



Hospital Training

Provider Training

Introductions and Agenda



- Superior HealthPlan
- STAR and STAR MRSA
- STAR+PLUS
- STAR+PLUS Medicare-Medicaid Plan (MMP)
- STAR Kids
- STAR Health (Foster Care)
- CHIP and CHIP Perinate
- Verifying Eligibility
- Medical Management
- Cultural Competency and Disability Sensitivity
- Claims and Payment Processing
- Secure Provider Portal
- Superior Departments
- Superior Partners
- Questions and Answers

Superior HealthPlan



- Only health plan with statewide Health Maintenance Organization (HMO) license.
- First health plan with child welfare experience nationally.
- Leader in Pay for Performance programs.
- Large provider network.
- Superior provides Medicaid and CHIP programs in contracted Health and Human Services (HHS) service areas throughout the state. These programs include:
 - STAR, including Medicaid Rural Service Area (MRSA)
 - STAR+PLUS, including Medicaid Rural Service Area (MRSA)
 - STAR Kids
 - STAR Health (Foster Care)
 - STAR+PLUS Medicare-Medicaid Plan (MMP)
 - CHIP/Perinate, including Rural Service Area (RSA)

NCQA Accreditation



- National Committee for Quality Assurance (NCQA) awards accreditation to participating health plans.
 - NCQA is a private, non-profit organization. It was founded in 1990 to help improve healthcare quality.
 - Superior is the top-rated Medicaid plan in Texas. We have a rating of 4 out of 5 in NCQA's Medicaid Health Insurance Plan Ratings 2016 – 2017.
 - NCQA Accreditation ratings are based on:
 - Health Effectiveness Data and Information Set (HEDIS) scores
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores
 - NCQA Accreditation standard scores





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STAR and STAR MRSA

STAR and STAR MRSA



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) dependent on age
- Supplemental Security Income (SSI) recipients
 - Must join if 21 years old and older and live in the Medicaid Rural Service Area (MRSA)
 - Must join if 20 years old and under

STAR Benefits



Include, but are not limited to:

- Medical and surgical services
- Hospital services
- Texas Health Steps
- Transplants
- Prescriptions (Unlimited)
- Therapy - Physical, Speech and Occupational
- Durable Medical Equipment (DME)
- Dental and vision services
- Mental and behavioral health services
- Maternity services



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STAR+PLUS

STAR+PLUS



- This 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 STAR+PLUS program is Service Coordination, which is 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

STAR+PLUS Dual Eligible Members



- Dual-eligible are members who receive both Medicare and Medicaid
- Medicare is the primary payer 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.)

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
- Podiatry services
- Prenatal care
- Primary care services
- Radiology, imaging and x-rays
- Specialty doctor services
- Unlimited prescriptions
- Vision services



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STAR Kids

STAR Kids – Effective 11/1/16



- Senate Bill 7, 83rd Legislature, 2013:
 - Directed HHS to establish a mandatory, managed care program tailored to provide Medicaid benefits to children and young adults with disabilities (STAR Kids).
 - Requires inclusion of the Medically Dependent Children Program (MDCP).
- Mission:
 - Enable STAR Kids members to live and thrive in a setting that maximizes their health, safety and overall well-being.

STAR Kids Eligibility



- Medicaid populations who must participate in STAR Kids include children and young adults, age 20 and younger, who receive:
 -
 - Social Security Income (SSI) and SSI-related Medicaid
 - SSI and Medicare
 - Medically Dependent Children (MDCP) waiver services
 - State plan services and coordination only for
 - Youth Empowerment Services (YES) waiver services
 - IDD waiver services (e.g., CLASS, DBMD, HCBS, TxHmL)
 - Members who reside in community-based ICF-IID or in Nursing Facilities (NF)

STAR Kids Benefits



Include, but are not limited to:

- Dental and vision services
- Durable Medical Equipment (DME)
- Hospital services
- Long-Term Services and Supports (LTSS)
- Maternity services
- Medical and surgical services
- Mental and behavioral health services
- Mental health rehabilitation services
- Mental health targeted case management
- Telemonitoring, telehealth and telemedicine services
- Texas health steps
- Therapy - physical, speech, occupational
- Transplants
- Unlimited prescriptions

