Hospital 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
- 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 Comission (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/CHIP Perinate
- In addition to the products above, Superior also offers the following, in limited-service areas:
  - Health Insurance Marketplace (Ambetter Health)
  - Medicare Advantage (Wellcare By Allwell)
- Superior is among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings.

Verify Eligibility

- Texas Medicaid Benefits Card
- Your Texas Benefits webpage
- Superior's ID Card
- 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 Health: 1-877-687-1196
  - Wellcare By Allwell (HMO): 1-844-796-6811
  - Wellcare By Allwell (HMO SNP): 1-877-935-8023

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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
- Adoption Assistance or Permanency Care Assistance (AAPCA)
  - Children who are adopted from foster care; or
  - Children who were in foster care but establish a permanent home with family members because they could not be reunited with their parents.

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STAR+PLUS

STAR+PLUS Eligibility

- 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 considered Medical Assistance Only (MAO) for purpose 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, 21 years of age and older, who is federally recognized as a tribal member
  - Nursing facility resident, 21 years of age and older, who receives services through the Program of All Inclusive Care for the Elderly (PACE)

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.).

SNF Benefits for Dual-Eligible Members

- Medicare is the primary payor for all acute care services (e.g., Primary Care Physician [PCP], hospital, outpatient services), Skilled Nursing Facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the Resource Utilization Group (RUG).
- STAR+PLUS (Superior).
  - Covers Vent and Trach add-on services.
  - Is the primary payor for the co-insurance for the SNF Unit Rate for days 21-100 (if the stay meets qualifying hospital stay criteria and skillable needs) and add-on services.
  - Is the primary payor for the Nursing Facility Unit Rate starting day 101.

LTSS

- Both dual and non-dual STAR+PLUS members may qualify for Long Term Services and Supports (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

- Individuals who meet all of the following criteria will be eligible for STAR+PLUS MMP:
  - 21 years of age or older at the time of enrollment
  - Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B
  - Enrolled in the Superior STAR+PLUS Medicaid program
  - Reside in Bexar, Dallas or Hidalgo Counties
    - (Note: The MMP program is available in 6 counties; these are the 3 which Superior services).
- Not included are individuals who reside in Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICF/IID), and individuals with developmental disabilities who get services through one of these waivers:
  - Community Living Assistance and Support Services (CLASS)
  - Deaf Blind with Multiple Disabilities Program (DBMD)
  - Home and Community-based Services (HSC)
  - Texas Home Living (TxHmL)

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STAR Kids

STAR Kids Eligibility

- Medicaid populations who must participate in STAR Kids include children and young adults with disabilities, special needs or chronic care conditions who are 20 years of age and younger, and receive:

  - Social Security Income (SSI) and SSI-related Medicaid
  - SSI and Medicare
  - Medically Dependent Children (MDCP) Waiver program
  - Waiver programs:
    - Youth Empowerment Services (YES) waiver services
    - IDD waiver services (e.g., CLASS, DBMD, HCBS, TxHmL)
    - Members who reside in community-based ICF-IID or in Nursing Facilities (NF)

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STAR Health (Foster Care)

STAR Health Eligibility

- Children and young adults:
  - In DFPS conservatorship.
  - In kinship care.
  - Young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement.
  - Young adults 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 webpage.
  - An infant born to a mother who is enrolled in STAR Health
  - Children 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).
  - Children through age 17 and young adults aged 18 through the month of their 21st 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 webpage.
  - 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.

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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 Perinate (Unborn Child)

- Coverage for pregnant woman (unborn child):
  - Families with income at or below 185% FPL:
    - Facility charges are not covered by Superior – Bill TMHP.
    - Newborn qualifies for Medicaid coverage once born.
  - Families with income above 186-200% FPL:
    - Facility charges associated labor and delivery until birth are covered by Superior.
    - Newborn qualifies as CHIP Perinate Newborn once born.
- Providers must notify Superior of admissions for all CHIP Perinate deliveries regardless of FPL.

