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STAR, STAR+PLUS and CHIP

Provider Training

July 2017

Introductions & Agenda



- Provider Roles and Responsibilities
- STAR and STAR MRSA
- Texas Health Steps Program
- STAR+PLUS
- CHIP
- CHIP Perinate
- OB and Postpartum Program
- Medical Management
- Superior Pharmacy Services
- Quality Improvement
- Abuse, Neglect and Exploitation
- Claims – Filing and Payment
- Claims – Electronic Visit Verification
- Secure Provider Portal
- Superior Departments
- Questions and Answers

Who is Superior HealthPlan?

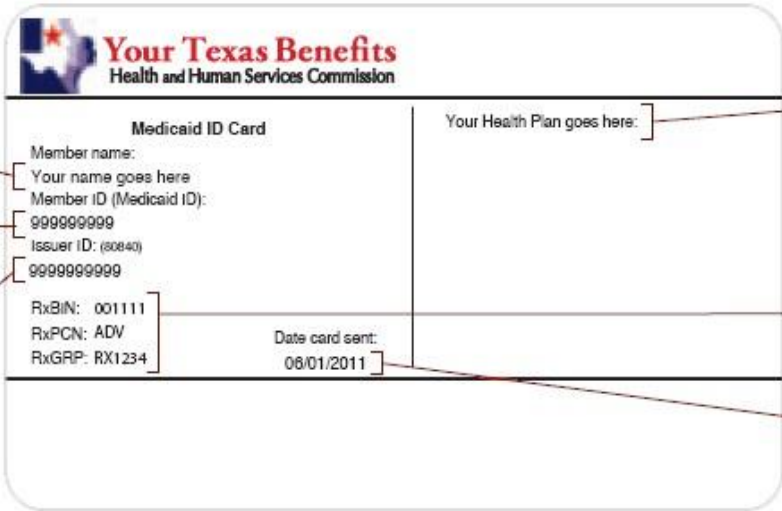


- Superior, a subsidiary of Centene Corporation, manages health care for Medicaid and CHIP members across Texas.
- Superior has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Superior provides Medicaid and CHIP programs in contracted Health and Human Services (HHS) service areas throughout the state. These programs include:
 - Ambetter from Superior HealthPlan
 - CHIP
 - STAR
 - STAR Health (Foster Care)
 - STAR Kids
 - STAR+PLUS
 - STAR+PLUS Medicare-Medicaid Plan (MMP)
 - Superior HealthPlan Medicare Advantage (HMO and HMO-SNP) Plans

Superior Member ID Cards



- The Member ID Cards contain at least the following information:
 - Member name
 - PCP (except CHIP perinate mother)
 - Prescription information
 - Program eligibility
 - Superior HealthPlan contact information
- Images of Member ID Cards can be found in the Superior Provider Manual.



This is where your name appears.

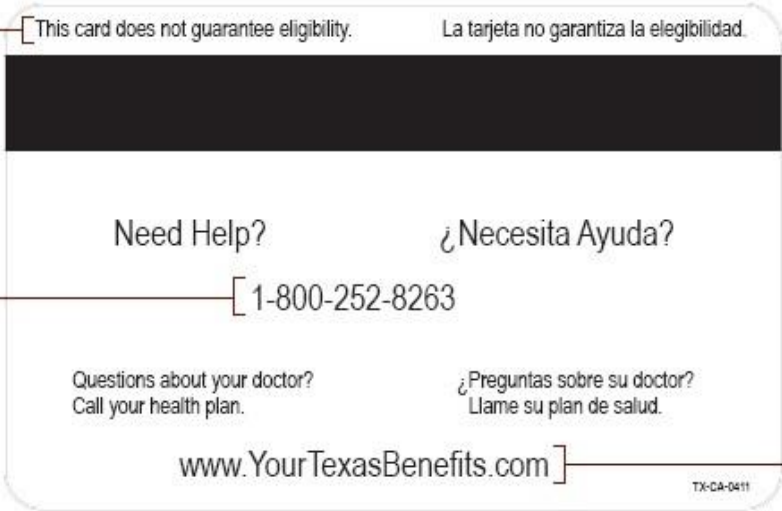
This is your Medicaid ID number.

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

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.

Call this number if you need help using this card.

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

Go to this website to learn more about this card.



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Provider Roles and Responsibilities

Provider Roles and Responsibilities



- Eligibility Verification
- PCP Responsibilities
- After-Hours Telephone Arrangements
- PCP Access to Care Requirements
- Referrals
- Member Self-Referral
- Cultural Competency

Primary Care Provider (PCP) Responsibilities



- Serve as a “Medical Home.”
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member.
- Be accessible to patients 24/7/365.
- Responsible for the coordination of care and referrals to specialists.
- Enroll as a Texas Health Steps provider or refer member to a participating Texas Health Steps provider.

Primary Care Provider (PCP) Responsibilities



- Ensure accurate information in Provider Directories by updating contact information including:
 - Address
 - Phone number
 - Provider listing
 - Hours of operation
- Report all encounter data on CMS 1500 (HCFA) or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.

PCP Accessibility



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- Arrange coverage with another Superior provider if one is not available.
- Office phone must be answered during normal business hours.
- After-hours calls should be documented in an after-hour call log and transferred to the patient's medical record.
- Contact Account Management if requirement cannot be fulfilled.

After Hours Telephone Arrangements



- Acceptable
 - If the phone call is answered by an answering service, the call must be returned within 30 minutes by the PCP or other designated provider.
 - If the phone call is answered by an answering machine, it must direct patients to call another number where someone must be available to answer the designated number.
 - If the phone call is transferred to another location, someone must answer the phone and contact the PCP or on-call provider, who must return call within 30 minutes.
- Unacceptable
 - Phone calls only answered during office hours or directing patients to leave a message.
 - Phone message directs patients to the ER.
 - Answering machine or answering service is not bilingual (English and Spanish).
 - Returning after-hours calls outside of 30 minutes.

PCP Access to Care Requirements



- Superior requires that a provider's hours of operation for Medicaid and CHIP members be no less than those offered to commercial patients.
- Appointment Access Guide:
 - Routine Care
 - Provided within two (2) weeks of request.
 - Urgent Care
 - Provided within 24 hours of request.
 - Emergent Care
 - Provided immediately (same day).

