STAR Kids and STAR Health LTSS Billing Clinic

Provider Training

Introductions and Agenda

- Introduction to Superior HealthPlan
- Verify Eligibility
- Service Coordination
- Referrals and Prior Authorizations
- Claims Filing and Payment Options
- STAR Kids LTSS Billing Matrix
- Electronic Visit Verification (EVV)
- Website and Secure Provider Portal
- Superior HealthPlan Departments
- Questions and Answers

Who is Superior HealthPlan?

- Superior, a subsidiary of Centene Corporation, manages health care for Medicaid and CHIP members across Texas.
- Superior has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Superior provides Medicaid and CHIP programs in contracted Texas Health and Human Services Commissions (HHSC) service areas throughout the state. These programs include:
  - Ambetter from Superior HealthPlan
  - CHIP
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - Wellcare By Allwell (HMO and HMO DSNP) Plans

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.
- Services include all Medicaid Benefits, including prescription drugs, primary and specialty care, hospital care, Personal Care Services (PCS), Private Duty Nursing (PDN), therapies, medical supplies and equipment, and behavioral health services.
- Superior offers STAR Kids in the following service areas: Bexar, Hidalgo, Lubbock, West, El Paso, Nueces, and Travis.

STAR Kids Program Objectives

- Provide Medicaid benefits that are customized to meet the health care needs of recipients through a defined system of care
- Better coordinate care of recipients
- Improve health outcomes
- Improve access to health services
- Achieve cost containment and cost efficiency
- Reduce administrative complexity
- Reduce potentially preventable events, including out-of-home residential care, through provision of care management and appropriate services
- Establish a health home
- Coordinate with long-term services and supports provided outside the health plan
- Provide a plan for transitioning provision of benefits from STAR Kids to STAR+PLUS when the member turns 21

What is STAR Health?

- STAR Health is a statewide managed care program that provides services to children and young adults:
  - In DFPS conservatorship
  - In kinship care
  - Aged 18 through the month of their 22nd birthday who voluntarily agree to continue in foster care placement
  - Aged 18 through the month of their 21st birthday, who are Former Foster Care Child Members or who are participating in the Medicaid for Transitioning Foster Care Youth Program
  - Adoption Assistance (AA) and Permanency Care Assistance (PCA) members that qualify and choose to remain in STAR Health

What is STAR Health?

- Superior is the only MCO contracted with HHSC to provide services for all STAR Health members statewide.
- STAR Health is committed to:
  - Understanding the foster care community
  - Being sensitive to the needs of the foster care population
  - Providing accessible and integrated care
  - Providing an electronic Health Passport to better support coordination of care
  - Delivering appropriate education to all stakeholders

Why STAR Health?

- STAR Health services the needs of foster children by:
  - Providing great access to health-care services
  - Assisting in the coordination of health-care services
  - Establishing a Medical Home (Primary Care Provider [PCP])
  - Offering telehealth services
  - Providing emergency support and services
- Due to abuse and neglect, children and youth in foster care often have greater health-care needs, including:
  - A history of physical and/or emotional trauma
  - Not receiving proper dental and vision care
  - Needing additional behavioral health services
  - Needing assistance in treatment for asthmas, depression, etc.
  - The presence of developmental delays

STAR Kids and STAR Health LTSS Services

- STAR Kids and STAR Health members receive all the benefits of the traditional Medicaid program. In addition, they may also be eligible to receive several Long-Term Services and Supports (LTSS) services. These include:
  - Community First Choice Services
  - Day Activity and Health Services (DAHS)* (Members 18 and older)
  - Financial Management Services
  - Personal Care Services
  - Private Duty Nursing

*STAR Kids only

Medically Dependent Children Program (MDCP) Waiver Program

- The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.
  - The following LTSS services are covered only for members in MDCP
    - Respite Care
    - Supported Employment
    - Financial Management Services
    - Adaptive Aids
    - Employment Assistance
    - Flexible Family Support Services
    - Minor Home Modifications
    - Transition Assistance Services

Community First Choice

- Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities.
- CFC services are available for members who:
  - Are eligible for Medicaid and enrolled in STAR Kids or STAR Health
  - Need an institutional level of care:
    - Intermediate Care Facility for Individuals with an Intellectual Disability or Related conditions (ICF/IID)
    - Nursing Facility
    - Institution for Mental Disease [IMD]
  - Need services provided in the CFC program
- CFC services include
  - Personal Assistance Services (PAS)
  - Habilitation
  - Emergency Response Services (ERS)
  - Support Management

Community First Choice

- CFC assessments will be conducted by Superior or the Local Intellectual & Developmental Disabilities Authority (LIDDA).

- If the PCP determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination and request an assessment.

- CFC services should be billed either directly to Superior or through TMHP if EVV validation is required. Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the HHS STAR Kids billing matrix.

