superior healthplan™

Billing Clinic

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

Provider Training

Introductions & Agenda

- Verifying Eligibility
- Authorization Process
- Establishing Medical Necessity (After an Adverse Determination)
- Claims Submissions
- Electronic Funds Transfer
- Superior HealthPlan Departments
- Secure Provider Portal
- FQHC & RHC Billing Information

Verifying Eligibility

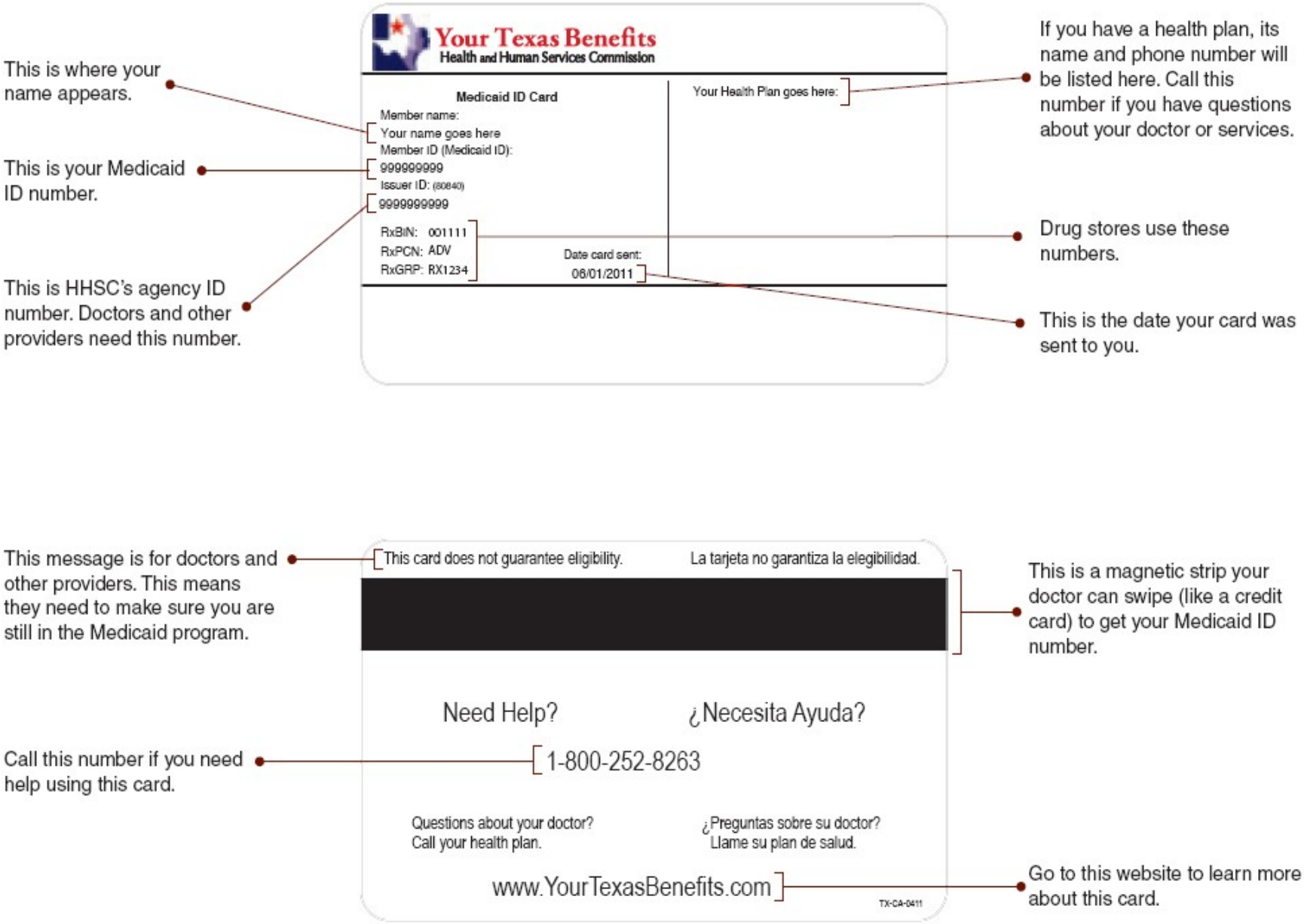
Correctly Identify a Member's Medicaid Plan

Verify Eligibility

- Texas Medicaid Benefit Card (TMBC)
  - TexMedConnect - http://www.TMHP.com/pages/edi/edi_texmedconnect.aspx.
- Superior Identification Card
- Superior Website: www.SuperiorHealthPlan.com.
- Contact Member Services:
  - STAR, CHIP: 1-800-783-5386
  - CHIP RSA: 1-800-820-5685
  - STAR Health: 1-866-912-6283
  - STAR+PLUS: 1-877-277-9772
  - STAR Kids: 1-844-590-4883
  - MRSA (Medicaid Rural Service Area): 1-877-644-4494
- Verify eligibility the first of each month using our website or by contacting Member Services.

Superior Member ID Cards

- The member ID cards contain the following information:
  - Member name
  - Primary Care Provider (except CHIP Perinate mother)
  - Prescription information
  - Program eligibility
  - Superior contact information
- Copies of sample member ID cards can be found in the Superior Provider Manual.


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.
Your Texas Benefits
Health and Human Services Commission
Medicaid ID Card
Member name:
Your name goes here
Member ID (Medicaid ID):
999999999
Issuer ID: (80840)
9999999999
RxBIN: 001111
RxPCN: ADV
RxGRP: RX1234
Your Health Plan goes here:
Date card sent:
06/01/2011
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 card does not guarantee eligibility.
La tarjeta no garantiza la elegibilidad.
This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.
Need Help?
¿Necesita Ayuda?
Call this number if you need help using this card.
1-800-252-8263
Questions about your doctor?
Call your health plan.
¿Preguntas sobre su doctor?
Llame su plan de salud.
www.YourTexasBenefits.com
TX-CA-0411
Go to this website to learn more about this card.

Authorization Process

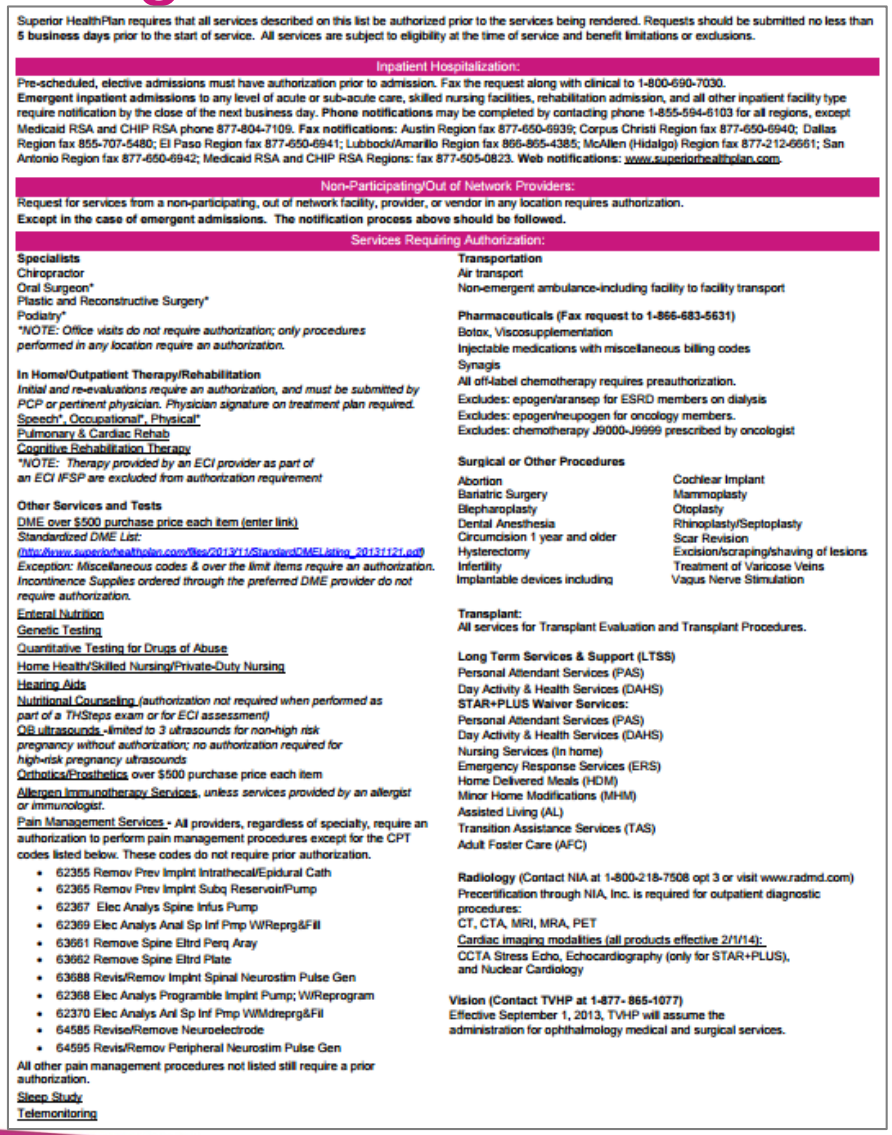
Ensure Proper Authorizations are in Place

Medical Management Authorizations

- Prescheduled elective admissions must have authorization prior to admission.
- All out of network services require an authorization.
- Initiate authorizations five (5) working days in advance for non-emergency services.
- Escalate requests to the Medical Management Supervisors or Managers, if needed.
- If additional documentation is requested from Medical Management, submit by fax or through the Superior website.
  www.SuperiorHealthPlan.com
  Phone: 1-800-218-7508
  Fax: 1-800-690-7030

Services Requiring Authorization

- The most current list of services requiring prior authorization are found on the Superior website under Provider Resources.



Superior HealthPlan requires that all services described on this list be authorized prior to the services being rendered. Requests should be submitted no less than **5 business days** prior to the start of service. All services are subject to eligibility at the time of service and benefit limitations or exclusions.

Inpatient Hospitalization:

Pre-scheduled, elective admissions must have authorization prior to admission. Fax the request along with clinical to 1-800-690-7030.
Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, and all other inpatient facility type require notification by the close of the next business day. **Phone notifications** may be completed by contacting phone 1-855-594-6103 for all regions, except Medicaid RSA and CHIP RSA phone 877-804-7109. **Fax notifications:** Austin Region fax 877-650-6939; Corpus Christi Region fax 877-650-6940; Dallas Region fax 855-707-5480; El Paso Region fax 877-650-6941; Lubbock/Amarillo Region fax 866-865-4385; McAllen (Hidalgo) Region fax 877-212-6661; San Antonio Region fax 877-650-6942; Medicaid RSA and CHIP RSA Regions: fax 877-505-0823. **Web notifications:** www.superiorhealthplan.com.

Non-Participating/Out of Network Providers:

Request for services from a non-participating, out of network facility, provider, or vendor in any location requires authorization.
Except in the case of emergent admissions. The notification process above should be followed.

Services Requiring Authorization:

Specialists
Chiropractor
Oral Surgeon*
Plastic and Reconstructive Surgery*
Podiatry*
**NOTE: Office visits do not require authorization; only procedures performed in any location require an authorization.*

In Home/Outpatient Therapy/Rehabilitation
Initial and re-evaluations require an authorization, and must be submitted by PCP or pertinent physician. Physician signature on treatment plan required.
Speech*, Occupational*, Physical*
Pulmonary & Cardiac Rehab
Cognitive Rehabilitation Therapy
**NOTE: Therapy provided by an ECI provider as part of an ECI IFSP are excluded from authorization requirement*

Other Services and Tests
DME over $500 purchase price each item (enter link)
Standardized DME List:
(http://www.superiorhealthplan.com/files/2013/11/StandardDMEListing_20131121.pdf)
Exception: Miscellaneous codes & over the limit items require an authorization. Incontinence Supplies ordered through the preferred DME provider do not require authorization.
Enteral Nutrition
Genetic Testing
Quantitative Testing for Drugs of Abuse
Home Health/Skilled Nursing/Private-Duty Nursing
Hearing Aids
Nutritional Counseling *(authorization not required when performed as part of a THSteps exam or for ECI assessment)*
OB ultrasounds *-limited to 3 ultrasounds for non-high risk pregnancy without authorization; no authorization required for high-risk pregnancy ultrasounds*
Orthotics/Prosthetics over $500 purchase price each item
Allergen Immunotherapy Services, *unless services provided by an allergist or immunologist.*
Pain Management Services - All providers, regardless of specialty, require an authorization to perform pain management procedures except for the CPT codes listed below. These codes do not require prior authorization.

