FQHC Training

Provider Training

Introductions and Agenda

- STAR
- STAR+PLUS
- STAR+PLUS Medicare-Medicaid Plan (MMP)
- STAR Kids
- STAR Health (Foster Care)
- CHIP and CHIP Perinate
- Ambetter from Superior HealthPlan (Health Insurance Marketplace)
- Wellcare By Allwell (Medicare Advantage and D-SNP)
- Medical Management
- Cultural Competency and Disability Sensitivity
- Hospital Billing Guidelines
- Claims and Payment Processing
- Corrected Claims and Appeals (Medicaid/CHIP/MMP)
- Complaints and Appeals (Ambetter and Wellcare By Allwell)
- Secure Provider Portal
- Health Passport
- Superior Departments
- Superior Partners
- Questions and Answers

Superior HealthPlan

- Superior provides Medicaid and CHIP programs in Texas Health and Human Services Commission (HHSC) service areas throughout the state. These programs include:
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - CHIP and CHIP Perinate
- In addition to the products above, Superior also offers the following, in limited-service areas:
  - Health Insurance Marketplace (Ambetter from Superior HealthPlan)
  - Medicare Advantage (Wellcare By Allwell [HMO and HMO DSNP])
- Superior is among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the National Committee for Quality Assurance's (NCQA) Medicaid Health Insurance Plan Ratings

Verify Eligibility (Medicaid/CHIP)

How to Verify Eligibility:

- Texas Medicaid Benefits Card
- TexMed Connect – by visiting Your Texas Benefits website
- Superior's ID Card
- By visiting Superior's Secure Provider Portal
- Contacting Superior's Member Services department at:
  - STAR 1-800-783-5386
  - STAR+PLUS: 1-877-277-9772
  - STAR Kids: 1-844-590-4883
  - STAR Health: 1-866-912-6283
  - CHIP/CHIP Perinate 1-800-783-5386
  - STAR+PLUS MMP: 1-866-896-1844
  - Ambetter: 1-877-687-1196
  - Wellcare By Allwell (HMO): 1-844-796-6811
  - Wellcare By Allwell (HMO DSNP): 1-877-935-8023

Provider Roles and Responsibilities

Primary Care Provider (PCP) Responsibilities

- Serve as a “Medical Home”
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member
- Develop an Integrated Primary Care (IPC), which involves the integration of behavioral health services into primary care, where appropriate
- Be accessible to members 24 hours a day, 7 days a week, 365 days a year
- Responsible for the coordination of care and referrals to specialists
- Verify member eligibility prior to rendering services
- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider

PCP Responsibilities

- Update contact information to ensure accurate information is available in Provider Directories.
- Report all encounter data on a CMS 1500 form or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Coordinate with non-network providers, when needed (Center for Independent Living, Local Intellectual and Developmental Disability Authority [LIDDAS], housing, etc.).
- Arrange coverage with another Superior provider if one is not available.
- Office phone must be answered during normal business hours.
- After-hours calls should be documented in an after-hour call log and transferred to the patient's medical record.

Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
  - Ambetter Value and Virtual members will require a referral* to be submitted through the secure provider portal.
- Specialist may not refer to another specialist.
- Members may also self-refer for several services.

**Referrals are not required for OB/GYN, Mental Health/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia*

Texas Health Steps

Texas Health Steps

For Medicaid-eligible children, adolescents and young adults under 21 years old, the comprehensive preventive care program combines:

- Diagnostic screenings
- Communication and outreach
- Medically necessary follow-up care including:
  - Dental
  - Hearing examinations
  - Vision
- Age-appropriate screenings must include, but are not limited to:
  - Autism - Lead - Sexually Transmitted Diseases
  - Developmental - Mental Health - Tuberculosis
  - Hearing - Nutrition - Vision

For complete Texas Health Steps Exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule.

Checkup Requirements

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

Checkup Requirements

- Members new to Superior
  - Within first 90 Calendar Days (unless documentation of previous checkup is provided).
- Existing members
  - Please see the Texas Health Steps Periodicity Schedule - Large (PDF).
  - Members under 3 years old have multiple checkups within each year; 6 outpatient checkups in the first year.
  - Members over 3 years of age have an annual checkup which must occur within 364 Calendar Days following their birth date.
- Exceptions (outside of periodicity)
  - Medically necessary: developmental delays, medical concerns, suspected abuse (use modifier code SC).
  - Mandated services: state or federal requirements (use modifier code 32).
  - Unusual anesthesia: procedures which usually require no anesthesia or local anesthesia (use modifier code 23).

Oral Evaluation and Fluoride Varnish

- This program will allow Medicaid-eligible Texas Health Steps members and Children with Special Health Care Needs (CSHCN) who are 6 to 35 months old to receive an oral evaluation and fluoride varnish during medical checkups.
  - Limited to 10 fluoride treatments.
  - Providers must be certified to provide oral evaluations and fluoride varnishes.
  - Once a provider has completed the training, they will need to submit their certification to their Superior Account Manager.
  - The training is available as a free continuing education course on the Texas Health Steps website.
  - Provider should bill with procedure code 99429 and modifier U5 with the diagnosis Z00.129.

Blood Lead Level Reporting

Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms, visit DSHS TXCLPPP webpage.
- Centers for Disease Control (CDC) Childhood Lead Poisoning Prevention and Screening guidelines can be found on the Department of State Health Services (DSHS) website:
  - Prevention: DSHS Blood Lead Surveillance webpage.
  - Screening: DSHS Screening Guidelines webpage.

