Behavioral Health Billing Clinic

STAR, STAR Health, STAR Kids, STAR+PLUS (non-nursing facility) and CHIP

Provider Training

Agenda

- Benefits & Services
- Verifying Eligibility
- Authorizations & Medical Necessity
- Claim Submissions
- Electronic Payments & Remittance
- Telemedicine & Telehealth
- Billing by service type
- MHR/TCM Services
- Applied Behavior Analysis
- Case Mgmt for Pregnant Women
- Trauma informed Care APM Star Health
- Health Passport
- Fraud, Waste and Abuse
- Secure Provider Portals and Website
- Quality Improvement
- Provider Responsibilities

Benefits and Services

Behavioral Health Benefits

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

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

Verifying Eligibility

Verify Eligibility

- Texas Medicaid Benefit Card (TMBC) (STAR Only)
  - TexMedConnect: www.TMHP.com/pages/edi/edi_texmedconnect.aspx.
- Availity Provider Portal: Availity Essentials
- Secure Provider Portal: Provider.SuperiorHealthPlan.com.
- Contact Member Services:
  - STAR, CHIP: 1-800-783-5386
  - STAR Health: 1-866-912-6283
  - STAR Kids: 1-844-590-4883
  - STAR+PLUS: 1-877-277-9772
- Verify eligibility the first of each month using the provider portal or by contacting Member Services.
- Viewing the member's Superior issued ID card (Member ID card is not a guarantee of enrollment or payment).

Authorizations & Medical Necessity

Behavioral Health Authorizations

Providers can submit authorizations via:

- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Availity Provider Portal: Availity Essentials
- Phone: 1-844-744-5315
- Fax:
  - Inpatient: 1-800-732-7562
  - Outpatient: 1-866-570-7517

Superior HealthPlan contracts with several licensed Utilization Review Agents (URAs) FAQs and Information for delegated URAs are posted on our website: Prior Authorization | Superior HealthPlan

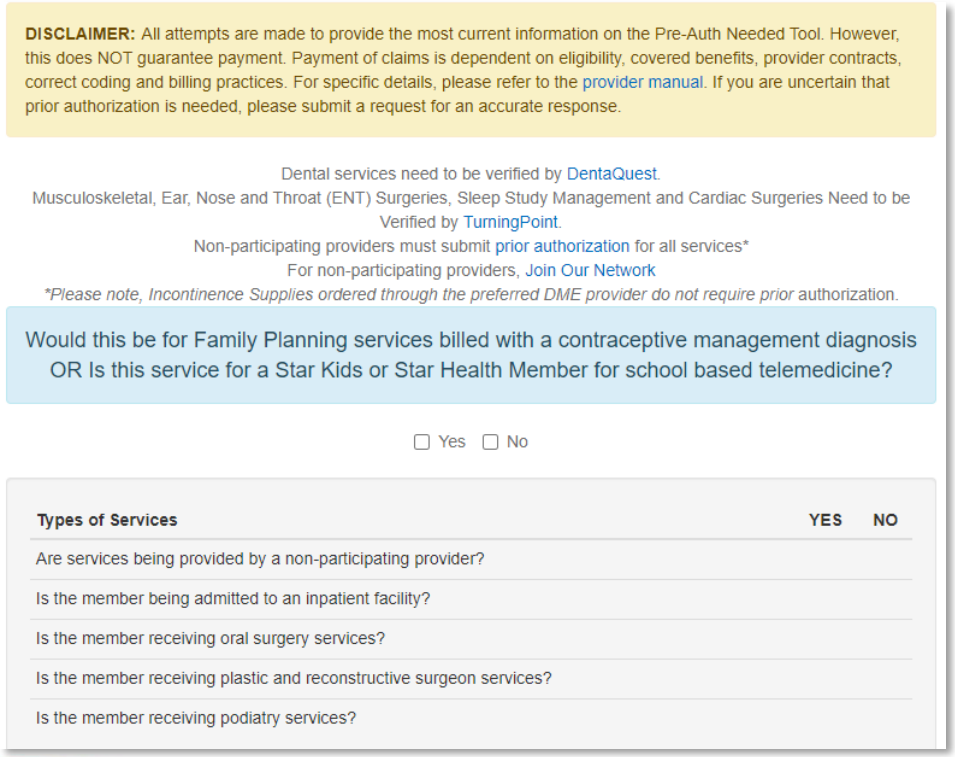
- Magellan Healthcare for Applied Behavioral Analysis
  - Phone: 1-800-424-4812
  - Fax: 1-888-656-0368

Behavioral Health Authorizations

- All out of network services require an authorization.
  - Emergent and urgent services provided by an out-of-network provider do not require prior authorization.
- Inpatient hospitalizations require notification within one (1) business day
- PHP/IOP can be requested up to one (1) business day in advance of services
- Residential Detox authorizations can be requested by SUD providers the next business day following admission
- Ideally providers will initiate authorizations five (5) Business Days in advance for **non-emergency** services

Medicaid Pre-Authorization Tool

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



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

Dental services need to be verified by DentaQuest.
Musculoskeletal, Ear, Nose and Throat (ENT) Surgeries, Sleep Study Management and Cardiac Surgeries Need to be Verified by TurningPoint.
Non-participating providers must submit prior authorization for all services*
For non-participating providers, Join Our Network
*Please note, Incontinence Supplies ordered through the preferred DME provider do not require prior authorization.

Would this be for Family Planning services billed with a contraceptive management diagnosis OR Is this service for a Star Kids or Star Health Member for school based telemedicine?

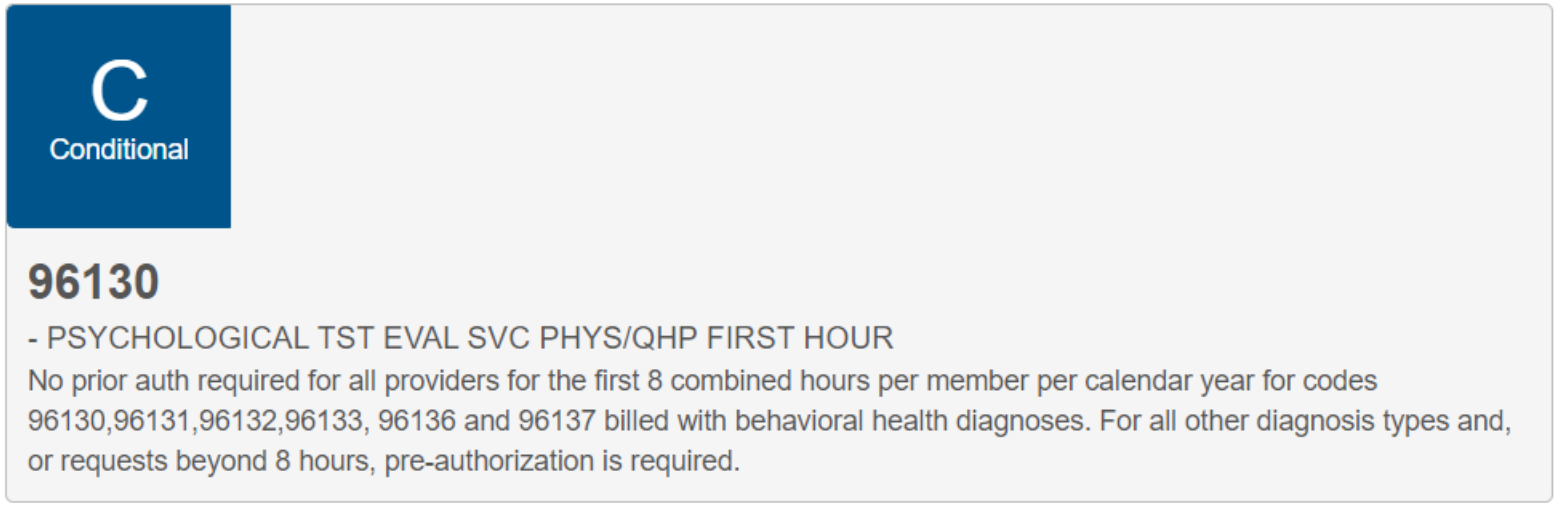
☐ Yes ☐ No

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

Psychological, Neurobehavioral and Neuropsychological Testing

No prior auth required for participating providers for the first 8 combined hours per person per calendar year for codes 96130-96133 and 96136-96137 when billed with behavioral health diagnoses.