- 62355 Remov Prev Implnt Intrathecal/Epidural Cath
- 62365 Remov Prev Implnt Subq Reservoir/Pump
- 62367 Elec Analys Spine Infus Pump
- 62369 Elec Analys Anal Sp Inf Pmp W/Reprg&Fill
- 63661 Remove Spine Eltrd Perq Aray
- 63662 Remove Spine Eltrd Plate
- 63688 Revis/Remov Implnt Spinal Neurostim Pulse Gen
- 62368 Elec Analys Programble Implnt Pump; W/Reprogram
- 62370 Elec Analys Anl Sp Inf Pmp W/Mdreprg&Fil
- 64585 Revise/Remove Neuroelectrode
- 64595 Revis/Remov Peripheral Neurostim Pulse Gen

All other pain management procedures not listed still require a prior authorization.
Sleep Study
Telemonitoring

Transportation
Air transport
Non-emergent ambulance-including facility to facility transport

Pharmaceuticals (Fax request to 1-866-683-5631)
Botox, Viscosupplementation
Injectable medications with miscellaneous billing codes
Synagis
All off-label chemotherapy requires preauthorization.
Excludes: epogen/aransep for ESRD members on dialysis
Excludes: epogen/neupogen for oncology members.
Excludes: chemotherapy J9000-J9999 prescribed by oncologist

Surgical or Other Procedures
Abortion
Bariatric Surgery
Blepharoplasty
Dental Anesthesia
Circumcision 1 year and older
Hysterectomy
Infertility
Implantable devices including
Cochlear Implant
Mammoplasty
Otoplasty
Rhinoplasty/Septoplasty
Scar Revision
Excision/scraping/shaving of lesions
Treatment of Varicose Veins
Vagus Nerve Stimulation

Transplant:
All services for Transplant Evaluation and Transplant Procedures.

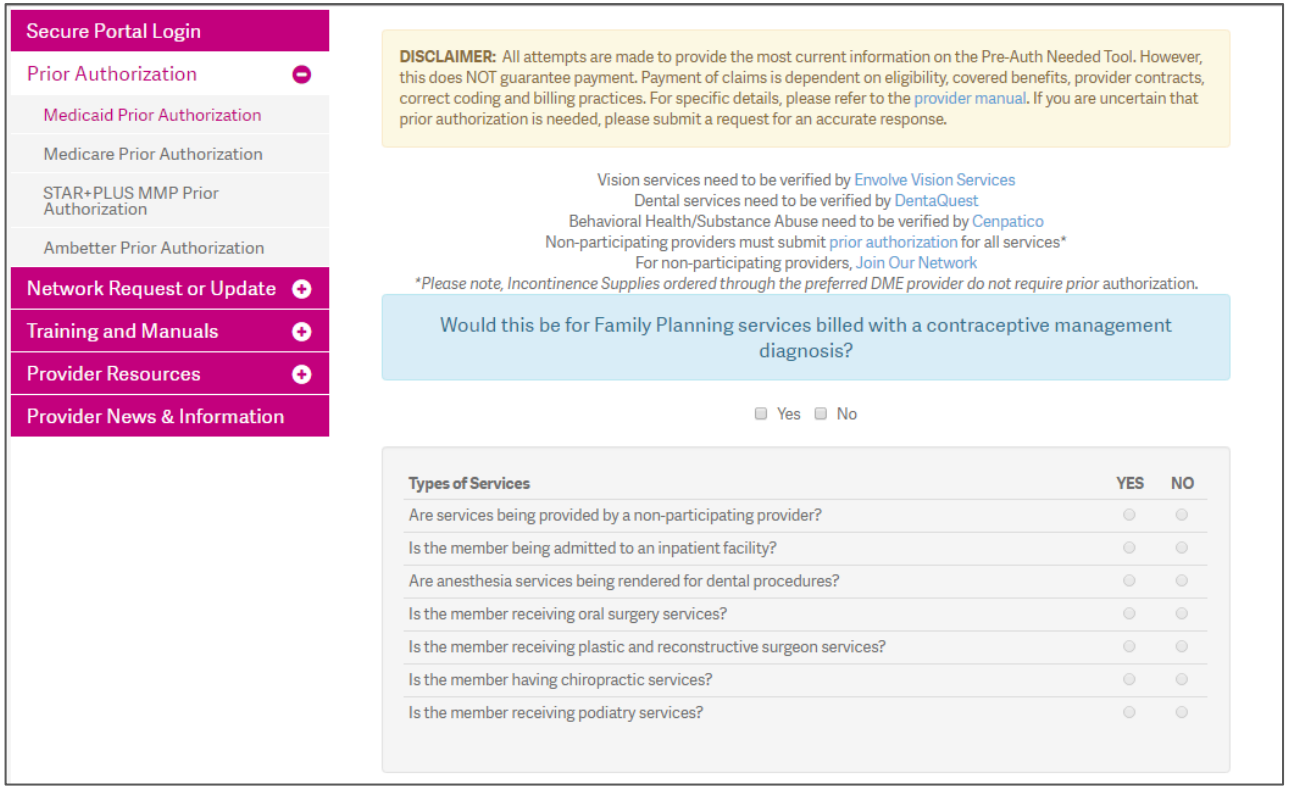
Long Term Services & Support (LTSS)
Personal Attendant Services (PAS)
Day Activity & Health Services (DAHS)
STAR+PLUS Waiver Services:
Personal Attendant Services (PAS)
Day Activity & Health Services (DAHS)
Nursing Services (In home)
Emergency Response Services (ERS)
Home Delivered Meals (HDM)
Minor Home Modifications (MHM)
Assisted Living (AL)
Transition Assistance Services (TAS)
Adult Foster Care (AFC)

Radiology (Contact NIA at 1-800-218-7508 opt 3 or visit www.radmd.com)
Precertification through NIA, Inc. is required for outpatient diagnostic procedures:
CT, CTA, MRI, MRA, PET
Cardiac imaging modalities (all products effective 2/1/14):
CCTA Stress Echo, Echocardiography (only for STAR+PLUS), and Nuclear Cardiology

Vision (Contact TVHP at 1-877- 865-1077)
Effective September 1, 2013, TVHP will assume the administration for ophthalmology medical and surgical services.

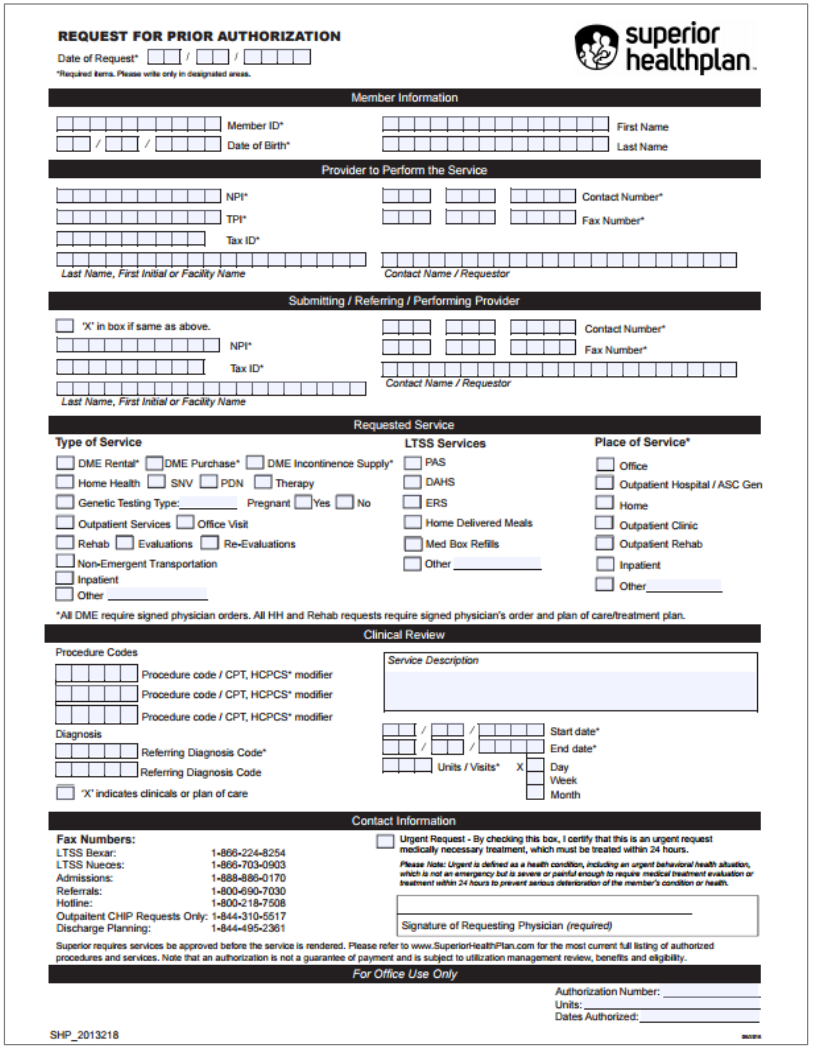
Medicaid Pre-Authorization Tool

- Providers can determine if a prior authorization is required by using the Pre-Auth tool on the Superior website, answering a series of questions and searching by procedure codes.



Prior Authorization Form

- The Prior Authorization form is located on the Superior website, under Provider Resources and then clicking the Forms page.
- Prior Authorizations can be submitted thought the Secure Provider Portal.



REQUEST FOR PRIOR AUTHORIZATION

Date of Request* ☐☐ / ☐☐ / ☐☐☐☐

*Required items. Please write only in designated areas.

superior healthplan

Member Information

Member ID* ☐☐☐☐☐☐☐☐☐☐

Date of Birth* ☐☐ / ☐☐ / ☐☐☐☐

First Name ☐☐☐☐☐☐☐☐☐☐

Last Name ☐☐☐☐☐☐☐☐☐☐

Provider to Perform the Service

NPI* ☐☐☐☐☐☐☐☐☐☐

TPI* ☐☐☐☐☐☐☐☐☐☐

Tax ID* ☐☐☐☐☐☐☐☐☐

Last Name, First Initial or Facility Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Contact Number* ☐☐☐ ☐☐☐ ☐☐☐☐

Fax Number* ☐☐☐ ☐☐☐ ☐☐☐☐

Contact Name / Requestor ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Submitting / Referring / Performing Provider

☐ 'X' in box if same as above.

NPI* ☐☐☐☐☐☐☐☐☐☐

Tax ID* ☐☐☐☐☐☐☐☐☐

Last Name, First Initial or Facility Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Contact Number* ☐☐☐ ☐☐☐ ☐☐☐☐

Fax Number* ☐☐☐ ☐☐☐ ☐☐☐☐

Contact Name / Requestor ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Requested Service

Type of Service

☐ DME Rental* ☐ DME Purchase* ☐ DME Incontinence Supply*

☐ Home Health ☐ SNV ☐ PDN ☐ Therapy

☐ Genetic Testing Type:_____ Pregnant ☐ Yes ☐ No

☐ Outpatient Services ☐ Office Visit

☐ Rehab ☐ Evaluations ☐ Re-Evaluations

☐ Non-Emergent Transportation

☐ Inpatient

☐ Other _____

LTSS Services

☐ PAS

☐ DAHS

☐ ERS

☐ Home Delivered Meals

☐ Med Box Refills

☐ Other _____

Place of Service*

☐ Office

☐ Outpatient Hospital / ASC Gen

☐ Home

☐ Outpatient Clinic

☐ Outpatient Rehab

☐ Inpatient

☐ Other_____

*All DME require signed physician orders. All HH and Rehab requests require signed physician's order and plan of care/treatment plan.

Clinical Review

Procedure Codes

☐☐☐☐☐ Procedure code / CPT, HCPCS* modifier

☐☐☐☐☐ Procedure code / CPT, HCPCS* modifier

☐☐☐☐☐ Procedure code / CPT, HCPCS* modifier

Diagnosis

☐☐☐☐☐ Referring Diagnosis Code*

☐☐☐☐☐ Referring Diagnosis Code

☐ 'X' indicates clinicals or plan of care

Service Description

☐☐ / ☐☐ / ☐☐☐☐ Start date*

☐☐ / ☐☐ / ☐☐☐☐ End date*

☐☐☐☐ Units / Visits* X ☐ Day ☐ Week ☐ Month

Contact Information

Fax Numbers:

LTSS Bexar:	1-866-224-8254
LTSS Nueces:	1-866-703-0903
Admissions:	1-888-886-0170
Referrals:	1-800-690-7030
Hotline:	1-800-218-7508
Outpatient CHIP Requests Only:	1-844-310-5517
Discharge Planning:	1-844-495-2361

☐ Urgent Request - By checking this box, I certify that this is an urgent request medically necessary treatment, which must be treated within 24 hours.

Please Note: Urgent is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to require medical treatment evaluation or treatment within 24 hours to prevent serious deterioration of the member's condition or health.

_____

Signature of Requesting Physician *(required)*

Superior requires services be approved before the service is rendered. Please refer to www.SuperiorHealthPlan.com for the most current full listing of authorized procedures and services. Note that an authorization is not a guarantee of payment and is subject to utilization management review, benefits and eligibility.

For Office Use Only

Authorization Number: _____

Units: _____

Dates Authorized: _____

SHP_2013218

High-Tech Imaging: NIA

- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for high-tech imaging services, including:
  - CT/CTA
  - MRI/MRA
  - PET Scan
  - CCTA
  - Nuclear Cardiology/MPI
  - Stress Echo
- Echocardiography (STAR+PLUS).
- Inpatient and ER procedures do not require authorization.
- All claims should be submitted to Superior through paper claims submission, or electronic submission on Provider.SuperiorHealthPlan.com.

High-Tech Imaging: NIA

- The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures.
- Servicing providers may request authorization and check status of an authorization by:
  - Accessing www.RadMD.com.
  - Utilizing the toll free number, 1-800-642-7554.

Establishing Medical Necessity

After an Adverse Determination

Medical Management Denials

- Adverse Determination (Denial) - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
- Type of Denial
  - Administrative Denials (non-clinical reasons)
    - Member ineligibility; and/or
      - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by the State; and/or
      - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by the State (Non-covered Benefit).
    - No prior authorization
    - Late notification
    - Alberto N. missing information denial
  - Medical Necessity
    - Medical director or appropriate practitioner reviewer may make an adverse determination (organization determination) to deny, terminate or reduce services when insufficient clinical information is received to determine medical necessity for requested service(s).

