Durable Medical Equipment (DME) Comprehensive Provider Training

Introductions and Agenda

By the end of this training, you will be able to understand and/or identify the follow:

- Member products and benefits
- Tools and resources for DME
- Differences between benefits for Medicaid acute and waiver programs
- Internal teams and their responsibilities for each program
- Payer Hierarchy
- Authorization requirements and appropriate documentation
- Incomplete documentation process
- Medical Necessity Appeals
- Authorization approval acute/waiver for determining reimbursement
- Provider's role and responsibilities
- Contractual Agreement
- Billing Compliance/False Claims Act
- Fraud, Waste, and Abuse
- Additional Helpful Topics

What is Superior HealthPlan?

- Superior, is a subsidiary of Centene Corporation, manages health care for members across Texas.
- Superior has been a contracted Managed Care Organization (MCO) since December 1999 serving all 254 counties and providing health care to 2 million Texas residents throughout the state.
- Superior works with Texas Health and Human Services Commission (HHSC) to offer STAR STAR+PLUS, STAR Kids, STAR Health (Medicaid) and Children's Health Insurance Plan (CHIP). Since 2008 Superior has been the exclusive provider of STAR Health, which supports children and youth in foster care.
- Superior also offers Medicare and STAR+PLUS Medicare-Medicaid Plan (MMP) coverage along with Ambetter, the product offered through the Health Insurance Marketplace.
- Since 2015, Superior has been one of the top-rated Medicaid plans in Texas and since 2019 Superior has maintained the NCQA Distinction in Multicultural Health Care, which is earned by organizations that excel in providing culturally and linguistically sensitive services while working with reduce health-care disparities.

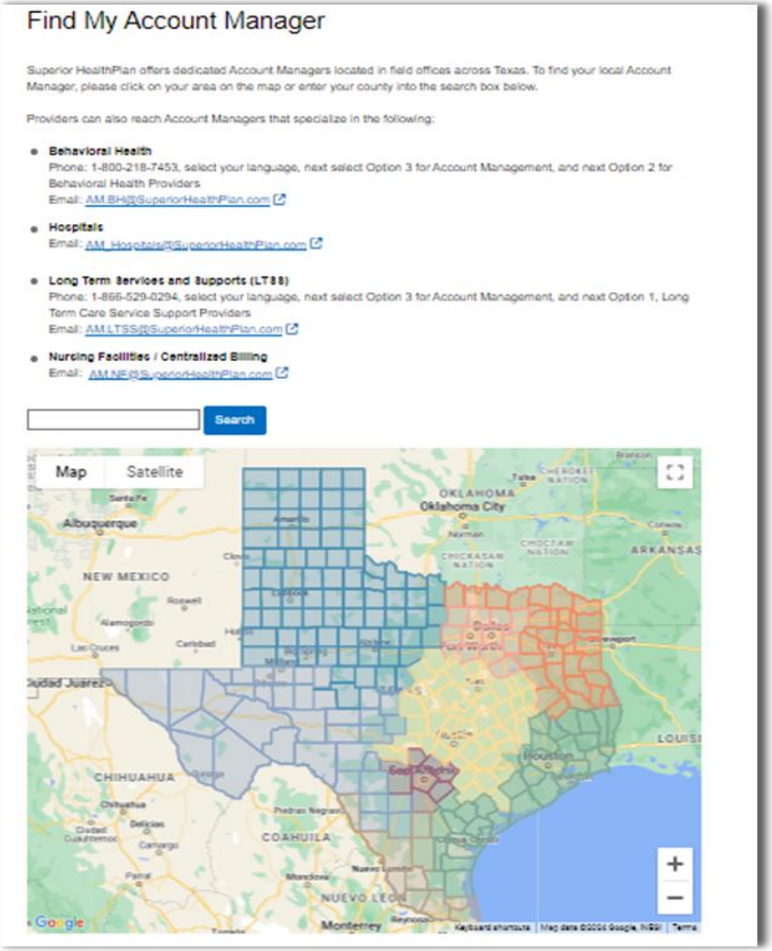
Provider Services

- Provider Services is available to assist providers with questions, member eligibility, claim status, payments, claim appeals, corrections, and finding Superior network providers.
- For claims-related questions, be sure to have your claim number, Taxpayer identification Number (TIN) and other pertinent information available as Health Insurance Portability and Accountability Act (HIPAA) validation will occur.
- Providers should utilize the provider service team as your first point of contact for assistance.
  - Available Monday through Friday 8:00 a.m. to 5:00 p.m. CST
    - CHIP, STAR, STAR+PLUS, STAR+PLUS Medicare-Medicaid Plan (MMP), STAR Kids: 1-877-391-5921
  - Available Monday through Friday 8:00 a.m. to 6:00 p.m. CST
    - Wellcare By Allwell: HMO: 1-800-977-7522 / DSNP: 1-877-935-8023
    - STAR Health (Foster Care): 1-877-391-5921
    - Ambetter from Superior HealthPlan: 1-877-687-1196

Account Management

- Superior's Account Managers represents the voice, partnership, and engagement of all network providers. Account Managers ensure our providers are well informed, up to date on processes and requirements, and have overall satisfaction with Superior.
- An Account Manager understands that they represent Superior when building a relationship with providers.
- Account Managers are looked to for their expertise in all business functions of Superior both by our external customers (providers) and internal partners (other departments).
- The performance expectations of an Account Manager is that of integrity, accountability, innovation, and passionate customer service.
- The roles and responsibilities of an Account Manager include but are not limited to:
  - Conducting Provider Trainings
  - Conducting Provider Visits
  - Outreaches
  - Quality Improvement
  - Claims Assistance
  - Provider Advisory Group Events

Find My Account Manager



- For questions, please contact your designated Account Manager. To access their contact information visit, Find My Account Manager.

SuperiorHealthPlan.com

Regional Account Manager Contact Information

Contacting Field Operations

SDA	Regional Inbox	Phone / Regional Extension
Region 1- Bexar	AM.SanAntonio@SuperiorHealthPlan.com	866-615-9399 Ext. 87390
Region 2- El Paso/Lower West	AM.ElPaso@SuperiorHealthPlan.com	877-391-5923 Ext. 87392
Region 3- Central/Travis	AM.Austin@SuperiorHealthPlan.com	800-218-7453 Ext. 87395
Region 4- Hidalgo	AM.Hidalgo@SuperiorHealthPlan.com	877-278-4268 Ext. 87394
Region 5- Dallas/Northeast/Tarrant	AM.Dallas@SuperiorHealthPlan.com	866-529-0294 Option 3
Region 6- Lubbock/Upper West	AM.Lubbock@SuperiorHealthPlan.com	866-534-5957 Option 3
Region 7- Nueces	AM.CorpusChristi@SuperiorHealthPlan.com	800- 656-4817 Option 3
Region 7- Harris/Jefferson	AM.Houston@SuperiorHealthPlan.com	800- 656-4817 Option 3

Service Coordination

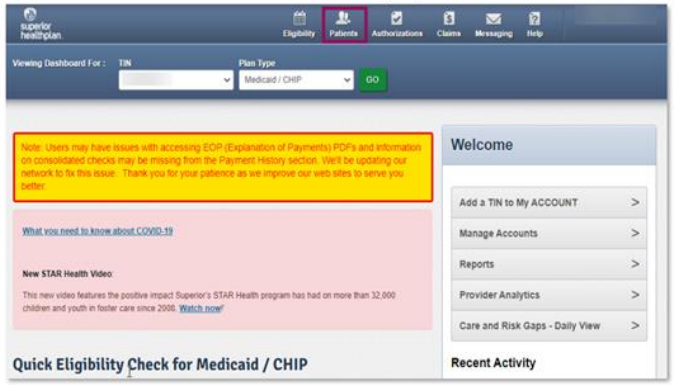
- Single point of contact for the member for both clinical and non-clinical support.
- Review assessments and develop plan of care utilizing input from member, family and providers.
- Coordinate with the member's Primary Care Physician (PCP), specialist(s), and LTSS providers to ensure the member's health and safety needs are met in the least restrictive setting.
- Refer member to support services such as disease management and community resources.
- Utilizes a multidisciplinary approach in meeting members' medical and behavioral health needs.
- Conducts mandatory telephonic or face-to-face contacts.
- Works with DME providers and PCPs to ensure services to member are as efficient as possible.

How to Find a Service Coordinator

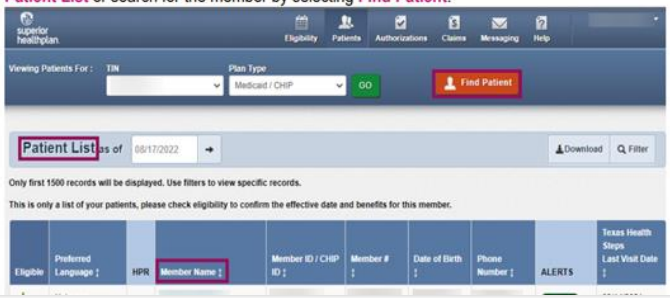
Superior's Secure Provider Portal

To locate a member's assigned Service Coordinator using Superior's Secure Provider Portal please follow the steps below:

1. Go to Provider.SuperiorHealthPlan.com and log in to Superior's Secure Provider Portal.
2. From the Main Tool Bar select the **Patients** tab at the top of your screen.

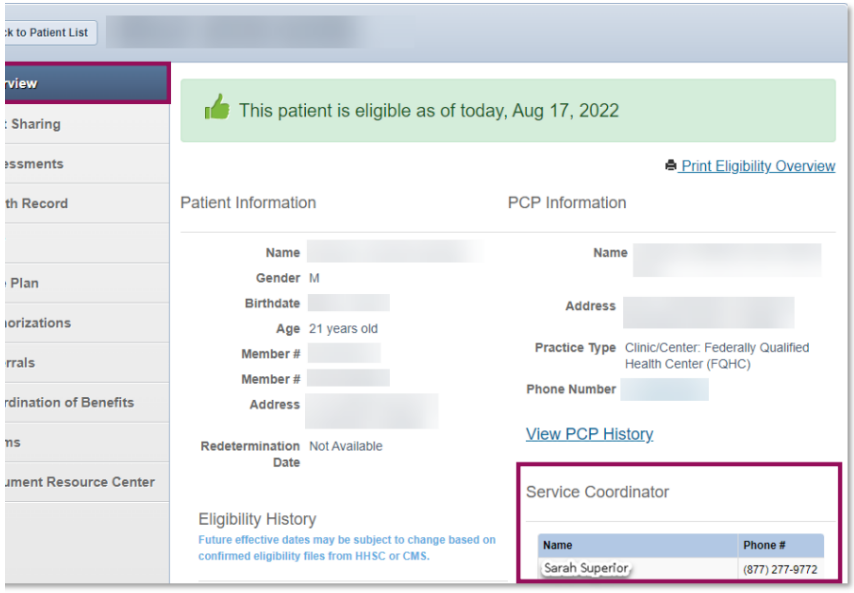


3. The **Patient List** will appear on the screen. You can find and select the member's name from the **Patient List** or search for the member by selecting **Find Patient**.



- Once you have selected **Find Patient**, enter the **Member ID or Last Name** and their **Birthdate**, then click **Find**.

t the **Overview** tab to display the assigned **Service Coordinator** along with their phone num



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What is STAR+PLUS?

- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program, which makes the member eligible for the HCBS (Home Community Based Services) under the STAR+PLUS (C) waiver program.
- The STAR+PLUS program is designed to integrate the delivery of Acute Care and Long-Term Services and Supports (LTSS) through a managed care system, combining traditional health care services with LTSS, such as providing help in the home with daily living activities, home modifications, and personal assistance.
- Members, their families, providers, and Superior work together to coordinate the members' healthcare and long-term care community support services.
- The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a member.
- Covered Services/Benefits include but are not limited to:
  - DME and supplies
  - LTSS services
  - STAR+PLUS Waiver Services

What is STAR+PLUS MMP?