PCP Access to Care Requirements



- Appointment Access Guide (continued):
 - Referrals to Specialists
 - Appointments should be available within 30 days of the request for non-urgent conditions.
 - Preventive Health Services
 - Consistent with the Texas Health Steps Periodicity Schedule for STAR and STAR+PLUS and American Academy of Pediatrics (AAP) periodicity schedule for CHIP.
 - Preventive Health Services for Adults
 - Provided within 90 days of request.

Marketing Guidelines



- Providers must adhere to Marketing Guidelines as outlined by HHS and referenced in their provider contract.
- Providers can educate/inform patients about the CHIP/Medicaid Managed Care programs in which the provider participates.
- Providers can inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate.
- Providers **cannot** recommend one MCO over another MCO.
- Providers must distribute and/or display health-related materials for all contracted MCOs or choose not to distribute and/or display for any contracted MCO.
- Providers must display stickers submitted by all contracted MCOs or choose to not display stickers for any contracted MCOs.
- More information and a complete list of Marketing Guidelines can be found in the Provider Manual at <https://www.SuperiorHealthPlan.com/providers/training-manuals.html>.

Referrals



- All health-care services are coordinated through PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.

Referrals



Members may self-refer for the following services:

- Family planning
- Texas Health Steps
- Case management for children and pregnant women
- Vision
- Behavioral health
- True emergency services
- Well woman annual examinations

Verify Eligibility



Providers should verify member eligibility prior to delivering service at each visit by:

- Logging on to Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- Viewing the member's Superior issued ID card (Member ID card is not a guarantee of enrollment or payment).
- Contacting Superior's Member Services Department at:
 - 1-800-783-5386 STAR/MRSA, CHIP/RSA and Perinate
 - 1-866-516-4501 STAR+PLUS
 - 1-877-644-4494 Medicaid Rural Service Area (MRSA)
- Viewing the member's "Your Texas Benefits" Medicaid Card.
- Visiting TexMedConnect at <https://secure.tmhp.com/TexMedConnect>.



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STAR and STAR MRSA

STAR and STAR MRSA Eligibility



Who is covered in Texas?

- Families, children and pregnant women
 - Based on income level, age, family income and resources/assets.
- Newborns
 - Born to mothers who are Medicaid-certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday.
- Cash assistance recipients
 - Based on receipt of Temporary Assistance for Needy Families (TANF) and dependent on age.

STAR and STAR MRSA Benefits



Include, but are not limited to:

- Dental and vision services
- Durable Medical Equipment (DME)
- Hospital services
- Maternity services
- Medical and surgical services
- Mental and behavioral health services
- Prescriptions (unlimited)
- Texas Health Steps
- Therapy - physical, speech and occupational
- Transplants

STAR and STAR MRSA Transportation Benefits



- Transportation is available for doctor visits.
- If a STAR Medicaid member needs a ride to your office, they should call the Medical Transportation Program (MTP) as soon as they know their next appointment date with your office or at least 48 hours before their appointment.
- Members under 18 years old may be required to travel with an adult.
- To request services, advise the member to call MTP toll free at 1-877-MED-TRIP (1-877- 633-8747). Transportation specialists are available to take requests weekdays, 8:00 a.m. to 5:00 p.m.
- MTP can help with money for gas for someone who drives the member to an appointment.
- MTP does not furnish transportation when it is included in the daily rates of programs such as nursing homes, day activities and health services.

Adoption Assistance or Permanency Care Assistance



Effective September 1, 2017, individuals in the Texas Department of Family and Protective Services (DPFS) Adoption Assistance or Permanency Care Assistance (AAPCA) program will begin getting their Medicaid services through a STAR Managed Care Organization.

- Individuals in the AAPCA program who meet the following criteria will move to STAR on September 1, 2017:
 - Don't receive:
 - Supplemental Security Income (SSI)
 - Medicare
 - 1915(c) waiver services
 - Don't have a disability as determined by the U.S. Social Security Administration or the State of Texas.
 - Don't live in:
 - a nursing facility
 - an intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID)

Please note:

- *Individuals who get AAPCA services will still have the same Medicaid benefits under their selected health plan as they had been receiving prior to enrolling in managed care.*
- *Individuals in the AAPCA program who receive SSI, will be enrolled in STAR Kids, effective September 1, 2017.*
- *Individuals receiving 1915(c) waiver services are already enrolled in STAR Kids.*

Adoption Assistance or Permanency Care Assistance



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- Beginning in May 2017, people who have AAPCA coverage will get additional information about the transition and about choosing a health plan from the state's enrollment broker, Maximus.
 - Individuals will need to choose their health plan by August 14, 2017.
 - Individuals who do not select a health plan by this date, will be assigned one by the Texas Health and Human Services (HHS).
- Existing authorizations for those who enroll September 1, 2017
 - Approved and active prior authorizations for covered services will be forwarded to the Superior STAR plan prior to September 1, 2017, by HHS.
 - These prior authorizations will remain valid and will be honored by Superior.
 - Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place.

Adoption Assistance or Permanency Care Assistance



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- If providers have questions about AAPCA services changing to managed care, please email:
 - Managed_Care_Initatives@hhsc.state.tx.us.
- For more information, please visit:
 - <https://hhs.texas.gov/services/health/medicaid-chip/programs/adoption-assistance-or-permanency-care-assistance-managed-care-expansion>.



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Texas Health Steps Program

Overview



For Medicaid-eligible children, adolescents and young adults under 21 years old, the comprehensive preventive care program combines:

- Diagnostic screenings
- Communication and outreach
- Medically necessary follow-up care including:
 - Dental
 - Hearing examinations
 - Vision
- Age-appropriate screenings must include, but are not limited to:
 - Autism
 - Developmental
 - Hearing
 - Lead
 - Mental Health
 - Nutrition
 - Sexually Transmitted Diseases
 - Tuberculosis
 - Vision
- For complete Texas Health Steps Exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule: <http://www.dshs.state.tx.us/thsteps/providers.shtm>

Checkup Requirements



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- Comprehensive health and development history (mental and physical).
- Comprehensive unclothed physical exam.
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) immunization schedule.
- Appropriate laboratory tests with documentation (including blood lead level assessments and other tests appropriate for age and risk).
- Health education including anticipatory guidance.
- Referral services, i.e., Comprehensive Care Program (CCP) services, Women, Infants and Children (WIC), family planning and dental services.