Appealing Medical Management Denials

- Peer-to-Peer Review
  - When medical necessity cannot be established, a peer-to-peer review is offered. A peer-to-peer discussion is available to the ordering physician, nurse practitioner, physician assistant during the prior authorization, denial or appeal process with regard to medical necessity.
- Communication of Denials
  - Denial letters will be sent to member, requesting provider and servicing provider to include:
    - The clinical basis for the denial.
    - Criteria used to make the medical necessity decision
    - Member appeal/complaint or fair hearing rights fully explained.
- Provider may request an appeal in writing an appeal on behalf of member, if authorized to do so.
  - Mail: Superior HealthPlan
    Attn: Appeal Coordinator
    5900 E. Ben White Blvd.
    Austin, TX 78741
  - Fax: 1-866-918-2266
- For questions, providers may call 1-877-398-9461 / TTY: 1-800-735-2989.

Appealing Medical Management Denials

- Authorized representatives of members acting on their behalf, may appeal adverse determinations regarding their care and service (designation of a member's authorized representative must be submitted in writing).

- Types of Medical Necessity Appeals:
  - Level 1: Internal/standard appeal (appeal to Superior HealthPlan)
  - Level 2: External appeal (appealing to a third party)
    - CHIP = IRO (independent review organization)
    - STAR/STAR+PLUS/STAR Health/STAR Kids = FH (Fair Hearing – HHSC)
  - Claims: Medical necessity appeals only *(Note: Administrative denials only have complaint rights)*.
    - Appeals must be submitted to Superior within 120 days from the date of the last denial.

Appeal Timeframe by Product

Medicaid

- Provider or member has:
  - 30 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal for STAR, STAR+PLUS, STAR Health and STAR Kids.
  - 60 days for MMP
  - 90 days for CHIP
  - 180 days for Ambetter
  - 90 calendar days from the date of notification of adverse determination to file a Fair Hearing for STAR products
    - Non-covered benefit denial also has Fair Hearing rights.
  - Complaint rights
- Superior will review and respond to the appeal within 30 calendar days.

Appeal Timeframe by Product

CHIP/CHIP RSA

- Provider or member has:
  - 90 calendar days from the date of the notification of adverse determination to file an appeal
  - IRO rights
  - Complaint rights
- Provider or member does not have Fair Hearing rights.
- Appeal is to be completed within 30 calendar days.

Expedited Appeals

- Expedited Appeals
  - IP expedited appeals are processed within one (1) working day of appeal request.
  - All other expedited appeals are completed within three (3) days.
- Expedited Appeals Criteria
  - Will it cause severe pain if not processed within a 30 day time frame?
  - Is it life/limb threatening if not processed within a 30 day time frame?
  - Has it been reviewed by a medical director?

Provider Complaints

- Provider complaints can be submitted in writing, verbally or online.
  - Mail:
    Superior HealthPlan
    Attn: Compliant Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
  - Fax:
    Attn: Compliant Department
    1-866-683-5369
  - Verbally:
    During a face-to-face interaction/visit or telephone call into any Superior department.
  - Online:
    https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html
- Complaint form can be printed, completed and faxed or mailed to Superior for resolution response. Form can be found under **Filing Provider Complaints:**
  https://www.SuperiorHealthPlan.com/providers/resources/complaint-procedures.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.
  - 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

Claim Submissions

Clean Claims

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

Claims Filing: Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS):
  - Filed on CMS-1450/UB-04 or CMS 1500
  - Filed electronically through clearinghouse
  - Filed directly through Superior's Provider Portal
- Claims must be completed in accordance with Medicaid billing guidelines.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.
- Mailing Address (paper claims):

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

Paper Claims Filing

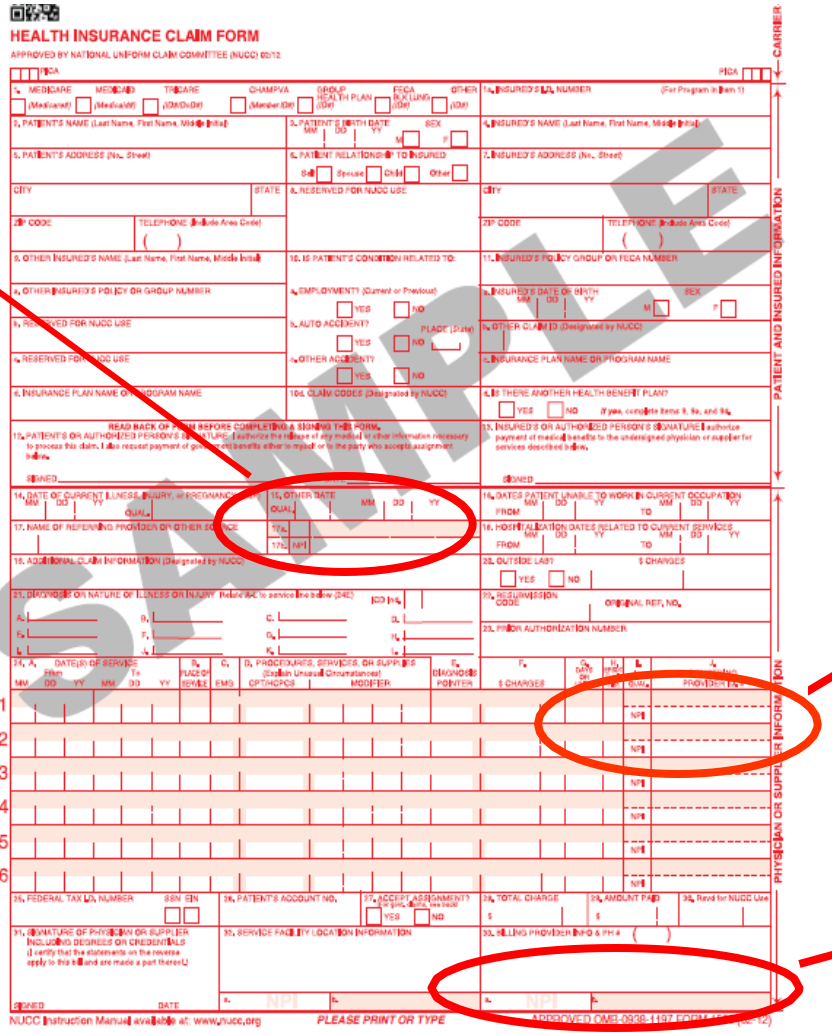
- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS-1450/UB-04 or CMS 1500 red form (not a copy).
    - Handwritten claim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

CMS 1500 Form

Referring Provider: [C]

17 Name of the referring provider and

17b NPI



Rendering Provider: [R]

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

These are required fields when billing Superior claims.

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

Billing Provider: [R]

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

Identifying a Claim Number

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

Note: Remember that rejected claims have never made it through Superior's claims system for processing. The claim number that is provided on the rejection letter is a claim image number that helps us retrieve a scanned image of the rejected claim.

Identifying a Claim Number

- **Electronic**: Secure Provider Portal or EDI through a clearinghouse.
  - Your response to your submission is viewable through an EDI rejection/acceptance report, rejection letters, Superior Provider Portal and EOPs.
- **Paper**: Mailed to our processing center.
  - Your response to your submission is viewable through rejection letters, Superior's Provider Portal and EOPs.

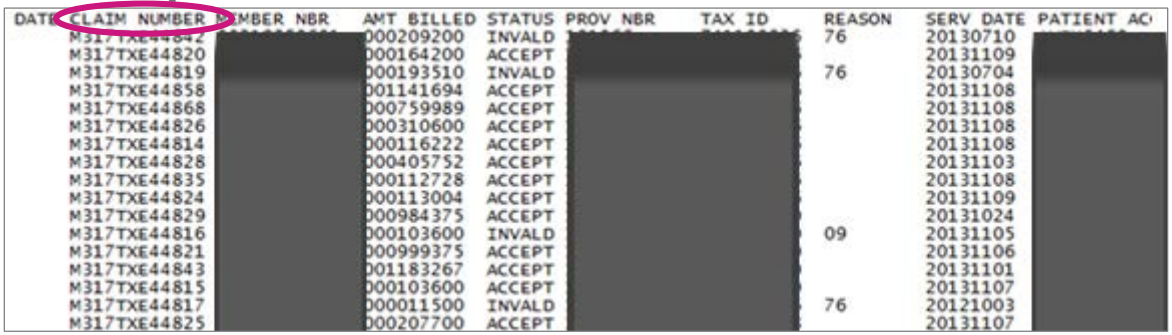
Note: On all correspondence, please reference either the claim number/control number.

Where do I find a Claim Number?

You can find claim numbers on:

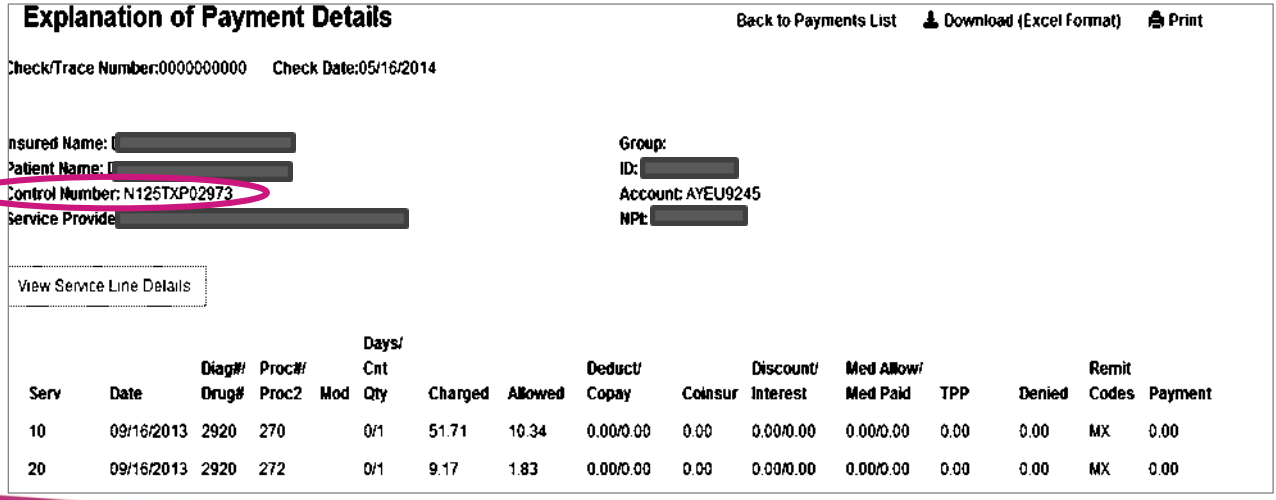
- EDI reports
- Explanation of Payment Details on the Provider Portal

EDI Reports



DATE	CLAIM NUMBER	MBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842		00209200	INVALD			76	20130710	
	M317TXE44820		00164200	ACCEPT				20131109	
	M317TXE44819		00193510	INVALD			76	20130704	
	M317TXE44858		01141694	ACCEPT				20131108	
	M317TXE44868		00759989	ACCEPT				20131108	
	M317TXE44826		00310600	ACCEPT				20131108	
	M317TXE44814		00116222	ACCEPT				20131108	
	M317TXE44828		00405752	ACCEPT				20131103	
	M317TXE44835		00112728	ACCEPT				20131108	
	M317TXE44824		00113004	ACCEPT				20131109	
	M317TXE44829		00984375	ACCEPT				20131024	
	M317TXE44816		00103600	INVALD			09	20131105	
	M317TXE44821		00999375	ACCEPT				20131106	
	M317TXE44843		01183267	ACCEPT				20131101	
	M317TXE44815		00103600	ACCEPT				20131107	
	M317TXE44817		00011500	INVALD			76	20121003	
	M317TXE44825		00207700	ACCEPT				20131107	

Explanation of Payment Details on Provider Portal



Explanation of Payment Details

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

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

Insured Name: [redacted]
Patient Name: [redacted]
Control Number: N125TXP02973
Service Provide[redacted]

Group:
ID: [redacted]
Account: AYEU9245
NPI: [redacted]

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

Electronic Claims Filing

- Claims can be submitted through Superior's Secure Provider Portal.
- Claims can also be submitted by using a Superior preferred trading partner/clearinghouse.
- If provider uses Electronic Data Interchange (EDI) software but is not set up with a trading partner/clearinghouse, they must bill Superior by submitting paper claims or through the Secure Provider Portal until the provider has established a relationship with a trading partner/clearinghouse listed on our website.
  - For Superior electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **68069**.
  - Contact EDI: EDIBA@Centene.com

Electronic Claims Filing

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

- Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- Is on payment hold under the authority of HHSC or its authorized agent(s).
- Has provided neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

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

Claim Adjustments, Reconsiderations & Disputes

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

Corrected Claim Filing

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

Corrected Claims Filing

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

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

Claims Appeal Form

- A claims appeal is a request for reconsideration of a claim for anything other than medical necessity and/or any request that would require review of medical records to make a determination.
- Submit appeal within 120 days from the date of adjudication or denial.
- Can be submitted electronically through Superior's Provider Portal or be submitted in writing.
- Claims appeals must be in writing and submitted to:

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

Appeals Documentation

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

Billing Reminders

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

Billing Reminders - Authorizations

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

Billing Reminders - Authorizations

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

Billing Reminders - Elective Delivery Policy

- Superior will review all Neonatal Intensive Care Unit (NICU) admissions delivered prior to 39 weeks to determine whether the delivery was elective or medically necessary.
- If elective, Superior will deny the delivering physician and the facility (for both the delivery and the NICU).
- Superior will not deny other physicians (Anesthesia, Neonatology) or other facilities, if the infant is transferred due to medical necessity.
- If you have any questions regarding this policy, please contact Provider Services at 1-877-391-5921.