- For all other diagnosis types and/or requests beyond 8 hours, preauthorization is required



Authorization Checklists

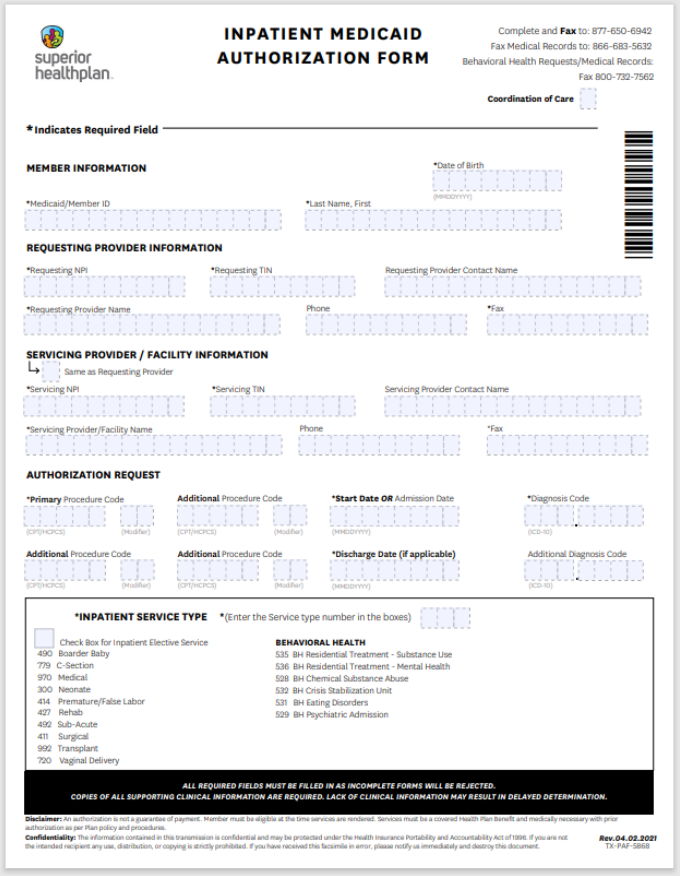
Prior Auth Checklists for key Authorization types are posted under the "How To" section of the Provider Training and Manuals Tab on the website: Provider Training and Manuals | Superior HealthPlan

Checklists posted:

- Partial Hospitalization (PHP) / Intensive Outpatient (IOP)
- Behavioral Health Outpatient Services
- Electroconvulsive Therapy (ECT)
- Psych & Neuro Psych Testing
- Substance Use Disorder (SUD)

Prior Authorization Form

- Prior authorizations can also be submitted at: Provider.SuperiorHealthPlan.com
- Medicaid Authorization Forms and the Texas Standard Prior Authorization Request Form are located on: SuperiorHealthPlan.com/ProviderForms



superior healthplan

INPATIENT MEDICAID AUTHORIZATION FORM

Complete and **Fax** to: 877-650-6942
Fax Medical Records to: 866-683-5632
Behavioral Health Requests/Medical Records: Fax 800-732-7562

Coordination of Care

***Indicates Required Field**

MEMBER INFORMATION

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

REQUESTING PROVIDER INFORMATION

*Requesting NPI
*Requesting TIN
Requesting Provider Contact Name
*Requesting Provider Name
Phone
*Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider
*Servicing NPI
*Servicing TIN
Servicing Provider Contact Name
*Servicing Provider/Facility Name
Phone
*Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
***Start Date OR** Admission Date (MMDDYYYY)
*Diagnosis Code (ICD-10)
Additional Procedure Code (CPT/HCPCS) (Modifier)
Additional Procedure Code (CPT/HCPCS) (Modifier)
***Discharge Date (if applicable)** (MMDDYYYY)
Additional Diagnosis Code (ICD-10)

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

Check Box for Inpatient Elective Service
490 Boarder Baby
779 C-Section
970 Medical
300 Neonate
414 Premature/False Labor
427 Rehab
492 Sub-Acute
411 Surgical
992 Transplant
720 Vaginal Delivery

BEHAVIORAL HEALTH
535 BH Residential Treatment - Substance Use
536 BH Residential Treatment - Mental Health
528 BH Chemical Substance Abuse
532 BH Crisis Stabilization Unit
531 BH Eating Disorders
529 BH Psychiatric Admission

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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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TX-PAF-5868

Authorization TAT Requirements

Program	Authorization Type	TAT
Medicaid	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
Medicaid and CHIP	Urgent	3 Business Days
Medicaid and CHIP	Inpatient	1 Business Day

Medical Management Denials

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

Peer-to-Peer Options

Peer-to-Peer Review

When medical necessity cannot be established, a peer-to-peer review is offered for Inpatient and outpatient behavioral health services. A peer-to-peer discussion is available to the ordering physician, nurse practitioner, or physician assistant during the prior authorization denial process regarding medical necessity.

- Pre-Denial Peer-to-Peer
  - A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination.
- Post-Denial Peer-to-Peer
  - An opportunity to discuss is available to the member's requesting or servicing provider after the adverse determination has been rendered for both inpatient and outpatient services. This is like a case consultation and will not result in an overturn since this is not an appeal

If you miss the Peer-to-Peer window, initiate an appeal; if member is still inpatient, request an expedited appeal by calling 1-877-398-9461 or faxing 1-866-918-2266

Appealing Medical Management Denials

- Communication of Denials
  - Denial letters will be sent to member, requesting provider and servicing provider to include:
    - The clinical basis for the denial
    - Criteria used to make the medical necessity decision
    - Member appeal/complaint, external review (CHIP) or fair hearing rights (Medicaid) fully explained

- The provider may request an appeals on behalf of the member.
  - Mail: Superior HealthPlan
    Attn: Appeal Coordinator
    5900 E. Ben White Blvd.
    Austin, TX 78741
  - Fax: 1-866-918-2266

Medical Necessity Internal Appeals

- Standard Member Appeals
  - A Medicaid internal health plan appeal can be submitted orally or in writing and must be requested within **60 Calendar Days** of the date of the Adverse Benefit Determination letter.
  - The appeal will be acknowledged within 5 Business Days of receipt, and the entire appeal process completed within 30 Calendar Days of receipt of the request for appeal.
  - Medicaid members, or their authorized representative, may request an extension of the appeal time frame, for an additional 14 Calendar Days, or if there is a need for additional information and if the delay is in the best interest of the member.
  - A physician who was not involved in the initial Adverse Benefit Determination, and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the appeal.
  - An appeal resolution letter is mailed within 30 Calendar Days of receiving the appeal request.

Medical Necessity Internal Appeals

- Expedited Member Appeals
  - A Medicaid member, a member's authorized representative, or the member's physician or other health care provider may request an expedited appeal of an Adverse Benefit Determination if waiting 30 Calendar Days for a standard resolution could seriously jeopardize the member's life or health.
    - Superior's Medical Management will review the request for expedited review.
  - If the Medical Director determines expediting the review is not medically necessary, the appeal will be processed within the standard appeal timeframe of 30 Calendar Days.
  - If the Medical Director determines expediting the review is medically necessary, an expedited appeal is resolved no later than 72 hours from receipt of the appeal request. Verbal notification is provided to the appeal requestor (member or provider) on the day of the decision.
    - Written notification is sent to the member and/or member's representative within 1 Business Day of the decision.