Checkup Requirements



- Members new to Superior
 - Within first 90 days (unless documentation of previous checkup is provided).
- Existing members
 - Follow periodicity schedule <http://www.dshs.state.tx.us/thsteps/providers.shtm>
 - Members under three (3) years old have multiple checkups within each year; six (6) outpatient checkups in the 1st year.
 - Members over three (3) years old have an annual checkup which must occur within 364 days following their birth date.
- Exceptions (outside of periodicity)
 - Medically necessary: developmental delays, medical concerns, suspected abuse (use modifier code SC).
 - Mandated services: state or federal requirements (use modifier code 32).
 - Unusual anesthesia: procedures which usually require no anesthesia or local anesthesia (use modifier code 23).

Missed Appointments



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- Providers should complete a Missed Appointment form and fax it to MAXIMUS at 1-512-533-3867, who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, child care, money for gasoline, etc.).
 - Missed Appointment form is available at:
www.dshs.state.tx.us/thsteps/POR.shtm.
- More information is available through your local regional Texas Health Steps Providers Services Representative:
<http://www.dshs.state.tx.us/thsteps/regions.shtm>.

Superior Outreach and Resources



- New members receive a member packet along with a reminder outreach for their initial exam.
- Existing members receive a reminder card and a call for their annual exam prior to their birth date.
- Newborns receive a card with all the periodic exams that are required in the first three (3) years of their life.

Texas Health Steps Outreach and Informing



- Staff contacts newly enrolled Texas Health Steps recipients to inform them of the services available and to:
 - Encourage them to use the preventive medical and dental checkup services.
 - Provide them with a list of all Texas Health Steps providers in their area.
 - Assist them in setting an appointment.
- Providers can make a referral by phone to the State of Texas outreach team at 1-877-847-8377.

Refusal of Exam



- Superior is required to log all member refusal for service to the Texas HHS.
- The refusal should be recorded in the member's medical record and communicated to Superior's Member Services department 1-800-783-5386.
- If a patient indicates that their exam was previously completed, Superior will:
 - Look for that claim in our system and, if there is no claim on file, will contact the provider of service to verify the member's statement.

Oral Evaluation and Fluoride Varnish



This program will allow Medicaid eligible Texas Health Steps members and Children with Special Health Care Needs (CSHCN) who are six (6) to 35 months old to receive an oral evaluation and fluoride varnish during medical checkups.

- Limited to 10 fluoride treatments.
- Providers must be certified to provide oral evaluations and fluoride varnishes.
- Once a provider has completed the training, they will need to submit their certification to their Superior Account Manager.
- The training information is available on the Department of Social and Health Services (DSHS) Oral Health Program website along with the registration form. The information can be accessed at the following site: www.dshs.state.tx.us/dental/firstdentalhomeTraining.shtm
- Provider should bill with procedure code 99429 and modifier U5 with the diagnosis Z00.129.

Children of Traveling Farm Workers



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- The Texas Health and Human Services (HHS) defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health-care needs, provide direct education about the health-care system and the services available and arrange appointments and transportation.
- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed a “Travel Packet” and other helpful pieces of information to ensure these children get the health-care services they need.
- For more information, call Member Connections at 1-800-783-5386.

Enrollment and Training



- Enrollment as a Texas Health Steps provider must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com.
- A separate Texas Health Steps TPI number is required.
- Training from the Texas Health and Human Services (HHS) is mandatory for Texas Health Steps providers.
- Free continuing education hours are available at <http://www.txhealthsteps.com/cms/>.



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STAR+PLUS

What is STAR+PLUS?



- The STAR+PLUS program is designed to integrate the delivery of acute care and Long-Term Services and Supports (LTSS) through a managed care system, combining traditional health care (doctors visits) with LTSS, such as providing help in the home with:
 - Daily living activities, home modifications and personal assistance
- Members, their families and providers work together to coordinate member's health care, long-term care and community support services.
- The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a member.

STAR+PLUS Eligibility



Mandatory Population

- Adults 21 years old and older who:
 - Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income.
 - Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program).

STAR+PLUS Dual-Eligible Members



- Dual-eligible describes members who receive both Medicare and Medicaid.
- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services)
- Medicaid Acute Care (TMHP) - covers co-insurance, deductible and some LTSS (ex: incontinence supplies).
 - All non-LTSS services must be billed through Medicare as primary payer and TMHP as secondary.
- STAR+PLUS – ONLY covers LTSS (ex: Personal Attendant Services [PAS], Day Activity and Health Services [DAHS], etc.).

Medicaid Non-Dual Services



- Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.
- STAR+PLUS covers both Acute Care Services and Long-Term Support Services.
 - Exception: For IDD members, Superior pays for Acute Care Services **only**.
- Superior has contracted with Envolve Pharmacy Solutions as the Pharmacy Benefit Manager (PBM).

STAR+PLUS Benefits



Include, but are not limited to:

- Ambulance services
- Audiology services
- Behavioral health services
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency services
- Family planning services
- Laboratory
- Medical checkups
- Physical, occupational and speech therapy (PT/OT/ST)
- Podiatry services
- Prenatal care
- Prescription medications
- Primary care services
- Radiology, imaging and x-rays
- Specialty doctor services
- Unlimited prescriptions
- Vision services

STAR+PLUS - LTSS



- Personal Attendant Services (PAS)
- Day Activity and Health Services (DAHS)
- STAR+PLUS Waiver Services
 - Adaptive Aids
 - Minor Home Modification
 - Adult Foster Care
 - Consumer Directed Services
 - DME
 - Emergency Response System
 - Home Delivered Meals
 - Skilled Nursing
 - PT/OT/ST
 - Medical Supplies
 - Residential Care/Assisted Living
 - Transition Assistance Services

Medicaid for Breast and Cervical Cancer Program



Effective September 1, 2017, women in the Medicaid for Breast and Cervical Cancer (MBCC) program will receive all of their Medicaid services, including cancer treatment, through a Managed Care Organization that offers STAR+PLUS.

- After selecting and transitioning into a STAR+PLUS health plan, women who receive MBCC services will have the same Medicaid benefits they have today. In addition, STAR+PLUS members receive:
 - Unlimited prescriptions.
 - A service coordinator to help them find the right providers for their needs.
 - A primary care provider to make sure all of their needs are addressed.
 - Value-added services which are extra services like respite, extra vision services, and health and wellness services.
- Women who get MBCC services will have a nurse as their service coordinator. The service coordinator can help:
 - Identify and address medical needs.
 - Understand Medicaid benefits.
 - Ensure access to needed specialty services.
 - Coordinate community supports including services that might be non-medical or not covered by Medicaid.