Billing Reminders - Obstetrics: Delivery Claim Requirements

- Delivery and Postpartum services must be billed separately for all products.
  - Improves our ability to report HEDIS quality outcomes for Postpartum Care.
- Corrected claims can be submitted within 120 days from the Explanation of Payment date for payment with the separate procedures codes.
- Superior will reimburse for two (2) postpartum visits.

Reimbursable Codes	
Procedure Code	**Code Description**
59409 59612	Vaginal Delivery Only
59514 59620	C-Section Delivery Only
59430	Postpartum Outpatient Visit

Non-Reimbursable Codes	
59400 59410	Vaginal Delivery including Postpartum Care
59510 59615	C-Section Delivery & Postpartum Care
59610 59614 59618 59622	Delivery after C-Section including Postpartum Care

Billing Reminders - Sterilization Form

- Providers must complete all sections of the Sterilization Consent Form as applicable.
  - All of the fields must be completed legibly in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form.
- Providers must resubmit denied consent forms with all required fields on the consent form itself completed legibly.
  - Resubmission with information indicated on a cover page or letter will not be accepted.
- Copies of the Sterilization Consent Form and instructions (English/Spanish) can be found at www.SuperiorHealthPlan.com.
  - Provider Resources > Forms > Member Management.

Billing Reminders - Sports Physicals

- Superior will reimburse sports physicals for eligible members:
  - STAR, STAR Health and CHIP members only
  - Ages 4-17 (STAR and CHIP) and ages 4-18 (STAR Health)
  - One (1) per calendar year
- For prompt claim payment please follow these guidelines:
  - Diagnosis Code: Z02.5
  - CPT Codes: 99382-99385 or 99392-99395
- Reimbursement will be $35.00 (there is no co-pay).

Billing Reminders - STAR+PLUS

- STAR+PLUS Service Coordination team prior authorization phone number: 1-877-277-9772
- The prior authorization number starts with “OP” followed by 10 digits (Ex: OP2279143510).
- If a provider bills less than the contracted amount, the claim will pay the lesser of the amounts.
- In the Diagnosis Codes section, enter **Diagnosis Code 1** (required).
- In the Service Line Number 1 section, enter required information:
  - From Date, To Date, Place of Service, Procedure Code, Charges, Days/Units.
  - Use the Diagnosis Pointer checkboxes to associate the previously entered Diagnosis Code 1, 2, 3 & 4 with the Service Line as needed.
- Providers will receive a Notfiction of Authorization letter that will indicate if the member is Waiver or Non-Waiver.
  - Review the LTSS Billing Matrix found in the STAR+PLUS Handbook on the DADS website for additional information.
- Include rendering provider information.

Billing Reminders

Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS-1450/UB-04 or CMS 1500 forms.

- NPI of a referring or ordering physician on a claim.
- Appropriate two-digit location code must be listed.
- Appropriate modifiers must be billed when applicable.
- Taxonomy codes are required on encounter submissions for the referring or ordering physician.
  - ZZ qualifier for CMS 1500 or B3 qualifier for UB04 to indicate taxonomy

Provider Training

- Superior offers targeted billing presentations depending on the type of services provided and billed for.
  - Example: LTSS Billing Clinics
- There are also product-specific trainings available on STAR, STAR+PLUS, STAR Health and STAR Kids.
  - Access the schedule for face-to-face trainings or webinars at

    https://www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html

superior healthplan™

FQHC & RHC Billing Information

FQHC: Medicaid & CHIP Billing Procedures

- The Federally Qualified Health Center (FQHC) must bill a T1015 procedure code and applicable modifier for general medical services.
- Exception claims (“other” health visits, e.g. well-child, vision care and mental health) must be billed with appropriate or applicable CPT codes.
- An FQHC is paid their full encounter rate for medical services directly from Superior.
- An FQHC is paid a contracted rate by the CHIP Dental MCO for dental services.
- All Optometry provider claims should be billed directly to Envolve Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatico.

RHC: Medicaid Billing Procedures

- The Rural Health Clinic (RHC) must bill a T1015 procedure code for general medical services.
- Exceptions claims (“other” health visits, e.g. Texas Health Steps and Family Planning) must be billed with appropriate or applicable CPT codes.
- An RHC is paid their full encounter rate directly from Superior.
- All services provided at an RHC and billed on a CMS 1500 form must be submitted using a location, POS code 72. This includes Texas Health Steps/Well visits and Family Planning Services.
- Services rendered at an RHC facility and billed with a location code other than 72 may be denied.
- Providers must use the appropriate modifiers in order to receive payment for services.
- All Optometry provider claims should be billed directly to Envolve Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatico.

RHC: CHIP Billing Procedures

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

RHC: CHIP Billing Procedures

- An RHC is paid a contracted rate by the CHIP Dental MCO for dental services.
- All Optometry provider claims should be billed directly to Envolve Vision using the standard billing formats.
- Behavioral health services should be billed directly to Cenpatico.

Note: CHIP coverage is secondary when coordinating benefits with all other insurance coverage. Coverage provided under CHIP will pay benefits for Covered Services that remain unpaid after all other insurance coverage has been applied.

Electronic Funds Transfer (EFT)

Signing up for EFT and
Retrieving your EOPs

Outgoing

- Providers receive the information back from Superior in two (2) ways:
  - On Paper: EOP (Emdeon)
  - Electronically: 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 vs. Paper Check

- Providers will receive a paper check unless they are signed up for EFT through PaySpan.
- Did you know?
  - A provider can submit claims by paper and still enroll for EFT/ERA.
  - A provider that prefers their EDI vendor can still go through their vendor to submit their claims.
    - We simply divert the return file (the ERA [835]) through PaySpan along with EFT.

Payspan

- Superior has partnered with Payspan to offer expanded claim payment services.
  - EFT
  - Online remittance advices (ERA's/EOPs)
  - Health Insurance Portability Accountability Act (HIPAA) 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com.
- For further information, contact Payspan1-877-331-7154, or email ProvidersSupport@PayspanHealth.com or contact your local Account Manger or Provider Services at 1-877-391-5921.

Superior HealthPlan Departments

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Answering questions
    - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
      - STAR/CHIP/Perinate: 1-800-783-5386
      - MRSA: 1-877-644-4494
      - STAR+PLUS: 1-866-516-4501
      - STAR Kids: 1-844-590-4883
      - STAR Health: 1-866-912-6283
      - CHIP RSA: 1-800-820-5685

Provider Services

- The Provider Services staff can help you with:
  - Answering 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.
- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
  - STAR/CHIP/STAR+PLUS/STAR Kids: 1-877-391-5921
  - MRSA: 1-877-644-4494
  - CHIP RSA: 1-800-522-8923

Account Management

- Account Managers are here to assist you with:
  - Face-to-face orientations and Provider Portal training.
  - Office visits to review ongoing claim trends and quality performance reports.
- 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 our website.
  - https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html

Network Development

- Providers who offer services to our members should be contracted with Superior.
- To get contracted, providers must contact our Network Development department and request a contract.
  - By Phone: 1-877-391-5921.
  - By Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com
  - By Website: www.SuperiorHealthPlan.com

Secure Provider Portal

Submitting Claims

Secure Provider Portal & Website

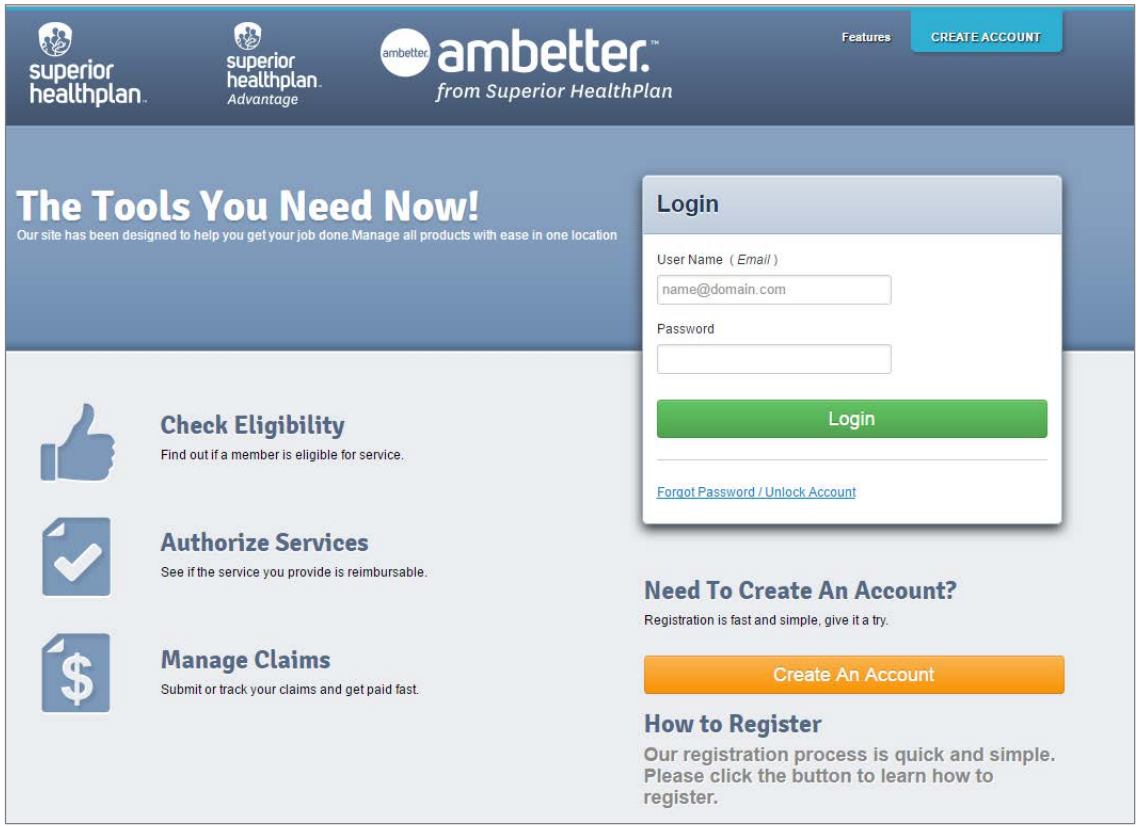
Superior is committed to providing you with all of the tools, resources and support you need to be make your business transactions with Superior as smooth as possible. One of the most valuable tools is our Provider Portal. Once you are registered you get access to the full site.

- Secure Provider Portal Features:
  - View multiple TINs
  - Access daily patient lists from one screen
  - Manage Batch Claims for free
  - Simplify prior authorization process
  - Check patient care gaps
  - Streamline office operations
- Public Site:
  - Provider Directory with online lookup tool.
  - Map of Account Managers by region.
  - Newsletters, new posts, provider manuals, forms and helpful links.

Registration

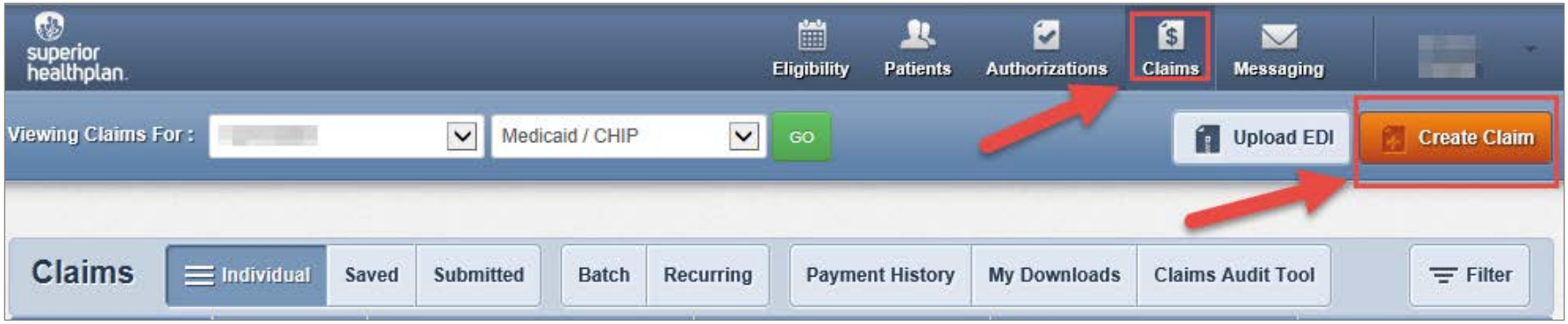
To register, visit: Provider.SuperiorHealthPlan.com

- 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.



