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STAR Kids

Provider Training

Introductions and Agenda



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Who is Superior HealthPlan?



- Superior, a subsidiary of Centene Corporation, manages health care for Medicaid and CHIP members across Texas.
- Superior has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Superior provides Medicaid and CHIP programs in contracted Texas 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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STAR Kids Overview

STAR Kids Background



- Senate Bill 7, 83rd Legislature, 2013:
 - Directed Texas 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 20 years of age 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).
 - Those who reside in community-based Intermediate Care Facility/Individuals with an Intellectual Disability (ICF-IID) or in Nursing Facilities (NF).

STAR Kids Excluded Population



- Individuals excluded from participating in STAR Kids include:
 - Adults 21 years of age or older.
 - Children and young adults 20 years of age and younger enrolled in STAR Health
 - Children and young adults 20 years of age and younger who reside in the Truman Smith Children's Care Center or a state veteran's home.



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STAR Kids Medicaid Managed Care Benefits

STAR Kids Program Benefits



- Include, but are not limited to:
 - Medical and Surgical Services
 - Hospital Services
 - Texas Health Steps
 - Transplants
 - Prescriptions (Unlimited)
 - Therapy – Physical (PT), Speech (ST), Occupational (OT)
 - Durable Medical Equipment (DME)
 - Mental and Behavioral Health Services
 - Mental Health Rehabilitation Services
 - Mental Health Targeted Case Management
 - Maternity Services
 - Long Term Services and Supports (LTSS)
 - Telemonitoring, Telehealth and Telemedicine Services

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)

Private Duty Nursing



- PDN services include nursing and caregiver training and education, and must be available to all members determined eligible through the STAR Kids Screening and Assessment Instrument (SK-SAI).

Personal Care Services



- PCS must be available to members who require assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) or Health Maintenance Activities (HMAs) because of a physical, cognitive or behavioral limitation related to the member's disability or chronic health condition.

Personal Care Services Oversight



- Effective September 1, 2020, HHS mandated MCOs to require PCS agencies to conduct unannounced visits to validate that services are rendered and billed correctly.
- This requirement was put into place for the STAR Health, STAR Kids and STAR+PLUS programs.
- To comply with this new requirement, Superior has initiated audits of randomly selected PCS agencies to validate agency compliance with program integrity policies and procedures.
- Upon receipt of Superior's PCS oversight audit request, all requested documentation should be submitted to Statewide.AM@SuperiorHealthPlan.com within the specified timeframe.

Community First Choice



- Community First Choice (CFC) is part of Senate Bill 7 from the 2013 Texas Legislature requiring HHS to put in place a cost-effective option for attendant and habilitation services for people with disabilities.
- CFC services are available for STAR Kids members who:
 - Need help with activities of daily living (dressing, bathing, eating, etc.).
 - Need an institutional level of care (Intermediate Care Facility for Individuals with an Intellectual Disability or related conditions [ICF/IID] or Institution for Mental Disease [IMD]).
 - Currently receive PCS.
 - Are individuals on the waiver interest list or are already getting services through a 1915(c) waiver.

Community First Choice



- CFC will include PCS, Habilitation, Emergency Response Services and Support Management.
- CFC assessments will be conducted by Superior.
- If the Primary Care Physician (PCP) determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination at 1-800-218-7508 and request an assessment.
- CFC services should be billed directly to Superior on paper, electronically through Superior's Secure Provider Portal (Provider.SuperiorHealthPlan.com) or your clearinghouse.
- Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the Texas Medicaid and Healthcare Partnership (TMHP) manual.

Day Activity Health Services



- DAHS includes nursing and personal care services, therapy extension services, nutrition services, transportation services and other supportive services for members, 18-20 years of age.

Types of Waivers



- Medicaid 1915(c) waiver programs include:
 - Home and Community-Based Services (HCBS).
 - Community Living Assistance and Support Services (CLASS).
 - Deaf-Blind with Multiple Disabilities (DBMD).
 - Medically Dependent Children Program (MDCP).
 - Texas Home Living (TxHmL).
 - Youth Empowerment Services (YES).

Home and Community-Based Services (HCS) Waiver



- Provides individualized services to individuals who qualify for ICF/IID level of care.
- Services include adaptive aids, minor home modifications, dental treatment, nursing, supported home living, respite, day habilitation, residential services, employment assistance, supported employment and professional therapies.
- Professional therapies include PT, OT, ST and language pathology, audiology, social work, behavioral support, dietary services and cognitive rehabilitation therapy.
- Financial management services and support consultation are available to individuals who use the Consumer Directed Services (CDS) option.

Community Living and Assistance Support Services (CLASS) Waiver



- Provides home and community-based services to persons having a diagnosis of a “related condition” by a licensed physician qualifying them for placement in an ICF/IID.
 - A related condition is a disability other than an intellectual disability (ID) or mental illness which originates before 22 years of age, and is found to be closely related to the ID because the condition substantially limits life activity; similar to that of individuals with an ID and requires treatment or services similar to those required for individuals with an ID.

CLASS Services



- Services available to individuals receiving CLASS waivers include:

Case Management	Prevocational Services	Residential Habilitation	Respite (In-Home and Out-of-Home)
Employment Assistance	Supported Employment	Adaptive Aids/Medical Supplies	Dental Treatment Services
Occupational Therapy	Physical Therapy	Prescriptions	Skilled Nursing
Speech and Language Pathology	Behavioral Support	Minor Home Modifications	Specialized Therapies
Support Family Services	Continued Family Services	Transition Assistance Services	

- Financial management services and support consultation are available to individuals who use the consumer-directed services option.

