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)
  - Verify on Texas Medicaid & Healthcare Partnership (TMHP) TexMedConnect and My Account Guides
- Superior's ID Card
- Superior's Secure Provider Portal
- 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.

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.
  - Fax: 1-800-690-7030

Authorization TAT Requirements

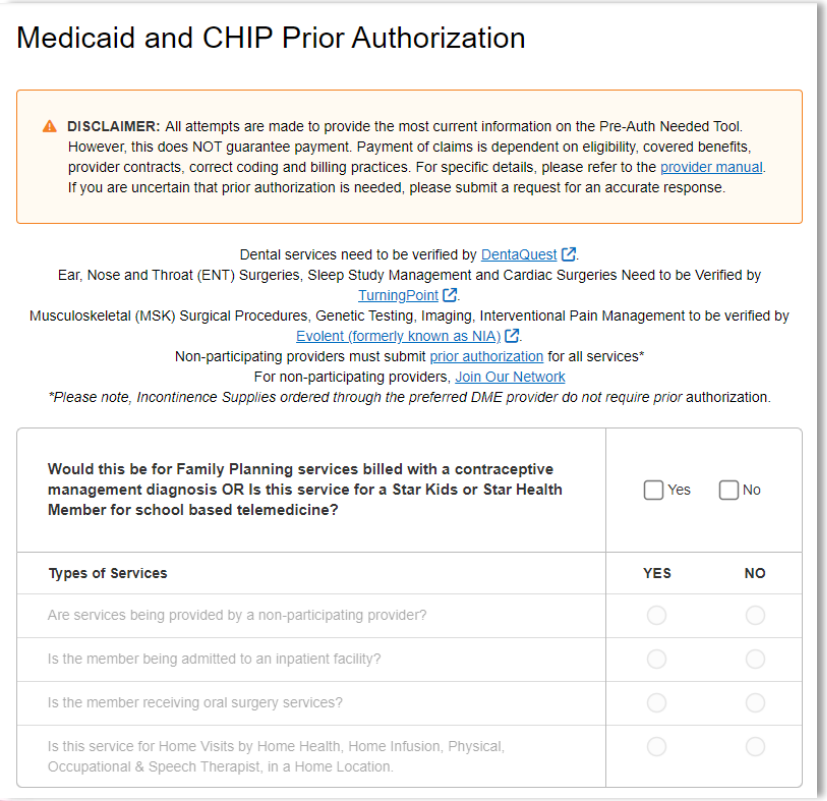
Program	Authorization Type	TAT
STAR (Medicaid), STAR Health, STAR Kids and STAR+PLUS	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
Medicaid and CHIP	Urgent, Outpatient and Inpatient Elective	3 Calendar Days
Medicaid and CHIP	Inpatient	1 Business Day

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.)
  - Pharmaceuticals
  - Surgical/Other Procedures
  - Transplants
  - Long-Term Services and Support (LTSS)
  - Radiology

Medicaid Pre-Authorization Tool

- Providers can determine if a prior authorization is required by using the Pre-Auth Needed Tool answering a series of questions and searching by procedure codes found on Superior's Authorization Requirements webpage.



Medicaid and CHIP Prior Authorization

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.