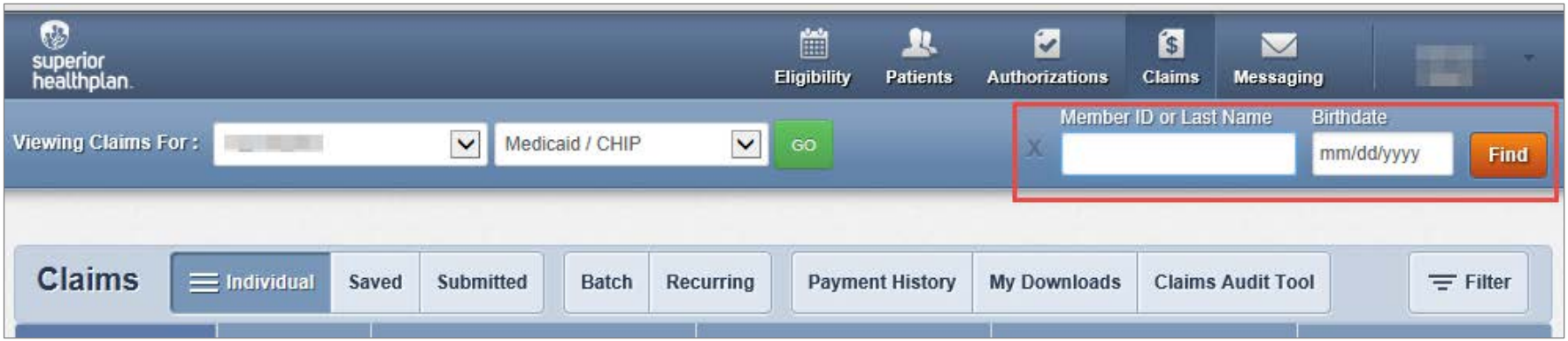
Create Professional Claims

- From the **navigation menu**:
  - Select **Claims** at the top of the landing page.
  - Then select **Create Claim**.



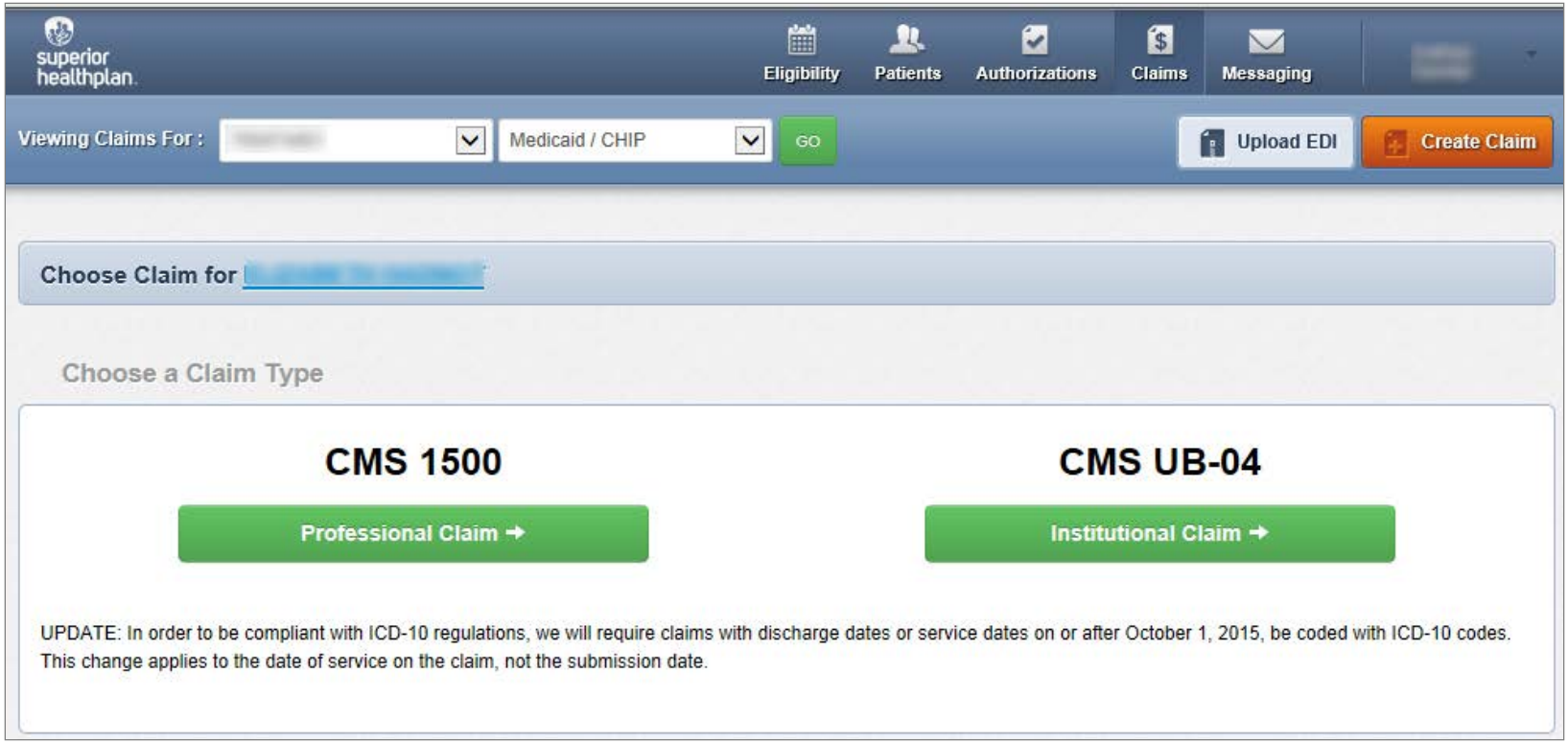
Create Professional Claims

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



Create Professional Claims

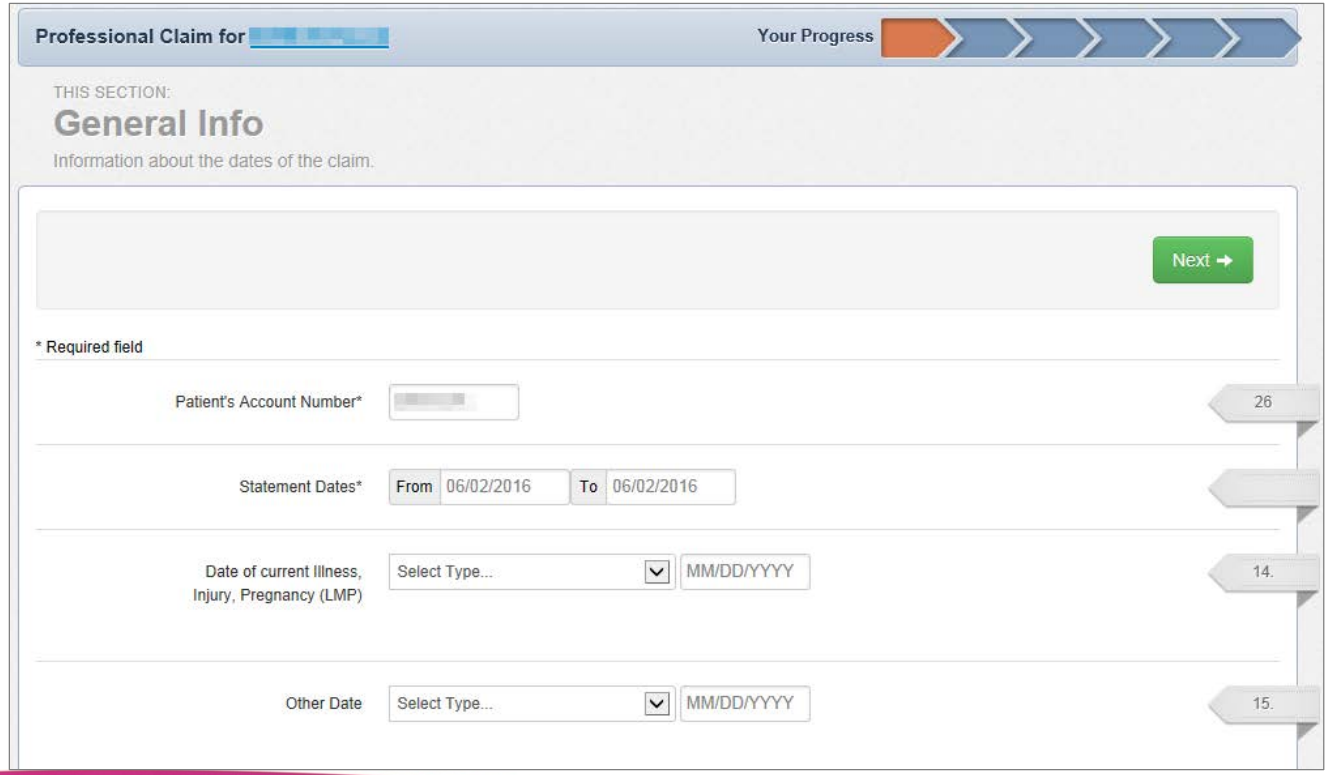
- **Choose a Claim Type**.
- Select **Professional Claim.**