Deaf, Blind, Multiple Disability (DBMD) Waiver



- Provides home and community-based services as an alternative to residing in an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to people of all ages who are deaf, blind or have a condition that will result in deaf-blindness and who have an additional disability.
- Services available to individuals receiving the DBMD waiver include:

Case Management	Day Habilitation	Residential Habilitation	Respite
Supported Employment	Prescriptions	Financial Management Services	Adaptive Aids/Medical Supplies
Assisted Living	Audiology Services	Behavioral Support	Chore Services
Dental Treatment	Dietary Services	Employment Assistance	Intervener
Minor Home Modifications	Nursing	Orientation and Mobility	Physical, Speech, Hearing and Language Therapy
Transition Assistance Services			

- Support consultation is also available to individuals who use the CDS option.

Medically Dependent Children Program (MDCP) Waiver



- Available to members who meet income, resource and medical necessity requirements for nursing facility level of care, include services unavailable under the state plan, as a cost-effective alternative to living in a nursing facility.
- Support families caring for children and young adults who are medically dependent.
- Encourage de-institutionalization of children in a nursing facility.
- MDCP waiver services:
 - Adaptive aids*
 - Minor home modifications*
 - Transition assistance services
 - Employment assistance*
 - Flexible family support services*
 - Financial management services*
 - Respite services*
 - Supported employment*

**These services are available through the CDS option. Pursuant to SB 1207, all services will soon be available through CDS.*

Texas Home Living (TxHML)

Waiver



- Provides selected services and supports for individuals who qualify for ICF/IID level of care and live in their family homes or their own homes.
- Services provided through the TxHML waiver includes:

Adaptive Aids	Minor Home Modifications	Behavioral Support	Dental Treatment
Nursing	Community Support	Respite	Day Habilitation
Employment Assistance	Supported Employment	Specialized Therapies	Physical Therapy
Occupational Therapy	Speech and Language Pathology	Audiology	Dietary Services

- Financial management services and support consultation are available to individuals who use the CDS option.

Youth Empowerment Services (YES) Waiver



- Program for children and young adults 3 to 19 years of age that are at risk of hospitalization because of serious emotional disturbance.
- Allows for more flexibility in the funding of intensive community-based services for children and adolescents 3 to 19 years of age with serious emotional disturbances and their families.

Nurse Advice Line



- 24/7 Nurse Advice Line
- Available by calling:
 - 1-844-590-4883
- Staff is bilingual in English and Spanish.
- All Texas licensed RNs

My Health Pays® Rewards



- Members can earn My Health Pays® rewards for completing health activities.
- Rewards can be used to help pay for:
 - Utilities.
 - Transportation.
 - Telecommunications.
 - Childcare services.
 - Education.
 - Rent.
 - Rewards can also be used at Walmart stores to pay for everyday items (not including alcohol, tobacco or firearms products).
- Rewards can be earned for receiving a flu vaccine, completing Texas Health Steps checkups and for completing an annual well woman exam.
- Pregnant members can also receive rewards for prenatal visits and postpartum doctor visits within 7-84 days of delivery.

My Health Pays® Rewards



- My Health Pays® Rewards include:
 - \$20 for completing a Texas Health Steps checkup within 90 days of enrollment, one per calendar year (up to 20 years of age).
 - \$120 for completing 6 Texas Health Steps on schedule (ages 0-15 months).
 - \$20 for completing a yearly Texas Health Steps checkup (3 to 20 years of age).
 - \$20 for getting a well-woman exam, one per calendar year (18-20 years of age).
 - \$10 for members getting a flu shot (18-20 years of age).

Value-added Services (VAS)



- Over-the-Counter (OTC) quarterly benefit.
- Behavioral health inpatient – 7 day follow-up appointment incentive.
- Camp.
- In Home Respite care services (Non-MDCP).
- Sports physicals.

Restrictions and limitations may apply. For a complete and up-to-date list of VAS, please review the **Value-Added Services for Superior STAR Kids Members** section found on [Superior's Plan Benefits, Services, & Co-Pays webpage](#).

STAR Kids

Transportation Benefits



- Superior's Medical Ride Program (NEMT Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- Transportation includes rides to the doctor, dentist, hospital, pharmacy and other places members receive Medicaid services.
- Transportation services are provided by SafeRide.
- Superior's Medical Ride Program will cover the cost of an attendant for members needing assistance while traveling.
 - Providers may receive a request to provide proof of documentation of medical necessity.
- Children 14 years of age and younger must be accompanied by a parent, guardian or other authorized adult.

Medical Ride Program Services



- Services offered by Superior's Medical Ride Program include, but are not limited to:
 - Passes or tickets for mass transit within and between cities or states.
 - Commercial airlines transportation.
 - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
 - The enrolled ITP can be the member, the member's family member, friend or neighbor.
 - Car, van or private bus services, including wheelchair-accessible vehicles, if necessary.
 - Members 20 years of age and younger requiring long-distance trips may be eligible to receive the cost of meals and/or lodging to obtain a covered health-care service.

Requesting NEMT Services



- Superior members should request rides as early as possible, and at least two Business Days before they need the ride.
- It is the responsibility of the member to coordinate all information needed from both the provider and Superior timely, in order for Superior or SafeRide to consider the request.
- Appointments can be requested Monday through Friday, 8:00 a.m. – 5:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).
- For any questions, concerns or complaints about SafeRide, Superior medical providers and nursing facilities can contact 1-855-932-2322 (Monday through Friday, 8:00am – 6:00pm CST) for assistance.



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Provider Roles and Responsibilities

Provider Roles and Responsibilities



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

Eligibility Verification



- Providers should verify member eligibility prior to delivering service at each visit by:
 - Logging into Superior's Secure Provider Portal at www.SuperiorHealthPlan.com.
 - Viewing the member's Superior-issued ID card (Member ID card is not a guarantee of enrollment or payment).
 - Contacting Superior's Member Services Department at 1-844-590-4883.
 - Viewing the member's "Your Texas Benefits" Medicaid Card.
 - Logging into TexMedConnect at www.tmhp.com/Pages/EDI/EDI_TexMedConnect.aspx.