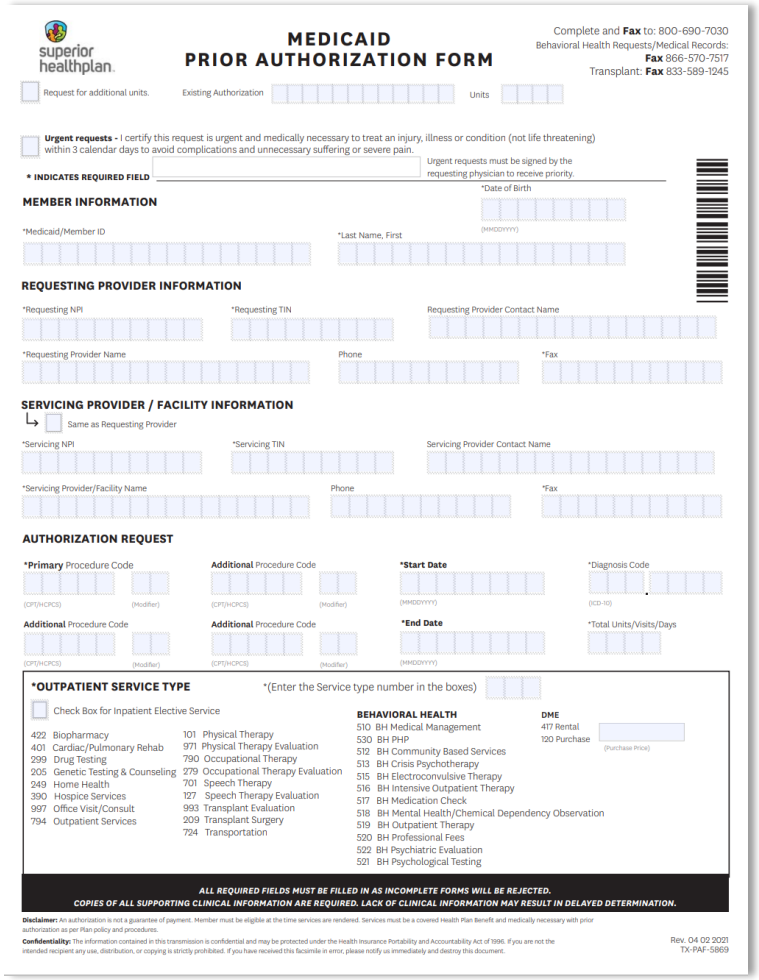
Dental services need to be verified by DentaQuest.
Ear, Nose and Throat (ENT) Surgeries, Sleep Study Management and Cardiac Surgeries Need to be Verified by TurningPoint.
Musculoskeletal (MSK) Surgical Procedures, Genetic Testing, Imaging, Interventional Pain Management to be verified by Evolent (formerly known as NIA).
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 OR Is this service for a Star Kids or Star Health Member for school based telemedicine?	☐ 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?	○	○
Is the member receiving oral surgery services?	○	○
Is this service for Home Visits by Home Health, Home Infusion, Physical, Occupational & Speech Therapist, in a Home Location.	○	○

Prior Authorization Form

- Authorization Forms are located at Superior's Provider Forms webpage.
- Providers may also utilize the **Texas Standard Prior Authorization Request (PDF)** found on Superior's Provider Forms webpage.
- Prior authorizations can also be submitted through Superior's Secure Provider Portal.



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MEDICAID
PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records: **Fax** 866-570-7517
Transplant: **Fax** 833-589-1245

☐ 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.

*** INDICATES REQUIRED FIELD** Urgent requests must be signed by the requesting physician to receive priority.

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
971 Physical Therapy Evaluation
790 Occupational Therapy
279 Occupational Therapy Evaluation
701 Speech Therapy
127 Speech Therapy Evaluation
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
420 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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Evolent
(formerly National Imaging Associates (NIA))

- Evolent is contracted with Superior to perform utilization review for:
  - High-Tech Imaging Services
  - Interventional Pain Management (IPM)
  - Genetic and Molecular Testing
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
  - Physical, Occupational and Speech Therapy Treatment Services*
    - Note: Authorization requirements vary by product
- For IPM, a separate prior authorization number is required for each procedure ordered.
- The ordering physician is responsible for obtaining authorizations.
- Emergency room and inpatient procedures do not require prior authorization; however, notification of admission is still required through Superior.
  - Observation Imaging Services do not require authorization
- To obtain authorization through Evolent, visit RadMD.com or call 1-800-642-7554.
- Claims should still be submitted to Superior for processing.

*Non-STAR+PLUS HCBS Waiver Members

TurningPoint Healthcare Solutions

- TurningPoint Healthcare Solutions is contracted with Superior to process prior authorization requests for medical necessity and appropriate length of stay for:
  - Certain Cardiac procedures
  - ENT surgeries
- Emergency related procedures do not require prior authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services should verify that the necessary prior authorization has been obtained. Failure to do so may result in non-payment of claims.
- Prior authorization requirements for facility and radiology may also be applicable.
- **TurningPoint's Procedure Coding and Medical Policy Information (PDF)** can be located under *Billing Resources* on Superior's Provider Resources webpage.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
  - Web Portal Intake: TurningPoint Provider Login
  - Telephonic Intake: 1-469-310-3104 or 1-855-336-4391
  - Facsimile Intake: 1-214-306-9323

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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 Calendar 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 Business 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.
- Register for the provider training on the new EMR process at Register GoTo Webinar.

