Behavioral Health

Provider Training

Agenda

- Benefits and Services
- Telemedicine and Telehealth
- Authorization Process
- Pharmacy Benefits and Transportation
- Fraud, Waste and Abuse
- Claims Filing and Payment
- Secure Provider Portal
- Superior HealthPlan Departments
- Questions and Answers

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Benefits and Services

Behavioral Health Benefits

- Traditional Day and Outpatient Services
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Medication Management Therapy
  - Individual, Group and Family Therapy
- Inpatient Mental Health Services
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation
- Substance Use Disorder Treatment
  - Individual and Group Therapy
  - Residential Treatment
  - Outpatient services
- Enhanced Services
  - Targeted Case Management or Rehabilitative Services
- Telemedicine and Telehealth
- Pharmacy Benefits – Prescription Drugs
  - Pharmacy Benefit Manager (PBM) = Envolve Pharmacy Solutions

Please Note: The behavioral health benefits referenced above are not an all-inclusive list, and not available for all products.

STAR

Who is covered in Texas?

- Adults, children and pregnant women
  - Based on income level, age, family income and resources/assets
- Newborns
  - Born to mothers who are Medicaid-certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday
- Cash assistance recipients
  - Based on receipt of Temporary Assistance for Needy Families (TANF) and dependent on age
- Supplemental Security Income (SSI) recipients
  - Must join if 21 years of age and older, and live in the Medicaid Rural Service Area (MRSA)
  - May join if 20 years of age and younger

STAR Health

- STAR Health is Medicaid for children who are in the custody of the Texas Department of Family and Protective Services (DFPS).
- STAR Health includes young adults who were previously in foster care (18-21 years of age).
- Superior is the sole Medicaid Managed Care Organization (MCO) managing health care for children and youth in foster care in all 254 counties in Texas.
- Superior collaborates very closely with DFPS to make sure children in foster care in the state of Texas receive all Medicaid health-care services including physical and behavioral health services, as well as dental and pharmacy Medicaid covered services.

STAR Health Eligibility

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

Former Foster Care Children Program (FFCC)

- Members under 26 years of age who were receiving Medicaid when they aged out of foster care at 18 years of age or older.

- Eligibility
  - Were enrolled in foster care at the time of their 18th birthday
  - Must be 18-25 years of age
  - Were a Medicaid recipient when they left foster care
  - Must be a U.S. citizen or legal immigrant

STAR Health 3-in-30 Services

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3 IN 30 A Comprehensive Approach to Better Care for Children

1 — 3-Day Initial Medical Exam

In 3 business days, children entering DFPS care must see a doctor to be checked for injuries or illnesses and get any treatments they need.

2 — CANS Assessment

In 30 days, children (ages 3-17) must get a CANS assessment. The CANS is a comprehensive trauma-informed behavioral health evaluation. It gathers information about the strengths and needs of the child and helps in planning services that will help the child and family reach their goals.

3 — Texas Health Steps Medical Check-Up

In 30 days, children must see a doctor for a complete check-up with lab work.
This makes sure:

- We address medical issues early.
- Kids are growing and developing as expected.
- Caregivers know how to support strong growth and development.

Trauma-Informed Care Alternative Payment Model

- Superior has an Alternative Payment Model (APM) for behavioral health therapy providers serving STAR Health members. When a provider uses an approved evidenced-based, trauma-informed care modality to treat trauma-related behavioral health symptoms and issues, they can receive an additional 10% payment to their submitted claim.

- Additional information on this program can be found online at: STAR Health Trauma-Informed Care Alternative Payment Model

- Please submit your certifications to ProviderCertifications@SuperiorHealthPlan.com.
  - Certifications are only valid for a set period of time from the issue date and must be renewed and resubmitted periodically.

Trauma-Informed Care Alternative Payment Model

There are 5 therapy modalities that will be recognized for this APM:

