

Nursing Facility Provider Manual



December 2016

Bexar, Lubbock, Nueces, Hidalgo, Dallas, Central, West counties

A black and white photograph of a nurse with curly hair, wearing a white uniform with a stethoscope, leaning over a table to serve a tray to an elderly man. The tray contains a glass of water and a cup. The man is sitting in a chair, looking up at the nurse. The background shows a window with a view of trees. The entire image is overlaid with a semi-transparent magenta circle containing the contact information.

Questions?
Call
1-877-391-5921

SuperiorHealthPlan.com

SHP_20163621



Quick Reference Guide

Superior HealthPlan Office Locations

Austin Regional Office and Administrative Headquarters

Office Address: 5900 E. Ben White Blvd., Austin, TX 78741

Contact: Phone: 1-800-218-7453

Counties covered through this office:

Travis SDA: Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson

Central RSA: Blanco, Brazos, Burleson, Colorado, De Witt, Freestone, Gillespie, Gonzales, Grimes, Jackson, Kerr, Lampasas, Lavaca, Leon, Limestone, Llano, Madison, Mills, Robertson, San Saba, Washington

Corpus Christi Regional Office

Office Address: 711 N. Carancahua, Suite 600, Corpus Christi, TX 78401

Contact: Phone: 1-800-656-4817

Counties covered through this office:

Nueces SDA: Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kennedy, Kleberg, Live Oak, Nueces, Refugio, San Patricio, Victoria

Harris SDA: Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Waller, Wharton

Jefferson SDA: Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler, Walker

Dallas Regional Office

Office Address: 4001 McEwen Rd, Suite 300, Dallas, TX 75244

Contact: Phone: 1-866-529-0294

Counties covered through this office:

Dallas SDA: Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall

Tarrant SDA: Denton, Hood, Johnson, Parker, Tarrant, Wise

El Paso Regional Office

Office Address: 6070 Gateway East, Suite 400, El Paso, TX 79905

Contact: Phone: 1-877-391-5923

Counties covered through this office:

El Paso SDA: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, Pecos, Presidio

West RSA: Brown, Coke, Coleman, Concho, Crane, Crockett, Dimmit, Ector, Edwards, Frio, Glasscock, Irion, Kimble, Kinney, LaSalle, Loving, Mason, McCulloch, Menard, Midland, Reagan, Real, Reeves, Runnels, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Uvalde, Val Verde, Ward, Winkler, Zavala

Lubbock Regional Office

Office Address: 7202 Slide Road, Suite 202, Lubbock TX 79424

Contact: Phone: 1-866-862-8308

Counties covered through this office:

Lubbock SDA: Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, Lubbock, Lynn, Potter, Randall, Swisher, Terry

West RSA: Andrews, Archer, Armstrong, Bailey, Baylor, Borden, Briscoe, Callahan, Castro, Childress, Clay, Cochran, Collingsworth, Cottle, Dallam, Dawson, Dickens, Donley, Eastland, Fisher, Foard, Gaines, Gray, Hall, Hansford, Hardeman, Hartley, Haskell, Hemphill, Howard, Jack, Jones, Kent, King, Knox, Lipscomb, Martin, Mitchell, Moore, Motley, Ochiltree, Oldham, Nolan, Palo Pinto, Parmer, Roberts, Scurry, Shackelford, Sherman, Stephens, Stonewall, Taylor, Throckmorton, Wheeler, Wichita, Wilbarger, Yoakum, Young

McAllen Regional Office

Office Address: 3900 North 10th Street, Suite 600, McAllen, Texas 78501

Contact: Phone: 1-877-278-4268

Counties covered through this office:

Hidalgo SDA: Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, Zapata

San Antonio Regional Office

Office Address: 7990 IH 10 W, Suite 300, San Antonio, TX 78230

Contact: Phone: 1-866-615-9399

Counties covered through this office:

Bexar SDA: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson

Tyler Regional Office

Office Address: 3258 Earl Campbell Pkwy, Tyler, TX 75701

Contact: Phone: 1-866-529-0294

Counties covered through this office:

Northeast RSA: Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Cooke, Delta, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Lamar, Marion, Montague, Morris, Nacogdoches, Panola, Rains, Red River, Rusk, Sabine, San Augustine, Shelby, Smith, Titus, Trinity, Upshur, Van Zandt, Wood

Waco Regional Office

Office Address: Wells Fargo Building, 1105 Wooded Acres, Suite 325, Waco, TX 76710