Verify Eligibility

Verify Eligibility

- Superior Identification Card
- Visit Superior's Secure Provider Portal
- STAR Kids Member Services: 1-844-590-4883
- STAR Health Member Services: 1-866-912-6283
- Texas Medicaid Benefits Card
- Visit TMHP's TexMed Connect and My Account Guides webpage
- Maximus Enrollment Broker: 1-800-964-2777

Note: It is recommended to verify eligibility the 1st of each month using Superior's website or by contacting Member Services.

STAR Kids Member ID Card

superior healthplan™

TEXAS STAR Kids Your Health Plan ★ Your Choice | TEXAS Health and Human Services

MEMBER NAME:
SUPERIOR MEMBER ID #:

Rx GROUP ID# :
Rx BIN #:
Rx PCN:
PBM:

PRIMARY CARE PROVIDER
NAME:
PHONE:
EFFECTIVE DATE:

SuperiorHealthPlan.com

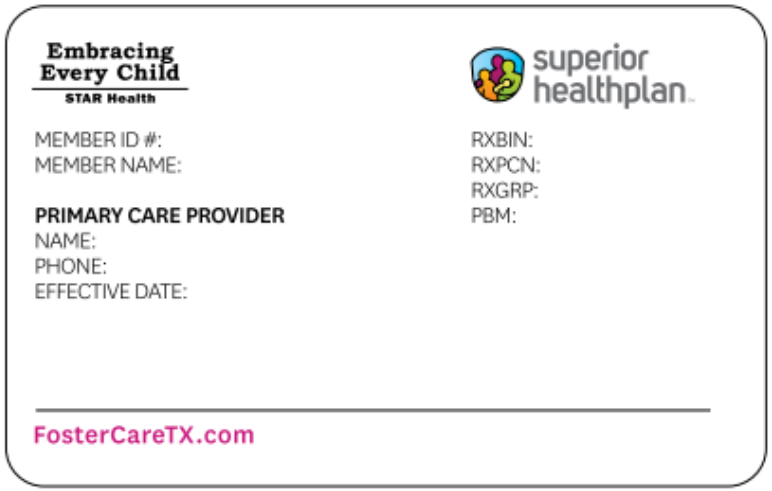
Member Services | Behavioral Health | Nurse Advice Line: 1-844-590-4883
Available 24 hours a day/7 days a week
Service Coordinator: 1-844-433-2074
Available Monday-Friday, 8 a.m.-5 p.m.

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.

Servicios para miembros | Salud del comportamiento | La línea de consejería de enfermería: 1-844-590-4883
Disponible 24 horas al día/7 días a la semana
Coordinandora de Servicios: 1-844-433-2074
Disponible de 8 a.m. a 5 p.m., de lunes a viernes

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que tambien éstan eligibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

STAR Health Member ID Card



Disclaimer: Documentation in Health Passport is required* when caring for STAR Health members. For more information, please visit Superior's Health Passport webpage.

*may not apply to members over 18 years of age

Service Coordination

Service Coordination

- Service Coordinator role
  - Clinical and non-clinical support
    - 24/7/365 accessibility to staff via the Member Services hotline:
      - STAR Kids: 1-844-590-4883
      - STAR Health: 1-866-912-6283
  - Direct support
    - Coordinate care for members with special health-care needs
    - Monitor adherence to treatment plan
    - Coordinate discharge planning
    - Assist with transition plan
    - Promote best practice/evidence-based services
    - Identify and report potential abuse/neglect

Locating a Member's Service Coordinator

- Members and providers are able to access the name and phone number of the assigned Service Coordinator through the Secure Member and Secure Provider Portals.
- When providers access eligibility on a specific member, the assigned Service Coordinator and phone number is displayed on the **Eligibility Overview** page, under **Care Gaps**.
- Call Service Coordination at:
  - STAR Kids: 1-844-433-2074
  - STAR Health: 1-866-912-6283

Referrals and Prior Authorizations

Referrals and Prior Authorizations

- A Primary Care Physician (PCP) is required to refer a member to a specialist when medically-necessary care is needed beyond the scope of the PCP and when a referral is required by the specialist.
  - Some specialists may not require a referral.
  - If the member has an existing relationship with a specialist, a referral is not needed.
- A specialist cannot refer to another specialist.
- PCP must document the coordination of referrals and services provided between the PCP and specialist.
- Referrals to out-of-network providers will be made when medically-necessary to do so.
- No referral or authorization is needed for emergent or urgent services as long as the specialist is in Superior's network or accepts Medicaid. If the specialist is not a Superior or Medicaid provider, members may receive a bill.
- *Please note: If emergent or urgent services were provided in an office setting, providers should contact Superior as soon as possible after the visit, as some services require an authorization.*

Referrals and Prior Authorizations

- All out-of-network services require an authorization, as well as some other services and treatments provided in a specialist's office.
- Existing authorizations for acute services will be honored for up to 90 days or until the end of the authorization or until Superior conducts a new assessment.
- Existing authorizations for Long-Term Services and Supports will be honored for 6 months, or until Superior conducts a new assessment.
- If a member has Medicare or private insurance, they do not need a referral or authorization from Superior to continue seeing a specialist or PCP.
- To view more information on continuity of care, please visit Superior's STAR Kids webpage.

