superior healthplan™

STAR+PLUS Long-Term Services and Supports (LTSS) Billing Clinic

Provider Training

Introductions and Agenda

- Introduction to Superior HealthPlan
- Verifying Eligibility
- Service Coordination
- Prior Authorizations
- Electronic Visit Verification
- Claims Filing and Payment Options
- STAR+PLUS Billing Matrix
- Superior's 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 Commission (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)

What is STAR+PLUS?

- 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 (doctors visits) with LTSS, such as providing help in the home with daily living activities, home modifications and personal assistance.
- Members, their families and providers work together to coordinate members' healthcare, long-term care and 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.

What is STAR+PLUS MMP?

- STAR+PLUS MMP is a fully integrated managed care model for individuals who are enrolled in Medicare and Medicaid.
- Services include all Medicare benefits, including parts A, B and D, and Medicaid benefits, including LTSS and flexible benefits/value added benefits.
- STAR+PLUS MMP is an opt-in/opt-out program.
- Superior offers STAR+PLUS MMP in Bexar, Dallas and Hidalgo counties.

What is CFC?

- Community First Choice (CFC) is part of Senate Bill 7 from the 2013 Texas Legislature requiring HHSC to put in place a cost-effective option for attendant and habilitation (HAB) services for people with disabilities.
- CFC services are available for STAR+PLUS members who:
  - Are eligible for Medicaid and enrolled in STAR+PLUS
  - 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 includes PAS, HAB, Emergency Response Services and Support Management.

Community First Choice (CFC)

- 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 Texas Medicaid & Healthcare Partnership (TMHP) if EVV validation is required. Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the HHS STAR+PLUS Handbook.

Verifying Eligibility

Verify Eligibility

- Superior's Secure Provider Portal
- Superior STAR+PLUS Member Services: 1-877-277-9772
- Superior STAR+PLUS MMP Member Services: 1-866-896-1844
- Superior STAR+PLUS or STAR +PLUS MMP Card
- Texas Medicaid Benefits Card
- TMHP's TexMedConnect 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.

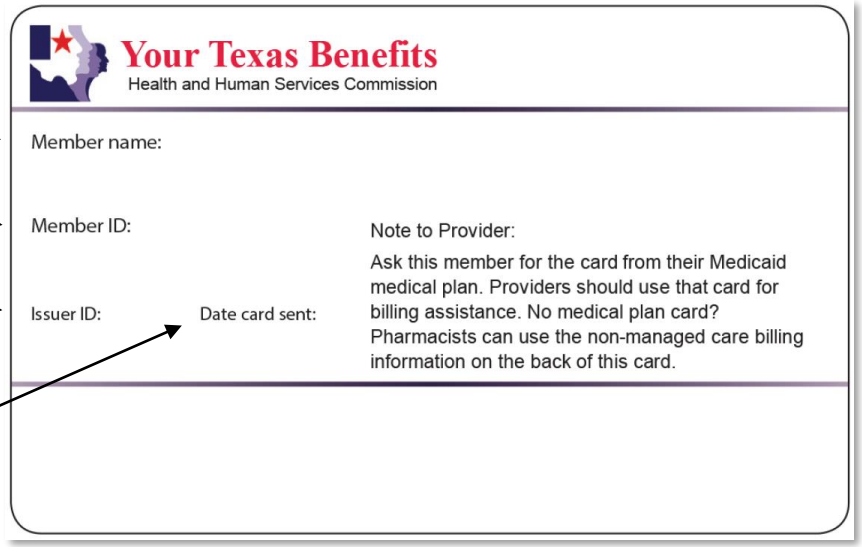
Member ID Cards

This is where your name appears.

This is your Medicaid ID number.

This is HHSC's agency ID number. Doctors and other providers need this number.