Missed Appointments and Refusal of Exam

- Missed Appointments:
  - Providers should complete a Missed Appointment form and fax it to MAXIMUS at: 1-512-533-3867, who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, childcare, money for gasoline, etc.).
  - Missed Appointment is found on the HHSC Texas Health Steps Forms. Please see the Texas Health Steps Provider Outreach Referral Form (PDF).
- Refusal of Exam:
  - Superior is required to log all member refusal for service to the Texas HHSC.
  - The refusal should be recorded in the member's medical record and communicated to Superior's Member Services department at: 1-800-783-5386.
  - If a patient indicates that his or her exam was previously completed, Superior will:
    - Look for that claim in our system and, if there is no claim on file, will contact the provider of service to verify the member's statement.

Children of Traveling Farm Workers

- HHSC defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health-care needs, provide direct education about the health-care system and the services available and arrange appointments and transportation.
- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed a “Travel Packet” and other helpful pieces of information to ensure these children get the health-care services they need.
- Providers who provide care to Superior members, who are a children of Traveling Farmworkers, can direct the parent to call Member Services for assistance on program benefits or to help schedule an appointment by calling 1-800-783-5386.

Enrollment and Training

- Enrollment as a Texas Health Steps provider must be completed through the Texas Medicaid and Healthcare Partnership (TMHP) website.
- A separate Texas Health Steps Texas Provider Identifier (TPI) number is required.
- Training from HHSC is mandatory for Texas Health Steps providers.
- Free continuing education hours are available at Texas Health Steps Course Catalog.

STAR

STAR Eligibility

Who is covered by the STAR Program in Texas?

- Families, children and pregnant women
  - Based on income level, age, family income and other resources/assets
- Newborns
  - Born to mothers who are Medicaid-eligible at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday
- Temporary Assistance for Needy Families (TANF) recipients or TANF-related benefits
- Former children in Foster Care, ages 21-25

STAR+PLUS

STAR+PLUS

- STAR+PLUS is a Texas Medicaid program integrating the delivery of acute care services and Long-Term Services and Supports (LTSS) to aged, blind and disabled Medicaid recipients through a managed care system.
- The STAR+PLUS program is designed to assist Medicaid recipients with chronic and complex conditions who require more than acute care services.

STAR+PLUS Eligibility

- The following Medicaid-eligible individuals must enroll in the STAR+PLUS program:
  - Supplemental Security Income (SSI) eligible 21 and over
  - Individuals 21 and over who are Medicaid-eligible because they are in a Social Security exclusion program.
    - These individuals are conserved Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS (c) waiver eligibility.
  - Dual-eligible individuals who are 21 and over covered by both Medicare and Medicaid
  - Individuals 21 and over who reside in a nursing facility
- The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:
  - Nursing facility resident, age 21 and over, who is federally recognized as a tribal member
  - Nursing facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE)

STAR+PLUS Eligibility

- ICF-IID Program and IDD Waiver Services
  - Individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program, or an IDD Waiver are eligible for Acute Care services through STAR+PLUS. These individuals will not be eligible for the HCBS STAR+PLUS Waiver Services while enrolled in the ICF-IID Program or an IDD Waiver.

- Medicaid for Breast and Cervical Cancer (MBCC)
  - STAR+PLUS Members between age 18 and 65 in active treatment for breast or cervical cancer, or certain precancerous conditions, determined eligible by HHSC's Breast and Cervical Cancer Services program and receives recertification for continued services every 6 months.

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.).

Long Term Services and Supports (LTSS)

- Both dual and non-dual STAR+PLUS members may qualify for LTSS. Services include:
  - Day Activity and Health Services (DAHS)
  - Primary Home Care

- Other services under the STAR+PLUS Home and Community-Based Services (HCBS) waiver include but are not limited to:
  - Personal Assistance Services
  - Adaptive aids
  - Assisted living
  - Emergency response services
  - Home delivered meals
  - Minor home modifications
  - Respite care

STAR+PLUS Medicare-Medicaid Plan (MMP)

STAR+PLUS MMP Eligibility

- A fully integrated managed care model for individuals 21 years of age and older who are enrolled in Medicare and Medicaid.
  - Eligible members are able to opt out of the MMP program
- Superior offers this program in Dallas and Hidalgo counties only.
- Individuals who meet all of the following criteria are eligible for STAR+PLUS MMP:
  - Age 21 or older at the time of enrollment
  - Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B
  - Required to receive their Medicaid benefits through the Superior STAR+PLUS
  - Reside in Bexar, Dallas or Hidalgo counties
- Superior covers:
  - All Medicare benefits, including parts A, B and D
  - Medicaid benefits, including LTSS
  - Flexible benefits
  - Supplemental Benefits

STAR Kids

STAR Kids Eligibility

- STAR Kids integrates the delivery of state plan services, behavioral health services and LTSS benefits for children and young adults age 20 and younger with disabilities.
- The following Medicaid-eligible individuals must enroll in the STAR Kids program:

  - Receive Supplemental Security Income (SSI) and SSI-related Medicaid
  - Receive SSI and Medicare
  - Receive Medically Dependent Children (MDCP) waiver services
  - Receive Intellectual and Developmental Disabilities (IDD) waiver services, including:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf-Blind with Multiple Disabilities (DBMD)
    - Home and Community-Based Services (HCS)
    - Texas Home Living (TxHmL)
  - Members who reside in a community-based intermediate care facility for individuals with intellectual disabilities (ICF-IID) or in a Nursing Facility.

