superior healthplan™

Provider Training

STAR Health

Revised March 2016

Who is Superior HealthPlan?

- Is the only managed care organization to assist the State of Texas with the health benefits to Foster Care recipients since STAR Health's inception in 2008.
- Has served Texas Medicaid members since 1999.
- Currently, serves over 900,000 members in the Medicaid and CHIP Programs throughout Texas.
- An HMO licensed by the Texas Department of Insurance (TDI) in all 254 counties in the State of Texas.

In the Foster Care World

- Victims of Child Abuse and Neglect
- Scientific studies have documented the link between the abuse and neglect of children and a wide range of medical, emotional, psychological and behavioral disorders.
- Abused and neglected child victims may be linked to:

  - *Fetal Alcohol Syndrome*
  - *Intrauterine Assault*
  - *Shaken Baby Syndrome*
  - *Developmental Delays*
  - *Bonding and/or Attachment Disorders*
  - *Brain Trauma*
  - *Domestic Violence*
  - *Self/Sibling Abuse*
  - *Depression*
  - *Alcoholism*
  - *Drug abuse*
  - *Teen Pregnancy*
  - *Obesity*
  - *Crime*

Why STAR Health?

- Better serve needs of foster children by:
  - Providing greater access to health care services
  - Assisting in the coordination of health care services
  - Establishing a Medical Home (Primary Care Provider)
  - Providing emergency support and services

- Children in foster care have greater health care needs:
  - May be abused and neglected
  - May need more behavioral health services
  - May need more help in treatment with asthma, depression, etc.
  - Developmental delays may be present
  - Dental and Vision Services

STAR Health's Commitment

- Understand the foster care community
- Be sensitive to the needs of the foster care population
- Provide accessible and integrated care
- Provide an electronic Health Passport
- Deliver appropriate education to all stakeholders

STAR Health's Commitment

- Continuity of Care
  - Improve network adequacy and access to care
  - Pay claims timely
- Integration of All Health Services
  - Physical, Behavioral, Dental, Vision, and Pharmacy
  - Coordinate with Medical Home (Primary Care Provider)
- Service Coordination & Service Management
  - Coordinate communication among Medical Consenters, caregivers, members, providers, DFPS Staff, Guardians Ad Litem, Attorneys Ad Litem, Courts for the best interest of the child
  - Ensure coordination and sharing of health information between providers and other agencies/programs (Health Passport, ECI, WIC, Medical Transportation Program, etc.)

STAR Health Members

- Mostly children and young adults:
  - In foster care
  - In Kinship care
  - Who choose to remain in a paid foster care placement (through the month of their 22nd birthday)
  - Who aged out of foster care at age 18 (through the month of their 21st birthday)

The Patient Protection and Affordable Care Act

- Texas provides Medicaid benefits to adults under age 26 who were receiving Medicaid when they aged out of foster care at age 18 or older. This program is called the Former Foster Care Children Program (FFCC).
- To get benefits with the FFCC program, they must:
  - Have been in foster care on their 18th birthday
  - Be 18-25 years old
  - Have been getting Medicaid when they left foster care and
  - Be a U.S. citizen or legal immigrant

The Patient Protection and Affordable Care Act

- FFCC members will receive health care benefits in two separate programs based on their age:
- Members who are 18-20 years old will continue to get their benefits in the STAR Health program unless they want to change to a STAR plan.
- Members who 21-25 years old will get their Medicaid benefits through a STAR plan of their choice.

NOTE: There are no income, asset or educational requirements to qualify for the FFCC program.

STAR Health Basics

Overview

Traditional Medicaid vs. STAR Health

Traditional Medicaid

1. Enrollment – detailed application and approval process prior to enrollment in a Medicaid HMO (benefits available upon enrollment effective date)
2. Coverage may be interrupted if child moves
3. Difficulty with locating doctors and specialists
4. Accessing member's medical history can be difficult when child moves
5. When immediate health problems or concerns take place, it can be difficult to get quick answers on what to do

STAR Health

1. Enrollment – Health care services are available immediately after child is removed from the home
2. Provides statewide coverage
3. Member hotline available 365/24/7 to assist in locating doctors and specialists (Primary Care Provider (PCP) makes referrals to specialists)
4. Health Passport will provide electronic access to child's health record
5. 24-hour Nurse line (NurseWise®) available to assist when immediate questions need to be answered quickly

Overview

Traditional Medicaid vs. STAR Health

Traditional Medicaid

6. May need to see different providers for immunizations and checkups for Texas Health Steps
7. Some providers are not familiar with the special needs of children in Conservatorship
8. No coordination of treatment for children with serious medical or mental health issues
9. Caregivers have to call multiple places to access the services that they need (i.e. schedule appointments, locate a provider, confirm eligibility on a child)

STAR Health

6. Can go to any Texas Health Steps provider in the Superior Network for check ups and immunizations (to include lead screening)
7. Continuous training will be given to all STAR Health providers in order to address the unique needs of children and young adults in foster care
8. A Service Management team is available for all children with serious medical and/or mental health issues. Service Coordinators are also assigned to children with complex needs.
9. Caregivers can contact STAR Health to access any service they need (continuity of care)

Eligibility

- Texas Medicaid Benefit Card
- DFPS 2085B Form
- Superior HealthPlan Identification Card
- Superior HealthPlan Website: SuperiorHealthPlan.com
- Contact Member Services: 1-866-912-6283

STAR Health ID Card

The Member ID Card contains the following information:

Member ID #
Member Name
Primary Care Provider
Name
Phone
Effective Date
Additional Pharmacy Information
Program and Superior's logo

- Disclaimer: Documentation in Health Passport is required* when caring for STAR Health members.
- Please go to: SuperiorHealthPlan.com or Cenpatico.com for more information.
- Copies of the STAR Health ID Card can be found in the Superior Provider Manual.

*May not apply to members over the age of 18

Health Care Providers

Primary Care Provider (PCP) or Medical Home Availability:

- Available 24 hours a day, 7 days a week
- Appointment availability standards:
  - **Routine Exam:** Within two (2) weeks of request
  - **Urgent Care:** Within the same day of request
  - **Emergency Care:** Immediate (NO prior authorization, nor medical consenter approval is required for this type of care).
  - **Referrals to Specialist :** Seen within four (4) weeks of request

Health Care Providers

Primary Care Provider (PCP) or Medical Home Availability:

- Arrange coverage with another Superior provider if not available.
- Office phone must be answered during normal business hours.
- Contact Provider Relations if requirement cannot be fulfilled.
- After-hours calls should be documented in an after-hour call log and transferred to the patient's medical record.

Health Care Providers

PCP or Medical Home After-hours Availability:

- Acceptable
  - Phone answered by an answering service must be returned within 30 minutes by the PCP or other designated provider.
  - Phone answered by an answering machine that directs patients to call another number where someone must be available to answer the designated number.
  - Phone transferred to another location where someone will answer the phone and contact the PCP or on-call provider, who can return call within 30 minutes.
- Unacceptable
  - Phone only answered during office hours or directs patients to leave a message.
  - Phone message directs patients to the ER.
  - Answering machine or answering service is not bilingual (English and Spanish).
  - Returning after-hours calls outside of 30 minutes.

Health Care Providers

PCP or Medical Home Compliance – Early Childhood Intervention (ECI)

- Assist in ensuring mandated timelines for ECI are adhered to.
- Early Childhood Intervention [DARS Inquiries]: 1-800-628-5115
  - All health care professionals are required under Federal & State regulations to refer children (under age 3) to ECI within two business days of identification of a disability or suspected developmental delay.
  - Works with child, family, medical consenter and provider to develop an Individual Family Service Plan (IFSP) which can include physical, occupational, and speech therapies.
  - Medical consenters may self-refer to a local ECI provider without a referral from the PCP.

Health Care Providers

PCP or Medical Home Expectations

- Communicate member needs with Service Management:
  - Physical,
  - Behavioral,
  - Vision,
  - Dental,
  - Specialty and/or Diagnostic Assessments, and
  - Other organizations (WIC, Medical Transportation Program, DME, etc.)
- Provide referrals and secure authorizations.
- Deliver patient education - healthy lifestyles and wellness
- Ensure emergency care follow-up

Health Care Providers

PCP or Medical Home Expectations

- Assure heightened attentiveness to potential abuse or neglect and reporting requirements
- Use and support the update of Health Passport information for continuity of care
- Use of valid screening and assessment instruments to identify members with Mental Health (Texas Health Steps Behavioral Health Forms)
- Identify members suffering trauma to the brain and referring to appropriate specialty provider

Health Care Providers

Specialty Care Provider Expectations

- Maintain contact with Primary Care Provider (PCP) by:
  - Supporting the Medical Home and Integrated Primary Care
  - Sharing information
  - Adopting and interacting with the Member's Health Passport

- Appointments within 30 days of request

STAR Health is not responsible for payment of any unauthorized, non-emergency services provided by Out-Of-Network Providers

Health Care Providers

Electronic Visit Verification

- Personal Care Service (PCS), Personal Attendant Service (PAS) and CFC (attendant care and habilitation) providers must electronically verify visit.
- Electronic Visit Verification (EVV) is a telephone and computer-based system that electronically verifies service visits.
- Providers are responsible for choosing a vendor and for ensuring that their vendor submits accurate data to Superior.

Health Care Providers

Electronic Visit Verification

- PAS, PCS, and CFC providers (attendant and HAB) will verify service times using EVV process.
- EVV vendor will send verification data to Superior.
- Superior will compare provider claims to verification data prior to adjudication.
- Only verified units of service will be paid.
- Superior offers training on EVV. Check the Provider Calendar at SuperiorHealthPlan.com.

Health Care Providers

Behavioral Health Care Provider Expectations

- Comply with the *Psychotropic Medication Utilization Parameters for Foster Children*
  - www.dfps.state.tx.us/documents/about/pdf/TxFostercareParameters-September2013.pdf
- Expand the use of Evidence-Based practices
  - Trauma focused cognitive behavioral therapy
  - Cognitive behavioral therapy for sexually abused children
- Provide services to targeted populations
  - Abandonment issues
  - ADHD
- Provide documentation required for judicial review
  - Initial assessments and monthly reviews

Health Care Providers

All STAR Health Provider Requirements

Comply with:

- **Court orders**
  - Render court ordered health care services for the child
  - Provide documentation (reports/reviews) as requested
  - Testify in court
- **Superior's Policy and Procedures** as provided in Superior's Provider Manual
- **Maintenance and provision of Medical Records**
  - Must be HIPAA compliant
  - Release medical records to DFPS and/or Medical Consenters
- **Providing Accurate Contact Information**
  - Keeping information up to date to ensure provider directories and online provider lookup is accurate

Serving Superior's Members

Cultural Sensitivity
Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with patients and the health and wellness of the patients themselves.

Cultural Competency Contractual Requirements
It is important to:

- Treat all STAR Health members with dignity and respect
- Respect the importance of different cultures
- Respect the importance of spiritual beliefs

NurseWise® Call Center

- 1-866-912-6283
- Available 24/7/365
- Staff is bilingual in English and Spanish
- All Texas licensed RNs

Value Added Services

- Care Grants
- Gift Card Program
- Drug Store/Over the Counter Benefit
- Extra Vision Services
- Sports Physicals
- Boys and Girls Club Membership

See Member Handbook for any changes or updates

Medical Transportation Program

- HHSC's Medical Transportation Program (MTP) serves STAR Health members that have no other means of transportation for non-emergent medical, behavioral, dental or vision appointments.
- Request MTP by calling: **1-877-633-8747***
  - Available Monday- Friday from 8:00 am to 5:00 pm.
  - Requires **two working days advance notice** for most requests, but will attempt to accommodate urgent requests. For appointments a long way out of town, requests should be made a minimum of five days prior.
  - Call in request as far in advance as possible.

*Houston/Beaumont area call: 1-855-687-4786.
*Dallas area call: 1-855-687-3255.

Medical Transportation Program

- **Mileage Reimbursement – MTP** may also reimburse mileage for the client, a parent, friend, or someone else to take the client to health care services, if the trip is scheduled in advance and the driver abides by the MTP guidelines.

- **Coordination** – Call **Superior's Member Services Department** for assistance with transportation, if necessary. Foster Care Member Services can be reached at 1-866-912-6283.

- **Bus Tokens** - Superior provides **bus tokens** for medical and non-medical visits such as health education classes. Contact Superior's Member Service Department for assistance.

Texas Health Steps Requirements

What is a Texas Health Steps Medical Checkup?

Texas Health Steps is a comprehensive preventative care program for all Medicaid-eligible children birth through age 20.

Texas Health Steps Medical Checkups are to be performed by a licensed health practitioner who is enrolled in Texas Medicaid as a Texas Health Steps provider. These initial screenings should also include, at a minimum:

Family History	Labratory tests
Physical examinations	Vision and Hearing Screenings
Dental assessment, checkup and treatments	Developmental and Nutritional assessments
Measurements (height, weight and infant head circumference)	Lead Screenings
Mental Health assessment	Immunizations
Tuberculosis Test (often called TB)	ADHD assessments
***Reminder*: Not all STAR Health Primary Care Providers are Texas Health Steps providers**	

Texas Health Steps Medical Checkups

Must be completed within 30 days:

- When a child initially enters DFPS Conservatorship
- Does not apply to each time the child changes placement

Texas Health Steps Medical Checkups must be completed by a STAR Health Texas Health Steps provider and documented in the Health Passport.

Texas Health Steps Laboratory Services must be submitted to the DSHS Laboratory Services Section.

NOTE: There might be other licensing requirements for different placements.

Ongoing Texas Health Steps Medical Checkups

- Children under the age of 3 require more frequent Texas Health Steps Medical Checkups.

3 – 5 days	6 months	18 months
2 weeks	9 months	24 months
2 months	12 months	30 months
4 months	15 months	

- Children age 3 through age 20 years old must have medical checkups scheduled one year after the previous checkup, and no later than the child's next birthday.
- Immunizations must be conducted according to the ACIP routine immunization schedule.

Texas Health Steps Dental Checkups

- Dental services include:
  - Routine dental checkup.
  - Cleaning of teeth.
  - Emergency dental care.
  - Fluoride treatments to prevent cavities.
  - Fixing cavities.
  - Braces (except for cosmetic reasons).
  - X-rays as needed.
  - Other services as needed.

- No referral is needed from a child's provider for regular dental checkups or other dental services.

- Please contact DentaQuest for assistance: 1-888-308-4766.

Texas Health Steps Medical Checkups

Children may need more frequent Medical checkups when:

- The physician determines the checkup is “medically necessary.”
- There is a high risk of the child getting sick (e.g., if another child in the home has a high level of lead in the blood).
- A child enters Head Start, day care, foster care, or pre-adoption.
- The child needs anesthesia for required dental services.

Blood Lead Level Reporting

Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics, and other healthcare facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms visit: https://www.dshs.state.tx.us/lead/child.shtm

Missed Appointments

- Complete a Missed Appointment Form and fax it to MAXIMUS for member follow-up
- Missed Appointment Form is available at: www.dshs.state.tx.us/thsteps/POR.shtm
- More information is available through your local regional Texas Health Steps Provider Relations Representative: http://www.dshs.state.tx.us/thsteps/regions.shtm

Texas Health Steps Dental Checkups

Initial Texas Health Steps Dental Checkups

- Children age 6 months and over need to have a dental checkup within 60 days of entry into DFPS conservatorship.