Contact: Phone: 1-800-218-7453

Counties covered through this office:

Central RSA: Bell, Bosque, Comanche, Coryell, Erath, Falls, Hamilton, Hill, McLennan, Somervell

Contents

SECTION 1

INTRODUCTION

Superior Policies and Objectives	1
Member Rights and Responsibilities	1
Member Education	3
Contacting Superior	4

SECTION 2

PROVIDER ROLES

The Role of the Nursing Facility Provider	5
General Responsibilities	5
Coordination with Entities Providing Non-Capitated Services	7
Hospice	7
Preadmission Screening and Resident Review (PASRR)	8
Reporting Abuse, Neglect, or Exploitation (ANE)	8
Report to the Department of Family and Protective Services (DFPS)	8
Report to Local Law Enforcement:	9
Failure to Report or False Reporting:	9
Fraud, Waste and Abuse Prevention	9
Reporting Fraud, Waste and Abuse	9
Information Needed to Report Fraud, Waste and Abuse	10
To report fraud, waste or abuse, choose one of the following:	10
Key Information for Nursing Facility Providers	10
The Role of a Primary Care Provider (PCP)	11
Who Can Serve as a PCP?	11
A Specialist as a PCP	11
Roles of Specialty Care Providers (Specialist)	12
Member's Right to Designate an OB/GYN	12
Network Limitations	12
Continuity of Care	13
Newly Enrolled Members	13
Acute Care Services	13
Members Diagnosed with a Terminal Illness	13
Community Based Long-Term Services & Supports (LTSS)	13
Members who Move out of the Service Area	13

SECTION 3

ELIGIBILITY AND DISENROLLMENT

Health Plan Enrollment14

Verifying Member Medicaid Eligibility.....14

 Your Texas Benefits15

 Pharmacies15

 Involuntary Disenrollment Due to Member Non- Compliance15

 Hospice Enrollment16

STAR+PLUS Program16

 Mandatory Members17

 Voluntary Members17

 Excluded Individuals17

 Dual Eligible Members17

 Disenrollment18

 Renewal19

 Members Who Move to a Facility Outside of the Service Area19

SECTION 4

COVERED BENEFITS AND SERVICES

Direct Access to Care - Medicaid Members Only20

Nursing Facility Add-On Services.....20

Interpreter/Translation Services23

Utilization Management Criteria.....23

Coordination with Other State Program Services24

 Coordination with Public Health24

Additional Benefits25

 Prescriptions.....25

 Roles of a Pharmacy.....25

 Behavioral Health.....25

 Value Added Services.....26

SECTION 5

SERVICE COORDINATION

Service Coordinator Responsibility27

Nursing Facility Responsibility28

SECTION 6

ROUTINE, URGENT AND EMERGENCY SERVICES

Routine, Urgent and Emergency Services Defined29

 Routine Care29

 Urgent Condition.....29

 Emergency Medical Condition29

Access to Routine, Urgent and Emergent Care.....30

Emergency Pharmacy Services - Medicaid Only.....30

 Pharmacy Compounds30

Emergency Transportation31

Non-Emergency Ambulance Transportation	31
Authorization Tips:	31
Approvals/Denials.....	32
STAR+PLUS Non-Urgent Transportation	32
Emergency Dental Services-Medicaid only	33
Non-Emergency Dental Services	33
SECTION 7	
PRIOR AUTHORIZATION	
Prior Authorization Requirements	34
Radiology Authorizations	34
SECTION 8	
CLAIMS AND ENCOUNTERS ADMINISTRATION	
Claim Filing Guidelines.....	35
Timely Filing Requirements	36
Payment Requirements.....	36
Durable Medical Equipment (DME) and Other Common Pharmacy Products	37
Nursing Facility Unit Rate.....	37
Adjusted Claims-Daily Unit Rate	37
Applied Income – Nursing Facility Unit	38
Coordination of Benefits for STAR+PLUS Members with Medicare	38
Coordination of Benefits for Members Enrolled in the STAR+PLUS Medicare-Medicaid Plan (MMP)	38
Acute Care Service	39
Coordination of Benefits	39
Out-of-Network Reimbursement	39
Claims Filing Guidelines for Add-On Services.....	40
Timely Filing Requirements	40
Payment Requirements	40
Billing Codes	40
Claims Reconsiderations	41
Submitting a Claim Appeal	41
Corrected Claim.....	42
Filing a Corrected Claims.....	42
SECTION 9	
COMPLAINT PROCEDURES	
Filing a Provider Complaint	43
Resolving a Complaint.....	43
Appealing a Resolution	43
Member Complaints	44
Filing a Complaint	44
What a Member Can Expect When Filing a Complaint	44
Member Appeal of a Complaint Resolution	44
How Superior Can Assist the Member with Filing Complaints or Appeals	45