STAR Health
(Foster Care)

STAR Health Eligibility

- Children and young adults:
  - In DFPS conservatorship
  - In kinship care
  - Aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement
  - Aged 18 through the month of their 21st birthday, who are Former Foster Care Child Members or who are participating in the Medicaid for Transitioning Foster Care Youth Program. To learn more, visit HHSC's Medicaid for transitioning and Former Foster Care Youth.
  - With an infant born to a mother who is enrolled in STAR Health
  - Through age 17 and young adults aged 18 through the month of their 21st birthday who are receiving Supplemental Security Income (SSI) or who were receiving Supplemental Income before becoming eligible for Adoption Assistance (AA)or Permanency Care Assistance (PCA)
  - Through age 17 and young adults aged 18 through the month of their 21st birthday who are enrolled in a 1915(c) Medicaid Waiver and AA or PCA. To learn more, visit HHSC's Adoption Assistance or Permanency Care Assistance.
  - Who are STAR Health members under 21 years of age will be disenrolled from Superior upon election of hospice
    - Hospice care and treatment services will be available to these individual through fee-for-service Medicaid

3 in 30

- 3 in 30 is a collaborative effort between the Texas Department of Family and Protective Services (DFPS), HHSC and Superior.
- 3 in 30 combines three separate, yet critical, tools for assessing the medical, behavioral, and developmental strengths and needs of children and youth in foster care, when entering DFPS conservatorship.
- Each assessment is a requirement set forth by Senate Bill 11. Together, the three assessments chart the path for ensuring STAR Health members get the care and services they need at the time they enter foster care.

3 in 30

- 3 Day Initial Medical Exam
  - Within 3 Business Days, children entering DFPS care must see a doctor to be checked for injuries or illnesses and get any treatments they need.
- Texas Child and Adolescent Needs and Strengths (CANS) 3.0 Assessment
  - Within 30 Days, children (3-17 years of age) must get a CANS 3.0 assessment. The CANS 3.0 is very similar to the CANS 2.0 in that it is still 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. The difference is that there are two additional modules – Medical Health and Exploitation.
- Texas Health Steps Medical Check-Up (also known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
  - Within 30 calendar days, children must see a Texas Health Steps doctor for a complete check-up with lab work. This makes sure:
    - Medical issues are addressed early
    - Kids are growing and developing as expected
    - Caregivers know how to support strong growth and development

CHIP (Children's Health Insurance Program) and CHIP Perinate

CHIP Eligibility

- 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 calendar days of enrollment, and at least every 12 months thereafter during the re-enrollment period for any reason.
- CHIP members must re-apply yearly on their original enrollment date.

CHIP Cost Sharing

- Most families in CHIP pay an annual enrollment fee to cover all children in the family (based on family income).
- The total amount that a family must contribute out-of-pocket is capped based on family income.
- CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency setting (based on family income).
- The amount of the co-pay is listed on the front of the member's ID card, or on the patient list located on Superior's Secure Provider Portal.

Medicaid and CHIP Benefits

Medicaid and CHIP Benefits

- Include, but are not limited to:
  - Medical and surgical services
  - Applied Behavioral Analysis (effective 2/1/2022)
  - Hospital services
  - Texas Health Steps
  - Transplants
  - Unlimited prescriptions
  - Durable Medical Equipment (DME)
  - Mental and behavioral health services
  - Maternity services
  - Dental and vision services
  - Therapy (Physical, Speech, Occupational)

CHIP Perinate

CHIP Perinate Eligibility

Unborn children of low-income pregnant women who do not qualify for Medicaid either due to citizenship status or whose income exceeds the minimum allowed to qualify for Coverage process once the child is born:

- CHIP Perinate Newborn
  - Category B: Lasts for 12 months from mother's eligibility determination date for babies born to mothers within 186%-<200% FPL
  - No co-pay
- Medicaid
  - Category A: Babies born to mothers at or below 185% of FPL
  - Coverage lasts for 12 months from baby's date of birth

CHIP Perinate Benefits

- Covered Services (Professional)
  - Up to 20 prenatal care visits (more if medically necessary with authorization).
  - Prescriptions based on CHIP formulary (DME is not a covered benefit for CHIP Perinate).
  - Case management and care coordination.
  - 3 ultrasounds of the baby when medically indicated.
  - Labor with delivery of child.
  - 2 postpartum visits within 60 Days of delivery; first postpartum visit must be after delivery global period (45 Days).

CHIP Perinate Benefits

- Covered Services (Hospital)
  - For women with income at 186% up to 200% FPL, all eligible hospital facilities and professional charges are covered by CHIP Perinate.
  - For women with income at or below 185% FPL, all eligible hospital. facilities charges are covered by TMHP, and professional charges are covered by the CHIP Perinate health plan.
- Non-Covered Services
  - A mother's hospital visits for any services not related to labor with delivery.
  - Services not related to a pregnancy diagnosis.
  - Supplies affiliated with certain diagnoses (e.g. DME supplies not covered for diabetes).
  - If mother fails to notify the state of the birth of the child, all services will be non-covered.
- Provider must call in authorizations for all deliveries regardless of member's income (FPL).