CHIP Perinate Birth Reporting

- Mothers will report the birth through the Emergency Medicaid Form H3038-P. T access this form visit HHSC's Form H3038-P, CHIP Perinatal - Emergency Medical Services Certification webpage.
- The same form is used as an indicator for newborn to be placed on Medicaid.
- To ensure payment, the hospital also may fax the completed form to 1-877-542-5951.
- Mothers must notify CHIP Perinate of the birth by calling
- 1-877-KIDS-NOW (1-877-543-7669). The following information must be provided:
  - Date baby was born
  - Baby's gender
  - Baby's name

CHIP Perinate Hospital Billing

- Mother is <=185% (Category A) and form H3038-P is not submitted:
  - Emergency Medicaid cannot be established for the Mother or for the Newborn from the date of birth for 12 months of continuous Medicaid coverage.
  - A new application for assistance is required if Form H3038-P is not submitted within 90 Days of delivery.
  - No retroactive charges would be paid.
- Mother is 186%-200% FPL (Category B):
  - Superior pays for hospital and professional charges.

Covered Benefits – Medicaid, CHIP and STAR+PLUS MMP

Medicaid, STAR+PLUS MMP and CHIP Benefits

- Include, but are not limited to:
  - Ambulance services
  - Hospital Services
  - Behavioral health services
  - Birthing center services
  - Cancer screening and treatment
  - Dialysis
  - Durable medical equipment and supplies
  - Emergency services
  - Laboratory
  - Medical checkups
  - Podiatry services
  - Prenatal care
  - Radiology, imaging and x-rays
  - Specialty physician services
  - Prescription drugs

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.

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Ambetter Health
(Health Insurance Marketplace)

Ambetter Health Enrollment

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

Ambetter Health Value

- Ambetter Health Value uses a tailored network approach to offer Ambetter Health's robust benefits at budget-family premiums to members.
- 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:
  - Preferred PCP groups which members will be able to utilize as a medical home.
    - ID Cards will display "**Ambetter Value Medical Group**" or **"Ambetter Value CH Provider Partner".**
  - Any specialty care rendered by a specialist outside of the preferred PCP groups 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, Durable Medical Equipment, 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 Virtual Access

- Ambetter Virtual Access leans into the changing dynamics of how providers are delivering care, and how members are seeking care, increasing access to primary and urgent care services in a nimble way.
- Ambetter Virtual Access most closely mirrors the network offered within Silver and Gold.
  - 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 to which members will automatically be assigned.
    - Members under the age of 18 are the exception as they will be assigned to a local PCP.
  - Beginning in 2023 members will be utilizing a new Teladoc application that can be downloaded on a phone or table or by visiting the Teladoc Health Ambetter Virtual Access webpage.
  - Teladoc (or local PCP) will be responsible to submit a referral to Ambetter in order for any specialty care provider to render services to our members.

Ambetter Virtual Access

- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Durable Medical Equipment, Ambulance, 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.
- The network centers on an online, easily accessible medical home offering, with key features such as:
  - Creates a patient-centered care plan within the app.
  - Easy to access, member-friendly reminders for follow-ups, picking up prescriptions, etc.
  - Full incorporation of virtual behavioral health providers.
- In Texas, members will be enrolled in plans that require referrals. It is possible that providers may see Virtual Access members from other states with a different referral requirement.
  - Always check the member's ID card to determine if a referral is or is not required.

Ambetter Health Benefits

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- 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%)
  - Chronic disease management
  - Maternity and newborn care
  - Pediatric services, including dental and vision care
    - Pediatric dental services may be separately provided through a stand-alone dental plan that is certified by the Marketplace
  - Outpatient or ambulatory services
  - Laboratory services
  - Rehabilitative and habilitative services and devices
  - Hospitalization
  - Emergency services
  - Mental health and substance use services, both inpatient and outpatient
  - Prescription drugs

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Wellcare By Allwell

Medicare Advantage(HMO)
Medicare Advantage Special Needs Plan (SNP)

Wellcare By Allwell (HMO and HMO SNP) Eligibility

- Wellcare By Allwell (HMO and HMO SNP) 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 SNP:** Individuals who qualify for Medicaid coverage through the state of Texas and are eligible for Medicare.
  - **HMO/HMO SNP:** Enrollees must also live in a county offering their selected plan.

