superior healthplan™

STAR, STAR+PLUS and CHIP

Provider Training

Introductions and Agenda

- Provider Roles and Responsibilities
- STAR
- Texas Health Steps Program
- STAR+PLUS
- Transportation
- CHIP
- CHIP Perinate
- OB and Postpartum Program
- Medical Management
- Superior Pharmacy Services
- Quality Improvement
- Abuse, Neglect and Exploitation
- Claims – Filing and Payment
- Claims – Electronic Visit Verification
- Secure Provider Portal
- Superior Departments
- Questions and Answers

Who is Superior HealthPlan?

Superior HealthPlan:

- Is a subsidiary of Centene Corporation providing healthcare 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.
- Contracted with the State of Texas to provide all Medicaid lines of business, including:
  - STAR/CHIP
  - STAR Kids
  - STAR+PLUS
  - STAR Health (Foster Care)
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - Ambetter Health
  - WellCare By Allwell (HMO and HMO DSNP) Plans
- Among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the NCQA Medicaid Health Insurance Plan Ratings.

Provider Roles and Responsibilities

Primary Care Provider (PCP) Responsibilities

- Serve as a “Medical Home”
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member
- Develop an Integrated Primary Care (IPC), which involves the integration of behavioral health services into primary care, where appropriate
- Be accessible to members 24 hours a day, 7 days a week, 365 days a year
- Responsible for the coordination of care and referrals to specialists
- Verify member eligibility prior to rendering services
- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider

PCP Responsibilities

- Update contact information to ensure accurate information is available in Provider Directories.
- Report all encounter data on a CMS 1500 form or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.
- Coordinate with non-network providers, when needed (Center for Independent Living, LIDDAS, housing, etc.).
- Arrange coverage with another Superior provider if one is not available.
- Office phone must be answered during normal business hours.
- After-hours calls should be documented in an after-hour call log and transferred to the patient's medical record.

Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope, such as mental health referrals.
  - There may be times when a referral to an out-of-network may be appropriate. Superior will review the out-of-network request and make a medical necessity decision on the request.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.
- Members may self-refer for the following services:
  - Family planning
  - Texas Health Steps
  - True emergency services
  - Case management for children and pregnant women
  - Behavioral Health
  - Vision
  - Well woman examinations

Referrals for Non-Capitated Services

- Non-capitated services are excluded from covered services; however, STAR and STAR+PLUS members may be eligible to receive them from Texas Medicaid providers on a Fee-for-Service basis.
- When it is determined that a member may need a non-capitated service, Superior staff will assist the member in requesting these services.
- Claims for non-capitated services should be submitted directly to the HHSC Claims Administrator for reimbursement.
- Non-Capitated services for STAR members include, but are not limited to:
    - Early Childhood Intervention (ECI) case management/Service Coordination;
    - Early Childhood Intervention Specialized Skills Training;
    - Community First Choice (CFC) services
    - Texas Health Steps Personal Care Services for Members birth through age 20

Non-Capitated Services

- Non-Capitated services for both STAR and STAR+PLUS members:
  - Texas Health Steps Dental, (including orthodontal)
  - Texas Health Steps environmental lead investigation (ELI);
  - Texas School Health and Related Services (SHARS);
  - Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);
  - During an Inpatient Stay under one of the instances identified in the UMCC where fee-for-service or the previous MCO is responsible for payment for Hospital facility charges associated with the Inpatient Stay, such charges are Non-Capitated Services
- Non-Capitated services for STAR+PLUS Only:
  - Medicaid hospice services
  - Preadmission Screening and Resident Review (PASRR) screenings, evaluations, and specialized services
  - Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members
  - Substance Use Disorder treatment in a Chemical Dependency Treatment Facility (CDTF) for Dual Eligible Members

Behavioral Health Care Provider Expectations

- Expand the use of evidence-based practices, including:
  - Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Informed Care, Parent-Child Interaction Therapy (PCIT), Trust-Based Relational Intervention (TBRI), Post Traumatic Stress Disorder (PTSD) and Attention-Deficit Hyperactivity Disorder.
    - Members prescribed ADHD medications should have at least one follow-up visit within 30 days of the prescription and at least 2 additional visits within nine months after the 30-day visit.
- Refer members with known or suspected physical health problems or disorders to their PCP for examination and treatment.
  - Behavioral health providers may provide physical health services if they are within the scope of their license.
- Contact members who have missed appointments within 24 hours to reschedule.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities
- Send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's behavioral health status to the PCP, with the consent of the member or the member's legal guardian.

Behavioral Health Providers and IDD Members

- It is important that behavioral health providers learn to recognize and understand that the behavior of people with IDD is a form of communication and not a symptom of their disability.
- Providers must recognize that people with IDD experience the same types of behavioral health disorders as others.
- Below are some tools and resources for providers to use to strengthen their skills and knowledge, as it relates to working with members with IDD:
  - The University of Texas Health Science Center at San Antonio (UTHSCSA) has created training modules for direct service workers and health care professionals who support those with IDD and behavioral health needs.
    - You can view the training modules on the Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities website
  - The National Child Traumatic Stress Network (NCTSN) is a training guide and manual for providers helping children and families living with IDD and whom may have experienced trauma:
    - The Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma - English
    - The Road to Recovery: Supporting Children with Intellectual and Developmental Disabilities Who Have Experienced Trauma - Spanish

Behavioral Health Providers and IDD Members

- Information about trauma, trauma-informed planning and interventions, and wellness and resiliency for people with IDD can be found on the Mobilizing Action for Resilient Communities (MARC) website.
- The HHSC Crisis Service Guide provides information on state-funded crisis services and organizations that can help connect people to resources. Crisis services are available 24/7 and include prompt face-to-face crisis assessment, crisis intervention services, crisis follow-up and relapse prevention services.
  - For more information, see the HHSC Crisis Services Guide (PDF).
- The National Association for the Dually Diagnosed (NADD) provides a network for continued advancement of research and quality supports for people experiencing intellectual/developmental disabilities and mental health conditions.
  - For more information, see the *Diagnostic Manual – Intellectual Disability(DM-ID-2) A Textbook of Diagnosis of Mental Disorders in Persons with Intellectual Disability* is a diagnostic manual of diagnosis of mental disorders in persons with intellectual disabilities.