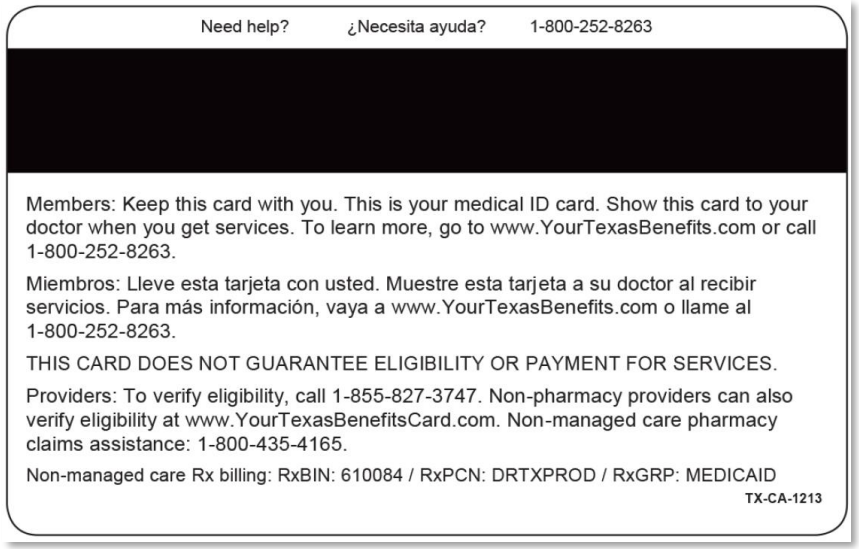
This is the date the card was sent to you.



This is a magnetic strip your doctor can swipe (like a credit card) to get your Medicaid ID number.

Go to this website or call this number to learn more about this card.

This message is for doctors and providers. This means they need to make sure you are still in the Medicaid program.



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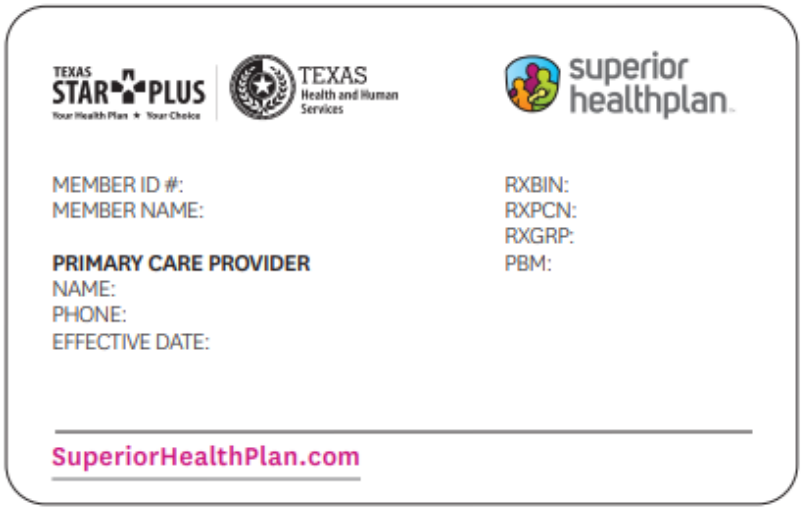
STAR+PLUS Member ID Cards



STAR+PLUS MMP ID Card

Service Coordination

Service Coordination

- Single point of contact for the member.
- Review assessments and develop plan of care utilizing input from member, family and providers.
- Coordinate with the member's Primary Care Physician (PCP), specialist 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.

Contacting a Member's Service Coordinator

- Members and providers will be 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: 1-877-277-9772.

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.
- 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.*

Services Requiring Prior Authorizations

- DAHS, assisted living, respite, PAS/PHC, home health, home delivered meals, adult foster care, emergency response services, consumer directed services and minor home modifications
- DME
  - Non waiver items below $500 generally will not require prior authorization.
    - Please note providers should verify if prior authorization is required by visiting Superior's Medicare Prior Authorization webpage.
  - If waiver-specific DME item, then prior authorization is required.
- Skilled Nursing, PT/OT/ST – except at initial evaluation

Please note: Refer to the Provider Manual for complete guidelines which can be found on Superior's Training and Manuals webpage.