Helpful Billing Hints

- Prenatal visits
  - Initial visits bill with Evaluation and Management (E&M) codes (99201 - 99205) with modifier TH to indicate prenatal visit.
  - Subsequent visits bill with E&M codes (99211-99215) with modifier TH to indicate prenatal visits.
- Postpartum visits bill Current Procedural Terminology (CPT) code 59430.
- Three sonograms are allowed per pregnancy. Additional sonograms, with authorization, are covered if the patient has a high-risk diagnosis.
- Primary diagnosis for all covered services must be pregnancy-related (all other services are not covered benefits).

Ambetter from Superior HealthPlan

Health Insurance Marketplace

Ambetter Enrollment

- Annual open enrollment period
- Ambetter offers several levels of plan options, each one representing a different type of coverage.
  - Ambetter Premier (Silver and Gold)
  - Ambetter Value
- 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's Coverage Area Map.

Ambetter Value

- Value has 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 Health Value plan design differs in the following:
  - New for 2024, members will be assigned a PCP at the practitioner level.
  - Any specialty care rendered by a specialist outside of the PCP's 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, Ambulance 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 Benefits

- Essential Health Benefits (EHBs) are the same for every plan within the state. The EHBs outlined in the Affordable Care Act are:
  - Preventive and wellness services (covered at 100%)
  - Maternity and newborn care
  - Outpatient or ambulatory services
  - Emergency services
  - Prescription drugs
  - Laboratory services
  - Pediatric services
  - Mental health and substance abuse services
  - Hospitalization
  - Various therapy services (such as physical therapy) and devices

Wellcare By Allwell

Medicare Advantage

Medicare Advantage Special Needs Plan (D-SNP)

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

Wellcare By Allwell Benefits - DSNP

- All Part A and Part B benefits by Medicare
- Part B drugs – such as chemotherapy drugs
- Part D drugs – no deductible at network retail pharmacies or mail order*
- Additional benefits and services such as:
  - Dental
  - Vision
  - No Cost / Low-Cost PCP copay*
  - $0 generic prescription drugs
- For a summary of plan benefits, visit the Wellcare By Allwell website

Dependent on plan

Medicare Covered Services

- Covered Services include, but are not limited to:
  - Home Health Services
  - Behavioral Health
  - Hospital Inpatient/Outpatient
  - Lab and X-Ray
  - Medical Equipment and Supplies
  - Physician Services
  - Podiatry
  - Prescribed Medicines
  - Therapy Services
  - Annual Wellness Visit
  - Chiropractic Services

**Specific counties only*

Behavioral Health Benefits

Behavioral Health Benefits

- Traditional and Day Treatment 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
- Pharmacy Benefits - Prescription Drugs

Please note: The behavioral health benefits referenced above are not available for all products.

Case Management for Children and Pregnant Women (CPW)

- Superior is responsible for managing the delivery of Case Management for Children and Pregnant Women (CPW) services for Superior (STAR, STAR+PLUS, STAR Health, STAR Kids) and STAR+PLUS Medicare-Medicaid Plan (MMP) programs.
  - CPW services for STAR Health members are limited to members who are not in Department of Family and Protective Services (DFPS) conservatorship.
  - CPW services are available to STAR Health members who are in categories 3, 4, 5 and 6 of the target population.
- Authorization is not required for CPW Case Management Services.
- Specific documentation for the comprehensive visit and follow-up visits, the billable components of case management are required.

Case Management for Children and Pregnant Women (CPW)

- FQHCs may provide CPW Case Management services; however, must obtain approval from HHSC **and** complete HHSC Case Management Training.
- Providers that are interested in providing CPW services must complete pages 2 through 7 of the *Individual and Group Provider Credentialing Application (PDF)* found in the Credentialing section of Superior's Provider Forms webpage.
- For additional information on CPW Case Management Services please review the *Case Management for Children and Pregnant Women (CPW) Quick Reference Guide (PDF)* found in the *Quick Reference Guides & Contacts* section of Superior's Provider Resources webpage.

Medical Management

Prior Authorization Tool

- Procedures and/or services that require authorization can be found at:
  - Superior's Medicaid and CHIP Prior Authorization webpage.
  - Ambetter's Prior Authorization webpage.
  - Superior's Medicare Prior Authorization webpage.
  - Superior's STAR+PLUS MMP Prior Authorization webpage.

Authorization Request Response Times

Program	Authorization Type	TAT
STAR, STAR+PLUS, STAR Kids and STAR Health	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
CHIP and Medicaid	Urgent, Outpatient and Inpatient Elective	3 Calendar Days
CHIP and Medicaid	Inpatient	1 Business Day
STAR+PLUS MMP	Initial Concurrent	As soon as medically indicated, up to 3 calendar days
STAR+PLUS MMP	Urgent Expedited Authorization/ Ongoing Concurrent	1 Business Day
STAR+PLUS MMP	Standard Authorization	3 Business Days

Please note: Timeframes above are not applicable to emergent services.