- For children already in foster care, set up the dental checkup within 30 days of the child turning 6 months of age.

Texas Health Steps Dental Checkups

Ongoing Texas Health Steps Dental Checkups

- Dental checkups for children ages 3 through 20 years are due every 6 months.

- Children age 6 months through 35 months of age who are likely to develop early childhood tooth decay should have dental checkups as often as every 3 months. The child's dentist will let you know the frequency.

Pharmacy Benefits

US Script: Pharmacy Benefit Manager (PBM)

US Script, Inc. will:

- Provide Pharmacy services to Superior members.
- Be responsible for payment of pharmacy claims.
- Follow the Texas Vendor Drug Program (VDP) which creates a standard:
  - Drug Formulary/Preferred Drug List
  - Specialty Pharmacy List
  - Clinical and Utilization Management Edits
- Implement these on behalf of Superior HealthPlan for our STAR Health members.

Superior will maintain:

- Oversight of US Script to ensure proper claim payment, formulary and edits are being applied accurately
- Performs Prior Authorization of injectable meds with J Code, some specialty and chemotherapy agents
- Provide Pharmacy Management to the Plan
- Interact with pharmacies, physicians, and plans, facilitates questions, concerns, requests such as fax forms.
- Assists with claims for placement changes for Foster Care members
- Assists with any abductions by checking recent pharmacy transactions and reporting as appropriate

72-hour ER Pharmacy Supply

- State and Federal law require that a pharmacy dispense a 72-hour (3 days) supply of medication to any member awaiting a prior authorization (PA) or medical necessity (MN) determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy for medications not included in the PDL.
- If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy will dispense an emergency 72-hour prescription.
- All US Script participating pharmacies are authorized to provide the smallest amount of medication for a 72-hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee whether or not the PA or MN request is ultimately approved or denied.

US Script: Contact Information

Out-Patient Rx (PBM: US Script)

- Resolution Help Desk: 800-460-8988 (Most often used by pharmacies)
- Prior Authorization Requests Phone: 866-399-0928
- Prior Authorization Requests Fax: 866-399-0929
- Prior Authorization Requests E-form: To Be Determined

In-Clinic Rx administration (Superior PA Dep't)

- Prior Authorization Requests Phone: 800-218-7453 ext. 22272
- Prior Authorization Requests Fax: 866-683-5631

Appeal (Superior Appeal Dep't)

- Appeals Requests Phone: 800-218-7453 ext. .22168
- Appeals Requests Fax: 866-918-2266

US Script: Contact Information

- Pharmacy Complaints:
  - STAR Health Complaint Hotline: 1-866-912-6283

- E-forms:
  - SuperiorHealthPlan.com/for-providers/provider-resources/forms/

Compliance

Quality Improvement

Working with our Provider Community

- Manage and review annual HEDIS rates to identify interventions to improve HEDIS scores
- Maintain compliance with quality related areas of HHSC regulations
- Generates, distributes and analyzes provider profiles
- Performs medical record audits in relation to complaints
- Conducts provider satisfaction surveys annually
- Review, investigates and analyzes quality of care concerns (member complaints)

Quality Improvement

Quality Assessment and Performance Improvement (QAPI)

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

HIPAA / Fraud, Abuse and Waste

Health Insurance Portability Accountability Act (HIPAA) of 1996

- Providers and Contractors are required to comply with HIPAA guidelines http://www.hhs.gov/ocr/privacy.

Fraud, Abuse and Waste (Claims/Eligibility)

- Providers and Contractors are all required to comply with State and Federal provisions that are set forth.
- To report Fraud, Waste and Abuse, call the numbers listed below:
  - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
  - Texas Attorney General Medicaid Fraud Control Hotline: 1-888-662-4328
  - Superior HealthPlan Fraud Hotline: 1-866-685-8664

Abuse or Neglect

What if you suspect abuse or neglect of a child?

Call
1-800-252-5400
or
9-1-1
Available 24 / 7 / 365

Service Management

Delivery Model

- Sole Functions of the Service Management program are to coordinate and integrate the physical and behavioral health to meet the needs of children in STAR Health
- Integrated Physical & Behavioral Health service teams located in seven (7) regions across the state (El Paso, Dallas, Lubbock, Austin, Houston, San Antonio, Corpus Christi)
- Service Managers and Coordinators (physical and behavioral) make up the core infrastructure with specialized teams
- Senior Management staff include: CEO/President of Complex Care Program, VP of Medical Management, and other key management staff located throughout the state
- Additional internal resources are comprised of: Connections Representatives, STAR Health Liaisons, Member Advocates, Inpatient Service Management Nurses, Prior Authorization and Referral Staff

Clinical and Non-Clinical Support

- 24/7/365 accessibility to STAR Health staff via the STAR Health Member Services hotline at 1-866-912-6283
- Identification of member's needs
- Referrals/pre-authorizations/certifications
- Communicate with doctor and other providers to develop a "Health Care Service Plan" to address the unique needs of the client
- Coordinate services with other entities to ensure integration of care (ECI, WIC, DME, Medical Transportation Program, etc.)

Direct Support

- Members With Special Health Care Needs
  - Follow-up and document reported results
  - Complex case management
  - Specialty program
  - Intellectual developmental disabilities management
  - Asthma disease management
- Monitor adherence to treatment plan to promote permanency
  - Follow-up and document reported results
- Promote best practice/evidence-based services
  - Includes compliance with Psychometric Medications on utilization standards
- Identify and report potential abuse/neglect

Disease Management Programs

- Part of a person-based approach to disease management
- Holistically address the needs of members that relate to chronic conditions that are prevalent in members.
- Participation criteria apply to members with primary diagnosis applicable to the disease management programs.
- Members have the choice to participate with the programs activities or opt out of the program.

Asthma Disease Management

STAR Health's Asthma Management program is an interaction designed program to identify and treat asthma patients in the following steps:

- Initial tele-assessment
- Education for low-risk members
- Telephone initial visit and self-management tools for medium risk members
- Home interaction for high risk members
- Coordination of referral service

Intellectual Developmental Disabilities (IDD)

This program seeks to identify and support those with a diagnosis of Intellectual Disability, Autism, Asperger Syndrome, or Pervasive Developmental Disorder through the following:

- Assessment of need related to the IDD diagnosis
- Coordination of services and supports with providers who are knowledgeable about developmental disabilities
- Referrals to appropriate waiver programs
- Communication and coordination with the DFPS Developmental Disability Specialists
- Education of caregivers about the diagnosis and appropriate treatment interventions

Community First Choice

Community First Choice (CFC) is part of Senate Bill 7 from the 2013 Texas Legislature requiring HHSC to put in place a cost-effective option for attendant and habilitation services for people with disabilities.

CFC Services are available for STAR Health members who:

- Need help with activities of daily living (dressing, bathing, eating, etc.)
- Need an institutional level of care (Intermediate Care Facility for Individuals with an Intellectual Disability or Related conditions (ICF/IID) or Institution for Mental Disease (IMD).
- Currently receive personal care services (PCS).
- Are individuals on the waiver interest list or are already getting services through a 1915 (c) waiver.

Community First Choice

- CFC will include PCS, Habilitation, Emergency Response Services, and Support Management.
- CFC assessments will be conducted by Superior HealthPlan.
- If the PCP determines that a member should receive a CFC service or needs an authorization, PCPs should call Service Coordination at 1-800-218-7508 and request an assessment.
- CFC services should be billed directly to Superior via paper, through the Secure Web Portal or your clearinghouse.
- Use appropriate procedure codes and modifiers as outlined in the billing matrix found in the Uniformed Manage Care Manual.

Coordination with Service Organizations

- Early Childhood Intervention (ECI)
- Texas School Health and Related Services (SHARS)
- DSHS Mental Health Targeted Case Management
- DSHS Case Management for Children and Pregnant Women
- DFPS Targeted Case Management
- Local Mental Health Authorities (LMHA)
- Women, Infants and Children Program (WIC)
- Medical Transportation Program (MTP)

Communication and Confidentiality

STAR Health will ensure coordination and sharing of any health information between Caregivers, Medical Consenters, DFPS workers, Courts and all providers (as appropriate) to guarantee that all foster children's healthcare needs are met.

STAR Health, by law, will keep all health records and medical information private. Discussions with the doctors or other healthcare providers are also kept private. STAR Health will always make sure that any sharing of medical information will meet all State and Federal confidentiality laws.

Advance Directives

Federal and state law require MCOs and providers to maintain written policies and procedures for informing all members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through Advance Directives.

STAR Health does not require a member to have an advance directive as a condition for receiving health care nor does STAR Health discriminate against a member based on whether or not the member has or does not have Advanced Directive.

Medical Management

Pre-Appeals Process

In order to minimize service denials, STAR Health is committed to the unique nature of foster children.

STAR Health will contact the provider, caregiver, medical consenter, and/or DFPS to request any additional, related information to help the approval of the service or with the development of other care options to meet the member's needs

- STAR Health will make a decision on a service authorization within **3 days.**
- This process can be extended up to 14 days if more information is needed

Alberto N Process

When the Superior receives a request for prior authorization for a member under age 21, and the request does not contain the complete documentation and/or information:

- Superior will return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, and when possible, Superior will contact the Medicaid provider by telephone and obtain the information necessary to complete the prior authorization process.

- If the documentation/information is not provided with ***sixteen (16) business hours of Superior's request*** to the Medicaid provider, Superior will send a letter to the member or medical consenter for STAR Health explaining that the request cannot be acted upon until the documentation/information is provided.

- If the documentation/information is not provided to Superior within seven calendar days (7) of its letter to the member, the PCN will issue an administrative denial. The provider may resubmit for a new review with a complete request including the missing information.

How to Obtain a Referral/Authorization

- Use the Prior Authorization (PA) Request Form found on our website and submit via fax to 1-800-690-7030
- Call in your request to 1-800-218-7508
- Log on to the Superior's Web Portal
- Receive a Reference Number for Inpatient Hospitalization or Outpatient authorizations
- For up-to-date PA List, visit: SuperiorHealthPlan.com/for-providers/provider-resources/

Referrals/Authorizations Tips

- Primary Care Provider must initiate the referral
- Specialist may NOT refer to another Specialist, unless the Specialist chooses to act as the member's PCP
- ***Remember:*** The following information must be provided to the referral specialist at least 5 working days in advance for non-emergent services:
  - Demographics
  - Provider Information (NPI, Tax ID, fax number, and contact number)
  - Requested services, HCPCS and CPT codes (if applicable), and dates of service, using the referral authorization form located on the web site
  - Clinical information needed to process request

MRI/MRA, CT/CTA, CCTA, Stress Echo, Nuclear and PET SCANS

- An authorization will be required for all services noted above
- Magellan Health Providers of Texas/National Imaging Associates (NIA) has been selected to administer the program
- The Primary Care Provider will be responsible for obtaining authorization for the procedures
- All other radiology procedures will not require authorization
- Inpatient and ER procedures will not require authorization
- All claims should be submitted to Superior through the usual processes:
  - Website: SuperiorHealthPlan.com
  - Electronic submission
  - Paper claim submission

MRI/MRA, CT/CTA, CCTA, Stress Echo, Nuclear and PET SCANS (continued)

Servicing providers may request authorization by:

- Accessing www.radmd.com
- Utilizing the toll free number: **1-800-648-7554**

Servicing providers and imaging facilities may access status of authorizations by:

- Accessing www.radmd.com
- Accessing Integrated Voice Response (IVR) through a toll free number 800-642-7554. To check on the status of an authorization press 1, 1, then enter or speak the tracking number

Immunotherapy Services Administered by Non-Allergists

Superior has removed the prior authorization requirement for non-allergists who wish to only administer allergy shots prescribed by a credentialed allergy services provider.

Providers do not need prior authorization, but **must submit 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.

Non-allergists, such as PCPs, may apply for credentialing to perform allergy skin testing and to prescribe immunotherapy.

Codes 95115 or 95117 should be used when administering these services. Please note all applicable Medicaid billing guidelines apply.

Claims – Filing and Payment

Provider Services

The Provider Services staff can help you with:

- Questions on claim status and payments
- Assisting with claims appeals and corrections
- Finding Superior Network providers

For claims related questions, be sure to have your claim number, TIN, and other pertinent information available as HIPAA validation will occur.

- You can contact them Monday through Friday, 8:00 a.m. to 5:00 p.m. local time.

1-866-439-2042

Claims Filing

- Claims must be filed within 95 days from the Date of Service (DOS).
- Providers should include a copy of the Explanation of Payment (EOP) when other insurance is involved.
- Claims must be completed in accordance with TMHP billing guidelines.
- Filed on a red CMS 1500 or UB04.
- Filed electronically through clearinghouse.
- Filed directly through web portal.
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) NPI are all required when billing Superior claims.
- Initial Claims: web portal, clearinghouse, or by mail:

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

Claim Adjustments, Disputes & Reconsiderations

- If a provider wants to adjust/correct a claim or submit a claim appeal, these must be received within 120 days from the date of notification or denial.
  - Adjusted or Corrected Claim: The Provider is changing the original claim. Correction to a prior- finalized claim that was in need of correction as a result of a denied or paid claim.
  - Claim Appeals: Often require additional information from the Provider.
    - Request for Reconsideration: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - Claim Dispute: Provider disagrees with the outcome of the Request for Reconsideration.
- Both can be submitted via the web portal or through a paper claim. Paper claims require a Superior Corrected Claim or Claim Appeal form. Find them under Resources at www.superiorhealthplan.com.

Claims Filing: Submitting Claims

Web Portal: Provider.SuperiorHealthPlan.com/sso/login

Initial, Adjusted* and Corrected* Claims by paper:

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

Reconsiderations/Appeals* and Disputes* by paper:

- Superior HealthPlan, P.O. Box 3000, Farmington, MO 63640-3800

Electronic Claims: Visit the web for a list of our Trading Partners:
SuperiorHealthPlan.com/for-providers/electronic-transactions/
Superior Emdeon ID 68069

*Must reference the original claim number.

Claims Filing: Deadlines

First Time Claim Submission

- 95 days from date of service.

Adjusted or Corrected Claims

- 120 calendar days from last timely processed claim.