Member ID Cards



- Member ID cards contain the following information:
 - Member name.
 - PCP (except CHIP Perinate mother).
 - Prescription information.
 - Program eligibility.
 - Superior HealthPlan contact information.
- Images of STAR Kids member ID cards can be found in the Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual, located at www.SuperiorHealthPlan.com/providers/training-manuals.html.

PCP Responsibilities



- Serve as a “Medical Home.”
- Be available for PCP selection (Physicians and Mid-Level Practitioners contracted as PCPs may be selected as a PCP by the member).
- Be accessible to members 365/24/7.
- Coordinate care and referrals to Specialists.
- Enroll as a Texas Health Steps provider or refer member to a participating Texas Health Steps Provider.
- Update contact information including address, phone number, provider listing or hours of operation to ensure accurate information in Provider Directories.
- Sign Form 2601 to verify medical necessity for MDCP services.
- Report all encounter data on CMS 1500 or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.

After-Hours Telephone Arrangements



- Acceptable
 - Phone answered by an answering service must be returned within 30 minutes by the PCP or other designated provider.
 - Phone answered by an answering machine that directs members to call another number where someone must be available to answer the designated number.
 - Phone transferred to another location where someone will answer the phone and contact the PCP or on-call provider, who can return call within 30 minutes.
 - After hours calls should be documented in an after-hour call log and transferred to the member's medical record.
- Unacceptable
 - Phone only answered during office hours or directs members to leave a message.
 - Phone message directs members to the Emergency Room (ER).
 - Answering machine or answering service is not bilingual (English and Spanish).
 - Returning after-hours calls outside of 30 minutes.

PCP Access to Care Requirements



- Superior requires that the hours of operation that providers offer to Medicaid and CHIP members be no less than those offered to commercial members.
- Appointment Access Guide
 - Routine Care: Provided within 2 weeks of request.
 - Urgent Care: Provided within 24 hours of request.
 - Emergent Care: Provided immediately (same day).
 - Referrals to Specialists: Appointments should be available within 30 days of the request for non-urgent conditions.
 - Preventive Health Services: Consistent with the Texas Health Steps Periodicity Schedule.
 - Preventive Health Services for Adults: Provided within 90 days of request.

Referrals



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

Member Self-Referrals



- Members may self-refer for the following services:
 - Family Planning.
 - Texas Health Steps.
 - Case Management for Children and Pregnant Women.
 - Vision.
 - Behavioral Health.
 - True Emergency Services.
 - Well Woman Annual Examinations.

Physician Certification (2601) – STAR Kids



- HHS requires a Screening and Assessment Instrument (SAI) assessment to be conducted when a STAR Kids or STAR Health member is released from the HHS interest list for HCBS in the MDCP.
- Following the assessment, Superior will supply the medical provider with the Physician Certification (2601) (Medical Necessity [MN] Form), certifying that the STAR Kids or STAR Health member meets nursing facility level of care.
- The MN Form is the physician's certification of medical necessity for the member's need for ongoing services under the supervision of a physician.
- Services include, but are not limited to, Minor Home Modifications (MHM), Respite Services, Flexible Family Support Services, Transition Assistance Services, Adaptive Aids, Supported Employment, Community First Choice (CFC) Services and Employment Assistance.

Physician Certification (2601) – STAR Kids



- The medical provider's signature is required only at initial request of STAR Kids or STAR Health MDCP services, and any significant Change in Condition (CIC). TMHP will grant final approval for STAR Kids or STAR Health MDCP services.
- The MN Form must be signed and obtained from a Physician (MD), Osteopathic Medicine (DO) or Military Physician, who has examined the member and reviewed the medical record within the last 12 months. The provider must be a Medicaid provider.
- The physician is certifying that the member meets the nursing facility level of care, and that the member would benefit from the additional services that are provided under the HCBS program.

Physician Certification (2601) – STAR Kids



- Providers have 5 business days from the initial request to submit the form.
 - If not received within the timeframe, Superior will complete additional attempts to obtain the signature.
 - If no response is received, the member is notified and Superior will notify the Program Support Unit at HHS.
- For additional information:
 - Call 1-866-912-6283.
 - Review the Physician Certification (2601) - STAR Kids and STAR Health Frequently Asked Questions, located in the “Member Management” section of www.SuperiorHealthPlan.com/providers/resources/forms.html.

Cultural Competency



- Cultural Sensitivity
 - Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with members, and the health and wellness of the members themselves.
- Cultural Competency Contractual Requirements
 - It is important to:
 - Treat all STAR Kids members with dignity and respect.
 - Respect the importance of different cultures.
 - Respect the importance of spiritual beliefs.



Health Home

Health Homes



- Superior uses National Committee for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) recognized providers as Health Homes.
 - NCQA reviews applications for recognition and recognizes providers who meet the criteria.
 - More information on seeking recognition at <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>.

Accessing a Health Home



- Superior creates a monthly file of all participating PCMH providers.
 - Participating providers across Texas.
 - Member Services uses the file to identify health homes for members.
 - Case Management and Service Coordination use the file to identify health homes when needed.



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Texas Health Steps Requirements

Texas Health Steps Overview



- Comprehensive preventive care program that combines diagnostic screenings, communication and outreach, and medically necessary follow-up care, including dental, vision and hearing examinations for Medicaid-eligible children, adolescents and young adults under 21 years of age.
- Age-appropriate screenings must include but are not limited to:
 - Nutrition
 - Developmental
 - Autism
 - Mental Health
 - Vision
 - Hearing
 - Tuberculosis
 - Lead
 - Sexually Transmitted Diseases
- For complete Texas Health Steps exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule:
<https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers>

Required Elements of Checkup



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

Checkup Requirements



- Members new to Superior:
 - Within first 90 days (unless documentation of previous checkup is provided).
- Existing members:
 - Follow periodicity schedule: <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers>
 - Members under 3 years of age have multiple checkups within each year; 6 outpatient checkups in the first year.
 - Members over 3 years of age have an annual checkup which must occur within 364 days following their birth date.