Claims
Filing and Payment

LTSS Claims Filing

- Claims must be filed within 95 days from the Date of Service (DOS).
  - Filed on a red CMS 1500
  - Filed electronically through clearinghouse
  - Filed directly through Superior's Secure Provider Portal.
  - 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims
- A provider may submit a corrected claim or claim appeal within 120 days from the date the Explanation of Payment (EOP) or denial is issued.

LTSS Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Visit Superior's Secure Provider Portal
  - Electronic Claims:
    - Visit Superior's Billing and Coding webpage for a list of our Trading Partners
  - Superior Emdeon ID 68069
- Paper Claims - Initial and Corrected*
  - Superior HealthPlan
    P.O. Box 3003
    Farmington, MO 63640-3803
- Paper Claims - Requests for Reconsideration* and Claim Disputes*
  - Superior HealthPlan
    P.O. Box 3000
    Farmington, MO 63640-3800

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

Electronic Claim Filing Tips

- If the clearinghouse does not have Superior's **Payer ID 68069**, they may drop the claim to paper.
- If a provider uses EDI software but it is not setup with a clearinghouse, they must bill Superior through paper claims or through the Secure Provider Portal until the provider has established a relationship with a clearinghouse listed on Superior's website.
- To send claim adjustments through EDI, the CLM05 -3 "Claim Frequency Type Code" must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
- Claims can also be submitted through the Secure Provider Portal. Claims submitted through the portal are considered electronic claims.

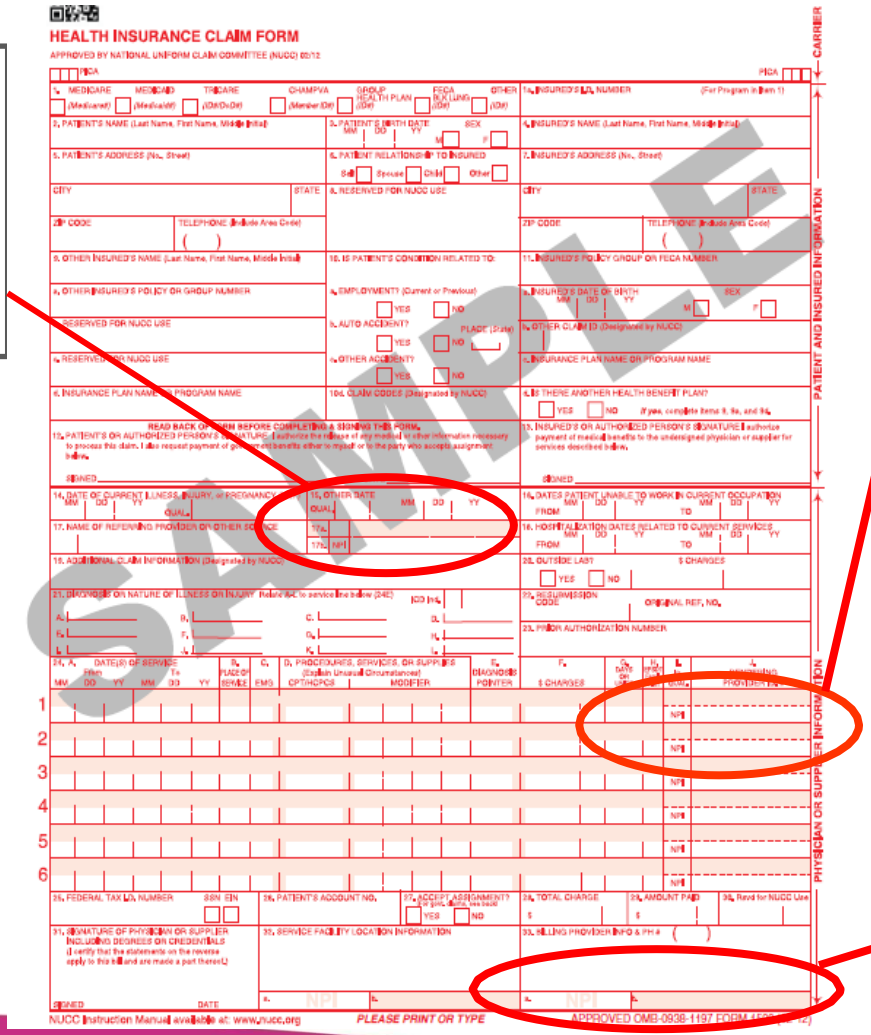
Paper Claim Filing Tips

To assist the mail center in improving the speed and accuracy to complete scanning, 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 1500 red form (not a copy)
- Handwritten claim forms are no longer accepted

CMS 1500 Form Tips

Referring Provider: [C]
17 Name of the referring provider and 17b NPI



Rendering Provider: [R]
Place your NPI in box 24J (unshaded) and Taxonomy Code with a ZZ Modifier in box 24J (shaded). **These are required fields when billing Superior claims**.