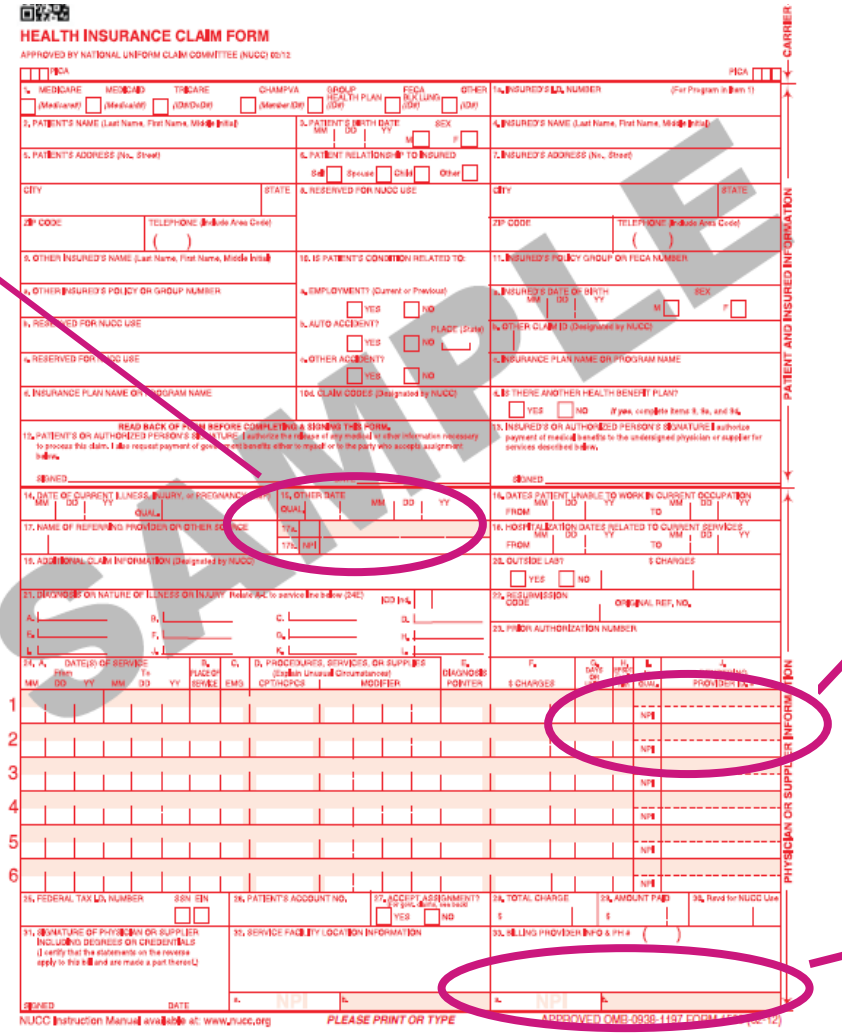
Claim Reconsiderations and Disputes

- 120 calendar days from last timely processed claim.

CMS 1500 Requirements

If Populated:

17a NPI # and
Taxonomy #



NPI # and Taxonomy # in box 24J is required when billing Superior claims

Billing NPI# in box 33a and Taxonomy # in 33b

Common Billing Errors

- Member date of birth or name not matching ID card/member record
- Code combinations not appropriate for demographic of patient
- Not filed timely
- No itemized bill provided when required
- Diagnosis code not to the highest degree of specificity; 4th or 5th digit when appropriate
- Illegible paper claim

PaySpan Health

Superior has partnered with PaySpan Health to offer expanded claim payment services to include:

- Electronic Claim Payments (EFT)
- Online remittance advices (ERAs/EOPs)
- HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System

Register at: www.PaySpanHealth.com

For further information contact 1-877-331-7154, or email Providersupport@PAYSPANHEALTH.COM

Member Balance Billing

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

Superior HealthPlan Departments – We're here to help you!

Complaints

Superior requires complaints be submitted in writing

- The website contains a complaint form that can be completed and submitted online or printed, completed and faxed or mailed to Superior for resolution response.
  - **Address:**
    Superior HealthPlan
    ATTN: Complaint Department
    2100 South IH-35, Suite 200
    Austin, Texas 78704
  - **Fax number:** 1-866-683-5369
  - **Website:** SuperiorHealthPlan.com “Contact Us”

Provider Network

Contracting and Implementation

The Network Development & Contracting Department is a centralized team that handles all contracting for new and existing providers to include:

- New provider contracts
- Adding providers to existing Superior contracts
- Adding additional products (i.e. CHIP, STAR, STAR+PLUS) to existing Superior contracts
- Amendments to existing contracts

Contract Packets can be requested

- SuperiorHealthPlan.com/providers/become-a-provider/
- 1-877-391-5923 x 22534

Provider Re-Credentialing

- Completed every three (3) years from date of initial credentialing
- Applications and notices mailed 180, 150, and 120 days out from due date
- Lack of timely submission can result in members being reassigned and system termination

Helpful Web Sites

fostercaretx.com

SuperiorHealthPlan.com

Cenpatico.com

Superior's Web Site

Submit:

- Claims
- Online Authorization Requests
- Request for EOPs
- Provider Complaints
- Notification of Pregnancy (NOP)
- Submit COB Claims
- Submit Adjusted Claims

Verify:

- Eligibility
- Claim Status

View:

- Provider Directory
- Provider Manual
- Provider Training Schedule
- Links for additional Provider Resources
- Claim Editing Software

Web Portal Enhancements

- Manage all product lines and multiple TINs from one account
  - *Office Manager Accounts available*
- Primary Care Physicians Panel- Texas Health Steps Last Exam Date:
  - *View the date of the member's last Texas Health Steps Exam on file*
- Eligibility section for providers
- Auth Detail & History
  - *New Display Features: Authorization denial reason*
- Submit batched or individual claims
- Download EOP’s
- Secure Messaging

Web Portal Enhancements

Alerts section indicates whether a member has a potential gap in care.

Examples of Care Gap Alert Categories and descriptions

Adult Preventive
No mammogram in most recent 12 month
No Chlamydia test in past 12 months in patient 16-25 years.
No PAP in past 12 months

Diabetes
DM - Not seen in past 6 months
DM - No retinal eye exam in past 12 months
DM - No HbA1C screening in past 12 months

Cardiac
CAD - Not seen in past 12 months
HTN - Not seen in past 12 months

Flu Vaccine
No flu vaccine in past 12 months.

Child Preventive
Immunizations not current for age

Requesting Assistance

STAR Health	1-866-439-2042
Cenpatico (Behavioral Health)	1-866-218-8263
DentaQuest (Dental Services)	1-888-308-9345
TVHP (Vision Services)	1-866-642-9488

Questions and Answers

Provider Training

Health Passport Clinical Training Guide

Health Passport

- The Health Passport is a secure web-based application built using core clinical and claims information to deliver relevant healthcare information when and where it is needed.

- Using the Health Passport, you can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination
  - Eliminate waste
  - Reduce errors

Health Passport: Modules

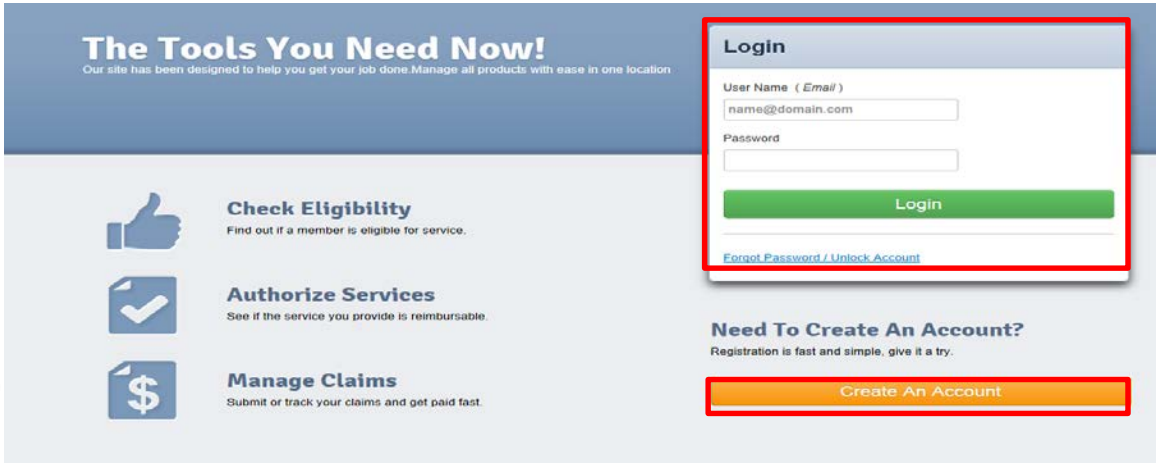
- **Face Sheet**—An easy-to-read summary that includes member demographics, care gaps, Texas Health Steps and Dental last visit dates, active allergies, active medications and more.
- **Contacts**—Easily find a foster child's PCP, Medical Consenter, Caregiver, Caseworker, and Service Coordinator contact information in one place.
- **Allergies**—Providers can use interactive fields to add or modify allergies at the point-of-care. Once an allergy is charted, it's instantly checked for medication interactions.
- **Assessments**—Providers can document Texas Health Steps, Dental and Behavioral Health forms directly online. Mailing or faxing in documents critical to patient care for display is still available.
- **Growth Chart**—Providers can chart weight, height, length and head circumference at the point of care to track growth of infants and children.

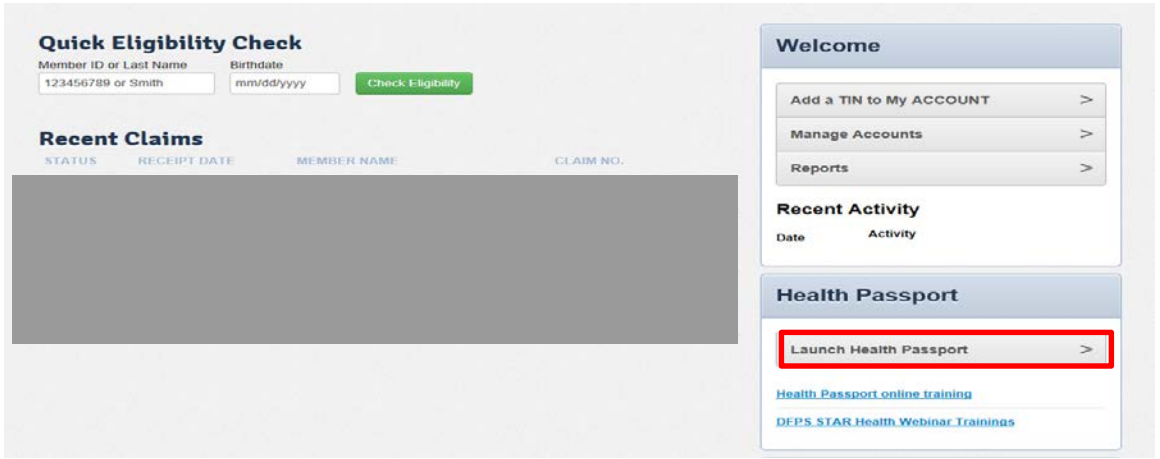
Health Passport: Modules

- **Immunizations**—A comprehensive list of a person's immunizations collected from ImmTrac.
- **Labs**—All lab results are made available, where providers typically only have access to the lab results they've requested.
- **Medication History**—A summary of medications filled and access to more detail, including name of the prescription, the prescribing clinician, date filled, and dosage. Indicators representing drug-drug, drug-allergy, and drug-food interactions appear when applicable as soon as new medications or allergies are added to the member record.
- **Patient History**—Past visits with details that include the description of service, treating provider, diagnosis and the service date.

Provider Access Setup

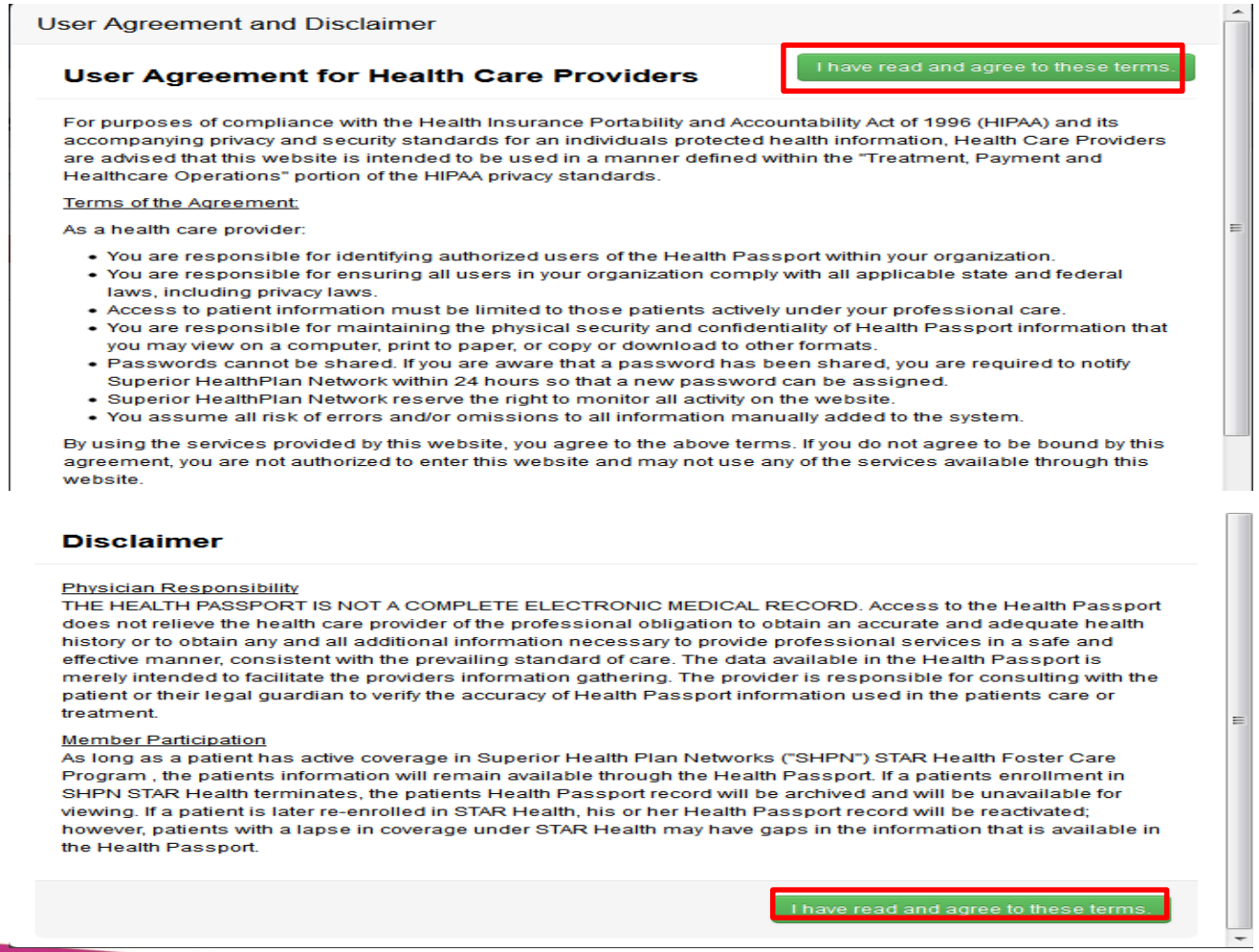
Step 1: Go to the Superior website to login for providers.
Step 2: To **Login**, enter the **Username** (Email) and **Password** you created during registration. If you need to create an account, click the **Create an Account** button to register.
Step 3: To access Health Passport, click the **Launch Health Passport** button from your account homepage





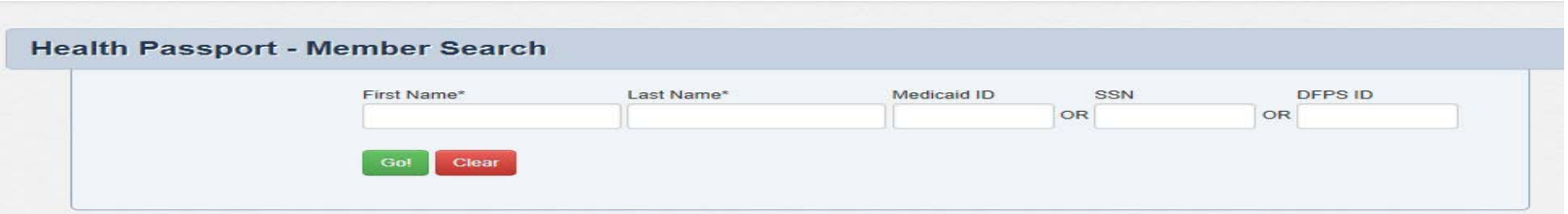
Disclaimer

The User Agreement and Disclaimer will appear. Once you have read the agreement, click **I have read and agree to these terms** to continue.