STAR Kids LTSS Services



- LTSS services available to STAR Kids members:
 - Private Duty Nursing (PDN)
 - Personal Care Services (PCS)
 - Community First Choice (CFC)
 - Day Activity Health Services (DAHS)



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STAR+PLUS Medicare-Medicaid Plan (MMP)

STAR+PLUS MMP



- A fully integrated managed care model for individuals 21 years and over who are enrolled in Medicare and Medicaid.
- Superior offers this program in Bexar, Dallas and Hidalgo counties only.
- Superior covers:
 - All Medicare benefits, including parts A, B and D
 - Medicaid benefits, including LTSS
 - Flexible benefits
 - Value added services for individuals who enroll in the program
- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions and who get services through one of these waivers: Individuals With Developmental Disabilities
 - Community Living Assistance and Support Services (CLASS)
 - Deaf Blind with Multiple Disabilities Program (DBMD) or
 - Home and Community-Based Services (HSC).

STAR+PLUS MMP Benefits



- STAR+PLUS MMP offers the same basic health services members have been getting through Medicare. These include, but are not limited to:
 - 24-hour emergency care
 - Ambulance service
 - Doctor and clinic visits
 - Family planning services
 - Hearing tests and aids
 - Home health services
 - Hospital care
 - Lab and X-ray services
 - Major organ transplants
 - Surgery
- STAR+PLUS MMP includes Medicaid LTSS such as, but not limited to:
 - Adaptive aids
 - Adult day care
 - Adult foster care
 - Assisted living/home care
 - Emergency response services
 - Medical supplies
 - Nursing
 - Nursing home services
 - Personal assistance
 - Short-term help for caregivers
 - Therapies



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STAR Health (Foster Care)

STAR Health Members



- Children and young adults:
 - In foster care
 - In kinship care
 - Who choose to remain in a paid foster care placement (through the month of their 22nd birthday)
 - Who aged out of foster care at age 18 (through the month of their 21st birthday)

Why STAR Health?



- Children in foster care have greater health-care needs:
 - May be abused and neglected
 - May need more behavioral health services
 - May need more help in treatment with asthma, depression, etc.
 - May have developmental delays
 - May need dental and vision service
- Better serves the needs of foster children by:
 - Providing greater access to health-care services
 - Assisting in the coordination of health-care services
 - Establishing a Medical Home (Primary Care Provider)
 - Coordinating emergency support and services



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CHIP (Children's Health Insurance Program), CHIP Perinatal and CHIP Perinate

CHIP Enrollment



- Children who are under the age of 19 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
 - Durable Medical Equipment (DME)
 - Hospital services
 - Mental and behavioral health services
 - Medical and surgical services
 - Prescriptions
 - Therapy – physical, speech, occupational
 - Transplants
 - Well-child exams and preventive health services
- For a full list of covered benefits, please refer to the Provider Manual at <https://www.SuperiorHealthPlan.com/providers/training-manuals.html>

CHIP Perinatal Overview



- Who is covered?
 - Unborn children of low-income pregnant women who do not qualify for Medicaid.
- Providers must call in authorizations for “all” deliveries for members regardless of income.
- Providers must inform mothers that they must tell the state about the birth of the child.
 - Mothers can call 1-800-647-6558 or 1-877-KIDS-NOW (1-877-543-7669).

CHIP Perinatal 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 Perinatal Birth Reporting



- Mothers will report the birth through Emergency Medicaid Form H3038-P: <https://hhs.texas.gov/node/18133>
- The same form is used as an indicator for newborn to be placed on Medicaid.
- To ensure payment, the hospital also may fax the completed form to 1-877-542-5951.
- Mothers must notify CHIP Perinate of the birth by calling
- 1-877-KIDS-NOW (1-877-543-7669). The following information must be provided:
 - Date baby was born
 - Baby's gender
 - Baby's name

CHIP Perinate Newborn Coverage



For newborns $\leq 185\%$ FPL:

- HHS will provide 12 months continuous Medicaid coverage from the date of birth.
- Hospital facility services and professional services claims will be billed to Medicaid, rather than Superior.
- The newborn will be prospectively enrolled in Medicaid Managed Care if he/she qualifies and lives in a Managed Care service area.