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Claim Submissions

Claims Submission

- Clean Claim – A claim submitted by a provider for healthcare services rendered to a member that contains accurate and compete data in all claim fields required to adjudicate and accurately report and finalize the claim.
- First time claims must be submitted within 95 Calendar Days from the date of service
- Rejected Claims – An unclean claim that does not contain all elements necessary to process the claim, and/or is not the responsibility of the health plan for adjudication.
  - All rejected claims must be corrected and resubmitted within 95 Calendar Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.
- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS 1450 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 CMS 1450 to indicate taxonomy.

Clean Claims

- Clean claims will be processed within 30 Calendar Days.
- For electronic pharmacy claim submissions, claims will be paid in 18 Calendar 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-Calendar 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.

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).

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 Superior's Secure Provider Portal until the provider has established a relationship with a trading partner/clearinghouse listed on Superior's Billing and Coding webpage.
  - 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**.
  - Contact EDI: EDIBA@Centene.com

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 Calendar 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 Superior's Provider Forms webpage.

Corrected Claims Filing

- Corrected Claims – 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.
  - 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 CMS 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 CMS 1500 form.
- Must be submitted within 120 Calendar Days from the date on the EOP
- Corrected claims can be filed through Superior's secure provider portal or through your clearinghouse.
- A Corrected Claim form may be used when submitting a Corrected Claim and mailing it 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 Calendar Days from the date of adjudication or denial.
- Can be submitted electronically through Superior's Secure 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, 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 Provider Procedures Manual), the service will not pay as the services are considered to be informational only.

Billing Reminders – Authorizations

- 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

- 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 – Delivery Claim Requirements

- 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 Calendar 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 Consent Form

- 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 Superior's Provider Forms webpage.

Billing Reminders – Sports Physicals

- 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
- Sports physicals must be submitted on a separate claim than the one for the encounter rate and **cannot be** billed with T1015.
- Reimbursement will be $35.00 (there is no co-pay).

Member Balance Billing

- Providers may not bill members directly for covered services for STAR, STAR Health, STAR Kids, STAR+PLUS or CHIP.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Superior STAR, STAR Health, STAR Kids, STAR+PLUS and CHIP Perinate members do not have co-payments. Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (under CHIP Benefits).
- Additional details can be found in your provider contract with Superior.

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 Visit Verification

Electronic Visit Verification

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Service providers or CDS employees providing covered services to an individual or health plan member must use one of the three HHSC approved methods to clock in and out.
- The EVV system records the time the service provider or CDS employee begins providing services and the time the service provider or CDS employee stops providing services.
- Once a provider or Financial Management Services Agency (FMSA) has ensured an EVV visit passes all validation edits they may reference the time recorded in the EVV system to determine billable units/hours.

Programs and Services Requiring EVV

- STAR+PLUS
  - Personal Attendant Services (PAS)
  - In-Home Respite Services
  - Community First Choice (CFC) PAS and Habilitation (HAB)
  - Protective Supervision
- STAR Health
  - PCS
  - CFC PAS
  - CFC HAB
- STAR Kids
  - PCS
  - CFC PAS
  - CFC HAB
- For a list of all current programs and services requiring EVV refer to:
  - State-Required Personal Care Services (PDF)
  - Cures Act Home Health Care Services (PDF)

EVV Claims

- EVV-relevant claims for programs required to use EVV, must be billed to TMHP and are subject to the EVV claims matching process performed by the EVV Aggregator.
- Providers and FSMAs must verify all data elements on EVV claims, including times entered in the EVV system, prior to submitting to EVV Aggregator.
- Providers and FMSAs must ensure the appropriate authorization has been received prior to services being rendered and billed on the claim.
- TMHP submits daily files directly to Superior for all accepted EVV transactions and claims.
- EVV Claims are analyzed by the EVV Aggregator in accordance with EVV data matching requirements before claim adjudication.

EVV Claims

- Units should be billed using the rounded "Pay Hours" calculated in the EVV vendor System.
  - Example: If a client was services for 48 minutes, this should be rounded down to 45 minutes and .75 units should be billed.
  - If a client was serviced for 52 minutes, this would be rounded up to 1 hour and a full unit should be billed for the visit.

- All Unit Increments should be billed in the following format after rounding:

Service Time	Units
60 minutes	1
45 minutes	.75
30 minutes	.50
15 minutes	.25
0 minutes	0

EVV Claims

- The EVV Aggregator conducts validation on data from the EVV visit transaction verifying the data on the billed claim matches the visit data in the EVV portal before forwarding the claim to Superior for adjudication.
- To prevent claim denials, providers and FMSAs should verify the EVV visit transaction is accepted before billing.
- When billing claims, providers and FMSAs must verify the data elements billed match the data listed in the EVV portal.
- Only EVV claims with claim line items displaying a match result code of EVV01, listed in the EVV Portal, may be paid by Superior.
- Providers and FMSAs are required to resubmit claim denials to TMHP.