Wellcare By Allwell Benefits

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Wellcare By Allwell covers:

- All Part A and Part B benefits by Medicare.
- Part B drugs – such as chemotherapy drugs.
  - Part D drugs – available at network retail pharmacies or mail order (deductibles may apply for HMO members).
- Additional benefits and services such as wellness programs, over-the-counter items and mental health services. For a summary of plan benefits, visit the Wellcare By Allwell website.
- For HMO SNP **(DSNP)** members: Acute Medicaid services not covered by Medicare.
  - Medicare deductibles and coinsurance are covered by Medicaid.

Medicare Covered Services

- Covered Services include, but are not limited to:
  - Ambulance
  - Behavioral Health
  - Dental*
  - Hearing
  - Hospital Inpatient/Outpatient
  - Lab and X-Ray
  - Medical Equipment and Supplies
  - Physician
  - Podiatry
  - Prescribed Medicines
  - Therapy
  - Transportation*
  - Vision*
  - Wellness Programs

**Specific counties only*

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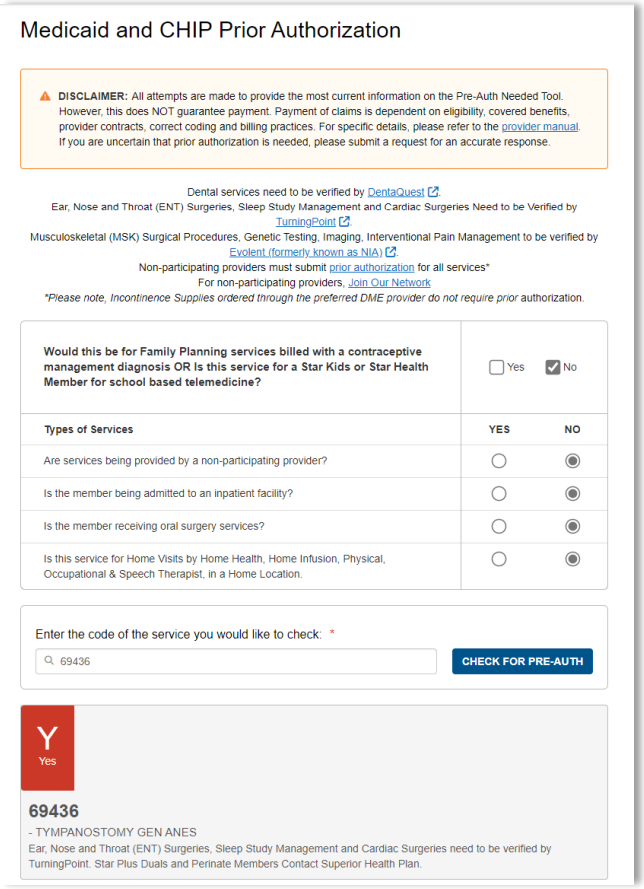
Medical Management

Prior Authorization Tool

- Use the Pre-Auth Needed Tool to quickly determine if a service or procedure requires prior authorization.

- Pre-Auth Needed tools can be found under the *Prior Authorization Electronic Pre-Screen Look-up Tools* section of Superior's Authorization Requirements webpage.



Prior Authorization Requests

- Authorizations for all products may be requested through Superior's Secure Provider Portal.
- Forms are available on our website for providers to fax on Superior's Provider Forms webpage or Ambetter's Provider Resources webpage.
- Providers can also call-in requests:
  - Medicaid/CHIP/Wellcare By Allwell/MMP
    - 1-800-218-7508 (Physical Health)
    - 1-844-744-5315 (Behavioral Health)
  - Ambetter Health
    - 1-877-687-1196 (Physical or Behavioral Health)

Medicaid/CHIP Prior Authorization

Emergent Inpatient Requests

- Must be submitted the next Business Day following admission.