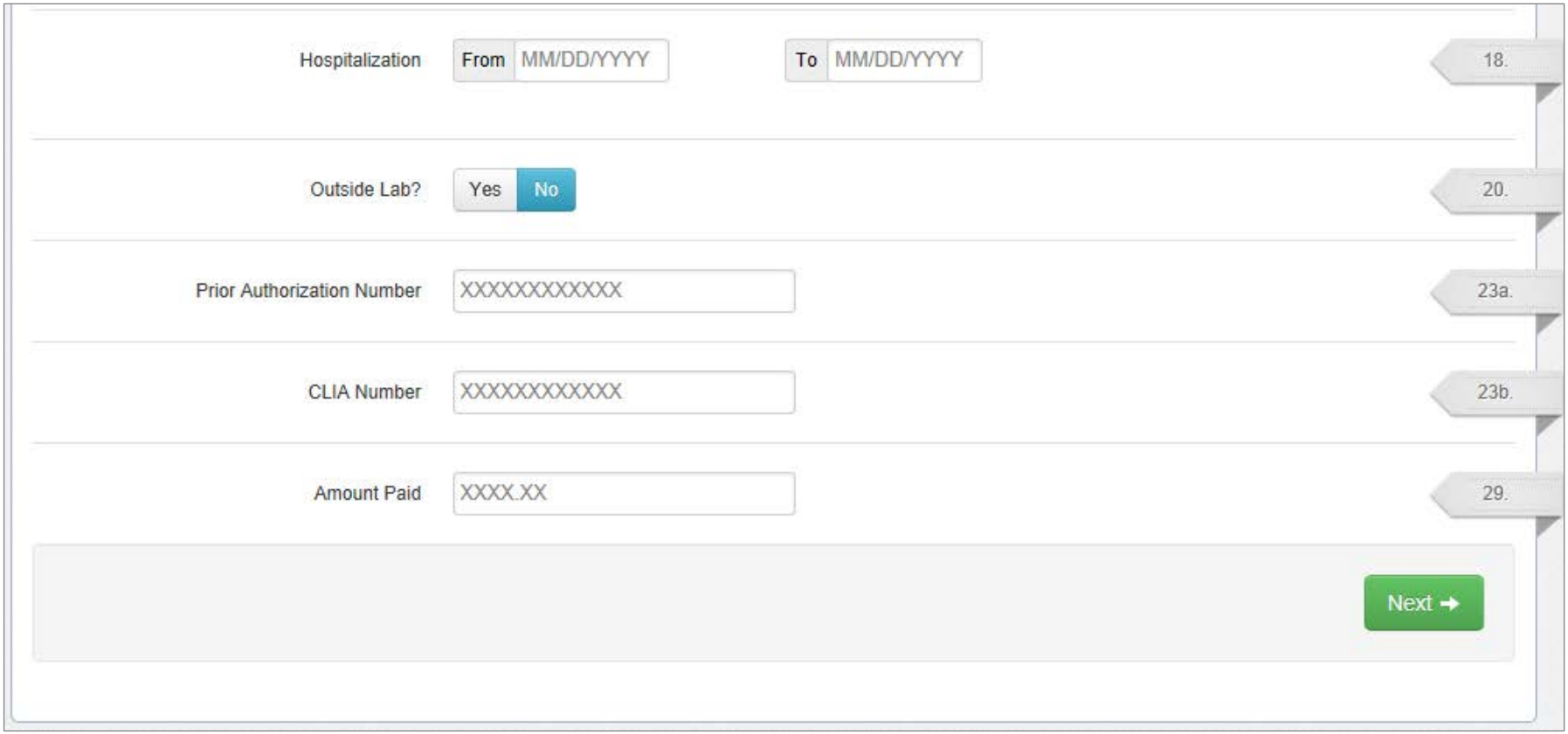
General Information

- Enter **Patient Account Number**
  - *** = required**

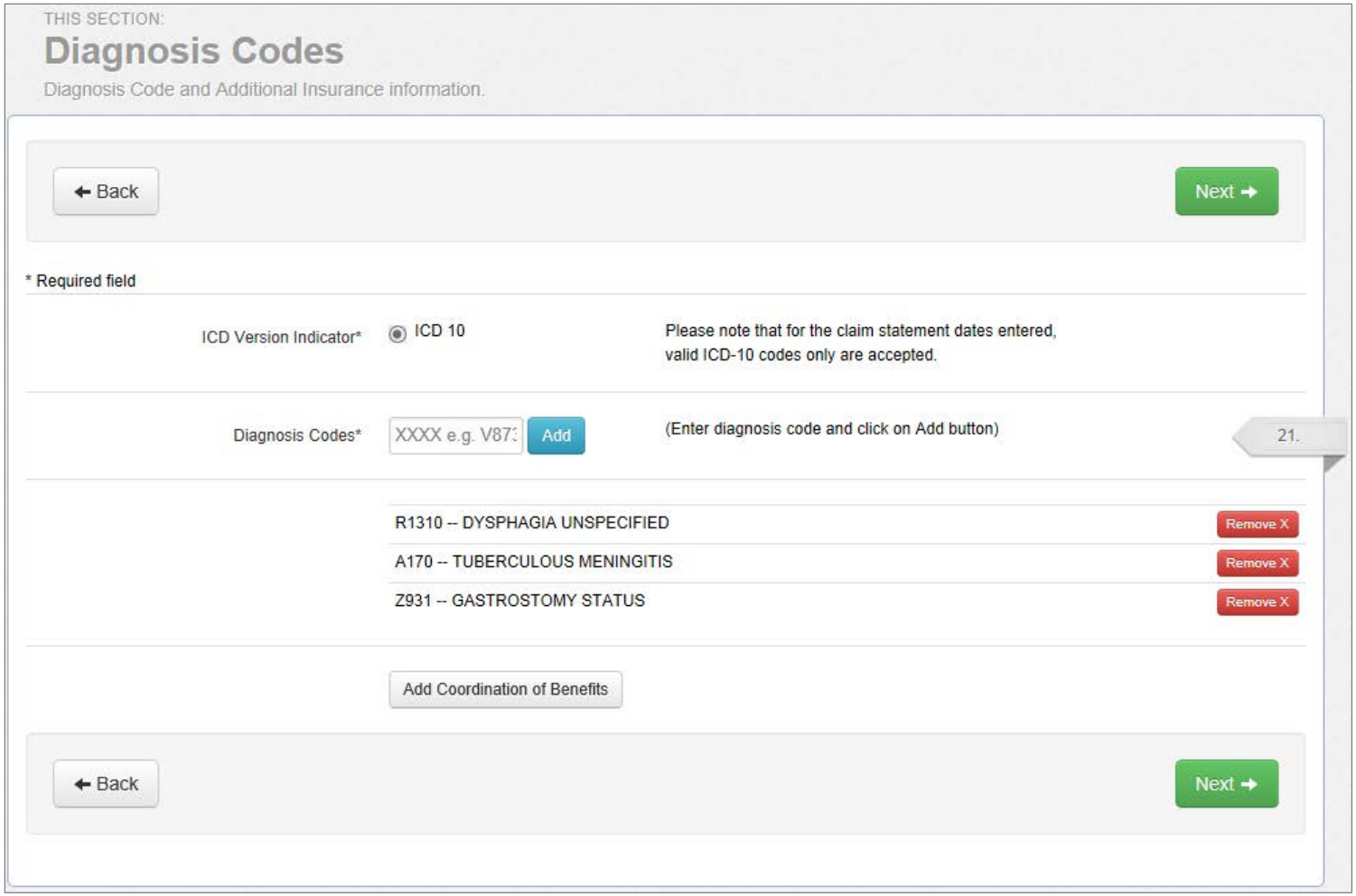
Note: This is the internal patient account number assigned by servicing provider.



General Information

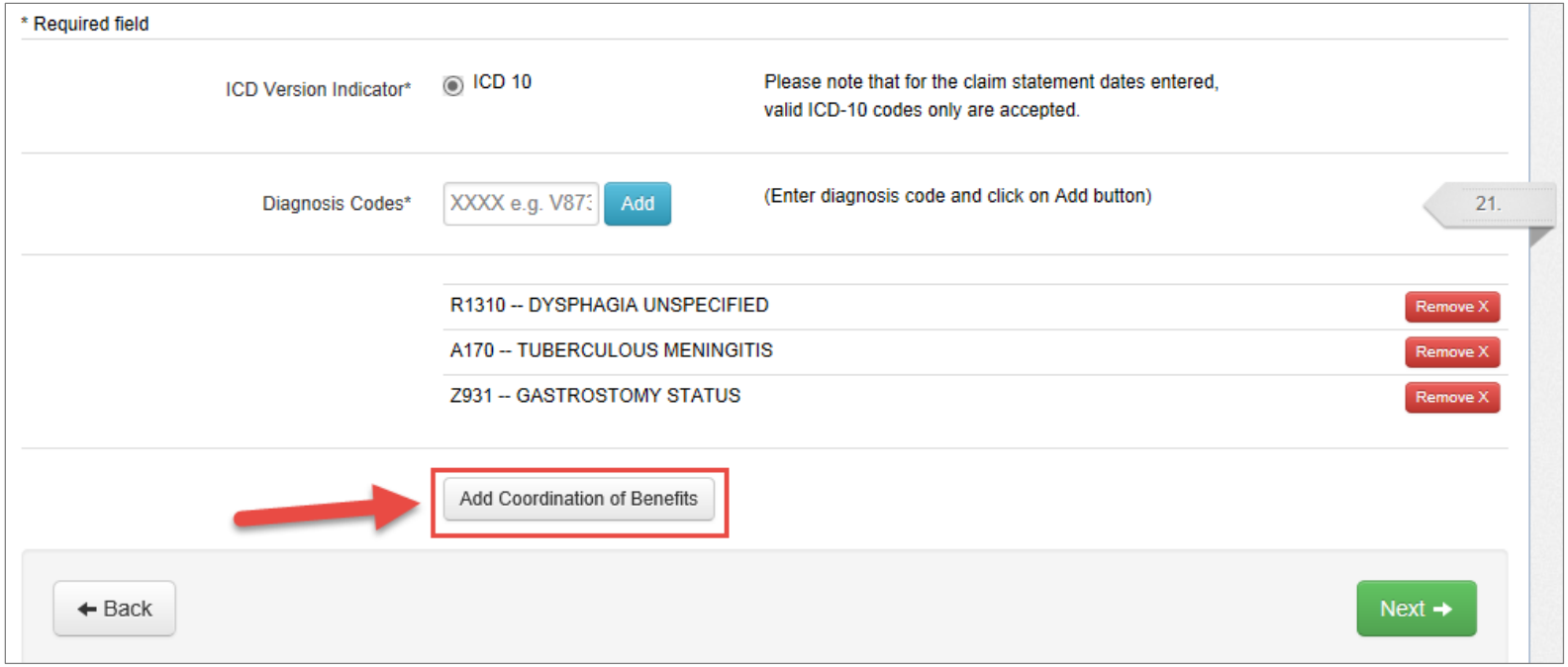


Diagnosis Codes



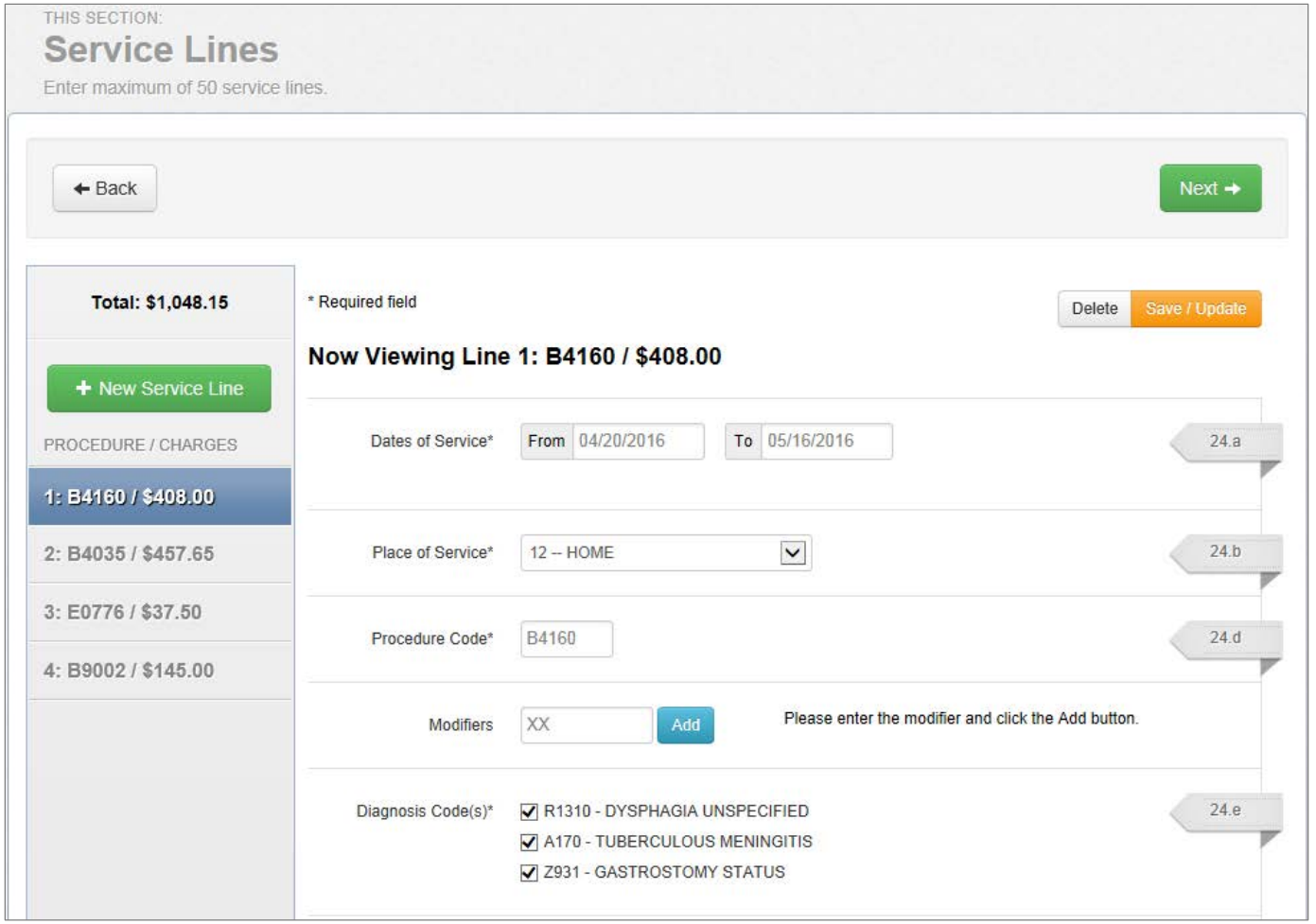
Coordination of Benefits

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

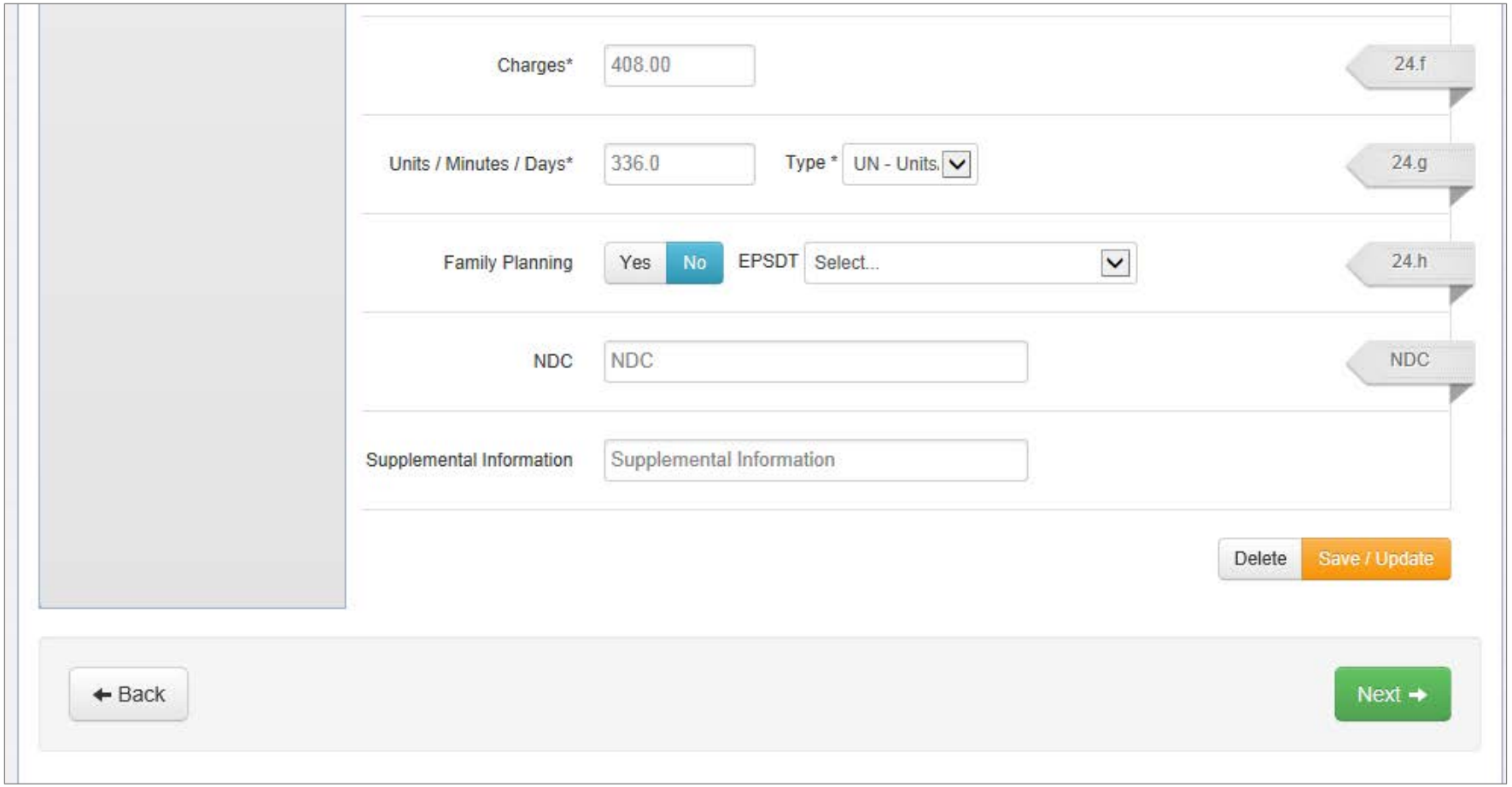


Service Lines

- Enter maximum of 50 services lines.