STAR

STAR Eligibility

Who is covered in Texas?

- Families, children and pregnant women
  - Based on income level, age, family income and resources/assets.
- Newborns
  - Born to mothers who are Medicaid-certified at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday.
- Cash assistance recipients
  - Based on receipt of Temporary Assistance for Needy Families (TANF) and dependent on age.
- Former children in foster care, ages 21-25

Texas Health Steps Program

Overview

- Comprehensive preventive care program that combines diagnostic screenings, communication and outreach, and medically necessary follow-up care, including dental, vision and hearing examinations for Medicaid-eligible children, adolescents and young adults under 21 years of age.

- Age-appropriate screenings must include, but are not limited to:
  - Autism
  - Developmental
  - Hearing
  - Lead
  - Mental Health
  - Nutrition
  - Sexually Transmitted Diseases
  - Tuberculosis
  - Vision

- Medically necessary follow-up care including:
  - Dental
  - Hearing examinations
  - Vision
- For complete Texas Health Steps Exam information, please view the HHSC Texas Health Steps Medical Checkups Periodicity Schedule.

Enrollment and Training

- Enrollment as a Texas Health Steps provider must be completed through the Texas Medicaid and Healthcare Partnership (TMHP) website.
- Training from HHSC is mandatory for Texas Health Steps providers.
- Free continuing education hours are available at Texas Health Steps Course Catalog.

Checkup Requirements

- Comprehensive health and development history (mental and physical).
- Comprehensive unclothed physical exam.
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) immunization schedule.
- Appropriate laboratory tests with documentation (including blood lead level assessments and other tests appropriate for age and risk).
- Health education including anticipatory guidance.
- Referral services, i.e., Comprehensive Care Program (CCP) services, Women, Infants and Children (WIC), family planning and dental services.

Please note: Each of the components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule must be completed and documented in the member's medical record. Any component or element not completed must also be noted in the medical record along with the reason why and the plan to complete it.

Checkup Requirements

- Members new to Superior
  - Within first 90 days (unless documentation of previous checkup is provided).
- Existing members
  - Please see the Texas Health Steps Periodicity Schedule - Large (PDF)
  - Members under 3 years of age have multiple checkups within each year; 6 outpatient checkups in the first year.
  - Members over 3 years of age have an annual checkup which must occur within 364 days following their birth date.
- Exceptions (outside of periodicity)
  - Medically necessary: developmental delays, medical concerns, suspected abuse (use modifier code SC).
  - Mandated services: state or federal requirements (use modifier code 32).
  - Unusual anesthesia: procedures which usually require no anesthesia or local anesthesia (use modifier code 23).

Missed Appointments

- Providers should complete a Missed Appointment form and fax it to MAXIMUS at 1-512-533-3867, who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, childcare, money for gasoline, etc.).
- For more information, please see the Texas Health Steps Regional Provider Relations Representatives (PDF).

Superior Outreach and Resources

- New members receive a member packet along with a reminder outreach for their initial exam.
- Existing members receive a reminder card and a call for their annual exam prior to their birth date.
- Newborns receive a card with all the periodic exams that are required in the first 3 years of their life.

Texas Health Steps Outreach and Informing

- Staff contacts newly enrolled Texas Health Steps recipients to inform them of the services available and to:
  - Encourage them to use the preventive medical and dental checkup services.
  - Provide them with a list of all Texas Health Steps providers in their area.
  - Assist them in setting an appointment.
- Providers can make a referral by phone to the State of Texas outreach team at 1-877-847-8377.

Refusal of Exam

- Superior is required to log all member refusals for service to HHSC.
- The refusal should be recorded in the member's medical record and communicated to Superior's Member Services department at 1-800-783-5386.
- If a patient indicates that their exam was previously completed, Superior will:
  - Look for that claim in our system and, if there is no claim on file, will contact the provider of service to verify the member's statement.

Oral Evaluation and Fluoride Varnish

- This program will allow Medicaid-eligible Texas Health Steps members and Children with Special Health Care Needs (CSHCN) who are 6 to 35 months to receive an oral evaluation and fluoride varnish during medical checkups.
  - Limited to 10 fluoride treatments.
  - Providers must be certified to provide oral evaluations and fluoride varnishes.
  - Once a provider has completed the training, they will need to submit their certification to their Superior Account Manager.
  - The training information is available on the HHSC website along with the registration form. The information can be accessed on HHSC's Oral Evaluation and Fluoride Varnish in the Medical Home webpage.
  - Provider should bill with procedure code 99429 and modifier U5 with the diagnosis Z00.129.

Blood Lead Level Reporting

Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms, visit DSHS TXCLPPP webpage.
- Centers for Disease Control (CDC) Childhood Lead Poisoning Prevention and Screening guidelines can be found on the Department of State Health Services (DSHS) website:
  - Prevention: DSHS Blood Lead Surveillance webpage
  - Screening: DSHS Screening Guidelines webpage

Children of Traveling Farm Workers

- HHSC defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode.”
- Superior will assess the child’s health-care needs, provide direct education about the health-care system and the services available and arrange appointments and transportation.
- Superior will attempt to accelerate services to these individuals before they leave the area.
- Superior has developed a “Travel Packet” and other helpful pieces of information to ensure these children get the health-care services they need.
- Providers who provide care to Superior members, who are a children of Traveling Farmworkers, can direct the parent to call Member Services for assistance on program benefits or to help schedule an appointment by calling 1-800-783-5386.

STAR+PLUS

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.
- Individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program, or an IDD Waiver are eligible for Acute Care services through STAR+PLUS.
- Members, their families and providers work together to coordinate member's health care, 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.

STAR+PLUS Eligibility

The following Medicaid-eligible individuals must enroll in the STAR+PLUS program:

- Supplemental Security Income (SSI) eligible 21 and over.
- Individuals 21 and over who are Medicaid eligible because they are in a Social Security exclusion program.
  - These individuals are considered Medical Assistance Only (MAO) for purposes of HCBS STAR+PLUS waiver eligibility
- Dual eligible individuals who are 21 and over covered by both Medicare and Medicaid.
- Individuals 21 and over who reside in a nursing facility.