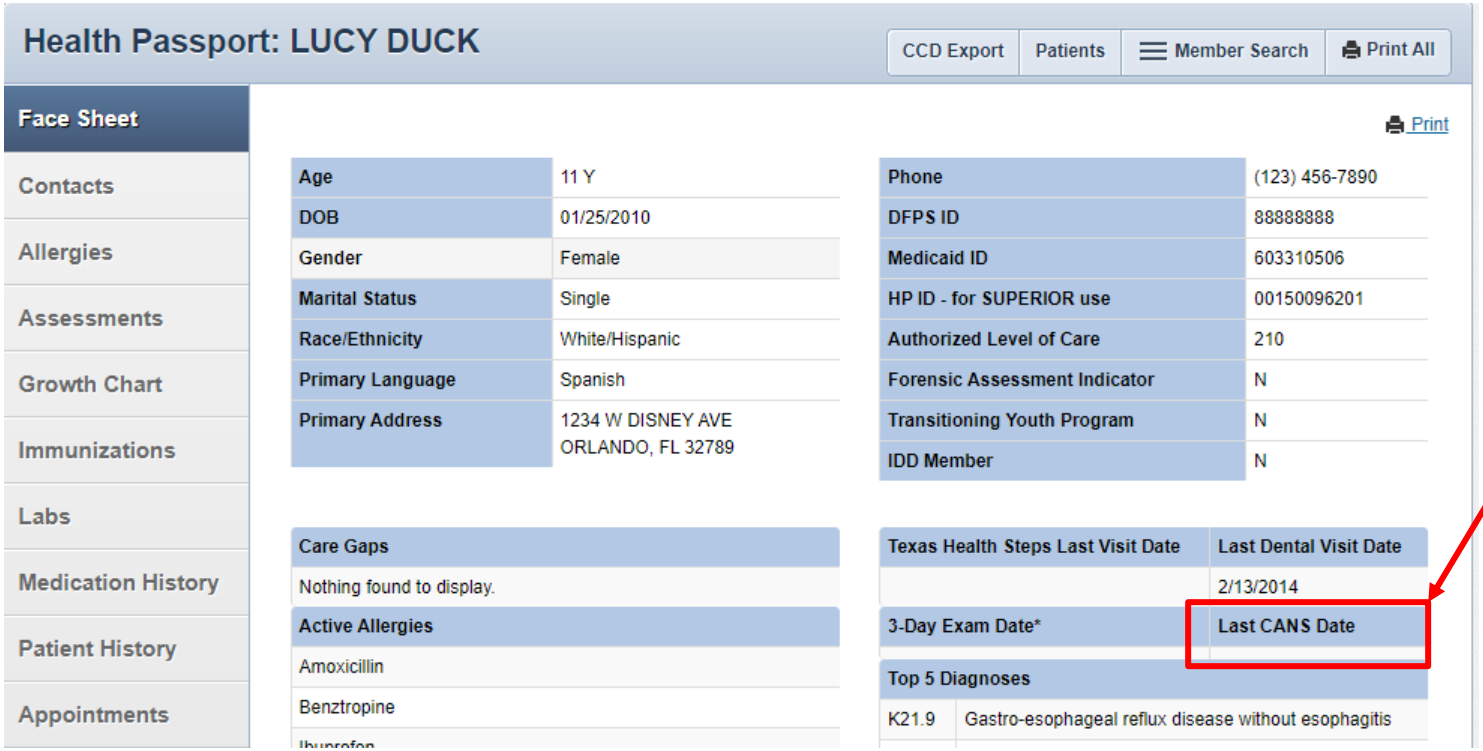
1. **Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)** – Recognized as evidence-based and validated for use with children and adolescents.
   - Certification is valid for 5 years.
2. **Eye Movement Desensitization and Reprocessing (EMDR)** – Recognized as evidence-based, validated for use with adults.
   - This certificate is a lifelong certificate and will not need to be resubmitted.
3. **Cognitive Processing Therapy (CPT)** – Recognized as evidence-based, primarily focused on adults.
   - Certification is valid for 3 years.
4. **Prolonged Exposure (PE)** – Recognized as evidence-based, validated for adolescents (PE-A) and adults.
   - This certificate is a lifelong certificate and will not need to be resubmitted.
5. **Parent Child Interaction Therapy (PCIT)** – Recognized as evidence-based, validated for children ages 2-7.
   - This certificate is a lifelong certificate and will not need to be resubmitted.

Child and Adolescent Needs and Strengths Assessment (CANS 2.0)

- Multi-purpose tool developed with the primary objectives of permanency, safety and improved quality of life for youth in foster care.
- Completed by a licensed clinician who is certified to administer the tool.
- Children who are 3-17 years of age at the time of removal are required to have a CANS assessment **within 30 days** of entering foster care.
- Children who turn 3 while in care are required to have a CANS within 30 days of their 3rd birthday.
- CANS 2.0 re-assessments are required annually while an eligible child remains in foster care.
- Certified providers can be reimbursed for completion of the CANS 2.0 assessment.
  - CPT 90791 and modifier TJ
- Additional information can be found online at www.FosterCareTX.com/for-providers/resources.html.

Checking CANS 2.0 Status

Providers can log into Health Passport to verify when the last CANS assessment was completed for a STAR Health member. Health Passport also indicates the PID number needed to submit an assessment through eCANS.



