Provider Manual

superior healthplan™

March 2024

STAR - Bexar, El Paso, Hidalgo, Lubbock, MRSA (Central, Northeast, West), Nueces, Travis

CHIP - Bexar, El Paso, Lubbock, Nueces, RSA (Central, East, North, West), Travis

STAR+PLUS - Bexar, Dallas, Hidalgo, Lubbock, MRSA (Central, West), Nueces

STAR Kids - Bexar, El Paso, Hidalgo, Lubbock, Nueces, Travis, MRSA (West)

STAR Health - Statewide

STAR, CHIP	1-877-391-5921
STAR+PLUS	1-877-391-5921
STAR Kids	1-877-391-5921
STAR Health	1-877-391-5921

SuperiorHealthPlan.com

SHP_20239735 Rev. 03/22/24

TEXAS Health and Human Services | TEXAS STAR Your Health Plan ★ Your Choice | TEXAS STAR PLUS Your Health Plan ★ Your Choice | TEXAS STAR Kids Your Health Plan ★ Your Choice | CHIP | Embracing Every Child STAR Health

Quick Reference Guide

Superior HealthPlan Contacts

Claims Inquiries/Status 1-877-391-5921

Provider Services/Claims

STAR 1-877-391-5921

STAR+PLUS 1-877-391-5921

STAR Kids 1-877-391-5921

CHIP 1-877-391-5921

STAR Health (Foster Care) 1-877-391-5921

Medicare Advantage 1-877-391-5921

Provider Complaints Inquiry email:
TexasProviderComplaints@SuperiorHealthPlan.com

Credentialing ..... 1-800-820-5686, Ext. 22281

Medical Management 1-800-218-7508
(Referrals/Authorizations) FAX: 1-800-690-7030

NICU & Emergency Inpatient Authorizations

Austin 1-800-218-7453
FAX: 1-877-650-6939

Corpus Christi 1-800-656-4817
FAX: 1-877-650-6940

Dallas 1-866-529-0294
FAX: 1-855-707-5480

El Paso 1-877-391-5923
FAX: 1-877-650-6941

Lubbock 1-866-862-8308
FAX: 1-866-865-4385

Hidalgo ..... FAX: 1-877-212-6661

San Antonio 1-866-615-9399
FAX: 1-877-650-6942

STAR & CHIP ..... FAX: 1-877-505-0823

Behavioral Health Inpatient Authorizations 1-844-842-2537
FAX: 1-866-900-6918

Behavioral Health Outpatient Authorizations 1-844-744-5315
FAX: 1-855-772-7079

Care Management Referral 1-855-757-6567

STAR+PLUS LTSS FAX Number for Pre-auth 1-866-895-7856

Member Services

STAR, CHIP 1-800-783-5386

STAR+PLUS 1-877-277-9772

STAR Kids 1-844-590-4883

STAR Health 1-866-912-6283

Member Connections 1-800-783-5386

24-Hour Nurse Advice Line 1-800-783-5386

Superior El Paso Office 1-877-391-5923
LOCAL: 1-915-778-7475

Superior San Antonio Office 1-866-615-9399
LOCAL: 1-210-562-2700

Superior Austin Office 1-800-218-7453
LOCAL: 1-512-692-1465

Superior Corpus Christi Office 1-800-656-4817
LOCAL: 1-361-994-5600

Superior Dallas Office 1-866-534-5949

Superior Houston Office 1-866-529-0295

Superior Lubbock Office 1-866-862-8305
LOCAL: 1-806-698-5400

Superior McAllen Office 1-877-278-4268

Quick Reference Guide

Subcontractors

24-Hour Nurse Advice Line..... 1-800-783-5386

DentaQuest 1-888-308-9345

National Imaging Assoc.(NIA) 1-800-642-7554

TurningPoint Healthcare Solutions .. 1-855-336-4391

Envolve Benefit Options..... 1-866-897-4785

Pharmacy Benefit Management:
Out-Patient Rx
- Pharmacy Help Desk 1-833-750-4508
  (Most often used by pharmacies)
- Prior Auth Requests Phone..... 1-866-768-7147
- Prior Auth Requests Fax 1-833-423-2523

Clinician Administered Drugs (CAD)
- Prior Auth Requests Phone..... 1-866-768-7147,
- Prior Auth Requests Fax 1-866-683-5631

Acaria – Specialty Pharmacy 1-833-277-2631

State Contacts

CHIP Eligibility and Help Line..... 1-800-647-6558

HHS - Office of Inspector General ... 1-800-436-6184
(Medicaid Fraud)

HHS Provider Resolution – CHIP and Medicaid
email: HPM_complaints@HHS.state.tx.us

HHS Provider Resolution – STAR Health
email: star.health@HHS.state.tx.us

HHS Texas Health Steps 1-512-873-6300
Austin Regional Office

HHS Texas Health Steps..... 1-915-834-7675
El Paso Regional Office

HHS Texas Health Steps..... 1-210-655-8760
San Antonio Regional Office

Texas Access Alliance 1-800-964-2777
(STAR Help Line)

Superior HealthPlan Medical Ride Program
..... 1-855-932-2318
(STAR/STAR Health/STAR Kids/STAR+PLUS)

Automated Inquiry System (AIS) 1-800-925-9126
(STAR/STAR Kids/STAR+PLUS)

Prescription Help Desk 1-800-435-4165
(Texas Medicaid/CHIP)

Medicaid Eligibility and Help Line ... 1-800-964-2777

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SECTION 1
INTRODUCTION

Superior HealthPlan contracts with Texas Health and Human Services (HHS) to provide services to Medicaid and CHIP members in several programs.

Superior also has a contract with the Centers for Medicare and Medicaid Services (CMS) for Superior HealthPlan Advantage, a Medicare Health Maintenance Organization (HMO) Special Needs Plan (SNP) for dual eligible members (those receiving both Medicare and Medicaid services). Superior has a three-party agreement between HHS and CMS to provide services for STAR+PLUS Medicare-Medicaid Plan (MMP), a plan for dual eligible members that meet certain criteria.

Specifically, Superior provides services to members that participate in the following programs in certain areas of the state of Texas:

- STAR
- STAR+PLUS
- STAR Kids
- STAR Health (foster care)
- CHIP
- STAR+PLUS Medicare-Medicaid Plan (MMP)
  (A separate Provider Manual for this product is available at www.SuperiorHealthPlan.com.)
- STAR+PLUS Nursing Facility
  (A separate Provider Manual for this product is available at www.SuperiorHealthPlan.com.)
- Allwell from Superior HealthPlan (HMO and HMO SNP)
  (A separate Provider Manual is available for this product at www.SuperiorHealthPlan.com.)
- Ambetter from Superior HealthPlan
  (A separate Provider Manual for this product is available at www.SuperiorHealthPlan.com.)

Superior Policies and Objectives

Superior conducts its business affairs in accordance with the standards and rules of ethical business conduct, and abides by all applicable federal and state laws. Changes to procedures and the most updated information will be posted on the Superior HealthPlan website. Superior's policies are designed to assist HHS in achieving the following four main objectives:

- Improved access to care.
- Improved quality of care.
- Improved member health status.
- Improved provider and member satisfaction.

Superior has processes, policies and procedures to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas regulatory requirements. For more information on HIPAA, see Section 16.

Member Rights and Responsibilities

Superior members are given rights and responsibilities as outlined in the Texas Administrative Code (TAC) 1 TAC §§353.201-353.203. Providers should be aware of what information is being conveyed to their patients. See Member Rights and Responsibilities, found in the Attachments section (which include rights and responsibilities for Medicaid and CHIP members), are outlined in the Superior member handbooks.

STAR Program Objectives

The objectives of the STAR program are to:

- Provide acute medical care assistance.
- Establish a medical home for clients through a Primary Care Provider (PCP).
- Emphasize preventive care.
- Improve access to and quality of care.
- Improve health outcomes.
- Improve client and provider satisfaction.
- Improve cost effectiveness and efficiency.
- Provide disease management.

STAR+PLUS Program Objectives

The objectives of the STAR+PLUS program are to:

- Prevent or delay the institutionalization of members through an effective use of Long-Term Services and Supports (LTSS) services.
- Provide comprehensive service coordination which includes assessing, service planning, monitoring and coordinating care for members with complex, chronic or high cost health care or social support needs.
- Assign Medicaid-only members to a medical home and integrate primary, acute and long-term care services into one consumer-driven managed care system.
- Ensure members receive the appropriate level of care in the least restrictive setting, consistent with their personal health and safety needs.
- Improve access to health care needs and improve members' current quality of care.
- Create accountability and control on costs and outcomes of care.
- Promote provider and member satisfaction by coordination of services.
- Coordinate Medicare services between Medicaid and Medicare for members who are dual eligible.
- Provide comprehensive, community-based education to members regarding STAR+PLUS, while ensuring access to services for persons with physical or mental disabilities and persons with limited English proficiency.

Services are to be provided in a manner that promotes:

- Meaningful quality of life and autonomy for members.
- Maximum dignity and respect for all members.
- Member participation in care decisions by self-determination and/or person-centered planning.
- Member satisfaction.
- Independent living in members' homes and other community settings.

- Preservation and support of members' family and community support systems.
- Cost-effective, quality health care delivery.
- Accessibility to covered services when needed by member.
- Coordination with services outside the scope of Medicaid for true service integration.

STAR Kids Program Objectives

The objectives of the STAR Kids program are to:

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

STAR Kids Definitions

1915(i) Home and Community-Based Services - Adult Mental Health (HCBS-AMH)

Home and Community-Based Services-Adult Mental Health (HCBS-AMH) is a state-wide program that provides home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each individual's needs, to enable them to live and experience successful tenure in their chosen community. Services are designed to support long-term recovery from mental illness.

Community Living Assistance and Support Services (CLASS) Waiver Program

The Community Living Assistance and Support Services (CLASS) program provides home and community-based services to people with related conditions as a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). A related condition is a disability, other than an intellectual disability, that originated before age 22 that affects the ability to function in daily life.

Deaf Blind with Multiple Disabilities (DBMD) Waiver Program

The Deaf Blind with Multiple Disabilities (DBMD) program provides home and community-based services to people who are deaf blind and have another disability. This is a cost-effective alternative to an intermediate care facility for individuals with an intellectual disability or related conditions (ICF/IID). The DBMD program focuses on increasing opportunities for consumers to communicate and interact with their environment.

Dual-Eligible

Medicaid recipients who are also eligible for Medicare.

Home and Community-Based Services (HCS) Waiver Program

The Home and Community-Based Services (HCS) program provides individualized services and supports to people with intellectual disabilities who are living with their families, in their own homes or in other community settings, such as small group homes where no more than four people live. The local authority provides service coordination.

Long-Term Services and Supports (LTSS)

LTSS means assistance with daily healthcare and living needs for individuals with a long-lasting illness or disability.

Medically Dependent Children Program (MDCP) Waiver Program

The Medically Dependent Children Program (MDCP) provides services to support families caring for children who are medically dependent and encourages the transition of children in nursing homes back to the community.

The following is a list of covered services for members who qualify for STAR Kids and STAR Health MDCP services:

- Respite Care
- Supported Employment
- Financial Management Services
- Adaptive Aids
- Employment Assistance
- Flexible Family Support Services
- Minor home modifications
- Transition Assistance Services

Texas Home Living (TxHmL) Waiver Program

The Texas Home Living Program (TxHmL) provides selected essential services and supports to people with an intellectual disability or a related condition who live in their own home or their family's home.

Youth Empowerment Services (YES) Waiver Program

The Youth Empowerment Services (YES) waiver provides comprehensive home and community-based mental health services to youth between the ages of three and 18, up to a youth's 19th birthday, who have a serious emotional disturbance. The YES waiver not only provides flexible supports and specialized services to children and youth at risk of institutionalization and/or out-of-home placement due to their serious emotional disturbance, but also strives to provide hope to families by offering services aimed at keeping children and youth in their homes and communities.

STAR Health Mission Statement

The mission of STAR Health is to:

1. Ensure continuous and uninterrupted delivery of integrated covered services, centralized Service Coordination and the effective management of healthcare data and information;
2. Ensure the Target Population is provided with a consistent source of healthcare through a Medical Home; and
3. Continue to improve healthcare outcomes for the Target Population through enhanced quality of services.

STAR Health Objectives

The objectives of the STAR Health program are to:

- Provide timely access to quality care through a network designed to meet the needs of the members.
- Ensure that all members receive efficient and effective quality services that positively impact desired health outcomes.
- Ensure providers receive timely and accurate payment for services rendered.

- Ensure a service coordination program that will design member Individual Service Plans (ISP) that are thoughtfully crafted, regularly monitored, and altered appropriately over time to suit the needs and preferences STAR Health members.
- Develop and maintain the Medical Home Services Model through the management and coordination of covered services.
- Ensure all members birth through age 20 receive a THSteps medical checkup as soon as practicable, but no later than 30 Days of enrollment. The MCO must ensure all members 6 months through age 20 receive a THSteps dental checkup as soon as practicable but no later than 60 Days of enrollment. Ensure all members less than 6 months old at the time of enrollment receive a THSteps dental checkup within 30 Days of turning six months old.
- Maintain an electronic Health Passport to ensure that each member's health information is provided to DFPS Staff, DFPS residential contractors, SSCC staff, the court system, Court Appointed Special Advocate (CASA) staff, providers, members, and Medical Consenters is timely, accurate, portable, and readily accessible.
- Submit timely, accurate and complete Encounter Data of covered services provided to SH members to HHSC.
- Ensure Members have timely access to Medically Necessary behavioral health services, which may include mental health and Substance Use Disorder (SUD) treatment and crisis hotlines, as well as timely and appropriate follow-up care.
- Provide access to covered outpatient drugs, biological products, certain Limited Home Health Supplies (LHHS), and vitamins and minerals through formularies and a Medicaid Preferred Drug List (PDL) developed by the Vendor Drug Program (VDP).
- Delivery of Covered Services without discrimination. STAR Health will deliver Medically Necessary Covered Services to diverse populations without disparity and provide services with Cultural Competency.
- Provide continuity of care that ensures the delivery of medically necessary covered services to members is not interrupted or disrupted.
- Provide comprehensive disease management programs or coverage for disease management services for asthma, diabetes, and other chronic or complex conditions, including behavioral health conditions or diseases prevalent in the STAR Health population.
- Actively participate in safeguarding STAR Health program integrity against fraudulent claims and other types of Fraud, Waste, or Abuse by members or service providers.
- Provide cost-effective services.
- Provide a single statewide service delivery area.

CHIP Program Objectives

The objectives of the CHIP program are to:

- Increase the number of insured children in Texas.
- Establish a medical home for clients through a Primary Care Provider (PCP).
- Emphasize preventive care.
- Improve access to and quality of care.
- Improve health outcomes.
- Improve client and provider satisfaction.
- Improve cost effectiveness and efficiency.

Contacting Superior

Provider Services

Superior has customer service staff to assist you telephonically with your day-to-day operations, questions and/or concerns. You can contact Superior's Provider Services department Monday through Friday, 8 a.m. to 5 p.m. (CST) (For STAR Health, 8 a.m. to 6 p.m.) toll-free for inquiries such as, but not limited to, member eligibility, benefits, authorization requirements, covered services, each applicable MCO program, non-capitated services, how to access Superior's Secure Provider Portal, claim and appeal status and general program questions. During after hours, state-approved holidays, and weekends the Provider Service line is answered by Superior's 24-hour Nurse Advice Line. The Nurse Advice Line can provide assistance with eligibility and authorizations for needed services, and instructions on how to verify enrollment for a member with an urgent condition or an emergency medical condition. Superior's Provider Services department can be reached at: 1-877-391-5921

Account Management

Your office is assigned an Account Manager to help you with questions, inquiries and training needs related to any of our programs. Additionally, personalized support is provided by field support staff. To find your local Account Manager's contact information, please call Provider Services or visit SuperiorHealthPlan.com/FindMyAM.

SECTION 2
PROVIDER ROLES AND RESPONSIBILITIES

The Role of a Primary Care Provider

The Primary Care Provider (PCP) is the cornerstone of Superior. The PCP serves as the "medical home" for the member. The "medical home" concept should assist in establishing a member and provider relationship and, ultimately, better health outcomes. The PCP is responsible for the provision of all primary care services for Superior's members (Please note, STAR Kids dual eligible members are not required to have a PCP). The PCP is responsible for either being enrolled as a Texas Health Steps provider or referring members due for a Texas Health Steps checkup to a Texas Health Steps provider. In addition, the PCP is responsible for referring and obtaining authorization for members needing specialty services to Superior network providers, as well as certifying medical necessity for Waiver programs and LTSS services. See Prior Authorization Lists, found in the Attachments section, for a list of services and procedures requiring prior authorization.

Becoming a Texas Health Steps Provider

Providers performing Medical, Dental and Care Management services can become Texas Health Steps providers. You must be an enrolled Texas Health Steps provider in order to be reimbursed for Texas Health Steps services. Enrollment must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com. For more information on Texas Health Steps, please review Section 5.

Who Can Serve as a Primary Care Provider (PCP)

Credentialed providers in the following specialties can serve as a PCP:

- Family Practitioner
- General Practitioner
- Internal Medicine Practitioner
- Advanced Family Practice Nurses
- Certified Nurse Midwives
- Physician Assistants
- Pediatrician
- OB/GYN
- Specialist (when appropriate, as described below)
- Nurse Practitioner
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

PCP For Newborns

To make a PCP selection for an unborn child, all pregnant women should be referred to Superior's Member Services department at:

STAR and CHIP 1-800-783-5386

STAR+PLUS..... 1-877-277-9772

STAR Kids 1-844-590-4883

STAR Health 1-866-912-6283

Providers are also encouraged to direct the Medicaid mother to her HHS case worker to ensure the newborn is officially deemed eligible for the Medicaid program.

A Specialist as a Primary Care Provider

Members with disabilities, special health-care needs and chronic or complex conditions have the right to designate a specialist as their PCP (excluding STAR Kids dual eligible members). A specialist may serve as a PCP only under certain circumstances, and with approval of Superior's Chief Medical Officer. To be eligible to serve as a PCP, the specialist must:

- Meet Superior's requirements for PCP participation, including credentialing.
- Contract with Superior as a PCP.

All requests for a specialist to serve as a PCP must be submitted to Superior on the Specialist as PCP Request Form, found in the Attachments section and available on the Superior website. The request should contain the following information:

- Certification by the specialist of the medical need for the member to utilize the specialist as a PCP.
- A statement signed by the specialist that they are willing to accept responsibility for the coordination of all of the member's health-care needs.
- Signature of the member on the completed Specialist as PCP Request Form, found in the Attachments section.

Superior will approve or deny the request for a specialist to serve as a PCP and provide notification of the decision to the member no later than 30 Days after receiving the request. The effective date of the designation of a specialist as a member's PCP may not be applied retroactively.

If the request is denied, Superior will provide a written notification to the member, which will include the reasons for the denial. The member may file an appeal as a result of the decision to deny the request for specialist as a PCP. See Section 11 for an explanation of the member appeal process.

Roles of Specialty Care Providers (Specialist)

The specialist partners with the PCP to deliver specialty care to members. A key component of the specialist's responsibility is to maintain ongoing communication with the member's PCP. Superior prefers that specialists are board-certified in their area of expertise, but it is not required.

Specialty care practitioners and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services.

All members are allowed to: 1) select a network ophthalmologist or therapeutic optometrist to provide eye health-care services, other than surgery and 2) have access, without a PCP referral, to eye health-care services from a network specialist who is an ophthalmologist or therapeutic optometrist for nonsurgical services. In addition, Superior ensures that STAR Kids members have access to a network specialist provider for common pediatric medical specialties, including general surgery, cardiology, orthopedics, urology, neurology, pulmonology, otolaryngology and ophthalmology.

PCPs must make referrals for specialty care on a timely basis, based on the urgency of the member's medical condition, but no later than five Days.

Role of an OB/GYN

Superior allows female members to select an obstetrician/gynecologist (OB/GYN) without a referral from their PCP. An OB/GYN can provide a member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- Referral to a specialist within the network.

Female members may:

- Go to any Superior contracted OB/GYN for all women's care services. Neither a referral nor prior authorization is required.
- Receive family planning services from an in or out-of-network provider without a referral or prior authorization.

As noted above, an OB/GYN may also serve as a PCP. Superior allows members (excluding STAR Kids dual eligible members) to pick any OB/GYN, whether that doctor is in the same network as the member's PCP or not.

Role of a CHIP Perinatal Provider

A CHIP perinatal provider provides care for the unborn child. CHIP perinatal members (pregnant women) are not required to select a PCP. CHIP perinatal members can go to any Superior-contracted CHIP perinatal provider, listed in the CHIP Perinate section of the CHIP provider directories, for prenatal and postpartum care. Benefits provided are limited to services that affect the health of the unborn child.

CHIP perinatal members are categorized into two different groups:

1. At or below the Medicaid eligibility threshold or
2. Above the Medicaid eligibility threshold.

The Medicaid eligibility threshold is indicated on the perinatal member's Superior ID card. A "Category A" designation indicates at or below the Medicaid eligibility threshold and a "Category B" designation indicates the member is above the Medicaid eligibility threshold.

Superior is responsible for payment of professional services only for perinatal members at or below the Medicaid threshold. Hospital claims for CHIP perinatal members at or below the Medicaid threshold should be filed to the Texas Medicaid Health Partnership (TMHP), limited to prenatal, postpartum and delivery services.

Superior is responsible for payment of both professional and facility charges related to prenatal, delivery and postpartum services for perinatal members above the Medicaid threshold.

Role of a Pharmacy

Members have the right to obtain Medicaid and CHIP covered medications from any Superior network pharmacy. These pharmacies are located on Superior's website. Providers and members can also call Superior's Member Services department to locate a network pharmacy. Network pharmacies are required to perform prospective and retrospective drug utilization reviews, coordinate with the prescribing physician, ensure members receive all medications for which they are eligible, and ensure adherence to the Medicaid and CHIP formularies administered through the Texas Vendor Drug Program (VDP) and the Medicaid Preferred Drug List (PDL). The pharmacy must coordinate the benefits when a member also has primary insurance or receives Medicare Part D services.

Additional pharmacy information is located on Superior's website at https://www.SuperiorHealthPlan.com/providers/resources/pharmacy.html.

Role of a Dental Provider

Dental plan members may choose their main dental homes. Dental plans will assign each member to a main dental home if they do not choose one in a timely manner. Whether chosen or assigned, each member who is six months or older must have a designated main dental home. Dental services for STAR Health members are included and delivered through Superior's STAR Health benefits. STAR Health Members do not choose or receive services from a Dental Managed Care Organization.

Role of a Main Dental Home

A main dental home serves as the member's main dentist for all aspects of oral health care. The main dental home has an ongoing relationship with that member to provide comprehensive, continually accessible, coordinated and family-centered care. The main dental home provider also makes referrals to dental specialists when appropriate. Federally Qualified Health Centers, individuals who are general dentists and pediatric dentists can serve as main dental homes.

Helping Members Find Dental Care

The dental plan member ID card lists the name and phone number of a member's main dental home provider. The member can contact the dental plan to select a different main dental home provider at any time. If the member selects a different main dental home provider, the change is reflected immediately in the dental plan's system, and the member is mailed a new ID card within five Business Days.

If a member does not have a dental plan assigned or is missing a card from a dental plan, the member can contact the Enrollment Broker's toll free telephone number at 1-800-964-2777 (Medicaid members) and 1-877-543-7669 (CHIP members).

Role of Health Home

Health Home means a primary care provider practice or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid. The role of the Health Home is to provide members with multiple chronic physical and emotional conditions with a team-based approach to care while covering a holistic array of services and supports extending beyond what can be provided by the member's PCP. Health Homes operate in conjunction with two other entities; a primary care practice and/or a specialty care practice. Health Homes are designed to provide easy access to care between providers while ensuring quality of care continues.

Health Homes provide for the following services:

1. Patient self-management education
2. Provider education
3. Evidence-based models and minimum standards of care
4. Patient-centered and family-centered care
5. Patient and family support (including authorized representatives)
6. Service Coordination

Network Limitations

Superior members must seek services from a Superior contracted provider. Exceptions include when a provider is not accessible within the network, or to ensure continuity of care for a newly enrolled Superior member as described below. All out-of-network services require an authorization.

A referral is needed to access most specialists. A specialist may not refer to another specialist.

Continuity of Care

There are situations that arise when Superior may need to approve services out-of-network. Superior may need to provide authorization for continuity in the care of a member whose health condition has been treated by a specialty care provider or whose health could be placed in jeopardy if medically necessary covered services are disrupted or interrupted. In these cases, Superior may provide authorization to a non-contracted provider to provide the medically necessary services until the

transition to a network provider may be completed. The following are circumstances in which continuity of care apply. Pre-existing conditions are not imposed.

Please note, continuity of care for out-of-network providers have additional details that apply, including:

- Members who change MCOs and have an existing prior authorization with their previous MCO, will need request prior authorization from Superior. Please send proof of the prior authorization along with the request. Continuity of care based on prior authorization with another MCO will be honored for up to 90 Days, or until the end of the authorization or until Superior has evaluated and assessed the member and issued or denied a new authorization.
- Members may receive necessary, covered services that are not available in-network.
- Members who have been diagnosed with, and receiving treatment for a terminal illness at the time of enrollment with Superior, can continue to receive care from their current provider for a period of nine months (12 months for STAR Kids) from the date the member became eligible with Superior.
- Pregnant members who are in their second or third trimester of pregnancy can remain under the care of their current OB/GYN through their immediate postpartum care, and the follow-up checkup within the first six weeks for delivery, even if the OB/GYN is Out-of-Network.

Newly Enrolled Members

Prior authorization may be requested for up to a 90-Day initial continuity of care period to allow time for the transition to a Superior participating provider.

- Continuity of care will no longer apply after the initial 90-Day period, until the end of an authorization or until Superior has evaluated and assessed the member and issued or denied a new authorization.
- If covered services are not available within Superior's network, Superior may authorize or continue authorizing services to a non-participating provider for as long as those services are necessary and not available in the Network.

Members Diagnosed with a Terminal Illness

Continuity of care also applies to prior authorization requests for members diagnosed with a terminal illness. A member can continue receiving care from their current provider for a period of nine months (12 months for STAR Kids) from the date the member became eligible with Superior.

Pregnant Members

Superior will provide out-of-network authorization to a pregnant member who is in their second or third trimester of pregnancy to remain under the care of her current OB/GYN through her immediate postpartum care, and the follow-up checkup within the first six weeks for delivery.

- In cases where the member wishes to change her OB/GYN to one who is in-network, the member will be allowed to do so as long as the provider agrees to accept her in the second or third trimester of pregnancy.

Community-Based Long-Term Care Services

At the time of new program implementation, Superior will provide continued authorization for services prior authorized for a period not to exceed six months or until a new assessment is completed and a new authorization is issued, whichever comes first. Please refer to Section 9 for details on how to request an out-of-network authorization.

Members Who Move Out of the Service Area

Superior will continue to provide and coordinate services for members who move out of the service area until the member is disenrolled from Superior.

Direct Access to Care

Members have direct access to the following services and providers without first accessing care through the PCP:

- Obstetric or gynecologic services for female members (as described below).
- Routine vision services, to include eye exams and eyewear (according to benefit limitations).
- Behavioral health services.
- Network ophthalmologists or therapeutic optometrists to provide eye health-care services other than surgery.

Telemedicine and Telehealth Services

As a second option to face-to-face visits, any provider in the Superior HealthPlan network can offer telehealth services to Superior members (except for STAR+PLUS dual members) for certain healthcare needs. "Telehealth services" are virtual healthcare visits with a provider through a mobile app, online video or other electronic method. These may include, but are not be limited to telemedicine, telemonitoring and telehealth services.

Superior treats telehealth services with in-network providers in the same way as face-to-face visits with in-network providers. A telehealth visit with an in-network Superior provider does not require prior authorization.

A telehealth visit with an in-network Superior provider is subject to the same co-payments, co-insurance and deductible amounts as an in-person visit with an in-network provider.

Providers may be reimbursed for a patient site facility fee when services are performed by a:

- County Indigent Health Care Program
- Physician
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Outpatient Hospital

Please note: A facility fee is not available if the patient site is the patient's home.

Providers delivering telemedicine, telemonitoring and telehealth services to eligible Superior members should reference the Texas Medicaid Provider Procedures Manual, for billing guidance and applicable modifiers.

For more information, contact Superior's Member Services department at:

STAR and CHIP 1-800-783-5386

STAR+PLUS..... 1-877-277-9772

STAR Kids..... 1-844-590-4883

STAR Health 1-866-912-6283

Primary Care Providers Patient Panels

All providers have the right to regulate the number of members they are willing to accept into their practice. Since assignment is based on the member's choice, Superior does not guarantee that any provider will receive a set number of members.

If a provider declares a specific capacity for their Superior patient panel size and wants to make a change to that capacity, the provider must:

- Contact Superior's Account Management Department; and
- Provide notification of the change on or before the 15th of the month for the change to become effective on the first Day of the following month. If the change is requested after the 15th of the month, the change will become effective the first Day of the second month following the request.

When an existing provider, with an assigned panel, terminates from a group, the group may request in writing to have the patient panel transferred to a participating provider within the group. This request should be sent to Account Management. Call Provider Services for your Account Manager contact information or visit SuperiorHealthPlan.com/FindMyAM.

PCPs are able to access their Panel Reports on Superior's Secure Provider Portal. Please see Section 17. A member may choose to select another provider to act as the member's PCP.

Under no circumstance can a provider take retaliatory action against a member due to disenrollment from the provider's panel.

Provider Responsibilities

General guide for network participation by all providers (excluding STAR Kids dual eligible):

- Provide Superior's members with a professionally recognized level of care and efficacy consistent with community standards, compliant with Superior's clinical and non-clinical guidelines and within the practice of your professional license.
- Abide by the terms of your Superior Provider Participation Agreement.
- Comply with all of Superior's policies, procedures, rules and regulations, including those found in the Provider Manual.
- Facilitate inpatient and ambulatory care services at in-network facilities.
- Arrange referrals for care and service within Superior's network.
- Verify member eligibility prior to requesting authorizations or providing services.
- Ensure member understands right to obtain medication from any network pharmacy.
- Maintain confidential medical records consistent with Superior's medical records guidelines as outlined in the Medical Records Guidelines, found in the Attachments section, and applicable HIPAA regulations. *Please note: Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through portals or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule.*
- Maintain a facility that promotes patient safety.
- Participate in Superior's Quality Improvement program initiatives.
- Participate in provider orientations and continuing education.
- Abide by the ethical principles of your profession.
- Notify Superior if you are undergoing an investigation, or agree to written orders by the state licensing agency.
- Notify Superior if a member has a change in eligibility status by contacting Provider Services.
- Maintain professional liability insurance in the amounts that meet Superior's credentialing requirements and/or state-mandated requirements.
- Notify Superior if there is a change in your office address, tax ID number or any other demographic changes.
- Maintain enrollment status with Texas Medicaid. *Please note: Texas Medicaid will deny claims for prescriptions, items and services ordered, referred or prescribed for any Medicaid, Children with Special Health Care Needs Services Program (CSHCN) or Healthy Texas Women member when the provider who ordered, referred or prescribed the items or services is not enrolled in Texas Medicaid. This applies to both in-state and out-of-state providers.*
- Comply with the requirements of Texas Government Code §531.024161 regarding the submission of claims involving supervised providers.

- Maintain the Participating Provider Conflict of Interest and Health Care Entity Financial Interest Policy and Disclosure statements to reflect current status.
- Provide at no cost to HHS or its delegates any requested records in accordance with the timelines, definitions, formats and instructions specified by HHS.
- Further details about the designees and types of requests can be found within network provider contracts.

Reminder: Providers can contact Provider Services with any questions at 1-877-391-5921. To find an Account Manager in your area, visit SuperiorHealthPlan.com/FindMyAM.

Updates to Contact Information

Superior contracted providers must inform Superior of any changes to the provider's address, telephone number, group affiliation, etc. Medicaid providers must also notify the Texas Medicaid and Health Partnership (TMHP) of any organizational or demographic changes. Provider demographic changes can be updated through Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Advance Directives

Providers must inform Superior members, 18 years of age and older, of their rights to be involved in decisions regarding their medical care. This includes documentation of advance directives, their right to refuse withhold or withdraw medical and mental treatment and the rights of the member or member's representative to facilitate medical care or make treatment decisions when the member is unable to do so as stipulated in the Advance Directives Act, Chapter 166, Texas Health and Safety Code: http://www.statutes.legis.state.tx.us/Docs/HS/htm/HS.166.htm.

Providers must document such information in the member's permanent medical record. Primary Care Providers are responsible for informing their patients about completing an advance directive. Please see the Advance Directive Notice, found in the Attachments section for more details. The forms can be found at https://hhs.texas.gov/laws-regulations/forms/advance-directives. If you would like a printed copy, or need assistance regarding advance directives, contact Provider Services.

Appointment Availability

Consistent with the HHS Uniform Managed Care Contracts for STAR, CHIP, STAR+PLUS, STAR Kids and STAR Health, the appointment availability standards are required as noted in the table below. Superior has added examples of presenting symptoms to clarify the type of care that may be required.

Superior requires the hours of operation that providers offer to Medicaid and CHIP members be no less than those offered to commercial patients. Superior's PCPs and specialty care providers must have adequate office hours to accommodate appointments for members using the following appointment access guide. Members must have access to covered services within the timelines specified by HHS and Texas Department of Insurance (TDI). "Day" is defined as a Calendar Day, and the standards are measured from the date of presentation or request, whichever occurs first. Superior's Quality Improvement (QI) Department performs accessibility and availability studies on Superior's network to ensure access and quality of care for all Superior members. If Superior determines that a provider fails to comply with access standards, corrective action will be required of that provider to maintain their contract with Superior.

Appointment Access Guide

Type of Care	Example	Appointment Availability	Primary Provider Type
"Emergency Care" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: • Death, placing the member's health in serious jeopardy, permanent impairment of bodily functions, serious dysfunction of any bodily organ or part. • With respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.	Radiating chest pain, severe shortness of breath.	Services must be provided upon member presentation at the service delivery site. For non-life threatening behavioral health emergencies within six hours.	PCP, Specialist, Hospital
"Urgent Care" is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health. This includes treatment for behavioral health services provided by a licensed behavioral health clinician for STAR Health members. "Urgent Behavioral Health Situation" is defined as a behavioral health condition that requires attention and assessment within 24 hours, but which does not place the member in immediate danger to themself or others and the member is able to cooperate with treatment.	Fever, persistent vomiting, wants to hurt or has thoughts about hurting themselves or others.	Appointment must be offered within 24 hours of the request, including urgent specialty care.	PCP, Specialist, Licensed Behavioral Health Clinician
"Routine Primary Care" is defined as health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.	Services designed to prevent disease, to detect disease and treat early, or to manage the course of disease effectively.	Within 14 Days of request.	PCP
Routine Specialty Care is defined as health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.	Referral for non-urgent condition.	Within 21 Days of request.	Specialist
"Preventive Health Services" for Children. Consistent with the Texas Health Steps periodicity schedule for STAR, STAR+PLUS, STAR HEALTH, and STAR KIDS. For CHIP consistent with the American Academy of Pediatrics (AAP) periodicity schedule.	Texas Health Steps visits.	Within 14 Days for members less than six months of age. Within two months for members six months through age 20. For existing members age 36 months and older the Texas Health Step annual medical checkup is due on the child's birthday.	PCP
Preventive Health Services for Adults	Annual physical, well woman examination.	Within three months of request for members 21 years of age or older.	PCP, Gynecologist
Prenatal Care	Routine prenatal care visits.	Within 5 Days for initial appointments or immediately if an emergency exists.	Obstetrical services providers
High risk pregnancy or new member in the third trimester	Bleeding, no previous prenatal care.	Within five Days of request or immediately if an emergency exists.	Obstetrical services providers

Type of Care	Example	Appointment Availability	Primary Provider Type
Routine Initial Visits and Follow-Up Behavioral Health Care	Acute/chronic psychiatric and substance use disorders.	Within 14 Days of request	Behavioral Health Care Provider, Psychiatrist, Psychologist

Accessibility 24/7

PCPs must be accessible to Superior members 24 hours per day, seven days per week. The provider must comply with the following after-hours telephone availability standards:

- Office phone is answered during normal business hours.
- After business hours, provider must have the following arrangements:
  - **The office telephone is answered after-hours by an answering service that meets language requirements of the major population groups (English and Spanish) and can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes.**
  - **The office telephone is answered after normal business hours by a recording in the language of each of the major population groups served (English and Spanish), directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable.**
  - **The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP, or another designated medical provider, who can return the call within 30 minutes.**

Examples of unacceptable after-hours coverage include:

- The office telephone is only answered during office hours.
- The office telephone is answered after-hours by a recording that tells patients to leave a message.
- Returning after-hours calls outside of 30 minutes.
- The answering machine is not bilingual (English and Spanish).
- The office telephone is answered after-hours by a recording that directs patients to go to an emergency room for any services needed.

Covering Providers

PCPs must arrange for coverage with another Superior-contracted provider during scheduled or unscheduled time off. In the event of a PCP having unscheduled time off, notify the Account Management department of the coverage arrangements that have been made in the PCP's absence. Covering providers must have an active National Provider Identifier (NPI) number in order to receive payment. For provision of services to Medicaid members, providers must also be actively enrolled in Texas Medicaid.

Member Education

Superior abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services for our members. Materials are also made available in large print, braille and on CD when requested. A variety of sources are used to inform Superior members, in a culturally sensitive manner, about the health plan and the services available to them. This includes, but is not limited to:

- Superior member handbooks
- Superior's member quarterly newsletter, Healthy Moves
- Targeted disease management brochures
- Superior provider directory
- Superior web site, www.SuperiorHealthPlan.com
- Special mailings

To obtain a sample of any of the materials listed above, contact Member Services.

All educational materials are available in written text in both English and Spanish, and in other languages, if needed. These materials are also modified to a 6th grade reading level or below, as measured by the appropriate score on the Flesch-Kincaid Readability Scale.

You can refer your patients to our member advocate staff for personalized member education. See a sample Member Advocate Referral Form, found in the Attachments section, or refer them to Superior's Member Services department.

Superior encourages providers to assist in member education regarding healthy lifestyles. Preventive health guidelines, which include health education and counseling topics are included in Section 12.

Referrals

Superior providers are required to refer members for specialty services within the Superior network. Referrals to out-of-network providers will be made when medically necessary. All out-of-network services require an authorization.

Key highlights:

- A PCP is required to refer a member to a specialist when medically necessary care is needed beyond the scope of the PCP.
- A member should be referred to a specialist by their PCP.
- A specialist cannot refer to another specialist. All member care should be coordinated through the PCP.
- Some services require prior authorization. See the Prior Authorization Lists, found in the Attachments section for details.
- PCPs are required to request authorization for services requiring authorization.
- PCPs must document the coordination of referrals and services provided between the PCP and specialist. (Requirement does not apply for STAR Kids dual eligible members).

All providers are required to follow the processes outlined in Section 8. Superior's prior authorization and notification requirements are included in the Prior Authorization Lists, found in the Attachments section and available on the Superior website..

Reporting Abuse, Neglect or Exploitation (ANE)

Superior and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to HHS if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and HHS;
- Adult day care centers; or

- Licensed adult foster care providers.

Contact HHS at 1-800-458-9858.

Report to the Department of Family and Protective Services (DFPS)

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - **HCSSAs – also required to report any HCSSA allegation to HHS.**
  - **Unlicensed adult foster care provider with three 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 (LMHAs), community center, or mental health facility operated by the Department of State Health Services;**
  - **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; and**
- An adult with a disability receiving services through the Consumer Directed Services option.

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org.

Report to 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 DFPS.

Report to Superior HealthPlan

In addition to reporting to HHS and DFPS, a care provider must report the findings within one Business Day to Superior HealthPlan.

Providers should submit a copy of the ANE findings within one Business Day of receipt of the findings from DFPS and the individual remediation, on confirmed allegations, to Superior's secure fax line at 1-833-856-6863.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, HHS or a law enforcement agency (see: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, HHS or a law enforcement agency regarding ANE (see: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- The provider must provide Superior with a copy of the Abuse, Neglect, and Exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS). In addition, the provider is responsible for reporting individual remediation on confirmed allegation to Superior.

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Fraud, Waste and Abuse Prevention

The Medicaid and CHIP programs include an important element of fraud, waste and abuse prevention, which requires the cooperation and participation of Superior's contracted providers in prevention and reporting of potential fraud, waste or abuse. Superior has a fraud, waste and abuse plan that complies with state and federal law, including Texas Government Code § 531.113, Texas Government Code § 533.012, 1 Tex. Admin. Code §§ 353.501-353.505, and 1 Tex. Admin. Code §§ 370.501-370.505. It is your responsibility as a participating provider to report any member or provider suspected of potential fraud, waste or abuse. All reports will remain confidential.

Reporting Fraud, Waste or Abuse

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care providers, or a person getting benefits is doing something wrong. Doing something wrong could be fraud, waste, or abuse which is against the law. For example, tell us if you think someone is:

- Getting paid for services that were not provided or necessary.
- Upcoding for services provided to receive higher reimbursement.
- Unbundling when billing for services provided.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

To report fraud, waste or abuse, you may file a report directly to the Texas Office of Inspector General (OIG), or you may report an issue to Superior. To report fraud, waste or abuse:

- Call the OIG Hotline at 1-800-436-6184.
- Visit https://oig.hhs.texas.gov/report-fraud-waste-or-abuse and select "Report Fraud" to report fraud, waste and abuse to complete the online form. Contact Superior's Corporate Special Investigative Unit directly at:

  Centene Corporation
  Superior HealthPlan Fraud and Abuse Unit
  1390 Timberlake Manor Parkway, Suite 450
  Chesterfield, MO 63017
  Toll-free Number: 1-866-685-8664

Information Needed to Report Fraud, Waste or Abuse

When reporting a provider (doctor, dentist, therapist, pharmacist, etc.) include as much information as possible, such as:

- Name, address and phone number of provider.
- Name and address of the facility (hospital, nursing home, home health agency, etc.).
- Medicaid number of the provider and facility, if you have it.
- Type of provider (physician, therapist, pharmacist, etc.).

- Names and phone numbers of other witnesses who can aid in the investigation.
- Dates of events.
- Summary of what happened.

When reporting a member (a person who receives benefits), include:

- The person's name.
- The Medicaid or CHIP program in which the member is/was enrolled (STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP)
- The person's date of birth, social security number or case number if available.
- The city where the person resides.
- Specific details about the fraud, waste or abuse.

Coordination of Care

Superior and its providers partner to identify and manage services for all members, including persons with disabilities, chronic or complex conditions and Members and Children with Special Health Care Needs (MSHCN/CSHCN). This includes development of a plan of care to meet the needs of the member, which is updated at least annually. The plan of care is based on health needs, PCP and specialist(s) recommendations, periodic reassessment of the member's developmental and functional status and service delivery needs. For members needing a referral to Care Management, please see Section 8.

As a provider managing a member with special health-care needs, Superior looks to its providers serving that member to:

- Be part of a multidisciplinary team responsible for the delivery of care, when determined to be medically necessary for effective treatment, to avoid separate and fragmented evaluations and service plans.
- Provide an effective plan of care for the member so the needs of care can be reasonably met.
- Develop specialty care and support service recommendations to be incorporated into the plan of care.
- Include the patient's behavioral health provider, if applicable in the multidisciplinary team serving the member's physical and behavioral health needs, to include an exchange of medical records for the patient as needed.
- Provide information to the member and the member's family concerning the specialty care recommendations.
- Provide necessary medical tests or procedures to monitor disabilities within the provider's office (if available), or at a Superior-contracted provider's office/facility, which is located at or near the provider's office.
- Participate in preadmission hospital planning for non-emergency hospitalizations.
- Participate in hospital discharge planning.
- Submit, in a timely manner, all required information for the Health Passport. (STAR Health only).*

*For STAR Health Only – Behavioral Health providers are required to provide the following information for the Health Passport:

1. Primary and secondary (if present) diagnosis;
2. Screening and assessment information;
3. Brief initial and monthly (or more frequently if a member's medical condition indicates) narrative summary of clinical visits/progress for inclusion in the Health Passport;
4. Scores on each outcome rating form(s);
5. Referrals to other providers or community resources;

6. Evaluations of each Member's progress at intake, monthly, and as significant changes are made in the ISP; and
7. Any other relevant healthcare information.

Community First Choice Provider Responsibilities

Provider Responsibilities

- The CFC services must be delivered in accordance with the member's service plan.
- The program provider must maintain current documentation which includes the member's service plan, ID/RC (if applicable), staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable).
- The Home and Community-Based Services (HCS) or Texas Home Living (TxHmL) program provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- The program provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member that are required to ensure the member's health, safety and welfare. The program provider must maintain documentation of this training in the member's record.
- The program provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified, that an Adult Protective Services investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc.). The program provider must also provide the member/Legally Authorized Representative (LAR) with information on how to report acts or suspected acts of abuse, neglect and exploitation and the Adult Protective Services hotline (1-800-252-5400).
- The program provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- The program provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member) or other person who files a complaint, presents a grievance or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- The program provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks).
- For CFC ERS, the program provider must have the appropriate licensure to deliver the service.
- Per the CFR §441.565 for CFC, the program provider must ensure that any additional training requested by the member/LAR of CFC Personal Assistance Services (PAS) or habilitation (HAB) service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The program provider must adhere to Superior's financial accountability standards.

- The program provider must prevent conflicts of interest between the program provider, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The program provider must prevent financial impropriety toward a member, including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

STAR+PLUS, STAR Health and STAR Kids Provider Responsibilities

Role of a Long-Term Services and Supports Provider

The Long-Term Services and Supports (LTSS) provider serves certain members participating in the STAR+PLUS, STAR Health and STAR Kids program. An LTSS provider assists a member by providing a variety of non-medical services, such as adult day care, adult foster care, home delivered meals, personal attendant services, home modifications, respite services, etc. LTSS services require an authorization.

Long-Term Services and Supports Provider Responsibilities

LTSS providers deliver a continuum of care and assistance ranging from in-home and community-based services for elderly people and persons with disabilities who need assistance in maintaining their independence, to institutional care for those who require that level of support, seeking to maintain independence for individuals while providing the support required. LTSS providers have certain responsibilities for the STAR+PLUS, STAR Health and STAR Kids program and the members they serve. This includes, but is not limited to:

- Contacting Superior to verify member eligibility and/or authorizations for service.
- Providing continuity of care.
- Coordinating with Medicaid and Medicare.
- Coordinating Medicaid and Medicare benefits for dual eligibles, as applicable.
- Notifying Superior of any change in member's physical condition or eligibility.

LTSS providers are required to provide covered health services to members within the scope of their Superior agreement and specialty license. Superior offers LTSS providers access to necessary supports and resources, access to emergency services for their safety and protection, and a means to communicate grievances.

Superior must require that LTSS providers submit periodic cost reports and supplemental reports to HHS in accordance with 1 Tex. Admin. Code Chapter 355, including Subchapter A (Cost Determination Process) and 1 Tex. Admin. Code § 355.403 (Vendor Hold). If an LTSS provider fails to comply with these requirements, HHS will notify Superior to hold payments to the LTSS provider until HHS instructs Superior to release the payments. HHS will forward notices directly to LTSS providers about such cost reports and information that is required to be submitted. LTSS services must be previously authorized and all requests should be faxed to the STAR+PLUS Service Coordination Department at 1-866-895-7856 and for STAR Kids LTSS Service Coordination Department at 1-877-644-4561.

In the event LTSS providers require assistance in the delivery of service, providers may:

1. Contact Provider Services at 1-877-391-5921, available Monday through Friday, 8:00 a.m. to 5:00 p.m. CST, except for state-approved holidays.
2. Contact the 24-hour Nurse Advice Line which is available 24 hours a day, seven days a week to obtain medical guidance and support from a nurse at:
    - STAR: 1-800-783-5386
    - STAR Health: 1-866-912-6283
    - STAR Kids: 1-844-590-4883
    - STAR+PLUS: 1-877-277-9772

STAR+PLUS and STAR Kids Attendant Care Rate Enhancement

LTSS providers contracted with Superior may participate in the attendant care enhanced payment program. The following STAR+PLUS LTSS services are eligible for enhanced payments:

- Personal Assistant Services (PAS) both waiver and non-waiver.
- Day Activity and Health Services (DAHS).
- Assisted Living and Residential Care Services (ALRC).
- Habilitation (under CFC).

The following STAR Kids LTSS services is eligible for enhanced payments:

- Day Activity and Health Services

Superior will reimburse providers at the same participation level as they are assigned by HHS, if applicable. Superior will increase the fee schedules for the codes included in the enhancement program for Superior contracted providers who are contracted to participate in Superior's Attendant Care Enhanced Payment Program. For providers who are enrolled and subsequently do not continue participation with HHS for Aging and Disability Services, the level will remain the same throughout the duration of their participation in the program.

For assisted living facilities that do not hold a contract with HHS for Aging and Disability Services, Superior will establish an additional amount to be added on to the unit rates by type of service. If based upon Superior's review of quality measures and determines a change to the provider's level, Superior will supply appropriate advance notice to such providers.

There are two distinct processes that encompass Superior's Rate Enhancement Program which is in place for participating providers. These processes are Annual Attestation and Rate Level Changes. Non-participating providers cannot participate in rate enhancement through Superior.

Annual Attestation Process

Annually, Superior conducts outreach to providers in its Rate Enhancement Program to obtain an affidavit attesting to their participation in the Rate Enhancement Program for STAR+PLUS and STAR Kids and the pass through of enhanced payments to their direct care staff. Towards the end of each year, these providers will be asked to submit a new attestation for the following calendar year.

Each affidavit is effective for a specific calendar year. However, any affidavit received on or after September 1, will be processed for both the current and upcoming calendar year.

Providers who contract during the plan year, and are participating in rate enhancement, should submit an affidavit that would be good for the existing plan year.

Rate Level Changes

Providers may communicate changes to their rate enhancement level at any time during the year. For providers that are assigned a new participation level by HHS for PAS or DAHS, these providers must submit the updated level in writing to Superior requesting a change in participation level.

Superior will verify new participation levels using the list as published on the HHS website under the Attendant Compensation Rate Enhancement webpage. All rate enhancement level changes are effective the month following the month the notice was provided to Superior. Rate enhancement level changes are made prospectively, and will not be made retrospectively.

Please note: Without an affidavit on file, Superior cannot process a rate change. Providers will need to submit an affidavit with their level change for the remaining plan year, if there is none on file. Please refer to the Rate Enhancement Affidavit, found in the Attachments section.

Provider Responsibilities for Employment Assistance (EA) and Supported Employment (SE)

Employment Assistance is provided as an HCBS STAR+PLUS and STAR Kids MDCP Waiver service to a member to help the member locate competitive employment or self-employment. EA services include, but are not limited to, the following:

- Identifying a member's employment preferences, job skills and requirements for a work setting and work conditions;
- Locating prospective employers offering employment compatible with a member's identified preferences, skills and requirements; and
- Contacting a prospective employer on behalf of a member and negotiating the member's employment.

Supported Employment services provide assistance as HCBS Waiver service to a member who, because of a disability, requires intensive, ongoing support to be self-employed, work from home or perform in a work setting at which members without disabilities are employed. SE provides the supports necessary in order to sustain paid employment. SE services include, but are not limited to, the following:

- Employment adaptations, supervision and training related to a member's assessed needs;
- If the member is under age 22, ensure provision of SE, as needed, if the services are not available through the local school district; and
- If the member is under age 22, SE may be provided through the STAR+PLUS Waiver if documentation is maintained in the member's record, that the service is not available to the member, under a program funded under the Individuals with Disabilities Education Act (20 U.S.C. §1401 et seq).

The provider must develop and update quarterly a plan for delivering EA/SE including documentation of the following information:

- Name of the member;
- Member's employment goal;
- Strategies for achieving the member's employment goal, including those addressing the member's anticipated employment support needs;
- Any concerns about the effect of earnings on benefits, and a plan to address those concerns;
- Progress toward the member's employment goal;
- If progress is slower than anticipated, an explanation of why the documented strategies have not been effective, and a plan improve the effectiveness of the member's employment search; and
- Names of the people, in addition to the member, whose support is or will be needed to ensure successful employment placement, including the corresponding level of support those persons are providing or have committed to providing.

Additional STAR Kids Provider Responsibilities

Coordination with the Department of Family and Protective Services (DFPS)

Superior works with the DFPS and foster care parents to ensure that the at-risk population, both children in custody and not in custody of DFPS, receive needed health care. Children who are served by DFPS may transition in and to various areas of the state rapidly.

During the transition period for a child moving between custodians and beyond, providers must:

- Schedule medical or behavioral appointments within 14 Days of the requested appointment or earlier as requested by DFPS.
- Provide periodic written updates on the treatment status of members to DFPS as required by DFPS.
- Provide medical records to DFPS upon request.
- Participate, when requested by DFPS, in planning to establish permanent homes for members.

- Testify in court for child protection litigation as required by DFPS.
- Comply with DFPS policy regarding medical consenter and release of confidential information.
- Refer suspected cases of abuse or neglect to DFPS.
- Participate in Superior's training activities regarding DFPS coordination.

For assistance with members and DFPS, providers should call Superior's STAR Kids Member Services department at 1-844-590-4883.

To report concerns of abuse, neglect or exploitation of children, the elderly or people with disabilities, contact the Texas Abuse/Neglect Hotline at 1-800-252-5400, or at www.txabusehotline.org.

STAR Health Provider Responsibilities

Primary Care Provider/Behavioral Health Integration and Communication

Primary Care Providers (PCPs) must screen members for any behavioral condition, may treat members within the appropriate scope of their practice and may refer members for treatment to a network behavioral health provider.

In the STAR Health program, PCPs and behavioral health providers are required to send each other initial and quarterly summary reports of a member's physical and behavioral health status. Reports between PCP and behavioral health providers may be required more frequently if clinically indicated, directed by the Service Coordination Team, or court ordered.

Reports must include information required for judicial review of medical care under Texas Family Code 266.007. These reports can be provided directly between providers or via the Health Passport. Providers may fax reports to the Health Passport utilizing the Health Passport Coversheet and directions provided, found in the Attachments section. Behavioral Health providers are required to provide the following information for Health Passport:

1. Primary and secondary (if present) diagnosis;
2. Assessment information;
3. Brief narrative summary of clinical visits/progress;
4. Scores on each outcome rating form(s);
5. Referrals to other providers or community resources;
6. Evaluations of each member's progress at intake, monthly, and at termination of the HCSP, or as significant changes are made in the treatment plan; and
7. Any other relevant care information.

Behavioral Health providers are also required to submit an initial and monthly or more frequently, if a member's

medical condition indicates, narrative summary report of a member's behavioral health status for inclusion in the Health Passport. This information will be available to the member's providers, the Service

Coordination Team, and DFPS staff.

Coordination with the Department of Family and Protective Services (DFPS)

Superior works with the DFPS and foster care parents to ensure that the at-risk population, both children in custody and not in custody of DFPS, receive needed health care. Children who are served by DFPS may transition in and to various areas of the state rapidly.

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- Schedule medical or behavioral appointments within 14 Days of the requested appointment or earlier as requested by DFPS.
- Provide periodic written updates on the treatment status of members to DFPS as required by DFPS.
- Provide medical records to DFPS upon request.
- Participate, when requested by DFPS, in planning to establish permanent homes for members.
- Testify in court for child protection litigation as required by DFPS.
- Comply with DFPS policy regarding medical consenter and release of confidential information.
- Refer suspected cases of abuse or neglect to DFPS.
- Participate in Superior's training activities regarding DFPS coordination.

Providers must report any allegation or suspicion of a child abuse or neglect within 48 hours of becoming aware that a child may be abused or neglected (see: Texas Family Code §261.101). For assistance with members and DFPS, providers should call Superior's STAR Health Member Services Department at 1-866-912-6283.

To report concerns of abuse, neglect or exploitation of children, the elderly, or people with disabilities, contact the Texas Abuse/Neglect Hotline at 1-800-252-5400, or at www.txabusehotline.org.

Medical Record Keeping

Superior's Requirements

Superior requires all providers (physician, hospital and ancillary) to maintain sound medical record keeping practices that are consistent with Superior's Medical Records Guidelines, found in the Attachments section. Superior requires that records be maintained in compliance with all HIPAA regulations and other federal and state laws. Records must be kept in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review. Whether using paper or electronic record keeping systems, medical records need to be identifiable by the patient name and be accessible. All medical records must be kept for at least seven years from the anniversary date of last treatment. Records of patients younger than 18 shall be retained until the patient reaches age 21 or for seven years from the last treatment date, whichever is longer. Medical records must be accessible at the site of the member's PCP or other provider.

Compliance Audits for Medical Record Documentation

Superior may audit record-keeping practices and individual member medical records in conjunction with ongoing Quality Assessment and Performance Improvement (QAPI) program activities. The standards in the Medical Record Guidelines, found in the Attachments section, will be utilized during medical record documentation reviews by Superior. Providers scoring less than 80% on medical record audits may be placed under a corrective action plan, subject to additional medical record reviews or referred to Superior's Quality Improvement Committee (QIC) for recommendations.

Superior encourages providers to request medical records that document care previously provided to members that are new to their panel. This will assist in assuring the member receives continuous care, as well as helping determine the most appropriate course of treatment for the patient.

Access to Records and Audits by Superior HealthPlan

Subject only to applicable State and federal confidentiality or privacy laws, Provider shall permit Superior or its designated representative access to Provider's Records, at Provider's place of business in this State during normal business hours, or remote access of such Records, in order to audit, inspect, review, perform chart reviews, and duplicate such Records. If performed on site, access to Records for the purpose of an audit shall be scheduled at mutually agreed upon times, upon at least 30 Business Days prior written notice by Superior or its designated representative, but not more than 60 Days following such written notice.

Electronic Medical Record (EMR) Access

Provider will grant Superior access to Provider's Electronic Medical Record (EMR) system in order to effectively case manage Members and capture medical record data for risk adjustment and quality reporting. There will be no other fees charged to Superior for this access.

Required Use of Forms

Superior does not require specific forms for medical record documentation. Various professional organizations have created flow sheets or templates that can improve documentation processes. Superior encourages use of flow sheets and standardized forms for documentation as a method to improve continuity and coordination of care for members.

Confidentiality of Medical Records

All providers rendering services to Superior members are required to maintain medical records that conform to the requirements of the HIPAA and other federal and state laws. Practitioners should maintain confidentiality of medical records and treatment information in accordance with state and federal laws. To ensure the member's privacy, medical records should be kept in a secure location and accessible only by authorized personnel. Practitioners must periodically train their staff about member information confidentiality.

Marketing Guidelines for Superior Providers

Superior providers must adhere to marketing guidelines as outlined by HHS and referenced in their contract with Superior for the STAR, STAR+PLUS, CHIP, STAR Health (foster care) and STAR Kids programs. The permitted and prohibited guidelines are below.

The HHS marketing guidelines applicable to Medicaid and CHIP providers include the following permitted actions and activities:

1. Providers are permitted to educate/inform their patients about the CHIP/Medicaid Managed Care programs in which they participate.
2. Providers may inform their patients of the benefits, services and specialty care services offered through the Managed Care Organizations (MCOs) in which they participate. However, providers may not recommend one MCO over another MCO, offer patients incentives to select one MCO over another, or assist the patient in deciding to select a specific MCO. Providers are prohibited from soliciting enrollment or disenrollment in an MCO or distributing plan-specific materials.
3. At the patients' request, providers may give patients the information necessary to contact a particular MCO or refer the member to an MCO Member Orientation.
4. Providers must distribute and/or display health-related materials for all contracted MCOs, or choose not to distribute and/or display for any contracted MCO.
    a. Health-related posters cannot be larger than 16" x 24".
    b. Health-related materials may have the MCO's name, logo and contact information.
    c. Providers are not required to distribute or display all health-related materials provided by each MCO with whom they contract. Providers can choose which items to distribute and/or display from each contracted MCO, as long as they distribute or display one or more items from each contracted MCO.
5. Providers must display stickers submitted by all contracted MCOs or choose to not display stickers for any contracted MCO. MCO stickers indicating the provider participates with a particular health plan cannot be larger than 5" x 7" and cannot indicate anything more than "MCO/Dental Contractor is accepted or welcomed here."
6. Providers may choose whether to display items such as children's books, coloring books and pencils provided by each contracted MCO. Providers can choose which items to display as long as they display one or

more from each contracted MCO. Items may only be displayed in common areas.

7. Providers may distribute Children's Medicaid/CHIP applications to families of uninsured children and assist with completing the application.
8. Providers may direct patients to enroll in the CHIP/ Medicaid Managed Care Programs by calling the Administrative Services Contractor.
9. The MCO may conduct member orientation for its members in a private conference room at a provider's office but NOT in common areas at a provider's office.
10. Bargains, premiums or other considerations on prescriptions may not be advertised in any manner in order to influence a member's choice of pharmacy or promote the volume of prescriptions provided by the pharmacy. Advertisement may only convey participation in the Medicaid/CHIP program.
11. The MCO may organize and participate in a Health Fair with a willing provider in which the provider assists with immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing MCO specific materials.

The HHS marketing guidelines applicable to MCOs include the following prohibited actions and activities:

1. Distribute marketing materials directed to Medicaid or CHIP members without prior approval from Superior, who is responsible for obtaining HHS approval.
2. Distribute marketing materials to Medicaid or CHIP members that is written above the 6th grade reading level.
3. Offer incentives or giveaways valued over $15 and over $75 in the aggregate annually to potential Medicaid or CHIP patients.
4. Provide incentives or giveaways to MCO members or potential members for the purpose of providers distributing them to members or potential members.
5. Give gift cards to members or potential members that are redeemable for cash or allow the member or potential member to purchase alcohol, tobacco and drugs.
6. Directly or indirectly, engage in door-to-door, telephone and other cold call marketing activities.
7. Market in or around public assistance offices, including eligibility offices.
8. Use "spam."
9. Make any assertion or statement (orally or in writing) that the MCO is endorsed by the Centers of Medicare and Medical Services (CMS), a federal or state government agency, or similar entity.
10. Market to persons currently enrolled in another CHIP or Medicaid Managed Care MCO.
11. Induce or accept a member's enrollment or disenrollment in Superior.
12. Use terms that would influence, mislead, or cause potential members to contact Superior, rather than ASC for enrollment.
13. Portray the MCO's competitors in a negative manner.
14. Make false, misleading or inaccurate statements or misrepresentations of fact or law relating to Superior or the CHIP and Medicaid Managed Care programs, services or benefits.
15. Make giveaways conditional based on enrollment with the MCO.
16. Charge members for goods or services distributed at events.
17. Charge members a fee for accessing the MCO's or the provider's website.
18. Influence enrollment in conjunction with the sale or offering of any private insurance.
19. Use marketing agents who are paid solely by commission.
20. Post MCO-specific, non-health related materials or banners in provider offices.
21. Conduct member orientations in common areas of provider offices.
22. Solicit enrollment or disenrollment in an MCO, or distribute MCO-specific materials at a marketing activity. (This does not apply to health fairs where providers do immunizations, blood pressure checks, etc. as long as the provider is not soliciting enrollment or distributing plan specific MCO materials.)

23. Make charitable contributions or donations from Medicaid/CHIP funds.
24. Purchase or otherwise acquire mailing lists from third party vendors, or pay HHS contractors or sub-contractors to send plan specific materials to potential members.
25. Reference the commercial component of the MCO in any of its CHIP or Medicaid Managed Care marketing materials.
26. Discriminate against a member or potential member because of race, creed, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care.
27. Assist with enrollment form or influencing MCO selection.
28. Make false, misleading or inaccurate statements relating to services or benefits of the MCO or the CHIP or Medicaid Managed Care Programs, or relating to the providers or potential providers contracting with the MCO.
29. Direct mail marketing to potential members.
30. Post, display, or make available plan-specific, non-health-related materials or banners in or around the area immediately near the door of provider offices or provider facilities such as hospitals or labs.

HHS Medicaid or CHIP Program Suspension

In the event that Superior does not receive its full premium payment for one or more periods under its state contracts with HHS, Superior's obligation to pay you for services you provide to members shall be suspended until such time as HHS makes payment in full to Superior under such contracts. Your obligations to submit claims and/or encounters for the services you render shall not be postponed or otherwise modified. This payment suspension provision shall supersede any conflicting provision found in your provider contract with Superior.

Network Termination

A provider may terminate from the Superior network in accordance with the provider's Participation Agreement. Refer to your Superior contract for written notification time frames and/or contact the Provider Services department. All termination requests must be received in writing. Please include the TIN, NPI, termination date and the reason for the termination. Your Account Manager can help you facilitate a termination.

SECTION 3
ELIGIBILITY AND DISENROLLMENT

HHS is responsible for determining Medicaid and CHIP eligibility. Contact Superior's Member Services department if you need to locate a HHS eligibility office.

The state's Enrollment Broker, Maximus, is responsible for enrolling individuals into the Medicaid and CHIP programs. The Enrollment Broker can be contacted at the Medicaid Managed Care help line at 1-800-964-2777.

When a member gains Medicaid or CHIP eligibility, the state's Enrollment Broker sends the member an enrollment packet, informing the member of the health plan choices in their area. The packet will also inform the member to select a health plan and a PCP within 15 Days. Members applying for CHIP will need to select a plan and a PCP within 15 Days of gaining eligibility.

Verifying Member Eligibility

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service before rendering services. There are several ways to do this:

HHS Resources

- Use TexMedConnect on the TMHP website at www.tmhp.com.
- Log into your TMHP user account and access the Medicaid Client Portal for providers.
- Call the TMHP Contact Center or the Automated Inquiry System (AIS) at 1-800-925-9126 or 1-512-335-5986.
- Call Provider Services at the patient's medical or dental plan.
- For CHIP, providers can verify eligibility by:

  CHIP Inquiry System: 1-800-645-7164

  CHIP Customer Service: 1-800-647-6558

Important: Do not send patients who forgot or lost their cards to a HHS benefits office for a paper form. They can request a new card by calling 1-800-252-8263. Medicaid Members also can go online to order new cards or print temporary cards.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by members. A copy is required during the appeal process if the member's eligibility becomes an issue.

Superior Resources

- Accessing Superior's secure Provider Portal at Provider.SuperiorHealthPlan.com. This website is updated upon receipt of information from the state and eligibility may change (i.e. be retroactive or terminate). As a result, eligibility verification from the website does not guarantee payment.
- The member's plan-issued Superior ID card. See ID Cards, found in the Attachments section, for sample member ID cards. Possession of a member ID card is not a guarantee of current enrollment or guarantee of payment.

- Calling Superior's member hotline will provide an interactive IVR or you can also contact a live agent:

  STAR and CHIP 1-800-783-5386

  STAR+PLUS..... 1-877-277-9772

  STAR Kids..... 1-844-590-4883

  STAR Health 1-866-912-6283

Providers Access to Medicaid Medical and Dental Health Information

Medicaid providers can log into their TMHP user account and access the Medicaid Client Portal for providers. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan (FFS or Managed Care). This information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be.

The specific functions available are:

- Access to a Medicaid patient's medical and dental health information including medical diagnosis, procedures, prescription medicines and vaccines on the Medicaid Client Portal through My Account.
- Enhances eligibility verification available on any device, including desktops, laptops, tablets, and smart phones with print functionality.
- Texas Health Steps and benefit limitations information.
- A viewable and printable Medicaid Card.
- Display of the Tooth Code and Tooth Service Code for dental claims or encounters.
- Display of the Last Dental Anesthesia Procedure Date.

Additionally, an online portal is available to patients at www.YourTexasBenefits.com where they can:

- View, print, and order a Your Texas Benefits Medicaid card
- See their medical and dental plans
- See their benefit information
- See Texas Health Steps Alerts
- See broadcast alerts
- See diagnosis and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see their available medical and dental information

Please Note: The YourTexasBenefits.com Medicaid Client Portal displays information for active patients only. Legally Authorized Representatives can view anyone who is part of their case.

Pharmacies

Electronic eligibility verification (e.g., NCPDP E1 Transaction) is available to check eligibility when rendering a prescription.

Important: Do not send patients who forgot or lost their cards to an HHS benefits office for a paper form. They can request a new card by calling 1-855-827-3748. Medicaid members also can go online to order new cards or print temporary cards.

Additional Forms that can be Used to Verify Eligibility

Form 1027-A: Temporary Medicaid Eligibility Verification form can be used as evidence of Medicaid eligibility. This form is issued as temporary proof of Medicaid eligibility while the member is waiting for their Your Texas Benefits Medicaid Card.

Form 2085-B: STAR Health (foster care) members also receive a DFPS Form 2085-B, which is the Designation of Medical Consenter Form.

Involuntary Disenrollment Due to Member Non-Compliance

There may be instances when a PCP feels that a member should be removed from their panel. Superior requires notification of such requests so educational outreach can be arranged with the member. All notifications to remove a patient from a panel must:

- Be made in writing;
- Contain detailed documentation; and
- Be directed to Superior's Compliance Department.

Upon receipt of a request, Superior may:

- Interview the provider or their staff requesting the disenrollment, as well as any additional providers who are relevant to the request;
- Interview the member; or
- Review any relevant medical records.

Examples of reasons a PCP may request to remove a member from their panel could include, but are not limited to:

- If a member is disruptive, unruly, threatening or uncooperative to the extent that the member seriously impairs the provider's ability to provide services to the member, or to other patients, and the member's behavior is not caused by a physical or behavioral condition.
- If a member refuses to comply with managed care guidelines, such as repeated emergency room use, combined with refusal to allow the provider to treat the underlying medical condition.

A PCP cannot request a member be disenrolled for any of the following reasons:

- Adverse change in the member's health status or utilization of services which are medically necessary for the treatment of a member's condition.
- On the basis of the member's race, color, national origin, sex, age, disability, political beliefs or religion.

Under no circumstances can a provider take retaliatory action against a member due to disenrollment from either the provider or a plan. HHS will make the final decision.

Hospice Enrollment

Pursuant to Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), states are required to provide concurrent hospice care and treatment services for children enrolled in Medicaid and CHIP who elect hospice care. Due to this change in federal law, a family that elects to receive hospice care for a child is no longer required to waive treatment for the child's terminal illness.

Concurrent treatment services include:

- Covered treatment services (including services related to the individual's terminal illness).
- Hospice care to include palliative care, including medical and support services related to the individual's terminal illness.

STAR and STAR Health Medicaid enrollees under 21 years of age will be disenrolled from managed care upon election of hospice. Hospice care and treatment services will be available to these individuals through fee-for-service Medicaid.

STAR Kids enrollees will receive hospice services as a carve-out benefit through fee-for-services Medicaid, but will retain their STAR Kids enrollment status. Acute care services (including services related to the treatment of the terminal illness) will be provided to STAR Kids members by Superior.

CHIP members will receive hospice care and treatment services (including services related to the treatment of the terminal illness) through Superior.

STAR Program

The Medicaid State of Texas Access Reform (STAR) program provides primary, acute care and pharmacy services for pregnant women, newborns and children with limited income. The program operates statewide under the authority of the Texas Health Care Transformation and Quality Improvement Program 1115 Waiver.

Mandatory Members

The following individuals must participate in the STAR program:

- Pregnant women.
- Newborn.
- Temporary Assistance for Needy Families (TANF) recipients or TANF-related benefits.
- Former children in foster care, ages 21-25.

Voluntary Members

The following Medicaid-eligible individuals may voluntarily enroll in the STAR program:

- Former children in foster care, ages 18-20

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participation in the STAR program:

- Medicaid recipients residing in institutions or nursing facilities.
- Medically needy program participants.
- Children in foster care.
- Refugees.
- Individuals who receive SSI or Medicare.

To find additional information on Medicaid programs available to your patients, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip.

Newborn Enrollment

If a woman is a Superior Medicaid member at the time of her delivery, the newborn is automatically a Superior STAR member from the date of birth in areas where Superior STAR is present. Providers should educate and encourage members to report newborns to 2-1-1 to ensure newborn's coverage is established timely.

Key Newborn Information: Superior expects that newborns receive their Medicaid ID within 30 Days of birth. If a provider bills Superior within 30 Days from the date of birth (DOB), then the claim should be submitted with mother's Medicaid ID plus the letter "A" and for multiples, "B" or "C." If the provider bills Superior 30 Days after the DOB, then they must bill Superior with the newborn's Medicaid ID.

Disenrollment

When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR program and from Superior. HHS is solely responsible for determining if and when a member is disenrolled from the Medicaid program. Members can be disenrolled from Superior, but still be eligible for Medicaid through another health plan or program. Please also review the information regarding Span of Coverage in Section 4 of this manual.

Renewal

In order to maintain Medicaid eligibility a member must submit all the appropriate information to HHS during the renewal period. HHS will mail the member requesting additional information or confirmation that their Medicaid was approved through the HHS renewal administrative process. The notification or request for information is sent three months prior to their renewal date. Providers are encouraged to remind members to submit their renewal information timely to avoid loss of coverage. If a Superior member becomes temporarily ineligible (for six months or less) for Medicaid, but regains Medicaid eligibility within the six month timeframe and resides in the same service area, the member will be automatically re-enrolled by HHS in Superior. Superior and the state's Enrollment Broker will make every effort to re-enroll the member with the previous PCP. The member will also have the option to switch plans.

STAR+PLUS Program

STAR+PLUS is a Texas Medicaid program integrating the delivery of acute care services and long-term services and supports (LTSS) to aged, blind and disabled Medicaid recipients through a managed care system. The STAR+PLUS program is designed to assist Medicaid recipients with chronic and complex conditions who require more than acute care services.

The STAR+PLUS program operates under the federal Medicaid waiver Home and Community-Based Services in order to mandate participation and to provide Home and Community-Based Services. HHS is the oversight agency for the STAR+PLUS program.

Mandatory Members

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 (c) 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.
- Individuals age 18 to 64 and qualify for Medicaid for Breast and Cervical Cancer

Voluntary Members

The following Medicaid-eligible individuals may opt to enroll in the STAR+PLUS program:

- Nursing facility resident, age 21 and over, who is federally recognized as a tribal member.
- Nursing facility resident, age 21 and over, who receives services through the Program of All Inclusive Care for the Elderly (PACE).

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participation in the STAR+PLUS program:

- Nursing facility residents who reside in the Truman W. Smith Children's Care Center or reside in a state veterans home.
- Residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).
- Residents of institutions of mental disease or state hospitals.
- Children in the conservatorship of the Texas Department of Family and Protective Services (DFPS).
- Dual eligible (individuals who have both Medicare and Medicaid) who are residents of Intermediate Care Facilities for Persons with IID (ICF/IID) Community Living Assistance and Support Services.
- Persons enrolled in a waiver program other than the HCBS STAR+PLUS(c) nursing facility waiver program.
- Individuals not eligible for full Medicaid benefits (e.g., frail elderly program, Qualified Medicare Beneficiary [QMB], Service Limited Medicare Beneficiary [SLMB], Qualified Disabled Working Individual [QDWI], undocumented immigrants).
- Individuals receiving long-term care services through non-Medicaid funded programs.

To find additional information on Medicaid programs available to your patients, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip.

Dual Eligible Members

Dual eligible members have both Medicare and Medicaid health insurance coverage. Medicare or the member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare co-insurance and deductibles for dual eligible members unless enrolled in Superior's Medicare Advantage Special Needs Plans (SNP), Superior HealthPlan Advantage.