External Appeal Rights

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for Superior service denials and reductions.
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 Calendar Days of Superior's appeal decision letter.
- If requested, the External Medical Review through an IRO is completed before a State Fair Hearing.
- There are two types of EMR requests – standard and expedited:
  - Standard EMR Request – IRO Review is completed no later than 10 Business Days following receipt of Superior's records related to the service denial or reduction determination.
  - Expedited EMR Request – IRO review is completed the next Business Day following receipt of the Superior's record for urgent requests.

External Appeal Rights

- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services: Upheld, Partially Overturned or Fully Overturned.
- The IRO will send written notification of its EMR decision to the member, the member's authorized representative or member's LAR (if applicable), Superior and the HHSC EMR Intake Team.
- Superior will implement any partial or full overturn by the IRO within 72 hours.
- Withdrawal of EMR or State Fair Hearing Requests:
  - EMR – The member, the member's authorized representative, or the member's LAR must initiate an EMR withdrawal request to Superior before the IRO Review is initiated.
  - State Fair Hearing – If the EMR decision is to overturn Superior's adverse determination, the State Fair Hearing will proceed unless the member or member's representative withdraws the request. If the request is not withdrawn, regardless of the EMR decision, the member, the member's authorized representative or the member's LAR is required to attend the State Fair Hearing.
- A recording of the HHSC EMR Provider Training is available to providers.
  - https://register.gotowebinar.com/recording/4623254401546558726

Claim Submissions

Claims Filing: Submitting Claims

- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Secure Availity Portal: Availity Essentials
- Electronic Claims:
  - View a list of Superior's Trading Partners: SuperiorHealthPlan.com/Billing
  - Payer ID 68068 for behavioral providers with a behavioral services contract.

- Paper Claims - Initial
  - Superior HealthPlan
    Behavioral Health Claims
    P.O. Box 6300
    Farmington, MO 63640-6806
- Paper Claims - Requests for Corrections, Reconsideration* and Claim Disputes*
  - Superior HealthPlan Behavioral Health Appeals
    P.O. Box 6000
    Farmington, MO 63640-3809

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

Claims Filing

- Claims must be filed within 95 Calendar Days from the Date of Service (DOS).
- A provider may submit a corrected claim or claim appeal within 120 Calendar Days from the date of Explanation of Payment (EOP) or denial is issued.
- Providers should include a copy of the EOP when other insurance is involved.
- Claims must be completed in accordance with Texas Medicaid & Healthcare Partnership (TMHP) billing guidelines.
- Filed on a red CMS 1500 or UB04 form.
- Filed electronically through clearinghouse.
- Filed directly through web portal.

Clean Claims

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

Clean Claim Requirements

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

Clean Claim Requirements

Paper Claims

- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS-1450/UB-04 or CMS 1500 red form (not a copy).
    - Handwritten claim forms are not accepted.
  - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

Claims Payment

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

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

Identifying a Claim Number

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

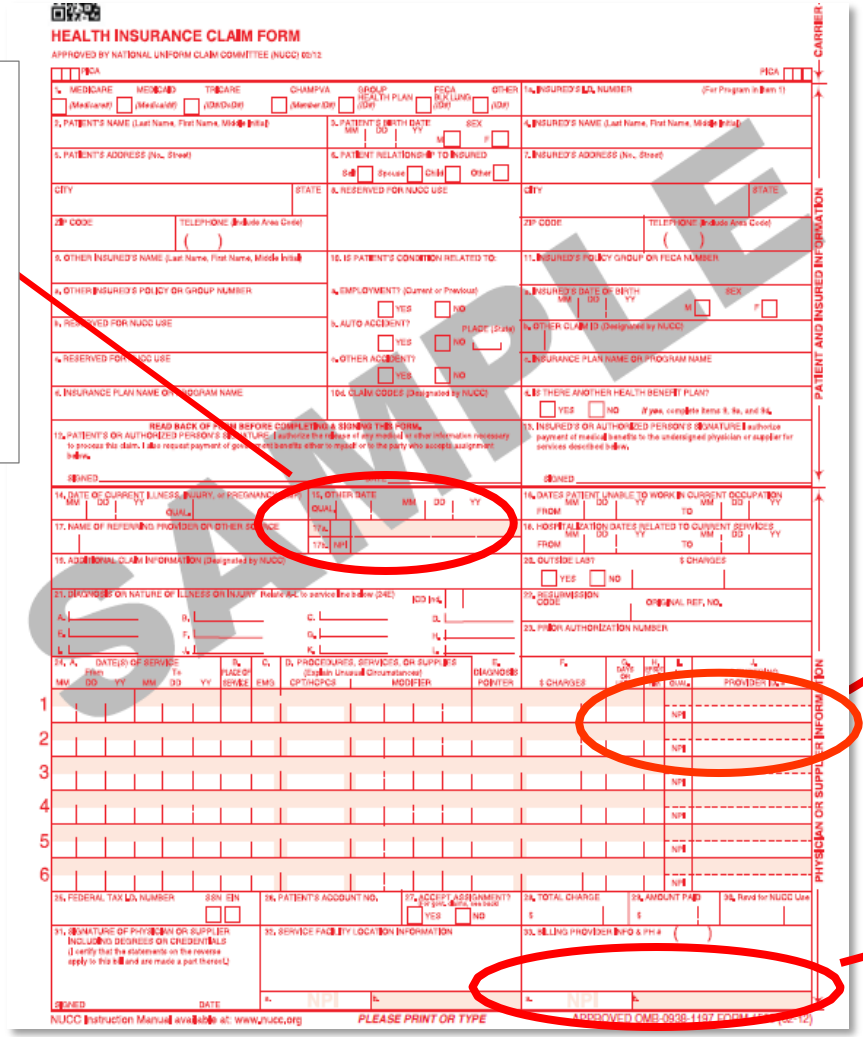
Note: Remember that rejected claims have never made it through Superior's claims system for processing. All rejected claims must be corrected and resubmitted within 95 Calendar Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.

CMS 1500 Form

Referring Provider: [C]

17 Name of the referring provider

17b NPI



Rendering Provider: [R]

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

These are required fields when billing Superior claims

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

Billing Provider: [R]