- The STAR+PLUS program includes Medicare-Medicaid Plan (MMP), a Texas Dual Demonstration project fully intergrading the managed care model for individuals 21 and over who are enrolled in Medicare and Medicaid. The MMP plan includes all Medicare benefits for Part A, B and D and the Medicaid benefits, wrap-around services and LTSS.
- STAR+PLUS MMP is an opt-in/opt-out program.
- Covered Services/Benefits include but are not limited to:
  - Service Coordination to target member outreach and care coordination
  - DME and supplies
  - LTSS services
  - STAR+PLUS Waiver Services

Note: All services are subject to benefit coverage, limitations and exclusions.

What is STAR Kids?

- STAR Kids is a health insurance program designed for children with disabilities, special needs, or chronic conditions, who are age 20 or younger receiving Social Security Income (SSI) and SSI related Medicaid, the Medically Dependent Children (MDCP),Youth Empowerment (YES), and Intellectual Developmental Disability (IDD) waiver services.
- Medicaid members participating in the STAR Kids program receive all the benefits of the traditional Texas Medicaid program and waiver services.
- STAR Kids benefits/services include, but are not limited to:
  - DME and supplies
  - LTSS
  - Adaptive Aids
  - Minor Home Modifications
- STAR Kids does provide a plan for transitioning provision of benefits from STAR Kids to STAR+PLUS when the member turns 21.

Program Benefits: Medicaid Home Health (acute) and Waiver

- Medicaid Home Health Services benefits available under STAR Products include but are not limited to:
  - DME
  - Adaptive aids
  - Medical supplies
- The STAR+PLUS Home and Community Base Services (HCBS) is a Medicaid waiver program for members who are 21 years of age or older that offers the following:
  - Combines acute care and long-term services and support (LTSS)
  - Home modifications
  - Respite (short-term supervision)
  - Personal assistance services (PAS)
  - Continuum of care with a wide range of options with increased flexibility
  - Safe alternative to nursing facility (NF) placement.
  - Ancillary supplies, and equipment
  - Durable and non-durable medical equipment not available under the Texas state plan.
- The annual cost limit of this program is $10,000 per Individual Service Plan year.

Home and Community Based Services (HCBS)

133 Access to the Community

- The HCBS Settings Rule on the Code of Federal Regulation title 42 Section 441.301(c)(4)(i) requires the member to have full access to the greater community. This includes opportunities to engage in community life, control personal resources, and receive services in the community in the same way a person not receiving Medicaid services.
  - The MCO must ensure the following:
    - Providers not have policies or practices in place that restrict or obstruct the member's access to the community
    - Must also ensure provider service and support practices do not create an environment that is institutional in nature
    - Must support the member's desire to participate in the community
  - The MCO must use the person-centered planning process to:
    - Ensure the member has opportunities and supports needed to participate in their community when they want
    - Both individually and in groups
    - Identify, develop, and make available information
      - Transportation options for community access
      - Assist the member with developing meaningful relationships with other members
      - Ensure the member has services, resources, and support

Home and Community Based Services (HCBS)

1143.2 Services Available to STAR+PLUS Home and Community Based Services Program Members

- Services necessary for the individual to remain in or return to the community are identified from the array of services available through the STAR+PLUS HCBS program.
- STAR+PLUS HCBS program services include:
  - Adaptive Aids and Medical Supplies
  - Minor Home Modifications (MHMs)
- For more information, visit HHSC's STAR+PLUS Handbook webpage.

HHSC STAR+PLUS Guidelines

6400, Adaptive Aids and Medical Supplies

- Adaptive aids and medical supplies are specialized medical equipment and supplies, including devices, controls or appliances that enable members to increase their abilities to perform Activities of Daily Living (ADLs), or to perceive, control or communicate with the environment in which they live. Adaptive aids and medical supplies are reimbursed with STAR+PLUS HCBS program funds, when specified in the Individual Service Plan (ISP), with the goal of providing individuals a safe alternative to Nursing Facility placement.
- This service includes items necessary
  - For life support
  - Ancillary supplies
  - Durable and non-durable medical equipment not available under the Texas state plan
    - Vehicle modifications
    - Service animals and supplies,
    - Environmental adaptations
    - Aids for daily living

HHSC STAR+PLUS Guidelines

- The state allows a member to select a relative or legal guardian, other than a legally responsible individual, to be the member's provider for this service if the relative or legal guardian meets the requirements for this type of service.
- Adaptive aids and medical supplies are limited to the most cost-effective items that:
  - Meet the member's needs;
  - Directly aid the member to avoid premature NF placement
  - Provide NF residents an opportunity to return to the community.
- For more information, please visit HHSC's STAR+PLUS Handbook.

Understanding DME

- DME and Adaptive Aids (AA) are benefits available to all Medicaid and Medicare members.

- DME is specialized medical equipment that can stand repeated use, and/or supplies, including devices, that enable individuals with illness or injury to increase their abilities to perform activities of daily living or perceive, control or communicate with the environment in which they live.

HHSC Minor Home Modifications (MHMs)

6600, MHMs

- MHMs are those physical adaptations to a member's home, required by the service plan, that are necessary to ensure the member's health, welfare and safety, or that enable the member to function with greater independence in the home.
- Such adaptations may include:
  - Installation of ramps and grab-bars
  - Widening of doorways
  - Modification of bathroom facilities
  - Installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies
- Excluded are adaptations or improvements to the home that are:
  - General utility, and are not of direct medical or remedial benefit to the member such as:
    - Carpeting
    - Roof repair
    - Central air conditioning
    - Adaptations that add to the total square footage of the home
- All services are provided in accordance with applicable state or local building codes. Modifications are not made to settings that are leased, owned or controlled by providers contracted with the MCO.

HHSC Minor Home Modifications (MHMs)

6610 Responsibilities Pertaining to MHM

- To ensure cost-effectiveness in the purchase of MHMs, the MCO must:
  - Determine and document the needs and preferences of the member for the MHM
  - Document the necessity for the MHM.
- The MCOs have their own policies and procedures for bidding, awarding contracts, doing inspections and completing MHMs.
- For more information, please visit HHSC's STAR+PLUS Handbook.

Payer Hierarchy

- Who pays the bill?
  - Commercial (Private) Insurance
  - Medicaid Only/Non-Duals – Superior is primary payer
  - Dual Coverage – Medicare is the Primary payer, Texas Medicaid & Healthcare Partnership (TMHP) is secondary, Superior is last payer
  - Waiver – is the payor of last resort (only if member has waiver)
- Note concerning Hierarchy and Prior Authorization Requirements:
  - If a client's primary coverage is private insurance and Medicaid is secondary, prior authorization is required for Medicaid reimbursement.
  - If the primary coverage is Medicare, if Medicare approves the service, and Medicaid is secondary, prior authorization is not required. Medicaid will pay only the coinsurance or deductible according to current payment guidelines.
  - If Medicare denied the service, then Medicaid prior authorization is required. The Medicare Remittance Advice Notice (MRAN) containing Medicare's final disposition must accompany the prior authorization request.
  - If the service is a Medicaid-only service, prior authorization is required, but if member has primary insurance, it would still be the primary payer prior to Medicaid.

Prior Authorizations

Superior's Authorizations Procedures

Superior has adopted a prior authorization process for specific procedures and/or services. Failure to obtain prior authorization for services that require prior authorization will result in an administrative denial. Please note, if any prior authorization form is returned with the language "PA Not Required" the requesting provider should verify if the service is a covered benefit and requires authorization using the prior authorization tool located on the Superior website.

- Prior authorization requests can be submitted by phone, fax or online through Superior's Secure Provider Portal**.**
  - **Phone Requests**
    - Authorization phone requests require subsequent submission of applicable documentation and clinical information to facilitate the medical necessity review of the request.
    - Authorization phone assistance is available on weekdays from 8am – 5pm CST
      - Physical Health Phone: 1-800-218-7508
  - **Fax Requests**
    - Providers should include a completed Authorization Request form and all required documentation including clinical information to the authorization request submitted through Fax.
    - Physical Health Fax: 1-800-690-7030
    - Waiver auth request must be faxed to the Service Coordination team 1-844-795-3720
    - For Authorization Request forms for applicable services, visit Superior's Provider Forms webpage.
  - **Secure Provider Portal**
    - Providers are encouraged to utilize the Secure Provider Portal for electronic submission of authorization requests.
    - The provider portal includes notation of 'required fields' for submission of all necessary information for a complete authorization request.
- Providers who require training on the appropriate procedures for authorization request entry through the secure provider portal should contact their designated Account Manager.

SuperiorHealthPlan.com

Required Documentation Elements for Physician's Order

- Member's Name, Medicaid ID number, and date of birth
- Description of item(s) needed, quantity, price
- Appropriate Healthcare Common Procedure Codes (HCPC)
- Pertinent diagnosis/conditions that relate to the need for the item
- Date of Service (Start and end date)
- Objective supporting clinical documentation
- Length of need
- Treating physician's name with National Provider Identifier (NPI) and Tax Identification Number (TIN)
- Current date treating physician signed the order on or before start date and no older than 90 days before the actual date of service.
- The physician's order must be retained in the records of both the DME supplier/medical provider and the requesting physician or allowed practitioner and is subject to retrospective review.
- An allowed ordering practioner is a Physician Assistant (PA) or an advanced practice registered nurse who is licensed as a Certified Nurse Practioner (CNP) or Clinical Nurse Specialist (CNS).
- DME orders signed by Doctors of Philosophy are not acceptable.

Authorization Documents

- Prior authorization request form –if submitting request by phone or fax submission
- Needed based on services provided:
  - Letter of Medical Necessity
  - QRP Seating Assessment
  - Manufacturer’s specifications of the requested seating system, including all components and accessories
  - Custom Manual and Power Wheelchair Seating Assessment Form.
  - Medical necessity and justification for all accessories and components (Custom Manual and Power Wheelchairs)
  - Home Accessibility Assessment
  - H &P with clinical notes (including growth charts when applicable) must be current within last 6 months
  - Alternate therapies tried and failed (Enteral and Incontinent Supplies)
  - Manufacturer’s MSPR or Invoice with full description and product number of item(s) being requested.
  - Current functional level (K level 0-4) (Orthotics and Prosthetics)
  - Orthotist/Prosthetist evaluation and exam (Orthotics and Prosthetics)

Authorization Documents

- Incontinent Supplies (all below):
  - Specific diagnosis/condition that is causing the increased urination or stooling
  - Client's height, weight, and waist size
  - Number of times per day the physician has ordered the supply to be used
  - Quantity of disposable supplies requested per month
  - All alternative treatment options for incontinence that member has tried/failed
  - Statement of why member has not tried alternative treatments for incontinence (if applicable)
- Overlimit items - Provider must submit documentation as to why over the allowable is needed and why the allowable is not sufficient.
- For more information please visit, Superior's Clinical, Payment & Pharmacy Policies webpage.