Texas Health Steps Medical Checkups



- Children may need more frequent medical checkups when:
 - The physician determines the checkup is “medically necessary.”
 - There is a high risk of the child getting sick (e.g., if another child in the home has a high level of lead in the blood).
 - A child enters Head Start, day care, foster care or pre-adoption.
 - The child needs anesthesia for required dental services.

Missed Appointments



- Providers should complete a missed appointment form and fax it to MAXIMUS who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, child care, money for gasoline, etc.).
- Missed appointment form is available at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/forms>.
- More information is available through your local regional Texas Health Provider Relations Representatives:
<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/th-regional-contacts.pdf>

Texas Health Steps Outreach and Informing



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

Children of Traveling Farm Workers



- HHS defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health-care needs, provide direct education about the health care system and the services available, and arrange appointments and transportation.

Children of Traveling Farm Workers



- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed helpful pieces of information to ensure these children get the health-care services they need.
- The referral process for providers who provide care to Superior members who are children of traveling farm workers is to direct the parent to call Member Services for assistance on program benefits or to help schedule an appointment by calling 1-800-783-5386.

Refusal of Exam



- Superior is required to log all member refusal for service to HHS.
- The refusal should be recorded in the member's medical record and communicated to Superior's Member Services department at:
 - 1-844-590-4883
- If a member indicates that their exam was previously done, Superior will:
 - Look for that claim in our system, and if there is no claim on file, will contact the provider of service to verify the member's statement.

Oral Evaluation and Fluoride Varnish



- This program will allow STAR Kids members who are 6 months to 35 months of age to receive an oral evaluation and fluoride varnish during medical checkups.
 - Limited to 10 fluoride treatments.
 - Providers must be certified to provide oral evaluations and fluoride varnishes.
 - Once a provider has completed the training, he or she will need to submit certification to his or her Superior Account Manager.
 - The training information is available on the Oral Health Program website, along with the registration form. You can access the information at <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers/oral-evaluation-fluoride-varnish-medical-home>.
 - The provider should bill with procedure code 99429 and modifier U5 with the diagnosis codes Z00121 or Z00129.

Blood Lead Level Reporting



Texas Childhood Lead Poisoning Prevention Program (TXCLPPP):

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms visit: <https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers>.

Enrollment and Training



- Enrollment as a Texas Health Steps Provider must be completed through TMHP at www.tmhp.com.
- A separate Texas Health Step Texas Provider Identifier (TPI) number is required.
- Training from the HHS is mandatory for Texas Health Steps Providers.
- Free continuing education hours are available at <http://www.txhealthsteps.com/cms/>.



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Service Coordination

Service Coordination



- Service Coordination basics
- Service Coordinator role
 - Clinical and non-clinical support
 - 24/7/365 accessibility to STAR Kids staff via the STAR Kids Member Services hotline at 1-844-590-4883.
 - Direct support
 - Coordinate care for members with special health-care needs.
 - Monitor adherence to treatment plan.
 - Coordinate discharge planning.
 - Assist with transition plan.
 - Promote best practice/evidence-based services.
 - Identify and report potential abuse/neglect.



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Prior Authorizations

Prior Authorizations (PA)



- Acute Care Authorization Process
- Notification of Admissions
- Therapy Authorizations
 - Initial and Ongoing Treatment Services
 - Initial Evaluation and Re-evaluation
 - Early Childhood Intervention (ECI)
- Incomplete Information Process
- LTSS Authorization Process
- Behavioral Health Prior Authorization

Therapy Treatment Authorizations



- Providers must include specific information when submitting therapy prior authorization requests for Medicaid and CHIP members.
- The following clinical documentation must be submitted when requesting a prior authorization for therapy:
 - Current objective assessment.
 - Treatment goals.
 - Progress reporting.
 - Frequency and duration.
- Documentation must be dated within the last 60 calendar days.
- MD signatures must be dated the day of the evaluation or after, and specify the frequency and duration of the service.
- Providers must follow and adhere to practice standards for all clinical treatment areas. The details for each of the four criteria can be found online at www.SuperiorHealthPlan.com/providers/resources.html under “*Therapy Documents and Policy Clarification.*”

Therapy Services - No Prior Authorization Needed



- Effective June 1, 2021 prior authorization is no longer required for initial evaluations or re-evaluations for PT/OT/ST.
- Early Childhood Intervention (ECI)
 - Therapy services for members under 3 years of age do not require prior authorization for contracted providers.
 - Health-care professionals are required, under federal and state regulations, to refer children under 3 years of age to ECI within 2 business days once a disability or developmental delay is identified/suspected.
 - Superior will work with contracted providers to provide ECI services to members who have been determined eligible.
 - For more information, please visit <https://hhs.texas.gov/services/disability/early-childhood-intervention-services>.

Acute Care Services Requiring PA



- Some common acute services that require authorization are:
 - DME items with a purchase price > \$500.
 - Enteral nutrition.
 - Home health/Skilled Nursing/Private Duty Nursing.
 - Hearing aids.
 - Orthotics/prosthetics.
 - Non-emergent ambulance transportation.
 - Therapy (physical, occupational and speech).
 - Incontinence supplies.

Acute Care Services Requiring PA



- For a full list of acute services that require authorization:
 - Look up Superior's most current Prior Authorization (PA) list found at www.SuperiorHealthPlan.com/providers/provider-resources/.
 - Call the PA department at 1-800-218-7508, Monday through Friday, 8:00 a.m. - 5:00 p.m. (CST) and speak to a live agent.

LTSS Require Authorizations



- All LTSS require authorization:
 - Personal Attendant Services (PAS).
 - Day Activity and Health Services (DAHS) (available for > 18 years of age).
 - MDCP - Employment assistance/supported employment.
 - Cognitive Rehabilitative Therapy.
 - Community First Choice (CFC).
 - Private Duty Nursing (PDN).
 - Personal Care Services (PCS).