LTSS Authorizations

- PAS
- Day Activity and Health Services (DAHS)
- STAR+PLUS Waiver Services:
  - Adaptive aids
  - Adult foster care
  - Assisted living facility
  - Dental Services
  - Emergency response system
  - Employment Assistance
  - Financial Management Services
  - Home delivered meals
  - In-home skilled nursing care
  - Medical supplies
  - Mental Health Rehabilitative Services
  - Mental Health Targeted Case Management
  - Minor home modification
  - Personal Assistant Services
  - Respite Care Services
  - Supported Employment
  - Therapy (PT/OT/ST)
  - Transitional Assistance Services
  - Supplemental Transition Services

How do I authorize LTSS or CFC?

- All authorizations for LTSS and CFC are obtained through the Service Coordination department.
- The name of each member's Service Coordinator can be viewed once a member's eligibility is confirmed through the Secure Provider Portal.
- To initiate prior authorization requests or any changes to an authorization, providers may call the Service Coordination department at: 1-877-277-9772 or fax in a 2067 Form.
  - To access the form, visit HHSC's Form H2067, Case Information webpage
  - Fax Numbers:
    - STAR+PLUS 1-866-895-7856
    - STAR+PLUS MMP 1-855-277-5700

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 EOP or denial is issued.

Initial Submission

- Claims must be completed in accordance with TMHP billing guidelines.
- Use appropriate modifiers and procedure codes from HHSC's LTSS Codes and Modifiers webpage.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.

LTSS Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Superior's Secure Provider Portal
  - Electronic Claims:
  - Superior Payer ID 68069
  - Visit the website for a list of our Trading Partners on Superior's Billing and Coding webpage
- 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.*

Claims Filing Addresses for STAR+PLUS MMP Members

Addresses are different for MMP members.

- Initial claim submission, Adjusted/Corrected Claims, reconsiderations and disputes by paper:
  - Superior HealthPlan STAR+PLUS MMP
    P. O. Box 3060
    Farmington, MO 63640-3822
- Providers can file through the Secure Provider Portal or their clearinghouse for Initial and Adjusted/Corrected Claims.

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 Electronic Data Interchange (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 (HCFA) Form Tips

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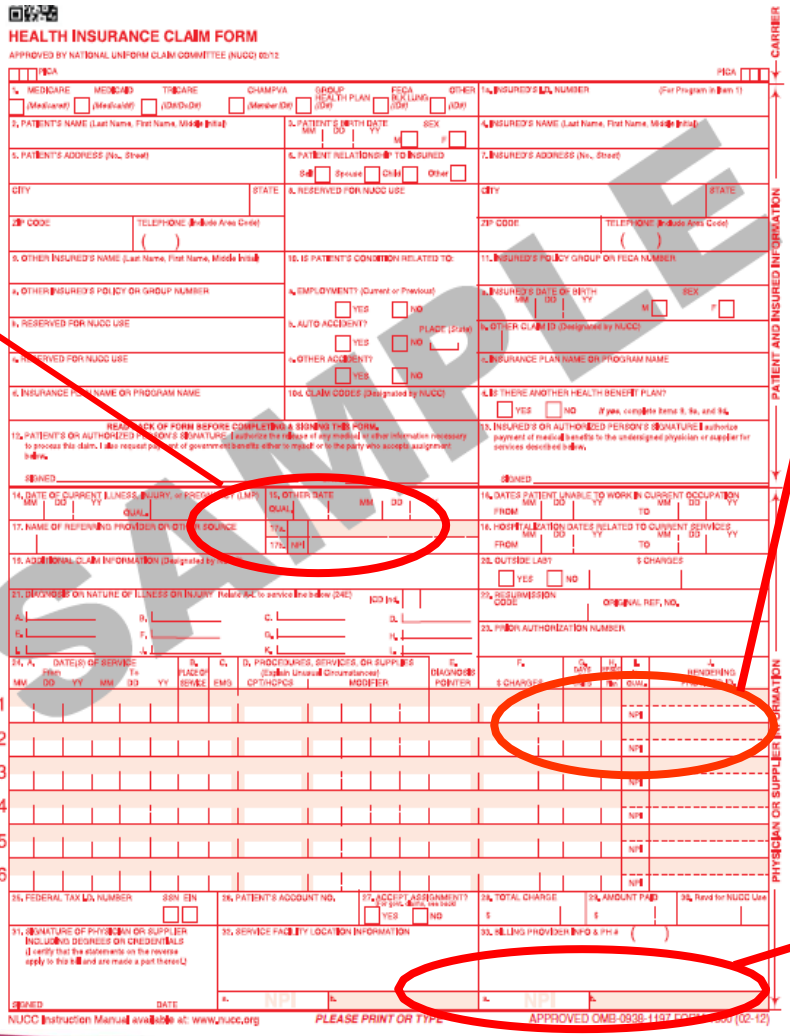
Referring Provider: [C]
17 Name of the referring provider and 17b NPI