Authorization Request Response Times

Program	Authorization Type	TAT
Wellcare By Allwell	Standard	Expeditiously as the member's health condition required, but no later than 14 Calendar Days after receipt of request
Wellcare By Allwell	Standard Extension	Up to 14 additional Calendar Days (not to exceed 28 Calendar Days from receipt of original request)
Wellcare By Allwell	Expedited	Expeditiously as the member's health condition requires, but no later than within 72 hours after receipt of request
Wellcare By Allwell	Expedited Extension	Add 11 Days up to 14 additional Calendar Days (not to exceed 17 Calendar Days after receipt of original request
Wellcare By Allwell	Initial Concurrent	As soon as medically indicated; up to 3 calendar days
Wellcare By Allwell	Ongoing Concurrent	As soon as medically indicated; usually within 1 Business Day of request depending on the plan's policy
Ambetter	Prospective/Urgent	Within the time appropriate to the circumstance, but no later than 72 hours from receipt of the request
Ambetter	Prospective/Non-Urgent	3 Calendar Days
Ambetter	Concurrent	24 Hours
Ambetter	Retrospective	30 Calendar Days

Prior Authorization Requests

- Authorizations for all products may be requested through Superior's web portal at: Provider.SuperiorHealthPlan.com.
- Forms are available on Superior's Provider Forms webpage or Ambetter.SuperiorHealthPlan.com.
  - Fax numbers:
    - Medicaid/CHIP:
      - Medical – Inpatient: 1-866-683-5632; Outpatient: 1-800-690-7030
      - Behavioral Health – Inpatient: 1-800-732-7562; Outpatient: 1-866-570-7517
    - STAR+PLUS MMP:
      - Medical – Inpatient: 1-877-259-6960; Outpatient: 1-877-808-9368
      - Behavioral Health – Inpatient: 1-866-900-6918; Outpatient: 1-855-772-7079
    - Ambetter:
      - Medical – Inpatient: 1-866-838-7615; Outpatient: 1-855-837-3447
      - Behavioral Health – Inpatient: 1-844-824-9016; Outpatient: 1-844-307-4442
    - Wellcare By Allwell:
      - Medical – Inpatient: 1-855-837-3535; Outpatient: 1-877-808-9368
      - Behavioral Health – Inpatient: 1-866-900-6918; Outpatient: 1-855-772-7079
- Providers can also call-in requests:
  - Medicaid/CHIP/Wellcare By Allwell/MMP – 1-800-218-7508
  - Ambetter - 1-877-687-1196

National Imaging Associates (NIA)

- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for several services, including:
  - Outpatient High-Tech Imaging Services for all products.
  - Non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR and STAR+PLUS members 21 years of age and older.
  - Outpatient physical, occupational and speech therapy treatment services for Superior Medicaid (STAR, STAR+PLUS non-HCBS waiver), CHIP and Ambetter members.
  - Effective 1/1/2024, Musculoskeletal Surgical procedures for Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids), CHIP, STAR+PLUS MMP, Wellcare By Allwell and Ambetter members.
- The ordering physician is responsible for obtaining an authorization by:
  - Accessing (formerly NIA, Inc.) Evolent's website
  - Calling 1-800-642-7554 (Medicaid); 1-866-214-1703 (Medicare) or 1-800-424-4916 (Ambetter)
- NIA QRGs and FAQs are available on Superior's Authorization Requirements webpage.

TurningPoint Healthcare Solutions

- Superior partners with TurningPoint Healthcare Solutions to process prior authorization requests for medical necessity and appropriate length of stay for Cardiac procedures and ENT surgeries for Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids), CHIP, Wellcare By Allwell and Ambetter members
- Emergency related procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
  - Web Portal Intake: TurningPoint Provider Login
  - Telephonic Intake: 1-855-253-1100
  - Facsimile Intake: 1-214-306-9323

Cultural Competency and Disability Sensitivity

Cultural Sensitivity

- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with patients, and the health and wellness of the patients themselves.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
  - Knowledge
    - Provider's self-understanding of race, ethnicity and influence.
    - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
  - Skills
    - Ability to communicate effectively with the use of cross-cultural interpreters.
    - Ability to utilize community resources.
  - Attitudes
    - Respect the importance of cultural forces.
    - Respect the importance of spiritual beliefs.

How Can Providers Help?

- Know your patients. Capture information about accommodations that might be required.
- Identify patients with limited health literacy.
- Use simple language, short sentences and define technical terms for patients.
- Supplement instructions with appropriate materials (videos, models, graphic materials, translated written materials, interpreting, etc.).
- Ask patients to explain your instructions (teach back method) or demonstrate the procedure.
- Ask questions that begin with “how” and “what,” rather than closed-ended yes/no questions.

How Can Providers Help?

- Organize information so that the most important points stand out and repeat this information.
- Reflect the age, cultural, ethnic and racial diversity of patients.
- Provide information in their primary language (for Limited English Proficiency [LEP] patients) or preferred alternate format, i.e. large print or braille.
- Improve the physical environment in your office by using universal symbols.
- Offer assistance with completing health-care forms.

Resources For Your Practice

- Complimentary Interpretation Services
  - Superior provides interpretation services to our providers at no cost. To obtain access to a telephonic interpreter, follow these steps:
    1. Use a phone in the exam room, call the Member Services number located on the back of the patient's Superior member ID card.
    2. Tell the representative that you need an interpreter in the desired language.
    3. When connected, use the speakerphone function to communicate with the patient.
- Cultural Sensitivity & Health Literacy Training
  - Superior has resources for providers regarding cultural competency and health literacy. This includes, but is not limited to:
    - Trainings and resources found on Superior's QI Program webpage.
    - Superior Provider Manuals found on Superior's Training and Manuals webpage.

