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Billing Clinic
(STAR, STAR Health, STAR Kids, STAR+PLUS [non-nursing facility], and CHIP)

Provider Training

Introductions and Agenda

- Verifying Eligibility
- Authorization Process
- Establishing Medical Necessity (After an Adverse Determination)
- Claims Submissions
- FQHC and RHC Billing Information
- Electronic Payments and Remittance
- Secure Provider Portal
- Superior HealthPlan Departments
- Questions and Answers

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Verifying Eligibility

Verify Eligibility

- Texas Medicaid Benefit Card (TMBC) (STAR Only)
  - TexMedConnect - www.TMHP.com/pages/edi/edi_texmedconnect.aspx.
- Superior Identification Card
- Secure Provider Portal: www.Provider.SuperiorHealthPlan.com.
- Contact Member Services:
  - STAR, CHIP: 1-800-783-5386
  - STAR Health: 1-866-912-6283
  - STAR Kids: 1-844-590-4883
  - STAR+PLUS: 1-877-277-9772
- Verify eligibility the first of each month using our website or by contacting Member Services.

Superior Member ID Cards

- The member ID cards contain the following information:
  - Member name
  - Primary Care Provider (PCP) (except CHIP Perinate mother and STAR+PLUS dual members)
  - Prescription information
  - Program eligibility
  - Superior contact information
- Copies of sample member ID cards can be found in the Superior Provider Manual.

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Authorization Process

Ensure Proper Authorizations are in Place

Medical Management Authorizations

- Prescheduled elective admissions must have authorization prior to admission.
- All out of network services require an authorization.
  - Emergent and urgent services provided by an out-of-network provider do not require prior authorization.
- Initiate authorizations 5 Business Days in advance for non-emergency services.
- If clinical information is requested by Medical Management, submit by fax or through the Superior's Secure Provider Portal.

  www.Provider.SuperiorHealthPlan.com
  Fax: 1-800-690-7030

Authorization TAT Requirements

Program	Authorization Type	TAT
STAR (Medicaid), STAR Health, STAR Kids and STAR+PLUS	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
Medicaid and CHIP	Urgent, outpatient and Inpatient Elective	3 Business Days
Medicaid and CHIP	Inpatient	1 Business Day

Authorization TAT Requirements

Authorization Type	TAT
Concurrent Review – The process of obtaining clinical information to establish medical necessity for a continued inpatient stay, including review for extending a previously approved admission.	• For Medicaid and CHIP, all urgent requests must be reviewed the same day, or within 1 business day of notification of admission, or within 1 business day of next review date. • Timeframe should not exceed 72 hours or 3 Calendar Days.
Retrospective Review – A form of utilization review for health-care services that have been provided to a member.	If discharge can be confirmed at the time of the initial request/notification of the admission, post-service review timeframes may be applied. A medical necessity determination and written notification is made within 30 Calendar Days from the date of the request.

Services Requiring Authorization

- Services requiring authorization include, but are not limited to:
  - Specialty procedures, including Chiropractic, Podiatry, Oral Surgery and Plastic and Reconstructive Surgery
  - In-Home and Outpatient Therapy/Rehabilitation
  - Durable Medical Equipment (Over $500, Incontinence Supplies, Enteral Nutrition, etc.)
  - Transportation
  - Pharmaceuticals
  - Surgical/Other Procedures
  - Transplants
  - Long-Term Services and Support (LTSS)
  - Radiology
  - Vision

Medicaid Pre-Authorization Tool

- Providers can determine if a prior authorization is required by using the Pre-Auth Needed Tool on the Superior website, answering a series of questions and searching by procedure codes: SuperiorHealthPlan.com/PriorAuth

Secure Portal Login
Prior Authorization
Medicaid Prior Authorization
Medicare Prior Authorization
STAR+PLUS MMP Prior Authorization
Ambetter Prior Authorization
Network Request or Update
Training and Manuals
Provider Resources
Provider News & Information

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services need to be verified by Envolve Vision Services
Dental services need to be verified by DentaQuest
Behavioral Health/Substance Abuse need to be verified by Cenpatico
Non-participating providers must submit prior authorization for all services*
For non-participating providers, Join Our Network
Please note, Incontinence Supplies ordered through the preferred DME provider do not require prior authorization.

Would this be for Family Planning services billed with a contraceptive management diagnosis?

