	U3	UC	Habilitation Consumer Directed Services (SPW) (CFC)	1 hour = 1 unit
T2021	U7	U7	U7	US	Habilitation Service Responsibility Option (SRO) (Non-SPW) (CFC)	1 hour = 1 unit
T2021	U3	U3	U3	US	Habilitation Service Responsibility Option (SRO) (SPW) (CFC)	1 hour = 1 unit

Please note: effective September 1, 2019, T2021 will change to T2017 and must be billed in 15 minute increments.

LTSS Billing Codes

Home Delivered Meals

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5170	U3				SPW Home Delivered Meals	1 unit = 1 meal
S5170	U7				Non-SPW Home Delivered Meals	1 unit = 1 meal

LTSS Billing Codes

Minor Home Modifications

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5165					Minor home modifications	1 unit per service

Nurse Delegation and Supervision

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
G0162					RN assessment for delegation of PCS or CFC tasks	15 mins = 1 unit
G0162	U1				RN training and ongoing supervision of delegated tasks	15 mins = 1 unit

LTSS Billing Codes

Personal Attendant Services (PAS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	U7	U5			PAS Agency Model (Non-SPW)	1 hour = 1 unit
S5125	U7	U5	U7		PAS Agency Model (Non-SPW) (CFC)	1 hour = 1 unit
S5125	U3	U3			PAS Agency Model (SPW)	1 hour = 1 unit
S5125	U3	U3	U3		PAS Agency Model (SPW) (CFC)	1 hour = 1 unit
S5125	U3	U5			PAS Protective Supervision Agency Model (SPW)	1 hour = 1 unit

Please note: Effective September 1, 2019, S5125 must be billed in 15 minute increments.

LTSS Billing Codes

Personal Attendant Services (PAS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	99	99	99	UC	PAS Consumer Directed Services (CDS) (Non-SPW)	1 hour = 1 unit
S5125	99	99	U7	UC	PAS Consumer Directed Services (CDS) (Non-SPW) (CFC)	1 hour = 1 unit
S5125	U3	99	99	UC	PAS Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S5125	U3	99	U3	UC	PAS Consumer Directed Services (CDS) (SPW) (CFC)	1 hour = 1 unit
S5125	U3	U5	99	UC	PAS Protective Supervision (CDS) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Personal Attendant Services (PAS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	99	99	99	US	PAS Service Responsibility Option (SRO) (Non-SPW)	1 hour = 1 unit
S5125	99	99	U7	US	PAS Service Responsibility Option (SRO) (Non-SPW) (CFC)	1 hour = 1 unit
S5125	U3	99	99	US	PAS Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit
S5125	U3	99	U3	US	PAS Service Responsibility Option (SRO) (SPW) (CFC)	1 hour = 1 unit
S5125	U3	U5	99	US	PAS Protective Supervision (SRO) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Personal Care Services (PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	U6				PCS Agency model	15 mins = 1 unit

LTSS Billing Codes

Physical, Occupational, Speech Therapy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9131	U7	U5			Physical Therapy; Home per diem Agency Model (Non-SPW)	1 hour = 1 unit
S9131	U3	U3			Physical Therapy; Home per diem Agency Model (SPW)	1 hour = 1 unit
S9131	U3	99	99	UC	Physical Therapy; Home per diem Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S9131	U3	99	99	US	Physical Therapy; Home per diem Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit
S9128	U7	U5			Speech Therapy in the Home per diem Agency Model (Non-SPW)	1 hour = 1 unit
S9128	U3	U3			Speech Therapy in the Home per diem Agency Model (SPW)	1 hour = 1 unit

LTSS Billing Codes

Physical, Occupational, Speech Therapy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9128	U3	99	99	UC	Speech Therapy in the Home per diem Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S9128	U3	99	99	US	Speech Therapy in the Home per diem Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit
S9129	U7	U5			Occupational Therapy: Home per diem Agency Model (Non-SPW)	1 hour = 1 unit
S9129	U3	U3			Occupational Therapy: Home per diem Agency Model (SPW)	1 hour = 1 unit
S9129	U3	99	99	UC	Occupational Therapy: Home per diem Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S9129	U3	99	99	US	Occupational Therapy: Home per diem Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Prescribed Pediatric Extended Care (PPEC)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1025					Prescribed pediatric extended care, greater than 4 hours	4.25 hours or more = 1 unit
T1026					Prescribed pediatric extended care, up to 4 hours	1 hour = 1 unit
T2002					Non-emergency transportation	1 day = 1 unit

LTSS Billing Codes

Residential Care/Assisted Living

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	99	U8	U1	U1	Assisted Living Apartment -- Single Occupancy (one day) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	99	U7	U1	U1	Assisted Living Apartment -- Single Occupancy (one day) Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	99	U6	U1	U1	Assisted Living Apartment -- Single Occupancy (one day) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	99	U5	U1	U1	Assisted Living Apartment -- Single Occupancy (one day) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	99	U4	U1	U1	Assisted Living Apartment -- Single Occupancy (one day) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	99	U3	U1	U1	Assisted Living Apartment -- Single Occupancy (one day)Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Residential Care/Assisted Living

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	99	U8	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	99	U7	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	99	U6	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	99	U5	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	99	U4	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	99	U3	U2	U1	Residential Care Apartment -- Double Occupancy (one day) Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Residential Care/Assisted Living

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	99	U8	U2	U2	Residential Care -- Non-Apartment (one day) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	99	U7	U2	U2	Residential Care -- Non-Apartment (one day) Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	99	U6	U2	U2	Residential Care -- Non-Apartment (one day) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	99	U5	U2	U2	Residential Care -- Non-Apartment (one day) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	99	U4	U2	U2	Residential Care -- Non-Apartment (one day) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	99	U3	U2	U2	Residential Care -- Non-Apartment (one day) Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5151					Respite Care --Nursing Facility	1 day = 1 unit
S5151	99	U3			Respite Care -- Adult Foster Care (Level 1)	1 day = 1 unit
S5151	99	U4			Respite Care -- Adult Foster Care (Level 2)	1 day = 1 unit
S5151	99	U5			Respite Care -- Adult Foster Care (Level 3)	1 day = 1 unit

Please note: Effective September 1, 2019, S5151 will change to T1005 and must be billed in 15 minute increments.

LTSS Billing Codes

Respite Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5151	99	U8	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	99	U7	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	99	U6	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	99	U5	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	99	U4	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	99	U3	U1	U1	Respite Care -- Assisted Living Apartment (Single Occupancy) Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5151	99	U8	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	99	U7	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	99	U6	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	99	U5	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	99	U4	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	99	U3	U2	U1	Respite Care -- Residential Care Apartment (Double Occupancy) Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5151	99	U8	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	99	U7	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	99	U6	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	99	U5	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	99	U4	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	99	U3	U2	U2	Respite Care -- Residential Care (Non-Apartment) Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5151	U3	U3			Respite Care -- In-Home	1 hour = 1unit
S5151	U3	99	99	UC	Respite Care -- Consumer Directed Services (CDS) (SPW)	1 hour = 1unit
S5151	U3	99	99	US	Respite Care -- SPW, Service Responsibility Option (SRO) (SPW)	1 hour = 1unit

LTSS Billing Codes

Skilled Nursing

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9123	U3	U3			Nursing Services -- RN (1 visit) Nursing Care in the Home by RN Agency Option (AO) (SPW)	1 hour = 1 unit
S9123	U3	99	99	UC	Nursing Services -- RN (1 visit) Nursing Care in the Home by RN Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S9123	U3	99	99	US	Nursing Services -- RN (1 visit) Nursing Care in the Home by RN Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit
T1001					Nursing assessment/evaluation	1 visit = 1 unit
S9124	U3	U3			Nursing Services -- LVN (1 visit) Nursing Care in Home by LVN Agency Option (AO) (SPW)	1 hour = 1 unit
S9124	U3	99	99	UC	Nursing Services -- LVN (1 visit) Nursing Care in Home by LVN Consumer Directed Services (CDS) (SPW)	1 hour = 1 unit
S9124	U3	99	99	US	Nursing Services -- LVN (1 visit) Nursing Care in Home by LVN Service Responsibility Option (SRO) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Transition Assistance Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2038					Transition assistance services	1 unit per service

Common Billing – Denials

The EOP provides the Denial Code and explanation. This is not an all inclusive list.

Denial Code	Definition
EXNB	Service is not a covered benefit of Texas Medicaid
EX18	Duplicate claim service
EXA1	Authorization not on file
EXK6	Service is the responsibility of Medicare
EXya	Denied after review of patients claim history
EX29	The time limit for filing has expired
EXMA	Provider Medicaid ID number not on file
EX46	This service is not covered
EX35	Benefit maximum has been reached
EXDV	Procedure is inappropriate for provider specialty
EXx3	Procedure code unbundled from global procedure code
EXx9	Procedure code pairs incidental, mutually exclusive or unbundled
EX86	Invalid deleted missing modifier
EXDX	Services for the diagnosis submitted are not covered
EXDZ	Service has exceeded the authorized limit
EXHT	No authorization on file for services billed

Common Billing Rejections

Rejection Code	Definition
06	The provider identification and tax identification numbers are either missing or do not match the records on file. [Hint: check for taxonomy code].
B7	Data not properly aligned within new claim form fields. Ensure updated practice management software/printer is utilized to support the submission of the new CMS 1500 (02/12) version.
09	Member not eligible for date of service.
08	Incomplete or invalid member information. Please verify the member information that was submitted on the claim. [If you feel the member information submitted is correct, you can contact provider services to ensure you have the correct id number or to verify member information].
RE	The claim(s) submitted was black and white or handwritten. Only claim forms that are printed in flint OCR red, J6983 (or exact match) ink are accepted as of 4/1/13. Please submit claims through the Centene web portal, electronic clearing house or correct paper form in accordance with the CMS guidelines.
15	Member not eligible for date of service; the provider identification and tax identification numbers are either missing or do not match the records on file.

This is not an all inclusive list. Rejections are not in Superior's system because the missing or invalid information prevents the system from recognizing the claim. EDI submissions will need to occur within 95 days of DOS but you can appeal a rejection in writing within 120 days from the date of the letter.

You do not receive an EOP with a rejection. You will receive a letter that details the rejection reason.

Clean Claim

- 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.
  - 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.
- 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.

PaySpan Health

- Superior has partnered with PaySpan Health to offer expanded claim payment services:
  - Electronic Claim Payments (EFT)
  - Online remittance advices (Electronic Remittance Advices [ERAs]/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
  - Practice Management or Patient Accounting System
- Register at: www.PaySpanhealth.com.
- For further information:
  - Call PaySpan at 1-877-331-7154.
  - E-mail: ProvidersSupport@Payspanhealth.com.
  - Call Superior's Provider Services at 1-877-391-5921.

Explanation of Payment

- Paper EOP (through Emdeon)
- ERA/835 - Electronic Remittance Advice
  - PaySpan (EFT and ERA)
  - Providers may be set up to receive through their clearinghouse/trading partners (and still receive a paper check).

EFT or Paper Check

- Providers will receive a paper check unless they are signed up for EFT through PaySpan.
- A provider can submit claims on paper and still enroll for EFT/ERA. A provider that likes their EDI vendor can still go through his or her vendor.
- We simply divert the return file – aka the ERA (835) – through PaySpan.
- Some providers will ask for ERA (835) to be sent through their clearinghouse as well as PaySpan. This requires special permission from health plan leadership or corporate as it entails an additional cost.

Superior's Secure Provider Portal

Submitting Claims

Superior's Secure Provider Portal

Superior is committed to providing all of the tools, resources and support providers need to be ensure business transactions with Superior are as smooth as possible. One of the most valuable tools is Superior's Secure Provider Portal. Once registered, providers gain access to the full site.