If you do not have an NPI, place your API (atypical provider number/LTSS #) in Box 33b.

Billing Provider: [R]
33a Billing NPI #

33b Billing Taxonomy # (or API # if no NPI)

LTSS Billing Tips

- Verify member eligibility prior to providing services.
- Services require prior authorization through Superior.
- Providers must ensure they reference and use HHSC's STAR Kids LTSS billing codes when submitting claims to Superior. For more information please visit, HHSC's LTSS Billing Matrix and Crosswalk webpage.
- Codes with defined modifier and correct formatting is required
- Modifier errors may result in a denial
- Ensure claims requiring EVV validation are submitted to TMHP

Common Billing Errors

- Member date of birth or name not matching ID card/member record
- Code combinations not appropriate for demographic of member
- Not filed timely
- Procedures billed do not match services authorized
- Modifier format or accuracy errors for service type
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate
- Illegible paper claim

Claims Filing: Deadlines

- First Time Claim Submission
  - 95 Days from date of service
- Corrected Claims
  - 120 Days from the date of Explanation of Payment or denial is issued
  - Must reference original claim number on corrected claim
- Claim Appeals
  - 120 Days from the date of EOP or denial is issued
  - Must be submitted in writing with supporting appeal documentation

Identifying a Claim Number from Superior

- 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. It can be found in the following:
  - Electronic Data Interchange (EDI) rejection/acceptance reports
  - Rejection letters*
  - Secure Provider Portal
  - EOP
- Sample claim number: N125TXP02973
- When calling into Provider Services, please have your claim number ready for expedited handling.

**Remember that rejected claims have never made it through Superior's claims system for processing. The claim number that is provided on the rejection letter is a claim image number that helps us retrieve a scanned image of the rejected claim.*

Submitting Claims

- There are 2 ways of submitting your claims to Superior:
  - Electronic: Provider Portal or EDI via a clearinghouse
    - Your response to your submission is viewable via an EDI rejection/acceptance report, rejection letters, Superior Provider Portal and EOPs.
  - Paper: Mailed to our processing center
    - Your response to your submission is viewable via rejection letters, Secure Provider Portal and EOPs.

**Note: On all correspondence, please reference either the 'Claim Number' or 'Control Number'.*

Corrected Claims

- A corrected claim is a correction of information to a previously finalized clean claim.
  - For example – correcting a member's date of birth, a modifier, diagnosis (Dx code), etc.
  - The original claim number must be billed in field 22 of the HCFA 1500 form.
  - The appropriate frequency code/resubmission code should also be billed in field 22 of the HCFA 1500 form.
  - A corrected claim form, found in the Provider Manual, may be used when submitting a corrected claim.

Claim Appeals

- A claim appeal can be requested when the provider disagrees with the outcome of the adjudication of the claim.
- Claim appeals must be submitted in writing and submitted via mail or may be requested through the provider portal.
- Claim appeals must include supporting documentation, including:
  - Copy of EOP of appealed claim (not required for web portal claim appeals).
  - Explanation of reason for claim appeal (via letter, completed claim appeal form or web entry explanation).

Appeals Documentation

Examples of supporting documentation may include, but are not limited to:

- A copy of the Superior EOP (required)
- A letter from the provider stating why they feel the claim payment is incorrect (required)
- A copy of the original claim
- An EOP from another insurance company
- Documentation of eligibility verification such as copy of ID card, Texas Medicaid Benefits Card (TMBC), TMHP documentation, call log, etc.
- Overnight or certified mail receipt as proof of timely filing
- Centene EDI acceptance reports showing the claim was accepted by Superior
- Prior authorization number and/or form or fax

PaySpan Health

- Superior has partnered with PaySpan Health to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs).
  - Online remittance advices (ERAs/EOPs).
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System.
- Register on the PaySpan Health website.
- For further information contact 1-877-331-7154, or email ProviderSupport@PaySpanHealth.com.

Member Balance Billing

- Providers may NOT bill STAR Kids or STAR Health members directly for covered services.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Providers may inform members of costs for non-covered services and secure a private pay form prior to rendering.
- Members do not have co-payments.
- Additional details can be found in the Superior Provider Manual.

STAR Kids LTSS Billing Matrix

Effective 12/1/2022

Updates for December 1, 2022

- Auth Updates:
  - A majority of authorizations will not need to be updated, as HCPCS codes were not changed for many services
  - For members who had an authorization spanning the 12/1 effective date of the new crosswalk, a new authorization will be created for dates of service 12/1 and after.
  - If a new authorization was required, claims for dates of service 12/1 and on will need to be billed on a separate claim
- Claims Updates
  - STAR Health billing will continue to follow the Texas Medicaid Provider Procedures Manual (TMPPM) for non-MDCP services.
  - Claims for STAR Health MDCP members must be submitted utilizing the STAR Kids billing matrix for MDCP codes and modifiers with the exception of the U6 modifier, which should not be used for STAR Health MDCP claims.