Yes No

Types of Services	YES	NO
Are services being provided by a non-participating provider?		
Is the member being admitted to an inpatient facility?		
Are anesthesia services being rendered for dental procedures?		
Is the member receiving oral surgery services?		
Is the member receiving plastic and reconstructive surgeon services?		
Is the member having chiropractic services?		
Is the member receiving podiatry services?		

Prior Authorization Form

- The Outpatient Medicaid Authorization Form is located at
- SuperiorHealthPlan.com/ProviderForms
- Providers may also utilize the Texas Standard Prior Authorization Request Form at SuperiorHealthPlan.com/ProviderForms
- Prior authorizations can also be submitted through the Secure Provider Portal.

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MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records: **Fax** 855-772-7079

Request for additional units. Existing Authorization Units

Urgent requests - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

Urgent requests must be signed by the requesting physician to receive priority.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

*Medicaid/Member ID | Last Name, First | *Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI | *Requesting TIN | Requesting Provider Contact Name

Requesting Provider Name | Phone | *Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

*Servicing NPI | *Servicing TIN | Servicing Provider Contact Name

Servicing Provider/Facility Name | Phone | Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | ***Start Date** (MMDDYYYY) | *Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier) | **Additional** Procedure Code (CPT/HCPCS) (Modifier) | **End Date** (MMDDYYYY) | Total Units/Visits/Days

***OUTPATIENT SERVICE TYPE** (Enter the Service type number in the boxes)

Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
299 Drug Testing
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services

101 Physical Therapy
790 Occupational Therapy
701 Speech Therapy
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
517 BH Medication Check
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

DME
417 Rental
120 Purchase (Purchase Price)

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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TX-PAF 5869

NIA

Radiology Authorizations

- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for high-tech imaging services, including:
  - CT/CTA
  - MRI/MRA
  - PET Scan
  - CCTA
  - Nuclear Cardiology/MPI
  - Stress Echo
  - Echocardiography (STAR+PLUS)
- Inpatient and ER procedures do not require authorization.
- The servicing provider (PCP or Specialist) will be responsible for obtaining authorization for the procedures.
- Servicing providers may request authorization and check status of an authorization by:
  - Accessing www.RadMD.com.
  - Utilizing the toll-free number: 1-800-642-7554
- All claims should be submitted to Superior through paper claims submission, or electronic submission on Provider.SuperiorHealthPlan.com.

NIA

IPM Authorizations

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- NIA also manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR, STAR Health and STAR+PLUS members 21 years of age and older.
- It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below.
- Authorizations are valid for 30 Days from the date of the request.
- Outpatient IPM procedures requiring prior authorization include:
  - Spinal Epidural Injections.
  - Pravertebral Facet Joint Injections or Blocks.
  - Pravertebral Facet Joint Denervation (Radiofrequency Neurolysis).
  - Sacroiliac Join Injections.

NIA

IPM Authorizations

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- A separate prior authorization number is required for each procedure ordered.
- To obtain authorization through NIA, visit RadMD.com or call 1-800-642-7554.
- Prior authorization is not required through NIA for services performed in the emergency department or on an inpatient basis.
  - Authorization and/or notification of admission is still required through Superior.

NIA

Outpatient and Habilitative Therapy Services

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- Superior expanded our partnership with NIA to include utilization review of outpatient PT/OT/ST treatment services for Medicaid (STAR, STAR+PLUS*), CHIP and STAR+PLUS Medicare-Medicaid Plan (MMP) members.
  - Only applicable to Medicaid STAR+PLUS members receiving non-waiver services.
- Therapy services requiring prior authorization through NIA include treatment performed in an outpatient or home setting by in-network PT/OT/ST therapy providers.
- Prior authorization requests for therapy services delivered by out-of-network providers must be submitted to Superior.
- Therapy evaluations no longer require prior authorization.
- Claims for therapy services will continue to be processed by Superior.

