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Billing Clinic

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

Provider Training

Introductions and Agenda

- Verifying Eligibility
- Authorization Process
- Establishing Medical Necessity (After an Adverse Determination)
- Claims Submissions
- FQHC and RHC Billing Information
- Electronic Payments and Remittance
- Superior HealthPlan Departments
- Secure Provider Portal
- Questions and Answers

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Verifying Eligibility

Verify Eligibility

- Texas Medicaid Benefit Card (TMBC) (STAR Only)
  - TexMedConnect - www.TMHP.com/pages/edi/edi_texmedconnect.aspx.
- Superior Identification Card
- Secure Provider Portal: www.Provider.SuperiorHealthPlan.com.
- Contact Member Services:
  - STAR, CHIP: 1-800-783-5386
  - STAR Health: 1-866-912-6283
  - STAR Kids: 1-844-590-4883
  - STAR+PLUS: 1-877-277-9772
- Verify eligibility the first of each month using our website or by contacting Member Services.

Superior Member ID Cards

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

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.
  - Emergent and urgent services provided by an out-of-network provider do not require prior authorization.
- Initiate authorizations 5 business days in advance for non-emergency services.
- If clinical information is requested by Medical Management, submit by fax or through the Superior's Secure Provider Portal.
  www.Provider.SuperiorHealthPlan.com
  Fax: 1-800-690-7030

Authorization TAT Requirements

Program	Authorization Type	TAT
STAR (Medicaid), STAR Health, STAR Kids and STAR+PLUS	Outpatient	3 business days
CHIP	Outpatient	2 business days
Medicaid and CHIP	Urgent, outpatient	1 business day
Medicaid and CHIP	Inpatient	1 business day

Authorization TAT Requirements

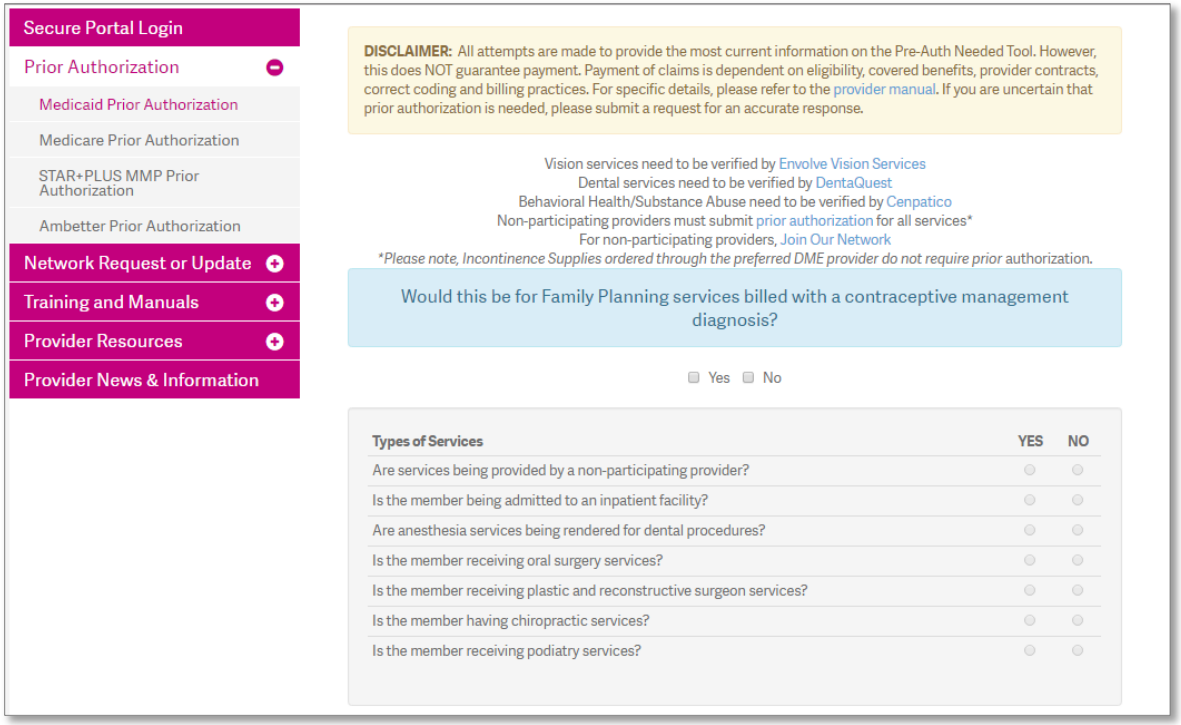
Authorization Type	TAT
Concurrent Review – The process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission.	• For Medicaid and CHIP, all urgent requests must be reviewed the same day, or within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

Services Requiring Authorization

- Services requiring authorization include, but are not limited to:
  - Specialty procedures, including Chiropractic, Podiatry, Oral Surgery and Plastic and Reconstructive Surgery.
  - In-Home and Outpatient Therapy/Rehabilitation.
  - Durable Medical Equipment (Over $500, Incontinence Supplies, Enteral Nutrition, etc.).
  - Transportation.
  - Pharmaceuticals.
  - Surgical/Other Procedures.
  - Transplants.
  - Long-Term Services and Support (LTSS).
  - Radiology.
  - Vision.

Medicaid Pre-Authorization Tool

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

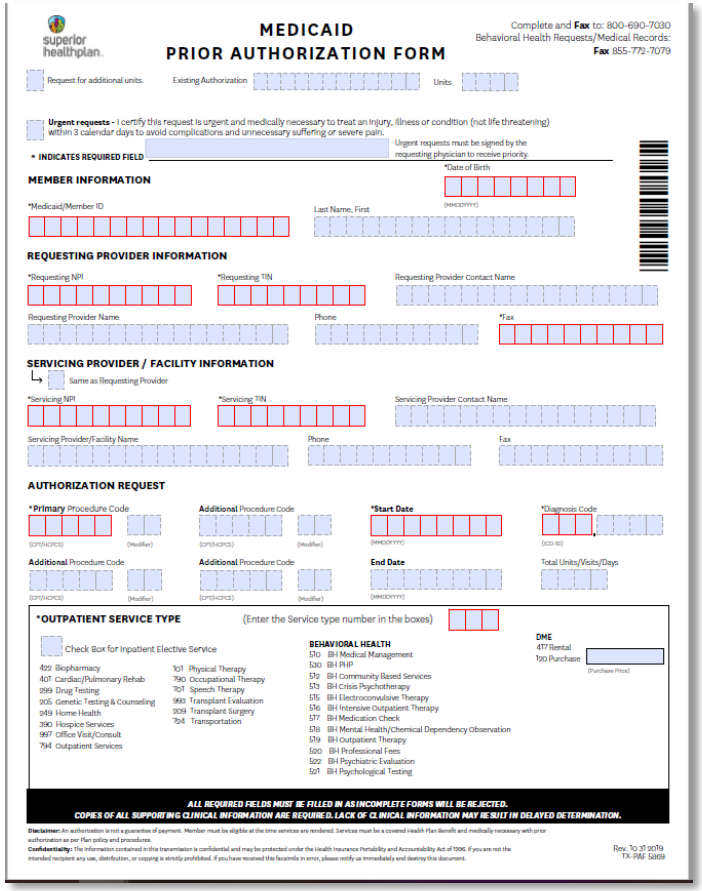


Prior Authorization Form

- The 2020 Outpatient Medicaid Authorization Form is located at www.SuperiorHealthPlan.com/providers/resources/forms.html

- Providers may also utilize the Texas Standard Prior Authorization Request Form at www.SuperiorHealthPlan.com/providers/resources/forms.html.

- Prior authorizations can also be submitted through the Secure Provider Portal.



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MEDICAID
PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records:
Fax 855-772-7079

Request for additional units. Existing Authorization Units

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

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

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Medicaid/Member ID | Last Name, First | *Date of Birth (MM/DD/YYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI | *Requesting TIN | Requesting Provider Contact Name

Requesting Provider Name | Phone | *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI | *Servicing TIN | Servicing Provider Contact Name

Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

*Primary Procedure Code (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | *Start Date (MM/DD/YYYY) | *Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) | Additional Procedure Code (CPT/HCPCS) (Modifier) | End Date (MM/DD/YYYY) | Total Units/Visits/Days

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

Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
999 Drug Testing
905 Genetic Testing & Counseling
949 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services
161 Physical Therapy
790 Occupational Therapy
761 Speech Therapy
993 Transplant Evaluation
909 Transplant Surgery
764 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
520 BH PHP
572 BH Community Based Services
573 BH Crisis Psychotherapy
575 BH Electroconvulsive Therapy
576 BH Intensive Outpatient Therapy
577 BH Medication Check
578 BH Mental Health/Chemical Dependency Observation
579 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
720 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev. To 1f 2019
TX-PAF 5869

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

TurningPoint Healthcare Solutions

- Effective November 15, 2019, Superior started working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint is responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures.
- This process applies to: Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS), CHIP, Allwell from Superior HealthPlan and Ambetter from Superior HealthPlan.
- Physicians started submitting requests to TurningPoint for prior authorization beginning on November 1, 2019 for dates of service on or after November 15, 2019.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under billing resources at the following link: www.SuperiorHealthPlan.com/providers/resources.html.

TurningPoint Healthcare Solutions

- Prior authorization will be required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Knee Arthroplasty and Arthroscopy	Spinal Fusion Surgeries
Uni/Bi-compartmental Knee Replacement	Cervical
Hip Arthroplasty and Arthroscopy	Lumbar
Acromioplasty and Rotator Cuff Repair	Thoracic
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Osteochondral Defect Repair	Laminectomy/Discectomy

*This is not an all-inclusive list. For a detailed list of impacted Current Procedural Terminology (CPT) codes, visit TurningPoint's Web Portal or www.SuperiorHealthPlan.com/providers/preauth-check.html.