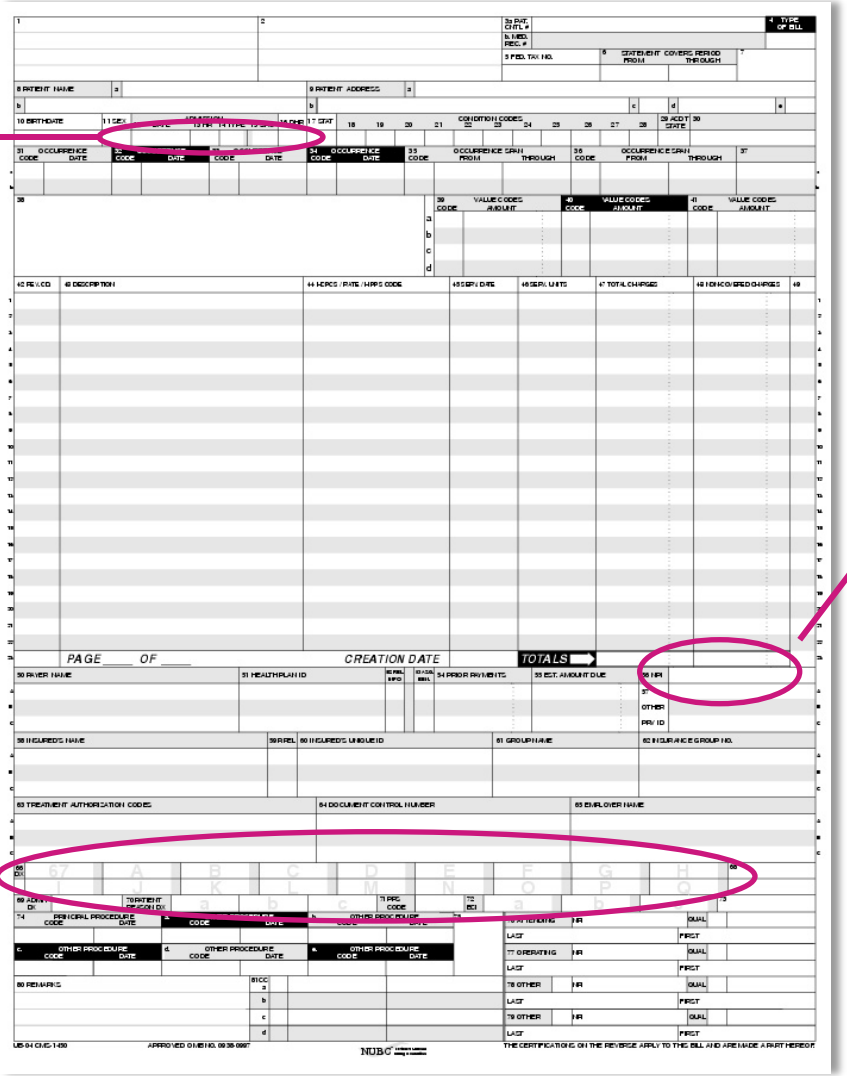
Billing NPI # in box 33a and Billing Taxonomy # (or API # if no NPI) in 33b

UB-04 Requirements

Admission Information

Billing Provider NPI

Diagnosis code(s) and POA indicator(s)



Taxonomy Codes

Providers should ensure PEMS and NPPES have the appropriate taxonomy codes listed for their NPIs

- Texas Medicaid & Healthcare Partnership's Provider Enrollment and Management System (PEMS) Provider Enrollment | TMHP
- National Plan & Provider Enumeration System (NPPES) NPPES

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 Calendar Days from the date of adjudication or denial.
  - Adjusted or Corrected Claim: The provider is changing the original claim.
  - Correction to a Prior Claim: Finalized claim that was in need of correction as a result of a denied or paid claim.
  - Claim Appeals: Often require additional information from the provider.
    - Request for Reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - Claim Dispute: Provider disagrees with the outcome of the request for reconsideration.
- Claim Adjustments/Corrections and Submissions can be processed through the Provider Portal or a paper claim.
  - Paper claims require a Superior Corrected Claim or Claim Appeal form.
    - Claim forms can be found at SuperiorHealthPlan.com/ProviderForms.

Corrected Claims Filing

- 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.
- Corrections can be made to, but are not limited to:
  - Patient Control Number (PCN)
  - Date of Birth (DOB)
  - Date of Onset
  - Place of Service (POS)
  - Present on Admission (POA)
  - Quantity Billed
  - Prior Authorization Number (PAN)
  - Beginning DOS
  - Ending DOS or Discharge Date

Corrected Claims Filing

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

  Superior HealthPlan
  Attn: Behavioral Health Claims
  P.O. Box 6000
  Farmington, MO 63640-3809

Claims Appeal Form

- A claims appeal is a request for reconsideration of a claim for anything other than medical necessity.
- Submit appeal within 120 Calendar Days from the date of adjudication or denial.
  - Can be submitted in writing or electronically through: Provider.SuperiorHealthPlan.com
- Claim appeals in writing should be submitted to:
  - Superior HealthPlan Behavioral Health Appeals
    P.O. Box 6000
    Farmington, MO 63640-6806

Appeals Documentation

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

Billing Reminders - Authorizations

- When calling in to request an authorization, or to notify of a patient admission, please have available the Tax Identification Number (TIN) and NPI or LTSS ID number that will be used to bill your claim. If these numbers are not presented, your request will not be processed.
- The TIN/NPI used to request the authorization must match what is used to bill the claim, or the claim will deny.
- If the claim denies because it was billed with a different TIN/NPI combination than was authorized:
  - Verify that the TIN/NPI combination on the requested authorization matches what was billed.
  - If authorization and claim match, contact Provider Services at 1-877-391-5921.
  - If the claim was billed incorrectly, a corrected submission is required.

Billing Reminders - Authorizations

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

Billing Reminders

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

Member Balance Billing

- Providers may not bill members directly for covered services for Medicaid or CHIP.
- Superior Medicaid and CHIP Perinate members do not have co-payments. Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (under CHIP Benefits).
- Additional details can be found in your provider contract with Superior and in the *Balance Billing: Superior Medicaid and CHIP (PDF)* found under the *Billing Resources* section at: SuperiorHealthPlan.com/ProviderResources.

Common Billing Errors

- Member date of birth or name not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- No itemized bill provided when required
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate
- Illegible paper claim

Common Claim Denials

Denial Code	Definition
EX29	The time limit for filing has expired
EXA1	No authorization on file that matches service(s) billed
EXBG	Type of Bill missing or Incorrect on claim, please resubmit
EXCd	Medicare coverage rules not followed therefore services not eligible
EXDZ	Service has exceeded the Authorized Limit
EXE3	Modifier Missing or Invalid
EXHP	No Authorization on file that matches service(s) billed
EXIM	Resubmit with correct Modifier
EXL6	Bill Primary Insurer 1st resubmit with EOB
EXMA	Provider NPI, Tax ID, and or Taxonomy not on State File
EXMt	Not Medically Necessary Services
EXNB	Service not covered, provider responsibility, do not bill member
EXNP	Authorization requested for non-plan provider
EXNu	Did not use authorized provider-non par
EXQV	Code not Payable without Primary Procedure code
EXVV	Missing or Invalid POA

Electronic Payments and Remittance

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

PaySpan

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

Telemedicine and Telehealth

What is Telemedicine?

- Telemedicine services are healthcare services delivered to a patient at a different physical location using telecommunications or information technology.
- Providers must be licensed in Texas or be under the supervision of a provider licensed in Texas. Provider types able to practice telemedicine include:
  - Physicians
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician's Assistants
  - Certified Nurse Midwives
  - Federally Qualified Health Center (FQHC)
- Providers must use a HIPAA-compliant system for all interactions.

What is Telehealth?

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

- A distant site provider does not need to conduct a physical examination in order for behavioral health services to be rendered.

- The distant site provider is able to conduct a “face-to-face” evaluation via telehealth at an established medical site prior to providing ongoing care. They may also provide treatment for a patient referred by another physician who completed a “face-to-face” evaluation via telemedicine at an established medical site.
  - The Centers for Medicare and Medicaid Services (CMS) define the distant site as the telehealth site where the provider/specialist is seeing the patient at a distance or consulting with a patient’s provider.

What is Telehealth?