Becoming a CANS 2.0 Provider

- To become a CANS-certified provider:
  1. Access the CANS training at www.schoox.com/academy/CANSAcademy/register. The Texas Comprehensive 2.0 (Child Welfare) is the appropriate version to complete the required certification.
     - The training cost is $12.
     - Discount coupon codes can be requested for groups of 5 or more by emailing ecans.support@uky.edu.
  2. Complete the entire training to receive certification.
  3. Submit the CANS 2.0 certificate to TXCANS@SuperiorHealthPlan.com
     - Please include your National Provider Identifier (NPI) in the email.

STAR+PLUS

- The STAR+PLUS program is designed to integrate the delivery of acute care and LTSS through a managed care system, combining Medicaid acute health care with Long Term Services and Supports (LTSS).
- LTSS services allow a member to remain in the community, and includes:
  - Personal assistance services (PAS) and Adult Day Care (DAHS).
- Members, their families and providers work together to coordinate a member's health care, long-term care and community support services.
- A key component of the program is Service Coordination, a special kind of care management performed by Superior clinical staff to coordinate all aspects of care for a member.

STAR+PLUS

- Adults 21 years of age and older who:
  - Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income.
  - Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program).

STAR+PLUS Dual-Eligible Members

- Dual-eligible describes members who receive both Medicare and Medicaid.
- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services).
- Medicaid Acute Care (TMHP) - covers co-insurance, deductible and some LTSS (ex: incontinence supplies).
  - All non-LTSS services must be billed through Medicare as primary payer and TMHP as secondary.
- STAR+PLUS – ONLY covers LTSS (ex: Personal Attendant Services [PAS], Day Activity and Health Services [DAHS], etc.).

STAR+PLUS MMP

- The Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) program combines Medicare and Medicaid services into one product.
- Dual Eligibility: Who Qualifies?
  - Medicare Part A, and/or Medicare Part B and Full Medicaid (STAR+PLUS).
  - Enrollees must live in Bexar, Dallas and Hidalgo counties.
- Coordination of Care:
  - Provide all Medicare Part A and Part B benefits, Texas Medicaid services not covered by Medicare, Pharmacy (Medicare Part D) and STAR+PLUS LTSS services.
  - Facilitate access to the appropriate providers in the geographic location of the member.
  - Educate providers about coverage and encouraging them to participate in the Care Plan.

STAR Kids

- STAR Kids provides Medicaid benefits to individuals with disabilities, which include children and young adults 20 years of age and younger who receive:
  - 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).

Mental Health Targeted Case Management

- STAR, STAR Health, STAR Kids, STAR+PLUS and MMP members may qualify for Targeted Case Management based on the CANS or Adult Needs and Strengths Assessment (ANSA) and other diagnostic criteria.
- Members who have been diagnosed with a Severe and Persistent Mental Illness (SPMI) or a Severe Emotional Disturbance (SED) are also authorized to receive these services.

Mental Health Targeted Case Management

- SED is defined as psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.

- SPMI is defined as a diagnosis of bipolar disorder, major clinical depression, schizophrenia or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders accompanied by:
  - Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping or employment) due to the disorder.
  - Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.
  - Risk for institutionalization.

Mental Health Rehabilitative Services

- STAR, STAR Health, STAR Kids, STAR+PLUS and MMP members may qualify to receive Mental Health Rehabilitative Services.
- Mental Health Rehabilitation Services are defined as age-appropriate services determined by Texas Health and Human Services (HHS) and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders for children, and to restore the member to their best possible functioning level in the community.
- Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan.

Targeted Case Management and Mental Health Rehabilitative Services

- Superior requires that facilities and multi-specialty groups that provide Mental Health Targeted Case Management and Mental Health Rehabilitative Services submit an attestation **annually** as required by Senate Bill 58 of the 83rd Legislative Session.
  - Failure to submit an attestation timely may result in denials or recoupment.
- Attestations can be submitted to ProviderCertifications@SuperiorHealthPlan.com.
- For information on utilization management and billing guidelines, please visit https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/local-mental-health-authorities.

SB58 Enrollment with TMHP

- Texas Medicaid & Healthcare Partnership (TMHP) enrollment files should reflect an LMHA's SB58 status.
- Providers must contact TMHP immediately to added these provider types and specialties to their enrollment application.

Superior SB58 Providers

- Participating Local Mental Health Authority (LMHA) facilities must submit a rendering provider roster to Superior to add both licensed and non-licensed providers to their current contract.
  - These rosters are submitted to SHP.NetworkDevelopment@SuperiorHealthPlan.com
- Non LMHA multi specialty groups must submit additions to their group through the Add a Provider to an Existing Group Contract form, found on Superior's Newtwork Request or Update webpage. SuperiorHealthPlan.com/JoinOurNetwork

Transportation Benefits

- Superior's HealthPlan's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members (STAR, STAR Health, STAR Kids and STAR+PLUS) 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 patients needing assistance while traveling.
  - Providers may receive a request to provide proof of documentation of medical necessity.
- Children 17 years old and younger must be accompanied by a apparent, guardian or other authorized adult.
- Superior members should request rides as early as possible, and at least two Business Days before they need the ride.