NIA Genetic and Molecular Testing

- Effective September 1, 2022, utilization review for genetic and molecular testing services will be delegated to NIA for Medicaid, CHIP, and STAR+PLUS MMP members.
- Authorization requests for dates of service on or after September 1st can be submitting beginning August 23rd for in-network providers.
  - 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

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- Superior is working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint is 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, Wellcare By Allwell (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: SuperiorHealthPlan.com/ProviderResources

TurningPoint Healthcare Solutions

- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services 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: www.myturningpoint-healthcare.com
  - Telephonic Intake: 469-310-3104 | 855-336-4391
  - Facsimile Intake: 214-306-9323

TurningPoint Healthcare Solutions

Musculoskeletal Surgical Procedures

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

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

*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/PriorAuth

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TurningPoint Healthcare Solutions

Cardiac Surgical Procedures

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- Prior authorization is required for the following Cardiac Surgical Procedures in both inpatient and outpatient settings:
  - Arterial procedures
  - Loop recorders
  - Coronary angioplasty/stenting
  - Non-coronary angioplasty/stenting
  - Coronary artery bypass grafting
  - Pacemaker
  - Implantable Cardioverter Defibrillator (ICD)
  - Pacemaker revision or removal
  - ICD revision or removal
  - Valve replacement
  - Left atrial appendage occluders
  - Wearable cardiac defibrillator

TurningPoint Healthcare Solutions

ENT and Sleep Study

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- Prior authorization is required for the following 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

Ears, Nose and Throat (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

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Establishing Medical Necessity

Medical Management Denials

- Type of Denial
  - Adverse Determination (Medical Necessity) Denial - a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations.
    - Medical necessity is defined as health services that are reasonably necessary to:
      - Prevent illness or medical conditions
      - Provide early screening, interventions and/or treatments for conditions that cause suffering or pain, physical deformity, or limitations in function
  - Contractual (Administrative) Denials (non-clinical reasons)
    - Late notification
    - Failure to obtain prior authorization
    - Missing information denial
  - Non-Covered Benefit Denial
    - Member has exceeded annual benefit limit as specified in the member's Schedule of Benefits as defined by the State.
    - Requested service specifically excluded from the benefits package as stated in the Certificate of Coverage as defined by the State (Non-covered Benefit).

Appealing Medical Management Denials

- Peer-to-Peer Review
  - When medical necessity cannot be established, a peer-to-peer review is offered. A peer-to-peer discussion is available to the ordering physician, nurse practitioner, physician assistant during the prior authorization, denial or appeal process regarding medical necessity.
- Communication of Denials
  - Denial letters will be sent to member, requesting provider and servicing provider to include:
    - The clinical basis for the denial
    - Criteria used to make the medical necessity decision
    - Member appeal/complaint, external review or fair hearing rights fully explained
- The provider may request an appeal in writing on behalf of the member.
    - Mail: Superior HealthPlan
Attn: Appeal Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
    - Fax: 1-866-918-2266

External Appeal Rights

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for Superior service denials and reductions.
- 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.
- 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.

External Appeal Rights

- 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.
- 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 withdrawal request 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

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Claim Submissions

Claims Filing: Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS):
  - Filed on CMS 1450/UB-04 or CMS 1500 (HCFA) filed electronically through clearinghouse
  - Filed directly through Superior's Provider Portal
- Claims must be completed in accordance with Medicaid billing guidelines.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.
- Mailing Address (paper claims)

  Superior HealthPlan
  Attn: Claims
  P.O. Box 3003
  Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims (only applicable for form CMS 1500).

Paper Claims Filing

- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages
  - Do not fold the forms
  - Claim must be typed using a 12pt font or larger and submitted on original CMS-1450/UB-04 or CMS 1500 red form (not a copy)
    - Handwritten claim forms are no longer accepted
  - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

Clean Claims

- Clean claims will be processed within 30 Days.
- For electronic pharmacy claim submissions, claims will be paid in 18 Days.
- Once a clean claim is received, Superior will either pay the total amount of the claim or part of the claim in accordance with the contract, or deny the entire claim or part of the claim, and notify the provider why the claim will not be paid within the 30-day claim payment period.
- Each claim payment check will be accompanied by an Explanation of Payment (EOP), which itemizes your charges for that reimbursement and the amount of your check from Superior.
- Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Superior, or the date of electronic transmission if payment is made electronically.

Clean Claim Requirements

- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS-1450/UB-04 or CMS 1500 forms.
  - NPI of a referring or ordering physician on a claim.
  - Appropriate two-digit location code must be listed.
  - Appropriate modifiers must be billed when applicable.
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician.
    - ZZ qualifier for CMS 1500 or B3 qualifier for UB04 to indicate taxonomy.
- For additional information on the clean claim requirements, review the Superior HealthPlan STAR, STAR+PLUS, CHIP & STAR Health and STAR Kids Provider Manual at SuperiorHealthPlan.com/ProviderManuals.
- .