SECTION 10

ADVERSE DETERMINATIONS, ACTIONS AND APPEALS

Adverse Determinations	46
Appeal of an Adverse Determination on an Add-On Service	46
Filing a Standard Appeal	47
Resolving a Standard Appeal	48
Expedited Appeals	48
Resolving an Expedited Appeal	49
State Fair Hearings	49
Expedited Fair Hearings	50
Resolving a Level of Care Determination	50
Other Available Provider and Member Resources	50
Consumer Rights and Services	50
Long-Term Care (LTC) Ombudsman	51
Health Plan Management	51
HHSC Office of the Ombudsman	51

SECTION 11

QUALITY IMPROVEMENT

Quality Improvement Department	52
Practice Guidelines	52

SECTION 12

CULTURAL COMPETENCY IN SERVING SUPERIOR'S MEMBERS

Cultural Sensitivity	54
Knowledge	54
Skills	54
Attitudes	55
Resources for Cultural Competency	55

SECTION 13

SUPERIOR'S PROVIDER PORTAL

Registering for the Provider Portal	56
Benefits of the Provider Portal	56
Provider Portal Help Desk	57

SECTION 1

INTRODUCTION

Welcome to Superior HealthPlan's STAR+PLUS program for Medicaid Nursing Facility managed care members. We thank you for participating in our network of providers. Superior is a Managed Care Organization (MCO), contracted by the Texas Health and Human Services Commission (HHSC), to provide health-care services to members enrolled in the STAR+PLUS program. Superior also works with the Texas Department of Aging and Disability Services (DADS) to ensure that benefits to Nursing Facility residents are timely and appropriately provided and available.

This manual is a reference guide for Nursing Facility providers and their staff providing services to members, who participate in our STAR+PLUS program. Nursing Facility services are a covered benefit for qualifying STAR+PLUS members age 21 and older who need acute health-care services and long-term care services. The STAR+PLUS program includes Medicare-Medicaid Plan (MMP), a Texas Dual Demonstration project that fully integrates a managed care model for individuals who are enrolled in Medicare and Medicaid. Services include all Medicare benefits: parts A, B and D and Medicaid benefits, wrap-around services and long-term services and support (LTSS). Please review the Superior HealthPlan STAR+PLUS MMP Provider Manual at www.SuperiorHealthPlan.com for complete program details.

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. Superior's policies are designed to assist HHSC in achieving an integrated delivery system of acute and LTSS through the following objectives:

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

Member Rights and Responsibilities

Member Rights:

1. Members 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 their medical records and discussions with providers will be kept private and confidential.
2. Members 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 members will see most of the time and who will coordinate their care. Members have the right to change to another plan or provider. That includes the right to:
 - a. Be told how to choose and change health plans and PCPs.
 - b. Choose any health plan that is available in the member's area and choose a PCP from that plan.
 - c. Change PCPs.

- d. Change health plans without penalty.
 - e. Be told how to change health plans or PCPs.
3. Members have the right to ask questions and get answers about anything they do not understand. That includes the right to:
- a. Have their provider explain their health-care needs to them and talk about the different ways their health-care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. Members 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 providers in deciding what health care is best for them.
 - b. Say yes or no to the care recommended by providers.
5. Members have the right to use each available complaint and appeal process through Superior and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
- a. Make a complaint to Superior or to the state Medicaid program about health care, providers or their health plan.
 - b. Get a timely answer to complaints.
 - c. Use the Superior appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. Members 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, 7 days a week to get any emergency or urgent care needed.
 - 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 providers and when talking to Superior. Interpreters include people who can speak in a member's native language, help someone with a disability or help a member understand the information.
 - e. Be given information members understand about their health plan rules, including the health-care services they can get and how to get them.
7. Members have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force them to do something they do not want to do, or is to punish them.
- a. Members have a right to know that doctors, hospitals and others who care for them can advise them about their health status, medical care, and treatment. Superior cannot prevent them from giving members this information, even if the care or treatment is not a covered service.
 - b. Members have a right to know that they are not responsible for paying for covered services. Doctors, hospitals and others cannot require members to pay copayments or any other amounts for covered services.

