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)

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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.

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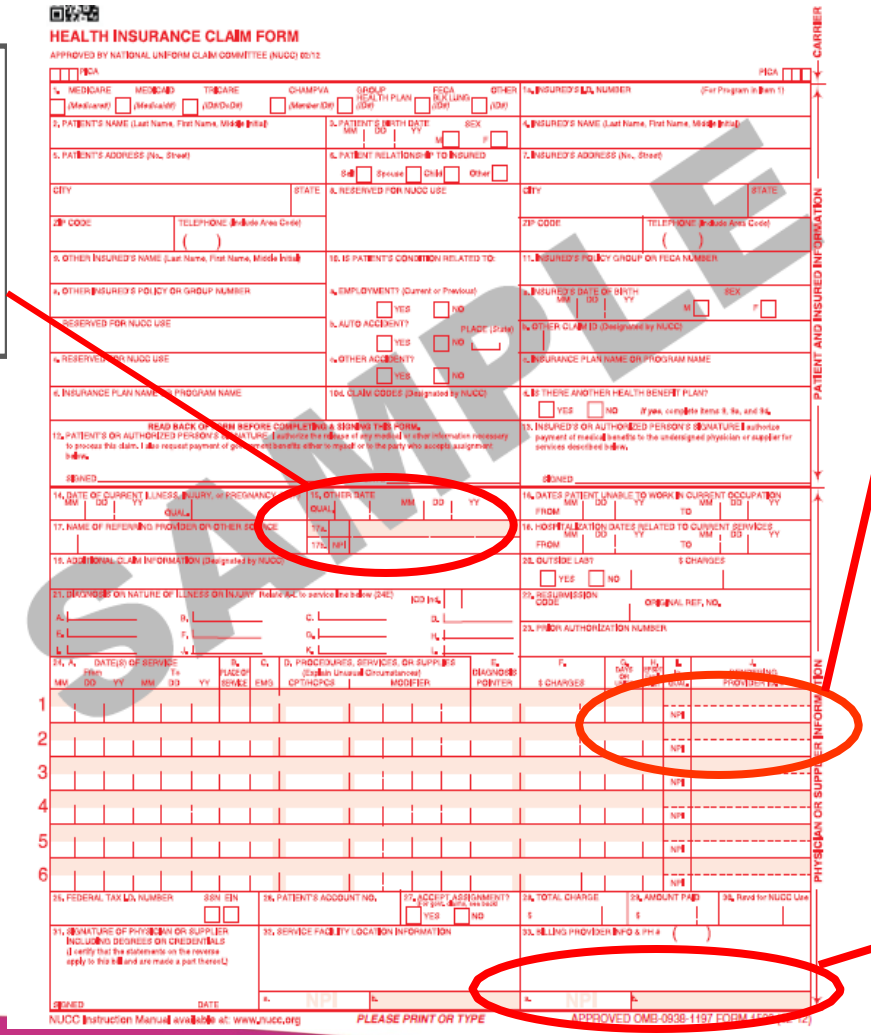
Claims
Filing and Payment

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

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)

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.
- 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 do 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				251C00000X	CFC Attendant care and habilitation, Agency model	15 mins = 1 unit
T1019	U2				251C00000X	CFC Attendant care and habilitation, SRO model	15 mins = 1 unit
T1019	U4				251C00000X	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:

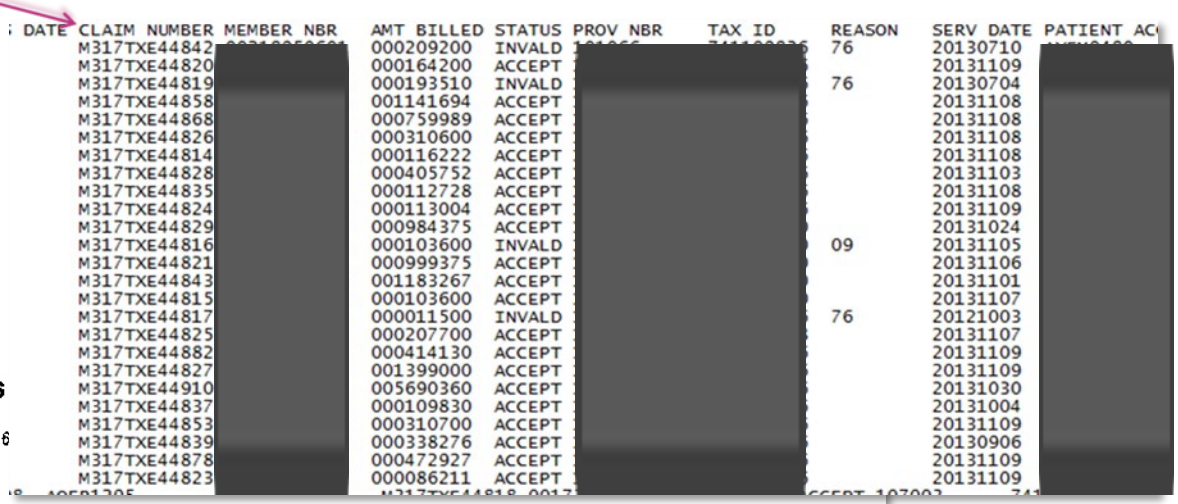
- Electronic: Provider Portal or EDI via a clearinghouse
  - Your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior Provider Portal and EOPs.
- Paper: Mailed to our processing center
  - Your response to your submission is viewable via rejection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

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		000164200	ACCEPT				20131109	
	M317TXE44819		000193510	INVALD			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				20131024	
	M317TXE44816		000103600	INVALD			09	20131105	
	M317TXE44821		000999375	ACCEPT				20131106	
	M317TXE44843		001183267	ACCEPT				20131101	
	M317TXE44815		000103600	ACCEPT				20131107	
	M317TXE44817		000011500	INVALD			76	20121003	
	M317TXE44825		000207700	ACCEPT				20131107	
	M317TXE44882		000414130	ACCEPT				20131109	
	M317TXE44827		001399000	ACCEPT				20131109	
	M317TXE44910		005690360	ACCEPT				20131030	
	M317TXE44837		000109830	ACCEPT				20131004	
	M317TXE44853		000310700	ACCEPT				20131109	
	M317TXE44839		000338276	ACCEPT				20130906	
	M317TXE44878		000472927	ACCEPT				20131109	
	M317TXE44823		000086211	ACCEPT				20131109	

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.

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 Claims

- 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 Claims

- 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.

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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

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Questions and Answers