Transportation Benefits

- 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 patient, the patient's family member, friend or neighbor.
  - Car, van, private bus services, including wheelchair-accessible vehicles, if necessary.
  - Members aged 20 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.
- 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

CHIP

- Children who are under 19 years of age and whose family's income is below 200% of the Federal Poverty Level (FPL) are eligible, if they do not qualify for Medicaid coverage.
- CHIP members are allowed to change health plans within 90 days of enrollment, and at least every 12 months thereafter during the re-enrollment period for any reason.
- CHIP members must apply and qualify for coverage annually.

Wellcare By Allwell (Medicare)

- Wellcare By Allwell (HMO and HMO DSNP) is a Medicare federal health insurance program for people ages 65 and older, and those under 65 with qualifying disabilities.
- Eligibility: Who Qualifies?
  - **HMO**: Individuals enrolled in Medicare only
  - **HMO DSNP**: Individuals who qualify for Medicaid coverage through the state of Texas and are eligible for Medicare
  - Enrollees must also live in a county offering their selected plan

Wellcare By Allwell (Medicare)

- Wellcare By Allwell provides complete continuity of care. This includes:
  - Integrated coordination of care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM)
  - Additional services specific to the member's needs
- Superior's approach to care management facilitates the integration of community resources, health education and disease management.
  - It promotes access to care as the beneficiaries are served through a multidisciplinary team including Registered Nurses (RN), social workers, pharmacy technicians and behavioral health case managers all co-located in a single, locally based unit.
- Members have access to the following provider types:
  - Clinical Social Workers (CSW)
  - Psychiatrists
  - Clinical Psychologists
  - Psychiatric Nurse Practitioners

Ambetter Enrollment

- Annual open enrollment period.
- Ambetter from Superior HealthPlan offers several levels of plan options, each one representing a different type of coverage.
  - Ambetter Essential/Balanced/Secure
  - Ambetter Value
  - Ambetter Virtual
- All plans have cost shares in the form of copays, coinsurance and deductibles.
  - Some members will qualify for assistance with their cost shares based on their income level.
  - This assistance would be paid directly from the government to Superior.
- Dependent coverage to 26 years of age.
- Ambetter coverage is available for members in several counties throughout Texas. For a full list of the counties, visit: Ambetter.SuperiorHealthPlan.com/for-brokers/coverage-area-map.html.

Ambetter Value

- New plan design with a more restrictive yet inclusive and adequate network being offered within a limited set of counties:
  - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson
- The Ambetter Value plan design differs in the following:
  - HCA Physicians Groups are the preferred PCP groups in which members will be able to utilize as a medical home.
    - ID Cards will display "**Ambetter Value Medical Group**"
  - **Any specialty care rendered by a specialist outside of the HCA Physicians Group will require a referral prior to services being rendered to our members**
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia
  - The above provider or facility types will still be required to be in-network and prior authorization requirements will continue to apply as applicable

Ambetter Virtual

- New plan design which most closely mirrors the network offered within Essential/Balanced/Secure.
  - There are a few exceptions most noticeably within our Hospital systems network.
- The Ambetter Virtual Access plan design differs in the following:
  - Teladoc is the preferred PCP group in which members will automatically be assigned to.
    - Members under the age of 18 are the exception as they will be assigned to a local PCP
  - Teladoc (or local PCP) will be responsible to submit a referral to Ambetter from Superior Health Plan in order for any Specialty care provider to render services to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia
  - The above provider or facility types will still be required to be in-network and prior authorization requirements will continue to apply as applicable.

Health Insurance Portability and Accountability Act (HIPAA)

- 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

myStrength

- myStrength is a digital tool that provides resources to members to promote mental health and well-being.
- With myStrength members can:
  - Learn techniques to reduce stress.
  - Track their mood online.
  - Manage depressive or anxious thoughts.
  - Access and share inspirations.
  - Explore hundreds of articles and activities.
- Providers can sign up for myStrength for free to demonstrate the program to members.
  - Visit www.mystrength.com and click Sign Up.
  - Register using your work email address and the Access Code **TXProvider**.

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Telemedicine and Telehealth

What is Telemedicine?

- Telemedicine services are medical services delivered by a physician to a patient at a different physical location. Using telecommunications or information technology, providers are able to see and hear the patient 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 Midwifes
- Providers must use a HIPAA-compliant system for all interactions.

What is Telehealth?

- Telehealth services are behavioral health services provided by licensed or certified providers to a patient at a different physical location other than the health professional using telecommunications or information technology.