Member Responsibilities:

1. Members must learn and understand each right they have under the Medicaid program. That includes the responsibility to:
 - a. Learn and understand their rights under the Medicaid program.
 - b. Ask questions they do not understand about their rights.
 - c. Learn what choices of health plans are available in their area.
2. Members must abide by the Superior and Medicaid policies and procedures. That includes the responsibility to:
 - a. Learn and follow Superior and Medicaid rules.
 - b. Choose their health plan and a PCP quickly.
 - c. Make any changes in their health plan and PCP in the ways established by Medicaid and by Superior.
 - d. Keep scheduled appointments.
 - e. Cancel appointments in advance when they cannot keep them.
 - f. Always contact their PCP first for non-emergency medical needs.
 - g. Be sure they have approval from their PCP before going to a specialist.
 - h. Understand when they should and should not go to the emergency room.
3. Members must share information about their health with PCPs and learn about service and treatment options. That includes the responsibility to:
 - a. Tell their PCP about their health.
 - b. Talk to their providers about their health-care needs and ask questions about the different ways their health-care problems can be treated.
 - c. Help their providers get their medical records.
4. Members must be involved in decisions relating to service and treatment options, make personal choices and take action to maintain their health. That includes the responsibility to:
 - a. Work as a team with their provider in deciding what health care is best for them.
 - b. Understand how the things they do can affect their health.
 - c. Do the best they can to stay healthy.
 - d. Treat providers and staff with respect.
 - e. Talk to their provider about all of their medications.

Member Education

Superior abides by state contractual agreements to ensure we provide appropriate cultural and linguistic services to our members. Materials are made available in large print, Braille and on compact disc (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 Handbook
- Superior website: www.SuperiorHealthPlan.com
- Quarterly newsletters
- Special mailings
- Superior Provider Directory

To obtain a sample of any of the materials listed above, contact our Member Services department or access the Member Portal at www.SuperiorHealthPlan.com. All educational materials are available in written text, both English and Spanish, and can be made available in other languages or formats such as Braille or large print, if needed. These materials are written at or below a 6th grade reading level, as measured by the appropriate score on the Flesch-Kincaid Readability Scale.

You may always refer your residents to our Member Services department at 1-866-516-4501 for personalized member education or to request information or materials.

Contacting Superior

Superior has staff to assist you with your day-to-day operations, questions and/or concerns. Every Nursing Facility provider will have a designated Account Manager that can coordinate an in-service/training for facility staff, provide face-to-face support in the facility and assist with answering questions about Superior’s policies and procedures. You may also contact Superior’s Provider Services department at 1-877-391-5921 for inquiries including program information or assistance with claims.

For help finding your assigned Nursing Facility Account Manager or Service Coordinator, see Quick Reference Guide – Superior HealthPlan Office Locations. You can also go to www.SuperiorHealthPlan.com and click on “For Providers > Provider Resources > Find my Account Manager.” Once on this page, search by city or click your county from the map. Each county is linked to the corresponding Account Management regional office contact information.

Helpful numbers:

Provider Services.....	1-877-391-5921
Provider Portal Help Desk.....	1-866-895-8443
Member Services	1-866-516-4501
Cenpatico Behavioral Health.....	1-800-466-4089
DentaQuest.....	1-888-308-9345
National Imaging Association (NIA)	1-800-642-7554
Envolve Pharmacy Solutions Help Desk	1-800-460-8988 (For providers and pharmacy only)
Envolve Prior Authorization Requests.....	1-866-399-0928
Envolve Prior Authorization Fax.....	1-866-399-0929

SECTION 2

PROVIDER ROLES

The Primary Care Provider (PCP) is responsible for monitoring the quality of care of Superior members. PCPs and Specialty Care Providers must maintain the appropriate privileges with Superior contracted Nursing Facilities to provide care to members.

The Role of the Nursing Facility Provider

Nursing Facility providers provide institutional care to Medicaid recipients whose medical condition regularly requires the attention and skills of licensed nurses. Nursing homes provide for the medical, social and psychological needs of each resident, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid program or Medicare Part D), medical supplies and equipment, rehabilitative services and personal needs items.