CMS 1500 Form

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Referring Provider: [C]

17 Name of the referring provider

17b NPI

Rendering Provider: [R]

Place your NPI (National Provider Identifier #) in box 24J (unshaded) and Taxonomy Code in box 24J (shaded).

These are required fields when billing Superior claims.

If you do not have an NPI, place your API (Atypical Provider Identifier #/LTSS #) in Box 33b.

Billing Provider: [R]

Billing NPI # in box 33a and Billing Taxonomy # (or API # if no NPI) in 33b.

Identifying a Claim Number

- Superior assigns claim numbers for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.
- When calling Provider Services, please have the following ready to expedite handling:
  - Claim Number (can be found on the Secure Provider Portal)
  - Electronic Data Interchange (EDI) Rejection/Acceptance reports
  - Rejection letters
  - EOP

Note: Remember that rejected claims have never made it through Superior's claims system for processing. All rejected claims must be corrected and resubmitted within 95 Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.

Electronic Claims Filing

- Claims can be submitted through Superior's Secure Provider Portal.
- Claims can also be submitted by using a Superior preferred trading partner/clearinghouse.
- If provider uses EDI software but is not set up with a trading partner/clearinghouse, they must bill Superior by submitting paper claims or through the Secure Provider Portal until the provider has established a relationship with a trading partner/clearinghouse listed at: SuperiorHealthPlan.com/Billing
  - For Superior medical electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **68069**.
  - For Superior behavioral health claim submissions, the correct payor ID is **68068**.
    - For MMP, Wellcare By Allwell and Ambetter, behavioral health claims are submitted to 68069.
  - Contact EDI: EDIBA@Centene.com

Electronic Claims Filing

Superior will not pay any claim submitted by a provider, if the provider:

- Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- Is on payment hold under the authority of HHSC or its authorized agent(s).
- Has provided neonatal services provided on or after September 1, 2013, if submitted by a hospital that does not have a neonatal level of care designation from HHSC.*
- Has provided maternal services provided on or after September 1, 2013, if submitted by a hospital that does not have a maternal level of care designation from HHSC.*

**In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.*

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 Days from the date of adjudication or denial.
  - Adjusted or Corrected Claim: The provider is changing the original claim.
  - Correction to a Prior Claim: Finalized claim that was in need of correction as a result of a denied or paid claim.
  - Claim Appeals: Often require additional information from the provider.
    - Request for Reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - Claim Dispute: Provider disagrees with the outcome of the request for reconsideration.

- Claim Adjustments/Corrections and Submissions can be processed through the Provider Portal or a paper claim.
  - Paper claims require a Superior Corrected Claim or Claim Appeal form.
    - Claim forms can be found at SuperiorHealthPlan.com/ProviderForms

Corrected Claims Filing

- A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission required corrections.
- Corrections can be made to, but are not limited to:
  - Patient Control Number (PCN)
  - Date of Birth (DOB)
  - Date of Onset
  - X-Ray Date
  - Place of Service (POS)
  - Present on Admission (POA)
  - Quantity Billed
  - Prior Authorization Number (PAN)
  - Beginning DOS
  - Ending DOS or Discharge Date

Corrected Claims Filing

- Must reference original claim number on EOP within 120 Days of adjudication date.
- Can be submitted electronically, through your clearinghouse/EDI software or through Superior's Provider Portal.
- Corrected or adjusted paper claims can also be submitted with a corrected claim form attached and sent to:

  Superior HealthPlan
  Attn: Claims
  P.O. Box 3003
  Farmington, MO 63640-3803

Claims Appeal Form

- A claims appeal is a request for reconsideration of a claim for anything other than medical necessity and/or any request that would require review of medical records to make a determination.
- Submit appeal within 120 Days from the date of adjudication or denial.
  - Can be submitted electronically through Superior's Provider Portal or be submitted in writing.
- Claims appeals must be in writing and submitted to:

Superior HealthPlan
Attn: Claims Appeals
P.O. Box 3000
Farmington, MO 63640-3800

Appeals Documentation

- Examples of supporting documentation may include, but are not limited to:
  - A copy of Superior's EOP (required).
  - A letter from the provider stating why they feel the claim payment is incorrect (required).
  - A copy of the original claim.
  - An EOP from another insurance company.
  - Documentation of eligibility verification such as copy of ID card, TMBC, Texas Medicaid and Healthcare Partnership (TMHP) documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing.
  - Centene EDI acceptance reports showing the claim was accepted by Superior.
  - Prior authorization number and/or form or fax.