Superior HealthPlan Advantage will coordinate the payment of the Medicare Advantage cost sharing amounts for dual eligible members up to the Medicaid fee schedule. Under Superior HealthPlan Advantage, there is no copayment for services received at a skilled nursing facility. Superior will reimburse Long-Term Services and Supports (LTSS) covered under the STAR+PLUS program. Superior STAR+PLUS benefits will not change or reduce any Medicare benefits for which a member is eligible.

Members with traditional Medicare coverage may choose to use their existing Primary Care Providers (PCP), and may access specialty services without prior approval from Superior. Dual eligible members do not have to select a separate PCP through Superior for their LTSS services. The Service Coordinator will communicate and coordinate services with the member's Medicare PCP to ensure continuity of care. Dual eligible members should notify their service coordinators that they have Medicare coverage, and will provide the name of their chosen PCP.

Dual eligible members have identification cards that indicate Long-Term Care (LTC) services only, and must show their ID cards each time they receive Superior STAR+PLUS covered services. Dual eligibles enrolled in Superior HealthPlan Advantage must show their ID cards each time they receive physician or hospital services. Dual eligibles do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

For dual eligible members, claims will process according to the member's Medicare insurance, and as per CMS guidance on processing Medicare Part D and/or Part B pharmacy claims. Medicare (part B or D) covered drugs and/or products must be billed to Medicare and/or commercial insurance (if there is commercial insurance on file) prior to billing Medicaid. For medications which are exclusions to CMS Medicare coverage, if the medications are included under the Medicaid formulary

they will be adjudicated under the Medicaid benefit as a "wrap-around" drug. "Wrap-around" drugs/products include non-prescription (over-the-counter medications), some products used in symptomatic relief of cough and colds, limited home health supplies (LHHS) and some prescription vitamins and mineral products, which are identified on the HHS Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (Texas VDP) formulary. Please note:

- A member with a Medicare Advantage plan will not affect the coverage of wrap benefits.
- Over-the-counter "wrap-around" drugs require a prescription for Medicaid payment (these drugs will not be covered by Medicaid without a prescription).

Note: If a STAR+PLUS dual member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's ID card.

Newborn Enrollment

If a woman is a Superior STAR+PLUS member at the time of delivery, the newborn is automatically a Superior STAR member from the date of birth in areas where Superior STAR is present. Providers should educate and encourage members to report newborns to 2-1-1 to ensure newborn's coverage is established timely. Newborns should receive a Medicaid ID number within 30 days of birth. Until that time, all claims (with the exception of pharmacy) related to the care of the newborn should be filed with the mother's Medicaid ID number followed by the letter "A". For multiple births, use the letter "B" or "C" as needed. For assistance regarding pharmacy services and newborns, contact the STAR+PLUS Member Services Department at 1-877-277-9772.

Disenrollment

When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR+PLUS program and from Superior. HHS is solely responsible for determining if and when a member is disenrolled from the Medicaid program. Members can be disenrolled from Superior, but still be eligible for Medicaid through another health plan or program. Please also review the information regarding Span of Coverage in Section 4 of this manual.

Renewal

Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to recertify with HHS each year. To maintain SSI benefits, the SSA may require information from the person related to their SSI benefits. The person or their representative payee may call the SSA. HHS does not play a role in determining SSI eligibility. Providers are encouraged to remind members to keep their information current with SSA.

If a Superior member becomes temporarily ineligible (for six months or less) for Medicaid, but regains Medicaid eligibility within the six month timeframe and resides in the same service area, the member will be automatically re-enrolled by HHS in Superior. Superior and the state's Enrollment Broker will make every effort to re-enroll the member with the previous PCP. The member will also have the option to switch plans.

STAR Kids Program

STAR Kids is a statewide program for children and youth, age 20 or younger, who either receive SSI Medicaid or are enrolled in the Medically Dependent Children Program (MDCP). STAR Kids will provide acute and community-based Medicaid benefits to children with disabilities. Children and youth who receive services through other 1915(c) waiver programs will receive their basic health services (acute care) through STAR Kids, but will continue receiving 1915(c) waiver services through HHS.

STAR Kids integrates the delivery of state plan services, behavioral health services and LTSS benefits for children and young adults age 20 and younger with disabilities.

Mandatory Members

The following Medicaid-eligible individuals MUST enroll in the STAR Kids program:

- Receive Supplemental Security Income (SSI) and SSI-related Medicaid.
- Children and young adults, age 20 and younger, who receive SSI and Medicare.
- Receive Medically Dependent Children Program (MDCP) waiver services.
- Receive Youth Empowerment Services (YES) waiver services.
- Reside in a community-based intermediate care facility for individuals with intellectual disabilities (ICF-IID) or in a nursing facility (NF).
- Receive intellectual and developmental disabilities (IDD) waiver services including:
  - **Community Living Assistance and Support Services (CLASS).**
  - **Deaf-Blind with Multiple Disabilities (DBMD).**
  - **Home and Community-Based Services (HCS).**
  - **Texas Home Living (TxHmL).**

Excluded Individuals

The following Medicaid-eligible individuals are excluded from participating in STAR Kids:

- Adults age 21 years or older.
- Children and young adults, age 20 and younger, enrolled in STAR Health.
- Children and young adults, age 20 and younger, who reside in the Truman Smith Children's Care Center or a state veteran's home.

To find additional information on Medicaid programs available to your members, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip.

Dual Eligible Members

Dual eligible members have both Medicare and Medicaid health insurance coverage. Medicare or the member's Medicare Health Maintenance Organization (HMO) is the primary payer and will reimburse all Medicare-covered services. The state Medicaid program serves as a secondary payer and will continue to reimburse Medicare co-insurance and deductibles for dual eligible members.

Members with traditional Medicare coverage may choose to use their existing Primary Care Providers (PCP), and may access specialty services without prior approval from Superior. Dual eligible members do not have to select a separate PCP through Superior for their LTSS services. The Service Coordinator will communicate and coordinate services with the member's Medicare PCP to ensure continuity of care. Dual eligible members should notify their Service Coordinators that they have Medicare coverage, and will provide the name of their chosen PCP.

Dual eligible members have identification cards that indicate Long-Term Care (LTC) services only, and must show their ID cards each time they receive Superior STAR Kids covered services. Dual eligibles do not receive the unlimited prescription drug benefit because the delivery of primary and acute care services are beyond the scope of the Medicaid managed care program.

Note: If a STAR Kids dual eligible member has Medicare, Medicare is responsible for most primary, acute and behavioral health services. Therefore, the PCP's name, address and telephone number are not listed on the member's ID Card.

Newborn Enrollment

If a woman is a Superior STAR Kids member at the time of delivery, the newborn is automatically a Superior STAR

member from the date of birth in areas where Superior STAR is present. Providers should educate and encourage members to report newborns to 2-1-1 to ensure newborn's coverage is established timely. Newborns should receive a Medicaid ID number within 30 days of birth. Until that time, all claims (with the exception of pharmacy) related to the care of the newborn should be filed with the mother's Medicaid ID number followed by the letter "A". For multiple births, use the letter "B" or "C" as needed. For assistance regarding pharmacy services and newborns, contact the STAR Kids Member Services Department at 1-844-590-4883.

Disenrollment

When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR Kids program and from Superior. HHS is solely responsible for determining if and when a member is disenrolled from the Medicaid program. Members can be disenrolled from Superior, but still be eligible for Medicaid through another health plan or program. Please also review the information regarding Span of Coverage in Section 4 of this manual.

Renewal

People who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to recertify with HHS each year. To maintain SSI benefits, the SSA may require information from the person related to their SSI benefits. The person or their representative payee may call the SSA. HHS does not play a role in determining SSI eligibility. Providers are encouraged to remind members to keep their information current with SSA.

If a Superior member becomes temporarily ineligible (for six months or less) for Medicaid, but regains Medicaid eligibility within the six month timeframe and resides in the same service area, the member will be automatically re-enrolled by HHS in Superior. Superior and the state's Enrollment Broker will make every effort to re-enroll the member with the previous PCP. The member will also have the option to switch plans.

STAR Health Program

STAR Health is a statewide program designed to provide medical, dental, vision, pharmacy and behavioral health benefits.

Mandatory Members

The following groups are mandatory to participate in Superior STAR Health program:

- Children and young adults under 18 in DFPS conservatorship.
- Members age 18-22 who voluntarily agree to continue in a foster care placement.

Members in a waiver program will be enrolled in STAR Health but receive waiver services from the waiver program. These waiver programs include:

- Community Living Assistance and Support Services (CLASS).
- Home and Community-Based Services (HCS).
- Deaf-Blind Multiple Disabilities (DBMD).
- Medically Dependent Children Program (MDCP).
- Texas Home Living (TxHmL).

Voluntary Members

- Young adults who have exited care and are eligible for Medicaid for Former Foster Care Children (FFCC) from age 18-20.
- AAPCA program members that qualify and choose to remain in STAR Health.

Excluded Individuals

Members excluded from the STAR Health program are children who are:

- In the Texas Youth Commission (TYC).
- In the Texas Juvenile Probation Commission (TJPC).
- From other states placed in Texas.
- In Medicaid-paid facilities such as nursing homes, state-supported living centers or Intermediate Care.
- Facilities for the Mentally Retarded (ICF-MR).
- Placed outside the State of Texas.
- Manifestly dangerous.
- Young adults eligible for Medicaid for Former Foster Care Children (FFCC) from age 21-26.

To find additional information on Medicaid programs available to your patients, please visit: https://www.hhs.texas.gov/services/health/medicaid-chip.

Newborn Enrollment

If a woman is a Superior STAR Health member at the time of delivery, the newborn is automatically a Superior STAR Health member from the date of birth. Providers should educate and encourage members to report newborns to 2-1-1 to ensure newborn's coverage is established timely.

Newborns should receive a Medicaid ID number within 30 Days of birth. Until that time, all claims (with the exception of pharmacy) related to the care of the newborn should be filed with the mother's Medicaid ID number followed by the letter "A". For multiple births, use the letter "B" or "C" as needed. For assistance regarding pharmacy services and newborns, contact the STAR Health Member Services Department at 1-866-912-6283.

Disenrollment

When a member becomes ineligible for Texas Medicaid, STAR Health or no longer in DFPS conservatorship, the member is disenrolled from the STAR Helath program and from Superior. HHS is solely responsible for determining if and when a member is disenrolled from the Medicaid program and STAR Health Members can be disenrolled from Superior, but still be eligible for Medicaid. Under some situations, HHSC may determine the member can remain in STAR Health based on the member's Medicaid eligibility. Please also review the information regarding Span of Coverage in Section 4 of this manual.

Dual Eligible Members

Superior will supplement the Medicare coverage for STAR Health members by providing Long-Term Services and Supports (LTSS) as Medicaid wrap-around services, including:

- Community First Choice (CFC) services for qualified members
- Medically Dependent Children Program (MDCP) services for qualified members
- Personal Care Services (PCS)
- Prescribed Pediatric Extended Care Centers (PPECC)
- Private Duty Nursing (PDN)

Superior may not require a provider to obtain a denial or explanation of benefits from Medicare prior to covering these services.

CHIP Program

The Balanced Budget Act (BBA) of 1997 (P.L. 105-33) created the state Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. In Texas, this is referred to as the "CHIP" program and provides health insurance to uninsured children in families with incomes too high to qualify for Medicaid.

Enrollees

Children under age 19 and whose family's income is below the Medicaid eligibility Federal Poverty Level (FPL) are eligible to enroll in the CHIP program (for 12 month eligibility) if they do not qualify for Medicaid coverage. The three CHIP eligibility categories are:

- 101% to 150% of FPL
- 151% to 185% of FPL
- 186% to 200% of FPL

Exception: A CHIP Perinatal mother in a family with an income at or below Medicaid eligibility threshold may be eligible to have the costs of birth covered through emergency Medicaid. Clients under the Medicaid eligibility threshold will receive Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHS's Enrollment Broker.

Children of families with group health insurance or Medicaid coverage are not eligible for the CHIP program. Providers are required to contact the health plan immediately when a pregnant CHIP or Medicaid member is identified.

Newborn Enrollment

Providers are required to contact Superior immediately when a CHIP member becomes pregnant. Most CHIP members who become pregnant will qualify for Medicaid. Providers should educate and encourage members to report newborns to 2-1-1 to ensure newborn's coverage is established timely.

Some CHIP members will maintain their CHIP coverage through delivery of the baby. However, in most cases, the CHIP benefit does not cover the newborn from date of birth. CHIP coverage for the newborn of a mother who is CHIP-eligible at the time of delivery is not automatic. The CHIP mother must complete an application to CHIP in order for the newborn's eligibility for CHIP coverage to be considered.

Perinatal

The CHIP Perinatal coverage provides prenatal, delivery and postpartum care for the unborn children of low-income women who do not qualify for Medicaid. Once born, the child will receive CHIP benefits for the duration of the 12 month coverage period, beginning with the month of enrollment as a CHIP Perinatal member (begins on the month of enrollment as an unborn child, plus 11 months). The CHIP Perinatal program includes:

- Members above the Medicaid eligibility threshold (Category B on ID card).
- Members at or below the Medicaid eligibility threshold (Category A on ID card).

Perinate Newborn

The mother of the CHIP Perinate Newborn has 15 Days from the time the enrollment packet is sent by HHS's contracted CHIP Enrollment Broker to enroll in a health plan. If a health plan selection is not made, the CHIP Perinate Newborn is defaulted into a health plan and the mother is notified of the plan choice. When this occurs, the mother has 90 Days to select another health plan.

Once a CHIP Perinate Newborn member's coverage expires, the child will be added to their siblings' active CHIP program case. If there is no active CHIP program case, then in the tenth month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP program member's information.

The following rules apply to CHIP Perinate Newborns:

- A CHIP Perinate (unborn child) who lives in a family with an income at or below the Medicaid eligibility threshold will be deemed eligible for Medicaid, and moved to Medicaid for 12 months of continuous coverage

(beginning on the date of birth), after the birth is reported to HHS's Enrollment Broker.

- A CHIP Perinatal mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of birth covered through emergency Medicaid. Clients under the Medicaid eligibility threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHS's Enrollment Broker.
- A CHIP Perinate Newborn will continue to receive coverage through the CHIP Perinatal program as a "CHIP Perinate Newborn" if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHS's Enrollment Broker.
- A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in their CHIP Perinatal health plan. Copayments, cost-sharing and enrollment fees do not apply to children enrolled in the CHIP Perinate Program.

Disenrollment

When a member becomes ineligible for CHIP, the member is disenrolled from the CHIP program and from Superior. HHS or the HHS Administrative Services Contractor determines CHIP member enrollment and disenrollment into the CHIP program. Members can be disenrolled from Superior and have CHIP through another health plan or program.

Under no circumstances can a provider take retaliatory action against a member due to disenrollment from either the provider or a plan. All final disenrollment decisions are made by HHS.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member's health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member's enrollment period, or (2) the end of the traditional CHIP member's enrollment period. In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP member's information. Once the child's CHIP Perinatal coverage expires, the child will be added to their siblings' existing CHIP case.

Please note, CHIP members are allowed to make health plan changes under the following circumstances:

- For any reason within 90 Days of enrollment in CHIP.
- For cause at any time.
- If the client moves to a different service delivery area.
- During the annual re-enrollment period.

Renewal

Once enrolled with Superior, a CHIP member is enrolled for the period of 12 months or the duration of the 12 months the family has coverage. CHIP members must re-enroll every 12 months. A CHIP member may be deemed to Medicaid if eligible at any point during their enrollment in CHIP.

At the beginning of the tenth month, the CHIP program will send a notice to the family outlining the next steps for renewal or continuation of coverage. Failure of the member to respond to the renewal notice will result in the member's disenrollment from Superior at the end of the 12-month enrollment period. Providers are encouraged to remind the member to submit all the necessary information for CHIP renewal timely to avoid loss of coverage.

SECTION 4
COVERED BENEFITS AND VALUE-ADDED SERVICES

Medicaid Program Benefits for STAR, STAR+PLUS, STAR Kids, STAR Health and CHIP

Superior is required to provide specific, medically necessary services to its Medicaid members. Please refer to the current Texas Medicaid Provider Procedures Manual for a more inclusive listing of limitations and exclusions.

Superior will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in STAR, STAR+PLUS, STAR Kids, STAR Health or CHIP programs.

Medicaid benefits include, but may not be limited to:

- Ambulance services.
- Audiology services, including hearing aids.
- Behavioral health services, including:
  - **Attention Deficit Hyperactivity Disorder (ADHD) services.**
  - **Colaborative Care Model services.**
  - **Counseling services for adults (21 years of age and over).**
  - **Home health services.**
  - **Inpatient mental health services for children.**
  - **Non-Emergency Medical Transportation.**
  - **Outpatient mental health services.**
  - **Outpatient substance use disorder treatment services including:**
    - **Assessment.**
    - **Detoxification services.**
    - **Counseling treatment.**
    - **Medication assisted therapy.**
  - **Psychiatry services.**
  - **Telemedicine, Telemonitoring and Telehealth.**
- Birthing services provided by a licensed birthing center.
- Birthing services provided by a physician or advanced practice nurse in a licensed birthing center.
- Breast Pump Coverage, found in the Attachments section.
- Cancer screening, diagnostic and treatment services.
- Chiropractic services.
- Dental and vision services.
- Dialysis.
- Doctor and clinic visits.
- Durable medical equipment and supplies.
- Emergency services.

- Family planning services.
- Home health-care services.
- Hospital services, including inpatient and outpatient.
- Immunizations.
- Laboratory.
- Mastectomy, breast reconstruction and related follow up procedures including:
  - **Inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed.**
  - **Surgery and reconstruction on the other breast to produce symmetrical appearance.**
  - **Treatment of physical complications from the mastectomy and treatment of lymphedema; pro phylactic mastectomy to prevent the development of breast cancer.**
  - **External breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.**
- Medical checkups and Comprehensive Care Program (CCP) services for children, adolescents and young adults (birth through 20) through the Texas Health Steps program.
- Medical supplies and equipment.
- Mental health care.
- Oral evaluation and fluoride varnish in the medical home in conjunction with Texas Health Steps medical checkups for children six months through 35 months of age.
- Podiatry.
- Prenatal care.
- Prescription drugs.
- Primary care services.
- Preventive service, including an annual adult well check for patients 21 years of age and over.
- Radiology, imaging and X-rays.
- Residential substance use disorder treatment services including:
  - **Detoxification services.**
  - **Substance use disorder treatment (including room and board).**
- Specialty physician services.
- Therapies – physical, occupational and speech.
- Transplantation of organs and tissues.
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which cannot be accomplished by glasses.)

Member Handbook

Every Superior STAR, STAR+PLUS, STAR Kids, STAR Health and CHIP member receives a member handbook

when enrolled in Superior. Each handbook includes information about Superior that the member needs to know, including benefits. A copy of each Superior member handbook can be accessed through:

- The Superior HealthPlan website at www.SuperiorHealthPlan.com or www.FosterCareTX.com (STAR Health).
- Superior's Member Services Department by calling:

  STAR and CHIP 1-800-783-5386

  STAR+PLUS..... 1-877-277-9772

  STAR Kids..... 1-844-590-4883

  STAR Health 1-866-912-6283

Spell of Illness Limitation

The Medicaid spell of illness limitation is applied to STAR+PLUS members, and is defined as 30 Days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 Days of an inpatient care admission, reimbursement for additional inpatient care is not considered until the patient has been out of an acute facility for 60 consecutive Days.

Exceptions to the spell of illness limitation for inpatient admissions are listed below:

- A prior approved solid organ transplant. The 30 Day spell of illness for transplants begins on the date of the transplant, allowing additional time for the inpatient stay.
- Texas Health Steps-eligible clients who are 20 years of age and younger when a medically necessary condition exists.
- Applicable diagnoses exempt from the spell of illness limitation include the following as described in the DSM-V (parenthetical codes are corresponding ICD-10 codes): Schizophrenia (F20), Schizoaffective disorder (F25), Schizophreniform (F20), Bipolar I and Bipolar II Disorder (F31) with any severity or status, and Major Depressive Disorder (F32 and F33) with any variation or subtype. However, the diagnosis must be a specific condition rather than a general behavioral health condition. For example, MCOs are not required to exempt "unspecified" or "not classified" diagnoses. Examples of diagnoses that are unspecified include (but are not limited to) F31.9 (bipolar disorder, unspecified), F20.9 (schizophrenia, unspecified type), F20.89 (other specified types of schizophrenia, unspecified).

Annual Inpatient Admission Maximum Limitation - STAR Health

The Medicaid Program's $200,000 annual maximum inpatient admission limitation does not apply to STAR, STAR+PLUS or STAR Kids members. The $200,000 annual limit DOES APPLY to STAR Health members. Claim payment for inpatient admissions for a STAR Health member will not exceed the $200,000 limit.

Superior HealthPlan Medical Ride Program (Non-Emergency Medical Transportation Services)

What is Superior's Medical Ride Program?

Superior's Medical Ride Program provides NEMT to non-emergency health-care appointments for members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. Ambulance transportation is not covered under this program. Transportation services are available to STAR, STAR Health, STAR Kids, STAR+PLUS and MMP members. Eligibility is based on product and program requirements. CHIP and CHIP Perinate members are excluded under

this program. Superior is required to facilitate the most cost-effective mode of curb-to-curb transportation that meets a member's individual need. Superior can authorize an attendant to accompany the member if an additional level of service is required.

What Services Are Offered by Superior's Medical Ride Program?

There are many types of transportation services included in Superior's Medical Ride Program. They include:

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb service transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary. These are types of rides where the member is picked up and dropped off at the entrance/exit of their home or clinic.
- Mileage reimbursement for an individual transportation participant (ITP) using their own vehicle for a verified completed trip to a covered health-care service. The ITP can be the member, the member's family member, friend, or neighbor.
- Members aged 20 years old or younger may be eligible to receive the cost of meals associated with a long-distance trip to obtain a covered health-care service. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- Members aged 20 years old or younger may be able to receive the cost of lodging associated with a long-distance trip to obtain a covered health-care service. Lodging services are limited to the overnight stay and do not include any amenities or incidentals, such as phone calls, room service, or laundry service.
- For some situations, members aged 20 years old or younger may be eligible to receive funds in advance of a trip to cover authorized NEMT (ride/transportation) services.

If you have a member needing assistance while traveling to and from their appointment with you, Superior's Medical Ride Program will cover the costs of an attendant. You may be asked to provide documentation of medical necessity for transportation of the attendant to be approved. The attendant must remain at the location where covered health-care services are being provided, but may remain in the waiting room during the member's appointment.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years of age must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adult on file to travel alone. Parental consent is not required if the health-care service is confidential in nature.

If you have a member you think would benefit from receiving Superior's Medical Ride Program services, please refer them to Superior's Medical Ride Program provided by SafeRide at 1-855-932-2318 for more information.

How to Schedule a Ride

To request NEMT Services or for more information about services offered by Superior's Medical Ride Program, members, advocates and providers can call Superior's Medical Ride Program provided by SafeRide.

Superior members should request rides as early as possible, and at least two Business Days before they need the ride. In certain circumstances, they may request a ride with less than two Business Days' notice. These circumstances include:

- Being picked up after being discharged from a hospital;
- Trips to the pharmacy to pick up a medication or approved medical supplies;
- Trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

SafeRide

General Call Center:	1-855-932-2318; TTY: 7-1-1
Dedicated Provider ONLY Line:	1-855-932-2322; TTY: 7-1-1
Hours:	8:00 a.m.-6:00 p.m. CST, Monday-Friday
Where's My Ride?:	1-855-932-2319; TTY: 7-1-1
Hours:	4:00 a.m.-8:00 p.m. CST, Monday-Saturday

It is the responsibility of the member to coordinate all information needed from both the provider and Superior timely, in order for Superior or SafeRide to consider the request. The member should be advised to follow up with SafeRide to check on their status prior to the request date.

In situations where transportation is not part of a member's covered benefit, additional transportation assistance may be available to qualifying Superior members. Please refer members to the Value-added Services section of their member handbook for specific information on transportation-related benefits. Providers can also direct members to contact Member Services to see if additional benefits are available to them.

How to Change or Cancel a Ride

Members must notify SafeRide prior to the approved and scheduled trip if their medical appointment is cancelled. To change or cancel a ride, the member should log into the SafeRide member portal or call SafeRide at 1-855-932-2318 at least 24 hours in advance.

Coordination with Other State Program Services

Coordination with Public Health

Superior is required, through its contractual relationship with HHS, to coordinate with public health entities regarding the provision of services for essential public health services. Providers must assist Superior in these efforts by:

- Complying with public health reporting requirements regarding communicable diseases and/or diseases which are preventable by immunization as defined by state law.
- Assisting in notifying or referring to the local public health entity, as defined by state law, any communicable disease outbreaks involving members.
- Reporting to the local public health entity for Tuberculosis (TB) contact investigation and evaluation and preventive treatment of persons whom the member has come into contact within one Business Day of identification. This includes:
  - **Ensuring all members who have TB or are at risk are screened for TB.**
  - **Accessing procedures for reporting TB and appropriate DSHS forms from www.dshs.State.tx.us/idcu/disease/tb/forms.**
  - **Contacting Superior's Member Services Department.**
- Reporting all confirmed cases of STD/HIV to the local public health entity for STD/HIV contact investigation, and evaluation and preventive treatment of persons whom the member has come into contact. This includes:
  - **Accessing required forms for reporting from: http://www.dshs.texas.gov/hivstd/reporting/ or by calling Superior's Member Services Department.**
  - **Keeping information confidential about members who have received STD/HIV services.**
- Referring for Women, Infant and Children (WIC) services and information sharing for the purposes of eligibility determination.

- Assisting in the coordination and follow-up of suspected or confirmed cases of childhood lead exposure.
- Referring lead screening tests to the HHS laboratory.
- Reporting of immunizations provided to the statewide ImmTrac Registry, including parental consent to share data.
- Cooperating with activities required of public health authorities to conduct the annual population and community-based needs assessment.
- Identifying members who are less than three years of age and suspected of having a developmental delay or disability, and referring to Early Childhood Education (ECI) providers for screening and assessment within two Business Days from the day the member is identified.
- Using materials from HHS available on https://hhs.texas.gov/services/disability or by contacting 1-877-787-8999.
- Complying with the release of records within 45 Days so that screening may be completed.

Coordination for Services Not Directly Provided Through Superior

There are several services that are available to Superior members based on their STAR, STAR+PLUS, STAR Kids, STAR Health (foster care) or CHIP eligibility and are accessed outside of Superior's provider network. In addition, the services are not a part of the managed care program. These services are found in the Texas Medicaid Provider Procedures Manual (TMPPM) and include the following:

- Admissions to inpatient mental health facilities as a condition of probation.
- Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program.
- Early Childhood Intervention (ECI) Case Management/Service Coordination.
- Early Childhood Intervention - Specialized Skills Training.
- For STAR, Texas Health Steps Personal Care Services for members birth through age 20.
- HHS contracted providers of Long-Term Services and Supports (LTSS), Care Management or Service Coordination for individuals who have intellectual or developmental disabilities.
- HHS hospice care.
- HHS or DSHS HCBS Waiver programs, including CLASS, DBMD, HCS, TxHmL and YES.
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services for Dual Eligible Members.
- PASRR screenings, evaluations and specialized services for STAR Kids and STAR+PLUS members.
- Texas Health Steps dental services (including orthodontia for STAR, STAR Kids, STAR Health and CHIP).
  Note: Medicaid children who are ages birth through 20 years and CHIP children receive dental services through a managed care dental services model. Members must select a dental plan and a primary dentist. STAR Health Texas Health Steps dental services are accessed through the Superior Dental Management Organization (DMO). STAR Health members are not required to select a primary dentist.
- Texas Health Steps Environmental Lead Investigations (ELI).
- Texas Health Steps Medical Case Management - Medicaid only.
- Texas School Health and Related Services (SHARS) - Medicaid only.
- Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation).

All network providers are encouraged to refer to and coordinate services with the above agencies. If more information or assistance is required, contact Superior's Member Services Department or complete and submit the Member Advocate Referral Form, found in the Attachments section.

Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC is a nutrition program for pregnant, breastfeeding women and families with children younger than five years of age. Through WIC, families can get healthy food, one-on-one counseling with nutritionists, breastfeeding support and more.

Case Management for Children and Pregnant Women (CPW)

Case Management for Children and Pregnant Women (CPW) services are provided to help Medicaid eligible children and pregnant women to gain access to necessary medical, social, educational, and other services related to a member's condition, health risk, or high-risk condition. Superior assesses a person's need for these services and then develops a service plan to address those needs. Superior is responsible for managing the delivery of CPW services for STAR, STAR+PLUS, STAR Health, and STAR Kids programs. CPW services for STAR Health members are limited to members who are not in Department of Family and Protective Services (DFPS) conservatorship. CPW services are available to STAR Health members who are in catagories 3, 4, 5 and 6 of the Target Population:

- Category 3: Age 18 to 20 years old (through the month of their 21st birthday) and who are enrolled in STAR Health as Former Foster Care Children (FFCC) or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) program
- Category 4: Infants born to a mother who is enrolled in STAR Health
- Category 5: Children through age 17 and young adults aged 18 through the month of their 21st birthday who are receiving Supplemental Security Income (SSI) or who were receiving SSI before becoming eligible for Adoption Assistance (AA) or Permanency Care Assistance (PCA)
- Category 6: Children through age 17 and young adults aged 18 through the month of their 21st birthday who are enrolled in a 1915(c) Medicaid Waiver and AA or PCA

Prior authorization Superior will not require prior authorization for CPW services. Services must be provided within 14 days of referral.

Program/ Population	SUPERIOR HEALTHPLAN Care Management Team (Case Managers, Service Coordinators, Service Managers)	CPW Network Provider
STAR Health Categories 1 and 2	• Assistance with accessing medical and social services. • Provision of health education and resources related to the Member's health condition, health risk, or high-risk condition.	STAR Health members in DFPS Conservatorship and Former Foster Care Child (FFCC) Members are **not eligible for CPW services**.
• STAR Health Categories 3 through 6 • STAR MSHCN • STAR Non-MSHCN • STAR Kids • STAR+PLUS	• Performs comprehensive screening / assessment to evaluate care needs • Identify the Member's physical, behavioral, functional, and psychosocial needs. • Engage / coordinate with the Member / Member's Legally Authorized Representative (LAR) and appropriate providers in the development, review / updates of the goals and interventions on Member's Individual Service Plan (ISP) or Plan of Care. • Assist the member / LAR in obtaining access to services including making referrals to specialty providers and scheduling appointments; with follow up to ensure needed services are provided. • Conduct post-hospitalization discharge calls to address any potential unmet needs, perform reassessments, and encourage importance of compliance with follow-up appointments and connects families to value added services. • Assist / link members with appropriate resources to address Non-Medical Drivers of Health issues such as transportation, housing, or food. • Provide health education related to the Member's health condition, health risk, or high-risk condition. • Connect the Member to Covered and non-covered services necessary to meet the Member's identified needs. • Follow up outreach and monitor to ensure needs identified in member's service plan is being met. • Facilitate and collaborate on the development of a transition plan for transitioning youth into adulthood (prior to age 21).	**CPW CAN PROVIDE:** • Conduct in-person visits for family needs assessment / evaluation of member's unmet needs, identify family challenges and strengths. • Development of service plans to meet or address the member's unmet needs. • Assist with care coordination to appropriate community resources or service providers to meet member's needs. • Follow up to ensure needs identified in the service plan are being met. • Assist member /family in coordination / advocacy for accessing and or addressing education / school related issues, and or attend school meetings as appropriate. • Assist member with application and appealing the SSI denial. **CPW CANNOT PROVIDE:** • Direct health care or health education. • Direct clinical, medical or therapy services. • Diagnosing a client, or determining a need for a specialist.

Coding & Claims Submission

CPW services are Medicaid physical health benefits, and should be billed to the appropriate physical health Superior Payer. Refer to Section 10, Claims and Encounters Administration for billing information for paper claims. Electronic claims should be submitted to Payer ID 68069.

- Procedure code G9012 is to be used for all CPW services.
- Modifiers are used to identify which service component is provided.
- CPW services are limited to one visit per day, per member.
- Additional visits on the same day from any provider will be denied as part of another service rendered on the same day.
- CPW services are not billable when a person is an inpatient at a hospital or other treatment facility.

Reminder: Billable services are defined in program rule 25 TAC §27.11.

Provider Statement of Need

Superior requires providers to submit a Provider Statement of Need (PSON) before an assessment for Personal Assistance Services (PAS), Personal Care Services (PCS) and Community First Choice (CFC) Habilitation (HAB) is conducted for the STAR+PLUS, STAR Kids and STAR Health programs.

Following the assessment, the provider will receive information regarding the number of provider hours (if any) to be authorized for their patient, and have the opportunity to discuss any concerns related to that determination. These steps are designed to facilitate more holistic collaboration between the provider and Superior's Service Coordination team, which includes increased communication regarding the member's functional needs and the way those needs are being met, as well as the opportunity to ensure that any underlying medical conditions or complications are addressed by appropriate medical professionals. This process is also designed to preserve consistency among Medicaid programs and facilitate transitions between them, in compliance with updated contractual requirements implemented by HHS, which require that a PSON process be implemented for both STAR Kids and STAR Health.

The following guidelines apply:

Assessment

Initial PAS, PCS or CFC HAB Request

- A Provider Statement of Need (PSON) is required by a provider who has examined the member and reviewed the medical record within the last 12 months in order to initiate the assessment process.
- The PSON will only be accepted from a physician, advanced practice registered nurse or physician assistant, and must be signed by the provider no more than 90 Days prior to the date of the request.
- Superior's Service Coordination Team will be responsible for coordinating with the physician to obtain the required PSON, or in the alternative, may accept a PSON obtained by the service provider.
- Superior's Service Coordinator will complete the functional needs assessment following receipt of the PSON.
- For STAR Health members only, PCS may be provisionally initiated for up to 60 Days once eligibility has been established through the functional assessment.

PAS, PCS or CFC HAB Change in Condition

- A new functional needs assessment is required when there is any change in the member's condition or environment.

- Superior's Service Coordination Team will be responsible for coordinating with the physician to obtain the required PSON, or in the alternative, may accept a PSON obtained by the service provider.

PAS, PCS or CFC HAB Reassessment

- A new functional needs assessment will be completed by Superior's Service Coordinator, a minimum of once a year.
- A new PSON will be obtained prior to the member's annual reassessment for PAS/HAB services each year. Superior's Service Coordination Team will be responsible for coordinating with the physician to obtain the required PSON, or in the alternative, may accept a PSON obtained by the service provider.

Determination/Authorization

1. Superior will notify the provider of the recommended hours (if any) derived from the completed assessment.
2. The provider will have the opportunity to discuss any concerns or questions related to the recommended hours, to include indicating formal disagreement with those hours, and obtain a complete copy of the assessment document if needed.
3. The functional needs assessment will be sent to a Superior Medical Director for review and determination if the provider does not agree with the assessment and recommendation.

For any questions, please feel free to contact your dedicated Account Manager, or Provider Services at 1-877-391-5921.

Span of Coverage

Span of Coverage refers to the payment responsibility for hospital facility charges when there are Medicaid enrollment changes during the hospital stay. This policy does not apply to CHIP.

Summary of Policy

A Medicaid enrollment change is any change in managed care enrollment, including:

- Member moves from Fee-For-Service (FFS) to managed care
- Member moves from managed care to FFS
- Member moves between Managed Care Organizations (MCOs) in the same managed care program (i.e., STAR, STAR+PLUS, STAR Kids, STAR Health)
- Member moves between managed care programs

When an enrollment change occurs while a member is in the hospital, the previous payer (former MCO or FFS) remains responsible for the hospital facility charge until discharge, transfer, or loss of Medicaid eligibility.

The current payer (new MCO or FFS) is responsible for all other covered services beginning on the effective date of the enrollment change. See table below for details:

Scenario	Hospital Facility Charge	All Other Covered Services
Member retroactively enrolled in managed care	New MCO	New MCO
Member prospectively moves from FFS to managed care	FFS	New MCO
Member moves from managed care to FFS	Former MCO	FFS
Member moves between MCOs in the same program	Former MCO	New MCO
Member moves between MCO programs	Former MCO	New MCO

STAR and STAR+PLUS

Span of Coverage for STAR and STAR+PLUS is specific to stays in a single hospital without transfers. “Discharge”and Transfer” are defined as follows:

- Discharge means a formal release of a member from an Inpatient Hospital stay when the need for continued care at an inpatient level has concluded. Movement or Transfer from one Acute Care Hospital or Long-Term Care Hospital/facility and readmission to another within 24 hours for continued treatment is not a discharge.
- Transfer means the movement of the Member from one Acute Care Hospital or Long-Term Care Hospital/facility and readmission to another Acute Care Hospital or Long-Term Care Hospital or facility within 24 hours for continued treatment.
- When there is a hospital transfer, Span of Coverage no longer applies. The MCO is responsible for assessing, authorizing, arranging, coordinating, and providing Covered Services. The MCO must provide Medically Necessary Covered Services to all Members beginning on the Member’s date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services.

STAR Kids, STAR Health, and Dual Demonstration

The Span of Coverage guidelines for STAR Kids, STAR Health and Dual Demonstration include “transfer” under the definition of discharge.

Authorization of Hospital Transfers

If the member is in FFS at the time of the transfer request, Texas Medicaid & Healthcare Partnership (TMHP) is responsible for making the authorization determination for transfer to the second hospital.

If the member is in managed care at the time of the transfer request, the MCO with which the member is enrolled at the time of the transfer request is responsible for making the authorization determination for transfer to the second hospital.

If there is an enrollment change between the date of authorization and the date of transfer, the new MCO must honor the authorization of the previous payer (FFS or former MCO) in accordance with the continuity of care requirements in the managed care contracts.

Reimbursement Coordination Between Payers

The two payers must coordinate payments to the hospitals in accordance with the client transfer policy outlined in the Texas Medicaid Provider Procedures Manual (TMPPM), Inpatient and Outpatient Hospital Services Handbook.

Examples:

- 10/1 – Member is enrolled with MCO A
- 10/25 – Member admitted to Hospital 1
- 11/1 – Member changes enrollment to MCO B
- 11/15 – Member transfers to Hospital 2

MCO A is responsible for:

- All covered services from 10/1 through 10/31
- Hospital 1 facility charges from 11/1 through 11/15

MCO B is responsible for:

- All covered services except the Hospital 1 facility charge from 11/1 through 11/15
- All covered services, including the Hospital 2 facility charge, beginning on 11/15

STAR

Benefits Overview

Medicaid members participating in the STAR program receive all the benefits of the traditional Texas Medicaid program, as listed on page 41 of this manual.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A STAR member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Centers (PPECC), or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided). The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the member's medical condition or the authorized hours are not commensurate with the member's medical needs. Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours, unless additional hours are medically necessary.

Adoption Assistance or Permanency Care Assistance

Effective September 1, 2017, individuals in the Texas Department of Family and Protective Services (DFPS) Adoption Assistance or Permanency Care Assistance (AAPCA) programs began getting their Medicaid services through a STAR or STAR Kids Managed Care Organization. Individuals who received AAPCA services have the same Medicaid benefits under their selected health plan as they had been receiving prior to enrolling in managed care. Beginning September 1, 2020, certain children in AAPCA will have the choice between STAR Kids and STAR Health. Members will be sent a packet in the mail about their upcoming transition, including information about the available health plans and how to pick a plan.

AAPCA clients who met the following criteria were moved to STAR on September 1, 2017.

- Don't receive:
  - **Supplemental Security Income (SSI)**
  - **Medicare**
  - **1915(c) waiver services**
- Don't have a disability as determined by the U.S. Social Security Administration or the State of Texas.
- Don't live in:
  - **a nursing facility**
  - **an intermediate care facility for individuals with intellectual or developmental disabilities or related conditions (ICF/IID)**
- AAPCA clients who met the following criteria were moved to STAR Kids on September 1, 2017.
  - **Receive Supplemental Security Income (SSI).**
  - **Have a disability as determined by the U.S. Social Security Administration or the State of Texas**

Note: Individuals who get services through a 1915(c) waiver and individuals who get Medicare are already in STAR Kids.

Individuals may contact the DFPS regional adoption assistance eligibility specialist assigned to their case and verify the mailing address on file, to ensure they receive enrollment materials in the mail. If an individual does not know who their eligibility specialist is, they can call the DFPS hotline at 1-800-233-3405.

If providers have questions about AAPCA services changing to managed care, please email Managed_Care_Initatives@HHS.state.tx.us.

For more information, please visit:

https://hhs.texas.gov/services/health/medicaid-chip/programs/adoption-assistance-or-permanency-care-assistance-managed-care-expansion.

Additional Benefits

Adult Well Check

This annual adult physical exam is an additional benefit for STAR non-dual members 21 years and older. The annual adult well exam may be received in addition to the member's annual OB/GYN visit for females. Members can self-refer to an OB/GYN provider without a referral from their PCP. All newly enrolled members should obtain a well checkup within 90 Days of enrollment.

Prescriptions

Additional Benefits for STAR Prescriptions

All STAR non-dual members receive unlimited prescriptions as part of the Medicaid Managed Care program.

Value-added Services

Superior offers coverage beyond the traditional Medicaid benefits. Collectively, this additional coverage is referred to as Value-added Services (VAS). VAS may be actual health care services, benefits or positive incentives that HHS determines will promote healthy lifestyles and improve health outcomes.

Some of these extra services include:

- Expanded vision benefits
- Over-the-counter items
- Sports/camp physicals

For an up-to-date list of these services, go to www.SuperiorHealthPlan.com. For more information about these or other extra services, please call 1-877-391-5921.

Service Coordination

Service Coordination is available to STAR members identified with Special Health Care Needs (MSCHN). STAR physical and behavioral health service coordinators ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs to appropriate for the treatment of Members with Special Health Care Need's conditions. The STAR service coordination team develop a service plan a will work and ensure access to treatment by a multidisciplinary team when necessary. The Service Coordinator will work with members, their family or community supports, doctor(s), and other providers to:

- Identify their needs.
- Help make sure members receive their services on time.
- Make sure they choose providers and access covered services.
- Coordinate Superior-covered services with social and community support services.
- Coordinate Non-capitated Services and enlist the involvement of community organizations that could provide non-covered services for the overall health and well-being of our members.
- Conduct complex Care Management.

- Refer members to disease management.
- Coordinate Discharge Planning.
- Assist with Transition Plan.
- Promote best practice/evidence-based services.
- Identify and report potential abuse/neglect.

Development of the Individual Service Plan (ISP) Narrative

The ISP-Narrative is a regularly updated document developed by working with the member, their LAR and other caretakers, and their providers in a person-centered, culturally competent manner. The Service Plan includes but is not limited to the following.

- The member's history.
- The member's service preferences.
- Short-term and long-term goals.
- Member's strengths and supports.
- A summary of the members' current medical and social needs and concerns.
- List of covered benefits and frequency.
- Description of services.
- List of non-covered services, community support, and other resources.

Each member's ISP-Narrative is updated:

- At least bi-annually for AAPCA and annually for MSHCN.
- Following a significant change in a health condition that impacts service needs.
- Upon request of the member or the member's LAR.

STAR+PLUS

Benefits Overview

Medicaid members participating in the STAR+PLUS program receive all the benefits of the traditional Texas Medicaid program, as found in Section 4.

Superior will provide functionally-necessary community LTSS services to all STAR+PLUS members beginning on the members' date of enrollment regardless of pre-existing condition, prior diagnosis and/or receipt of any prior health care services. Superior will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any members enrolled in the STAR+PLUS program.

All adult members in STAR+PLUS who are not covered by Medicare, or are dual eligible and receiving STAR+PLUS Waiver services receive unlimited medically necessary prescription drugs. Dual eligible STAR+PLUS members will continue to receive pharmacy benefits from their Medicare Part D pharmacy plan.

Long-Term Services and Supports (LTSS)

Below is a listing of the community-based LTSS included under the STAR+PLUS Medicaid managed care program. Additional information on LTSS may be found online at https://hhs.texas.gov/.

The HHS uniform managed care contract terms and conditions is the final authority on STAR+PLUS.

Key Information for Long-Term Services and Supports Providers

As a reminder, the following are tips to providing LTSS services:

- Verify member eligibility with Superior before performing services.
- Ensure necessary referral/authorizations have been obtained from Superior prior to provision of services.
- Use the HHS provider ID given to you by Superior or your NPI and taxonomy code when filing claims for LTSS services.
- Bill and report LTSS services in compliance with the HHS Billing Matrix for LTSS HCPC codes and STAR+PLUS Modifiers Matrix.
- Notify the member's service coordinator whenever there is a change in the member's physical or mental condition, upon knowledge of an inpatient or nursing facility admissions, all member complaints or grievances, or if you identify a member needs services outside the Superior contracted scope of services with the provider.
- Ensure for members who are eligible for both Medicare and Medicaid that covered Medicare services are billed to Medicare as primary prior to accessing services under Medicaid or HCBS STAR+PLUS (c) waiver services.
- Refer to the LTSS bulletin(s) posted on the Texas Medicaid Health care Partnership (TMHP) website at www.tmhp.com for additional information.

Traditional Benefits

Medicaid facility and community-based LTSS benefits available include:

Personal Assistant Services (PAS)

Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and delegated nursing tasks that have been delegated by a registered nurse (RN). PAS are subject to Electronic Visit Verification (EVV). See Section 20 for more details on EVV. There are three options available to STAR+PLUS members desiring the delivery of PAS:

1. **Consumer-Directed Services** - In the consumer-directed model, the member or the member's legally authorized representative is the employer of record and retains control over the hiring, management and termination of an individual providing PAS. The member is responsible for assuring that the employee meets the requirements for PAS, including the criminal history check. Member uses a Financial Management Services Agency (FMSA) to handle the employer-related administrative functions such as payroll, substitute (back-up) attendant in place and filing tax-related reports of PAS. To participate as a Superior FMSA providing services under the consumer-directed model, a FMSA must be specifically identified to provide consumer direct services by HHS.
2. **Service Responsibility Option** - In the service responsibility option, the member or the member's legally authorized representative chooses an agency in the Superior provider network who is the employer of record. In this model, the member selects the personal attendant from the agency's personal attendant employees. The schedule is set up based on the member input, and the member manages the PAS. The member retains the right to supervise and train the personal attendant. The member may request a different personal attendant and the agency would be expected to honor the request. The agency establishes the payment rate, benefits and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports of PAS.
3. **Agency Model** - In the agency model, the member chooses an agency to hire, manage and terminate the individual providing PAS. The agency is selected by the member from a list of agencies within Superior's provider network. The Service Coordinator and member develop the schedule and send it to the agency. The member retains the right to supervise and train the personal attendant. The member may request a different

personal attendant and the agency is expected to honor the request. The agency establishes the payment rate, benefits and provides all administrative functions such as payroll, substitute (back-up) and filing tax-related reports of PAS.

To participate as a PAS network provider with Superior, the provider must have an executed agreement with Superior, be licensed by HHS for the delivery of PAS services and must comply with the Texas Administrative Code (TAC) in Title 40, Part 1, Chapter 41, Sections 41.101, 41.103, and 41.105 and Chapter 43.

Day Activity and Health Services (DAHS)

LTSS offered to individuals residing in the community, Monday-Friday except holidays, for a maximum of two 2 units/Day. Members attending DAHS a minimum of one hour to three hours is one unit of service that can be billed. If members attends DAHS three to six hours per Day it should be billed as two units of services. Member's attendance at DAHS includes travel time to/from the DAHS if member is transported by the facility.

- If member requires specialized services, such as therapies, on days of attendance at a DAHS facility, transportation to and from a DAHS facility must be approved to provide required services.
- If the DAHS facility provides transportation for a member to a non-therapy medical DAHS facility, time spent transporting can be claimed as part of the service unit.
- If the DAHS facility does not provide transportation, the DAHS facility must coordinate transportation with other resources.

Services include nursing and personal care services, nutrition services, transportation services, social and recreational activities and other supportive services. These services are provided at adult day care facilities licensed by the Department of State Health Services (DSHS) and certified by HHS.

Providers submitting requests for authorization of DAHS services can utilize the HHS forms 3050 and 3055, or submit the following clinical elements:

1. A list of all active diagnoses related to the member's need for DAHS.
2. A description of any functional disability related to the member's medical diagnoses.
3. A current medication list, including any PRN medications.
4. A record of the member's vital signs as obtained at the time of the assessment, to include blood pressure, pulse, respiration, height, weight and blood sugar, if applicable.
5. An indication of the member's dietary needs, specifying whether the member has no special dietary requirements, or needs (for example, a bland diet, diabetic diet, low sodium diet, etc.).A description of the member's personal care requirements, to include an indication of the degree of assistance required (no setup or physical assistance, one-person physical assistance or two-person physical assistance), in the following areas:
   a. Transfer. b. Ambulation. c. Eating. d. Toileting.
6. A description of the member's potential to stabilize, maintain or improve functioning from attending DAHS.
7. A list of the interventions to be performed by the nurse at the DAHS facility, to include the nature of the intervention as well as the frequency. For example, this may include:
   a. Occupational therapy, physical therapy or speech therapy.
   b. Respiratory therapy.
   c. Medication administration.
   d. Wound care.
   e. Meal setup.
   f. Health teaching/training.
   g. Other.
8. Physician's orders indicating the need for LVN or RN care/supervision, along with the above elements.

Minimum Wage Requirements for STAR+PLUS Attendants

Persons providing attendant services must be paid at the prevailing minimum wage rate as set by HHS. Superior must ensure that facilities and agencies that provide attendant services in community settings pay attendants at or above the minimum rates described below. This requirement applies to the following types of services, whether or not the member chooses to self direct these services:

- Day Activity Health Care Services (DAHS);
- Primary Home Care (PHC);
- Personal Assistance Services (PAS);
- Personal Assistance Services - CFC;
- Acquisition, maintenance and enhancement of skills in CFC; and
- Texas Health Steps Personal Care Services (PCS);
- Assisted Living Facility (ALF) Services; and
- Residential care (RC).

This requirement applies to personal attendants providing services to members in the CDS option. This requirement does not apply to attendant services provided by non-institutional facilities, such as adult foster care and nursing facilities.

Title 40 Texas Administrative Code §§49.312 requires that persons working as personal attendants in the services/programs listed above, whether as employees or contractors of a provider or as employees or contractors of subcontractors, be paid at or above a specified hourly base wage.

In addition, providers are required to notify persons hired as personal attendants of the required base wage.

Newly employed or contracting attendants hired on or after September 1, 2013, must be notified of the required base wages within three Days of being hired.

Superior may require providers to submit annual attestations and sample notices to employees/contracted employees ensuring that the minimum wage requirements were paid at or above the required hourly base wages as specified above.

HCBS STAR+PLUS Waiver Services

Superior will provide an array of services under the HCBS STAR+PLUS waiver. This includes the following benefits:

- **Adaptive Aids and Medical Supplies**: Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.
- **Adult Foster Care (AFC)**: Provides a 24-hour living arrangement in an HHS-contracted foster home for persons who, because of physical, mental or emotional limitations, are unable to continue independent functioning in their own homes. Services may include meal preparation, housekeeping, minimal help with personal care, nursing tasks, supervision, companion services, help with activities of daily living and provision of or arrangement for transportation. The unit of service is one Day.
- **Assisted Living Facility (ALF)**: Provides 24-hour living arrangement for persons who, because of physical or mental limitations, are unable to continue independent functioning in their own home. Services are provided in personal care facilities licensed by HHS. Participants are responsible for their room and board costs and, if applicable, copayments for ALF services.
- **Dental Services**: Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries. Services are capped at $5,000 per waiver plan year, but may be extended an additional $5,000 when oral surgeon services are required.
- **Emergency Response Services (ERS)**: Provided through an electronic monitoring system for use by functionally impaired individuals who live alone or are isolated in the community. In an emergency, the individual can press a call button to signal for help. The electronic monitoring system, which has a 24-hour, seven days a week monitoring capability, helps insure that the appropriate person or service agency responds to an alarm call from the individual.

- **Employment Assistance**: Provides identification of member's preferences, skills and work setting/condition needs, locating available jobs that match the member's criteria/needs and negotiating the member's potential employment with the employer. Please note, Employment Assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
- **Financial Management Services**: Services provided by Certified Financial Management Services Agencies (FMSA) to support members who hire their own service providers under the Consumer Directed Services (CDS) option.
- **Home Delivered Meals**: Meals services provide hot, nutritious meals delivered to an individual's home. The benefit limitation is one meal per Day, and the need for a home delivered meal must be part of the individual service plan. Home delivered meals will be provided to individuals who are unable to prepare their own meals and for whom there are no other persons available to do so, or where the provision of a home delivered meal is the most cost-effective method of delivering a nutritionally adequate meal. Modified diets, where appropriate, will be provided to meet individual requirements. Menu plans will be reviewed and approved by a registered dietician licensed by the Texas State Board of Examiners of Dietitians or has a baccalaureate degree with major studies in food and nutrition, dietetics or food service management. Any agency providing home delivered meals must comply with all state and local health laws and ordinances concerning preparation, handling and serving of food. Home Delivered Meal Providers must report any member illnesses, potential threats to the member's safety or observable changes in the member's condition to the MCO, orally within one Business Day and in writing within five Business Days.
- **In-Home Skilled Nursing Care**: Direct delivery of skilled tasks/procedures by a registered or practical nurse based on an assessment of the member's health care needs, guidance by professional practice standards and physician order if required. Texas Board of Nurse Examiners allows delegation of nursing tasks to unlicensed persons following the development of a care plan and education on proper health maintenance.
- **Mental Health Rehabilitative Services**: Services are defined as age-appropriate services determined by HHS and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children, and to restore the member to their best possible functioning level in the community.
- **Mental Health Targeted Case Management**: Assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these if they have been assessed and diagnosed with a severe and persistent mental illness (SPMI) or a severe emotional disturbance (SED) and they are authorized to receive Mental Health Rehabilitative Services.
- **Minor Home Modifications**: Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home.
- **Personal Assistant Services (PAS)**: Provides in-home assistance to individuals as authorized on their Individual Service Plan (ISP) with the performance of activities of daily living, household chores and nursing tasks that have been delegated by a registered nurse (RN). PAS is subject to Electronic Visit Verification (EVV). See Section 20 for more details.
- **Respite Care Services**: Available on an emergency or short term basis to relieve those persons normally providing unpaid care for a STAR+PLUS waiver member unable to care for themselves. In-home respite care services are subject to EVV. See Section 20 for details on EVV.
- **Supported Employment**: Service available to members who earn at least minimum wage, that provides employment adaptations, supervision and additional training to sustain employment.
- **Therapy (Occupational, Physical, Speech)**: Includes the evaluation, examination and treatment of physical, functional, speech and hearing disorders and/or limitations. A full range of services are provided in the member's home or a rehabilitative center by a licensed therapist or an assistant under the direction of a licensed therapist.
- **Transitional Assistance Services (TAS)**: Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs

associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings and set-up fees for utilities.

- **Supplemental Transition Services (STS)**: Service offered through Medicaid MCOs to assist members who are transitioning from a Nursing Facility (NF) into the community, along with the support of a home and community-based services program authorized by a 1915(c) or 1115 waiver. Form H1746-A NF resident discharged from the facility into a home and community-based services program is eligible to receive up to $2,500 in STS for assistance with moving and setting up a household. STS is available on a one-time only basis and only after TAS has been exhausted.

Additional Benefits

Adult Well Check

This annual adult physical exam is an additional benefit for STAR+PLUS non-dual members 18 years of age and older. The annual adult well exam may be received in addition to the member's annual OB/GYN visit for females. Members can self-refer to an OB/GYN provider without a referral from their PCP. All newly enrolled members should obtain a well checkup within 90 Days of enrollment.

Medicaid for Breast and Cervical Cancer (MBCC) Program

Effective September 1, 2017, women in the Medicaid for Breast and Cervical Cancer (MBCC) program will receive all of their Medicaid services, including cancer treatment, through a Managed Care Organization that offers STAR+PLUS.

After selecting and transitioning into a STAR+PLUS health plan, women who receive MBCC services will have the same Medicaid benefits they have today. In addition STAR+PLUS members receive:

- Unlimited prescriptions.
- A service coordinator to help them find the right providers for their needs.
- A primary care provider to make sure all of their needs are addressed.
- Value-added Services which are extra services like respite, extra vision services, and health and wellness services.

Women who get MBCC services will have a nurse as their service coordinator. The service coordinator can help:

- Identify and address medical needs
- Understand Medicaid benefits
- Ensure access to needed specialty services
- Coordinate community supports including services that might be non-medical or not covered by Medicaid.

To make sure materials are mailed to the right address, individuals may visit yourtexasbenefits.com or call 2-1-1 to confirm the address on file is correct.

If providers have questions about MBCC services changing to managed care, please email Managed_Care_Initatives@HHS.state.tx.us.

For more information, please visit:

https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-programs-services/medicaid-breast-cervical-cancer-program-managed-care-expansion.

Community First Choice (CFC)

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. The services available under CFC are:

- **Personal Assistance Services (PAS)**: Help with daily living activities and health-related tasks.
- **Habilitation**: Services to help members learn new skills and care for themselves.

- **Emergency Response Services (ERS)**: Help members who live alone or are alone for most of the day.
- **Support Management**: Training to help members learn how to select, manage and dismiss attendants.

Who Can Receive CFC Services?

To be eligible for Community First Choice services through Superior HealthPlan, an individual must:

- Be eligible for Medicaid and enrolled in either STAR+PLUS, STAR Health or STAR Kids.
- Need an institutional level of care such as a hospital, an Intermediate Care Facility (ICF) for Individuals with an Intellectual Disability (IID), nursing facility (NF) or Institution for Mental Disease (IMD).
- Need services provided in the CFC program.

Assessments

- For STAR+PLUS members with physical disabilities, Superior will complete the Medical Necessity Level of Care assessment (MN/LOC) and CFC Assessment. MN/LOC and SK-SAI assessments will be transmitted to TMHP who determines MN for the NF LOC.
- For STAR+PLUS members with an IDD diagnosis or a related condition, the Local Intellectual and Developmental Disability Authority (LIDDA) will complete the Intellectual Disability/Related Condition (ID/RC) assessment and the CFC assessment for members 21 and over. The LIDDA will transmit the ID/RC to HHS who makes the determinations on the ICF LOC.
- All CFC assessments will be person-centered and will result in a plan of care reflecting the needs and goals of the member.
- Assessments will be conducted initially and at least annually.

Authorizations

- Upon completed and approved assessments, a plan of care will be created and presented to the member.
- Member and/or their LAR and/or medical consenter will accept the plan of care and select their providers/ provider agencies for their approved CFC services.
- Superior will create and issue authorizations that will be valid for up to one year from the date of the initial/ annual assessment.
- If a member already receiving PAS becomes eligible for habilitation services, the member may desire to switch to a habilitation-contracted provider if necessary, or decline habilitation services.
- PAS Only:
  - **Members with no identified habilitation service need will select a Superior contracted PAS provider.**
  - **Authorization will utilize the CFC PAS-only codes/modifiers and rate.**
- PAS with HAB:
  - **Members with any identified habilitation service need will select a Superior contracted HAB/PAS provider.**
  - **Must use a single provider for HAB and PAS services.**
  - **Single Authorization will utilize the habilitation codes/ modifiers and rate.**
- HAB Only:
  - **Members with a habilitation service need, but no PAS need, will select a Superior contracted HAB provider.**

  - **Authorization will utilized the habilitation codes/modifiers and rate.**
- Non-CFC PAS and ERS:
  - **Continue to use existing LTSS codes/modifiers and rates.**

CFC Standards

- CFC services must be provided in accordance with HHS rule 1 TAC, Part 15, Chapter 354, Subchapter A, Division 27 and includes the following:
  - **CFC PAS/HAB assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing and acquisition, maintenance and enhancement of skills necessary for the member to accomplish ADLs, IADLs and health-related tasks;**
  - **CFC ERS: Electronic devices to ensure continuity of services and supports; and**
  - **Support Management: Voluntary training on how to select, manage and dismiss attendants.**
- The CFC services must be delivered in accordance with the member's service plan.
- Provider must have current documentation, which includes the member's service plan, ID/RC when applicable, staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable).
- Provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- Provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member which are required to ensure the member's health, safety and welfare. The provider must maintain documentation of this training in the member's record.
- Provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified that a DFPS investigation has begun, through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline at www.txabusehotline.org or 1-800-252-5400.
- Provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- Provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member) or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- Provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- Per the CFR §441.565 for CFC, the provider must ensure that any additional training requested by the member/LAR of CFC PAS/HAB service providers is procured.

- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The provider must adhere to Superior's billing guidelines as outlined in Section 10. In addition, proper procedure codes and CFC modifiers must be used when billing. Furthermore, all attendant services and habilitation providers/provider agencies must use an HHS-approved Electronic Visit Verification (EVV) vendor to submit their timesheets. Additional details about EVV can be found in Section 20.
- The provider must prevent conflicts of interest between themselves, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The provider must prevent financial impropriety toward a member including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.
- Agencies that provide attendant care are required to conduct unannounced home visits to validate services are being rendered and billed correctly.

Cognitive Rehabilitation Therapy (CRT)

CRT is a service that assists an individual in learning or re-learning cognitive skills that have been lost or altered as a result of damage to brain cells/chemistry in order to enable the individual to compensate for the lost cognitive functions. CRT has been proven to help individuals with an acquired brain injury (ABI) recover or compensate for cognitive skills that have been lost or altered as a result of damage to brain cells or brain chemistry.

To qualify for CRT, the services must be deemed medically necessary, the member must be enrolled in the STAR+PLUS HCBS program and have:

- Medicaid eligibility;
- An approved medical necessity/level of care (MN/LOC); and
- A need for at least one HCBS service.

Establishing Medical Necessity for CRT

One of the two following assessment tests must be performed on a qualifying member, and indicate the need for CRT. These tests are a covered benefit.

- Neurobehavioral Assessment - performed by a physician, nurse practitioner or physician assistant.
- Neuropsychological Assessment - performed by a psychiatrist, psychologist, neuro-psychologist or licensed psychological associate.

For dual eligible members receiving acute care through Medicare, Superior will still help establish medical necessity and coordinate the assessment test with the member's Medicare provider.

Providers of CRT

Treatment is provided in an outpatient setting or in the member's home and is overseen by a physician or neuro-psychologist and requires judgment, knowledge and skills of a speech and language pathologist or occupational therapist.

Dental Services

Services provided by a licensed dentist such as dentures, routine cleaning, emergency procedures, preventive care and treatment of injuries are a benefit available to STAR+PLUS waiver members. Services are capped at $5,000 per waiver plan year, but may be extended an additional $5,000 when oral surgeon services are required.

Financial Management Services

Financial Management Services (FMS) are a benefit available to STAR+PLUS waiver members. Certified Financial Management Services Agencies (FMSA) provide assistance to members to manage funds associated with services elected for self-direction and is provided by a Consumer-Directed Service option. The FMSA must meets necessary qualifications to provide financial management services, including completing the mandatory FMSA enrollment training provided by HHS and meeting eligibility requirements for an HHSC FMSA contract. Examples of FMS include, but are not limited to:

- Providing required initial orientation, ongoing training, assistance and support for employer-related responsibilities;
- Verifying qualifications of applicants before services are delivered and monitoring continued eligibility of service providers;
- Approving and monitoring budgets for services delivered through the CDS option;
- Managing payroll, including calculations of employee withholdings and employer contributions and depositing these funds with appropriate agencies (FMSAs are not allowed to use a payroll agent);
- Complying with applicable government regulations concerning employee withholdings, garnishments, mandated withholdings and benefits;
- Preparing and filing required tax forms and reports;
- Paying allowable expenses incurred by the employer;
- Providing status reports concerning the individual's budget, expenditures and compliance with CDS option requirements;
- Responding to the employer or designated representative as soon as possible, but at least within two Business Days after receipt of information requiring a response from the CDS Agency.

Intellectual and Developmental Disabilities (IDD)

Members with Intellectual and Developmental Disabilities (IDD) or Related Conditions (RC) who do not qualify for Medicare, and receive services through the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) Program or an IDD Waiver can receive Acute Care Services through Superior STAR+PLUS or STAR Health. Authorization will be required for applicable medically necessary acute care or behavioral health services managed through Superior.

Note: These individuals will not be eligible for HCBS STAR+PLUS Waiver services while enrolled in the ICF-IID Program or an IDD Waiver.

Prescriptions

Additional Benefits for STAR+PLUS Prescriptions

All STAR+PLUS non-dual members 18 years of age and older receive unlimited prescriptions as part of the Medicaid Managed Care program.

Service Coordination

The Superior Service Coordinator provides a specialized level of care management service that includes but is not limited to:

- Identification of needs, including physical health, mental health services and LTSS services for STAR+PLUS members.
- Development of a Service Plan of Care as appropriate to address those identified needs.
- Assistance to ensure timely and a coordinated access to an array of providers and covered services;

- Facilitate communication/care coordination across medical/behavioral/specialists as appropriate to meet member's unique and holistic needs.
- Coordination of covered services with social and other services delivered outside the benefit plan as necessary and appropriate.
- Conduct mandatory telephonic or face to face contacts.

Service Coordination services provided to members are:

- Review assessments and develop plan of care utilizing input from member, family and providers.
- Coordinate with the member's PCP, Specialist and LTSS providers to ensure the member's health and safety needs are met in the least restrictive setting.
- Refer members to support services such as disease management and community resource.
- Authorize LTSS services.

Service Coordination utilizes a multidisciplinary approach in meeting the member's needs including behavioral health.

Levels of Service Coordination

To provide Service Coordination, we collaborate with the member, caregiver/family and informal supports desired by the member, all treating providers regardless of network status, and community resources.

For each identified member, the Service Coordination team identifies the appropriate level assignment using the following criteria:

- Level 1
  - **Members, including dual eligible, receiving Home and Community-Based Services STAR+PLUS Waiver services and/or with complex medical needs.**
  - **Members who reside in or move from nursing facility/institution to community.**
  - **Members with Serious and persistent mental illness, (SPMI).**
- Level 2
  - **Dual eligible members who do not meet Level 1 criteria.**
  - **Non-Waiver members receiving Personal Assistance Services (PAS), CFC Services or Day Activity and Health Services (DAHS).**
  - **Members with a history of BH and/or substance use issues during the previous year.**
- Level 3
  - **All members who do not meet criteria for Level 1 or 2.**
- Companion Cases
  - **Both members will be assigned the same Service Coordinator at the highest Level of complexity.**

Discharge Planning

The Service Coordinator or Care Manager collaborates in concurrent review with Superior's nurses who follow members while they are in hospital in order to schedule needed assessments and work with the member, family, attending physician, discharge planner, PCP and other relevant providers to coordinate services and equipment required at discharge. If a member was receiving any LTSS prior to admission to a hospital, once a member is discharged, Service Coordination staff notifies LTSS providers to resume services. If an LTSS provider becomes aware of a member that is admitted to a hospital, the provider should alert the Service Coordinator when services cease after the admission and resume once the member returns home from the hospital.

Transition Plan

Superior's Continuity of Care Transition Plan ensures consistent, unduplicated care without disruption for all new

members receiving care at the time of enrollment from in-network and out-of-network providers including, but not limited to: PCPs, specialists, behavioral health (BH), LTSS and home health providers. We identify new members receiving care from out-of-network providers in multiple ways such as: current service files and information from the transferring MCO or HHS, provider authorization requests, completed Health Risk Screening (HRS), outreach to LTSS providers, PCPs, BH and/or other specialty providers not reflected on transfer files, and other member or provider contact or referrals.

Services ordered prior to the member's enrollment, (e.g., medical equipment or supplies or home modifications approved but not completed prior to enrollment), Superior staff contact the provider to ensure the member continues to receive. The Service Coordinator will contact the member to ensure there are no gaps in services. LTSS providers should contact Service Coordination for current service authorizations at the time of enrollment with Superior.

Members entering into a nursing facility will receive an assessment within 30 Days of admission by their Service Coordinator. The Service Coordinator works with the member, family and providers to develop/implement a transition plan that includes necessary community LTSS and transition services. Members interested in transitioning out of the nursing facility will receive an assessment and education regarding the transition process from the Service Coordinator.

Level I and II members are assigned a Service Coordinator upon enrollment. Any member or provider may request a Service Coordinator by calling 1-877-277-9772.

Members receiving Service Coordination are assigned a Service Coordinator and will be provided contact information within five Business Days. Superior will post Service Coordinator assignments to the secure Provider Portal as well as notify the member of any changes. Superior must notify members within five Business Days of the name and phone number of their new Service Coordinator, if their Service Coordinator changes.

Support Consultation Services (SCS)

Support consultation is an optional service offered to STAR+PLUS waiver members who receive services through the Consumer Directed Service (CDS) option. Support consultation, delivered by a HHS-certified support advisor, provides coaching and training for employer-related issues such as interviewing, hiring or managing of providers. Financial management services (FMS) are provided by financial management service agencies (FMSAs). A FMSA must have a sufficient number of certified support advisors available as an independent employee hired by the individual using the CDS option or through a contract to provide services when requested by an employer.

A certified support advisor may provide services as an independent employee or through an entity (not providing other program or Care Management services to the individual receiving services) or through employment or contract with a FMSA. Support consultation may be provided over the phone or in person. An applicant must be able and willing to fulfill the requirements of Texas Administrative Code, Title 40, Part 1, Chapter 41, Consumer Directed Services (CDS).

Support Consultation is not a separate billable service to Superior. If SCS is needed for members who choose the CDS option, it can be built into the member's budget. Providers should refer to the HHS rate analysis for LTSS to determine rates that are allowed to be used for determining the member's budget.

Value-added Services

Superior STAR+PLUS members also have access to other services in addition to Medicaid-covered benefits and services, depending on their health needs. Collectively, this additional coverage is referred to as Value-added Services (VAS). Some of those extra services include:

- A 24-hour nurse advice line staffed by registered nurses.
- Online mental health resources.
- Emergency response services that ensure members have access to emergency help while home alone.

- Access to household, personal care and oral care items.
- Access to dental services such as exams, cleanings and x-rays.
- Extra vision services to help cover the cost of eyeglasses.
- Extra services and benefits for pregnant women.
- Home delivered meals following discharge from a hospital or nursing facility.
- Respite care services to help while a member's family or other unpaid caregiver is taking a break.
- Short-term phone help offering a phone and minutes.

*This not a comprehensive list of all Value-added Services available to members. For the most up-to-date list of services, please visit www.SuperiorHealthPlan.com. Value-added Service may vary based on whether or not a member also has Medicare or HCBS STAR+PLUS Waiver cover, or based on where the member lives. Restrictions and limitations may apply. For more information about these or other extra services, please call 1-877-391-5921.

STAR Kids

Benefits Overview

Medicaid members participating in the STAR Kids program receive all the benefits of the traditional Texas Medicaid program, as listed in Section 4.

Additional benefits include, but may not be limited to, access to telemedicine, telemonitoring and telehealth. For information on how STAR Kids members can access telemedicine, telemonitoring and telehealth, please reference the STAR Kids Provider Directory found at https://www.SuperiorHealthPlan.com/members/medicaid/find-a-provider.html.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Center (PPECC), or a combination of both PDN and PPECC for ongoing skilled nursing. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A client may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided.) The combined total hours between PDN and PPECC services are not anticipated to increase unless there is a change in the client's medical condition or the authorized hours are not commensurate with the client's medical needs. In accordance with 1 Tex. Admin. Code § 363.209(c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary.

Long-Term Service and Supports Services

- **Adaptive Aids:** (STAR Kids MDCP members only): Includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.
- **Community First Choice Services:** Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities, and/or individuals who meet the institutional level of care for an Institution for Mental Disease (IMD).
- **Day Activity and Health Services (DAHS):** (Members 18 years of age and older only): Services include nursing and personal care services, nutrition services, transportation services, social and recreational activities and other supportive services. These services are provided at adult day care facilities licensed by the Department of State Health Services (DSHS) and certified by HHS.

- **Employment Assistance** (STAR Kids MDCP members only): Provides identification of member's preferences, skills and work setting/condition needs, locating available jobs that match the member's criteria/needs and negotiating the member's potential employment with the employer. Please note, Employment Assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
- **Financial Management Services:** Services provided by Certified Financial Management Services Agencies (FMSA) to support members who hire their own service providers under the Consumer Directed Services (CDS) option.
- **Flexible Family Support Services** (STAR Kids MDCP members only): Direct care services needed because of a member's disability, that help a member participate in child care, post-secondary education, employment, independent living, or support a member's move to an independent living situation.
- **Minor Home Modifications** (STAR Kids MDCP members only): Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security and accessibility within their home.
- **Personal Care Services:** Provide assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and health-related tasks through hands-on assistance, supervision or cueing, including nurse-delegated tasks.
- **Private Duty Nursing:** Nursing services for members who meet medical necessity criteria and who require individualized, continuous skilled care beyond the level of skilled nursing visits provided under Texas Medicaid home health services.
- **Respite Care:** (STAR Kids MDCP members only): Direct care services needed because of a member's disability, that provide a primary caregiver temporary relief from care-giving activities when the primary caregiver would usually perform such activities.
- **Supported Employment:** (STAR Kids MDCP members only): Service available to members who earn at least minimum wage that provides employment adaptations, supervision and additional training to sustain employment.
- **Transition Assistance Services:** (STAR Kids MDCP members only): Assists individuals who are discharging from a nursing facility to the community and set up their household. A maximum of $2,500 is available on a one-time basis to help offset the costs associated with setting up their household. Some examples of what TAS money provides payment for are security deposits, moving expenses, essential furnishings, and set-up fees for utilities.

Screening and Assessment Instrument

The STAR Kids Screening and Assessment Instrument (SAI) is a comprehensive tool developed specifically for STAR Kids. The SAI is designed to look at the totality of a member's care and health status, along with any psycho-social needs.

Upon receipt of the member's eligibility, Superior's Service Coordination Team will perform a brief telephonic screening to determine, as closely as possible, what immediate needs and level of Service Coordination the member may require. Upon the completion of the initial screening, the SAI will be scheduled, as applicable.

The SAI will be administered by a trained member of the Service Coordination Team. For members with behavioral health needs, this may include a Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC), or other licensed behavioral health professional. For members requiring specialized medical care, the assessment may require up to four hours to perform and should be performed in the member's home, unless the member/member's LAR request otherwise. Both the member and member's LAR must be present for the assessment.

Service Coordination

All STAR Kids members are placed into a service coordination level (one of three levels based on complexity) and assigned a named Service Coordinator. Members are identified through various ways including, but not limited to, the STAR Kids SAI, clinical rounds, referrals from Superior staff, claims, hospital census and direct from providers or self-referral. The Service Coordinator facilitates the obtaining of capitated and non-capitated services needed by the member.

Refer a member by contacting the Service Coordination Department at 1-844-433-2074.