Medicaid for Breast and Cervical Cancer Program



Beginning in May 2017, women in the MBCC program will get information in the mail about the upcoming change to managed care, including information about choosing a health plan.

- Individuals will have until August 14, 2017, to choose their health plan.
 - Women who have not selected a health plan by this date, will be assigned one by the Texas Health and Human Services (HHS).
 - For individuals who become eligible after September 1, 2017, the state's enrollment broker, Maximus, will send the member an enrollment packet informing the member of the health plan choices in her area.
- Existing authorizations for those who enroll September 1, 2017:
 - Approved and active prior authorizations for covered services will be forwarded to the Superior STAR+PLUS plan prior to September 1, 2017, by HHS.
 - These prior authorizations will remain valid and will be honored by Superior.
 - Providers don't need to resubmit authorization requests to the health plans if an authorization is already in place.

Medicaid for Breast and Cervical Cancer Program



- If providers have questions about MBCC services changing to managed care, please email:
 - Managed_Care_Initatives@hhsc.state.tx.us.
- For more information, please visit:
 - <https://hhs.texas.gov/services/health/medicaid-chip/programs/medicaid-breast-cervical-cancer-program-managed-care-expansion>.

Service Coordination



- Dedicated, centralized Service Coordination line: 1-877-277-9772
- Coordinate care for members with special health-care needs.
- Utilizes a multidisciplinary approach in meeting member's needs.
- Available to all STAR+PLUS members.
- Members are assigned a Service Coordinator who they can call directly.
- Service Coordinators participate with the member, their family or representative, and other members of the interdisciplinary team to provide input for the development of the plan of care.

LTSS Assessments



- Members receiving LTSS services are assessed annually or as needed to continue services.
- Service Coordinators review the assessment(s) to identify service needs with the member in developing a plan of care.
- Assessments are also reviewed biannually and upon notification of a change of condition.
- Discharge planning begins at the start of an inpatient hospitalization.

Prior Authorizations



Services and supplies requiring authorization:

- Adult Foster Care
- Assisted Living
- DAHS
- DME over \$500 – per unit
- Emergency Response Services
- Home Delivered Meals
- Home Health
- Incontinence supplies*
- Minor Home Modifications
- PAS or PHC
- PT, OT, ST
- Skilled Nursing

Prior Authorization Process



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- For LTSS services, call the Service Coordination department at: 1-877-277-9772
- You may also LTSS fax authorization requests to: 1-866-895-7856.
- Authorizations for skilled nursing, PT/OT, or other Acute Care Services, request through the Superior's Secure Provider Portal.

Value Added Services



- Superior offers a diverse array of Value-Added Services (VAS) for each product line including, but not limited to:
 - STAR and CHIP
 - A 24-hour nurse advice line.
 - Extra behavioral health services.
 - Extra vision benefits.
 - Includes \$150 toward prescription eyewear.
 - STAR+PLUS
 - A 24-hour nurse advice line.
 - Extra dental benefits.
 - Members may get up to \$250 each year for exams, x-rays, cleanings and fluoride treatments (for members age 21 and older).
 - Extra vision services
 - \$100 for choice of upgraded eyeglass frames and lenses or contact lenses every year.
- Complete listing of current VAS can be found at www.SuperiorHealthPlan.com.



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CHIP
(Children's Health
Insurance Program)

CHIP Eligibility



- Children who are under 19 years old and whose family's income is below 200% of the Federal Poverty Level (FPL) are eligible if they do not qualify for Medicaid coverage.
- CHIP members are allowed to change health plans within 90 days of enrollment, and at least every 12 months thereafter during the re-enrollment period for any reason.
- CHIP members must re-apply yearly on their original enrollment date.

CHIP Benefits



- Include, but are not limited to:
 - Dental and vision services
 - DME
 - Hospital services
 - Medical and surgical services
 - Mental and behavioral health services
 - Prescriptions
 - PT, OT, ST
 - Transplants
 - Well-child exams and preventive health services
- For a full list of covered benefits, please refer to the Provider Manual at www.SuperiorHealthPlan.com.

CHIP Cost-Sharing



- Most families in CHIP pay an annual enrollment fee to cover all children in the family (based on family income).
- The total amount that a family must contribute out-of-pocket is capped based on family income.
- CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency setting (based on family income).
- The amount of the co-pay is listed on the front of the member's ID card or on the patient list located on the Secure Provider Portal at Provider.SuperiorHealthPlan.com.



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CHIP Perinate

CHIP Perinate Eligibility



Unborn children of low-income pregnant women who do not qualify for Medicaid either due to citizenship status or whose income exceeds the minimum allowed to qualify for Medicaid.

- Coverage process once the child is born:
 - CHIP Perinate Newborn
 - Category B: Lasts for 12 months from mother's eligibility determination date for babies born to mothers within 186% - <200% FPL.
 - No co-pay.
 - Medicaid
 - Category A: Babies born to mothers at or below 185% of FPL.
 - Coverage lasts for 12 months from baby's date of birth.

CHIP Perinate Benefits



- Covered Services (Professional)
 - Up to 20 prenatal care visits (more if medically necessary with authorization).
 - Prescriptions based on CHIP formulary (DME is not a covered benefit for CHIP Perinatal).
 - Case management and care coordination.
 - Three ultrasounds of the baby when medically indicated.
 - Labor with delivery of child.
 - Two post partum visits within 60 days of delivery; first postpartum visit must be after delivery global period (45 days).

CHIP Perinate Benefits



- Covered Services (Hospital)
 - For women with income at 186% up to 200% FPL, all eligible hospital facilities and professional charges are covered by CHIP Perinate.
 - For women with income at or below 185% FPL, all eligible hospital facilities charges are covered by TMHP and professional charges are covered by the CHIP Perinate health plan.
- Non-Covered Services
 - A mother's hospital visits for any services not related to labor with delivery.
 - Services not related to a pregnancy diagnosis.
 - Supplies affiliated with certain diagnoses (e.g. DME supplies not covered for diabetes).
 - If mother fails to notify the state of the birth of the child, all services will be non-covered.
- Provider must call in authorizations for all deliveries regardless of member's income (FPL).