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 number) in Box 33b

Billing Provider: [R]
33a Billing NPI number

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

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

Billing Tip Reminders

- National Provider Identifier (NPI) of rendering provider.
- Appropriate 2-digit location code must be listed.
- ZZ qualifier to indicate taxonomy (24 J shaded/33b) when you are billing with your NPI number.
- Ensure appropriate modifiers have been entered.
- Taxonomy codes are required on encounter submissions effective for the rendering and billing providers.
- Ensure the EVV data matches the units/hours on the claim.
- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS 1500 forms.

Claims Filing Deadlines

- First Time Claim Submission
  - 95 Days from date of service
- Corrected Claims
  - 120 Days from the date of EOP 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

- Superior assigns claim numbers (aka Claim Control Number or Submission ID) 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:
  - EDI Rejection/Acceptance reports
  - Rejection Letters*
  - Secure Provider Portal
  - EOP
- Sample claim number: N125TXP02973
- When calling into Provider Services, please have the claim number ready for expedited handling.

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

Authorization and Billing Tips

- Avoid denials: Remember to use the right Tax ID LTSS number when requesting authorizations.
- If the authorization denies because it was billed with a different combination than was authorized, providers can appeal by:
  - Rebilling with correct combination
  - Requesting reconsideration by providing the authorization number you did obtain and ask it be assigned to the correct combination

Recurring Bills Reminder

- Superior frequently issues authorizations that span over multiple dates of service.
- To avoid claim denials, the dates of service billed on a claim must be covered under one single authorization.
- If the dates of service billed are covered by multiple authorizations, the claim should be split and billed on separate claims for each authorization.

Adjustments, Reconsiderations and Disputes

- All claim adjustments (corrected claims), requests for reconsideration or disputes must be received within 120 days from the date of notification or denial.
- Adjusted or Corrected Claim: The provider is changing the original claim. Correction to a prior-finalized claim that was in need of correction as a result of a denied or paid claim.
- Claim Appeals: Often require additional information from the provider.
  - Request for Reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
  - Claim Dispute: Provider disagrees with the outcome of the request for reconsideration
- For easy-to-fill Corrected Claim or Claim Appeal forms visit Superior's Provider Forms webpage.

Corrected Claim Filing Tips

- Must reference original claim number from EOP.
- Must be submitted within 120 days of adjudication paid date.
- Resubmission of claims can be done through a clearinghouse or through Superior's Secure Provider Portal.
  - To send both individual and batch claim adjustments through a clearinghouse, you must provide the following information to your billing company: the CLM05-3 must be "7" and in the 2300 loop a REF *F8* must be sent with the original claim number (or the claim will reject).
  - For batch adjustments, upload this file to a clearinghouse or through the Secure Provider Portal.
  - To send individual claim adjustments through the portal, log in to your account, select "Claim" and then the "Correct Claim" button.
- Corrected or adjusted paper claims can also be submitted to:

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

Appealing Denied Claims

- Submit appeal within 120 days from the date of adjudication or denial.
- Claims appeals may be submitted:
  - In writing:
    Superior HealthPlan
    Attn: Claims Appeals
    P.O. Box 3000
    Farmington, MO 63640-3800
  - Through the Secure Provider Portal.
    - At this time, batch adjustments are not an option through the portal.
- Attach and complete the Claim Appeal form from Superior's website.
- 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:
  - Electronic Claim Payments (EFT)
  - Online remittance advices (Electronic 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:
  - Call PaySpan at: 1-877-331-7154.
  - E-mail: ProvidersSupport@Payspanhealth.com.