LTSS Billing Codes

Adult Day Care (Members age 18 through 21st birth month)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5101					Day Activities and Health Services (DAHS) 3 to 6 hours	3-6 hours = 1 unit
S5101					DAHS over 6 hours	6 hours or more = 2 units
S5101	U6				Day Activities and Health Services (DAHS) 3 to 6 hours (MDCP)	3-6 hours = 1 unit
S5101	U6				DAHS over 6 hours (MDCP)	6 hours or more = 2 units

LTSS Billing Codes

Minor Home Modifications

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5165					Minor home modifications	1 unit per service
S5165	UC				Minor Home Modifications (CDS)	1 unit per service

Emergency Response*

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5161	U2				Emergency Response Services (Monthly) (CFC)	1 month = 1 unit
S5161	U2	U6			Emergency Response Services (Monthly) (CFC) (MDCP)	1 month = 1 unit

*S5160 (Emergency Response Services (Installation and training) was removed effective12/1/2022)

LTSS Billing Codes

Community First Choice Attendant Care Only (CFC-PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	UD	U1			CFC PCS Attendant care only – Agency Model	15 minutes = 1 unit
T1019	UD	U1	U6		CFC PCS Attendant care only – Agency Model (MDCP)	15 minutes = 1 unit
T1019	UD	U2			CFC PCS Attendant care only – SRO Model	15 minutes = 1 unit
T1019	UD	U2	U6		CFC PCS Attendant care only – SRO Model (MDCP)	15 minutes = 1 unit
T1019	UD	UC			CFC PCS Attendant care only - CDS Model	15 minutes = 1 unit
T1019	UD	UC	U6		CFC PCS Attendant care only - CDS Model (MDCP)	15 minutes = 1 unit

Note: CFC Personal Care Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Attendant Care and Habilitation (CFC-HAB)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	U9	U1			CFC Attendant care and habilitation, Agency model	15 minutes = 1 unit
T1019	U9	U1	U6		CFC Attendant care and habilitation, Agency model (MDCP)	15 minutes = 1 unit
T1019	U9	U2			CFC Attendant care and habilitation, SRO model	15 minutes = 1 unit
T1019	U9	U2	U6		CFC Attendant care and habilitation, SRO model (MDCP)	15 minutes = 1 unit
T1019	U9	UC			CFC Attendant care and habilitation, CDS model	15 minutes = 1 unit
T1019	U9	UC	U6		CFC Attendant care and habilitation, CDS model (MDCP)	15 minutes = 1 unit

Note: CFC Habilitation Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Nurse Delegation and Supervision

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
G0162	U1				RN assessment for delegation of PCS tasks	15 minutes = 1 unit
G0162	U1	U6			RN assessment for delegation of PCS tasks (MDCP)	15 minutes = 1 unit
G0162	U2				RN assessment for delegation of CFC tasks	15 minutes = 1 unit
G0162	U2	U6			RN assessment for delegation of CFC tasks (MDCP)	15 minutes = 1 unit
G0495					RN training and ongoing supervision of delegated tasks	15 minutes = 1 unit
G0495	U6				RN training and ongoing supervision of delegated tasks (MDCP)	15 minutes = 1 unit

LTSS Billing Codes

Personal Care Services (PCS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1019	U1				PCS – Agency model	15 minutes = 1 unit
T1019	U2				PCS – SRO model	15 minutes = 1 unit
T1019	UC				PCS – CDS model	15 minutes = 1 unit
T1019	UB	U1			PCS – BH condition – Agency model	15 minutes = 1 unit
T1019	UB	U2			PCS – BH condition – SRO model	15 minutes = 1 unit
T1019	UB	UC			PCS – BH condition, CDS model	15 minutes = 1 unit

Note: Personal Care Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Private Duty Nursing (PDN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1000	TE				PDN, LVN	15 minutes = 1 unit
T1000	TE	U6			PDN, LVN (MDCP)	15 minutes = 1 unit
T1000	TE	UA*			PDN, Specialized LVN	15 minutes = 1 unit
T1000	TE	UA	U6		PDN, Specialized LVN (MDCP)	15 minutes = 1 unit
T1000	TD				PDN, RN	15 minutes = 1 unit
T1000	TD	U6			PDN, RN (MDCP)	15 minutes = 1 unit
T1000	TD	UA			PDN, Specialized RN	15 minutes = 1 unit
T1000	TD	UA	U6		PDN, Specialized RN (MDCP)	15 minutes = 1 unit

*The UA Specialized Services modifier may only be used for Private Duty Nursing for members with a tracheostomy or who are ventilator dependent.