Member Search

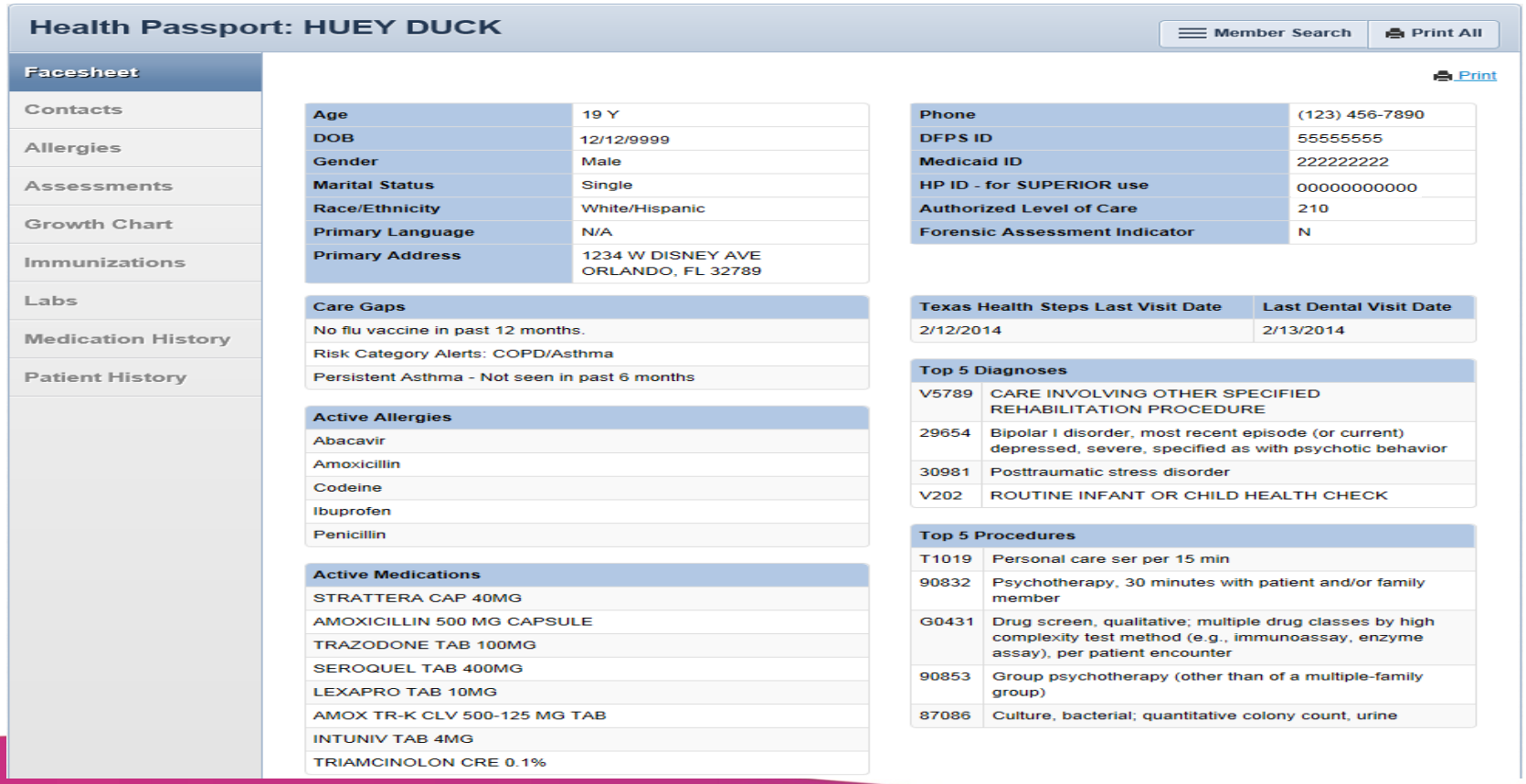
To search a member, enter the first few letters of the first and last name and one of the three ID numbers (Medicaid ID, SSN, or DFPS ID) and click **Go**.



The search results will display the full name of the member and other demographic information.
Click the member name to access the member's health record.

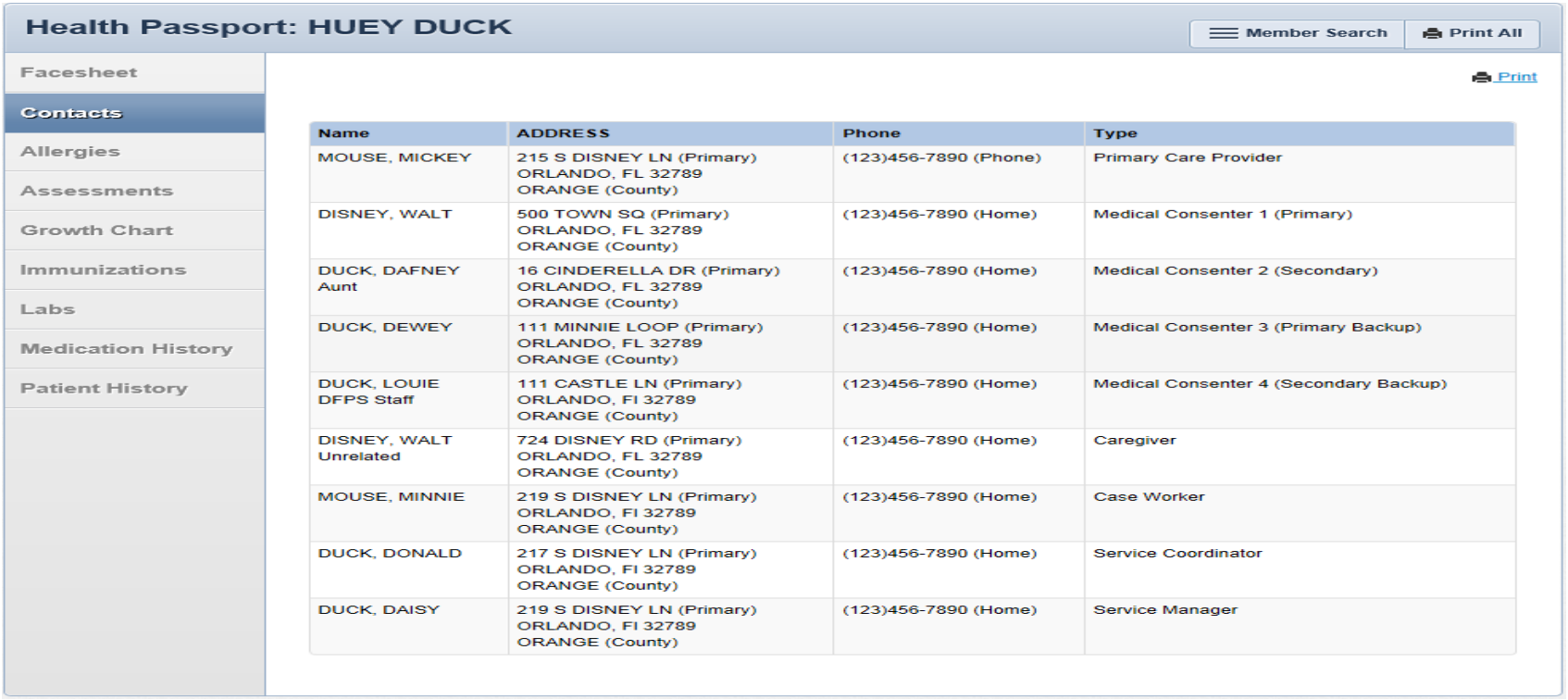
Face Sheet

This module provides a quick overview of the member's health record including common diagnoses and procedures, active medications, active allergies, care gaps, and member demographics.



Contacts

This module displays a member's medical and personal contacts.



Name	ADDRESS	Phone	Type
MOUSE, MICKEY	215 S DISNEY LN (Primary) ORLANDO, FL 32789 ORANGE (County)	(123)456-7890 (Phone)	Primary Care Provider
DISNEY, WALT	500 TOWN SQ (Primary) ORLANDO, FL 32789 ORANGE (County)	(123)456-7890 (Home)	Medical Consenter 1 (Primary)
DUCK, DAFNEY Aunt	16 CINDERELLA DR (Primary) ORLANDO, FL 32789 ORANGE (County)	(123)456-7890 (Home)	Medical Consenter 2 (Secondary)
DUCK, DEWEY	111 MINNIE LOOP (Primary) ORLANDO, FL 32789 ORANGE (County)	(123)456-7890 (Home)	Medical Consenter 3 (Primary Backup)
DUCK, LOUIE DFPS Staff	111 CASTLE LN (Primary) ORLANDO, FI 32789 ORANGE (County)	(123)456-7890 (Home)	Medical Consenter 4 (Secondary Backup)
DISNEY, WALT Unrelated	724 DISNEY RD (Primary) ORLANDO, FL 32789 ORANGE (County)	(123)456-7890 (Home)	Caregiver
MOUSE, MINNIE	219 S DISNEY LN (Primary) ORLANDO, FI 32789 ORANGE (County)	(123)456-7890 (Home)	Case Worker
DUCK, DONALD	217 S DISNEY LN (Primary) ORLANDO, FI 32789 ORANGE (County)	(123)456-7890 (Home)	Service Coordinator
DUCK, DAISY	219 S DISNEY LN (Primary) ORLANDO, FI 32789 ORANGE (County)	(123)456-7890 (Home)	Service Manager

NOTE: Caregivers are not necessarily considered Medical Consenters.

Allergies

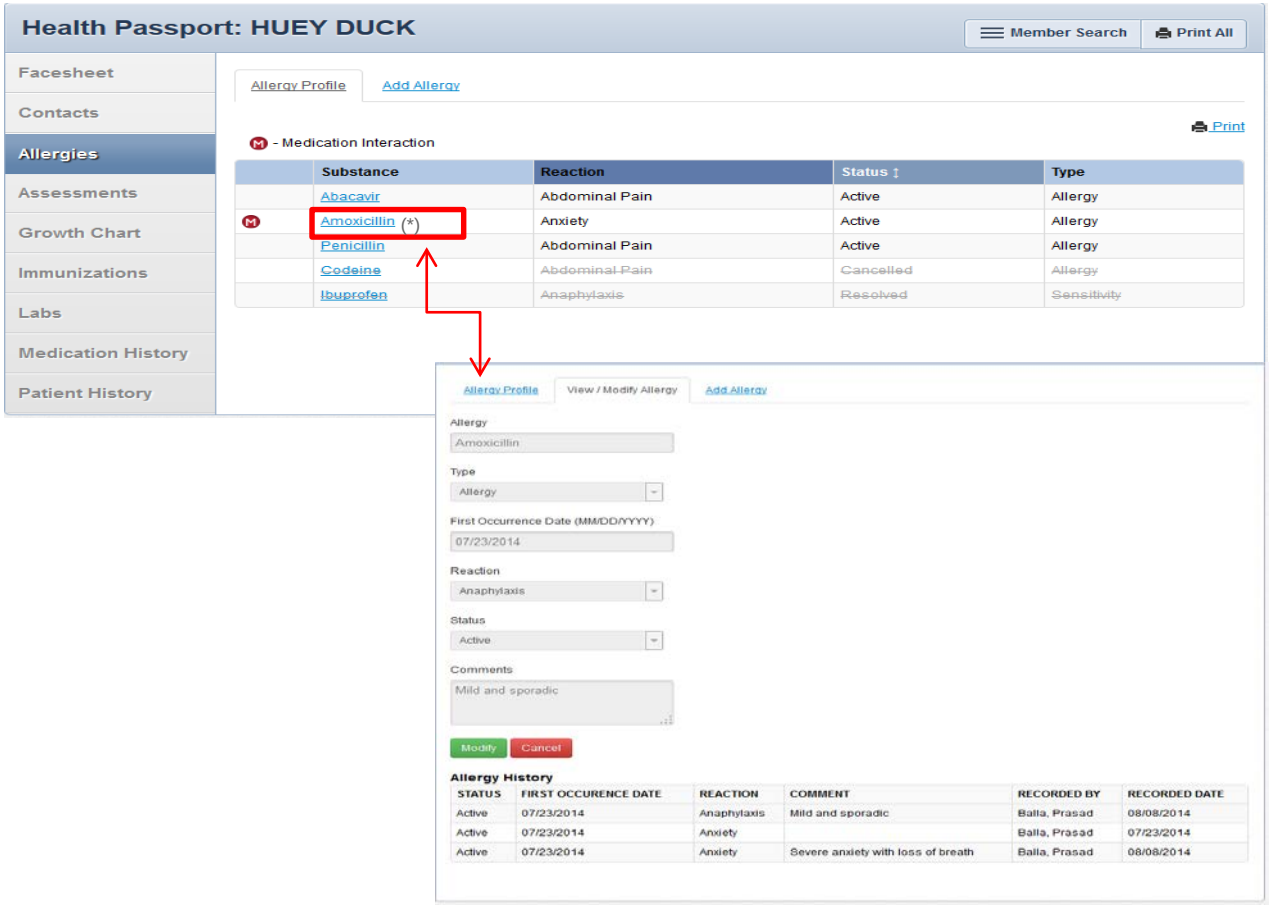
This module contains all allergies for a member entered by providers. Click the allergy name to view the allergy history.

Ⓜ indicates an interaction with a prescribed medication.

If an allergy has a comment associated with it, an asterisk **(*)** appears next to the allergy name.