- Telehealth is a benefit when provided by these provider types:
  - Early Childhood Intervention (ECI)
  - Licensed Professional Counselor
  - Licensed Marriage and Family Therapists (LMFT)
  - Licensed Clinical Social Workers (LCSW)
  - Psychologist
  - Licensed Psychological Associate
  - Provisionally Licensed Psychologist
  - Licensed Dietitian
  - CCP providers (Occupational Therapist, Speech-language Pathologist)
  - Home Health agency
  - School Health and Related Services (SHARS)
  - FQHC
  - RHC

Covered Benefits of Telemedicine and Telehealth

- For a list of Current Procedural Terminology (CPT) codes that are covered under telemedicine and telehealth, please see the *TMHP Telecommunication Services Handbook (PDF):*
  - Texas Medicaid Provider Procedures Manual | TMHP

- Telemedicine and Telehealth may be delivered via:
  - Synchronous audiovisual or audio interaction between the provider and the client in another location using a mobile app or live online video.
  - Asynchronous store and forward technology using:
    - Clinically relevant photographic or video images, including diagnostic images.
    - The patient's medical records (i.e. medical history, lab results and prescriptive histories).
  - Other forms of audiovisual communication that allow the provider to meet the in-person visit standard of care.

Covered Benefits of Telemedicine and Telehealth

- Claim should be billed with the appropriate modifiers to indicate services provided
  - 95 Synchronous Audio/video technology – telemedicine or telehealth
  - 93 Synchronous telephone Audio only- telemedicine
  - FQ Synchronous telephone Audio only technology- telehealth
- Procedure codes for behavioral health services are subject to the same benefits and limitations as in-person visits.
- Patient site providers may be reimbursed for Q3014 in a facility setting; however, it is not a benefit of telehealth services.

Billing by Service Type

Psychologist Delegated Services

- Psychological services provided by a Licensed Psychological Associate (LPA), Provisionally Licensed Psychologist (PLP), psychology intern or post-doctoral fellow must be billed under the supervising psychologist's Medicaid provider identifier or the Medicaid identifier of the legal entity employing the supervising psychologist.
- Services provided by a psychologist, Licensed Psychological Associate (LPA), Provisionally Licensed Psychologist (PLP), psychology intern or post-doctoral fellow must be billed with a modifier on each claim detail line.
- Superior requires provider to submit claims for psychological delegated services with the modifier identifying the provider type rendering the service billed.

Psychologist Delegated Services	Modifier
Clinical Psychologist	AH
Pre-Doctoral Psychology Intern or Post-Doctoral Psychology Fellow	UB
License Psychological Associate	UC
Provisionally Licensed Psychologist	U9

Psychologist Delegated Services

- Services performed by a LPA or PLP will be reimbursed at 70% of the psychologist rate. Services performed by the psychology intern or post-doctoral fellow will be reimbursed at 50% of the psychologist rate.
- The Licensed Clinical Social Worker (LCSW), Marriage and Family Therapists (MFT), Licensed Professional Counselor (LPC), Advanced Practice Registered Nurse (APRN) or Physician's Assistant (PA) performing the mental health service may bill for the performed services.
- The LCSW, MFT, LPC, APRN or PA must not bill for services performed by people under his or her supervision.

Twelve Hour System Limitation

- The following provider types are limited to a maximum combined total of 12 hours per provider, per day, regardless of the number of persons seen for outpatient mental health services:
  - Psychologist
  - APRN
  - PA
  - LCSW
  - LMFT
  - LPC
- Court-ordered and DFPS-directed services are not subject to the 12-hour per provider, per day system limitation when billed with modifier H9.
- Physicians are not subject to the 12-hour system limitation since they can delegate and may submit claims in excess of 12 hours per day.
- Psychologists can delegate to multiple LPAs, PLPs, interns, or post-doctoral fellows.
  - Delegated services are not subject to the 12-hour system limitation

Twelve Hour System Limitation

The following table lists the procedure codes for mental health services included in the system limitation, along with the time increments the system will apply based on the billed procedure code. The time increments applied will be used to calculate the 12-hour per day system limitation.

Procedure Code	Time Applied	Procedure Code	Time Applied	Procedure Code	Time Applied
90791	60 minutes	90837	60 minutes	96130	60 minutes
90792	60 minutes	90838*	60 minutes	96131*	60 minutes
90832	30 minutes	90846	50 minutes	96132	60 minutes
90833*	30 minutes	90847	50 minutes	96133*	60 minutes
90834	45 minutes	96116	60 minutes	96136	30 minutes
90836*	45 minutes	96121*	60 minutes	96137*	30 minutes

*Add-on procedure codes indicated with an asterisk must be billed with the appropriate primary procedure code.

Inpatient Facility

- Admissions to acute care hospitals for inpatient psychiatric services are a benefit of Texas Medicaid for persons of all ages in fee-for-service Medicaid or managed care.

- Inpatient facility services include but are not limited to:
  - Partial Hospitalization Program (PHP) – Provider's contract must outline codes and pricing
  - Intensive Outpatient Program (IOP) – Provider's contract must outline codes and pricing
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation

- May require authorization
  - To facilitate the retrospective review, clinical documentation to support the medical necessity of the inpatient admission must be submitted with the claim for the inpatient stay.
  - Notification of admission is still required at the time of admission.
    - Lack of notification may result in a contractual denial for failure to comply
  - Observation does not require authorization

Substance Use Disorder Treatment

- PHP and IOP services must be specified in your provider contract by revenue code.
- Withdrawal Management and Treatment Services require prior authorization through Superior before provisioning these services
- SUD services may include individual, group and/or family treatment services, withdrawal management services, residential treatment services, medication assisted treatment and evaluation and treatment (or referral for treatment) for co-occurring physical and behavioral health conditions.
- Facility must be a Licensed Chemical Dependency Treatment Center (CDTF) per HHSC requirements for PAR providers.
- Levels of Service: This would be based on the members condition and the needed level of care.

Partial Hospitalization Program (PHP)

- Partial Hospitalization Program services include the same behavioral health or substance use disorder (SUD) services that would be offered during an inpatient stay, except that the patient does not stay at the hospital overnight.

- To bill for PHP, providers must bill revenue codes:
  - 912 Behavioral health treatment services, partial hospitalization, less intensive
  - 913 Behavioral health treatment services, partial hospitalization, intensive

Intensive Outpatient Program (IOP)

- The Intensive Outpatient Program is a structured program that offers outpatient therapy, which typically includes both individual and group therapy.
  - Family therapy may also be offered, as needed.

- IOP Programs are typically 3-5 days per week, usually for a minimum of 3 hours per day.

- To bill for IOP, providers must bill revenue codes:
  - 905 Behavioral health treatment services, intensive outpatient psychiatric
  - 906 Behavioral health treatment services, intensive outpatient chemical dependency

PHP and IOP – Prior Authorization Required

- Providers should submit a member's mental health medical record summary with a prior authorization request for these services.

- The approval of PHP and IOP are based on the availability and medical necessity and appropriateness of the recommended service.
  - If a member/member's family is unwilling or unable to support the members participation in an out-patient level of care for applicable behavioral health services, and inpatient services is the only available or viable option for the family/patient, the applicable service will be approved, if medically necessary.

IOP and PHP as Step Down Level of Care

- If PHP or IOP is needed immediately upon discharge, the processing of the prior authorization request will be processed according to the urgency of the PHP or IOP admission.

- When a member is discharged from an inpatient facility and an order for outpatient PHP or IOP services provided, those services may not need to be initiated or necessary immediately upon the member's discharge for inpatient hospitalization.

