STAR Kids
LTSS Billing Clinic

Provider Training

Introductions and Agenda

- Presenter Introductions
- Referrals and Prior Authorizations
- Claims Filing and Payment
- Claims – Long Term Services and Supports (LTSS) Billing Codes
- Claims – Electronic Visit Verification (EVV)
- Website and Secure Provider Portal
- 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) since December 1999.
- Superior provides Medicaid and CHIP programs in contracted Health and Human Services (HHS) service areas throughout the state. These programs include:
  - CHIP
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - STAR+PLUS Medicare-Medicaid Plan (MMP)

Referrals and Prior Authorizations

Referrals and Prior Authorizations

- A Primary Care Physician (PCP) is required to refer a member to a specialist when medically-necessary care is needed beyond the scope of the PCP.
- A specialist cannot refer to another specialist.
- PCP must document the coordination of referrals and services provided between the PCP and specialist.
- Referrals to out-of-network providers will be made when medically-necessary to do so.
- No referral or authorization is needed for emergent or urgent services as long as the specialist is in Superior's network or accepts Medicaid. If the specialist is not a Superior or Medicaid provider, members may receive a bill.
- *Please note: If emergent or urgent services were provided in an office setting, providers should contact Superior as soon as possible after the visit, as some services require an authorization.*

Referrals and Prior Authorizations

- All out-of-network services require an authorization, as well as some other services and treatments provided in a specialist's office.
- Existing authorizations for acute services and long-term services and supports will be honored for 6 months, until the authorizations expires or until Superior conducts a new assessment.
- If a member has Medicare or private insurance, they do not need a referral or authorization from Superior to continue seeing a specialist or PCP.
- To view more information on continuity of care, please visit: www.SuperiorHealthPlan.com/providers/resources/star-kids.html.

Claims
Filing and Payment

LTSS Claims Filing

- Claims must be filed within 95 days from the Date of Service (DOS).
  - Filed on a red CMS 1500 or UB04.
  - Filed electronically through clearinghouse.
  - Filed directly through the Secure Provider Portal.
  - 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims.
- A provider may submit a corrected claim or claim appeal within 120 days from the date of Explanation of Payment (EOP) or denial is issued.

CMS 1500 Form Tips

superior healthplan

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

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

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

Billing Provider: [R]
33a Billing NPI #

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

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 05/12

SAMPLE

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM

LTSS Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com
  - Electronic Claims:
    - Visit the website for a list of our Trading Partners: www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
  - 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 3000
    Farmington, MO 63640-3800

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

LTSS Billing Tips

- Verify member eligibility prior to providing services.
- Services require prior authorization through Superior.
- Effective November 1, 2016 – Providers must ensure they reference and use HHSC's STAR Kids LTSS billing codes when submitting claims to Superior. This can be found at the link below, under Provider Resources: hhs.texas.gov/services/health/medicaid-and-chip/programs/star-kids
- Codes with defined modifier and correct formatting is required.
- Modifier errors may result in a denial.

Common Billing Errors

- Member date of birth or name not matching ID card/member record.
- Procedures billed to not match services authorized.
- Modifier format or accuracy errors for service type.
- Illegible paper claim.

Claims Filing: Deadlines

- First Time Claim Submission
  - 95 days from date of service
- Corrected Claims
  - 120 days from the date of Explanation of Payment or denial is issued
  - Must reference original claim number on corrected claim
- Claim Appeals
  - 120 days from the date of EOP or denial is issued
  - Must be submitted in writing with supporting appeal documentation

LTSS Billing Codes

Day Activities and Health Services (DAHS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
S5101					225CX0006X	Day Activities and Health Services (DAHS) 3 to 6 hours	3-6 hours = 1 unit
S5101					225CX0006X	DAHS over 6 hours	Over 6 hours = 2 units

Emergency Response

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
S5161	U3	U3			333300000X	Emergency Response Services (Monthly)	1 month = 1 unit
S5160					333300000X	Emergency Response Services (Installation and training)	1 unit per service

LTSS Billing Codes

Minor Home Modifications

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
S5165					171WH0202X	Minor home modifications	1 unit per service

Community First Choice Attendant Care Only (CFC-PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1019	UD				251J00000X	CFC PCS Attendant care only – Agency Model	15 mins = 1 unit
T1019	U1				251J00000X	CFC PCS Attendant care only – SRO Model	15 mins = 1 unit
T1019	U3				251J00000X	CFC PCS Attendant care only - CDS Model	15 mins = 1 unit