National Imaging Associates – Radiology Authorizations



- National Imaging Services (NIA) is contracted with Superior to perform utilization review for High-Tech Imaging Services, including:
 - Coronary Computed Tomography Angiography (CCTA)
 - Computerized Tomography (CT)/Computed Tomography Angiography (CTA)
 - Cardiology/Myocardial Perfusion Imaging (MPI)
 - Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiography (MRA)
 - Nuclear
 - Positron Emission Tomography (PET) Scan
 - Stress Echo
- The ordering physician is responsible for obtaining an authorization by:
 - Accessing www.radmd.com, or calling 1-800-642-7554.
- Emergency room, observation and inpatient imaging procedures do not require authorization.
- Servicing providers and imaging facilities may access status of authorizations by:
 - Accessing www.radmd.com, or accessing Integrated Voice Response (IVR) at 1-800-642-7554.

NIA Genetic and Molecular Testing



- Utilization review for genetic and molecular testing services is delegated to NIA for Medicaid, CHIP, and STAR+PLUS MMP members.
- Authorization requests for out-of-network providers should continue to be submitted to Superior.
- Claims should be submitted to Superior for processing
- NIA's Genetic and Molecular Testing clinical guidelines can be found on [NIA's Genetic Testing Policies webpage](#).

TurningPoint HealthCare Solutions



- Superior HealthPlan is working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint will be responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures.
- In addition, Superior has expanded the partnership with TurningPoint HealthCare Solutions to process prior authorization requests for medical necessity and appropriate length of stay for certain Cardiac procedures and Ear, Nose and Throat (ENT) surgeries and sleep study procedures.
- This process applies to: STAR, STAR Health, STAR Kids, STAR+PLUS, CHIP, Allwell from Superior HealthPlan (HMO and HMO SNP) and Ambetter from Superior HealthPlan.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under Billing Resources found at www.SuperiorHealthPlan.com/providers/resources.html.

TurningPoint HealthCare Solutions



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

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

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

TurningPoint Healthcare Solutions – Cardiac Surgical Procedures



- Prior authorization is required for the following cardiac surgical procedures in both inpatient and outpatient settings:
 - Arterial Procedures
 - Coronary Angioplasty/Stenting
 - Coronary Artery Bypass Grafting
 - Implantable Cardioverter Defibrillator (ICD)
 - ICD Revision or Removal
 - Left Atrial Appendage Occluders
 - Loop Recorders
 - Non-Coronary Angioplasty/Stenting
 - Pacemaker
 - Pacemaker Revision or Removal
 - Valve Replacement
 - Wearable Cardiac Defibrillator

TurningPoint Healthcare Solutions – ENT and Sleep Study



- Prior authorization is required for the following Ears, Nose and Throat (ENT) surgeries and sleep studies performed in the inpatient, outpatient, physician's office and in-home settings:

Sleep Study Procedures

Actigraphy

Home sleep study

Multiple sleep latency and
maintenance of wakefulness testing

Polysomnography

ENT Surgeries

Balloon dilation Esophagoscopy

Cochlear implant device

Laryngoscopy and Laryngoplasty

Rhinoplasty and Septoplasty

Sinus surgery

Thyroidectomy and Parathyroidectomy

Tonsillectomy with or without adenoidectomy

Tympanostomy and Tympanoplasty

TurningPoint HealthCare Solutions



- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services listed on the previous slide should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
 - Web Portal Intake: <http://www.myturningpoint-healthcare.com>
 - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
 - Facsimile Intake: 1-214-306-9323



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Pharmacy Benefits

Pharmacy Benefits



- Pharmacy Benefit Manager (PBM)
 - Responsible for timely and accurate payment of pharmacy claims.
 - Provides pharmacy network for Superior members.
 - Responsible for prior authorization of prescriptions, as applicable.
- Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL) has been adopted for STAR Kids.

Specialty Drugs



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

Family Planning: Long Acting Reversible Contraception (LARC)



- Providers, including hospital and facility providers, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), may be reimbursed for the insertion of the LARC, along with the device itself.
 - LARCs may be reimbursed to the hospital/facility, in addition to the facility reimbursement, when insertion is performed immediately postpartum.
 - Insertion within 10-15 minutes of placental delivery for IUDs.
 - Insertion prior to discharge for implantable contraceptive capsules.
 - FQHCs and RHCs may receive reimbursement for covered LARC devices in addition to the encounter rate paid for the visit.
- Providers can prescribe and obtain LARC products on the Medicaid formulary from certain specialty pharmacies that work with LARC manufacturers. Additional information on the pharmacy benefit can be located at <https://www.txvendordrug.com/formulary/formulary/long-acting-reversible-contraception-products>.

How to Access the Formulary/PDL



- Superior utilizes the Texas VDP formulary which is available on smartphones, tablets or similar technology on the web at www.epocrates.com.
- Texas VDP Website for PDL and clinical PA criteria: www.txvendordrug.com
- Texas PDL/PA Criteria to be used for Superior Members:
www.txvendordrug.com/formulary/PDLSearch.asp

72-Hour ER Prescription



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

DME and Medical Supplies - Pharmacy Providers



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

Pharmacy Contact Information – Superior HealthPlan



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



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Quality Improvement

Quality Improvement



- Superior's Quality Improvement Department works with the provider community to:
 - Manage and review annual Healthcare Effectiveness Data and Information Set (HEDIS) rates to identify interventions to improve HEDIS scores.
 - Maintain compliance with quality related areas of HHS regulations.
 - Generates, distributes and analyzes selected provider profiles.
 - Coordinates office site visits related to complaints regarding physical appearance, physical accessibility, adequacy of wait time and adequacy of treatment record.
 - Conducts provider satisfaction surveys annually.
 - Review, investigates and analyzes quality of care concerns (member complaints).