STAR+PLUS Eligibility

- ICF-IID Program and IDD Waiver Services
  - Individuals with intellectual disabilities or related conditions who do not qualify for Medicare and who receive services through the ICF-IID Program, or an IDD Waiver are eligible for Acute Care services through STAR+PLUS. These individuals will not be eligible for the HCBS STAR+PLUS Waiver Services while enrolled in the ICF-IID Program or an IDD Waiver.
- Medicaid for Breast and Cervical Cancer (MBCC)
  - STAR+PLUS Members between age 18 and 65 in active treatment for breast or cervical cancer, or certain precancerous conditions, determined eligible by HHSC's Breast and Cervical Cancer Services program and receives recertification for continued services every 6 months.

STAR+PLUS Dual-Eligible Members

- Dual-eligible describes members who receive both Medicare and Medicaid.
- Medicare is the primary payor for all acute care services (e.g. PCP, hospital, outpatient services).
- Medicaid Acute Care (TMHP) – serves as the secondary payer and covers co-insurance, deductible and some LTSS (ex: incontinence supplies).
  - All non-LTSS services must be billed through Medicare as primary payer and TMHP as secondary.
- STAR+PLUS covers LTSS (ex: Personal Attendant Services [PAS], Day Activity and Health Services [DAHS], etc.) and is the payor of last resort.

STAR+PLUS - LTSS

- Personal Assistance Services (PAS)
- Day Activity and Health Services (DAHS)
- STAR+PLUS Waiver Services:
  - Adaptive Aids/Durable Medical Equipment (DME)
  - Adult Foster Care
  - Cognitive Rehabilitation therapy (CRT)
  - Emergency Response Services (ERS)
  - Home Delivered Meals
  - Minor Home Modification (MHM)
  - Long-Term Home Nursing
  - Medical Supplies
  - Assisted Living
  - Skilled Nursing
  - Therapy Services (PT/OT/ST)
  - Adult Foster Care (AFC)
  - Home-Delivered Meals
  - Respite Care
  - Transition Assistance Services
  - Employment Assistance
  - Supported Employment

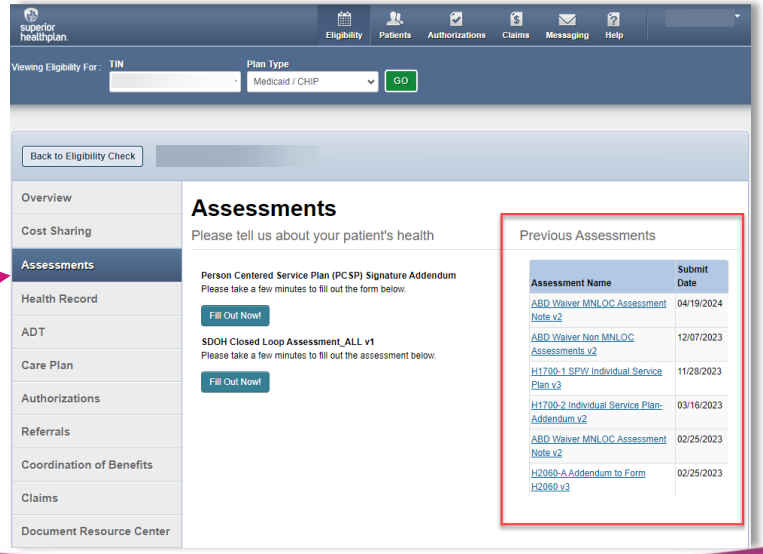
Service Coordination

- Service Coordinator Role
  - Clinical and non-clinical support
    - 24/7/365 accessibility to STAR+PLUS staff via STAR+PLUS Member Services and Superior's Nurse Advice Line at 1-877-277-9772
    - Identification of member's needs
    - Referrals/pre-authorizations/certifications
    - Communication with doctor and other providers to develop an Individual Service Plan (ISP)
    - Conduct mandatory telephonic and/or face to face contacts
    - Coordinate care with other entities to ensure integration of care
  - 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

LTSS Assessments

- Members receiving LTSS services are assessed annually, or as needed, to continue services.
- Service Coordinators review the assessment(s) to identify service needs with the member in developing a plan of care.
- Assessments are also reviewed biannually and upon notification of a change of condition.
- The Service Plan must be provided to the member and the member's authorized representatives and providers in the language and format requested.

Note: Providers can access Service Plans and ISP documents on the Provider Portal using the Assessment tab.



Medical Necessity and Level of Care Assessment – Physician's Signature

- HHSC requires a Medical Necessity Level of Care (MNLOC) Assessment to be conducted when a STAR+PLUS member requests HCBS STAR+PLUS Waiver Program services.
- The Medical Necessity (MN) Form is used to obtain certification from the member's medical provider regarding the need for LTSS in the HCBS waiver program.
- Services include, but are not limited to:
  - Minor Home Modifications
  - Respite Services
  - Emergency Response Services (ERS)
  - Home Delivered Meals (HDM)
  - Adaptive Aids/Orthotics/Prosthetics
  - Assisted Living
  - Community First Choice (CFC) Services
  - Long-Term Nursing

Medical Necessity and Level of Care Assessment – Physician's Signature

- A MN signature is required after the initial assessment for services from the HCBS waiver program. TMHP will grant final approval into the HCBS waiver program upon initial request and annually based on the MNLOC assessment performed by a nurse.
- The MN Form must be signed by a physician (MD), Osteopathic Medicine (DO) or military physician who has examined the member and reviewed the medical record within the last 12 months. The provider must be a Medicaid provider.
- The signing physician is certifying that the member meets nursing facility level of care, and that the member would benefit from the additional services provided under the HCBS waiver program.
- These additional benefits will provide the member with a higher level of service coordination, including registered-nurse care, additional home visits and additional HCBS waiver benefits that will allow them to stay safe in the community.