TurningPoint Healthcare Solutions

- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
  - Web Portal Intake: www.myturningpoint-healthcare.com
  - Telephonic Intake: 469-310-3104 | 855-336-4391
  - Facsimile Intake: 214-306-9323

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Establishing Medical Necessity

Medical Management Denials

- Type of Denial
  - Adverse Determination (Medical Necessity) Denial - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
    - Medical necessity is defined as health services that are reasonably necessary to:
      - Prevent illness or medical conditions.
      - Provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, or limitations in function.
  - Contractual (Administrative) Denials (non-clinical reasons)
    - Late notification.
    - Failure to obtain prior authorization.
    - Alberto N. missing information denial.

Medical Management Denials

- Type of Denial
  - Non-Covered Benefit Denial
    - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by the State.
    - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by the State (Non-covered Benefit).

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, external review (CHIP) or fair hearing rights (Medicaid) fully explained.

Appealing Medical Management Denials

- The provider may request an appeal in writing on behalf of the member.
  - Mail: Superior HealthPlan
    Attn: Appeal Coordinator
    5900 E. Ben White Blvd.
    Austin, TX 78741
  - Fax: 1-866-918-2266

Appealing of Adverse Determination

- Types of Medical Necessity Appeals:
  - Level 1: Internal/standard appeal (appeal to Superior HealthPlan)
  - Level 2: External appeal (appealing to a third party)
    - CHIP (External Review must be requested directly through Maximus.)
    - STAR/STAR Health/STAR Kids/STAR+PLUS = Fair Hearing (FH) - HHS

- Medical necessity appeals *(Note: Contractual denials only have complaint rights)*.
    - Appeals must be submitted to Superior within 60 days from the date of the last denial.

Appeal Timeframe by Product

Medicaid

- Provider or member has:
  - 60 calendar days from the date of the notification of adverse determination (date of denial letter) to file an appeal for STAR, STAR Health, STAR Kids and STAR+PLUS.
    - 30 calendar days for an expedited appeal.
  - 90 days for CHIP.
  - 120 calendar days from the date of notification of adverse determination to file a FH for STAR products.
    - Non-covered benefit denial also has FH 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.
  - Independent Review Organization (IRO) rights.
  - Complaint rights.
- Provider or member does not have FH rights.
- Appeal is to be completed within 30 calendar days.

Expedited Appeals

- Expedited Appeals
  - IP expedited appeals are processed within 1 working day of appeal request.
  - All other expedited appeals are completed within 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: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
  - Fax:
    Attn: Complaint Department
    1-866-683-5369
  - Verbally:
    During a face-to-face interaction/visit or telephone call into any Superior department.
  - Online:
    www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html
- Complaint form can be printed, completed and faxed or mailed to Superior for resolution response. The form can be found under Contact – Complaint Form: www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.

Compliance

Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines, found at 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

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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.

Claims Filing: Initial Submission

- Mailing Address (paper claims):

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

- Effective January 1, 2020, medical eye services provided by an ophthalmologist will be submitted to Superior for processing.

Paper Claims Filing

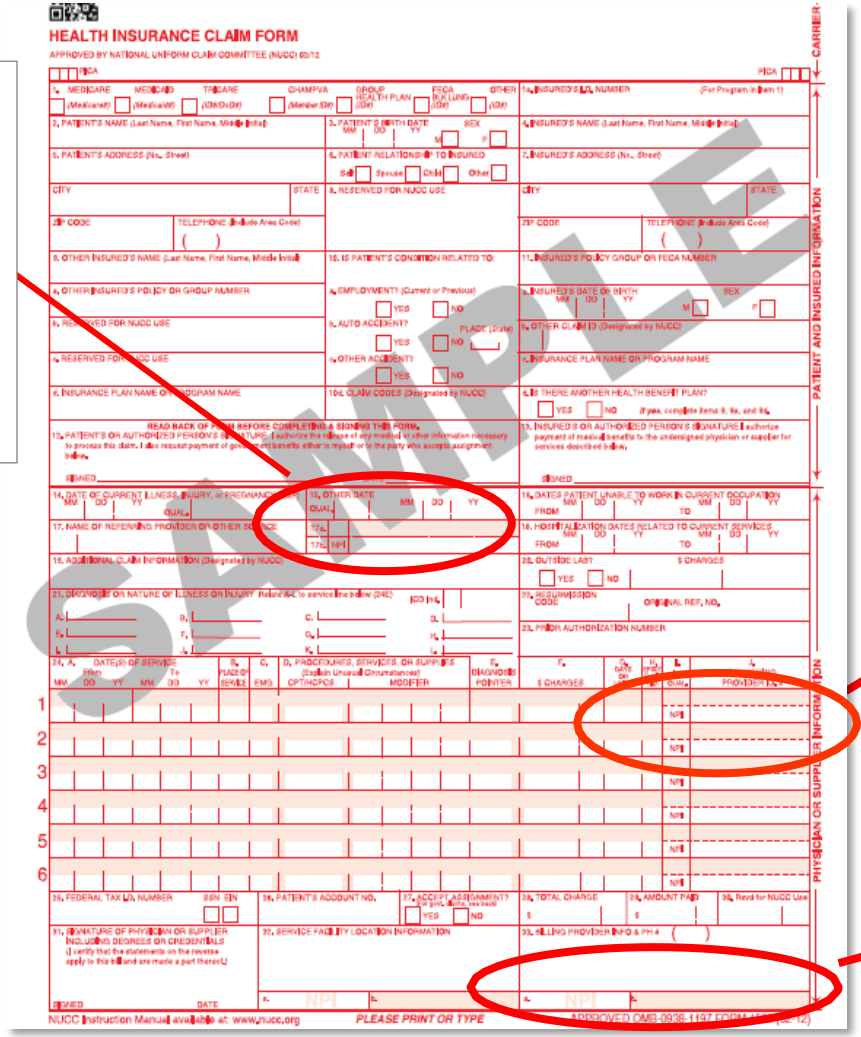
- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS-1450/UB-04 or CMS 1500 red form (not a copy).
    - Handwritten claim 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

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).
  - Electronic Data Interchange (EDI) Rejection/Acceptance reports.
  - Rejection letters.
  - EOP.

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

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

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.

Electronic Claims Filing

- If provider uses 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 at www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html.
  - For Superior medical electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **68069**.
  - For Superior behavioral health claim submissions, the correct payor ID is **68068**.
    - For MMP, Allwell and Ambetter, behavioral health claims are still submitted to 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, 2013, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2013, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

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

Behavioral Health Retrospective Utilization Review

- Effective July 1, 2020, Superior will transition to retrospective utilization review for inpatient behavioral health admissions for members.
- Notification of admission is still required at the time of admission.
  - Lack of notification may result in a contractual denial for failure to comply.
- To facilitate the retrospective review, clinical documentation to support the medical necessity of the inpatient admission must be submitted with the claim for the inpatient stay.
- Superior will send a request for clinical records if not received with the claim.
  - The facility will be required to submit the records within 5 business days of the request.
  - If medical records are not included with the claim, Superior will review the admission to determine medical necessity based upon any clinical information available for the admission.

Claim Adjustments, Reconsiderations and Disputes

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

Corrected Claims Filing

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

Corrected Claims Filing

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

Superior HealthPlan
Attn: 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:
  - 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.

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 Superior's 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 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 completed legibly.
  - Resubmission with information indicated on a cover page or letter will not be accepted.
- Copies of the Sterilization Consent Form and Instructions can be found at Claim forms can be found at www.SuperiorHealthPlan.com/providers/resources/forms.html.

Billing Reminders - Sports Physicals

- Superior will reimburse sports physicals for eligible members:
  - STAR, STAR Health and CHIP
  - 4-17 years of age (STAR and CHIP) and 4-18 years of age (STAR Health)
  - 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).

Clean Claim Requirements

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

Provider Training

- Depending on the type of services provided and billed for, Superior offers targeted billing presentations located on www.SuperiorHealthPlan.com/providers/training-manuals.html.
  - Example: LTSS Billing Clinics
- There are also product-specific trainings available on STAR, STAR Health, STAR Kids and STAR+PLUS.
  - Access the schedule for face-to-face trainings or webinars at www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html.

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FQHC and RHC Billing Information

FQHC: Medicaid and CHIP Billing Procedures

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

FQHC: Medicaid and CHIP Billing Procedures

- Providers must bill with modifier “TH” for antepartum or postpartum care.
- Claims must be billed with the appropriate family planning diagnosis code for family planning services.
- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to the Prospective Payment System [PPS] encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
  - Please note: After-hours care and Long Acting Reversible Contraception (LARC) services will be paid in addition to the provider’s PPS encounter rate.

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

Electronic Payments and Remittance

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

EFT vs. Paper Check

- Providers will receive a paper check and EOP, 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 PaySpan at 1-877-331-7154, email ProviderSupport@PayspanHealth.com or contact your local Account Manager or Provider Services at 1-877-391-5921.

Superior HealthPlan Departments

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 a member's Service Coordinator.
  - Locating your 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:
  - Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS) and CHIP: 1-877-391-5921

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 locate your Account Manager by using the field office map located at www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html.