Billing Reminders

- All institutional claims must contain Present on Admission (POA) indicators and Superior will utilize the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
  - For per diem hospital payments, Superior utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.
- If a provider bills for procedure codes not identified as valid encounter services (identified specifically in the TMHP manual available at www.tmhp.com), the service will not pay as the services are considered to be informational only.

Billing Reminders - Authorizations

Authorizations

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- When calling in to request an authorization, or to notify of a patient admission, please have available the Tax Identification Number (TIN) and NPI or LTSS ID number that will be used to bill your claim. If these numbers are not presented, your request will not be processed.
- The TIN/NPI used to request the authorization must match what is used to bill the claim, or the claim will deny.
- If the claim denies because it was billed with a different TIN/NPI combination than was authorized:
  - Verify that the TIN/NPI combination on the requested authorization matches what was billed.
  - If authorization and claim match, contact Provider Services.
  - If the claim was billed incorrectly, a corrected submission is required.

Billing Reminders
Authorizations

- Superior may issue authorizations that extend to multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under a single authorization.
- Bill must reflect the services under the authorization, including billing period.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Billing Reminder

Elective Delivery Policy

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- Superior will review all Neonatal Intensive Care Unit (NICU) admissions delivered prior to 39 weeks to determine whether the delivery was elective or medically necessary.
- If elective, Superior will deny the delivering physician and the facility (for both the delivery and the NICU).
- Superior will not deny other physicians (Anesthesia, Neonatology) or other facilities, if the infant is transferred due to medical necessity.
- If you have any questions regarding this policy, please contact Provider Services at 1-877-391-5921.

Billing Reminders

Obstetrics: Delivery Claim Requirements

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- Delivery and Postpartum services must be billed separately for all products.
  - Improves Superior's ability to report HEDIS quality outcomes for Postpartum Care.
- Corrected claims can be submitted within 120 Days from the Explanation of Payment date for payment with the separate procedure codes.
- Superior will reimburse for two postpartum visits.

Reimbursable Codes	
Procedure Code	**Code Description**
59409 59612	Vaginal Delivery Only
59514 59620	C-Section Delivery Only
59430	Postpartum Outpatient Visit

Non-Reimbursable Codes	
59400 59410	Vaginal Delivery including Postpartum Care
59510 59615	C-Section Delivery & Postpartum Care
59610 59614 59618 59622	Delivery after C-Section including Postpartum Care

Billing Reminders

Sterilization Form

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- Providers must complete all sections of the Sterilization Consent Form as applicable.
  - All of the fields must be completed legibly in order for the consent form to be valid. Any illegible field will result in a denial of the submitted consent form.
- Providers must resubmit denied consent forms with all required fields on the consent form completed legibly.
  - Resubmission with information indicated on a cover page or letter will not be accepted.
- Copies of the Sterilization Consent Form and Instructions can be found at Claim forms can be found at www.SuperiorHealthPlan.com/providers/resources/forms.html.

Billing Reminders

Sports Physicals

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- Superior will reimburse sports physicals for eligible members:
  - STAR, STAR Kids, STAR Health and CHIP
  - 4-18 years of age
  - 1 per calendar year
- For prompt claim payment, please follow these guidelines:
  - Diagnosis Code: Z02.5
  - CPT Codes: 99382-99385 or 99392-99395
- Reimbursement will be $35.00 (there is no co-pay).

Provider Training

- Depending on the type of services provided and billed for, Superior offers targeted billing presentations located on SuperiorHealthPlan.com/ProviderTrainings
  - Example: LTSS Billing Clinics
- There are also product-specific trainings available on STAR, STAR Health, STAR Kids and STAR+PLUS.
  - Access the schedule for face-to-face trainings or webinars at SuperiorHealthPlan.com/ProviderCalendar

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FQHC and RHC Billing Information

FQHC: Medicaid and CHIP Billing Procedures

- In order to receive the full PPS encounter rate, Federally Qualified Health Centers (FQHCs) must bill a T1015 procedure code and all applicable modifiers on the first service line, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge).
- CMS 1500 claim form
- Bill using location 50
- Bill with the billing provider's NPI in box 33a and billing provider's taxonomy in box 33b
  - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission
- Rendering Provider NPI/taxonomy is required for all services in box 24J

FQHC: Medicaid and CHIP Billing Procedures

- Providers must bill with modifier "TH" for antepartum or postpartum care.