Secure Provider Portal:

- Provides up-to-date member eligibility and Service Coordinator assignment.
- Secure claim submission portal to submit claims at no cost.
- Provides a claim wizard tool that walks through filling in a claim to submit online.
- Provides claim status and payment information.
- Allows providers to request and check the status of an acute care authorization.

Superior's Website

SuperiorHealthPlan.com

- Contains Provider Directories and online lookup.
- Features a map where providers can easily identify the office of the field Account Manager assigned to them.
- Contains an archive of Provider Manuals, newsletters, bulletins, forms and important links to keep providers up to date on any new changes that may affect them.

Registration

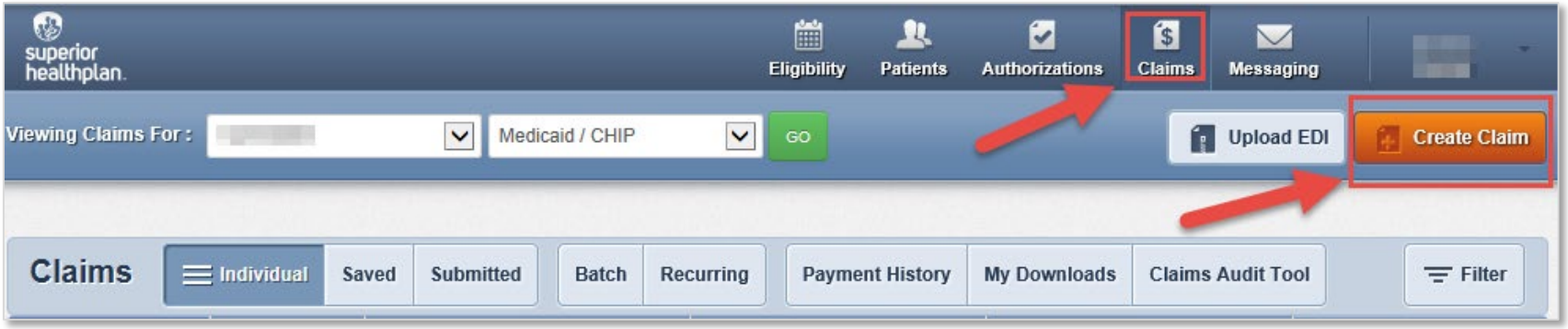
To register, visit: Provider.SuperiorHealthPlan.com.

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

Create Professional Claims

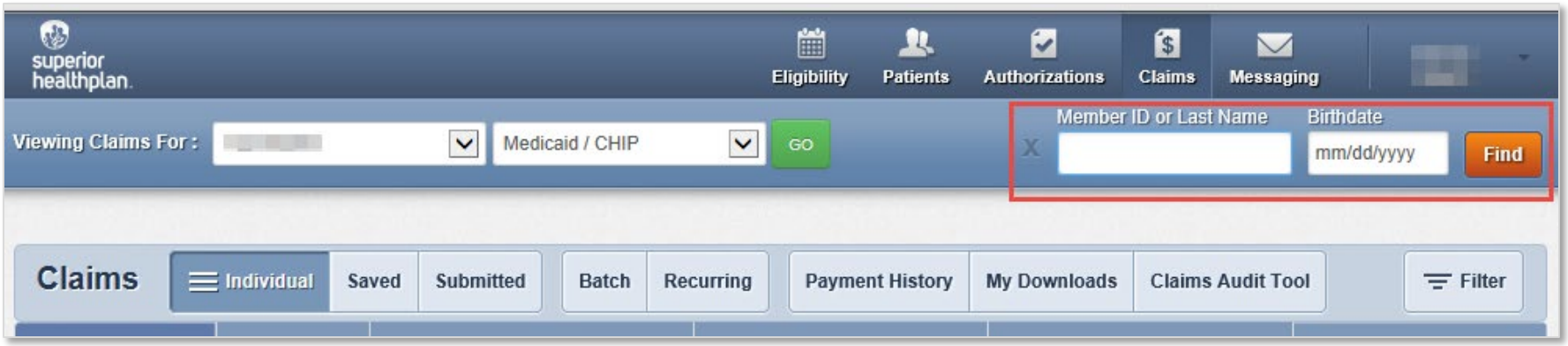
From the **Navigation Menu**:

- Select **Claims** at the top of the landing page.
- Then select **Create Claim**.



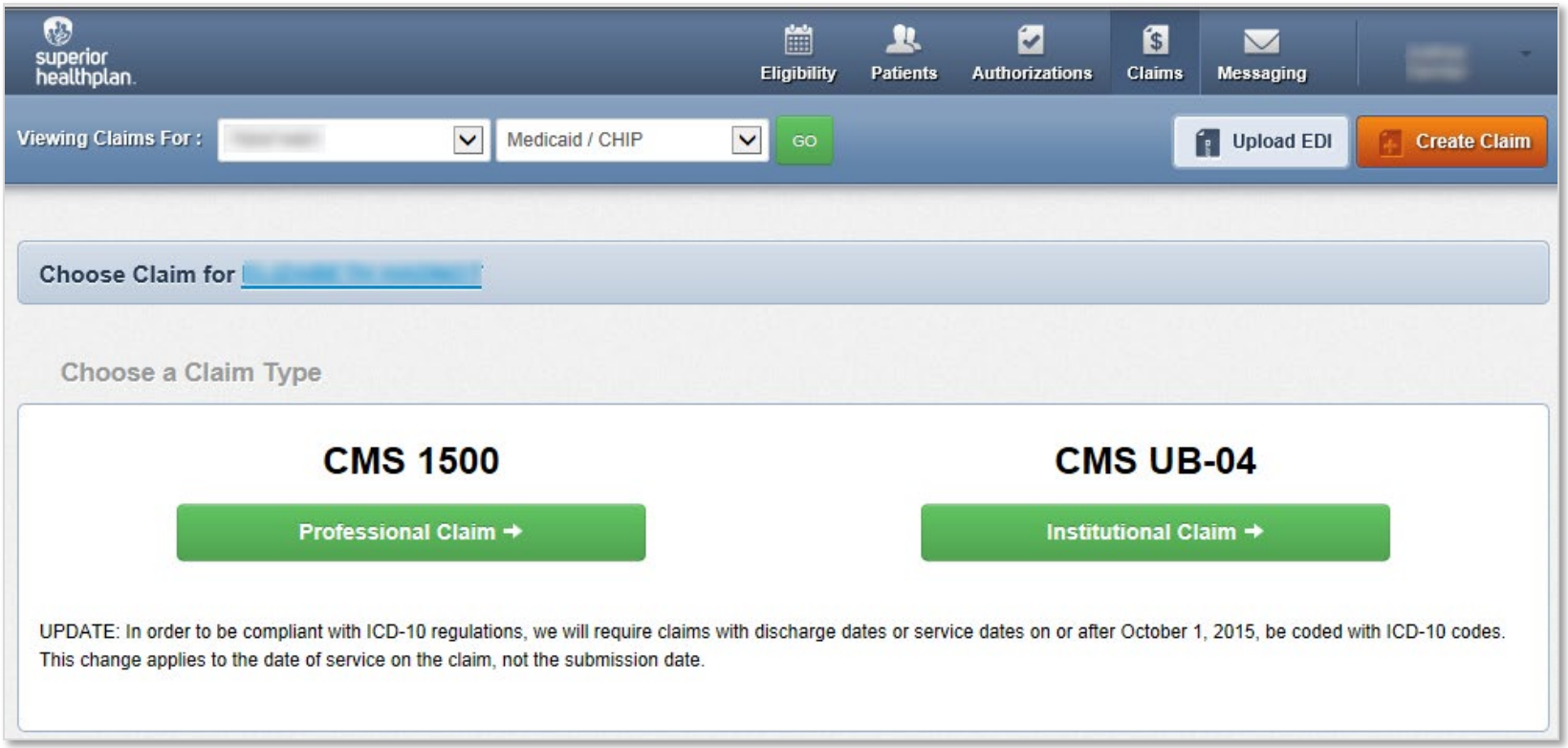
Create Professional Claims

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



Create Professional Claims

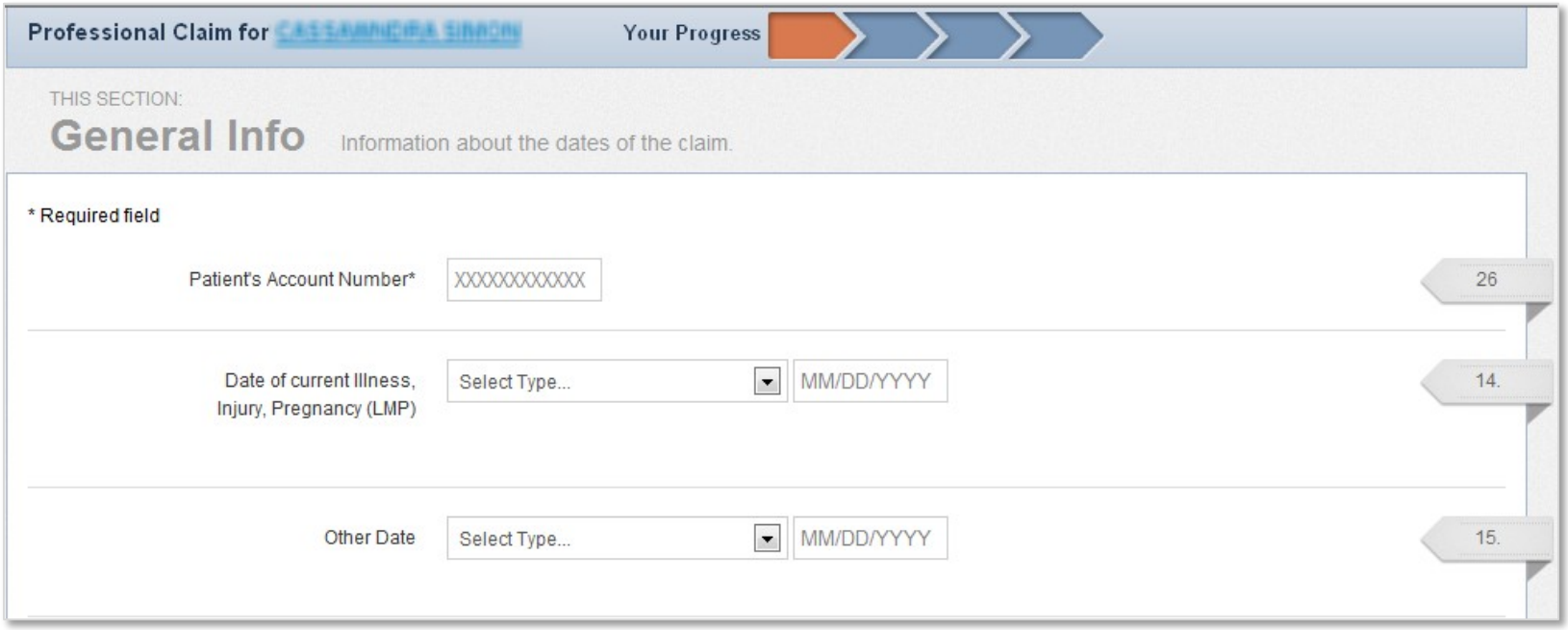
- **Choose a Claim Type**.
- Select **Professional Claim**.



General Information

*** = required**

- Enter **Patient Account Number**
  Note: This is the internal patient account number assigned by servicing provider.