Medical Necessity and Level of Care Assessment – Physician's Signature

- Providers have 5 Business Days from the initial request to submit the form.
  - If not received within the timeframe, Superior will complete additional attempts to obtain the signature.
  - If the physician does not sign the MNLOC, the member will not receive HCBS waiver services.
  - If no response if received, the member and the Program Support Unit at HHSC are notified.
- Forms can be returned:
  - Electronically, using Adobe Sign e-signature: SHP.Intake@SuperiorHealthPlan.com
  - Via fax: 1-866-703-0502
- For additional information, please call 1-877-277-9772 or reference the Medical Necessity and Level of Care Assessment Physician's Signature FAQs (STAR+PLUS and MMP), found under "Member Management" at Superior's Provider Resources webpage.

LTSS Authorizations

- All LTSS require prior authorization including, but not limited to:
  - Adult Foster Care
  - Assisted Living
  - DAHS
  - Adaptive Aids/DME over $500 per unit
  - Emergency Response Services (ERS)
  - Home Delivered Meals
  - Respite Services
  - Minor Home Modifications
  - PAS
  - PT/OT/ST
  - Long-Term Nursing
  - Employment Assistance
  - Supported Employment
- Existing authorizations for LTSS will be honored for 6 months, or until Superior conducts a new assessment.

Prior Authorization Process

- For LTSS services, please call the Service Coordination department at 1-877-277-9772.
- You may also fax LTSS authorization requests to 1-866-895-7856.
- Authorizations for skilled nursing (Acute), PT/OT/ST for STAR+PLUS HCBS Waiver members or other Acute Care Services must be requested through Superior's Secure Provider Portal.

Transportation

STAR and STAR+PLUS Transportation Benefits

- Superior's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- Transportation includes rides to the doctor, dentist, hospital, pharmacy and other places members receive Medicaid services.
- Transportation services are provided by SafeRide.
- Members must request rides at least two business days in advance and it is the responsibility of the member to coordinate all information needed from both the provider and Superior for SafeRide to consider the request.
- Appointments can be requested Monday through Friday, 8:00 a.m. – 6:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).

Medical Ride Program Services

- Services offered by Superior's Medical Ride Program include, but are not limited to:
  - Passes or tickets for mass transit within and between cities or states.
  - Commercial airlines transportation.
  - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
    - The enrolled ITP can be the patient, the patient's family member, friend or neighbor.
  - Car, van or private bus services, including wheelchair-accessible vehicles, if necessary.
  - Members 20 years of age and younger requiring long-distance trips may be eligible to receive the cost of meals and/or lodging to obtain a covered health-care service.
- Superior's Medical Ride Program will cover the cost of an attendant for patients needing assistance while traveling.
  - Providers may receive a request to provide proof of documentation of medical necessity.
- Children 14 years of age and younger must be accompanied by a parent, guardian or other authorized adult.

CHIP
(Children's Health Insurance Program)

CHIP Eligibility

- Children who are under 19 years of age and whose family's income is below 200% of the Federal Poverty Level (FPL) are eligible if they do not qualify for Medicaid coverage.
- CHIP members are allowed to change health plans within 90 days of enrollment, and at least every 12 months thereafter during the re-enrollment period, for any reason.
- CHIP members must re-apply yearly on their original enrollment date.

CHIP Cost-Sharing

- Most families in CHIP pay an annual enrollment fee to cover all children in the family (based on family income).
- The total amount that a family must contribute out-of-pocket is capped based on family income.
- CHIP families also pay co-payments for doctor visits, prescription drugs, inpatient hospital care and non-emergent care provided in an emergency setting (based on family income).
- The amount of the co-pay is listed on the front of the member's ID card, or on the patient list located on Superior's Secure Provider Portal.

Medicaid and CHIP Covered Benefits

Medicaid and CHIP Benefits

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

Behavioral Health Benefits

- Traditional and Day Treatment Outpatient Services
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Medication Management Therapy
  - Individual, Group and Family Therapy
- Inpatient Mental Health Services
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation

Substance Use Disorder Treatment

- Individual and Group Therapy
- Residential Treatment
- Outpatient services

Enhanced Services

- Targeted Case Management or Rehabilitative Services

Telemedicine

Pharmacy Benefits - Prescription Drugs

Please note: The behavioral health benefits referenced above are not available for all products.

Value Added Services (VAS)

- Superior offers a diverse array of VAS for each product line including, but not limited to:
  - A 24-hour nurse advice line
  - Joy for All ™ companion pet
  - Extra vision benefits
    - Includes $150 toward prescription eyewear
  - Online mental health resources
  - Over-the-counter items
- A complete listing of current VAS can be found on Superior's VAS webpage.

CHIP Perinate

CHIP Perinate Eligibility

- Unborn children of low-income pregnant women who do not qualify for Medicaid either due to citizenship status or whose income exceeds the minimum allowed to qualify for Medicaid.
- Coverage process once the child is born:
  - CHIP Perinate Newborn
    - Category B: Lasts for 12 months from mother's eligibility determination date for babies born to mothers within 186%-<200% FPL.
    - No co-pay.
  - Medicaid
    - Category A: Babies born to mothers at or below 185% of FPL.
    - Coverage lasts for 12 months from baby's date of birth.

CHIP Perinate Benefits

- Covered Services (Professional)
  - Up to 20 prenatal care visits (more if medically necessary with authorization)
  - Prescriptions based on CHIP
  - Case management and care coordination
  - 3 ultrasounds of the baby when medically indicated
  - Labor with delivery of child
  - 2 postpartum visits within 60 days of delivery; first postpartum visit must be after delivery global period (45 days)

CHIP Perinate Benefits

- Covered Services (Hospital)
  - For women with income at 186% up to 200% FPL, all eligible hospital facilities and professional charges are covered by CHIP Perinate.
  - For women with income at or below 185% FPL, all eligible hospital facilities charges are covered by TMHP, and professional charges are covered by the CHIP Perinate health plan.
- Non-Covered Services
  - A mother's hospital visits for any services not related to labor with delivery.
  - Services not related to a pregnancy diagnosis.
  - Supplies affiliated with certain diagnoses (e.g. DME supplies not covered for diabetes).
  - If mother fails to notify the state of the birth of the child, all services will be non-covered.
- Provider must call in authorizations for all deliveries regardless of member's income (FPL).