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Secure Provider Portal

Submitting Claims

Secure Provider Portal and Website

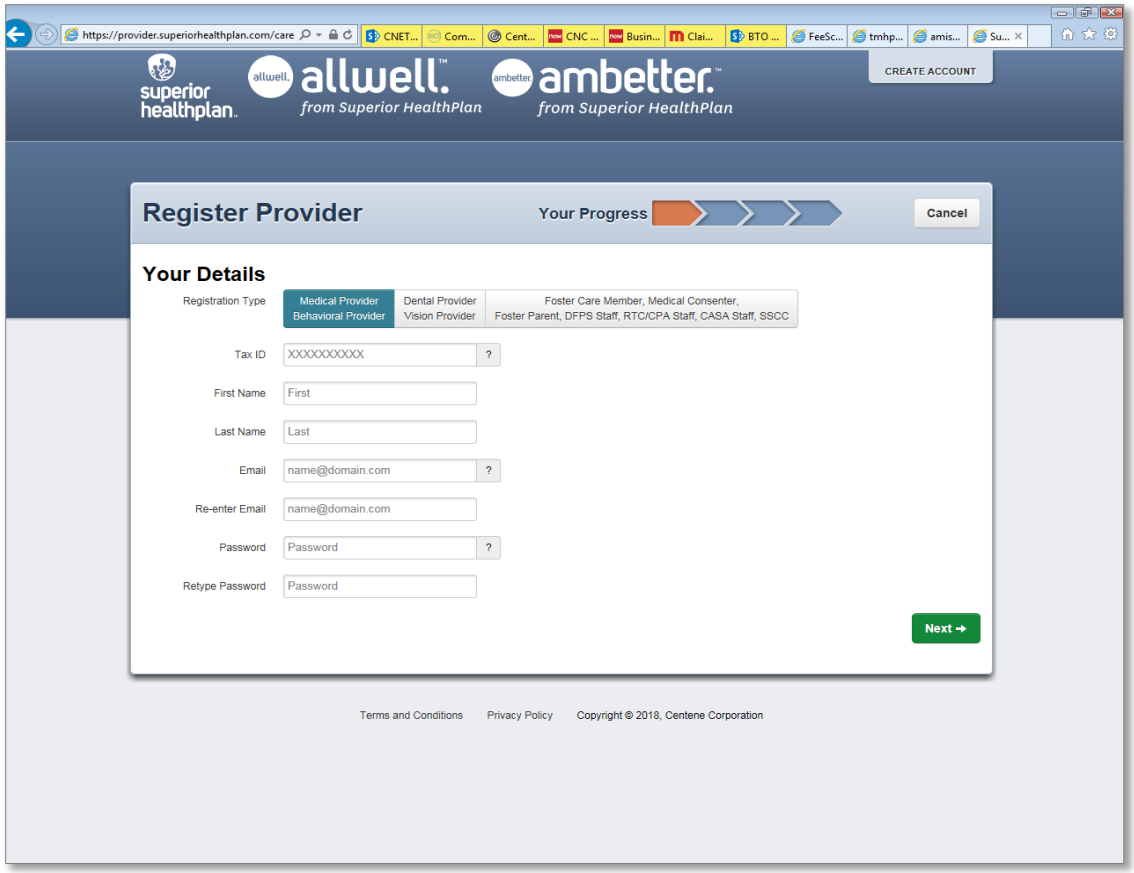
Superior is committed to providing you with all of the tools, resources and support you need to make your business transactions with Superior as smooth as possible. One of the most valuable tools is Superior's Secure Provider Portal. Once you are registered you get access to the full site.

- 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, news posts, provider manuals, forms and helpful links.

Registration

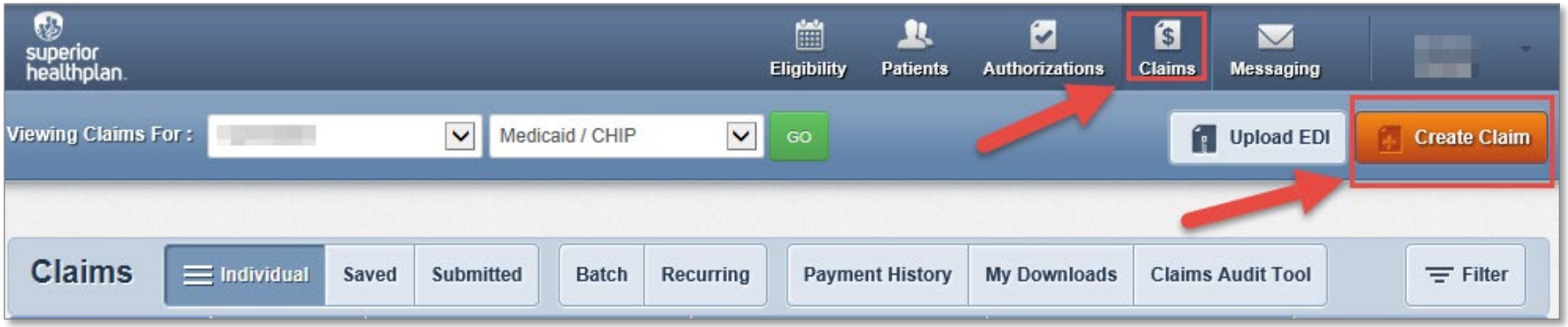
To register, visit Provider.SuperiorHealthPlan.com.

- 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.