CHIP Perinate Newborn Hospital Benefits



- Income at 186% up to 200% FPL (Category B on ID card):
 - All hospital facility and professional charges are covered by CHIP Perinate and paid by Superior.
- Income at or below 185% FPL (Category A on ID card):
 - Must obtain Emergency Medicaid (return form H3038-P) in order for the hospital facility charges to be considered for payment by Medicaid.
 - Hospital facility charges are not a covered benefit under CHIP Perinate.
 - Professional fees are a covered benefit of CHIP Perinate and are paid by Superior.
 - Once HHS receives the H3038-P form, Emergency Medicaid coverage will be added for the mother.

CHIP Perinate Newborn Hospital Billing



- If Mother is <185% and form H3038-P is not submitted:
 - Emergency Medicaid cannot be established for the Mother or for the Newborn from the date of birth for 12 months of continuous Medicaid coverage.
 - A new application for assistance is required if Form H3038-P is not submitted within 90 days of delivery.
 - No retroactive charges would be paid.
- If Mother is >185%:
 - CHIP Perinatal health plan pays for hospital and professional charges.

Helpful Tips



- Must call in authorizations for all deliveries regardless of member's income (FPL).
- Providers should inform mothers they must call and report birth to state 1-877-KIDS-NOW (1-877-543-7669).
- There is no co-pay for CHIP Perinatal.



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Verifying Eligibility

Verify Eligibility



- Texas Medicaid Benefits Card
- TexMed Connect – www.YourTexasBenefits.com
- Superior's ID Card
- Secure Provider Portal – www.Provider.SuperiorHealthPlan.com
- Contacting Superior's Member Services department at:
 - STAR/STAR MRSA 1-800-783-5386
 - CHIP/Perinate/RSA: 1-800-783-5386
 - STAR+PLUS: 1-877-277-9772
 - STAR Kids: 1-844-590-4883
 - STAR Health: 1-866-912-6283

Superior Member ID Cards



- The Member ID Cards contain at least the following information:
 - Member name
 - Prescription information
 - Primary Care Provider (except CHIP Perinate Mother)
 - 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.

Your Texas Benefits
Health and Human Services Commission

Medicaid ID Card

Member name:
Your name goes here

Member ID (Medicaid ID):
999999999

Issuer ID: (80840)
999999999

RxBIN: 001111
RxPCN: ADV
RxGRP: RX1234

Date card sent:
08/01/2011

Your Health Plan goes here:

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 card does not guarantee eligibility. La tarjeta no garantiza la elegibilidad.

Need Help? ¿Necesita Ayuda?

1-800-252-8263

Questions about your doctor? Call your health plan. ¿Preguntas sobre su doctor? Llame su plan de salud.

www.YourTexasBenefits.com

TX-CA-0411

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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Medical Management

Medical Management



- Superior is accredited by the National Committee for Quality Assurance.
- Compliant with Texas Department of Insurance (TDI), Centers for Medicare & Medicaid Services (CMS) and NCQA regulations while following HHS contractual obligations.
- Prior Authorization is managed by a centralized team.
- Concurrent Review is managed regionally.

Prior Authorization



- Pre-scheduled, elective admissions and some outpatient services require prior authorization.
- Prior Authorization list is available at:
<https://www.SuperiorHealthPlan.com/providers/resources.html>
- Pre-Auth Needed tool:
<https://www.SuperiorHealthPlan.com/providers/preauth-check.html>
- Turn around time for determination of outpatient services and elective procedures is:
 - CHIP – two (2) days from the date of request
 - Medicaid – three (3) days from date of request

Prior Authorization



- 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 www.Provider.SuperiorHealthPlan.com
 - Use the Request for Authorization form found on the website, complete and submit by fax to 1-800-690-7030
 - Outpatient CHIP requests only: 1-844-310-5517
 - Discharge Planning: 1-844-495-2361
 - Providers can also call in request to 1-800-218-7508
 - If you have an urgent request, indicate “this is urgent and must be treated within 24 hours”

Prior Authorization – Emergent Inpatient Requests



Must be submitted the next business day following admission.