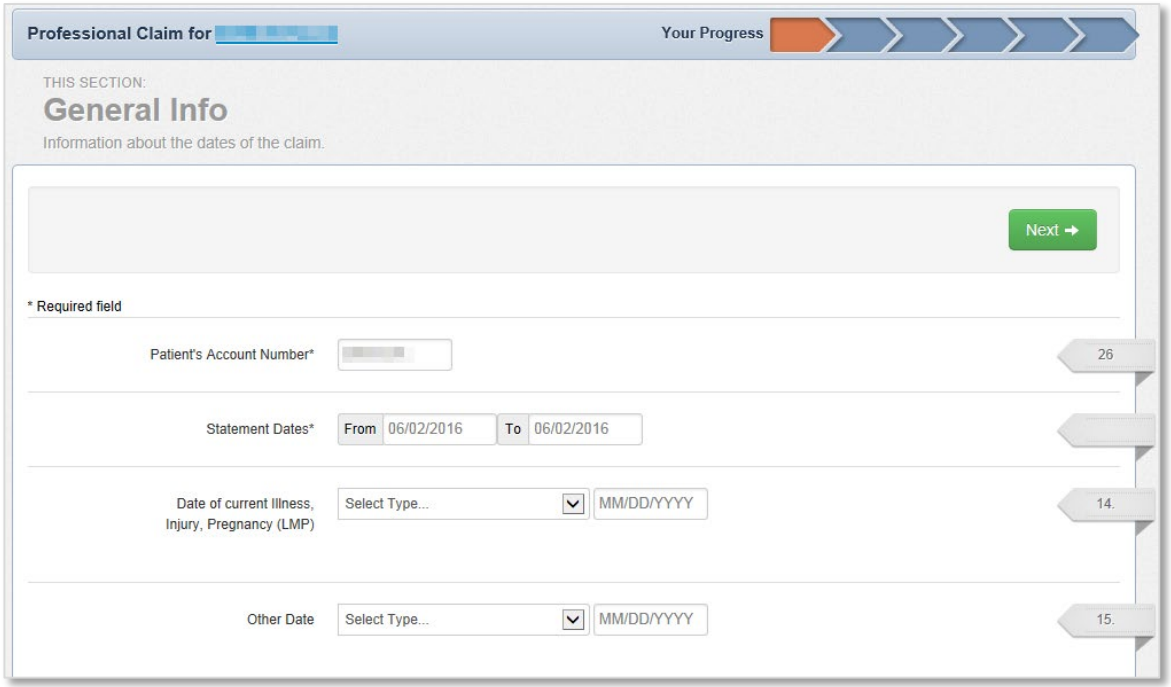


General Information

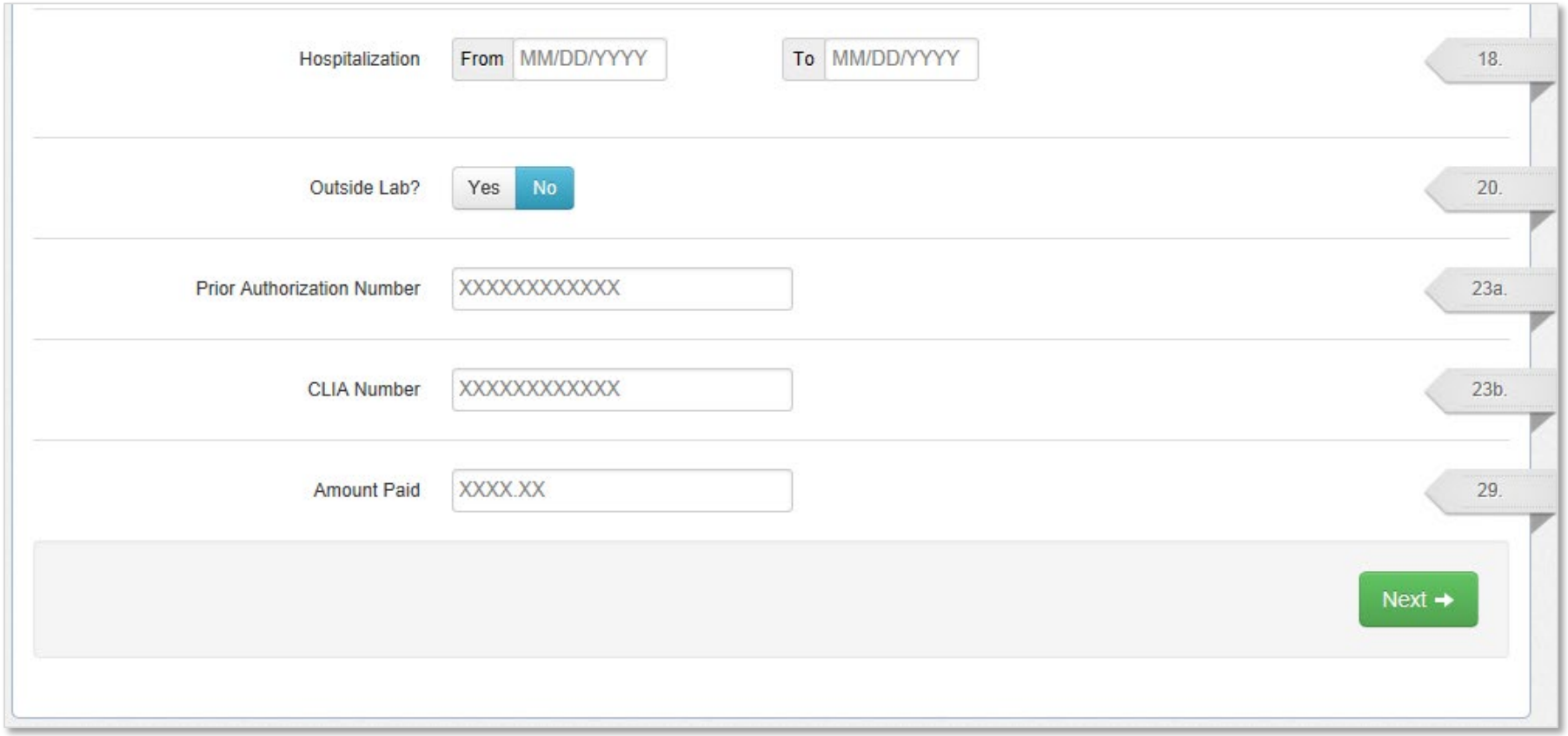
*** = required**

- Enter **Patient Account Number**

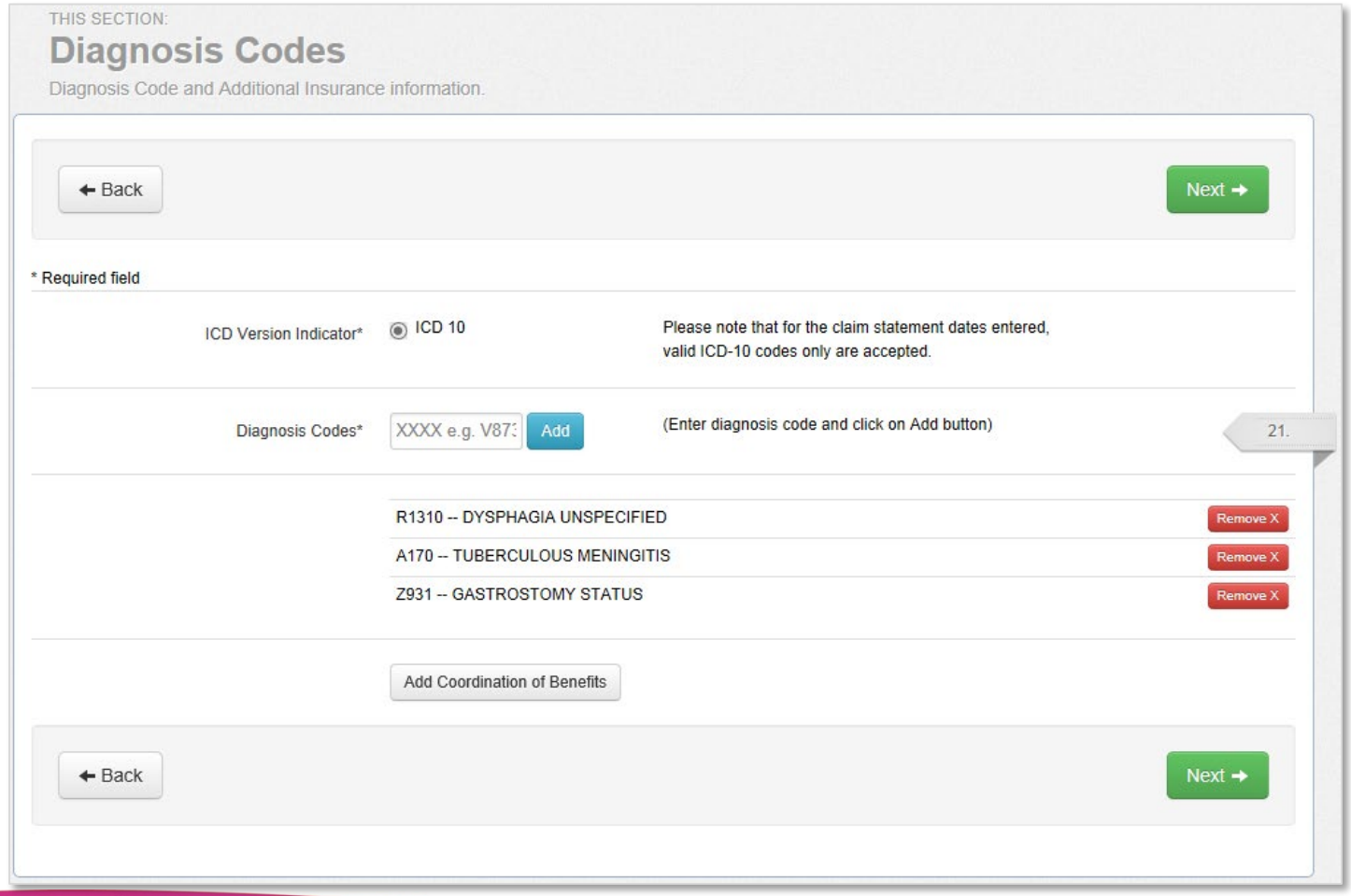
Note: This is the internal patient account number assigned by servicing provider.