Miscellaneous Codes/Unclassified Procedure Codes

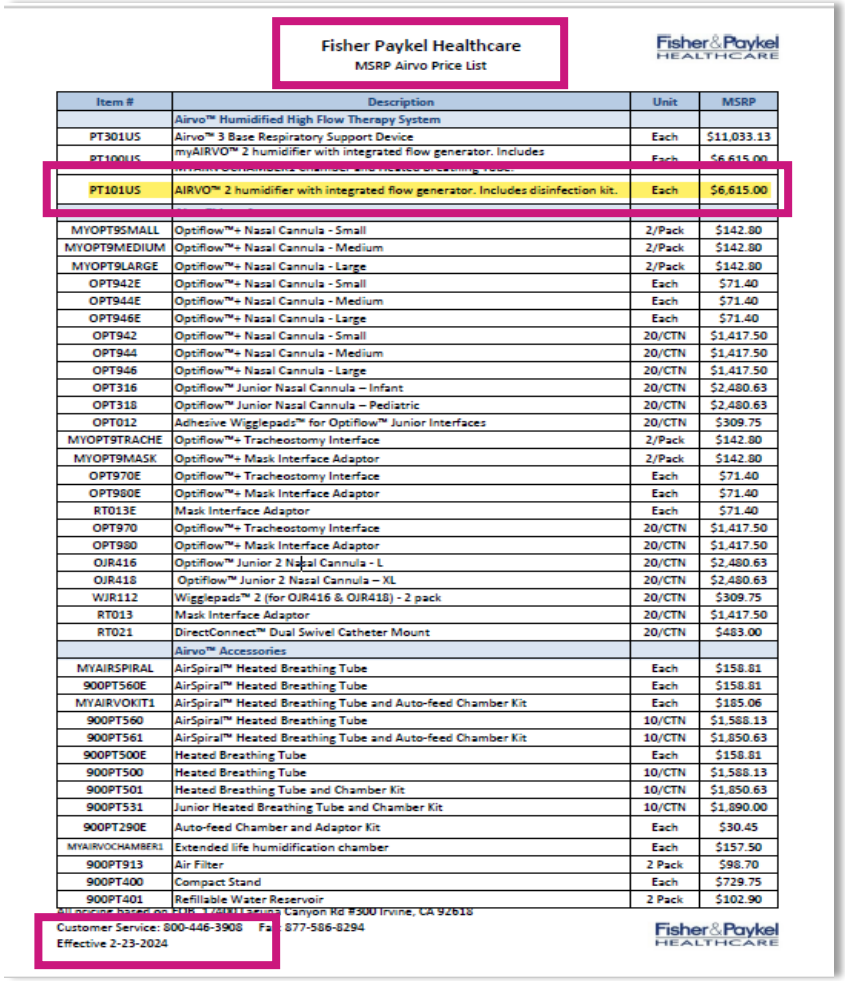
The Administrative Simplification provisions of the HIPAA of 1996 mandate the use of national coding and transaction standards. Correct coding requires that providers use the most specific code that matches the service being requested, based on the code's description.

- Services that do not have a unique Current Procedural Terminology (CPT) or Healthcare Common Procedure (HCPCS) procedure code may require use of a miscellaneous or unclassified procedure code. Such codes require prior authorization.
- Letter of Medical Necessity (LOMN) documenting alternative measures and alternative DME or supplies that have tried and failed to meet the member's medical needs or have been ruled out and an explanation of why they have failed or have been ruled out.
- Additional documentation requirements for a miscellaneous or unclassified procedure codes include:
  - Medical records that document the medical necessity of the requested service.
  - A clear, concise description of the service.
  - The provider's fee with Manufacturer Suggested Retail Price (MSRP) or manufacturer cost invoice.
    - MSRP/Invoice date must be within (2) two years of the date of service on the claim
    - MSRP/Invoice must be clearly marked with Manufacturer name.
    - Multiple Misc. code on the claim, MSRP must be clearly marked with each CPT code
- For more information please visit, Superior's Clinical, Payment & Pharmacy Policies webpage.

Unacceptable Documents for MSRP

- Unacceptable documents for MSRP for those invoices' services requiring manual pricing are as follows:
  - MSRP submitted with an Appeal ONLY is not acceptable proof of a clean claim submission.
  - Documents that are unreadable.
  - Home Health Services (Title XIX) DME/Medical Supplies Physician Order Form.
  - Documents labeled as “Delivery Ticket.”
  - Documents that are typed on billing company letterhead and do not contain proof of pricing per company supplying the item.
  - Alterations to invoices submitted for invoice-based claim pricing.

Examples of Acceptable MSRP/Invoice Documentation



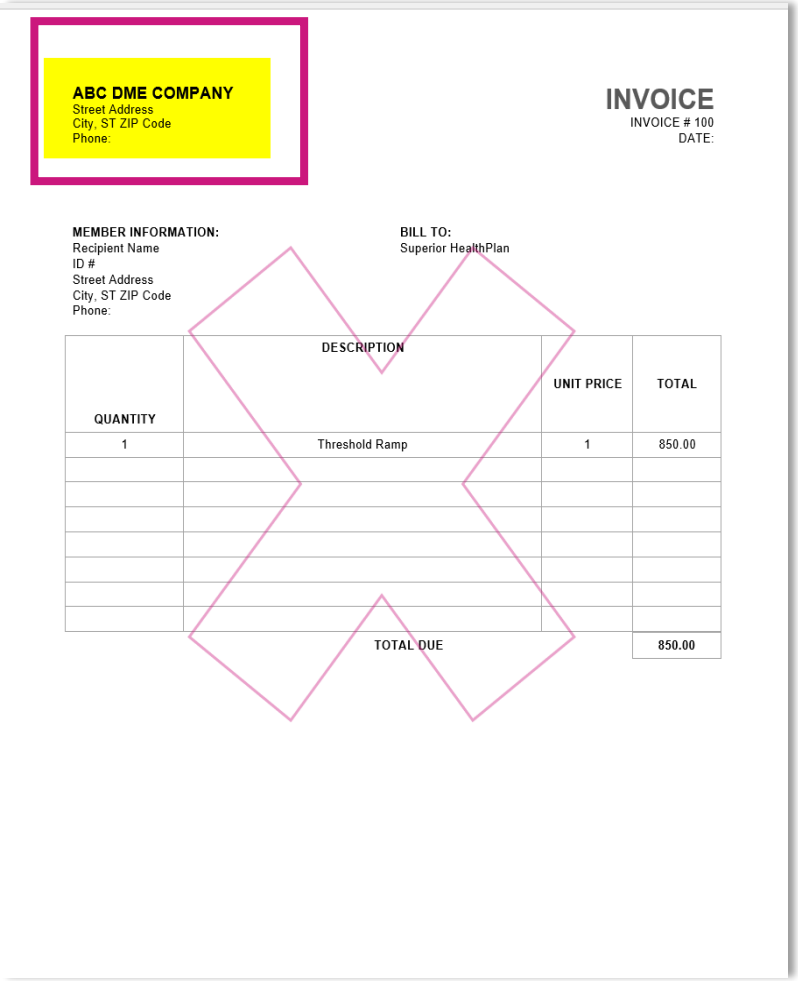
Fisher Paykel Healthcare
MSRP Airvo Price List

Fisher & Paykel HEALTHCARE

Item #	Description	Unit	MSRP
	Airvo™ Humidified High Flow Therapy System		
PT301US	Airvo™ 3 Base Respiratory Support Device	Each	$11,033.13
PT100US	myAIRVO™ 2 humidifier with integrated flow generator. Includes	Each	$6,615.00
PT101US	AIRVO™ 2 humidifier with integrated flow generator. Includes disinfection kit.	Each	$6,615.00
MYOPT9SMALL	Optiflow™+ Nasal Cannula - Small	2/Pack	$142.80
MYOPT9MEDIUM	Optiflow™+ Nasal Cannula - Medium	2/Pack	$142.80
MYOPT9LARGE	Optiflow™+ Nasal Cannula - Large	2/Pack	$142.80
OPT942E	Optiflow™+ Nasal Cannula - Small	Each	$71.40
OPT944E	Optiflow™+ Nasal Cannula - Medium	Each	$71.40
OPT946E	Optiflow™+ Nasal Cannula - Large	Each	$71.40
OPT942	Optiflow™+ Nasal Cannula - Small	20/CTN	$1,417.50
OPT944	Optiflow™+ Nasal Cannula - Medium	20/CTN	$1,417.50
OPT946	Optiflow™+ Nasal Cannula - Large	20/CTN	$1,417.50
OPT316	Optiflow™ Junior Nasal Cannula – Infant	20/CTN	$2,480.63
OPT318	Optiflow™ Junior Nasal Cannula – Pediatric	20/CTN	$2,480.63
OPT012	Adhesive Wigglepads™ for Optiflow™ Junior Interfaces	20/CTN	$309.75
MYOPT9TRACHE	Optiflow™+ Tracheostomy Interface	2/Pack	$142.80
MYOPT9MASK	Optiflow™+ Mask Interface Adaptor	2/Pack	$142.80
OPT970E	Optiflow™+ Tracheostomy Interface	Each	$71.40
OPT980E	Optiflow™+ Mask Interface Adaptor	Each	$71.40
RT013E	Mask Interface Adaptor	Each	$71.40
OPT970	Optiflow™+ Tracheostomy Interface	20/CTN	$1,417.50
OPT980	Optiflow™+ Mask Interface Adaptor	20/CTN	$1,417.50
OJR416	Optiflow™ Junior 2 Nasal Cannula - L	20/CTN	$2,480.63
OJR418	Optiflow™ Junior 2 Nasal Cannula – XL	20/CTN	$2,480.63
WJR112	Wigglepads™ 2 (for OJR416 & OJR418) - 2 pack	20/CTN	$309.75
RT013	Mask Interface Adaptor	20/CTN	$1,417.50
RT021	DirectConnect™ Dual Swivel Catheter Mount	20/CTN	$483.00
	Airvo™ Accessories		
MYAIRSPIRAL	AirSpiral™ Heated Breathing Tube	Each	$158.81
900PT560E	AirSpiral™ Heated Breathing Tube	Each	$158.81
MYAIRVOKIT1	AirSpiral™ Heated Breathing Tube and Auto-feed Chamber Kit	Each	$185.06
900PT560	AirSpiral™ Heated Breathing Tube	10/CTN	$1,588.13
900PT561	AirSpiral™ Heated Breathing Tube and Auto-feed Chamber Kit	10/CTN	$1,850.63
900PT500E	Heated Breathing Tube	Each	$158.81
900PT500	Heated Breathing Tube	10/CTN	$1,588.13
900PT501	Heated Breathing Tube and Chamber Kit	10/CTN	$1,850.63
900PT531	Junior Heated Breathing Tube and Chamber Kit	10/CTN	$1,890.00
900PT290E	Auto-feed Chamber and Adaptor Kit	Each	$30.45
MYAIRVOCHAMBER1	Extended life humidification chamber	Each	$157.50
900PT913	Air Filter	2 Pack	$98.70
900PT400	Compact Stand	Each	$729.75
900PT401	Refillable Water Reservoir	2 Pack	$102.90

All pricing based on FOB: 17400 Laguna Canyon Rd #300 Irvine, CA 92618
Customer Service: 800-446-3908 Fax: 877-586-8294
Effective 2-23-2024

Fisher & Paykel HEALTHCARE



ABC DME COMPANY
Street Address
City, ST ZIP Code
Phone:

INVOICE
INVOICE # 100
DATE:

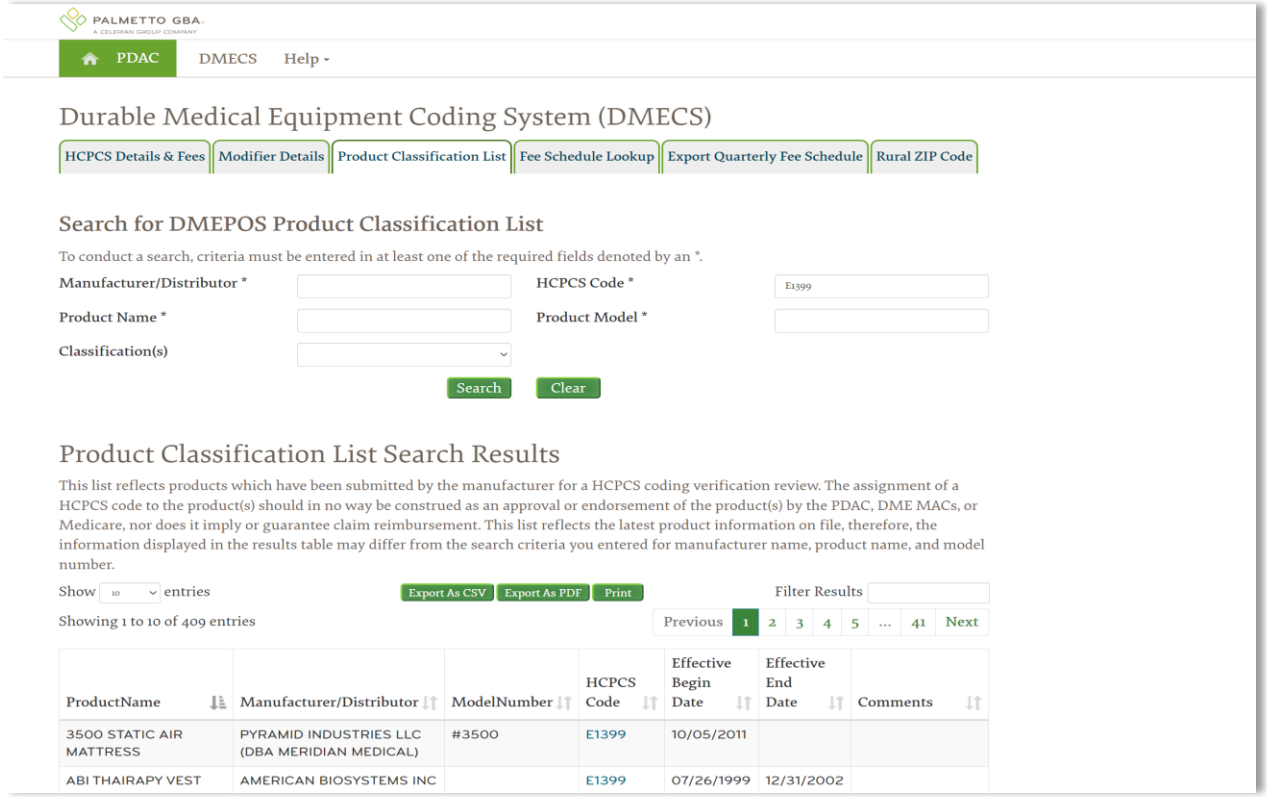
MEMBER INFORMATION:
Recipient Name
ID #
Street Address
City, ST ZIP Code
Phone:

BILL TO:
Superior HealthPlan

QUANTITY	DESCRIPTION	UNIT PRICE	TOTAL
1	Threshold Ramp	1	850.00
	TOTAL DUE		850.00

Resource DME Coding System

- For general information on the DME Coding system please visit the Pricing, Data Analysis and Coding (PDAC) - DME Coding System (DMECS) Information webpage.