General Responsibilities

Providers must comply with each of the items listed below:

- To coordinate with member's assigned Primary Care Provider (PCP).
- To provide availability 24 hours a day, seven days a week.
- To submit updates to provider's contact information, if and when, there are changes. Network providers must inform both Superior and the Department of Aging and Disability Services (DADS) of any changes to their address, telephone number, group affiliation, etc.
- To provide Superior with access to medical records and access to the facility.
- To comply with the timelines, definitions, formats and instructions specified by HHSC.
- To provide records requested within three (3) business days of the request. *Note: If, at the time of the request for access to medical records, HHSC or the Office of Inspector General (OIG) or another state or federal agency believes records have been altered or destroyed, the Nursing Facility must provide records at the time of the request or in less than 24 hours.*
- To provide notice to Superior of plan termination per requirements in the agreement with Superior.
- To provide notice to Superior's designated Service Coordinator via phone, fax, email or other electronic means no later than one (1) business day after the following events:

Event	Notification
A significant adverse change in the member's physical or mental condition or environment that could lead to hospitalization.	One (1) business day
An emergency room visit.	One (1) business day
Death of a member.	72 hours

Event	Notification
An admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, LTSS provider, non-contracted bed, or another nursing or long-term care facility or involuntary discharge of a member initiated by the facility.	One (1) business day

- To submit Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor.
- To submit Minimum Data Set (MDS) assessments, as required to federal Centers for Medicare and Medicaid Services (CMS) and associated MDS Long-Term Care Medicaid Information Section to HHSC's administrative services contractor.
- To complete and submit Preadmission Screening and Resident Review (PASRR) Level I screening information to HHSC's administrative services contractor.
- To coordinate with Local Authorities (LA) and Local Mental Health Authorities (LMHA) to complete a PASRR Level 2 evaluation when an individual has been identified through the PASRR Level 1 screen as potentially eligible for PASRR specialized services.
- To respect the member's right to designate a specialist as their PCP as long as the specialist agrees.
- To respect the member's right to select and have access to, without a PCP referral, a network ophthalmologist or therapeutic optometrist to provide eye health-care services other than surgery.
- To respect a member's right to obtain medication from any network pharmacy.
- To respect a member's Advance Directives and Power of Attorney and include these documents in their medical record.
- To inform members of covered services and the costs for non-covered services prior to rendering these services by obtaining a signed private pay form from the member.
- To refer members to specialists and health-related services and documentation of coordination of referrals and services provided between PCP and specialist.
- To make a referral to network facilities and contractors, including access to a second opinion.
- To ensure medical records reflect all aspects of member care including ancillary services.
- To ensure the use of electronic medical records conform to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.
- To ensure proper justification to Superior regarding out-of-network referrals, including partners not contracted with Superior.
- To inform members on how to report abuse, neglect and exploitation.
- To train staff on how to recognize and report abuse, neglect and exploitation.
- To make reasonable efforts to collect applied income, document those efforts and notify the Service Coordinator or Superior's designated representative when the provider has made two (2) unsuccessful attempts to collect applied income in a month.

Coordination with Entities Providing Non-Capitated Services

Superior is required, through its contractual relationship with HHSC, to coordinate with public health entities regarding the provision of services for essential public health services or for services not directly provided by Superior. Providers must assist in these efforts. The Texas Medicaid Provider Procedures Manual (TMPPM) includes the following services:

- For STAR+PLUS Nursing Facility non-dual members in the Dallas Service Delivery Area (SDA), behavioral health is provided through FFS. For STAR+PLUS Nursing Facility dual members in the Dallas SDA, behavioral health is through provided NorthSTAR. Effective January 1, 2017, STAR+PLUS Nursing Facility residents in Dallas will receive their behavioral health services from Superior through Cenpatco.
- Tuberculosis (TB) services provided by DSHS-approved providers (directly observed therapy and contact investigation).
- Hospice services provided by Home and Community Support Service Agencies contracted with DADS.
- PASRR Level 1 screenings, Level 2 evaluations and specialized services are provided by DADS-contracted LA and DSHS-contracted LMHA. Specialized services provided by the LA include:
 - Service coordination, alternate placement and vocational training.
 - Specialized services provided by the LMHA include mental health rehabilitative services and targeted case management.
 - Specialized services provided by a Nursing Facility or Long-Term Care and Supports for individuals identified with intellectual and developmental disabilities (IDD), including physical therapy, occupational therapy, speech therapy and customized adaptive aids.
- LTSS for individuals who have IDD provided by DADS-contracted providers.