Outpatient Withdrawal Management Services

- HCPC H0016 – Alcohol and/or drug services; medical/somatic – medical intervention in ambulatory setting
  - Eligible for billing and reimbursement as a stand-alone code
  - Limited to once per day per patient, any provider
- HCPC H0050 – Alcohol and/or drug services, brief intervention, per 15 minutes
- HCPC S9445 – Patient education, not otherwise classified, non-physician provider, individual, per session
  - Must be billed with H0016 to be considered for reimbursement
  - Limited to once per day per patient, any provider
  - Eligible for reimbursement on the same date of service as outpatient SUD treatment by the same or different provider when medically necessary and identified in the person's treatment plan

Outpatient Treatment Services

- HCPC H0004 – Behavioral health counseling and therapy, per 15 minutes
- HCPC H0005 – Alcohol and/or drug services; group counseling by a clinician
- limited to 135 units of group counseling and 26 hours of individual counseling per calendar year when provided by a Chemical Dependency Treatment Facilities (CDTF)
- Denied if billed on the same date of service as residential withdrawal management
  - Procedure codes H0012, H0031, H0047, S9445, T1007
- Denied if billed on the same date of service as residential treatment
  - Procedure code H2035

Residential Withdrawal Management Services

Residential Withdrawal Management:

- HCPC H0012 – Residential sub-acute detoxification for alcohol and/or drug services
  - Eligible for billing and reimbursement as a stand-alone code
  - Limited to once per day per patient, any provider

The following services must be billed with H0012 to be considered for reimbursement and are limited to once per day per patient, any provider:

- HCPC H0031 – Mental health assessment by non-physician
- HCPC S9445 – Patient education, not otherwise classified, non-physician provider, individual, per session
- HCPC T1007 – Alcohol and/or substance abuse services, treatment plan development and/or modification
- HCPC H0047 – Room and board for residential treatment services

Residential Treatment Services

- Residential treatment programs provide a structured therapeutic environment where persons reside with staff support and deliver comprehensive substance use disorder treatment with attention to co-occurring conditions, as appropriate. The frequency and duration of services should be based on meeting the person's needs and achieving the person's treatment goals.

- HCPC H2035 – Residential Treatment Services
  - Limited to once per day per patient, any provider
  - Under age 21 may exceed benefit limit
  - Facility must be a SUD facility per HHSC requirements
  - Requires Authorization for Par and Non-Par Providers
    - May authorize up to 35 days per episode of care, not to exceed 70 days per rolling six months.

- Residential Treatment Services are to be billed as outpatient only on a CMS 1500 form.

MHR/TCM

Mental Health Rehabilitative (MHR) and Mental Health Targeted Case Management (TCM)

MHR and TCM Services

- Mental Health Rehabilitation (MHR) – Includes services that are individualized, age-appropriate and provide training and instructional guidance that restore an individual's functional deficits due to serious mental illness or serious emotional disturbance.
- Mental Health Targeted Case Management (TCM) – Services are furnished to assist persons in gaining access to needed medical, social/behavioral, education and other services and supports.
- Billing for MHR/TCM services is limited to participating LMHA or Non-LMHA groups who have completed all of the required trainings, are contracted and attested with Superior.
- Our clinical trainers offer a comprehensive training on this topic. You can sign up for this training on our website under Behavioral Health Clinical Training Behavioral Health Clinical Trainings | Superior HealthPlan

MHR TCM Annual Attestation

Providers are required to attest annually to the following, prior to delivering MHR/TCM services. The attestation confirms:

- Participating providers are trained and certified to administer the Adult Needs and Strengths Assessment (ANSA) or the CANS assessment tools and agree to use these tools to recommend a level of care by using the current DSHS Clinical Management for Behavioral Health Services (CMBHS) web-based system.

- The participating provider has completed **all** training requirements outlined in the Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual (UMCM) Chapter 15 before delivering any MHR and Mental Health TCM Services.

- The participating entity will complete the Texas Standard Prior Authorization Request Form for all LOC 4 and will submit to Superior.

MHR TCM Annual Attestation

Attestation cont.

- The participating entity will provide Mental Health Rehabilitative Services and Targeted Case Management using the DSHS TRR UM Guidelines and the ANSA or the CANS tools for assessing a member's needs for services.

- The participating entity has the ability to provide covered persons with the full array of TRR services either directly or through sub-contract.

- The participating entity is familiar with the HHSC cost reporting process and will participate in this process.

Without an attestation on file for the dates of service, the claims will deny.

Superior does periodically audit providers to ensure compliance

MHR Billing Codes and Modifiers

MHR Service	HCPC Code
Day Program for Acute Needs	H2012
Medication Training and Support	H0034
Crisis Intervention	H2011
Skills Training and Development	H2014
Psychosocial Rehabilitative Services	H2017

Service Description	Modifier
Group Services for Adults	HQ
Group Services for Child/Youth	HA/HQ
Individual Services for Child/Youth	HA
Individual Services Provided by RN	TD
Group Services Provided by RN	HQ/TD
Individual Crisis Services	ET

TCM Billing Codes and Modifiers

- Mental Health Targeted Case Management (TCM) Services must be billed using procedure code T1017.
- T1017 must be billed with the appropriate modifiers. To ensure timely and appropriate reimbursement, modifier TF or TG must be placed in the first position.
- Intensive Case Management and Routine Case Management are benefits for child and adolescent members who are 20 years of age and younger.
  - These services cannot be billed for the same date of service.
- Routine Case Management is a benefit for adult members 21 years of age and older.

Modifier	Modifier Description	Modifier Position	Eligible Population
TF	Routine Case Management	Primary	Children / Adolescents / Adults
TG	Intensive Case Management	Primary	Children / Adolescents
HA	Child / Adolescent Program	Secondary	Children / Adolescents
HZ	Funded by Criminal Justice Agency	N/A	N/A

MHR / TCM Billing Reminders

- Multiple claims for the same service to the same member can be processed for both MHR and TCM.
- Superior does not require providers to submit a Medicare or private insurance denial for services that are never covered and/or paid by Medicare or private insurance, including Targeted Case Management and Rehabilitative Services.
  - Exception: For dual-eligible individuals, providers will not bill Superior, as services for these individuals will be billed through TMHP.
- For MHR and TCM, Superior does not require the name of a rendering provider on claims submitted to the Managed Care Organization (MCO) if that provider is not a type that enrolls in Medicaid (CSSPs, Peer Providers, Family Partners, and some QMHPs).
  - A rendering provider number is required if the individual delivering the service is licensed and has a Medicaid provider number.

MHR / TCM Billing Reminders

Reimbursement of the following services is limited to certain diagnosis codes as outlined in the Texas Medicaid Provider Procedures Manual Behavioral Health and Case Management Services Handbook* and requires those diagnosis, to be placed in the **PRIMARY** (first) position. Failure to place the diagnosis code in the correct position may result in a denial of the claim.

Service Category	Procedure Codes
Medication Training and Support	H0034
Day Program for Acute Needs	H2012
Skills Training and Development	H2014
Psychosocial Rehabilitation Services	H2017
Mental Health Targeted Case Management	T1017

* Provider Manuals | TMHP

MHR / TCM

- Participating LMHA facilities must submit a rendering provider roster to Superior to add both licensed and non-licensed behavioral health providers to their current contract
  - Rosters can be submitted to LMHA.Load@SuperiorHealthPlan.com
- Non-LMHA multi-specialty groups must submit additions to their group through the Add a Provider to an Existing Group Contract form, located on Superior's Network Request or Update page: SuperiorHealthPlan.com/JoinOurNetwork
- MHR/TCM Group providers must also submit the *Group National Provider Identifier Demographic* Form located under the *Credentialing section of Provider Forms* on SuperiorHealthPlan.com/ProviderForms
- Child Abuse Neglect Registry (from 1600) must be submitted for QMHPs prior to them rendering services to Superior HealthPlan Members. The link to the DFPS form is located under *Forms* on our website

Applied Behavior Analysis Services

Applied Behavior Analysis Services

The Texas Medicaid Provider Procedures Manual (TMPPM) clinical policy contains the medical necessity criteria for the new ABA benefit.