Regions	Fax
Travis (Austin)	1-877-650-6939
Bexar (San Antonio)	1-877-650-6942
Nueces (Corpus Christi)	1-877-650-6940
El Paso	1-877-650-6941
Lubbock/Amarillo	1-866-865-4385
Dallas	1-855-707-5480
Hidalgo	1-877-212-6661
STAR RSA/CHIP RSA	1-877-505-0823
Behavioral Health	1-800-732-7562

Clinical Submission

- Clinical submission for inpatient requests should include:
  - Member's history and physical
  - Physician's orders
  - Physician's progress notes
  - Medication Administration Record (MAR)
  - Lab results
  - Radiology reports
  - Plan of care
  - Discharge planning
  - Level of care (med/surg, intermediate/ICU)
- Superior uses InterQual criterial to meet admission and continued stay criteria.

Clinical Submission

Medicaid/CHIP

- Clinical submission may be made by fax to:

Region	Fax
Austin (Travis Region)	1-877-264-6547
Corpus Christi (Nueces Region)	1-866-912-6291
Dallas Region	1-855-232-3606
El Paso/Lubbock/Amarillo Region	1-866-683-5620
San Antonio Region (Bexar)	1-866-683-5632
Hidalgo Region	1-866-895-4080
STAR RSA/CHIP RSA	1-877-804-5268

Medical Necessity Reviews

Clinical submission is due by 2:00 p.m., the next Business Day following the request for authorization. If received on time, it is then reviewed by a Concurrent Review Nurse.

- If medical necessity is met:
  - Admission or continued stay will be approved at the set days determined by the Concurrent Review Nurse.
  - A letter of approval will be sent to the facility addressed to the facility and physician.
- If medical necessity is not met:
  - A medical necessity review will be sent to the Medical Director for determination.

If clinical submission is not received by the deadline, the request for authorization will be sent to the Medical Director for medical necessity review.

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
  - Physical Occupational and Speech Therapy (STAR, STAR+PLUS* and CHIP only)
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
- 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 authorization; however, prior authorization and/or notification of admission is still required through Superior.
  - Observation Imaging Services also do not require authorization
- To obtain authorization through NIA, visit RadMD.com or call:
  - Medicaid: 1-800-642-7554
  - Medicare: 1-866-214-1703
  - Ambetter: 1-800-424-4916
- Claims should still be submitted to Superior for processing.

*For non-STAR+PLUS HCBS Waiver Members

TurningPoint Healthcare Solutions

- Superior partners with TurningPoint Healthcare Solutions 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 authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- **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

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.
- More information regarding Cultural Sensitivity can be found in the Provider Manual on Superior's Training and Manuals webpage.

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).
- Improve the physical environment in your office by using universal symbols.
- Offer assistance with completing health-care forms.

Hospital Billing Guidelines

Present on Admission

- Present on Admission (POA) – present at time the order for inpatient admission occurs.
- Conditions that are considered POA could include, but are not limited to, conditions that develop during:
  - An outpatient encounter
  - Emergency department visits
  - Outpatient surgery
  - Observation
- POA value is mandatory for inpatient hospital claims using prospective payment
- For a list of POA Indicators visit Centers for Medicare & Medicaid Services (CMS) Coding webpage.
- For more information on POA, see the **Inpatients and Outpatient Hospital Services Handbook** on TMHP's Texas Medicaid Provider Procedures Manual.

Observation

- Round clock times to beginning and end of the nearest hour. Partial units should be rounded up or down.
- 1 hour = 1 unit
- Observation units over 48 will be denied.
- Date of admission should be the date the member was admitted to the hospital.
- ER and observation services may be reimbursed separately as outpatient services if:
  - Member is admitted >24 hours after presenting in ER without being placed in observation status; or
  - Member is admitted >48 hours after being placed on observation status.

Spell of Illness

- Spell of Illness applies to STAR+PLUS and STAR Health members 21 years of age and older and refers to 30 Days of inpatient hospital care.
  - May accrue intermittently or consecutively
- After 30 Days, reimbursement for additional care isn't considered until member has been out of acute care for 60 consecutive Days.
- A provider is allowed to bill a client without obtaining a signed Client Acknowledgment Statement for all services incurred on noncovered days because of eligibility or spell of illness limitation. Total client liability is determined by reviewing the itemized statement and identifying specific charges incurred on the noncovered days.
- The following diagnoses will remove the Spell of Illness limitation for the entire inpatient hospital stay:
  - Bipolar I and Bipolar II disorder
  - Major depressive disorder
  - Schizophreniform
  - Schizoaffective disorder
  - Schizophrenia