Member Balance Billing

- Providers may NOT bill STAR+PLUS or STAR+PLUS MMP 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 (including STAR+PLUS MMP members) do not have co-payments.
- Additional details can be found in the Superior Provider Manuals.

STAR+PLUS Billing Matrix

Effective 12/1/2022

Prior Authorization Updates for December 1, 2022

- A majority of prior 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.

LTSS Billing Codes

Adult Foster Care

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5140	U1				Adult Foster Care -- Level 1	1 day = 1 unit
S5140	U2				Adult Foster Care -- Level 2	1 day = 1 unit
S5140	U3				Adult Foster Care -- Level 3	1 day = 1 unit

LTSS Billing Codes

HAB

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2017	U5	U7			CFC Habilitation, Agency model (Non-HCBS)	15 minutes = 1 unit
T2017	U5	U7	UC		CFC Habilitation, CDS option (Non-HCBS)	15 minutes = 1 unit
T2017	U5	U7	UD		CFC Habilitation, SRO model (Non-HCBS)	15 minutes = 1 unit
T2017	U3	U7			CFC Habilitation, Agency model (HCBS)	15 minutes = 1 unit
T2017	U3	U7	UC		CFC Habilitation, CDS option (HCBS)	15 minutes = 1 unit
T2017	U3	U7	UD		CFC Habilitation, SRO model (HCBS)	15 minutes = 1 unit

Note: CFC HAB services requires EVV validation and must be billed to TMHP.

LTSS Billing Codes

Day Activities and Health Services (DAHS)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5101					DAHS 3 to 6 hours	3-6 hours = 1 unit
S5101					DAHS over 6 hours	Over 6 hours = 2 units

Emergency Response Services*

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5160					Emergency Response Services (Installation and Testing)	1 unit per service
S5161	U3				Emergency Response Services (Monthly) (STAR+PLUS HCBS)	1 month = 1 unit
S5161	U3	U7			Emergency Response Services (Monthly) (STAR+PLUS HCBS) (CFC)	1 month = 1 unit

LTSS Billing Codes

Employment Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
H2023	U3				Supported Employment (SPW)	15 minutes = 1 unit
H2023	U3	UC			Supported Employment (CDS) (SPW)	15 minutes = 1 unit
H2023	U3	UD			Supported Employment (SRO) (SPW)	15 minutes = 1 unit
H2025	U3				Employment Assistance (SPW)	15 minutes = 1 unit
H2025	U3	UC			Employment Assistance (CDS) (SPW)	15 minutes = 1 unit
H2025	U3	UD			Employment Assistance (SRO) (SPW)	15 minutes = 1 unit

LTSS Billing Codes

Financial Management Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2040	U5	U9			Financial Management Services Fee, Monthly Fee (non - STAR+PLUS HCBS)	1 month = 1 unit
T2040	U5	U9	U7		Financial Management Services Fee, Monthly Fee (non - STAR+PLUS HCBS) (CFC)	1 month = 1 unit
T2040	U3	U9			Financial Management Services Fee, Monthly Fee (STAR+PLUS HCBS)	1 month = 1 unit
T2040	U3	U9	U7		Financial Management Services Fee, Monthly Fee (STAR+PLUS HCBS) (CFC)	1 month = 1 unit

LTSS Billing Codes

Home Delivered Meals

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5170					SPW Home Delivered Meals	1 meal = 1 unit

Minor Home Modifications

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5165					Minor home modifications	1 unit per service