The Role of the Service Coordinator

The service coordinator will provide:

- Clinical and Non-Clinical Support
  - Identification of member's needs.
  - Referrals/pre-authorizations/certifications.
  - Communicate with doctor and other providers to develop an Individual Service Plan (ISP) to address the unique needs of the member.
  - Conduct mandatory telephonic and/or face to face contacts.
  - Coordinate services with other entities to ensure integration of care (ECI, WIC, DME, Medical Transportation Program, etc.).
- Direct Support
  - Coordinate Care for members with special health-care needs.
    - Refer members to disease management, such as (Asthma, Diabetes, Depression, etc.), as applicable.
    - Conduct complex Care Management.
    - Assist with coordination into any specialty programs.
    - Conduct intellectual and developmental disabilities management.
    - Follow-up and document reported results.
  - Monitor adherence to treatment plan to promote optimum health status
    - Follow-up and document reported results.
  - Coordinate Discharge Planning
    - Collaborates in concurrent review when a member is in the hospital and coordinates services and equipment required at discharge.
  - Assist with Transition Plan
    - Ensures consistent, non-duplicated care without disruption for all new members receiving care at the time of enrollment from in-network and out-of-network providers.
  - Promote best practice/evidence-based services
    - Includes compliance with Psychotropic Medications on utilization standards.
  - Identify and report potential abuse/neglect

Development of the Individual Service Plan (ISP) Narrative

The ISP-Narrative is a regularly updated document developed by working with members, their LAR and other caretakers, and their providers in a person-centered, culturally competent manner. The purpose of the ISP-Narrative is to articulate assessment findings, goals, service needs and member preferences, as well as to measure outcomes over time. ISPs include:

- Summary information describing the recommended service needs identified through the STAR Kids Screening and Assessment Process.
- Covered services currently received.
- Covered services not currently received, but that the member might benefit from.

- A description of non-covered services that could benefit the member.
- Member and family goals and service preferences.
- Natural strengths and supports of the member including helpful family members, community supports or special capabilities of the member.
- With respect to maintaining and maximizing the health and well-being of the member, a description of roles and responsibilities for the member, their LAR, others in the member's support network, key service providers, the member's health home, the MCO, and the member's school (if applicable).
- A plan for coordinating and integrating care between providers and covered and non-covered services.
- Short and long-term goals for the member's health and well-being.
- If applicable, services provided to the member through YES, TxHmL, DBMD, HCS, CLASS or third-party resources, and the sources or providers of those services.
- Plans specifically related to transitioning to adulthood for members age 15 and older.
- Any additional information to describe strategies to meet service objectives and member goals.

Each member's ISP-Narrative is updated:

- At least annually.
- Following a significant change in health condition that impacts service needs.
- Upon request from the member or the member's LAR.
- At the recommendation of the member's PCP.
- Following a change in life circumstance.
- Following the STAR Kids Screening and Assessment Process or re-assessment process.

Levels of Service Coordination

For each STAR Kids member, the Service Coordination team identifies the appropriate level assignment using the following criteria:

Level 1

- MDCP STAR Kids members.
- Members receiving Private Duty Nursing services.
- Members with complex needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members with severe emotional disturbance (SED) or severe and persistent mental illness (SPMI).
  - SED is defined as psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.
  - SPMI is defined as a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:
    - Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
    - Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.

- Members at risk for institutionalization.

All Level 1 members must receive a minimum of four face-to-face Service Coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the member or member's LAR.

Level 2

- Members who do not meet the requirements for Level 1 classification, but receive Personal Care Services (PCS), or Community First Choice (CFC).
- Members that Superior believes would benefit from a higher level of Service Coordination based on results from the STAR Kids Screening and Assessment Instrument (SAI) and additional Superior findings.
- Members with a history of substance use disorder (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function.

All Level 2 members must receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually, unless otherwise requested by the member or member's LAR.

Level 3

Level 3 members include those who do not qualify as Level 1 or Level 2. All Level 3 members must receive a minimum of one face-to-face visit annually and at least three telephonic Service Coordination outreach contacts yearly.

How a Provider Can Access a STAR Kids Member's Service Coordinator

Service Coordination provides the members with initial and ongoing assistance with identifying, selecting, obtaining, coordinating and using covered services and other supports to enhance the member's well-being, independence, integration in the community and potential for productivity. STAR Kids providers can access Service Coordination by calling 1-844-433-2074.

Adult Transition Planning

Superior must help to assure that STAR Kids members receive early and comprehensive transition planning to help prepare them for service and benefit changes that will occur following their 21st birthday. Superior is responsible for conducting ongoing transition planning starting when the member turns 15 years old. Superior must provide transition planning services as a team approach through the named Service Coordinator, if applicable, and with a Transition Specialist. Transition Specialists must be an employee of Superior and wholly dedicated to counseling and educating members and others in their support network about considerations and resources for transitioning out of STAR Kids. Transition Specialists must be trained on the STAR+PLUS system and maintain current information on local and state resources to assist the member in the transition process. Transition planning must include the following activities:

1. Development of a continuity of care plan for transitioning Medicaid services and benefits from STAR Kids to the STAR+PLUS Medicaid managed care model without a break in service.
2. Prior to the age of 10, the MCO must inform the member and the member's LAR regarding LTSS programs offered through HHS and, if applicable, provide assistance in completing the information needed to apply. HHS LTSS programs include CLASS, DBMD, TxHmL and HCS.
3. Beginning at age 15, the MCO must regularly update the ISP with transition goals.
4. Coordination with Texas Workforce Commission (TWC) to help identify future employment and employment training opportunities.

5. If desired by the member or the member's LAR, coordination with the member's school and Individualized Education Plan (IEP) to ensure consistency of goals.
6. Health and wellness education to assist the member with self-management.
7. Identification of other resources to assist the member, the member's LAR, and others in the member's support system to anticipate barriers and opportunities that will impact the member's transition to adulthood.
8. Assistance applying for community services and other supports under the STAR+PLUS program after the member's 21st birthday.
9. Assistance identifying adult healthcare providers.

Member's Right to Designate an OB/GYN (Excludes STAR Kids dual eligible Members):

Superior allows the member to pick any OB/GYN (within the Superior Network), whether that doctor is in the same network as the member's Primary Care Provider or not.

For Female Members

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

Additional Benefits

Pharmacy Prescriptions

All STAR Kids members (who are not covered by Medicare) receive unlimited prescriptions as part of the Medicaid Managed Care program.

Community First Choice (CFC)

Community First Choice (CFC) is a Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities. The services available under CFC are:

- **Personal Assistance Services (PAS)**: Help with daily living activities and health-related tasks.
- **Habilitation**: Services to help members learn new skills and care for themselves.
- **Emergency Response Services (ERS)**: Help members who live alone or are alone for most of the day.
- **Support Management**: Training to help members learn how to select, manage and dismiss attendants.

Who Can Receive CFC Services?

To be eligible for Community First Choice services through Superior HealthPlan, an individual must:

- Be eligible for Medicaid and enrolled in STAR Kids.
- Need an institutional level of care such as a hospital, an Intermediate Care Facility (ICF) for Individuals with an Intellectual Disability (IID), nursing facility (NF) or Institution for Mental Disease (IMD).
- Need services provided in the CFC program.

Assessments

- For STAR Kids members with physical disabilities, Superior will complete the STAR Kids Screening and Assessment Instrument (SK-SAI). The SK-SAI assessment will be transmitted to TMHP who determines MN for the NF LOC. Prior to the assessment transmission to HHS form 2601 is requested and required for all initial assessments or with a significant change-in-status assessment. The form 2601 can be requested, but is not required, for annual reassessments when there are no significant change-in-status assessments.
- For STAR Kids members with an IDD Diagnosis or a related condition, Superior will complete an SK-SAI for all members under 21 who are enrolled in STAR Kids, as well as the Local Intellectual and Developmental Disability Authority (LIDDA) and Intellecutal Disability/Related Condition (ID/RC) assessment. The LIDDA will transmit the ID/RC to HHS who makes the determinations on the ICF LOC.
- All CFC assessments will be person-centered and will result in a service plan reflecting the needs and goals of the member.
- Assessments will be conducted initially and at least annually.

Authorizations

- Upon completed and approved assessments, a service plan will be created and presented to the member.
- Member and/or their LAR will accept the service plan and select their providers/provider agencies for their approved CFC services.
- Superior will create and issue authorizations valid up to one year from the date of the initial/annual assessment.
- If a member already receiving PAS becomes eligible for habilitation services, the member may desire to switch to a habilitation-contracted provider if necessary, or decline habilitation services.
- PAS Only:
  - **Members with no identified habilitation service need will select a Superior contracted PAS provider.**
  - **Authorization will utilize the CFC PAS-only codes/modifiers and rate.**
- PAS with HAB:
  - **Members with any identified habilitation service need will select a Superior contracted HAB/PAS provider.**
  - **Must use a single provider for HAB and PAS services.**
  - **Single Authorization will utilize the habilitation codes/ modifiers and rate.**
- HAB Only:
  - **Members with a habilitation service need, but no PAS need, will select a Superior contracted HAB provider.**
  - **Authorization will utilized the habilitation codes/modifiers and rate.**
- Non-CFC PAS and ERS:
  - **Continue to use existing LTSS codes/modifiers and rates.**

CFC Standards

- CFC services must be provided in accordance with HHS rule 1 TAC, Part 15, Chapter 354, Subchapter A, Division 27 and includes the following:
  - **CFC PAS/HAB assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing and acquisition, maintenance and enhancement of skills necessary for the member to accomplish ADLs, IADLs and health-related tasks;**
  - **CFC ERS: Electronic devices to ensure continuity of services and supports; and**

- **Support Management: Voluntary training on how to select, manage and dismiss attendants.**

- The CFC services must be delivered in accordance with the member's service plan.
- Provider must have current documentation, which includes the member's service plan, ID/RC when applicable, staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable) and nursing assessment (if applicable).
- Provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- Provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member which are required to ensure the member's health, safety and welfare. The provider must maintain documentation of this training in the member's record.
- Provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when, from the time they are notified that a DFPS investigation has begun, through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator, cooperating with the investigation, etc). The program provider must also provide the member/LAR with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline (1-800-647-7418).
- Provider must address any complaints received from a member/LAR and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/LAR with the appropriate contact information for filing a complaint.
- Provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member) or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- Provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/ GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- Per the CFR §441.565 for CFC, the provider must ensure that any additional training requested by the member/LAR of CFC PAS/HAB service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The provider must adhere to Superior's billing guidelines as outlined in Section 10. In addition, proper procedure codes and CFC modifiers must be used when billing. Furthermore, all attendant services and habilitation providers/provider agencies must use an HHS-approved electronic visit verification (EVV) vendor to submit their timesheets. Additional details about EVV can be found in Section 20.
- The provider must prevent conflicts of interest between themselves, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member or service provider could financially benefit.
- The provider must prevent financial impropriety toward a member including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Span of Coverage (Hospital) - Responsibility during a Continuous Inpatient Stay[1]

If a member is disenrolled from a STAR Kids MCO and enrolled in another STAR Kids MCO during an inpatient stay, then the former STAR Kids MCO will pay all facility charges until the member is discharged from the hospital, residential substance use disorder treatment facility, or residential detoxification for substance use disorder treatment facility, or until the member loses Medicaid eligibility. The new STAR Kids MCO will be responsible for all other Covered Services on the Effective Date of Coverage with the STAR Kids MCO.

	Scenario	Hospital Facility Charge	All Other Covered Services
1	Member moves from FFS to STAR Kids	FFS	New MCO
2	Member moves from STAR, STAR Health or STAR+PLUS to STAR Kids	Former MCO	New MCO
3	Member Moves from CHIP to STAR Kids	New MCO	New MCO
4	Adult member moves from STAR Kids to STAR or STAR+PLUS	Former STAR Kids MCO	New STAR or STAR+PLUS MCO
5	Member moves from STAR Kids to STAR Health	Former STAR Kids MCO	New STAR Health MCO
6	Member retroactively enrolled in STAR Kids	New MCO	New MCO
7	Member moves between STAR Kids MCOs	Former MCO	New MCO

[1] This document is not intended to supersede any HHS Contract. This is a reference tool determining the span of coverage limitation. For up to date references, please see the STAR Kids contract.

Value-added Services

Superior STAR Kids members also have access to other services in addition to Medicaid-covered benefits and services, depending on their health needs. Collectively, this additional coverage is referred to as Value-added Services (VAS). Some of those extra services include:

- My Health Pays is a rewards program for members that complete certain health and wellness activities. Rewards include:
  - $20 for members who get their Texas Health Steps checkup within 90 Days of joining Superior.
  - $120 for members birth to 15 months that get all six Texas Health Steps checkups on schedule.
  - $10 for members 18-20 years who get their annual flu shot.
  - $20 for members 18-20 years who get their annual well woman exam (females only).
- $30 every calendar quarter for commonly-used over-the-counter medications through a mail-order program.
- Up to $150 each year for members to enroll into an approved camp.
- Up to eight hours of respite care services each year for members not in the Medically Dependent Children Program (MDCP).
- **In Hidalgo and Nueces service areas only**: Up to 32 hours of respite care services each year for members not in the Medically Dependent Children Program (MDCP).
- $20 gift card and a journal one time per year for members who complete a follow-up appointment within seven Days of leaving an inpatient behavioral health or substance abuse stay.
- Up to 10 Home Delivered Meals per year following discharge from an acute inpatient hospital stay.
- Hypoallergenic Mattress Cover and Pillow Case for members enrolled in Asthma Care Management program

*This not a comprehensive list of all Value-added Services available to members. For the most up-to-date list of services, please visit https://www.SuperiorHealthPlan.com/members/medicaid/value-added-services.html. Restrictions and limitations may apply. For more information about these or other extra services, please call 1-877-391-5921.

STAR Health

The STAR Health program is a statewide managed care program that provides services to Texas foster care children in the Department of Family and Protective Services (DFPS) conservatorship, young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement, young adults aged 18 through the month of their 21st birthday who are Former Foster Care Children or who are participating in the Medicaid for Transitioning Foster Care Youth program and Adoption Assistance or Permanency Care Assistance (AAPCA) members that qualify and choose to remain in STAR Health. Superior is contracted with HHS to provide managed care services for all STAR Health members statewide.

Additional benefits include, but may not be limited to, access to telemedicine, telemonitoring and telehealth. For information on how STAR Health members can access telemedicine, telemonitoring and telehealth, please reference the STAR Health Provider Directory found at https://www.SuperiorHealthPlan.com/members/medicaid/find-a-provider.html.

Benefits Overview

Medicaid members participating in the STAR Health program receive all the benefits of the traditional Texas Medicaid program, as listed in section 4 of this manual.

Prescribed Pediatric Extended Care Centers and Private Duty Nursing

A STAR Health member has a choice of Private Duty Nursing (PDN), Prescribed Pediatric Extended Care Centers (PPECC), or a combination of both PDN and PPECC when receiving ongoing skilled nursing services. PDN and PPECC are considered equivalent services, and must be coordinated to prevent duplication. A member may receive both in the same day, but not simultaneously (e.g., PDN may be provided before or after PPECC services are provided). Per 1 Tex. Admin. Code §363.209 (c)(3), PPECC services are intended to be a one-to-one replacement of PDN hours, unless additional hours are medically necessary.

Long-Term Services and Supports (LTSS)

Superior provides the following benefits:

- **Adaptive Aids**: For STAR Health MDCP members only, includes devices, controls or medically necessary supplies that enable individuals with functional impairments to perform activities of daily living or control the environment in which they live.
- **Community First Choice Services**: Medicaid benefit that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities, and/or individuals who meet the institutional level of care for an Institution for Mental Disease (IMD).
- **Employment Assistance (STAR Health MDCP members only)**: Provides identification of member's preferences, skills and work setting/condition needs, locating available jobs that match the member's criteria/needs and negotiating the member's potential employment with the employer. Please note, Employment Assistance is not available to members receiving services through a program funded by the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.
- **Financial Management Services**: Services provided by Certified Financial Management Services Agencies

(FMSA) to support members who hire their own service providers under the Consumer Directed Services (CDS) option.

- **Flexible Family Support Services (STAR Health MDCP members only)**: Direct care services needed because of a member's disability, that help a member participate in child care, post-secondary education, employment, independent living, or support a member's move to an independent living situation.
- **Minor Home Modifications (STAR Health MDCP members only)**: Includes services that assess the need for, arrange for and provide home modifications and/or improvements to an individual's residence to enable them to reside in the community and to ensure safety, security, and accessibility within their home.
- **Personal Care Services**: Provides assistance with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL) and health-related tasks through hands-on assistance, supervision or cueing, including nurse-delegated tasks.
- **Private Duty Nursing**: Nursing services for members who meet medical necessity criteria and who require individualized, continuous skilled care beyond the level of skilled nursing visits provided under Texas Medicaid home health services.
- **Respite Care (STAR Health MDCP members only)**: Direct care services needed because of a member's disability, that provide a primary caregiver temporary relief from care-giving activities when the primary caregiver would usually perform such activities.
- **Supported Employment: (STAR Health MDCP members only)**: Service available to members who earn at least minimum wage that provides employment adaptations, supervision and additional training to sustain employment.

Providers must verify member eligibility for STAR Health LTSS services by contacting Superior's STAR Health Member Services at 1-866-912-6283.

Court-Ordered Services

Providers are encouraged to contact Superior at the onset of administering Court-Ordered Services. The following process will be followed in regard to Court-Ordered Services.

- Service Coordination staff will obtain a copy of the court order from either the provider or DFPS and will scan it into the Care Management system.
- Superior, in conjunction with HHS and DFPS, will determine who is financially responsible for payment of the Court-Ordered Services.
  - If it is determined that Superior is responsible, an authorization will be created in the Care Management system and a letter will be sent to the provider and DFPS notifying them of the approval.
  - If it is found that Superior is not financially responsible for the Court-Ordered Services (for example if the Court-Ordered Services are not a Medicaid covered service), then the Superior Service Coordination Team will assist in coordinating receipt of the services.

Please fax court orders to Superior's Medical Management Department at 1-866-702-4837.

3 in 30

The 3 in 30 combines three separate, yet critical, tools for assessing the medical, behavioral, and developmental strengths and needs of children and youth entering the DFPS conservatorship. Each assessment is a requirement set forth by Senate Bill 11. Together, the three assessments chart the path for ensuring STAR Health members get the care and services they need at the time they enter foster care.

Under current law, certain STAR Health members are required to undergo an initial medical assessment within three Business Days of entering DFPS care. STAR Health members must also receive a Texas Health Steps Medical Checkup (Texas Health Steps) and the Child and Adolescent Needs and Strengths 2.0 (CANS 2.0) Assessment within the first 30 Days of removal.

The initial 3-Day Medical Exam, along with the Texas Health Steps medical checkup and the CANS 2.0 Assessment, allows DFPS to gain a greater understanding of the needs and strengths of STAR Health members.

3 in 30 Components

3-Day Medical Exam

Senate Bill (SB) 11 (85R) set forth requirements for certain children and youth to receive an initial medical exam within the first three Business Days of entering DFPS conservatorship under certain circumstances. The child's caseworker will indicate if the member requires the 3-Day exam.

3-Day Medical Exam components include:

- Vital Signs:
  - Growth parameters include obtaining weight and height/length for all children and youth and head circumference for children under three years of age.
  - For children older than two years of age, consider calculation of Body Mass Index (BMI) to assess nutritional needs.
- History:
  - Not only do you, as the provider, conduct the 3-Day Medical Exam with the context of the reasons for removal with specific mention of presence or absence of sexual abuse, physical abuse, physical neglect, nutritional neglect, exposure to violence or environmental hazards, but you also obtain a good medical history for the child. Obtain any known past medical history and current concerns, medications, allergies. Specifically, look for signs and symptoms of:
    - Health conditions related to risks reported/documented by DFPS
    - Physical and intellectual disabilities
    - Vision, hearing, communication deficits
    - Mental illness, suicidality, aggression or emotional distress
    - Pregnancy, sexually transmitted infections, substance abuse
- Physical Exam
  - Complete exam, including all body surfaces, with respect to the child or youth's level of distress.
  - Consider child abuse specialist consultation if guidance/assistance is needed, for example, when history or physical indicates concerns for sexual abuse, physical abuse, or failure to thrive. Evaluation of suspected/alleged physical or sexual abuse should follow established protocols.
- Tests:
  - Any laboratory or other tests will be done at your discretion
  - Formal hearing, vision and TB surveillance skin testing in children over one year of age is not required with the initial 3-Day Medical Exam but may be done at the medical professional's discretion.
- Treatment:
  - Medically necessary medications, equipment, patient education, consults/referrals, and/or transfer to higher level of care.
  - If child is a newborn, consider completing Texas Health Steps 3-Day newborn visit.
- Follow-up
  - Provide written communication of follow-up expectations based on medical necessity.
  - Provide written communication of medically necessary equipment or referrals; particularly important if exam is conducted outside of medical home setting.
  - If examiner is a Texas Health Steps provider, schedule follow-up and Texas Health Steps 30-Day visit.

Texas Health Steps Checkup

All children entering DFPS conservatorship must receive a preventive health care visit, known as a Texas Health Steps medical checkup, within 30 Days of entering DFPS conservatorship. These medical checkups are periodic preventive health care services for children enrolled in Medicaid, from birth through 20 years of age.

Texas Health Steps medical checkups include:

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

Providers must adhere to Superior's billing guidelines as outlined in Section 10. In addition, in order for the Texas Health Steps exam to be considered timely, proper procedure codes and Texas Health Steps modifiers must be used when billing. Refer to the Texas Health Steps Quick Reference Guide for the most up to date instructions on billing: http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/THStepsQRG/THSteps_QRG.pdf

Child and Adolescent Needs and Strengths 2.0 (CANS 2.0) Assessment

In accordance with SB 125 (84R), children entering foster care must receive a developmentally-appropriate, comprehensive assessment called the CANS 2.0 Assessment. This assessment is for children three to 17 years of age, and includes a trauma evaluation and interviews with individuals who know the child's needs.

The CANS 2.0 assessment is completed via eCANS, which feeds the assessment to Health Passport, where it can be accessed for future review.

Timing of Components

The 3-Day Medical Exam provides for immediate understanding of the child's medical and mental health status. This exam enables DFPS to obtain the needed medical care and treatment for certain children and youth. Together, the Texas Health Steps Checkup and CANS 2.0 Assessment contribute information within the first 30 Days of care, specifying medical, behavioral, and developmental strengths and challenges. This information can be used to develop the unique service plan for a STAR Health member, which must be presented to the court with jurisdiction over the child's legal case within the first 45 Days of care.

Requirement	Timeline
Three-Day Medical Exam	Within three Business Days of removal
Texas Health Steps Medical Check-Up	Within 30 Days of removal
Child and Adolescent Strengths and Needs Assessment	Within 30 Days of removal and then annually thereafter

For more information or questions on 3 in 30, providers may contact their Superior Account Manager.

Early Childhood Intervention (ECI)

Early Childhood Intervention (ECI) is a statewide program for families with children, birth to three years of age, with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services. Services are provided by a variety of local agencies and organizations across Texas.

If a member has a developmental delay or disability, required identification and referral is needed within two Business Days for the ECI program, or members may need to meet other ECI criteria specific to the program.

Members may have self-referrals to any network ECI provider.

Screening and Assessment Instrument

The STAR Kids Screening and Assessment Instrument (SAI) is a comprehensive tool developed specifically for STAR Kids which is also used for certain members of the STAR Health population. The SAI is designed to look at the totality of a member's care and health status, along with any psycho-social needs and provides understanding of the member's functional needs and limitations.

STAR Health members who are receiving MDCP, CFC, or Personal Care Services (PCS) will receive an assessment initially and at least annually. The SAI is administered by a specially trained member of the STAR Health Service Coordination team. For members requiring specialized medical care, the assessment may require up to four hours to perform and should be performed in the member's home, unless the member/member's Medical Consenter request otherwise. Both the member and member's Medical Consenter must be present for the assessment.

Personal Care Services

Personal Care Services (PCS) are support services provided to members who require assistance with activities of daily living, instrumental activities of daily living and health-related functions because of a disability or chronic health condition. Providers will identify and refer members for personal care services, which will enable the member to live independently in the community rather than in an institutional setting.

To obtain authorization for PCS for STAR Health members, contact Superior at 1-866-912-6283 or call Service Coordination.

PCS is subject to Electronic Visit Verification (EVV). For more information, see Section 20.

Contraceptive Services

Any member in the STAR Health program may request and receive any contraceptive service except sterilization without the consent of the child's parents, caregivers or managing conservator.

Exceptions to Medical Consent Policy

For children under age 18 years who are under the managing conservatorship of DFPS, there are exceptions to the Medical Consent Policy. This includes:

- Withholding or withdrawing life sustaining treatment.
- Abortion.
- Organ donation/anatomical gifts.
- Admission to mental health facility.
- Early Childhood Intervention (ECI) or Independent School District (ISD).
- Drug research program.
- Electroconvulsive Therapy (ECT).
- Aversive conditioning.

Routine, Urgent and Emergent Services

Residential Placement for Children

DFPS often requires medical and/or behavioral health assessments for children in foster care in order to determine an appropriate residential placement for the child. These assessments must be provided within required timeframes to minimize the disruption that children in foster care experience when placed in an inappropriate residential setting. Superior is contractually required to assist DFPS with scheduling appointments for these assessments within either three (3) or five (5) Days of request, depending on the severity of the child's needs.

Providers must assist Superior by prioritizing the scheduling of these appointments so that required timeframes are

met. Providers must also coordinate with Superior to provide the results of the assessments, including diagnosis and recommendations, to DFPS within two (2) Business Days.

The Family Code requires that a comprehensive assessment be administered to every child ages 3-17 who enters conservatorship on or after September 1, 2016. The Child and Adolescent Needs and Strengths (CANS) 2.0 (child welfare) is the required tool for this assessment. Superior must schedule these assessments and ensure their completion within 30 Days of member enrollment. Providers certified in administering the CANS assessment must coordinate with Superior to complete the assessment and provide a diagnostic impression and recommendations within 30 Days of member enrollment.

Non-Covered Supports for Members with Primary Needs

Children with Primary Medical Needs (PMN) are children who cannot live without mechanical supports or the services of others because of non-temporary, life-threatening conditions, including:

- The inability to maintain an open airway without assistance, not including the use of inhalers for asthma.
- The inability to be fed except through a feeding tube, gastric tube or a parenteral route.
- Use of sterile techniques or specialized procedures to promote healing, prevent infection, prevent cross-infection or contamination, or prevent tissue breakdown.
- Multiple physical disabilities including sensory impairments.

The MCO must:

1. Coordinate with DFPS to assist members with PMN during a placement change, to ensure a safe and timely transition.
2. Arrange prior-authorized appropriate non-emergency transportation and supports to members with PMN, which may include the use of an ambulance or provision of skilled nursing services for the duration of transportation.
3. Provide safe assembly and disassembly of the member's DME in conjunction with the provision of these services.
4. In the case of an unplanned or emergent placement change, provide up to a 48-hour observation stay in an inpatient setting when appropriate placement or supports are not immediately in place.

For the purposes of this section, a placement change includes, but is not limited to, a member's initial transition into conservatorship, a member's transition between residences while in conservatorship, or a member's exit out of conservatorship to another residence. A placement change does not include transitioning into or out of an inpatient setting.

CANS (Child and Adolescent Needs and Strengths) 2.0 Assessment

The Texas Child and Adolescent Needs and Strengths (CANS) Comprehensive 2.0 (child welfare) assessment for children ages three to 17 years of age placed in foster care is required within 30 Days of entering DFPS conservatorship, and annually thereafter. The CANS Comprehensive 2.0 (child welfare) assessment means the comprehensive and developmentally appropriate child welfare assessment required by Texas Family Code § 266.012. This assessment is not the same as the CANS assessment facilitated by Local Mental Health Authorities or multi-specialty groups for utilization of Mental Health Rehabilitative Services and Mental Health Targeted Case Management Services. The CANS Comprehensive 2.0 (child welfare) assessment must include a trauma screening and interviews with individuals having knowledge of the child's needs.

Providers are required to become trained and certified in order to administer the CANS Comprehensive 2.0 (child welfare) assessment. Superior requires PCPs have screening and evaluation procedures for the detection and

treatment of, or referral for, any known or suspected behavioral health problems and disorders. Superior will provide training to Network PCPs on:

1. Using the results and recommendations of the Texas CANS Comprehensive 2.0 (child welfare) assessment tool to guide treatment decisions;
2. The MCO's referral process for behavioral health services and clinical coordination requirements for such services; and
3. Coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

For more information, please contact your assigned Superior Account Manager.

Department of Family and Protective Services Reporting

Behavioral health providers and physical health providers who treat a behavioral health condition are responsible for appropriate referrals to DFPS for suspected or confirmed cases of abuse.

To report concerns of abuse, neglect or exploitation of children or people with disabilities contact the Texas Abuse/Neglect hotline at 1-800-252-5400, or www.txabusehotline.org.

Court-Ordered Commitment of Members

A member who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation, must receive the services ordered by that court of competent jurisdiction.

Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Superior cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a Court-Ordered Commitment for members. The member can only appeal the commitment through the court system.

To ensure services are not inadvertently denied, providers must contact Superior and provide telephonic or written clinical information as well as a copy of the court order.

Process

The following process will be followed in regard to Court-Ordered Services:

- Service Coordination staff will obtain a copy of the court order from either the provider or DFPS and will scan it into the Care Management System.
- Superior, in conjunction with HHS and DFPS, will then determine who is financially responsible for payment of the Court-Ordered Services.
  - If it is determined that Superior is responsible, an authorization will be created in the Care Management System and a letter will be sent to the provider and DFPS notifying them of the approval.
  - If it is found that Superior is not financially responsible for the Court-Ordered Services (for example the Court-Ordered Services are not a Medicaid covered service), then the Superior Service Coordination Team will assist in coordinating receipt of the services.

Superior will make best efforts to authorize services from the court order once provided. To ensure accurate claims payment, the provider should call 1-866-218-8263 to verify services are authorized.

Any professional service provided that is part of a court order must be billed with an E9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court-Ordered Services that require authorization or notification per the Superior Prior Authorization list must also have an authorization. Facilities providing court-ordered services

should bill using the appropriate code (8 or 08) in the Source of Admission field of the UB-92 claim form.

In the event that prior authorization is not secured and a court ordered service is denied, the claim can be resubmitted through the reconsideration process and will be reprocessed accordingly with the written clinical or court documentation.

For behavioral health services, the procedures for authorization of continued stay for placement purposes are listed below:

- Extended stay days are used in situations where acute treatment has concluded or medical necessity criteria is no longer met, and the child or youth does not have a secure placement per DFPS.
  - Extended stay days are authorized after verification from DFPS of the continued placement issue and DFPS provides an update on the status of the placement search.
  - Extended stay days are authorized up to a total of 15 Days for non-acute days.
  - Superior is responsible for extended stay days for members that were on STAR Health coverage, no insurance, private insurance or another MCO on date of admission, and are confirmed to have STAR Health coverage prior to starting extended stay days.
  - STAR Health members admitted under Fee for Service (FFS) traditional Medicaid receive extended stay days via TMHP.
- UM staff may transition a member back to acute care days from extended stay days when medical necessity criteria is met and treatment is clinically appropriate.
- The member is eligible for 15 extended stay Days per inpatient hospitalization, not necessarily consecutive days.
  - A member can access extended stay days and then qualify under acute care days and subsequently transition back to placement days as long as it does not exceed a total of 15 extended stays per inpatient hospitalization.
- Exclusions to extended stay days include any one of the following:
  - Members with court commitments longer than 14 Days
  - Member does not meet admission criteria and no acute days have been authorized.

Member's Right to Designate an OB/GYN

Superior allows the member to pick any OB/GYN (within the Superior network), whether that doctor is in the same network as the member's Primary Care Provider or not.

For Female Members

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

Additional Benefits

Prescriptions

All STAR Health Medicaid members receive unlimited medically necessary prescriptions as part of the Medicaid Managed Care program.

Community First Choice (CFC)

Community First Choice (CFC) is a Medicaid benefit for qualifying members that provides services for people with Intellectual and Developmental Disabilities (IDD) and/or physical disabilities and/or individuals who meet the institutional level of care for an Institution for Mental Disease (IMD). The services available under CFC are:

- **Personal assistance services (PAS/PCS)**: Help with daily living activities and health-related tasks.
- **Habilitation**: Services to help members learn new skills and care for themselves.
- **Emergency Response Services (ERS)**: Help members who live alone or are alone for most of the day.
- **Support Management**: Training to help members learn how to select, manage and dismiss attendants.

Who Can Receive CFC Services?

To be eligible for Community First Choice services through Superior HealthPlan, an individual must:

- Be eligible for Medicaid and enrolled in STAR Health.
- Need an institutional level of care such as a hospital, an Intermediate Care Facility (ICF) for Individuals with an Intellectual Disability (IID), nursing facility (NF) or Institution for Mental Disease (IMD).
- Need services provided in the CFC program.

Assessments

- For STAR Health members with the MDCP waiver, PCS or CFC, Superior will complete the STAR Kids Screening and Assessment Instrument (SK-SAI) when indicated. The SK-SAI assessments will be transmitted to TMHP who determines Medical Necessity (MN).
- For STAR Health members with an IDD Diagnosis or a related condition, the Local Intellectual and Developmental Disability Authority (LIDDA) will complete the Intellectual Disability/Related Condition (ID/RC) and CFC assessments. The LIDDA will transmit the ID/RC to HHS who makes the determinations on the ICF LOC and Superior will be notified. For members who are under 21 years and enrolled in STAR Health, Superior will complete an SK-SAI assessment to determine functional need.
- For STAR Health members with a Serious Emotional Disturbance (SED) or Severe and Pervasive Mental Illness (SPMI), the Local Mental Health Authority or comprehensive mental health provider will complete the Child and Adolescent Needs and Strengths (CANS) 2.0 Assessment or the Adult Needs and Strengths Assessment (ANSA). If a member assesses into Level of Care (LOC) 4 and is under 21 years of age, the LMHA or provider will notify Superior. When indicated, Superior will complete an SK-SAI assessment to determine functional need.
- All CFC assessments will be person-centered and will result in a plan of care reflecting the needs and goals of the member.
- Assessments will be conducted initially and at least annually.

Authorizations

- Upon completed and approved assessments, a plan of care will be created and presented to the member.
- The member and/or their LAR and/or medical consenter will accept the plan of care and select their providers/ provider agencies for their approved CFC services.

- Superior will create and issue authorizations that will be valid for up to one year from the date of the initial/ annual assessment.
- If a member already receiving PAS becomes eligible for habilitation services, the member may desire to switch to a habilitation-contracted provider if necessary, or decline habilitation services.
- Providers must verify authorization for STAR Health LTSS services by contacting Superior's STAR Health Member Services at 1-866-912-6283.
- PAS Only:
  - Members with no identified habilitation service need will select a Superior contracted PAS provider.
  - Authorization will utilize the CFC PAS-only codes/modifiers and rate.
- PAS with HAB:
  - Members with any identified habilitation service need will select a Superior contracted HAB/PAS Provider.
  - Must use a single provider for HAB and PAS services.
  - Single Authorization will utilize the habilitation codes/ modifiers and rate.
- HAB Only:
  - Members with a habilitation service need but no PAS need will select a Superior contracted HAB provider.
  - Authorization will utilized the habilitation codes/modifiers and rate.
- Non-CFC PAS and ERS:
  - Continue to use existing LTSS codes/modifiers and rates.

CFC Standards

- CFC services must be provided in accordance with HHS rule 1 TAC, Part 15, Chapter 354, Subchapter A, Division 27 and includes the following:
  - CFC PAS/HAB assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) through hands-on assistance, supervision, and/or cueing and acquisition, maintenance and enhancement of skills necessary for the member to accomplish ADLs, IADLs and health-related tasks;
  - CFC ERS: Electronic devices to ensure continuity of services and supports; and
  - Support Management: Voluntary training on how to select, manage and dismiss attendants.
- The CFC services must be delivered in accordance with the member's service plan.
- Provider must have current documentation, which includes the member's service plan, ID/RC when applicable, staff training documentation, service delivery logs (documentation showing the delivery of the CFC services), medication administration record (if applicable), and nursing assessment (if applicable).
- Provider must ensure that the rights of the members are protected (e.g., privacy during visitation, to send and receive sealed and uncensored mail, to make and receive telephone calls, etc.).
- Provider must ensure, through initial and periodic training, the continuous availability of qualified service providers who are trained on the current needs and characteristics of the member being served. This includes the delegation of nursing tasks, dietary needs, behavioral needs, mobility needs, allergies and any other needs specific to the member which are required to ensure the member's health, safety and welfare. The provider must maintain documentation of this training in the member's record.
- Provider must ensure that the staff members have been trained on recognizing and reporting acts or suspected acts of abuse, neglect and exploitation. The program provider must also show documentation regarding required actions that must be taken when from the time they are notified that a DFPS investigation has begun through the completion of the investigation (e.g., providing medical and psychological services as needed, restricting access by the alleged perpetrator,

cooperating with the investigation, etc). The program provider must also provide the member/Medical Consenter with information on how to report acts or suspected acts of abuse, neglect and exploitation and the DFPS hotline (1-800-647-7418).

- Provider must address any complaints received from a member/Medical Consenter and have documentation showing the attempt(s) at resolution of the complaint. The program provider must provide the member/Medical Consenter with the appropriate contact information for filing a complaint.
- Provider must not retaliate against a staff member, service provider, member (or someone on behalf of a member), or other person who files a complaint, presents a grievance, or otherwise provides good faith information related to the misuse of restraint, use of seclusion, or possible abuse, neglect or exploitation.
- Provider must ensure that the service providers meet all of the personnel requirements (age, high school diploma/GED OR competency exam and three references from non-relatives, current Texas driver's license and insurance if transporting, criminal history check, employee misconduct registry check, nurse aide registry check, OIG checks). For CFC ERS, the program provider must ensure that the provider of ERS has the appropriate licensure.
- Per the CFR §441.565 for CFC, the provider must ensure that any additional training requested by the member/Medical Consenter of CFC PAS/HAB service providers is procured.
- The use of seclusion is prohibited. Documentation regarding the appropriate use of restrictive intervention practices, including restraints must be maintained, including any necessary behavior support plans.
- The provider must adhere to Superior's billing guidelines as outlined in Chapter 10 of this manual. In addition, proper procedure codes and CFC modifiers must be used when billing. In addition, all attendant services and habilitation providers/provider agencies must use an HHS-approved electronic visit verification (EVV) vendor to submit their timesheets. Additional details about EVV can be found in Section 20.
- Provider must prevent conflicts of interest between themselves, a staff member, or a service provider and a member, such as the acceptance of payment for goods or services from which the program provider, staff member, or service provider could financially benefit.
- The provider must prevent financial impropriety toward a member including unauthorized disclosure of information related to a member's finances and the purchase of goods that a member cannot use with the member's funds.

Intellectual and Developmental Disabilities (IDD)

Members with Intellectual and Developmental Disabilities (IDD) or Related Conditions (RC) who do not qualify for Medicare, and receive services through the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) Program or an IDD Waiver can receive Acute Care Services through Superior STAR Health. Authorization will be required for applicable medically necessary acute care services managed through Superior as well as for any behavioral health services managed through Superior.

Service Coordination

Service Coordination is available to all STAR Health members. STAR Health physical and behavioral health service coordinators and managers support health treatment providers by facilitating communication between all members of a child/youth's treatment team.

All STAR Health members are stratified into a service coordination level (one of three levels based on complexity) and assigned a named Service Coordinator. The member's appropriate service coordination level is determined using all available information including, but not limited to, evaluation, assessment, stratification reporting, claims, hospital census, information from DFPS/CBC, provider information or member/caregiver information. The Service Coordinator facilitates the access to, and utilization of capitated and non-capitated services needed by the member.

The Role of the Service Coordinator

STAR Health Service Coordinators are responsible for assisting members, Medical Consenters, Caregivers and DFPS/CBC staff with:

- Facilitating access to Covered Services, including scheduling appointments.
- Expediting the scheduling of screenings and assessments used to determine residential placements.
- Clarifying information regarding navigating the Prior Auth (PA), complaints, appeals, and State Fair Hearings processes.
- Ensuring providers respond timely to requests for medical information or supporting documentation needed for court hearings, PA, or to populate Health Passport records.
- Facilitating the inclusion of updated information in member's Health Passport from healthcare providers demonstrating adherence to services listed on the ISP.
- Coordinating the sharing of health information between providers, specialists, and other programs, such as ECI.
- Identification of members suspected of having an SED/SPMI and arranging for a Texas CANS 2.0 assessment by a comprehensive provider.
- Provision of information as requested by DFPS staff to facilitate development of the DFPS plan of care, preparation for court hearings, and participation upon request in DFPS Family Group Conferences (FGCs).
- Encouraging Behavioral Health (BH) providers to use EBPs and promising practices and confirming that a member's BH providers and PCPs are sharing information.
- Serving as a Member Advocate.
- Conducting outreach to members that are preparing to transition out of SH referring these members to the Transitioning Youth Program (TYP) and developing a transition plan.

Since children in foster care have diverse and unique needs, STAR Health developed specialized Service Coordination programs to address those needs. Specialized programs include:

- Physical health programs focusing on members with diabetes, asthma or obesity as well as those with complex medical needs.
- Behavioral health programs targeting members with intellectual and developmental disabilities, ADHD, depression, youth transitioning out of foster care and members with behavioral complex needs.

Physical and behavioral health service coordinators coordinate to ensure that all needs of each child are addressed. This collaboration is supported through close work and frequent communication between the physical and behavioral STAR Health teams. This allows for joint service planning to occur with greater ease to better support children, youth and caregivers in foster care.

The member's PCP medical home maintains responsibility for the member's ongoing health-care needs. Superior's service coordinators support the physician by tracking compliance with the Health Care Service Plan, and facilitating communication between the PCP and other members of the care management team. The service coordinators also facilitate referrals and linkages to available community resources and providers, such as specialty services, local health departments and school-based clinics.

A service coordinator assesses the member to learn more about their unique needs and whether coordination of services will result in more appropriate and cost-effective care through development of a service plan. During this assessment, member information is obtained from the member or medical consenter, attending physician and other health-care providers.

Individual Service Plan (ISP)

The purpose of the ISP is to articulate assessment findings, short- and long-term goals, service needs, and member

preferences. The ISP is used to communicate and help align expectations between the member, medical consenter, DFPS staff, STAR Health and key providers. The ISP is used to measure member outcomes over time.

How a Provider Can Access a STAR Health Member's Service Coordinator

Collaboration with a member's providers is very important to the success of the service coordination process. STAR Health Service Coordinators welcome contact with providers. Providers may contact the member's assigned Service Coordinator through Member Services by calling 1-866-912-6283, or by accessing their direct phone number which can be found on Health Passport.

Value-added Services

Superior STAR Health members have access to other services in addition to Medicaid-covered benefits and services, depending on their health needs. Collectively, this additional coverage is referred to as Value-added Services (VAS).

Some of those extra services include:

- Expanded vision benefits.
- Over-the-counter items.
- Sports/camp physicals.
- Care grants.
- My Health Pays Program.
- Gift card/journal after a behavioral health inpatient stay.

For an up-to-date list of these services, go to www.SuperiorHealthPlan.com. For more information about these or other extra services, please call 1-877-391-5921.

CHIP

Superior is required to provide specific medically necessary services to its CHIP members, as designated in the CHIP member handbook that is provided to every CHIP member. These medically necessary health services must be:

- Furnished in the most appropriate and least restrictive setting in which services can be safely provided.
- Provided at the most appropriate level or supply of service which can be safely provided, and could not be omitted without adversely affecting the member's physical health or quality of life.

There is no lifetime maximum on benefits; however, enrollment period (a 12-month period) or limitations apply to certain services, as specified in the listings on the following pages. Superior will not impose any pre-existing condition limitations or exclusions, or require evidence of insurability to provide coverage to any CHIP-eligible member.

Some members may have copayments and in this case, copayments apply until the member reaches their annual cost-sharing maximum. Some CHIP members might have additional group or individual coverage available to them. When this occurs, Superior will coordinate benefits as the secondary insurance payer.

CHIP members are eligible to receive an unlimited number of prescriptions per month, and may receive up to a 90-Day supply of drugs.

Member's Right to Designate an OB/GYN

Superior allows the member to pick any OB/GYN (within the Superior network), whether that doctor is in the same

network as the member's Primary Care Provider or not.

For Female Members

Members have the right to pick an OB/GYN without a referral from their Primary Care Provider. An OB/GYN can give the member:

- One well-woman checkup each year.
- Care related to pregnancy.
- Care for any female medical condition.
- A referral to a specialist doctor within the network.

Benefits Overview

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing

The following information is the benefits table for CHIP and CHIP Perinate newborn members.

Type of Benefit	Description of Benefit	Limitations	Copay
Inpatient General Acute and Inpatient Rehabilitation	Services include, but are not limited to, the following: · Hospital-provided Physician or provider services · Semi-private room and board (or private if medically necessary as certified by attending) · General nursing care · Special duty nursing when medically necessary · ICU and services · Patient meals and special diets · Operating, recovery and other treatment rooms · Anesthesia and administration (facility technical component) · Surgical dressings, trays, casts, splints · Drugs, medications and biologicals · Blood or blood products that are not provided free-of charge to the patient and their administration · X-rays, imaging and other radiological tests (facility technical component) · Laboratory and pathology services (facility technical component) · Machine diagnostic tests (EEGs, EKGs, etc.) · Oxygen services and inhalation therapy · Radiation and chemotherapy · Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. · Hospital, physician and related medical services, such as anesthesia, associated with dental care · Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. · Surgical implants · Other artificial aids including surgical implants · Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. · Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit · Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	· Requires authorization for non-emergency care and care following stabilization of an emergency condition. · Requires authorization for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by cesarean section.	Applicable level of inpatient copay applies.

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	Description of Benefit	Limitations	Copay

Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	• Requires authorization and physician prescription. • 60 Days per 12-month period limit.	Copays do not apply.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services - Radiation and chemotherapy • Blood or blood products that are not provided free-of charge to the patient and the administration of these products. • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Outpatient services provided at an outpatient hospital and ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • Implantable devices are covered under Inpatient and outpatient services and do not count towards the DME 12-month period limit • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic skeletal and/or congenital - craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	May require prior authorization and physician prescription.	• Applicable level of co-pay applies to prescription drug services. • Co-pays do not apply to preventive services or outpatient services.

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	**Description of Benefit**	**Limitations**	**Copay**
Physician/ Physician Extender Professional Services (continued)	• Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: - cleft lip and/or palate; or - severe traumatic skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	May require authorization for specialty services.	• Applicable level of copay applies to office visits. • Copays do not apply to preventive services.
Prenatal care and pre-pregnancy family services and supplies	• Covered, unlimited prenatal care and medically necessary care related to diseases, illness or abnormalities related to the reproductive system, and limitations and exclusions to these services are described under inpatient, outpatient and physician services.	Primary and preventive health benefits do not include pre-pregnancy family reproductive services and supplies, or prescription medications prescribed only for the purpose of primary and preventive reproductive health care.	Copays do not apply.
Birthing Center Services	Covers birthing services provided by a licensed birthing center.	• Limited to facility services (e.g., labor and delivery). • Applies only to CHIP members.	None
Services rendered by a Certified Nurse Midwife or physician in a licensed birthing center.	• Covers prenatal services and birthing services rendered in a licensed birthing center. • CHIP perinate newborn members: Covers services rendered to a newborn immediately following delivery.	• Limited to facility services (e.g., labor and delivery). • Applies only to CHIP members.	None

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	**Description of Benefit**	**Limitations**	**Copay**
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetic, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements.	• Requires prior authorization and physician prescription. • $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).	Copays do not apply.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	• Requires prior authorization and physician prescription. • Services are not intended to replace the child's caretaker or to provide relief for the caretaker. • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. • Services are not intended to replace 24-hour inpatient or skilled nursing facility services.	Copays do not apply.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • When inpatient psychiatric services are ordered under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the The court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • Does not require PCP referral	• Requires prior authorization for non-emergency services. • Does not require Primary Care Provider referral. • When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Copays do not apply.

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	**Description of Benefit**	**Limitations**	**Copay**
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Neuropsychological and psychological testing (visits can be furnished in a variety of community-based settings [including school and home-based] or in a state-operated facility) • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial ospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • When outpatient psychiatric services are ordered under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division • 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education and crisis services • Does not require PCP referral	• May require prior authorization. • Does not require Primary Care Provider referral. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility. • When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. • A Qualified Mental Health Professional Provider – Community Services (QMHP-CS), as is defined and credentialed by the Texas Department of State Health Services (DSHS) in standards (T.A.C.Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(31). QMHP-CSs are providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs are a Local Mental Health Authorities Provider. A QMHP must be working under the authority of a DSHS entity, be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. QMHPs are acceptable providers as long as the services are within the scope of the services that are typically provided by OMHPs. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education and crisis services.	Copays do not apply.
Inpatient and Residential Substance Use Disorder Treatment Services	Services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral	• Requires prior-authorization for non-emergency services. • Does not require Primary Care Provider referral.	Copays do not apply.

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	**Description of Benefit**	**Limitations**	**Copay**
Outpatient Substance Use Disorder Treatment Services	Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per Day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services and life skills training • Does not require PCP referral	• May require prior authorization. • Does not require Primary Care Provider referral.	Copays do not apply.
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: - Physical, occupational and speech therapy - Developmental assessment	Requires prior authorization and physician prescription.	Copays do not apply.
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness • Up to a maximum of 120 Days with a six month life expectancy • Patients electing hospice services may cancel this election at anytime • Services apply to the hospice diagnosis	• Requires authorization and physician prescription. • Services apply to the hospice diagnosis. • Up to a maximum of 120 Days with a six month life expectancy. • Patients electing hospice services may cancel this election at anytime.	Copays do not apply.
Emergency Services, including Emergency Hospitals, Physicians and Ambulance Services	Superior does not require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, seven days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, removal of cysts, and treatment relating to oral abscess of tooth or gum origin.	Requires authorization for post-stabilization services.	Applicable copays apply to non-emergency ER visits. (Facility only).
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Requires authorization.	Copays do not apply.

CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing			
Type of Benefit	**Description of Benefit**	**Limitations**	**Copay**
Vision Benefit	Superior may reasonably limit the cost of the frames/lenses. Services include: · One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization · One pair of non-prosthetic eyewear per 12-month period	· Superior may reasonably limit the cost of the frames/lenses. · Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.	Applicable levels of copay applies to office visits billed for refractive exam.
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	· Requires authorization for 12 visits per 12-month period limit (regardless of number of services or modalities provided in one visit). · Requires authorization for additional visits.	Applicable level of copay applies to chiropractic office visits.
Tobacco cessation	Covered up to $100 for a 12-month period limit for a plan-approved program · Superior defines plan-approved program. · May be subject to formulary requirements.	· Does not require authorization · Health plan defines plan-approved program. · May be subject to formulary requirements.	Copays do not apply.
Care management and care coordination services	These services include outreach, Care Management, care coordination and community referral.		
Drug Benefits	Services include, but are not limited to, the following: · Outpatient drugs and biologicals; including pharmacy dispensed and provider-administered outpatient drugs and biologicals; and · Drugs and biologicals provided in an inpatient setting.	Some drug benefits require prior authorization.	Applicable level of copay applies for pharmacy dispensed drug benefits.
Value-added Services	· 24-hour nurse advice line · Extra vision services · School/sports physical	Does not require authorization.	Copays do not apply.

CHIP and CHIP Perinate Newborn Exclusions from Covered Services

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e., cannot be prescribed for family planning).
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient and other articles which are not required for the specific treatment of sickness or injury.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court , other than a court of competent jurisdiction pursuant to the Texas Health and Safety Code Chapters 573, Subchapters Band C, 574, Subchapter D or 462, Subchapter D and Texas Family Code Chapter 55, Subchapter D.

- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Superior.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Dental devices solely for cosmetic purposes.
- Out-of-network services not authorized by Superior except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by Superior.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor.
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping.
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities.
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training and vision therapy.
- Reimbursement for school-based physical therapy, occupational therapy or speech therapy services are not covered except when ordered by a physician/PCP.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ when the recipient is not covered under Superior.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam and American Samoa).

CHIP DME Supplies

Note: DME supplies are not a covered benefit for CHIP Perinate members (unborn child), with the exception of a limited set of disposable medical supplies, published at https://www.txvendordrug.com/, when they are obtained from an authorized pharmacy provider.

CHIP and CHIP Perinate Newborn DME and Supplies

Supplies	Covered	Excluded	Comments/Member Contract Provisions
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency, it is covered as an incidental supply.
Alcohol, Rubbing		X	Over-the-counter supply.
Alcohol, Swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age four or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X		For covered DME items.
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for the treatment of craniofacial anomalies, requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age four or over, and only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment and tape. Many times these items are dispensed in a kit which includes all necessary items for one dressing site change.

CHIP and CHIP Perinate Newborn DME and Supplies			
Supplies	**Covered**	**Excluded**	**Comments/Member Contract Provisions**
Dressing Supplies/ Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/ Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery.
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease.
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease (expected to last longer than 60 Days when prescribed by the physician and authorized by Superior.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder • Dysphagia that results in a medical need for a liquid diet • Presence of a gastrostomy, or • Disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than 12 months of age unless medical necessity is documented and other criteria, listed above, are met Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age four or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.

CHIP and CHIP Perinate Newborn DME and Supplies			
Supplies	**Covered**	**Excluded**	**Comments/Member Contract Provisions**
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/ Diabetic			See Diabetic Supplies.
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/ Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal.
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps and lotions.
Parenteral Nutrition/ Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when Superior has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: • when used to dilute medications for nebulizer treatments • as part of covered home care for wound care • for indwelling urinary catheter irrigation
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, tubes, ties, holders, cleaning kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter and Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the Primary Care Provider and approved by Superior.
Urinary, Indwelling Catheter and Supplies	X		Covers catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Covers supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

CHIP Perinatal

Covered CHIP Perinatal services must meet the definition of medically necessary covered services. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Copays do not apply to CHIP Perinatal members. CHIP Perinate newborn members are eligible for 12-months continuous coverage following enrollment in the program.

A newborn born to a perinatal mother whose financial status is at or below the Medicaid eligibility threshold (Category A on ID card) may be enrolled in Medicaid if they qualify.

Babies born to perinatal members who are above the Medicaid eligibility threshold (Category B on ID card) will be enrolled with Superior as a CHIP Perinate newborn. The newborn's CHIP Perinate newborn continues for 12 months from the date of the mother's initial CHIP Perinatal enrollment.

The following information is the benefits table for CHIP Perinatal members.

CHIP Perinatal Schedule of Benefits

Type of Benefit	Description of Benefit
Inpatient General Acute and Inpatient Rehabilitation	For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with income above the Medicaid eligibility threshold (Perinates who do not qualify for Medicaid once born), benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related to miscarriage or a non-viable pregnancy. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • dilation and curettage (D&C) procedures; • appropriate provider-administered medications; • ultrasounds, and • histological examination of tissue samples.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	• Not a covered benefit
Birthing Center Services	• Applies only to CHIP Perinate Members (unborn child) with income above the Medicaid eligibility threshold (who will not qualify for Medicaid once born). • Covers birthing services provided by a licensed birthing center. • Limited to facility services related to labor with delivery.

CHIP Perinatal Schedule of Benefits	
Type of Benefit	**Description of Benefit**
Services Rendered by a Certified Nurse Midwife or physician in a licensed birthing center	Covers prenatal services, birthing services, and services rendered to a newborn immediately following delivery in a licensed birthing center. Prenatal services subject to the following limitations: • Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: 1. One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; 2. One (1) visit every (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and 3. One (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review. Visits after the initial visit must include: • Interim history (problems, marital status, fetal status); • Physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and • Laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy, multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (including health center) and Ambulatory Health Care Center	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs. • Outpatient services associated with (a) miscarriage or (b) a nonviable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider administered medications; - ultrasounds, and - histological examination of tissue samples. (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age confirmation or miscarriage or nonviable pregnancy. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. (5) Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit.

CHIP Perinatal Schedule of Benefits	
Type of Benefit	**Description of Benefit**
Physician/Physician Extender Professional Services	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth • Physician office visits, inpatient and outpatient services • Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation • Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. - Administration of anesthesia by Physician (other than surgeon) or CRNA - Invasive diagnostic procedures directly related to the labor with delivery of the unborn child. - Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) • Hospital-based Physician services (including Physician performed technical and interpretive components) • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis and FIUT. • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Professional services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider administered medications; - ultrasounds, and - histological examination of tissue samples
Prenatal care and pre-pregnancy family services and supplies	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; (2) one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and (3) one (1) visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and two (2) postpartum visits (maximum within 60 Days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: • interim history (problems, marital status, fetal status); • physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and • laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Rehabilitation services	Not a covered benefit
Hospice care services	Not a covered benefit
Emergency services, including emergency hospitals, physicians and ambulance services	Superior does not require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent lay person definition of emergency health condition. • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. • Emergency ground, air and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit. • Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Not a covered benefit
Vision benefit	Not a covered benefit
Chiropractic services	Not a covered benefit

CHIP Perinatal Schedule of Benefits	
Type of Benefit	**Description of Benefit**
Tobacco cessation	Not a covered benefit
Care management and care coordination services	Covered benefit - these services include outreach, Care Management, care coordination and community referral.
Drug benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider-administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting Services must be medically necessary for the unborn child.
Value-added services	• 24-hour nurse advice line. • Start Smart for Your Baby, a special program that includes birthing classes, Care Management and baby showers.
Home and Community Health Services	Not a covered benefit
Inpatient Substance Use Disorder Treatment Services	Not a covered benefit
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	Not a covered benefit (With the exception of a limited set of disposable medical supplies, published at http://www.txvendordrug.com/formulary/limited-hhs.shtml and only when they are obtained from a CHIP-enrolled pharmacy provider.)
Outpatient Mental Health Services	Not a covered benefit
Inpatient Mental Health Services	Not a covered benefit

CHIP Perinate Exclusions from Covered Services

- For CHIP Perinates in families with income at or below the Medicaid eligibility threshold (Perinates who qualify for Medicaid once born), inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
- Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning).
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, services related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies, with the exception of a limited set of disposable medical supplies, published at https://www.txvendordrug.com/formulary/home-health-supplies, when they are obtained from an authorized pharmacy provider.
- Home and Community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance use disorder treatment services and residential substance abuse treatment services.
- Outpatient substance use disorder treatment services.
- Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.

- Tobacco Cessation Programs.
- Chiropractic services.
- Medical transportation not directly related to labor or threatened labor, miscarriage or nonviable pregnancy and/or delivery of the covered unborn child.
- Personal comfort items including, but not limited to, personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community.
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Coverage while traveling outside of the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam and American Samoa).
- Mechanical organ replacement devices including, but not limited to artificial heart.
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery.
- Prostate and mammography screening.
- Elective surgery to correct vision.
- Gastric procedures for weight loss.
- Cosmetic surgery/services solely for cosmetic purposes.
- Out-of-network services not authorized by Superior except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity.
- Medications prescribed for weight loss or gain.
- Acupuncture services, naturopathy and hypnotherapy.
- Immunizations solely for foreign travel.
- Routine foot care such as hygienic care.
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
- Corrective orthopedic shoes.
- Convenience items.
- Over-the-counter medications.
- Orthotics primarily used for athletic or recreational purposes.
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel).
- Housekeeping.
- Public facility services and care for conditions that federal, state or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse.
- Vision training, vision therapy or vision services.
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services.
- Donor non-medical expenses.
- Charges incurred as a donor of an organ.

CHIP Copay Requirements

Federal Poverty Level (FPL)	Office Visits (Non-preventive)	Non-Emergency ER	Generic Drug	Brand Drug	Facility Co-pay, Inpatient (Per Admission)	Cost-sharing Cap
At or below 151%	$5	$5	$0	$5	$35	5% of family income**
Above 151% up to and including 186%	$20	$75	$10	$25 for insulin, $35 for all other drugs***	$75	5% of family income**
Above 186% up to and including 201%	$25	$75	$10	$25 for insulin, $35 for all other drugs***	$125	5% of family income**

*Per 12-month term of coverage. **Per 12-month term of coverage. ***Copays for insulin cannot exceed $25 per prescription for a 30-day supply, in accordance with Section 1358.103 of the Texas Insurance Code.

Co-payments do not apply, at any income level, to:

1. Well-baby and well-child care services, as defined by 42 C.F.R. §457.520;
2. Preventative services, including immunizations;
3. Pregnancy-related services;
4. Native Americans or Alaskan Natives;
5. CHIP Perinatal Members (Perinates (unborn children) and Perinate Newborns);
6. Outpatient office visits for mental health (MH) and substance use disorder (SUD) services and MH/SUD residential treatment services, in accordance with 42 CFR §457.496(d)(2).

Additional Benefits

Value-added Services

Superior CHIP members also have access to other services in addition to CHIP-covered benefits and services. These additional benefits are Value-added Services (VAS).

For an up-to-date list of Value Added Services, go to www.SuperiorHealthPlan.com. For more information about these services, please call Member Services at 1-800-783-5386.

Service Coordination

Service Coordination is available to CHIP members identified with Special Health Care Needs (MSCHN). CHIP physical and behavioral health service coordinators ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs to appropriate for the treatment of Members with Special Health Care Need's conditions. The CHIP service coordination team develop a service plan a will work and ensure access to treatment by a multidisciplinary team when necessary. The Service Coordinator will work with members, their family or community supports, doctor(s), and other providers to:

- Identify their needs.
- Help make sure members receive their services on time.

- Make sure they choose providers and access covered services.
- Coordinate Superior-covered services with social and community support services.
- Coordinate Non-capitated Services and enlist the involvement of community organizations that could provide non-covered services for the overall health and well-being of our members.
- Conduct complex Care Management.
- Refer members to disease management.
- Coordinate Discharge Planning.
- Assist with Transition Plan.
- Promote best practice/evidence-based services.
- Identify and report potential abuse/neglect.

Development of the Individual Service Plan (ISP) Narrative

The ISP-Narrative is a regularly updated document developed by working with the member, their LAR and other caretakers, and their providers in a person-centered, culturally competent manner. The Service Plan includes but is not limited to the following.

- The member's history;
- The member's service preferences;
- Short-term and long-term goals,
- Member's strengths and supports;
- A summary of the members' current medical and social needs and concerns
- List of covered benefits and frequency
- Description of services
- List of non-covered services, community support, and other resources

Each member's ISP-Narrative is updated:

- At least bi-annually for AAPCA and annually for MSHCN.
- Following a significant change in a health condition that impacts service needs.
- Upon request of the member or the member's LAR.

SECTION 5
TEXAS HEALTH STEPS

Texas Health Steps is a 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 the age of 21. Superior is committed to the health and wellness of each member and encourages providers to follow the steps outlined in this section when providing preventive health services to Superior members.

Superior's goal is to have a preventive health visit with a Texas Health Steps enrolled provider within 90 Days of a new member's enrollment in the plan, and for every existing Superior member to have a preventive health visit in accordance with the periodicity guidelines.

STAR Health (foster care) members are subject to the following requirements:

- All children newly enrolled in the STAR Health program need a Texas Health Steps checkup within 30 Days of enrollment.
- An annual medical checkup for existing members age 36 months and older are due on the child's birthday.
- New members who are age six months and over must have a dental checkup within 60 Days of enrolling in the STAR Health program.

If you need additional information or have questions about STAR Health requirements, please call Superior's STAR Health Member Services department at 1-800-912-6283.

Becoming a Texas Health Steps Provider

Providers performing Medical, Dental and Care Management services can become Texas Health Steps providers. You must be an enrolled Texas Health Steps provider in order to be reimbursed for Texas Health Steps services. Enrollment must be completed through Texas Medicaid and Healthcare Partnership's (TMHP) Provider Enrollment and Management System (PEMS) at www.tmhp.com. For additional information, training material is available in the PEMS Learning Path on the TMHP Learning Management System (LMS) and on the TMHP Provider Enrollment Help at https://www.tmhp.com/topics/provider-enrollment/provider-enrollment-help.

More About Texas Health Steps

Additional details regarding the Texas Health Steps and Comprehensive Care program services, including private duty nursing, prescribed pediatric extended care centers and therapies can be found in the Texas Medicaid Provider Procedures Manual, Volume 2: Children's Services Handbook and in subsequent Medicaid bulletins at www.tmhp.com. Refer to the Texas Medicaid Provider Procedures Manual (TMPPM) for information regarding Texas Health Steps medical and dental program, including Texas Health Steps environmental lead investigation (ELI) and Comprehensive Care Program services, including private duty nursing, prescribed pediatric extended care centers, and therapies.

Medical checkups must be performed in accordance with the Texas Health Steps medical checkups periodicity schedule that is based in part on the American Academy of Pediatrics (AAP) recommendations. Providers can

find an updated Texas Health Steps periodicity schedule at https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers.

Superior is responsible for facilitating all covered services as described in the Texas Medicaid Provider Procedures Manual, per terms of Superior's contract with the HHS.

Medical Checkups and Screenings

Superior encourages PCPs to perform the Texas Health Steps checkups. However, Superior will allow any network provider to perform the Texas Health Steps medical checkup and screening, as long as the individual is also recognized as a Texas Health Steps provider by HHS. It is the responsibility of the PCP to ensure that these checkups are provided in their entirety and at the required intervals. Immunizations must be provided as part of the examination. Members may not be referred to local health departments to obtain immunizations.

If the PCP is not the provider performing the Texas Health Steps checkup, the performing provider must provide the PCP with a report regarding the screening. In addition, if the performing provider diagnoses a medical condition that requires additional treatment, the patient must be referred back to their PCP or a referral for further treatment must be obtained from the PCP. Superior will not issue retroactive prior authorizations for follow up treatment.

Medical Checkup

All initial screenings are to be performed by the member's PCP or other network Texas Health Steps provider. Initial screenings are also to be performed within the age guidelines as outlined on the Texas Health Steps Medical Checkup Periodicity Schedule, located on the Department of State Health Services (DSHS) website at https://www.hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers. Initial screenings will include, at a minimum:

- Comprehensive health and developmental history that includes:
  - **Nutritional assessment.**
  - **Developmental assessment, including use of standardized screening tools.**
  - **Autism screening.**
  - **Mental health assessment.**
  - **Tuberculosis screening with skin test based on risk.**
- Comprehensive unclothed physical examination that includes:
  - **Oral assessment.**
  - **Measurements (height/length, weight, BMI and infant head circumference).**
  - **Sensory screening (vision and hearing).**
- Laboratory tests (including blood lead level assessments and other tests appropriate for age and risk).
- Immunizations according to the Advisory Committee on Immunization Practices (ACIP) immunization schedule.
- Health education/anticipatory guidance.
- Referral services (e.g., CCP services, WIC, family planning and dental services).

Sports physical exams do not qualify as Texas Health Steps checkups and they are not covered Medicaid benefits.

***Please note**: Sports/school physicals are a Superior HealthPlan Value Added Service (VAS) for STAR members up to age 19 and for CHIP and STAR Health members from 4-18 years of age. Providers may be reimbursed for sports physicals*

performed at the same time as a Texas Health Steps checkup or during a separate medical visit. For additional billing information on these services, please reference Superior's Comprehensive Billing Clinic located on SuperiorHealthPlan.com/ProviderTrainings.

Performing Newborn Screenings

Inpatient newborn examinations billed with newborn procedure codes 99460, 99461 and 99463 are counted as Texas Health Steps medical checkups and include, at a minimum:

- Family and neonatal history.
- Physical exam (including length, weight and head circumference).
- Vision and hearing screening.
- Health education/anticipatory guidance.
- State-required newborn hereditary/metabolic test.
- Hepatitis B immunizations.

The first regular checkup should still be scheduled between discharge and 5 Days. The second regular checkup should be scheduled at 2 weeks and should include the second metabolic screen.

A mental health screening for behavioral, social and emotional development is required at each Texas Health Steps checkup birth through 20 years of age.

The 85th Texas Legislature, Regular Session, passed legislation regarding maternal postpartum depression screenings during an infant's Texas Health Steps checkup. Based on requirements specified in House Bill 2466, Texas Health Steps checkups will allow maternal postpartum depression screening as part of mental health screenings for infants prior to their first birthday.

A maternal postpartum depression screening may be completed and reimbursed once per provider, in the 12 months following the infant's birth during a Texas Health Steps checkup when the screening is completed using a validated screening tool. Validated screening tools include the following:

- Edinburgh Postnatal Depression Scale (EPDS)
- Postpartum Depression Screening Scale (PPDS)
- Patient Health Questionnaire (PHQ-9)

Positive screenings require the provider to discuss the screening results with the mother, discuss the possibility of depression and the impact depression may have on the mother, the family and the health of the infant. They must also refer the mother to a provider who can perform further evaluation and determine an appropriate course of treatment.

Providers completing maternal postpartum depression screening must use procedure code G8341 or G8510 in order to receive separate reimbursement. Providers must document the screening in the infant's medical record.

Additional information on changes to mental health screenings in adolescents and infants will be posted as soon as it is available.

Texas Health Steps encourages providers to routinely check their webpage and TMHP Provider Notices and Banner Messages for updates on Texas Health Steps checkup components, policy changes, and other important information.

Newborn Testing

Any provider attending the birth of a baby must require testing for PKU, galactosemia, hypothyroidism, sickle hemoglobin and congenital adrenal hyperplasia on all newborns as required by Texas law. All infants must be tested a second time at one to two weeks of age. These tests must be submitted to the DSHS Laboratory Services Section. For complete information, instructions and newborn screening forms contact:

Department of State Health Services

Laboratory Services Section
Mail Code: 1947
PO BOX 149347
Austin, TX 78714-9347

Toll Free: 888-963-7111 ext 7333
Phone: 512-776-7333
NewbornScreeningLab@dshs.texas.gov
dshs.texas.gov/lab/newbornscreening.shtm

Performing Adolescent Screenings

Adolescent preventive screenings are covered under the Texas Health Steps medical program. An "adolescent preventive visit" is not considered an exception to periodicity. The adolescent screening visits are performed in addition to regular Texas Health Steps periodic checkups.

The protocol for performing these screens includes:

- Comprehensive/anticipatory health guidance for adolescents and their parents.
- Screening for specific conditions common to adolescents.
- Immunizations to prevent selected infectious diseases.

A mental health screening for behavioral, social and emotional development is required at each Texas Health Steps checkup birth through 20 years.

The 85th Texas Legislature, Regular Session, passed legislation regarding mental health screenings in adolescents. Based on requirements specified in House Bill 1600, Texas Health Steps must make changes to checkup requirements for mental health screenings in adolescents.

Mental health screenings may be completed annually for all adolescents 12 through 18 years of age. Separate reimbursement will be available to providers annually when mental health screening is completed annually using one or more of the validated, standardized mental health screening tools approved by Texas Health Steps. Texas Health Steps recommends all clients who are 12 through 18 years of age receive a mental health screening annually.

Providers completing mental health screenings in adolescents must continue to use procedure code 96160 or 96161. Texas Health Steps has added one additional screening tool for mental health screenings in adolescents. Approved screening tools now include:

- Pediatric Symptom Checklist (PSC-17)
- Pediatric Symptom Checklist (PSC-35)
- Pediatric Symptom Checklist for Youth (Y-PSC)
- Patient Health Questionnaire (PHQ-9)
- Patient Health Questionnaire Modified for Adolescents (PHQ-A [depression screen])
- Car, Relax, Alone, Forget, Family, and Trouble Checklist (CRAFFT)
- Patient Health Questionnaire (PHQ-A [anxiety, eating problems, mood problems and substance abuse].
- Rapid Assessment for Adolescent Preventive Services (RAAPS).

Exceptions to Periodicity Allowed

On occasion, a child may require a Texas Health Steps checkup that is outside of the recommended schedule. Such reasons for an exception to periodicity include:

- Medical necessity (developmental delay, suspected abuse).
- Environmental high risk (for example, sibling of child with elevated lead blood level).
- Required to meet state or federal exam requirements for Head Start, day care, foster care or pre-adoption.
- Required for dental services provided under general anesthesia.

Exceptions to periodicity must be billed on the CMS 1500 and should comply with the standard billing requirements as discussed in Section 10.

If a provider other than the PCP performs the exception to periodicity exam, the PCP must be provided with medical record information. In addition, all necessary follow up care and treatment must be referred to the PCP.

Environmental Lead Investigation (ELI)

Lead Screening and Testing

In accordance with current federal regulations, Texas Health Steps requires blood lead screening at ages notated on the Texas Health Steps Periodicity Schedule and must be performed during the medical checkup.

Environmental lead risk assessments, as part of anticipatory guidance, should be completed at all check-ups through age six when testing is not mandated, and may be performed using the Lead Risk Questionnaire, Form Pb-110, which is provided in both English and Spanish at https://www.dshs.state.tx.us/lead/providers.shtm#screening. Providers may also opt to use an equivalent form of their choice.

The initial lead testing may be performed using a venous or capillary specimen, and must either be sent to the DSHS Laboratory or performed in the provider's office using point-of-care testing. If the client has an elevated blood lead level of 5 mcg/dL or greater, the provider must perform a confirmatory test using a venous specimen. The confirmatory specimen may be sent to the DSHS Laboratory, or the client or specimen may be sent to a laboratory of the provider's choice.

All blood lead levels in clients who are 14 years of age or younger must be reported to DSHS. Reports should include all information as required on the Child Blood Lead Reporting, Form F09-11709 or the Point-of-Care Blood Lead Testing report Form Pb-111, which can be found at http://www.dshs.state.tx.us/lead/providers.shtm or by calling 1-800-588-1248.

Information related to blood lead screening and reporting for clients who are 15 years of age or older is available on the DSHS Blood Lead Surveillance Group's website at http://www.dshs.state.tx.us/lead/providers.shtm.

Initial blood lead testing using point-of-care testing (procedure code 83655 with modifier QW) may be reimbursed to Texas Health Steps medical providers when performed in the provider's office. Providers must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver.

Blood lead testing is part of the encounter rates for FQHCs and RHCs and is not reimbursed separately. Providers may obtain more information about the medical and environmental management of lead poisoned children from the DSHS Childhood Lead Poisoning Prevention Program by calling 1-800-588-1248 or visiting the web page at http://www.dshs.state.tx.us/lead.

Laboratory Testing

All laboratory specimens collected as a required component of a Texas Health Steps checkup (see the Texas Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Health and Safety Code § 33.016 for analysis unless the Texas Medicaid Provider Procedures Manual, Children's Services Handbook provides otherwise. For forms and supplies, providers should contact the Laboratory Services Section at the phone number or website below:

DSHS – Laboratory Services Section

1100 West 49th Street
Austin, Texas 78756-3199
1-888-963-7111, ext. 7318
www.dshs.state.tx.us/lab/default.shtm

Providers may not bill for supplies and services provided by the DSHS laboratory. Tests for hemoglobin/hematocrit, chlamydia, gonorrhea and lead must be sent to the DSHS lab, with the exception of point-of-care testing in the provider's office for the initial lead specimen. All other tests may be sent to the lab of the provider's choice.

Screenings

The Texas Health Steps Medical Checkups Periodicity Schedule outlines laboratory tests to be completed during comprehensive health screenings. These include the following:

Birth through 10 Years of Age:

- Newborn Screening Panel
- Blood Lead Screening
- Anemia
- Dyslipidemia
- Type 2 Diabetes

11 through 20 Years of Age:

- Dyslipidemia
- Type 2 Diabetes
- STD/STI Screening
- Human Immunodeficiency Virus (HIV) Test

Providers must refer to the current version of the Texas Health Steps Medical Checkups Periodicity Schedule available on the Department of State Health Services (DSHS) website at https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/medical-providers.

Immunizations

Children, adolescents and young adults must be immunized during medical checkups and, according to the Advisory Committee on Immunization Practices (ACIP) schedule, by age and immunizing agent. Superior requires the immunizations be done unless medically contraindicated or against parental beliefs.

Providers are required to submit immunization information to the Texas Immunization Registry (ImmTrac) when an immunization is given. Written consent must be obtained by provider from parent or guardian before any information is included in the registry. The consent is valid until member becomes 18 years of age (those 18 and older may now consent for their records to be maintained in ImmTrac as well). Provider must verify consent before information is included in ImmTrac. If provider is unable to verify consent, the provider will be notified by ImmTrac and given instructions for obtaining the consent and resubmitting the immunization to the registry. For more information, please see the ImmTrac website at https://immtrac.dshs.texas.gov.