Medicaid FQHC Billing Guidelines

FQHC Claims Filing

- All claims must be submitted on a CMS-1500 or 837P form
  - Forms can be found on Superior's Provider Forms webpage.
- All services provided in the FQHC should be billed with location code 50
  - If a service is provided outside of the FQHC, use the location code appropriate to where the service was provided.
- Modifiers:
  - All Evaluation and Management (E&M) services and T1015 must be billed with the modifier indictor that describes the type of provider rendering the service (AH, AJ, AM, SA, TD, TE, U1, U2 or U7).
  - Modifier 25 is not required for multiple encounters on the same day for the same patient; however, it is required with the appropriate vaccine administration codes.
  - Modifier TH must be submitted for all pre- and postnatal services and must be in the first modifier position.
  - Modifier EP must be submitted on the T1015 and the E&M service line for Texas Health Step services and any additional required modifier.

FQHC Claims Filing - Continued

- All Medicaid (STAR, STAR Health, STAR Kids and STAR+PLUS) and CHIP services provided in an FQHC must be billed with a T1015 service line.
  - Claims billed with location code 50 without a T1015 service line will not receive the Prospective Payment System (PPS) payment and may result in denial.
- The PPS rate should be entered in the charge field on the T1015 service line.
- National Drug Code (NDC) information is required to be billed on claims containing Clinician-Administered Drugs (CADs).
- Long-Acting Reversible Contraception (LARC) devices may be paid in addition to the provider's PPS encounter rate with the appropriate removal/insertion code.
  - These should be billed with the family planning visit E&M and diagnosis code, T1015 and the LARC device code. 58300 is considered informational.

FQHC Claims Filing – Sports Physicals

- Superior will reimburse sports physicals for eligible members:
  - STAR, STAR Health, STAR Kids and CHIP members only
  - 4-17 years of age (STAR and CHIP) and 4-18 years of age (STAR Health)
  - 1 per Calendar Year
- For prompt claim payment please follow these guidelines:
  - Diagnosis Code: Z02.5
  - Current Procedural Terminology (CPT) Codes: 99382-99385 or 99392-99395
- Billing and payment for sports physicals:
  - Sports physicals must be billed with the appropriate E&M and diagnosis code in the primary position. Sports physical claims should not be billed with T1015. This is an incorrectly billed claim and will result in denial.
- Reimbursement will be $35.00 (there is no co-pay).

Behavioral Health Claims

- Claims must be filed on a CMS-1500 claim form:
  - Using Location Code 50.
  - With a procedure code T1015 and all applicable modifiers (AH, AJ, AM, SA, TD, TE, U1, U2 or U7) in order to receive an encounter payment, and a PPS rate on first service line of the claim form, in addition to the appropriate procedure code: 90791, 90792, 90832, 90833*, 90834, 90836*, 90837, 90838*, 90846, 90847, 90853, 90899, 96116, 96130, 96132 or 96136.
- Behavioral diagnosis needs to be in first position to process to Behavioral Health platform.
- For Superior electronic claim submissions, ensure that your Electronic Data Interchange (EDI) and clearinghouse has the correct payor ID, 68068.

Please note: Providers will not be reimbursed an encounter rate without a face-to-face encounter procedure code on the claim.

Additional Claims Information

- For telehealth services, FQHC providers must bill the appropriate E&M procedure code, along with T1015.
- Claims need to be billed with place of service 50, along with the modifier 95 to indicate the telehealth services.
  - All other applicable modifiers must be billed as well.
- The following billing resources, are listed in *the Quick Reference Guides & Contacts* section of Superior's Provider Resources webpage.
  - FQHC Frequently Asked Questions (FAQ)
  - Quick Reference Guide (QRG)

Medicare FQHC Billing Guidelines

Medicare FQHC Claims Filing

- Medicare FQHC claims must be billed on a UB-04 with the following types of bills (TOBs):

Code	Description
771	Admit to Discharge
777	Adjustment
778	Cancel
770	No Payment
77Q	Reopening

Medicare FQHC Claims Filing

All claims must have the appropriate G-code for proper payment:

Code	Description	Revenue code
G0466	FQHC Visit New Patient	052X or 0519
G0467	FQHC Visit Established Patient	052X or 0519
G0468	FQCH Visit, Initial Preventative or Annual Wellness Visit	052X or 0519
G0469	FQHC Visit, Mental Health New Patient	0900 or 0519
G0470	FQHC Visit, Mental Health Established Patient	0900 or 0519

Visit the Centers for Medicare & Medicaid Services FQHC webpage to see the most recent payment rates.