- 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 patient 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 patient at a distance or consulting with a patient’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 audiovisual interaction between the provider and the client in another location using a mobile app or live online video.
  - Asynchronous store and forward technology using:
    - Clinically relevant photographic or video images, including diagnostic images.
    - The patient'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.

Covered Benefits of Telemedicine and Telehealth

- For a list of Current Procedural Terminology (CPT) codes that are covered under telemedicine and telehealth, please see the TMHP Telecommunication Services Handbook at www.TMHP.com.
  - The codes listed must be billed with modifier 95
  - Procedure codes that indicate remote in the description do not need modifier 95
  - Procedure codes for behavioral health services are subject to the same benefits and limitations as in-person visits
- Patient site providers may be reimbursed for Q3014 in a facility setting; however, it is not a benefit of telehealth services.

Covered Benefits of Telemedicine and Telehealth

- 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.
- Reimbursement may not be provided for audio-only interactions, such as telephone consultations, text-only email messages and facsimile transmissions.
  - After the COVID-19 pandemic, Superior will only reimburse for telephone-only services when a HIPAA-compliant platform is used to conduct them.

STAR Health

CANS 2.0 Assessment

- CANS 2.0 telehealth is a permanent option for children ages 3-17 years old.
- A certified TX CANS 2.0 assessment provider in Superior's network must perform the CANS 2.0 assessment.
- Members will have a choice of their CANS 2.0 telehealth providers within the network.

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Authorization Process

Behavioral Health Authorizations

- Inpatient Hospitalization
- Psychological Testing
- Partial Hospitalization Program (PHP) Mental Health (MH) and Substance Use Disorder (SUD)
- Intensive Outpatient Program (IOP) MH and SUD
- Residential Treatment for MH (CHIP and Ambetter Only)
- SUD Residential
- Information on specific authorization requirements for each services as well as frequency limitations can be found on our Behavioral Health Quick Reference Guide, found on Superior's Behavioral Health webpage: SuperiorHealthPlan.com/ProviderBehavioralHealth

Behavioral Health Authorizations

- Providers can submit authorizations via:
  - Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - Phone
    - All other products: 1-844-744-5315
    - Ambetter: 1-844-259-3934
  - Fax:
    - All other products: 1-855-772-7079
    - Ambetter: 1-844-307-4442
- Providers can determine if authorization is needed by submitting the code through the Pre-Auth Needed Tool: SuperiorHealthPlan.com/PriorAuth

Targeted Case Management and Mental Health Rehabilitative Services Authorizations

- Authorization is not required for Targeted Case Management and Mental Health Rehabilitative Services.
- The participating entity must complete the Texas Standard Prior Authorization Request Form for all Level of Care (LOC) 4 and deviations and will submit to Superior.
- Crisis Services do not require prior authorization; however, provider must submit authorization within two Business Days of the crisis event.
- Provider must submit justification documents if not able to submit authorization within the timeframe.

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Pharmacy Benefits and Transportation

Pharmacy Benefits

- Pharmacy Benefit Manager (PBM):
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
  - Responsible for review of prior authorizations for prescriptions, as applicable.

Specialty Drugs

- Specialty medications are typically filled through a specialty pharmacy such as but not limited too: AcariaHealth or CVS Caremark Specialty Pharmacy.
  - Only Synagis® is required to be filled through AcariaHealth or CVS Caremark Specialty Pharmacy.

AcariaHealth	CVS Caremark
Phone: 1-855-535-1815	Phone: 1-800-237-2767
Fax: 1-877-541-1503	Fax: 1-800-323-2445
Web: www.AcariaHealth.com	Web: www.CVSSpecialty.com

How to Access the Formulary/PDL

- Superior utilizes the Vendor Drug Program (VDP) formulary at www.Epocrates.com (accessible via smartphones and similar technology.
- Preferred Drug List (PDL) and clinical prior authorization criteria for Medicaid and CHIP: SuperiorHealthPlan.com/Pharmacy
- PDL for Ambetter from Superior HealthPlan members: https://ambetter.superiorhealthplan.com/provider-resources/pharmacy.html
- PDL for Wellcare By Allwell members: wellcare.superiorhealthplan.com/drug-pharmacy/formulary.html

72-Hour 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 an 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.

Pharmacy Contact Information

Ambetter from Superior HealthPlan

- Envolve Pharmacy Solutions is simplifying the prescriber process with a streamlined prior authorization process that can be accessed online through CoverMyMeds.
  - Automates drug prior authorizations for any medication and allows prescribers to begin the process electronically.
  - Visit the “CoverMyMeds” link at pharmacy.envolvehealth.com/pharmacists.html.