Resource DME Coding System

- The PDAC contractor maintains the Durable Medical Equipment Coding System (DMECS).
- This interactive tool can be used to search for the following information:
  - Coding guide for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) manufacturers, distributors, and suppliers that provides HCPCS Level II coding information applicable to claim submission to the DME MAC.
- DMECS is not a substitute for official CMS HCPCS releases which is found on the CMS HCPCS – General Information webpage.
- HCPCS codes are considered valid or invalid for submission to the DME Medicare Administrative Contractors (MAC) based on either CMS or DME MAC instructions.
- View Basic elements of DMECS visit the DMECS Basics webpage.
- View videos for each DMECS search interface visit the DMECS Training webpage.
- View listings that provide new products added to the Product Classification List (PCL) each month visit the DMECS Update Listing webpage.

Utilization Management Authorizations

Utilization Management reviews DME authorization request for member benefits under the Medicaid HomeHealth (acute) program that are made in accordance with generally-accepted clinical practices, while considering the special circumstances of each case that may require an exception to the standard. Clinical screening criteria are used for the review of medical necessity of the requested service. If the medical necessity of a prior authorization cannot be confirmed by clinical staff, a Texas licensed physician/medical director reviews the case and includes the opportunity for a peer discussion with the rendering/ordering provider. The medical director reviews all potential Adverse Benefit Determinations for medical necessity.

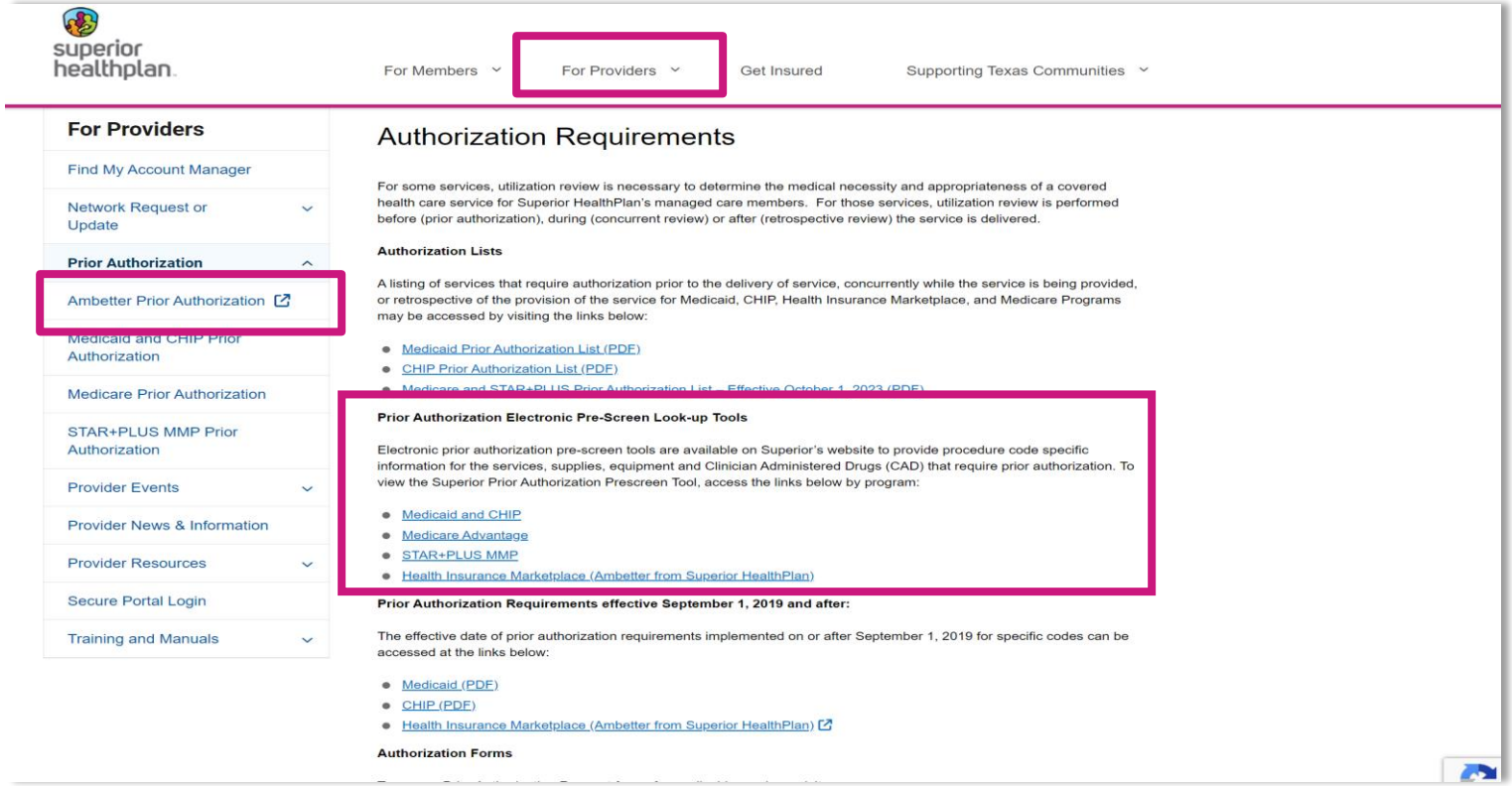
- The following are used for the review of medical necessity, as well as provider peer-to-peer review:
  - Federal and/or State Laws and Rules
  - Proprietary clinical guidelines
  - Interqual® criteria
  - Texas Medicaid Provider Procedures Manual (Medicaid)
- To request a copy of the criteria used to make a specific decision providers can:
  - Contact Provider Services at 1-877-391-5921
  - Review the clinical policies by visiting Superior's Clinical, Payment & Pharmacy Policies webpage
- Services Requiring authorization include, but are not limited to:
  - DME items with a purchase price greater than $500. There are exception to this rule
  - All miscellaneous codes (i.e. E1399) or noncovered CPT codes require authorization
  - Noncovered CPT codes are reviewed by the Medical Director for Medical Necessity
- For a full and current list of acute services that require authorization, visit Superior's Authorization Requirements webpage.

Centralized Authorization Team (CAT)-Waiver Authorizations

- All services provided under LTSS, and waiver programs require authorizations These authorizations are created based on information submitted by Service Coordination Team.
- The CAT consists of Program Coordinators and Service Coordinators who create authorizations for STAR, STAR Health, STAR Kids, STAR+PLUS), CHIP, STAR+PLUS Medicare-Medicaid Plan (MMP).
- The Service Coordination Team is responsible and following up with members after services have been received.
- CAT Team Authorizes the following services as requested by the Service Coordination Team:
  - MHM
  - Adaptive Aids and Waiver DME
  - Skilled Nursing
  - PAS and Delegated Nursing
  - TAS, Supported Employment, Employment Assistance
  - LTSS Adverse Determinations and MD Reviews
  - DAHS
- Typically, Service Coordination will initiate the request for DME from providers. However, at times providers receive requests from the physician, member, caregiver, or HomeHealth for services available through the waiver program. Special circumstance request may be considered through the waiver program.
- To initiate LTSS waiver authorization request or any changes to an authorization, providers may:
  - Call the Service Coordination department at 1-877-277-9772
  - Fax Service Coordination DME Team Fax number at 1-844-795-3720 (Adaptive Aids and Waiver DME request only)

Prior Authorization Tool

- To View the PA Electronic Pre-Screen Look-up Tools please visit Superior's Authorization Requirements webpage.
- Select **For Providers** from top Menu then choose **Prior Authorization** tab from side Menu.



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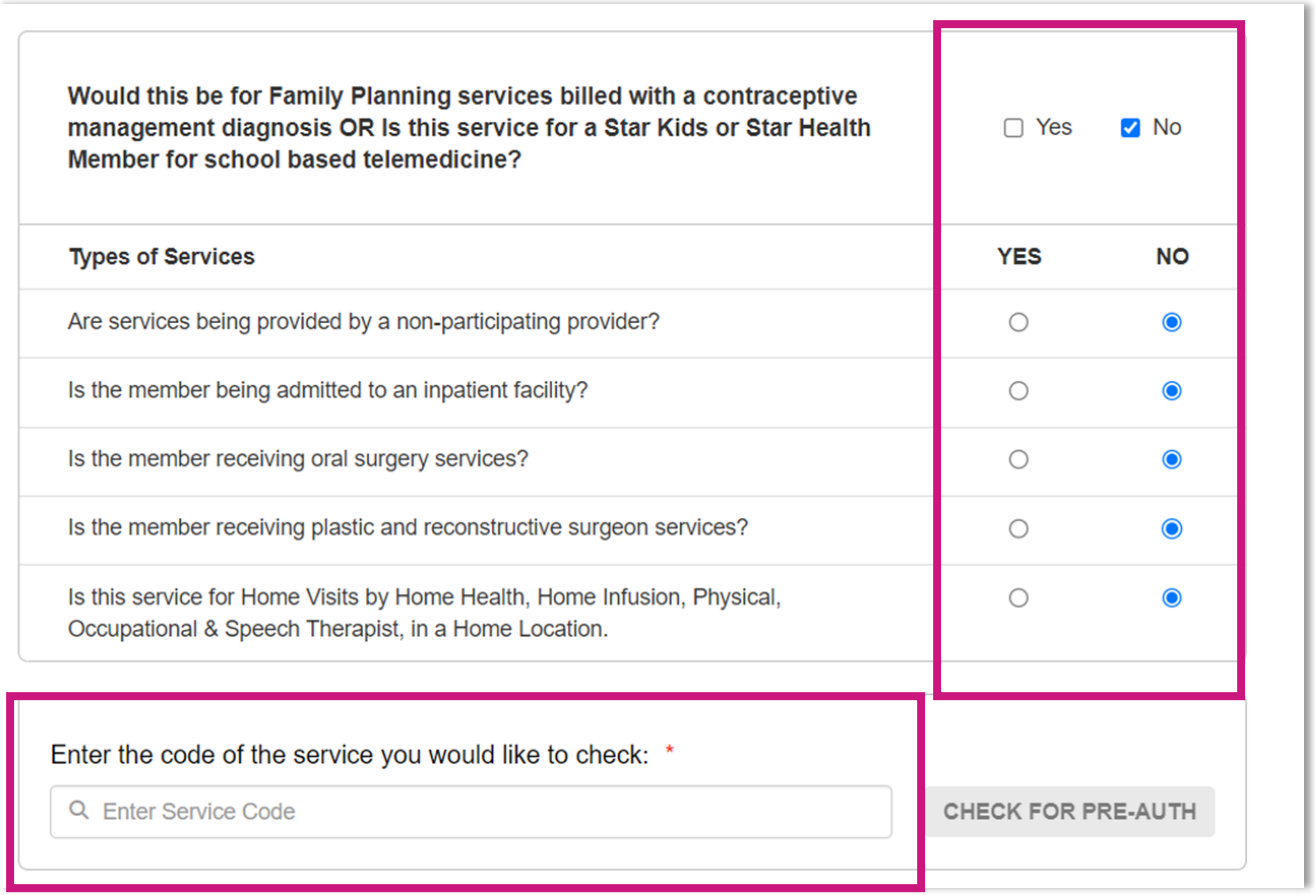
Prior Authorization Tool

- Complete each question for **Yes** or **No** option prior to entering the CPT code.