- Applied Behavior Analysis (ABA) services for individuals under 21 years of age* with Autism Spectrum Disorder (ASD). This new Medicaid benefit was effective February 1, 2022, and is available for the following Superior programs:
  - STAR
  - STAR Health
  - STAR Kids
  - * STAR+PLUS Medicaid for Breast and Cervical Cancer (MBCC) Program
- Superior requires prior authorization be obtained for **all** ABA services prior to the delivery of service.

Applied Behavior Analysis Services

Authorizations for ABA

- Utilization review for prior authorization requests are managed by Magellan Healthcare. Prior authorization requests can be submitted to Magellan Healthcare by fax 1-888-656-0368 or by calling 1-800-424-4812.

- The following ABA resources are listed in the *Delegated Utilization Review Agent (URA) Resource Documents - FAQ and QRGs* section on SuperiorHealthPlan.com/PriorAuth:
  - Autism Applied Behavioral Analysis Provider Orientation
  - Autism Benefit Services Initial/Continued Treatment Plan Template

- Providers should include the valid prior authorization number received for the provision of ABA services on the claim form.

ABA procedural codes

Procedure Code	Description	Specialty/ Licensure	Modifier
97151	ABA Initial evaluation or Re-evaluation	Master's level/ LBA	HO only
97151	ABA Re-evaluation	Master's level/ LBA	HO only
97153	ABA Individual treatment	Master's level/ LBA	HO only
97154	ABA Group treatment	Master's level/ LBA	HO
97155	ABA Individual treatment	Master's Level/ LBA or Bachelor's level/ LaBA	HO or HN
97156	ABA parent/ caregiver/ family education and training	Master's Level/ LBA or Bachelor's level/ LaBA	HO or HN
97158	ABA Group treatment	Master's Level/ LBA or Bachelor's level/ LaBA	HO or HN
99366	Interdisciplinary team meeting	Not specified	None required

Applied Behavior Analysis Services

- Covered ABA procedure codes are reimbursed for the direct service time.
  - Pre and post work for the session are not reimbursed separately.
  - Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under procedure code 97151).

- Concurrent Provider Billing
  - Superior will not reimburse multiple ABA providers during one ABA session with a child/youth when more than one ABA provider is present
  - Concurrent billing is excluded except when the family and the child/youth with ASD are receiving separate services, and the child/youth is not present in the family session.

- Billing for Administrative Time Prohibited
  - Superior will not reimburse for ABA treatment services when the child/youth and/or family is not present or is not engaged in a therapeutic relationship with the provider

Applied Behavior Analysis Services

- 97151 Initial evaluation is authorized for a 30-day period/ limited to 6 hours (24 units)
- 97151 Re-evaluation is authorized for a 30-day period/ limited to 6 hours (24 units)
- Direct treatment for the child/youth is limited to a total of 8 hours per day, inclusive of procedure codes 97153, 97154, 97155, 97158
- 99366 is limited to diagnosis code F840-Austism and is contingent upon prior authorization of ABA evaluation, re-evaluation, or treatment team. May be reimbursed for interdisciplinary team meetings attended by qualified non-physician healthcare providers

Telehealth ABA Services

Some service delivery to children/youth and/or parents/caregivers may be delivered remotely.

- It is the provider's responsibility to ensure that remotely delivered telehealth services are within scope of practice, not contraindicated for the child/youth, family, or particular situation, are clinically appropriate and effective, and in compliance with Texas licensure and standards for telehealth.

ABA evaluation and treatment services may only be delivered via telehealth using synchronous audio-visual technology or a similar technology.

Procedure codes 97151, 97155, 97156, 97158 and 99366 may be delivered via telehealth and require Modifier 95 to designate remote delivery.

Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW)

CPW services are provided to help Medicaid eligible children and pregnant women to gain access to necessary medical, social, educational, and other services related to a member's condition, health risk or high-risk condition.

Provider Enrollment: To be eligible for reimbursement for CPW, providers must be actively enrolled with Texas Medicaid through TMHP.

- RNs, LSWs, doulas, and Community Health Workers (CHWs) may enroll with Texas Medicaid to provide CPW services as an independently practicing individual or as a performing provider with a group

Contracted Behavioral Health Providers must have medical language amended to existing Superior contracts to bill for CPW services as a par provider.

Case Management for Children and Pregnant Women (CPW)

Prior Authorization

- Currently Superior does not require prior authorization for CPW services. Should Superior require prior authorization in the future, a notice will be posted 90 Calendar Days prior to the implementation date for the prior authorization requirement.
- Superior's Quality Assurance (QA) program will validate the quality of CPW services and providers on an ongoing basis through retrospective utilization review

Member Referral Process

- Providers play a vital role in Superior's Care Management program. If you have Superior members who would benefit from disease or care management, including referrals for CPW providers,
  - contact Superior's Care Management department at 1-855-757-6567
  - refer a member for Case Management through Superior's Secure Provider Portal. Enter members information in the eligibility screen and complete the information under the referral tab.

Case Management for Children and Pregnant Women (CPW)

- Coding and Claims Submission
  - CPW services are limited to one CPW visit per day, per member.
    - Additional visits on the same day from any provider will be denied as part of another service rendered on the same day.
  - CPW services are not billable when a person is admitted to an inpatient hospital or other treatment facility.
  - Procedure code G9012 is to be used for all CPW services.
  - Modifiers are used to identify which service component is provided.
  - These claims must be submitted to the **MEDICAL platform (68069)**

Please refer to the table below for coding requirements:

Service	Coding Requirements
Comprehensive Visit (in person)	G9012 with modifiers U2 and U5
Comprehensive Visit (synchronous audiovisual)	G9012 with modifiers U2, U5 and 95
Follow-up Visit (in person)	G9012 with modifiers U5 and TS
Follow-up Visit (synchronous audiovisual)	G9012 with modifiers U5, TS and 95
Follow-up Visit telephone(audio-only)	G9012 with modifiers TS and 93

Trauma-Informed Care Alternative Payment Model

Trauma-Informed Care Alternative Payment Model

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

- Additional information on this program, please review Superior's Provider News article, *STAR Health Trauma-Informed Care Alternative Payment Model:*
  - https://www.superiorhealthplan.com/newsroom/star-health-trauma-informed-care-alternative-payment-model-06012021.html

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

Trauma-Informed Care Alternative Payment Model

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

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

Trauma-Informed Care Alternative Payment Model

The requirements for participating are as follows:

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

Turning Point Program

Turning Point Program

A Psychiatric Hospital Diversion Program for Children and Youth in STAR Health.

- Benefits of this new program include:
  - Access to a 24-hour crisis information line
  - Mental health assessment
  - Intensive Counseling
  - Family supports and skills building
  - Crisis support and intervention planning

- To learn more about Turning Point:
  - Visit Superior's Turning Point Program webpage: https://www.fostercaretx.com/for-members/stay-healthy/behavioral-health/turning-point.html
  - Call the Dallas/Fort Worth location at: 1-817-909-1171
  - Call the Lubbock location at 1-866-912-6283
  - More information is also available online at www.ACHservices.org for the Dallas/Fort Worth Location or the Lubbock Location at Turning Point - Empowering Children - Giving Hope (txgbr.org)
  - Download a PDF of the Turning Point Flyer (PDF): https://www.fostercaretx.com/content/dam/centene/fostercare/pdfs/SHP_20207120A-FC-Turning-Point-Flyer-M-EN-ES-508-04052022-DFW.pdf

Health Passport

Health Passport

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

Health Passport Contractual Requirement

- It is a contractual requirement for behavioral health providers treating STAR Health members to document outcome measurement scores in Health Passport. The following information must be documented within Health Passport:
  - Primary and secondary (if present) diagnosis
  - Assessment information
  - Brief narrative summary of clinical visits and progress
  - Scores on each outcome rating form(s)
  - Referrals to other providers or community resources
  - Evaluations of each member's progress at intake, monthly and at termination of the Health Care Service Plan (HCSP) or as significant changes are made in the treatment plan
  - Any other relevant care information
- Behavioral health providers must submit an initial and monthly narrative summary report of a member's behavioral health status for inclusion in Health Passport.
- Additional information on this requirement can be found in our provider manual or by reviewing Superior's Provider News article, *Health Passport Requirements for Behavioral Health Providers Serving STAR Health Members*: https://www.superiorhealthplan.com/newsroom/health-passport-requirement-for-bh-providers.html.