Helpful Billing Hints



- Prenatal visits
 - Initial visits bill with E&M codes (99201 - 99205) with modifier TH to indicate prenatal visit.
 - Subsequent visits bill with E&M codes (99211-99215) with modifier TH to indicate prenatal visits.
- Postpartum visits bill CPT code 59430.
- Three sonograms are allowed per pregnancy. Additional sonograms, with authorization, are covered if the patient has a high risk diagnosis.
- Primary diagnosis for all covered services must be pregnancy-related (all other services are not covered benefits).



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OB and Postpartum Program

OB and Newborn Programs



- Start Smart for Your Baby® consists of Case Management services, education (baby showers*), and orientation for members who are pregnant.
- The program eliminates barriers our pregnant members have in accessing care and provides information and assistance on benefits.
- Outreach workers with knowledge of community resources and agencies are ready to assist members with housing, transportation, employment and continued education.
- In order for your patients to be eligible to receive these benefits from Superior, please submit a Notification of Pregnancy (NOP) form upon initial prenatal visit for each of your Superior patients.

* In some areas

Notification of Pregnancy (NOP)



- Superior HealthPlan's Notification of Pregnancy (NOP) Incentive Program rewards providers, on a quarterly basis, for completing and submitting NOP forms in a timely manner.
- Program implemented to identify Superior members who may have a history of preterm delivery and/or other conditions that may complicate pregnancy.
- Effective 1/1/2017, the only NOP forms that will be accepted for the NOP incentive program must be submitted via Provider.SuperiorHealthPlan.com

Notification of Pregnancy (NOP)



- Quarterly Notification of Pregnancy (NOP) Incentive Program Plan available for completing NOP forms within 60 days of the initial/first provider visit based on number of forms submitted correctly:
 - 5-10 forms = \$100 gift card
 - 11-20 forms = \$200 gift card
 - 21-30 forms = \$400 gift card
 - 31 + forms = \$800 gift card
- Contact your Account Manager for further information.



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Medical Management

Prior Authorization



- Procedures and/or services that require authorization can be found on Superior's website at www.SuperiorHealthPlan.com.
- Initiating a prior authorization:
 - Must be at least five (5) business days prior to requested date of service (for non-emergency services).
 - Log on to your online account at Provider.SuperiorHealthPlan.com
 - Use the Request for Authorization form found on the website, complete and submit via fax to 1-800-690-7030; OR
 - Call in your request to 1-800-218-7508.
 - If you have an urgent request, indicate "this is urgent and must be treated within 24 hours."

Therapy Authorizations



- Occupational, Physical or Speech Therapy prior authorization requests for initial evaluation must originate directly from the office of the member's PCP or other pertinent physician by phone, fax or web.
 - Requests for therapy re-evaluation may originate from the therapy provider or the referring provider.

Therapy Authorizations



- Authorization is required for all therapeutic services to include:
 - Initial evaluations
 - Include evaluation order signed by PCP (or a neurologist, orthopedic physician, ENT, rehabilitation physician or plastic surgeon when referring for concerns related to craniofacial anomalies (e.g., cleft lip or palate) specifying the disciplines to be evaluated.
 - Copy of the most recent Texas Health Steps checkup or wellness visit.
 - Copy of a developmental screening performed by PCP with last 30 days (ASQ or PED's which is the required developmental screenings).
 - For speech therapy evaluation requests, documentation of a hearing screening performed within the following guidelines:

Age	Hearing Screening Performed
Birth – 3 years old	Within 6 months
3 years & 1 month old – 6 years old	Within 12 months
6 years old and up	None

Note: If the member has failed the hearing screening, results of a full audiological assessment must also be submitted, to include documentation of treatment for any hearing loss that has been identified.

Therapy Authorizations



- Re-evaluations
 - Include evaluation order signed by PCP specifying discipline to be re-evaluated.
 - Documentation from PCP identifying medical necessity for re-evaluation.
 - Requests should be submitted no more than 30 days prior to the end of existing treatment authorization.
- Initial treatment services
 - Treatment orders signed by PCP specifying frequency and duration.
 - Brief statement of member's medical history and any prior therapy treatment.
 - Clear diagnosis and reasonable prognosis.
- Ongoing treatment services
 - Include objective demonstration of member's progress toward each prior treatment goal.
 - Explanation of any changes to the member's plan-of-care and clinical rationale for revising plan.

Therapy Authorizations



Early Childhood Intervention (ECI)

- Therapy services for members under three (3) years old do not require authorization for contracted providers.
- Health-care professionals are required, under federal and state regulations, to refer children under three (3) years old to ECI within two (2) business days once a disability or developmental delay is identified/suspected.
- Superior will work with contracted providers to provide ECI services to members who have been determined eligible.
- Providers can contact 1-800-628-5115 or visit www.dars.state.tx.us for more information.

Radiology Authorization



- National Imaging Services (NIA) is contracted with Superior to perform utilization review for High-Tech Imaging Services.
- The ordering physician is responsible for obtaining an authorization by:
 - Accessing www.radmd.com; or
 - Calling 1-800-642-7554
- Emergency room, observation and inpatient imaging procedures do not require authorization.
- Servicing providers and imaging facilities may access status of authorizations by:
 - Accessing www.radmd.com; or
 - Accessing Integrated Voice Response (IVR) at 1-800-642-7554

Non-emergent Ambulance Transport



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

- Non-emergency transport by ambulance can be provided:
 - To or from a scheduled medical appointment.
 - To or from a licensed facility for treatment.
 - To a member's home after discharge when there is a medical condition such that the use of an ambulance is the only appropriate means of transportation.

NOTE: Hospital-to-hospital transports are considered for emergencies only when the required treatment for the emergency medical condition is not available at the first hospital and Superior has not included payment for such transports in the hospital reimbursement.

Non-emergent Ambulance Transport



All non-emergency ambulance transports require authorization.

- How can you find a participating ambulance provider?
 - In-network ambulance providers can be found at <https://ProviderSearch.SuperiorHealthPlan.com/> and by using the Specialty search field.
- How can you get a prior authorization?
 - Calling the Medical Management department at 1-800-218-7508.
 - Faxing a request for prior authorization to 1-800-690-7030.
 - Faxing clinical information establishing medical necessity to 1-800-690-7030.
 - Submitting the request and clinical information through the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Utilization Management (UM)



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- InterQual criteria are used for the review of medical necessity as well as provider peer-to-peer review.
- Medical Director reviews potential adverse determinations for medical necessity.
- If necessity cannot be established, denial letters will be sent to the member and provider that include the clinical basis for the denial, and the member appeal rights will be fully explained.
- Provider may also appeal on behalf of the member, if authorized to do so.