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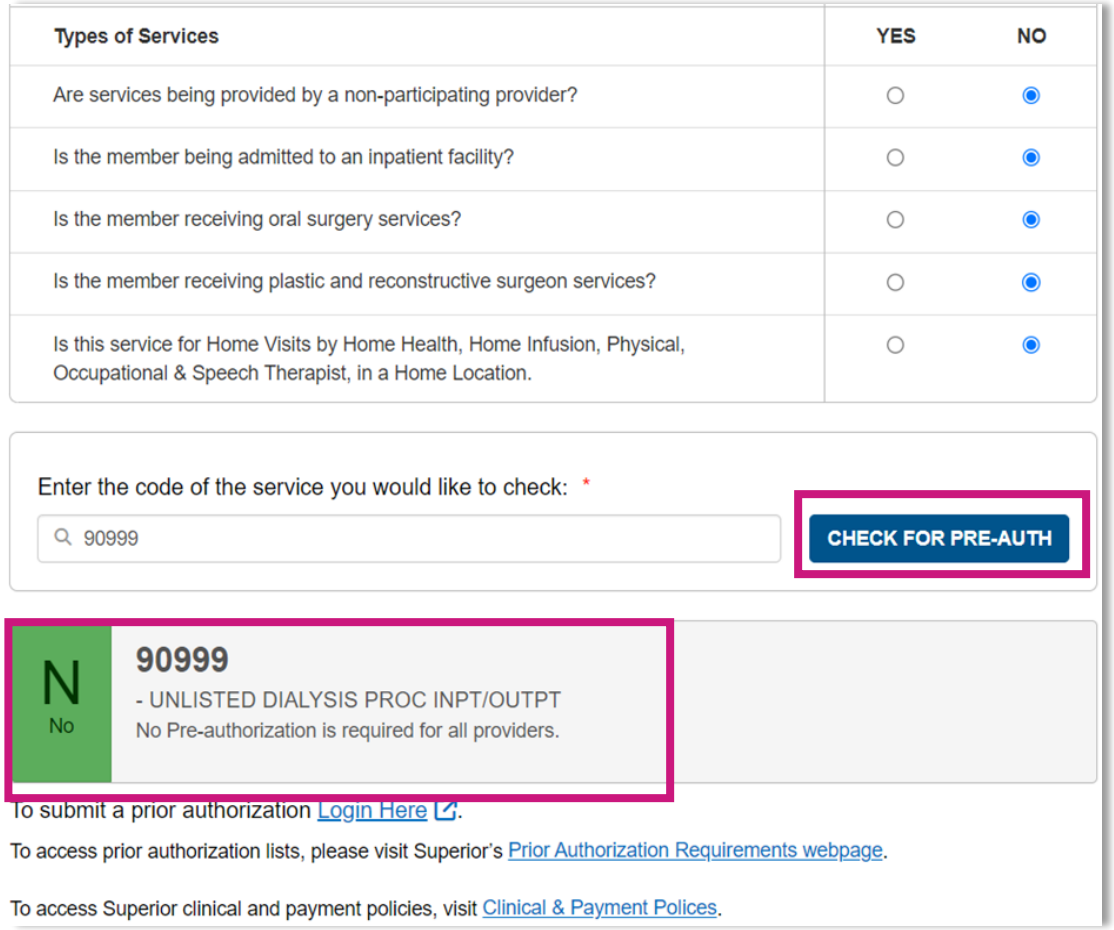
Prior Authorization Tool

- After completing questions, a box will appear to enter the CPT code. Enter CPT code and select **CHECK FOR PRE-AUTH**.
- Once selected an indicator will appear showing Green “N” or Red “Y” Please note some CPT codes could be conditional and will show a Blue “C”.



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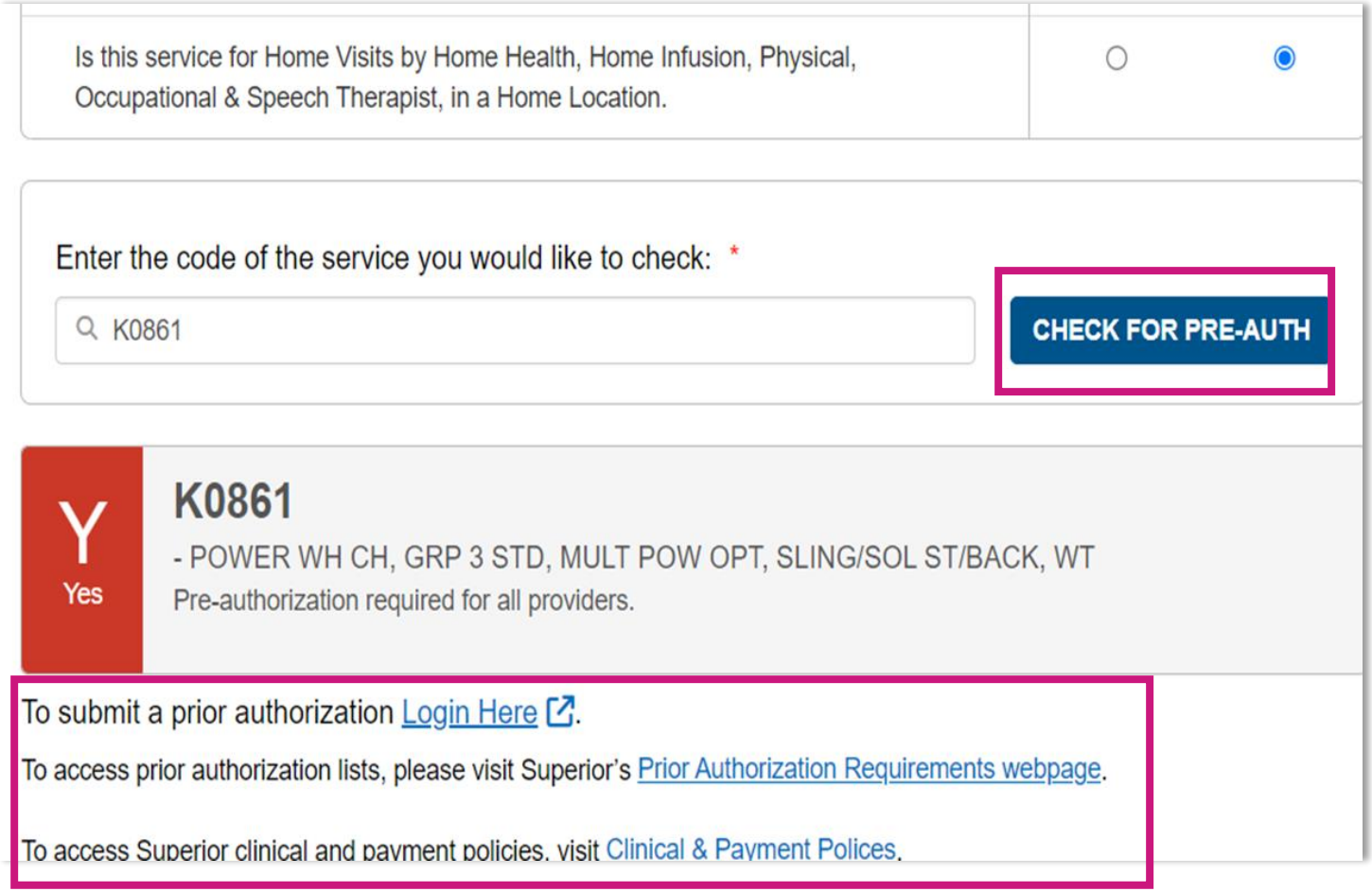
Prior Authorization Tool

- If authorization is required, submit an authorization by selecting **Login Here**.
- To access polices select **Clinical & Payment Policies**.



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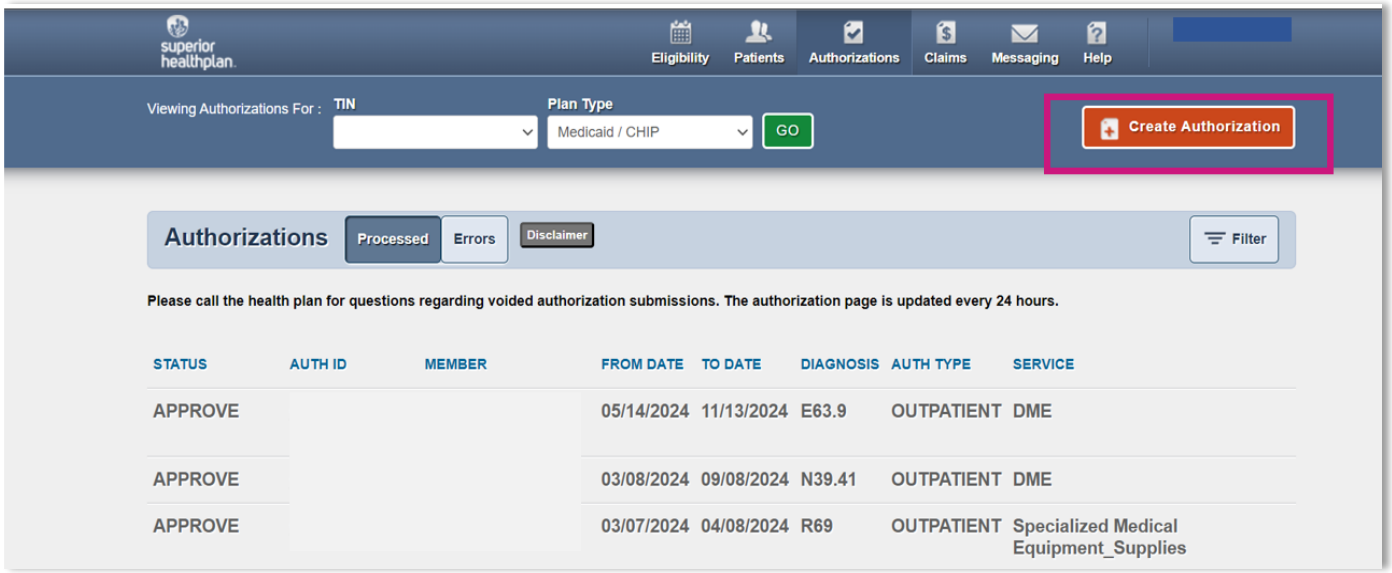
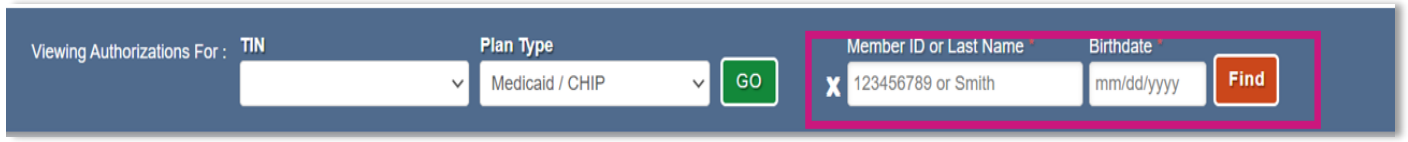
Secure Provider Portal: Authorization Process

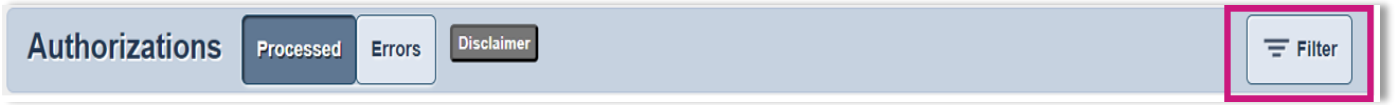
- Log into Superior's Secure Provider Portal.
- After logging in, providers can select **Authorization** in the upper menu options.
- Select **TIN** and **Plan Type** prior to clicking green **GO** icon to see all current Authorizations.