General Information

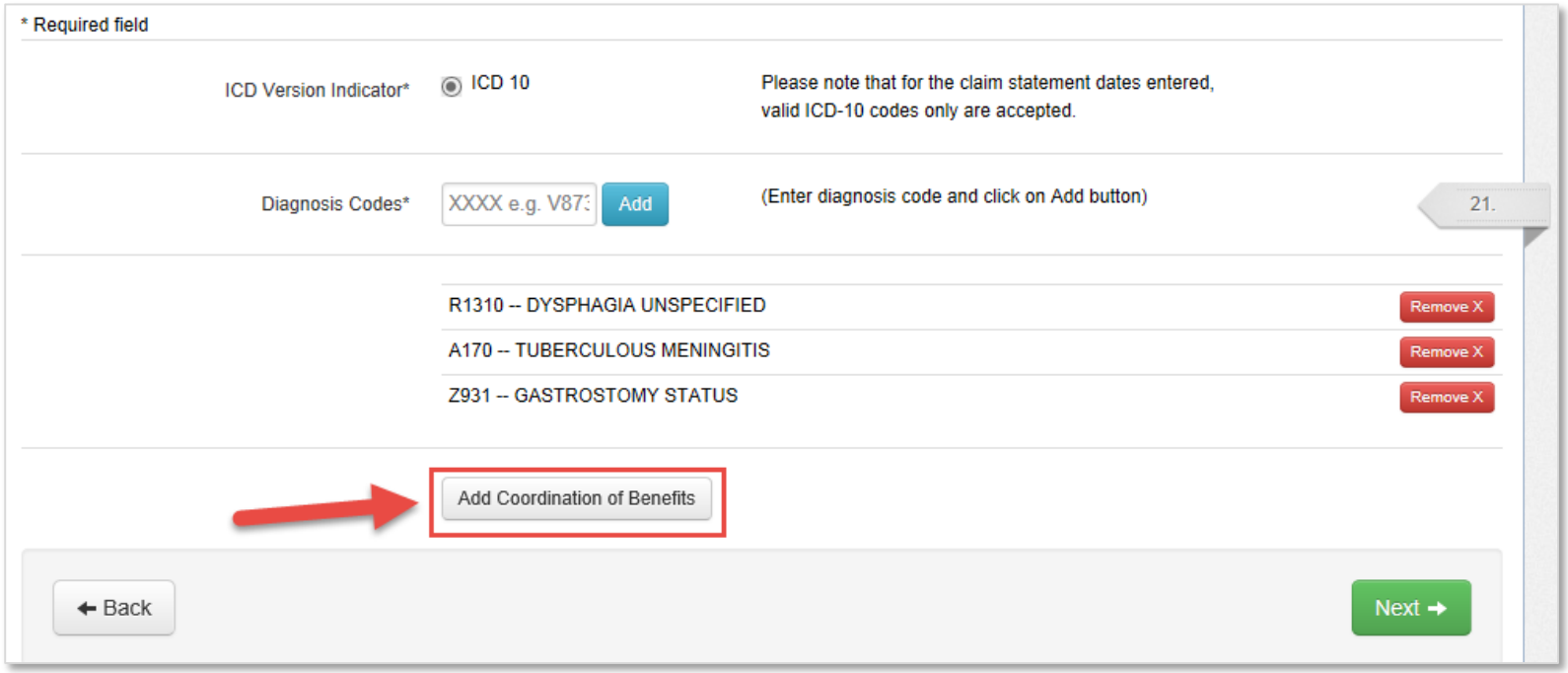


Diagnosis Codes



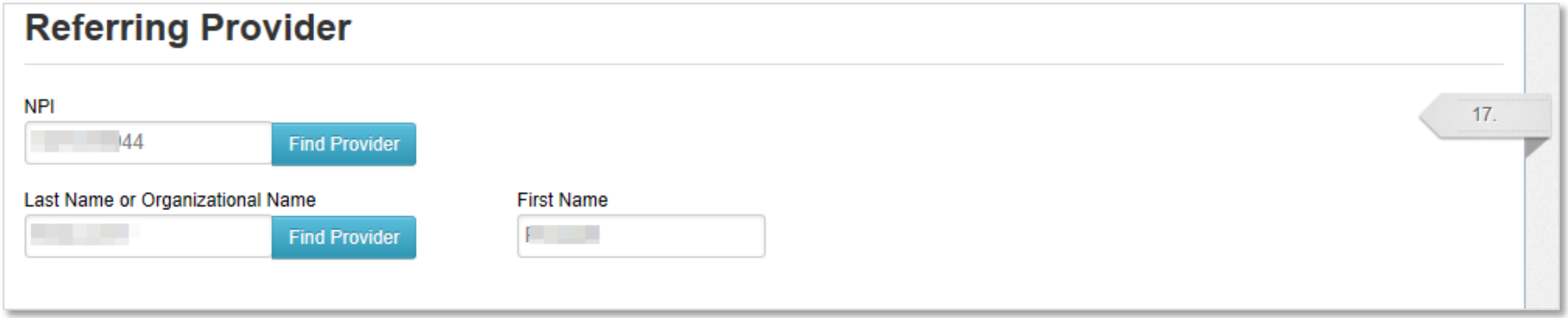
Coordination of Benefits

- If applicable, select **Coordination of Benefits.**



Referring Provider

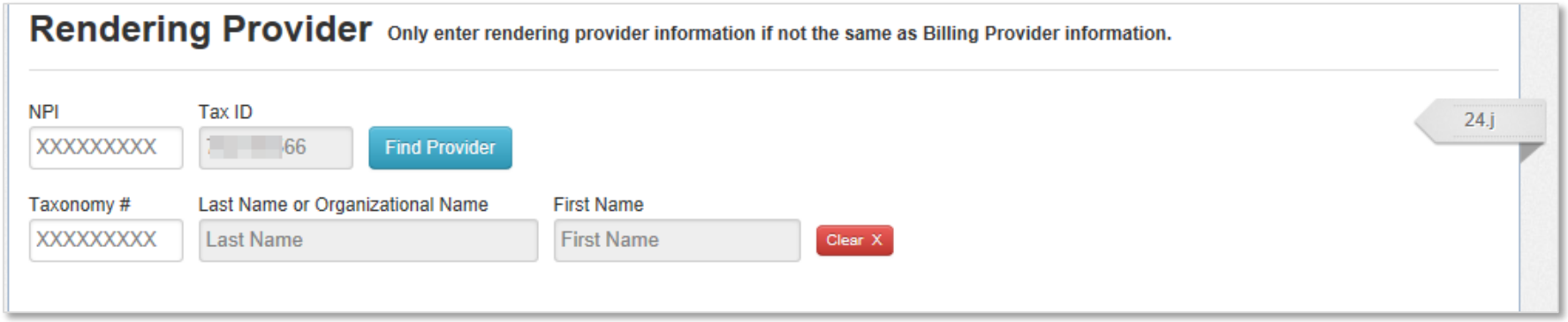
- In the **Referring Provider** section, enter information as needed.



Rendering Provider Section

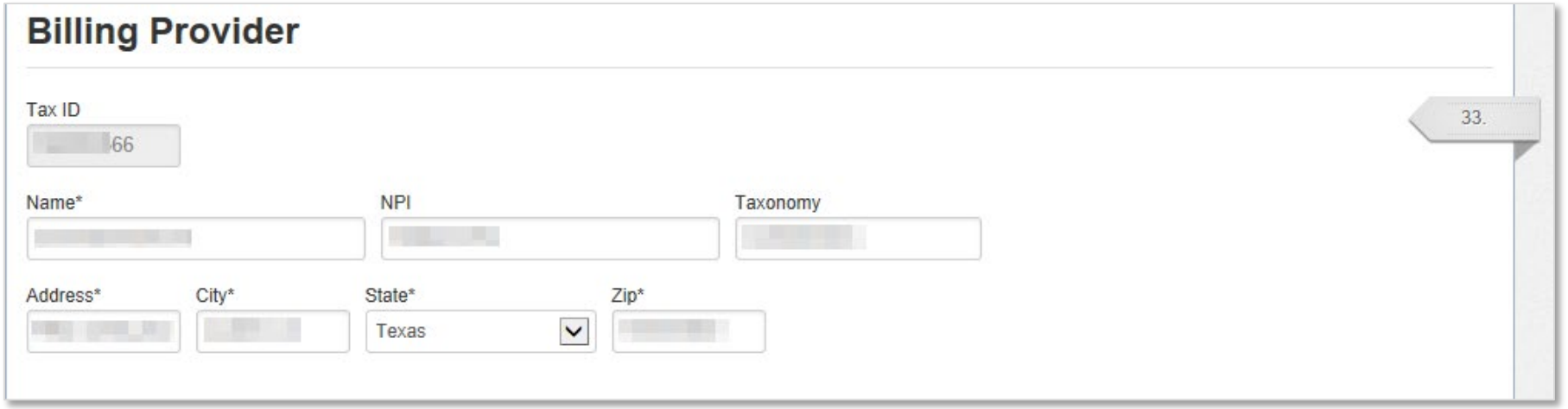
- In the **Rendering Provider** section:
  - Enter your **NPI** number.
  - Select the provider info from the drop-down list associated with your location and taxonomy code.

Note: Only enter rendering provider information if not the same as billing provider information.



Billing Provider Section

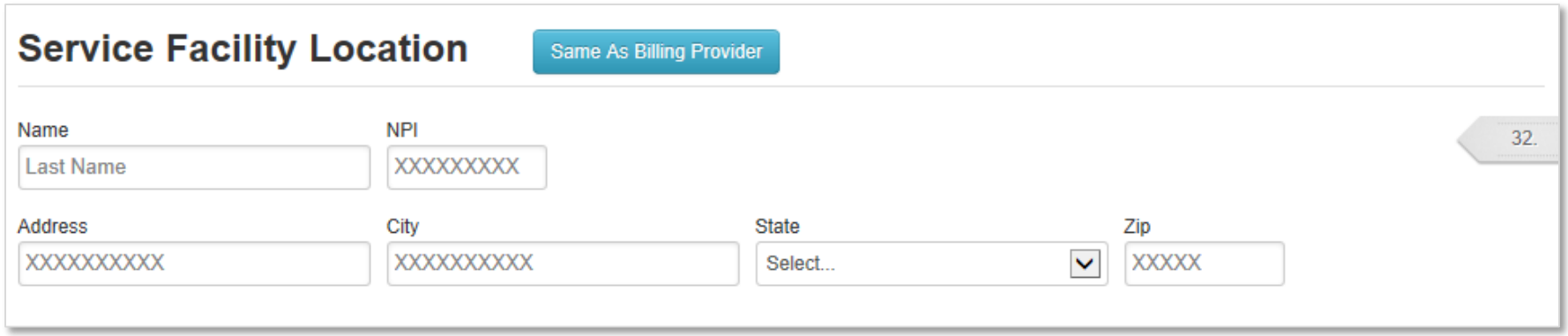
- In the **Billing Provider** section, enter the required information.