Regions	Fax	Phone
Travis (Austin)	1-877-650-6939	1-800-218-7453, ext.22026 or 22175
Bexar (San Antonio)	1-877-650-6942	1-866-615-9399
Nueces (Corpus Christi)	1-877-650-6940	1-800-656-4817
El Paso	1-877-650-6941	1-877-391-5923
Lubbock/Amarillo	1-866-865-4385	1-866-862-8308
Dallas	1-877-650-6939	1-866-529-0294
Hidalgo	1-877-212-6661	1-877-278-4268
STAR RSA/CHIP RSA	1-877-505-0823	1-877-804-7109

Clinical Submission



- Clinical submission for inpatient requests should include:
 - Member's history and physical
 - Physician's orders
 - Physician's progress notes
 - Medication Administration Record (MAR)
 - Lab results
 - Radiology reports
 - Plan of care
 - Discharge planning
 - Level of care (med/surg, intermediate/ICU)
- Superior uses InterQual criterial to meet admission and continued stay criteria.

Clinical Submission



Clinical submission may be made by fax to:

Region/Product	Fax
Austin (Travis Region)	1-877-264-6547
Corpus Christi (Nueces Region)	1-866-912-6291
Dallas Region	1-866-232-3606
El Paso Region	1-866-626-6073
Lubbock/Amarillo Region	1-866-683-5620
San Antonio Region (Bexar)	1-866-683-5632
Hidalgo Region	1-866-895-4080
STAR RSA/CHIP RSA	1-877-804-5268
STAR Health (Foster Care)	1-866-241-6422

Medical Necessity Reviews



If clinical submission is received on time, it is reviewed by Concurrent Review Nurse.

- If medical necessity is met:
 - Admission or continued stay will be approved at the set days determined by the Concurrent Review Nurse.
 - A letter of approval will be sent to the facility addressed to the facility and physician.
- If medical necessity is not met:
 - A medical necessity review will be sent to the Medical Director for determination.

If clinical submission is not received by that the deadline, the request for authorization will be sent to Medical Director for medical necessity review.

MRI/MRA, CT/CTA and PET Scans



- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for imaging services.
 - You can find the NIA: High Tech Imaging QRG for Ordering Physicians at <https://www.SuperiorHealthPlan.com/providers/resources.html>
- An authorization is required for outpatient MRI/MRA, CT/CTA and PET scans.
- The PCP and specialist is responsible for obtaining authorization for the imaging procedures by:
 - Accessing www.radmd.com
 - Calling 1-800-642-7554
- Inpatient and ER imaging procedures will not require separate authorization.

MRI/MRA, CT/CTA and PET Scans



- All claims should be submitted to Superior via the:
 - Secure Provider Portal: www.Provider.SuperiorHealthPlan.com
 - Electronic Claims
 - Paper Claim Submission
- Servicing providers and imaging facilities may access status of authorizations by:
 - Accessing www.radmd.com
 - Accessing IVR (Integrated Voice Response) at 1-800-642-7554
 - To check on the status of an auth press 1, 1, then enter or state the tracking number

Cultural Competency and Disability Sensitivity

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 <https://www.SuperiorHealthPlan.com/providers/training-manuals.html>

How Can Health-Care Providers Help?



- Know your patients. Capture information about accommodations that might be required.
- Identify patients with limited health literacy.
- Use simple language, short sentences and define technical terms for patients.
- Supplement instructions with appropriate materials (videos, models, graphic materials, translated written materials, interpreting, etc.).
- Ask patients to explain your instructions (teach back method) or demonstrate the procedure.
- Ask questions that begin with “how” and “what,” rather than closed-ended yes/no questions.
- Organize information so that the most important points stand out and repeat this information.
- Reflect the age, cultural, ethnic and racial diversity of patients.
- Provide information in their primary language (for Limited English Proficiency [LEP] patients).
- Improve the physical environment in your office by using universal symbols.
- Offer assistance with completing health-care forms.