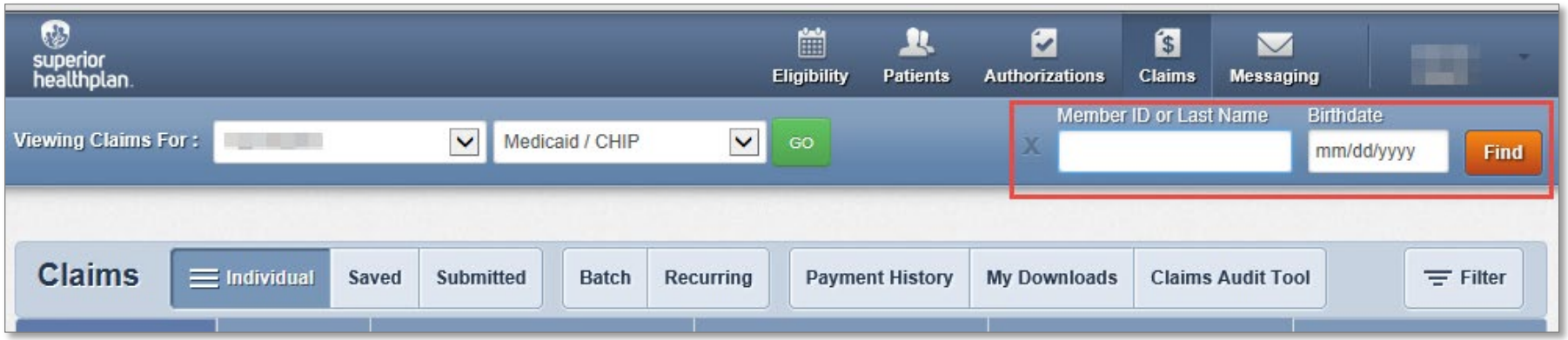
Create Professional Claims

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



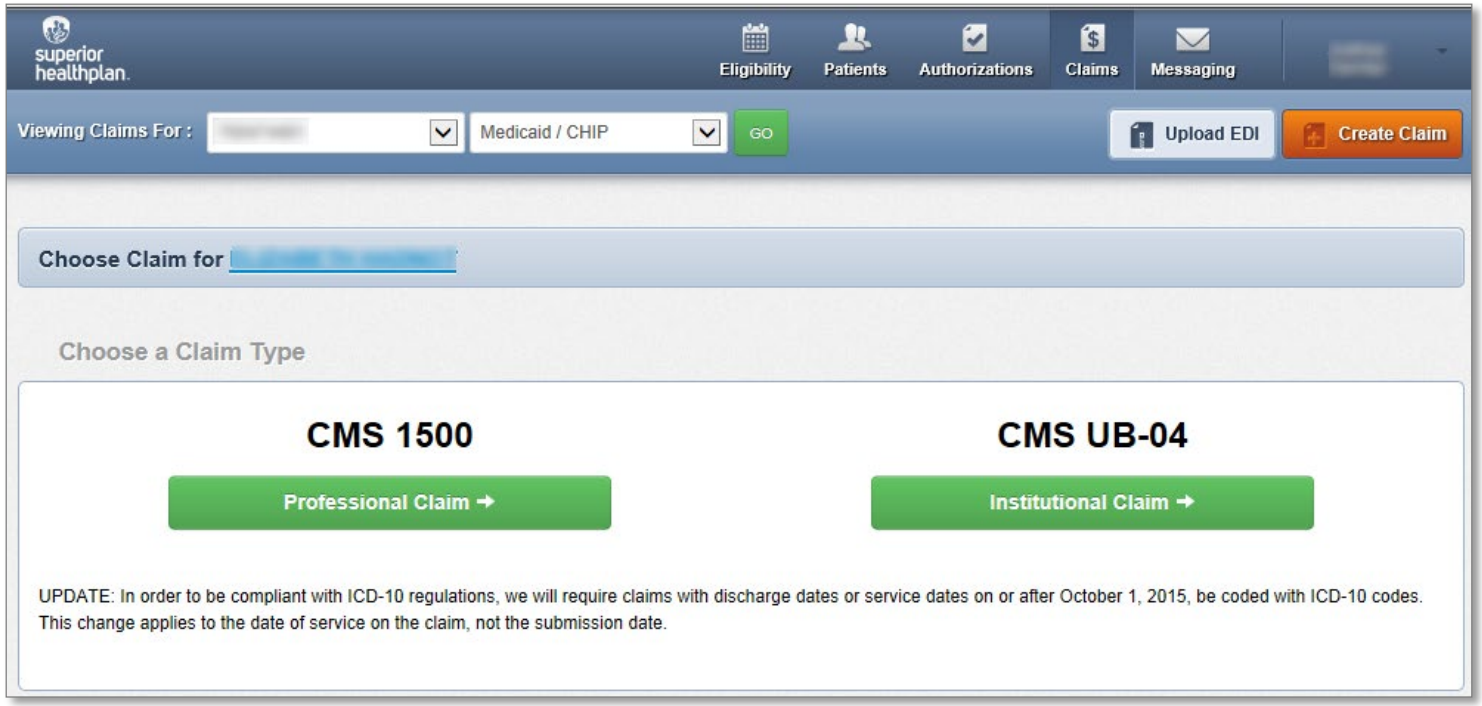
Create Professional Claims

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



Create Professional Claims

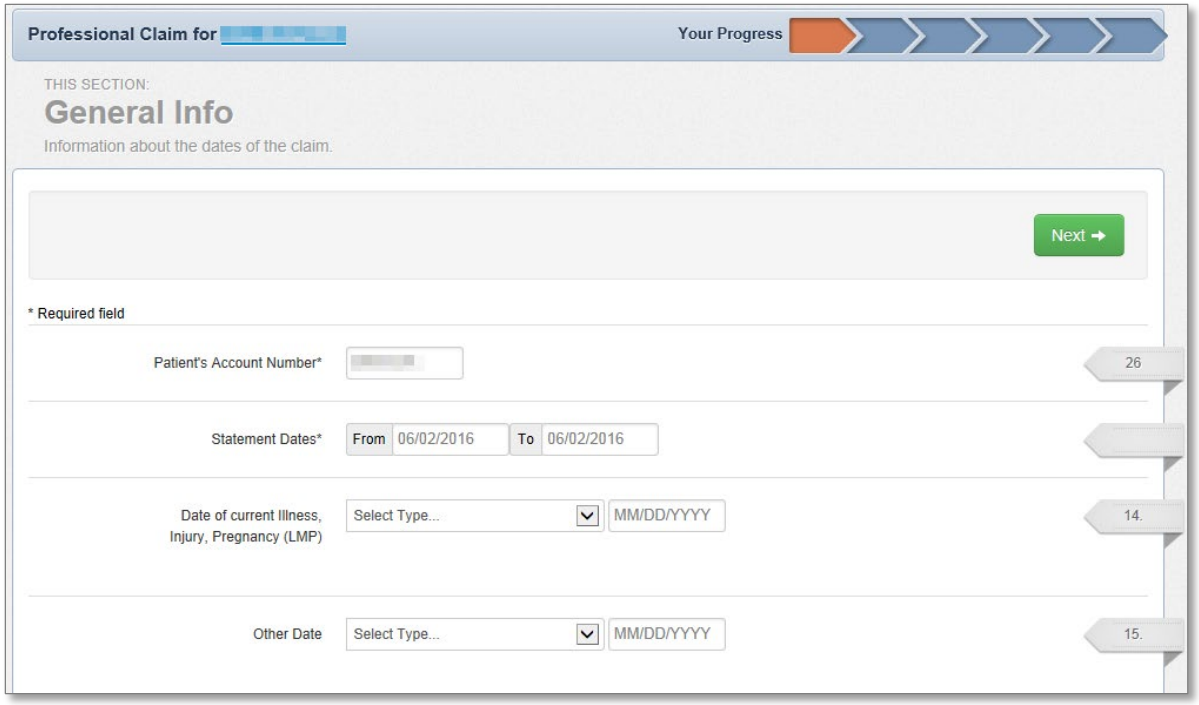
- **Choose a Claim Type.**
- Select **Professional Claim.**



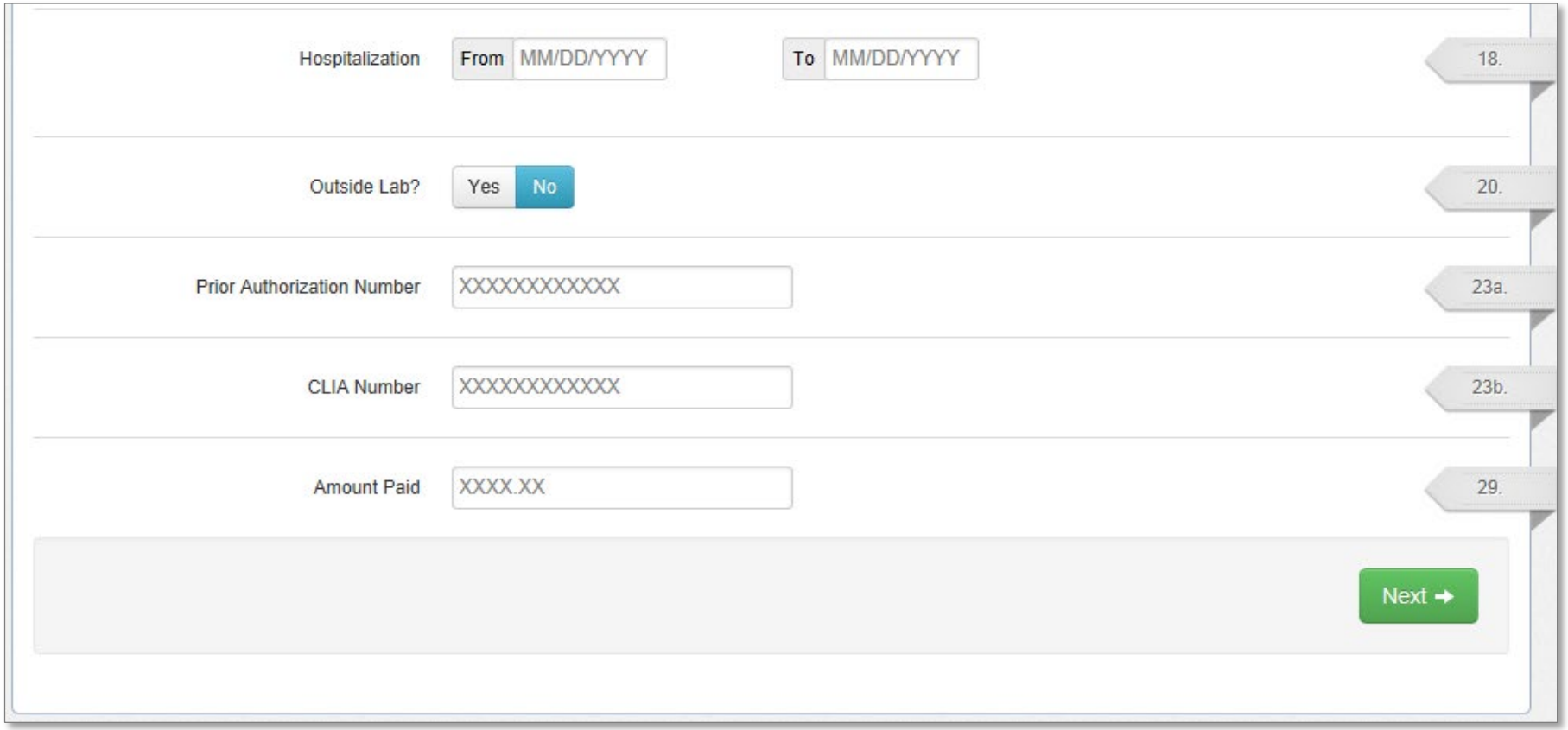
General Information

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

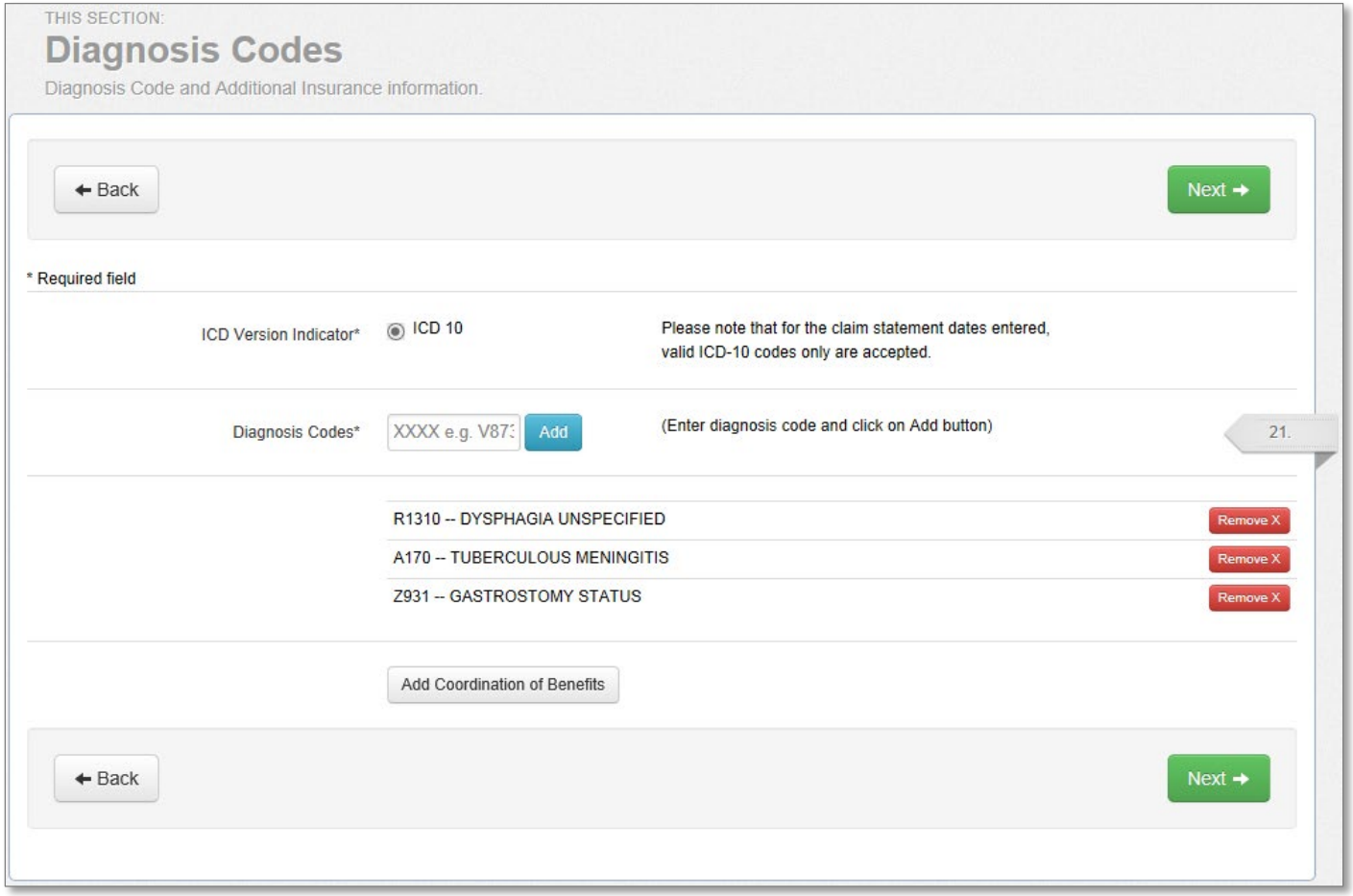
Note: This is the internal patient account number assigned by servicing provider.