Helpful Billing Hints

- Prenatal visits
  - Initial visits bill with Evaluation and Management (E&M) codes (99201 - 99205) with modifier TH to indicate prenatal visit.
  - Subsequent visits bill with E&M codes (99211-99215) with modifier TH to indicate prenatal visits.
- Postpartum visits bill Current Procedural Terminology (CPT) code 59430.
- Primary diagnosis for all covered services must be pregnancy-related (all other services are not covered benefits).

OB, Family Planning and Postpartum Programs

Start Smart for your Baby

Program Goals

- Reduce pregnancy complications, preterm and low birth weight deliveries, NICU admissions and length of stays
- Increase prenatal, postpartum, and well child rates

Start Smart Services

- Perinatal Care Management and Care Coordination
  - During pregnancy, postpartum, and for NICU (if indicated)
  - Clinical education and coordination for health concerns
  - Management of social and psychosocial issues
  - Addressing Non-Medical Determinants of Health
- Health Education
  - Educational App
  - Baby Showers
  - Puff Free Pregnancy
- Additional Services
  - My Health Pays Rewards

Members will have access to Wellframe®, an educational app that posts daily articles, provides secure messaging to the Care Management team and can remind members about medications and appointments.

Notification of Pregnancy

- Superior's Notification of Pregnancy (NOP) Incentive Program rewards providers on a quarterly basis for completing and submitting NOP forms in a timely manner.
  - Forms should be submitted upon the initial prenatal visit for each of your Superior patients.
- This program was implemented to identify Superior members who may have a history of preterm delivery, psychosocial issues and/or other conditions that may complicate pregnancy.
- NOP forms must be submitted via Superior's Secure Provider Portal.
- Quarterly NOP Incentive Program Plan available for completing NOP forms within 60 days of the initial/first provider visit based on number of forms submitted correctly:
  - 5-10 forms = $100 gift card
  - 11-20 forms = $200 gift card
  - 21-30 forms = $400 gift card
  - 31+ forms = $800 gift card
- Contact your Account Manager for further information. To access their contact information visit, Find My Account Manager.

Healthy Texas Women

- The Healthy Texas Women program provides family planning and reproductive health services to eligible women in Texas. These services help women plan their families, whether it is to achieve, postpone or prevent pregnancy.
- Members eligible to receive services include:
  - Women 15 to 44 years of age (women 15-17 years of age must have parental or legal guardian consent)
  - Citizen or legal immigrants
  - Members who live in Texas
  - Members who do not have health insurance
  - Members who are not pregnant
  - Members who meet the monthly family income limits

Healthy Texas Women

- Program benefits include, but are not limited to:
  - Pregnancy testing
  - Pelvic examinations
  - Screening and treatment for cholesterol, diabetes and high blood pressure
  - Breast and cervical cancer screenings
  - Screening and treatment for postpartum depression
  - Oral contraceptive pills
  - Sexually Transmitted Diseases (STD) infection services
  - HIV screening
  - Permanent sterilization

Healthy Texas Women Plus

- The Healthy Texas Women (HTW) Plus program was launched to provide an enhanced, cost effective and limited postpartum care services package for women enrolled in the HTW program.
- HTW Plus services focus on treating major health conditions recognized as contributing to maternal morbidity and mortality in Texas, including:
  - Postpartum depression and other mental health conditions.
    - Services include individual, family and group psychotherapy services, and peer specialist services.
  - Cardiovascular coronary and asthma conditions.
    - Services include imaging studies, blood pressure monitoring, diabetes testing and anticoagulant, antiplatelet, antihypertensive and asthma medications.
  - Substance use disorders, including drug, alcohol and tobacco use.
    - Services include Screening, Brief Intervention, and Referral for Treatment (SBIRT), outpatient substance use counseling, smoking cessation services, Medication-Assisted Treatment (MAT) and peer specialist services.
- HTW clients with a pregnancy in the previous 12 months are eligible for these new postpartum care services for up to 12 months.
- To determine if a member is eligible for HTW Plus, call 1-866-993-9972.

HHSC Family Planning Program

superior healthplan

- The HHSC Family Planning Program helps fund clinics to provide quality, comprehensive, low-cost and accessible family planning and reproductive health care services to women and men.
- Services include, but are not limited to:
  - Contraceptive services
  - STD infection screening and treatment
  - Pregnancy testing and counseling
  - Limited prenatal services
  - Health screenings for diabetes, hyperlipidemia and hypertension
- To be eligible, members must:
  - Live in Texas
  - Be 64 years of age and younger
  - Have a reported monthly income that does not exceed 250% of the current FPL
- For additional information, contact 1-512-776-7796.

Primary Health Care Program

- The Primary Health Care (PHC) Program works with clinics across Texas to ensure eligible men, women and children get comprehensive PHC services to prevent, detect and treat health problems.
- This program is available to anyone who:
  - Is a Texas resident.
  - Has an income level at or below 200% of FPL guidelines.
  - Isn't a beneficiary of other non-HHSC programs or benefits that provide the same services.
- Members who are interested in applying must do so in person at a clinic contracted to provide PHC Program services in or near the county in which they reside.
- For additional information, contact PrimaryHealthCare@hhs.texas.gov.

Primary Health Care Program

- Program services include:
  - Health education
  - Diagnosis and treatment
  - Emergency services
  - Family planning services
  - Diagnostic testing (e.g. X-rays and labs)
  - Preventive health services, including immunizations

Medical Management

Prior Authorization

- Procedures and/or services that require authorization can be found on Superior's Authorization Requirements webpage.
- Initiating a prior authorization:
  - Must be at least 5 Business Days prior to requested date of service (for non-emergency services).
  - Log on to your online account at Superior's Secure Provider Portal.
  - Use the Request for Authorization form found on the website, complete and submit to via fax to the number on the form.
  - If you have an urgent request, indicate “This is urgent and must be treated within 24 hours.”

Early Childhood Intervention (ECI)

- ECI
  - Therapy services for members under 3 years of age do not require prior authorization for contracted providers.
  - Health-care professionals are required, under federal and state regulations, to refer children under 3 years of age to ECI within 2 Business Days once a disability or developmental delay is identified/suspected.
  - Superior will work with contracted providers to provide ECI services to members who have been determined eligible.
  - For more information, please visit HHSC's ECI webpage.