Case Management (CM)



- Superior members with identified needs are assessed for CM enrollment.
- Members identified through various ways including, but not limited to:
 - Census
 - Claims
 - Clinical rounds
 - Directly from providers
 - Hospital
 - Referrals from Superior staff
 - Self- referral
- CM facilitates communication between PCP, member, managing physician and the CM team.
- Refer a member by contacting the Case Management department at 1-800-218-7508.

Disease Management



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- Superior partners with Nurtur, a disease management company, for members with asthma, diabetes and other complex health conditions.
- Nurtur's health coaches coordinate with both the member and providers to focus on disease specific conditions.

Notification of Admissions



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- Hospitals must notify Superior of all emergent admissions no later than the close of the next business day.
- All non-emergency, elective inpatient admissions require authorization.
- Notify Superior regarding an urgent/emergent admission by contacting the appropriate service area in which the member resides (located in Provider Manual and online).
- Any service/procedure that is a non-covered benefit according to the Texas Medicaid Provider Procedures Manual is still considered a non-covered benefit according to Superior.



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Superior Pharmacy Services

Pharmacy Benefits



- Pharmacy Benefit Manager (PBM)
 - Responsible for timely and accurate payment of pharmacy claims
 - Provides pharmacy network for Superior members
 - Responsible for authorizations of prescriptions, as applicable
- Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL) has been adopted for Medicaid and CHIP
 - View VDP formulary and PDL here:
<https://www.SuperiorHealthPlan.com/providers/resources/pharmacy.html>

Specialty Drugs



- Medications on the HHS specialty drug list may be obtained from AcariaHealth or CVS Caremark if not under limited drug distribution.
- Contact Information:
 - Phone: 1-855-535-1815
 - Fax: 1-877-541-1503
 - Web: www.acariahealth.com

How to Access the Formulary/PDL



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

72-Hour ER Prescription



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

DME & Medical Supplies - Pharmacy Providers



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- If a pharmacy enrolled in Superior's PBM wishes to provide services that are not on the VDP formulary, the pharmacy must enroll as a DME provider, and obtain a separate contract with Superior for medical services.
- Includes medically necessary items such as nebulizers, ostomy supplies or bed pans and other supplies and equipment.
- For children (birth through 20 years old), this includes items typically covered under the Texas Health Steps program including, but not limited to, prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies and some nutritional products.

Pharmacy Contact Information



- Assists with questions, concerns from prescribers and members.
 - Phone: 1-800-218-7453 ext. 22272
 - Fax: 1-866-683-5631
 - E-forms: www.SuperiorHealthPlan.com/contact-us
- In-Clinic Rx administration (Superior Authorizations dept.)
 - Authorization Requests Phone: 1-800-218-7453 ext. 22272
 - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superiors Appeals dept.)
 - Appeals Requests Fax: 1-866-918-2266
 - Appeals Requests Phone: 1-800-218-7453 ext. 22168



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Quality Improvement

Quality Improvement



Working with our provider community:

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

Quality Improvement



Quality Assessment and Performance Improvement (QAPI):

- Monitors quality of services and care provided to members through:
 - Appointment availability audits
 - After-hours access audits
 - Tracking/trending of complaints
- Providers participate in QAPI by:
 - Volunteering for Quality Improvement Committees
 - Responding to surveys and requests for information
 - Vocalizing opinions
- Quality Improvement Committee (QIC)
 - Comprised of contracted providers from different regions and specialties
 - Appointed by Superior's Chief Medical Director
 - Serves as Peer Review Committee
 - Advises on proposed quality improvement activities and projects
 - Evaluates, reviews and approves clinical practice and preventative health-care guidelines

Cultural Sensitivity



- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with patients, and the health and wellness of the patients themselves.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
 - Knowledge
 - Provider's self-understanding of race, ethnicity and influence.
 - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
 - Skills
 - Ability to communicate effectively with the use of cross cultural interpreters.
 - Ability to utilize community resources.
 - Attitudes
 - Respect the importance of cultural forces.
 - Respect the importance of spiritual beliefs.
- More information regarding Cultural Sensitivity can be found in the Provider Manual at www.SuperiorHealthPlan.com.



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Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation (ANE)



- Abuse:
 - Intentional mental, emotional, physical or sexual injury to children, the elderly or people with disabilities, or failure to prevent such injury.
- Neglect:
 - Failure to provide a child, the elderly or a person with a disability with food, clothing, shelter and/or medical care; and/or leaving a child in a situation where the child is at risk of harm.
- Exploitation:
 - Misuse of a child, the elderly or a person with a disability for personal or monetary benefit. This includes taking Social Security or SSI (Supplemental Security Income) checks, abusing a joint checking account and taking property and other resources.

How to Report ANE



- Providers must report any allegation or suspicion of ANE to the appropriate entity:
 - Department of Family and Protective Services (DFPS)
 - To report a child who has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs)
 - An unlicensed foster care provider with three (3) or fewer beds.
 - A child with disability or child residing in or receiving services from local authority, local mental health authority (LMHAs), community center or mental health facility operated by the Department of State Health Services (DSHS).
 - A child with disability receiving services through the Consumer Directed Services option.
 - Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free at 1-800-252-5400.

How to Report ANE



Department of Aging and Disability Services (DADS)

- Report an adult or child who resides in or receives services from:
 - Nursing facilities
 - Assisted living facilities
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DFPS
 - Day care centers
 - Licensed foster care providers
- Phone: 1-800-647-7418

Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.



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Claims – Filing and Payment

Clean Claims



- 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 a provider's charges for that reimbursement and the amount of the provider's 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 (HCFA) 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
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims (only applicable for form CMS 1500).

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 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.