Span of Coverage

- The payment responsibility for hospital facility charges when there are Medicaid member enrollment changes during the hospital stay.
- The previous payer (former Managed Care Organization [MCO] or Fee For Service [FFS]) remains responsible for the hospital facility charge until discharge, transfer or loss of Medicaid eligibility.
- A Medicaid member enrollment change is any change in managed care enrollment, including:
  - Member moves from fee-for-service (FFS) to managed care.
  - Member moves from managed care to FFS.
  - Member moves between managed care organizations (MCOs) in the same managed care program (i.e., STAR, STAR Health, STAR Kids, STAR+PLUS).
  - Member moves between managed care programs.

Span of Coverage

- When an enrollment change occurs while a member is in the hospital:
  - The previous payer (former MCO or FFS) responsible for the hospital facility charge until discharge, transfer or loss of Medicaid eligibility.
  - The current payer (new MCO or FFS) is responsible for all other covered services beginning on the effective date of the enrollment change.
- **Discharge** - formal release of a member from an Inpatient Hospital stay.
  - Movement or Transfer from one Acute Care Hospital or Long-Term Care Hospital/facility and readmission to another within 24 hours for continued treatment is not a discharge.
- **Transfer** - movement of the Member from one Acute Care Hospital or Long-Term Care Hospital/facility and readmission to another Acute Care Hospital or Long-Term Care Hospital or facility within 24 hours for continued treatment.

Span of Coverage

- STAR and STAR+PLUS:
  - Specific to stays in a single hospital **without transfers.**
  - When there is a hospital transfer after the member's enrollment change:
    - Span of Coverage no longer applies.
    - The MCO in which the member is enrolled is responsible for the facility stay for the 'transferred to' facility.
- STAR Health, STAR Kids, STAR+PLUS MMP:
  - Span of Coverage guidelines for STAR Kids, STAR Health and Dual Demonstration include "transfer" under the definition of discharge.

Span of Coverage - Authorization of Hospital Transfers

- If the member is in FFS at the time of the transfer request:
  - TMHP makes the authorization determination for transfer to the second hospital.
- If the member is in managed care at the time of the transfer request:
  - The MCO with which the member is enrolled at the time of the transfer request makes the authorization determination for transfer to the second hospital.
- If there is an enrollment change between the date of authorization and the date of transfer:
  - The new MCO must honor the authorization of the previous payer (FFS or former MCO).

Behavioral Health Retrospective Utilization Review

- Superior conducts retrospective utilization review for inpatient behavioral health admissions for members.
- Notification of admission is required at the time of admission.
  - Lack of notification may result in a contractual denial for failure to comply.
- To facilitate the retrospective review, clinical documentation to support the medical necessity of the inpatient admission must be submitted with the claims for the inpatient stay.
- Superior will send a request for medical records if not received with the claim.
  - The facility will be required to submit the records within 5 Business Days of the request.
  - If medical records are not included with the claim, Superior will review the admission to determine medical necessity based upon any clinical information available for the admission.

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Claims and Payment Processing

Claim Filing Reminders

- Claims must be filed within 95 Calendar Days from the Date of Service (DOS):
  - Filed on CMS-1450/UB-04 or CMS 1500 (HCFA)
  - Filed electronically through clearinghouse
  - Filed directly through Superior's Provider Portal
- Claims must be completed in accordance with Medicaid billing guidelines
- The corrected claim number must be inserted in field 64 of the UB-04 or field 22 of the HCFA 1500 forms. The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 or field 22 on the HCFA 1500 forms
- Frequency/resubmission codes can be found:
  - For 1500 Claim Forms visit National Uniform Claim Committee 1500 Claim Form Reference Instruction Manual
  - For UB-04 Claim Forms visit National Uniform Billing Committee Resources webpage
    Please note: Omission of these data elements may result in denials