Vaccines for Children

The Department of State Health Services (DSHS) uses the Center for Disease Control and Prevention (CDC) federal contracts to purchase vaccines at federal contract prices for provision to providers enrolled in Medicaid. Vaccines not available on a federal contract will be purchased using a state contract price or using state purchasing procedures for vaccines not on a state contract. The vaccines purchased will be based on the most current recommended childhood immunization schedule of the ACIP.

DSHS will purchase, store and distribute vaccines purchased using the Texas Vaccines for Children program (TVFC). DSHS will monitor vaccine reports and track vaccine distribution to Medicaid providers to assure an adequate

inventory of vaccines for Medicaid providers. Vaccines are ordered through regional and local health departments. A TVFC provider may not charge for the vaccine itself, but is permitted to charge an administration fee.

If you are not enrolled in the TVFC program, contact the DSHS Central Office at VacCallCenter@dshs.state.tx.us or call toll-free at 1-800-252-9152. To enroll, a provider must:

- Fill out the Provider Enrollment and Provider Profile forms.
- Agree to maintain screening records.
- Agree to screen for eligibility.

More information is also available at https://www.dshs.texas.gov/immunize/tvfc/. Providers will not be reimbursed for a vaccine that is available through TVFC.

Dental Checkups

Patients are required to enroll in a Medicaid dental plan. Members must select a dental plan and main dentist. Patients should be encouraged to visit a Texas Health Steps dental provider from within their dental plan's network for routine dental checkups. Routine dental checkups do not require a referral.

Dental checkups are required once every six months from the last date of dental service for Medicaid clients age 6 months through 20 years of age. *Please note: STAR Health members must receive dental checkups within 60 Days of eligibility.*

If dental checkups result in treatment requiring a facility or anesthesia charge, the dentist must contact Superior's Medical Management department to request authorization for facility services and dental procedures at 1-800-218-7508.

First Dental Home

First Dental Home (FDH) is a package of services aimed at improving the oral health of children six through 35 months of age. FDH is provided by enrolled Texas Health Steps pediatric and general dentists. In addition to a standard set of services, FDH provides simple, consistent messages to parents or caregivers of very young children about proper oral health.

Oral Evaluation and Fluoride Varnish

Oral Evaluation and Fluoride Varnish (OEFV) in the medical home offers limited oral health services provided by Texas Health Steps enrolled physicians, physician assistants and advance practice registered nurses. The service is provided in conjunction with the Texas Health Steps medical checkup and includes immediate oral evaluation, fluoride varnish application, dental anticipatory guidance and referral to a dental home.

Providers must attend the FDH training or OEFV training offered by the Department of State Health Services Oral Health program to be certified to bill for these services. For more information on both programs, go to https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/dental-providers/first-dental-home.

An OEFV visit is billed utilizing CPT code 99429 with U5 modifier. The service must be billed with one of the following medical checkup codes: 99381, 99382, 99391 or 99392. The provider must document all components of the OEFV on the appropriate documentation form and maintain record of the referral to a dental home. Federally Qualified Health Centers and Rural Health Centers do not receive additional reimbursement for these services.

Medicaid Non-Emergency Dental Services

Superior is not responsible for paying for routine dental services provided to STAR, STAR+PLUS, STAR Kids and CHIP members. The services are paid through Dental Managed Care Organizations. Dental services for STAR Health members are included and delivered through Superior's STAR Health benefits. STAR Health Members do not choose or receive services from a Dental Managed Care Organization.

Superior is responsible for paying for treatment and devices for craniofacial anomalies, and for Oral Evaluation and Fluoride Varnish Benefits (OEFV) provided as part of a Texas Health Steps medical checkup for members age six through 35 months. Providers must attend the first dental home training or OEFV training offered by the Department of State Health Services Oral Health program to be certified to bill for these services. For more information on both programs, go to https://www.hhs.texas.gov/providers/health-services-providers/texas-health-steps/dental-providers/first-dental-home.

When providing OEFV benefits, please use the following guidelines:

- OEFV benefits include (during a visit) intermediate oral evaluation, fluoride varnish application, dental anticipatory guidance and assistance with a main dental home choice.
- OEFV is billed by Texas Health Steps providers on the same day as the Texas Health Steps medical checkup.
- OEFV must be billed concurrently with a Texas Health Steps medical checkup utilizing CPT code 99429 with U5 modifier.
- Documentation must include all components of the OEFV.
- Texas Health Steps providers must assist members with establishing a main dental home and document member's main dental home choice in the member's file.

Superior will pay for devices for craniofacial anomalies, hospital, physician and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment craniofacial anomalies.

Comprehensive Care Program: Referrals for Necessary Services

The Comprehensive Care program (CCP) is an expansion of the Texas Health Steps program. CCP services are designed to treat and improve specific physical and mental health problems of STAR, STAR+PLUS, STAR Kids and STAR Health children discovered during the Texas Health Steps checkup. These services may include:

- Psychiatric hospitals.
- Private Duty Nursing.
- Occupational therapy.
- Speech therapy.
- Durable medical equipment.
- Medical supplies.
- Licensed professional counselors.
- Licensed social workers with at least a masters degree.
- Advanced clinical practitioners.
- Dieticians.

Providers should follow the prior authorization, notification and referral procedures as outlined in Section 9.

Documentation of Completed Texas Health Steps Components and Elements

Each of the six components and their individual elements according to the recommendations established by the Texas Health Steps periodicity schedule for children as described in the Texas Medicaid Provider Procedures Manual must be completed and documented in the medical record. Any component or element not completed must be noted in the medical record, along with the reason it was not completed and the plan to complete the component or element. The medical record must contain documentation on all screening tools used for TB, growth

and development, autism, and mental health screenings. The results of these screenings and any necessary referrals must be documented in the medical record. THSteps checkups are subject to retrospective review and recoupment if the medical record does not include all required documentation.

THSteps checkups are made up of six primary components. Many of the primary components include individual elements. These are outlined on the Texas Health Steps Periodicity Schedule based on age and include:

1. **Comprehensive health and developmental history** which includes nutrition screening, developmental and mental health screening and TB screening.
    - A complete history includes family and personal medical history along with developmental surveillance and screening, and behavioral, social and emotional screening. The Texas Health Steps Tuberculosis Questionnaire is required annually beginning at 12 months of age, with a skin test required if screening indicates a risk of possible exposure.
2. **Comprehensive unclothed physical examination** which includes measurements: height or length, weight, fronto-occipital circumference, BMI, blood pressure, and vision and hearing screening.
    - A complete exam includes the recording of measurements and percentiles to document growth and development including fronto-occipital circumference (0-2 years) and blood pressure (3-20 years). Vision and hearing screenings are also required components of the physical exam. It is important to document any referrals based on findings from the vision and hearing screenings.
3. **Immunizations**, as established by the Advisory Committee on Immunization Practices, according to age and health history, including influenza, pneumococcal and HPV.
    - Immunization status must be screened at each medical checkup and necessary vaccines such as pneumococcal, influenza and HPV must be administered at the time of the checkup and according to the current ACIP "Recommended Childhood and Adolescent Immunization Schedule-United States," unless medically contraindicated or because of parental reasons of conscience including religious beliefs.
    - The screening provider is responsible for administration of the immunization and are not to refer children to other immunizers, including Local Health Departments, to receive immunizations.
    - Providers are to include parental consent on the Vaccine Information Statement, in compliance with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac).
    - Providers may enroll, as applicable, as Texas Vaccines for Children providers. For information, please visit https://www.dshs.texas.gov/immunize/tvfc/.
4. **Laboratory tests**, as appropriate, which include newborn screening, blood lead level assessment appropriate for age and risk factors, and anemia.
    - Newborn Screening: Send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section in Austin. Providers must include detailed identifying information for all screened newborn members and the member's mother to allow DSHS to link the screens performed at the Hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
    - All laboratory specimens collected as a required component of a Texas Health Steps checkup (see the Texas Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Health and Safety Code § 33.016 for analysis unless the Texas Medicaid Provider Procedures Manual, Children's Services Handbook provides otherwise.

- Anemia screening at 12 months.
- Dyslipidemia Screening at nine to 12 years of age and again 18-20 years of age
- HIV screening at 16-18 years
- Risk-based screenings include:
  - dyslipidemia, type 2 diabetes, and sexually transmitted infections including HIV, syphilis and gonorrhea/chlamydia.

5. **Health education** (including anticipatory guidance), is a federally mandated component of the medical checkup and is required in order to assist parents, caregivers and clients in understanding what to expect in terms of growth and development. Health education and counseling includes healthy lifestyle practices as well as prevention of lead poisoning, accidents and disease.
6. **Dental referral** every six months until the parent or caregiver reports a dental home is established.
   - Clients must be referred to establish a dental home beginning at six months of age or earlier if needed. Subsequent referrals must be made until the parent or caregiver confirms that a dental home has been established. The parent or caregiver may self-refer for dental care at any age.

Use of the THSteps Child Health Record Forms can assist with performing and documenting checkups completely, including laboratory screening and immunization components. Their use is optional, and recommended. Each checkup form includes all checkup components, screenings that are required at the checkup and suggested age appropriate anticipatory guidance topics. They are available online in the resources section at www.txhealthsteps.com.

Children of Traveling Farm Workers

Families who travel for farm work encounter numerous barriers obtaining health care services for their children on a daily basis. High mobility, lack of transportation, language and cultural barriers, inaccessibility to health care services, socioeconomic status and lack of health insurance coverage are only a few obstacles faced by this population in accessing care. Superior providers should cooperate with the state, outreach programs, Texas Health Steps regional program staff and Superior staff to identify children of traveling farm workers and provide accelerated services to them.

Children of traveling farm workers due for a Texas Health Steps medical checkup can receive their periodic checkup on an accelerated basis prior to leaving the area. A checkup performed under this circumstance is an accelerated service, but should be billed as a checkup. Performing a make-up exam for a late Texas Health Steps medical checkup previously missed under the periodicity schedule is not considered an exception to periodicity nor an accelerated service. It is considered a late checkup. The flexibility of the “due” period for members over the age of three years (extending to 364 Days from their birthday) allows for children of traveling workers to be scheduled for checkups at their convenience.

If you become aware of a Superior member who is a traveling farm worker or the child of a traveling farm worker, notify Superior by calling

- STAR: 1-800-783-5386
- STAR: Health 1-866-912-6283
- STAR Kids: 1-844-590-4883
- STAR+PLUS: 1-877-277-9772

Note: Provider can also refer members to utilize the numbers above.

This will allow Superior to complete an assessment to better coordinate and accelerate services for that member.

SECTION 6
ROUTINE, URGENT AND EMERGENCY SERVICES

Routine, Urgent and Emergency Services Defined

Medically necessary health services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided. Medically necessary health services must also be provided at the most appropriate level or supply of service which can safely be provided and could not be omitted without adversely affecting the member's physical health or the quality of life.

Except for emergency care in a true emergency, members are encouraged to contact the PCP prior to seeking care. In the case of a true emergency, members are encouraged to visit their nearest emergency department.

The following are definitions for routine, urgent and emergency care:

- Routine care is health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent, designed to prevent disease altogether, to detect and treat it early or to manage its course most effectively. Examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.
- An urgent condition is defined as a health condition, including an urgent behavioral health situation, which is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that their condition requires medical treatment evaluation or treatment within 24 hours by the member's PCP or PCP designee to prevent serious deterioration of the member's condition or health.
- An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:
  - Placing the member's health in serious jeopardy.
  - Serious impairment of bodily functions.
  - Serious dysfunction of any bodily organ or part.
  - Serious disfigurement.
  - With respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

Access to Routine, Urgent and Emergent Care

Members must have access to covered services within the timelines specified by HHS and Texas Department of Insurance (TDI). "Day" is defined as a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first. In coordination with the definitions above, this includes the following:

- Routine primary care and Behavioral Health appointments must be provided within 14 Days (unless requested earlier by DFPS).
- Routine specialty care referrals must be made on a timely basis, based on the urgency of the member's medical condition, but no later than five Days.
- Initial outpatient behavioral health visits must be provided within 10 Business Days/14 Days or within seven Days upon discharge from an inpatient psychiatric setting.

- Urgent care, including urgent specialty care and Behavioral Health, must be provided within 24 hours.
- Emergency services must be provided upon member presentation at the service delivery site, including at non-network and out-of-area facilities.

Non-Emergency Services

Non-emergency primary care services are not covered benefits for members of Medicaid managed care health plans when those services are delivered in the hospital-based emergency department (ED). A PCP and/or specialist physician in a physician office and/or clinic setting primarily provides these services. When a member seeks services that are not considered a covered benefit in the hospital-based ED, the provider of those services can bill a member if the member has been properly informed in advance of their potential financial liability. The determination of an emergency condition is based on the prudent layperson definition as described above under emergency medical condition.

Below are examples of non-emergency situations:

- Routine follow up care.
- Removal of sutures.
- Well child checkups/adult checkups.
- Immunizations, including tuberculosis.
- Other non-emergency primary care services.

Hospital Emergency Department Claims

Hospital emergency department claims are paid in accordance to the rate schedule included in the contract agreement between Superior and the hospital. For out-of-network providers, hospital emergency department claims are paid in accordance with state guidelines.

Emergency Department Claims

Superior considers reimbursement for all services provided in an emergency room setting, and does not require any emergency room claims satisfy the prudent lay person standard. Superior does apply specify payment criteria based on CMS coding principles for billing emergency department services. Reference Payment Policy, Emergency Department (ED) Evaluation and Management (E&M) Coding for Facility Claims, Reference Number: CC.PP.064 on Superior's website for complete information on this Policy. The Optum Emergency Department Claim (EDC) Analyzer is used to determine the emergency department E/M level to be reimbursed for certain facility claims. The EDC Analyzer applies an algorithm that takes three factors into account in order to determine a Calculated Visit Level for the emergency department E/M services rendered.

The three factors used in the calculation are as follows:

- Presenting problems – as defined by the ICD-10 reason for visit (RFV) diagnosis;
- Diagnostic services performed – based on intensity of the diagnostic workup as measured by the diagnostic CPT codes submitted on the claim (i.e. lab, x-ray, EKG/RT/other diagnostic, CT/MRI/ultrasound); and
- Patient complexity and co-morbidity – based on complicating conditions or circumstances as defined by the ICD-10 principal, secondary, and external cause of injury diagnosis codes.

Facilities may experience adjustments to the level 4 or 5 E/M codes submitted to reflect a lower E/M code calculated by the EDC Analyzer or may receive a denial for the code level submitted. For certain facilities who experience adjustments to a level 4 or 5 E/M code, the Plan may estimate reimbursement for the adjusted code based on historical claims experience, and in such event the facility may resubmit an adjusted claim which the Plan will adjudicate based on the new charges submitted in accordance with this policy.

Note that a Payment Policy applicable to claims for professional services provided in the Emergency Room place of service is located on Superior's website as well, reference Leveling of Emergency Room Services, Reference Number: CC.PP.053.

Urgent/Emergent Hospital-to-Hospital Ambulance Transportation

Superior is required to cover emergency ambulance services. Urgent/Emergency hospital-to-hospital transportation does not require prior authorization. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 TAC §353.2, is not available at the first facility and Superior has not included payment for such transports in the hospital reimbursement.

Emergency air transportation providers must notify Superior within one Business Day of providing emergency air transportation (hospital-to-hospital), when applicable.

Non-Emergent Ambulance Transportation

Superior covers medically necessary non-emergency ambulance services. All non-emergency ambulance transportation requires prior authorization. Non-emergency ambulance transport is defined as ambulance transport provided for a member to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the member's home after discharge when the member has a medical condition such that the use of an ambulance is the only appropriate means of transportation.

All ambulance transports which do not meet the definition of an emergency medical condition as per 1 TAC §353.2, require prior authorization, including:

- All facility-to-facility transports.
- All out of state transports.
- All air, ground and water transport.

Prior authorization may be obtained by:

- Calling the Medical Management department at 1-800-218-7508.
- Faxing a request for prior authorization which includes clinical information establishing medical necessity to 1-800-690-7030.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through our secure Provider Portal at Provider.SuperiorHealthPlan.com.

Authorization Tips:

1. Authorizations are only accepted from a Medicaid-enrolled physician, nursing facility, health care provider, or other responsible party in accordance with Human Resources Code (HRC) §32.024 (t). Other responsible parties include staff working with a health care service provider submitting prior authorizations on behalf of the provider or facility.
2. If the request is submitted by administrative staff, the request will still be required to include the physician's or physician extender's orders with the prior authorization unless the physician or physician extender sign the prior authorization form.
3. An ambulance provider may not request a prior authorization for non-emergent ambulance transports. Ambulance providers may assist in providing necessary information such as NPI number, fax and business

address to the requesting physician but the prior-authorization request must be signed and submitted by the Medicaid-enrolled physician, health-care provider or other responsible party.

Approvals/Denials

Superior utilizes approved utilization management criteria to review requests for medical necessity. Superior will provide an approval or denial letter for the prior authorization to the requesting entity, as well as the ambulance provider. The ambulance provider is ultimately responsible for ensuring that a prior authorization has been obtained prior to transport; non-payment may result for services provided without a prior authorization or when the authorization request is denied. Appeals for denials of medical necessity follow the standard provider appeal process, refer to Section 11.

SECTION 7
BEHAVIORAL HEALTH SERVICES

Superior provides behavioral health services (mental health and substance use disorder) for Superior members. Superior is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance use disorder providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals and Local Mental Health Authority (LMHA) facilities.

The availability of specific behavioral health services is determined by the scope of Medicaid and CHIP benefits offered through the HHS programs. Please refer to Section 4.

Please note, inpatient hospital services require notification. This includes services provided in freestanding psychiatric facilities for children and adults enrolled in the Medicaid and CHIP programs. Notification requirements are outlined in Section 9.

Some members are eligible for Value-added Services. Value-added Services are behavioral health-care services, benefits or positive incentives that HHS determines will promote healthy lifestyles and improve health outcomes among members. For a complete listing of Superior's current Value-added Services, refer to the Superior member handbook.

To access behavioral health benefits, please contact Member Services at:

STAR, CHIP 1-800-783-5386

STAR+PLUS 1-877-277-9772

STAR Kids 1-844-590-4883

STAR Health 1-866-912-6283

Or visit the Superior website at https://www.SuperiorHealthPlan.com/contact-us/phone-directory.html.

Behavioral Health Services Explained

Behavioral health services are covered services for the treatment of mental or emotional disorders and for the treatment of substance use disorders. Superior has defined "behavioral health" as encompassing both acute and chronic psychiatric and substance use disorders as referenced in the most recent ICD-10-CM/PCS. Substance Use Disorders (SUD) are defined as the problematic use of alcohol, prescription drugs, illegal drugs (e.g., cannabis, opioids, stimulants, inhalants, hallucinogens, "club" drugs, other synthetic euphoriants), and other substances that may be identified in the future that causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Superior will authorize, review and pay claims for medically necessary treatment, including inpatient hospital services. Superior's clinical program focuses on individualized treatment strategies that promote resiliency and recovery using evidence-based practices. The goal of this program is to support the provision and maintenance of a quality-oriented patient care environment, and to provide easy access to quality mental health and substance use disorder treatment services. Providers may reach out to Superior for available trainings on these programs, including Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), Trauma Informed Care (TIC), Parent-Child Interaction Therapy (PCIT), Trust Based Relational Intervention (TBRI), Post Traumatic Stress Disorder (PTSD) and Child Parent Psychotherapy (CPP).

Primary Care Provider's Role in Behavioral Health

PCPs are responsible for coordinating the member's physical and behavioral health care, including making referrals to behavioral health practitioners when necessary. However, the member does not need a referral to access mental health or substance use disorder treatment with a participating Superior provider. The PCP serves as the "medical home" for the member.

In addition, PCPs (excluding STAR Kids dual eligible) must adhere to screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders. Practitioners should follow generally-accepted clinical practice guidelines for screening and evaluation procedures, as published through appropriate professional societies and governmental agencies, such as the National Institute of Health. PCPs can also reference Superior's behavioral health assessment tools online at www.SuperiorHealthPlan.com/providers/resources/behavioral-health.html to assist in making appropriate referrals. Providers may make referrals to Care Management services through the Secure Provider Portal or by calling 1-855-757-6567.

PCPs may provide behavioral health related services within the scope of their practice (excluding STAR Kids dual eligible members).

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is one of the most common childhood psychiatric conditions. ADHD is a valid neurobiological condition that can cause significant impairment.

Superior makes available evidence-based guidelines for the effective diagnosis and treatment of ADHD on the public website at: https://www.SuperiorHealthPlan.com/providers/resources/quality-improvement/practice-guidelines.html.

The table below includes the diagnosis codes that identify Attention Deficit Disorder. Superior encourages providers to apply the diagnosis code to the highest specificity to assist with optimal coding.

Diagnosis Code	Attention Deficit Disorder
ICD-10 code F90.9	Attention Deficit Disorder, predominantly inattentive type (if only sufficient symptoms for inattention have been met)
ICD-10 code F90.9	Attention Deficit Disorder, predominantly hyperactive-impulsive type (if only sufficient symptoms of hyperactivity-impulsivity have been met) or Attention Deficit Disorder, Combined type (if sufficient symptoms of both inattention and hyperactivity-impulsivity have been met)
ICD-10 code F90.8	Attention Deficit Disorder, residual type
ICD-10 code F90.9	Attention Deficit Disorder Not Otherwise Specified (for individuals with prominent symptoms of inattention or hyperactivity-impulsivity who do not meet the full criteria)

Follow-up Care for Children Prescribed ADHD Medication

Members who are newly prescribed ADHD medications should have at least one follow-up visit within 30 Days of the prescription. Members who remain on the medication should have at least two additional visits within nine months after the 30 Day visit.

Reimbursement

Claims billed by a physical health provider will be considered for reimbursement by Superior when billed with an ADHD diagnosis code. Reimbursement will be based on the prevailing Texas Medicaid fee schedule and the contracted reimbursement agreement with Superior.

Integrated and/or Complex Care Management

Superior operates a behavioral health Integrated Care Management (ICM) program staffed with licensed behavioral health professionals and led by the Superior medical director. PCPs can refer members into this program by contacting Superior. Members demonstrating a high level of risk or high needs, or that have unmet psychosocial needs, may be included in this program. The program components include:

- A screening assessment tool.
- A comprehensive assessment once admitted to the program.
- The development of a care plan in conjunction with the member, the member's family, social support system and the managing practitioner.
- A referral to the appropriate providers, as necessary.
- Regular monitoring of the member's progress in the care plan.
- Focus studies and utilization management reporting requirements (specified by individual mental health service type).

Superior's Integrated Care Management staff collaborate on members' care with both medical and behavioral health diagnoses. With permission from the member, efforts are made to collaborate and share information with both medical and behavioral health providers treating the member. Coordination with other agencies and service providers that enhance the ability of members to receive appropriate and necessary services, such as transportation or community service organizations, are also considered an integral part of the program.

Emergency Behavioral Health Services

An emergency behavioral health condition means any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine requires immediate intervention and/or medical attention. In an emergency, without immediate intervention and/or medical attention, the member would present an immediate danger to themself or others, or would be rendered incapable of controlling, knowing or understanding the consequences of their actions.

In the event of a behavioral health emergency, the safety of the member and others is paramount. The member should be instructed to seek immediate attention at an emergency room or other behavioral health crisis service. An emergency dispatch service or 911 should be contacted if the member is a danger to self or others and is unable to go to an emergency care facility.

A behavioral health emergency occurs when the member is:

- Suicidal.
- Homicidal.
- Violent towards others.
- Suffering a precipitous decline in functional impairment and is unable to take care of activities of daily living.
- Alcohol or drug dependent with signs of severe withdrawal.

There is no required pre-certification or notification of emergency services, including emergency room and ambulance services. For questions regarding emergency behavioral health services, please contact 1-844-842-2537.

Mental Health Targeted Case Management

STAR, STAR+PLUS, STAR Health and STAR Kids members may qualify for Targeted Case Management. Targeted Case Management is designed to assist members with gaining access to needed medical, social, educational and other services and supports. Members are eligible to receive these based on a standardized assessment (the Child and Adolescent Needs and Strengths [CANS] or Adult Needs and Strengths Assessment [ANSA]) and other diagnostic criteria used to establish medical necessity.

Members who have been assessed and diagnosed with a Severe and Persistent Mental Illness (SPMI) or a Severe

Emotional Disturbance (SED) are also authorized to receive these services:

- SED is defined as psychiatric disorders in children and adolescents which cause severe disturbances in behavior, thinking and feeling.
- SPMI is defined as a diagnosis of bipolar disorder, major clinical depression, schizophrenia, or another behavioral health disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) accompanied by:
  - Impaired functioning or limitations of daily living (including personal grooming, housework, basic home maintenance, managing medications, shopping, or employment) due to the disorder, or
  - Impaired emotional or behavioral functioning that interferes substantially with the member's capacity to remain in the community without supportive treatment or services.
  - Members at risk for institutionalization.

Mental Health Rehabilitative Services

STAR, STAR+PLUS, STAR Health and STAR Kids members may qualify to receive Mental Health Rehabilitative Services. Mental Health Rehabilitation Services are defined as age-appropriate services determined by HHS and federally-approved protocol as medically necessary to reduce a member's disability resulting from severe mental illness for adults, or serious emotional, behavioral or mental disorders for children, and to restore the member to their best possible functioning level in the community.

Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help a member achieve a rehabilitation goal as defined in the member's rehabilitation plan. Superior requires that facilities and multi-specialty groups that provide Mental Health Targeted Case Management and Mental Health Rehabilitative Services submit an attestation annually as required by Senate Bill 58 of the 83rd Legislative Session. If providers do not submit their attestation, their claims for Mental Health Targeted Case Management and Mental Health Rehabilitative services will be denied. Attestations can be submitted to ProviderCertifications@SuperiorHealthPlan.com.

Member Access to Behavioral Health Services

Superior members may access behavioral health services through several mechanisms. These include:

- A referral from their PCP (a referral from the PCP is not required to access behavioral health services).
- Member self-referral to any Superior network behavioral health provider.
- Members experiencing life-threatening behavioral health emergencies should call 911. Members can also go to the nearest emergency room or a crisis center. Members should not wait for an emergency to get help.
- Members can contact Superior for help with depression, mental illness, substance abuse or emotional questions directly at: :

  STAR, CHIP 1-800-783-5386
  STAR+PLUS 1-877-277-9772
  STAR Kids 1-844-590-4883
  STAR Health 1-866-912-6283

Coordination Between Behavioral Health and Physical Health Services

Superior recognizes that communication is the link that unites all the service components and is a key element in any program's success. To advance this objective, providers are required to obtain a consent for disclosure of information from the member permitting exchange of clinical information between the behavioral health provider

and the member's physical health provider.

If the member refuses to release the information, they should indicate their refusal on the release form. In addition, the provider will document the reasons for declination in the medical record. Superior monitors compliance of the behavioral health providers to ensure a consent and an authorization to disclose information form has been signed by the member. Superior also ensures that regular reports are sent to the PCP, for members agreeing to the disclosure. For participants in the STAR Health program, behavioral health providers document updates in the Health Passport system.

Superior promotes the development of Integrated Primary Care (IPC) at the member's Medical Home (Primary care) and involves the integration of behavioral health services into primary care during the regular provision of primary care services where appropriate. IPC occurs at the same time and by the same provider ideally, or by the behavioral health provider seeing the member in tandem with the PCP. The IPC is a model distinct from co-location of services, which is considered to be parallel care rather than integrated care. IPC is also distinct from sequential care, which denotes behavioral health care that occurs either before or after the primary care and at the same or a different location. Information on IPC, integrated physical and behavioral health care, and other useful resources and tools can be found online at http://www.integratedprimarycare.com.

Primary Care Provider Requirements

Primary Care Providers are required to:

- Send the behavioral health provider initial and quarterly (or more frequently if clinically indicated or court ordered) summary reports of the member's physical and behavioral health status. The report must include, at a minimum:
  - **Behavioral health medications prescribed.**
  - **Behavioral health medication effects reported during PCP visits and information about physical health conditions and treatments that may affect behavioral health conditions and treatments.**
- Administer a screening tool at intake, and at least annually thereafter, to identify members who need behavioral health referrals. Behavioral health assessment tools, if available, may be utilized by the PCP.
- Send a copy of the physical health consultation record and the behavioral health screening tool results to the behavioral health provider who referred the member. Make referrals to behavioral health providers when the required Texas Health Steps screen reveals the need for a mental health, substance use disorder and/or developmental disability assessment.
- Make referrals to behavioral health providers when the required Texas Health Steps screen reveals the need for:
  - **A mental health referral, including identification of Severe Emotional Disturbance [SED]**
  - **Substance use disorder**
  - **Developmental disability assessment (See Section 4, STAR Health sub-section for Early Childhood Intervention which outlines the referral process(es) for children under three).**

Behavioral Health Provider Requirements

Behavioral health providers agree to:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment, with the consent of the member or the member's legal guardian.
- Only provide physical health services if such services are within the scope of the network practitioner's clinical licensure.
- 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.

- Contact members who have missed appointments within 24 hours to reschedule appointments.
- For STAR Health members, complete initial and monthly summaries of member's behavioral services to be posted on the Health Passport and made available to the PCP Targeted Case Management & Psychosocial Rehab providers.
- Network Facilities and Community Mental Health Centers must ensure members who are discharging from inpatient care are scheduled for outpatient follow-up and/or continuing treatment prior to the member's discharge. The outpatient treatment must occur within seven Days from the date of discharge.
- Coordinate with state psychiatric facilities and Local Mental Health Authorities (Please note, STAR+PLUS Dallas members should contact Superior for behavioral health services).
- Provide an attestation to MCO that organization has the ability to provide, either directly or through sub-contract, the members with the full array of Mental Health Rehabilitative (MHR) and Targeted Case Management (TCM) services as outlined in the Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Uniform Managed Care Manual, Chapter 15 (as part of Credentialing process).
- Annually complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA) and/or Child and Adolescent Needs and Strengths (CANS) assessment tools if providing MHR and TCM.
- Use RRUMG as the medical necessity criteria for MHR and TCM services.
- Qualified Mental Health Professionals for Community Services (QMHP-CS) requirement minimums are as follows:
  - Demonstrated competency in the work to be performed; and
  - Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education or early childhood intervention; or be a Registered Nurse (RN);
  - An LPHA is automatically certified as a QMHP-CS. A CSSP, a Peer Provider, and a Family Partner can be a QMHP-CS if acting under the supervision of an LPHA. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by an LPHA. A Peer Provider must be a certified peer specialist, and a Family Partner must be a certified Family Partner.
  - The name of a performing provider is not required on claims submitted to Superior, if that provider is not a type that enrolls in Medicaid (such as CSSPs, PPs, FPs, non-LPHA QMHPs and Targeted Case Managers).
- A qualified provider of Mental Health Rehabilitative and Targeted Case Management services must:
  - Demonstrate competency in the work performed; and
  - Possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education or early childhood intervention;
  - Be a Registered Nurse (RN); or
  - Follow HHS established qualification and supervisory protocols.
- Superior is prohibited from establishing additional supervisory protocols with respect to the providers of TCM or MHR.

ICD-10 Diagnostic Codes for Behavioral Health Claims

Medical record documentation and referral information must be documented using the ICD-10 classifications. as well as the most current Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

Laboratory Services

Behavioral health providers should facilitate the provision of in-office laboratory services for behavioral health patients whenever possible or at a location that is within close proximity to the behavioral health provider's office. Providers may refer Superior members to any in-network independent laboratory as needed for laboratory services.

Assisting Behavioral Health Providers

Superior works to educate and assist physical health and behavioral health providers in the appropriate exchange of medical information. Behavioral health utilization reporting is completely integrated into the Superior's quality improvement process. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any deficiencies.

Department of Family and Protective Services

Behavioral health providers and/or physical health providers who are treating a behavioral health condition are responsible for appropriate referrals to the Department of Family and Protective Services (DFPS) for suspected or confirmed cases of abuse.

To report concerns of abuse, neglect or exploitation of children, the elderly or people with disabilities, contact the Texas Abuse/Neglect Hotline at 1-800-252-5400 or www.txabusehotline.org.

Behavioral health providers and/or physical health providers must coordinate with DFPS and foster parents for the care of a child who is receiving services from, or has been placed in, conservatorship of DFPS and must respond to request from DFPS by providing medical records.

Court-Ordered Commitments and Claims

Superior will provide covered Medicaid inpatient services to members, birth through 20 years of age and 65 years of age and older, who has been ordered to receive inpatient psychiatric services under court of competent jurisdiction including services ordered pursuant to the Texas Health and Safety Code Chapters 573 or 574, and the Texas Code of Criminal Procedure, Chapter 46B, or as a condition of probation. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination. Superior cannot deny, reduce or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court-ordered commitment for members, birth through 20 years of age and 65 years of age and older. Superior will not deny, reduce or controvert the court orders for Medicaid inpatient mental health covered services for members of any age if the court-ordered services are delivered in an acute care hospital. Superior may not limit substance use disorder treatment or outpatient mental health services for members of any age provided pursuant to a court order or a condition of probation. The member can only appeal the commitment through the court system. These requirements are not applicable when the member is considered incarcerated, as defined by Uniform Managed Care Manual (UMCM) Chapter 16.

To ensure services are not inadvertently denied, providers must contact Superior at the numbers listed in this section and provide telephonic or written clinical information as well as a copy of the court order.

Any professional services provided that are part of a court order must be billed with an H9 modifier as described in the Texas Medicaid Provider Procedures Manual. Court-Ordered Services that require authorization or notification per Superior's prior authorization list must also have an authorization.

Facilities providing Court-Ordered Services should bill using the appropriate code (8 or 08 per the Texas Medicaid Provider Procedures Manual) in the Source of Admission field of the UB-04 claim form.

Superior will make best efforts to authorize services from the court order once provided. To ensure accurate claims payment, the provider should call 1-877-391-5921.

SECTION 8
MEDICAL MANAGEMENT

Superior's Medical Management department works with its network providers to facilitate quality care through its refined Medical Management program. This program includes utilization management, care management/ complex care management and disease management components, as well as other features such as 24-hour nurse triage, referrals, second opinions prior authorization/pre-certification, concurrent review, retrospective review, and discharge planning. This section focuses on utilization management, care management/complex care management and disease management. See Section 9 for information on prior authorization, notifications and referrals.

A special certification for Utilization Review Agents (URA) is issued through the Texas Department of Insurance (TDI) and required to conduct utilization review in Texas. Superior contracts with several Texas licensed URAs to perform utilization review. A list of the name and license number for each contracted URA is listed below.

- Centene Management Company, LLC - URA #5396
- Centene Pharmacy Services, Inc. - URA #1774935
- Magellan Healthcare, Inc. - URA #5197
- Texas National Imaging Associates, Inc. - URA #5258
- Turningpoint Healthcare Solutions, LLC - URA #2395464

Utilization Management Criteria

Utilization management decisions are made in accordance with currently accepted medical or behavioral health care practices, taking into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. Criteria are used for the review of medical necessity, as well as provider peer-to-peer review. The medical director reviews all potential Adverse Benefit Determinations for medical necessity. At least annually, the vice president of medical management or a designee assesses the consistency with which reviewers apply the criteria. Providers can contact Superior's Prior Authorization department at 1-800-218-7508 to request a copy of the criteria used to make a specific decision. Providers can review utilization management clinical policies by visiting https://www.SuperiorHealthPlan.com/providers/resources/clinical-payment-policies.html. Utilization review decision making is based on appropriateness of care and service and the existence of coverage. Superior does not reward providers or other individuals for issuing medically necessary denials. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Superior uses the following guidelines to make medical necessity decisions, on a case-by-case basis, based on the information provided on the member's health status: Federal and/or State law/guidelines, where applicable; utilization management clinical policies; proprietary clinical guidelines and/or Interqual® criteria. InterQual was developed by generalist and specialist physicians representing a national panel from academic as well as community-based practices, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. Superior also utilizes the Texas Medicaid Provider Manual for clinical criteria for applicable Medicaid covered services.

Superior's Care Management Services

Care management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's health care needs, using communication and available resources to promote quality, cost effective outcomes. Care management is a member-centered, goal-oriented and culturally relevant process. This helps to ensure a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Care Management Process

All Superior members with identified needs are assessed for Care Management enrollment. Members with needs may be identified through a variety of means to include, but not limited to, clinical rounds, referrals from Superior staff, claims, hospital census and direct referral from providers or self-referral.

Superior's Care Management program contains the following key elements:

- Screen and identify members who potentially meet the criteria for Care Management.
- Assess the member's risk factors and social determinants of health to determine the need for Care Management.
- Notify the member of their enrollment in Superior's Care Management program.
- Develop and implement a Care Management care plan that accommodates the specific cultural and linguistic needs of the member.
- Establish care plan objectives and monitor outcomes.
- Refer and assist the member in ensuring timely access to providers.
- Coordinate medical, Non-Medical Drivers of Health NMDOH and other support services.
- Monitor care and services telephonically, through home visits if necessary or via in-app text through Wellframe.
- Revise the care plan as necessary.
- Assess the member's satisfaction with complex Care Management services.
- Assist member in screening and referral to Case Management for Children and Pregnant Women (CPW) Provider.
- Measure the program's effectiveness.

In order to refer a member for enrollment in Superior's Care Management program call the CM Provider Hotline Monday through Friday 8 a.m. to 5 p.m. (CST) (8 a.m. to 6 p.m. [CST] for STAR Health), at 1-855-757-6567 or submit a Care Management referral via Superior's Secure Provider Portal.

Care Management as Provider Support

Superior's Care Management teams support providers by tracking compliance with the Care Management plan and facilitating communication between the PCP, member, managing physician and the Care Management team. The Care Manager also facilitates referrals and links to community providers, such as community organizations, local health departments and school-based clinics. The managing physician maintains responsibility for the member's ongoing care needs. The Superior Care Manager will collaborate with the PCP and/or managing physician if the member is not following the plan of care or requires additional services.

Superior will provide complex Care Management services for members who have high risk, high cost, complex or catastrophic conditions. The Superior Care Manager will work with all involved providers to coordinate care, provide referral assistance and other care coordination as required. The Superior Care Manager may also assist with a member's transition to other care, as indicated, when the member's benefits end.

Specialized Types of Care Management

Superior's Care Managers work with the member to create a customizable plan of care in order to promote appropriate cost effective care as well as adherence to Care Management plans. Superior offers Care Management programs for, but not limited to, the following behavioral, mental or physical conditions:

- Asthma.
- Members with special health care needs.
- Complex and chronic illness and injury.
- Diabetes.

- Sickle Cell.
- Transplant.
- Chronic Obstructive Pulmonary Disease (COPD).
- Congenital Heart Failure (CHF).
- Obesity.
- Transitional Care.
- ER Diversion.
- Complex Care Management (CCM)/Superutilizer.
- Integrated Care Management.

In addition, Superior members have access to the following specialized Care Management programs:

Start Smart for Your Baby® Program

Start Smart for Your Baby® (Start Smart) is an award-winning Care Management program available to women who are pregnant or just had a baby. Start Smart is a comprehensive program that covers all phases of the pregnancy, postpartum and newborn periods. The program includes mailed educational materials for newly identified pregnant members and for new mothers after delivery.

Start Smart members are also encouraged to participate in educational seminars. Seminar topics include information related to plan benefits, pregnancy, breast feeding, postpartum and newborn health topics. These events are conducted with the assistance of community resource specialists. Home based visits are also available to members, as needed.

Puff Free Pregnancy® Program

Puff Free Pregnancy® is a program aimed at eliminating tobacco use during pregnancy. The program provides telephonic outreach, education and support services to reduce the health risks associated with smoking during pregnancy, such as low birth weight and perinatal mortality, by reducing the use of tobacco products. Internal clinical guidelines for the program are developed from nationally recognizedevidenced based guidelines published by the American College of Obstetricians and Gynecologists and the U.S. Public Health Services. Members are identified for the program by a provider, Care Manager or through self-referral. A lifestyle coach works with the member to develop an individualized quit plan. Program length is from the date of enrollment until delivery with post-delivery abstinence status documented by telephone.

In addition to Care Management, Superior also offers health education classes through Superior's health education program in some of the communities in which our members reside. Classes are offered on specific health-related topics such as hypertension, diabetes, asthma and nutrition. Contact Superior's Care Management department to determine what is available in your area.

Disease Management

Disease management is defined as a system of coordinated health-care 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 health coaches coordinate with both the member and their providers to focus on disease-specific conditions as listed below. To refer a member for disease management services, contact Superior at 1-800-218-7453. To learn more about Superior's Disease Management Programs, please see the Disease Management Program Guides located at https://www.SuperiorHealthPlan.com/providers/resources/quality-improvement.html under Quality Resources.

PHCO DM programs aren't varied by product as they were historically. Products are offered a program based off our member stratification report (disease management prioritization report). Programs fall into the following buckets:

1. Respiratory (Asthma, COPD)
2. Diabetes (Type 1 & 2)
3. Cardiac (CAD, HF, HTN, HLP)
4. Lifestyle (adult weight management, pediatric obesity, tobacco cessation puff free pregnancy, nutrition, exercise, stress)

The PHCO shared services team does not currently manage any behavioral health programs; assuming these programs

are managed at the market level. All current shared services disease management programs are listed in 1-4 above and are available to all products.

Please note: some disease management programs have age restrictions.

Disease Management Process

Superior uses medical and pharmacy claims, utilization and health screening data and referrals to identify potentially eligible members with qualifying conditions for disease management. Outreach calls to the member are made to introduce the disease management program, assess their willingness to participate, enroll them in the program and complete an initial assessment. Members are assigned a health coach with expertise in the member's primary condition. The health coach will coordinate with providers, members of the service coordination or Care Management teams (if applicable), and assist with special needs such as nutrition, exercise and social services. Coaching includes a series of pre-scheduled outbound phone.

Utilization Monitoring of Psychotropic Drugs

Superior's Psychotropic Medication Utilization Review (PMUR) program for children is modeled on the HHS parameters assessing prescribing as defined by the Texas Family Code Sec. 266.001(7). These parameters can be found at https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/psychiatric/psychotropic-medication-utilization-parameters.pdf.

Superior's PMUR program parameters for adults follow evidenced-based, peer-reviewed industry standards for the prescribing of psychotropic medications and metabolic monitoring such as polypharmacy and diabetes screening for members taking antipsychotic medications. These parameters must be adhered to by all practitioners providing services to Medicaid members. Medications prescribed to members in various Medicaid programs include but are not limited to STAR Health, STAR Kids, STAR, CHIP and STAR+PLUS. Superior's Behavioral Health Medical Director (BHMD) or Clinical Pharmacist reviews members identified against medical, pharmacy, lab work and other clinical histories. If drug use falls outside of parameters and is not supported by medical histories, if indicated, the BHMD or Clinical Pharmacist will contact the provider for a peer-to-peer discussion on appropriate psychotropic medication prescribing standards and regime.

The reviewer will collaboratively formulate a plan of treatment with the provider, document the plan and send copies to the treatment provider and stakeholders, if applicable. If there is evidence of noncompliance with the treatment plan by the provider, additional provider outreach may be necessary. Staff will report any provider who persistently refuses to follow the plan of treatment to Quality Improvement staff as a Quality of Care concern (QOC). Superior's Medical Directors will employ our standard process to address Providers who fail to adhere to PMUR guidance.

SECTION 9
PRIOR AUTHORIZATION, NOTIFICATION AND REFERRALS

A prior authorization is a formal medical necessity determination request submitted to Superior by a provider prior to a service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health services proposed, including the setting in which the proposed care will take place.

Prior Authorization Requirements

Superior has adopted a prior authorization process for specific procedures and/or services. These procedures and/or services are listed on Superior's prior authorization list. The Prior Authorization Lists can be found in the Attachments section or at www.SuperiorHealthPlan.com/providers/preauth-check.html.

Failure to obtain prior authorization for services that require prior authorization will result in an administrative denial. Outreach will be made to the appropriate provider for all requests with incomplete or insufficient documentation. To find prior authorization forms, please visit SuperiorHealthPlan.com/providers/resources/forms.html.

An authorization is not required if an authorization from the primary insurance carrier indicating approval is received, Superior will coordinate and override any authorization related claim denials, as appropriate. If the other insurance carrier has denied and Superior is being asked to pay as primary for a service that requires an authorization, the provider will be required to request authorization prior to payment with Superior as primary.

Authorization Process

When calling in to request an authorization or to notify of a patient admission, please have available the Tax Identification Number (TIN) and National Provider Identifier (NPI) or LTSS ID Number (Atypical ID) that you will use to bill your claim. The representative handling your call will be requesting the numbers from you. If you do not have your identifiers available, your request will not be processed and you will be asked to call back with the necessary information. It will be very important that the numbers you use to request your authorization match the numbers you will use to bill your claim or your claim will deny.

If you have any questions about this requirement, you can call the Provider Services hotline, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP 1-877-391-5921

Behavioral Health 1-844-744-5315

Timelines for Initiating a Prior Authorization

Requesting providers must initiate a prior authorization of non-emergency services (e.g., elective inpatient admissions, elective/outpatient services) prior to providing the requested service. It is recommended that requests be submitted five Business Days prior to the desired start date in order to allow time for processing. Submit requests by contacting Superior's Prior Authorization department at:

Website: www.SuperiorHealthPlan.com
Phone: 1-800-218-7508
Fax: 1-800-690-7030
1-844-495-2361 (Discharge Planning)

Please note, if any prior authorization form is returned with the language "PA Not Required" the requesting provider should verify if the service is a covered benefit and requires authorization using the prior authorization tool located on the Superior website at: https://www.SuperiorHealthPlan.com/providers/preauth-check.html. If you have an urgent request that requires immediate attention after normal business hours, or on the weekend, please contact Superior's 24/7 Nurse Advice Line at 1-800-783-5386.

Prior Authorization Turn Around Timelines

Superior will respond to complete prior authorization requests within two Business Days for CHIP products, and within three Business Days for non-CHIP products. This excludes LTSS authorizations.

Urgent requests for services to be rendered within three Days may be submitted with reason for urgency indicated.

Superior's Inpatient Notification Form and Medicaid and CHIP Prior Authorization Form, found in the Attachments section, include requirements for reason for urgency. In order to eliminate any delays, all clinical information required must be submitted along with the authorization request.

Authorization TAT Requirements

Program	Authorization Type	TAT
STAR (Medicaid), STAR+PLUS, STAR Kids and STAR Health	Outpatient, Inpatient Elective	three Business Days
CHIP	Outpatient, Inpatient Elective	two Business Days
CHIP and Medicaid	Urgent, Outpatient and Inpatient Elective	three Calendar Days
CHIP and Medicaid	Inpatient	one Business Day

Second Opinions

Members are allowed to a second opinion if there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian or a social worker exercising a custodial responsibility.

Authorization for a second opinion will be granted to a network provider or an out-of-network provider if there is not an in-network practitioner available. The second opinion will be provided at no cost to the member.

If the provider who will see the member for a second opinion is not in-network, an authorization is required. An authorization can be obtained by:

Contacting the Prior Authorization department at:
Website: www.SuperiorHealthPlan.com
Phone: 1-800-218-7508
Fax: 1-800-690-7030

Prior Authorization Requests Not Received Prior to Service

If an authorization is required but not obtained prior to the services being rendered, the provider will receive a contractual denial for failure to comply with health plan requirements related to prior authorization. Reference Section 11, Contractual Denials. Retrospective authorizations are not given without documentation explaining why the request was not submitted prior to rendering the service.

For Medicaid member prior authorization requests, the services have a Start of Care exception: Private Duty Nursing, Home Health Services, Therapy (Speech/Occupational/Physical).

Discharge Planning

As part of our ongoing mission to ensure better health outcomes for our members, Superior provides timely and appropriate discharge planning services for a seamless transition from a hospital, emergency room, observation stay or outpatient surgery to the member's home setting. Discharge planning services includes:

- Home Health Services
  - Skilled Nurse Visits
  - Private Duty Nursing
  - Home Health Aides
- Outpatient Services
  - Wound Care
- Durable Medical Equipment (including supplies)
- Any other urgent discharge needs for members transitioning to the home setting

Requests for prior authorization for discharge planning services for all products, except STAR+PLUS Dual and STAR+PLUS Dual Waiver, can be made by phone, fax or web by contacting Superior at:

Phone: 1-800-218-7453, ext. 22128 Web: www.SuperiorHealthPlan.com

Fax: 1-844-495-2361

Please ensure that prior authorization requests for discharge planning are submitted within 48 hours of outpatient surgery, discharge from a hospital, emergency room or observation stay. If a member is discharged during non-business hours and/or the weekend, providers should submit discharge planning requests the following Business Day.

Fill out a Superior HealthPlan Prior Authorization form. Visit www.SuperiorHealthPlan.com to download the form.

1. Attach a discharge order from the hospital (signed script, discharge paperwork, electronic or verbal order and Title 19). Provide ICD-10, CPT codes and HCPC codes with frequency, duration and amount of units or visits being requested.
2. Fax request (form and discharge order) to 1-844-495-2361.

- Please note: On the fax cover sheet and the prior authorization form, be sure to write **URGENT DISCHARGE PLANNING**. This will expedite the processing of the request and **authorization will be received within 24 business hours of submission**.

Prior Authorization Notification Process for Incomplete Information or Insufficient Documentation (IPAR)

For any incomplete or insufficient documentation request for all Medicaid members, Superior will return the request to the Medicaid provider by faxing a letter detailing the information necessary to complete the prior authorization request. Superior will notify the member of the request for additional/complete information that was sent to the provider.

If the documentation/information is not provided within three Business Days from Superior's provider notification of insufficient or incomplete documentation, the request may result in an adverse benefit determination.

The provider may resubmit a new request once they have the necessary documentation that would render the request complete.

STAR Health Members

For STAR Health members, after all new documentation received from the provider is reviewed and the PA request is still missing necessary information to process the request or does not meet criteria for the service requested, Superior also contacts the member or the member's medical consenter to request any additional available and necessary information related to the prior authorization request. If Superior is unable to reach a member or member's medical consenter, Superior contacts the member's DFPS caseworker as a secondary contact.

Tips for Outpatient Prior Authorization Requests

To request prior authorization, use Superior's Medicaid and CHIP Prior Authorization Request Form, found in the Attachments section. In order to ensure the request can be processed promptly, include member information, provider information (NPI, tax ID, fax number, contact number), requested service, date of service (DOS) and objective clinical information to support medical necessity.

Occupational Therapy (OT), Physical Therapy (PT) and/or Speech Therapy (ST) Prior Authorization

Prior authorization is needed for treatment requests including post-hospitalization discharge. For STAR, STAR+PLUS (non waiver) and CHIP members, therapy treatment requests should be submitted to National Imaging Associates (NIA) via www.RADmd.com. STAR Kids, STAR Health and STAR+PLUS Waiver members, treatment requests should be submitted to Superior.

Initial treatment authorization requests should include:

- Date of evaluation
- Member's age and date of birth
- For speech therapy requests, the member's language knowledge/exposure must be established through a thorough case history and relevant caregiver interview. The documentation must include all of the following that apply:
  - home language(s)
  - school/daycare/community language(s) of instruction/exposure
- A brief statement of the member's medical history, including onset date of the illness, injury or exacerbation that requires the therapy services and any prior therapy treatment.
- Relevant review of systems
- Pertinent physical assessment, including a description of the member's current deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.

- A clear diagnosis and reasonable prognosis, including the member's potential for meaningful and significant progress.
- A description of the member's functional impairment with a comparison of prior level of function to current level of function.
- A statement of the prescribed treatment modalities and their recommended frequency/duration.
- Proposed patient and/or caregiver education.
- Treatment goals which are specific to the member's diagnosed condition or impairment. Treatment goals must be functional and written in the S.M.A.R.T. format (specific, measurable, attainable, relevant and time based)
- Treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted. Treatment goals must relate to member specific functional skills.
- Treatment plan may not be more than 60 Days old.
- If the treatment plan is part of a medically necessary program to maintain or prevent a significant functional regression, it must document skilled services to be provided and have goals that address maintenance.

Note: Initial prior authorization for therapy requests must be received no later than three Business Days from the start of care date.

Bilingual Assessment and Treatment

- The member's language knowledge/exposure must be established through a thorough case history and relevant caregiver interview. The documentation must include all of the following that apply:
  - home language(s)
  - school/daycare/community language(s) of instruction/exposure
- If child is exposed to more than one language, an appropriate bilingual assessment of speech and language abilities should be performed.
- If no standardized tool is available, results should be reported using appropriate objective assessment methods. Examples may include criterion-referenced tests, probes, language samples, dynamic assessment, or MLU, etc. in order to differentiate a language disorder versus a language difference as well as the severity of that disorder, should it be identified.
- If a standardized bilingual language test is utilized as part of the objective assessment, documentation of its type of administration must be stated for either dual language administration or monolingual administration use only.

Continued Authorization Visits

Progress toward treatment goals must be clearly documented in an updated treatment plan/current progress summary. This documentation must be submitted by the servicing provider at the end of each authorization period or when additional visits are being requested. The treatment plan must be signed and dated by the PCP (MD, DO, PA or NP) or appropriate specialist.

In lieu of having the treatment plan signed, the provider may submit a physician referral/order signed and dated the day of the evaluation or after specifying the frequency and duration of the requested service regardless of history.

Documentation must include the following:

- Number of therapy visits authorized and number of therapy visits attended.
- A clear diagnosis and reasonable prognosis including the member's potential for meaningful and significant progress.
- A description of the member's current functional deficits and their severity level documented using objective data. This may include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information as appropriate for the member's condition or impairment.

- Objective demonstration of the member's progress towards each prior treatment goal.
- Treatment goals are developed by the treating therapist to be met within the timeframe specified on the treatment plan. If any goals are unmet, it is the treating therapist's responsibility to objectively describe specific barriers to progress that were encountered and make appropriate modifications to the treatment plan in order to meet the member's needs.
- For all unmet treatment goals, report the status of the goal at the beginning of the previous treatment period and the current status at the time of reporting, as they compare to the target.
- If the treatment plan was written with maintenance goals, a status statement would be expected for each maintenance goal directed at a skilled service.
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
- A clear, member-specific prognosis with established discharge criteria.
- A description of the member's functional impairment with a comparison of prior level of function to current level of function, when applicable.
- Treatment goals must be written in the S.M.A.R.T. format (Specific, Measurable, Attainable, Relevant and Time-based), and relate to member-specific functional outcomes.
- Updated treatment plan/progress summary may be no older than 60 Days old.
- Treatment plan must be signed and dated by the treating therapist.

Please note: As the member's medical need for therapy decreases, it is expected that the therapy frequency will be decreased as well.

Members demonstrating a need for low to moderate frequency may be approved three or six months for chronic conditions. Members demonstrating the need for high frequency may be authorized up to four weeks. All services that are rendered by a therapy assistant must be billed utilizing a UB modifier.

Place of service decisions should be based on the member's medical condition, therapy goals, appropriateness of equipment, environment and service, rather than convenience of the member or provider.

Guidelines for OT, PT and/or ST treatment service can be found online at www.SuperiorHealthPlan.com.

Requests for Durable Medical Equipment

To verify if the requested Durable Medical Equipment requires prior authorization, please utilize the Pre-Auth Needed Tool online at www.SuperiorHealthPlan.com/priorauth. Documentation requirements include:

- A physician or allowed practitioner order on a prescription or request form (signature must be current, on or before the start date, and no older than 90 Days before the actual date of service) and must contain all of the following elements:
  - Member's name
  - Description of the item or items, quantity, price
  - Appropriate HCPC codes. For misc. HCPC codes, if an item is manually priced, providers must submit documentation of one of the following for consideration of purchase or rental with the appropriate procedure codes (at time of prior authorization and claims submission):
  - The MSRP or average wholesale price (AWP), whichever is applicable
  - The provider's documented invoice cost
    Note: Handwritten alterations (crossing out of information or changing values) of the invoice render the invoice invalid.
  - Pertinent diagnosis/conditions that relate to the need for the item
  - Date of service (start and end date)
  - Objective supporting clinical documentation
  - Length of need (length of time that the member will need the requested equipment/supply)

- The treating practitioner's name and signature
- The date the treating practitioner signed the order

DME orders signed by doctors of philosophy are not accepted.

No prior authorization is required for incontinence supplies up to the allowable amount when using a preferred DME supplier. For the list of preferred DME suppliers, go to www.SuperiorHealthPlan.com.

Skilled Nursing Visits and Home Health Aid

Home Health Services requests, including Skilled Nursing Visits (SNV) and Home Health Aid (HHA), Telemonitoring must include:

- Member's name
- Pertinent diagnosis/conditions that relate to the need for the service
- Appropriate CPT codes
- Plan of care
- Objective supporting clinical documentation
- Frequency and duration
- Date of service (start and end date)
- Practitioner order with signature of requesting practitioner, advanced nurse practitioner, clinical nurse specialist or physician assistant

Note: Initial prior authorization for therapy requests must be received no later than three Business Days from the start of care date.

Private Duty Nursing Authorization Requirements

For Medicaid (STAR, STAR Health, STAR Kids) and CHIP members, Superior will review all prior authorizations for Private Duty Nursing (PDN) requests based on medical necessity. For Medicaid STAR, STAR Health and STAR Kids, initial PDN requests must be submitted within three Business Days from start of care.

Home Health Services requests for Private Duty Nursing Authorization must include:

- Initial and recertification requests related to PDN require the following to initiate services:
  - Completed Home Health Plan of Care (signed by physician or allowed practitioner within 30 Days from start of care);
  - Completed CCP Prior Authorization Request Form;
- Completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form which includes:
  - The identification of the client and the responsible adult, and the requested start/end dates, and number of PDN hours requested per week.
  - A Nursing Care Plan Summary, which includes a problem list with specific measurable outcomes and current progress towards goals.
  - The Summary of Recent Health History or an updated 90-Day summary for subsequent PDN services.
  - The Rationale for PDN hours, and for subsequent PDN requests, the rationale for the PDN hours to either increase, decrease, or stay the same. The rationale should include the medical necessity documentation to substantiate the request for PDN hours.
  - Completed Schedule of Services 24-hour daily flow sheet.
  - Signed acknowledgement.

For extended 6-month authorizations for Medicaid STAR, STAR Health and STAR Kids members, the THSteps-CCP Prior Authorization Private Duty Nursing 6-Month Authorization form must also be completed.

Every submitted authorization request for PDN hours is reviewed by Superior's Medical Management department for medical necessity and appropriate member-to-nurse ratio determination. The submitted Plan of Care should include the appropriate PDN hours and member-to-nurse ratio. HHS's approved PDN ratio criteria and billing methodology are available on the Superior Provider Portal at Provider.SuperiorHealthPlan.com.

It is best practice to submit recertification prior authorization requests at least seven Business Days in advance in order for clinical information to be reviewed, and to prevent delays in care. If it is initially determined that the request does not meet medical necessity, additional documentation may be requested.

Requests for Specialized Services

Specialized Services require prior authorization, these services include, but are not limited to: Elective Inpatient Procedures, Outpatient Surgery, Ophthalmology Services, Dental Therapy Under General Anesthesia, Bariatric Surgery, Allergen Immunotherapy Services, Quantitative Urine Drug Testing,
Non-Emergent Ambulance Transport and Excision of Lesions.

- Member's name
- Pertinent diagnosis/conditions that relate to the need for the service
- Appropriate CPT codes
- Objective supporting clinical documentation
- Frequency and duration
- Date of service (start and end date)

Quantitative Testing for Drugs of Abuse

Superior is committed to delivering cost effective, quality care to its members. This effort includes prior authorization protocols that include medical necessity review to ensure that certain diagnostic lab tests are medically necessary. Requests for prior authorization will be accepted up to 10 Business Days after specimen collection and reviewed for medical necessity.

Superior requires prior authorization for Quantitative Urine Testing for Drugs of Abuse. Laboratory providers must ensure that any drugs of abuse diagnostic testing is prior authorized to facilitate payment. Superior requires laboratory providers to contact ordering providers to verify that a prior authorization number has been obtained for these services. It is the ordering provider's responsibility to request prior authorization for these tests. Laboratory providers may request a prior authorization for Quantitative Testing if the ordering practitioner fails to request for these services.

Immunotherapy Services

Non-allergists, such as PCPs, may apply for credentialing to perform allergy skin testing and to prescribe immunotherapy. PCPs continue to be permitted to administer allergy shots in their offices and clinics. Allergy shots may be given to Superior members who are under the care of an allergist or other credentialed allergy service provider. However, the allergist or other allergy service provider should maintain the responsibility for prescribing and determining the composition and dosing of the allergen serum.

Superior does not require a prior authorization for non-allergists who wish to only administer allergy shots prescribed by a credentialed allergy services provider as long as the non-allergist has submitted a one-time attestation which states that they have been informed of the recommendations for the appropriate equipment and personnel to provide allergy immunotherapy safely.

These include:

- Allergen and venom extract storage (4°C refrigerator with alarm).
- 1 ml (for AIT) and 3 ml (for VIT) disposable (safety) syringes with 27-gauge 5/8 inch needles.

- Epipen auto injectors – 0.3 mg for adults and 0.15 mg for children.
- Crash cart, BLS+ level.
- Glucagon.
- Vital signs monitor.
- Oxygen administration equipment.
- Personnel with BLS+ training.
- Personnel trained to give shots and to recognize and treat anaphylaxis.

The Allergy Skin Testing and Immunotherapy for Non-Allergists and Allergy Immunotherapy for Non-Allergists can be found in the Attachments section.

Once completed, all attestation requests should be emailed to Credentialing@SuperiorHealthPlan.com. Providers will receive notice of verification, or of denial or requests for additional information within 30 Days of submission. Providers must receive verification before administering allergy shots.

Codes 95115 or 95117 should be used when administering these services.

Prior authorization is required for Immunotherapy Services that are above the Medicaid allowable.

Physician Verbal Orders

Verbal physician or allowed practitioner orders may only be given to people authorized to receive them under state and federal law. It must be documented as a verbal order from a physician or allowed practitioner. They must be written, signed and dated by the RN or qualified therapist responsible for furnishing or supervising the ordered service.

Verbal orders will be considered for the full duration of the request. The provider is responsible for obtaining the physical physician or allowed practitioner signature within two weeks. The provider must keep this documentation in the member's file. Superior will do a random, monthly audit for compliance. If it is found that a requesting provider is not in compliance, Superior will no longer accept verbal orders for their requested services.

Out-of-Network Provider Prior Authorization Requirements

Superior recognizes that there may be instances when a referral to an out-of-network provider is appropriate. If an in-network provider is accessible and available to render services, Superior will redirect to an in-network provider. Superior will review the out-of-network request and make a medical necessity decision on the request. All providers who do not have a contract with Superior, must be enrolled as a Medicaid, CHIP or LTSS provider through HHS, to be eligible for authorization to provide services to Superior-enrolled members.

All out-of-network services require prior authorization, with the exception of emergent/urgent services delivered through an out of network provider, and covered services rendered by out of network, hospital-based radiologists, pathologist, emergency room physicians, anesthesiologists and neonatologists.

No prior authorization is required for member access for the following services, if the provider of service is not in Superior's contracted network:

- Early Childhood Intervention (ECI) services
- Services through an Indian Health Care Provider (IHCP) enrolled as a Federally Qualified Health Center (FQHC)
- Family planning services
- Emergent transport in an ambulance
- Transport in an ambulance to a higher level of care

Specialty Referrals

A PCP is required to refer a member to a specialist when medically necessary care is needed, beyond the scope of care provided by the PCP. All health care services should be coordinated through the PCP for referrals to an in-network provider,

when available. Requests for out-of-network specialty providers require prior authorization. Some services, such as family planning and ECI, are an exception and only require self-referral. An authorization number is provided when a request meets criteria after review. An authorization is not a guarantee of payment and is subject to eligibility criteria.

Specialist Referrals to Another Specialist

Superior does not allow specialty providers to refer directly to another specialist. This request must be coordinated through and submitted by the PCP. The specialist may order diagnostic tests without PCP involvement. For members with disabilities, special health care needs, or chronic and complex conditions, there may be instances where a specialist may choose to act as the PCP for a member and assume all of the responsibilities of a PCP. In these situations, members are allowed direct access to the specialist PCP. If the specialist accepts PCP assignment for this member, the specialist may refer the member to other specialists or admit the member to the hospital.

Member Self-Referrals

There are some services to which a member has access without a referral from the PCP. Superior's STAR, STAR Health, STAR Kids and STAR+PLUS members do not need a referral from the PCP for the following services:

- Family planning.
- Texas Health Steps medical and dental checkups.
- Care Management for children and pregnant women.
- Vision.
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope)
- True emergency services.
- Well woman annual examinations.
- OB care.

Superior's CHIP members may self-refer for:

- Well child annual exams.
- Dental.
- Vision.
- Behavioral health (behavioral health related services may be provided by the PCP if it is within their scope).
- True emergency services.
- Well woman annual examinations.
- OB care for those who do not qualify for Medicaid.

Inpatient Notification Requirements

Hospitals must notify Superior of all emergent admissions no later than the close of the next Business Day. Prior authorization is not required for emergency services, urgent care services and post-stabilization services. All non-emergency, elective inpatient admissions require a prior authorization. Emergent inpatient admissions to any level of acute or sub-acute care, skilled nursing facilities, rehabilitation admission, Behavioral Health and all other inpatient facility type require notification. Phone notifications for physical health inpatient admissions may be completed by contacting 1-855-594-6103 for all regions. Fax notifications can be sent to the primary admission fax for physical health at 1-877-650-6942.

Behavioral health admissions may be completed by contacting 1-844-842-2537. Fax notifications can be sent to the primary fax admission fax for behavioral health at 1-800-732-7562.

Failure to notify an emergent inpatient admission by the next Business Day will result in a late notification denial, unless otherwise stated within a contract with Superior. Once the timely request for authorization is received, the request is screened for eligibility and benefit coverage and an authorization number is provided to the hospital by Superior. Clinical will be obtained through a request to the hospital Care Management department or or Utilization Review department.

The URA must make a determination by the close of the next Business Day following the date of request for authorization. In order to meet state requirements, a receipt is required for the clinical on the Day following the request for authorization unless otherwise stated within a contract with Superior. The utilization management clinician will review the clinical to

determine medical necessity and appropriateness of services, including setting of care, are met according to InterQual criteria for medical and behavioral health admissions and 28 T.A.C. §3.8001 et seq. for substance use disorders. If medical necessity is not met through InterQual criteria, clinical policy or 28 T.A.C. §3.8001 et seq, a secondary review is completed by a physician (medical director) to make a final determination. A reasonable opportunity for peer-to-peer discussion is offered to the requesting physician prior to an adverse determination decision.

If approved, a letter will be faxed to the hospital, with approved days and the date of the next review. If a denial is issued, a denial letter is sent to notify the provider of the denial and provide instructions for peer-to-peer review and/or appeal.

Applied Behavior Analysis (ABA)

Superior entered into an agreement with Magellan Healthcare, to implement a prior authorization program for Medicaid's new autism benefit. The Medicaid benefit for Applied Behavior Analysis (ABA) services is for members under 21 years of age with Autism Spectrum Disorder (ASD). This new Medicaid benefit will be available for the following Superior programs:

- STAR
- STAR Health
- STAR Kids
- STAR+PLUS Medicaid for Breast and Cervical Cancer (MBCC) Program

It is the responsibility of the treating Licensed Behavioral Analyst (LBA) to obtain authorization. Providers rendering the below services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Prior authorization is required for the following ABA services:

- Initial evaluation
- Individual treatment
- Group treatment
- Parent/caregiver/family education and training
- Other ABA policies and procedures: ABA re-valuation and interdisciplinary team meeting procedures do not require authorization.

Prior authorization requests should be submitted to Magellan Healthcare by fax 1-888-656-0368 or by calling 1-800-424-4812.

Radiology

For imaging services, Superior uses NIA to provide prior authorization of services. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible. It is the responsibility of the ordering physician to obtain authorization. Providers rendering the below services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

Prior authorization is required for the following outpatient radiology procedures:

- CT/CTA
- MRI/MRA
- PET Scan
- MUGA Scan
- Cardiac imaging modalities: CCTA Stress Echo, Echocardiography (only for STAR+PLUS) and Nuclear Cardiology

Other imaging policies and procedures:

- Emergency room, observation and inpatient imaging procedures do not require authorization.

To reach NIA and obtain authorization, visit RadMD.com or call 1-800-642-7554.

Interventional Pain Management

NIA manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures. It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined below.

Outpatient IPM procedures requiring prior authorization include:

- Spinal Epidural Injections
- Spinal Cord Stimulators
- Paravertebral Facet Joint Injections or Blocks
- Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
- Sacroiliac Joint Injections

Note: A separate prior authorization number is required for each procedure ordered.

Prior authorization is not required through NIA for services performed in the emergency department, on an inpatient basis or in conjunction with a surgery. Prior authorization and/or notification of admission is still required through Superior.

To obtain authorization through NIA, visit RadMD.com or call 1-800-642-7554.

Physical Medicine

NIA provides utilization management for outpatient rehabilitative and habilitative physical (PT), occupational (OT), and speech (ST) therapy services for Superior Medicaid (STAR, STAR+PLUS HCBS Waiver) and CHIP members. This program is consistent with industry-wide efforts to manage the increasing utilization of these services and to ensure quality of care. The provider specialties included in this program are in network PT, OT, and ST providers only.

Prior authorization is not required for Early Childhood Intervention services.

NIA manages the prior authorization process for outpatient therapy services for in network PT, OT, and ST providers only. Claims continue to be processed by Superior.

Services requiring authorization:

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Places of service included in the program:

- Outpatient facilities
- Skilled nursing facilities
- Home health settings

Places of service excluded from the program:

- Hospital emergency departments
- Inpatient hospital or observation status settings
- Acute rehab hospitals

Initial PT, OT, and ST evaluation CPT codes do not require authorization. All other billed codes, even if performed on the same date as the initial evaluation, will require authorization prior to billing. After the initial visit, providers will have up to three Business Days to request approval for the first visit. If requests are received within this timeframe, NIA can backdate the authorization to include other services rendered on the same day as the evaluation.

Providers are encouraged to utilize www.RadMD.com to request prior authorization for therapy services. If providers are unable to use the website, they may call 1-800-424-4916.

Musculoskeletal Care Management (MSK)

In keeping with our commitment of promoting continuous quality improvement for services provided to Superior HealthPlan members, Superior HealthPlan has partnered with NIA to implement a Musculoskeletal Care Management (MSK) program. This program includes prior authorization for non-emergent MSK procedures for Superior HealthPlan members. This decision is consistent with industry-wide efforts to ensure clinically appropriate quality of care and to manage the increasing utilization of these services.

How the Program Works

MSK Surgeries: Prior authorization will be required for the following non-emergent inpatient and outpatient hip, knee, shoulder, lumbar and cervical surgeries:

Hip

- Revision/Conversion Hip Arthroplasty
- Total Hip Arthroplasty/Resurfacing
- Femoroacetabular Impingement (FAI) Hip Surgery (includes CAM/pincher & labral repair)
- Hip Surgery - Other (includes synovectomy, loose body removal, debridement, diagnostic hip arthroscopy, and extra-articular arthroscopy knee)

Knee

- Revision Knee Arthroplasty
- Total Knee Arthroplasty (TKA)
- Partial-Unicompartmental Knee Arthroplasty (UKA)
- Knee Manipulation under Anesthesia (MUA)
- Knee Ligament Reconstruction/Repair
- Knee Meniscectomy/Meniscal Repair/Meniscal Transplant
- Knee Surgery - Other (includes synovectomy, loose body removal, diagnostic knee arthroscopy, debridement with or without chondroplasty, lateral release/patellar realignment, articular cartilage restoration)

Shoulder

- Revision Shoulder Arthroplasty
- Total/Reverse Shoulder Arthroplasty or Resurfacing
- Partial Shoulder Arthroplasty/Hemiarthroplasty
- Shoulder Rotator Cuff Repair
- Shoulder Labral Repair
- Frozen Shoulder /Adhesive Capsulitis Repair
- Shoulder Surgery - Other (includes debridement, manipulation, decompression, tenotomy, tenodesis, synovectomy, claviculectomy, diagnostic shoulder arthroscopy)

Cervical

- Cervical Anterior Decompression with Fusion -Single & Multiple Levels
- Cervical Posterior Decompression with Fusion -Single & Multiple Levels
- Cervical Posterior Decompression (without fusion)
- Cervical Artificial Disc Replacement - Single & Two Levels
- Cervical Anterior Decompression (without fusion)

Lumbar

- Lumbar Microdiscectomy
- Lumbar Decompression (Laminotomy, Laminectomy, Facetectomy & Foraminotomy)
- Lumbar Spine Fusion (Arthrodesis) With or Without Decompression - Single & Multiple Levels
- Lumbar Artificial Disc - Single & Multiple Levels

Sacroiliac

- Sacroiliac Joint Fusion

Cardiac Surgeries

Superior uses TurningPoint Healthcare Solutions for prior authorizations requests for cardiac surgeries. The program is designed to work collaboratively with physicians to promote member safety through the practice of high quality and cost-effective care for Medicaid and CHIP members undergoing cardiac surgeries.

Prior authorization will be required for the following cardiac surgeries in both inpatient and outpatient settings:

- Arterial procedures
- Coronary angioplasty/stenting
- Coronary artery bypass grafting
- Implantable Cardioverter
- Defibrillator (ICD)
- ICD revision or removal
- Left atrial appendage occluders
- Loop recorders
- Non-coronary angioplasty/stenting
- Pacemaker
- Pacemaker revision or removal
- Valve replacement
- Wearable Cardiac Defibrillator

Emergency-related services do not require authorization.

For questions regarding prior authorization requirements, or impacted CPT codes, please contact TurningPoint by email at providersupport@turningpoint-healthcare.com or by calling TurningPoint Provider Support at 1-855-336-4391.

Ear, Nose and Throat Surgery and Sleep Study

Superior uses TurningPoint Healthcare Solutions for prior authorizations requests for Ear, Nose and Throat (ENT) Surgery and Sleep Studies. This program will apply to all Medicaid and CHIP members undergoing ENT surgeries and sleep study procedures.

Prior authorization will be required for the following ENT surgeries and sleep studies performed in the inpatient, outpatient, physician's office and in-home settings:

Ears, Nose and Throat (ENT) Surgeries:

- Tonsillectomy with or without adenoidectomy
- Sinus surgery
- Rhinoplasty and septoplasty
- Laryngoscopy and laryngoplasty
- Cochlear implant device
- Tympanostomy and tympanoplasty
- Thyroidectomy and parathyroidectomy
- Balloon dilation esophagoscopy

Sleep Study Procedures:

- Polysomnography
- Multiple sleep latency and maintenance of wakefulness testing
- Actigraphy
- Home sleep study

For questions regarding prior authorization requirements, or impacted CPT codes, please contact TurningPoint by email at providersupport@turningpoint-healthcare.com or by calling TurningPoint Provider Support at 1-855-336-4391.

Long-Term Services and Supports

STAR+PLUS Long-Term Services and Supports (LTSS) services must obtain authorizations. All requests should be faxed to the STAR+PLUS Service Coordination department at 1-866-895-7856.

LTSS Providers: Notifications to Superior for Changes in a Members's Status

LTSS providers must notify the member's service coordinator whenever there is a change in the member's physical or mental condition, upon knowledge of an inpatient or nursing facility admissions, all member complaints or grievances, or if you identify a member needs services outside the Superior contracted scope of services with the provider.