National Imaging Associates (NIA)

- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for:
  - High-Tech Imaging Services
  - Interventional Pain Management (IPM)
  - Genetic and Molecular Testing
  - Physical, Occupational and Speech Therapy Treatment Services*
  - Musculoskeletal surgical procedures (Effective 1/1/2024)
- For IPM, a separate prior authorization number is required for each procedure ordered.
- The ordering physician is responsible for obtaining authorizations.
- Emergency room and inpatient procedures do not require prior authorization; however, notification of admission is still required through Superior.
  - Observation Imaging Services do not require prior authorization
- To obtain authorization visit Evolent's website (formerly NIA, Inc.) or call 1-800-642-7554.
- Claims should still be submitted to Superior for processing.

**Non-STAR+PLUS HCBS Waiver Members*

TurningPoint Healthcare Solutions Expansion

- TurningPoint Healthcare Solutions is contracted with Superior to process prior authorization requests for medical necessity and appropriate length of stay for:
  - Certain Cardiac procedures
  - ENT surgeries
  - Sleep study procedures
- Emergency related procedures do not require prior authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services should verify that the necessary prior authorization has been obtained. Failure to do so may result in non-payment of claims.
- Prior authorization requirements for facility and radiology may also be applicable.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under “Billing Resources” at Superior's Provider Resources webpage.
- For questions, utilization management or precertification, and to submit PA requests, please contact TurningPoint at:
  - Web Portal Intake: TurningPoint Provider Login
  - Telephonic Intake: 1-855-336-4391
  - Facsimile Intake: 1-833-409-5393

Non-emergent Ambulance Transport

Superior is required to cover non-emergency ambulance services when medically necessary and when ordered by a physician.

- Non-emergency transport by ambulance can be provided:
  - To or from a scheduled medical appointment.
  - To or from a licensed facility for treatment.
  - To a member's home after discharge when there is a medical condition such that the use of an ambulance is the only appropriate means of transportation.

Please note: Hospital-to-hospital transports are considered for emergencies only when the required treatment for the emergency medical condition is not available at the first hospital, and Superior has not included payment for such transports in the hospital reimbursement.

Non-emergent Ambulance Transport

- All non-emergency ambulance transports require authorization.
  - How can you find a participating ambulance provider?
    - In-network ambulance providers can be found on Superior's Find a Provider webpage, using the Specialty search field.
  - How can you get a prior authorization?
    - Calling the Medical Management department at 1-800-218-7508.
    - Faxing a request for prior authorization to 1-800-690-7030.
    - Faxing clinical information establishing medical necessity to 1-800-690-7030.
    - Submitting the request and clinical information through Superior's Secure Provider Portal.

Utilization Management (UM)

- InterQual criteria, the Texas Administrative Code (TAC) and policies are used for the review of medical necessity, as well as provider peer-to-peer review.
- Superior Medical Director reviews potential adverse determinations for medical necessity.
- If necessity cannot be established, denial letters will be sent to the member and provider that include the clinical basis for the denial, and the member appeal rights will be fully explained.
- Provider may also appeal on behalf of the member, if authorized to do so.

Care Management (CM)

- The following conditions and/or diagnoses are examples of appropriate referrals to the Case Management Department.
- The Care Management Department is staffed by individuals with extensive medical or social work experience in areas such as obstetrics, oncology, behavioral health, medical/surgical, HIV/AIDS and physical rehabilitation for children and adults.
- The following conditions and/or diagnoses are examples of appropriate referrals to the Case Management Department:
  - Adults or children with serious or complex medical needs
  - Social issues (social isolation, hunger, housing, domestic violence)
  - Asthma
  - Diabetes
  - High blood pressure
  - Heart problems
  - COPD
- CM facilitates communication between PCP, member, managing physician and the CM team.
- Refer a member by contacting the Care Management department at 1-855-757-6567 or submit a referral through Superior's Secure Provider Portal.

Disease Management

- Disease management is defined as a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.
- Superior provides disease management for chronic medical and behavioral health conditions to help individuals improve their health and well being.
- Superior coordinates with both the member and their providers to focus on disease-specific conditions including, but not limited to:
  - Heart Disease/Heart Failure (STAR+PLUS only)
  - Attention Deficit Disorder (ADHD) (STAR and CHIP)
  - Substance Use Disorder
  - Bipolar/Schizophrenia (STAR, STAR+PLUS)
  - Perinatal Depression
  - Depression
  - Sickle Cell (STAR and CHIP)
- To refer a member to disease management, contact Superior at 1-800-218-7453.

Notification of Admissions

- Hospitals must notify Superior of all emergent admissions no later than the close of the next Business Day.
- All non-emergency, elective inpatient admissions require authorization.
- Notify Superior regarding an urgent/emergent admission by contacting the appropriate service area in which the member resides (located in Provider Manual and online).
- Any service/procedure that is a non-covered benefit according to the Texas Medicaid Provider Procedures Manual is still considered a non-covered benefit according to Superior.

External Medical Reviews

External Medical Reviews

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for Superior service denials and reductions.
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 calendar days of Superior's appeal decision letter.
- To request an External Medical Review, the member or the member's representative, should either:
  - Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the member Notice of Internal Appeal Decision letter and mail or fax it to Superior by using the address or fax number at the top of the form; or
  - Call Superior at 1-877-398-9461

External Medical Reviews

- There are two types of EMR requests – standard and expedited:
  - Standard EMR Request – Appropriate for when the member's life or health, or the member's ability to attain, maintain, or regain maximum function is not jeopardized.
    - IRO Review is completed no later than 10 Business Days following receipt of Superior's records related to the service denial or reduction determination.
  - Expedited EMR Request – If a member believes that waiting for a standard External Medical Review will seriously jeopardize the member's life or health, or the member's ability to attain, maintain, or regain maximum function, the member or member's representative may ask for an expedited EMR.
    - IRO review is completed the next business day following receipt of the Superior's record for urgent requests.
- Superior must send the service reduction or denial information to HHSC within 3 Business Days of receiving the EMR request for standard requests and within 1 Business Day for expedited requests.