General Information

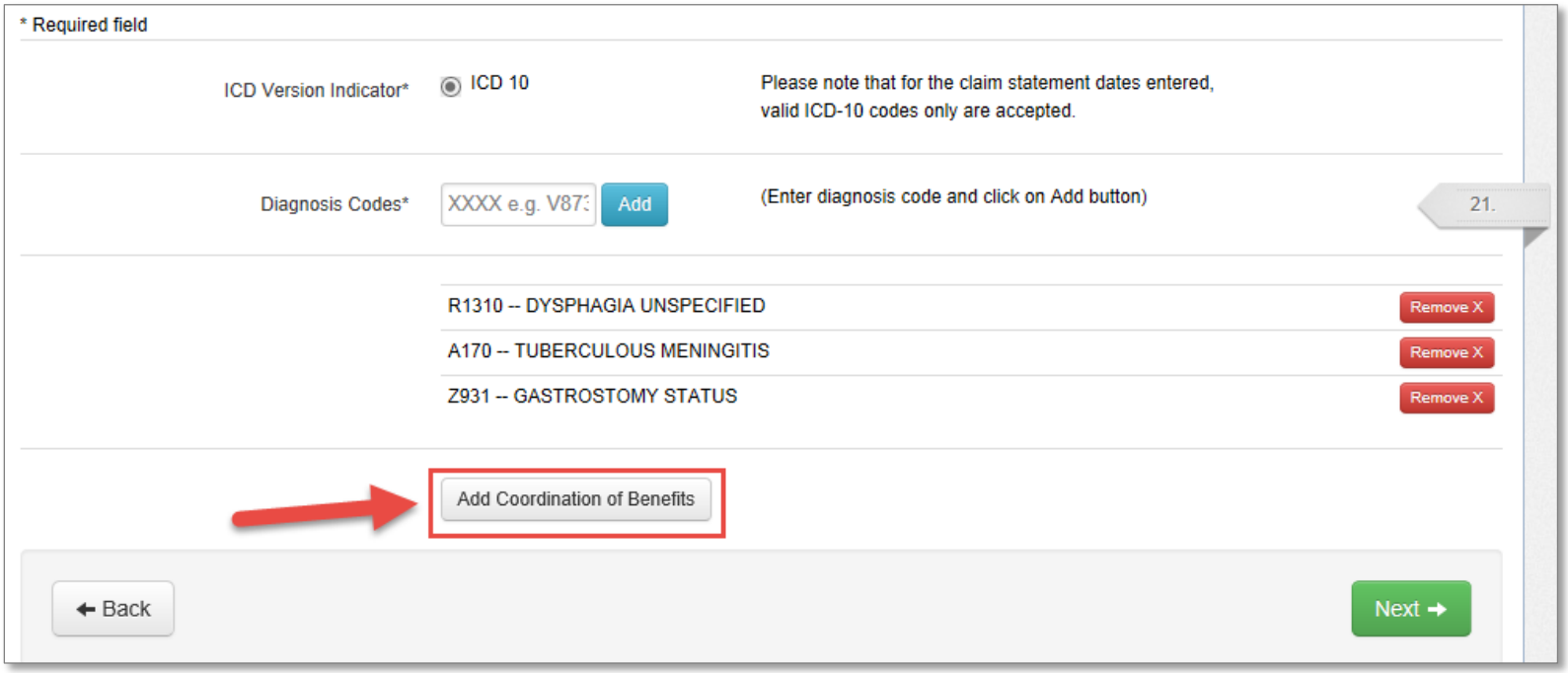


Diagnosis Codes



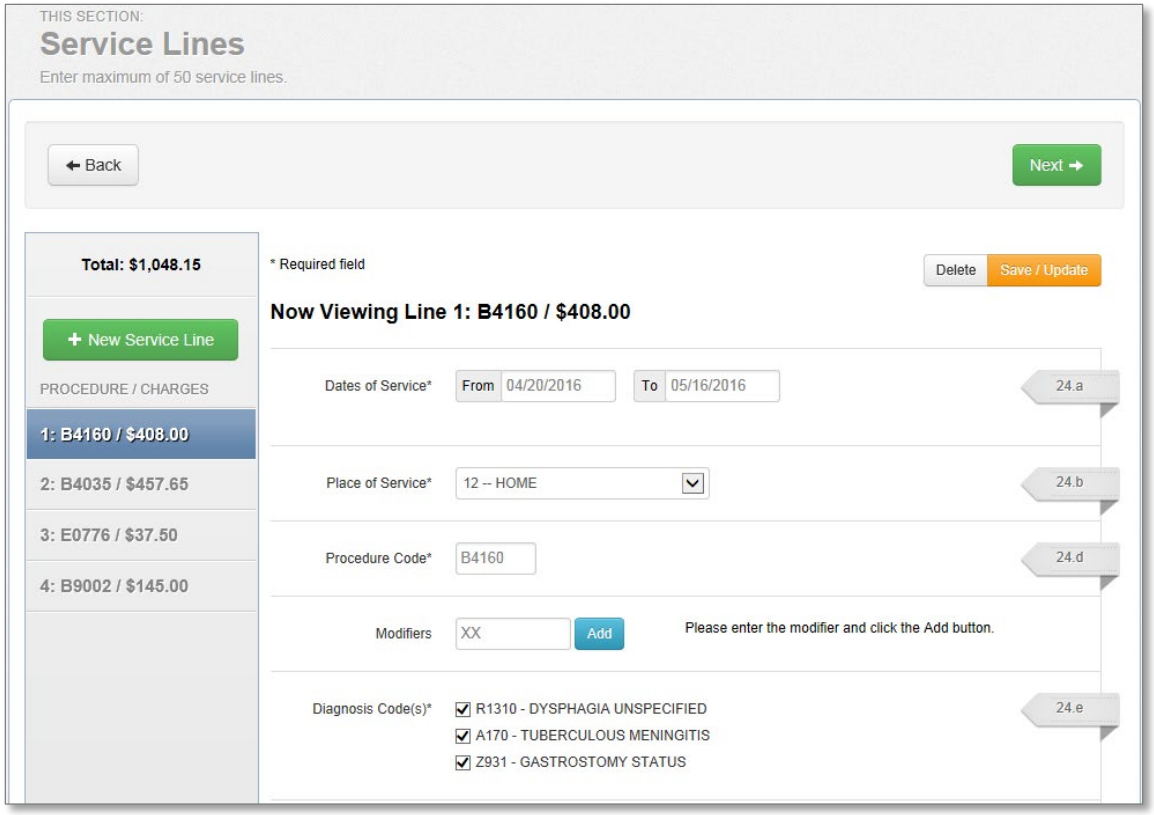
Coordination of Benefits

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

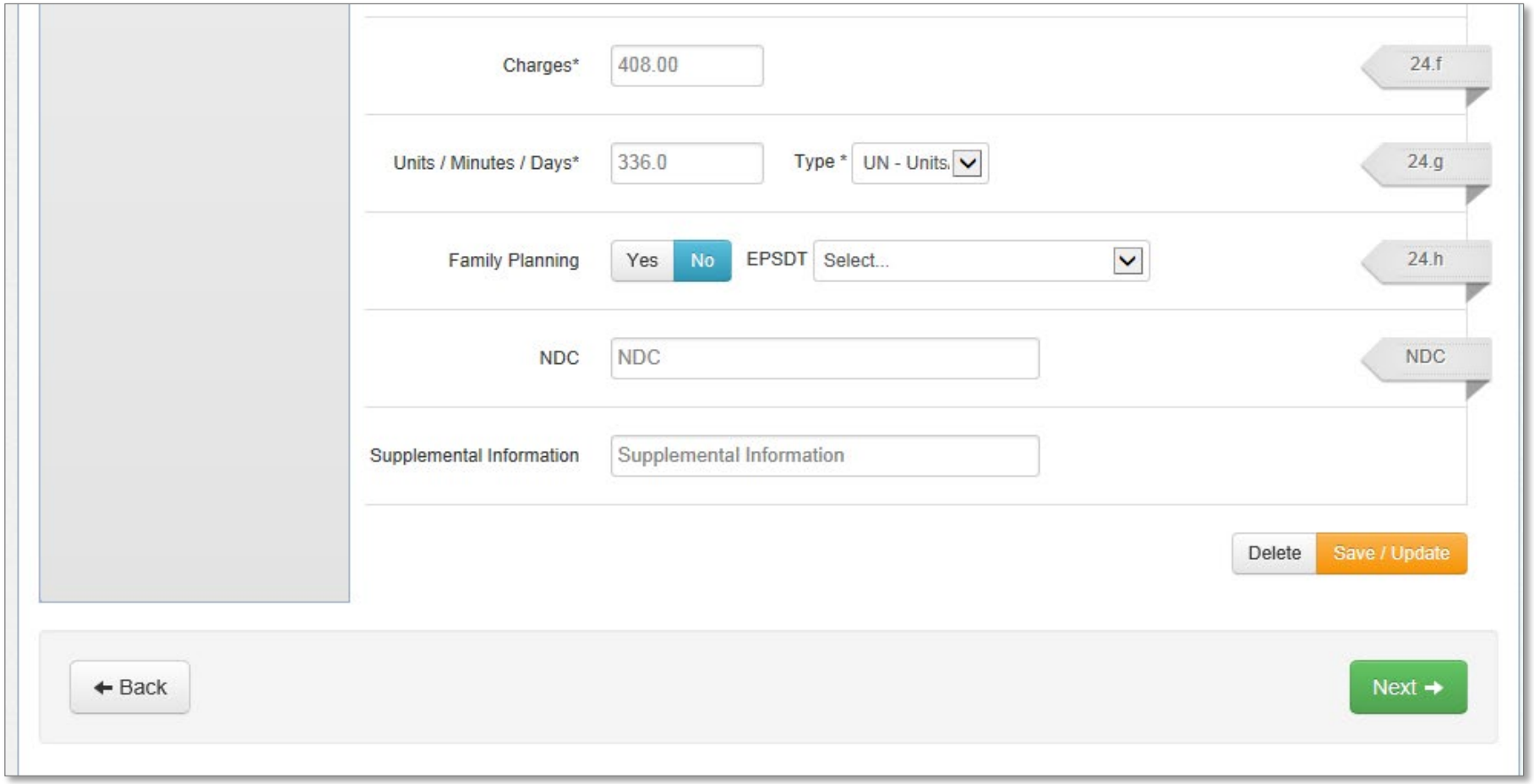


Service Lines

- Enter maximum of 50 services lines.