Additionally, the LTSS provider must notify Superior when services need to be suspended due to any of the following situations:

1. An individual temporarily or permanently leaves the contracted service delivery area.
2. The individual moves to a location where services cannot be provided under the PHC/PAS Program.
3. The individual dies.
4. The individual is admitted into an institution, which is a:
    a. Hospital
    b. Nursing facility
    c. State school
    d. State hospital
    e. Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
    f. Correctional facility

The LTSS provider must also notify Superior when services are scheduled to resume after a suspension.

Service Suspensions

In the event the member's services are suspended the provider must notify Superior as soon as they become aware of the need to suspend services but no later than the first Business Day after the provider suspends services. The notice must include:

1. The date of service suspension
2. The reason(s) for the suspension
3. The duration of the suspension, if known

Resuming Services After Suspension

A provider must resume services after suspension on the earliest of the following:

1. Upon the individual's return home, or the date the provider becomes aware of the individual's return home, if applicable.
2. On the date agreed to and specified in writing by Superior.
3. The LTSS provider must send confirmation that services have resumed no later than seven Days after the start date of the resumed services.

SECTION 10
CLAIMS AND ENCOUNTERS ADMINISTRATION

Depending on your contractual arrangement with Superior, you are required to submit a claim or encounter for each service you render to a Superior member, to the applicable address and/or submission methods referenced in this section. Superior will not accept claims submitted to addresses and/or by submission methods not specified in this section.

Network providers are encouraged to participate in Superior's electronic claims/encounter filing program through Centene Corporation, Superior's parent organization. Centene Corporation has the capability to receive an ANSI X12N 837 professional, institutional and encounter transactions. In addition, Centene Corporation has the capability to generate an ANSI X12N 835 electronic Explanation of Payment (EOP). Superior also has the capability to receive an ANSI X12N 276 health claims status inquiry, and to generate an ANSI X12N 277 health claims status response transaction through Centene Corporation. For more information on electronic claim filing and transactions, contact the Centene EDI Department at 1-800-225-2573 ext. 6075525 or at EDIBA@centene.com.

Providers may elect to submit electronic professional or institutional claims through Superior's Provider Portal at Provider.SuperiorHealthPlan.com. Providers may also use a clearinghouse for electronic claim submissions.

Providers may submit claims on paper, utilizing the standardized CMS-1500 and/or UB-04/CMS-1450 claim forms.

For assistance with accessing the Provider Portal, contact the web applications support desk 1-866-895-8443 or at TX.WebApplications@SuperiorHealthPlan.com.

To file a claim or encounter for behavioral health, vision, dental or pharmacy services, see specific filing information under Submitting Paper Claims and/or Electronic Filing within this section.

Claim Information

Adjusted Claim – The re-adjudication of a previously finalized claim, as result of a claims reconsideration or claims appeal.

Claim Appeal – A claim that has been previously adjudicated as a clean claim and the provider is appealing the disposition through written notification with supporting documentation to Superior and in accordance with the appeal process as defined in this manual. Please see Claim Appeal Process within this section for more information.

Claim Reconsideration – A claim that has been previously adjudicated as a clean or unclean claim.

- **Unclean (deficient denied) claim** - Reconsideration request that includes the missing information necessary to complete adjudication of the claim.
- **Clean claim** – Reconsideration request for which no additional information/documentation is required from the provider to re-adjudicate the claim.

Please see Claim Reconsiderations within this section for more information.

Clean Claim – A claim submitted by a provider for medical care or Health Care Services rendered to a Member that contains accurate and complete data in all claim fields required to adjudicate and accurately report and finalize the claim. Please see Claim Appeal Process within this section for more information. Please see CMS 1500 Claim Form – Clean Claim Requirements and UB-04/CMS 1450 – Clean Claim Requirements within this section for more information.

Corrected Claim – A corrected claim is a resubmission of an original clean claim that was previously adjudicated and included all elements necessary to process the claim, but one or more elements included in the original claim submission required corrections.

Deficient Denied Claim – An unclean claim denied for the purpose of obtaining additional information from the provider. A deficient denied claim requires submission of a Reconsideration Request or a Corrected Claim. Please see Claim Reconsiderations and Corrected Claim Process within this section for more information.

Provider Complaint (claim-related) – A claim that has been prior appealed and the provider is dissatisfied with the outcome of the claim appeal. Please see Filing a Provider Complaint within Section 15 of this manual for more information.

Rejected Claim (Unclean claim) – 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. Claims can be rejected by the provider's clearinghouse, the health plan's EDI process or through the health plan's claims process.

Timely Claim Filing* – The receipt of a clean claim must be within the timeframe applicable to the claim type.

- All outpatient (office, facility, ancillary) provider claims must be received by Superior within 95 Days from each date of service on the claim.
- All inpatient hospital claims (including all interim bills) must be received by Superior within 95 Days from the date of discharge.
- All original nursing facility room and board claim submissions must be received within 365 Days from the date of service on the claim.

*A rejected (unclean) claim submission does not satisfy timely claim submission requirements.

Timely filing – Claim Appeals and Reconsiderations

All claim appeals and requests for reconsideration must be received by Superior within 120 Days from the most recent adjudication date of the claim.

Unclean Claim – A claim submitted by a provider for medical care or health-care services rendered to a member, that does not contain all of the data necessary for Superior to adjudicate and accurately report and process the claim. An unclean claim must be re-submitted to Superior as a clean claim within 95 Days from the date of service of the claim.

Medicaid and CHIP Processing and Payment Requirements

Superior must administer an effective, accurate and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, and the contract, including Chapter 2 of the HHS Uniform Managed Care Manual. In addition, Medicaid and CHIP claim requirements are exempt from the Texas Insurance and Administrative Code claims Prompt Pay requirements.

Superior and its subcontractors cannot directly or indirectly charge or hold a member or provider responsible for **claims adjudication or transaction fees**.

Fee Schedule Changes and Updates

Superior will give providers at least 30 Days notice of changes to Superior's fee schedule, excluding changes derived from changes to the Medicaid fee schedule, before implementing the change.

If the provider's contracted fee schedule is derived from the Medicaid fee schedule, Superior will implement fee schedule changes no later than 60 Days after the Medicaid fee schedule change, and any retroactive claim adjustments will be completed within sixty 60 Days after HHS retroactively adjusts the Medicaid fee schedule.

In the event that Superior implements a contractual rate reduction, Superior will submit written request to HHS's Director of Program Operations and receive HHS approval, at least 90 Days prior to the planned effective date of reimbursement rate reduction.)

Claims Not Eligible for Reimbursement

Superior will not pay any claim submitted by a provider:

- Excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, abuse or waste.
- On payment hold under the authority of HHS or its authorized agent(s).
- For neonatal services provided on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHS.*
- For maternal services provided on or after September 1, 2021, if submitted by a hospital that does not have a maternal level of care designation from HHS.*

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

Present on Admission

Superior validates the following when adjudicating a claim:

- Institutional claims must contain **Present on Admission** (POA) indicators.
  - Superior utilizes the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
  - For all inpatient hospital payments, Superior utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.

Upon receipt of a clean claim, Superior will adjudicate the claim for payment or denial within the 30 Day claim processing timeframe. If denied in whole or in part, Superior will notify the provider of why the claim will not be paid.

The date of a claim payment is the date of issue of a check for payment, or the date of Electronic Funds Transmission (EFT) if payment is made electronically.

Questions about Claims

For all questions related to claim filing, claim status and claim appeals, call the Provider Services department at:

STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP 1-877-391-5921

Capitated Provider Encounters

Some providers may receive a monthly capitation for services. These services may vary per each individual provider, and if applicable, will be listed in the provider's contract with Superior. If you receive monthly capitation for services, you must file a proxy claim on a CMS 1500 for each service provided. This is referred to as an "encounter."

Capitated services are adjudicated to reflect zero dollar payment amounts. It is mandatory that a capitated provider submit encounter claims to Superior, in order for Superior to utilize the encounter data to evaluate all aspects of quality and utilization management.

Claim Payment Timeliness

Clean claims will be processed within 30 Days of receipt.

Each adjudicated claim will be reflected on an EOP, which includes details of the denied or paid claim. See a sample Explanation of Payment in the Attachments section.

Claims Submission Information

All Superior Medicaid and CHIP claims, including special billing (newborns, Value-added Services, supplemental security income, compounded medications, NEMT Services, medical eye care services etc.) should be submitted to:

Superior Claims Department
PO Box 3003
Farmington, MO 63640-3803

Hospital inpatient claims for **CHIP Perinatal** members who are 0-185% FPL should be sent to:

TMHP
P.O. Box 200555
Austin, Texas 78720-0555

Special Instructions for CHIP Perinatal Claims:

- All inpatient hospital claims submitted for CHIP Perinatal members who are 0-185% FPL (Category A on ID card) should be submitted to the Texas Medicaid Claims Administrator (TMHP) as these claims are not processed by Superior.
- All inpatient hospital claims submitted for CHIP Perinatal members above the Medicaid threshold (Category B on ID card) should be submitted to Superior.

Claims for **behavioral health** services are submitted to Superior:

Superior HealthPlan
P.O. Box 6300
Farmington, MO 63640-3806

Claims for eye care services (routine eye exams and eyewear) are submitted to Envolve Benefit Options:

Envolve Benefit Options - Claims
PO Box 7548
Rocky Mount, North Carolina 27804
1-866-897-4785

Dental claims for STAR (Value-added Services only), STAR+PLUS (Value-added and Waiver Services) and STAR Health (foster care) are submitted to DentaQuest:

DentaQuest
TX HHS Dental Program - Claims
PO Box 2906
Milwaukee, WI 53201-2906
1-888-308-4766

Claims for non-emergency medical transportation (NEMT) services should be submitted through the vendor's electronic adjudication system. Questions surrounding NEMT claims should be directed to:

SafeRide Health
106 Jefferson St. Suite 300
San Antonio, TX 78205
1-855-932-2320

Claims for pharmacy benefits should be submitted electronically through the Express Scripts claims adjudication system. Questions surrounding pharmacy claims should be directed to:

Pharmacy Services
Attn: Medicaid Paper Claims
P.O. Box 989000
West Sacramento, CA 95798-9000

STAR Kids Claim Submission Information

Guidelines for STAR Kids member claims, including MDCP waiver services, is provided in the following:

a. Daily rate claims for services rendered in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IDDs) or other related conditions:
   - Superior is not responsible for daily rate claims rendered in an ICF or IDD. These claims should be submitted to HHS for processing (providers may access information on MDCP claims filing through HHS at https://apps.hhs.texas.gov/providers/MDCP/index.cfm). Superior will cover acute care services, and these claims should be sent to Superior.

b. Claims for custom DME or augmentative devices when the member changes MCOs and the authorizing MCO is not the Member's MCO on the date of delivery:
   - If the member was eligible with Superior on the date the custom DME was ordered, Superior will cover the service and claims can be sent to Superior for processing. If the claims are not billed with the date the item is ordered, they will deny for lack of eligibility and have to be appealed for payment.

c. Claims for minor home modifications for a MDCP STAR Kids Waiver member when the member changes MCOs and the authorizing MCO is not the member's MCO on the date of completion of the modifications:
   - If the member was eligible with Superior on the date the minor home mod was started, Superior will cover the service and claims can be sent to Superior for processing. If the claims are not billed with the date the Minor Home Mod was started, they will deny for lack of eligibility and have to be appealed for payment.

d. Claims for LTSS
   - Please refer to the chart below for reference on billing STAR Kids claims.

	SSI	SSI (dual)	MDCP	MDCP (dual)	HHS IDD Waiver	HHS IDD Waiver (dual)	YES Waiver	YES Waiver (dual)
Capitated State Plan LTSS								
Personal Care Services (PCS)	Y	Y	N**	N**	N***	N***	N**	N**
Private Duty Nursing (PDN) services	Y	Y	Y	Y	Y	Y	Y	Y
Prescribed pediatric extended care center (PPECC) services	Y	Y*	Y	Y*	Y	Y*	Y	Y*
Day Activity and Health Services (DAHS)	Y	Y	Y	Y	Y	Y	Y	Y

	SSI	SSI (dual)	MDCP	MDCP (dual)	HHS IDD Waiver	HHS IDD Waiver (dual)	YES Waiver	YES Waiver (dual)
Capitated CFC Services for Qualified Members								
CFC PAS/HAB	Y	Y	Y	Y	N	N	Y	Y
ERS	Y	Y	Y	Y	N	N	Y	Y
Support Management	Y	Y	Y	Y	N	N	Y	Y
Capitated MDCP services for MDCP members								
Respite (in facility / in camp / in home)	N	N	Y	Y	N	N	N	N
Supported Employment	N	N	Y	Y	N	N	N	N
Employment Assistance	N	N	Y	Y	N	N	N	N
Adaptive Aids (NOS, medical equipment, vehicle modification)	N	N	Y	Y	N	N	N	N
Minor home modification	N	N	Y	Y	N	N	N	N
Flexible family support services	N	N	Y	Y	N	N	N	N
Transition assistance services	N	N	Y	Y	N	N	N	N
Financial management services	N	N	Y	Y	N	N	N	N

Y = Service is payable through Superior.

N = Not a covered service for this membership type by Superior, however payment may be available through alternate resources such as the member's CLASS, TxHmL, HCS, or DBMD waiver program.

* Wraparound and crossover for dual eligible STAR Kids members is paid FFS.
** MDCP and YES clients meet the level of care for CFC, so when they need attendant care, they will always get CFC rather than PCS to obtain the higher match.
*** HHS IDD waiver clients qualify for CFC, which is non-capitated. Because they qualify for CFC, they do not qualify for PCS.

Claims Status

Claim status can be be obtained through the Superior web portal as well as by calling the provider hotline. For your convenience, the hotline provides telephony readback of claims status as well as connecting you to a live agent. The hotlines may be reached at the following:.

STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP 1-877-391-5921

Note: Online claims status is maintained for 24 months

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. Superior's software will analyze CPT-4 codes, HCPCS Level II codes, industry standard modifiers and location to compare against rules that have been established by the American Medical Association (AMA) and CMS.

In order to maintain its high standard of clinical accuracy, credibility and physician acceptance, our code editing

software is updated regularly to keep current with medical practices, coding practices, annual changes to the CPT Manual and other industry standards. Superior conducts regular reviews to focus on the annual changes to the CPT Manual and the specialty sections of the CPT Manual.

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 following list gives examples of conditions where code-editing software will make a change on submitted codes:

- Unbundling - Submitting a comprehensive procedure code along with multiple incidental procedure codes that are an inherent part of performing the procedure.
- Fragmentation - Billing all incidental codes or itemizing the components of procedures separately when a more comprehensive code is available.
- Age/Gender – Submitting codes inappropriate for the member's age or gender because of the nature of the procedure.

Superior may request medical records or other documentation to assist in the determination of medical necessity, appropriateness of the coding submitted or review of the procedure billed.

Superior will give providers 90 Days' notice prior to implementation or changes. Superior edits claims based on its posted payment policies, which can be found at www.SuperiorHealthPlan.com/providers/resources/clinical-payment-policies.html.

Postpayment Claim Audit

Superior will complete all audits of a provider claim no later than two years after receipt of a clean claim, regardless of whether the provider participates in Superior's network. 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.

In addition, the two-year limitation does not apply when the officials or entities identified in the Prior Authorization Lists, found in the Attachments section. Section 9.02(c), conclude an examination, audit, or inspection of a provider more than two years after Superior received the claim. Finally, the two year limitation does not apply when HHS has recovered a capitation from Superior based on a Member's ineligibility. If an exception to the two year limitation applies, then Superior may recoup related payments from providers.

If an additional payment is due to a provider as a result of an audit, Superior will make the payment no later than 30 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 Days after it completes the audit. If the provider disagrees with Superior's request, Superior will give the provider an opportunity to appeal, and may not attempt to recover the payment until the provider has exhausted all appeal rights.

Overpayment Identified by a Provider

A provider may identify an overpayment as result of multiple reasons, but may include:

- Erroneous billing by a provider using incorrect NPI, taxonomy, or incorrect member identification number.
- Payment to the provider by a primary insurance Payer, previously unknown or unreported to Superior.
- Duplicative billing by a provider for services previously billed or paid.
- Erroneous billing by a provider for services not rendered.

A provider has an obligation to notify Superior in writing immediately upon identification of an overpayment, but

no more than 30 Days from the date of discovery. Providers must submit the notification of overpayment in writing to Superior. The overpayment can be remediated through refund to Superior, or a provider may request Superior recoup the payment issued in error.

The written notification of overpayment can be submitted on Superior's website electronically or in written form through USPS.

- "Contact Us" Form on the Superior website
- Mail to:

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

The notification should include details of whether the provider plans to submit a refund as a result of the overpayment, or is requesting Superior recoup the overpayment. The notice of overpayment must include the following details:

- Claim number
- Date of Payment/Explanation of Payment (EOP)
- Provider NPI
- Member identification number
- Date of Service

If a provider requests Superior recoup the overpayment, the prior erroneous payment(s) will be reversed by Superior within 30-60 Days of receipt of the request. When the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

If a provider wishes to refund the overpayment by issuing a check to Superior, the refund check must be submitted to Superior within 30 Days of notification of the overpayment, or 60 Days from the date of the discovery of the overpayment, whichever is less. If a refund check is not received within that timeframe, Superior will proceed with recoupment of the overpayment(s).

Each claim overpayment should be accompanied with a copy of the EOP indicating the overpaid claim or claims for which the refund is being submitted, and a brief description of the reason for the overpayment.

Alternatively, a provider may submit the following information with the refund check, if a copy of the EOP is not available:

- Provider Name, Tax ID and NPI; and
- Member Name, date of birth, and Member Medicaid or CHIP identification number; and
- Claim date(s) of service; and
- Brief description/reason for the overpayment.

To submit a refund check, a provider should mail the check and supporting documents to:

Superior HealthPlan
P.O. Box 664007
Dallas, TX 75266-4007

Overpayments Identified by Superior HealthPlan

Superior HealthPlan may also identify overpayments made to a provider, that may occur as result of HHS's retroactive disenrollment of a member who was eligible with Superior at the time of service/submission and

payment of the claim, claims processing errors, retroactive Medicaid or CHIP program or benefit changes, or identification of a primary insurance Payer responsible for payment of a portion or full payment of the claim.

In these circumstances, Superior will typically reverse the prior payment of the claim and recoup the monies paid in error, unless the provider contract requires, or the provider has previously requested that Superior allow the provider the opportunity to refund the overpayment prior to recoupment.

If a provider receives notification of overpayment, and request for refund, the provider should include a copy of the notification of overpayment letter with the refund check, and mail to:

Superior HealthPlan
P.O. Box 664007
Dallas, TX 75266-4007

If the overpayment is recouped, the reversal of the prior payment will be reflected on the provider's EOP after the claim is adjusted, and the monies prior paid will be deducted from the net amount due for claim payments as documented on the current EOP.

If a provider has requested, or the provider's contract requires prior notification and opportunity to submit a refund as result of an overpayment identified by Superior, the provider will receive a letter explaining the reason for the overpayment, and requesting a refund be submitted within the appropriate timeframe as documented in the overpayment notice to the provider. If the refund is not received within that timeframe, Superior will proceed with reversal of the erroneous payment, recouping the payment prior issued.

Third Party Liability

Third party liability is defined as the legal responsibility of another individual or entity to pay for all or part of the services provided to members. Federal and state law require Medicaid (STAR/STAR+PLUS/STAR Kids/CHIP) be the payer of last resort. STAR, STAR+PLUS, STAR Kids and CHIP providers must comply with the provisions of 1 TAC §354, relating to third party recovery in the Medicaid program.

Coordination of Benefits

Superior does not actively pursue Coordination of Benefits (COB) for STAR Health members. Any other insurance, including Medicare, is always primary to Medicaid coverage. If a STAR, STAR+PLUS, STAR Kids (including Medicare dual eligible STAR Kids), or CHIP member has other insurance, you must submit your claim to the primary insurance for consideration. For Superior payment consideration, file the claim with a copy of the EOB, EOP or rejection letter from the other insurance. *Please note: Services that are non-covered by Medicare do not require a Medicare denial EOP to be processed for payment by Superior.* If this information is not sent with an initial claim filed for a member with other insurance, the claim will pend and/or deny until this information is received. If a member has more than one primary insurance (Medicaid would be the third payer), the claim can be submitted through EDI, the Secure Provider Portal or on paper.

Information Sources for Third Party Recovery

Third Party Recovery (TPR) means the recovery of payments on behalf of a member by Superior from an individual or entity with the legal responsibility to pay for the covered service. Superior providers are requested to provide Superior with any TPR information that they obtain from the member. TPR information should be reported to Superior's Provider Services Department at:

STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP 1-877-391-5921

The Your Texas Benefits Medicaid card (formerly Medicaid Form 3087) also contains a TPR column. The TPR column

will indicate if other insurance has been reported by including an "M" (Medicare) and/or a "P" (Other Insurance). See a sample Your Texas Benefits Medicaid Card in the Attachments section.

Billing Codes

It is important that providers bill with codes applicable to the date of service on the claim. Billing with obsolete codes will result in denial/rejection of the claim and a consequent delay in payment. Claims should be billed using the following coding:

- Submit professional claims with current and valid CPT-4, HCPCS, or ASA codes and ICD-10 codes.
- Submit institutional claims with valid revenue codes and CPT-4 or HCPCS (when applicable), ICD-10 codes and DRG codes (when applicable).

Claims must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 11-148), regarding mandatory state use of national correct coding initiatives, including all applicable rules, regulations and methodologies implemented as a result of this initiative.

Superior requires the use of valid ICD-10 diagnosis codes to the ultimate specificity, for all claims. See the ICD-10 coding manual for details.

The highest degree of detail can be determined by using the tabular list (volume one) of the ICD-10 coding manual in addition to the alphabetic list (volume two), when locating and designating diagnosis codes. Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

The tabular list gives additional information such as exclusions and subdivisions of codes not found elsewhere in the manual. Any three-digit code that has subdivisions must be billed with the appropriate subdivision code(s) and be carried out to ultimate specificity if appropriate.

Ancillary providers (e.g., labs, radiologists, etc.) and those physicians interpreting diagnostic testing may use appropriate and most current V codes for laboratory exam, radiological exam, NEC and other specified exam as the principal diagnosis on the claim. Please consult your ICD-10 Manual for further instruction.

Failure to code diagnoses to the appropriate level of specificity will result in denial of the claim and a consequent delay in payment.

Delivery and Postpartum Services Billing

Claims for delivery and postpartum services must be billed separately for all products. Superior will reimburse for two postpartum visits. Please see the tables below for Reimbursable and Non-Reimbursable Codes:

Reimbursable Codes				
Procedure Code				**Code Description**
59409		59612		Vaginal Delivery Only
59514		59620		C-Section Delivery Only
59430				Postpartum Outpatient Visit
Non-Reimbursable Codes				
Procedure Code				**Code Description**
59400		59410		Vaginal Delivery including Postpartum Care
59510				C-Section Delivery & Postpartum Care
59610	59614	59618	59622	Delivery after C-Section including Postpartum Care

Private Duty Nursing Billing

Home health agencies must bill Private Duty Nursing (PDN) services for client's birth through 20 years of age who have had a tracheostomy or are ventilator-dependent.

Superior requires providers to bill procedure code T1000 with modifiers TD UA (services performed by a RN), TE UA (services performed by a LVN) or U3, TD, UA (Independently Enrolled Specialized LVN) or U3, TD, UA (Independently Enrolled Specialized RN), in addition to one of the diagnosis codes in the table below. Diagnosis must be in the first diagnosis position on the claim form.

Diagnosis Codes						
J9500	J9501	J9502	J9503	J9504	J9509	J95850
Z430	Z930	Z990	Z9911	Z9912	Z9981	Z9989

National Drug Code

The National Drug Code (NDC) is an 11-digit number on the package or container from which the medication is administered. All providers must submit an NDC for professional or outpatient claims submitted with provider-administered prescription drug procedure. Codes in the "A" code series do not require an NDC. N4 must be entered before the NDC on claims. Units of measurement are required for each NDC code submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ME – Milligram
- ML – Milliliter
- UN – Unit

Unit quantities are also required for each NDC code submitted.

Superior will reimburse providers only for clinician-administered drugs and biologicals whose manufacturers participate in the Centers for Medicare & Medicaid Services (CMS) Drug Rebate Program and that show as active on the CMS list for the date of service the drug is administered. CMS maintains a list of participating manufacturers and their rebate-eligible drug products, which is updated quarterly on the CMS website.

When providers submit claims for clinician-administered drug procedure codes, they must include the National Drug Code of the administered drug as indicated on the drug packaging. Superior will deny claims for drug procedure codes under the following circumstances:

- The NDC submitted with the drug procedure code is not on the CMS drug rebate list that was current on the date of service.
- The NDC submitted with the drug procedure code has been terminated.
- The drug procedure code is submitted with a missing or invalid NDC.

To avoid claim denials, providers must speak with the pharmacy or wholesaler with whom they work to ensure the product purchased is on the current CMS list of participating manufacturers and their drugs. Anytime a provider submits a national drug code on a claim, regardless if the Healthcare Common Procedure Coding System (HCPCS) is on the Vendor Drug Program NDC to HCPCS crosswalk, the following guidelines must be followed:

1. Length of National Drug Code must be 11
2. Data in National Drug Code must be numeric
3. First five characters of National Drug Code can't be 00000 or 99999

Payment Integrity

Superior may conduct audits of a provider's claims internally, directly through the health plan. In addition, Superior also contracts with companies that conduct payment integrity audits on Superior's behalf. Payment integrity audits review claims to validate appropriate billing/payment to include identification of overpayments.

When a payment integrity audit is conducted, notification of the audit and a list of the claims that will be reviewed is sent to the provider. The request contains the documentation that must be included with the clinical record. Clinical documentation must be received on or before the due date indicated in the audit request. **Failure to timely submit the requested records may result in recovery of the previously paid claim**.

Following review of the clinical documentation, results of the review is supplied to the provider. If discrepancies between the provider's billing and review of the medical record documentation is identified, providers are given details of the inconsistencies with the opportunity to remediate potential findings prior to finalization of the review.

Providers are given the opportunity to appeal the final audit findings prior to recovery of any identified overpayment. The appeal must be submitted in writing and include evidence to support the provider's appeal of the overpayment. **The appeal request must be received within 45 Calendar Days from the date of the audit-finding letter**. If no appeal of the audit findings is received within the time frame, Superior and its contracted vendors will proceed with recovery of the identified overpayment.

Electronic Billing

Superior encourages all providers to file claims and/or encounters electronically.

Electronic claims have the same filing deadlines as paper claims (please see Claims Information in this section). Electronic claims submissions are required within 95 Days of the date of service.

Options for electronic filing:

1. Electronic claims/encounter program through the EDI Department:

   Network providers are encouraged to participate in Superior's electronic claims/encounter filing program through Centene Corporation. Centene Corporation has the capability to receive an ANSI X12N 837 professional, institutional and encounter transaction. In addition, Centene Corporation has the capability to generate an ANSI X12N 835 electronic EOP. For more information on electronic claim filing, contact the EDI Department at 1-800-225-2573 ext. 6075525 or at EDIBA@centene.com.

   Submission of a claim to the clearing house does not guarantee that the claim was transmitted or received by Superior. Providers are responsible for monitoring their error reports to ensure all transmitted claims and encounters appear on reports.

2. Website filing through Superior's Secure Provider Portal:

   Providers may also elect to submit claims both CMS-1500 and UB-04/CMS 1450 through Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

   This option does not require use of a clearing house. Claims are submitted directly to Superior for consideration of payment. There is no cost for this service. Providers can also use this website to review status of claim submissions. For more information on the Provider Portal and other website features, refer to Section 17.

To process your claim or encounter, please remember the following:

- All documentation must be legible.
- Superior utilizes the EDI version 5010 guidelines as mandated by HIPAA rules.
- PCPs and all participating providers must submit

claims or encounter data for every patient visit, even though they may receive a monthly capitation payment.

- All claims and encounter data must be submitted on either a CMS 1500 or UB-04/CMS 1450 form, or on electronic media in an approved, HIPAA-compliant format.
- Superior members should not be billed by any provider for covered services. Please refer to your provider contract with Superior. Superior STAR, STAR Health (foster care), STAR KIDS and STAR+PLUS members do not have copayments or out-of-pocket expenses for covered benefits.
- Superior CHIP members may have copayments. These cost sharing arrangements are described in Section 4.
- CHIP Perinatal members do not have copayments or cost sharing arrangements. CHIP members who are Native Americans or Alaskan natives do not have copayments.
- Medicaid newborns should receive a Medicaid ID number within 30 Days of their birth. Until that time, all claims related to the care of the newborn should be filed with the mother's Medicaid ID number followed by the letter "A." For multiple births use the letter "B" or "C" as needed.
- Emergency services claims should follow standard billing procedures outlined herein and as noted in terms of individual contracts.

Behavioral health providers who wish to file claims electronically should contact Account Management at:

STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP..... 1-877-391-5921

Routine vision providers should contact the Envolve Benefit Options Provider Relations Department at 1-888-756-8768 for information regarding electronic billing.

Note: Please contact Superior Provider Services at 1-877-391-5921 for Medical eye care services.

Dental providers should contact DentaQuest regarding dental claims at 1-888-308-9345.

Pharmacy claims questions should be directed to Pharmacy Services at 1-800-460-8988.

Billing the Member

Providers may not bill members directly for STAR, STAR Health (foster care), STAR KIDS, STAR+PLUS or CHIP covered services. Superior reimburses only those services that are medically necessary and a covered benefit in the STAR, STAR Health, STAR Kids, STAR+PLUS or CHIP programs. This information can be found in your provider contract with Superior.

Superior STAR, STAR Health, STAR KIDS, STAR+PLUS and CHIP Perinatal members do not have copayments. Superior CHIP members may share costs. Cost sharing information is included in Section 4.

Member Acknowledgement Statement

The only occasion when a provider may bill a member is when the member has completed a member acknowledgement statement.

A provider may bill a member for a claim denied as not being medically necessary or not a part of a covered service if both of the following conditions are met:

- A specific service or item is provided at the request of the patient.
- The provider has obtained and kept a written member acknowledgement statement signed by the client. The member acknowledgment statement must read as follows: "I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under the Texas Medicaid Assistance program or the Children's Health Insurance Program as being reasonable and medically necessary for my care. I understand that Superior, through its contract with HHS, determines the medical necessity of the services or items

that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

Private Pay Form

In STAR, STAR+PLUS,STAR Kids, STAR Health (foster care) and CHIP there are very limited instances when a provider may bill the member, if non-covered Medicaid or Chip services are provided. The provider must inform the member before services are provided that the member will be responsible for paying for all services. It is suggested that the provider use the member acknowledgment statement provided above as the Private Pay form, or use the Private Pay Agreement form found in the Texas Medicaid Provider Procedures Manual. Superior has provided a sample of the Private Pay Agreement, found in the Attachments section, for your reference. Without written, signed documentation that the member has been properly notified of their private pay status, the provider cannot ask for payment from a member.

Use of Assistant Surgeons

An assistant surgeon is defined as a physician who utilizes professional skills to assist the primary surgeon on a specific procedure. The procedures that are allowed an assistant surgeon are Medicare-approved procedures as indicated in the Texas Medicaid Provider Procedures Manual. An assistant surgeon's presence at the surgeries listed on the Medicare-approved assistant surgeon list are presumed to be medically necessary. All assistant surgeon's procedures, including those on the assistant surgeon's list, are subject to retrospective review for medical necessity by Superior's Medical Management Department. All assistant surgeon's procedures are subject to Superior policies and are not subject to policies established by contracted hospitals.

Hospital medical staff bylaws that require an assistant surgeon be present for a designated procedure are not grounds for reimbursement. Medical staff bylaws alone do not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests an assistant surgeon be present for the surgery. Coverage and subsequent reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the procedure.

Claims Tied To Multiple Authorizations

Superior frequently issues authorizations that extend to multiple dates of service. To avoid claim denials, the dates of service billed on a claim must be covered under a single authorization. If the dates of service billed are covered by multiple authorizations, the claim may be split and billed one of the following ways for each authorization:

- On separate lines within a single claim; or
- On separate claim forms as multiple claims.

Ensure that each claim dates of services match the authorization dates of service.

Billing Errors

Table 11-1 lists common billing errors. Accessing the information in this table may help you to avoid rejected claims or encounters.

Table 11-1 Common Billing Errors

Type	Information
CPT/HCPCS	Use specific CPT or HCPCS codes. Avoid the use of non-specific or "catch-all" codes (i.e. 99070) unless required by HHS. Use the most current CPT or HCPCS codes according to Texas Medicaid guidelines.
Diagnosis Codes	Use current diagnosis codes and code to the highest level of specificity available.
Accident Claims	Attach liability carrier disposition or accident details/supporting documentation if no liability carrier is involved.
Medicaid and CHIP- NPI number CMS 1500	Field 17a: Qualifier 0B, 1G, G2 or LU plus taxonomy of referring. Field 17b: NPI of ordering and referring providers (If unable to attain please populate with servicing provider's NPI. This field will not be used for claims processing but is required to be filled) Effective October 1, 2017 claims will reject if field 17b is not appropriately filled out. Field 24jb: NPI of servicing providers. Enter the billing NPI if services are not provided by an individual (e.g., DME, independent lab, home health, RHC/FQHC general medical exam, etc.). Field 24i : Qualifier = ZZ. Field 24ja: Servicing provider primary taxonomy code. Field 25 : Tax identification number. Field 33: ZIP+4 of the billing provider's service location. Field 33a: NPI of billing provider. Field 33b: Qualifier = ZZ plus taxonomy code of the billing provider. Provider must bill with their attested taxonomy.
Medicaid andCHIP - NPI number UB-04/ CMS 1450	Form Locator Field 1: Billing provider service location name, address and ZIP+4. Form Locator Field 5: Tax identification number of billing provider. Form Locator Field 56: NPI number of billing provider. Form Locator Field 81: B3 qualifier. Form Locator Field 76: NPI of attending physician. Form Locator Field 76 Qual: B3 plus taxonomy of attending physicians. Form Locator Field 77: NPI of operating physician. Form Locator Field 77 Qual: B3 plus taxonomy of operating physician. Effective October 1, 2017 the referring provider will need to be billed in boxes 78 and 79 and include the NPI and taxonomy information.
CHIP NPI	Populate box 24j of the CMS 1500 and box 51 of the UB-04/CMS 1450 with the appropriate provider Superior assigned number for services rendered. (Please contact Provider Services.)
Member Information	Ensure that member's name, date of birth and ID number coincides with Superior ID card, DFPS Medicaid 2085 or HHS "Your Texas Benefits" Medicaid card (formerly Medicaid form 3087).
Other Insurance	Verify other insurance information and attach primary insurance EOP with the paper claim or include primary insurance EOP electronically using EDI or Superior's Secure Provider Portal.
Texas Health Steps	Bill all required Texas Health Steps components per Medicaid guidelines. Texas Health Steps condition indicator must be provided.
Therapy Services	Attach MD evaluation order for processing. Therapy evaluations do not require a modifier.
Ambulance Claims	When drop off location has a valid NPI, box 32 should be completed with facility name and complete address (street, city, state, zip code), including NPI noted in 32a. When drop off location DOES NOT have a valid NPI, box 32 and 32a should be left blank (ex. member's home). Please note: If services are for air ambulance, box 32 and 32a should be completed using the facility information where the member will receive treatment.

Claims Reconsiderations

A request for reconsideration of the claim can be initiated by a provider or by the health plan.

If initiated by the provider, the reconsideration request may be submitted orally or in writing, and must be received within 120 Days of the original adjudication of the claim.

- Oral request - No additional information or documentation is required from the provider to re-adjudicate the claim.
- Written request - Additional information/documentation is required to support the reconsideration (adjustment) request.
  - These may be submitted on paper or electronically through the secure provider portal.

- If submitted on paper, the provider must submit the Reconsideration Request Form with the applicable documentation (See Claim Reconsideration Form, found in the Attachment section.) Examples of reconsideration requests that require written request include:
  - Claims denied for missing sterilization consent form
  - Claims denied for other insurance, primary Payer Explanation of Payment required
  - Claims denied for invoice required
  - Claims denied for itemized bill required
  - Claims denied as result of billing an unlisted procedure code
  - Claims denied administratively, requesting medical records to substantiate payment (Not related to medical necessity denial/appeal)

The required information/documentation must be submitted along with the Claim Reconsideration Request Form, found in the Attachments section, within 120 Days of the deficient claim denial.

Medical Necessity Claim Appeal

A medical necessity appeal is a written request from a member or provider who is appealing on the member's behalf to reconsider a medical necessity denial. This applies to a retrospective review of a service that has already been performed but is partially or fully denied. Please refer to Section 11 for instructions on how to submit medical necessity appeals.

Rejected Claim Process (Unclean Claim)

Rejected claims are returned with messages that provide the reason for rejection. Provider's submitting claims through the portal must resolve any errors in order to successfully submit.

Unclean paper claims may also be rejected with a letter from Superior HealthPlan explaining the reason for the rejection. **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**.

Corrected Claim Process

Providers may correct any necessary field of the HCFA-1500 and UB-04 forms. The descriptions of each field for a HCFA-1500 can be found within the Claims and Encounters section.

Corrected claims may be submitted electronically via EDI, Superior's Secure Provider Portal or by mail.

All corrected claims:

- Must be free of handwritten or stamped verbiage (paper claims). Must be submitted on a standard red and white UB-04 or HCFA 1500 claim form (paper claims).
- Original claim number must be inserted in field 64 of the UB-04 or field 22 of the HCFA 1500 of the paper claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the UB-04 and 22 of the HCFA 1500.
  - The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for HCFA 1500 claim forms or the UB Editor (Uniform Billing Editor) for UB-04 claim forms.
- Corrected claims must be sent within 120 Days of the most recent adjudicated date of the claim, as reflected in the Explanation of Payment. To submit corrected claims on paper, mail to the following address:

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

Failure to comply with the above data elements may result in denials or rejections.

Claim Appeal Process

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. All claims appeals regarding the amount reimbursed or regarding a denial for a particular service must be submitted in writing and include all necessary documentation. Any adjustments as the result of a claim appeal will be provided by check with an EOP, reflecting the adjustment of the claim. A Claim Appeal Form, found in the Attachments section, must be sent in with a claim appeal.

When submitting claims, please follow these guidelines:

- Claims must be received by Superior within 95 Days from each date of service on the claim. Final inpatient hospital claims must be received by Superior within 95 Days from the date of discharge.
- All claim appeals must be finalized within 24 months from the date of service.
- All appeals of claims and requests for adjustments must be received by Superior within 120 Days from the date of the last denial of and/or adjustment to the original claim.

To submit an appeal on paper, mail the appeal to the following address:

Superior HealthPlan
Attn: Claims Appeals
P.O. Box 3000
Farmington, Missouri 63640-3800
Fax: 1-833-951-1187

Providers may submit appeals via fax only for single member claim appeals. CMS 1500 or UB04 claims cannot be faxed.

Superior will process the appeal and make a determination within 30 Days from the date of receipt of the appeal. Superior's contract with each provider allows for the resolution of disputes through binding arbitration.

Refer to Section 11 for instruction on how to submit medical necessity appeals.

Provider Appeal Process to HHS (related to claim recoupment due to member disenrollment)

Upon notification of a claims payment recoupment, the first step is for the provider to recheck Member eligibility to determine if a member eligibility change was made to Fee-for-Service or to a different managed care organization on the date of service.

1. **Member eligibility changed to Fee-for-Service on the date of service**

   Provider may appeal claim payment recoupment by submitting the following information to HHS:

   - A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
   - **The Explanation of Benefits (EOB) showing the original payment.** Note: This is also used when issuing the retro-authorization as HHS will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.

- **The EOB showing the recoupment and/or the plan's "demand" letter for recoupment.** If sending the demand letter, it must identify the client name, identification number, DOS and recoupment amount. The information should match the payment EOB.
- **Completed clean claim.** All paper claims must include the rendering and billing provider NPI and Taxonomy Code. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.
- **Note:** Label the request "**Expedited Review Request**" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.
- Mail appeal requests to:
  Texas Health and Human Services
  HHS Claims Administrator Contract Management
  Mail Code-91X
  P.O. Box 204077
  Austin, Texas 78720-4077

Prepare a new paper claim for each claim that was recouped, and insert the new claims as attachments to the administrative appeal letter. Include documentation such as the original claim and the statement showing that the claims payment was recouped.

Submission of the new claims is not required before sending the administrative appeal letter. However, if a provider appeals prior to submitting the new claims, the provider must subsequently include the new claims with the administrative appeal.

HHS Claims Administrator Contract Management only reviews appeals that are received within 18 months from the date-of-service. In accordance with 1 TAC § 354.1003, providers must adhere to all filing and appeal deadlines for an appeal to be reviewed by HHS Claims Administrator Contract Management and all claims must be finalized within 24 months from the date of service.

2. Member eligibility changed from one Managed Care Organization (MCO) to another on the Date-of-Service

Providers may appeal claims payment recoupments and denials of services by submitting the following information to the appropriate MCO to which the Member eligibility was changed on the date of service:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The EOB showing the original payment. The EOB showing the recoupment and/or Superior's "demand" letter for recoupment must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Documentation must identify the client name, identification number, DOS, and recoupment amount, and other claims information.
- Note: Label the request "Expedited Review Request" at the top of the letter to ensure the appeal request is reviewed prior to 18 months from the date of service.

Submit appeals online at: Provider.SuperiorHealthPlan.com

Mail Fee-for-Service related appeals to:
Texas Health and Human Services
HHS Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

CMS 1500 Form - Billing Requirements

Only CMS 1500 claim forms printed in Flint OCR Red, J6983 ink (or exact match) are acceptable. Although the CMS-1500 form can be downloaded and printed, copies of the form cannot be used for submission of claims, since the copy may not accurately replicate the scale or OCR color of the form.

See a sample CMS 1500 in the Attachments section.

Paper claims submitted outside of this format will be rejected. Providers are highly encouraged to submit forms electronically via our secure Provider Portal.

CMS 1500 Claim Form - Clean Claim Requirements

The following table outlines each field within a CMS 1500 form. Please note:

- Required fields (indicated as "R") must be completed on all claims. Claims with missing or invalid required field information will be rejected or denied.
- Conditional fields (indicated as "C") must be completed if the information applies to the situation or the service provided.
- Not Required field (indicated as "Not Required") will not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	Insurance Program Identification	Check only the type of health coverage applicable to the claim. This field indicates the payer to whom the claim is being filed. Select "D", other.	Not Required
1a	Insured ID Number	The 10 digit Medicaid ID number on the member's Superior ID card.	R
2	Patient's Name (Last Name, First Name, Middle Initial)	Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames.	R
3	Patient's Birth Date / Sex	Enter the patient's eight digit date of birth (MM/DD/YYYY) and mark the appropriate box to indicate the patient's sex/gender. M = male F = female	R
4	Insured's Name	Enter the patient's name as it appears on the member's Superior ID card.	R
5	Patient's Address (Number, Street, City, State, Zip code), Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a 9-digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1.	R
6	Patient's Relation to Insured	Always mark to indicate self.	C
7	Insured's Address (Number, Street, City, State, Zip code), Telephone (include area code)	Enter the patient's complete address and telephone number including area code on the appropriate line. First line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Second line – In the designated block, enter the city and state. Third line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)5551414). Note: Patient's telephone does not exist in the electronic 837 Professional 4010A1.	Not Required
8	Reserved for NUCC use		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
9	Other Insured's Name (Last Name, First Name, Middle Initial)	Refers to someone other than the patient. Required if patient is covered by another insurance plan. Enter the complete name of the insured.	C
9a	Other Insured's Policy or Group Number	Required if # 9 is completed. Enter the policy or group number of the other insurance plan.	C
9b	Reserved for NUCC use	This field was previously used to report "Other Insured's Date of Birth, Sex" but it does not exist in 5010A1. The NUCC will provide instructions for any use of this field.	Not Required
9c	Reserved for NUCC use	This field was previously used to report "Employers Name or School Name" but it does not exits in 5010A1. The NUCC will provide instructions for any use of this field.	Not Required
9d	Insurance Plan Name or Program Name	Required if # 9 is completed. Enter the other insured's (name of person listed in box 9) insurance plan or program name.	C
10a, b, c	Is Patient's Condition Related To:	Enter a yes or no for each category/line (a, b and c). Do not enter a yes and no in the same category/line.	R
10d	Reserved for Local Use		Not Required
11	Insured's policy group or FECA number	Required when other insurance is available. Enter the policy, group, or FECA number of the other insurance.	C
11a	Insured's Date of Birth / Sex	Same as field 3.	C
11b	Other Claim ID (Designated by NUCC)	The "Other Claim ID" is another identifier applicable to the claim.	
11c	Insurance Plan Name or Program Name	Enter name of the insurance health plan or program.	C
11d	Is There Another Health Benefit Plan	Mark yes or no. If yes, complete # 9a-d and #11c.	R
12	Patient's or Authorized Person's Signature	Enter "Signature on File," "SOF," or the actual legal signature. The provider must have the member's or legal guardian's signature on file or obtain their legal signature in this box for the release of information necessary to process and/or adjudicate the claim.	Required
13	Patient's or Authorized Person's Signature		Not Required
14	Date of Current Illness), or Injury (), or Pregnancy (LMP)	Enter the six digit (MM/DD/YY) or eight digit (MM/DD/YYYY) date reflecting the first date of onset for the Present Illness, Injury or LMP (last menstrual period) if pregnant. Enter the applicable qualifier to identify which date is being reported: 431 Onset of Current Symptoms or Illness 484 Last Menstrual Period Enter the qualifier to the right of the vertical, dotted line.	C
15	Other Date	Enter another date related to the patient's condition or treatment. Enter the date in the six digit (MM|DD|YY) or eight digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported: 454 Initial Treatment 304 Latest visit or Consultation 453 Acute manifestation of a Chronic Condition 439 Accident 455 Last X-ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the patient's condition or treatment.	C

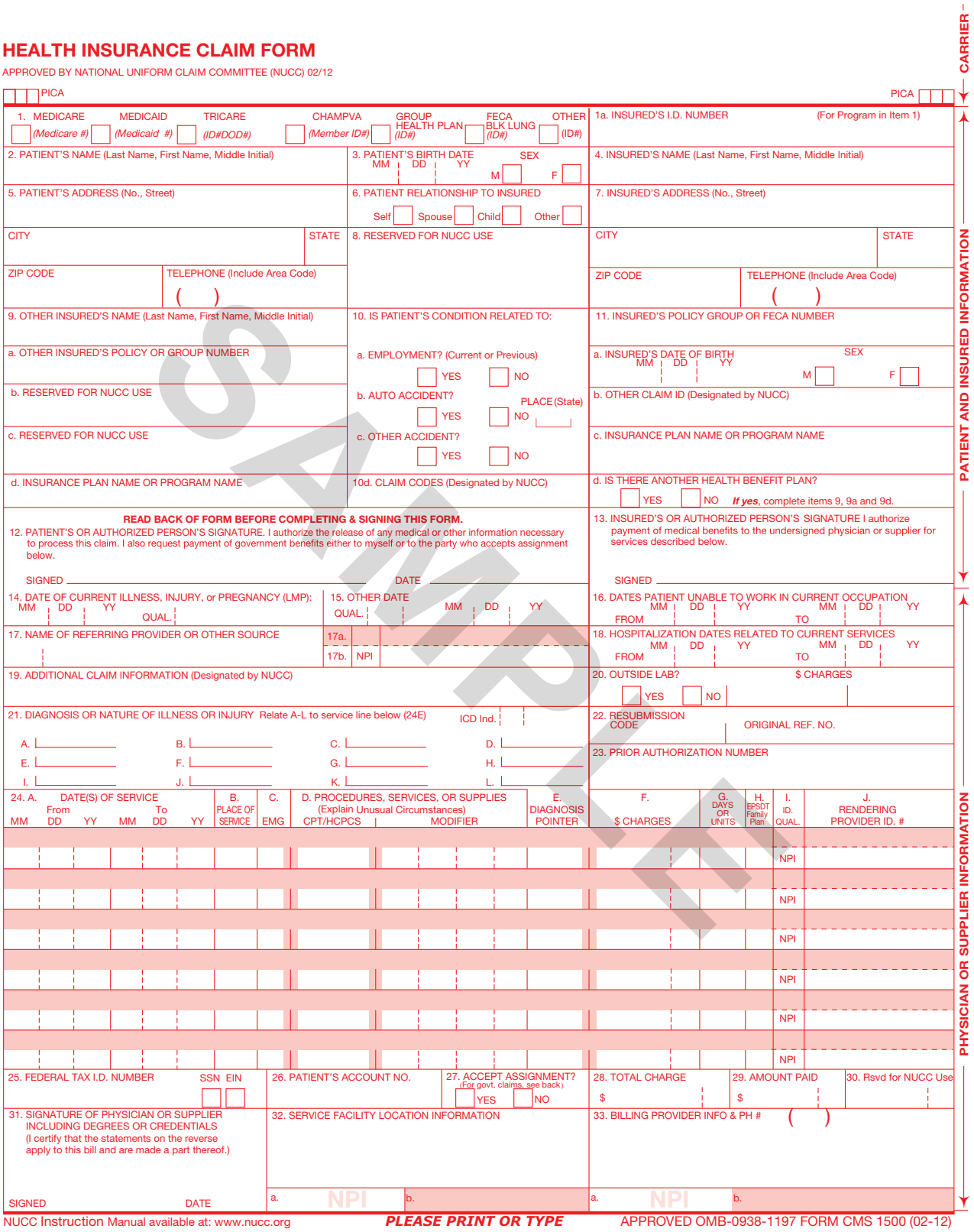
Field #	Field Description	Instruction or Comments	Required or Conditional
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, a six digit (MM/DD/YY) or eight digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.	C
17	Name of Referring Physician or Other Source	Enter the name (First Name, Middle Initial, Last Name) followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim. If multiple providers are involved, enter one provider using the following priority order: 1. Referring provider 2. Ordering provider 3. Supervising provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter the applicable qualifier to identify which provider is being reported: DN Referring provider DK Ordering provider DQ Supervising provider Enter the qualifier to the left of the vertical, dotted line.	C
17a	ID Number of Referring Physician	Required if 17 is completed. Use ZZ qualifier for taxonomy code. Must bill taxonomy provider is attested to.	C
17b	NPI Number of Referring Physician	Required if 17 is completed. If unable to obtain referring NPI, servicing NPI may be used.	C
18	Hospitalization Dates Related to Current Services		Not Required
19	Supervising Physician for Referring Physician	If there is a Supervising Physician for the referring or ordering provider that is listed in Block 17, the name and NPI of the supervising provider must go in Block 19.	Not Required
20	Outside Lab/Charges	Check the appropriate box. The information may be requested for retrospective review. If "yes," enter the provider identifier of the facility that performed the service in block 32	Not Required
21	Diagnosis or Nature of Illness or Injury. (Relate Items A-L to service line below (24E)	The "ICD Indicator" identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim. Enter the applicable ICD indicator to identify which version of ICD codes is being reported: 0 ICD-10-CM Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes to identify the patient's diagnosis and/or condition. List no more than 12 ICD-10-CM diagnosis codes. Relate lines A - L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field. Claims missing or with invalid diagnosis codes will be denied for payment.	R
22	Resubmission Code / Original Reference Number	For resubmissions or adjustments, enter the 12 character document control number (DCN) of the original claim.. Note: For resubmissions submitted via EDI, the CLM05-3 must be "7" and in the web loop a RED "F8" must be sent with the original claim number.	R
23	Prior Authorization Number	Superior does not require the Prior Authorization Number on the Claims form; it is stored with the case internally, so must still be requested as needed. Providers are encouraged to enter their Clinical Laboratory Improvement Amendments (CLIA) Number as assigned. Enter any of the following: prior authorization number, referral number, mammography pre-certification number, or Clinical Laboratory Improvement Amendments (CLIA) number, as assigned by the payer for the current service. Do not enter hyphens or spaces within the number	R

<table>
<tr><th>Field #</th><th>Field Description</th><th>Instruction or Comments</th><th>Required or Conditional</th></tr>
<tr><td>24A -J</td><td>General Information</td><td>Box 24 contains six claim lines. Each claim line is split horizontally into shaded and unshaded areas. Within each unshaded area of a claim line there are 10 individual fields labeled A-J. Within each shaded area of a claim line there
are four individual fields labeled 24A-G, 24H, 24J and 24Jb. Fields 24A-G are
a continuous field for the entry of supplemental information. Instructions are provided for shaded and unshaded fields.
The shaded area for a claim line is to accommodate the submission of supplemental information, EPSDT qualifier, Provider Medicaid number qualifier, and provider Medicaid number.
Shaded boxes A-G is for line item supplemental information and is a continuous line that accepts up to 61 characters.
The un-shaded area of a claim line is for the entry of claim line item detail.</td><td>See Below</td></tr>
<tr><td>24A-G
Shaded</td><td>Supplemental
Information</td><td>The shaded top portion of each service claim line is used to report supplemental information for:
Qualifier along with NDC, units and base measurement code are required where applicable
Compound drug elements
Anesthesia start/stop time and duration
Unspecified, miscellaneous, or unlisted CPT and HCPC code descriptions
HIBCC or GTIN number/code</td><td>C</td></tr>
<tr><td>24A
Unshaded</td><td>Date(s) of Service</td><td>Enter the date the service listed in 24D was performed (MM/DD/YY). If there is only one date, enter that date in the From field. The To field may be left blank or populated with the From date. If identical services (identical CPT/HCPC code(s)) were performed, each date must be entered on a separate line.</td><td>R</td></tr>
<tr><td>24B
Unshaded</td><td>Place of Service</td><td>Enter the appropriate two digit CMS standard place of service (POS) code. A list of current POS codes may be found on the CMS website or the following link:
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html</td><td>R</td></tr>
<tr><td>24C
Unshaded</td><td>EMG</td><td>Enter Y (yes) or N (no) to indicate if the service was an emergency.</td><td>R</td></tr>
<tr><td>24D
Unshaded</td><td>Procedures, Services or Supplies CPT/HCPCS Modifier</td><td>Enter the five digit CPT or HCPC code and two character modifier if applicable. Only one CPT or HCPC and up to four modifiers may be entered per claim line. Codes entered must be valid for date of service. Missing or invalid codes will be denied for payment.
Only the first modifier entered is used for pricing the claim. Failure to use modifiers in the correct position or combination with the procedure code, or invalid use of modifiers, will result in a rejected, denied, or incorrectly paid claim. The following national modifiers are recognized as modifiers that will impact the pricing of your claim.
<table>
<tr><td>26</td><td>50</td><td>54</td><td>55</td><td>62</td></tr>
<tr><td>66</td><td>76</td><td>80</td><td>81</td><td>82</td></tr>
<tr><td>AA</td><td>AD</td><td>AS</td><td>ET</td><td>FP</td></tr>
<tr><td>GN</td><td>GO</td><td>GP</td><td>NU</td><td>QK</td></tr>
<tr><td>QX</td><td>QY</td><td>QZ</td><td>RR</td><td>SA</td></tr>
<tr><td>TC</td><td>TD</td><td>TE</td><td>TF</td><td>TG</td></tr>
<tr><td>TH</td><td>U1</td><td>U5</td><td>U6</td><td>U7</td></tr>
</table></td><td>R</td></tr>
<tr><td>24E
Unshaded</td><td>Diagnosis Pointer</td><td>In 24E, enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first, other applicable services should follow. The reference letter(s) should be A – L or multiple letters as applicable. ICD-10-CM diagnosis codes must be entered in Item Number 21 only. Do not enter them in 24E.</td><td>R</td></tr>
<tr><td>24F
Unshaded</td><td>Charges</td><td>Enter the charge amount for the claim line item service billed. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.</td><td>R</td></tr>
</table>

Field #	Field Description	Instruction or Comments	Required or Conditional
24G Unshaded	Days or Units	Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered. Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point. Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").	R
24H	Shaded EPSDT (Chcup) Family Planning	Leave blank.	Not Required
24H Unshaded	EPSDT (Chcup) Family Planning	For Early & Periodic Screening, Diagnosis and Treatment related services, enter the response in the shaded portion of the field as follows: If there is no requirement (e.g., state requirement) to report a reason code for EPDST, enter Y for "YES" or N for "NO" only. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. (A Y or N response is not entered with the code.) The two character code is right justified in the shaded area of the field. The following codes for EPSDT are used in 5010A1: AV Available – Not Used (Patient refused referral.) S2 Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) ST New Service Requested (Referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals.) NU Not Used (Used when no EPSDT patient referral was given.) If the service is Family Planning, enter Y ("YES") or N ("NO") in the bottom, unshaded area of the field.	C
24I Shaded	ID Qualifier	Use ZZ qualifier for taxonomy. Must bill taxonomy provider is attested to.	R
24J Shaded	Taxonomy Code	Enter the provider taxonomy code the provider is attested to. Use ZZ qualifier for taxonomy code.	R
24J Unshaded	NPI Provider Id	Enter the 10 character NPI ID of the provider who rendered services. If the provider is billing as a member of a group, the rendering individual provider's 10 character NPI ID may be entered. . Enter the billing NPI if services are not provided by an individual (e.g. DME, independent lab, home health, RHC/FQHC general medical exam, etc.)	R
25	Federal Tax ID Number Ssn/Ein	Enter the provider or supplier nine digit federal Tax ID number and mark the box labeled EIN.	R
26	Patient's Account Number	Enter the provider's billing account number.	Not Required
27	Accept Assignment	Enter an X in the YES box. Submission of a claim for reimbursement of services provided to a Medicaid recipient using Medicaid funds indicates the provider accepts Medicaid assignment. Refer to the back of the CMS 1500 (12-90) form for the section pertaining to Medicaid payments.	R
28	Total Charges	Enter the total charges for all claim line items billed – claim lines 24F. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	R
29	Amount Paid	Required when another carrier is the primary payer. Enter the payment received from the primary payer prior to invoicing Superior. Medicaid programs are always the payers of last resort. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($). If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line.	C

Field #	Field Description	Instruction or Comments	Required or Conditional
30	Reserved for NUCC Use	This field was previously used to report "Balance Due." "Balance Due" does not exist in 5010A1, so this field has been eliminated.	Not Required
31	Signature of Physician or Supplier Including Degrees or Credentials	Acceptable Signature Requirements for Submission include: Typed signature in box 31 Name of group in box 33 is listed in box 31 Handwritten signature in box 31 Stamped signatrue in box 31 Signature on file This feature does not exist in the electronic 837P.	Required
32	Service Facility Location Information	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the name and physical location. (P.O. box numbers are not acceptable here.) First line – Enter the business/facility/practice name. Second line– Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen.	C
32a	Npi – Services Rendered	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10 character NPI ID of the facility where services were rendered.	R, if Field #32 is populated
32b	Other Provider ID	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the two character qualifier ZZ followed by the taxonomy code (no spaces).	R, if Field #32 is populated
33	Billing Provider Info and Phone Number	Enter the billing provider's complete name, physical address (P.O. box numbers are not acceptable) (include the zip + 4 code) and phone number. First line – Enter the business/facility/practice name. Second line – Enter the street address. Do not use commas, periods, or other punctuation in the address (e.g., 123 N Main Street 101 instead of 123 N. Main Street, #101). Third line – In the designated block, enter the city and state. Fourth line – Enter the zip code and phone number. When entering a nine digit zip code (zip+4 codes), include the hyphen. Do not use a hyphen or space as a separator within the telephone number (i.e. (803)551414).	R
33a	Group Billing Npi	Required if the location where services were rendered is different from the billing address listed in field 33. Enter the 10 character NPI ID.	R
33b	Group Billing Other Id	Enter as designated below the Billing Group Medicaid ID number or taxonomy code the provider is attested to. Enter the provider taxonomy code. Use ZZ qualifier.	R

CMS 1500 Claim Form (Sample Only)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

UB-04/CMS 1450 Claim Form - Billing Requirements

A UB-04/CMS 1450 is the only acceptable claim form for submitting inpatient or outpatient hospital claims (including hospital-based ASCs and technical services) charges for reimbursement by Superior, per Section 10. In addition, a UB-04/CMS 1450 is required for comprehensive outpatient rehabilitation facilities (CORF), Federally Qualified Health Centers (excluding Texas Health Steps and family planning), Rural Health Centers (excluding Texas Health Steps and family planning), home health agencies, nursing home admissions, inpatient hospice services and dialysis services.

Incomplete or inaccurate information will result in the claim/encounter being rejected for corrections. Superior requires hospitals to bill interims/split bills for any hospital admission with total billed charges greater than $9,999,999.

UB-04/CMS 1450 Hospital Outpatient Claims/Ambulatory Surgery

The following information applies to outpatient and ambulatory surgery claims:

- Professional fees must be billed on a CMS 1500 claim form.
- Include the appropriate CPT code next to each revenue code.

Exceptions

Please refer to your provider contract with Superior or to the Texas Medicaid Provider Procedures Manual for revenue codes that do not require a CPT 4 code.

UB-04/CMS 1450 Outpatient and Ambulatory Surgery Claim Documentation

Additional specific information may be required in order to finalize a claim and should be submitted to Superior upon request.

UB-04/CMS 1450 - Clean Claim Requirements

The following table outlines each field within a UB-04/CMS 1450 claim form. Please note that:

- Required fields (indicated as “R”) must be completed on the claim form.
- Conditional fields (indicated as “C”) must be completed if the information applies to the situation or the service provided.
- Not Required fields (indicated as “Not Required”) do not need to be completed.

Field #	Field Description	Instruction or Comments	Required or Conditional
1	(Unlabeled Field)	Line 1: Enter the complete provider name. Line 2: Enter the complete mailing address. Line 3: Enter the city, state and zip+4 code (include hyphen). Line 4: Enter the area code and phone number.	R
2	(Unlabeled Field)	Enter the pay-to name and address.	Not Required
3a	Patient Control Number	Enter the facility patient account/control number	Not Required
3b	Medical Record Number	Enter the facility patient medical or health record number.	R
4	Type of Bill	Enter the appropriate 3 digit type of bill (TOB) code as specified by theNUBC UB-04/CMS 1450 Uniform Billing Manual minus the leading "0" (zero). A leading zero ("0") is not needed. Digits should be reflected as follows: 1st digit - Indicating the type of facility. 2nd digit - Indicating the type of care. 3rd digit - Indicating the billing sequence.	R
5	Federal Tax ID Number	Enter the nine digit number assigned by the federal government for tax reporting purposes.	R
6	Statement Covers Period From/Through	Enter begining and ending or admission and discharge dates for the services billed. Inpatient and outpatient observation stays must be billed using the admission date and discharge date. Outpatient therapy, chemotherapy, laboratory, pathology, radiology and dialysis may be billed using a date span. All other outpatient services must be billed using the actual date of service (MM/DD/YY).	R
7	(Unlabeled Field)	Not used.	Not Required
8 a-b	Patient Name	8a – Enter the patient's 10 digit Medicaid ID number on the member's Superior ID card. 8b – Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames. Titles: (Mr., Mrs., etc.) should not be reported in this field. Prefix: No space should be left after the prefix of a name e.g. McKendrick. Hyphenated names: Both names should be capitalized and separated by a hyphen (no space). Suffix: A space should separate a last name and suffix.	R
9 a-e	Patient Address	Enter the patient's complete mailing address. Line a: Street address Line b: City Line c: State Line d: ZIP code Line e: Country code (not required)	R (except line 9e)
10	Birthdate	Enter the patient's date of birth (MM/DD/YYYY)	R
11	Sex	Enter the patient's sex. Only M or F is accepted.	R
12	Admission Date	Enter the date of admission for inpatient claims and date of service for outpatient claims.	R

Field #	Field Description	Instruction or Comments	Required or Conditional
13	Admission Hour	Enter the time using two digit military time (00-23) for the time of inpatient admission or time of treatment for outpatient services. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	R
14	Admission Type	Required for inpatient admissions TOB 11X, 118X, 21X, 41X. Enter the one digit code indicating the priority of the admission using one of the following codes: 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma	C
15	Admission Source	Enter the one digit code indicating the source of the admission or outpatient service using one of the following codes: For Type of admission 1,2,3 or 5: 1 Physician referral 2 Clinic referral 3 Health maintenance referral (HMO) 4 Transfer from a hospital 5 Transfer from skilled nursing facility (SNF) 6 Transfer from another health care facility 7 Emergency room 8 Court/law enforcement 9 Information not available For type of admission 4 (newborn): 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Extramural birth 5 Information not available	C
16	Discharge Hour	Enter the time using two digit military time (00-23) for the time of inpatient or outpatient discharge. Discharge Hour must be left blank for Discharge Status 30. 00-12:00 midnight to 12:59 12- 12:00 noon to 12:59 01- 01:00 to 01:59 13- 01:00 to 01:59 02- 02:00 to 02:59 14- 02:00 to 02:59 03- 03:00 to 03:39 15- 03:00 to 03:59 04- 04:00 to 04:59 16- 04:00 to 04:59 05- 05:00 to 05:59 17- 05:00 to 05:59 06- 06:00 to 06:59 18- 06:00 to 06:59 07- 07:00 to 07:59 19- 07:00 to 07:59 08- 08:00 to 08:59 20- 08:00 to 08:59 09- 09:00 to 09:59 21- 09:00 to 09:59 10- 10:00 to 10:59 22- 10:00 to 10:59 11- 11:00 to 11:59 23- 11:00 to 11:59	C

Field #	Field Description	Instruction or Comments	Required or Conditional
17	Patient Status	Required for inpatient claims. Enter the two digit disposition of the patient as of the "through" date for the billing period listed in field 6 using one of the following codes: 01 Routine discharge 02 Discharged to another short-term general hospital for inpatient care 03 Discharged to SNF 04 Discharged to ICF 05 Discharged/transferred to a designated cancer center or children's hospital 06 Discharged to care of home health service organization 07 Left against medical advice 08 Reserved for national assignment 09 Admitted as an inpatient to this hospital (only for use on Medicare outpatient hospital claims) 20 Expired or did not recover 30 Still patient (to be used only when the client has been in the facility for 30 consecutive Days if payment is based on DRG) 40 Expired at home (hospice use only) 41 Expired in a medical facility (hospice use only) 42 Expired—place unknown (hospice use only) 43 Discharged/transferred to a federal hospital (such as a veteran's administration [VA] hospital or VA skilled nursing facility) 50 Hospice—home 51 Hospice—medical facility (includes patient who is discharged from acute hospital care but remains at the same hospital under hospice care) 61 Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital 63 Discharged/transferred to a Medicare certified long-term care hospital (LTCH) 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 Discharged/ Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 Discharged/transferred to a critical access hospital (CAH) 71 Discharged to another institution of outpatient services 72 Discharged to another institution	C
18-28	Condition Codes	Required when applicable. Condition codes are used to identify conditions relating to the bill that may affect payer processing. Each field (18-24) allows entry of a twp character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual.	
29	Accident State	Optional: Accident state	
30	(Unlabeled Field)	Not used.	