PaySpan

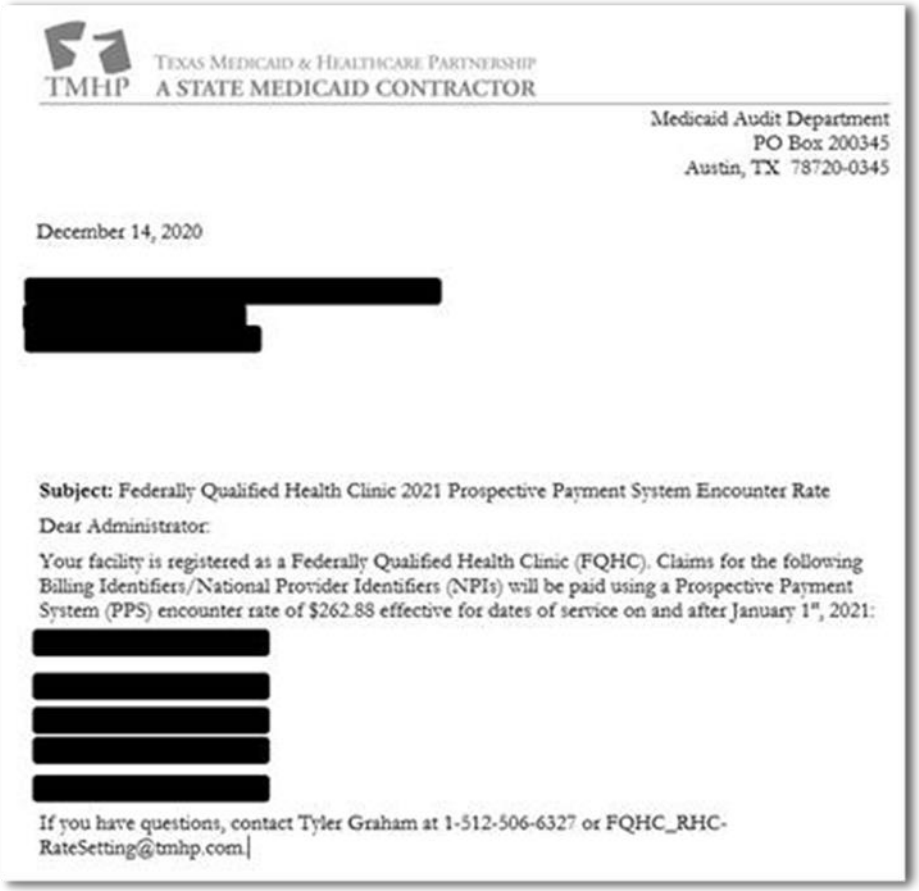
- Superior has partnered with PaySpan to offer expanded claim payment services.
  - Electronic Funds Transfer (EFT)
  - Online remittance advices (ERA's [Electronic Remittance Advice]/EOPs)
  - Health Insurance Portability Accountability Act (HIPAA) 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register by visiting the PaySpan Health webpage.
- For further information, contact PaySpan at 1-877-331-7154, or email ProvidersSupport@PaySpanHealth.com.

Medicaid Encounter Rate Process

Medicaid Encounter Rate Process

- FQHCs receive a letter from TMHP with their encounter rate.
- Once received, the FQHC is responsible for sending a copy of the encounter rate letter to the Superior Account Management team for update.
- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to PPS encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.

Medicaid Encounter Rate Letter Example



TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Medicaid Audit Department
PO Box 200345
Austin, TX 78720-0345

December 14, 2020

[redacted]

Subject: Federally Qualified Health Clinic 2021 Prospective Payment System Encounter Rate

Dear Administrator:

Your facility is registered as a Federally Qualified Health Clinic (FQHC). Claims for the following Billing Identifiers/National Provider Identifiers (NPIs) will be paid using a Prospective Payment System (PPS) encounter rate of $262.88 effective for dates of service on and after January 1st, 2021:

[redacted]

If you have questions, contact Tyler Graham at 1-512-506-6327 or FQHC_RHC-RateSetting@tmhp.com.

Corrected Claims and Appeals

Medicaid, CHIP and MMP

Corrected Claim

- A corrected claim is a correction or a change of information to a previously finalized clean claim in which additional information from the provider is required to perform the adjustment.
  - Must reference original claim number.
  - Must be submitted within 120 Calendar Days of adjudication paid date.
  - Can be submitted electronically, through your clearinghouse/Electronic Data Interchange (EDI) software or through Superior's Secure 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

Superior HealthPlan STAR+PLUS MMP
Attn: Claims - Correction
P.O. Box 4000
Farmington, MO 63640-4000

Appeals

- 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.
  - Must include Appeal Form:
    - This can be found on the *Claims* section of Superior's Provider Forms webpage.
    - Must include applicable documentation and information to support claim appeal.
  - Submit appeal within 120 Calendar Days from the date of adjudication or denial.
  - Can be submitted electronically through Superior's Secure Provider Portal or in writing.
- Claims submitted in writing should be sent to:

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

Superior HealthPlan STAR+PLUS MMP
Attn: Claims Appeals
P.O. Box 4000
Farmington, MO 63640-4000

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, Texas Medicaid Benefits Card (TMBC),TMHP documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing
  - Centene EDI acceptance reports showing the claim was accepted by Superior
  - Prior authorization number and/or form or fax

Member Balance Billing

- Providers may not bill members directly for covered services for Medicaid, CHIP or MMP.
- Superior reimburses only services that are medically necessary and a covered benefit.
- Superior Medicaid and CHIP Perinatal members do not have co-payments.
  - Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (please see “CHIP Benefits”).
- MMP providers must verify cost share each time a Superior member is scheduled to receive services.

Complaints and Appeals/Reconsiderations

Ambetter and Wellcare By Allwell

Ambetter Claims Reconsiderations and Disputes/Appeals

- A Request for Reconsideration is a communication from the provider about a disagreement with the original claim outcome (e.g. payment amount, denial reason, etc.).
  - Medical records are not typically required for a reconsideration, unless it relates to a code audit, a code edit or an authorization denial.
  - Providers may submit reconsiderations:
    - Via Provider Services
    - With the *Claim Dispute Form (PDF)* found on the *Claims and Claim Payment* section of Ambetter's Provider Resources webpage.
    - By sending a detailed written letter with the request to:

      Ambetter
      Claim Dispute
      PO Box 5000
      Farmington, MO 63640-5000
  - Providers will receive written notification of the decision within 30 Calendar Days of the dispute being received.