External Medical Reviews

- The member, the member's authorized representative, or the member's LAR may withdraw the member's request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing the member's External Medical Review request.
  - The request to withdraw the EMR must be submitted by mail, fax, by phone or in person.
- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services:
  - **Upheld** – IRO agrees with Superior's decision.
  - **Partially Overturned** – IRO allows a portion of the service request that Superior denied or reduced.
  - **Overturned** – IRO disagreed with Superior's decision entirely and approved all services that were reduced or denied.

External Medical Reviews

- Notification of the decision will be sent to Superior, the member, the member's authorized representative or the member's LAR and the HHSC EMR Intake team.
- Providers associated with the denied services that are the basis of the EMR request may make a written request for the IRO's EMR decision.
  - The IRO will verify the provider's association with the services and once confirmed, will provide written notice of the decision within 3 Business Days.
  - If it is determined that the provider is not associated with the denied services, then written notice will be sent within 3 Business Days denying the provider's request for the EMR decision.

Superior Pharmacy Services

Pharmacy Benefits

- PBM
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
- Centene Pharmacy Services (CPS)
  - Responsible for review of prior authorizations for prescriptions, as applicable.
- Superior utilizes the Vendor Drug Program (VDP) formulary and the Preferred Drug List (PDL) to determine whether a prior authorization is required. Authorization requirements may be determined on the PDL.
  - For more information, view the VDP Formulary webpage.
- For more information, please see the *Pharmacy Resources Guide and Benefit Overview (PDF)* located on Superior's Provider Pharmacy webpage.

How to Access the Formulary/PDL

- Superior utilizes the VDP formulary which is available on smart phones, tablets or similar technology on the epocrates website.
- For PDL and clinical authorization criteria visit the HHS VDP website.
- For Texas clinical prior authorization criteria for Superior members visit HHS VDP's Clinical Prior Authorization for Managed Care webpage.

72-Hour Prescription

superior healthplan

- A pharmacy may dispense a 72-hour (3-day) supply of medication to any member awaiting a prior authorization or medical necessity determination, if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- If the prescribing provider cannot be reached or is unable to request an authorization, the pharmacy may dispense an emergency 72-hour prescription if the pharmacist determines the member may experience a detrimental change to their health status without the drug.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

DME and Medical Supplies - Pharmacy Providers

- If a pharmacy enrolled in Superior's PBM wishes to provide services that are not on the VDP 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 or bed pans 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.

Pharmacy Contact Information

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: Please visit Superior's Contact Us webpage
- Pharmacy benefit prior authorization requests (Centene Pharmacy Services)
  - Authorization Requests Phone: 1-866-399-0928
  - Authorization Requests Fax: 1-833-423-2523
- Biopharmacy/Clinician Administered Drugs (CAD) Rx administration (Superior Authorizations Department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superiors Appeals Department)
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168
  - Appeals Requests Fax: 1-866-918-2266

Quality Improvement

Quality Improvement

- Quality Assessment and Performance Improvement (QAPI):
  - Monitors quality of services and care provided to members through:
    - Appointment availability audits.
    - After-hours access audits.
    - Tracking/trending of complaints.
  - Providers participate in QAPI by:
    - Volunteering for Quality Improvement Committees.
    - Responding to surveys and requests for information.
    - Vocalizing opinions.
- Quality Improvement Committee (QIC)
  - Comprised of contracted providers from different regions and specialties
  - Appointed by Superior's Chief Medical Director
  - Serves as Peer Review Committee
  - Advises on proposed quality improvement activities and projects
  - Evaluates, reviews and approves clinical practice and preventative health-care guidelines

Cultural Sensitivity

- Superior encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Sensitivity to differing cultural influences, beliefs and backgrounds can improve a provider's relationship with patients, and the health and wellness of the patients themselves.
- Principles related to cultural competency in the delivery of health-care services to Superior members include:
  - Knowledge
    - Provider's self-understanding of race, ethnicity and influence.
    - Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
  - Skills
    - Ability to communicate effectively with the use of cross-cultural interpreters.
    - Ability to utilize community resources.
  - Attitudes
    - Respect the importance of cultural forces.
    - Respect the importance of spiritual beliefs.

Cultural Sensitivity

- Complimentary Interpretation Services
  - Superior offers interpretation services to providers at no cost.
  - To access telephonic interpreters for your members or to schedule an in-person interpreter, please contact Superior's Member Services department.
    - Contact information can be found on Superior's Phone Directory.
- Trainings and Information:
  - The Culture, Language and Health Literacy website provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions and special populations.
    - For more information visit Health Resources & Services Administration Addressing Health Literacy webpage
  - EthnoMed contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants.
    - For more information visit EthnoMed website
  - Superior's Health Equity webpage offers information about cultural and linguistic competency and available language services.
    - For more information visit Superior's Quality Improvement webpage

Fraud, Waste and Abuse

Fraud, Waste and Abuse

- Report fraud, waste or abuse:
  - Call the Office of Inspector General (OIG) Hotline at 1-800-436-6184
  - Visit the HHSC OIG website and select “Report Fraud” to complete the online form
  - Contact Superior’s Corporate Special Investigative Unit directly at:

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

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

Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation (ANE)

- Abuse
  - Intentional mental, emotional, physical or sexual injury to children, the elderly or people with disabilities, or failure to prevent such injury.
- Neglect
  - An act or failure to act by a person responsible for a child's care, custody, or welfare evidencing the person's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger, rather than a substantial risk, to the child's physical health or safety.
- Exploitation
  - Misuse of a child, the elderly or a person with a disability for personal or monetary benefit. This includes taking Social Security or SSI checks, abusing a joint checking account and taking property and other resources.

How to Report ANE

- Providers must report any allegation or suspicion of ANE to the appropriate entity:
  - Department of Family and Protective Services (DFPS)
    - An adult who is elderly or has a disability, receiving services from:
      - Home and Community Support Services Agencies (HCSSAs)
      - Unlicensed adult foster care provider with 3 or fewer beds
    - An adult with a disability or child residing in, or receiving services from, one of the following providers or their contractors:
      - Local Intellectual and Developmental Disability Authority (LIDDA), Local Mental Health Authority (LMHA), community center or mental health facility operated by DSHS.
      - A person who contracts with a Medicaid managed care organization to provide behavioral health services
      - A managed care organization
      - An officer, employee, agent, contractor or subcontractor of a person or entity listed above
    - An adult with a disability receiving services through the Consumer Directed Services Option
  - Call the DFPS Abuse Hotline, 24 hours a day, 7 days a week, toll-free at:
    - 1-800-252-5400

How to Report ANE

- HHSC
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities
    - Assisted living facilities
    - HCSSAs (also required to report any HCSSA allegation to DFPS)
    - Adult day care centers
    - Licensed foster care providers
  - Phone: 1-800-458-9858
- Local Law Enforcement
  - If a provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.
- Superior HealthPlan
  - In addition to reporting to HHSC and DFPS, a care provider must report the findings within one Business Day to Superior.