Field #	Field Description	Instruction or Comments	Required or Conditional
31-34 a-b	Occurrence Code And Occurence Date	Occurrence Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Date: Required when applicable or when a corresponding Occurrence Code is present on the same line (31a-34a). Enter the date for the associated occurrence code in MM/DD/YYYY format. Enter the appropriate occurrence code(s) and date(s). Blocks 54, 61,62, and 80 must also be completed as required. Refer to Subsection 6.6.5, Occurrence Codes, in this section. Use one of the following codes if applicable: 01 Auto accident/auto liability insurance involved 02 Auto or other accident/no fault involved 03 Accident/tort liability 04 Accident/employment related 05 Other accident 06 Crime victim 10 Last menstrual period 11 Onset of symptoms 16 Date of last therapy 17 Date outpatient OT plan established or last reviewed 24 Date other insurance denied 25 Date benefits terminated by primary payer 27 Date home health plan of treatment was established 29 Date outpatient PT plan established or last reviewed 30 Date outpatient speech pathology plan established or last reviewed 35 Date treatment started for PT 44 Date treatment started for OT 45 Date treatment started for speech language pathology (SLP) 50 Date other insurance paid 51 Date claim filed with other insurance 52 Date renal dialysis initiated	C
35-36 a-b	Occurrence Span Code And Occurrence Date	Occurrence Span Code: Required when applicable. Occurrence codes are used to identify events relating to the bill that may affect payer processing. Each field (31-34a) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Occurrence Span Date: Required when applicable or when a corresponding Occurrence Span Code is present on the same line (35a-36a). Enter the date for the associated occurrence code in MM/DD/YYYY format. For inpatient claims, enter code 71 if this hospital admission is a readmission within seven Days of a previous stay. Enter the dates of the previous stay.	C
37	(Unlabeled Field)	Required for resubmissions or adjustments. Enter the 12 character document control number (DCN) of the original claim. A resubmitted claim MUST be marked using large bold print within the body of the claim form with “resubmission” to avoid denials for duplicate submission. Note: For resubmissions submitted via EDI, the CLM05-3 must be “7” and in the 2300 loop a REF “F8” must be sent with the original claim number.	R
38	Responsible Party Name and Address		Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
39-41 a-d	Value Codes Codes and Amounts	Code: Required when applicable. Value codes are used to identify events relating to the bill that may affect payer processing. Each field (39-41) allows entry of a two character code. Codes should be entered in alphanumeric sequence (numbered codes precede alphanumeric codes). Up to 12 codes can be entered. All "a" fields must be completed before using "b" fields, all "b" fields before using "c" fields, and all "c" fields before using "d" fields. For a list of codes and additional instructions refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual. Amount: Required when applicable or when a Value Code is entered. Enter the dollar amount for the associated value code. Dollar amounts to the left of the vertical line should be right justified. Up to eight characters are allowed (i.e. 199,999.99). Do not enter a dollar sign ($) or a decimal. A decimal is implied. If the dollar amount is a whole number (i.e. 10.00), enter 00 in the area to the right of the vertical line. Accident hour: For inpatient claims, if the patient was admitted as the result of an accident, enter value code 45 with the time of the accident using military time (00 to 23). Use code 99 if the time is unknown. For inpatient claims, enter value code 80 and the total days represented on this claim that are to be covered. Usually, this is the difference between the admission and discharge dates. In all circumstances, the number in this block is equal to the number of covered accommodation days listed in Block 46. For inpatient claims, enter value code 81 and the total days represented on this claim that are not covered. The sum of Blocks 39–41 must equal the total days billed as reflected in Block 6.	C
General	Revenue Codes and Description	For inpatient hospital services, enter the description and revenue code for the total charges and each accommodation and ancillary provided. List accommodations in the order of occurrence. List ancillaries in ascending order. The space to the right of the dotted line is used for the accommodation rate. NDC: Enter N4 and the 11 digit NDC number (number on packaged or container from which the medication was administered). Optional: The unit of measurement code and the unit quantity with a floating decimal for fractional units (limited to three digits) can also be submitted but they are not required. Do not enter hyphens or spaces within this number. Example: N400409231231GR0.025 Refer to: Subsection 6.3.4, National Drug Code (NDC), in this section.	C
42 Line 1-22	Rev CD	Enter the appropriate four digit revenue codes itemizing accommodations, services and items furnished to the patient. Refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions. Enter accommodation revenue codes first followed by ancillary revenue codes. Enter codes in ascending numerical value.	R
42 Line 23	Rev CD	Enter 0001 for total charges.	R
43 Line 1-22	Description	Enter a brief description that corresponds to the revenue code entered in the service line of field 42. Qualifier along with NDC, units and base measurement code are required where applicable, compound drug elements.	R
43 Line 23	Page ___ of ___	Enter the number of pages. Indicate the page sequence in the "PAGE" field and the total number of pages in the "OF" field. If only one claim form is submitted enter a "1" in both fields (i.e. PAGE "1" OF "1").	R

Field #	Field Description	Instruction or Comments	Required or Conditional
44	HCPCS/Rates	Required for outpatient claims when an appropriate CPT/HCPCS code exists for the service line revenue code billed. The field allows up to nine characters. Only one CPT/HCPC and up to two modifiers are accepted. When entering a CPT/HCPCS with a modifier(s) do not use spaces, commas, dashes or the like between the CPT/HCPC and modifier(s). Refer to the NUBC UB-04/CMS 1450 Uniform Billing Manual for a complete listing of revenue codes and instructions. Please refer to your current provider Contract with Superior or to the Texas Medicaid Provider Procedures Manual. Inpatient: Enter the accommodation rate per day. Match the appropriate diagnoses listed in Blocks 67A through 67Q corresponding to each procedure. If a procedure corresponds to more than one diagnosis, enter the primary diagnosis. Each service and supply must be itemized on the claim form. Home Health Services Outpatient claims must have the appropriate revenue code and, if appropriate, the corresponding HCPCS code or narrative description. Outpatient: Outpatient claims must have the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Each service, except for medical/surgical and intravenous (IV) supplies and medication, must be itemized on the claim form or an attached statement. Note: The UB-04 CMS-1450 paper claim form is limited to 28 items per outpatient claim. This limitation includes surgical procedures from Blocks 74 and 74a-e. If necessary, combine IV supplies and central supplies on the charge detail and consider them to be single items with the appropriate quantities and total charges by dates of service. Multiple dates of service may not be combined on outpatient claims.	C
45 Line 1-22	Service Date	Required on all outpatient claims. Enter the date of service for each service line billed (MM/DD/YY). Multiple dates of service may not be combined for outpatient claims.	C
45 Line 23	Creation Date	Enter the date the bill was created or prepared for submission on all pages submitted (MM/DD/YY).	R
46	Service Units	Provide units of service, if applicable. For inpatient room charges, enter the number of days for each accommodation listed. If applicable, enter the number of pints of blood. When billing for observation room services, the units indicated in this block should always represent hours spent in observation.	R
47 Line 1-22	Total Charges	Enter the total charge for each service line. Note: For multi-page claims enter "continue" on initial and subsequent claim forms. Indicate the total of all charges on the last claim and the page number of the attachment (for example, page 2 of 3) in the top right-hand corner of the form.	R
47 Line 23	Totals	Enter the total charges for all service lines.	R
48 Line 1-22	Non-Covered Charges	Enter the non-covered charges included in field 47 for the revenue code listed in field 42 of the service line. Do not list negative amounts.	C
48 Line 23	Totals	Enter the total non-covered charges for all service lines.	C
49	(Unlabeled Field)	Not used.	Not Required
50 a-c	Payer	Enter the name for each payer from which reimbursement is being sought in the order of the payer liability. Line A refers to the primary payer, B - secondary and C - tertiary.	R
51 a-c	Health Plan Identification Number		Not Required
52 a-c	Related Information	Required for each line (A, B, C) completed in field 50, Release of Information Certification Indicator. Enter "Y" (yes) or "N" (no). Providers are expected to have necessary release information on file. It is expected that all released invoices contain "Y".	R
53	Asg. Ben.	Enter "Y" (yes) or "N" (no) to indicate a signed form is on file authorizing payment by the payer directly to the provider for services.	R

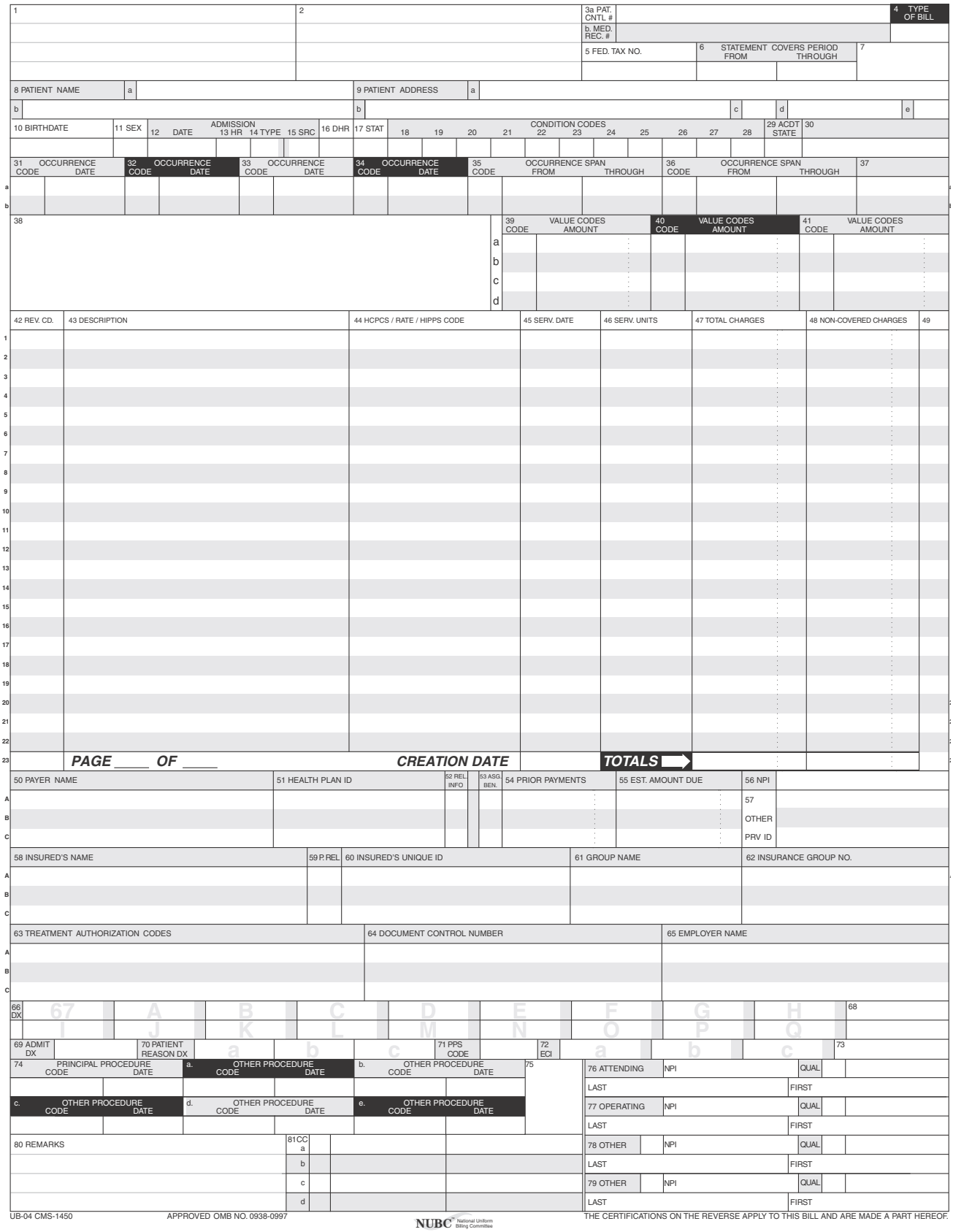
Field #	Field Description	Instruction or Comments	Required or Conditional
54	Prior Payments	Enter the amount received from the primary payer on the appropriate line when Medicaid/ Superior is listed as secondary or tertiary.	C
55	Estimated Amount Due		Not Required
56	National Provider Identifier	Enter the provider's 10 character NPI ID.	R
57	Taxonomy Code	Enter the provider taxonomy code the provider is attested to.	R
58	Insured's Name	For each line (A, B, C) completed in field 50, enter the name of the person who carries the insurance for the patient. In most cases this will be the patient's name. Enter the patient's name as it appears on the member's Superior ID card. Do not use nicknames.	R
59	Patient Relationship		Not Required
60	Insured's Unique ID	Required: Enter the patient's insurance/Medicaid ID exactly as it appears on the patient's ID card. Enter the insurance /Medicaid ID in the order of liability listed in field 50.	R
61	Group Name		Not Required
62	Insurance Group Number		Not Required
63	Treatment Authorization Codes		Not Required
64	Document Control Number	Enter the 12 character document control number (DCN), which is the original (corrected) claim number, of the paid health claim when submitting a replacement or void on the corresponding A, B, C line reflecting Superior from field 50. Applies to claim submitted with a Type of Bill (field 4) Frequency of "7" (Replacement of Prior Claim) or Type of Bill Frequency of "8" (Void/Cancel of Prior Claim). * Please refer to Section 10.	C
65	Employer Name		Not Required
66	Dx		Not Required
67	Principal Diagnosis Code and Present On Admission (POA) Indicator	Enter the principal/primary diagnosis or condition using the appropriate release/update of ICD-10-CM code(s) for the date of service. Diagnosis code submitted must be a valid ICD-10-CM code for the date of service and carried out to its highest level of specificity – four or five digit. "E" and most "V" codes are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied Enter the applicable POA indicator in the shaded area for inpatient claims. Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied. If a diagnosis code is exempt from POA, the POA indicator field must be left blank.	R
67 a-q	Other Diagnosis Code and POA Indicator	Enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM code for the date of service. Diagnosis codes submitted must be valid ICD-10-CM code for the date of service and carried out to its highest level of specificity – four or five digit. "E" and most "V" codes are not acceptable as a primary diagnosis. Claims with incomplete or invalid diagnosis codes will be denied. Enter the applicable POA indicator in the shaded area for inpatient claims. Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied.	C
68	(Unlabeled)	Not used.	Not Required

Field #	Field Description	Instruction or Comments	Required or Conditional
69	Admitting Diagnosis Code	Enter the diagnosis or condition provided at the time of admission as stated by the physician using the appropriate release/update ICD-10-CM code(s) for the date of service. Diagnosis codes submitted must be valid ICD-10-CM code(s) for the date of service and carried out to its highest level of specificity – four or five digit. "E" codes and most "V" are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied.	R
70 a,b,c	Patient Reason Code	Enter the ICD-10 code that reflects the patient's reason for visit at the time of outpatient registration. 70a requires entry, 70b-70c are conditional. Diagnosis codes submitted must be a valid ICD-10-CM code for the date of service and carried out to its highest digit – four or five. "E" codes and most "V" are not acceptable as a primary diagnosis. Claims with missing or invalid diagnosis codes will be denied.	R
71	PPS / DRG Code		Not Required
72 a,b,c	External Cause Code	These fields are not required, however if entering codes in these fields, enter additional diagnosis or conditions that coexist at the time of admission or that develop subsequent to the admission and have an effect on the treatment or care received using the appropriate release/update of ICD-10-CM code for the date of service. Diagnosis codes submitted must be valid ICD-10-CM code for the date of service and carried out to its highest level of specificity – four or five digit. "E" and most "V" codes are not acceptable as a primary diagnosis. Claims with incomplete or invalid diagnosis codes will be denied. Enter the applicable POA indicator in the shaded area for inpatient claims. Note: All hospital providers are required to submit a POA value for each diagnosis on the claim form and no hospital will be exempt from this POA requirement. Medicare crossover hospital claims with dates of admission on or after September 1, 2012, must also comply with the Medicaid requirement to include the POA values. Claims submitted without the POA indicators will be denied.	Conditional
73	(Unlabeled)		Not Required
74	Principal Procedure Code / Date	Required on inpatient claims when a procedure is performed during the date span of the bill. Code: Enter the ICD-10-CM procedure code that identifies the principal/primary procedure performed. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. Date: Enter the date the principal procedure was performed (MM/DD/YY). Required for EDI submissions.	C
74 a-e	Other Procedure Code / Date	Required on inpatient claims when a procedure is performed during the date span of the bill. Code: Enter the ICD-10-CM procedure code(s) that identify a significant procedure(s) performed other than the principal/primary procedure. Up to five ICD-10-CM codes may be entered. Do not enter the decimal between the 2nd or 3rd digits of code. It is implied. Date: Enter the date the principal procedure was performed (MM/DD/YY).	C
75	(Unlabeled)		Not Required
76	Attending NPI /Qual/ Last and First Name	Required when claim/encounter contains any services other than nonscheduled transportation services. If not required, do not send. The attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/ encounter. Secondary Identifier Qualifiers: 0B - State License Number 1G - Provider UPIN Number G2 – Provider Commercial Number	C
77	Operating NPI /Qual/ Last and First Name	Required when a surgical procedure code is listed on this claim. If not required, do not send. The name and identification number of the individual with the primary responsibility for performing the surgical procedure(s). Secondary Identifier Qualifiers: 0B - State License Number 1G - Provider UPIN Number G2 – Provider Commercial Number	C

Field #	Field Description	Instruction or Comments	Required or Conditional
78	Other NPI /Qual/ Last and First Name	The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim. Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send. ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send. 82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send. Secondary Identifier Qualifiers: 0B - State License Number 1G - Provider UPIN Number G2 – Provider Commercial Number	C
79	Other NPI /Qual/ Last and First Name	The name and ID number of the individual corresponding to the qualifier category indicated in this section of the claim. Provider Type Qualifier Codes/Definition/Situational Usage Notes: DN - Referring Provider. The provider who sends the patient to another provider for services. Required on an outpatient claim when the Referring Provider is different than the Attending Physician. If not required, do not send. ZZ - Other Operating Physician. An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved. If not required, do not send. 82 - Rendering Provider. The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim, i.e., a claim that includes both facility and professional fee components (e.g., a Medicaid clinic bill or Critical Access Hospital claim). If not required, do not send. Secondary Identifier Qualifiers: 0B - State License Number 1G - Provider UPIN Number G2 – Provider Commercial Number	C
80	Remarks	For DME billings the provider shows the rental rate, cost, and anticipated months of usage so that the provider's A/B MAC (A or HHH) may determine whether to approve the rental or purchase of the equipment. Where Medicare is not the primary payer because WC, automobile medical, no-fault, liability insurer or an EGHP is primary, the provider enters special annotations. In addition, the provider enters any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment. For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)	C
81	CC a-d	To report additional codes related to a Form Locator or to report external code list approved by the NUBC for inclusion to the institutional data set. Codes used for Medicare claims are available from Medicare contractors. Codes are also available from the NUBC (www.nubc.org) via the NUBC's Official UB-04 Data Specifications Manual.	C

Table 11-3 UB-04/CMS 1450 Data Elements

6.6.3 UB-04 CMS-1450 Blank Paper Claim Form



Electronic Funds Transfers and Electronic Remittance Advices

Superior provides electronic funds transfer (EFT) and electronic remittance advice (ERA) to participating providers to help reduce costs, improve speed for secondary billings and improve cash flow by enabling online access of remittance information and straight forward reconciliation payments. As a provider, you can gain the following benefits from using EFT and ERA:

- **Reduce accounting expenses** - ERAs can be imported directly into practice management or patient accounting systems, eliminating the need for manual re-keying.
- **Improve cash flow** - Electronic payments mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts** - Keep total control over the destination of claim payment funds, plus multiple practices and accounts are supported.
- **Match payments to advices quickly** - Associate electronic payments with ERAs quickly and easily.

For more information on EFT and ERA services, please contact PaySpan®, our electronic billing partner, at 1-877-331-7154 or at providersupport@payspanhealth.com.

Payment/Application of Interest

Calculation and application of interest is applied to all clean claims not timely processed. When interest is due, the payment is due.

Superior pays providers interest at an 18% annual rate, calculated daily, for the full period in which the clean claim, or portion of the clean claim remains unadjudicated beyond the 30-Day claims processing deadline. The principal amount on which the interest payment is calculated is the amount due but unpaid at the contracted rate for the service. Interest is applied to the payment of all clean claims not adjudicated in the appropriate 30 or 10 Day period, calculated from the date the claim is deemed clean.

Prior Authorization Requirements

Providers can access the Superior website for PA requirements. The prescreen tool can be found at https://www.superiorhealthplan.com/medicaidpriorauth.

Providers will need to select the applicable program, answer the questions by selecting the radio buttons and enter procedure code for each service/procedure to determine if prior authorization is required. Please reference Section 9 for more information on prior authorization requirements and procedures.

Additional Information for STAR+PLUS Claims and Encounters Administration

Claims Filing

Long-Term Services and Supports Claims Filing

All providers rendering LTSS services, with the exception of atypical providers, must use the CMS 1500 Claim Form or the HIPAA 837 Professional Transaction when billing claims. Atypical providers are LTSS providers that render non-health or non-medical services to STAR+PLUS members. Examples include pest control services and building and supply services. Atypical providers will submit appropriate documentation to Superior to accurately populate an 837 Professional Encounter.

Providers will bill and report LTSS in compliance with the STAR+PLUS LTSS Health Care Common Procedure Codes

(HCPC) and STAR+PLUS Modifiers Matrix (Matrix). The uniform billing requirements and billing Matrix can be found in the STAR+PLUS Handbook Appendices at https://hhs.texas.gov/laws-regulations/handbooks/starplus-handbook.

LTSS providers must use the designated position of the modifiers as indicated on the matrix when filing claims.

Reimbursement to LTSS Providers

Superior does not reimburse for services not provided to the member and does not reimburse for services when the member is out of the home as outlined above.

If a provider believes there is an extenuating circumstance surrounding a member's services the provider must contact Superior.

Nursing Facility Claims Filing

For complete Nursing Facility Claims Filing guidelines for Superior STAR+PLUS members, see the Superior Nursing Facility Provider Manual posted at www.SuperiorHealthPlan.com.

Attendant Care Enhanced Payment Methodology

LTSS providers contracted with Superior may participate in the STAR+PLUS attendant care enhanced payment program. The following LTSS services are eligible for rate enhancement if the provider completes the required annual attestation for rate enhancement, detailed in the Texas Administrative Code.:

- Personal Assistant Services (PAS) both waiver and non-waiver.
- Day Activity and Health Services (DAHS).
- Assisted Living Facility (ALF) and Residential Care Services (ALRC).
- Habilitation (under CFC).

Superior will reimburse providers at the attested participation level, using the rate schedules posted on the HHS website. For providers who were previously enrolled in the HHS Rate Enhancement Program, the rate enhancement level will remain the same throughout the duration of the provider's participation in Superior's program.

For providers that were not previously rate enhanced through HHS, providers will be assigned rate level "13" in Superior's program.

There are two distinct processes that encompass Superior's Rate Enhancement Program which is in place for participating providers. Non-participating providers cannot participate in rate enhancement through Superior. These processes are Annual Attestation and Rate Level Changes.

Annual Attestation Process

Annually, Superior conducts outreach to providers in its Rate Enhancement Program to obtain a notarized affidavit attesting to their participation in the Rate Enhancement Program for STAR+PLUS and the pass through of enhanced payments to their direct care staff. Towards the end of each year, these providers will be asked to submit a new attestation for the following calendar year.

Each affidavit is effective for a specific calendar year. However, any affidavit received on or after September 1, will be processed for both the current and upcoming calendar year.

Providers who contract during the plan year, and are participating in rate enhancement, should submit an affidavit that would be good for the existing plan year.

Rate Level Changes

Providers may communicate changes to their rate enhancement level at any time during the year. For providers that are assigned a new participation level by HHS for PAS or DAHS services, these providers must submit the updated level in writing to Superior requesting a change in participation level.

Rate enhancement level changes are made prospectively, and will not be made retrospectively.

Superior requests each provider to submit an annual attestation for Rate Enhancement. Without a completed annual affidavit on file, Superior cannot apply rate enhancement to a provider's payments, and the provider is automatically disenrolled from the rate enhancement program. Superior's annual attestation process is performed online, and may be accessed on Superior's Provider Forms webpage, located at: https://www.superiorhealthplan.com/providers/resources/forms.html

SECTION 11
ADVERSE BENEFIT DETERMINATIONS, ADVERSE DETERMINATIONS, AND APPEALS

Superior's Utilization Management Program complies with the state and federal regulatory and NCQA required requirements for utilization review to determine the medical necessity of a health care service.

- A Medicaid Adverse Benefit Determination means: the denial or limited authorization of a member or provider requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part of payment for service; the failure to provide services in a timely manner; the Plan's failure to timely process a request for authorization; denial of a member's request to obtain out of network services; or denial of a member's request to dispute a financial liability.
- A CHIP adverse determination means: a determination that health care services provided or proposed to be provided to a member are not medically necessary, or are experimental or investigational.

The information below outlines procedures for adverse actions, and the associated process for internal and external appeal of Medicaid adverse benefit determinations and CHIP adverse determinations.

Medicaid Adverse Benefit Determinations and CHIP Adverse Determinations

To conduct utilization review, all necessary information, including pertinent clinical information is required for submission with the authorization request, and is reviewed to determine the medical necessity of a requested service. If medical necessity cannot be confirmed through review of the clinical documentation, a peer to peer discussion is offered prior to issuing an adverse determination.

When the member is ineligible, has exceeded or requested non covered benefits an administrative denial is issued, which is a denial that is not based on medical necessity. If a provider initiates services without obtaining prior authorization, or does not comply with requirements related to notification of inpatient admissions, a contractual denial is issued to the provider, that may affect the payment of a submitted claim. These denials are also referred to as administrative denials, and are not based on medical necessity review.

A medical director will render medical necessity adverse determinations in response to authorization requests. Medicaid authorization requests for prescription benefits may be reviewed by a pharmacist.

When an adverse benefit determination or adverse determination is issued, the member, member's requesting provider, servicing provider and/or the member's PCP receive a notice of the adverse determination in writing. The letter describes the services that are being denied, the steps a member or authorized member representative can take to appeal the decision and how to request external review if the denial is upheld on appeal.

Peer-To-Peer Discussion and Opportunity to Discuss

A peer-to-peer discussion is offered to the requesting provider prior to an adverse determination, and an opportunity to discuss is available to the member's requesting or servicing provider after the adverse determination has been rendered. To schedule a pre or post denial discussion with the Medical Director who has reviewed the case or made the denial determination, call Medical Management at 1-877-398-9461, option 3.

Provider Contractual Denials and Non-Covered Benefit Denials

Contractual Denials

Medicaid and CHIP contractual (administrative) denials are not determined based on medical necessity. Upon notice of a contractual denial to a provider for failure to comply with the Plan's authorization requirements, the opportunity to submit documentation as evidence for reconsideration of the contractual denial is offered.

Providers have 60 Days from the date of the contractual denial to submit written documentation of the provider's compliance with authorization requirements. The required documentation for reconsideration of the contractual denial must be specific to address and remediate the reason for the contractual denial, and may include evidence of the provider's timely request for prior authorization or notification of inpatient admission, as well as documents reflecting retroactive member enrollment that did not afford the provider information that authorization through Superior's Medical Management was required. If the dispute of the contractual denial and associated documentation and evidence to support reconsideration is not received within 60 Days, the provider may forfeit the right for reconsideration of the denial.

Written request and documentation to reconsider a contractual denial must be submitted in writing by mail or FAX to:

Superior HealthPlan
ATTN: Medical Management Appeals
5900 E. Ben White Blvd.
Austin, Texas 78759
FAX: 866-918-2266

Medicaid members also receive notice of a contractual denial to a provider, if the denial resulted in the member not receiving the service related to the contractually denied authorization request.

Non-Covered Benefit Denials

Request for authorization of a service that is not a covered Medicaid state plan service for Medicaid members 21 years of age and older will be denied as not a covered Medicaid benefit. Medicaid non-covered benefit requests for Medicaid members younger than 21 years of age will be reviewed for medical necessity, but may be denied as not a covered benefit based on the medical necessity review. Medicaid non-covered benefit denials that are not based on medical necessity review are eligible for internal appeal, State Fair Hearing, and member complaint rights but are not eligible for External Medical Review rights.

CHIP requests for prior authorization are limited to CHIP Program covered services. See CHIP and CHIP Perinate Newborn Schedule of Benefits and Cost Sharing table in Section 4 of this Manual for the listing of covered and non-covered CHIP benefits. CHIP non-covered benefit denials that are not based on medical necessity are eligible for member complaint rights only. Authorization requests that are reviewed for medical necessity but denied as a non-covered benefit receive adverse determination member appeal and complaint rights, including External Review Organization (ERO) appeal rights.

Medical Necessity Denial Claim Disputes for Contracted Providers

Superior contracts with out of network physicians to review claims disputes related to medical necessity denials that remain unresolved subsequent to a provider appeal. The physician resolving the dispute is not an employee Superior. The determination of the physician resolving the dispute is binding on Superior and our contracted provider. The physician resolving the dispute is licensed in the State of Texas and the same specialty or a related specialty as the appealing provider.

Medicaid Appeal of Adverse Benefit Determination

A Medicaid member, a person acting on their behalf, or the member's physician or other health care provider may request an appeal of an adverse benefit determination for denials in whole or in part.

Members who disagree with the internal appeal decision, have the right to request external review through a State Fair Hearing with or without an External Medicaid Review. More information is provided in this section on member external appeal rights.

Member Advocate

Superior has designated member advocates who can assist a member or their representative through the adverse benefit determination Appeal process, assist with adherence to timelines to request appeal, and ensure members understand their rights and responsibilities as an appellant. If a member needs assistance from a member advocate, members should be directed to call Superior's Member Services Department to request a member advocate's assistance at the numbers listed below:

STAR and CHIP..... 1-800-783-5386
STAR+PLUS..... 1-877-277-9772
STAR Kids..... 1-844-590-4883
STAR Health..... 1-866-912-6283

Standard Member Appeals

A Medicaid internal health plan appeal can be submitted orally or in writing, and must be requested within 60 Days of receipt of the Adverse Benefit Determination letter. The appeal will be acknowledged within 5 Business Days of receipt, and the entire appeal process completed within 30 Days of receipt of the request for appeal. Any additional information that may be used during the appeal will be requested from the member and provider, and must be submitted within the timeframe specified in the appeal acknowledgement letter.

Medicaid members, or their authorized representative, may request an extension of the appeal time frame, for an additional 14 Days, or if there is a need for additional information and if the delay is in the best interest of the member. A member will be notified in writing if the appeal response timeframe is extended, and the member can file a complaint if he/she does not agree with the extended time frame.

A physician who was not involved in the initial Adverse Benefit Determination, and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the appeal. An appeal resolution letter is mailed with the appeal decision within 30 Days of receiving the appeal request.

Expedited Member Appeals

A Medicaid member, a member's authorized representative, or the member's physician or other health care provider may request an expedited appeal of an Adverse Benefit Determination if waiting 30 Days for a standard resolution could seriously jeopardize the member's life or health.

Superior's Medical Management will review the request for expedited review. If our Medical Director determines expediting the review is not medically necessary, the appeal will be processed within the standard appeal timeframe of 30 Days. Notice will be provided to the member and/or member's representative of the decision to process the appeal as a standard request, and complaint rights to dispute the denial of the expedited review provided, if the member or the member's representative does not agree with the decision to process the expedited request within the standard appeal timeframe of 30 Days.

An expedited appeal is resolved and notification sent to the member and/or member's representative within one Business Day, but no later than 72 hours of receipt of the appeal request.

Continuing Services During Appeal

To continue services while an appeal is pending, the denial must involve the termination, suspension or reduction of a previously authorized course of treatment and have been ordered by an authorized provider. The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. The health plan cannot request reimbursement of services without HHS approval.

To continue previously authorized services while the appeal is being processed:

- A request for an appeal must be submitted on or before the later of 10 Calendar Days from the date the original adverse determination letter is mailed, or the day the service will be reduced or end.
- The time period covered by the original authorization must not have ended.
- The member or their representative requests an extension of these benefits.

If the above are met, the services will continue until any of the following happen:

- The member cancels the appeal.
- The denial is upheld on internal health plan appeal, unless member requests external review for State Fair Hearing, with or without External Medical Review.
- The time period covered by the original authorization has ended.

External Appeals

If the adverse benefit determination was not overturned, in whole or in part, through the internal appeal process, External Appeal rights are available. These include a State Fair Hearing, with or without External Medical Review. A provider may request a State Fair Hearing with or without External Medical Review, on behalf of the member/patient.

The details for both the State Fair Hearing and External Medical Review appeal process are included in the sections below.

External Medical Reviews

Can a member ask for an External Medical Review?

If a member, as a member of the health plan, disagrees with the health plan's decision, the member has the right to ask for an External Medical Review. These include State Fair Hearing, with or without External Medical Review. An External Medical Review is an optional, extra step the member can take to get the case reviewed for free before the State Fair Hearing. The member may name someone to represent him or her by writing a letter to the health plan telling the MCO the name of the person the member wants to represent him or her. A provider may be the member's representative. A member cannot request only an External Medical Review. The member must exhaust the internal health plan appeal process prior to requesting an External Medical Review. The member or the members' representative, including the member's provider, must ask for the External Medical Review within 120 Days of the date Superior mails the letter with the internal appeal decision. If the member does not ask for the External Medical Review within 120 days, the member may lose his or her right to an External Medical Review. To ask for 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.

If the member asks for an External Medical Review within 10 days from the time the member gets the appeal decision from the health plan, the member has the right to keep getting any service the health plan denied, based on previously

authorized services, at least until the final State Fair Hearing decision is made. If the member does not request an External Medical Review within 10 Days from the time the member gets the appeal decision from the health plan, the service the health plan denied will be stopped.

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 member, the member's authorized representative, or the member's LAR must submit the request to withdraw the EMR using one of the following methods: (1) in writing, via United States mail or fax; or (2) orally, by phone or in person.

An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, the member has the right to withdraw the State Fair Hearing request. The Member may withdraw a State Fair Hearing request orally or in writing by contacting the hearings officer listed on Form 4803, Notice of Hearing.

If the member continues with a State Fair Hearing and the State Fair Hearing decision is different from the Independent Review Organization decision, the State Fair Hearing decision is final. The State Fair Hearing decision can only uphold or increase member benefits from the Independent Review Organization decision.

Can a member ask for an emergency External Medical Review?

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 emergency External Medical Review and emergency State Fair Hearing by writing or calling Superior. To qualify for an emergency External Medical Review and emergency State Fair Hearing the member must first complete Superior's internal appeals process.

State Fair Hearings

Can a Member ask for a State Fair Hearing?

If the adverse benefit determination is upheld during the internal health plan appeal process, the member or member's representative has the right to ask for an External State Fair Hearing. The member may name someone to represent them by contacting the health plan and giving the name of the person the member wants to represent them. A provider may be the member's representative if the provider is named as the member's authorized representative. The member or the member's representative must ask for the State Fair Hearing within 120 Days of the date on the health plan's letter that tells of the decision being challenged. If the member does not ask for the State Fair Hearing within 120 Days, the member may lose his or her right to a State Fair Hearing. If Superior continues or reinstates benefits and the request for continued services is not approved by the State Fair Hearing officer, Superior will not pursue recovery of payment for those services without written permission from HHS.

To ask for a State Fair Hearing, the member or the member's representative can call, fax or mail the request to:

Superior HealthPlan
ATTN: State Fair Hearings Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
Phone: 1-877-398-9461
FAX: 1-866-918-2266

If the member asks for a State Fair Hearing within 10 days from the time the member gets the hearing notice from the health plan, the member has the right to keep getting any service the health plan denied, based on previously authorized services, at least until the final hearing decision is made. If the member does not request a State Fair Hearing within 10 days from the time the member gets the hearing notice, the service the health plan denied will be stopped.

If the member asks for a State Fair Hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, the member or the member's representative can tell why the member needs the service the health plan denied. HHS will give the member a final decision within 90 Days from the date the member asked for the hearing.

Expedited State Fair Hearings

Medicaid members, or their authorized representatives, may request an expedited State Fair Hearing if they believe that waiting for a standard State Fair Hearing could seriously jeopardize the member's life or health. In order to qualify for an expedited State Fair Hearing, the member must have exhausted Superior's internal appeal procedures.

An expedited State Fair Hearing may be requested verbally by calling Superior or by completing the State Fair Hearing Form, and attaching the adverse determination letter or the appeal resolution letter, and sending to Superior.

CHIP Appeals

Standard Member Appeals

CHIP members, authorized representatives, or their physician or other health care provider may request an appeal of an Adverse Determination. The Adverse Determination is accepted, orally or in writing.

CHIP appeal requests must be received within 60 Days from the date of notification of the Adverse Determination. Superior sends an acknowledgement letter to the appellant for a standard appeal request within 5 Business Days of receipt of the appeal request. The standard appeal process is completed within 30 Days. Any additional information that may be used in consideration of the appeal will be requested by Medical Management during the appeal process, and must be submitted within the requested timeframe.

A physician, who was not involved in any previous level of review or decision-making and who has appropriate clinical expertise in treating the member's condition or disease, will review and render a decision on the appeal. An opportunity for a peer-to-peer discussion will be offered prior to issuing an adverse appeal resolution. An appeal resolution letter will be mailed to the appellant with the appeal decision.

If not later than the 10th working day after the date an appeal is requested or denied the enrollee's health care provider requests a particular type of specialty provider review the case, a health care provider who is of the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under consideration for review will review the denial or the decision denying the appeal. The specialty review will be completed within 15 working days of the date the health care provider's request for specialty review is received, and a resolution letter mailed to the member and requesting provider.

If the adverse determination is upheld on appeal, CHIP members, an authorized representative or their physician or other health care provider can request review of an Adverse Benefit Determination through an External Review Organization (ERO) if the internal appeal is an adverse determination.

CHIP members, an authorized representative, or their physician or other health care provider, can request an immediate review of an Adverse Benefit Determination through an External Review without first filing an appeal with Superior in a circumstance involving a member's life-threatening or urgent condition or when an appeal is not resolved in a timely manner. See information in this section regarding External Reviews.

Expedited Member Appeals

CHIP members, authorized representatives, or their physician or other health care provider, may request an expedited appeal of an Adverse Benefit Determination.

CHIP procedures for appealing an adverse determination include, in addition to the written appeal, a procedure for an expedited appeal of a denial of emergency care, a denial of continued hospitalization, or a denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. Expedited appeals can be requested by calling Medical Management at 1-800-398-9461, and must be requested within 60 days of the adverse determination notice.

Expedited appeals are reviewed by a health care provider who has not previously reviewed the case; and is of the same or a similar specialty as the health care provider who would typically manage the medical condition, procedure, or treatment under review in the appeal. The physician deciding the appeal must consider atypical diagnoses and the needs of atypical member populations.

The time for resolution of an expedited appeal is based on the medical immediacy of the condition, procedure, or treatment under review, but must not exceed one working day from the date all information necessary to complete the appeal is received. If additional information is required to reconsider the adverse determination, the information request will be requested, and must be returned within the timeframe specified in the request. An appeal resolution letter is mailed to the member or member's authorized representative with the expedited appeal decision. If the decision is to uphold the adverse determination, the member or authorized representative can request an expedited external review through an External Review Organization (ERO).

External Review Organization (ERO) Appeals

If the health plan's internal appeal decision is an adverse determination, the member, authorized representative, or the member's provider can request an external appeal review.

The CHIP External Review Organization (ERO) is Maximus Federal Services, who performs a secondary clinical review of the health plan's denial. There is no cost to the member for an External Review.

To request an External Review, the member or authorized representative must provide the following information: name and address, phone number, email address, whether the request is expedited or standard, a completed Appointment of Representative Form if someone is filing on the member's behalf, and a brief summary of the reason the member disagrees with Superior's decision.

Members may also complete the HHS Federal External Review Request Form to provide this information and include their adverse determination letter from Superior when mailing or faxing their request to MAXIMUS. This form is available on the Superior website. Requests for External Review can be mailed or faxed directly to MAXIMUS at:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Fax number: 1-888-866-6190

The MAXIMUS Federal Services examiner will contact Superior immediately after receiving the request for an External Review. Within 5 Business Days, Superior will give the examiner all documents and information used to make the internal appeal decision.

The member or member's representative will receive written notice of the final External Review decision as soon as possible. The member will receive notice no later than 45 days after the examiner receives the request for an External Review.

Expedited External Review: In a circumstance involving a CHIP member's life-threatening condition, the an immediate appeal to the External Review Organization is available, and the member is not required to complete the internal appeal process. The MAXIMUS examiner will give Superior and the member or member's representative the External Review decision as quickly as medical status requires. The member will get a decision no later than within 72 hours of receiving the request.

The member or member's representative will receive the decision by phone. MAXIMUS will also send a written version of the decision within 48 hours of the phone call. Superior is bound to comply with the decision of the External Review. If the ruling is in favor of the member, Superior must take action on the notice and provide authorization or coordinate the services after receiving the External Review decision notice.

SECTION 12
QUALITY IMPROVEMENT

Quality Assessment and Performance Improvement Program

Superior is committed to the provision of a well-designed and well-implemented Quality Assessment and Performance Improvement (QAPI) Program. Superior's culture, systems and processes are structured around its mission to improve the quality of services delivered to our providers and to our members. The purpose of the QAPI Program is to plan, implement and monitor ongoing efforts that demonstrate improvements in member safety, overall health and care experience.

Superior is accredited by the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to improving health-care quality. The NCQA seal is a widely recognized symbol of quality. NCQA health plan accreditation surveys include rigorous, on-site and off-site evaluations standards and selected HEDIS measures. A national oversight committee of physicians analyzes the survey findings and assigns an accreditation level based on the performance level of each plan being evaluated to NCQA's standards. This recognition is the result of Superior's long-standing dedication to provide quality health care service and programs to our members. Superior requires all practitioners and providers to cooperate with all QAPI activities, as well as allow Superior to use practitioner and/or provider performance data to ensure success of the QAPI Program.

Goals and Objectives

The following are Superior's goals and objectives for its QAPI Program:

- **Safety** - Care doesn't harm members.
- **Member Experience** - Members feel valued.
- **Efficiency** - Resources are used to maximize quality and minimize waste.
- **Eliminating Disparities** - Quality care is reliably received regardless of geography, income, language or diagnosis.

In support of the QAPI Program, the QI Department monitors the quality of health care services provided to Superior members, addressing two basic areas:

- Quality of service; and
- Quality of care.

To monitor the quality of services you provide to Superior's members, the QI Department reviews the availability of appointments for emergencies, urgent care and preventive care. Superior also monitors availability for after-hours calls from members, as well as how satisfied members are with services provided by you and your office staff.

To monitor quality of service, Superior's QI Department may assess:

- Satisfaction levels from Superior providers and members utilizing both satisfaction surveys and complaints.
- Turn-around time in responding to provider issues.
- Appropriate claims payment and adjustment timeframes.
- Customer service performance with incoming provider calls.

To monitor quality of care, Superior's review processes may include:

- Review and distribution of practice guidelines for diseases and conditions most likely to impact Superior's members, as well as pediatric and adult preventive health care guidelines, including compliance with practice guidelines.
- Targeted audits of primary care practices to promote the confidentiality of medical information and compliance with standards for appropriate medical record documentation, when necessary.
- Monitoring and support of communication systems that promote continuity and coordination of care.
- Investigation of potential quality of care complaints, including the tracking and trending of complaints.

Other Program Activities

QI initiatives (clinical and non-clinical Performance Improvement Projects (PIPs), focus studies, medical record audits, etc.) are selected:

- Based on having the greatest potential for improving health outcomes or the quality of service delivered to Superior's members and network providers;
- To test an innovative strategy; and
- To reflect distinctive regional emphasis on populations and cultures.

Superior's PIPs, focused studies and other QI initiatives are selected, designed and implemented in accordance with principles of sound research design and appropriate statistical analysis.

Superior's QAPI program description is posted on the secure portion of the Provider Portal at Provider.SuperiorHealthPlan.com.

Participation in the Quality Assessment and Performance Improvement Program

There are several ways that providers can participate in Superior's QAPI Program. You can participate by:

- Volunteering for committee service. Superior has an active Quality Improvement Committee (QIC) structure that is comprised of physician peers. The QIC and its subcommittees provide the voice of the provider in determining the current community standard of care and in providing direction to the plan on clinical and non-clinical issues that are most relevant to Superior's members. Stipends are usually provided for attendees.
- Being vocal. We are here to help you. If there is a problem we do not know about, Superior wants to hear why you are not happy with the plan, as well as your suggestions for how to fix the problem. Superior would also like to hear about things we do well, to model other processes after our successes.
- Responding to surveys and requests for information. If we do not hear your opinion, it cannot be a factor in our decision making.

For reporting of quality issues, or if you have questions related to Superior's QAPI Program, you can contact Superior's QI Department at:

Superior HealthPlan
ATTN: Senior Vice President, Population Health & Clinical Operations
5900 E. Ben White Blvd.
Austin, TX 78741
1-800-218-7453

The Quality Improvement Committee

This committee is an important link between Superior and its network providers. The QIC is comprised of contracted providers representing most geographic areas and a variety of specialties. Superior's Chief Medical Director appoints providers to the committee. Once appointed, members are asked to serve a minimum of one year. This committee advises the plan regarding proposed quality improvement activities and projects, evaluates the design as well as the results of clinical studies, reviews and approves clinical practice and preventive health care guidelines and oversees the activities of the Utilization Management Committee (UMC). The QIC also serves as the Peer Review Committee (PRC) when reviewing significant quality of care issues involving network providers.

The Utilization Management Committee

The UMC is a subcommittee of the QIC. This committee focuses on evaluation and monitoring of the Utilization Management Program and includes review of criteria used for decision making as well as oversight of the denial and appeal processes. This committee reviews specific issues related to over- and under-utilization and assists in the development of interventions or processes to improve the appropriateness of services available to and received by Superior's members.

Committee Meeting Schedules

The QIC and UMC meet every other month, on alternating months. Meetings are scheduled at a time agreed upon by the committee members and generally last one hour. Meetings are held at the Austin Superior office. Those members unable to easily travel to the Austin location may participate by telephone. If you have an interest in taking an active role on the QIC or UMC, please contact Provider Services.

Provider Profiling

In accordance with our HHS contract, Superior adopted a formal profiling process as a tool to partner with PCPs, high-volume specialists and hospitals to improve care and services provided to Superior members. The profiling process is intended to increase provider awareness of their performance, identify areas for process improvement and expand opportunities for Superior to work closely with providers in development, implementation and ongoing monitoring of site-based practice performance improvement initiatives. The Chief Medical Director has final authority and responsibility for the provider profiling program.

Program Goals

The following are Superior's goals for the provider profiling program:

- Increase provider awareness of performance in areas identified as key indicators.
- Motivate providers to establish measurable performance improvement processes in their practice sites relevant to Superior's member populations.
- Identify the best practices of high-performing providers by comparing findings to the state average, other providers of the same type and (when possible) other comparable data.
- Increase opportunities for Superior to partner with providers to achieve measurable improvement in health outcomes.

Program Objectives

The following are Superior's objectives for the provider profiling program:

- Establish and maintain an open dialogue related to performance improvement initiatives with identified providers.
- Produce and distribute provider-specific reports containing meaningful, reliable and valid data for evaluation by the plan monthly for PCPs, and annually for acute care hospitals and high-volume OB/GYNs and specialists.

Program Scope

Superior's provider profiling program includes monthly review of high-volume PCPs and annual reviews of high-volume OB/GYNs, specialists and acute care hospitals.

On average, high-volume providers deliver services to 70 percent of Superior's membership. High- volume providers who participate in the STAR, STAR+PLUS, STAR Health (foster care), STAR Kids and CHIP programs are included in the profiling activities.

PCP Provider Profiling Process

Superior provides PCP's monthly data through the 3M Health Information Systems (HIS) dashboard which provides insight into actual patterns of care of their patients. 3M HIS provides data analytics to transform healthcare. 3M uses Superior claims data, risk adjusted, to provide providers with detail on, as available, gaps in care, emergency department information, inpatient admissions and readmissions, PCP visits for the providers attributed members and potentially preventable events. The 3M Potentially Preventable Events (PPE) logic is included in the dashboard and provides a dynamic information for providers and Superior to understand and manage patients at risk of PPE. Further, 3M has a Value Index Score that captures provider quality in six domains: chronic and follow-up care, primary and secondary prevention, tertiary prevention, continuity of care, population health status and patient experience.

High-Volume OB/GYN, High-Volume Specialists and Acute Care Hospital Provider Profiling Process

High-volume OB/GYNs, specialists , including behavioral health specialist providers and hospitals are identified annually by Superior. Specific inclusion criteria are outlined in Table 14-1.

Table 14-1 Provider Profiling Applicability

Provider Type	Criteria	Data Source
High-Volume OB/GYNs	OB/GYN groups who served 50 or more members during the reporting year.	Claims data.
High-Volume Specialists	Specialists who served 50 or more members during the reporting year.	Claims data.
Acute Care Hospitals	Hospitals with 100 or more admissions during the reporting year.	Claims data.

When evaluating inclusion criteria or claims, the provider's total experience in all program types is used. Providers may be included in the profiles individually or as part of a group or system. Determination of providers included in the provider profiling process is the joint responsibility of select staff from the Quality Improvement, Medical Management and Account Management Departments.

All indicators are reviewed and approved by the QIC annually. Additionally, Superior disseminates all approved

inclusion criteria, indicators and performance benchmarks to providers through the Provider Portal before each measurement cycle. All indicators selected for inclusion in the process must have the following characteristics:

- Indicator data must be reliable and valid.
- Reliable comparative data must be available.
- Indicator topics must be meaningful to the provider, the plan and the membership.
- The provider must have the capability to effect improvement in performance.

Once identified, Superior will continue reporting indicators over multiple cycles to identify measurable performance improvement at both the system and provider levels.

Quality Indicator Data Source

The analytical software that is used by Superior applies the concept of a peer definition to make comparisons. All peer definitions start with a specialty designation and include all providers of the same specialty for purposes of comparison. Thus, for the set of episodes or population a provider is attributed to, their performance is compared to all participating same specialty providers in Superior's provider database.

Superior uses evidence-based medicine rules that can be measured in claims. These apply at the member level. Performance is determined by comparing the compliance rate for the quality rules attributed to a provider to the compliance rate of the other providers in the peer definition for that exact same mix of attributed rules. A quality index is calculated by dividing a provider's compliance rate for the attributed rules by the compliance rate for the exact same mix of rules by their peers. Thus, an index greater than one would indicate that a compliance rate is greater than peers for the exact mix of attributed rules.

Provider Profile Analysis

Aggregate data on provider profiles is analyzed by the Superior's QIC. Select staff from the Quality Improvement, Medical Management and Account Management departments analyzes individual data. Analysis includes identification of outliers, generally defined as those providers in the top and bottom five percent of the aggregate scoring for their peer group.

Provider Practice Profiles in Recredentialing

A copy of each provider profile may be utilized as the quality report in the provider recredentialing process and may be filed with select credentialing files.

Provider Profile Distribution

The PCP profile is refreshed monthly and available through the provider's assigned log-in to the 3M HIS portal. The High-Volume OB/GYN, Specialist and Acute Care Hospital profile is mailed to select providers. Staff from the Clinical Engagement Team (CET) are available to assist with review of performance detailed in the provider profile. The service area Medical Director, Quality Practice Advisor and Chief Medical Director may accompany CET staff in visiting those providers identified as outliers. Standards used to measure the provider are available to the provider.

Practice Guidelines

Superior's Practice and Preventive Health Guidelines are based on the health needs of its membership. Selected guidelines are evidence-based, adopted from recognized sources, and promoted to providers in an effort to ensure healthcare quality and uniformity of care provision to Superior's enrolled members. Superior's QI Department reviews all guidelines annually for updating and/or when new scientific evidence or national standards are published. All guidelines are approved by Superior's Quality Improvement Committee (QIC) annually and disseminated to providers via the provider e-newsletter, targeted mailings, other media sources and upon request. The most up-to-date list

of approved guidelines are available at https://www.SuperiorHealthPlan.com/providers.html. Superior's Quality Assessment and Performance Improvement (QAPI) Program assures that practice guidelines meet the following:

- Adopted guidelines are approved by Superior's QIC annually.
- Adopted guidelines are evidence-based and include preventive health services.
- Guidelines are reviewed on an annual basis and updated accordingly, but no less than annually.
- Guidelines are disseminated to providers in a timely manner via the following appropriate communication settings:
  - **Provider orientations and other group sessions**
  - **Provider e-newsletters**
  - **Online via https://SuperiorHealthPlan.com/providers/resources/quality-improvement/practice-guidelines.html**
  - **Targeted mailings**
- Guidelines are posted on Superior's website or paper copies are available upon request by contacting

Superior's Quality Improvement Department at:

Superior HealthPlan
ATTN: Senior Vice President, Population Health & Clinical Outcomes
5900 E. Ben White Blvd.
Austin, TX 78741
1-800-218-7453

Office Site Survey

Superior's Quality Improvement Committee (QIC) has adopted guidelines for office sites. See a sample of the Office Site Survey in the Attachments section.

Superior may conduct a site visit to the office of any physician or provider at any time for cause. Superior will conduct the site visit to evaluate any complaints or other precipitating events, which may include an evaluation of any facilities or services related to the complaint and an evaluation of any/all of the following:

- Physical accessibility (provider offices are required to be accessible to members with disabilities);
- Physical appearance;
- Adequacy of waiting and examining room space;
- Adequacy of medical/treatment record keeping;
- Appointment availability; and
- Equipment.

The survey will be conducted by Superior's Account Management staff or designee or through a contracted vendor.

Once the survey is completed, it is scored. If the score is less than 80%, or if any elements in the "access for the disabled" section of the form are not met, the provider office is required to submit a corrective action plan to Superior within 30 Days. Following submission of the corrective action plan, a second survey is scheduled within six months to evaluate compliance with office site guidelines.

If Superior receives another complaint about the same aspect of the performance for the office site within six months after completing the site visit, Superior will determine whether the practitioner's previous office site visit met the plan's standards and thresholds. If that is the case, Superior will follow up on the complaint and a subsequent visit is not required.

Survey Results

At the conclusion of an office site survey, the results will be reviewed with you or a designated member of your staff. You may make a copy of your survey for your records. If there are deficiencies, you may be asked to submit a corrective action plan.

SECTION 13
CULTURAL COMPETENCY IN SERVING SUPERIOR'S MEMBERS

Cultural Sensitivity

Superior places great emphasis on the wellness of its members. A large part of quality health care delivery is treating the whole patient and not just the medical condition. Superior encourages providers to provide culturally competent care that aligns with the National Standards on Culturally and Linguistically Appropriate Services (CLAS). Superior maintains policies which emphasize the importance of culturally and linguistically competent care to Superior's membership of all cultures, races, languages, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual members while protecting and preserving the dignity of each member. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and, in the long run, the health and wellness of the patients themselves.

The following is a list of principles for health care providers to include knowledge, skills and attitudes related to cultural competency in the delivery of health care services to Superior members.

Knowledge

- Provider's self-understanding of health disparities, as related to race, ethnicity or influence and the critical link between quality health care and the clinical encounter.
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns and the importance of building physician, patient-centered relationships.
- Understanding of the particular psycho-social stressors relevant to minority patients including war trauma, migration, acculturation stress and socioeconomic status.
- Understanding of the cultural differences within minority groups and how cultural dynamics influence cross-cultural behaviors.
- Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network.
- Understanding of the differences between culturally acceptable behavior of psycho-pathological characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
- Understanding of cultural factors that can affect decision-making based on cultural beliefs, lack of trust or other behavior patterns within minority groups.
- Understanding of the health service resources for minority patients.
- Understanding of the public health policies and its impact on minority patients and communities.

Skills

- Ability to facilitate and assess minority patients based on a psychological, social, biological, cultural, political or spiritual model.

- Ability to enhance patient communication effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority patients with an understanding of cultural differences in pathology.
- Ability to avoid under diagnosis or over diagnosis.
- Ability to apply treatment methods that enhance clinical assessment processes and adherence.
- Ability to utilize community resources such as church, community-based organizations (CBOs), self-help groups.
- Ability to provide therapeutic and pharmacological interventions with an understanding of the cultural differences in treatment expectations and biological response to medication.
- Ability to ask for consultation.

Attitudes

- Respect the "survival merits" of immigrants and refugees.
- Respect the importance of cultural forces.
- Respect the holistic view of health and illness.
- Respect the importance of spiritual beliefs.
- Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
- Be aware of transference and counter transference issues.

Resources for Cultural Competency

Superior provides CLAS-related educational opportunities for providers per its secure Provider Portal. Providers are able to participate in Superior's Cultural Competency Health Literacy Training, as well as participate in training opportunities administered by the State or nationally recognized organizations, found at www.SuperiorHealthPlan.com. Providers are also encouraged to participate in training provided by other organizations. For additional information regarding resources and trainings, visit:

- The HHS Center for Elimination of Disproportionality and Disparities, Office of Minority Health and Health Equity online course - http://www.txhealthsteps.com/cms/?q=office-of-minority-health-and-health-equity.
- "A Physician's Practical Guide to Culturally Competent Care," developed by the U.S. Department of Health and Human Services, Office of Minority Health - https://cccm.thinkculturalhealth.hhs.gov.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) site, https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy. Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Superior also provides ongoing provider training, which includes topics of health equity, including cultural competence, bias, diversity and inclusion, and is conducted through webinars, quarterly and refresher trainings on an as-needed-basis, during routine on-site visits and upon request. In addition, your local, state and national provider organizations are likely to have information resources available as well. Providers may request information and resources by contacting their Account Manager.

Interpreter/Translation Services

Superior is committed to ensuring that staff and subcontractors are educated about, remain aware of and are sensitive to the linguistic needs and cultural differences of our membership. Information about cultural and

linguistic competency and interpreter and translation services are included in a variety of communications media via Superior's Provider Manual, Provider Newsflash (e-newsletter), the Primary Care Update (in certain editions), training tools, etc., all of which are accessible on Superior's website. Providers are also informed of their ability to request assistance with professional interpreter and translation services with the utilization of Superior's interpreter and translation partners, 24-Hour Nurse Advice Line, Relay Texas and Telephone Interpreter Services Vendors to assist with Superior's membership when language or hearing impairment is a barrier to communication.

In order to meet this need, Superior provides or coordinates the following:

- A Member Services and Member Connections department that is staffed with bilingual personnel (Spanish and English).
- Trained professional language interpreters, including American Sign Language, are available for face-to-face communication at your office, if necessary, or via telephone to assist providers with discussing technical, medical or treatment information with members.
- A link to language interpreter services is available 24-hours-a-day, seven-days-a-week to assist providers and members in communicating with each other when there are no other translators available for the language.
- TTY (text telephone use of telephones for the hearing impaired) access for members who are hearing impaired. This is Relay Texas, 1-800-735-2989.
- Superior's Nurse Advice Line, which provides a 24-hours-a-day, seven-days-a-week bilingual (Spanish and English) line for medical assistance with access to the "language services associates" line for other languages.
- Superior member and health education materials are available in English and Spanish.

To access interpreter services for your patients, contact Superior's Member Services Department at:

STAR and CHIP 1-800-783-5386

STAR+PLUS..... 1-877-277-9772

STAR Kids..... 1-844-590-4883

STAR Health 1-866-912-6283

SECTION 14
CREDENTIALING PROGRAM

Superior has established rigorous standards for conducting the functions of provider selection and retention. To participate in the Superior network, all licensed individual practitioners and organizational providers must meet the qualifications specific to Superior along with government regulations and standards of approved accrediting bodies.

The provider application process focuses on the review and verification of each provider's license, accreditation, and competency attributes, according to the guidelines of the National Committee for Quality Assurance (NCQA), and the regulations of applicable governing bodies for the Texas Department of Insurance (TDI), HHS and the Office of Inspector General (OIG).

Superior's Credentials Committee, which is a subcommittee of Superior's Quality Improvement Committee (QIC), has final authority for review and appropriate approval of licensed physicians, other licensed health care professionals and certain facilities that have an independent relationship with the plan.

All credentialing and recredentialing questions should be directed to Superior's Credentialing Department at 1-800-820-5686 or Credentialing@SuperiorHealthPlan.com.

Credentialing Process

Applicants or affiliates applying for network status are required to undergo an in-depth evaluation and a primary source verification of their credentials to include but not limited to:

- Work history.
- Educational background.
- Training.
- Competency.

All participating providers within Superior's credentialing scope must be recredentialed every 36 months to remain a participating provider within Superior's network.

Facilities interested in participating with Superior are required to undergo an in-depth evaluation of primary source verifications that are specific to the facility type. For example, most facilities, if not accredited, are required to successfully complete either a State or Superior Site survey. Superior requires the utilization of the statewide Texas Credentialing Alliance and the contracted Credentialing Verification Organization (CVO) as part of the credentialing and re-credentialing process.

Providers are required to completed the Texas Standard Credentialing Application (TSCA) for practitioners and facilities are required to complete the Superior Facility Credentialing application. VeriSys (CVO services provider) will assist with your credentialing process for Superior HealthPlan, and credentialing documents are submitted to VeriSys through CAQH or Availity.

- To submit a practitioner application to CAQH, go to https://proview.caqh.org. A practitioner will need to register as a first time user to get started.
- To submit a practitioner or facility application to Availity, go to www.availity.com. Availity is the only forum to submit a facility credentialing application. Availity has a standard Facility credentialing application that is accepted by Superior. A new provider will need to register as a first time user to get started.
  - **Once the completed application is completed through Availity or CAQH, VeriSys automatically retrieves the submitted information and performs the primary source verifications of submitted credentials.**
  - **VeriSys verifies the credentialing application and returns results to Superior for a Credentialing decision.**

Initial Credentialing Process

Effective April 1, 2018, Superior began participation in the State Credentialing Verification Organization (CVO) credentialing program. Along with all other Medicaid MCOs, applications are submitted electronically via CAQH's or Availity portals. As a result of this change, providers and facilities only have to submit one application to request participation in all MCO networks. Additional instructions can be found on Superior's Provider Forms webpage at SuperiorHealthPlan.com/ProviderForms or on Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Superior verifies the information provided on the application through external primary sources. During this process, the applicant is promptly notified of any problems related to the collection and/or verification of these documents. The CVO began performing these functions, as of April 1, 2018. It is the sole responsibility of the applicant to produce all necessary information and documentation required to conduct a thorough examination of a provider's credentials. Failure to provide the necessary information within 60 Days from the initial application received date will result in termination/discontinuation of credentialing. If the provider ever seeks to join Superior in the future, the provider must begin the process from inception.

Electronic Applications

Superior accepts electronic applications on the appropriate TDI credentialing application or Superior facility credentialing form. You can access an electronic format of the TDI practitioner application at http://www.tdi.texas.gov/forms/formlisting.html. The electronic application must be submitted through the CVO portal.

Superior also accepts Practitioners' Council for Affordable Quality Health Care (CAQH) identification numbers. The CAQH is a catalyst for industry collaboration on initiatives that simplify health care administration. For more information on CAQH, visit their website at http://www.caqh.org/. With the implementation of the CVO, facility applicants will be afforded a similar application resource, through Availity, which is a vendor similar to CAQH.

Credentialing Criteria

Each candidate must complete an application for participation that includes the following minimum requirements:

- A valid National Product Identifier (NPI) number.
- Completed, signed and dated application for participation.
- Attestation of history of loss of license and/or clinical privileges, disciplinary actions and/or felony convictions.
- Attestation of lack of current substance and/or alcohol abuse.
- Attestation to mental and physical competence to perform the essential duties of the profession.
- Attestation to the correctness/completeness of the application.
- Signed and dated Release of Information form.
- Current unrestricted license in the state where the practice is located. Exception applies for some Long-Term Services and Support (LTSS) provider types.
- Current valid federal Drug Enforcement Administration (DEA) certificate (as applicable).
- Current liability insurance in compliance with minimum limits set by Superior's provider agreement (exception applies for some LTSS provider types).
- Proof of highest level of education and, in the case of physicians, proof of graduation from an accredited medical school or school of osteopathy, proof of completion of an accredited residency program, or proof of board certification. *Please note: Fellowship does not meet this requirement, but will be verified, as applicable to the specialty.*
- Current admitting privileges in good standing at an in-network inpatient facility or written documentation from a physician or group of physicians, who participate with Superior, stating that they will assume the inpatient care of all of the practitioner's plan members who require admission, and that they will do so at a participating facility.

- History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the practitioner for the past five years or any cases that are pending professional liability actions (when reviewing this history, the credentials committee will consider the frequency of case(s) as well as the outcome of the case[s]).
- Written explanation if practitioner has been sanctioned in a Medicare/Medicaid program.
- Disclosure of ownership or financial interest in any clinical laboratory, diagnostic testing center, hospital ambulatory surgery center, home health or other business dealing with the provision of ancillary health services, equipment or supplies. These documents will be requested by Superior, as part of the initial contracting packet of documents. The CVO is not involved in this process.
- Work history for the previous five years. Any gap greater than six months must be explained by the practitioner.

After the CVO completes the requisite verification, Superior's credentialing staff will review each application for completeness and correctness. Applicants who meet the participation criteria and are determined to have a clean file will be approved for participation following review by the Superior medical director or chair of the Credentials Committee. The Credentials Committee is provided with a list of clean files approved by the medical director, for informational purposes. Superior's credentialing policy defines a "clean file" as one with none of the following adverse activity present:

- No past or present suspensions or limitations of state licensure.
- No past or present suspensions or limitations of DEA licensure.
- Malpractice coverage in the amount required by plan.
- No past or present Medicare/Medicaid sanction activity.
- No preclusion from CMS Medicare list.
- No malpractice claims that resulted in a settlement or a verdict in favor of the plaintiff (claims ruled in favor of the defendant are acceptable for a clean file) or a notable trend in malpractice activity.
- No gaps in work history of six (6) months or longer for a minimum of five (5) years. If the practitioner has practiced fewer than five (5) years from the date of credentialing, the work history starts at the time of initial licensure.
- No outstanding negative balance for a period of greater than 180 Days.

Recredentialing Process

Superior formally recredentials practitioners at least every 36 months. The recredentialing cycle begins with the date of the initial credentialing decision.

In order to be compliant with recredentialing expectations, a request for information is sent to the provider no later than 180 Days before the provider is due to be recredentialed. Superior verifies the information provided by the applicant in support of their application for continued participation within Superior's network through external primary sources. As of April 1, 2018, this function will be performed by the State's CVO, and the results reviewed by Superior.

During the recredentialing process, the applicant is notified promptly of any discrepancies related to the collection and/or verification of these documents. It is the sole responsibility of the applicant to produce all necessary information and documentation required to conduct a thorough examination. Failure to provide the necessary information within 60 Days from the date the application for recredentialing was received will result in termination/discontinuation of recredentialing. If the provider ever seeks to join Superior in the future, the provider must begin the process from inception, as an initial applicant.

Expedited Credentialing

To qualify for expedited credentialing, the provider must: (1) be a member of an established health-care provider group that has a current contract in place with Superior, (2) be a Medicaid or CHIP enrolled provider, (3) agree to comply with the terms of the contract between Superior and the health-care provider group and (4) timely submit all documentation and information required by Superior as necessary to begin the credentialing process. The following practitioner types may utilize the expedited credentialing pathway:

- Dental specialists (including dentists and physicians providing dental specialty care; DDS/DMD)
- Dentists (DDS/DMD)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Physicians (MD or DO)
- Podiatrist (DPM)
- Psychologists (PhD/PsyD)
- Therapeutic Optometrist (O.D.)

Applicants, who qualify for the expedited credentialing process, as defined below, are identified as an "Expedited File." Expedited files, may be presented to the Credentials Committee or to the designated Medical Director for approval. Superior Credentialing defines an "expedited file" as one that meets the following criterion:

- Be licensed in this state by, and in good standing with, the appropriate Texas State Licensure Board;
- Submit all documentation and other information required by Superior as necessary to enable Superior to start the credentialing process; to include a signed participating provider attestation form and agree to comply with the terms of the current Superior participating provider group contract to which they are joining.
- Verification of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Data Bank (NPDB) query.
- Verification that the practitioner is not excluded from participation in federal health care programs (Medicare or Medicaid).

While being credentialed, Superior will treat the applicant as if they were a participating provider, providing services to the managed care plan's enrollees, including:

1. Authorizing the applicant physician to collect copayments from the enrollees; and
2. Making payments to the applicant physician.

Pending the approval of an expedited applicant, Superior will exclude the applicant from Superior's directory of participating physicians, website listing of participating physicians, or any other listing of participating physicians.

If, on completion of the credentialing process, Superior determines that the applicant does not meet the credentialing requirements and denies network membership:

1. Superior may recover from the applicant or the medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and
2. The applicant or the medical group may retain any copayments collected, or in the process of being collected, as of the date of the credentialing determination.

Right to Review and Correct Information

All providers participating with Superior have the right to review information obtained by the Credentialing Department or State CVO, to evaluate their credentialing and/or recredentialing file. This includes:

- Information obtained from any outside primary source such as malpractice insurance carriers, the Texas

Board of Medical Examiners and Texas Board of Nursing, with applicable State Licensing Boards.

- This does not allow a provider to review references, personal recommendations or other information that is peer review protected.
- Providers also have the right to request the status of the application at any time during the credentialing process by contacting Superior's Credentialing Department.

Should a provider believe any of the information used in the credentialing/recredentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a provider, they have the right to correct erroneous information.

To request release of such information, a written request must be submitted to Superior's Credentialing Department. Upon receipt of this information, the provider will have 10 Days to provide a written explanation detailing the error or the difference in information to Superior. Superior's Credentials Committee will then include this information as part of the credentialing/recredentialing process and will also include in the practitioner's file. If no response is received within 10 Days, the Credentialing Department, on behalf of Superior, assumes the provider does not dispute the accuracy of the information collected, and the file is presented to the medical director and/or the credentials committee.

Superior will notify the practitioner if information obtained during the credentialing process varies substantially from the information provided.

Requesting Reconsideration

If you are not satisfied with the Credentials Committee credentialing status determination, you may request reconsideration for new practitioners, or an appeal for established practitioners, of the decision in writing. Please send your written request to:

Superior HealthPlan
Attn: Credentialing Department
5900 E. Ben White Blvd.
Austin, TX 78741
Credentialing@SuperiorHealthPlan.com

Reconsideration requests for new practitioners must be received by Superior within 30 Days of the formal notice of denial. The appointed committee members will review the information and notification of the decision will be provided.

Appeals for re-credentialing practitioners must be received by Superior within 30 Days of the formal notice of denial. Superior will appoint an Appeals Committee. The Appeals Committee hears appeals of decisions from the Credentials Committee to deny, suspend or restrict participation or to terminate the participation status of a practitioner or facility. The appeal hearing will be scheduled no later than 60 Days from the provider's request.

The Appeals Committee may uphold, reject or modify the initial Credentials Committee recommendation. The Appeals Committee recommendation will be based upon the evidence admitted at the hearing and will be by the affirmative vote of the majority of the members of the Appeals Committee. The action of the Appeals Committee regarding any restriction, suspension or termination matter is a final decision, which will be communicated to the provider in writing.

SECTION 15
COMPLAINT PROCEDURES

Superior recognizes that there are times when you may not be satisfied with a matter handled by Superior. Providers have the right to file a complaint related to that matter. This section describes in detail the process to file a complaint, the response timeframes and the complainant's rights during the process.

The complaint process does not include appeals for determinations/actions based on medical necessity.

Complaint Definitions

Medicaid

Complaint: A complaint is an expression of dissatisfaction communicated by a complainant, orally or in writing, about any matter related to Superior, other than an action/Adverse Benefit Determination. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to:

1. The quality of care of services provided;
2. Aspects of interpersonal relationships such as rudeness of a provider or employee, or
3. The failure to respect the Medicaid member's rights.

CHIP

Complaint: A complaint is any dissatisfaction, expressed by a complainant, orally or in writing, with any aspect of the Superior's operation, including, but not limited to, dissatisfaction with:

1. Plan administration;
2. Procedures related to review or appeal of an Adverse Benefit Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G;
3. The denial, reduction or termination of a service for reasons not related to medical necessity;
4. The way a service is provided; or
5. Disenrollment decisions.

This term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding and reaching satisfaction.

Filing a Provider Complaint

Superior offers a number of ways to file a complaint:

- Online through Superior's website at https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.
- Faxing or mailing a complaint form to Superior for a resolution response. The link to the printable complaint form is https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.

- Mailing or faxing a written complaint to the following:

  Superior HealthPlan
  ATTN: Complaint Department
  5900 E. Ben White Blvd.
  Austin, TX 78741
  Fax: 1-866-683-5369

- Calling Provider Services at:

  STAR, STAR+PLUS, STAR Health, STAR Kids and CHIP 1-877-391-5921

What to Expect When You File a Complaint

When a complaint is received, a written acknowledgement letter is sent to the provider within five Business Days of receipt of the complaint. Superior then has 30 Days to resolve the complaint. The response to the complaint will be provided in writing in the form of a resolution letter. If the resolution/response is not satisfactory, a complaint appeal may be filed.

Superior maintains all documentation (fax, electronic and telephonic) related to the receipt and response to the complaint, to include routing and correspondence maintenance, within the current software solutions used for complaints processing. The system used accommodates a secure and complete record of each complaint and any complaint proceedings or actions taken on a complaint/complaint-appeal according to minimum record retention requirements.

Superior will maintain documentation on each complaint/appeal until five years after the termination of the contract with HHS. Such documentation for each complaint/appeal filed includes date of receipt, identification of the individual filing the complaint/appeal, all documentation pertaining to the complaint/appeal, identification of the individual recording the complaint/appeal, the substance and nature of the complaint/appeal, investigation details and the disposition and resolution of the complaint/appeal and the date resolved.

Appealing a Complaint Resolution

Complaint appeals must be submitted no later than 30 Days of the resolution/response letter. The appeal will be acknowledged within 5 Business Days of receipt and responded to within 30 Days of receipt. If the resolution/response is not satisfactory, a provider may ask that their appeal be reviewed and settled in accordance with the commercial arbitration rules of the American Arbitration Association, or the arbitration or litigation provisions as noted in the individual provider's contract with Superior.

Additional Filing Rights

After exhausting all complaint rights through Superior, providers have the right to file their complaint through external regulatory agencies if they are not satisfied with Superior's resolution to their complaint.

Complaints about a matter involving a Medicaid program

Providers have the right to file a complaint with HHS by submitting to:

Texas Health and Human Services
Health Plan Management – H-320
P.O. Box 85200
Austin, TX 78708-5200

Complaints about a matter involving the CHIP program

Providers have the right to complain to the Texas Department of Insurance (TDI) by contacting TDI at:

Texas Department of Insurance
Consumer Protection, MC: GC-CCO
P.O. Box 12030
Austin, TX 78711-2030

Medical Appeals

The complaint process does not include medical necessity appeals that are directed to the plan's Medical Management Department. Please refer to Section 11 of this manual for details related to medical necessity denials and appeal.

Member Complaints

Superior understands that there are times when a member is not satisfied wth Superior. In those instances, Superior affords members their right to file a complaint.

Definitions

Medicaid

A complaint is an expression of dissatisfaction expressed by a complainant, orally or in writing, about any matter related to Superior other than an action/Adverse Benefit Determination. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to:

1. The quality of care of services provided;
2. Aspects of interpersonal relationships such as rudeness of a provider or employee; or
3. The failure to respect the Medicaid member's rights

The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding and reaching satisfaction.

CHIP

A complaint is any dissatisfaction, expressed by a complainant, orally or in writing, with any aspect of the Superior's operation, including, but not limited to, dissatisfaction with:

1. Plan administration;
2. Procedures related to review or appeal of an Adverse Benefit Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G;
3. The denial, reduction, or termination of a service for reasons not related to medical necessity;
4. The way a service is provided; or
5. Disenrollment decisions.

The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding and reaching satisfaction.

Member Advocacy

Superior designates member advocates to support and assist members in writing or filing a complaint and monitoring the complaint through Superior's complaint process until the issue is resolved. Superior's Member Advocates are trained to interact directly with members to advocate on the member's behalf including assistance with the complaint process. The applicable Superior staff will facilitate the prompt receipt and appropriate recording of an oral complaint. The majority of Member Services Representatives are bilingual in English and Spanish but can further utilize Superior's contracted language line service for members speaking a language other than English or Spanish.

Member Rights in the Complaint Process

Superior works to preserve and protect the rights of members throughout the entire complaint process. Members have the right to:

- Designate an authorized or designated representative who can file a complaint on their behalf. An "authorized or designated representative" is any person or entity acting on behalf of the member and with the member's written consent. A provider may be an authorized representative. Members can print an Authorization to Disclose Health Information form on https://www.SuperiorHealthPlan.com/members/medicaid/resources/helpful-links.html.
- Have a language interpreter, including American Sign Language, available to them at any point in the process, free of charge.
- File a complaint directly with HHS or TDI once they member has exhausted Superior's complaint process.
- Have reasonable accommodations such as accessibility when needed.
- Receive an objective review and decision free of retaliation and discrimination.

Filing a Member Complaint

STAR, STAR+PLUS, STAR Kids, STAR Health and CHIP Member Complaints

Members can file a complaint at any time. Superior offers a number of ways a member can file a complaint:

- Online through a link on Superior's website at https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.
- Filing a complaint in writing by printing the complaint form found at https://www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html.

  The form may be mailed or faxed to:

  Superior HealthPlan
  ATTN: Complaint Department
  5900 E. Ben White Blvd.
  Austin, TX 78741
  Fax: 1-866-683-5369
- Calling the toll-free member hotline at:

  STAR and CHIP 1-800-783-5386

  STAR+PLUS 1-877-277-9772

  STAR Kids 1-844-590-4883

  STAR Health 1-866-912-6283

What a Member Can Expect When Filing a Complaint

When a complaint is received, a written acknowledgement letter is sent to the complainant within five Business Days of receipt of the complaint. Superior then has 30 Days to resolve the complaint. The response to the complaint will be provided in writing in the form of a resolution letter. If the resolution/response is not satisfactory, a complaint appeal may be filed.

Member Appeal of a Complaint Resolution

Complaint appeals must be submitted no later than 30 Days from the complaint resolution response. The complaint-appeal involves the review by a complaint appeal panel during a scheduled meeting. The appeal panel is composed of an equal number of members, providers and Superior employees. The doctors or other providers will be specialists in the area of care related to the complaint, and will not have reviewed the issue before. The meeting will be at a time and place that is acceptable and convenient to the member. The member may choose to send an authorized or designated representative in their place and have the right to submit written documentation that can be presented during the panel hearing. The panel reviews all of the information presented and makes a recommendation to Superior. The recommendation is presented to Superior HealthPlan Plan Product leadership for a final decision. No later than 30 Days from receipt of the complaint appeal panel request, Superior will mail the complaint appeal response letter to the member.

Additional Filing Rights

Medicaid Complaints

If a Medicaid member is not satisfied with the outcome of their complaint appeal, they can file a complaint with HHS at 1-866-566-8989 or by mail to:

Texas Health and Human Services
Health Plan Management – H-320
Attn: Resolution Services
P.O. Box 85200
Austin, TX 78708-520

For Assisted Living Facilities, STAR+PLUS members can resolve problems related to their room and board charge or copayment by calling the service coordination number on the back of their member ID card. For questions or concerns about their financial rights, members can contact the State Long-Term Care Ombudsman at 1-800-252-2412. To file a complaint of abuse, neglect or exploitation at a facility members can contact Consumer Rights and Services at 1-800-458-9858.

CHIP Complaints

CHIP members also have the right to complain to the Texas Department of Insurance (TDI) by calling toll free 1-800-252-3439 or contacting them in writing at:

Texas Department of Insurance
Consumer Protection, MC: GC-CCO
P.O. Box 12030
Austin, TX 78711-2030

MDCP/DBMD Escalation Help Line

What is the MDCP/DBMD escalation help line?

The MDCP/DBMD escalation help line assists people with Medicaid who get benefits through the Medically Dependent Children Program (MDCP) or the Deaf-Blind with Multiple Disabilities (DBMD) program.

The escalation help line can help solve issues related to the STAR Kids managed care program. Help can include answering questions about State Fair Hearings and continuing services during the appeal process.

When should members call the escalation help line?

Call when you have tried to get help but have not been able to get the help you need. If you don't know who to call, you can call 1-844-999-9543 and they will work to connect you with the right people.

Is the escalation help line the same as the HHS Office of the Ombudsman?

No. The MDCP/DBMD Escalation Help Line is part of the Medicaid program. The Ombudsman offers an independent review of concerns and can be reached at 1-866-566-8989 or go on the Internet (hhs.texas.gov/managed-care-help). The MDCP/DBMD escalation help line is dedicated to individuals and families that receive benefits from the MDCP or DBMD program.

Who can call the help line?

You, your authorized representatives or your legal representative can call.

Can members call any time?

The escalation help line is available Monday through Friday from 8 a.m.–8 p. After these hours, please leave a message and one of our trained on-call staff will call you back.

SECTION 16
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, includes administrative simplification provisions that require national standards for electronic health care transactions and code sets, unique health identifiers and security, as well as federal privacy protections for individually identifiable health information.

The Office for Civil Rights administers and enforces the Privacy Rule and the Security Rule.

Other HIPAA Administrative Simplification Rules are administered and enforced by the Centers for Medicare and Medicaid Services (CMS), and include:

- Transactions and code sets standards.
- Employer identifier standard.
- National provider identifier standard.
- Security Rule.
- Enforcement Rule.

The Enforcement Rule provides standards for the enforcement of all the Administrative Simplification Rules. A summary of the HIPAA Administrative Simplification Rules can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html.

Privacy Rule

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health-care clearinghouses, and those health-care providers that conduct certain health-care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

The Privacy Rule is located at 45 CFR Part 160 and Subparts A and E of Part 164.

In compliance with the privacy regulations, Superior has provided each member with a privacy notice, which describes how Superior can use or share a member's health records and how the member can get access to the information. In addition, the member privacy notice informs the member of their health care privacy rights and explains how these rights can be exercised.

Find a copy of Superior's Privacy Notice in the Attachments section.

As a provider, if you have any questions about Superior's privacy practices, contact Superior's compliance officer by calling 1-800-218-7453 or by emailing Superior.Compliance@SuperiorHealthPlan.com.

Members should be directed to Superior's Member Services Department with any questions about the privacy regulations. Member Services can be reached at the following phone numbers:

STAR and CHIP 1-800-783-5386

STAR+PLUS..... 1-877-277-9772

STAR Kids..... 1-844-590-4883

STAR Health 1-866-912-6283

Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by Superior. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity and security of electronic protected health information.

The Security Rule is located at 45 CFR Part 160, and Subparts A and C of Part 164.

Breach Notification Rule

The HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, requires HIPAA covered entities and their business associates to provide notification following a breach of unsecured protected health information. Similar breach notification provisions implemented and enforced by the Federal Trade Commission (FTC), apply to vendors of personal health records and their third party service providers, pursuant to section 13407 of the HITECH Act.

Definition of Breach

A breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the protected health information. An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised based on a risk assessment of at least the following factors:

- The nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification.
- The unauthorized person who used the protected health information or to whom the disclosure was made.
- Whether the protected health information was actually acquired or viewed.
- The extent to which the risk to the protected health information has been mitigated.

Breach Notification Requirements

Following a breach of unsecured protected health information, covered entities must provide notification of the breach to affected individuals, the Secretary, and, in certain circumstances, to the media. In addition, business associates must notify covered entities if a breach occurs at or by the business associate.

Transactions and Code Sets Regulations

Adopted Standards and Operating Rules

HIPAA required HHS to establish national standards for electronic transactions to improve the efficiency and

effectiveness of the nation's health care system.

These standards apply to all HIPAA-covered entities:

- Health plans.
- Health-care clearinghouses.
- Health-care providers who conduct electronic transactions, not just those who accept Medicare or Medicaid.
- Any provider who accepts payment from any health plan or other insurance company must comply with HIPAA if they conduct the adopted transactions electronically.

These providers must also have written agreements in place to ensure business associates comply with HIPAA. Examples of business associates include clearinghouses and independent medical transcriptionists.

Adopted Standard Code Sets

The HIPAA Code Sets regulation requires that all codes utilized in electronic transactions are standardized, utilizing national standard coding.