LTSS Billing Codes

Private Duty Nursing

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1000	U3	TE			PDN, Independently Enrolled LVN	15 minutes = 1 unit
T1000	U3	TE	U6		PDN, Independently Enrolled LVN (MDCP)	15 minutes = 1 unit
T1000	U3	TE	UA*		PDN, Independently Enrolled Specialized LVN	15 minutes = 1 unit
T1000	U3	TE	UA	U6	PDN, Independently Enrolled Specialized LVN (MDCP)	15 minutes = 1 unit
T1000	U3	TD			PDN, Independently Enrolled RN	15 minutes = 1 unit
T1000	U3	TD	U6		PDN, Independently Enrolled RN (MDCP)	15 minutes = 1 unit
T1000	U3	TD	UA		PDN, Independently Enrolled Specialized RN	15 minutes = 1 unit
T1000	U3	TD	UA	U6	PDN, Independently Enrolled Specialized RN (MDCP)	15 minutes = 1 unit

*The UA Specialized Services modifier may only be used for Private Duty Nursing for members with a tracheostomy or who are ventilator dependent.

LTSS Billing Codes

Out of Home Respite (Facility)

Code	Rev Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
S5151*	661				Respite Care, not hospice	Per diem
S5151*	661	U1			Respite Care, not hospice, with partial vent	Per diem
S5151*	661	U2			Respite Care, not hospice, with full vent	Per diem
S5151*	661	U3			Respite Care, not hospice, with trach	Per diem

*Was T1005

Out of Home Respite (Non-Facility)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2027					Respite care, camp setting	15 minutes = 1 unit

LTSS Billing Codes

Prescribed Pediatric Extended Care (PPEC)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1025					Prescribed pediatric extended care, greater than 4 hours	4.25 hours or more = 1 unit
T1025	U6				Prescribed pediatric extended care, greater than 4 hours (MDCP)	4.25 hours or more = 1 unit
T1026					Prescribed pediatric extended care, up to 4 hours	1 hour = 1 unit
T1026	U6				Prescribed pediatric extended care, up to 4 hours (MDCP)	1 hour = 1 unit
T2002					Non-emergency transportation	Per diem
T2002	U6				Non-emergency transportation (MDCP)	Per diem

LTSS Billing Codes

Adaptive Aids (Waiver)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2028					Adaptive Aid - NOS	1 unit per service
T2029					Adaptive Aid – Medical Equipment	1 unit per service
T2039					Adaptive Aid – Vehicle Modification	1 unit per service
T2028	UC				Adaptive Aid – NOS, CDS Option	1 unit per service
T2029	UC				Adaptive Aid – Medical Equipment, CDS Option	1 unit per service
T2039	UC				Adaptive Aid – Vehicle Modification, CDS Option	1 unit per service

LTSS Billing Codes

Transition Assistance Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2038					Transition Assistance Services	1 unit per service

Financial Management Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2040	U9	U1			Financial Management Service Fee, PCS	Monthly fee
T2040	U9	U2			Financial Management Service Fee, CFC	Monthly fee
T2040	U9	U2	U6		Financial Management Service Fee, CFC (MDCP)	Monthly fee
T2040	U9	U6			Financial Management Service Fee, MDCP	Monthly fee

LTSS Billing Codes

In Home Respite (Attendant)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1005*	U4	U1			Attendant, Agency model	15 minutes = 1 unit
T1005*	U4	U2			Attendant, SRO	15 minutes = 1 unit
T1005*	U4	UC			Attendant, CDS option	15 minutes = 1 unit
T1005*	U4	TD	U1		Attendant with RN delegation, Agency model	15 minutes = 1 unit
T1005*	U4	TD	U2		Attendant with RN delegation, SRO	15 minutes = 1 unit
T1005*	U4	TD	UC		Attendant with RN delegation, CDS option	15 minutes = 1 unit

*Was H2015

Note: In-Home Respite services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

In-Home Respite (LVN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1005*	TE	U1			LVN – Agency model	15 minutes = 1 unit
T1005*	TE	U2			LVN, Service, SRO	15 minutes = 1 unit
T1005*	TE	UC			LVN (CDS)	15 minutes = 1 unit
T1005*	TE	U7**	U1		Specialized LVN, Agency model	15 minutes = 1 unit
T1005*	TE	U7**	U2		Specialized LVN, SRO	15 minutes = 1 unit
T1005*	TE	U7**	UC		Specialized LVN, CDS option	15 minutes = 1 unit

*Was H2015

**The U7 Specialized Services modifier may only be used for In Home Respite for a member with a tracheostomy or who are ventilator dependent.