LTSS Billing Codes

Attendant Care and Habilitation (CFC-HAB)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1019	U9				251J00000X	CFC Attendant care and habilitation, Agency model	15 mins = 1 unit
T1019	U2				251J00000X	CFC Attendant care and habilitation, SRO model	15 mins = 1 unit
T1019	U4				251J00000X	CFC Attendant care and habilitation, CDS model	15 mins = 1 unit

Nurse Delegation and Supervision

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
G0162					3747P1801X or 251J00000X	RN assessment for delegation of PCS or CFC tasks	15 mins = 1 unit
G0162	U1				3747P1801X or 251J00000X	RN training and ongoing supervision of delegated tasks	15 mins = 1 unit

LTSS Billing Codes

Personal Care Services (PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1019	U6				3747P1801X or 251J00000X	PCS Agency model	15 mins = 1 unit
T1019	US				3747P1801X or 251J00000X	PCS – SRO* model	15 mins = 1 unit
T1019	UC				3747P1801X or 251J00000X	PCS, BH condition, CDS** option (non-CFC)	15 mins = 1 unit
T1019	UA	U6			3747P1801X or 251J00000X	PCS, BH*** condition – Agency model	15 mins = 1 unit
T1019	UA	US			3747P1801X or 251J00000X	PCS, BH*** condition – SRO* model	15 mins = 1 unit
T1019	UA	UC			3747P1801X or 251J00000X	PCS, BH*** condition, CDS** option (non-CFC)	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services
***Behavioral Health

LTSS Billing Codes

Private Duty Nursing (PDN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1000	TE				3747P1801X or 251J00000X	PDN, LVN	15 mins = 1 unit
T1000	TE	UA			3747P1801X or 251J00000X	PDN, Specialized LVN	15 mins = 1 unit
T1000	TD				3747P1801X or 251J00000X	PDN, RN	15 mins = 1 unit
T1000	TD	UA			3747P1801X or 251J00000X	PDN, Specialized RN	15 mins = 1 unit
T1000	U3	TE			3747P1801X or 251J00000X	PDN, Independently Enrolled LVN	15 mins = 1 unit
T1000	U3	TE	UA		3747P1801X or 251J00000X	PDN, Independently Enrolled Specialized LVN	15 mins = 1 unit
T1000	U3	TD			3747P1801X or 251J00000X	PDN, Independently Enrolled RN	15 mins = 1 unit
T1000	U3	TD			3747P1801X or 251J00000X	PDN, Independently Enrolled Specialized RN	15 mins = 1 unit

LTSS Billing Codes

Out of Home Respite (Facility)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1005	U0				310400000X or 385H00000X	Level 10: SE3	15 mins = 1 unit
T1005	U9				310400000X or 385H00000X	Level 9: RAD & SE2	15 mins = 1 unit
T1005	U8				310400000X or 385H00000X	Level 8: SSC, SE1, & RAC	15 mins = 1 unit
T1005	U7				310400000X or 385H00000X	Level 7: SSA, SSB, & RAB	15 mins = 1 unit
T1005	U6				310400000X or 385H00000X	Level 6: RAA	15 mins = 1 unit
T1005	U5				310400000X or 385H00000X	Level 5: CB2, CC1, & CC2	15 mins = 1 unit
T1005	U4				310400000X or 385H00000X	Level 4: BB2, CA2, PE1, IB2, PD2, CB1, & PD1	15 mins = 1 unit
T1005	U3				310400000X or 385H00000X	Level 3: PB2, BB1, PC1, PC2, IB1, CA1, & IA2	15 mins = 1 unit
T1005	U2				310400000X or 385H00000X	Level 2: BA1, PA2, IA1, PB1, BA2, & IA2	15 mins = 1 unit
T1005	U1				310400000X or 385H00000X	Level 1: PA1	15 mins = 1 unit