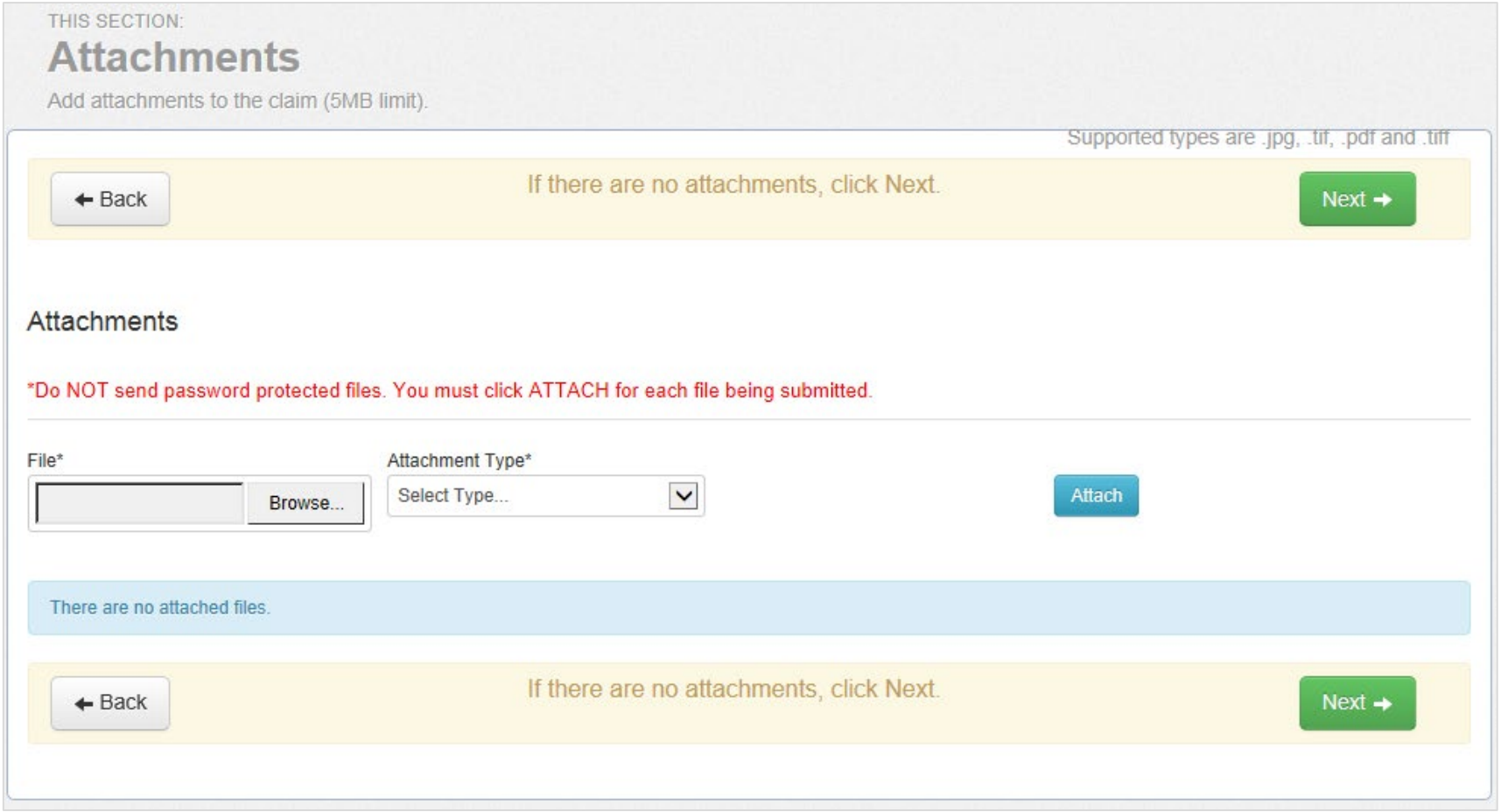
Service Facility Location Section

- In the **Service Facility Location** section, enter information as needed. Click **Same as Billing Provider** to automatically copy the billing provider information into the service facility fields.

- Click the **Next** button.



Attachment Section

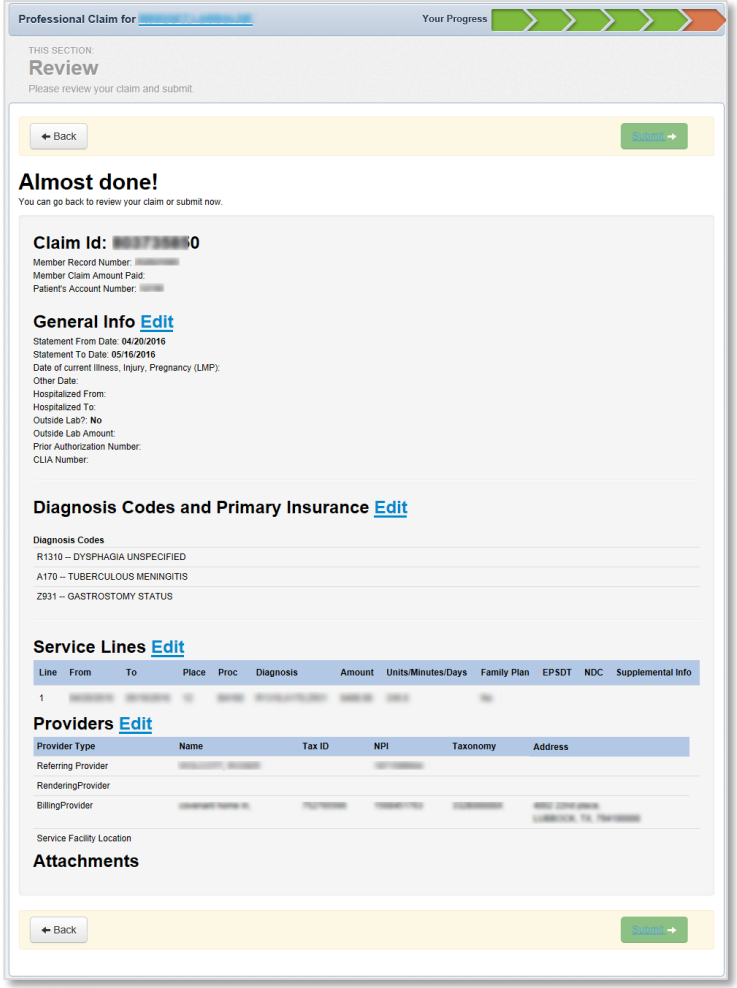


Review and Submit

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.

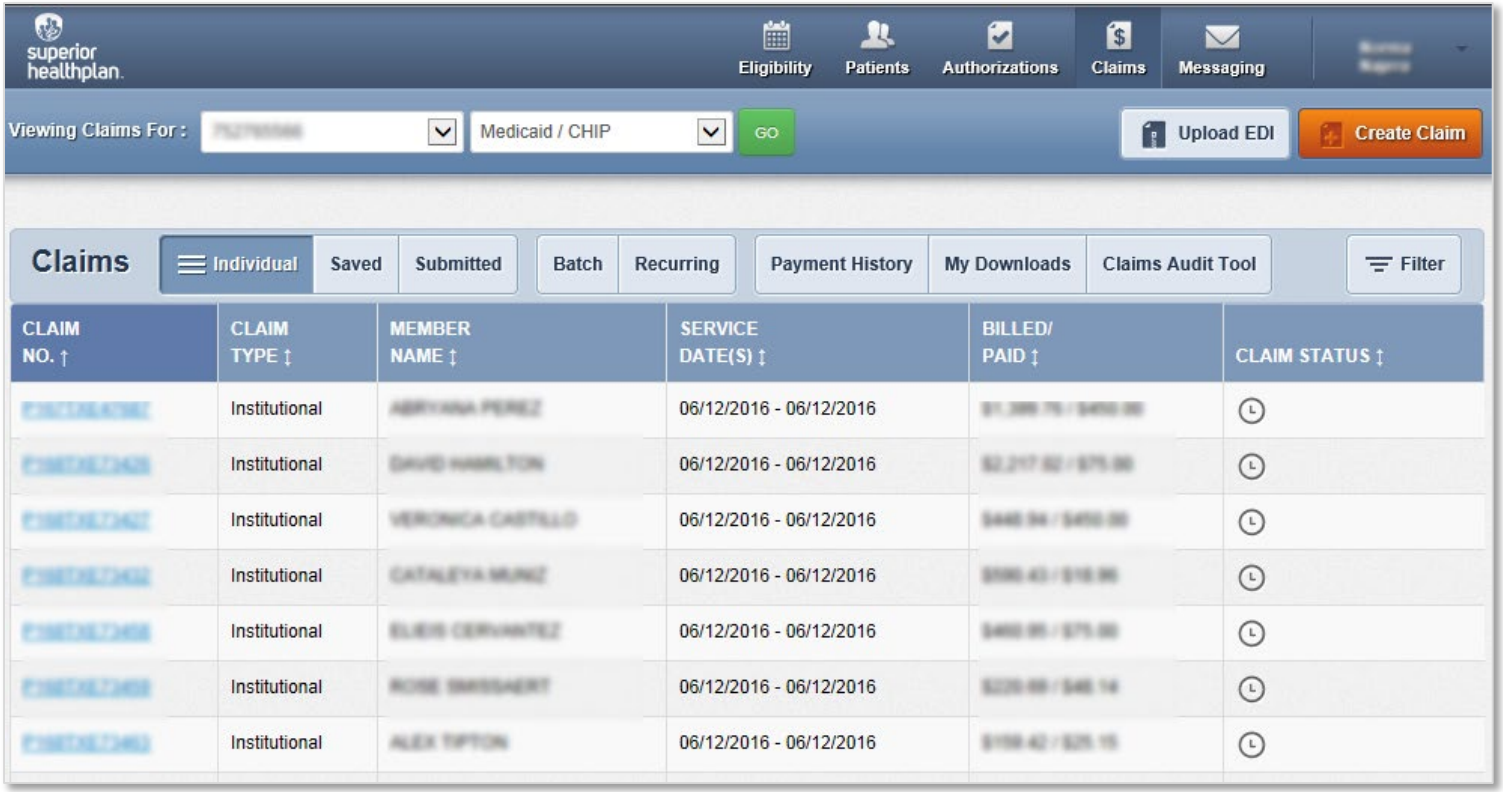


Claim Submitted Successfully

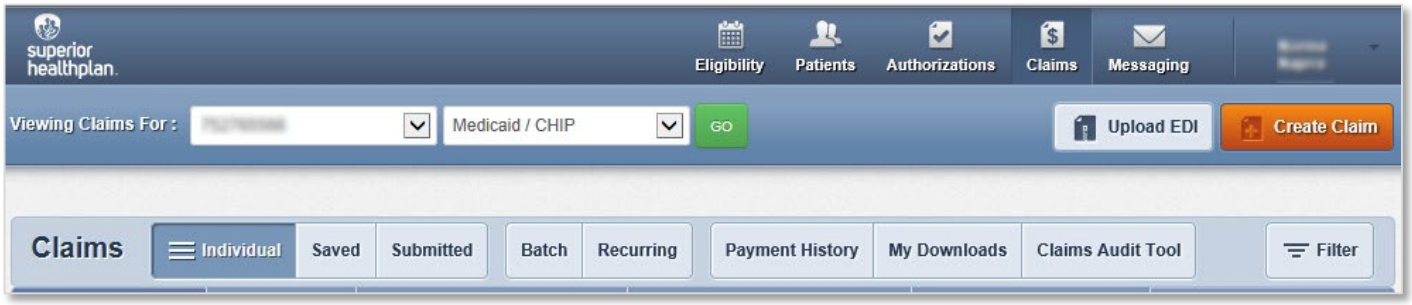
- Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Account Manager.

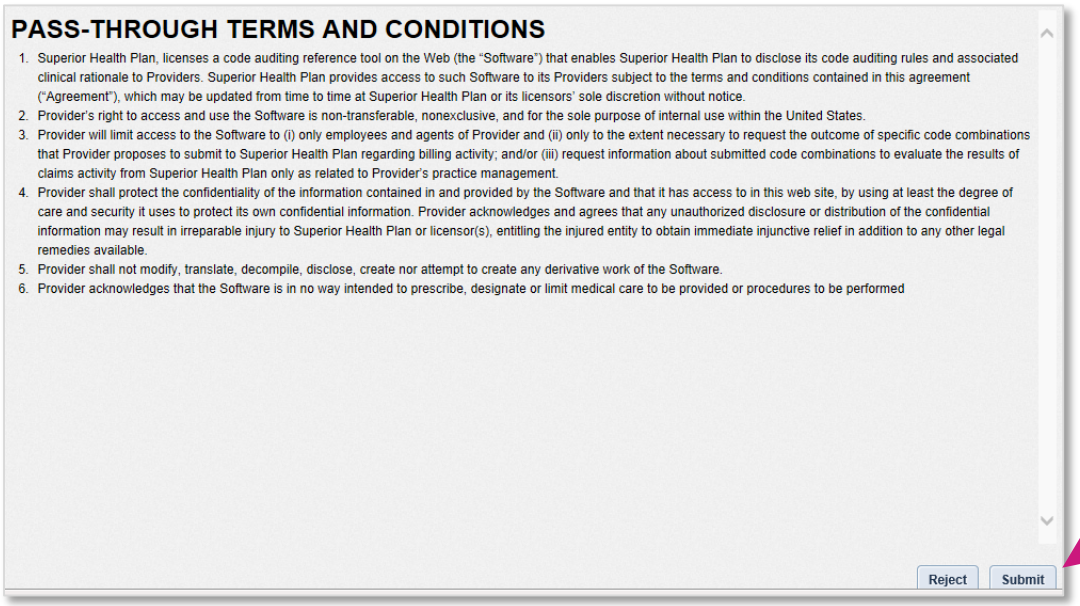
Checking Claim Status

- Claims status can be viewed on claims that have been sent via EDI, paper or Secure Provider Portal.