Claims – Filing and Payment

Claims Submission

- Clean Claim – A claim submitted by a provider for healthcare services rendered to a member that contains accurate and compete data in all claim fields required to adjudicate and accurately report and finalize the claim.
- First time claims must be submitted within 95 Days from the date of service
- Rejected Claims – An unclean claim that does not contain all elements necessary to process the claim, and/or is not the responsibility of the health plan for adjudication.
  - All rejected claims must be corrected and resubmitted within 95 Days of the date of service, and therefore a previously rejected claim will not be honored to substantiate timely claim filing.
- Superior's Provider Manual provides guidelines on how to submit clean claims and highlights the requirements for completing CMS 1450 or CMS 1500 forms.
  - NPI of a referring or ordering physician on a claim.
  - Appropriate two-digit location code must be listed.
  - Appropriate modifiers must be billed, when applicable.
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician
    - ZZ qualifier for CMS 1500 or B3 qualifier for CMS 1450 to indicate taxonomy.

Claims Filing

- 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
    - Medical Claims: 68069
    - Behavioral Health Claims: 68068
- Paper Claims - Medical
  - Superior HealthPlan, P.O. Box 3003, Farmington, MO 63640-3803
- Paper Claims – Behavioral Health
  - Superior HealthPlan, P.O. Box 6300, Farmington, MO 63640-3806

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

Claims Appeal

- A Claims Appeal is a request for reconsideration of a claim for anything other than medical necessity and/or any request that would require review of medical records to make a determination.
- Submit appeal within 120 Calendar Days from the date of adjudication or denial.
- Submissions must include an attachment outlining the reason for the appeal.
- Can be submitted electronically through Superior's Provider Portal or be submitted in writing.
- Claims Appeals must be in writing and submitted to:

  Superior HealthPlan
  Attn: Claims Appeals
  P.O. Box 3000
  Farmington, MO 63640-3800

Pre- and Post-payment Claims Monitoring

- Prepayment Code Editing
  - Superior uses code editing software to assist in improving accuracy and efficiency in claims processing, payment, reporting and to meet HIPAA compliance. The code editing software will detect, correct (when applicable), and document coding errors on provider claims prior to payment.
  - When a change is made on your submitted code(s), we will provide a general explanation of the reason for the change on your EOP (or remittance advice). The code-editing software will make a change on submitted codes for unbundling, fragmentation and age or gender.
- Post-payment Claim Audit
  - Superior will complete all audits of a provider claim no later than two years after received of a clean claim.
    - This limitation does not apply in cases of provider Fraud, Waste or Abuse that Superior did not discover within the two-year period following receipt of a claim.
  - If an additional payment is due to a provider as a result of an audit, Superior will make the payment no later than 30 Calendar Days after it completes the audit.
  - If the audit indicates that Superior is due a refund from the provider, Superior will send the provider written notice of the basis and specific reasons for the recovery no later than 30 Calendar Days after it completes the audit

Member Balance Billing

- Providers may not bill members directly for covered services for STAR, STAR+PLUS or CHIP.
- Superior reimburses only those services that are medically necessary and a covered benefit.
- Superior STAR, STAR+PLUS and CHIP Perinate members do not have co-payments. Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (under CHIP Benefits).
- Additional details can be found in your provider contract with Superior.

PaySpan/Zelis

- Superior has partnered with PaySpan, recently acquired by Zelis, to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs)
  - Online remittance advices (Electronic Remittance Advice [ERAs]/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register on the zelis website.
- For further information contact 1-855-496-1571, or email ClientService@zelispayments.com.

Claims – Electronic Visit Verification (EVV)*

**For LTSS providers*

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.

EVV Claims

- For STAR+PLUS, EVV is required for PAS, In-Home Respite services, CFC PAS and Habilitation and Protective Supervision.
  - For a list of all current programs and services requiring EVV refer to the Programs, Services and Service Delivery Options Required to Use EVV:
    - Personal Care Services Required to Use EVV (PDF)
    - Cures Act Home Health Care Services Required to Use EVV (PDF)
- 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

- Units should be billed using the rounded “Pay Hours” calculated in the EVV vendor system.
  - Example: If a client was services for 48 minutes, this should be rounded down to 45 minutes and .75 units should be billed.
  - If a client was serviced for 52 minutes, this would be rounded up to 1 hour and a full unit should be billed for the 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:
  - NPI or 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 will result in denials
    - Providers or FMSAs will be required to resubmit any denials to TMHP

Secure Provider Portal

Superior's Website and Secure Provider Portal

Visit Superior's website

View:

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

Visit Superior's Secure Provider Portal

Submit:

- Claims
- Prior Authorization Requests
- Request for EOPs
- Provider Complaints
- Notification of Pregnancy
- COB Claims
- Adjusted Claims
- Claim Editing Software

Verify:

- Member Eligibility
- Claim Status

Superior HealthPlan Departments

We're here to help you!

Contact Us

- Account Management:
  - Face-to-face orientations
  - Face-to-face web portal training
  - Office visits to review ongoing trends
  - For any questions, please contact your Account Manager. To access their contact information visit, Find My Account Manager.
- Provider Services: 1-877-391-5921
  - Questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
  - Available Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.
- Member Services: 1-800-783-5386 (STAR/CHIP); 1-877-277-9772 (STAR+PLUS)
  - Verifying eligibility
  - Reviewing member benefits
  - Assisting with non-compliant members
  - Helping to find additional local community resources
  - Available Monday – Friday, 8:00 a.m. to 5:00 p.m. local time

Questions and Answers

Let us know what we can do to help.

Thank you for attending!