Hospice

When additional or ongoing care is necessary, the Nursing Facility should coordinate with Superior's Service Coordinator to plan the member's discharge to an appropriate setting for extended services such as hospice. The Nursing Facility should contact Superior's Service Coordinator within one (1) business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed or another nursing home.

Hospice services are provided for STAR+PLUS members by Home and Community Service Agencies contracted with DADS. DADS manages the hospice program through provider enrollment contracts with hospice agencies which are licensed by the state and are Medicare-certified as hospice agencies. The hospice program provides palliative care to Superior members who sign statements electing hospice services and are certified by physicians to have six (6) months or less to live if their terminal illnesses run their normal courses. For dual eligible members, hospice services are provided through a Medicare-contracted agency and all services related to the member's terminal illness are also provided through a Medicare hospice agency.

Members enrolled in hospice waive their rights to all other Medicaid services related to their terminal illness. Hospice is covered by Medicare and members can remain enrolled in MMP while receiving hospice services, but can only receive hospice services that are not related to their terminal illness. Members who are dual eligible must elect hospice for both Medicare and Medicaid.

Policy and program question may be directed to DADS at 1-512-438-3519. Questions regarding billing, claims and authorizations should be directed to DADS at 1-512-538-2200 or providers can refer to the TMPPM for further coordination.

Preadmission Screening and Resident Review (PASRR)

PASRR is a review process that is federally mandated and requires that all individuals wishing to be admitted to a Medicaid-certified Nursing Facility be screened for mental illness, developmental disability (or related condition) or intellectual disability (mental retardation).

The PASRR Evaluation (PE) is also used to determine if the Nursing Facility is the appropriate placement for the member and if the member could benefit from specialized services. The evaluation can only be performed face-to-face by a member of the LA, and must be completed within 72 hours and submitted through the LTC Online Portal within seven (7) calendar days from the time that the request for the PE was received. A member cannot be admitted to a Nursing Facility until an evaluation is completed, submitted through the portal and the result confirms that the facility can meet the needs of the member.

PASRR Level 1 screenings, Level 2 evaluation and specialized services are provided by DADS-contracted LA and DSHS-contracted LMHA. Specialized services provided by the LA include:

- Service coordination, alternate placement and vocational training.
- Specialized services provided by the LMHA which include mental health rehabilitative services and targeted case management.
- Specialized services provided by a Nursing Facility or Long-Term Care and Supports for individuals identified as IDD include physical therapy, occupational therapy, and speech therapy and customized adaptive aids.

All PASRR specialized services are non-capitated, fee-for-service so should be billed directly to TMHP. Refer to the TMPPM for further instructions.

Reporting Abuse, Neglect, or Exploitation (ANE)

Superior and providers must report any allegation or suspicion of ANE that occurs within the delivery of LTSS 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 the DADS if the victim is an adult or child who resides in or receives services from:

- Nursing facilities.
- Assisted living facilities.
- Adult day care centers.
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS.
- Licensed adult foster care providers.

Contact DADS at 1-800-647-7418.

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 DADS.
 - Unlicensed adult foster care provider with three (3) or fewer beds.
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), 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.
- 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.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS 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, DADS or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.053; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- 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

Superior is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse. It is your responsibility as a participating provider to report any member or provider suspected of fraud and abuse. All reports will remain confidential.

Reporting Fraud, Waste and 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 weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid.
- Using someone else's Medicaid.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

Information Needed to Report Fraud, Waste and Abuse

To report fraud, waste or abuse, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;
- Visit <https://oig.hhsc.state.tx.us> and select “Click Here to Report Waste, Abuse, and Fraud” to complete the online form.
- Contact Superior’s Corporate Special Investigative Unit directly at:
Centene Corporation
Superior HealthPlan Fraud and Abuse Unit
7700 Forsyth Boulevard
Clayton, MO 63105
1-866-685-8664

To report fraud, waste or abuse, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
 - 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 (doctor, dentist, therapist, pharmacist, etc.).
 - Names and phone numbers of other witnesses who can help in the investigation.
 - Dates of events.
 - Summary of what happened.
- When reporting about someone who gets benefits, include:
 - The person’s name.
 - The person’s date of birth, Social Security number or case number if you have it.
 - The city where the person lives.
 - Specific details about the fraud, waste or abuse.