Secure Provider Portal: Authorization Process

- Once on the authorizations page you can select **Create Authorization** to begin a new request
- After 24 hours, can view the authorization status by searching with **Member ID or Last Name**, **Birthdate**, and other data by selecting **Filter**.







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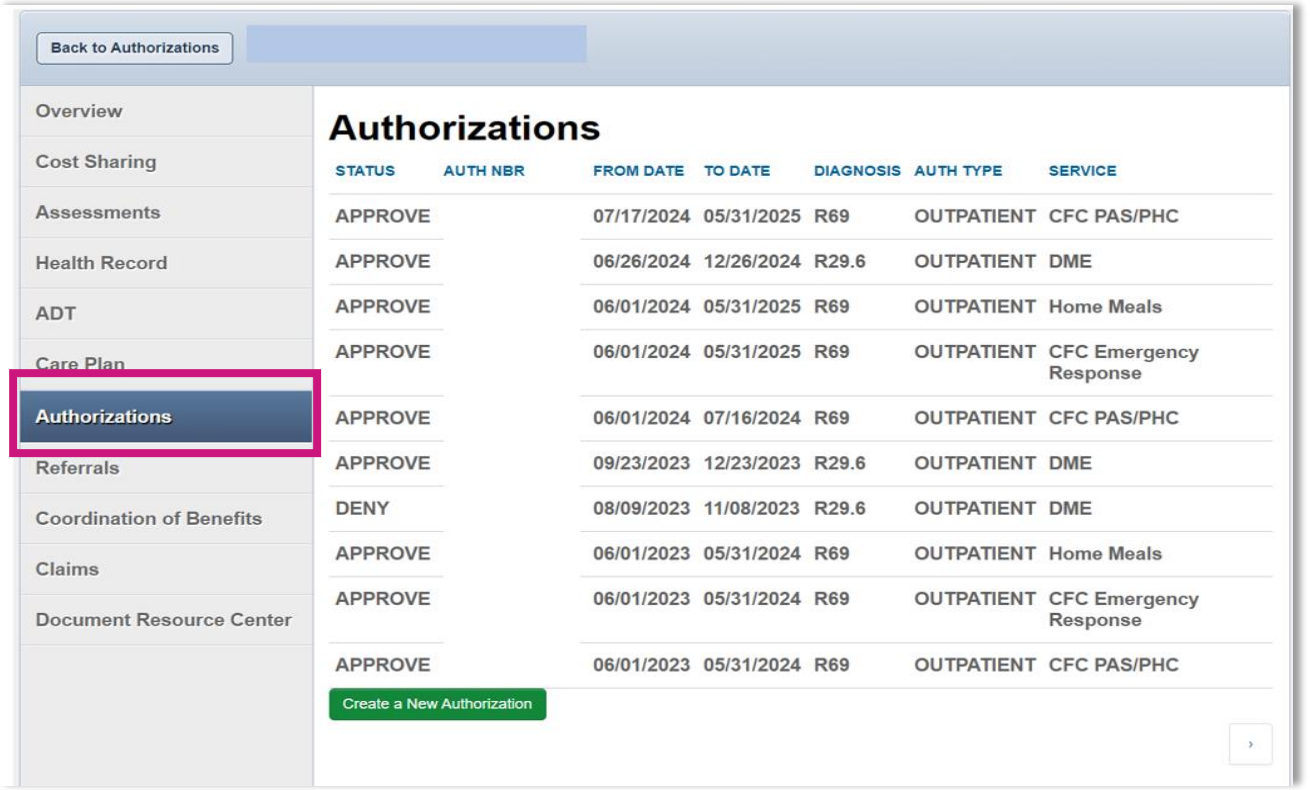
Secure Provider Portal: Authorization Process

- From member's Overview dashboard, the **Authorizations** tab provides all the member's authorization request.
- Providers can review past authorization request to see if the member has received same or similar equipment for items that require an authorization.



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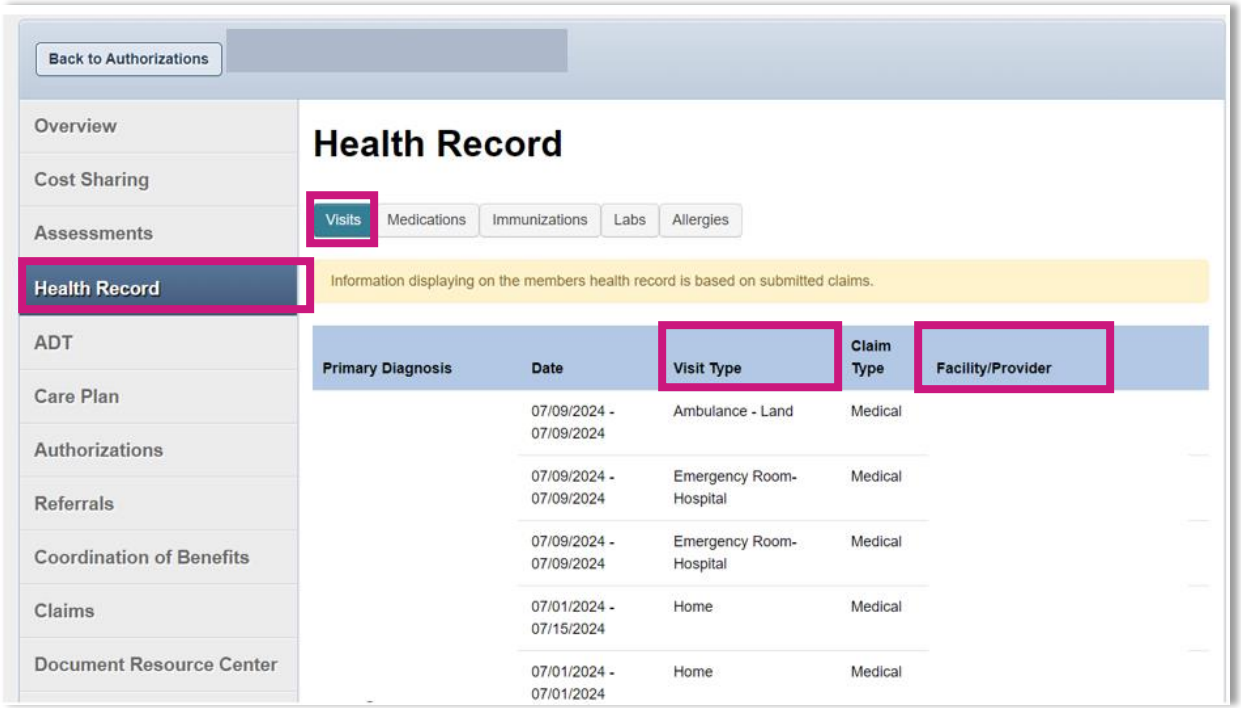
Secure Provider Portal: Authorization Process

- On the member's Overview, select **Health Record** and then select **Visits** to research to see if member has had same or similar DME items that did not require authorizations.
- View appropriate diagnosis the **Visit Type** of Home and **Facility/Provider**.



Secure Provider Portal: Authorization Process

- After reviewing these options in member's history, you can find same or similar DME, adaptive aids, or supplies previously provided to the member (both for items requiring authorizations and items that did not require an authorization).

Authorization Incomplete Information Process

- All essential elements must be included on each PA request. Essential Information is prescribed in HHSC's UMCM, Chapter 3.22, II. A., and includes all the following elements:
  - Member name, Medicaid ID number and date of birth
  - Requesting and rendering/servicing provider name, NPI, and TIN
  - Service requested – CPT, HCPCS
  - Service requested start and end date(s)
  - Quantity of service units requested

Authorization Incomplete Information Process

- Prior authorization requests are rejected back to the provider for resubmission if one or more essential information elements are missing, invalid, or illegible. The deficiency in the PA request is communicated to the provider with the request for resubmission of the PA request.
- Medicaid prior authorization requests must include complete and sufficient Clinical Information. Medical Management will communicate the request to supply the missing required clinical through faxed or phone call request within three (3) Business Days after receipt of an authorization request.
- The member/patient receives a written notice of the request for submission of the incomplete clinical information.
- Providers must supply the requested clinical information/documentation within three (3) Business Days after the request. If the clinical information/documentation is not received within the required timeframe, the case will be reviewed with the incomplete or insufficient information received with the PA request.
- The requested clinical should be faxed to Medical Management, using the appropriate fax number for the service for which authorization is requested.
- Medical Management provides notice of the determination of approval or denial of the prior authorization request within three business days after receipt of a complete prior authorization request.

Medical Necessity Appeal

- If the request for a service is denied for not meeting medical necessity criteria, it is considered an Adverse Determination. Superior will obtain all necessary information to make utilization management determinations. There are two denial types for authorization requests.
  - Administrative Denial - A denial received for non-clinical reasons, and can be issued when:
    - Member is ineligible
    - Member has exceeded annual benefit limits
    - Requested services are excluded from the benefits package
    - No prior authorization is on file
    - Late notification
  - Adverse Determination - A denial received for a service not meeting medical necessity and can be administered when:
    - Pertinent clinical information is missing.
    - Clinical information received does not meet medical necessity for the services requested.

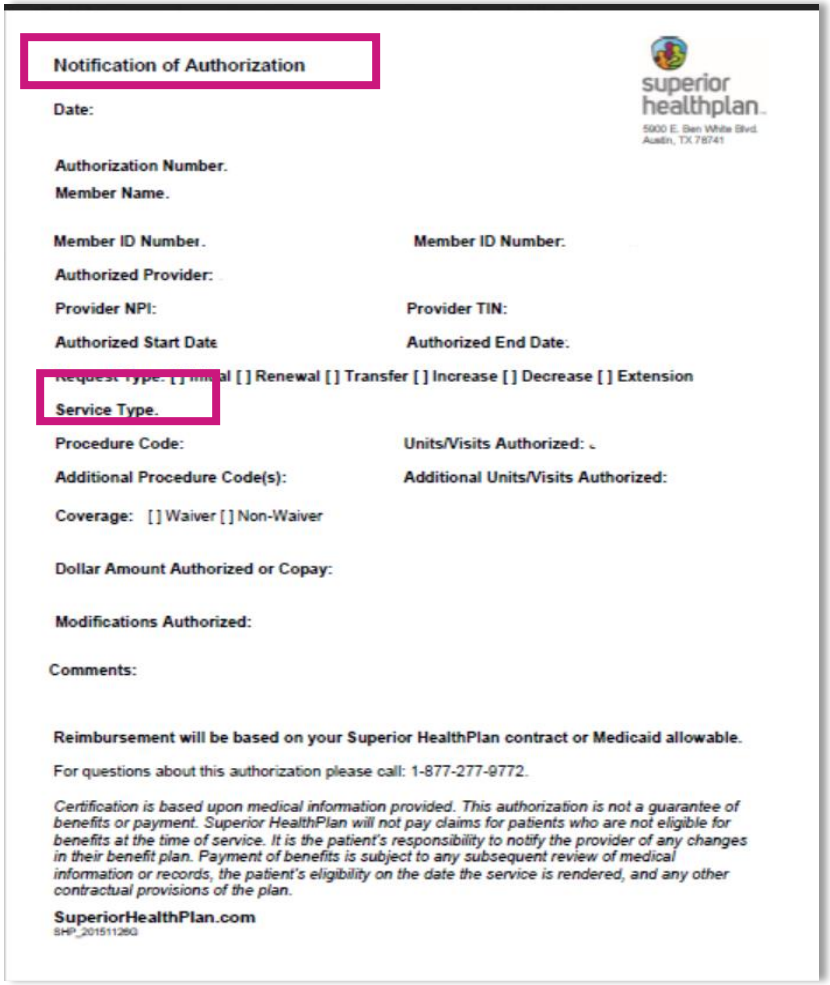
Medical Necessity Appeal

- A medical director will review all potential medical necessity denials and render a final decision. If the final decision is to deny the service requested, then a denial is rendered.
- Notification will be sent to the provider in writing describing the services being denied, along with the steps of the appeal process.
- Providers have 60 Calendar Days from the date of notification of adverse determination at file an appeal.