Quality Improvement



Quality Assessment and Performance Improvement (QAPI):

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



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Fraud, Waste and Abuse

Fraud, Waste and Abuse



- Report fraud, waste or abuse:
 - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
 - Visit <https://oig.hhsc.state.tx.us> and select “Click Here to report fraud, waste and abuse” to complete the online form.
 - Contact Superior’s Corporate Special Investigative Unit directly at:
Centene Corporation
Superior HealthPlan Fraud and Abuse Unit
7700 Forsyth Boulevard
Clayton, MO 63105
1-866-685-8664
- Examples of fraud, waste and abuse include:
 - Payment for services that were not provided or necessary.
 - Upcoding.
 - Unbundling.
 - Letting someone else use their Medicaid or CHIP ID.

Health Insurance Portability and Accountability Act



- Regulates who has access to a member's Protected Health Information (PHI).
- Individuals have the right to keep their PHI confidential.
- Superior has provided each member with a privacy notice.
- For questions about Superior's privacy practices, contact Superior's compliance officer by:
 - Calling: 1-800-218-7453
 - Emailing: Superior.Compliance@SuperiorHealthPlan.com



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Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation (ANE)



- Abuse:
 - Intentional mental, emotional, physical or sexual injury to a child with disabilities, or failure to prevent such injury.
- Neglect:
 - Failure to provide a child with food, clothing, shelter and/or medical care; and/or leaving a child in a situation where the child is at risk of harm. This may result in starvation, dehydration, over- or under-medication, unsanitary living conditions, and lack of heat, running water, electricity, medical care and personal hygiene.
- Exploitation:
 - Misuse of a child with disabilities for personal or monetary benefit. This includes taking Social Security or SSI checks, abusing a joint checking account and taking property and other resources.

How to Report ANE



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

How to Report ANE



- HHS
 - Report an adult or child who resides in or receives services from:
 - Nursing facilities.
 - Assisted living facilities.
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DFPS.
 - Day care centers.
 - Licensed foster care providers.
 - Call: 1-800-647-7418
- Local Law Enforcement
 - If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.



Medicaid Action, Appeals and Fair Hearing

Medicaid “Action”



- Adverse determination is one type of action:
 - Denial or limited authorization of a requested service.
 - Reduction, suspension or termination of a previously authorized service.
 - Denial in whole or in part of payment for service.
 - Failure to provide services in a timely manner.
 - Failure of an MCO make a timely decision.

Appeal of an Action



- Appeal is the formal process by which a member or his or her representative requests a review of the MCO's action.
- A provider may act as the member's representative for appeal of the MCO's action.
- An appeal request must be received within 60 calendar days of the notice of action.
- If urgent/emergent, the request for appeal of an action may be expedited.
- MCO will acknowledge the request for appeal within 5 business days.
- MCO will provide resolution of an appeal within 30 calendar days (expedited appeals are addressed within 72 hours).

HHS Fair Hearing



- Members have the right to access the HHS Fair Hearing process after they have exhausted the appeals process.
- Members must request a Fair Hearing within 90 days of the MCO notice of action.
- HHS schedules and conducts the Fair Hearing.
- The member must be present at the Fair Hearing (in person or telephonic).
- The MCO provides an evidence packet for the Fair Hearing and is in attendance at the Fair Hearing to present the MCO's reason for the action.
- A HHS Fair Hearing Officer makes the determination on a Fair Hearing request.

Medicaid External Appeal Rights - External Medical Review and State Fair Hearing

Medicaid Member New External Appeal Rights – May 2022



- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for:
 - Superior service denials and reductions (Phase I – effective 5/1/2022).
 - Eligibility denials for certain programs based on medical or functional necessity (Phase II implementation date not yet scheduled).
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 days of Superior's appeal decision letter.
- If requested, the External Medical Review through an IRO is completed before a State Fair Hearing.

Medicaid Member New External Appeal Rights – May 2022



- There are two types of EMR requests – standard and expedited:
 - Standard EMR Request – IRO Review is completed no later than 10 days following receipt of Superior's records related to the service denial or reduction determination.
 - Expedited EMR Request – IRO review is completed the next business day following receipt of the Superior's record for urgent requests.
- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services: Upheld, Partially Overturned or Fully Overturned.
- The IRO will send written notification of its EMR decision to the member, the member's authorized representative or member's LAR (if applicable), Superior and the HHSC EMR Intake Team.
- Superior will implement any partial or full overturn by the IRO within 72 hours.

Medicaid Member New External Appeal Rights – May 2022



- Withdrawal of EMR or State Fair Hearing Requests:
 - EMR – The member, the member's authorized representative, or the member's LAR must initiate an EMR request withdrawal communication to Superior before the IRO Review is initiated.
 - State Fair Hearing – If the EMR decision is to overturn Superior's adverse determination, the State Fair Hearing will proceed unless the member or member's representative withdraws the request. If the request is not withdrawn, regardless of the EMR decision, the member, the member's authorized representative or the member's LAR is required to attend the State Fair Hearing.
- Provider training on the new EMR process is available at:
<https://attendee.gotowebinar.com/recording/4623254401546558726>



Claims – Filing and Payment

Claims Filing



- Claims must be filed within 95 days from the Date of Service (DOS).
- 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.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be completed in accordance with TMHP billing guidelines.
- Filed on a red CMS 1500 or UB04.
- Filed electronically through clearinghouse.
- Filed directly through the Secure Provider Portal:
www.Provider.SuperiorHealthPlan.com
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims.