LTSS Billing Codes

Out of Home Respite (Facility) Partial Ventilator

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1005	U0	U3			310400000X or 385H00000X	Level 10: SE3 w/partial vent	15 mins = 1 unit
T1005	U9	U3			310400000X or 385H00000X	Level 9: RAD & SE2 w/partial vent	15 mins = 1 unit
T1005	U8	U3			310400000X or 385H00000X	Level 8: SE1 & RAC w/partial vent	15 mins = 1 unit
T1005	U7	U3			310400000X or 385H00000X	Level 7: SSA, SSB, RAB, & SSC w/partial vent	15 mins = 1 unit
T1005	U6	U3			310400000X or 385H00000X	Level 6: RAA w/partial vent	15 mins = 1 unit
T1005	U5	U3			310400000X or 385H00000X	Level 5: CC1 & CC2 w/partial vent	15 mins = 1 unit
T1005	U4	U3			310400000X or 385H00000X	Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 w/partial vent	15 mins = 1 unit
T1005	U3	U3			310400000X or 385H00000X	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 w/partial vent	15 mins = 1 unit
T1005	U2	U3			310400000X or 385H00000X	Level 2: PA2, IA2, PB1, BA2, IA2, & PB2 w/partial vent	15 mins = 1 unit
T1005	U1	U3			310400000X or 385H00000X	Level 1: PA1 & BA1 w/partial vent	15 mins = 1 unit

LTSS Billing Codes

Out of Home Respite (Facility) Tracheostomy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1005	U0	U5			310400000X or 385H00000X	Level 10: SE3 w/trach	15 mins = 1 unit
T1005	U9	U5			310400000X or 385H00000X	Level 9: RAD & SE2 w/trach	15 mins = 1 unit
T1005	U8	U5			310400000X or 385H00000X	Level 8: SE1 & RAC w/trach	15 mins = 1 unit
T1005	U7	U5			310400000X or 385H00000X	Level 7: SSA, SSB, RAB, & SSC w/trach	15 mins = 1 unit
T1005	U6	U5			310400000X or 385H00000X	Level 6: RAA w/trach	15 mins = 1 unit
T1005	U5	U5			310400000X or 385H00000X	Level 5: CC1 & CC2 w/trach	15 mins = 1 unit
T1005	U4	U5			310400000X or 385H00000X	Level 4: PE1, IB2, PD2, CB1, PE2, & CB2 w/trach	15 mins = 1 unit
T1005	U3	U5			310400000X or 385H00000X	Level 3: BB1, PC1, PC2, IB1, CA1, PD1, BB2, & CA2 w/trach	15 mins = 1 unit
T1005	U2	U5			310400000X or 385H00000X	Level 2: PA2, IA2, PB1, BA2, IA2, & PB2 w/trach	15 mins = 1 unit
T1005	U1	U5			310400000X or 385H00000X	Level 1: PA1 & BA1 w/trach	15 mins = 1 unit

LTSS Billing Codes

Out of Home Respite (Facility) Full Ventilator

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1005	U0	U7			310400000X or 385H00000X	Level 10: SE2 w/full vent	15 mins = 1 unit
T1005	U9	U7			310400000X or 385H00000X	Level 9: RAD & SE2 w/full vent	15 mins = 1 unit
T1005	U8	U7			310400000X or 385H00000X	Level 8: RAB, SSC, SE1, & RAC w/full vent	15 mins = 1 unit
T1005	U7	U7			310400000X or 385H00000X	Level 7: SSA & SSB w/full vent	15 mins = 1 unit
T1005	U6	U7			310400000X or 385H00000X	Level 6: CC2 & RAA w/full vent	15 mins = 1 unit
T1005	U5	U7			310400000X or 385H00000X	Level 5: CB1, PE2, CB2, & CC1 w/full vent	15 mins = 1 unit
T1005	U4	U7			310400000X or 385H00000X	Level 4: PD1, BB2, CA2, PE1, IB2, & PD2 w/full vent	15 mins = 1 unit
T1005	U3	U7			310400000X or 385H00000X	Level 3: BB1, PC1, PC2, IB1, & CA1 w/full vent	15 mins = 1 unit
T1005	U2	U7			310400000X or 385H00000X	Level 2: IA1, PB1, BA2, IA2, & PB2 w/full vent	15 mins = 1 unit
T1005	U1	U7			310400000X or 385H00000X	Level 1: PA1, BA1, & PA2 w/full vent	15 mins = 1 unit

LTSS Billing Codes

Prescribed Pediatric Extended Care (PPEC)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T1025					261QM3000X	Prescribed pediatric extended care, greater than 4 hours	4.25 hours or more = 1 unit
T1026					261QM3000X	Prescribed pediatric extended care, up to 4 hours	1 hour = 1 unit
T2002					261QM3000X	Non-emergency transportation	1 day = 1 unit

Out of Home Respite (Non-Facility)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T2027					385H2050X	Respite care, camp setting	15 mins = 1 unit