Adopted Standard Code Sets include:

1. Outpatient procedure and physician services coding - Current Procedure Terminology (CPT) codes - The CPT codes are used to describe medical procedures, and this code set is maintained by the American Medical Association. For more information on the CPT codes, please contact the American Medical Association (AMA) at 1-800-621-8335.
2. Supplies/not included in CPT - Health Care Common Procedure Coding System (HCPCS) - This code set, established by the CMS, primarily represents items and supplies and non-physician services not covered by the American Medical Association CPT-4 codes, which can be purchased from the American Medical Association (AMA) at 1-800-621-8335.
3. Diagnosis Coding - ICD-10-CM—International Classification of Diseases, 10th edition, Clinical Modification.
4. Hospital inpatient procedure coding - ICD-10-PCS—International Classification of Diseases, 10th edition, Procedure Coding System.

In addition, National Drug codes are required for submission on applicable claims to identify clinician administered drugs (CAD). Reimbursable CAD are found on the Texas Vendor Drug website, see: https://www.TXVendorDrug.com/formulary/clinician-administered-drugs

Adopted Transaction Standards

Under HIPAA, HHS adopted certain standard transactions for the electronic exchange of health care data. These transactions include:

- Claims and encounter information
- Payment and remittance advice
- Claims status
- Eligibility
- Enrollment and disenrollment
- Referrals and authorizations
- Coordination of benefits
- Premium payment

Transaction	Standard
Health claims (institutional, professional, and dental)	ASC X12N 837 Version 5010
Enrollment/disenrollment in a health plan	ASC X12N 834 Version 5010

Eligibility and benefit verification	ASC X12N 270/271 Version 5010
Claim payment (or EFT, electronic funds transfer)	ACH CCD+Addenda ASC X12N 835 Version 5010
Premium payment/explanation	ASC X12N 820 Version 5010
Claim status inquiry and response	ASC X12N 276/277 Version 5010
Coordination of benefits	ASC X12N 837 Version 5010
Prior authorization and referrals	ASC X12N 278 Version 5010
Referral certification	ASC X12N 278 Version 5010
Electronic Remittance Advice (ERA) / TRN Associated Trace Number	ASC X12N 835 Version 5010

For more information on conducting these transactions electronically, contact the EDI Department at 1-800-225-2573 ext. 25525 or by email at EDIBA@centene.com.

National Provider Identifier

The National Provider Identifier (NPI) is a HIPAA Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearing houses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about health care providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in all electronic HIPAA standards transactions.

As outlined in the federal regulation, covered providers must also share their NPI with other providers, health plans, clearinghouses and any entity that may need it for billing purposes.

All Superior providers must attest a valid NPI and taxonomy(ies) upon requesting an application for network participation with Superior.

Providers must also enroll with HHS through the Texas Medicaid and Health Partnership (TMHP) before a provider can deliver services to a Superior Medicaid or CHIP member and be reimbursed for those services.

For any questions about NPI, please contact Superior's Provider Services department.

SECTION 17
SUPERIOR'S PROVIDER PORTAL AND HEALTH PASSPORT

Provider Portal

Superior provides a secure Provider Portal that offers tools to assist your office staff any time of day. It is available for providers at Provider.SuperiorHealthPlan.com.

Registering for the Provider Portal

In order to use Superior's secure Provider Portal, you must first register online at Provider.SuperiorHealthPlan.com.

- You will be asked to enter your tax identification number, first name, last name, email address and to create a password. Your email address will also serve as your username.
- Once you submit the registration form, you will receive an email confirmation to validate your account.
- Your request for access will be reviewed and additional validation will be sent to your TIN's Account Manager for confirmation.

Each TIN is allowed to designate an Account Manager(s). This role is responsible for managing access permissions to their TIN, including adding and removing accounts and allowing users to access the modules with in the secure Provider Portal (claims, authorizations, eligibility, etc.). If registering for an Account Manager role, additional validation will be required.

Logins and passwords are unique, requiring each staff member within one office or group to register separate user accounts. Sharing accounts between staff is not permitted.

Please note, the secure Provider Portal will randomly launch the Challenge Survey on a quarterly basis to users with an account management role. This survey is a new tool to verify provider demographic data and is required to complete to help Superior monitor provider adherence to state requirements. The tool gives providers access to update or confirm their demographic information prior to accessing the secure Provider Portal modules.

Benefits of the Provider Portal

Here are some of the features currently available in the secure Provider Portal:

- **Verify Patient Eligibility**: Identify patient coverage, and program copays, if applicable, by simply entering the necessary search criteria (DOB, member ID, or patient name).
- **Print Member-Patient Panel Reports**: For Primary Care Providers (PCPs), login to your account and print a list of members assigned to you for primary care services. Other features included on the PCP Panel Report are:
  - CHIP copay amounts listed for each CHIP member assigned to your panel.
  - Date of last Texas Health Steps visit, or wellness exam.
  - Preventive visits due, including last mammogram.
  - View member care gap alerts. When a member has a "gap in care" (i.e. a preventive service not rendered within the allotted time frame) an alert symbol will appear. When a provider clicks on the member's name, the screen will revert to the member eligibility details page, which will display the care gap details (for example, "No Flu Vaccine in past 12 months.").

- Online Claims Submission:
  - Individual Claim Submissions - Submit both professional and institutional claims online for quicker payment. Claim corrections can also be submitted through the Secure Provider Portal.
  - Copy Claim Feature - Recreate claims without entering data twice.
  - Recurring Claims Tool - Quickly and easily submit repetitive, long-term care claims for multiple members.
  - Batch Claim Submissions - Avoid paying clearing house fees and submit batch claims online! Please note: Currently we only accept formatted 837 claims files. We apply HIPAA level 5 edits. Files must be in '.dat' or '.edi' formats and no larger than 25MB.
  - Claims Appeals - File appeals through the secure Provider Portal.
  - Claims Reconsiderations - Submit a request for review if it is believed a claim was incorrectly paid or denied.
  - Attachments - Attach additional documentation necessary during the online claim or appeal submission.
- **Check Claims Status Online**: Confirm the status of submitted claims and easily reconcile your patient accounts.
  Note: Online claims status is maintained for 24 months.
- **Authorizations**:
  - Submissions - Submit authorization requests directly.
  - Attachments - Attach clinical information needed.
  - Authorization Status - Check authorization status.

Note: Currently, Long-Term Support Services and Supports (LTSS) providers are unable to use this feature for authorization submission for PAS, DAHS and Assisted Living Facility (ALF).

- **Explanation of Payments**: Explanation of payments are available in the secure portal.
- **Update Demographic Information**: Update provider demographics such as, address, phone number and office hours.
- **Medicaid Authorization Pre-Screening**: Find the tool on our website under Provider Resources. Simply enter a valid procedure code, and the system will display the authorization requirements for that procedure. Non-participating providers will always require an authorization for non-emergent services.

Other valuable content made available at www.SuperiorHealthPlan.com includes an online provider directory and provider resource section containing bulletins, Frequently Asked Questions (FAQs), Provider Manuals, training presentations for all Superior products and other helpful website links.

Provider Portal Help Desk

For assistance with accessing the secure Provider Portal, contact the Web Applications Support Desk at 1-866-895-8443 or email TX.WebApplications@SuperiorHealthPlan.com.

Health Passport

The Health Passport is a community health record designed for foster care members and the STAR Health program. To get started using this resource, go to Provider.SuperiorHealthPlan.com, click on "Create New Account" and then "Register".

It is easy and free. You will need the following information to register for the Superior Provider Portal, which

includes access to the Health Passport (if validated):

- **Tax ID allows for multiple users** - Your provider group's office tax ID number allows multiple users to obtain their own user names and passwords.
- **Self-Select your user name and password** - We'll even help you set your own reminder for those times you might forget your password.
- **Secure user recognition** - When you sign in, Provider.SuperiorHealthPlan.com. automatically recognizes your account. This secure area helps to ensure the safety of all information that is available for searching and viewing on the site.

Training on the Health Passport navigation is available via the web. To access the training, log into the Superior Provider Portal and click on the "Health Passport online training" link.

This web-based tool is easy to learn and free to use. Some of the Health Passport administrative features include, but are not limited to:

- Web-based access you may use with existing computer equipment or a mobile phone.
- Secure network with role-based security protections.
- Administrative flexibility to meet the needs of different offices.

By capturing comprehensive demographic and clinical information about foster care members, the Health Passport supports delivery of appropriate health care services across the care continuum. The Health Passport allows the provider office and the STAR Health Program to:

- Coordinate care across medical and behavioral health providers.
- Increase access to clinical information at the point of care.
- Increase Texas Health Steps checkups and immunization rates.
- Reduce adverse drug events and medication waste due to redundant orders or over- utilization.
- Reduce repeat outpatient visits due to incomplete patient data.
- Decrease duplicate or wasteful diagnostic tests, immunization and other services.

The majority of the information in the Health Passport is gathered and loaded systematically. The effort required by you, as a provider, is minimal. We do ask that you:

- Complete entry of allergies for your foster care members online within the Health Passport.
- Provide the required Texas Health Steps forms.
- Provide quarterly reporting if you are a PCP.
- Provide initial evaluation and routine summary updates if you are a behavioral health provider.

This information can be directly entered into the Passport via the online forms or can be faxed to Superior at 1-866-274-5952, using the Health Passport Cover Sheet, found in the Attachments section.

With our other online tools, you can get the answers you need easier and faster:

- Verify member eligibility.
- Directly file professional and institutional claims.
- Check claim status.
- Find detailed member information, including benefit and plan information.

- Current news and events.
- Communicate directly with us via secured e-mail.
- View member lists.
- Access the Health Passport for STAR Health.

SECTION 18
PHARMACY SERVICES

Pharmacy Department Responsibilities

The Superior Pharmacy department promotes the most effective use of medications for our members. The Superior Pharmacy department is charged with oversight of administering the pharmacy benefit, ensuring member access to needed medications, employing appropriate utilization management tools and supporting the care management model. Superior Pharmacy is responsible for ensuring that medications are: a covered benefit, medically necessary, appropriate to the member's condition, rendered in the appropriate setting, and meet professionally-recognized standards of pharmaceutical care. In addition, the pharmacy department seeks to provide useful feedback about current prescribing patterns to improve the quality of patient care. Responsibilities of the pharmacy team include, but are not limited to:

- Ensure that pharmacy benefit services provided are medically necessary;
- Promote safe and effective drug therapy;
- Manage pharmacy benefit resources effectively and efficiently while ensuring that quality care is provided;
- Ensure that members can easily access prescription services;
- Actively monitor utilization to guard against over-utilization of services and fraud or abuse and to address gaps in care or under-utilization of needed medications;
- Participate with care management to promote optimal use of medication, focusing on ER and hospitalization avoidance;
- Manage tools for members that assist them in managing and taking their medications;
- Assist providers with the coordination of prescription services; and
- Work with quality initiatives and manage programs that increase the quality of pharmaceutical care for members.

Formulary Management

Superior will manage the provision of medications to members via utilizing the Texas VDP formulary for all Medicaid and CHIP programs. A link to the formulary is available on our website in addition to the listing found on the VDP website at www.txvendordrug.com. The VDP Preferred Drug List (PDL) is available for smartphones and on the web via www.epocrates.com. For additional information related to formularies, prior authorization and quantity limits, please refer to the Pharmacy Resource Guide, found in the Attachments section.

Prior Authorizations/Clinical Prior Authorization Edits:

Superior will utilize the Texas Vendor Drug Program prior authorization criteria for non-preferred medication requests. A copy of the criteria is available online at the PA XPRESS website via https://paxpress.txpa.hidinc.com/. STAR Prior authorizations will be performed within 24 hours after the request has been made. CHIP prior authorizations will be performed within two Business Days for approvals and three Business Days for denials. It is helpful to include all pertinent medical information in the original request to facilitate this process.

Superior HealthPlan encourages providers to review our website regarding specific medication requirements for drugs such as Synagis®. The prior authorization requirements for these medications under the pharmacy benefit

may have more robust or specific criteria requirements than other drugs and is available for review. The website also provides copies of the prior authorization forms which may help the provider in the prior authorization request.

In addition, the Texas VDP provides clinical prior authorization criteria to managed care organizations to ensure medications follow the latest FDA-approved product labeling, national guidelines and peer-reviewed literature via evidence-based clinical criteria. Please refer to our website for a link to the Clinical Prior Authorization criteria applied to Superior members: www.SuperiorHealthPlan.com/providers/resources/pharmacy/clinical-prior-authorization.html

Emergency Prescription Supply

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization is not available. This applies to all drugs requiring a prior authorization, either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical prior authorization edits.

The 72-hour emergency supply should be dispensed any time a prior authorization cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a prior authorization, the pharmacy should submit an emergency 72-hour prescription.

This short-term supply does not apply to DESI (Drug Efficacy Study Implementation) drugs, when the drug could be contraindicated to the member's condition or when starting and abruptly stopping the medication would be medically contraindicated. Emergency supply provision does not apply to non-formulary medications. Additionally, a 72-hour supply should not be used for non-emergent drugs nor for routine or continuous use to avoid the prior authorization process. An example of a non-emergent drug would be one for acne. An example of an emergent drug could include, but is not limited to: antibiotics, blood pressure, diabetes or asthma medications.

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.

To be reimbursed for a 72-hour emergency prescription supply, the pharmacy may call the pharmacy help desk line.

For more information about the 72-hour emergency prescription supply policy, call the pharmacy help desk at 1-800-460-8988.

Pharmacy Compounds

Providers must bill for compounds using the drug code and metric decimal quantity for each National Drug Code in the compound. Compounds should contain medication(s) that are covered by the Texas Vendor Drug formulary. The pharmacy should bill a compound properly using a compound indicator.

Appeals

In the event that a prior authorization is denied a written notification will be sent to the provider and member. This notification will provide additional information regarding the reason for the denial. The provider is encouraged to read over the denial notification. The denial notification will also contain instructions for contacting the appeals department and outline the appeals process. Contact information for the Superior Appeals Department is also available on our website.

Pharmacy Lock-In

Superior's Pharmacy department routinely monitors drug or medical claims for over-utilization, fraud, waste or abuse. Superior will follow current Office of Inspector General (OIG) criteria with respect to locking a member to a single pharmacy that meets criteria. Upon review, a member is locked via the vendor pharmacy benefit manager (PBM) platform and claims

will adjudicate only to the identified assigned pharmacy. Members are notified directly by the OIG if they meet criteria for lock-in. Additionally, the Superior Pharmacy team will work with appropriate parties to refer the member for other services such as but not limited to behavioral health consultation or drug treatment, etc. as appropriate.

Specialty Medications

Texas Health and Human Services (HHS) develops and maintains the specialty medication drug list as guidance for the distribution of these products from a specialty pharmacy.

Pharmacy Benefits

Medicaid and CHIP members have access to a large network of pharmacies for prescription needs. The pharmacy network includes retail chains, independent pharmacies, specialty pharmacies and mail order pharmacies. Medicaid and CHIP members may receive up to a 90-Day supply of certain maintenance medications. For a full listing of pharmacies in Superior's network go to https://providersearch.superiorhealthplan.com/. Medicaid members also have access to limited home health supplies that may be billed through the member's pharmacy benefit. A list of these supplies can be found at https://www.txvendordrug.com/about/manuals/pharmacy-provider-procedure-manual/9-home-health-supplies.

Pharmacy Claims Processing

Pharmacy claims adjudicate through the PBM's online adjudication system using the VDP's formulary. Claims submitted electronically have an 18-Day window. Claims submitted non-electronically have a 21-Day clean claim window. Clinical prior authorization criterion are also used when adjudicating claims, when applicable. The current PDL and list of implemented clinical prior authorizations can be viewed at https://www.SuperiorHealthPlan.com/providers/resources/pharmacy/clinical-prior-authorization.html.

Durable Medical Equipment

Superior reimburses for covered durable medical equipment (DME) and products commonly found in a pharmacy. For all qualified members, this includes medically necessary items such as nebulizers, ostomy supplies or bed pans and other supplies and equipment. For children (birth through age 20) Superior also reimburses for items typically covered under the Texas Health Steps program, such as the prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies, and some nutritional products.

To be reimbursed for DME or other products normally found in a pharmacy for children (birth through age 20), a pharmacy must submit their claim through Superior under the following guidelines:

- All documentation must be legible.
- Claims must use EDI version 5010 guidelines as mandated by HIPAA rules.
- Primary Care Providers (PCPs) and all participating providers must submit claims or encounter data for every patient visit, even though they may receive a monthly capitation payment.
- All claims and encounter data must be submitted on either a form CMS 1500 or UB-04 (See Section 11) or on electronic media in an approved HIPAA compliant format. For additional submission criteria, please refer to "Requests for Durable Medical Equipment" in Section 9.

Call 1-800-460-8988 for more information about DME and other covered products commonly found in a pharmacy for children (birth through age 20). Physicians will have the option to prescribe incontinence supplies without obtaining prior authorization from Superior for payment. To do so, the incontinence supplies must be dispensed through one of Superior's nationally contracted DME providers.

The waiver of authorization will only apply when ordering incontinence supplies through one of Superior's nationally contracted DME providers. The prior authorization requirement will remain in effect for incontinence supplies whenever a nationally contracted DME provider is not used.

Contact Information

Medical Pharmacy Medication Prior Authorization (Buy and Bill)

Phone 1-866-768-7147

Fax..... 1-866-683-5631

Retail Pharmacy Benefit Prior Authorization

Phone 1-866-768-7147

Fax (Prior Authorization) 1-833-423-2523

Prior authorization forms can be found on Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com. The provider may submit a web authorization request, or fax the form to Superior at the fax number above.

SECTION 19
DENTAL SERVICES

Medicaid Emergency Dental Services

Superior is responsible for emergency dental services provided to Medicaid members in a hospital, free standing emergency room or ambulatory surgical center setting. Superior will pay for hospital, physician and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and supporting structures, and removal of cysts;
- Treatment of oral abscess of tooth or gum origin; and
- Treatment and devices for correction of craniofacial anomalies and drugs.

CHIP Emergency Dental Services

Superior is responsible for emergency dental services provided to CHIP members and CHIP perinate newborn members in a hospital or ambulatory surgical center setting. Superior will pay for hospital, physician and related medical services (e.g., anesthesia and drugs) for:

- Treatment of a dislocated jaw, traumatic damage to teeth and removal of cysts.
- Treatment of oral abscess of tooth or gum origin.

CHIP Non-Emergency Dental Services

Superior is not responsible for paying for routine dental services provided to CHIP members. The services are paid through Dental Managed Care Organizations.

Superior is responsible for paying for treatment and devices for craniofacial anomalies.

SECTION 20
ELECTRONIC VISIT VERIFICATION (EVV)

Electronic Visit Verification (EVV) applies to program providers, Financial Management Services Agencies (FMSAs) or Consumer Directed Services (CDS) employers in the STAR+PLUS, STAR Kids and STAR Health programs providing Texas Medicaid attendant or attendant-like services or habilitation services*. EVV is a computer-based system that electronically verifies when service visits occur and documents the precise time service provision begins and ends. The purpose of EVV is to verify that individuals are receiving the services authorized for their support and for which the state is being billed.

*Effective April 1, 2016, EVV was set as required by HHS for LTSS-designated Providers with STAR+PLUS, STAR Health and Dual Eligible Integrated Care Demonstration. This includes Personal Assistance Services (PAS)/Primary Home Care (PHC) and Personal Care Services (PCS) provided in the home and in the community, In-home respite care, Community First Choice (CFC) Services and Personal Assistance Services/ Habilitation (PAS/HAB).
Effective November 1, 2016, EVV was set as required by HHS for LTSS-designated Providers with Star Kids. This includes Personal Care Services (PCS), Community First Choice (CFC) Services, Personal Assistant Services/ Habilitation (PAS/HAB), Flexible Family Support Services (FFSS) and In-home Respite Care.

Providers who contract with Superior on or after April 1, 2016 and provide services required to use EVV, must select and enroll with an HHS-approved EVV vendor prior to furnishing services to Superior members.

EVV Requirements

As a part of EVV compliance, providers must ensure Electronic Visit Verification data, including any necessary visit maintenance within 95 Days from the date of service is accurately documented in the EVV vendor system, in order to be properly reimbursed by Superior. EVV compliance and claim submissions are independent processes. EVV data must be captured and confirmed in the vendor systems prior to billing.

Providers can verify that their visits have been transmitted to Superior by utilizing the EVV Visit Log in the EVV vendor portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom as well as to verify that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available in the EVV vendor portal to check for unsent transmissions and/or inaccurate visit data.

General Information About EVV

What is EVV?

EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a Service Provider or CDS Employee, as defined in Chapter 8.7.1 of the UMCM, to provide certain services to a member. The EVV System documents the following:

- Type of service provided (Service Authorization Data);
- Name of the member to whom the service is provided (Member Data);
- Date and times the visit began and ended;
- Service delivery location;
- Name of the service provider or CDS Employee who provided the service (Service Provider Data); and
- Other information HHS determines is necessary to ensure the accurate adjudication of Medicaid claims.

Is there a law that requires the use of EVV?

Yes. In December of 2016, the federal 21st Century Cures Act added Section 1903(l) to the Social Security Act (42 USC. § 1396b(l)) to require all states to implement the use of EVV. Texas Government Code, Section 531.024172, requires HHS to implement an EVV System to electronically verify certain Medicaid services in accordance with federal law. To comply with these statutes, HHS required the use of EVV for all Medicaid personal care services requiring an in-home visit, effective January 1, 2021. HHS plans to require the use of EVV for Medicaid home health care services requiring an in-home visit, effective January 1, 2024.

Which services must a service provider or CDS Employee electronically document and verify using EVV?

The EVV required services that must be electronically documented and verified through EVV are listed on the HHS EVV website. Refer to the Programs, Services and Service Delivery Options Required to Use Electronic Visit Verification.

Check the EVV Service Bill Codes Table on the HHS EVV website for up-to-date information and specific HCPCS code(s) and modifiers for EVV-required services.

To learn more, please review the EVV Service Bill Codes Table found on the HHS website: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification#service-bill-codes-table

Who must use EVV?

The following must use EVV:

- Provider: An entity that contracts with an Superior to provide an EVV service.
- Service Provider: A person who provides an EVV required service and who is employed or contracted by a provider or a CDS Employer.
- CDS Employee: A person who provides an EVV required service and who is employed by a CDS Employer.
- Financial Management Services Agency (FMSA): An entity that contracts with an Superior to provide financial management services to a CDS Employer as described in Texas Administrative Code, Title 40, Part 1, Chapter 41, Subchapter A, § 41.103(25), Consumer Directed Services Option.
- CDS Employer: A member or LAR who chooses to participate in the CDS option and is responsible for hiring and retaining a service provider who delivers a service.

EVV Systems

Do providers and FMSAs Have a Choice of EVV Vendors?

Yes. A provider or FMSA must select one of the following two EVV Systems:

- EVV vendor system. An EVV vendor system is an EVV System provided by an EVV vendor selected by the HHS Claims Administrator, on behalf of HHS, that a provider or FMSA may opt to use instead of an EVV proprietary system. For additional information, please visit: https://www.tmhp.com/topics/evv/evv-vendors
- EVV proprietary system. An EVV proprietary system is an HHS-approved EVV System that a provider or FMSA may choose to use instead of an EVV vendor system. An EVV proprietary system:
  - Is purchased or developed by a provider or an FMSA.
  - Is used to exchange EVV information with HHS or Superior; and

- Complies with the requirements of Texas Government Code Section 531.024172 or its successors.
- More information on proprietary systems can be found at TMHP: https://www.tmhp.com/topics/evv/evv-proprietary-systems

Is EVV Required for CDS Employers?

Effective January 1, 2021, EVV is required for individuals utilizing the SRO/CDS option. CDS employers are able to select from the following three options for EVV responsibilities:

- Perform all required visit maintenance within the EVV system using a computer or other electronic device and approve the attendant's time worked in the EVV system.
- Have the FMSA complete all required EVV visit maintenance on their behalf; however, the CDS employer will approve the attendant's time worked in the EVV system.
- Have the FMSA complete all required EVV visit maintenance and the FMSA will confirm the attendant's time worked in the EVV system based on approval documentation from the CDS employer.

Does a CDS Employer have a choice of EVV Systems?

No. A CDS Employer must use the EVV System selected by the CDS Employer's FMSA.

What is the process for a provider or FMSA to select an EVV System?

- To select an EVV vendor from the state vendor pool, a provider or FMSA, signature authority and the agency's appointed EVV System administrator must complete, sign, and date the EVV Provider Onboarding Form located on the EVV vendor's website.
- To access state approved vendors and contact information, please visit: https://www.tmhp.com/topics/evv/evv-vendors. To use an EVV proprietary system, a Provider or FMSA, signature authority, and the agency's appointed EVV System administrator, must visit the TMHP Proprietary System webpage to review the EVV PSO Onboarding process and HHS EVV Proprietary System approval process.
- For more information about the EVV proprietary system and onboarding process, please visit: https://www.tmhp.com/topics/evv/evv-proprietary-systems

What requirements must a provider or FMSA meet before using the selected EVV System?

Before using a selected EVV System:

- The provider or FMSA must submit an accurate and complete form directly to the selected EVV vendor. To see state approved vendor information, please visit: https://www.tmhp.com/topics/evv/evv-vendors.
- Providers or FMSAs must submit the PSO Request Packet to enter the EVV PSO Onboarding Process which includes:
  - An EVV Proprietary System Request Form
  - EVV PSO Detailed Questionnaire (DQ)
  - TMHP Interface Access Request
- A program provider or FMSA must complete the EVV PSO Onboarding Process and receive written approval from HHS to use an EVV proprietary system to comply with HHS EVV requirements.
- If selecting either an EVV vendor or an EVV Proprietary System, a Provider or FMSA must:

  - Complete all required EVV training as described in the answer in the EVV Training section below; and
  - Complete the EVV System onboarding activities:
    - Manually enter or electronically import identification data;
    - Enter or verify member service authorizations;
    - Setup member schedules (if required); and
    - Create the CDS Employer profile for CDS Employer credentials to the EVV System.

Does a provider or FMSA pay to use the selected EVV System?

- If a provider or FMSA selects an EVV vendor system, the provider or FMSA uses the system free of charge.
- If a provider or FMSA elects to use an EVV proprietary system, the provider or FMSA is responsible for all costs for development, operation, and maintenance of the system.

Can a provider or FMSA change EVV Systems?

Yes. A provider or FMSA may:

- Transfer from an EVV vendor to another EVV vendor within the state vendor pool;
- Transfer from an EVV vendor to an EVV Proprietary System;
- Transfer from an EVV Proprietary System to an EVV vendor; or
- Transfer from one EVV Proprietary system to another EVV Proprietary system.

What is the process to change from one EVV System to another EVV System?

To change EVV Systems, a provider or FMSA must request a transfer as follows:

- To request a transfer to an EVV vendor, a provider or FMSA must submit an EVV Provider Onboarding Form to the new EVV vendor.
- To request a transfer to an EVV proprietary system, a provider or FMSA must submit the PSO Request packet and complete the EVV PSO Onboarding Process.
- A provider or FMSA must submit an EVV Provider Onboarding Form to the newly selected EVV vendor or an EVV PSO Request packet to TMHP at least 120 Days before the desired effective date of the transfer.
- If a provider or FMSA is transferring to an EVV vendor, the effective date of the transfer may be earlier than the desired effective date of the transfer if the provider or FMSA and the newly selected EVV vendor agree on an earlier date.
- If a provider or FMSA is transferring to an EVV proprietary system, the provider or FMSA, TMHP, and HHS will establish an effective date of transfer for the proprietary system that may be different than the desired effective date of the transfer.
- An FMSA must notify CDS Employers 60 days in advance of the planned Go-Live date to allow time for the FMSA to train CDS Employers and CDS Employees on the new EVV System.
- A provider or FMSA must complete all required EVV System training before using the new EVV System.
- A provider or FMSA who transfers to a new EVV vendor or proprietary system:
  - Will not receive a grace period and will be subject to all EVV policies including those related to compliance and enforcement; and
  - May have EVV claims denied or recouped if there are no matching accepted EVV visit transactions in the EVV Aggregator.

- After a provider or FMSA begins using a new EVV System, the Provider or FMSA must return all alternative devices supplied by the previous EVV vendor to the previous EVV vendor, if applicable.

Are the EVV Systems accessible for people with disabilities?

The EVV vendors provide accessible systems, but if a CDS Employer, service provider or CDS Employee needs an accommodation to use the EVV System, the vendor will determine if an accommodation can be provided. However, vendors will not provide a device or special software if the system user needs this type of accommodation.

If the provider or FMSA is using a proprietary system, the Service provider, CDS Employer or CDS Employee must contact the provider or FMSA to determine accessibility features of the system and if an accommodation can be provided.

EVV Service Authorizations

What responsibilities do Providers and FMSAs have regarding service authorizations issued by Superior for an EVV required service?

A provider and FMSA must do the following regarding service authorizations issued by Superior for an EVV-required service:

- Manually enter into the EVV System the most current service authorization for an EVV required service, including:
- Name of the MCO;
- Name of the Provider or FMSA;
  - Provider or FMSA Tax Identification Number;
  - National Provider Identifier (NPI) or Atypical Provider Identifier (API);
  - Member Medicaid ID;
  - Healthcare Common Procedural Coding System (HCPCS) code and Modifier(s);
  - Authorization start date; and
  - Authorization end date.
- Perform Visit Maintenance if the most current service authorization is not entered into the EVV System; and
- Manually enter service authorization changes and updates into the EVV System as necessary.

EVV Clock In and Clock Out Methods

What are the approved methods a service provider or CDS Employee may use to clock in and to clock out to begin and to end service delivery when providing services to a member in the home or in the community?

A service provider or CDS Employee must use one of the three approved electronic verification methods described below to clock in to begin service delivery and to clock out to end service delivery when providing services to a member in the home or in the community. A service provider or CDS Employee may use one method to clock in and a different method to clock out.

1. Mobile method
   - A service provider must use one of the following mobile devices to clock in and clock out:

    - The service provider's personal smart phone or tablet; or
    - A smart phone or tablet issued by the provider.
  - A service provider must not use a member's smart phone or tablet to clock in and clock out.
  - A CDS Employee must use one of the following mobile devices to clock in and clock out:
    - The CDS Employee's personal smart phone or tablet;
    - A smart phone or tablet issued by the FMSA; or
    - The CDS Employer's smart phone or tablet if the CDS Employer authorized the CDS Employee to use their smart phone or tablet.
  - To use a mobile method, a service provider or CDS Employee must use an EVV application provided by the EVV vendor or the PSO that the service provider or CDS Employee has downloaded to the smart phone or tablet.
  - The mobile method is the only method that a service provider or CDS Employee may use to clock in and clock out when providing services in the community.
2. Home phone landline
  - A service provider or CDS Employee may use the member's home phone landline, if the member agrees, to clock in and clock out of the EVV System.
  - To use a home phone landline, a service provider or CDS Employee must call a toll-free number provided by the EVV vendor or the PSO to clock in and clock out.
  - If a member does not agree to a service provider's or CDS Employee's use of the home phone landline or if the member's home phone landline is frequently not available for the service provider or CDS Employee to use, the service provider or CDS Employee must use another approved clock in and clock out method.
  - The provider or FMSA must enter the member's home phone landline into the EVV System and ensure that it is a landline phone and not an unallowable landline phone type.
3. Alternative device
  - A service provider or CDS Employee may use an HHS-approved alternative device to clock in and clock out when providing services in the member's home.
  - An alternative device is an HHS-approved electronic device provided at no cost by an EVV vendor or EVV PSO.
  - An alternative device produces codes or information that identifies the precise date and time service delivery begins and ends.
  - The alternative device codes are active for only seven Days after the date of service and must be entered into the EVV system before the code expires.
  - The service provider or CDS Employee must follow the instructions provided by the provider or CDS Employer to use the alternative device to record a visit.
  - An alternative device must always remain in the member's home even during an evacuation.

What actions must the provider or FMSA take if a service provider or CDS Employee does not clock in or clock out or enters inaccurate information in the EVV System while clocking in or clocking out?

- If a service provider does not clock in or clock out of the EVV System or an approved clock in or clock out method is not available, then the provider must manually enter the visit in the EVV System.

- If a service provider makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the provider must perform Visit Maintenance to correct the inaccurate service delivery information in the EVV System.
- If a CDS Employee does not clock in or clock out for any reason, the FMSA or CDS Employer must create a manual visit by performing Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to manually enter the clock-in and clock-out information and other service delivery information, if applicable.
- If a CDS Employee makes a mistake or enters inaccurate information in the EVV System while clocking in or clocking out, the FMSA or CDS Employer must perform Visit Maintenance in accordance with the CDS Employer's selection on Form 1722 to correct the inaccurate service delivery information in the EVV System.
- After the Visit Maintenance time frame has expired, the EVV System locks the EVV visit transaction and the program provider, FMSA or CDS Employer may only complete Visit Maintenance if Superior approves a Visit Maintenance Unlock Request.
- The EVV Policy Handbook requires the provider, FMSA or CDS Employer to ensure that each EVV visit transaction is complete, accurate and validated.

EVV Visit Maintenance

Is there a timeframe in which providers, FMSAs, and CDS Employers must perform Visit Maintenance?

In general, a provider, FMSA, or CDS Employer must complete any required visit Maintenance after a visit prior to the end of the Visit Maintenance timeframe as set in HHS EVV Policy Handbook.

Note: the standard Visit Maintenance timeframe as set in EVV Policy Handbook may be changed by HHS to accommodate providers impacted by circumstances outside of their control.

Are providers, FMSAs, and CDS Employers required to include information in the EVV System to explain why they are performing Visit Maintenance?

Yes. Program providers, FMSAs or CDS Employers must select the most appropriate Reason Code Number(s), Reason Code Description(s) and must enter any required free text when completing Visit Maintenance in the EVV System.

- Reason Code Number(s) describe the purpose for completing Visit Maintenance on an EVV visit transaction.
- Reason Code Description(s) describe the specific reason Visit Maintenance is necessary.
- Free text is additional information the program provider, FMSA or CDS Employer enters to further describe the need for Visit Maintenance.
- For more information, please review the Current HHSC EVV Reason Codes found on the HHS website: https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/electronic-visit-verification

EVV Training

What are the EVV training requirements for each EVV System user?

- Providers and FMSAs must complete the following training:
  - EVV System training provided by the EVV vendor or EVV PSO;

  - EVV Portal training provided by TMHP; and
  - EVV Policy training provided by HHS or Superior.
- CDS Employers must complete training based on delegation of Visit Maintenance on Form 1722, CDS Employer's Selection for Electronic Visit Verification Responsibilities:
  - Option 1: CDS Employer agrees to complete all Visit Maintenance and approve their employee's time worked In the EVV System;
    - EVV System training provided by the EVV vendor or EVV PSO;
    - Clock in and clock out methods; and
    - EVV Policy training provided by HHS, Superior or FMSA.
  - Option 2: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf; however, CDS Employer will approve their employee's time worked in the system:
    - EVV System training provided by EVV vendor or EVV PSO; and
    - EVV Policy training provided by HHS, Superior or FMSA.
  - Option 3: CDS Employer elects to have their FMSA complete all Visit Maintenance on their behalf:
    - Overview of EVV Systems training provided by EVV Vendor or EVV PSO; and
    - EVV policy training provided by HHS, Superior or FMSA.
- Providers and CDS Employers must train service providers and CDS Employees on the EVV methods used to clock in when an EVV required service begins and clock out when the service ends.
- For more information on Superior's EVV Training Requirement, please attend an EVV Training found on SuperiorHealthPlan.com/ProviderCalendar.

Compliance Reviews

What are EVV Compliance Reviews?

- EVV Compliance Reviews are reviews conducted by Superior to ensure providers, FMSAs, and CDS Employers are in compliance with EVV requirements and policies.
- Superior will conduct the following reviews and initiate contract or enforcement actions if providers, FMSAs or CDS Employers do not meet any of the following EVV compliance requirements:
  - EVV Usage Review - meet the minimum EVV Usage Score;
  - EVV Required Free Text Review – document EVV required free text; and
  - EVV Landline Phone Verification Review - ensure valid phone type is used.
  - The Superior EVV Compliance Plan is located by visiting SuperiorHealthPlan.com/ProviderResources, and clicking on EVV Provider Compliance Requirements.

EVV Claims

Are providers and FMSAs required to use an EVV System to receive payment for EVV required services?

Yes. All EVV claims for services required to use EVV must match to an accepted EVV visit transaction in the EVV Aggregator before reimbursement of an EVV claim by Superior. Superior may deny or recoup an EVV claim that does not match an accepted visit transaction.

Where does a provider or FMSA submit an EVV claim?

Providers and FMSAs must submit all EVV claims to the HHS Claims Administrator in accordance with Superior's submission requirements.

Providers must follow the standards outlined within the existing appeals process and include supporting EVV attendant data as applicable in order to substantiate claims payment. All EVV claims being appealed must be submitted to TMHP. Please see Claim Appeal Process within section 10 for more information.

EVV Claims Matching

What happens if a provider or FMSA submits an EVV claim to Superior instead of the HHS Claims Administrator?

If a provider or FMSA submits an EVV claim to Superior instead of the HHS Claims Administrator, Superior will reject or deny the claim and require the provider or FMSA to submit the claim to the HHS Claims Administrator.

What happens after the HHS Claims Administrator receives an EVV claim from a provider or FMSA?

The HHS Claims Administrator will forward the EVV claims to the EVV Aggregator for the EVV claims matching process. The EVV Aggregator will return the EVV claims and the EVV claims match result code(s) back to the HHS Claims Administrator for further claims processing. After completing the EVV claims matching process, the HHS Claims Administrator forwards the claim to Superior for final processing.

How does the automated EVV claims matching process work?

The claims matching process includes:

- Receiving an EVV claim line item.
- Matching data elements from each EVV claim line item to data elements from one or more accepted EVV transactions in the EVV Aggregator.
- Forwarding an EVV claim match result code to Superior once the claims matching process is complete.

The following data elements from the claim line item and EVV transaction must match:

- Medicaid ID;
- Date of service;
- National Provider Identifier (NPI) or Atypical Provider Identifier (API);
- Healthcare Common Procedure Coding System (HCPCS) code;

- HCPCS modifiers; and
- Billed units to units on the visit transaction, if applicable.

Note: No unit match is performed on CDS EVV claims and unit match is not performed on visit transactions against the billed units on the claim line item for specific services. Refer to the EVV Service Bill Codes Table for the specific services that bypass the units matching process.

Based on the result of the EVV claims matching process, the EVV Portal displays an EVV claims match result code. After the EVV claims matching process, the EVV Aggregator returns an EVV claims match result code to the claims management system for final claims processing.

EVV claim match codes viewable in the EVV Portal are:

- EVV01 – EVV Successful Match
- EVV02 – Medicaid ID Mismatch
- EVV03 – Visit Date Mismatch
- EVV04 – Provider Mismatch (NPI/API) or Attendant ID Mismatch
- EVV05 – Service Mismatch (HCPCS and Modifiers, if applicable)
- EVV06 – Units Mismatch
- EVV07 – Match Not Required
- EVV08 – Natural Disaster

If the EVV Aggregator identifies a mismatch between an accepted EVV visit transaction and an EVV claim line item, the EVV claims matching process will return one of the EVV claim match result codes of EVV02, EVV03, EVV04, EVV05, or EVV06. Superior will deny the EVV claim line item if it receives an EVV claim match result code of EVV02, EVV03, EVV04, EVV05, or EVV06.

When HHS implements a bypass of the claims matching process for disaster or other temporary circumstance:

- The EVV claims matching process will return a match result code of EVV07 or EVV08.
- Superior will not immediately deny an EVV claim with either of these claims match result codes for an unsuccessful EVV match.
- Superior may still deny an EVV claim if other claim requirements fail the claims adjudication process.
- If allowed by HHS, Superior may complete a retrospective review of a paid EVV claim line item with a match result code of EVV07 or EVV08 to ensure the paid claim line item has a successful EVV match.

How can a provider and FMSA see the results of the EVV claims matching process?

Providers and FMSAs may view the results of the EVV claims matching process in the EVV Portal. The EVV Portal contains a claim identifier for both the TMHP system and Superior's system. Superior's Provider Portal also provides additional claims status information, such as whether Superior has paid or denied the claim. In addition, Superior provides an Explanation of Payment (EOP) to providers and FMSAs to inform them of whether Superior paid or denied the claim, and if denied, the reason for denial.

For more information, please review the EVV Portal Job Aids section on the TMHP EVV Training webpage: https://www.tmhp.com/topics/evv/evv-training

Could Superior deny payment of an EVV claim even if the EVV claim successfully matches the EVV visit transaction?

Yes. Superior may deny payment for an EVV claim for a reason unrelated to EVV requirements, such as a member's loss of program eligibility or the provider's or FMSA's failure to obtain prior authorization for a service.

EVV Due Process Procedures for Recoupment of Overpayments: Missing EVV Information

Superior may periodically perform audits of EVV claims for a rolling 24 month lookback period.

In the event Superior identifies EVV claim overpayments Superior will provide written notice of the intent to recoup to the provider or FMSA within 30 Days from the completion of the audit. If the provider or FMSA intends to dispute Superior's findings, a response to the written notice must be received by Superior within 30 Business Days.

Providers and FMSAs have 60 Calendar Days from the notice date to correct and explain the deficiencies related to EVV claims identified in the audit before Superior may begin recovery effort for the identified overpayments. Superior may only recover for claims where deficiencies have not been corrected within 60 Calendar Days.

EVV Vendors

DataLogic (Vesta) Software, Inc.

Contact:	**Email:**	**Phone: 1-888-880-2400**
Sales & Training	info@vestaevv.com	Fax: 1-888-880-2400
Tech Support	support@vesta.net	
Website: www.vestaevv.com		

First Data Government Solutions (AuthentiCare)

Contact:	**Email:**	**Phone: 1-888-880-2400**
Sales & Training	AuthentiCareTXSupport@firstdata.com	Fax: 1-888-880-2400
Tech Support	AuthentiCareTXSupport@firstdata.com	
Website: www.firstdata.com		

For additional questions, contact Superior's Provider Services department at 1-877-391-5921.

Other EVV Notes

- Providers can verify that their visits have been transmitted to Superior by utilizing the EVV Visit Log in the EVV vendor portal. The EVV Visit Log is used to verify the hours of services delivered by whom and to whom as well as to very that all the visits were complete and accurate prior to the submission of a visit for billing. Additional reports are available to the providers in each vendor portal to check for unsent transmissions and/or inaccurate visit data.
- In the event of a retroactive authorization that may impact EVV visit data, providers should submit the HHS-approved request form for visit maintenance unlock. In extenuating circumstances, unlock requests that

exceed the 95 Day timeline will be reviewed to determine if the retroactive authorization had an impact on the EVV visit data for the specific member and authorization time period in question. Superior will work directly with a provider to gather the necessary information to determine if visit maintenance is necessary due to a retroactive authorization. Visit maintenance unlock approval will be considered on a case-by-case basis, and visit maintenance updates should be applied as appropriate per policy guidelines.

- Unlock requests that are received after the 95 Day timeline will be reviewed to determine if there were extenuating circumstances outside of the provider's control that would warrant approving the unlock request. Possible examples of an "extenuating circumstance" would be a retroactive change to a member's eligibility or vendor portal outage. In cases like these, Superior will work directly with a provider to gather the required information to determine if visit maintenance is necessary. Visit maintenance unlock approval will be considered on a case-by-case basis, and visit maintenance updates should be applied as appropriate per policy guidelines. In the case that a Visit Maintenance Unlock Request is denied, reason for denial will be provided to the program provider, FMSA or CDS employer. Any additional information or documentation that can be given from the program provider, FMSA or CDS employer will be considered and will require resubmission of the Visit Maintenance Unlock Request form. Once resubmission is received, it will be reviewed as an appeal request for visit maintenance unlock.
- EVV compliance and claim submissions are independent processes. EVV data must be captured and confirmed in the vendor systems prior to billing.
- EVV does not eliminate the need to obtain prior authorization. Providers still need to secure prior authorizations for these services prior to rendering services. If a provider has not received prior authorization for services, they must contact Superior at 1-877-391-5921.
  - For a list of services that require prior authorization, please visit SuperiorHealthPlan.com/PriorAuth.
- For EVV complaints regarding EVV approved vendors, providers can contact SHP_.EVV@SuperiorHealthPlan.com.
- For additional information relating to EVV please refer to the Superior Provider Resources page, located at: https://www.SuperiorHealthPlan.com/providers/resources.html.
- For general EVV questions, providers may contact:
  - Superior Provider Services at 1-877-391-5921.
  - HHS at EVV@hhs.texas.gov.

SECTION 21
ATTACHMENTS

Attachment A – Prior Authorization Lists

Superior HealthPlan Medicaid *Prior Authorization List*	**PHONE:** **o Physical Health: 1-800-218-7508** **o Behavioral Health: 1-844-744-5315** **o Clinician Administered Drugs (CAD): 1-866-768-7147** **FAX:** **o Physical Health: 1-800-690-7030** **o Behavioral Health: 1-866-570-7517** **o Clinician Administered Drugs (CAD): 1-866-683-5631**

▪ All services included in this listing require authorization prior to provision of the service or item.
▪ Prior authorization requests should be submitted no less than five Business Days prior to the start of service.
▪ Prior authorization is not a guarantee of payment.
▫ Reimbursement of authorized service(s) is dependent upon member eligibility, benefit limitations and exclusions.

ELECTRONIC PRIOR AUTHORIZATION LIST - CODE SPECIFIC

▪ In addition to this listing of services that require prior authorization, an online electronic tool is available that provides procedure code specific detail of services that require prior authorization: https://www.superiorhealthplan.com/providers/preauth-check/medicaid-pre-auth.html

INPATIENT HOSPITALIZATION

▪ Pre-scheduled admissions for elective procedures require prior authorization.
▪ Non-elective, non-scheduled inpatient admissions do not require prior authorization.
▪ Notification of admission is required within one Business Day of the admission is required.
▫ For information and requirements related to notification of non-elective inpatient admissions notification, refer to Prior Authorization requirements on Superior HealthPlan's website and Provider Manual.

NON-CONTRACTED PROVIDER SERVICES, SUPPLIES, EQUIPMENT

▪ Prior authorization requirements for non-contracted providers is not limited to services and items on this Prior Authorization List.
▪ With the exception of emergency and post stabilization care and some facility based professional services, receipt of ALL services or items from a non-contracted provider in all non-emergency room places of service require approval through Superior HealthPlan before provision of the service/item.

PRIOR AUTHORIZATION REQUIRED

Abortion	Elective termination of a live pregnancy
Allergy Testing and Immunotherapy	Allergy Testing and Immunotherapy Services *NOTE: Authorization not required for Allergists, Immunologists, Pulmonologists or ENTs.*
Applied Behavior Analysis	Applied Behavior Analysis Services *NOTE: For members under 21 years of age with Autism Spectrum Disorder. Contact Magellan (URA #5197) at 1-800-424-4812 (phone), 1-888-656-0368 (fax).*
Behavioral Health Services	Intensive Outpatient Program (IOP) Services (Mental Health/Substance Use Disorder)
	Partial Hospitalization Program (PHP) Services (Mental Health/Substance Use Disorder)
	Residential Treatment Center (RTC) Services (Substance Use Disorder)
Clinician Administered Drugs	*Including but not limited to:*
	Biologicals and certain biosimilars
	Botulinum toxins
	Chemotherapy and supportive care drugs
	Gene therapy
	Injectable medications with miscellaneous billing codes
	Intravenous immunoglobulins
	Intravitreal injectable medications for ophthalmology use
	Viscosupplementation
	NOTE: Certain provider specialties are excluded from the prior authorization requirements for clinician-administered drugs. Please refer to the online electronic tool for specific requirements and/or exclusions.
Dental Services: Dental Anesthesia	Sedation or general anesthesia for dental procedures for children six years of age or younger
Dental Services: STAR Health Orthodontia	Orthodontic Services *NOTE: Contact DentaQuest (URA #1786622) at 1-888-308-9345, or visit https://govservices.dentaquest.com.*
DME	Durable Medical Equipment (DME)
	Enteral and Total Parenteral (TPN) Nutrition formula and supplies
	Orthotics and Prosthetics
	NOTE: Many DME and medical supply items for Medicaid children and young adults 0-20 years of age do not require prior authorization.
	Refer to the prior authorization checklist for the most up to date prior authorization requirements: SuperiorHealthPlan.com/MedicaidPriorAuth
Hearing and Audiology Devices and Services	Cochlear device
	Hearing Aids
Home Health - Nursing Services	Skilled Nursing Visits
	Private Duty Nursing
Imaging Services	Cardiac Imaging Modalities STAR+PLUS ONLY (Stress Echo, Echocardiography and Nuclear Cardiology) *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
	Diagnostic Imaging (CT, CTA, MRI, MRA, PET) *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
Implantable Devices	Bone Anchor Hearing Aid (BAHA)
	Cochlear Implants NOTE: Surgeons requesting prior authorization, contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax)
	Intraocular lens
	Joint implant *Note: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554, or visit www.RadMD.com.*
	Neurostimulators
	Prosthetic implants

PRIOR AUTHORIZATION REQUIRED	
Interventional Pain Management	Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
	Paravertebral Facet Joint Injections or Blocks
	Sacroiliac Joint Injections
	Spinal Epidural Injections
	NOTE: For members 21 years of age and older, contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.
Non-emergent Ambulance Transportation	Non-emergent air ambulance transportation
	Non-emergent ambulance transportation *NOTE: The referring physician or facility must originate the request for prior authorization.*
Medicine Services: Sleep Studies	Sleep Studies. *NOTE: Contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax), or web portal http://www.myturningpoint-healthcare.com*
Medicine Services: Therapy Treatment	Cognitive Rehabilitative Services
	Outpatient Physical, Speech and Occupational Therapy *contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com. (STAR, STAR+PLUS)* *Contact Superior (STAR Health, STAR Kids and STAR+PLUS Waiver)* *NOTE: Prior authorization not required for ECI therapy, identified through ECI IFSP.*
Pathology and Laboratory Services	Quantitative Testing for Drugs of Abuse
Surgical Services and Procedures	Abdominal Hysterectomy
	Bariatric Surgery
	Circumcision (One year of age and older)
	Cardiac Surgeries and procedures ENT Services: Nasal/Sinus Endoscopy, Tonsillectomy & Adenoidectomy, Typanostomy, Myringotomy Procedures *NOTE: Contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax), or web portal http://www.myturningpoint-healthcare.com*
	Musculoskeletal Surgical Procedures *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
	Oral Surgery
	Reconstructive and Cosmetic Procedures
	Treatment of Varicose Veins
	Vagus Nerve Stimulation
Surgical Services and Procedures: Transplants	Organ Transplant Evaluation and Procedures

Superior HealthPlan CHIP
Prior Authorization List

PHONE:
o Physical Health: 1-800-218-7508
o Behavioral Health: 1-844-744-5315
o Clinician Administered Drugs (CAD): 1-800-218-7508, EXT. 22080

FAX:
o Physical Health: 1-800-690-7030
o Behavioral Health: 1-866-570-7517
o Clinician Administered Drugs (CAD): 1-866-683-5631

- **All services included in this listing require authorization prior to provision of the service or item.**
- **Prior authorization requests should be submitted no less than five Business Days prior to the start of service.**
- **Prior authorization is not a guarantee of payment.**
  - **Reimbursement of authorized service(s) is dependent upon member eligibility, benefit limitations and exclusions.**

INPATIENT HOSPITALIZATION

- **Pre-scheduled admissions for elective procedures require prior authorization.**
- **Non-elective, non-scheduled inpatient admissions do not require prior authorization.**
- **Notification of admission is required within one business day of the admission is required.**
  - **For information and requirements related to notification of non-elective inpatient admissions notification, refer to Prior Authorization requirements on Superior HealthPlan's website and Provider Manual.**

NON-CONTRACTED PROVIDER SERVICES, SUPPLIES, EQUIPMENT

- **Prior authorization requirements for non-contracted providers is not limited to services and items on this Prior Authorization List.**
- **With the exception of emergency and post stabilization care, and some facility based professional services, receipt of ALL services or items from a non-contracted provider in all places of service except emergency room place of service, require prior authorization through Superior HealthPlan before provision of the service/item.**

PRIOR AUTHORIZATION REQUIRED

Abortion	Elective termination of a live pregnancy
Allergy Testing and Immunotherapy	Allergy Testing and Immunotherapy Services *NOTE: Authorization not required for Allergists, Immunologists, Pulmonogists or ENTs*
Behavioral Health Services	Intensive Outpatient Program (IOP) Services (Mental Health/Substance Use Disorder)
	Partial Hospitalization Program (PHP) Services (Mental Health/Substance Use Disorder)
	Residential Treatment Center (RTC) Services (Mental Health/Substance Use Disorder)
Clinician Administered Drugs	*Including but not limited to:*
	Biologicals and certain biosimilars
	Botulinum toxins
	Chemotherapy and supportive care drugs
	Gene therapy
	Injectable medications with miscellaneous billing codes
	Intravenous immunoglobulins
	Intravitreal injectable medications for ophthalmology use
	Viscosupplementation
	NOTE: Certain provider specialties are excluded from the prior authorization requirements for clinician-administered drugs. Please refer to the online electronic prior authorization prescreen tool for specific requirements and/or exclusions.
DME/Medical Supplies*	Durable Medical Equipment (DME)
	Enteral and Total Parenteral Nutrition formula and supplies
	*NOTES:**
	1. Many DME and medical supply items do not require prior authorization. Refer to the prior authorization checklist for the most up to date prior authorization requirements: SuperiorHealthPlan.com/MedicaidPriorAuth
	2. Refer to CHIP covered service exclusions in CHIP Member Handbook, Covered and Excluded Supplies
Hearing and Audiology Devices and Services	Cochlear device *NOTE: Surgeons requesting PA should contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax)*
	Hearing Aids
Imaging Services	Diagnostic Imaging (CT, CTA, MRI, MRA, PET) *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
Implantable Devices	Bone Anchor Hearing Aid (BAHA)
	Cochlear Implants *NOTE: Surgeons requesting prior authorization, contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax)*
	Intraocular lens
	Joint implant *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
	Neurostimulators
	Osteogenesis stimulators
	Prosthetic implants
Non-emergent Medical Transportation	Non-emergent air ambulance transportation
	Non-emergent ambulance transportation *NOTE: The referring physician or facility must originate the request for prior authorization.*
Medicine Services: Sleep Studies	Sleep Studies *NOTE: Contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax).*
Medicine Services: Therapy	Cognitive Rehabilitative Services
	In Home and Outpatient Physical, Speech and Occupational Therapy. For Outpatient requests contact Texas National Imaging Associates at Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com. *NOTE: Prior authorization not required for ECI therapy, identified through ECI IFSP.*

Pathology and Laboratory Services	Quantitative Testing for Drugs of Abuse
	Genetic Testing and Molecular Diagnostics *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 or visit www.RadMD.com.*
PRIOR AUTHORIZATION REQUIREMENTS	
Surgical Services and Procedures	Circumcision (One year of age and older)
	Cardiac Surgeries and procedures ENT Services: Nasal/Sinus Endoscopy, Tonsillectomy & Adenoidectomy, Typanostomy, Myringotomy *NOTE: Contact TurningPoint Healthcare Solutions (URA #2395464) at 1-855-336-4391 (phone), 1-214-306-9323 (fax).*
	Musculoskeletal Surgical Procedures *NOTE: Contact Texas National Imaging Associates (URA #5258) at 1-800-642-7554 (phone), 1-888-656-6350 (fax), or visit www.RadMD.com.*
	Oral Surgery
	Reconstructive Procedures
	Treatment of Varicose Veins
	Vagus Nerve Stimulation
Surgical Services and Procedures: Transplants	Organ Transplant Evaluation and Procedures

Specialist as PCP Request Form

Date of Request:	**Date Received in MM:**
Member Name:	
Member ID Number:	
Member Phone Number:	
Member Address:	
PCP on Record:	
Member Diagnosis:	
Clinical Data:	
Specialist Signature:	
Member Signature:	
Member Reason for Requesting Specialist as PCP:	
Approved: ☐ **Yes** ☐ **No**	
Signature of CMD or MD:	
Internal Use Only **Date Sent to Member Services:**	
Date Sent to Provider Services:	

Note: Referral Authorization Number - 1-800-218-7508

(Form may be used for any Superior HealthPlan programs, as applicable.)

Please fax completed form to Superior HealthPlan, Medical Management at 1-800-690-7030.

SHP_2014701

Medical Record Guidelines

Medical records may be on paper or electronic. Superior requires that records be maintained in a legible, current, detailed, organized and comprehensive manner that permits effective patient care and quality review.

The records must reflect all aspects of patient care, including ancillary services. Superior may audit record keeping practices and individual Member medical records in conjunction with its ongoing Quality Assessment and Performance Improvement (QAPI) Program activities or as a result of Member complaints. Providers scoring less that 80% on medical record audits may be placed under a corrective action plan, may be subject to additional medical record reviews, or may be referred to Superior's Quality Improvement Committee for recommendations.

Superior has adopted the following standards regarding medical records. At a minimum, medical records shall include:

Written policy regarding confidentiality & safeguarding of Member information; records are protected through secure storage with limited access.
Records are organized, consistent and easily retrieved at the time of each visit. Written procedure for release of information and obtaining consent for treatment.
Each page in the record contains the patient's name or ID number.
Personal/biographical data includes address, age, sex, employer, home and work telephone numbers, and marital status as well as assessment of cultural and/or linguistic needs (preferred language, religious restrictions) or visual or hearing impairments.
All entries in the medical record contain author identification, are legible (to someone other than the writer), in ink and dated.
The history and physical exam records appropriate subjective and objective information for presenting complaints.
Problem List documenting significant illnesses, behavioral health and/or medical conditions; unresolved problems from previous office visits are addressed in subsequent visits.
Medication List includes instructions to Member regarding dosage, initial date of prescription, and number of refills.
Medical allergies and adverse reactions are prominently documented in a uniformed location in the medical record; If no known allergy, NKA or NKDA is documented.
An immunization record is established for pediatric Members or an appropriate history is made in chart for adults.
Past medical history (for patients seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.

SHP_2013222 Medical record Guidelines

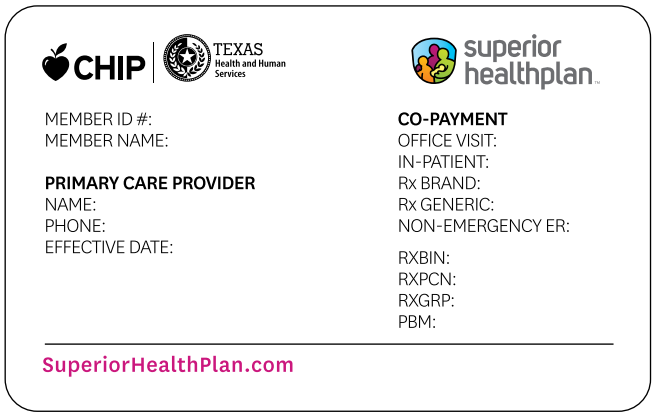
Physical, clinical findings and evaluation for each visit are clearly documented including appropriate treatment plan and follow-up schedule as indicated.
Consultation lab/imaging reports and other studies are ordered, as appropriate. Abnormal lab and imaging study results have explicit notations in the record for follow up plans. All entries are initialed by the ordering practitioner (or other documentation of review) to signify review.
All working diagnoses, and treatment plans are consistent with findings. Ancillary tests and/or services (diagnostic and therapeutic) ordered by practitioner are documented; encounter forms or notes include follow-up care, calls, or visits., with specific time of return noted in weeks, months, or PRN, and include follow up of outcomes and summaries of treatment rendered elsewhere.
No evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure (does the care appear to be medically appropriate?).
Health teaching and/or counseling is documented. If a consultation is requested, there is a note from the consultant in the record.
For Members ten (10) years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for Members seen three or more times, substance abuse history should be queried).
Documentation of failure to keep an appointment.
Evidence that an Advance Directive has been discussed with adults 18 years of age and older.

Additional Behavioral Health Documentation Standards:

- For Members receiving behavioral health treatment, documentation is to include "at risk" factors (danger to self/others, ability to care for self, affect, perceptual disorders, cognitive functioning, and significant social history).
- For Members receiving behavioral health treatment, an assessment is done with each visit relating to client status/symptoms to treatment progress. Documentation may indicate initial symptoms of behavioral health condition as decreased, increased, or unchanged during treatment period.
- For Members who receive behavioral health treatment, documentation shall include evidence of family involvement, as applicable, and include evidence that family was included in treatment planning and therapy sessions, when appropriate.
- For Members who receive behavioral health treatment, documentation shall include evidence of attempts by treating providers to communicate and coordinate behavioral health treatment with primary care providers and other behavioral health providers. This should include, at a minimum, the documentation of attempts to provide members' behavioral health diagnosis(es), current symptoms, behavioral health medications, any pertinent lab work, assessment and current treatment plan.

Attachment D – ID Cards

CHIP MEMBER ID CARD



Available 24 hours a day/7 days a week

Member Services	Behavioral Health Services
1-800-783-5386	1-800-783-5386

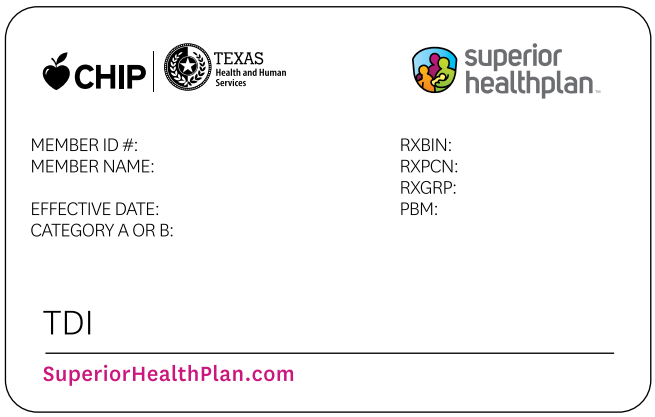
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Disponible 24 horas al día/7 días a la semana

Servicios para Miembros	Servicios de Salud del Comportamiento
1-800-783-5386	1-800-783-5386

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

CHIP PERINATE MEMBER ID CARD



Available 24 hours a day/7 days a week

Member Services 1-800-783-5386

In case of emergency, call 911 or go to the closest emergency room.

Disponible 24 horas al día/7 días a la semana

Servicios para Miembros 1-800-783-5386

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana.

Hospital Facility Billing

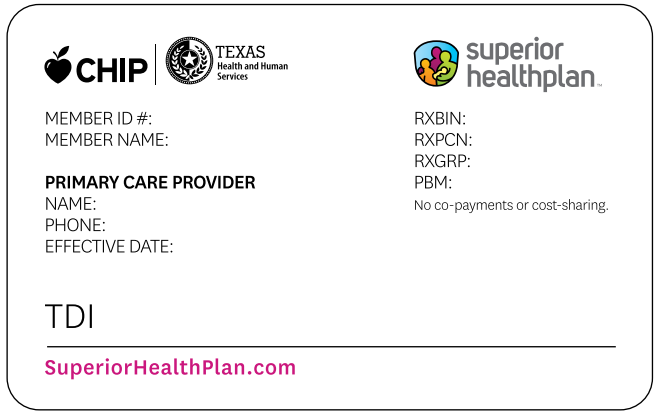
Category A: Bill TMHP if income is at or below the Medicaid eligibility threshold.

Category B: Bill Superior HealthPlan if income is above the Medicaid eligibility threshold.

Professional/Other Services Billing

Bill Superior HealthPlan regardless of FPL percentage.

CHIP PERINATE NEWBORN MEMBER ID CARD



Available 24 hours a day/7 days a week

Member Services	Behavioral Health Services
1-800-783-5386	1-800-783-5386

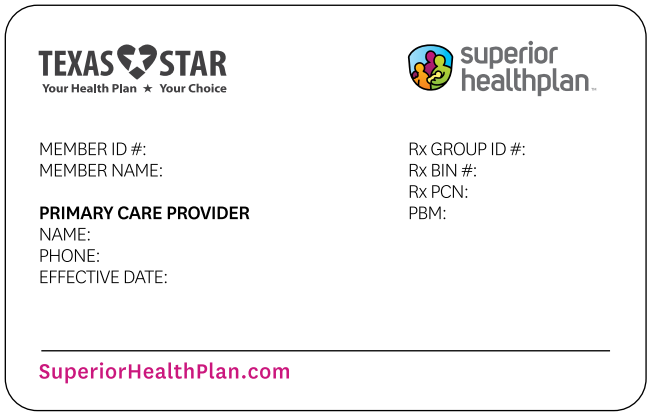
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.

Disponible 24 horas al día/7 días a la semana

Servicios para Miembros	Servicios de Salud del Comportamiento
1-800-783-5386	1-800-783-5386

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

STAR MEMBER ID CARD



Available 24 hours a day/7 days a week

Member Services
1-800-783-5386

Behavioral Health Services
1-800-783-5386

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

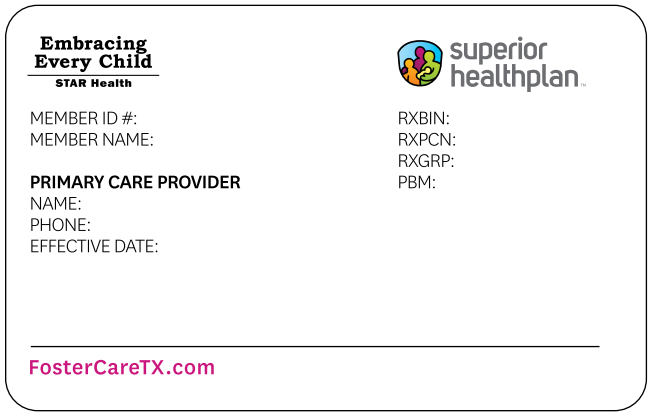
Disponible 24 horas al día/7 días a la semana

Servicios para Miembros
1-800-783-5386

Servicios de Salud del Comportamiento
1-800-783-5386

En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame al PCP dentro de 24 horas o tan pronto como sea posible.

STAR HEALTH MEMBER ID CARD



Member Services: 1-866-912-6283
Available 24 hours a day/7 days a week

Service Coordinator: 1-866-912-6283
Behavioral Health: 1-866-912-6283
Vision Services: 1-866-642-8959
Dental Services: 1-888-308-4766

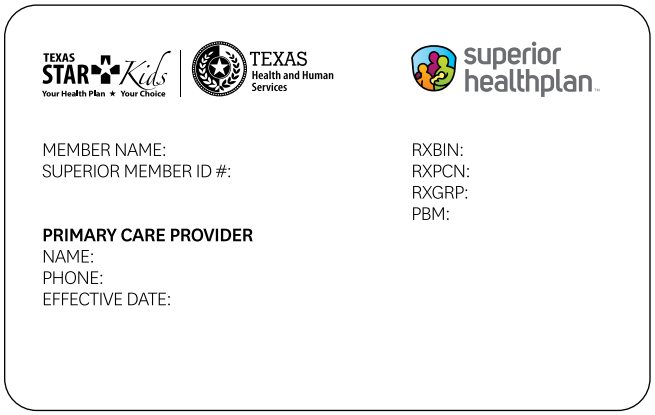
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.

Servicios para Miembros: 1-866-912-6283
Disponible 24 horas al día/7 días de la semana

Coordinandora de Servicios: 1-866-912-6283
Servicios de Salud del Comportamiento: 1-866-912-6283
Servicios de la Vista: 1-866-642-8959
Servicios Dentales: 1-888-308-4766

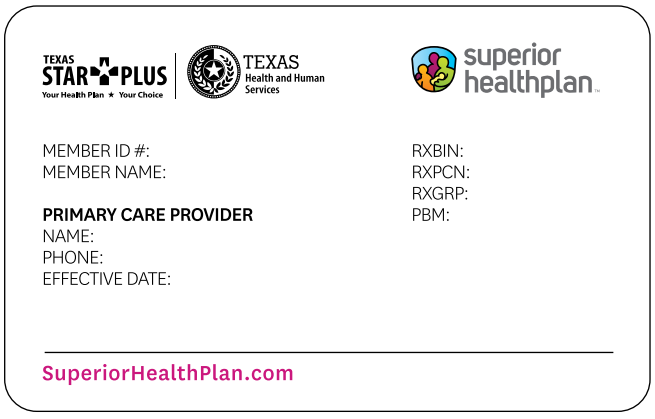
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible.

STAR Kids ID CARD



Member Services | Behavioral Health | Nurse Advice Line: 1-844-590-4883
Available 24 hours a day/7 days a week
Service Coordinator: 1-844-433-2074
Available Monday-Friday, 8 a.m.-5 p.m.
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.
Servicios para miembros | Salud del comportamiento | La línea de consejería de enfermería: 1-844-590-4883
Disponible 24 horas al día/7 días a la semana
Coordinandora de Servicios: 1-844-433-2074
Disponible de 8 a.m. a 5 p.m., de lunes a viernes
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que tambien éstan eligibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

STAR+PLUS MEMBER ID CARD



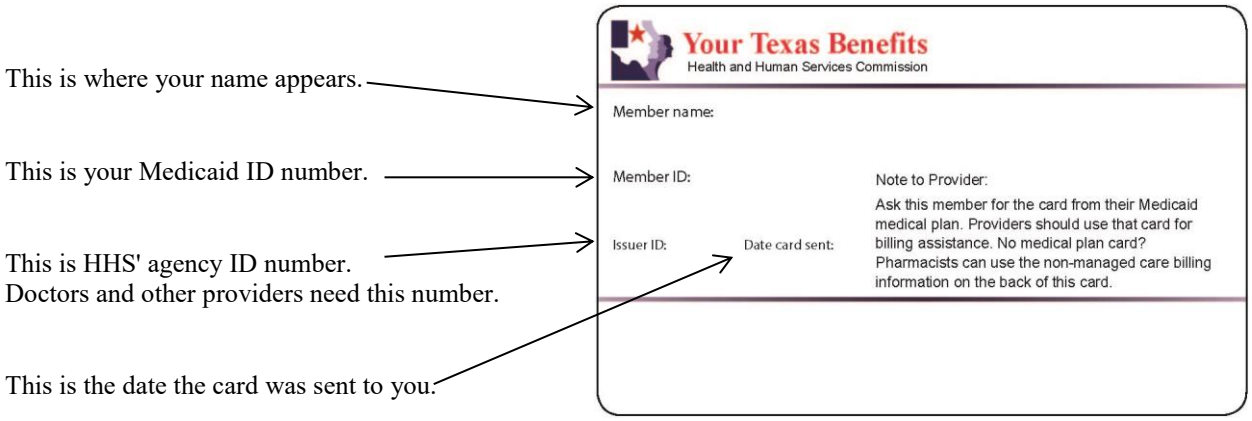
Member Services: 1-877-277-9772
Available 24 hours a day/7 days a week
Service Coordinator: 1-877-277-9772
Behavioral Health: 1-877-277-9772
In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible. Medicaid recipients who are also eligible for Medicare only have Long Term Services and Supports through Superior.
Servicios para Miembros: 1-877-277-9772
Disponible 24 horas al día/7 días de la semana
Coordinandora de Servicios: 1-877-277-9772
Servicios de Salud del Comportamiento: 1-877-277-9772
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después del tratamiento, llame a su PCP dentro de 24 horas o tan pronto como sea posible. Recipientes de Medicaid que tambien éstan eligibles para Medicare tienen solamente Servicios y Apoyos a Largo Plazo con Superior.

Attachment E – Your Texas Benefits Medicaid Card

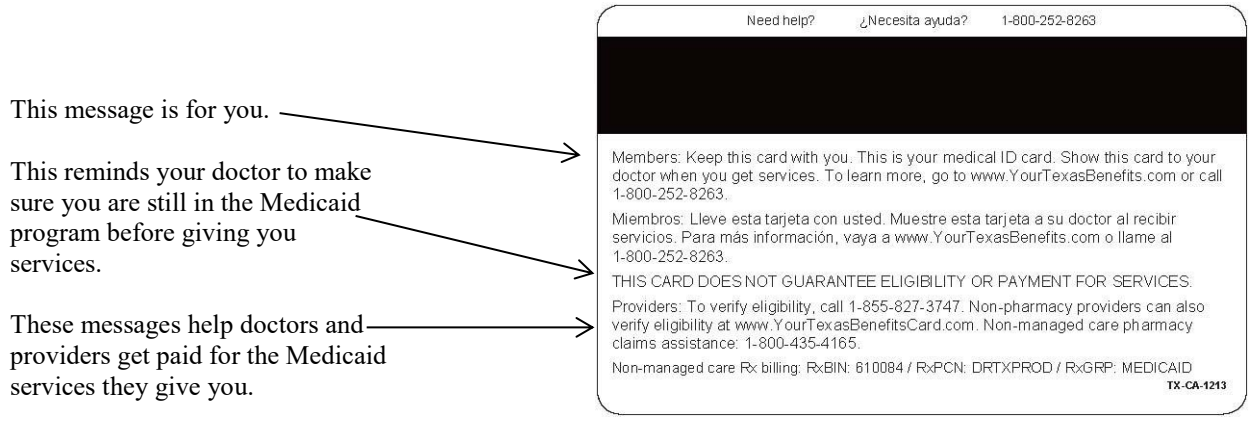
What does the Medicaid card look like?

The card is plastic, like a credit card, and it has your name and Medicaid ID number on the front.

Front of the card:



Back of the card:



Front of the card:

The Your Texas Benefits banner is in the top left corner of the card.

Your name appears just under the Your Texas Benefits banner.

Your Medicaid ID number appears just below your name.

Below your Medicaid ID number is the Issuer ID. This is HHS' agency ID number. Doctors and other providers need this number. Just to the right of the Issuer ID number is the date the card was sent to you.

Back of the card:

There is a magnetic strip across the top of the back side of the card. This holds digital information about you, such as your name and Medicaid ID number.

Below the magnetic strip is a message for you that says “Keep this card with you. This is your medical ID card. Show this card to your doctor when you get services. To learn more, go to www.YourTexasBenefits.com or call 1-800-252-8262.”

Below that is the same message in Spanish. Below the Spanish is text in all capital letters that says, “THIS CARD DOES NOT GUARANTEE ELIGIBILITY OR PAYMENT FOR SERVICES.”

Below that is a message for providers that says “To verify eligibility, call 1-855-827-3747. Non-pharmacy providers can also verify eligibility at www.YourTexasBenefits.com Non-managed care pharmacy claims assistance: 1-800-435-4165.”

At the bottom of the card is the following text: “Non-managed care Rx billing: RxBIN:610084 / RxPCN: DRTXPROD / RxGRP: MEDICAID.”

Attachment F – Member Advocate Referral Form

Member Advocate Referral Form

Superior HealthPlan Member Advocates can help provide personalized member education on various health topics or Superior services. To request assistance from a Member Advocate for a Superior Medicaid (STAR, STAR+PLUS, STAR Health or STAR Kids) or CHIP member, please complete the form below and fax to:

- **STAR/CHIP**: 1-866-224-8260
- **STAR/CHIP (pregnant members)**: 1-866-702-4738
- **STAR+PLUS/STAR Kids**: 1-844-727-6805
- **STAR Health**: 1-866-626-6069

Please Note: Providers must submit one form per member. This form may not be used to request PCP changes. Members may request a PCP change by contacting the Member Services number on the back of their Superior ID card. Member panel reports may be obtained through the Secure Provider Portal or by contacting your assigned Account Manager for assistance.