LTSS Billing Codes

PAS – Non HCBS

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	U5				PAS Agency Model (Non-HCBS)	15 minutes = 1 unit
S5125	U5	U7			PAS Agency Model (Non-HCBS) (CFC)	15 minutes = 1 unit
S5125	U5	UC			PAS CDS Option (Non-HCBS)	15 minutes = 1 unit
S5125	U5	U7	UC		PAS CDS Option (Non-HCBS) (CFC)	15 minutes = 1 unit
S5125	U5	UD			PAS SRO Model (Non-HCBS)	15 minutes = 1 unit
S5125	U5	U7	UD		PAS SRO Model (Non-HCBS) (CFC)	

Note: PAS and CFC PAS services require EVV validation and must be billed to TMHP

LTSS Billing Codes

PAS – STAR+PLUS HCBS

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	U3				PAS Agency Model (HCBS)	15 minutes = 1 unit
S5125	U3	U7			PAS Agency Model (HCBS) (CFC)	15 minutes = 1 unit
S5125	U3	U1			PAS Protected Supervision Agency Model (HCBS)	15 minutes = 1 unit
S5125	U3	UC			PAS CDS Option (HCBS)	15 minutes = 1 unit
S5125	U3	U7	UC		PAS CDS Option (HCBS) (CFC)	15 minutes = 1 unit

Note: PAS and CFC PAS services require EVV validation and must be billed to TMHP

LTSS Billing Codes

PAS – STAR+PLUS HCBS

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S5125	U3	U1	UC		PAS Protective Supervision CDS Option (HCBS)	15 minutes = 1 unit
S5125	U3	UD			PAS SRO Model (HCBS)	15 minutes = 1 unit
S5125	U3	U7	UD		PAS SRO Model (HCBS) (CFC)	15 minutes = 1 unit
S5125	U3	U1	UD		PAS Protective Supervision SRO Model	15 minutes = 1 unit

Note: PAS and CFC PAS services require EVV validation and must be billed to TMHP

LTSS Billing Codes

Physical, Occupational, Speech Therapy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9131	U3				Physical Therapy; Home per diem Agency model (SPW)	1 day = 1 unit
S9131	U3	UC			Physical Therapy; Home per diem CDS option (SPW)	1 day = 1 unit
S9131	U3	UD			Physical Therapy; Home per diem SRO option (SPW)	1 day = 1 unit
S9128	U3				Speech Therapy; Home per diem Agency model (SPW)	1 day = 1 unit
S9128	U3	UC			Speech Therapy; Home per diem CDS option (SPW)	1 day = 1 unit
S9128	U3	UD			Speech Therapy; Home per diem SRO model (SPW)	1 day = 1 unit

LTSS Billing Codes

Physical, Occupational, Speech Therapy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
S9129	U3				Occupational Therapy; Home per diem Agency model (SPW)	1 day = 1 unit
S9129	U3	UC			Occupational Therapy; Home per diem CDS option (SPW)	1 day = 1 unit
S9129	U3	UD			Occupational Therapy; Home per diem SRO model (SPW)	1 day = 1 unit

LTSS Billing Codes

Assisted Living Apartment – Single Occupancy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	U6				Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	U5				Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	U4				Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	U3				Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	U2				Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	U1				Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Assisted Living Apartment – Double Occupancy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	UB	U6			Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	UB	U5			Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	UB	U4			Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	UB	U3			Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	UB	U2			Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	UB	U1			Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Assisted Living – Non-Apartment

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2031	UA	U6			Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
T2031	UA	U5			Level 5: PB1, CA1, & PB2	1 day = 1 unit
T2031	UA	U4			Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
T2031	UA	U3			Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
T2031	UA	U2			Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
T2031	UA	U1			Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care – Out of Home

Code	Rev Code	Modifier 1	Modifier 2	Description	Units
S5151	663	UC		Respite Care --Nursing Facility	1 day = 1 unit
S5151		UD	U1	Respite Care -- Adult Foster Care (Level 1)	1 day = 1 unit
S5151		UD	U2	Respite Care -- Adult Foster Care (Level 2)	1 day = 1 unit
S5151		UD	U3	Respite Care -- Adult Foster Care (Level 3)	1 day = 1 unit