LTSS Billing Codes

Adaptive Aids (Waiver)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T2028					171WH0202X	Adaptive aid - NOS	1 unit per service
T2029					171WH0202X	Adaptive aid – Medical equipment	1 unit per service
T2039					171WH0202X	Adaptive aid – Vehicle modification	1 unit per service

LTSS Billing Codes

In Home Respite (Attendant)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	U1				310400000X or 385H00000X	Attendant, Agency model	15 mins = 1 unit
H2015	U1	US			310400000X or 385H00000X	Attendant, SRO*	15 mins = 1 unit
H2015	U1	UC			310400000X or 385H00000X	Attendant, CDS** option	15 mins = 1 unit
H2015	U1	UA			310400000X or 385H00000X	Attendant with RN delegation, Agency model	15 mins = 1 unit
H2015	U1	UA	US		310400000X or 385H00000X	Attendant with RN delegation, SRO*	15 mins = 1 unit
H2015	U1	UA	UC		310400000X or 385H00000X	Attendant with RN delegation, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

Transition Assistance Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T2038					305S00000X	Transition assistance services	1 unit per service

Financial Management Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
T2040	U8				251X00000X	Financial management service fee, PCS	Monthly fee
T2040	U5				251X00000X	Financial management service fee, CFC, **non-MDCP**	Monthly fee
T2040	U3				251X00000X	Financial Management Service Fee, **MDCP**	Monthly fee
T2040	U4				251X00000X	Financial Management Service Fee, CFC and **MDCP**	Monthly fee

LTSS Billing Codes

In Home Respite (LVN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	U3				310400000X or 385H00000X	LVN, Agency model	15 mins = 1 unit
H2015	U3	US			310400000X or 385H00000X	LVN, SRO*	15 mins = 1 unit
H2015	U3	UC			310400000X or 385H00000X	LVN, CDS** option	15 mins = 1 unit
H2015	U3	UA			310400000X or 385H00000X	Specialized LVN, Agency model	15 mins = 1 unit
H2015	U3	UA	US		310400000X or 385H00000X	Specialized LVN, SRO*	15 mins = 1 unit
H2015	U3	UA	UC		310400000X or 385H00000X	Specialized LVN, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

In Home Respite (RN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	U5				310400000X or 385H00000X	RN, Agency model	15 mins = 1 unit
H2015	U5	US			310400000X or 385H00000X	RN, SRO*	15 mins = 1 unit
H2015	U5	UC			310400000X or 385H00000X	RN, CDS** option	15 mins = 1 unit
H2015	U5	UA			310400000X or 385H00000X	Specialized RN, Agency model	15 mins = 1 unit
H2015	U5	UA	US		310400000X or 385H00000X	Specialized RN, SRO*	15 mins = 1 unit
H2015	U5	UA	UC		310400000X or 385H00000X	Specialized RN, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

Flexible Family Support Services (Attendant)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	99	U1			363LC1500X	Attendant, Agency model	15 mins = 1 unit
H2015	99	U1	US		363LC1500X	Attendant, SRO*	15 mins = 1 unit
H2015	99	U1	UC		363LC1500X	Attendant, CDS** option	15 mins = 1 unit
H2015	99	U1	UA		363LC1500X	Attendant with RN delegation, Agency model	15 mins = 1 unit
H2015	99	U1	UA	US	363LC1500X	Attendant with RN delegation, SRO*	15 mins = 1 unit
H2015	99	U1	UA	UC	363LC1500X	Attendant with RN delegation, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

Flexible Family Support Services (LVN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	99	U3			363LC1500X	LVN, Agency model	15 mins = 1 unit
H2015	99	U3	US		363LC1500X	LVN, SRO	15 mins = 1 unit
H2015	99	U3	UC		363LC1500X	LVN, CDS option	15 mins = 1 unit
H2015	99	U3	UA		363LC1500X	Specialized LVN, Agency model	15 mins = 1 unit
H2015	99	U3	UA	US	363LC1500X	Specialized LVN, SRO	15 mins = 1 unit
H2015	99	U3	UA	UC	363LC1500X	Specialized LVN, CDS option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

Flexible Family Support Services (RN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2015	99	U5			363LC1500X	RN, Agency model	15 mins = 1 unit
H2015	99	U5	US		363LC1500X	RN, SRO*	15 mins = 1 unit
H2015	99	U5	UC		363LC1500X	RN, CDS** option	15 mins = 1 unit
H2015	99	U5	UA		363LC1500X	Specialized RN, Agency model	15 mins = 1 unit
H2015	99	U5	UA	US	363LC1500X	Specialized RN, SRO*	15 mins = 1 unit
H2015	99	U5	UA	UC	363LC1500X	Specialized RN, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