- Contact Information
  - Phone: 1-866-399-0928
  - Fax: 1-866-399-0929

Pharmacy Contact Information

Wellcare By Allwell

- Clinician Administered Drugs
  - Phone: 800-218-7508
  - Fax: 1-877-808-9368
- Out-Patient Rx (PBM: Envolve Pharmacy Solutions)
  - Resolution Help Desk: 1-800-460-8988
- TTY: 1-866-492-9674
  - Prior Authorization Requests Phone: 1-866-399-0928
  - Prior Authorization Requests Fax: 1-866-399-0929
- Appeal Requests (Superior Prior Authorization Department)
  - Toll Free: 1-877-398-9461 ext. 22168
  - Fax: 1-866-918-2266

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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.hhs.gov/ 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:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid of CHIP ID

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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 form.
- Filed electronically through clearinghouse.
- Filed directly through web portal.
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.
- Billing Provider: Billing NPI in box 33a and Billing Taxonomy number in 33(b).

Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - View a list of Superior's Trading Partners: SuperiorHealthPlan.com/Billing
  - Superior Emdeon ID 68068
  - Ambetter Emdeon ID 68069
- Paper Claims - Initial and Corrected*
  - Superior HealthPlan
    Behavioral Health Claims
    P.O. Box 6300
    Farmington, MO 63640-6806
- Paper Claims - Requests for Reconsideration* and Claim Disputes*
  - Superior HealthPlan
    P.O. Box 6000
    Farmington, MO 63640-3809