EVV Claims

- EVV claims must be billed to TMHP and are subject to the EVV claims matching process.
- The info on EVV claims must match EVV transactions along the following data elements:
  - NPI or API
  - Date of Service
  - Medicaid ID
  - HCPCS Codes
  - Modifier(s), if applicable
  - Units (a requirement only for program providers, not CDS)
    - All EVV claims lines billed with mismatches between these data elements will result in denials
    - Providers or FMSAs will be required to resubmit any denials to TMHP.

Zelis/PaySpan– EFTs and ERAs

PaySpan/Zelis

- Superior has partnered with Zelis, formerly known as PaySpan, 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 on the Zelis website.
- For further information, call 1-877-331-7154 or email ProviderSupport@PaySpanHealth.com.

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Secure Provider Portal

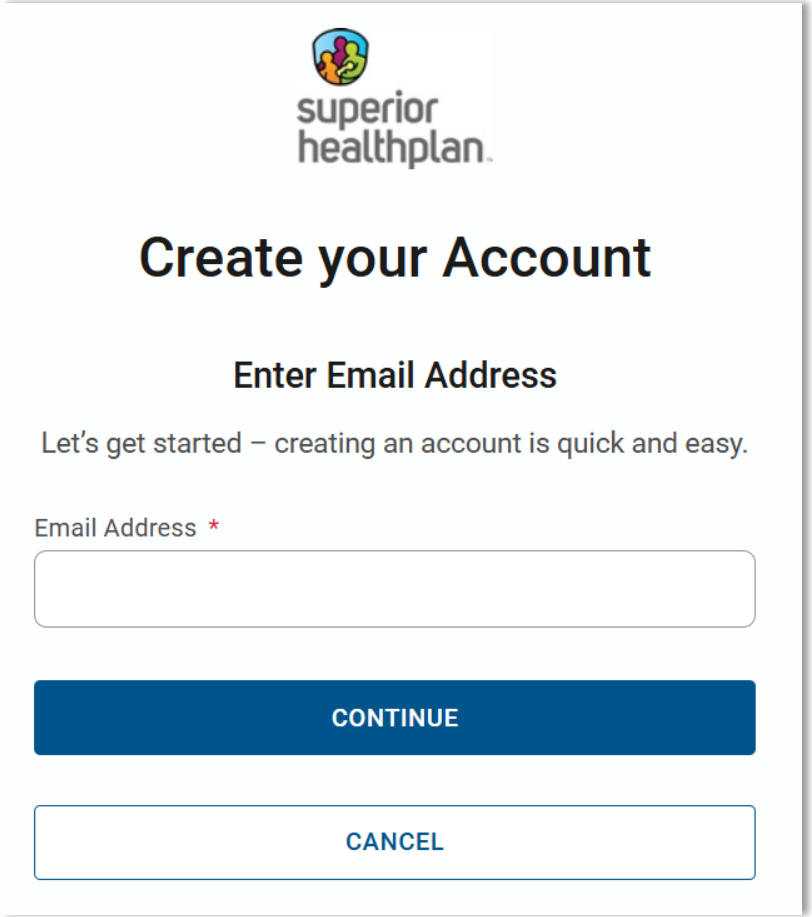
Secure Provider Portal and Website

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 Superior's Secure Provider Portal and click *Create New Account*.
- 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.



Provider Portal: Eligibility

- 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

- Create Claims
  - Professional, institutional, corrected and batch.
- View Payment History
  - Displays check date, check number and payment amount for a specific timeframe (data available online is limited to 18 months).
- Claim Auditing Tool
  - Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
  - Proactively determine the appropriate code/code combination representing the service for accurate billing purposes.
  - Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

Provider Portal: 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”

Superior HealthPlan Departments

Contact Us

- Account Management:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - For questions or more information, please contact Provider Services or your local Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services: 1-877-391-5921
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.
- Member Services: 1-800-783-5386 (STAR/CHIP); 1-877-277-9772 (STAR+PLUS); 1-866-912-6283 (STAR Health); 1-844-590-4883 (STAR Kids)
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Available Monday – Friday, 8:00 a.m. to 5:00 p.m. local time

Questions and Answers

Thank you for attending!