Service Lines



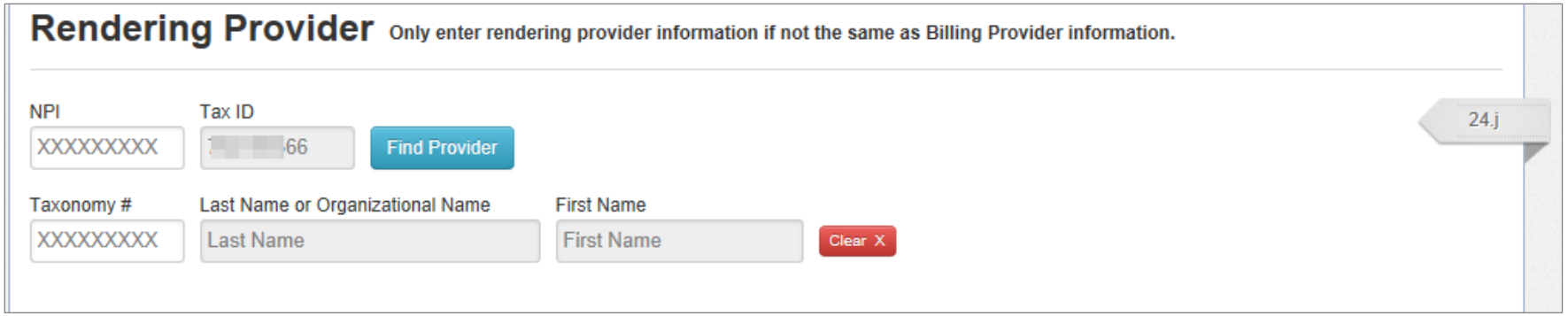
Referring Provider

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

Rendering Provider Section

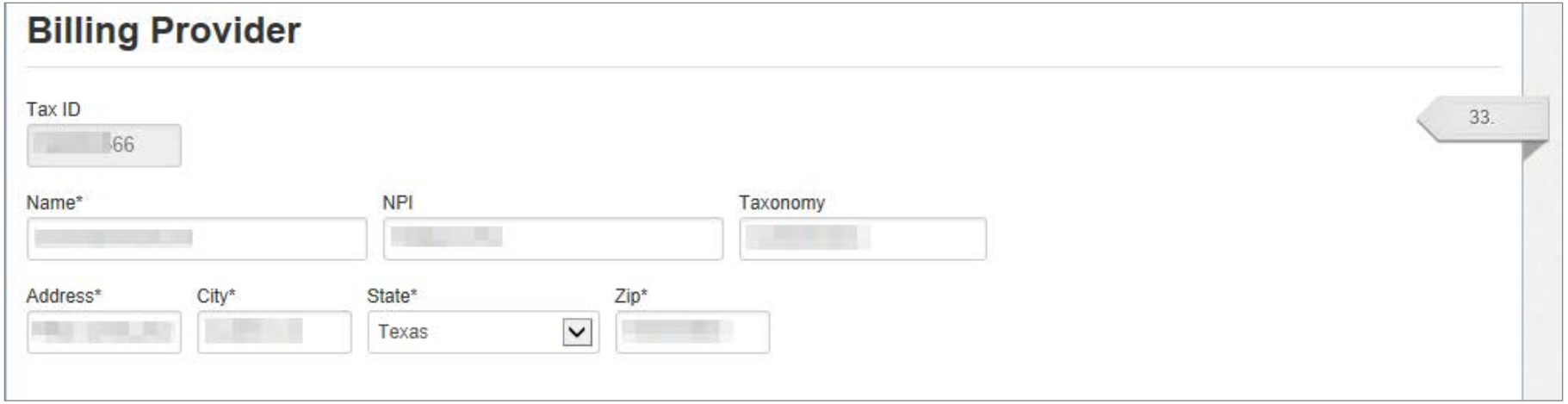
- In the **Rendering Provider** section:
  - Enter your **NPI** number.
  - Select the provider info from the drop-down list associated with your location and taxonomy code.

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



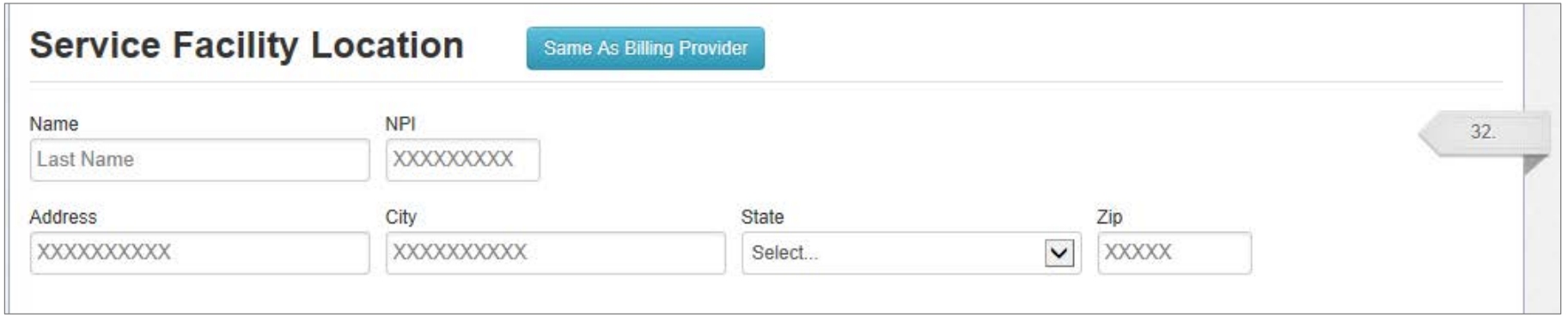
Billing Provider Section

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

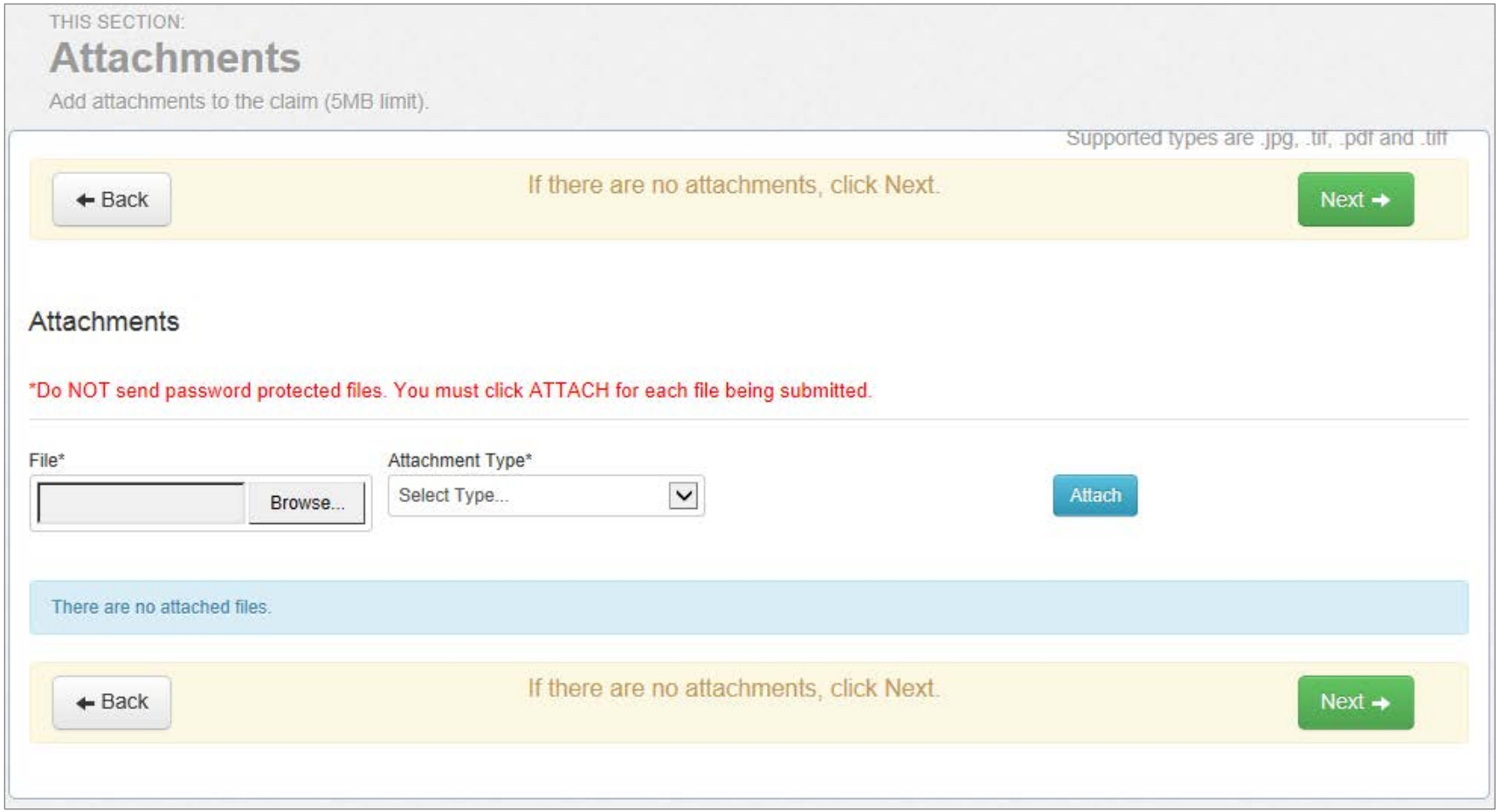


Service Facility Location Section

- 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

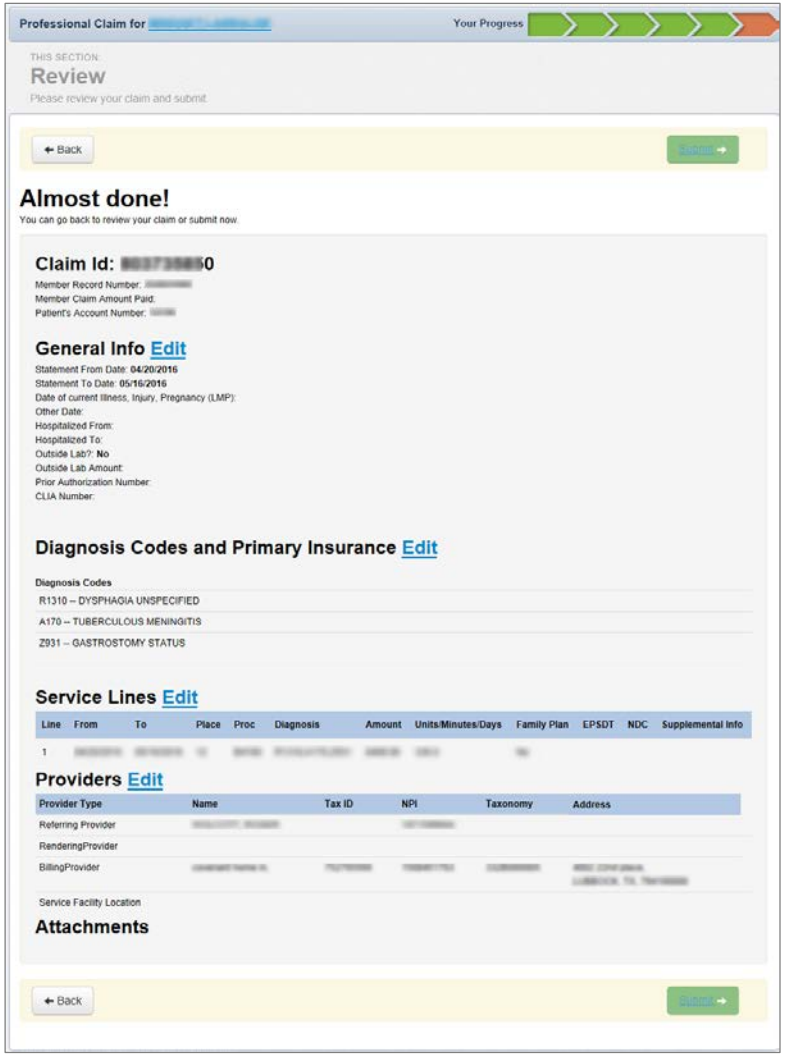


Review & Submit

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.