LTSS Billing Codes

Employment Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Taxonomy Code	Description	Units
H2023					251S00000X	Supported employment, agency model	15 mins = 1 unit
H2023	US				251S00000X	Supported employment, SRO*	15 mins = 1 unit
H2023	UC				251S00000X	Supported employment, CDS** option	15 mins = 1 unit
H2025					251S00000X	Employment assistance, Agency model	15 mins = 1 unit
H2025	US				251S00000X	Employment assistance, SRO*	15 mins = 1 unit
H2025	UC				251S00000X	Employment assistance, CDS** option	15 mins = 1 unit

*Service Responsibility Options
**Consumer Directed Services

Identifying a Claim Number from Superior

- 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. It can be found in the following:
  - Electronic Data Interchange (EDI) rejection/acceptance reports
  - Rejection letters*
  - Secure Provider Portal
  - EOP
- When calling into Provider Services, please have your claim number ready for expedited handling.

**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.*

Where do I find a Claim Number?

There are 2 ways of submitting your claims to Superior:

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

**Note: On all correspondence, please reference either the 'Claim Number' or 'Control Number'.*

Where do I find a Claim Number?

superior healthplan

Examples:

EDI Reports

DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842	[redacted]	000209200	INVALD	[redacted]	[redacted]	76	20130710	[redacted]
	M317TXE44820	[redacted]	000164200	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44819	[redacted]	000193510	INVALD	[redacted]	[redacted]	76	20130704	[redacted]
	M317TXE44858	[redacted]	001141694	ACCEPT	[redacted]	[redacted]		20131108	[redacted]
	M317TXE44868	[redacted]	000759989	ACCEPT	[redacted]	[redacted]		20131108	[redacted]
	M317TXE44826	[redacted]	000310600	ACCEPT	[redacted]	[redacted]		20131108	[redacted]
	M317TXE44814	[redacted]	000116222	ACCEPT	[redacted]	[redacted]		20131108	[redacted]
	M317TXE44828	[redacted]	000405752	ACCEPT	[redacted]	[redacted]		20131103	[redacted]
	M317TXE44835	[redacted]	000112728	ACCEPT	[redacted]	[redacted]		20131108	[redacted]
	M317TXE44824	[redacted]	000113004	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44829	[redacted]	000984375	ACCEPT	[redacted]	[redacted]		20131024	[redacted]
	M317TXE44816	[redacted]	000103600	INVALD	[redacted]	[redacted]	09	20131105	[redacted]
	M317TXE44821	[redacted]	000999375	ACCEPT	[redacted]	[redacted]		20131106	[redacted]
	M317TXE44843	[redacted]	001183267	ACCEPT	[redacted]	[redacted]		20131101	[redacted]
	M317TXE44815	[redacted]	000103600	ACCEPT	[redacted]	[redacted]		20131107	[redacted]
	M317TXE44817	[redacted]	000011500	INVALD	[redacted]	[redacted]	76	20121003	[redacted]
	M317TXE44825	[redacted]	000207700	ACCEPT	[redacted]	[redacted]		20131107	[redacted]
	M317TXE44882	[redacted]	000414130	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44827	[redacted]	001399000	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44910	[redacted]	005690360	ACCEPT	[redacted]	[redacted]		20131030	[redacted]
	M317TXE44837	[redacted]	000109830	ACCEPT	[redacted]	[redacted]		20131004	[redacted]
	M317TXE44853	[redacted]	000310700	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44839	[redacted]	000338276	ACCEPT	[redacted]	[redacted]		20130906	[redacted]
	M317TXE44878	[redacted]	000472927	ACCEPT	[redacted]	[redacted]		20131109	[redacted]
	M317TXE44823	[redacted]	000086211	ACCEPT	[redacted]	[redacted]		20131109	[redacted]

Explanation of Payment Details

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

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

Group:
ID: [redacted]
Account: AYEU9245
NPI: 1003885641

View Service Line Details

Serv	Date	Diag#/ Drug#	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	09/16/2013	2920	270		0/1	51.71	10.34	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00
20	09/16/2013	2920	272		0/1	9.17	1.83	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00

Payment History via Provider Portal (EOP)

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, diagnosis (Dx code), etc.
  - The original claim number must be billed in field 64 of the UB-04 form or field 22 of the HCFA 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 HCFA 1500 form.
  - A corrected claim form, found in the Provider Manual, may be used when submitting a corrected claim.