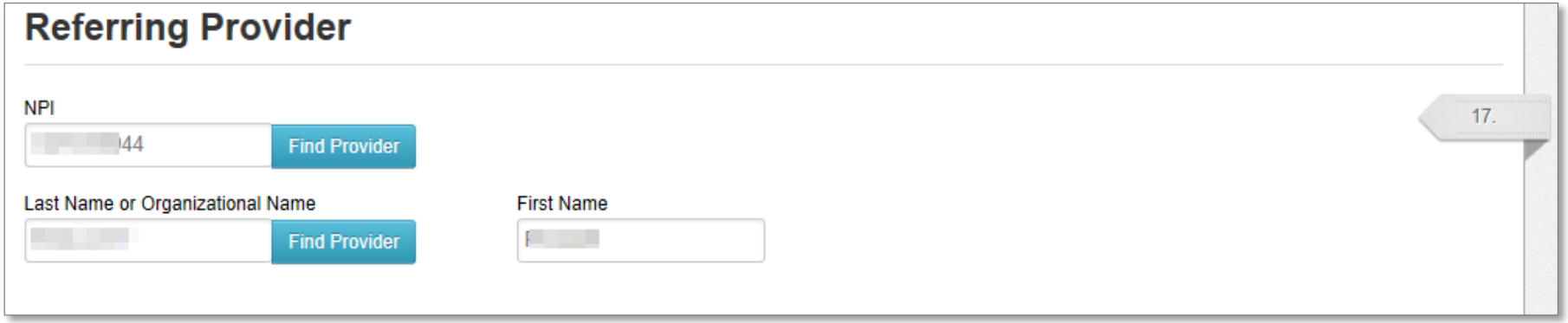


Service Lines



Referring Provider

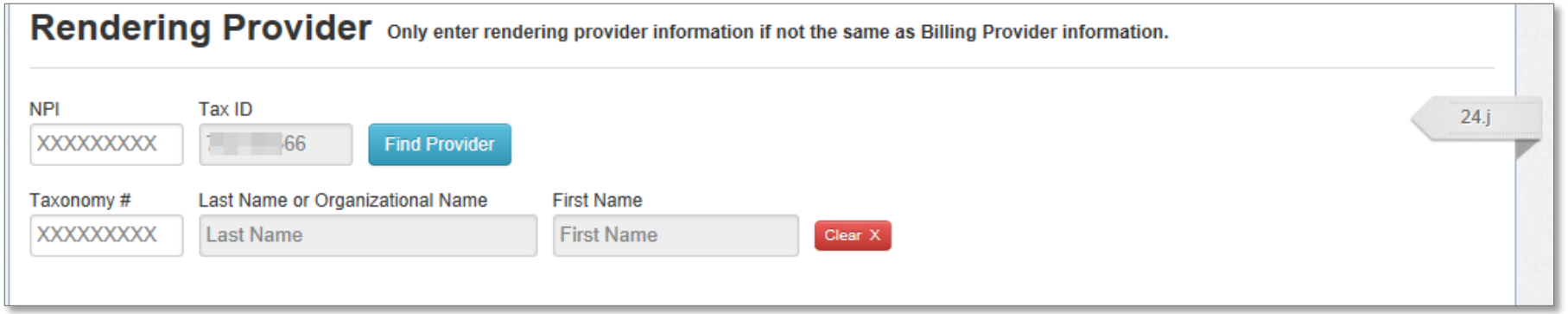
- In the **Referring Provider** section, enter information as needed.



Rendering Provider Section

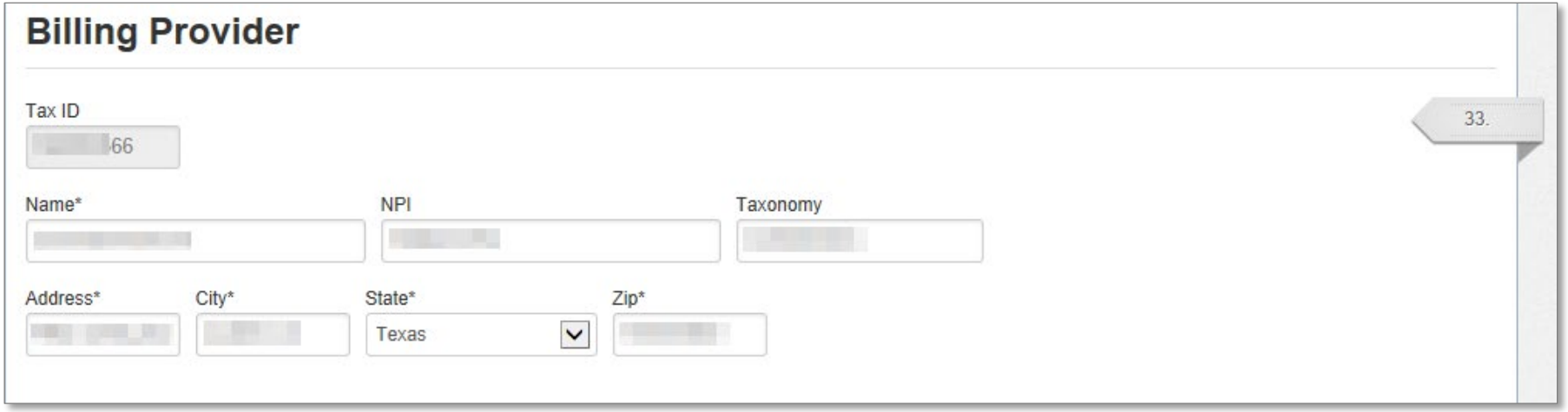
- In the **Rendering Provider** section:
  - Enter your **NPI** number.
  - Select the provider info from the drop-down list associated with your location and taxonomy code.