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Claims and Payment Processing

Present on Admission



- Present on Admission (POA) – present at time the order for inpatient admission occurs.
- Conditions that are considered POA could include, but are not limited to, conditions that develop during:
 - An outpatient encounter
 - Emergency department visits
 - Observation
 - Outpatient surgery
- POA value is mandatory for inpatient hospital claims using prospective payment.

Present on Admission



- ER and observation services may be reimbursed separately as outpatient services if:
 - Member is admitted >24 hours after presenting in ER without being placed in observation status; or
 - Member is admitted >48 hours after being placed on observation status.
- For more info on POA, see www.TMHP.com

Observation



- Round clock times to beginning and end of the nearest hour. Partial units should be rounded up or down
- 1 hour = 1 unit
- Observation units over 48 will be denied
- Date of admission should be the date the member presents at the hospital
- ER and Observation services may be reimbursed separately as outpatient services if:
 - Member is admitted >24 hours after presenting in ER without being placed in observation status; or
 - Member is admitted >48 hours after being placed on observation status

Claim Filing Reminders



- 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.
- The corrected claim number must be inserted in field 64 of the 1450 and field 22 of the 1500 forms. The appropriate frequency code/resubmission code should also be billed in field 4 of the 1450 and 22 of the 1500 forms.
- Frequency/resubmission codes can be found:
 - For 1500 Claim Forms
<http://www.nucc.org/index.php/1500-claim-form-mainmenu-35/1500-instructions-mainmenu-42>
 - For 1450 Claim Forms
<http://www.nubc.org/resources/index.dhtml>
 - *Please note: Omission of these data elements may result in denials.*

Claim Filing Reminders



- Acute Care Service are billed with T1015.
 - Please note: This is specific to Rural Health Clinics (RHC) and Federally Qualified Health Clinic (FQHC).
- 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

Corrected Claim vs Appeals



- Corrected Claim:
 - Adjustment requiring no supporting documentation
 - Prompted by provider or plan
- Appeal:
 - Requires supporting documentation
 - Medical appeals

Corrected Claim



- 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.
- Must reference original claim number on EOP within 120 days of adjudication paid date.
- Can be submitted electronically, through your clearinghouse/EDI software or through Superior's 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

Appeals



- 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.
- Must include Appeal Form:
 - <https://www.SuperiorHealthPlan.com/providers/resources/forms.html>
- Submit appeal within 120 days from the date of adjudication or denial.
- List of Present on Admission (POA) Indicators:
 - <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond/coding.html>
- Can be submitted electronically through Superior's Secure Provider Portal or in writing.
- Claims submitted in writing should be sent 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

Spell of Illness



- Spell of Illness applies to STAR+PLUS members only, and refers to 30 days of inpatient hospital care.
 - May accrue intermittently or consecutively
- After 30 days, reimbursement for additional care isn't considered until member has been out of acute care for 60 consecutive days.
- Exceptions:
 - A prior-approved solid organ transplant
 - Texas Health Steps eligible members, 20 years of age or younger, when a medically necessary condition exists

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 Superior provider contract.

Common Billing Errors



- Member name or DOB not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- First claim submission filed on a photo-copied claim form (not the original red claim form)
- Authorization numbers not provided
- Incorrect/missing taxonomy codes
- Inappropriate modifiers
- Diagnosis code not to the highest degree of specificity
- Illegible paper claim

Secure Provider Portal

Superior Website & Secure Provider Portal



www.SuperiorHealthPlan.com

Submit:

- Adjusted claims
- Claims
- COB claims
- Notification of pregnancy
- Prior authorization requests
- Provider complaints
- Request for Explanation of Payment (EOP)

Verify:

- Claim status
- Member eligibility

View:

- Claim editing software
- Links for additional provider resources
- Provider directory
- Provider manual
- Provider training schedule

How to Register for the Secure 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.