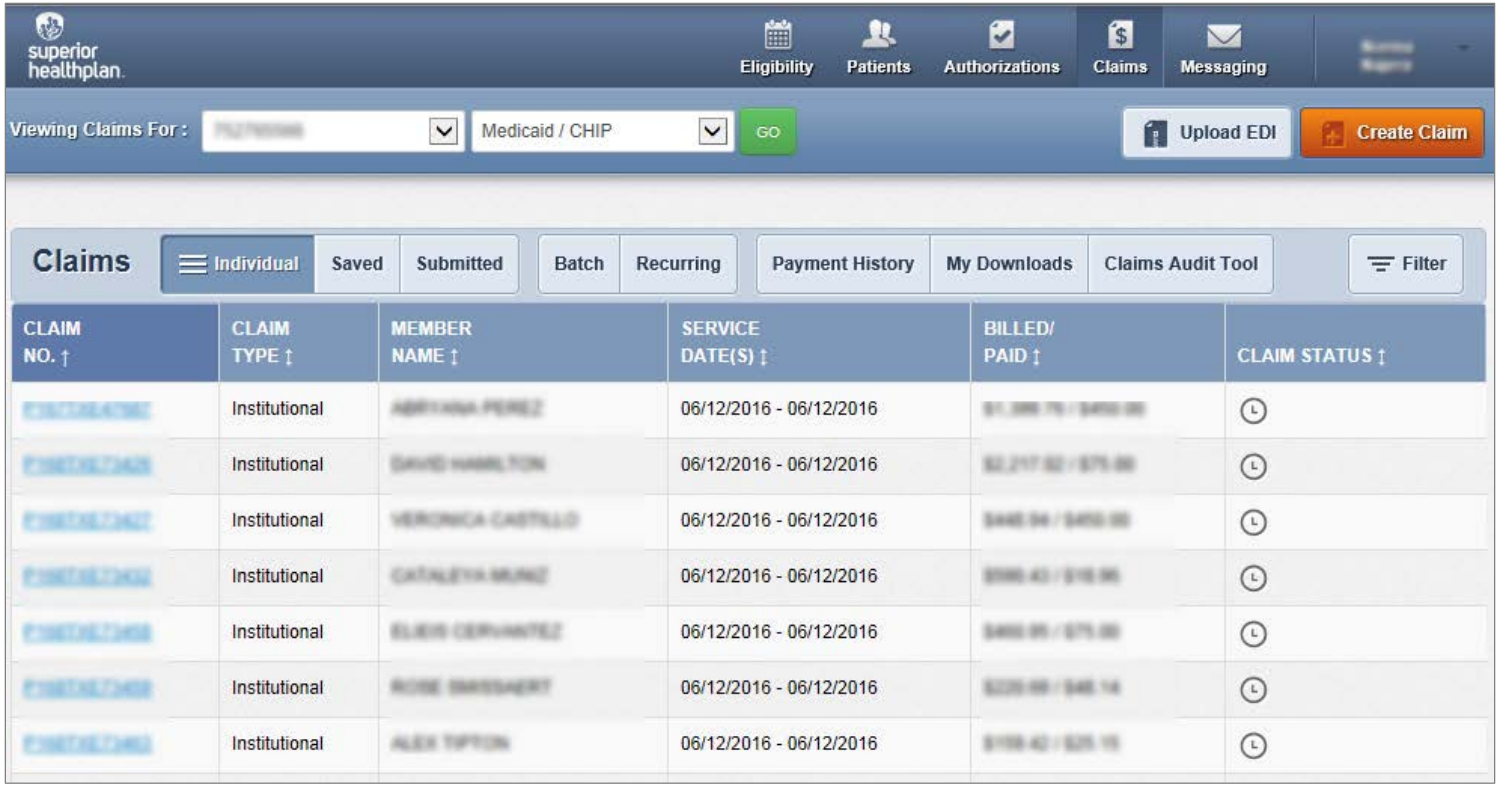


Claim Submitted Successfully

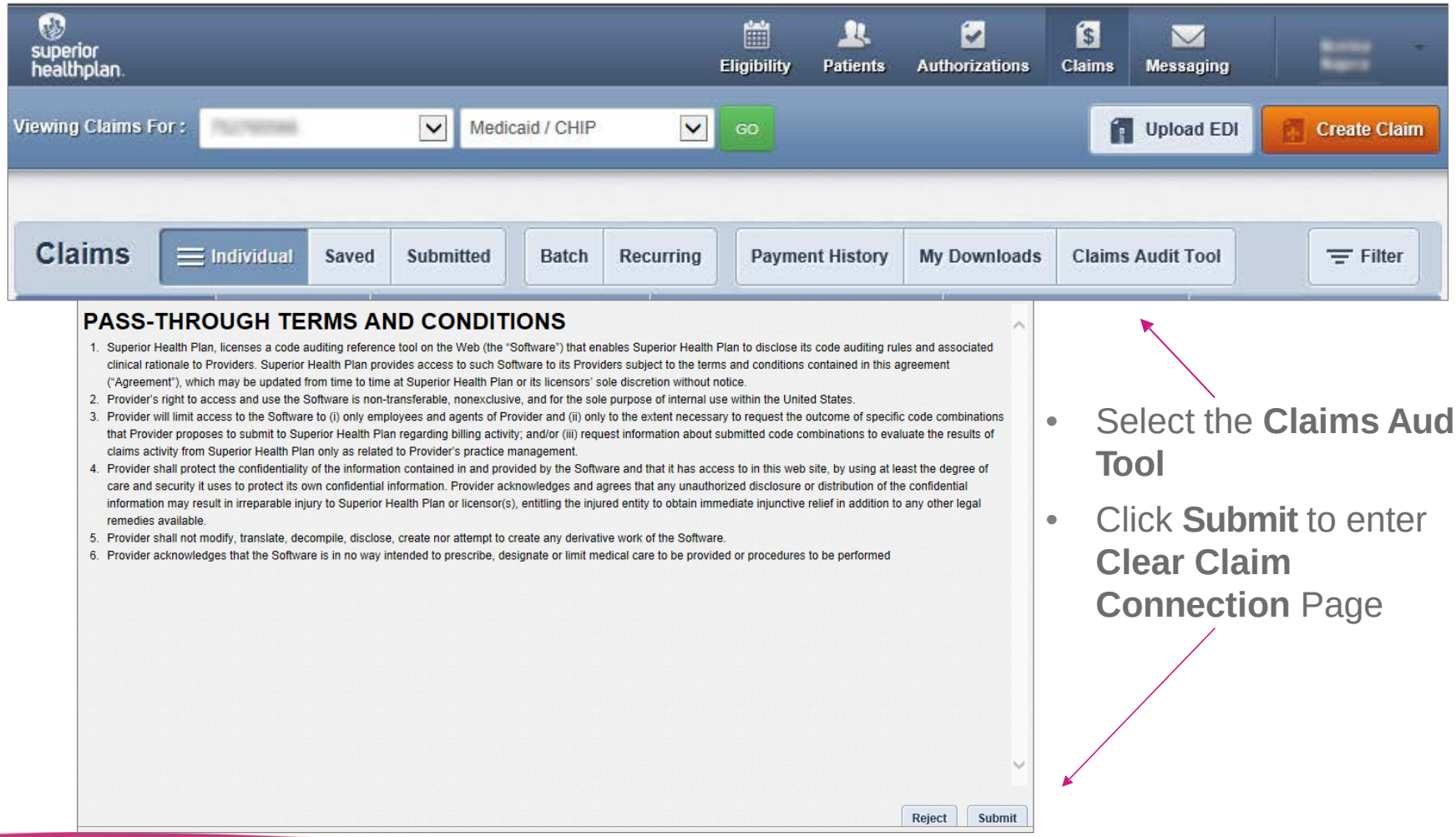
- Take note of the **Web Reference Number**, which may be used to identify the claim while using the **View Web Claim** feature. The **Web Reference Number** may also be useful in discussing a claim with your Account Manager.

Checking Claims Status

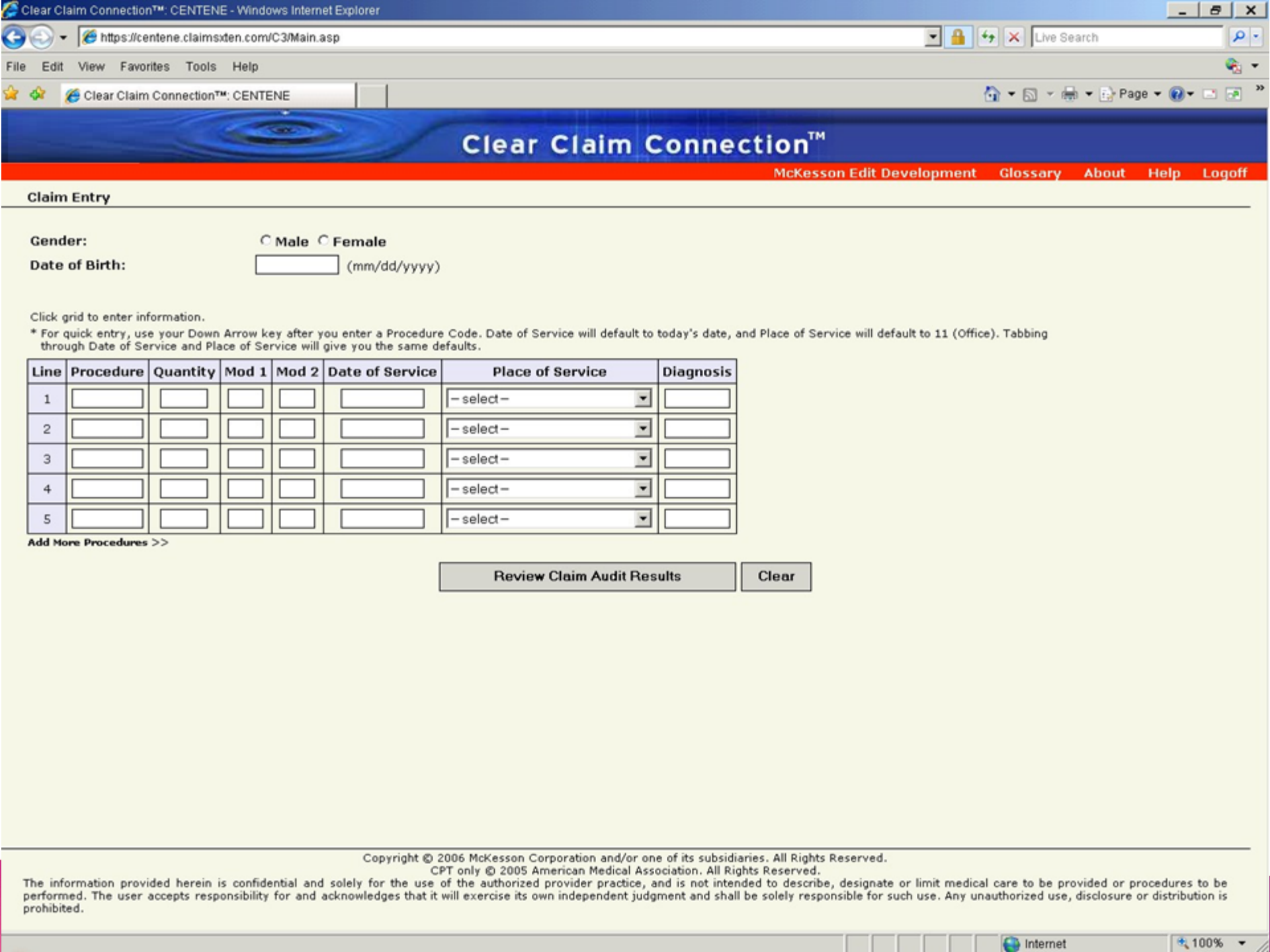
- Claims status can be viewed on claims that have been sent EDI, Paper or Secure Provider Portal.



Checking Claims 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
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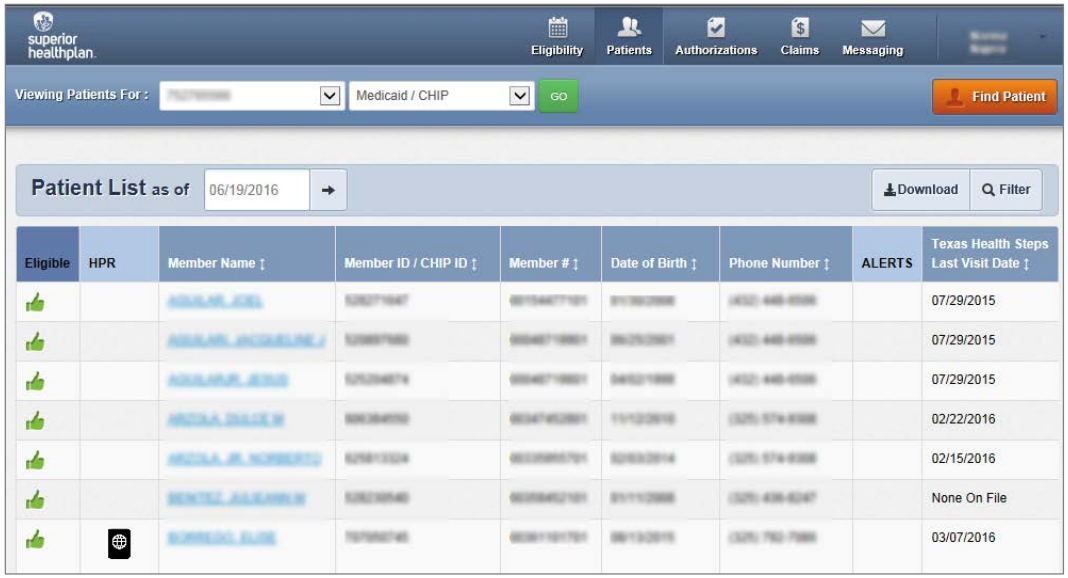
CPT only © 2005 American Medical Association. All Rights Reserved.
The information provided herein is confidential and solely for the use of the authorized provider practice, and is not intended to describe, designate or limit medical care to be provided or procedures to be performed. The user accepts 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%

Additional Features

- Eligibility and Service Coordinator information
- Primary Care Physicians Patient List
  - Pull list of patients and save as an Excel document or PDF.
  - See and sort by alerts including care gaps (missing Texas Health Steps checkups, well child checkups, etc.), Case Management, Disease Management or Special Needs.
  - See Emergency Room alerts. Providers can see when one of their patients has been to the ER within 90 days.



Questions & Answers

Thank you for attending!