Authorization Notification

- Once requested services have been authorized, Superior will send notification of authorization. The notification will include information about the member, servicing provider or facility and services authorized along with notation if approved under the waiver program or HomeHealth program.
- Prior authorization is not a guarantee of payment. Prior authorization is a process that validates the medical need for a service or procedure.
- Certain specific services and procedures require prior authorization to qualify for benefits. All payments are subject to determination of a member's eligibility, payment of required deductibles, copayments and coinsurance amounts, eligibility of charges as covered expenses, application of the exclusions and limitations and other provisions of the policy at the time services are rendered. As well as the provider's responsibility to submit a timely clean claim.
- Clean Claim – A claim submitted by a provider for medical care or Health Care Services rendered to a Member that contains accurate and complete data in all claim fields required to adjudicate and accurately report and finalize the claim.

Authorization Letters



Notification of Authorization

superior healthplan
5900 E. Ben White Blvd.
Austin, TX 78741

Date:

Authorization Number.
Member Name.

Member ID Number. **Member ID Number:**

Authorized Provider:

Provider NPI: **Provider TIN:**

Authorized Start Date **Authorized End Date.**

Request Type: [ ] Initial [ ] Renewal [ ] Transfer [ ] Increase [ ] Decrease [ ] Extension

Service Type.

Procedure Code: **Units/Visits Authorized:**

Additional Procedure Code(s): **Additional Units/Visits Authorized:**

Coverage: [ ] Waiver [ ] Non-Waiver

Dollar Amount Authorized or Copay:

Modifications Authorized:

Comments:

Reimbursement will be based on your Superior HealthPlan contract or Medicaid allowable.

For questions about this authorization please call: 1-877-277-9772.

Certification is based upon medical information provided. This authorization is not a guarantee of benefits or payment. Superior HealthPlan will not pay claims for patients who are not eligible for benefits at the time of service. It is the patient's responsibility to notify the provider of any changes in their benefit plan. Payment of benefits is subject to any subsequent review of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the plan.

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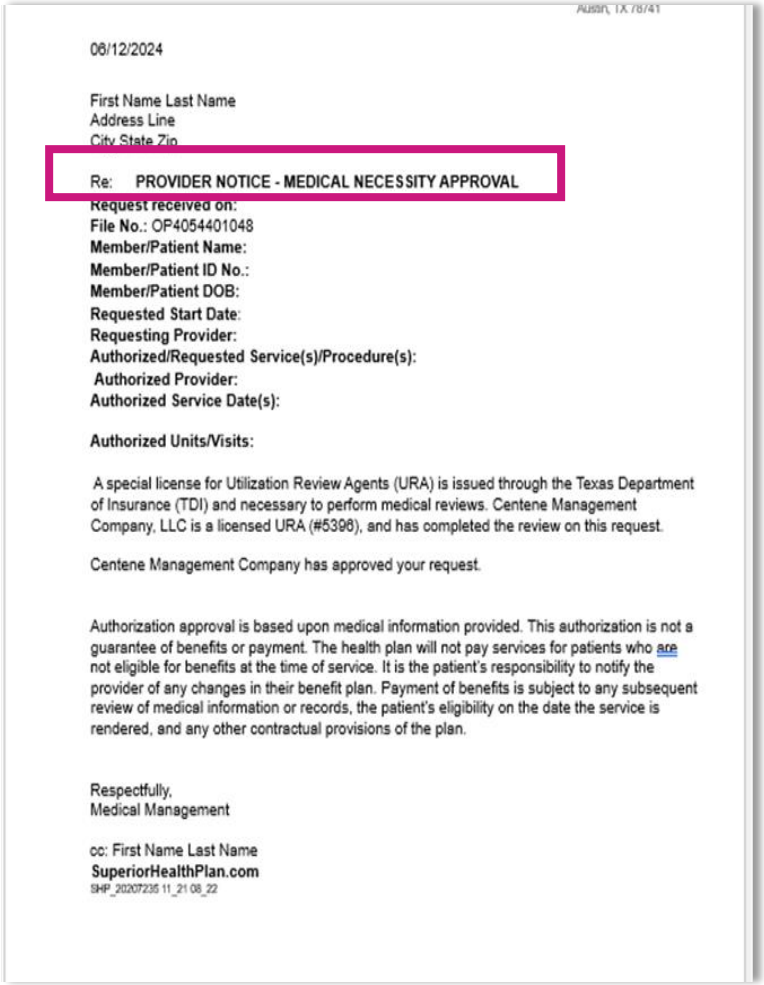


Austin, TX 78741

06/12/2024

First Name Last Name
Address Line
City State Zip

Re: **PROVIDER NOTICE - MEDICAL NECESSITY APPROVAL**
Request received on:
File No.: OP4054401048
Member/Patient Name:
Member/Patient ID No.:
Member/Patient DOB:
Requested Start Date:
Requesting Provider:
Authorized/Requested Service(s)/Procedure(s):
Authorized Provider:
Authorized Service Date(s):

Authorized Units/Visits:

A special license for Utilization Review Agents (URA) is issued through the Texas Department of Insurance (TDI) and necessary to perform medical reviews. Centene Management Company, LLC is a licensed URA (#5398), and has completed the review on this request.

Centene Management Company has approved your request.

Authorization approval is based upon medical information provided. This authorization is not a guarantee of benefits or payment. The health plan will not pay services for patients who are not eligible for benefits at the time of service. It is the patient's responsibility to notify the provider of any changes in their benefit plan. Payment of benefits is subject to any subsequent review of medical information or records, the patient's eligibility on the date the service is rendered, and any other contractual provisions of the plan.

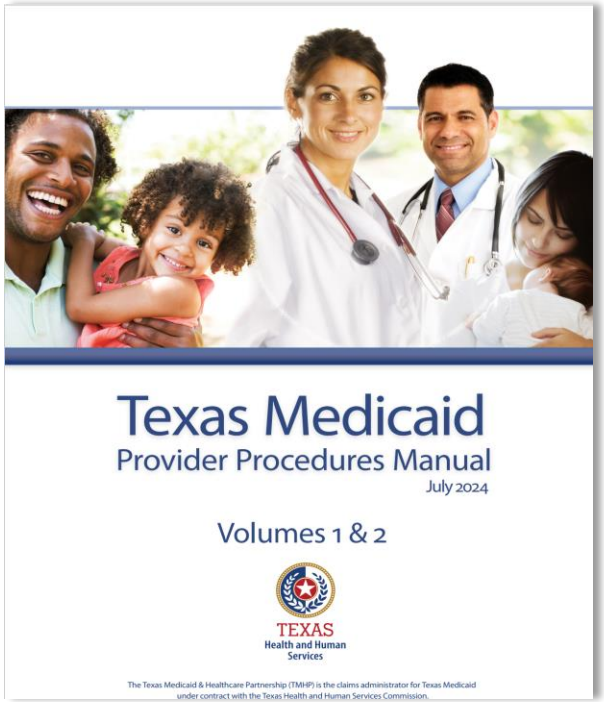
Respectfully,
Medical Management

cc: First Name Last Name
SuperiorHealthPlan.com
SHP_20207235 11_21 08_22

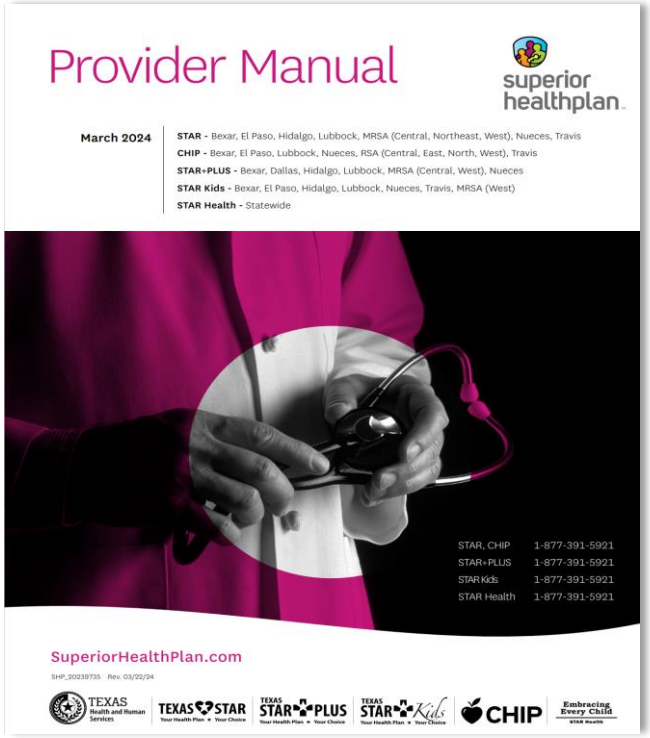
Provider Roles and Responsibilities

Resources

To view the *TMHP Provider Procedures Manual (PDF)* visit the Texas Medicaid Provider Procedures Manual webpage.



To view the *Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual (PDF)* visit Superior's Training and Manuals webpage.



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Texas Medicaid Provider Procedures Manual

- Anyone participating in Texas Medicaid must understand the requirements for participation. Texas Medicaid providers must follow the coding and billing requirements of the Texas Medicaid Provider Procedures Manual (TMPPM).
- These guidelines can be found on the TMHP website under the TMPPM. All providers are required to read and comply with “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information).
- In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 Texas Administrative Code (TAC) §371.1659.
- Failure to comply with specific Texas Medicaid requirements allows provider to being subject to sanctions. Providers can also be subject to Texas Medicaid sanctions for failure to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.

Contracted Providers

- Superior follows TMHP guidelines for Medicaid services.
- Provider and Contracted Providers shall **at all times** cooperate and comply with the requirements, policies, programs and procedures (policies) of Company and Payor, which may be described in the Provider Manual. Such policies do not in any way affect or remove the obligation of Contracted Providers to render care.
- It is the policy of Superior that DME is **medically necessary.** DME may be medically necessary when there is an expectation that the item requested will make a meaningful contribution to the treatment of the member's illness, injury, or malformation.
- The purpose of Superior clinical policy is to provide a guide to medical necessity. A component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results.
- Provider may not use the information provided by Superior to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were provided to a covered person or to misrepresent any aspect of the services.

Texas Medicaid Requirements

- For any purchased DME, adaptive aids, or supplies, the DME provider and the member must both sign the DME Certification and Receipt Form (PDF) available on the TMHP website, or any other specific Managed Care Organization's required form.
- The certification form must include the name of the item, the date the client received the equipment, supplies, or appliance, and the dated signatures of the provider and the client or primary caregiver.
- The client's signature on the certification form verifies the item(s) becomes the property of the client upon delivery.
- Durable medical equipment providers must retain all orders; copies of completed, signed, and dated physician's orders; delivery slips; and all other documentation along with corresponding invoices for all supplies provided to a client for each Date Of Service (DOS) that documents the date of delivery for all supplies provided to a client.
- The DOS is the date in which supplies are delivered to the client or shipped by a carrier to the client as evidenced by the dated tracking document attached to the invoice for that date.
- MCOs may require submission of the certification form for DME claims that meet or exceed a certain amounts.

Texas Medicaid Requirements

- Durable medical equipment providers must disclose these records to HHSC or its designee on request. These records and claims must be retained for a minimum of five years from the DOS or until audit questions, appeals, hearings, investigations, or court cases are resolved (Use of these services is subject to retrospective review.)
- All claims submitted for medical supplies must include the same quantities or units that are documented on the delivery slip or corresponding invoice and on physician order. They must reflect the number of units by which each product is measured.
- All claims submitted for medical supplies must reflect either one business day before or one business day after the date of service as documented on the delivery slip or corresponding invoice and the same time frame covered by the Physician's order.
- Claims for wheelchairs, components, and accessories must be submitted using the most appropriate procedure code that describes the item.