Claims Filing: Submitting Claims



- Secure Provider Portal:
 - Provider.SuperiorHealthPlan.com/sso/login
- Electronic Claims:
 - Visit the web 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.*

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

Claims Filing: Deadlines



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

CMS 1500 Requirements



If populated:

17a NPI # and
Taxonomy #

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUIOD) 0012

<input type="checkbox"/> FECA <input type="checkbox"/> PSIA											
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TODAY <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (USE ONLY) <input type="checkbox"/> OTHER <input type="checkbox"/>		14. INSURED'S ID NUMBER (For Program 10 Item 11)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY		4. PATIENT'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		5. INSURED'S NAME (Last Name, First Name, Middle Initial)		6. INSURED'S BIRTH DATE MM DD YY		7. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>	
8. PATIENT'S ADDRESS (No. & Street)		9. PATIENT'S RELATIONSHIP TO INSURED		10. INSURED'S ADDRESS (No. & Street)		11. INSURED'S CITY		12. INSURED'S STATE		13. INSURED'S ZIP CODE	
14. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		15. IS PATIENT'S CONDITION RELATED TO:		16. INSURED'S POLICY GROUP OR FECA NUMBER		17. INSURED'S DATE OF BIRTH MM DD YY		18. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		19. OTHER CLAIMED (Designated by NUIOD)	
20. INSURED'S POLICY OR GROUP NUMBER		21. EMPLOYMENT? (Current or Previous)		22. INSURED'S DATE OF BIRTH MM DD YY		23. INSURED'S SEX M <input type="checkbox"/> F <input type="checkbox"/>		24. OTHER CLAIMED (Designated by NUIOD)		25. INSURANCE PLAN NAME OR PROGRAM NAME	
26. IS PATIENT'S CONDITION RELATED TO:		27. AUTO ACCIDENT?		28. PLACED (Date)		29. OTHER CLAIMED (Designated by NUIOD)		30. INSURANCE PLAN NAME OR PROGRAM NAME		31. THERE ANOTHER HEALTH BENEFIT PLAN?	
32. YES <input type="checkbox"/> NO <input type="checkbox"/>		33. YES <input type="checkbox"/> NO <input type="checkbox"/>		34. YES <input type="checkbox"/> NO <input type="checkbox"/>		35. YES <input type="checkbox"/> NO <input type="checkbox"/>		36. YES <input type="checkbox"/> NO <input type="checkbox"/>		37. YES <input type="checkbox"/> NO <input type="checkbox"/>	
38. INSURED'S AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits directly either in regard to or in the party who accepts assignment of benefits.)											
39. INSURED'S SIGNATURE											
40. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY											
41. OTHER DATE											
42. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION											
43. DATE OF RETURN TO WORK											
44. NAME OF REFERRING PROVIDER (OTHER SOURCE)											
45. ADDITIONAL CLAIM INFORMATION (Designated by NUIOD)											
46. OUTSIDE LAST											
47. YES <input type="checkbox"/> NO <input type="checkbox"/>											
48. SIGNATURE											
49. ORIGINAL REF. NO.											
50. PRIOR AUTHORIZATION NUMBER											
51. FEDERAL TAX ID NUMBER											
52. PATIENT'S ACCOUNT NO.											
53. ACCEPT ASSIGNMENT?											
54. TOTAL CHARGE											
55. AMOUNT PAID											
56. BALANCE DUE TO PATIENT											
57. SIGNATURE OF PROVIDER OR SUPPLIER											
58. SERVICE FACILITY LOCATION INFORMATION											
59. BILLING PROVIDER ID #											

NUIOD Instruction Manual available at: www.nuiod.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1197-0012

NPI # and Taxonomy #
in box 24J is required
when billing Superior
claims

Billing NPI # in box
33a and Taxonomy #
in 33b

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 to submit your claims to Superior:

- 1. Electronic:** Through the Secure Provider Portal or EDI via a clearing house.
 - Your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior provider portal and EOPs.
- 2. Paper:** Mailed to our processing center
 - Your response to your submission is viewable via rejection letters, Superior Secure Provider Portal and EOPs.

Please 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			000209200	INVALID			76	20130710	
M317TXE44820			000164200	ACCEPT				20131109	
M317TXE44819			000193510	INVALID			76	20130704	
M317TXE44858			001141694	ACCEPT				20131108	
M317TXE44868			000759989	ACCEPT				20131108	
M317TXE44826			000310600	ACCEPT				20131108	
M317TXE44814			000116222	ACCEPT				20131108	
M317TXE44828			000405752	ACCEPT				20131103	
M317TXE44835			000112728	ACCEPT				20131108	
M317TXE44824			000113004	ACCEPT				20131109	
M317TXE44829			000984375	ACCEPT				20131024	
M317TXE44816			000103600	INVALID			09	20131105	
M317TXE44821			000999375	ACCEPT				20131106	
M317TXE44843			001183267	ACCEPT				20131101	
M317TXE44815			000103600	ACCEPT				20131107	
M317TXE44817			000011500	INVALID			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: AYE09245

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 Web Portal (EOP)

Common Billing Errors



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

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 original processing of the claim.
 - For example – Claim denied for no authorization, but there was an authorization obtained prior to services.
 - A claims appeal form, found in the Provider Manual, is required when submitting a request for reconsideration.

Claim Appeal Supporting Documents



- Examples of supporting documentation may include but are not limited to:
 - A copy of the Superior 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, Texas Medicaid Benefits Card (TMBC), TMHP documentation, call log, etc.
 - Overnight or certified mail receipt as proof of timely filing.
 - Centene EDI acceptance reports showing the claim was accepted by Superior.
 - Prior authorization number and/or form or fax.

PaySpan Health



- Superior has partnered with PaySpan Health to offer expanded claim payment services to include:
 - Electronic Claim Payments/Funds Transfers (EFTs).
 - Online remittance advices (Electronic 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, call 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 your provider contract with Superior.

Ophthalmology for Medical Eye Care Services



- Effective for service dates beginning January 1, 2020, Superior assumed the management of medical eye care services delivered by ophthalmologists for all Superior members.
- Envolve Vision continues to manage routine eye care services and full-scope of licensure optometric services for Superior.

Ophthalmology for Medical Eye Care Services



- Beginning January 1, 2020, Superior started managing all functions for ophthalmologists providing medical eye care services, including but not limited to:
 - Claim Processing and Appeals.
 - Contracting/Credentialing.
 - Prior Authorization.
 - Retrospective Utilization Review.
 - Medical Necessity Appeals.
 - Provider Complaints Related to Medical Eye Care Services.
 - Provider Relations/Account Management.
 - Provider Services.
 - Secure Provider Portal.
- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool at www.SuperiorHealthPlan.com/providers/preauth-check.html.