Additional Secure 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

Health Passport

Health Passport



- Health Passport is a secure web-based application, for STAR Health providers, built using core clinical and claims information to deliver relevant health-care information when and where it is needed.
 - Providers may access Health Passport on Superior's Secure Provider Portal at Providers.SuperiorHealthPlan.com
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
 - Improve care coordination
 - Eliminate waste
 - Reduce errors

Health Passport: Modules



- Face Sheet—An easy-to-read summary that includes member demographics, care gaps, Texas Health Steps (TH Steps) and last dental visit dates, active allergies, active medications and more.
- Contacts—Easily find a foster child's Primary Care Provider (PCP), medical consentor, caregiver, caseworker and service coordinator contact information in one place.
- Allergies—Providers can use interactive fields to add or modify allergies at the point-of-care. Once an allergy is charted, it's instantly checked for medication interactions.
- Assessments—Providers can document TH Steps, dental and behavioral health forms directly online. Mailing or faxing in documents critical to patient care for display is still available.
- Growth Chart—Providers can chart weight, height, length and head circumference at the point of care to track growth of infants and children.

Health Passport: Modules



- Immunizations—A comprehensive list of a person's immunizations collected from ImmTrac.
- Labs—All lab results are made available, where providers typically only have access to the lab results they've requested.
- Medication History—A summary of medications filled and access to more detail, including name of the prescription, the prescribing clinician, date filled, and dosage. Indicators representing drug-drug, drug-allergy and drug-food interactions appear, when applicable, as soon as new medications or allergies are added to the member record.
- Patient History—Past visits with details that include the description of service, treating provider, diagnosis and the service date.
- Appointments—On this module, users are able to add, modify and cancel their own appointments entries.

Additional Resources



- Please contact the Health Passport Support Desk with any questions:
 - Call: 1-866-714-7996
 - Email: TX_PassportAdmin@centene.com
- For more information on Health Passport and the resources provided, please visit <https://www.fostercaretx.com/providers/health-passport.html>
- Providers can schedule a live demo of Health Passport by reaching out to their local Account Manager.



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Superior HealthPlan Departments

Account Management



- Account Managers are here to assist you with:
 - Face-to-face orientations and Secure Provider Portal training
 - Office visits to review ongoing claim trends and quality performance reports
- Access a map with your Superior field office and Account Manager at:
<https://www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html>

Provider Services



- The Provider Services staff can help you with:
 - Answering questions on claim status and payments
 - Assisting with claims appeals and corrections
 - Finding Superior network providers
 - Locating your Service Coordinator and Account Manager
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:

– STAR/CHIP/STAR+PLUS/STAR Kids:	1-877-391-5921
– MRSA:	1-877-644-4494
– CHIP RSA:	1-800-522-8923

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/STAR MRSA	1-800-783-5386
– CHIP/RSA/Perinate:	1-800-783-5386
– STAR+PLUS:	1-877-277-9772
– STAR Kids:	1-844-590-4883
– STAR Health:	1-866-912-6283

Provider Complaints



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

Compliance



Health Insurance Portability Accountability Act (HIPAA) of 1996:

- Providers and contractors are required to comply with HIPAA guidelines <http://www.HHS.gov/ocr/privacy>.
- Fraud, Waste and Abuse (Claims/Eligibility):
 - Providers and contractors are all required to comply with state and federal provisions.
 - To report Fraud, Waste and Abuse, call the numbers listed below:
 - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
 - Texas Attorney General Medicaid Fraud Control Hotline: 1-800-252-8011
 - Superior HealthPlan Fraud Hotline: 1-866-685-8664



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Superior HealthPlan Partners

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, or email ProvidersSupport@PayspanHealth.com.

Specialty Companies/Vendors



Behavioral Health – Cenpatico www.cenpatico.com Phone: 1-877-264-6550	High Tech Radiology Imaging Services – NIA www.radmd.com Phone: 1-800-642-7554
Pharmacy Services – Envolve Pharmacy Solutions www.envolvehealth.com/pharmacy.html Phone: 1-(800) 460-8988	Vision Services – Envolve Benefit Options www.envolvehealth.com/benefit-options.html Phone: 1-866-642-9488
24/7 Nurse Advice Line - Nurse Response www.nursewise.com Phone: 1-800-783-5386, select “Nurse”	Dental Services – DentaQuest http://www.dentaquest.com/ Phone: 1-888-308-9345



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Questions & Answers

Thank you for attending!