LTSS Billing Codes

Respite Care – Assisted Living Apartment (Single Occupancy)

Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
S5151	U8	U9	U6	Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	U8	U9	U5	Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	U8	U9	U4	Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	U8	U9	U3	Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	U8	U9	U2	Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	U8	U9	U1	Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

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Respite Care – Assisted Living Apartment (Double Occupancy)

Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
S5151	U8	UB	U6	Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	U8	UB	U5	Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	U8	UB	U4	Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	U8	UB	U3	Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	U8	UB	U2	Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	U8	UB	U1	Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

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Respite Care – Assisted Living (Non-Apartment)

Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
S5151	U8	UA	U6	Level 6: PA1, BA1, PA2, BA2, IA1, & IA2	1 day = 1 unit
S5151	U8	UA	U5	Level 5: PB1, CA1, & PB2	1 day = 1 unit
S5151	U8	UA	U4	Level 4: SSA, PC2, BB2, IB2, & PD1	1 day = 1 unit
S5151	U8	UA	U3	Level 3: CA2, PC1, BB1, & IB1	1 day = 1 unit
S5151	U8	UA	U2	Level 2: RAA, RAB, CB1, RAC, CB2, SE2, PD2, PE1, & SSB	1 day = 1 unit
S5151	U8	UA	U1	Level 1: SSC, CC1, RAD, CC2, PE2, SE3, & SE1	1 day = 1 unit

LTSS Billing Codes

Respite Care – In-Home

Code	Modifier 1	Modifier 2	Description	Units
T1005	U3		Respite Care -- In-Home, Agency Option	15 minutes = 1 unit
T1005	U3	UC	Respite Care – In-Home, CDS Option	15 minutes = 1 unit
T1005	U3	UD	Respite Care – In-Home, SRO Model	15 minutes = 1 unit

Note: In-Home Respite requires EVV validation and claims must be billed to TMHP.

LTSS Billing Codes

Skilled Nursing

Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
T1001				Nursing assessment/evaluation	1 visit = 1 unit
S9123	U3			Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, Agency Option (SPW)	1 hour = 1 unit
S9123	U3	UA		Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, Agency Option (Specialized) (SPW)	1 hour = 1 unit
S9123	U3	UC		Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, CDS Option (SPW)	1 hour = 1 unit
S9123	U3	UC	UA	Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, CDS Option (Specialized) (SPW)	1 hour = 1 unit
S9123	U3	UD		Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, SRO Model (SPW)	1 hour = 1 unit
S9123	U3	UD	UA	Nursing Services -- RN (1 visit) Nursing Care in the Home by RN, SRO Model (Specialized) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Skilled Nursing

Code	Modifier 1	Modifier 2	Modifier 3	Description	Units
S9124	U3			Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, Agency Option (SPW)	1 hour = 1 unit
S9124	U3	UA		Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, Agency Option (Specialized) (SPW)	1 hour = 1 unit
S9124	U3	UC		Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, CDS Option (SPW)	1 hour = 1 unit
S9124	U3	UC	UA	Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, CDS Option (Specialized) (SPW)	1 hour = 1 unit
S9124	U3	UD		Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, SRO Model (SPW)	1 hour = 1 unit
S9124	U3	UD	UA	Nursing Services – LVN (1 visit) Nursing Care in Home by LVN, SRO Model (Specialized) (SPW)	1 hour = 1 unit

LTSS Billing Codes

Transition Assistance Services

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2038					Transition Assistance Services (SPW)	1 service = 1 unit

Non-Emergency Transport

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
T2003					Non-Emergency Transport – 1 way trip (non-HCBS)	1 trip = 1 unit

LTSS Billing Codes

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Cognitive Rehabilitation Therapy