Claim Filing Reminders

- All member and provider information must be completed.
- Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved.
- Claims can be submitted electronically through Superior's Secure Provider Portal, through a clearinghouse or on paper.
  - Visit the web for a list of our Trading Partners visit Superior Billing and Coding webpage
    - Superior Payer ID 68069 (medical) and 68068 (Medicaid/CHIP behavioral health)
- Mailing Addresses (Paper Claims):

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

Behavioral Health Services:
Superior HealthPlan
P.O. Box 6300
Farmington, MO 63640-3806

Ambetter
Attn: Claims
P.O. Box 5010
Farmington, MO 64640-5010

Wellcare By Allwell
Attn: Claims
P. O. Box 3060
Farmington, MO 63640-3822

Corrected Claims and Appeals (Medicaid/CHIP/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 (PDF)** form found under the *Claims* section of Superior's Provider Forms webpage 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 **Claims Appeal (PDF) f**orm found under the *Claims* section on Superior's Provider Forms webpage.
  - Must include applicable documentation and information to support claim appeal.
    - See next slide for documentation examples
  - 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.
  - All claim appeals must be finalized within 24 months from the date of discharge.
- 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), Texas Medicaid and Healthcare Partnership (TMHP) documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing.
  - Centene EDI acceptance reports showing the claim was accepted by Superior.
  - Prior authorization number and/or form or fax.

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.

Common Billing Errors

- Member name or date of birth (DOB) not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- First claim submission filed on a photo-copied claim form (not the original red claim form)
- Billed days not matching authorized days
- Incorrect/missing taxonomy codes
- Inappropriate modifiers
- Diagnosis code not to the highest degree of specificity
- Missing/Invalid National Drug Code (NDC) number(s)

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 manner in which a claim was processed.
  - 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)** under the *Claims and Claim Payment* section of Ambetter's Provider Resources webpage.
    - By sending a detailed written letter with the request.

Ambetter Claims Reconsiderations and Disputes/Appeals

- A Claim Dispute/Claim Appeal is only used when a provider has received an unsatisfactory response to a request for reconsideration.
  - The dispute must be submitted using the **Claim Dispute Form (PDF)** under the *Claims and Claim Payment* section of Ambetter's Provider Resources webpage.
  - The completed form should be mailed 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 under the *Reference Materials* section of 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.
- 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.

Superior Secure Provider Portal

Superior Website

- Visit Superior's website to view:
  - Links for additional provider resources
  - Provider directory
  - Provider manuals
  - Provider training materials and videos
  - Provider training schedule
  - How to locate your Account Manager

Superior Secure Provider Portal

- Visit Superior's Secure Provider Portal to:

Submit:

- Adjusted Claims
- Claims
- Coordination of Benefits (COB) Claims
- Notification of Pregnancy
- Prior Authorization Requests
- Provider Complaints
- Appeals/Reconsiderations

Verify:

- Claim Status
- Member Eligibility

View:

- Claim Editing Software
- Practice Guidelines and standards
- Explanation of payments
  - How to Locate an Explanation of Payment Using Superior's Secure Provider Portal (YouTube)

How to Register for the Secure Provider Portal

- Visit Superior's Secure Provider Portal.
- Enter your email, first and last name, preferred language and create your password.
- Each user within the provider's office must create his or her own username and password.
- For questions or issues regarding the portal, contact the 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 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 Texas Health 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.
- **ADT Notifications** – Access Admit Discharge and Transfer data
- **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

Account Management

- Account Managers are here to assist you with:
  - Face-to-face orientations
  - Secure Provider Portal training
  - Office visits to review ongoing claim trends and quality performance reports
- For any questions, or to schedule a training, you may contact our Hospital Account Management team at AM_Hospitals@SuperiorHealthPlan.com

Provider Services

- The Provider Services staff can help you with:
  - Answering questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Locating your Service Coordinator and Account Manager
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (STAR Health and Ambetter until 6:00 p.m.), by calling:
  - STAR/CHIP/STAR+PLUS/MMP/STAR Kids/STAR Health: 1-877-391-5921
  - Ambetter: 1-877-687-1196
  - Wellcare By Allwell (HMO): 1-800-977-7522
  - Wellcare By Allwell (HMO SNP): 1-877-935-8023