False Claims Act

- The False Claims Act establishes liability when any person or entity improperly receives from or avoids payment to the Federal government.
- The Act prohibits:
  - Knowingly presenting, or causing a false claim for payment or approval
  - Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
  - Conspiring to commit any violation of the False Claims Act
  - Falsely certifying the type or amount of property used
  - Certifying receipt of property on a document without completely knowing that the information is true
  - Knowingly buying government property from an unauthorized officer of the government
  - Knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the government
- For more information regarding the False Claims Act, please visit the CMS website.

Fraud, Waste, and Abuse Prevention

- The Medicaid and CHIP programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of Superior's contracted providers in prevention and reporting of potential fraud, waste or abuse.
- Superior has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501- 353.505, and 1 Tex. Admin. Code §§ 370.501-370.505.

Fraud, Waste, and Abuse

- It is everyone's responsibility as a participating provider to report any member or provider suspected of potential fraud, waste or abuse. All reports will remain confidential.
- Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care providers, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste, or abuse which is against the law.
- For example, tell us if you think someone is:
  - Getting paid for services that were not provided or necessary.
  - Upcoding for services provided to receive higher reimbursement.
  - Unbundling when billing for services provided.
  - Not telling the truth about a medical condition to get medical treatment.
  - Letting someone else use their Medicaid or CHIP ID.
  - Using someone else's Medicaid or CHIP ID.
  - Not telling the truth about money or resources to get benefits.

Reporting Fraud, Waste, and Abuse

- To report fraud, waste or abuse, you may file a report directly to the Texas Office of Inspector General (OIG), or you may report an issue to Superior.
- To report fraud, waste or abuse Providers can:
  - Call the OIG Hotline at 1-800-436-6184.
  - Visit HHSC's OIG website and select *OIG Fraud Reporting Form* 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
    1390 Timberlake Manor Parkway, Suite 450
    Chesterfield, MO 63017
    Toll-free Number: 1-866-685-8664

Additional Resources/Information

Billing Tips & Reminders

- Initial Submission Requirements:
  - Claims must be completed in accordance with TMHP billing guidelines
  - Use appropriate modifiers and HCPC codes
  - All member and provider information must be completed
  - Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved
  - Billing with authorization can be helpful when billing claim
  - For Miscellaneous codes or noncovered codes provide manufacturer's MSRP
  - Rejected claims must be corrected and resubmitted with 95 days of the date of service
  - Rejected claim do not substantiate timely claim filing

Billing Tips & Reminders

- Identified Billing Errors:
  - Missing modifiers
  - Review policies to ensure criteria meet for equipment or supplies
  - MSRP/Invoice date is not marked within two years of the date of service on the claim
  - MSRP/Invoice not clearly marked with Manufacturer name
  - CMS-1500 claim form or electronic equivalent must include the description of the unlisted code
  - Unlisted codes that do not have documentation will be denied
  - Billing quantity greater than allowed on the authorization span dates
  - Diagnosis code not the highest degree of specificity; 4th or 5th digit when appropriate
  - Completion of box 24J both shaded portions on HCFA 1500
  - Missing primary EOB on submission of secondary claim to Superior

Claim Corrections, Appeals, and Disputes

- All claim adjustments (corrected claims), requests for reconsideration or disputes must be received within 120 Calendar Days from the date of notification or denial for Medicaid claims.
  - Adjusted or Corrected Claim: A resubmission of an original clean claims that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission requires corrections. Example: correcting member's date of birth, a modifier, or diagnosis code.
  - Claim Appeals/Dispute: 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. Often requires additional information from the provider. Request for reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.)
- For easy-to-fill Corrected Claim or Claim Appeal forms please visit Superior's Provider forms webpage.

Note: Please ensure when submitting, the latest claim is referenced. Referencing the original claim versus newer claim, could result in unnecessary timely denials.

Qualified Rehab Professional

- A custom wheeled mobility system is a professionally manufactured device that provides motorized or manual wheeled mobility and body support specifically for individuals with impaired mobility including specialized seating positioning components, manual seating options, adjustable frame and other complex or specialized accessories.
- These requests require a seating assessment with measurements including specifications for exact mobility and seating equipment and all necessary accessories.
- A completed wheelchair seating assessment must be performed by an assistive technology professional (ATP) or qualified rehabilitation professional (QRP) and physical therapist (PT), occupational therapist (OT), or physician. The therapist or physician must be familiar with the member or must be the treating provider.
- Providers that render custom DME wheeled, and power mobility systems must enroll in Texas Medicaid as a specialized/custom wheeled mobility group provider and must have at least one qualified rehabilitation professional (GRP) performing provider. The Certified QRP providers must enroll in Texas Medicaid as performing providers under the DME provider group.

Qualified Rehab Professional

- The QRP is responsible for being present at and involved in the seating assessment of the client for the rental or purchase of a wheeled mobility system. This includes being present at the time of delivery to ensure the system functions correctly for the client's needs and verify the wheeled mobility system has been properly fitted to the client. The QRP must also verify the client, parent, guardian of the client, and/or caregiver of the client has received training and instruction regarding the wheeled mobility system's proper use and maintenance.
- Payment for QRP to submit their seating assessment claims (code 97542, normally 4 units for seating assessment and 8 units for training member on device) and it must be attached to the customer wheelchair authorization for payment to be reimbursed.
- Custom Wheelchair request are placed and authorized under the QRP as the servicing provider, the DME is placed as the requesting providers. Per TMPPM, custom wheelchairs must be set up under the QRP as they are the servicing provider. Providers must bill under the QRP.
- Standard wheelchairs are set up under the DME provider as a WC assessment performed by QRP is not required.

DME and Medical Supplies Pharmacy Providers

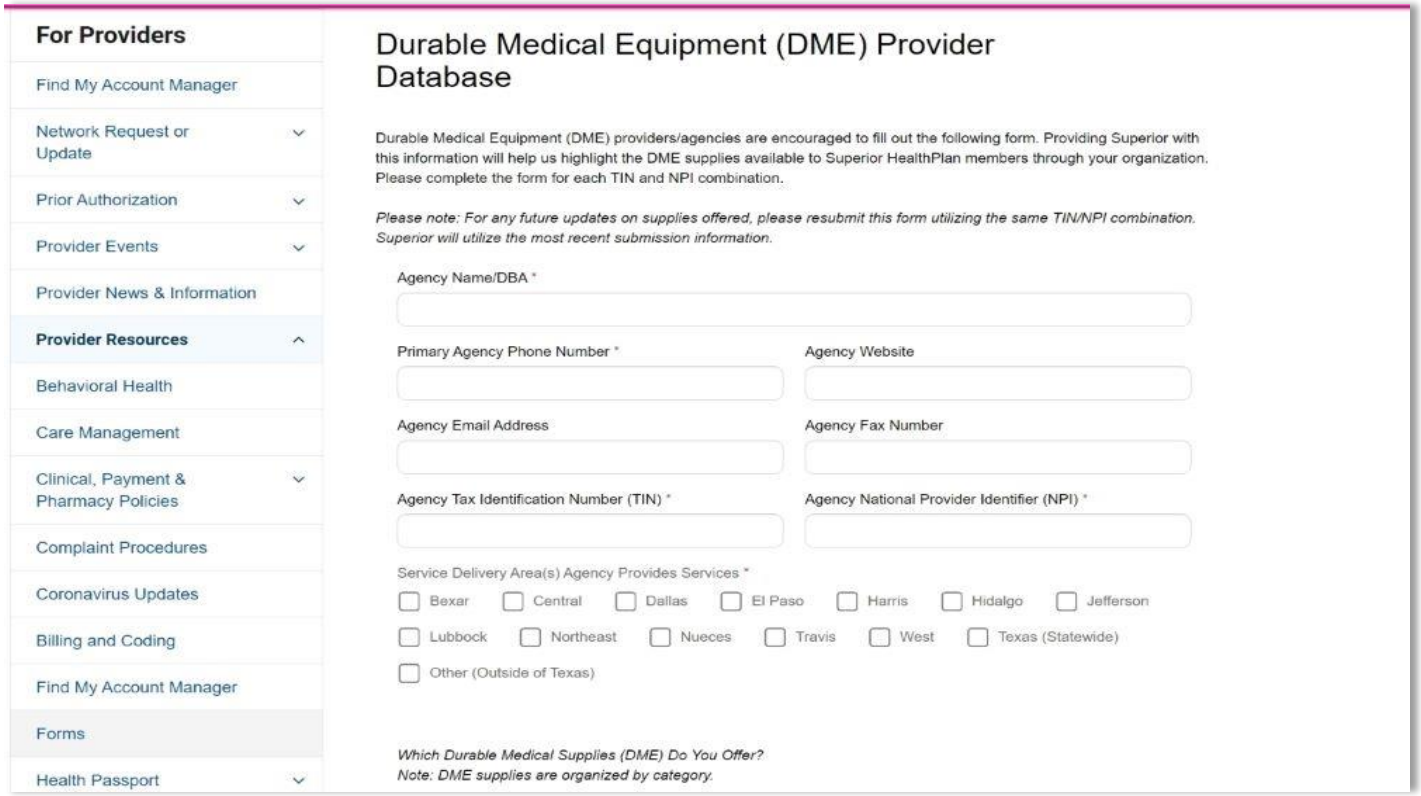
- If a pharmacy enrolled in Superior's Pharmacy Benefit Managers wishes to provide services that are not on the formulary, the pharmacy must enroll as a DME provider and obtain a separate contract with Superior for medical services.
- Includes medically necessary items such as nebulizers, ostomy supplies and other supplies and equipment.
- For children (birth through 20 years of age), this includes items typically covered under the Texas Health Steps program including, but not limited to, prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies and some nutritional products.

Change of Provider Request

- The member has the right to choose his/her home health and/or DME provider and to change providers. If the member requests services through a new provider, a change of provider letter must be submitted to the Plan with the authorization request.
- The letter must have the following elements:
  - Signed and dated by the member, parent or legal guardian
  - Include previous provider's name and effective service end date
  - Current provider's name and effective service start date

DME Provider Database

- To view more information, please visit Superior's DME Provider Database webpage.



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Tomorrow Health

- Superior is partnering with Tomorrow Health to connect patients and DME providers to improve care delivery and outcomes.
- This service is available to Superior members in the Bexar service delivery area.
- For questions contact Tomorrow Health at 1-844-402-4344.

Secure Provider Portal

- Superior is committed to providing our participating providers with the best tools possible to support their administrative needs. We encourage our participating providers to take advantage of our easy-to-use secure web portal for fast resolution on routine needs.
- The web portal can be used to:
  - Verify member eligibility
  - Submit electronic claim directly with no clearinghouse fees
  - Check claim status
  - Submit and confirm authorizations
  - View detailed patient lists
  - Update provider demographic information
  - Download EOP

To access the web portal please visit, Superior's Secure Provider Portal.

Newsflash (e-newsletter)

- Don’t miss important provider news and updates! Sign Up for Superior’s Provider Newsflash.

Stay up-to-date with the latest Provider News!

Follow the instructions below to begin.

1. Visit **SuperiorHealthPlan.com**.
2. Click on the **For Providers** tab.
3. Click on **Provider News & Information** found on the left side bar navigation menu.
4. Under **Provider News** on this page, click **Sign up to update your information to receive important news and updates on Superior HealthPlan** to begin the process.
5. Enter provider information and select **Submit** when complete.

SuperiorHealthPlan.com

Provider Trainings

- Additional Provider Trainings can be accessed on Superior's Training and Manuals webpage.
- To register for upcoming provider webinars please visit Superior's Provider Training Calendar

SuperiorHealthPlan.com

Updates

What best practices are you utilizing to obtain physicians Title XIX and documents needed for obtaining an authorization? Or what barriers are you working against?

Questions and Answers

Let us know what we can do to help.
Thank you for attending!

Survey

Please see the QR code below or utilize the link below for the survey.

https://cnc.sjc1.qualtrics.com/jfe/form/SV_eRw3K2i05rv2hh4