Key Information for Nursing Facility Providers

The following are some helpful tips for Nursing Facility providers:

- Verify member eligibility to ensure the first date of enrollment with the plan.
- Ensure necessary authorizations have been obtained from Superior for all add-on services.
- Use in-network providers for add-on services.
- Adhere to DADS clean claim rules, as found under on page 32 of the Superior’s Nursing Facility Provider Manual, Code of Federal Regulations, Title 42, §447.45(b).
- Notify the Service Coordinator whenever there is a change in the member’s physical or mental condition, an inpatient admissions or an emergency room visit.
- Ensure that covered Medicare services are billed to Medicare as primary for members who are eligible for both Medicare and Medicaid.

- File claims for PASRR and hospice directly to the administrative services contractor for Medicaid fee-for-service.
- Continue submitting your MDS, 3618 and 3619 forms through the LTC online portal.

The Role of a Primary Care Provider (PCP)

The PCP is the cornerstone of Superior and serves as the “medical home” for the member. The “medical home” concept should assist in establishing a member-provider relationship and ultimately better health outcomes. The PCP is responsible for the provision of all primary care services to Superior members. This includes providing behavioral health-related services within the scope of their practice. In addition, the PCP is responsible for referring and obtaining referral authorization for services requiring authorization. *Note: Dual eligible (Medicare/Medicaid) members will not be assigned a PCP. For dual eligible members (either fee-for-service or on a Medicare Advantage or an MMP plan) Medicare continues to be responsible for all acute care services including physician claims.*

For Medicare covered services, please reference the Medicare Advantage provider manual at www.SuperiorHealthPlan.com.

Who Can Serve as a PCP?

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

- Certified Nurse Midwife
- Advanced Registered Nurse Practitioner
- Family Practitioner
- Obstetrics and Gynecology (OB/GYN)
- General Practitioner
- Physician Assistant
- Internal Practitioner
- Specialist (when appropriate, as described below)
- Nurse Practitioner

A Specialist as a PCP

Members with disabilities, special health-care needs and chronic or complex conditions have the right to designate a specialist as their PCP. 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 designation, 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 Request for Specialist PCP Form located 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 he or she is willing to accept responsibility for the coordination of all of the member’s health-care needs.
- Signature of the member on the completed Request for Specialist PCP Form.

Superior will approve or deny the request for a specialist to serve as a PCP and provide notification to the member of the decision 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 a complaint if their request to have a specialist as a PCP is denied.

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 responsibilities is to maintain ongoing communication with the member's PCP. Superior prefers that specialists are board certified in his or her area of expertise, but it is not required. Specialty Care Providers and facilities are responsible for ensuring that necessary referrals/authorizations have been obtained prior to the provision of services. To ensure continuity and coordination of care for the member, every Specialty Care Provider should:

- Verify member eligibility or authorization of services such as hospitalization, facility transfer, pregnancy information, member moves out of the service area and a pre-existing condition that is not imposed.
- Be available for or provide on-call coverage through another source 24 hours a day for management of member care.
- Provide medical records that reflect all aspects of patient care including ancillary services. *Note: The use of electronic medical records must confirm to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws.*
- Provide justification to Superior regarding out-of-network referrals, including partners not contracted with Superior.
- Providers are required to inform members on how to report Abuse, Neglect or Exploitation (ANE) as described in this manual.
- Providers are required to train staff on how to recognize and report ANE as described in this manual.

Member's Right to Designate an OB/GYN

Superior HealthPlan members have the right to designate an OB/GYN, whether that doctor is in the same network as the member's PCP or not.

Attention Female Members

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

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

Network Limitations

Superior members must receive covered Medicaid services from Superior contracted providers. There may be exceptions where a provider is not accessible within Superior's contracted network of providers. To ensure appropriate receipt of covered service, a non-contracted or "out-of-network" provider may be approved on an exception basis.

Note: All out-of-network services require prior authorization.

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 could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

Newly Enrolled Members

Acute Care Services

Superior will consider an initial timeframe of up to a 90 days initial continuity of care period to allow time for the transition to a Superior HealthPlan participating provider.

- After the initial 90 period, continuity of care will no longer apply.
- If there is no participating provider who can perform the requested service, Superior may authorize or continue authorizing the service to a non-participating provider.

Members Diagnosed with a Terminal Illness

Continuity of care also applies to members diagnosed with a terminal illness. A member can continue receiving care from their current provider for a period of nine (9) months from the date the member became enrolled with Superior.