<u>The strikethroughs indicate</u>:

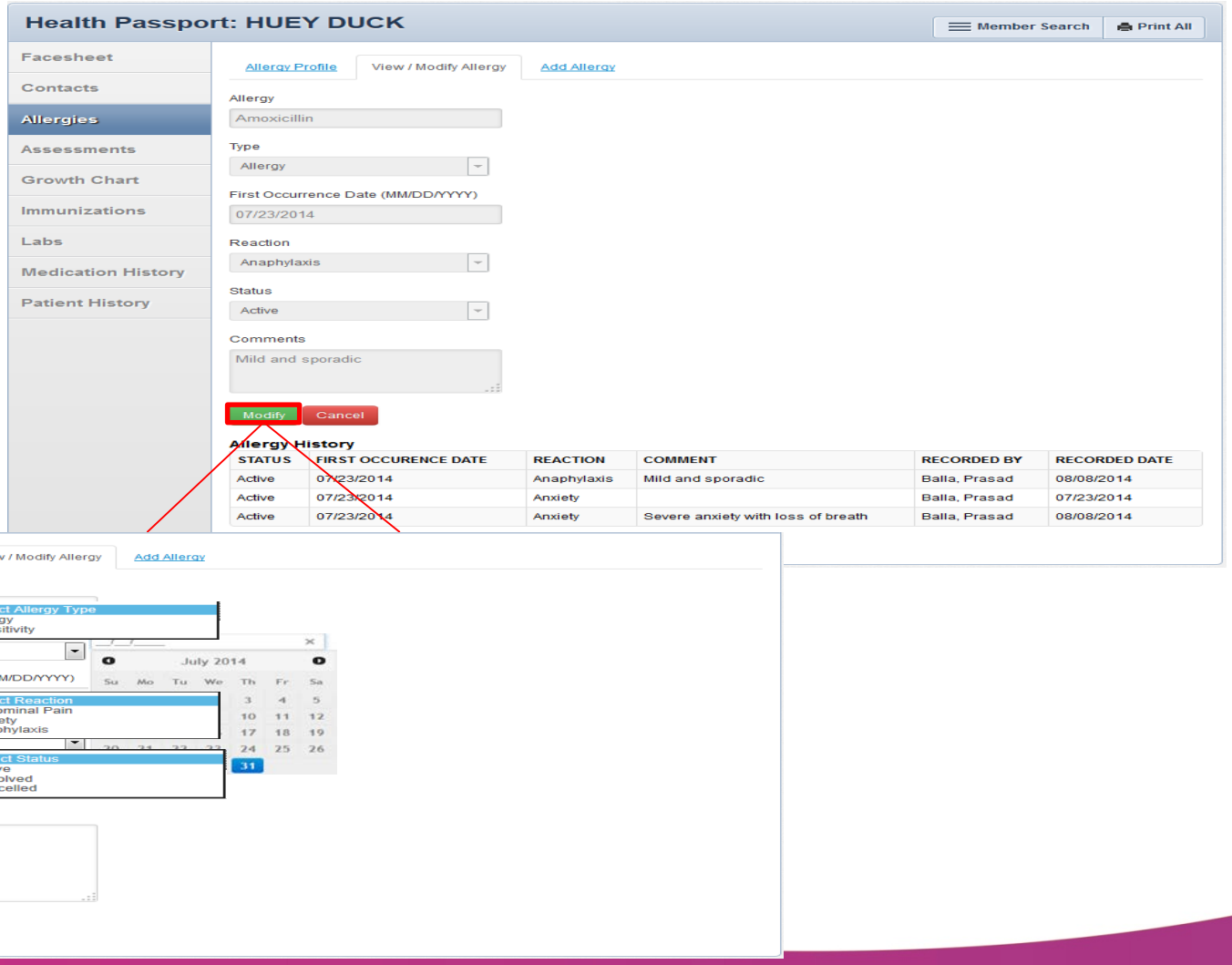
- Resolved status—an allergy the member no longer experiences.
- Canceled status—an allergy that could be mistakenly entered.



Modify Allergy

Providers have the ability to modify allergies.

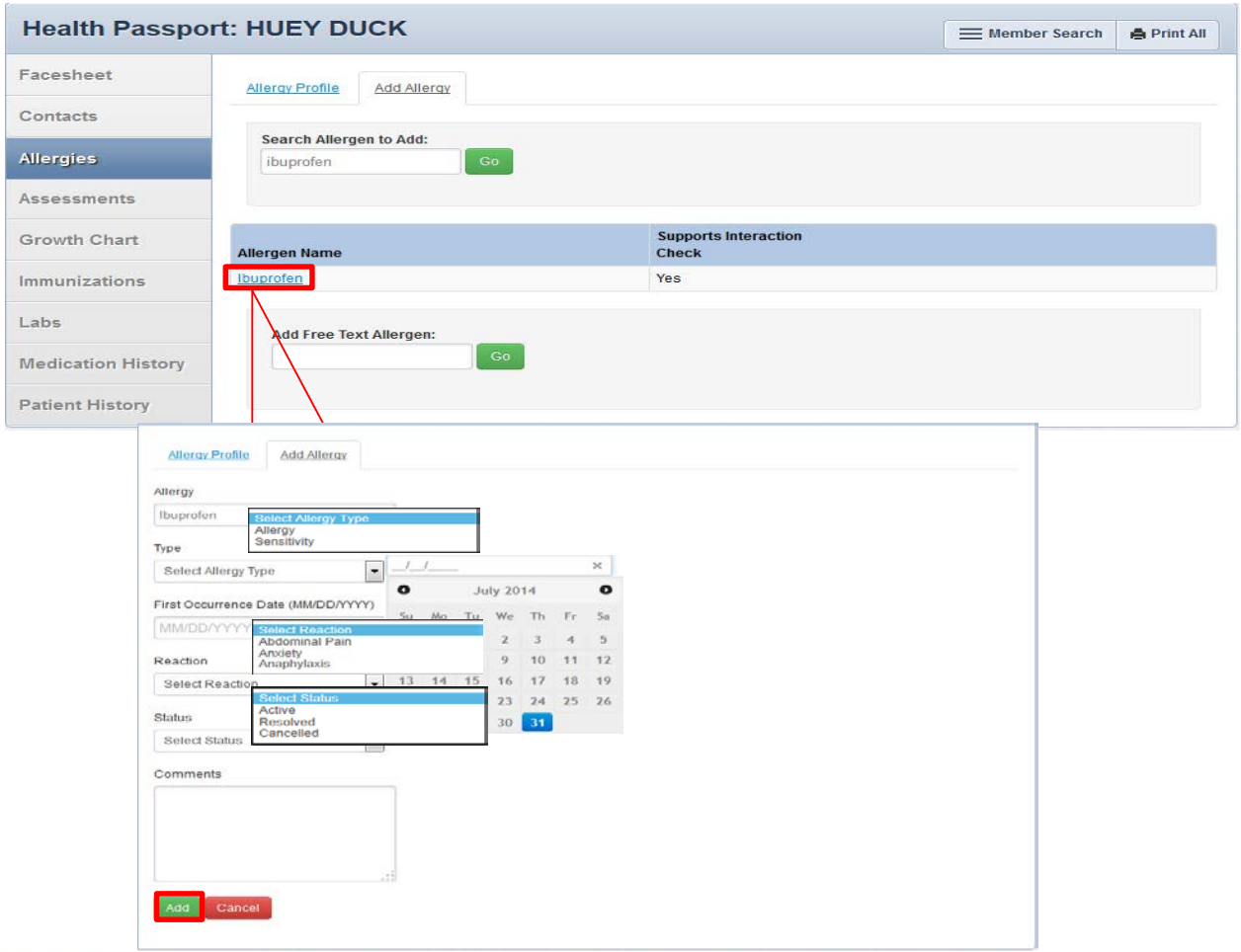
Step 1: Click **Modify**.
Step 2: Modify allergy name, type, occurrence date, reaction, status, or comments.
Step 3: Click **Update** to save changes.



Add Allergy

Providers have the ability to add an allergy.

Step 1: Search for an allergen and click **Go**. If not found, use the **Add Free Text Allergen** box.
Step 2: Select allergy name, type, occurrence date, reaction, status, and include comments, as applicable.
Step 3: Click **Add** to save changes.



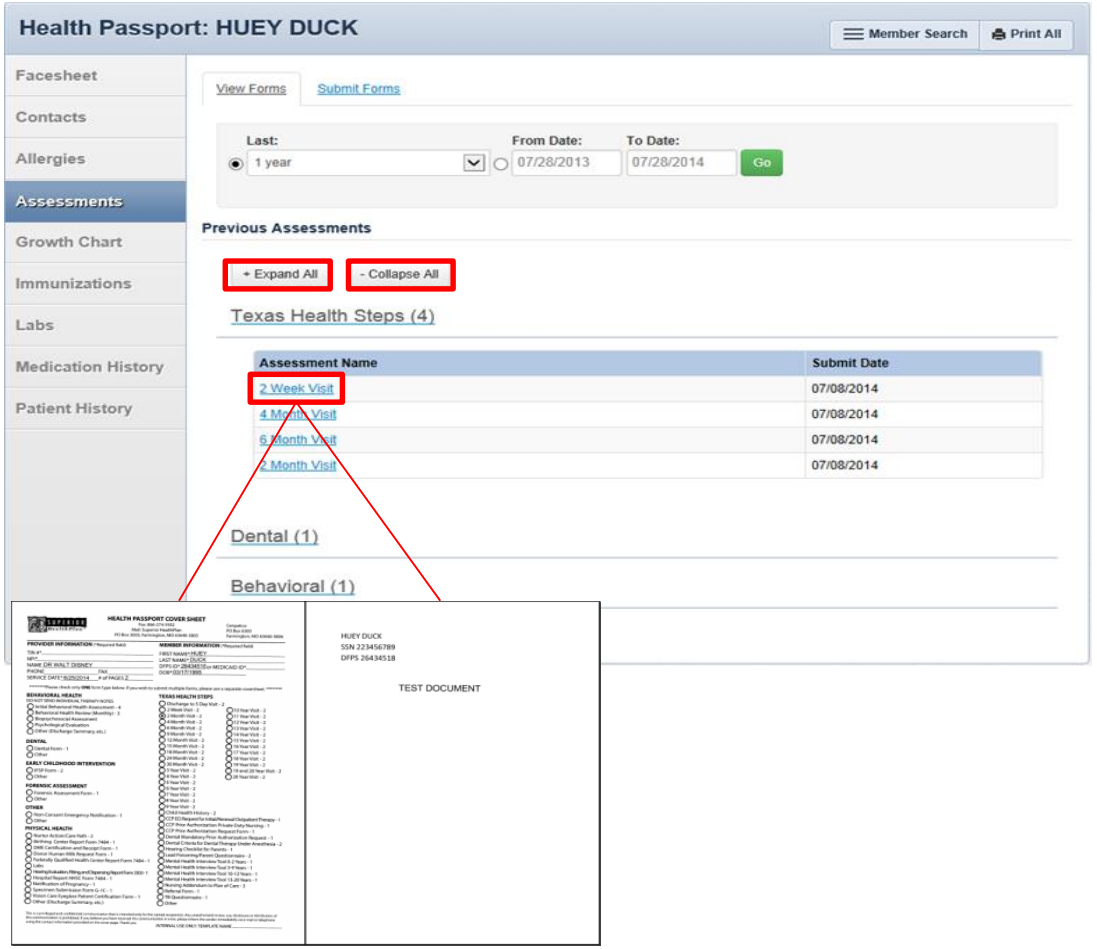
Assessments

This module allows providers to document Texas Health Steps, Dental and Behavioral Health forms directly online. Mailing or faxing in documents critical to patient care for display is also available.

Click on form name to open the document.

Expand or collapse all forms by clicking the **Expand All** and **Collapse All** buttons.

Fax: 866-274-5952
Mail: Superior HealthPlan PO Box 3003, Farmington, MO 63640-3803

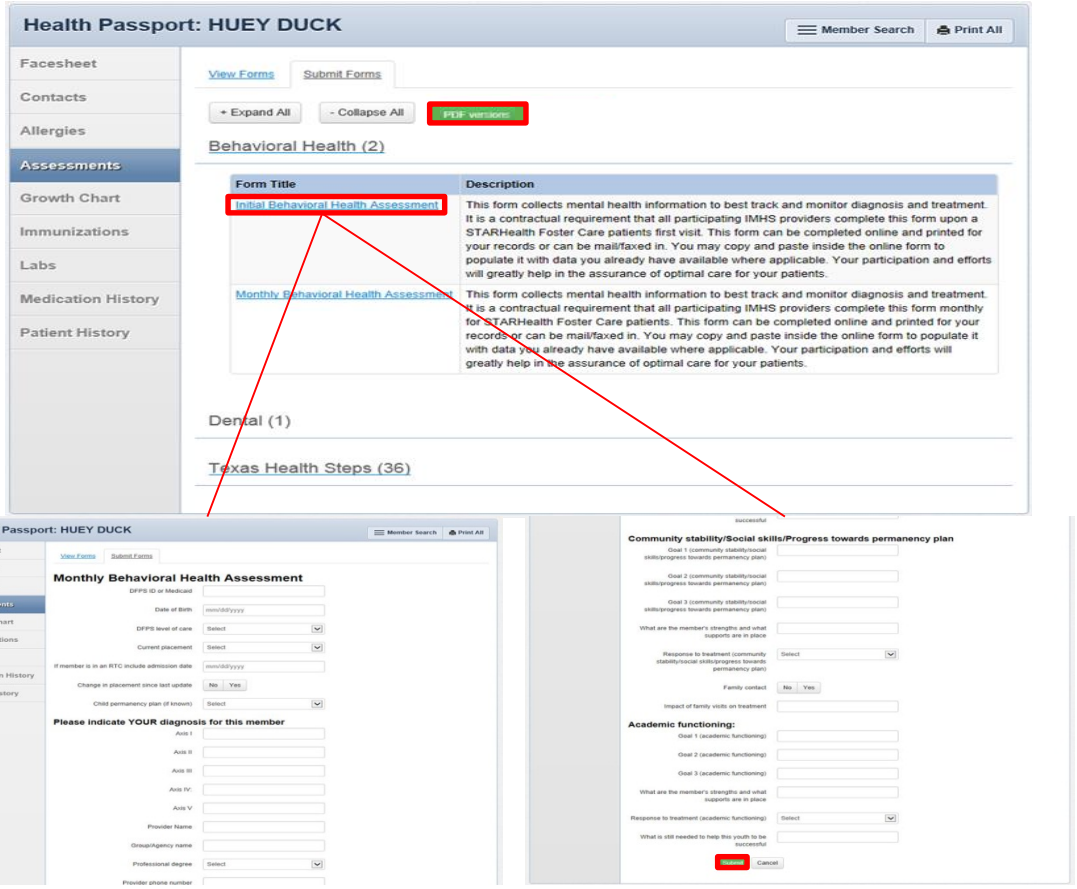


Submit Forms

To complete and submit forms, click on the **Submit Forms** tab.

Step 1: Open a form by selecting the **Form Title**.
Step 2: Fill in all relevant information.
Step 3: Click the **Submit** button.

Click **PDF versions** to be directed to the Health Passport Forms section on the Superior foster care website, where a blank form can be printed.