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



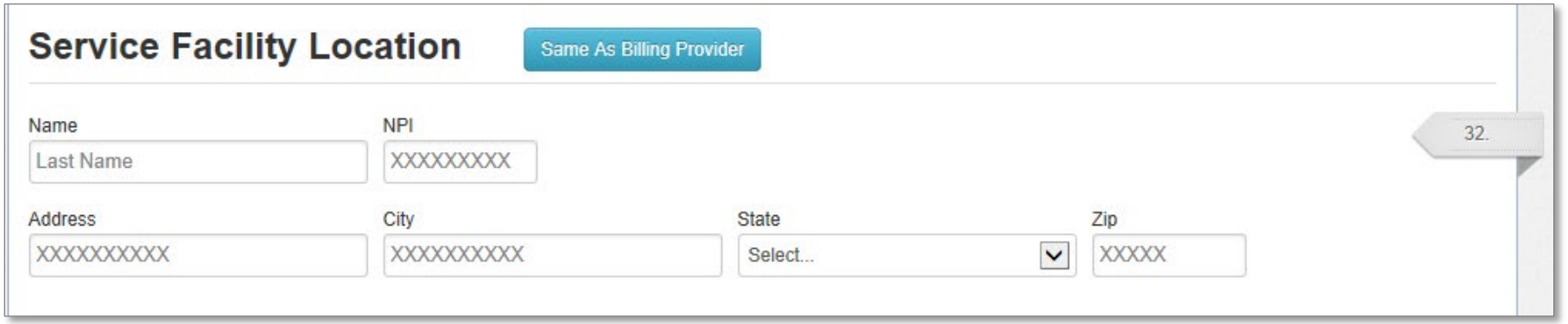
Billing Provider Section

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

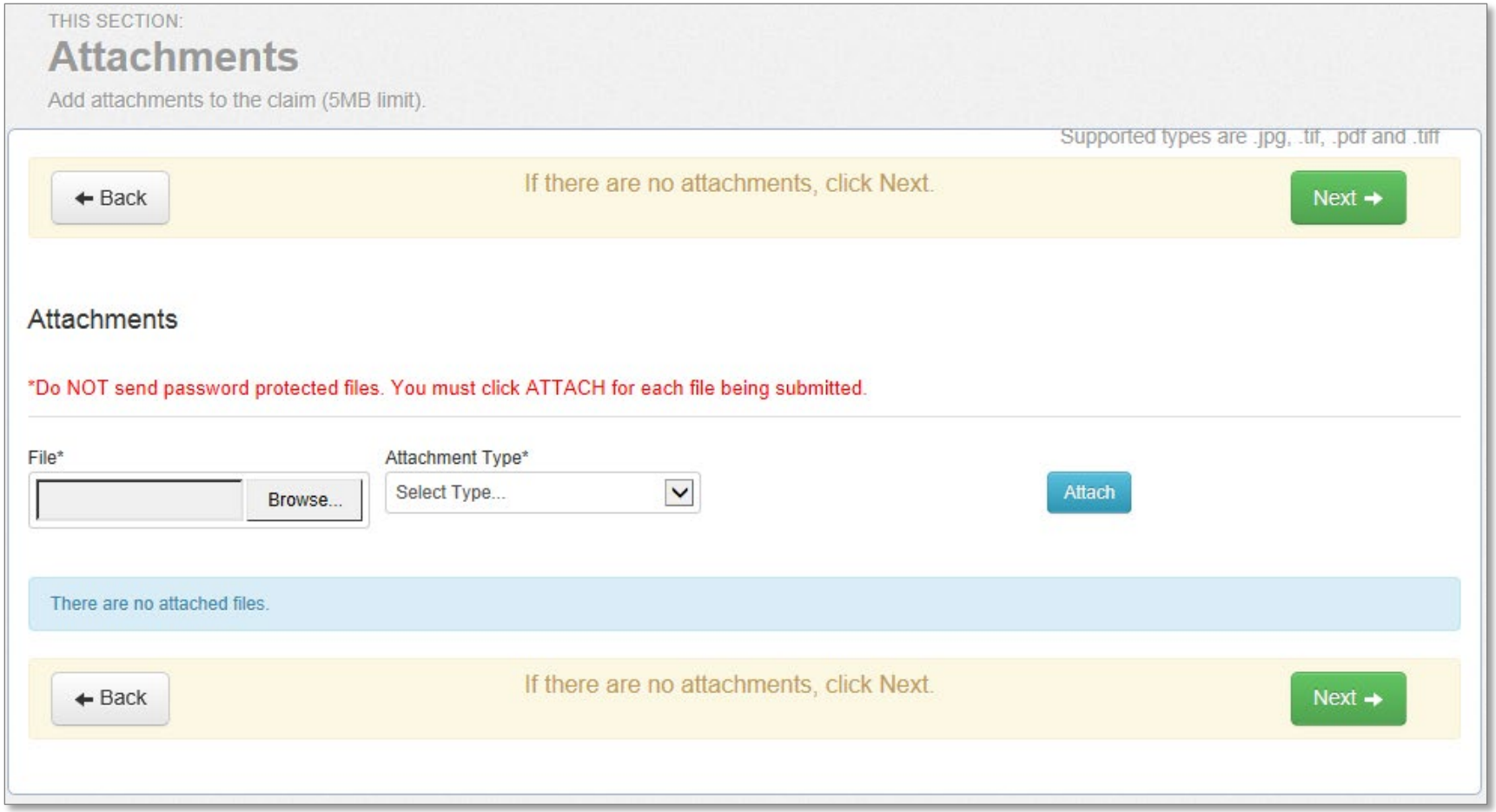


Service Facility Location Section

- 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

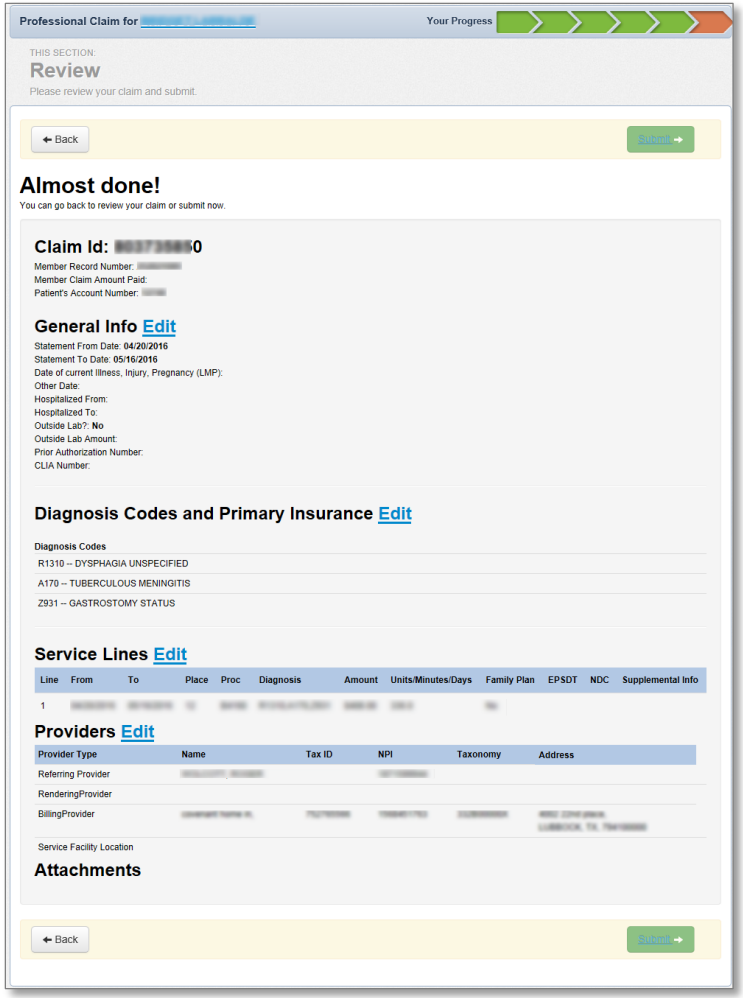


Review and Submit

Review to ensure that all information is correct.

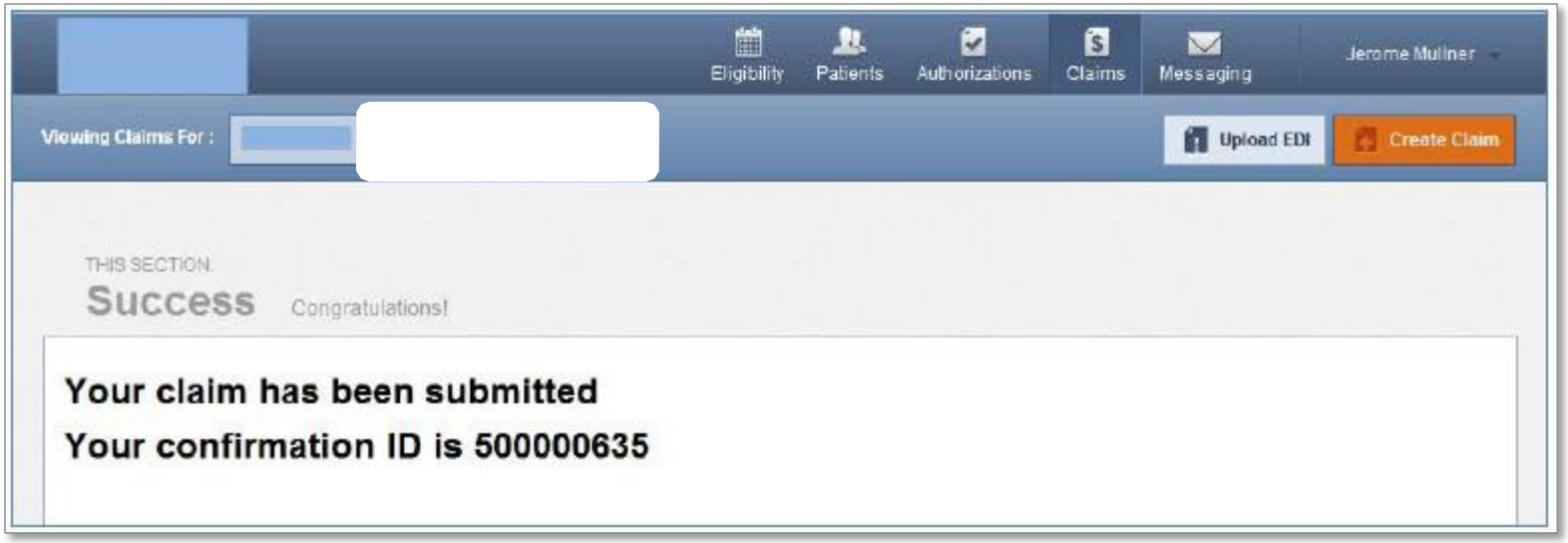
- If information is incorrect, click **Previous Step** to move to the section that needs changes and change the information within the section.

- If all information is correct, click **Submit Claim** and the claim will be transmitted. A “Claim Submitted” confirmation will be displayed.



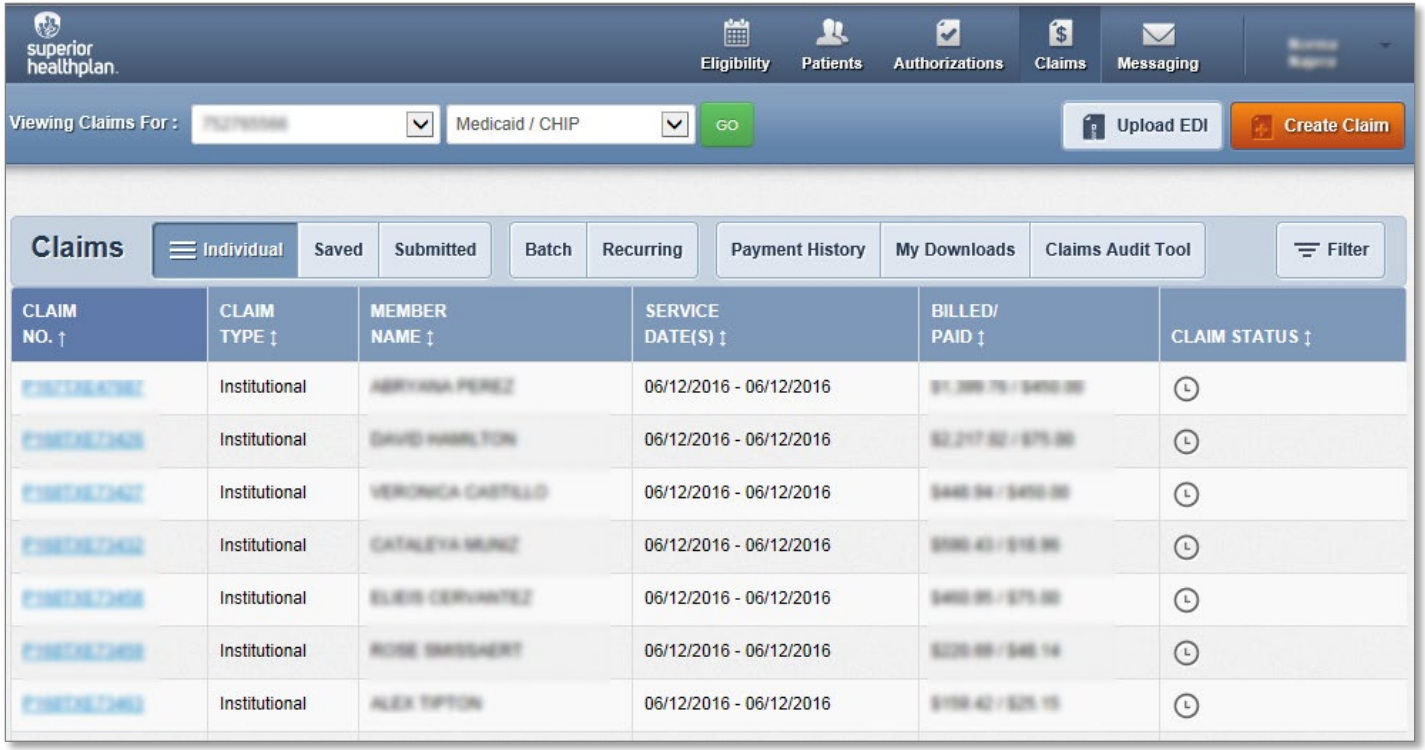
Claim Submitted Successfully

- 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.