- Claims must be billed with the appropriate family planning diagnosis code for family planning services.

- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to the Prospective Payment System [PPS] encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
  - Please note: After-hours care and Long Acting Reversible Contraception (LARC) services will be paid in addition to the provider's PPS encounter rate.

RHC: Medicaid and CHIP Billing Procedures

- The Rural Health Clinic (RHC) must bill a T1015 procedure code for general medical services.
- Exceptions claims ("other" health visits, e.g. Texas Health Steps and Family Planning) must be billed with appropriate or applicable CPT codes.
- A RHC is paid their full encounter rate directly from Superior.
- All services provided at an RHC and billed on a CMS 1500 form must be submitted using location POS code 72. This includes Texas Health Steps/Well visits and Family Planning Services.
- Services rendered at an RHC facility and billed with a location code other than 72 may be denied.
- Providers must use the appropriate modifiers in order to receive payment for services.

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Electronic Payments and Remittance

Signing up for Electronic Funds Transfer (EFT) and Retrieving your Explanation of Payment (EOP)

EFT vs. Paper Check

- Providers will receive a paper check and EOP, unless they are signed up for EFT through PaySpan.
- Did you know?
  - A provider can submit claims by paper and still enroll for EFT/ERA.
  - A provider that prefers their EDI vendor can still go through their vendor to submit their claims.
    - We simply divert the return file (the ERA [835]) through PaySpan along with EFT.

PaySpan

- Superior has partnered with PaySpan to offer expanded claim payment services.
  - EFT
  - Online remittance advices (ERA's/EOPs)
  - Health Insurance Portability Accountability Act (HIPAA) 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at www.PaySpanHealth.com.
- For further information, contact PaySpan at 1-877-331-7154, email ProviderSupport@PayspanHealth.com or contact your local Account Manager or Provider Services at 1-877-391-5921.

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Secure Provider Portal

Submitting Claims

Secure Provider Portal and Website

Superior is committed to providing you with all of the tools, resources and support you need to make your business transactions with Superior as smooth as possible. One of the most valuable tools is Superior's Secure Provider Portal. Once you are registered you get access to the full site.

- Secure Provider Portal Features:
  - View multiple TINs
  - Access daily patient lists from one screen
  - Manage Batch Claims for free
  - Simplify prior authorization process
  - Check patient care gaps
  - Streamline office operations
- Public Site:
  - Provider Directory with online lookup tool
  - Map of Account Managers by region
  - Newsletters, news posts, provider manuals, forms and helpful links

How to Register for the Provider Portal

- Visit Provider.SuperiorHealthPlan.com
- Enter your email, first and last name, select your language preference and choose your Password.
- Each user within the provider's office must create their own account

Create Your Account

Let's get started - creating an account is quick and easy.

Email

First Name

Last Name

Language Preference

English

Password

Provider Portal: Eligibility

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

Provider Portal: Authorizations

- Create Authorizations
  - Enter the patient’s member ID/last name and DOB and click “Find”
  - Populate the 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, DOS, type of service and more
  - To view all processed authorizations, click “Processed” and to view any authorizations with errors, click “Errors”

Please note: Authorizations update to the web portal every 24 hours.

Provider Portal: Claims

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- 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.

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Superior HealthPlan Departments

Account Management

- Account Managers are here to assist you with:
  - Face-to-face orientations
  - Provider Portal training
  - Office visits to review ongoing claim trends

- You can locate your Account Manager by using the field office map located at www.SuperiorHealthPlan.com/FindMyAM

Provider Services

- The Provider Services staff can help you with:
  - Answering questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Locating a member's Service Coordinator
  - Locating your Account Manager
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available, as HIPAA validation will occur.
- Available Monday - Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
  - Medicaid (STAR, STAR Health, STAR Kids, STAR+PLUS) and CHIP: 1-877-391-5921

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Answering questions
    - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
      - STAR, CHIP and Perinate: 1-800-783-5386
      - STAR+PLUS: 1-877-277-9772
      - STAR Health: 1-866-912-6283
      - STAR Kids: 1-844-590-4883

Provider Complaints

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

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Questions and Answers

Thank you for attending!