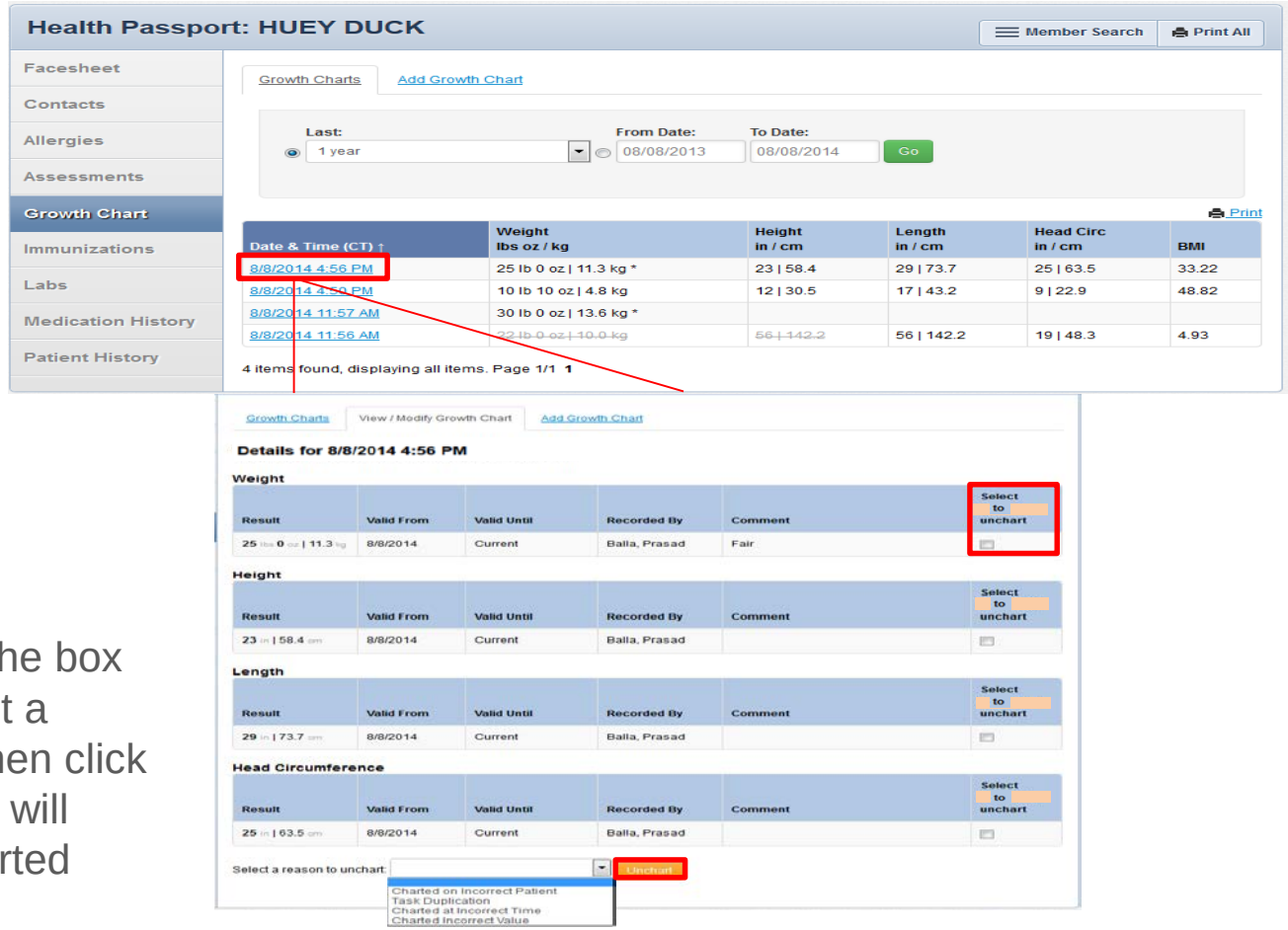


Growth Chart

This module contains height, weight, length, and head circumference entered by Providers and calculates BMI, when applicable.

Click a date and time to view details for that date.
An asterisk * indicates there is a comment associated with the entry.

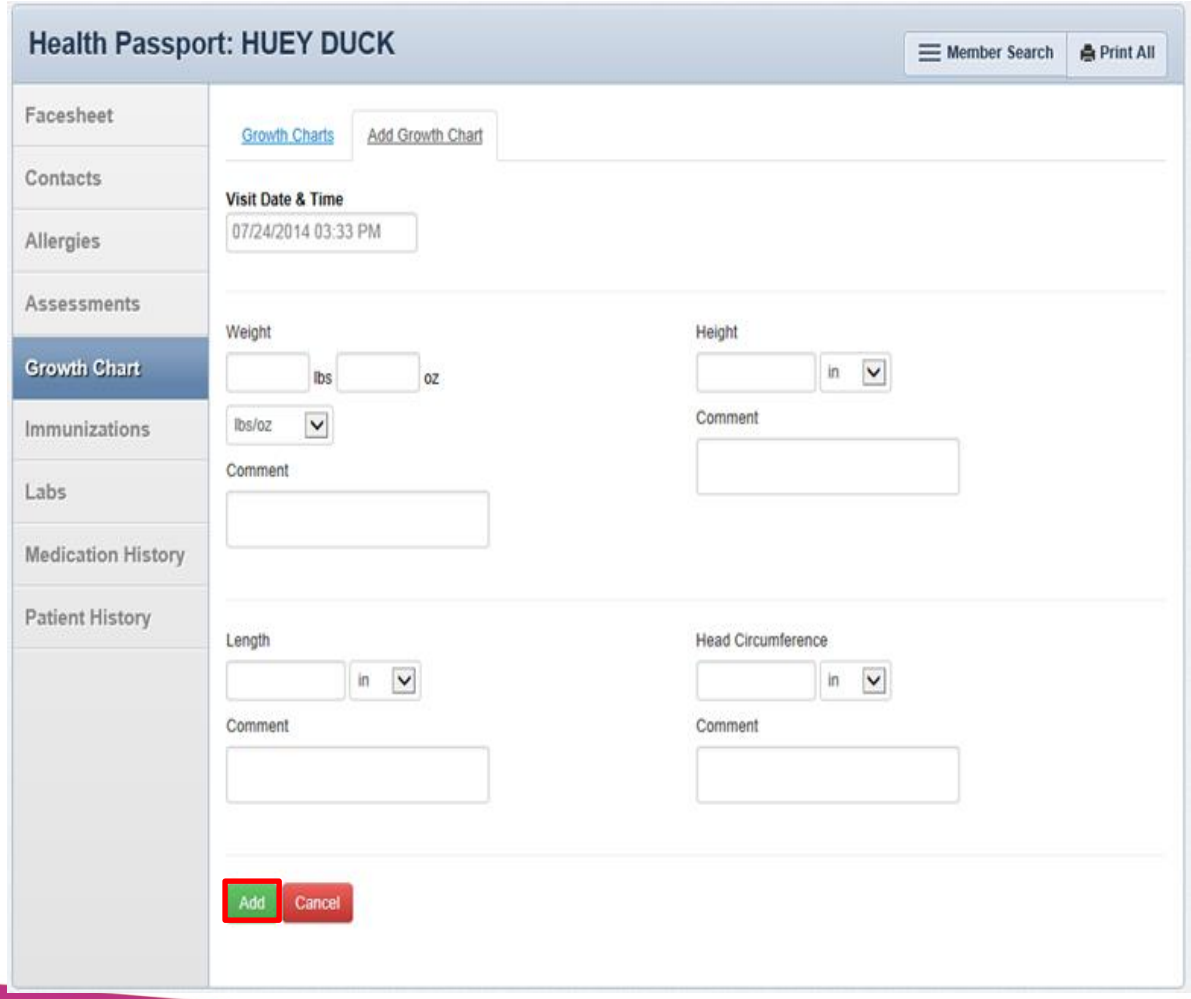
Modify chart by clicking the box **Select to unchart**, select a reason to unchart, and then click **Unchart**. A strikethrough will appear in place of uncharted entries.



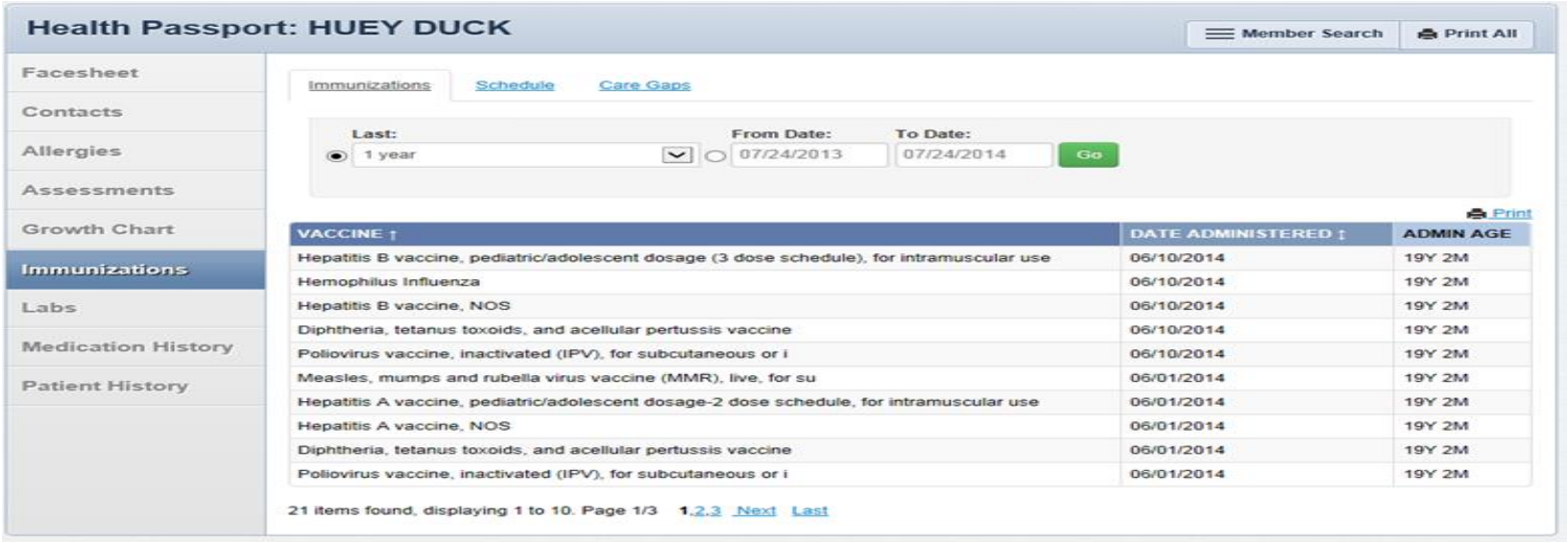
Add a Growth Chart

Click the **Add Growth Chart** tab to add new growth measurements.

Step 1: Fill in weight, height, length, head circumference, and add comments, if applicable.
Step 2: Click **Add**.



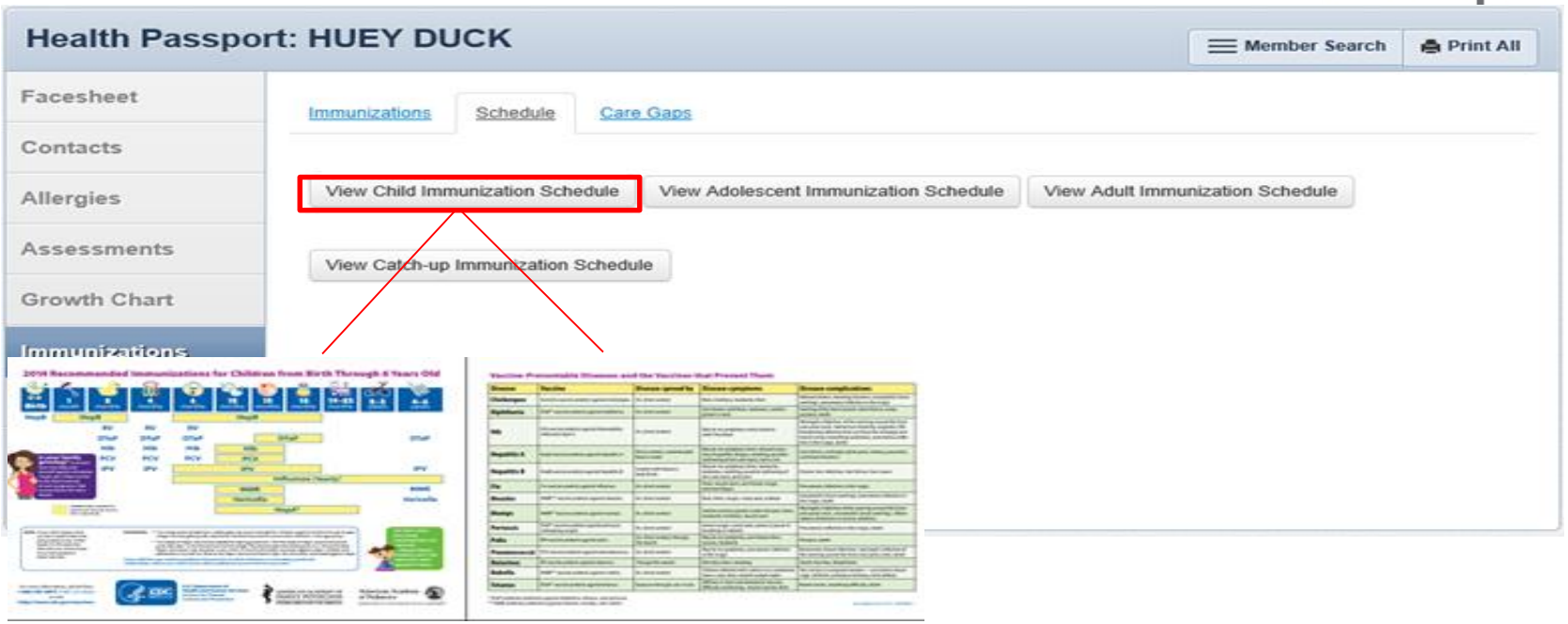
Immunizations



This module presents a comprehensive list of a member's immunizations that have been reported to ImmTrac, the Texas Immunization Registry.

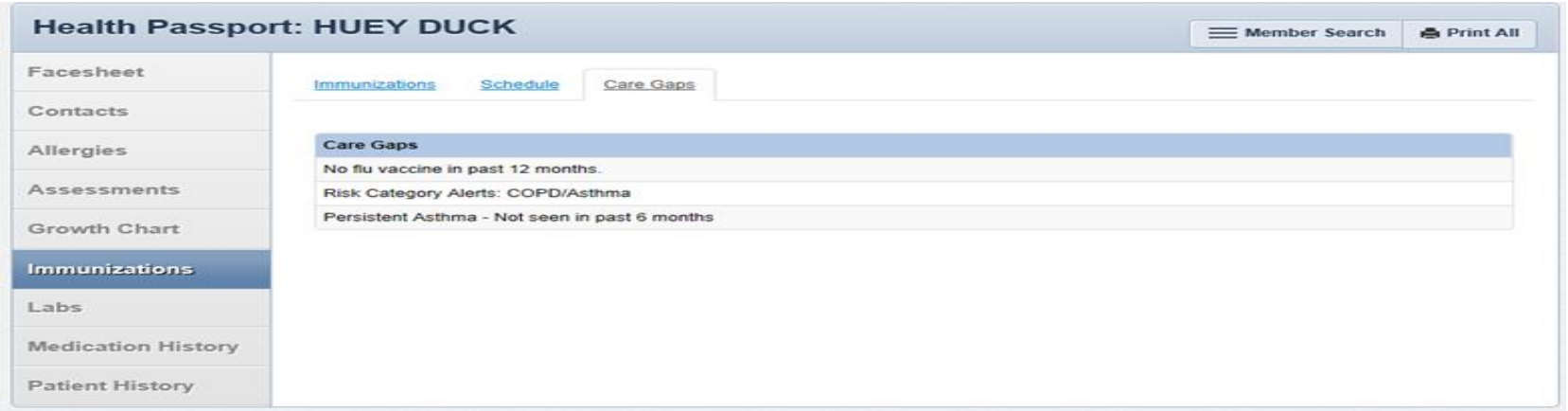
Additionally, there is a tab that displays immunization schedules for the Centers for Disease Control and Prevention. The Care Gaps tab shows any gaps in care, including missing immunizations.