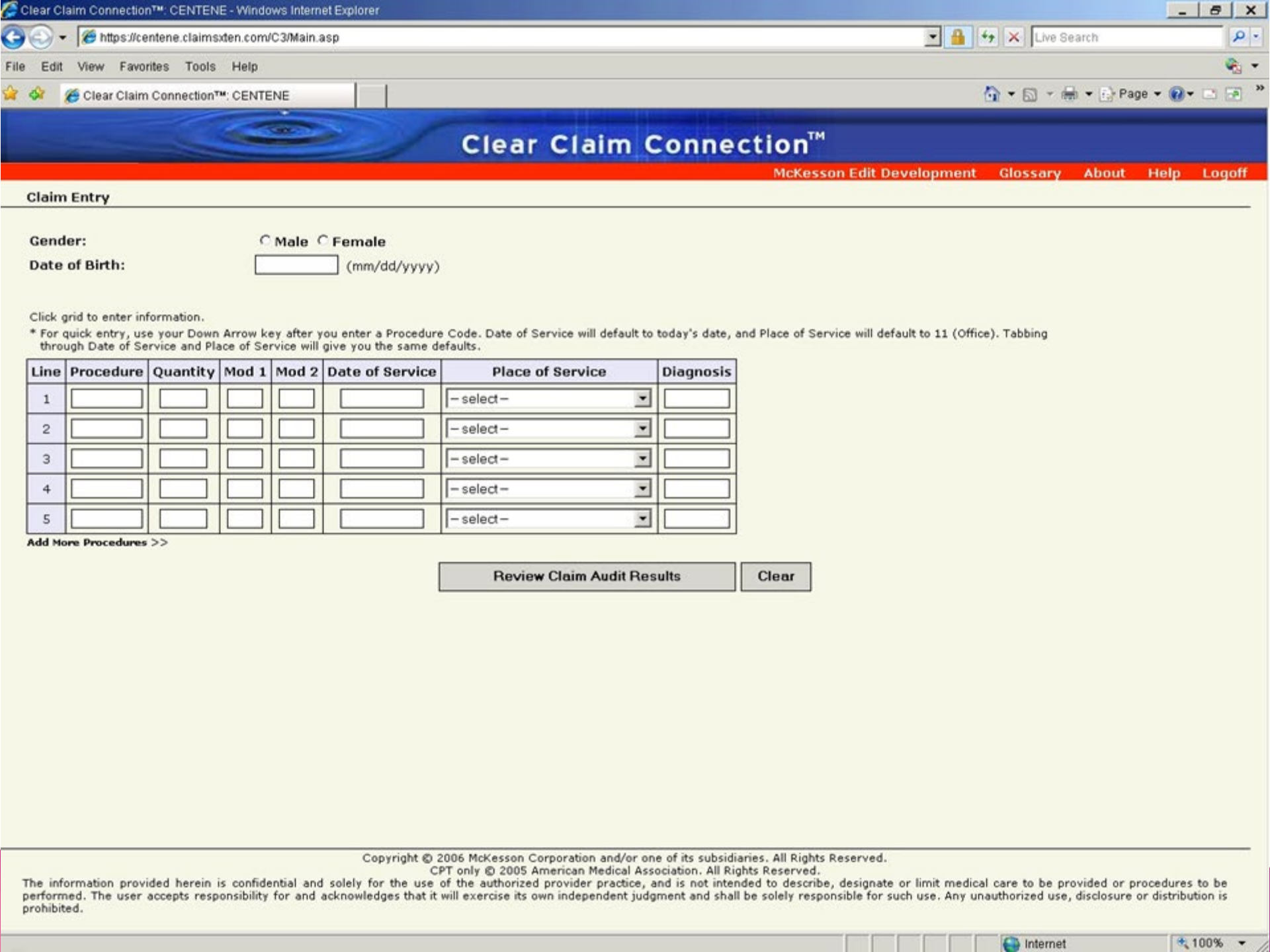


Checking Claim Status





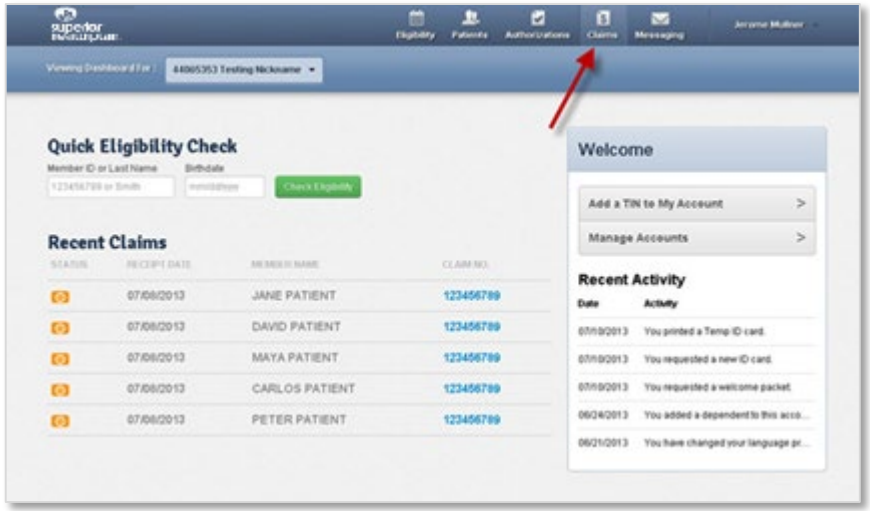
- Select the **Claims Audit Tool.**
- Click **Submit** to enter **Clear Claim Connection** Page.

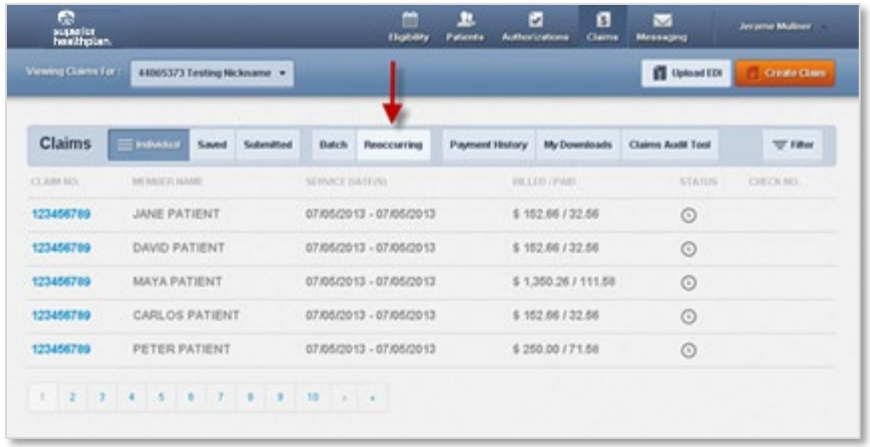

Clear Claim Connection™: CENTENE - Windows Internet Explorer
https://centene.claimsxten.com/C3/Main.asp
Live Search
File Edit View Favorites Tools Help
Clear Claim Connection™: CENTENE
Page
Clear Claim Connection™
McKesson Edit Development Glossary About Help Logoff
Claim Entry
Gender: Male Female
Date of Birth: (mm/dd/yyyy)
Click grid to enter information.
* For quick entry, use your Down Arrow key after you enter a Procedure Code. Date of Service will default to today's date, and Place of Service will default to 11 (Office). Tabbing through Date of Service and Place of Service will give you the same defaults.
Line Procedure Quantity Mod 1 Mod 2 Date of Service Place of Service Diagnosis
1 – select –
2 – select –
3 – select –
4 – select –
5 – select –
Add More Procedures >>
Review Claim Audit Results
Clear
Copyright © 2006 McKesson Corporation and/or one of its subsidiaries. All Rights Reserved.
CPT only © 2005 American Medical Association. All Rights Reserved.
The information provided herein is confidential and solely for the use of the authorized provider practice, and is not intended to describe, designate or limit medical care to be provided or procedures to be performed. The user accepts responsibility for and acknowledges that it will exercise its own independent judgment and shall be solely responsible for such use. Any unauthorized use, disclosure or distribution is prohibited.
Internet
100%

Create Recurring Claims

To create LTSS claims using the **Multiple Claim Submission Wizard**:

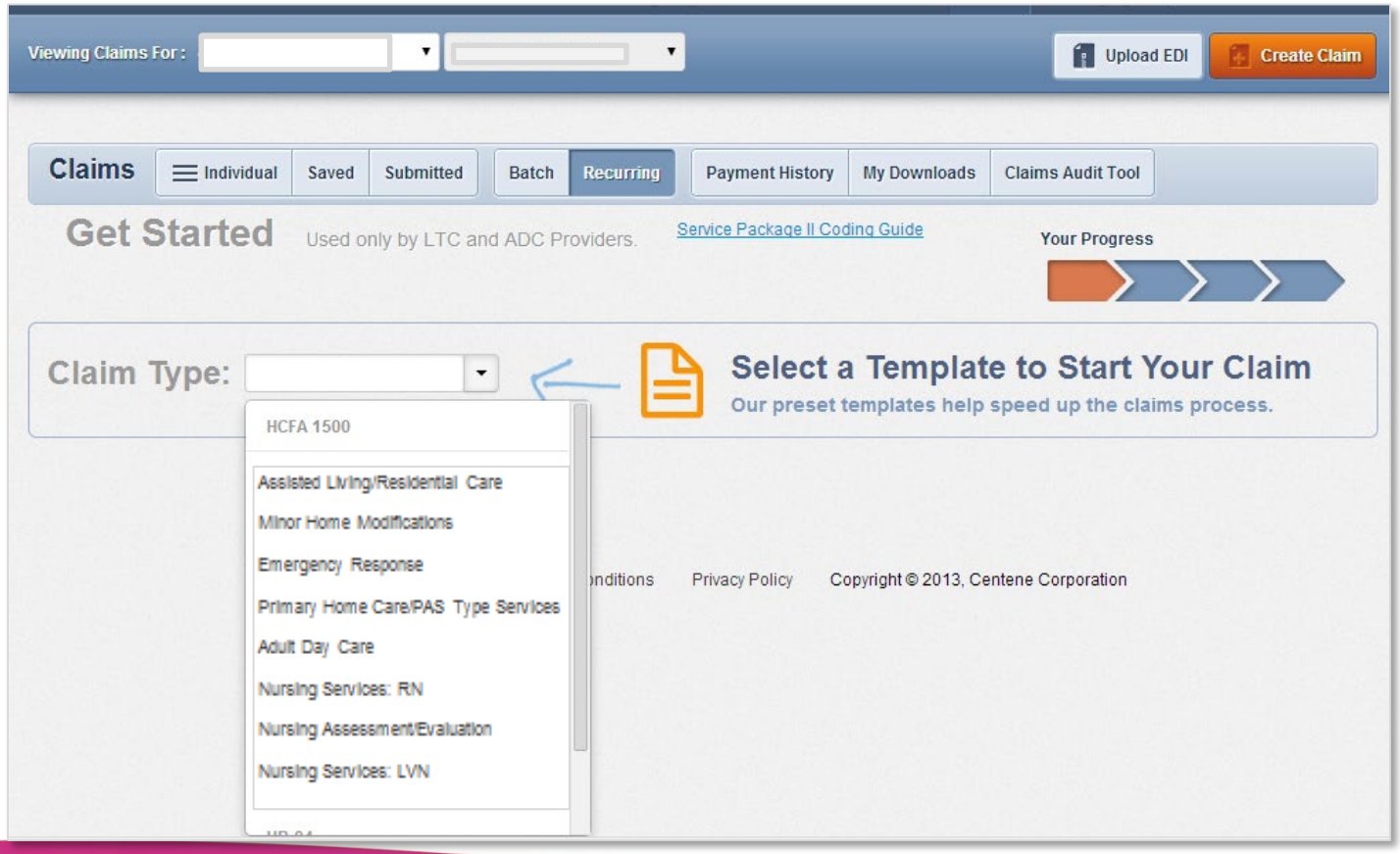
- Click on **Claims** tab
- Then click on **Reoccurring** tab.