PROVIDER INFORMATION

Provider Name: _____ Contact Person: _____

Provider Phone: _____ Date: _____

MEMBER INFORMATION

Member Name: _____

Member ID Number: _____ Member Phone: _____

Member Plan Type (Select one): STAR CHIP STAR+PLUS STAR Kids STAR Health

Please indicate the reason a Member Advocate is needed (Select all that apply):

Non-Compliant

Education of Plan Procedures

Abusive Behavior toward Medical Staff

Appointment No Show (Please include date): _____

Other (Please explain): _____

Providers can also contact a Member Advocate, by calling **Member Services**.

SuperiorHealthPlan.com

SHP_20228714

Attachment G – Inpatient Notification Form

superior healthplan

INPATIENT MEDICAID AUTHORIZATION FORM

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

Coordination of Care ☐

***Indicates Required Field**

MEMBER INFORMATION

*Date of Birth (MMDDYYYY)

*Medicaid/Member ID

*Last Name, First

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

*Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

*Servicing Provider/Facility Name

Phone

*Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR Admission Date (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Discharge Date (if applicable)** (MMDDYYYY)

Additional Diagnosis Code (ICD-10)

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

☐ Check Box for Inpatient Elective Service

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

BEHAVIORAL HEALTH

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

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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Rev.04.02.2021
TX-PAF-5868

Attachment H – Medicaid and CHIP Prior Authorization Form

superior healthplan

MEDICAID PRIOR AUTHORIZATION FORM

Complete and **Fax** to: 800-690-7030
Behavioral Health Requests/Medical Records:
Fax 866-570-7517
Transplant: **Fax** 833-589-1245

☐ Request for additional units. Existing Authorization _____ Units _____

☐ **Urgent requests -** I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 3 calendar days to avoid complications and unnecessary suffering or severe pain.

Urgent requests must be signed by the requesting physician to receive priority.

*** INDICATES REQUIRED FIELD**

MEMBER INFORMATION

*Medicaid/Member ID

Last Name, First

*Date of Birth (MMDDYYYY)

REQUESTING PROVIDER INFORMATION

*Requesting NPI

*Requesting TIN

Requesting Provider Contact Name

Requesting Provider Name

Phone

*Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ Same as Requesting Provider

*Servicing NPI

*Servicing TIN

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

***Primary** Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

***Start Date** (MMDDYYYY)

*Diagnosis Code (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date (MMDDYYYY)

Total Units/Visits/Days

*OUTPATIENT SERVICE TYPE

(Enter the Service type number in the boxes) ☐☐☐

☐ Check Box for Inpatient Elective Service

422 Biopharmacy
401 Cardiac/Pulmonary Rehab
299 Drug Testing
205 Genetic Testing & Counseling
249 Home Health
390 Hospice Services
997 Office Visit/Consult
794 Outpatient Services
101 Physical Therapy
971 Physical Therapy Evaluation
790 Occupational Therapy
279 Occupational Therapy Evaluation
701 Speech Therapy
127 Speech Therapy Evaluation
993 Transplant Evaluation
209 Transplant Surgery
724 Transportation

BEHAVIORAL HEALTH
510 BH Medical Management
530 BH PHP
512 BH Community Based Services
513 BH Crisis Psychotherapy
515 BH Electroconvulsive Therapy
516 BH Intensive Outpatient Therapy
517 BH Medication Check
518 BH Mental Health/Chemical Dependency Observation
519 BH Outpatient Therapy
520 BH Professional Fees
522 BH Psychiatric Evaluation
521 BH Psychological Testing

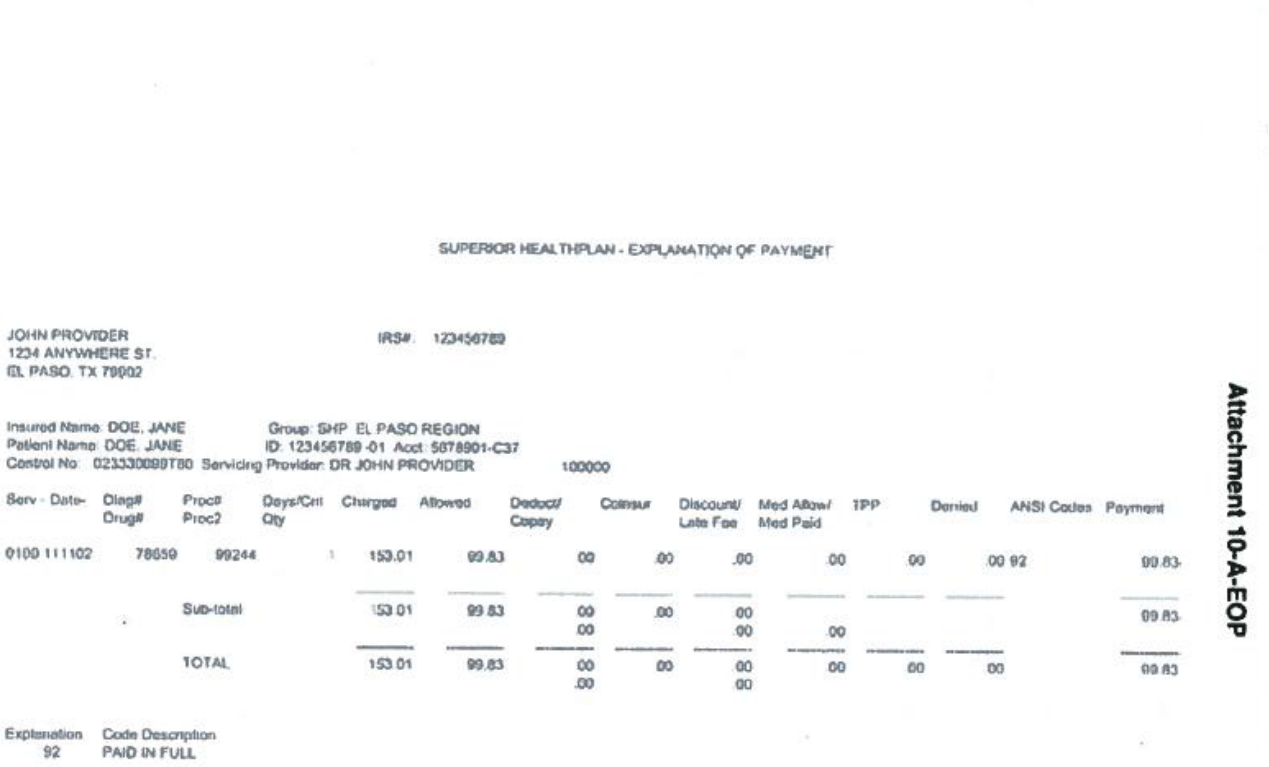
DME
417 Rental
120 Purchase (Purchase Price)

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

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Rev. 02 26 2021
TX-PAF-5869

Attachment I – Explanation of Payment



SUPERIOR HEALTHPLAN - EXPLANATION OF PAYMENT

JOHN PROVIDER
1234 ANYWHERE ST.
EL PASO, TX 79902

IRS#: 123456789

Insured Name: DOE, JANE
Patient Name: DOE, JANE
Control No: 023330099T80

Group: SHP EL PASO REGION
ID: 123456789 -01 Acct: 5678901-C37
Servicing Provider: DR JOHN PROVIDER 100000

Serv - Date-	Diag# Drug#	Proc# Proc2	Days/Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Late Fee	Med Allow/ Med Paid	TPP	Denial	ANSI Codes	Payment
0109 111102	78650	99244	1	153.01	99.83	00	.00	.00	.00	00	.00	92	99.83-
		Sub-total		153.01	99.83	00 .00	.00	00 .00	.00				99.83-
		TOTAL		153.01	99.83	00 .00	.00	00 00	.00	.00	.00		99.83-

Explanation	Code Description
92	PAID IN FULL

Attachment 10-A-EOP

Attachment J – Private Pay Agreement

Private Pay Agreement

I understand _____is accepting me as a private pay patient for the period of
(Provider Name)
_____, and I will be responsible for paying for any services I receive. The provider will not file a claim to Medicaid for services provided to me.

Signed: _____

Date: _____

Attachment K – Claim Appeal Form

DO NOT USE THIS FORM FOR A RECONSIDERATION REQUEST.
USE THE "RECONSIDERATION REQUEST FORM".

Claim Appeal Form

This form must be completed in its entirety. In order to consider your request, you must provide an explanation of your appeal and submit supporting documentation for the appeal. Any appeal request received with an incomplete form and/or missing documentation cannot be reviewed and will be returned to you for completion.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
Superior Claim Number*	Dates of Service*
Member Name*	Member ID*

Required fields

Where more than one of claim number, DOS, member name, or member ID applies for the same appeal reason, please include this information as an attachment.

Reason for the appeal:

- ☐ Claim was denied for no authorization, but authorization number _____was obtained.
- ☐ Claim was denied for no authorization, but no authorization is required for this service.
- ☐ Claim was denied for no authorization, however authorization was not obtained due to member's eligibility or medical condition.
- ☐ Claims was denied for Member not eligible, but member was eligible on DOS (attach eligibility information).
- ☐ Claim was not paid per the terms of my contract with Superior HealthPlan (attach relevant reimbursement section).
- ☐ Claim denied as non-covered benefit (attach supporting documentation as proof the service is a covered benefit).
- ☐ Claim was denied "Past Timely Filing" (attach proof of timely filing).
  - *Note: If the past timely filing deadline denial falls on a weekend or holiday, the provider may request a reconsideration (see Reconsideration Request Form, Attachment N within Provider Manual).*
- ☐ Claim was paid the incorrect amount (include calculation of expected payment and supporting information)
- ☐ Claim denied based on Superior HealthPlan's payment policy (attach medical records to support services provided).
  - *Note: Payment policies can be found at https://www.superiorhealthplan.com/providers/resources/clinical-payment-policies.html*
- ☐ Other. Please explain (and provide supporting documentation):

_____

_____

_____

Please ensure sufficient detail is provided to assist us in the review of your appeal.

Mail completed forms and all attachments to:
Superior HealthPlan
Claims Reconsiderations & Disputes Department
PO BOX 3000
Farmington, Missouri 63640-3800

Contact name & number of person requesting the appeal: _____

Attachment L – Claim Reconsideration Form

DO NOT USE THIS FORM TO REQUEST AN APPEAL. USE THE "CLAIM APPEAL FORM"

Reconsideration Request Form

Please Check Below - Attached is the *requested* information/documentation:

- ☐ Sterilization consent form
- ☐ Primary insurance EOP
- ☐ Invoice
- ☐ Itemized bill (inpatient hospital claims or as requested)
- ☐ Unlisted procedure code documentation
- ☐ Medical records related to a claim denial (**NOT** related to a medical necessity appeal)

Note: No form is required for the submission of corrected claims. Please refer to the *Corrected Claim Process* section of the Superior HealthPlan Provider Manual.

OR

Select only ONE reason for this request. If additional adjustment reasons apply, please submit a separate Adjustment Request Form for each reason/explanation code as listed on your EOP.

- ☐ Claim was denied for no authorization, but authorization number _____was obtained.
- ☐ Claim was denied due to lack of Provider Medicaid or CHIP enrollment through Texas Health and Human Services.
- ☐ Claim was not paid per the terms of my contract with Superior HealthPlan. Please explain and advise of your payment expectation/amount:

  _____

  _____

- ☐ Other. Please explain.

  _____

  _____

  _____

- ☐ **Check box if this Reconsideration Request is for multiple claims.** Please attach a separate list if more than one claim number and/or member ID is related to this reconsideration request.

Provider Name	Provider Tax ID
Provider NPI	Date of last Explanation of Payment
Superior Claim Number*	Dates of Service*
Member Name*	Member ID*

Required fields

Mail completed forms and all attachments to:
Superior HealthPlan
Claims Reconsiderations
PO BOX 3003
Farmington, Missouri 63640-3803

Contact name & number of person requesting the appeal: _____

Attachment M – CMS 1500

Save Form | Clear All Fields | Print Only Data | Print Form & Data | Email Form | Email Data Only | PDF SmartForms

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#DOD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM CMS 1500 (02-12)

Advance Directive Notice

Texas law now allows an option for a person's signature to be acknowledged by a notary instead of witness signatures and for digital or electronic signatures on the Directive to Physicians, Out-of-Hospital Do Not Resuscitate Order, and the Medical Power of Attorney, if certain requirements are met. Please have your attorney review the law in Health and Safety Code Chapter 166 for the details.

Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on.

- **Declaration for Mental Health Treatment** —This document allows you to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy and emergency mental health treatment. The instructions that you include in this declaration will be followed only if a court believes that you are incapacitated to make treatment decisions. Otherwise, you will be considered able to give or withhold consent for the treatments.
- **Directive to Physicians and Family or Surrogates Form** — This form is designed to help you communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury.
- **Medical Power of Attorney Form** — Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself.
- **Out-of-Hospital Do Not Resuscitate Information & Form** — This form instructs emergency medical personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does NOT affect the provision of other emergency care including comfort care.
- **Statutory Durable Power of Attorney** — This form is for designating an agent who is empowered to take certain actions regarding your property. It does not authorize anyone to make medical and other healthcare decisions for you.

As a patient, you have certain rights:

- You have the right to privacy of your medical files. Your personal and medical information is private. All medical records and information about your medical care must be kept private.
- You have the right to “Informed Consent.” Your doctor must tell you about all the good and bad things of any procedures, tests or treatments he plans to give you. You must give your doctor permission to treat you. You have the right to refuse any treatment.
- You have the right to know about your medical condition, any treatments and your chances of getting better.
- In most cases, your doctor will explain to you Advanced Directives and your rights as a patient.

Here are some examples of when you might need to use your Advance Directive:

- Irreversible Brain Damage: If you are unable to make medical decisions for yourself, your Advance Directive will tell your doctor how to care for you.
- Permanent Coma or any other unconscious state: If you are not awake to make a decision about your medical care, your Advance Directive will tell your doctor how to care for you.

SHP_2013226 Advance Directives

An Advance Directive can also limit life prolonging measures. For example, your Advance Directive could let your doctor know how you feel about some medical services (you can direct the doctor to give you these services or to not perform them if you have little chance of recovery):

- Cardiopulmonary Resuscitation (CPR): used to restore breathing and/or heartbeat.
- Intravenous (IV) Therapy: used to provide food and water to you if you cannot eat or drink.
- Feeding Tubes: tubes inserted through your nose, throat, etc. to provide nutrition to you if you cannot eat.
- Respirators: machines that help you to breathe if you cannot breath on your own.
- Dialysis: machine cleans your blood if your kidneys do not work

If you do not cancel your Advance Directive, the instructions you write down will be followed by your doctor.

Once you give your Advance Directive to your doctor, he must make sure it is legal before it becomes effective. According to the law, a "qualified patient" is a person diagnosed and certified in writing to have a terminal illness by two doctors. One of those doctors must be your personal doctor. Your doctor must personally examine you before you are considered terminally ill.

- A terminal illness is any illness that is incurable or irreversible. This means that the person would die without the use of life-sustaining procedures.
- The doctor who provides services written in the Advance Directive is protected by lawsuits (criminal and civil), unless the doctor acts negligently.
- The Advance Directive does not become effective until two doctors decide that you have a terminal condition and that life sustaining procedures are the only way to keep you alive. The doctor's statements that you are terminally ill must be written in your medical record. Life sustaining procedures mean mechanical or other "artificial means" of sustaining life. This does not include medications or procedures to make you comfortable or to make pain go away.
- The Advance Directive is not effective if you are pregnant at the time it is to be carried out. For example, if you are pregnant and suffer an accident that leaves you unable to make your own medical decisions, your Advance Directive will not be followed.
- If the doctor follows your Advance Directive, and you tell him you do not want life sustaining procedures, this is not to be considered euthanasia or "mercy killing". The Advance Directive is a legal document recognized under Texas law that allows a doctor to provide or withhold medical treatment as you instruct the doctor with your written wishes.

You can find advance directive forms at https://hhs.texas.gov/laws-regulations/forms/advance-directives.

Medicaid Member Rights and Responsibilities

Medicaid Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider (PCP). This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. This includes the right to:
    a. Be told of how to choose and change your health plan and your PCP.
    b. Choose any health plan you want that is available in your area and choose your PCP from that plan.
    c. Change your PCP.
    d. Change your health plan without penalty.
    e. Be told about how to change your health plan or your PCP.
3. You have the right to ask questions and get answers about anything you do not understand. This includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. This includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, internal health plan appeals, External Medical Reviews and State Fair Hearings. This includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
    b. MDCP/DBMD escalation help line for Members receiving Waiver services via the Medically Dependent Children Program or Deaf/Blind Multi-Disability Program.
    c. Get a timely answer to your complaint.
    d. Use the plan's appeal process and be told how to use it.
    e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    f. Ask for a State Fair Hearing with or without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. This includes the right to:
    a. Have telephone access to a medical professional 24 hours a Day, seven Days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.

e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have the right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to make recommendations about Superior's Member Rights and Responsibilities Policies.

Medicaid Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. This includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not know your rights: and
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. This includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a PCP quickly.
    c. Make any changes in your health plan and PCP in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your PCP first for your non-emergency medical needs.
    g. Be sure to have approval from your PCP before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your PCP and learn about service and treatment options. This includes the responsibility to:
    a. Tell your PCP about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. This includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional Member Responsibilities While Using Superior's Medical Ride Program (NEMT Services):

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT Services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT Services.

5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact SafeRide, the NEMT Service Provider, who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health & Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

As a member of Superior HealthPlan, you can ask for and get the following information each year:

- Information about Superior and our network providers – at a minimum Primary Care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of providers that are not accepting new patients and qualifications for each network provider such as:
    - Professional qualifications
    - Specialty
    - Medical school attended
    - Residency completion
    - Board certification status
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and State Fair Hearing procedures.
- A hard copy of Superior's Quality Improvement program. To request a hard copy, call Member Services at 1-800-783-5386.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits available. This is designed to make sure you understand the benefits to with you are entitled.
- How you can get benefits, including prior authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
    - What makes up emergency medical conditions, emergency services, and post-stabilization services?
    - The fact that you do no need prior authorization from your PCP for emergency care services.
    - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
    - The address of any places where providers and hospitals furnish emergency services covered by Medicaid.
    - A statement saying you have the right to use any hospital or other settings for emergency care.
    - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your PCP.
- Superior's practice guidelines.

CHIP and CHIP Perinate Member Rights and Responsibilities

Member Rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's PCP and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's PCP. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her PCP and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child’s health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have the right to make recommendations about Superior’s Member Rights & Responsibilities Policies.

21. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

Member Responsibilities:
You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your member handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other provider's co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

As a member of Superior HealthPlan, you can ask for and get the following information each year:

- Information about Superior and our network providers – at a minimum Primary Care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of providers that are not accepting new patients and qualifications for each network provider such as:
    - Professional qualifications
    - Specialty
    - Medical school attended
    - Residency completion
    - Board certification status
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and State Fair Hearing procedures.
- A hard copy of Superior's Quality Improvement program. To request a hard copy, call Member Services at 1-800-783-5386.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits available. This is designed to make sure you understand the benefits to with you are entitled.
- How you can get benefits, including prior authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:

    - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
    - The address of any places where providers and hospitals furnish emergency services covered by Medicaid.
    - A statement saying you have the right to use any hospital or other settings for emergency care.
    - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your PCP.
- Superior's practice guidelines.

CHIP Perinatal Member Rights and Responsibilities

Member Rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
13. To make recommendations about Superior's Member Rights and Responsibilities polices.

Member Responsibilities:

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the doctor's decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP member handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that you are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

STAR Health Member Rights and Responsibilities

STAR Health Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a PCP. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another provider in a reasonably easy manner. That includes the right to be told of how to choose and change your PCP.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the STAR Health health plan and through Medicaid, and get a timely response to complaints, appeals and State Fair Hearings. That includes the right to:
    a. Make a complaint to your STAR Health health plan or to the state Medicaid program about your health care, your provider or the STAR Health health plan.
    b. Get a timely answer to your complaint.
    c. Use the HHSC claim administrator's and STAR Health plan's appeal process and be told how to use it.
    d. Ask for a State Fair Hearing from the state Medicaid program and get information about how that process works.
    e. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works.
    f. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a Day, seven Days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have the right to know that you are not responsible for paying for covered services provided to your child. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.
10. You have the right to make recommendations about Superior's Member Rights & Responsibilities Policies.

STAR Health Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid Program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you don't know your rights.
2. You must abide by the STAR Health health plan's policies and procedures and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow the STAR Health health plan's rules and Medicaid rules.
    b. Choose a PCP quickly;
    c. Make any changes in your PCP in the ways established by Medicaid and by the STAR Health health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you can't keep them.
    f. Always contact your PCP first for your non-emergency medical needs.
    g. Be sure to have approval from your PCP before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your PCP and learn about service and treatment options. That includes the responsibility to:
    a. Tell your PCP about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

Additional member responsibilities while using Superior's Medical Ride Program:

1. When requesting NEMT services through Superior's Medical Ride Program, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT services to travel to and from your medical appointments.
7. If you have arranged for an NEMT service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health & Human Services (HHS) toll-free at 1-800-368-1019. You can also view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

As a member of Superior HealthPlan, you can ask for and get the following information each year:

- Information about Superior and our network providers – at a minimum Primary Care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, languages spoken (other than English), identification of providers that are not accepting new patients and qualifications for each network provider such as:
    - Professional qualifications
    - Specialty
    - Medical school attended
    - Residency completion
    - Board certification status
    - Demographics
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, internal health plan appeal, External Medical Review and State Fair Hearing procedures.
- Information about Superior's Quality Improvement Program. To request a hard copy, call Member Services or visit our website at www.SuperiorHealthPlan.com.
- Information about benefits available under the Medicaid program including the amount, duration, and scope of benefits available. This is designed to make sure you understand the benefits to with you are entitled.
- How you can get benefits, including prior authorization requirements, family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
    - What makes up emergency medical conditions, emergency services, and post-stabilization services?
    - The fact that you do no need prior authorization from your PCP for emergency care services.
    - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
    - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
    - A statement saying you have the right to use any hospital or other settings for emergency care.
    - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your PCP.
- Superior's practice guidelines.

Attachment P – Office Site Survey

PRACTIONER OFFICE SITE EVALUATION TOOL

Clinic Site/Practitioner Name: _____ Check One: Initial Credentialing _____ Recredentialing _____

Contact/Manager: _____ PCP _____ OB/GYN _____ Peds _____

Office Address: _____ Specialist _____

_____ Specialty: _____

Phone Number: _____ Review Completed By: _____

Fax Number: _____ Date of Review: _____

I. PHYSICAL ACCESSIBILITY AND APPEARANCE = 32 POINTS

A. GENERAL FACILITY	Points	Yes	No	N/A	Criteria	Comments
1. Is office address clearly visible from the street?	2				Address is clearly visible and can be seen from the street. YES or NO answer.	
2. Is office handicapped / wheelchair accessible?	3				This includes handicapped ramps available externally, doorways, handrails and at least one rest room. Wheelchair accessible restroom can be anywhere in the same building as the physician's office; it does not have to be in the same suite. YES or NO answer.	
3. Is parking adequate and close by?	1				At least one handicapped parking space. YES or NO answer.	
4. Is staff able to communicate with member in member's primary language?	3				At least one staff person speaks member's primary language, or can access interpretive services (including hearing impaired). YES or NO answer.	
5. Is bus service available to physician's office?	1				May be N/A if office is located in rural area or public transportation is not available in the area. YES, NO or N/A answer (N/A answer receives full point value).	
6. In case of fire, are exit signs visible?	2				Exit signs present at all exits. When physician's office is located in large office building, exits might only be identified in common areas such as hallways, lobby, etc. YES or NO answer.	
7. Are fire extinguishers working and accessible or does the entire building have a sprinkler system?	2				Either fire extinguishers or a sprinkler system for the entire building is acceptable. YES or NO answer.	

TOTAL POINTS: 14 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

B. WAITING ROOM	Points	Yes	No	N/A	Criteria	Comments
1. Does the waiting room accommodate and provide adequate seating for patients?	2				Assess the practitioner office needs through review of patient visits per hour and number of practitioners. YES or NO answer.	
2. Is there adequate lighting?	1				Lighting should be adequate for reading. YES or NO answer.	
3. Is the waiting area well ventilated?	1				Well ventilated, with functioning central air conditioning or heat. YES or NO answer.	
4. Is the waiting area clean and free of clutter?	1				Clutter includes any items which might be considered obstacles to safe passage in the area. YES or NO answer.	
5. Are patient educational pamphlets available, organized, and given to members?	2				Educational materials, including preventive health information, may be located in an area other than the waiting room and must be written in language understandable to members. YES or NO answer.	

TOTAL POINTS: 7 **SCORE:**

C. EXAM/PROCEDURE ROOMS	Points	Yes	No	N/A	Criteria	Comments
1. Do the number and size of examination rooms accommodate the patient needs?	1				Assess the practitioner office needs. YES or NO answer.	
2. Are the exam rooms clean and free from clutter?	1				Clutter includes any items which might be considered obstacles to safe passage in the area. YES or NO answer.	
3. Is the equipment able to accommodate an individual with a disability?	1				Providers are expected to have equipment who can accommodate an individual with a disability. YES or NO answer.	
4. Are efforts made to maintain privacy by keeping door closed during exam and consultation with doctor or staff?	3				This includes any area where patient care activities occur. YES or NO answer.	
5. Are drape sheets or gowns available to patients?	1				This includes any area where patient care activities occur. YES or NO answer.	
6. Are sinks and soap available in patient care areas?	2				Sinks in each exam room would be preferred, however it is acceptable if they are within the patient care area and easily accessible. YES or NO answer.	
7. Are gloves located in the exam/procedure rooms and in all patient care areas?	2				Staff should wear gloves for any invasive procedure (i.e. drawing blood, handling any body fluids or specimens). YES or NO answer.	

TOTAL POINTS: 11 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

Note: Reviewer to ask "Does the physician perform high risk procedures i.e. IV sedation, some surgical procedures, exercise stress test?" If YES, questions 1&2 require YES or NO answer. If NO, questions 1& 2 may be answered N/A.

II. RISK MANAGEMENT = 33 POINTS

A. EMERGENCY CARE	Points	Yes	No	N/A	Criteria	Comments
1. Is the office staff able to provide or facilitate emergency care/service to include use of basic emergency equipment such as: an operable Ambubag or mask/pocket mask, oxygen, and airways? **(see note above)** **List procedures performed in office:** _____ _____	3				A policy, procedure or protocol is in place for staff to initiate basic life support measures and to obtain emergency transport to an acute care facility, if indicated. YES, NO, or N/A answer (N/A answer receives full point value).	
2. Emergency medication is in stock and not expired? **(see note above**)	4				YES, NO, or N/A answer based on need related to high risk procedures (N/A answer receives full point value).	
3. Equipment is clean and in working order and a service log is maintained on all equipment? (cleaning/biomedical testing)	1				A log sheet should be maintained to document equipment checks. YES or NO answer.	
4. Is any staff member currently certified in CPR?	2				At least one employee, who is in the office during all work office hours, must have a current BCLS certification. YES or NO answer.	

TOTAL POINTS: 10 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

B. PLANS, LICENSURE/CERTIFICATION	Points	Yes	No	N/A	Criteria	Comments
1. Medications and syringes are not patient accessible/controlled substances are locked and signed out?	2				Any medications and sterile needles are stored away from public access. YES or NO answer.	
2. A needle disposal container is used?	2				Used needles and other sharp items are properly stored and disposed of in closed containers. YES or NO answer.	
3. Hazardous/biohazard waste is bagged and disposed of properly?	2				Red bags are available and used for disposal of biohazardous waste. YES or NO answer.	
4. Standard Universal Precautions are observed?	2				Protective equipment (i.e. gloves, gowns, goggles) are available to and used by all personnel when handling potentially infectious patients or materials. Must have supplies for good hand washing technique. YES or NO answer.	
5. Is there a procedure in place to check for expired medications?	2				Check drug expiration dates. Open vials of medications are to be dated and stored properly to include refrigeration if indicated. YES or NO answer.	
6. Prescription pads are not patient accessible?	2				Prescription pads are maintained away from public access in a locked environment. YES or NO answer.	
7. An inventory log of sample drugs is maintained?	2				Sample drugs are maintained away from public access. A log should be maintain and documentation either in log or progress notes when sample medications are dispensed. YES or NO answer.	
8. Medication refrigerator is clean and does not contain food or specimens?	2				Medications are to be stored in a separate refrigerator away from other items. YES or NO answer.	
9. Are current documents available for positions requiring licensure, certification or registration?	1				This category includes RN, LPN, RT, PT, CAN, Lab tech, Radiology Tech. Ask to see one license or certification of any staff member who is present at the time of review. YES or NO answer.	

TOTAL POINTS: 17 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

C. ANCILLARY SERVICES	Points	Yes	No	N/A	Criteria	Comments
1. Does the office have a CLIA registration certificate or a CLIA certificate of waiver? Certificate # _____; Exp. Date _____ Waiver # _____; Exp. Date List lab tests performed on site: _____ _____ _____ _____	2				If the physician's office performs any lab tests they must have a CLIA registration certificate or a CLIA certificate of waiver. A list of tests that can be performed under a waiver is available at www.cdc.gov; go to Danta and Statistics Page and choose CLIA. If no labs are performed in the office this question may be N/A. YES, NO or N/A answer (N/A answer receives full point value).	
2. Is X-ray equipment inspected and licensed according to applicable Federal, State and Local laws and regulations?	2				Calibration and evaluation of radiation equipment must be performed by a qualified, medical radiation physicist according to time frames established by federal, state and local laws and regulations. N/A may be used if no X-ray equipment present in the office. YES, NO or N/A answer (N/A answer receives full point value).	
3. Are radiation protective devices in place to include shields, warning signs and pregnant women alert?	2				Radiation signs posted and protection devices available for patient and staff. N/A may be used if no X-ray equipment present in the office. YES, NO or N/A answer (N/A answer receives full point value).	

TOTAL POINTS: 6 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

III. ACCESSIBILITY/AVAILABILITY OF APPOINTMENTS = 20 Points

	Points	Yes	No	N/A	Criteria	Comments
1. Is there a 24-hour answering service or machine instructing members how to obtain care?	3				There is a process to ensure that calls are routed to the appropriate staff members. YES or NO answer.	
2. Is physician coverage provided seven Days a week, 24 hours a Day?	3				YES or NO answer.	
3. Is the Health Plan's Member Service toll free number available?	2				Should be available to patients, upon request. YES or NO answer.	
4. What are the physician's office hours?					List in comments area.	Mon. Tues. Wed. Thurs. Fri. Sat.
5. Is there an appointment available for: A. Complete physical/Preventive Health exam or routine non-symptomatic visit within three months for adults and/or two months for a child? Actual # of Days B. PCP and Specialist: PCP routine, Non-Urgent symptomatic visit within 14 Days? Actual # Days Specialist routine, Non-Urgent symptoms visit within 30 Days? Actual # of Days C. Urgent visit: within 24 hours? D. Emergent visit: immediately? E. **OB/GYN providers only:** **Routine, pre-natal care visit within 14 days?** Medically necessary initial high-risk prenatal care within five Days?	2 2 2 2 2				Ask the office manager or staff member within what time frame patients are to be seen for these exams. Enter the actual # of Days it takes to get an appt. for a complete physical/preventive health exam and routine/symptomatic visit. **These standards are applicable to both PCP and Specialists.** YES, NO or N/A answer only if not a high-risk OB/GYN provider (N/A answer receives full point value).	A. _____ Days B. _____ Days C. _____ Days D. _____ Days E. _____ Days
6. Are patients seen by physicians within 15 minutes of scheduled appointments? Actual # of minutes	2				YES or NO answer.	_____ Minutes
7. Is the office accepting new patients?					YES or NO answer.	

TOTAL POINTS: 20 **SCORE:**

PRACTIONER OFFICE SITE EVALUATION TOOL

IV. MEDICAL RECORD KEEPING AND FILING = 15 POINTS

NOTE: This section of the tool does not replace ambulatory medical record review. For initial credentialing site visit, the reviewer must evaluate one, blind medical record to assess the adequacy of medical record keeping practices.

	Points	Yes	No	N/A	Criteria	Comments
1. Are medical records maintained in an area away from public access and easily located/ accessible by staff?	3				YES or NO answer.	
2. Are medical records kept in a secure and confidential manner?	2				If paper, secure access. If electronic, password, etc. YES or NO answer.	
3. Is written authorization obtained for the release of medical records?	3				Ask to see release form. YES or NO answer.	
4. Is there a confidentiality policy for medical records?	2				Accept verbal explanation by staff. YES or NO answer.	
5. Medical record is organized and a standard format is used to document care?	2				YES or NO answer.	
6. All pages contain patient identification?	1				YES or NO answer.	
7. The provider of service is identified on each entry?	1				YES or NO answer.	
8. Biographical/personal data is contained in the record?	1				YES or NO answer.	

TOTAL POINTS: 15 **SCORE:**

SCORING RECOMMENDATIONS

SECTION	Points Assigned	Points Scored	% of Total
I. Physical Accessibility and Appearance	32	0	0%
II. Risk Management	33	0	0%
III. Accessibility/Availability of Appointments	20	0	0%
IV. Medical Record Keeping and Filing	15	0	0%
TOTAL	100	0	0%

Passing score is 80% for each section.
If any section is less than 80%, written report of deficiencies is required.
If total score is less than 80%, formal corrective action and follow-up is required.

ANY "N/A" ANSWER WILL AUTOMATICALLY RECEIVE THE ASSIGNED SCORE FOR A "YES" ANSWER WHEN ENTERED INTO THE SYSTEM.

PRACTIONER OFFICE SITE EVALUATION TOOL

Additional Practitioners	Name	Degree	Notes

Site Visit Completed By: Print Name _____ Signature _____ Date _____

Site Visit Final Review: Print Name_____ Signature _____ Date_____

Attachment Q – Privacy Notice

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

***PLEASE REVIEW IT CAREFULLY*.**

Effective 07.01.2017
Revised 04.14.2023

For help to translate or understand this, please call 1-866-896-1844.
Hearing impaired TTY: 1-800-735-2989.
Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-896-1844. (TTY: 1-800-735-2989).

Interpreter services are provided free of charge to you.

Covered Entities Duties:

Superior HealthPlan is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Superior HealthPlan is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. Superior HealthPlan may create, receive or maintain your PHI in an electronic format and that information is subject to electronic disclosure.

This Notice describes how we may use and disclose your PHI, this includes information related to race, ethnicity, language, gender identity, and sexual orientation. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Superior HealthPlan reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Superior will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website.

Internal Protections of Oral, Written and Electronic PHI:

Superior protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:

    - Processing claims
    - Determining eligibility or coverage for claims
    - Issuing premium billings
    - Reviewing services for medical necessity
    - Performing utilization review of claims

- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include:

    - Providing customer services
    - Responding to complaints and appeals
    - Providing case management and care coordination
    - Conducting medical review of claims and other quality assessment improvement activities

    In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

    - Quality assessment and improvement activities
    - Reviewing the competence or qualifications of healthcare professionals
    - Case management and care coordination
    - Detecting or preventing healthcare fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes*** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- ***Appointment Reminders/Treatment Alternatives*** – We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- ***As Required by Law*** – If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- ***Public Health Activities*** – We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** – We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** – We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:

    - An order of a court
    - Administrative tribunal
    - Subpoena
    - Summons
    - Warrant
    - Discovery request
    - Similar legal request

- ***Law Enforcement*** – We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

    - Court order
    - Court-ordered warrant
    - Subpoena
    - Summons issued by a judicial officer
    - Grand jury subpoena

    We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** – We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to

determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

    - Cadaveric organs
    - Eyes
    - Tissues

- ***Threats to Health and Safety*** – We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** – If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

    - To authorized federal officials for national security
    - To intelligence activities
    - The Department of State for medical suitability determinations
    - For protective services of the President or other authorized persons

- ***Workers' Compensation*** – We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- ***Inmates*** – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

- ***Research*** – Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** – You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

- ***Right to Request Restrictions*** – You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications*** – You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.

- ***Right to Access and Received Copy of your PHI*** – You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review, or if the denial cannot be reviewed.

- ***Right to Amend your PHI*** – You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny

your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures*** – You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint*** – If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice*** – You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Superior HealthPlan
Attn: Privacy Official
5900 E. Ben White Blvd
Austin, TX 78741

Toll Free Phone Number: 1-800-218-7453
Relay Texas (TTY): 1-800-735-2989

HHSC Privacy Notice

Attachment R – Health Passport Cover Sheet

HEALTH PASSPORT COVER SHEET

Fax: 866-274-5952
Mail: Superior HealthPlan
PO Box 3003, Farmington, MO 63640-3803

PROVIDER INFORMATION (*Required field)

TIN #*_____
NPI*_____
NAME _____
PHONE _____FAX _____
SERVICE DATE*_____# of PAGES _____

MEMBER INFORMATION (*Required field)

FIRST NAME* _____
LAST NAME* _____
DFPS ID* _____ or MEDICAID ID* _____
DOB* _____

******** Please check only **ONE** form type below. If you wish to submit multiple forms, please use a separate coversheet. ********

BEHAVIORAL HEALTH

DO NOT SEND INDIVIDUAL THERAPY NOTES

- ☐ Initial Behavioral Health Assessment - 4
- ☐ Behavioral Health Review (Monthly) - 3
- ☐ Biopsychosocial Assessment
- ☐ Psychological Evaluation
- ☐ Trauma Screening Questionnaire (TSQ) – Adults
- ☐ Child and Adolescent Trauma Screen (CATS) Caregiver Report (7-17)
- ☐ Other (Discharge Summary, etc.)

DENTAL

- ☐ Dental Form - 1
- ☐ Other

EARLY CHILDHOOD INTERVENTION

- ☐ IFSP Form - 2
- ☐ Other

FORENSIC ASSESSMENT

- ☐ Forensic Assessment Form - 1
- ☐ Other

OTHER

- ☐ Non-Consent Emergency Notification - 1
- ☐ Other

PHYSICAL HEALTH

- ☐ 3-Day Exam
- ☐ 30-Day Exam
- ☐ Envolve People Care/Care Path - 2
- ☐ Birthing Center Report from 7484 - 1
- ☐ DME Certification and Receipt Form - 1
- ☐ Donor Human Milk Request Form - 1
- ☐ Federally Qualified Health Center Report Form 7484 - 1
- ☐ Labs
- ☐ Hearing Evaluation, Fitting, and Dispensing Report Form 3503-1
- ☐ Hospital Report HHSC Form 7484 - 1
- ☐ Notification of Pregnancy - 1
- ☐ Specimen Submission Form G-1C - 1
- ☐ Vision Care Eyeglass Patient Certification Form - 1
- ☐ Other (Discharge Summary, etc.)

TEXAS HEALTH STEPS

- ☐ Discharge to 5 Day Visit - 2
- ☐ 2 Week Visit - 2
- ☐ 2 Month Visit - 2
- ☐ 4 Month Visit - 2
- ☐ 6 Month Visit - 2
- ☐ 9 Month Visit - 2
- ☐ 12 Month Visit - 2
- ☐ 15 Month Visit - 2
- ☐ 18 Month Visit - 2
- ☐ 24 Month Visit - 2
- ☐ 30 Month Visit - 2
- ☐ 3 Year Visit - 2
- ☐ 4 Year Visit - 2
- ☐ 5 Year Visit - 2
- ☐ 6 Year Visit - 2
- ☐ 7 Year Visit - 2
- ☐ 8 Year Visit - 2
- ☐ 9 Year Visit - 2
- ☐ 10 Year Visit - 2
- ☐ 11 Year Visit - 2
- ☐ 12 Year Visit - 2
- ☐ 13 Year Visit - 2
- ☐ 14 Year Visit - 2
- ☐ 15 Year Visit - 2
- ☐ 16 Year Visit - 2
- ☐ 17 Year Visit - 2
- ☐ 18 Year Visit - 2
- ☐ 19 Year Visit - 2
- ☐ 20 Year Visit - 2
- ☐ Child Health History - 2
- ☐ CCP ECI Request for Initial/Renewal Outpatient Therapy - 1
- ☐ CCP Prior Authorization Private Duty Nursing - 1
- ☐ CCP Prior Authorization Request Form - 1
- ☐ CRAFFT
- ☐ Dental Mandatory Prior Authorization Request - 1
- ☐ Dental Criteria for Dental Therapy Under Anesthesia - 2
- ☐ Hearing Checklist for Parents - 1
- ☐ HEEADSSS
- ☐ Lead Poisoning/Parent Questionnaire - 2
- ☐ Mental Health Interview Tool 0-2 Years - 1
- ☐ Mental Health Interview Tool 3-9 Years - 1
- ☐ Mental Health Interview Tool 10-12 Years - 1
- ☐ Mental Health Interview Tool 13-20 Years - 1
- ☐ Nursing Addendum to Plan of Care - 3
- ☐ Pediatric Symptom Checklist (PSC-35)
- ☐ PSC-Y
- ☐ Referral Form - 1
- ☐ TB Questionnaire - 1
- ☐ Other

Attachment S – Allergy Skin Testing and Immunotherapy for Non-Allergists

Provider Attestation Statement
Allergy Skin Testing and Immunotherapy for Non-Allergists

Please submit via email to Credentialing@SuperiorHealthPlan.com or fax to 866-702-4831.

Physician's Name:	
Provider Type:	
NPI Number:	
Tax ID Number:	
Physical Address:	
Contact Number:	

Please check one or both of the following attestation statements which apply to you:

- ☐ I attest that I, as a non-allergist, am clinically trained to provide allergy skin testing and immunotherapy.
  (Please provide evidence of formal training, clinical experience, and subject matter expertise in the field of allergy skin testing and immunotherapy.)

- ☐ I attest that I understand allergy clinical practice guidelines recommend that I have the following equipment and staff to safely provide immunotherapy (allergy shots) to patients at my location of practice:
  - ☐ Aeroallergen and venom extract storage (4 degrees C refrigerator with alarm)
  - ☐ 1 ml (for AIT) and 3 ml (for VIT) disposable (safety) syringes with 27 gauge 5/8 inch needles
  - ☐ Epi-pen auto injectors – 0.3 mg for adults and 0.15 mg for children
  - ☐ Crash cart – BLS+ level
  - ☐ Glucagon
  - ☐ Vital Signs monitor
  - ☐ Oxygen administration equipment
  - ☐ Personnel with BLS+ training
  - ☐ Personnel trained to give shots, recognize and treat anaphylaxis

Physician Signature:		Date:	
Printed Name:			

By signing this document, I certify that the information provided herein is true, accurate and complete to the best of my knowledge. I understand that under my Provider Participation Agreement, Superior HealthPlan, and applicable Regulators including the Centers for Medicare and Medicaid Services, and the Texas Health and Human Services (HHS) or their Representatives, may inspect and evaluate my records related to Members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and Federal and State Laws or Regulations.

Attachment T – Allergy Immunotherapy for Non-Allergists

Provider Attestation Statement
Allergy Immunotherapy (Allergy Shot Administration ONLY) for Non-Allergists

Physician's Name:	
Provider Type:	
NPI Number:	
Tax ID Number:	
Physical Address:	
Contact Number:	

Please check the following attestation statement, and the specific equipment and trainings which apply to your place of service:

- ☐ I attest that I understand allergy clinical practice guidelines recommend that I have the following equipment and staff to safely provide immunotherapy (allergy shots) to patients at my location of practice:
  - ☐ Aeroallergen and venom extract storage (4 degrees C refrigerator with alarm)
  - ☐ 1 ml (for AIT) and 3 ml (for VIT) disposable (safety) syringes with 27 gauge 5/8 inch needles
  - ☐ Epi-pen auto injectors – 0.3 mg for adults and 0.15 mg for children
  - ☐ Crash cart – BLS+ level
  - ☐ Glucagon
  - ☐ Vital Signs monitor
  - ☐ Oxygen administration equipment
  - ☐ Personnel with BLS+ training
  - ☐ Personnel trained to give shots and to recognize and treat anaphylaxis

Physician Signature:		Date:	
Printed Name:			

By signing this document, I certify that the information provided herein is true, accurate and complete to the best of my knowledge. I understand that under my Provider Participation Agreement, Superior HealthPlan, and applicable Regulators including the Centers for Medicare and Medicaid Services, and the Texas Health and Human Services (HHS) or their Representatives, may inspect and evaluate my records related to Members and the provision of and payment for services to audit compliance with this review requirement, and other contractual requirements and Federal and State Laws or Regulations.

Primary Care Provider (PCP) Quick Reference Guide

General Information		
Website Please visit the Secure Provider Portal 24/7 for questions on claim status, to verify eligibility, to request or check status of an authorization, and to submit general questions.	Secure Provider Portal: Provider.SuperiorHealthPlan.com	
Provider Services Please contact Provider Services for questions on claim payments, rejections, denials, to verify eligibility or for help escalating any issues you may have. For claims related questions, be sure to have your claim number available. HIPAA Validation will still occur.	STAR, STAR Kids, STAR Health, STAR+PLUS and CHIP	1-877-391-5921
Member Services and After Hours Members can contact Member Services to change their PCP or for help with other questions. Our nurses are available to help members with urgent issues after hours and on holidays.	Relay Texas (TDD/TTY)	1-800-735-2989
	STAR and CHIP	1-800-783-5386
	STAR+PLUS	1-877-277-9772
	STAR Kids	1-844-590-4883
	STAR Health	1-866-912-6283
Provider Complaints SuperiorHealthPlan.com/ComplaintProcedures		

Claims Submission and Claims Payment	
Providers may submit claims in three ways: 1. Secure Provider Portal – Provider.SuperiorHealthPlan.com 2. EDI – 1-800-225-2573 ext. 25525, Payer ID: 68069, Behavioral Health Payer ID: 68068 3. Paper – See address below under Initial, Resubmission, Corrected or Reconsiderations.	
Initial, Resubmission, Corrected or Reconsiderations Superior HealthPlan P.O. Box 3003 Farmington, MO 63640-3803 Payer ID: 68069	**Claim Appeals** Superior HealthPlan P.O. Box 3000 Farmington, MO 63640-3800 Payer ID: 68069
Timely Filing Deadline 95 Days from the date of service	
Corrected Claims, Requests for Reconsideration or Claim Disputes 120 Days from the date of the Explanation of Payment (EOP)	
Electronic Funds Transfer (EFT)/Electronic Remittance Advice (ERA) – PaySpan To register for this free service, call 1-877-331-7154 or visit payspanhealth.com.	

Secure Provider Portal / Health Passport Help Desk	
Secure Provider Portal Help Desk	Phone: 1-866-895-8443 Email: TX.WebApplications@SuperiorHealthPlan.com
Health Passport (for STAR Health) Help Desk	Phone: 1-866-714-7996 Email: TX.PassportAdministration@SuperiorHealthPlancom

Provider Contracting
All contracting for new and existing providers is done through the Network Development and Contracting Management department. Contract packets can be requested by completing the Network Participation Request on our website at SuperiorHealthPlan.com/JoinOurNetwork. Network Development Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com Mail: Superior HealthPlan, ATTN: Contract Management, 7990 Interstate 10 West, Suite 300, San Antonio, TX 78230

Primary Care Provider (PCP) Quick Reference Guide

Provider Re-credentialing

Email: Credentialing@SuperiorHealthPlan.com
Fax: 1-866-702-4831
Mail: Credentialing Department, Superior HealthPlan, 5900 E. Ben White Blvd., Austin, TX 78741

Prior Authorizations

Providers may submit authorization in three ways:

- Secure Provider Portal: Provider.SuperiorHealthPlan.com
- Phone: 1-800-218-7508
- Fax Lines
  - Inpatient: 1-877-650-6942
  - Outpatient: 1-800-690-7030
  - Behavioral Health (Inpatient): 1-800-732-7562
  - Behavioral Health (Outpatient): 1- 866-570-7517

High-Tech Imaging Prior Authorizations

Radiology Services - National Imaging Associates (NIA): NIA will manage the prior authorization of non-emergent, advanced, outpatient imaging services rendered to Superior HealthPlan members such as Musculoskeletal, CT/CTA, MRI/MRA, PET Scan, CCTA, Nuclear Cardiology/MPI, Echocardiography and Stress Echo.

Note: Echocardiography authorization is only required for STAR Kids and STAR+PLUS members.

Phone: 1-800-642-7554
Website: RadMD.com

Interventional Pain Management (IPM)

Prior authorization for outpatient IPM procedures is required for:

- Spinal Epidural Injections.
- Paravertebral Facet Joint Injections or Blocks.
- Paravertebral Facet Joint Denrvation (Radiofrequency Neurolysis).
- Sacroiliac Joint Injections.

Phone: 1-800-642-7554
Website: RadMD.com

Ear, Nose and Throat (ENT) and Sleep Study, and Cardiac Surgical Procedures

Prior authorization is required for certain Musculoskeletal Surgical, Ear, Nose and Throat (ENT) and Sleep Study, and Cardiac Surgical Procedures in both inpatient and outpatient settings.

To verify if a service requires prior authorization, please visit SuperiorHealthPlan.com/PriorAuth.

• Telephonic Intake: 1-855-336-4391	• Facsimile Intake: 1-833-409-5393

Pharmacy Benefits Manager

Bin Number: 003858; Group ID: 2FDA

Prior Authorization Requests	Phone: 1-866-399-0928 Fax: 1-833-423-2523 Website: SuperiorHealthPlan.com/ProviderPharmacy
Pharmacy Appeals	Phone: 1-800-218-7453, ext. 22168 Fax: 1-866-918-2266
Resolution Help Desk	Phone: 1-800-460-8988

For the most current Provider Manual and Prior Authorization list, please visit SuperiorHealthPlan.com.

STAR+PLUS/LTSS
Quick Reference Guide

General Information	
Provider Services 1-877-391-5921 Relay Texas (TTY): 1-800-735-2989 or 711	**Website** SuperiorHealthPlan.com **Secure Provider Portal** Provider.SuperiorHealthPlan.com **Secure Provider Portal Help Desk** Phone: 1-866-895-8443 Email: TX.WebApplications@SuperiorHealthPlan.com
Member Services and After Hours (24-Hour Nurse Advice Line) 1-877-277-9772 Relay Texas (TTY): 711	
State Fair Hearing Requests Hotline 1-877-398-9461	

Provider Contracting
Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com **Web**: SuperiorHealthPlan.com/JoinOurNetwork

Claims Submission – Acute Care Services and LTSS (Non-dual)	
Providers may submit claims in three ways: 1. Secure Provider Portal: Provider.SuperiorHealthPlan.com 2. EDI: 1-800-225-2573, ext. 6075525, Payer ID: 68069 3. Paper: See address below under Initial, Resubmission, Corrected or Reconsiderations.	
Initial, Resubmission, Corrected or Reconsiderations Superior HealthPlan P.O. Box 3003 Farmington, MO 63640-3803 Payer ID: 68069	**Claim Appeals** Superior HealthPlan P.O. Box 3000 Farmington, MO 63640-3800 Payer ID: 68069
Timely Filing Deadline 95 Days from date of service	**Corrected Claims, Requests for Reconsideration or Claim Disputes** 120 Days from the date of the Explanation of Payment (EOP)
EFT/ERA – PaySpan To register for this free service, call 1-877-331-7154 or visit payspanhealth.com/.	

STAR+PLUS/LTSS
Quick Reference Guide

Prior Authorization – LTSS Service Coordination (E.g. PAS, DAHS, ERS)	
Phone: 1-877-277-9772 **Fax :** All LTSS (Fax) • Day Activity and Health Services (DAHS): 1-877-441-5811 • STAR+PLUS Medicare-Medicaid Plan (MMP): 1-855-277-5700 • STAR+PLUS (Medicaid): 1-866-895-7856 • Medical Necessity Level of Care (MNLOC) Physician's Signature and Provider Statement of Need (PSON) forms only: 1-866-703-0502	
Prior Authorization - Acute Care Services (Non-Dual) (E.g. In-home skilled nursing, PDN, most DME)	**Prior Authorization - Acute Care Services (Dual)** (E.g. In-home skilled nursing, PDN, most DME)
MMP (Fax): • Inpatient: 1-877-259-6960 • Outpatient (standard): 1-877-808-9368 • Incontinence: 1-800-690-7030 • Behavioral Health (Inpatient): 1-866-900-6918 • Behavioral Health (Outpatient): 1-855-772-7079 **Expedited (Phone):** 1-800-218-2508 **STAR+PLUS (Fax):** • Inpatient: 1-866-683-5632 • Outpatient: 1-800-690-7030 • Behavioral Health (Inpatient): 1-800-732-7562 • Behavioral Health (Outpatient): 866-570-7517	**Medicare (Fax):** • Inpatient: 1-855-537-3535 • Outpatient: 1-877-808-9368 • Behavioral Health (Inpatient): 1-866-900-6918 • Behavioral Health (Outpatient): 1-855-772-7079
Electronic Visit Verification	
Web: https://hhs.texas.gov/laws-regulations/handbooks/evvpph/section-2000-programs-services-billing **Email**: Electronic_Visit_Verification@hhsc.state.tx.us	
For the most current Provider Manual and Prior Authorization list, please visit SuperiorHealthPlan.com.	

Acute Care/Hospital Quick Reference Guide

General Information		
Secure Provider Portal Please visit the Secure Web Portal 24/7 for questions on claim status, to verify eligibility, to request or check status of an authorization, and to submit general questions.	Secure Provider Portal: Provider.SuperiorHealthPlan.com	
Provider Services Please contact Provider Services for questions on claim payments, rejections, denials, to verify eligibility or for help escalating any issues you may have. For claims related questions, be sure to have your claim number available. HIPAA Validation will still occur.	STAR, STAR Kids, STAR Health, STAR+PLUS and CHIP	1-877-391-5921
Member Services and After Hours Members can contact Member Services to change their PCP or for help with other questions. Our nurses are available to help members with urgent issues after hours and on holidays.	Relay Texas (TTY)	1-800-735-2989
	STAR and CHIP	1-800-783-5386
	STAR+PLUS	1-877-277-9772
	STAR Kids	1-844-590-4883
	STAR Health	1-866-912-6283
Provider Complaints	SuperiorHealthPlan.com/ComplaintProcedures	

Claims Submission and Claims Payment	
Providers may submit claims in three ways: 1. Secure Web Portal – Provider.SuperiorHealthPlan.com 2. EDI – 1-800-225-2573, ext. 25525, Payer ID: 68069, Behavioral Health Payer ID: 68068 3. Paper – See address below under Initial, Resubmission, Corrected or Reconsiderations.	
Initial, Resubmission, Corrected or Reconsiderations Superior HealthPlan P.O. Box 3003 Farmington, MO 63640-3803 Payer ID: 68069	**Claim Appeals** Superior HealthPlan P.O. Box 3000 Farmington, MO 63640-3800 Payer ID: 68069
Timely Filing Deadline 95 Days from the date of service	
Corrected Claims, Requests for Reconsideration or Claim Disputes 120 Days from the date of the Explanation of Payment (EOP)	
EFT/ERA – PaySpan Health To register for this free service, call 1-877-331-7154 or visit payspanhealth.com.	

Secure Provider Portal Help Desk
Phone: 1-866-895-8443 Email: TX.WebApplications@SuperiorHealthPlan.com

Provider Contracting
All contracting for new and existing providers is done through the Network Development and Contracting Management department. Contract packets can be requested by completing the Network Participation Request on our website at SuperiorHealthPlan.com/JoinOurNetwork Network Development Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com Mail: Superior HealthPlan, ATTN: Contract Management, 7990 Interstate 10 West, Suite 300, San Antonio, TX 78230

Acute Care/Hospital Quick Reference Guide

Provider Re-credentialing
Email: Credentialing@SuperiorHealthPlan.com Fax: 1-866-702-4831 Mail: Credentialing Department, Superior HealthPlan, 5900 E. Ben White Blvd., Austin, TX 78741
Provider Authorizations
Providers may submit authorizations in three ways: 1. Secure Provider Portal: Provider.SuperiorHealthPlan.com 2. Fax: 1-877-650-6942 3. Call: 1-800-218-7508

NICU and Emergent Hospital Admission Notification and Authorization	
Products	**Business Line**
STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP	1-855-594-6103 STAR/CHIP Inpatient (fax): 1-877-650-6942

High-Tech Imaging Prior Authorizations
Radiology Services - National Imaging Associates (NIA): NIA will manage the prior authorization of non-emergent, advanced, outpatient imaging services rendered to Superior members such as Musculoskeletal, CT/CTA, MRI/MRA, PET Scan, CCTA, Nuclear Cardiology/MPI, Echocardiography and Stress Echo. *Note: Echocardiography authorization is only required for STAR Kids and STAR+PLUS members.* Phone: 1-800-642-7554 Website: RadMD.com
Interventional Pain Management (IPM)
Effective January 1, 2021, prior authorization for outpatient IPM procedures is required for: • Spinal Epidural Injections. • Paravertebral Facet Joint Injections or Blocks. • Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis). • Sacroiliac Joint Injections. Phone: 1-800-642-7554 Website: RadMD.com
Ear, Nose and Throat (ENT) and Sleep Study, and Cardiac Surgical Procedures
Prior authorization is required for certain Musculoskeletal Surgical, Ear, Nose and Throat (ENT) and Sleep Study, and Cardiac Surgical Procedures in both inpatient and outpatient settings. To verify if a service requires prior authorization, please visit SuperiorHealthPlan.com/PriorAuth. • Telephonic Intake: 1-855-336-4391 • Facsimile Intake: 1-833-409-5393

Pharmacy Benefits Manager	
Bin Number: 003858; Group ID: 2FDA	
Prior Authorization Requests	Phone: 1-866-399-0928 Fax: 1-833-423-2523 Website: SuperiorHealthPlan.com/ProviderPharmacy
Pharmacy Appeals	Phone: 1-800-218-7453, ext. 22168 Fax: 1-866-918-2266
Resolution Help Desk	Phone: 1-800-460-8988
For the most current Provider Manual and Prior Authorization List, please visit SuperiorHealthPlan.com.	

Behavioral Health Provider Quick Reference Guide

<table>
<tr><th colspan="3">General Information</th></tr>
<tr><td>Website
Utilize the Superior HealthPlan website to find:
Training and manuals.
Preferred drug lists.
Provider news.
Network requests or updates.
Fraud, waste and abuse reporting.
Contact information (inquiries and complaints).
Your dedicated Account Manager.</td><td colspan="2">Website
SuperiorHealthPlan.com</td></tr>
<tr><td>Secure Provider Portal
Please visit the Secure Provider Portal 24/7 for questions on electronic claim submission, claim appeals and claim status checks and member eligibility verification.</td><td colspan="2">Secure Provider Portal
Provider.SuperiorHealthPlan.com</td></tr>
<tr><td colspan="3">Account Management
Account Managers provide training, education, assist with questions or help troubleshoot complex issues. Account Managers work to make doing business with Superior HealthPlan easy. Superior HealthPlan's Behavioral Health Providers can reach out to AM.BH@SuperiorHealthPlan.com to request assistance from an Account Manager who specializes in Behavioral Health. Each provider inquiry received is assigned to a Provider Account Manager.</td></tr>
<tr><td colspan="3">Trainings:
Behavioral Health Clinical Trainings
https://www.superiorhealthplan.com/providers/training-manuals/behavioral-health-clinical-trainings.html
Provider Training Calendar:
https://www.superiorhealthplan.com/providers/training-manuals/provider-training-calendar.html</td></tr>
<tr><td rowspan="3">Provider Services
Please contact Provider Services for questions on claims status, member eligibility and claim adjustment requests.</td><td>STAR, CHIP, STAR+PLUS, STAR Kids, STAR+PLUS MMP, Wellcare By Allwell</td><td>1-877-391-5921</td></tr>
<tr><td>STAR Health</td><td>1-877-391-5921</td></tr>
<tr><td>Ambetter</td><td>1-877-687-1196</td></tr>
<tr><td rowspan="8">Member Services
Members can contact Member Services for help with:
Benefit inquiries.
Assistance with locating a network provider.
Transportation assistance.
General inquiries and complaints.
Abuse, neglect and exploitation reporting.
Behavioral health crisis hotline.</td><td>STAR, CHIP</td><td>1-800-783-5386</td></tr>
<tr><td>STAR+PLUS</td><td>1-877-277-9772</td></tr>
<tr><td>STAR Kids</td><td>1-844-590-4883</td></tr>
<tr><td>STAR Health</td><td>1-866-912-6283</td></tr>
<tr><td>STAR+PLUS MMP</td><td>1-866-896-1844</td></tr>
<tr><td>Wellcare By Allwell (HMO and HMO DSNP)</td><td>1-877-826-5520</td></tr>
<tr><td>Ambetter</td><td>1-877-687-1196</td></tr>
<tr><td>Relay Texas (TTY)</td><td>1-800-735-2989</td></tr>
<tr><td>Provider Complaints
Provider complaints may be submitted through the Superior website, by mail or fax.</td><td colspan="2">Complaints (By Web)
SuperiorHealthPlan.com/ComplaintProcedures

Complaints (By Mail)
Superior HealthPlan Provider Complaints
5900 E. Ben White Blvd.
Austin, Texas 78741

Complaints (By Fax)
1-866-683-5369</td></tr>
</table>

Behavioral Health Provider Quick Reference Guide

Discharge Planning for Substance Use Disorder after Behavioral Health Providers are required to schedule a follow up appointment with in 7 and 30 Days after a member has been discharged from an Inpatient Psychiatric Facility. Members should be scheduled with their current OP provider. If a member has not been working with an OP provider, please schedule an appointment with one of the following:	**Superior HealthPlan Care Manager or Discharge Planner** • Contact Member Services at the numbers listed above **Teladoc** • 24-hour access to in-network providers for non-emergency health issues • For members 18 years of age or older • Online: https://member.teladoc.com/superior-healthplan • Phone: 1-800-835-2362 **Tejas Healthy at Home** • For Medicaid [STAR, STAR Health, STAR Kids, STAR+PLUS (non duals)] and CHIP members • Phone: 1-512-279-9375 • Online: healthyathome@tejashma.org

Claims Submission and Claims Payment

Paper claims should be mailed to:
Superior HealthPlan
Behavioral Health Claims
P.O. Box 6300
Farmington, MO 63640-6806

Wellcare By Allwell
Attn: Claims
PO BOX 3060
Farmington, MO 63640-3822

Ambetter
Attn: Claims
PO Box 5010
Farmington, MO 63640-5010

Paper claims must be submitted on CMS standardized claim forms, using a CMS-1500 or CMS-1450/UB-04 claim form.

Electronic claims can be submitted through the following:
- Secure Provider Portal: Provider.SuperiorHealthPlan.com
  - Availity Clearinghouse: Medicaid/CHIP Payer ID: 68068
  - Ambetter, Wellcare By Allwell and STAR+PLUS MMP Payer ID: 68069
- Phone: 1-877-344-8446
- Website: Availity.com
- Texas Medicaid and Healthcare Partnership (TMHP) Portal: secure.tmhp.com/TexMedConnect

Behavioral Health Provider Quick Reference Guide

Claim Appeals and Corrected Claims can be submitted on paper or electronically.

Paper claim appeals should be mailed to:
Superior HealthPlan:
Attn: Behavioral Health Appeals, P.O. Box 6000, Farmington, MO 63640-3809

Electronic claim appeals can be submitted through Superior's Secure Provider Portal: Provider.SuperiorHealthPlan.com

Must be received by Superior within 120 Days from the date the claim was finalized for reconsideration.

Claim Disputes
Ambetter:
Attn: Claims Dispute, P.O. Box 5000, Farmington, MO 63640-5000

Wellcare By Allwell:
Attn: Claim Dispute, P.O. Box 4000, Farmington, MO 63640-4400

Claim Payment
- Providers can receive paper or electronic payments and remittance.
- Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) is a free service for providers.
- To register for this service, call 1-877-331-7154 or visit PayspanHealth.com.

Claim Status
- Claim status can be obtained through the Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- For questions about a claim, call Superior Provider Services.

Secure Provider Portal / Health Passport Help Desk	
Secure Provider Portal Help Desk	Phone: 1-866-895-8443 Email: TX.WebApplications@SuperiorHealthPlan.com
Health Passport Help Desk (for STAR Health)	Phone: 1-866-714-7996 Email: TX.PassportAdministration@SuperiorHealthPlan.com

Provider Contracting

Providers can contact Superior for contracting opportunities by:
- Completing the Network Participation Request by visiting SuperiorHealthPlan.com/JoinOurNetwork.
- Sending an email to SHP.NetworkDevelopment@SuperiorHealthPlan.com.

Provider Credentialing

Email: Credentialing@SuperiorHealthPlan.com
Fax: 1-866-702-4831
Mail: Credentialing Department, Superior HealthPlan, 5900 E. Ben White Blvd., Austin, TX 78741

Prior Authorizations

Prior Authorization forms can be found by visiting SuperiorHealthPlan.com/ProviderBehavioralHealth.

Providers may submit authorizations by:
1. **Secure Provider Portal**: Provider.SuperiorHealthPlan.com
2. **Phone:**
   a. 1-844-744-5315 (Superior phone)
   b. 1-844-259-3934 (Ambetter phone)
   c. 1-800-424-4812 (Magellan HealthCare – Applied Behavioral Analysis Services)
3. **Fax:**
   a. Ambetter Prior Authorization: 1-844-307-4442 (Outpatient) or 1-800-732-7562 (Inpatient)
   b. Medicaid Prior Authorization: 1- 866-570-7517 (Outpatient) or 1-800-732-7562 (Inpatient)
   c. Wellcare By Allwell Prior Authorization: 1-855-772-7079 (Outpatient) or 1-866-900-6918 (Inpatient)
   d. Applied Behavioral Analysis: Magellan HealthCare Prior Authorization: 1-888-656-0368 (Outpatient/Inpatient)

Attachment V – Rate Enhancement Affidavit

Rate Enhancement Affidavit

A MATERIAL OR FALSE STATEMENT OR OMISSION MADE IN CONNECTION WITH THIS AFFIDAVIT MAY SUBJECT THE PERSON AND/OR ENTITY MAKING THE FALSE STATEMENT TO ANY AND ALL CIVIL AND CRIMINAL PENALTIES AVAILABLE PURSUANT TO APPLICABLE FEDERAL AND STATE LAW.

State of Texas_____§
County of_____§

Definitions:
Participating Provider: Someone participating in rate enhancement.
Rate Enhancement: An additional amount of monies paid to provider to be passed on for compensation of direct care staff.

I,_____ **(full name printed)**, swear an oath under penalty of law that I am _____**(title)** of_____ **(company)** and that the statements submitted in this affidavit are true and correct to the best of my knowledge.

I further swear that I or my company have met the requirements set forth in 15 TAC §355.112 which states that allowable enhancement fund compensation for attendants (as defined above) was applied either as salaries and/or wages, including payroll taxes and workers' compensation, or employee benefits to direct care staff.

I agree to submit to an audit, examination and review of books, records, documents and files, in whatever form they exist, of the named company and its affiliates, inspection of its places(s) of business and equipment, and to permit interviews of principals, agents, and employees. I understand that refusal to permit such inquiries shall be grounds for whatever civil and criminal penalties are available pursuant to applicable federal and state law and/or termination of my contract with Superior HealthPlan, Inc.

Should an audit result in a finding of non-compliance with these requirements, it could result in recoupment of those enhanced payments and termination of the contract with Superior HealthPlan. It shall also be grounds for whatever civil and criminal penalties are available pursuant to federal and state law.

To prevent any delay in processing, it is very important to include the following information on the returned affidavit: Tax Identification Number (TIN), your assigned NPI number and the nine digit HHSC contract number awarded to you from the Texas Health and Human Services **(not to be confused with your five-to-six digit license number)**.

Business Name: _____ Business Tax ID: _____

Program Type	HHSC Contract Number	Provider's Billing NPI or Atypical ID
PHC		
DAHS		
Assisted Living		

Please check one of the following:

☐ I contract with HHSC for Rate Enhancement and wish to participate in Superior's Rate Enhancement Program.
☐ I no longer contract with HHSC for Rate Enhancement as of _____ and wish to remain in Superior's Rate Enhancement Program.
- If selected, what is the *last rate you received during your contract with HHSC? _____
  **If we are unable to verify your previous rate with HHSC, confirmation will be required before we can process your submission.*

☐ I have never contracted with HHSC, but wish to request participation with Superior HealthPlan's Rate Enhancement Program, at the level allowed by Superior HealthPlan.
☐ I wish to be removed from Superior's Rate Enhancement Program. **Please Note**: By checking this box, I understand that I will no longer receive rate enhancement payments from Superior HealthPlan as of January 1, 2023.

_____

Affiant's Signature **Affiant's Phone Number and E-mail**

Date: _____

Attachment W – Breast Pump Coverage in Medicaid and CHIP

Texas Medicaid and CHIP cover breast pumps and supplies when Medically Necessary after a baby is born. A breast pump may be obtained under an eligible mother's Medicaid or CHIP client number; however, if a mother is no longer eligible for Texas Medicaid or CHIP and there is a need for a breast pump or parts, then breast pump equipment must be obtained under the infant's Medicaid client number.

Coverage in prenatal period	Coverage at delivery	Coverage for newborn	Breast pump coverage and billing
STAR	STAR	STAR	STAR covers breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
CHIP Perinatal, with income at or below 198% of federal poverty level (FPL)*	Emergency Medicaid	Medicaid fee-for-service (FFS) or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for newborns when the mother does not have coverage under CHIP. Breast pumps and supplies must be billed under the newborn's Medicaid ID.
CHIP Perinatal, with income above 198% FPL	CHIP Perinatal	CHIP Perinatal	CHIP covers breast pumps and supplies when Medically Necessary for CHIP Perinatal newborns. Breast pumps and supplies must be billed under the newborn's CHIP Perinatal ID.
STAR Kids	STAR Kids	Medicaid FFS or STAR**	Medicaid FFS, STAR, and STAR Health cover breast pumps and supplies when Medically Necessary for mothers or newborns. Breast pumps and supplies may be billed under the mother's Medicaid ID or the newborn's Medicaid ID.
STAR+PLUS	STAR+PLUS	Medicaid FFS or STAR**	
STAR Health	STAR Health	STAR Health	
None, with income at or below 198% FPL	Emergency Medicaid	Medicaid FFS or STAR**	Medicaid FFS and STAR cover breast pumps and supplies when Medically Necessary for the newborn when the mother does not have coverage. Breast pumps and supplies must be billed under the newborn's Medicaid ID.

*CHIP Perinatal Members with household incomes at or below 198% FPL must apply for Emergency Medicaid coverage for labor and delivery services. Texas Health and Human Services (HHS) mails the pregnant woman an Emergency Medicaid application 30 Days before her reported due date. When Emergency Medicaid covers a birth, the newborn is certified for 12 months of Medicaid coverage, beginning on the date of birth.

**These newborns will be in FFS Medicaid until they are enrolled with a STAR MCO. Claims should be filed with TMHP using the newborn's Medicaid ID if the mother does not have coverage.

Please note: Breast pumps are only a benefit after delivery.

Pharmacy Resource Guide and Benefits Overview

Formularies, Prior Authorization and Quantity Limits

Vendor Drug Program

Superior HealthPlan covers prescription medications as outlined by the Texas Health and Human Services (HHS) Vendor Drug Program (VDP) for Texas Medicaid (STAR, STAR Health, STAR Kids and STAR+PLUS) and CHIP members.

To assist in navigating the coverage of drugs for Medicaid and CHIP members specific to Superior, please review the following information.

VDP Formulary

- Superior must cover medications located on the VDP Formulary. To verify, please confirm that the Med End Date listed in the search is not past due.
  - To see covered drugs, please visit the VDP Formulary Search: TXVendorDrug.com/formulary/formulary-search
  - *Please note: Utilization management (prior authorization and quantity limits) for Superior may differ from VDP.*
- Preferred status and non-preferred status of a medication is determined by VDP.
  - To review which drugs are preferred vs non-preferred for each "market basket" (or therapeutic category), please visit the VDP Preferred Drug List: TXVendorDrug.com/formulary/prior-authorization/preferred-drugs
- Medicaid/CHIP formularies are National Drug Code (NDC) based, meaning not all NDCs may be covered by Medicaid.
  - A NDC is an 11-digit code that is specific to a medication. This code provides information related to the medication manufacturer, medication name, medication strength and package size. For example:
    - NDC Code: 00071-0155-23
      - 00071 is the manufacturer, Pfizer
      - 0155 is the product code, Lipitor 10mg
      - 23 is the package size, 90 count bottle
  - NDCs can only be added to the TX Medicaid VDP Formulary if the NDC is on the master CMS rebate file, once TX Medicaid VDP Formulary has received and approved the required Form 1326, Texas Drug Code Index Certification Of Information (COI) from the drug manufacturer.
  - If a pharmacy attempts to use a NDC not covered by the state for a medication covered or listed in the VDP formulary, it will reject as "product not covered." If this message is received, pharmacies will need to switch to a different NDC covered on the VDP formulary to get the claim to pay

Prior Authorization

Clinical Prior Authorizations for Pharmacy Benefit:

- Superior Pharmacy Benefit Medications can be picked up at your traditional retail/community pharmacies or delivered through mail order.
  - Examples: Abilify, Concerta, Humira
- Superior's clinical prior authorization requirements can differ from Fee-For-Service (FFS) to be less restrictive. **Providers should not use the VDP search to see clinical prior authorization requirements for Superior HealthPlan members.** Providers should visit our Superior Clinical Edits webpage for a full listing of clinical prior authorizations we require.
  - To review Superior's Clinical Edits webpage, please visit: SuperiorHealthPlan.com/ClinicalPriorAuth

- The VDP posts a clinical prior authorization chart that shows if Superior has implemented different approved clinical prior authorizations.
    - To review the VDP Clinical Prior Authorization Chart, please visit: www.TXVendorDrug.com/about/manuals/pharmacy-provider-procedure-manual/19-documents-and-forms/p-19-1-documents/p19-1-4
        - Key Abbreviations:
            - VDP = Fee for Service
            - SUP = Superior HealthPlan
            - Blank box = No prior authorization implemented
            - Half Diamond = MCO customized the prior authorization requirements (does not follow the state approved prior authorization criteria)
            - Full Diamond = MCO implements the state approved prior authorization criteria as is (no changes to criteria)

Clinician Administered Drugs (CAD)/Biopharmacy Prior Authorization Requests

- CAD/Biopharmacy are medications that are given in an outpatient setting in a doctor's office.
    - Examples: Botox, viscosupplements, Remicade, Rituxan
- CAD/Biopharmacy medications are typically billed under the medical benefit as a HCPCS (Healthcare Common Procedure Coding System) J Code
    - Example: J0585 = Botox
- CAD medication requests are submitted to Superior HealthPlan.
- To verify whether a medication is covered and if there are any prior authorization requirements, providers can utilize Superior's Online Prior Authorization Check Tool, found on: SuperiorHealthPlan.com/PriorAuth
- To find specific clinical prior authorization criteria for CAD medications, providers can utilize the clinical policies found on: SuperiorHealthPlan.com/Policies

Quantity Limits

To review Superior's Quantity Limits, please visit the Pharmacy Resources section, found on: SuperiorHealthPlan.com/Pharmacy

Additional Resources and Questions

For additional resources related to pharmacy, please visit: SuperiorHealthPlan.com/Pharmacy

For questions, please contact Centene Pharmacy Services at 1-866-768-7147.

5900 E. Ben White Blvd.
Austin, TX 78741

STAR, CHIP	1-877-391-5921
STAR+PLUS	1-877-391-5921
STAR Kids	1-877-391-5921
STAR Health	1-866-439-2042

SuperiorHealthPlan.com