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
97129	U3				Cognitive Rehabilitation Therapy – Initial 15 minutes	15 minutes = 1 unit
97130	U3				Cognitive Rehabilitation Therapy – Each additional 15 minutes	15 minutes = 1 unit
97129	U3	UC			Cognitive Rehabilitation Therapy – Initial 15 minutes, CDS Option	15 minutes = 1 unit
97130	U3	UC			Cognitive Rehabilitation Therapy – Each additional 15 minutes, CDS Option	15 minutes = 1 unit
97129	U3	UD			Cognitive Rehabilitation Therapy – Initial 15 minutes, SRO Model	15 minutes = 1 unit
97130	U3	UD			Cognitive Rehabilitation Therapy – Each additional 15 minutes, SRO Model	15 minutes = 1 unit

LTSS Billing Codes

Community/Work Reintegration (CRT)

Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4	Description	Units
97537	U3				Community/Work Reintegration	15 minutes = 1 unit
97537	U3	UC			Community/Work Reintegration, CDS Option	15 minutes = 1 unit
97537	U3	UD			Community/Work Reintegration, SRO Model	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 + PLUS Services Requiring EVV

- PAS
- Personal Care Services (PCS)
- In-home respite services
- CFC-PAS and HAB
- Protective Supervision
- 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 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 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.
  - Note: TMHP refers to the process of resubmitting claims as the appeals process.

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.

Superior's Secure Provider Portal

Submitting Claims

Superior's Website

Visit Superior's website for:

- Provider Directories and online lookup
- A map where providers can easily identify the office of the field Account Manager assigned to them
- Provider training schedule
- Links for additional provider resources

Superior's Secure Provider Portal

Superior is committed to providing all of the tools, resources and support providers need to be ensure business transactions with Superior are as smooth as possible. One of the most valuable tools is Superior's Secure Provider Portal. Once registered, providers gain access to the full site.

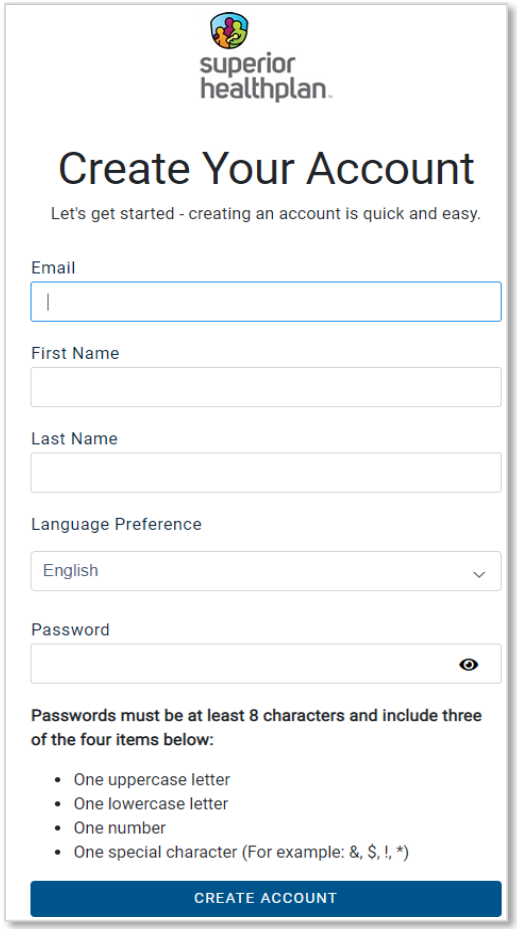
Secure Provider Portal:

- Provides up-to-date member eligibility and Service Coordinator assignment
- Secure claim submission portal to submit claims at no cost
- Provides a claim wizard tool that walks through filling in a claim to submit online
- Provides claim status and payment information
- Allows providers to request and check the status of an acute care authorization

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: 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 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
  - Product-specific training on STAR+PLUS, STAR+PLUS MMP and STAR/CHIP
- You can find the schedule for all of the 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 at: 1-877-277-9772, Monday through Friday, 8:00 a.m. to 5:00 p.m. CST

Compliance

- Health Insurance Portability Accountability Act (HIPAA) of 1996
  - Providers and contractors are required to comply with HIPAA guidelines HHS 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
  5900 E. Ben White Blvd.
  Austin, Texas 78741
  ATTN: Complaint Department
- 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

Questions and Answers