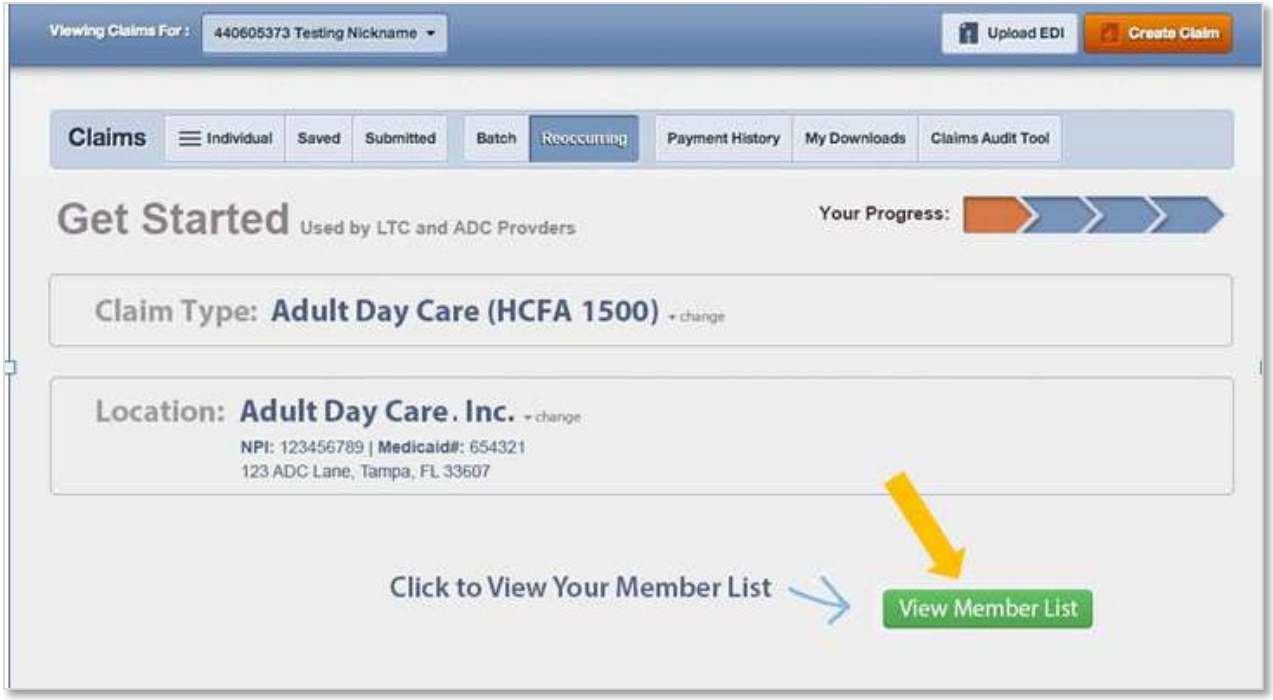
Create Recurring Claims

Select **Select a Template to Start Your Claim** from the drop-down.



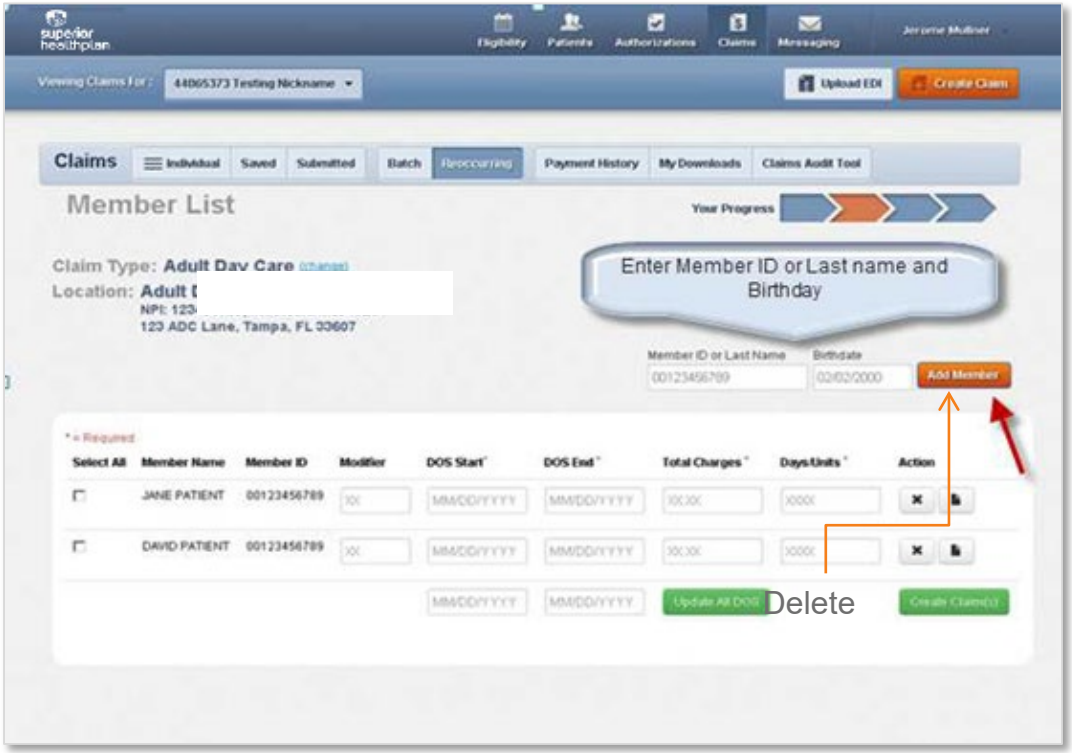
Create Recurring Claims

Click on **View Your Member List**. Member Lists only need to be created once during your first time using the **Multiple Claims Wizard**.



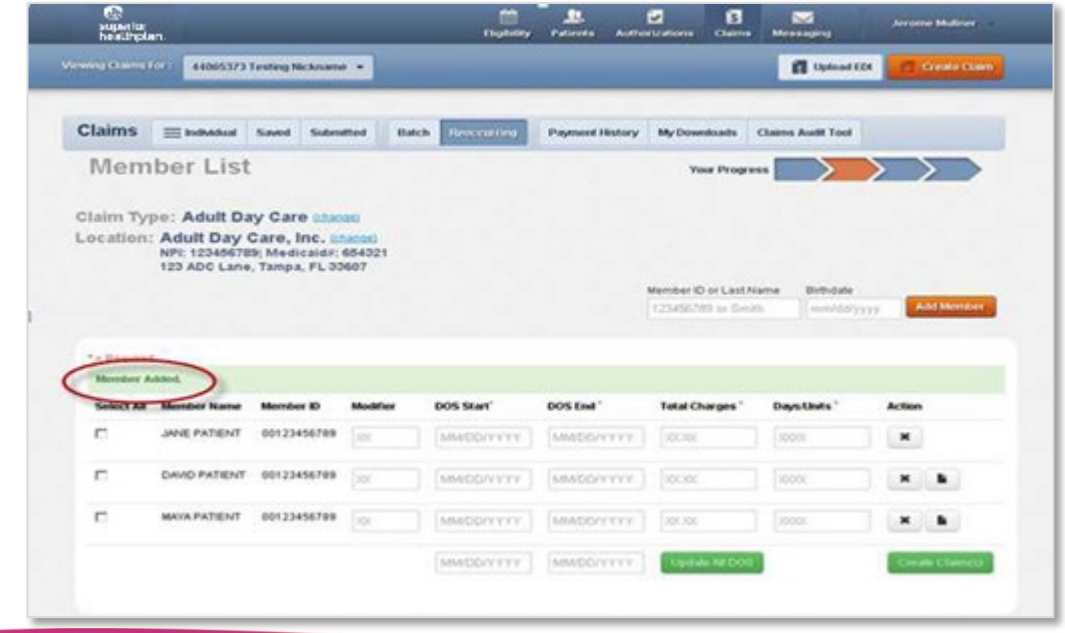
Create Recurring Claims

- Enter **Member ID** or **Last Name** and **Birthdate**. Member ID is the Medicaid ID on the Member ID card.