Note: In-Home Respite services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

In-Home Respite (RN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T1005*	TD	U1			RN, Agency model	15 minutes = 1 unit
T1005*	TD	U2			RN, SRO	15 minutes = 1 unit
T1005*	TD	UC			RN, CDS option	15 minutes = 1 unit
T1005*	TD	U7**	U1		Specialized RN, Agency Model	15 minutes = 1 unit
T1005*	TD	U7**	U2		Specialized RN, SRO	15 minutes = 1 unit
T1005*	TD	U7**	UC		Specialized RN, CDS option	15 minutes = 1 unit

*Was H2015

**The U7 Specialized Services modifier may only be used for In Home Respite for a member with a tracheostomy or who are ventilator dependent.

Note: In-Home Respite services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Flexible Family Support Services (Attendant)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9482*	U4	U1			Attendant, Agency model	15 minutes = 1 unit
S9482*	U4	U2			Attendant, SRO	15 minutes = 1 unit
S9482*	U4	UC			Attendant, CDS option	15 minutes = 1 unit
S9482*	U4	TD	U1		Attendant with RN delegation, Agency model	15 minutes = 1 unit
S9482*	U4	TD	U2		Attendant with RN delegation, SRO	15 minutes = 1 unit
S9482*	U4	TD	UC		Attendant with RN delegation, CDS option	15 minutes = 1 unit

*Was H2015

Note: Flexible Family Support Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Flexible Family Support Services (LVN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9482*	TE	U1			LVN, Agency model	15 minutes = 1 unit
S9482*	TE	U2			LVN, SRO	15 minutes = 1 unit
S9482*	TE	UC			LVN, CDS option	15 minutes = 1 unit
S9482*	TE	U7*	U1		Specialized LVN, Agency model	15 minutes = 1 unit
S9482*	TE	U7**	U2		Specialized LVN, SRO	15 minutes = 1 unit
S9482*	TE	U7**	UC		Specialized LVN, CDS option	15 minutes = 1 unit

*Was H2015

** The U7 Specialized Services modifier may only be used for Flexible Family Support Services for a member with a tracheostomy or who are ventilator dependent.

Note: Flexible Family Support Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Flexible Family Support Services (RN)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9482*	TD	U1			RN, Agency model	15 minutes = 1 unit
S9482*	TD	U2			RN, SRO	15 minutes = 1 unit
S9482*	TD	UC			RN, CDS option	15 minutes = 1 unit
S9482*	TD	U7**	U1		Specialized RN, Agency model	15 minutes = 1 unit
S9482*	TD	U7**	U2		Specialized RN, SRO	15 minutes = 1 unit
S9482*	TD	U7**	UC		Specialized RN, CDS option	15 minutes = 1 unit

*Was H2015

**The U7 Specialized Services modifier may only be used for Flexible Family Support Services for a member with a tracheostomy or who are ventilator dependent.

Note: Flexible Family Support Services require EVV validation and must be billed to TMHP.

LTSS Billing Codes

Employment Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2023	U1				Supported Employment, agency model	15 minutes = 1 unit
H2023	U2				Supported Employment, SRO	15 minutes = 1 unit
H2023	UC				Supported Employment, CDS option	15 minutes = 1 unit
H2025	U1				Employment Assistance, Agency model	15 minutes = 1 unit
H2025	U2				Employment Assistance, SRO	15 minutes = 1 unit
H2025	UC				Employment Assistance, CDS option	15 minutes = 1 unit

Electronic Visit Verification (EVV)

What is Electronic Visit Verification (EVV)?

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

STAR Kids and STAR Health Services Requiring EVV

- Personal Care Services (PCS)
- In-home respite services
- Flexible family support services
- Community First Choice (CFC)-PAS and Habilitation (HAB)
- For a list of all current programs and services requiring EVV refer to:
  State-Required Personal Care Services (PDF)
  Cures Act Home Health Care Services (PDF)

EVV Claims

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

EVV Claims

- Bill Units using the rounded “Pay Hours” calculated in the EVV vendor system.
  - Example: If a client was services for 48 minutes, .75 units (rounds up to 1 hour), 1 full unit should be billed for the respective visit. If a client was serviced 52 minutes (round up to 1 hour), 1 full unit should be billed for the respective visit.
- All unit increments should be billed in the following format after rounding:

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

EVV Claims

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

EVV Claims

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

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Website and Secure Provider Portal

Superior Website and Secure Provider Portal

Superior's Providers webpage

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for additional Provider Resources

Superior's Secure Provider Portal

Submit:

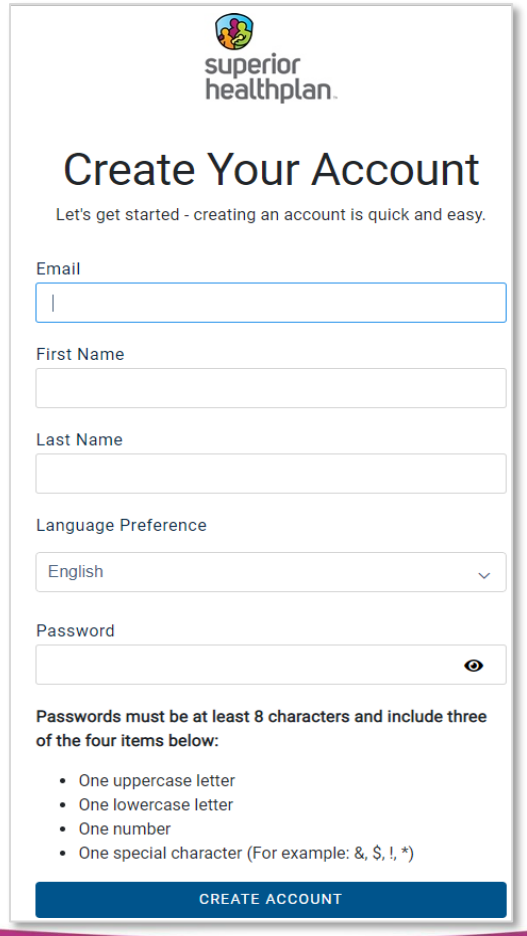
- Claims
- Request for EOPs
- Provider Complaints
- Coordination of Benefits (COB) Claims
- Adjusted Claims

Verify:

- Member Eligibility
- Claim Status

Registration

- To register, visit Superior's Secure Provider Portal.
  - 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.
  - Input the information as required and create your password.
  - Each user within the provider's office must create their own account.



Provider Portal: Eligibility

- Search for eligibility using:
  - Member's date of birth
  - Medicaid/CHIP/DFPS ID number or last name
  - Date of service

Provider Portal: Claims

- Claim Status
  - Claims update to the web portal every 24 hours
  - Status can be checked for a period of 18 months prior
- View Web Claims
  - Click on the claims module to view the last 3 months of submitted claims
- Unsubmitted Claims
  - Incomplete claims or claims that are ready to be submitted can be found under “Saved” claims
- Submitted Claims
  - Status will show “In Progress,” “Accepted,” “Rejected” or “Completed.”

Provider Portal: Claims

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

Provider Portal: Additional Information

- Resources
  - Practice guidelines and standards
  - Training and education
- Contact Us (Web Applications Support Desk)
  - Phone: 1-866-895-8443
  - Email: TX.WebApplications@SuperiorHealthPlan.com

Superior HealthPlan Departments

We're here to help you!

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations
  - Face-to-face Secure Provider Portal training
  - Office visits to review ongoing claim trends
  - Provider trainings
- For any questions, or to schedule a training, you may contact our LTSS Account Management team at: 1-866-529-0294.
  - Select your language
  - Select Option 3 for Account Management, and next
  - Select Option 1, Long Term Care Service Support Providers or AM.LTSS@SuperiorHealthPlan.com.

Provider Training

- Superior offers targeted billing presentations depending on the type of services you provide and bill for, such as:
  - Electronic Visit Verification (EVV), General Billing Clinics and product-specific training on STAR+PLUS, STAR+PLUS MMP and STAR/CHIP.
- You can find the schedule for all training presentations on Superior's Provider Training Calendar.

Provider Services

- The Provider Services staff can help you with:
  - Questions on claim payments
  - Assisting with claims appeals and corrections
  - Finding Superior Network Providers
  - Locating your Service Coordinator and Account Manager
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- You can contact Provider Services at 1-877-391-5921, Monday through Friday, 8:00 a.m. to 5:00 p.m. CST.

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility
  - Reviewing member benefits
  - Assist with non-compliant members
  - Help find additional local community resources
- You can contact Member Services Monday through Friday, 8 a.m. to 5.pm. CST at:
  - STAR Kids: 1-844-590-4883
  - STAR Health: 1-866-912-6283

Compliance

- Health Insurance Portability Accountability Act (HIPAA) of 1996
  - Providers and contractors are required to comply with HIPAA guidelines.
    - For more information visit, HHS's Health Information Privacy webpage.
- Fraud, Waste and Abuse (Claims/Eligibility)
  - Providers and contractors are all required to comply with State and Federal provisions that are set forth.
  - To report fraud, waste and abuse, call the numbers listed below:
    - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184.
    - Texas Attorney General Medicaid Fraud Control Hotline: 1-800-252-8011.
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664.
- For any compliance questions, you may also reach out to Provider Services at 1-877-391-5921.

Complaints

- A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to Superior, other than an action/adverse determination. Superior offers a number of ways to file a complaint, as listed below:
- Address:

  Superior HealthPlan
  ATTN: Complaint Department
  5900 E. Ben White Blvd.
  Austin, Texas 78741

- Fax number: 1-866-683-5369
- Website Links:
  - Submit online by visiting Superior's Complaint Information & Form
  - The *Complaint Form (PDF)* can be found on the *Filing Provider Complaints* section on Superior's Complaint Procedures webpage
- For assistance filing a complaint or to check on the status of a provider complain, providers may email TexasProviderComplaints@Centene.com

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Questions and Answers