Claims Filing: Submitting Claims



- Secure Provider Portal:
 - Provider.SuperiorHealthPlan.com
- Electronic Claims:
 - Visit the web for a list of our Trading Partners:
www.SuperiorHealthPlan.com/for-providers/electronic-transactions/
 - Superior Emdeon ID 68069
- Paper Claims – Initial and Corrected*
Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803
- Paper Claims – Requests for Reconsideration* and Claim Disputes*
Superior HealthPlan
P.O. Box 3003
Farmington, MO 63640-3803

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

Claims Filing: Deadlines



- First Time Claim Submission
 - 95 days from date of service
- Adjusted or Corrected Claims
 - 120 days from the date of Explanation of Payment (EOP) or denial is issued
- Claim Reconsiderations and Disputes
 - 120 days from the date of EOP or denial is issued

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
 - EOP
 - Rejection letters

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:** Mail 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	NUMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
M317TXE44842			000209200	INVALID			76	20130710	
M317TXE44820			000164200	ACCEPT				20131109	
M317TXE44819			000193510	INVALID			76	20130704	
M317TXE44858			001141694	ACCEPT				20131108	
M317TXE44868			000759989	ACCEPT				20131108	
M317TXE44826			000310600	ACCEPT				20131108	
M317TXE44814			000116222	ACCEPT				20131108	
M317TXE44828			000405752	ACCEPT				20131103	
M317TXE44835			000112728	ACCEPT				20131108	
M317TXE44824			000113004	ACCEPT				20131109	
M317TXE44829			000984375	ACCEPT			09	20131024	
M317TXE44816			000103600	INVALID				20131105	
M317TXE44821			000999375	ACCEPT				20131106	
M317TXE44843			001183267	ACCEPT				20131101	
M317TXE44815			000103600	ACCEPT			76	20131107	
M317TXE44817			000011500	INVALID				20121003	
M317TXE44825			000207700	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] Group: [REDACTED]

Patient Name: [REDACTED] ID: [REDACTED]

Control Number: N125TXP02072 Account: AYEU9245

Service Provider: [REDACTED] NPI: [REDACTED]

[View Service Line Details](#)

Serv	Date	Diag#/ Drug#	Proc#/ Proc2	Days/ Cnt Mod	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 HHS or its authorized agent(s).
- Has provided neonatal services on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHS.*
- Has provided maternal services on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHS.*

**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 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.
 - Find claims forms under **Provider Resources>Forms** at:
<https://www.SuperiorHealthPlan.com/providers/resources/forms.html>

Corrected Claims



- A Corrected Claim is a correction of information to a previously finalized Clean Claim.
 - For example – Correcting a member's date of birth, a modifier, Dx code, etc.
 - The original claim number must be billed in field 64 of the UB-04 form or field 22 of the CMS 1500 form.
 - The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 form or field 22 of the CMS 1500 form.
 - A Corrected Claim form, found in the Provider Manual, may be used when submitting a Corrected Claim.

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:
 - Beginning DOS
 - Date of Birth (DOB)
 - Date of Onset
 - Ending DOS or Discharge Date
 - Patient Control Number (PCN)
 - Place of Service (POS)
 - Present on Admission (POA)
 - Prior Authorization Number (PAN)
 - Quality Billed
 - X-Ray 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 the Secure 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

Common Billing Errors



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

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.
- Submissions must include an attachment outlining the reason for the appeal.
- 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.

Payspan



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

Billing Reminders



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- 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 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



Superior's Provider Manual provides guidelines on how to submit Clean Claims and highlights the requirements for completing CMS 1450 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 CMS 1450 to indicate taxonomy.

Member Balance Billing



- Providers may not bill members directly for covered services for STAR, STAR+PLUS or CHIP.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Superior STAR, STAR+PLUS and CHIP Perinatal members do not have co-payments. Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (under CHIP Benefits).
- Additional details can be found in your provider contract with Superior.

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>



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Claims – Electronic Visit Verification*

**For LTSS providers, as applicable*

Electronic Visit Verification



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- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies Personal Care Services (PCS), flexible family support and Community First Choice (CFC) service visits.
- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.
- Provider must ensure authorizations are in place prior to performing the service.

Electronic Visit Verification



- PCS, in-home respite services, flexible family support services and CFC (PAS/HAB) providers will verify service times using EVV process.
- EVV vendor will send verification data to Superior.
- Superior will compare provider claims to verification data prior to adjudication.
- Providers must bill each Date of Service (DOS) on separate service line items.
 - Provider should wait 72 hours after auto verification and/or completing visit maintenance prior to submitting the claim for those DOS. This ensures adequate time for the files to be transferred and loaded into the system accurately prior to the claims being processed.
- Only verified units of service will be paid.
- Superior offers training on EVV. Check the provider calendar at www.SuperiorHealthPlan.com.

EVV Important Reminder



- Units should be billed using the rounded quarter hour rules implemented with the EVV initiative.
 - 7 minutes = Go Down
 - 8 minutes = Go Up
 - For example:
 - If services provided were for 48 minutes, billed units would be .75 units (these were rounded down to the 45 minutes).
 - If services provided were for 52 minutes, billed units would be for 1 hour (these were rounded up).
- Breakdown of valid decimal values that should be billed:
 - 1 hour = 1 unit
 - 45 minutes = .75 units
 - 30 minutes = .5 units
 - 15 minutes = .25 units



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Secure Provider Portal

Superior Website & Secure Provider Portal



www.SuperiorHealthPlan.com

Submit:

- Claims
- Prior Authorization Requests
- Request for EOPs
- Provider Complaints
- Notification of Pregnancy
- COB Claims
- Adjusted Claims

Verify:

- Member Eligibility
- Claim Status

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for Additional Provider Resources
- Claim Editing Software

Provider Portal Highlights



- Manage all product lines and multiple TINs from one account
 - Office Manager accounts available
- PCP Panel - Texas Health Steps last exam date
 - View the date of the member's last Texas Health Steps exam on file
- Eligibility section for providers
- Authorization detail & history
 - New display features: Authorization denial reason
- Submit batched, individual or recurring claims
- Download EOPs
- Secure messaging
- Refer members to Case Management
- Review member alerts/care gaps

How to Register for the Provider Portal



- Provider.SuperiorHealthPlan.com.
- Enter your provider/group name, tax identification number, individual's name entering the form, office phone number and email address.
- Create user name and password.
- Each user within the provider's office must create their own user name and password.
- The provider portal is a free service and providers are not responsible for any charges or fees.