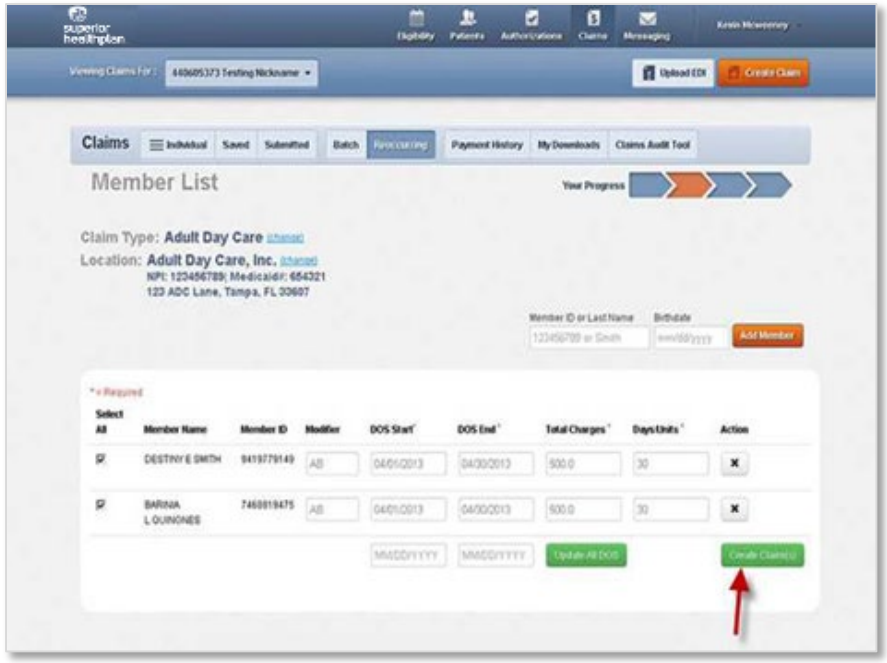
Create Recurring Claims

- 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 Claims

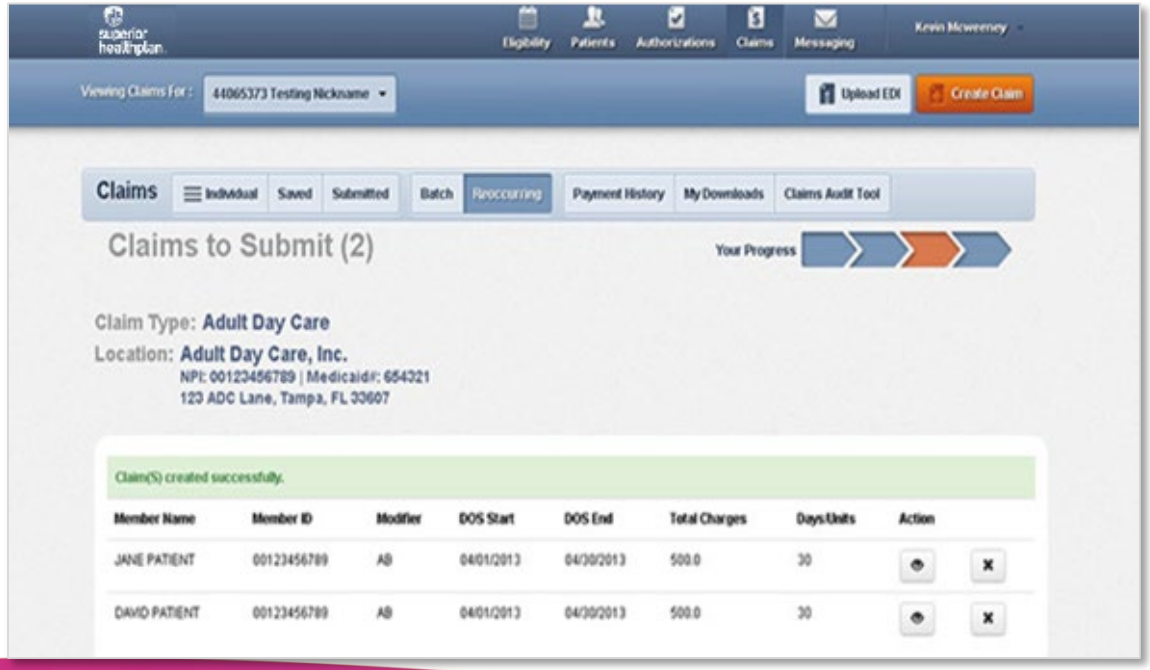
- Create claim(s) by selecting the appropriate member(s) from **Member List**.
- For each member selected enter the:
  - Bill Type
  - First date of service (DOS Start)
  - Last date of service (DOS End)
  - Rev Code (Revenue Code)
  - Serv Units (days or service units)
    - Note: Service Units must 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.



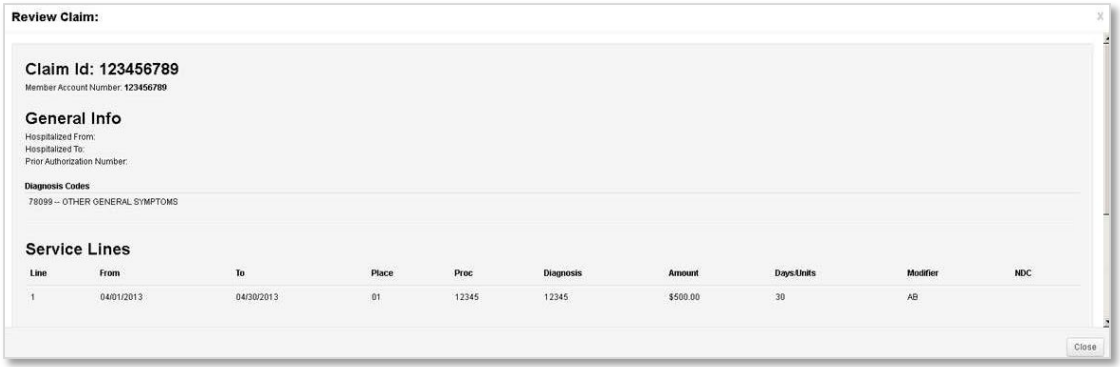
For additional details on required fields visit: https://www.dads.state.tx.us/Handbooks/sph/appendix/index.htm

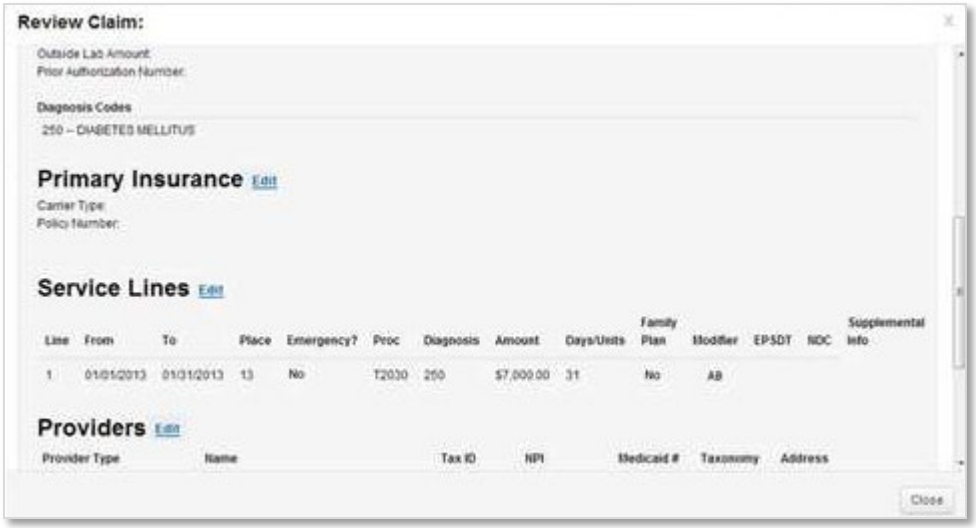
Create Recurring Claims

- You can review claims prior to submitting.
- To review click on the eye icon. 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.



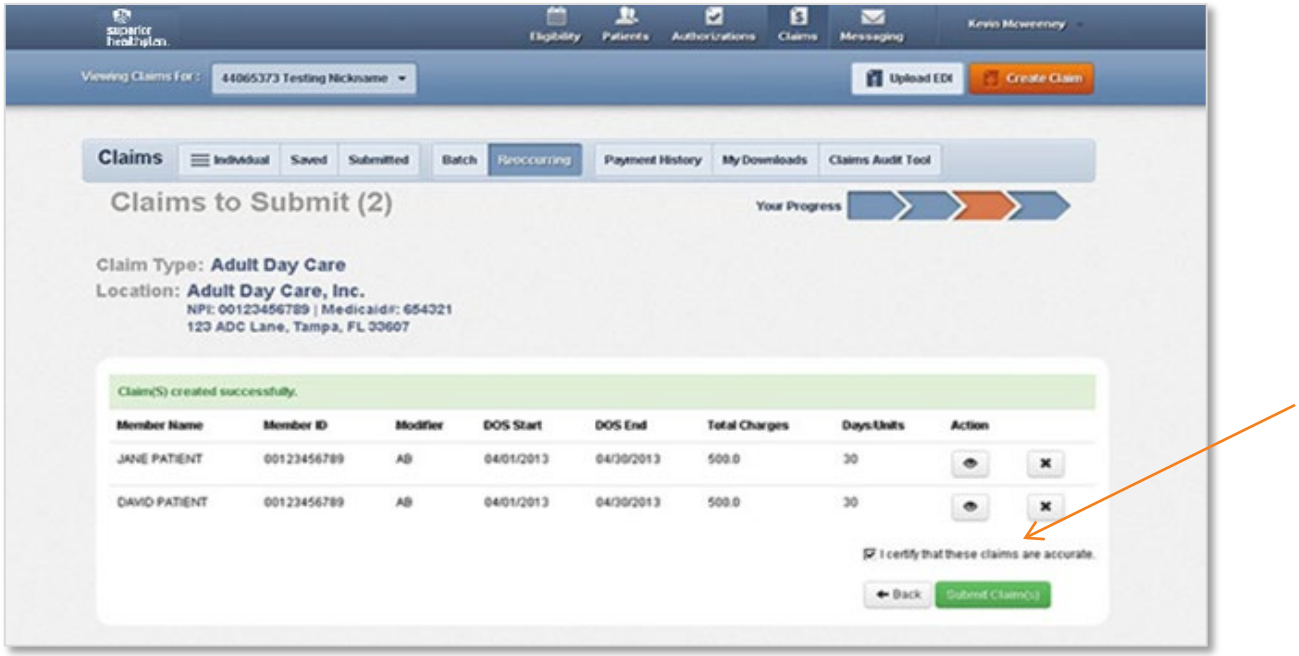
Create Recurring Claims





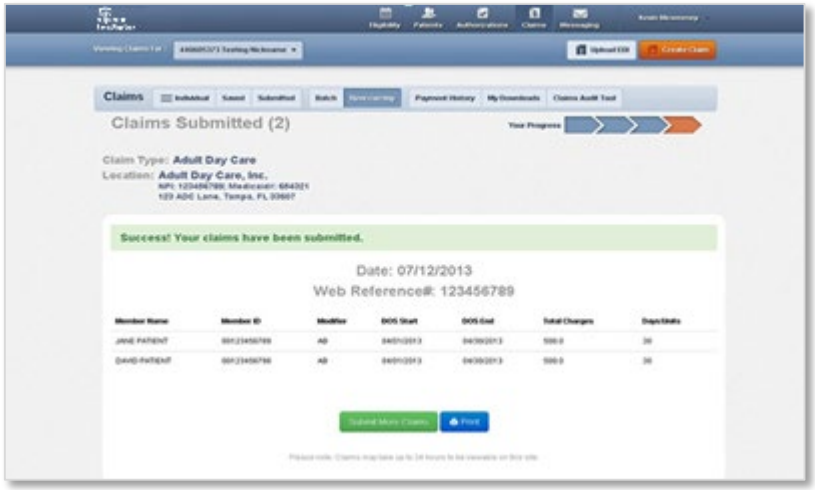
Create Recurring Claims

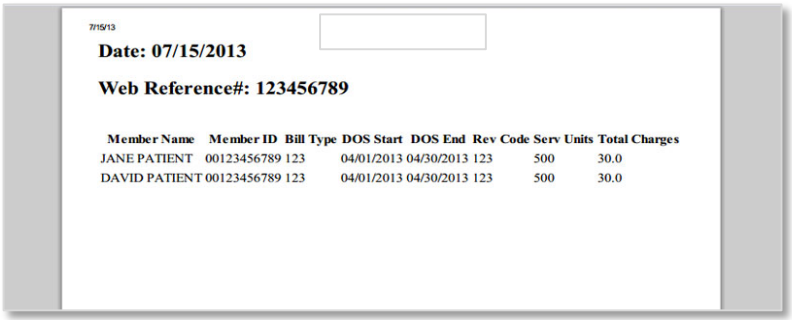
- After all the claims have been reviewed for accuracy, select **"I certify that these claims are accurate"** and click **Submit Claims**.



Create Recurring Claims

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





Superior HealthPlan Departments

We're here to help you!

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations.
  - Face-to-face Secure Provider 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 Account Manager on ~~https://~~www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html.

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 Member Services at 1-877-277-9772, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

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 Account Manager.
- 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 Provider Services at 1-877-391-5921, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

Provider Training

- Superior offers targeted billing presentations depending on the type of services you provide and bill for, such as:
  - Electronic Visit Verification (EVV), General Billing Clinics and product specific training on STAR+PLUS, STAR+PLUS MMP and STAR/CHIP.
- You can find the schedule for all of the training presentations on Superior's website at www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html.

Compliance

- Health Insurance Portability Accountability Act (HIPAA) of 1996
  - Providers and contractors are required to comply with HIPAA guidelines http://www.hhs.gov/ocr/privacy.
- Fraud, Waste and Abuse (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: 1-800-252-8011
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664
- For any compliance questions, you may also reach out to Provider Services at 1-877-391-5921.

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:
  - Submit Online: www.SuperiorHealthPlan.com/contact-us/complaint-hotline/complaint-form/
  - Form: www.SuperiorHealthPlan.com/files/2014/10/provider_complaint_form_10282014.pdf
- For assistance filing a complaint, please contact Provider Services at 1-877-391-5921.

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Questions and Answers