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

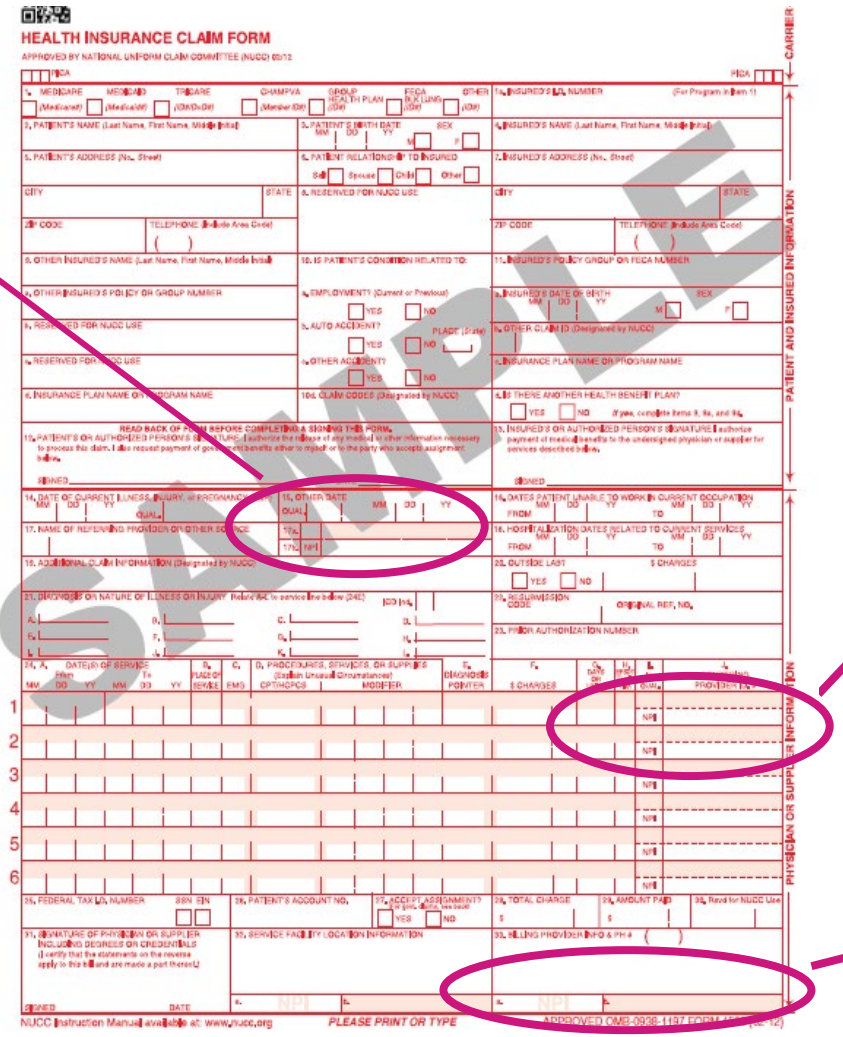
Claims Filing: Deadlines

- 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 #



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

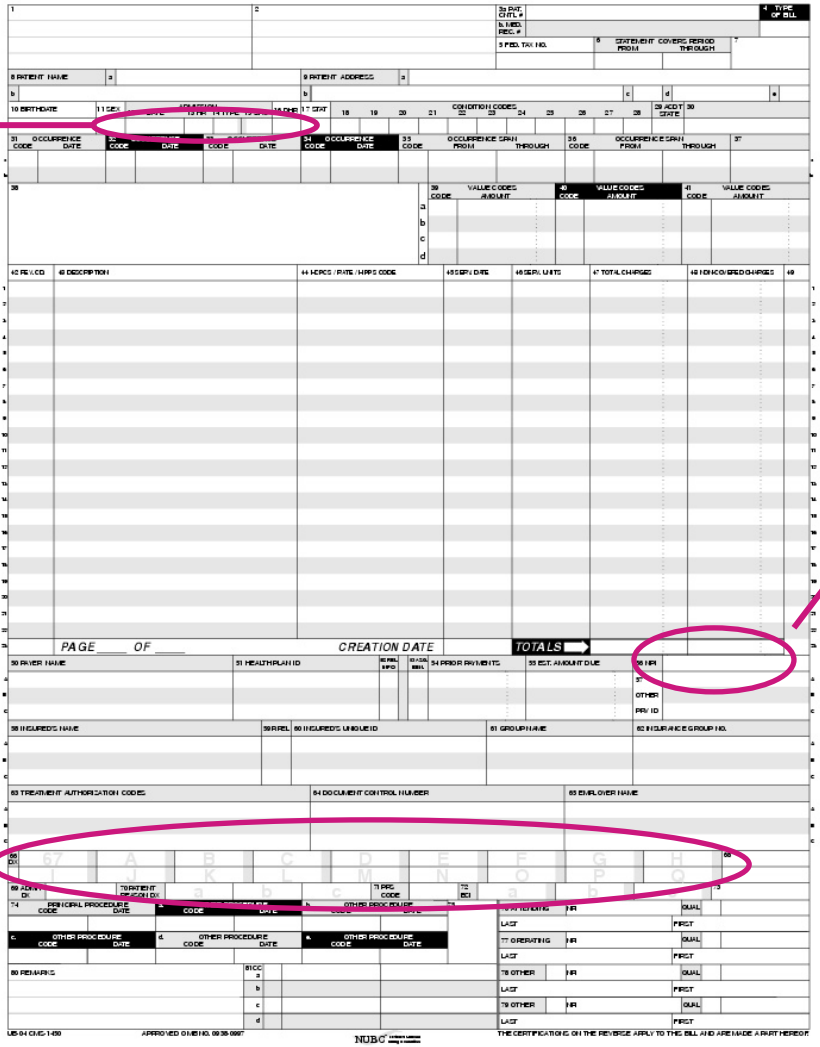
Billing NPI# in box 33a and Taxonomy # in 33b

UB-04 Requirements

Admission Information

Billing Provider NPI

Diagnosis code(s) and POA indicator(s)



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 in to 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 Superior retrieve a scanned image of the rejected claim.*

Common Billing Errors

- Member date of birth or name not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- 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 Superior HealthPlan STAR, STAR+PLUS, CHIP & STAR Health and STAR Kids 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 Superior HealthPlan STAR, STAR+PLUS, CHIP & STAR Health and STAR Kids 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 Benefit 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

Trauma-Informed Care Alternative Payment Model

- The requirements for participating are as follows:
  1. Submit a training certificate for one or more of the modalities listed below. Certificates can be submitted to ProviderCertifications@SuperiorHealthPlan.com.
  2. When submitting claims to Superior for the therapy modalities, use the identified billing modifier to indicate which modality was used.
     - U1 = Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)
     - U2 = Eye Movement Desensitization and Reprocessing (EMDR)
     - U3 = Cognitive Processing Therapy (CPT)
     - U4 = Prolonged Exposure (PE)
     - U5 = Parent Child Interaction Therapy (PCIT)
  3. Complete a baseline screening at the beginning of treatment. Follow-up screenings should be conducted every 90 Calendar Days, or at the conclusion of treatment (whichever comes first). There are 2 screenings available within Superior's Health Passport for this purpose. For children and adolescents, use the Child and Adolescent Trauma Screen (CATS). For adults, use the Trauma Screening Questionnaire (TSQ). Document in the patient's medical chart that an evidenced-based approach to trauma is being used.

PaySpan Health

- Superior partners with PaySpan Health to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs).
  - Online remittance advices (Electronic Remittance Advice [ERAs]/EOPs).
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System.
- Register at: www.PaySpanHealth.com.
- For further information contact 1-877-331-7154, or email ProviderSupport@PaySpanHealth.com.