Claim Appeals

- A claim appeal can be requested when the provider disagrees with the outcome of the adjudication of the claim.
- Claim appeals must be submitted in writing and submitted via mail, or may be requested through the provider portal.
- Claim appeals must include supporting documentation, including:
  - Copy of EOP of appealed claim (not required for web portal claim appeals).
  - Explanation of reason for claim appeal (via letter, completed claim appeal form or web entry explanation).

PaySpan Health

- Superior has partnered with PaySpan Health 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.PaySpanHealth.com.
- For further information contact 1-877-331-7154, or email ProviderSupport@PaySpanHealth.com.

Member Balance Billing

- Providers may NOT bill STAR Kids members directly for covered services.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Providers may inform members of costs for non-covered services and secure a private pay form prior to rendering.
- Members do not have co-payments.
- Additional details can be found in the Superior Provider Manual.

superior healthplan™

Claims Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

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

Programs and Services Requiring EVV

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

EVV Claims

- Providers will verify EVV service visits using their selected EVV vendor system.
- EVV claims are forwarded to Superior after the matching process is performed by the EVV Aggregator.
- EVV claim line items without matching EVV visit transactions will not be paid.
- To avoid denials, personal attendant services (PAS) claims for multiple dates of service should be billed on a separate line for each day with the number of units per day.

EVV Changes Effective September 1, 2019

- Effective September 1, 2019, program providers required to use EVV must bill EVV-relevant claims to Texas Medicaid Healthcare Partnership (TMHP) and are subject to the EVV claims matching process.
- Additionally, effective September 1, 2019, STAR+PLUS, PAS and In-Home Respite increments changed from 1 hour to 15 minute units.
  - Please refer to the Long-Term Services and Supports (LTSS) billing matrix and the EVV Service Bill Codes table for further clarification.
- Program providers should always verify EVV visits are accepted in the EVV Portal prior to claim submission.

EVV Changes Effective September 1, 2019

- Prior to submitting claims to Superior for adjudication, the EVV Aggregator matches EVV claim items billed with accepted EVV visit transactions using the following data elements:
  - Medicaid ID.
  - EVV visit date and claim date of service.
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API).
  - Healthcare Common Procedure Coding System (HCPCS) code.
  - HCPCS modifiers, if applicable.
  - Units.

- EVV claims that are not successfully matched with EVV visit transactions will result in denial.

- Providers are required to resubmit any claim denials back to TMHP.

CDS EVV – Effective January 1, 2021

- Effective January 1, 2021, financial management services agencies (FMSAs) will be required to use EVV for Consumer Directed Services (CDS).
- It is the responsibility of the FMSA to select an EVV vendor or elect to use a proprietary system to collect and transmit EVV visit data.
- EVV vendors will provide training to CDS employers and FMSAs on their EVV system.
- CDS employers are responsible for training their attendants on how to clock in/out of their EVV system.

CDS EVV – Billing After December 1, 2020

- CDS claims billed with dates of service on or after December 1, 2020 must be submitted to TMHP and will be subject to the EVV claims matching process.
- CDS claims must match EVV transaction data, including:
  - Medicaid ID.
  - EVV visit date.
  - NPI or API.
  - HCPCS codes.
  - HCPCS modifiers, if applicable.
- All CDS claims line items billed without matching EVV visit transactions will result in denials
- CDS employers will not use the EVV Portal. Instead, they will use the EVV vendor's system to view EVV data and reports.
- For more information on EVV milestones relating to CDS, please refer to the HHS 21st Century Cures Act webpage: https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/resources/electronic-visit-verification/21st-century-cures-act.

Website and Secure Provider Portal

Superior Website and Secure Provider Portal

www. SuperiorHealthPlan.com

View:

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

Provider.SuperiorHealthPlan.com

Submit:

- Claims
- Request for EOPs
- Provider Complaints
- Coordination of Benefits (COB) Claims
- Adjusted Claims

Verify:

- Member Eligibility
- Claim Status

Provider Portal: How to Register

- Visit 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.

Provider Portal: Claims

- Claim Status
  - Claims update to the web portal every 24 hours.
  - Status can be checked for a period of 18 months prior.
- View Web Claims
  - Click on the claims module to view the last 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.

Provider Portal: Additional Information

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

Questions and Answers