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 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.

CDS EVV – Billing After December 1, 2020



- 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 HHSC 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>

Telemedicine and Telehealth

What is Telemedicine?



- Telemedicine services are medical services delivered by a physician to a member at a different physical location. Using telecommunications or information technology, providers are able to see and hear the member in “real” time.
- Providers must be licensed in Texas or be under the supervision of a provider licensed in Texas. Provider types able to practice telemedicine include:
 - Physicians.
 - Clinical Nurse Specialists.
 - Nurse Practitioners.
 - Physician’s Assistants.
 - Certified Nurse Midwives.
- Providers must receive informed consent to treat using telemedicine services from the member, member’s parent or guardian.

What is Telehealth?



- Telehealth services are behavioral health services delivered by a physician to a member at a different physical location. Using telecommunications or information technology, that allows the providers are able to see and hear the member in “real” time.
- A distant site provider does not need to conduct a physical examination in order for behavioral health services to be rendered. The distant site provider is able to conduct a “face-to-face” evaluation via telehealth at an established medical site prior to providing ongoing care. They may also provide treatment for a member referred by another physician who completed a “face-to-face” evaluation via telemedicine at an established medical site.
 - The Centers for Medicare and Medicaid Services (CMS) define the distant site as the telehealth site where the provider/specialist is seeing the member at a distance or consulting with a member’s provider.

What is Telehealth?



- Telehealth is a benefit when provided by these provider types:
 - Licensed Professional Counselor.
 - Licensed Marriage and Family Therapists (LMFT).
 - Licensed Clinical Social Workers (LCSW).
 - Psychologist.
 - Licensed Psychological Associate.
 - Provisionally Licensed Psychologist.
 - Licensed Dietitian.

Covered Benefits of Telemedicine and Telehealth



- Telemedicine and Telehealth may be delivered via:
 - Synchronous (real time) audiovisual interaction between the provider and the client in another location using a mobile app or live online video.
 - Asynchronous technology (i.e. member sends information to the provider and provider responds after review). Documentation may include:
 - Clinically relevant photographic or video images, including diagnostic images.
 - The member's medical records (i.e. medical history, lab results and prescriptive histories).
 - Other forms of audiovisual communication that allow the provider to meet the in-person visit standard of care.
- Reimbursement may not be provided for audio-only interactions such as:
 - Telephone consultations.
 - Text-only email messages.
 - Facsimile transmissions.

Covered Benefits of Telemedicine and Telehealth



- For a list of CPT codes that are covered under telemedicine and telehealth, please see pages 6 and 10 of the TMHP Telecommunication Services Handbook (www.TMHP.com).
 - The codes listed must be billed with modifier 95.
 - Procedure codes for behavioral health services are subject to the same benefits and limitations as in-person visits.
- For behavioral health services, Q3014 must be billed with modifier 95.
- Patient site providers may be reimbursed for Q3014 in a facility setting; however, it is not a benefit of telehealth services.
- Texas Health Steps checkups are not a benefit under telemedicine or telehealth.
- Distant site providers issuing prescriptions must follow the same standards as would be applied during an in-person visit.



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Secure Provider Portal

Superior's Website and Secure Provider Portal



Visit www.SuperiorHealthPlan.com.

Submit:

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

Verify:

- Member Eligibility
- Claim Status

View:

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

How to Register for the Provider Portal



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

Provider Portal: Eligibility



- Search for eligibility using:
 - Member's date of birth.
 - Medicaid/CHIP/DFPS ID number or last name.
 - Date of service.
- View/Print Patient List
 - Member Panel.
 - Member Care Gap Alerts.
 - Both can be downloaded in Excel or PDF format.

Provider Portal: Authorizations



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

Note: Authorizations update to the Secure Provider Portal every 24 hours.

Provider Portal: Claims



- Claim Status
 - Claims update to the web portal every 24 hours.
 - Status can be checked for a period of time 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.

Additional Provider Portal Information



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

Provider Portal Highlights



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

Provider Portal Highlights



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

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



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Superior HealthPlan Departments

We're here to help you!

Account Management



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

Note: You can find a map on the Superior HealthPlan website that can assist you with contact information for your Account Manager.

Provider Grant Program



- Grants of up to \$5,000 are available each quarter to participating Superior providers promoting the health and well-being of the community.
- Deadline for submission is the last business day of the quarter.
- Providers can apply each quarter, but can only receive the grant once per year.
- Applicants will be notified of Superior's Grant committee's decision the month following the end of the quarter.
- Applications can be submitted on the Superior website:
www.SuperiorHealthPlan.com/providers/resources/provider-grants-program.html.
- Please note that submitting an online application does not guarantee funding. Please contact SHP.Grants@SuperiorHealthPlan.com with any additional questions.

Provider Services



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

Member Services



- Member Services staff can assist with:
 - Verifying eligibility.
 - Reviewing member benefits.
 - Assist with non-compliant members.
 - Help find additional local community resources.
 - Contact them Monday through Friday,
8:00 a.m. to 5:00 p.m. local time.
 - STAR Kids: 1-844-590-4883

Provider Contracting



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

Provider Credentialing



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

Provider Complaints



- A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to Superior. Superior offers a number of ways to file a complaint, as listed below:
 - Mail:
Superior HealthPlan
ATTN: Complaint Department
5900 E. Ben White Blvd.
Austin, Texas 78741
 - Fax:
1-866-683-5369
 - Online:
www.SuperiorHealthPlan.com/complaint-form/

Thank you for attending!



Thank you for your commitment to serving the needs of children in STAR Kids.

If you have additional questions, please contact your local Account Manager or select “Contact Us” at www.SuperiorHealthPlan.com.

Let us know what we can do to help.



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Questions and Answers