Fraud, Waste and Abuse

Fraud, Waste and Abuse

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184.
  - Visit https://oig.hhs.gov/ and select “Click Here to report fraud, waste and abuse” to complete the online form.
  - Contact Superior’s Corporate Special Investigative Unit directly at:

    Centene Corporation
    Superior HealthPlan Fraud and Abuse Unit
    7700 Forsyth Boulevard
    Clayton, MO 63105
    1-866-685-8664

- Examples of fraud, waste and abuse:
  - Payment for services that were not provided or necessary
  - Upcoding
  - Unbundling
  - Letting someone else use their Medicaid or CHIP ID

Secure Provider Portals Superior's Website and Useful Resources

Online Tools

Availity Essentials

Superior HealthPlan has chosen Availity Essentials as its new, secure provider portal.

Use Availity Essentials to verify member eligibility and benefits, submit claims, check claim status, submit authorizations, and more.

Essentials Registration & Support | Availity

https://www.availity.com/essentials-portal-registration/

- If you need additional assistance with your registration, please call Availity Client Services at 1-800-AVAILITY (282-4548). Assistance is available Monday through Friday, 7 a.m. – 7 p.m. CST

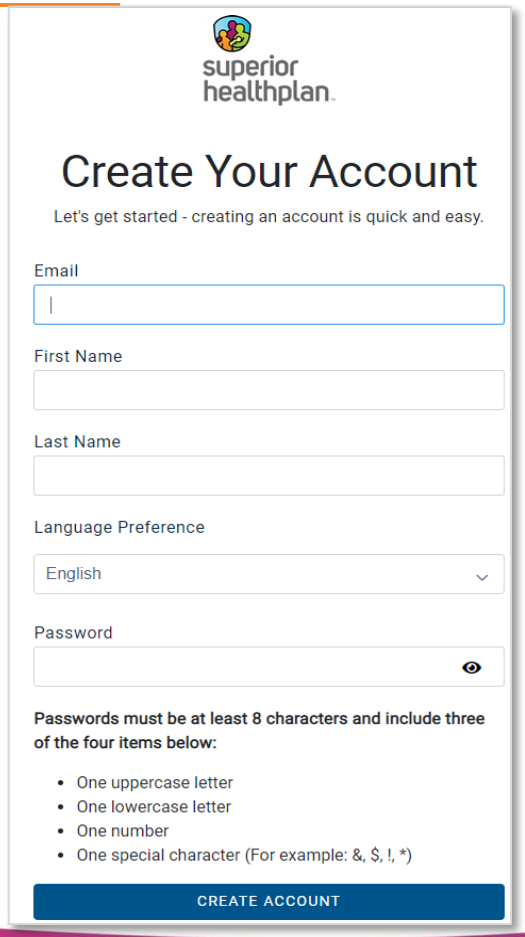
•**Receive Additional Functionality** in Superior's payer space on Essentials and use the heart icon to add apps to *My Favorites* in the top navigation bar.

•**Access *Manage My Organization Providers*** to save provider information. You can then auto-populate that information to eliminate repetitive data entry and reduce errors.

Superior's Secure Portal

Superior's Secure Provider Portal remains active as well.
To register, visit Provider.SuperiorHealthPlan.com.

- A user account is required to access the web portal. If you do not have a user account, click **Create An Account** to complete the registration process.
- Access to Care Gaps and member reports
- Access to Superior's Health Passport



SuperiorHealthPlan.com

The For Providers section contains many useful links

- Network Request or Update
  - To request a contract, add a product or even add a provider to your direct agreement
- Provider News & Information
  - Sign up for or view our latest news and updates
- Provider Events
  - RSVP to attend a quarterly Provider Advisory Group or Clinical Advisory Committee meeting in your area

SuperiorHealthPlan.com

Provider Resources

- Quick Reference Guides
- Forms
- Clinical, Payment & Pharmacy Policies
- Toolkits

Trainings and Manuals

- Provider Manuals
- Presentations
- How to guides and Videos

Highlights

CEUs:

- Behavioral Health Clinical Trainings (under trainings and manuals)
- Centene Institute for Advanced Health Education

Key BH Trainings:

- Outpatient Behavioral Health Training
- Negative Balance Training

Additional online Resources

Texas Medicaid Provider Procedures Manual | TMHP	Texas Medicaid Provider Procedures Manual • Refer to Behavioral Health and Case Management Services Handbook Section 4.2.2. and 4.5
Medical Documentation for Behavioral Health Practitioners (cms.gov)	Medical documentation for BH Practitioners
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56937	Specific Coding Guidelines section around codes for length of session

Quality Improvement

Quality Improvement

- Working with our provider community:
  - Manage and review annual Healthcare Effectiveness Data and Information Set (HEDIS) rates to identify collaborative interventions to improve HEDIS scores.
  - Maintain compliance with quality related areas of HHSC regulations.
  - Generate, distribute and analyze selected provider profiles.
  - Conduct and analyze provider satisfaction surveys annually to identify opportunities to provide better service.
  - Review, investigate and analyze quality of care concerns (member complaints).

- Monitors quality of care and services provided to members through:
  - Appointment availability audits
  - After-hours access audits
  - Tracking/trending of complaints

Quality Improvement

Quality Assessment and Performance Improvement (QAPI):

- Providers participate in QAPI by:
  - Volunteering for Quality Improvement Committees
  - Responding to surveys and requests for information
  - Vocalizing opinions
  - Attend our Clinical and Administrative Advisory Committee (CAAC) Meetings
    - The CAAC is inclusive to all STAR Kids providers, including Acute Care, Community-based, Behavioral Health, therapies, DME and supplies, and pharmacy Providers
    - Meetings & registration information is posted under Provider Events
      Provider Events (SuperiorHealthPlan.com)

If you are interested in learning more about Superior HealthPlan's QI Program, please contact Superior HealthPlan at 1-800-218-7453, ext. 82674 and ask to speak with the Quality Improvement Department.

Provider Responsibilities

Behavioral Health Provider Responsibilities

Behavioral health providers are required to:

- Comply with the Psychotropic Medication Utilization Parameters for Foster Care Children
  - For more information, visit: Texas Department of Family and Protective Services (DFPS) Psychotropic Medications webpage
- Expand the use of evidence-based practices, including:
  - Trauma focused cognitive behavioral therapy
  - Cognitive behavioral therapy for sexually abused children
- Provide services to targeted populations, including members with:
  - Abandonment issues
  - Attention Deficit Hyperactivity Disorder
- Provide documentation required for judicial review, including initial assessments and monthly reviews

Behavioral Health Provider Responsibilities

- Superior requires all providers (physician, hospital and ancillary) to maintain sound medical record keeping practices that are consistent with Superior's Medical Records Guidelines
- Medical records may be on paper or electronic. Superior requires that records be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review
- Superior's Medical Records requirements can be found in attachment C of the provider manual found on SuperiorHealthPlan.com/ProviderManuals
- Additional training regarding medical records can also be found in our *Outpatient Behavioral Health Provider Training* found on SuperiorHealthPlan.com/ProviderBehavioralHealth

Questions and Answers

Thank you for attending!