Immunizations: Schedule Tab



This tab offers child, adolescent, adult and catch-up immunization schedules. Click the respective schedule to open the document.

Immunizations: Care Gaps Tab



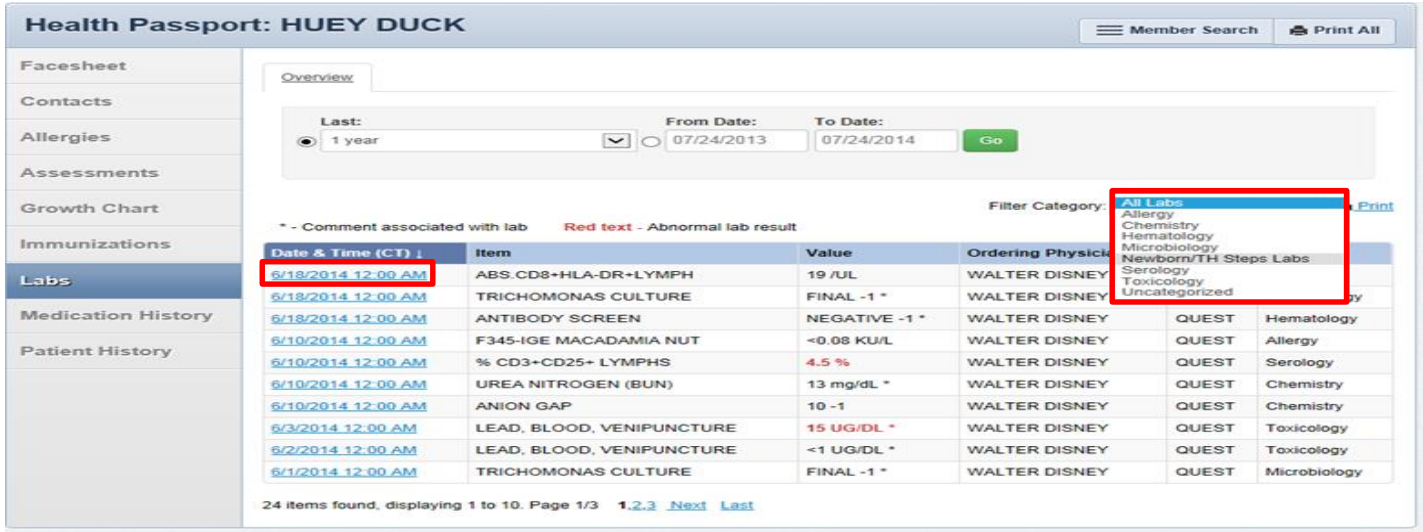
This tab allows you to gaps in care, including missing immunizations.

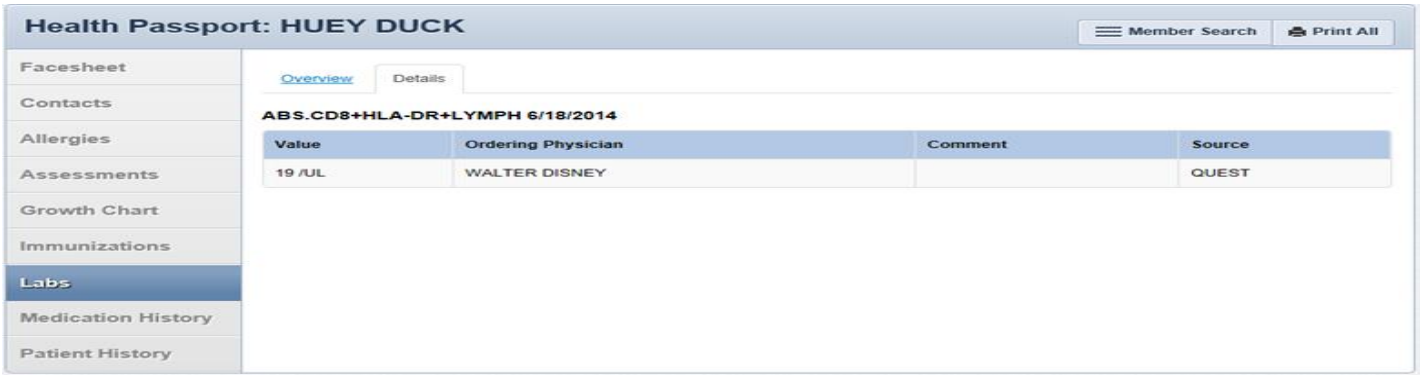
Labs

This module contains a list of a member's lab results.

Click on a date and time to view details of labs.

By selecting **Filter Category**, you can filter by lab type.





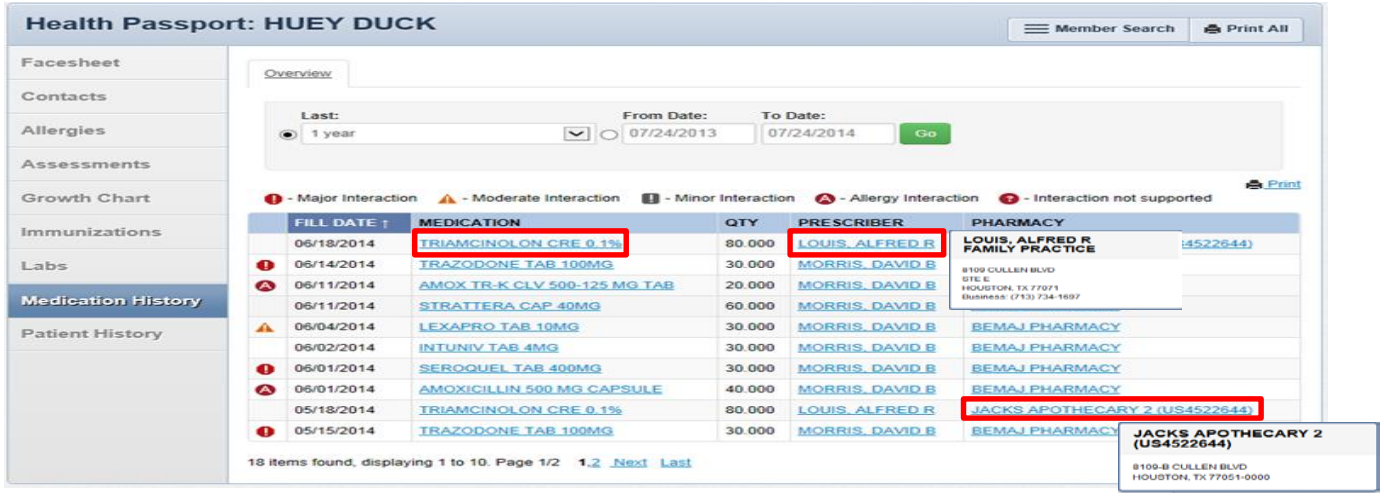
Medication History

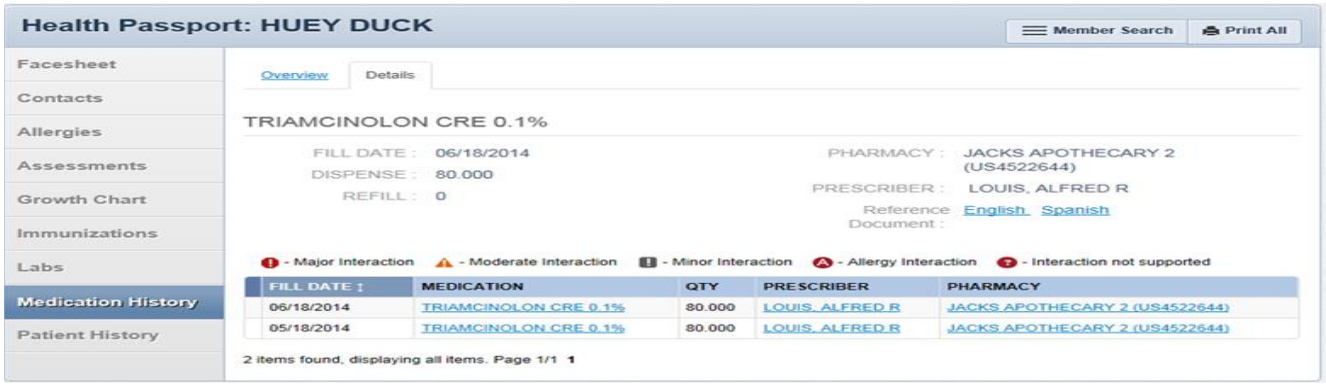
This module contains a detailed list of medications.

Click medication name to view more details.

Scroll over **Prescriber** and **Pharmacy** to view contact information.

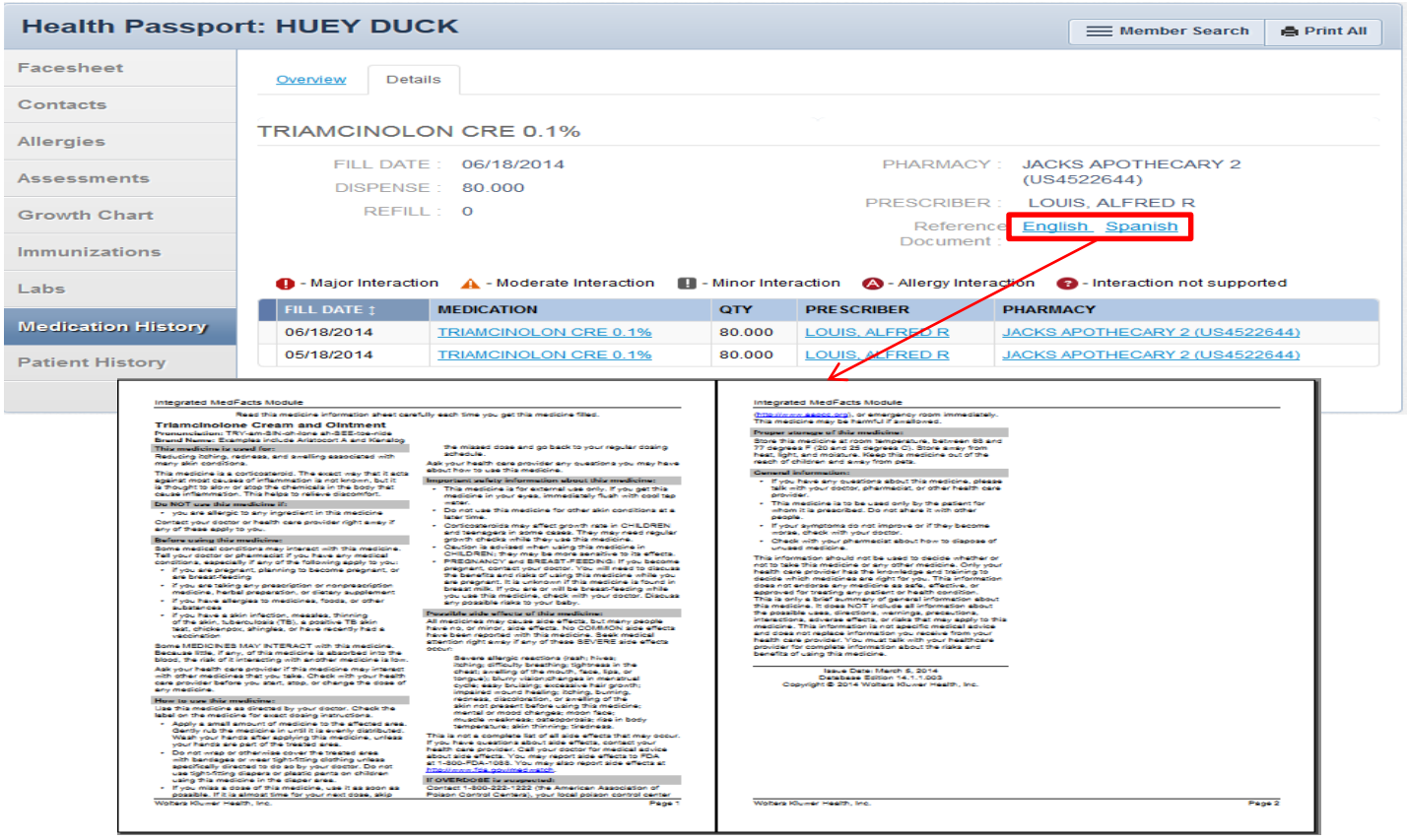
The legend of icons ( ) denote different medication interactions. Major interactions are potentially life threatening.





Medication History: Details Tab

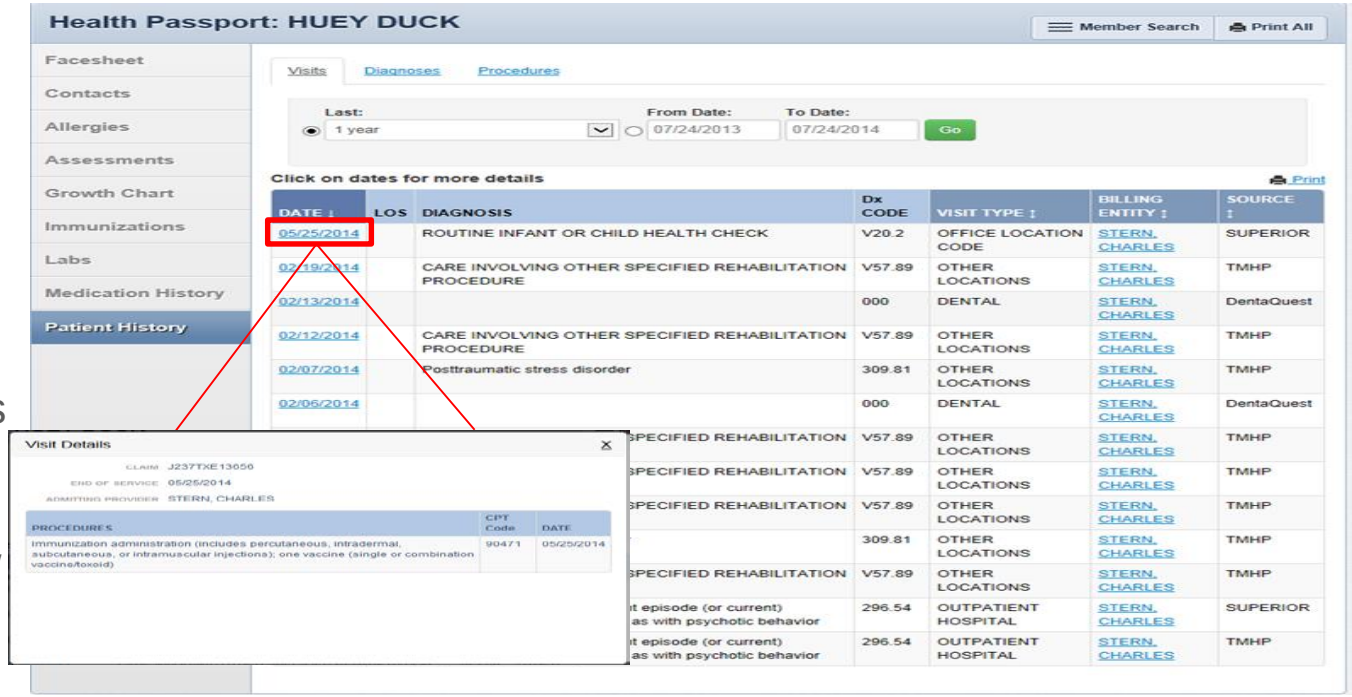
Select **English** or **Spanish** to open a reference document for the given medication.