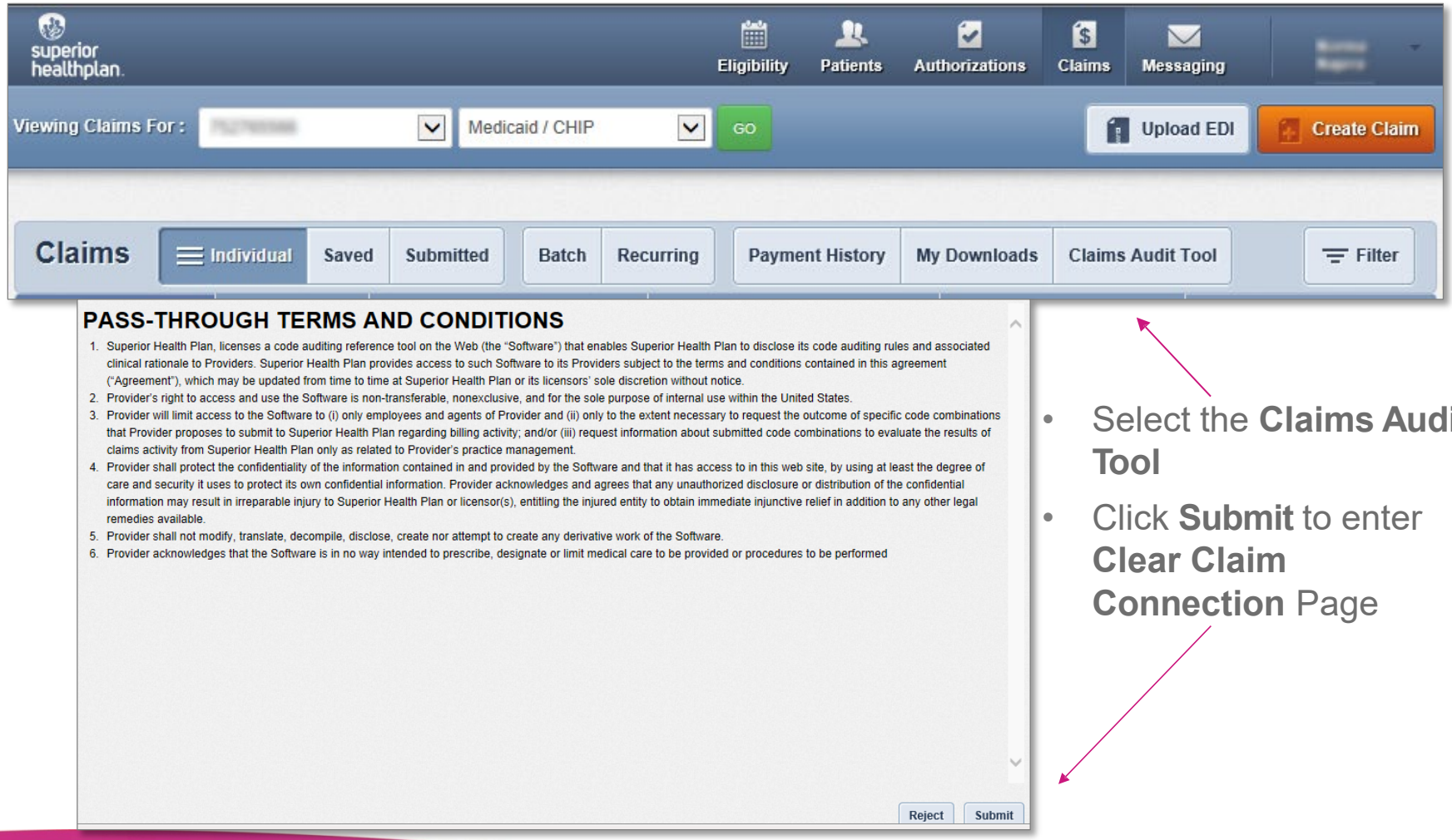


Checking Claims Status

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

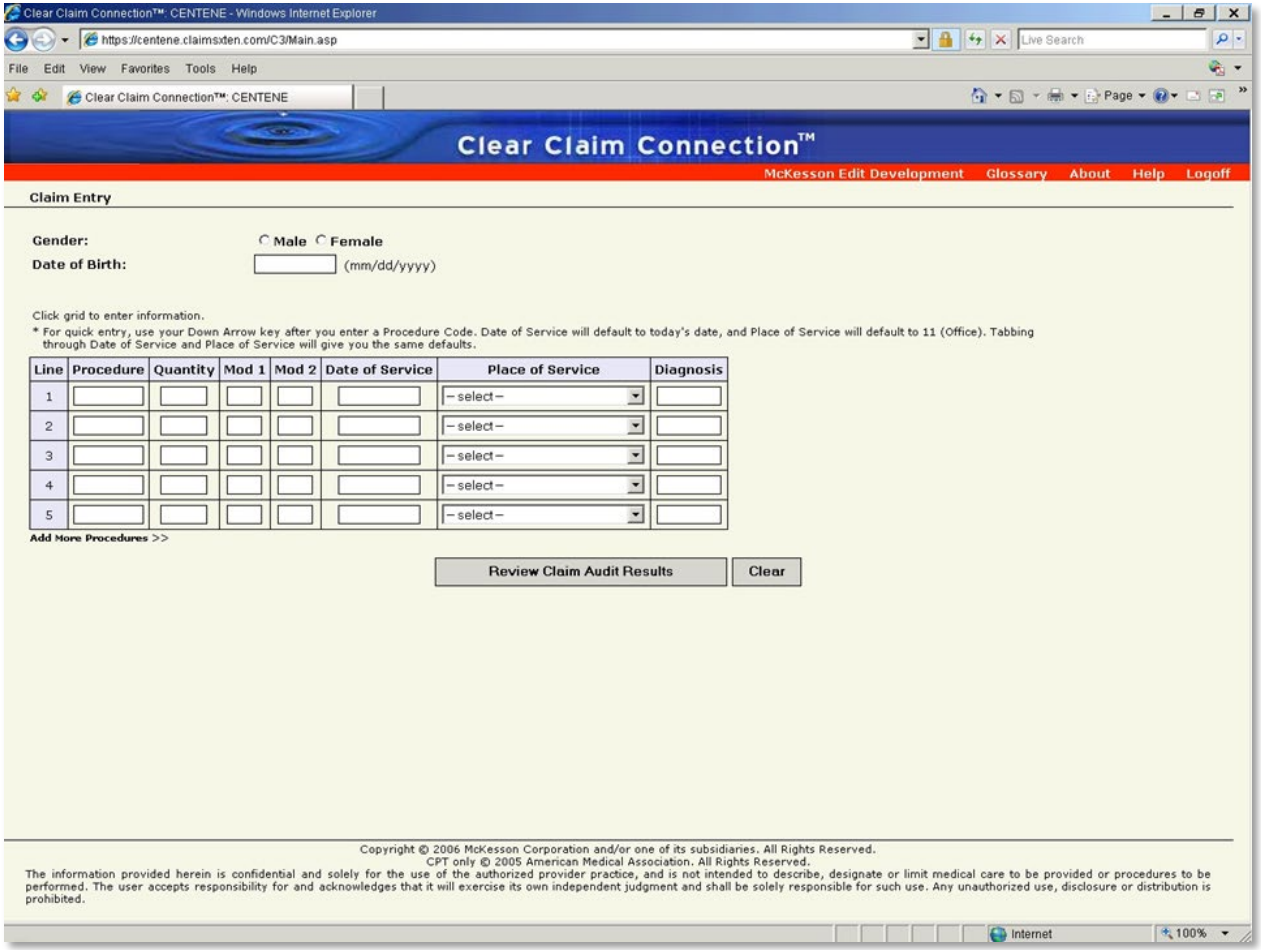


Checking Claims Status



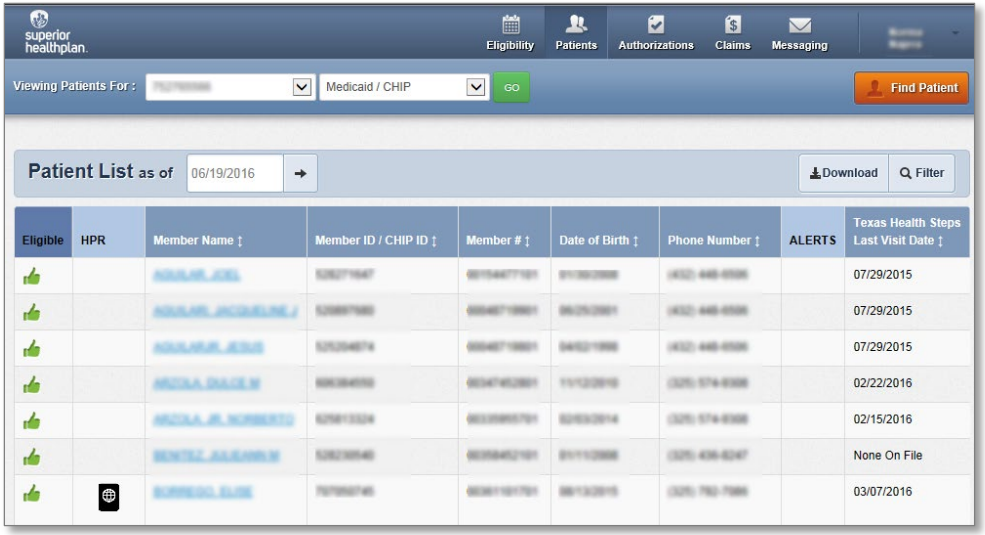
- Select the **Claims Audit Tool**
- Click **Submit** to enter **Clear Claim Connection** Page

Claim Audit Tool



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.



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Questions and Answers

Thank you for attending!