Ambetter Complaints

- A complaint is an expression of dissatisfaction about any aspect of Superior's administration.
  - Complaints can be submitted by members or providers. Ambetter will acknowledge receipt within 5 Business Days of receiving the complaint.
    - Ambetter will research and send a resolution letter with the outcome of the complaint within 30 Calendar Days.
  - No punitive action will be taken against a provider by Ambetter for acting as a member's representative.
  - Full details on Claim Reconsideration, Claim Dispute, Complaints and Appeals processes can be found in our Provider Manual on Ambetter's Provider Resources webpage.

Wellcare By Allwell Claims Reconsideration and Disputes

- A Request for Reconsideration is a communication from the provider about a disagreement with the manner in which a claim is processed.
  - Submit requests for reconsiderations to:
    Wellcare By Allwell
    Attn: Request for Reconsideration
    P.O. Box 3060
    Farmington, MO 63640-3822

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
  - Submit reconsiderations or disputes to:
    Wellcare By Allwell
    Attn: Claim Dispute
    P. O. Box 4000
    Farmington, MO 63640-4400

Ambetter Member Balance Billing

- Ambetter providers are prohibited from billing the member for any covered services except for copayments, coinsurance and deductibles.
- Contracted providers may only bill Ambetter members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered.
- Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call-in advance to cancel the appointment.

Wellcare By Allwell Member Balance Billing

- Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by Wellcare By Allwell.
- Providers may not seek payment from members for the difference between the billed charges and the contracted rate paid by Wellcare By Allwell.
- Contracted providers may only bill members for non-covered services if:
  - A request for prior authorization was denied by the plan and member received a written Notice of Denial of Medical Coverage in advance of receiving the service.
  - The member's Evidence of Coverage clearly states the item or service is never covered by the plan.

Secure Provider Portal

Superior Website and Secure Provider Portal

Secure Provider Portal Submit:

- Claims
- Adjusted claims
- COB claims
- Health Passport Information
- Notification of pregnancy
- Prior authorization requests
- Provider complaints
- Request for EOP
- Verify:
  - Claim status
  - Member eligibility

Superior's Provider Resources webpage:

- Provider directory
- Provider manual
- Provider training schedule
- Submit provider complaints
- Additional provider resources

How to Register for the Secure Provider Portal

- Visit Superior's Secure Provider Portal.
- Enter your email address, first and last name, language preference and password.
- Click on Create Account.
- You will receive an email to verify your account. You will then need to login to the portal to complete your registration.
- Each user within the provider's office must create his or her own use name and password.

Additional Secure Provider Portal 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

Health Passport

Health Passport

- Health Passport is a secure web-based application, for STAR Health providers, built using core clinical and claims information to deliver relevant health-care information when and where it is needed.
  - Providers may access Health Passport on Superior's Secure Provider Portal.
- 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

Health Passport: Modules

Health Passport modules include, but are not limited to:

- **Face Sheet**—An easy-to-read summary that includes member demographics, care gaps, Texas Health Steps (TH Steps) and last dental visit dates, active allergies, active medications and more.
- **Contacts**—Easily find a foster child's PCP, medical consenter, caregiver, caseworker and service coordinator contact information in one place.
- **Allergies**—Providers can use interactive fields to add or modify allergies at the point-of-care. Once an allergy is charted, it's instantly checked for medication interactions.
- **Assessments**—Providers can document TH Steps, dental, and behavioral health forms directly online. Mailing or faxing in documents critical to patient care for display is still available.
- **Growth Chart**—Providers can chart weight, height, length and head circumference at the point of care to track growth of infants and children.

Health Passport: Modules

- **Immunizations**—A comprehensive list of a person's immunizations collected from ImmTrac.
- **Labs**—All lab results are made available, where providers typically only have access to the lab results, they've requested.
- **Medication History**—A summary of medications filled and access to more detail, including name of the prescription, the prescribing clinician, date filled, and dosage. Indicators representing drug-drug, drug-allergy and drug-food interactions appear, when applicable, as soon as new medications or allergies are added to the member record.
- **Patient History**—Past visits with details that include the description of service, treating provider, diagnosis and the service date.
- **Admit Discharge and Transfer (ADT)** – All users can view a patient's ADT data in real time from Health Information Exchanges (HIEs) services.
- **Appointments**—On this module, users are able to add, modify and cancel their own appointments entries.

Additional Resources

- Please contact the Health Passport Support Desk with any questions:
  - Call: 1-866-714-7996
  - Email: TX.PassportAdministration@SuperiorHealthPlan.com
- For more information on Health Passport and the resources provided, please visit Superior's Health Passport webpage.
- Providers can schedule a live demo of Health Passport by reaching out to their local Account Manager.

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 contact your designated Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services:
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (STAR Health, Ambetter and Wellcare By Allwell until 6:00 p.m.), by calling:
    - Medicaid/CHIP/MMP: 1-877-391-5921
    - Ambetter: 1-877-687-1196
    - Wellcare By Allwell: 1-800-977-7522 (HMO)
      1-877-935-8023 (HMO SNP)

Contact Us

- 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
- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (Ambetter, MMP and Wellcare By Allwell until 8:00 p.m.), by calling:
  - STAR 1-800-783-5386
  - CHIP/CHIP Perinate: 1-800-783-5386
  - STAR+PLUS: 1-877-277-9772
  - STAR+PLUS MMP: 1-866-896-1844
  - STAR Kids: 1-844-590-4883
  - STAR Health: 1-866-912-6283
  - Ambetter 1-877-687-1196
  - Wellcare By Allwell (HMO) 1-844-796-6811
  - Wellcare By Allwell (SNP) 1-877-935-8023

Questions and Answers

Thank you for attending!