Patient History

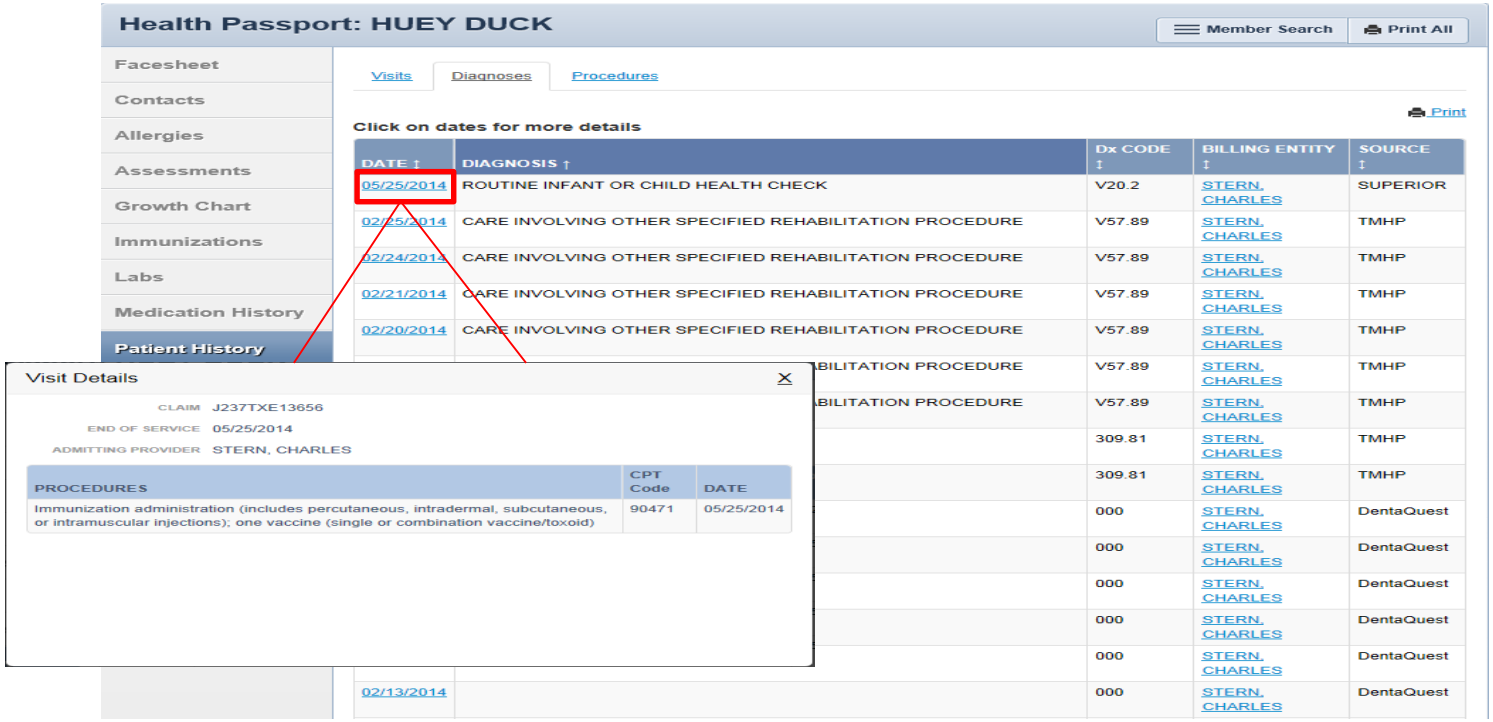
This module contains visit information from claims data on all services rendered, whether paid or denied. Claims come from all provider types and providers do not need to do anything extra for this data to load.

Click the date to view more visit details.



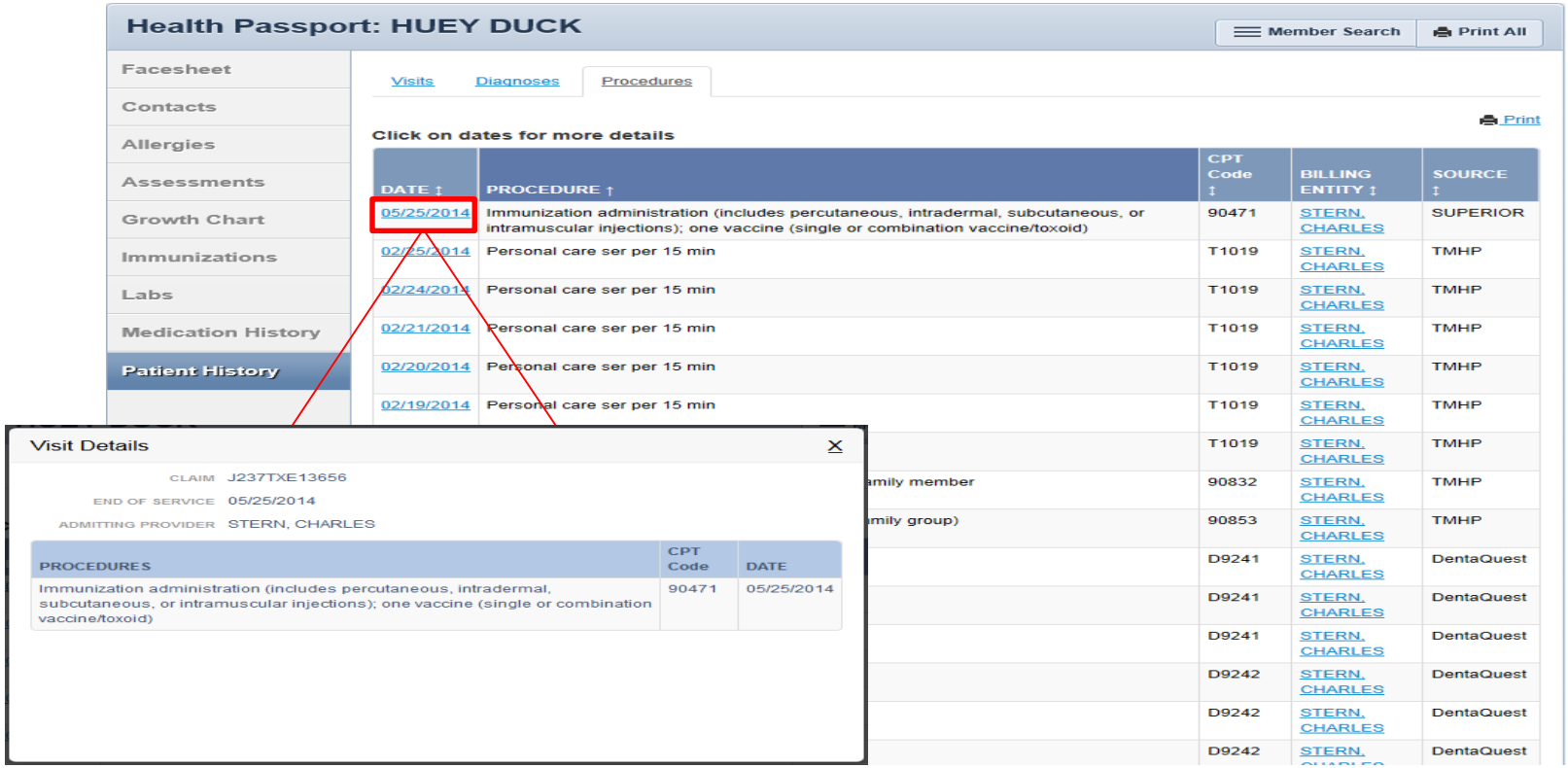
NOTE: This module should not be used as a tool for claims payments. There is lag time before data is loaded as providers have 95 days to bill, and Superior HealthPlan has 30 days to process.

Patient History: Diagnoses Tab



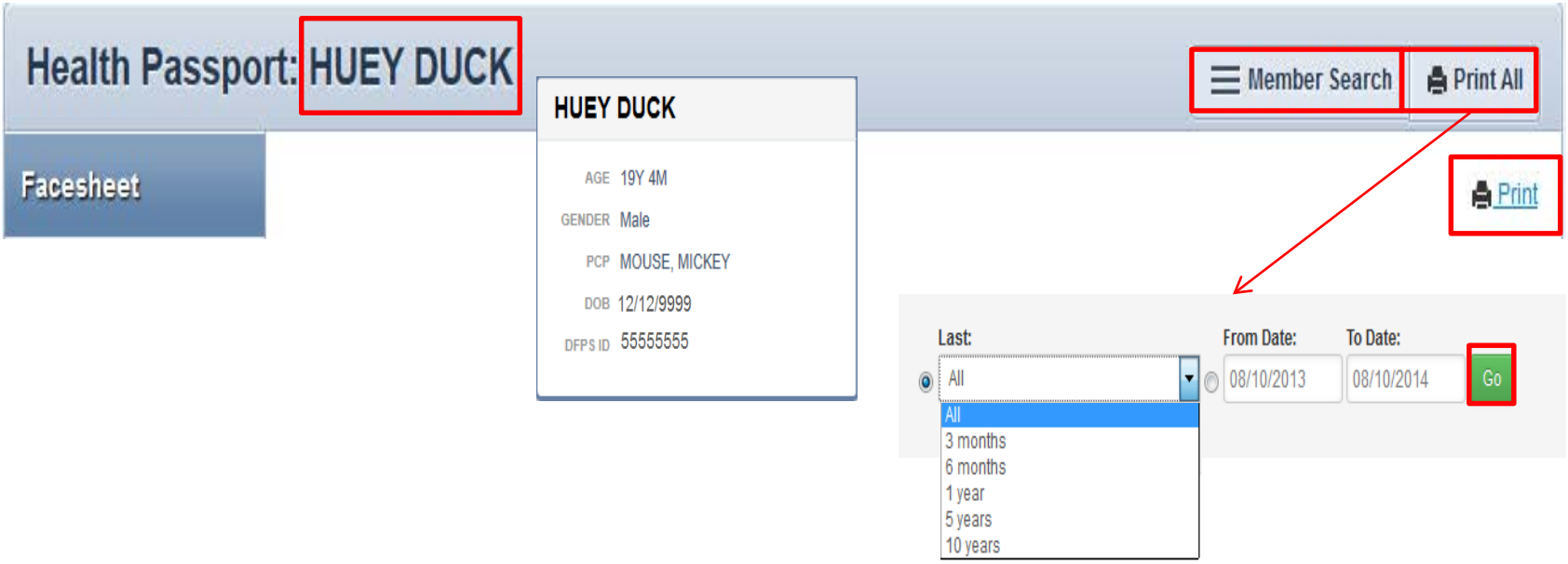
This tab lists visits by diagnoses. **Click** the date to view by diagnoses.

Patient History: Procedures Tab



Click the Procedures tab to view visits by procedures.

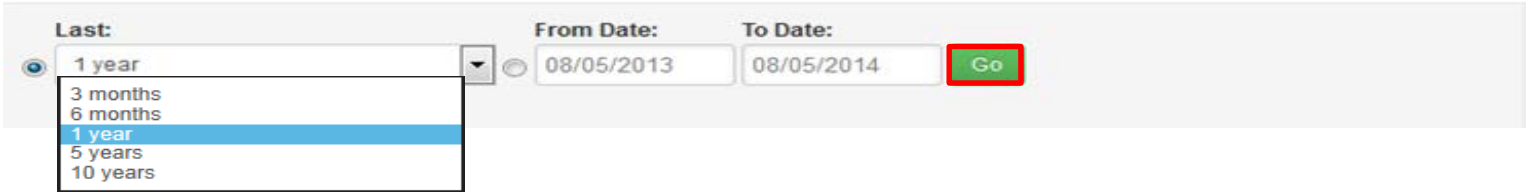
Other Tools



Member Search: to return to search screen
Print All: print complete health record by either (1) selecting a time frame or (2) selecting a date range and click **Go**.
Print: print single module
Demo Info: Hover over member name to view core demographic information.

Other Tools

To filter, select the time frame and date range and click **Go**.
Found on modules: **Assessments, Growth Chart, Immunizations, Labs, Medication History,** and **Patient History**

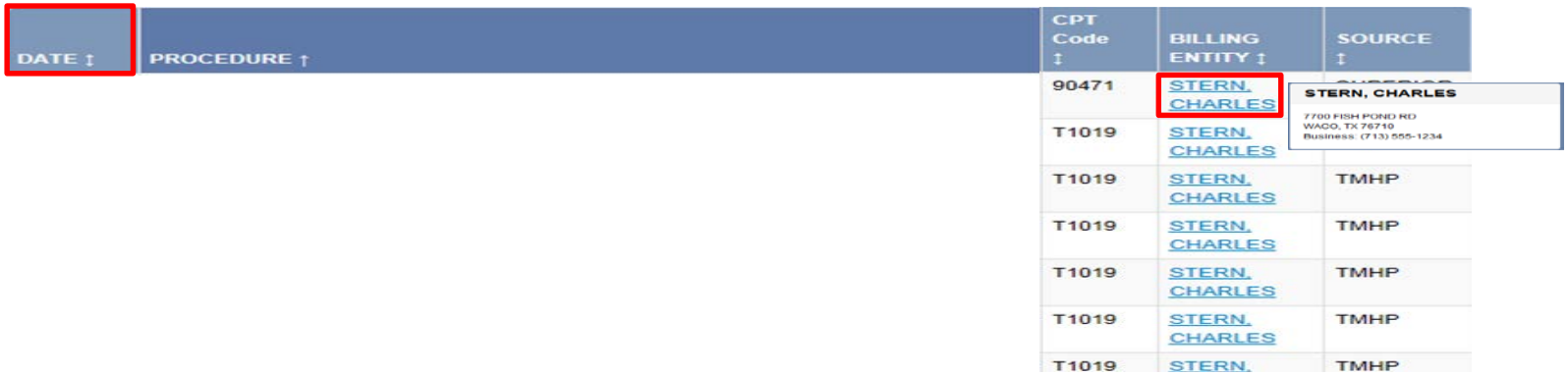


View more by clicking the **Page** or the **Next** and **Last** buttons.
Can be found on modules: **Allergies, Growth Chart, Immunizations, Labs, Medication History,** and **Patient History**

Other Tools

Sort information by clicking on the titles labeled with arrows.
Found on modules: **Allergies, Growth Chart, Immunizations, Labs, Medication History,** and **Patient History**

Hover over **Billing Entity** to view contact information for providers.
Found on module: **Patient History**



Contact Us

- Interested in a Live Demo? Call your Provider Network Representative to schedule a visit!
- Need additional Health Passport Help (Support Desk)
  - Call: 1-866-714-7996
  - Email: TX_PassportAdmin@centene.com

Questions and Answers

Thank You For Attending!

Thank you for your commitment to serving the needs of Children in Texas Foster Care.

If you have additional questions, please contact your local Provider Relations Specialist or select “Contact Us” at www.SuperiorHealthPlan.com

Let us know what we can do to help.