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Secure Provider Portal

Superior's Website and Secure Provider Portal

Secure Provider Portal

- Submit:
  - Claims
  - Prior Authorization Requests
  - Request for EOPs
  - Notification of Pregnancy
  - COB Claims
  - Adjusted Claims
  - Health Passport Information
- Verify:
  - Member Eligibility
  - Claim Status

SuperiorHealthPlan.com

- Resources:
  - Provider Directory
  - Provider Manual
  - Provider Training Schedule
  - Submit Provider Complaints
  - Additional Provider Resources

How to Register for the Secure 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 a username 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.

Secure Provider Portal

Eligibility

- Search for eligibility using:
  - Member's date of birth
  - Medicaid/CHIP/DFPS ID number or last name
  - Date of Service

Secure 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, dates of service, 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 Secure Provider Portal every 24 hours.

Secure Provider Portal

Claims

- Claim Status
  - Claims update to the Secure Provider Portal every 24 hours
  - Status can be checked for a period of time going back 18 months
- 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.”

Secure 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.

Secure Provider Portal

Additional Information

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

Secure Provider Portal

Highlights

- Manage all product lines and multiple TINs from one account
  - Office Manager accounts available
- Access the eligibility section for providers
- View authorization detail and history
  - New display features: Authorization denial reason
- Submit batched, individual or recurring claims
- Download EOPs
- Send/receive secure messages
- Refer members to Case Management
- Review member alerts/care gaps

Health Passport

- Health Passport is a secure web-based application built using core clinical and claims information to deliver relevant health-care information when and where it is needed for the STAR Health population.
- Medical Consenters, health care providers, Department of Family and Protective Services (DFPS) caseworkers and STAR Health staff may have access to the information.
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination
  - Eliminate waste
  - Reduce errors
- To log on to Health Passport, visit Provider.SuperiorHealthPlan.com
- For additional information, visit www.FosterCareTX.com/for-providers/health-passport.html.

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Superior HealthPlan Departments

Service Coordinators

- Available to members receiving behavioral and/or physical health services, depending on the level of service coordination assigned.
- Perform in-home assessments with members for LTSS to ensure members are able to live a healthy life in the setting of their choice.
- Coordinate referrals to other programs like Disease Management and Case Management, if necessary.
- Assist with coordinating care and follow-up with members.
- Visit or touch-base telephonically with members at least 2 times a year.

Behavioral Health Care Management

- Superior has experienced nurses, licensed clinical counselors and licensed CSWs who can assist members in coordinating all aspects of their care.
- Care Management services are available for any member.
- Levels of care management include:
  - **Care Coordination** – Lowest level, mostly short-term needs, social assistance, stable chronic conditions.
  - **Care Management** – Intermediate needs, may require additional time or resources to ensure member needs are addressed.
  - **Complex Care Management** – Significant illness burden and complexity. These members require longer term, ongoing assistance to address care gaps and service needs.

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Assist with inquiries related to administrative policies, procedures, and operational issues.

- Superior Account Management offers targeted presentations depending on the type of services you provide.

Please note: To find contact information for your Account Manager visit SuperiorHealthPlan.com/FindMyAM .

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, please 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:
  - Medicaid/CHIP/MMP/Wellcare By Allwell - 1-877-391-5921
  - Ambetter – 1-877-687-1196

**For STAR Health, Wellcare By Allwell and Ambetter, office hours are from 8 a.m. to 6 p.m. (Central Time), Monday through Friday.*

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Finding additional local community resources
  - Answering questions

Contact Member Services

- Available Monday - Friday, 8:00 a.m. to 5:00 p.m. local time (unless otherwise noted), by calling:
  - Wellcare By Allwell: 1-877-935-8023 (8 a.m. – 8 p.m.)
  - Ambetter: 1-877-687-1196 (8 a.m. – 8 p.m.)
  - STAR/CHIP/and Perinate: 1-800-783-5386
  - STAR Kids: 1-844-590-4883
  - STAR Health: 1-866-912-6283
  - STAR+PLUS: 1-877-277-9772
  - STAR+PLUS MMP: 1-866-896-1844 (8 a.m. – 8 p.m.)

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 to existing Superior contracts
  - Amendments to existing contracts

- Contract packets can be requested at SuperiorHealthPlan.com/JoinOurNetwork

Provider Credentialing

- Initial Credentialing
  - Complete a Texas Department of Insurance (TDI) credentialing application form for participation
  - Complete an electronic application
  - Provide Council for Affordable Quality Healthcare (CAQH) identification number
  - Email applications to SHP.NetworkDevelopment@SuperiorHealthPlan.com.

Provider Credentialing

- Re-credentialing
  - 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 re-assigned and system termination.
  - Email applications to Credentialing@SuperiorHealthPlan.com.
  - Failure to respond timely to requests for information or documentation will result in discontinuation of re-credentialing and termination of contract.

- All credentialing and re-credentialing 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 the 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/providers/resources/complaint-procedures.html

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Questions and Answers