Provider Portal: Eligibility



- Search for eligibility using:
 - Member's date of birth
 - Medicaid/CHIP/DFPS ID number or last name
 - Date of service
- View/print patient list:
 - Member panel
 - Member care gap alerts
 - Both can be downloaded in Excel or PDF format

Provider Portal: Authorizations



- Create Authorizations
 - Enter the patient's member ID/last name and DOB and click "Find."
 - Populate the six (6) sections of the authorization with the appropriate information starting with the service type section.
 - Follow the prompts and complete all required information.
 - Attach any required documentation, review and submit.
- Check Authorization Status
 - Enter web reference number and click "Search"; please allow at least 24 hours after submission to review status.
 - View authorization status, ID number, member name, dates of service, type of service and more.
 - To view all processed authorizations, click "Processed" and to view any authorizations with errors, click "Errors."

Note: Authorizations update to the web portal every 24 hours.

Provider Portal: Claims



- Claim Status
 - Claims update to the web portal every 24 hours.
 - Status can be checked for a period of time going back 18 months.
- View Web Claims
 - Click on the claims module to view the last three (3) months of submitted claims.
- Unsubmitted Claims
 - Incomplete claims or claims that are ready to be submitted can be found under “Saved” claims.
- Submitted Claims
 - Status will show “in progress,” “accepted,” “rejected” or “completed.”

Provider Portal: Claims



- Create Claims
 - Professional, institutional, corrected and batch.
- View Payment History
 - Displays check date, check number and payment amount for a specific timeframe (data available online is limited to 18 months).
- Claim Auditing Tool
 - Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
 - Proactively determine the appropriate code/code combination representing the service for accurate billing purposes.
 - Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

Additional Provider Portal Information



- Online Assessment Forms
 - Notification of pregnancy
- Resources
 - Practice guidelines and standards
 - Training and education
- Contact Us (Web Applications Support Desk)
 - Phone: 1-866-895-8443
 - Email: TX.WebApplications@SuperiorHealthPlan.com

Provider Portal Highlights



Alerts section indicates whether a member has a potential gap in care.

- Examples of Care Gap Alert categories and descriptions:
 - Adult Preventive
 - No mammogram in most recent 12 months
 - No chlamydia test in past 12 months in patient 16-25 years old
 - No PAP in past 12 months
 - Diabetes:
 - DM - Not seen in past six (6) months
 - DM - No retinal eye exam in past 12 months
 - DM - No HbA1C screening in past 12 months
 - Cardiac:
 - CAD - Not seen in past 12 months
 - HTN - Not seen in past 12 months
 - Flu vaccine
 - No flu vaccine in past 12 months
 - Child Preventive:
 - Immunizations not current for age



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Superior HealthPlan Departments

We're here to help you!

July 2017

Account Management



- Field staff are here to assist you with:
 - Face-to-face orientations
 - Face-to-face web portal training
 - Office visits to review ongoing trends
 - Office visits to review quality performance reports
- Superior Account Management offers targeted billing presentations depending on the type of services you provide. For example, we offer general and LTSS billing clinics.

Note: You can find a map at <https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html> that can assist you with contact information for your Account Manager.

Provider Services



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

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/MRSA/CHIP/RSA and Perinate:	1-800-783-5386
– STAR+PLUS:	1-866-516-4501
– STAR Kids:	1-844-590-4883
– STAR Health:	1-866-912-6283

Provider Contracting



- Network Development and Contracting is a centralized team that handles all contracting for new and existing providers to include:
 - New provider contracts
 - Adding providers to existing Superior contracts
 - Adding additional products (i.e. CHIP, STAR, STAR+PLUS) to existing Superior contracts
 - Amendments to existing contracts
- Contract packets can be requested at:
<https://www.SuperiorHealthPlan.com/providers/become-a-provider.html>

Provider Credentialing



- Initial Credentialing:
 - Complete a TDI credentialing application form for participation
 - Complete an electronic application
 - Provide Council for Affordable Quality Healthcare (CAQH) identification number
 - Email applications to SHP.NetworkDevelopment-Medicaid@SuperiorHealthPlan.com
- Re-credentialing:
 - Completed every three (3) years from date of initial credentialing
 - Applications and notices are mailed at 180, 120, 90 and 30 days out from the last day of the credentialing anniversary month
 - Lack of timely submission can result in members being re-assigned and system termination
 - Email applications to Credentialing@SuperiorHealthPlan.com
 - Failure to respond timely to requests for information or documentation will result in discontinuation of recredentialing and termination of contract.
- All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686, ext. 22281 or Credentialing@SuperiorHealthPlan.com.

Provider Complaints



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

Superior HealthPlan
ATTN: Complaint Department
5900 E. Ben White Blvd.
Austin, Texas 78741
 - Fax:

1-866-683-5369
 - Online:

<https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html>

Section 1557



What is Section 1557?

- On May 18, 2016, the U.S. Department of Health & Human Service (HHS) issued the Final Rule, Non Discrimination in Health Programs and Activities, implementing the prohibition of discrimination under Section 1557 of the Affordable Care Act of 2010 (ACA).
- Section 1557 is the civil rights provision of the ACA. It's the first Federal Civil Rights Law to prohibit sex discrimination in healthcare.
 - Section 1557 builds upon the pre-existing nondiscrimination regime in healthcare and provides for new protections.
 - It is intended to protect some of the most vulnerable populations from discrimination in the provision of health care services and programs.
 - While the ACA became law in 2010, this provision is just now being implemented due to litigation that challenged the ACA.

Background



This law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. A few provisions are:

- Prohibits the denial of health care or health coverage based on an individual's sex, including discrimination based on pregnancy, gender identity, and sex stereotyping.
- Provide appropriate auxiliary aids and services to individuals with disabilities.
- Requires covered entities to take reasonable steps to provide meaningful access to each individual with limited English proficiency.
- Requires covered entities to post a notice of individuals rights providing information about communication assistance for individuals with limited English proficiency.
- Requires covered entities to have a grievance procedure and a compliance coordinator.

Background



Who does Section 1557 apply to?

- Any health program which receives funds from HHS, i.e. hospitals that accept Medicare, doctors who accept Medicaid).

What Is required?

- The final rule requires that covered entities post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services.
- To reduce burden and costs, OCR has translated a sample notice and taglines for use by covered entities into 64 languages.
- For translated materials, visit www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

When is Section 1557 Effective?

- Federal Requirements of Section 1557 should be implemented in relevant materials as of October 16, 2016.
- Per CMS, the requirements of Section 1557 apply beginning with materials for CY 2017.



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Questions and Answers

Let us know what we can do to help.

Thank you for attending!