Member Services

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

Member Services

- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (unless otherwise noted), by calling:
  - STAR: 1-800-783-5386
  - CHIP/CHIP Perinate: 1-800-783-5386
  - STAR+PLUS: 1-866-516-4501
  - STAR+PLUS MMP (8:00 a.m. to 8:00 p.m.): 1-866-896-1844
  - STAR Kids: 1-844-590-4883
  - STAR Health (8:00 a.m. to 9:00 p.m.): 1-866-912-6283
  - Ambetter Health (8:00 a.m. to 8:00 p.m.): 1-877-687-1196
  - Wellcare By Allwell (HMO) (8:00 a.m. to 8:00 p.m.): 1-844-796-6811
  - Wellcare By Allwell (HMO SNP) (8:00 a.m. to 8:00 p.m.): 1-877-935-8023

Medicaid, CHIP and MMP Provider Complaints

- Provider complaints can be submitted in writing, verbally or online.
  - Mail:
    Superior HealthPlan
    Attn: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
  - Fax:
    Attn: Complaint Department
    1-866-683-5369
  - Verbally:
    During a face-to-face interaction/visit or telephone call into any Superior department.
  - Superior Online Complaint Form
- The complaint form can be printed, completed and faxed or mailed to Superior for resolution response.
  - Form can be found under *Filing Provider Complaints* section of the Superior's Complaint Procedures webpage.

Ambetter and Wellcare By Allwell Complaints

Ambetter Complaints

- Medical and Behavioral Claim disputes and appeals must be submitted in writing and mailed to:

  Ambetter
  P.O. Box 5000
  Farmington, MO 63640-5000

- Non-claim related complaints/grievances:

  Ambetter
  ATTN: Appeals
  Complaint Department
  5900 E. Ben White Blvd
  Austin, TX 78741

Wellcare By Allwell Complaints

- Mail:

  Wellcare By Allwell Complaint Department
  5900 E. Ben White Blvd
  Austin, TX 78741

- Verbally:
  - During a face-to-face interaction/visit or telephone call into any Superior department.

Compliance

Health Insurance Portability Accountability Act (HIPAA) of 1996:

- Providers and contractors are required to comply with HIPAA guidelines found on the HHS Office for Civil Rights (OCR) webpage.
- Fraud, Waste and Abuse (Claims/Eligibility):
  - Providers and contractors are all required to comply with state and federal provisions.
  - To report Fraud, Waste and Abuse, call the numbers listed below:
    - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
    - Texas Attorney General Medicaid Fraud Control Hotline: 1-800-252-8011
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664

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Superior HealthPlan Partners

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 on the PaySpan website.
- For further information, contact PaySpan at:
  - Phone: 1-877-331-7154
  - Email: ProvidersSupport@PaySpanHealth.com.

ICRS/Cotiviti

- Inpatient Claims Review Services (ICRS) is a nationwide health-care cost management company specializing in the review of inpatient claims. Superior contracts with ICRS to provide inpatient Diagnosis Related Group validation.
- Providers will receive a letter from ICRS requesting medical records.
  - The letter will provide detailed information explaining the request is to audit the DRG and facility service type.
- ICRS will then notify the provider of the results of the audit via mail.
- If you have questions regarding an audit, please call ICRS Provider Services at 1-770-379-2322 (Monday through Friday, 8 a.m. to 5 p.m. EST).

Specialty Companies/Vendors

Dental Services – DentaQuest Website: DentaQuest website Phone: 1-800-516-0165	**National Imaging Associates** Website: Evolent website Phone: 1-800-642-7554 (Medicaid) 1-866-214-1703 (Medicare) 1-800-424-4916 (Ambetter)
Pharmacy Services – Express Scripts, Inc. (Effective 1/1/24) Phone: 1-833-750-4300 Fax: 1-800-837-0959	**Vision Services – Envolve Vision** Website: Envolve website Phone: 1-888-756-8768
24/7 Nurse Advice Line Phone: 1-800-783-5386	**TurningPoing HealthCare Solutions** Email: Providersupport@turningpoint-healthcare.com Phone: 1-855-336-4391

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Questions and Answers

Thank you for attending!