Community Based Long-Term Services & Supports (LTSS)

Superior will consider an initial time frame of up to six (6) months for LTSS or until a new assessment is completed and new authorizations issued.

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 such time the member is disenrolled from Superior. Superior will be responsible for providing and coordinating services for the member until the member's eligibility with the new MCO is effective.

SECTION 3

ELIGIBILITY AND DISENROLLMENT

Health Plan Enrollment

The Health and Human Services Commission (HHSC) is responsible for determining Medicaid and CHIP eligibility. Contact Superior's Member Services department if you need to locate an HHSC 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's application is approved for Medicaid or CHIP, the state's Enrollment Broker sends the member an enrollment packet, informing the member of the health plan choices in his or her area. The packet will also instruct 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 Medicaid Eligibility

Each person approved for Medicaid benefits receives a "Your Texas Benefits Medicaid" card. However, having a card does not always mean a person has current Medicaid coverage. Providers should verify the resident's eligibility for all dates of service prior to services being rendered. There are several ways to do this:

- Call Superior HealthPlan at 1-866-516-4501.
- Visit Superior's Provider Portal at www.SuperiorHealthPlan.com.
- Use LTC TexMedConnect on the Texas Medicaid and Healthcare Partnership (TMHP) website at www.tmhp.com.
- Other Options:
 1. Call the Automated Inquiry System (AIS) line at 1-800-925-9126.
 2. Call the Your Texas Benefits Provider helpline at 1-855-827-3747.
 3. Swipe the resident's Your Texas Benefits Medicaid card through a standard magnetic card reader, if your office uses that technology.
- Your Texas Benefits Medicaid Card
 1. Temporary ID (Form 1027-A).
 2. Superior Health Plan ID Card.
 - If the member also receives Medicare health insurance coverage, 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 Superior ID card.

Important: Members can request a new "Your Texas Benefits Medicaid" card by calling 1-855-827-3748. Medicaid members can also go online to order new cards or print temporary cards at www.YourTexasBenefits.com. To request a Superior ID card, members can call 1-866-516-4501.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by members or proof of member eligibility from the Your Texas Benefits Medicaid card website at www.YourTexasBenefitsCard.com. A copy is required during the appeal process if the member's eligibility becomes an issue.

Your Texas Benefits

Your Texas Benefits gives providers access to Medicaid health information. Medicaid providers can log into the site to see a patient's Medicaid eligibility, services and treatments. This portal aggregates data (provided from TMHP) into one central hub - regardless of the plan [FFS or Managed Care]. All of this information is collected and displayed in a consolidated form (Health Summary) with the ability to view additional details if need be. It's free and requires a one-time registration.

To access the portal, visit YourTexasBenefitsCard.com and follow the instructions in the 'Initial Registration Guide for Medicaid Providers'. For more information on how to get registered, download the 'Welcome Packet' on the home page.

YourTexasBenefitsCard.com allows providers to:

- View available health information such as:
 - Vaccinations
 - Prescription drugs
 - Past Medicaid visits
 - Health Events, including diagnosis and treatment
 - Lab Results
- Verify a Medicaid patient's eligibility and view patient program information.
- View Texas Health Steps Alerts.
- Use the Blue Button to request a Medicaid patient's available health information in a consolidated format.

Patients can also log in to www.YourTexasBenefits.com to see their benefit and case information, print or order a Medicaid ID card, set up Texas Health Steps Alerts and more.

If you have questions, call 1-855-827-3747 or email ytb-card-support@hpe.com.

Pharmacies

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

Involuntary Disenrollment Due to Member Non- Compliance

There may be instances when a PCP feels that a member should be removed from his or her 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 his or her 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 his or her 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. HHSC 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+PLUS Program

STAR+PLUS is a Texas Medicaid program integrating the delivery of acute care services and Long-Term Services and Supports (LTSS) to Medicaid recipients who are age, blind and disabled, 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. The Health and Human Services Commission (HHSC) 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.

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 the Mentally Retarded (ICFMR).
- 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.

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 Medicare Advantage (HMO SNP).

Superior HealthPlan Medicare 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 Medicare 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 Medicare Advantage must show their ID cards each time they receive physician or hospital services. Dual eligible members 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 HHSC Drug Exception file. However, these wrap-around drugs/products must also follow Medicaid (TXVDP) 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 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.

Disenrollment

When a member becomes ineligible for Texas Medicaid, the member is disenrolled from the STAR+PLUS program and from Superior. HHSC 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, so it is important to check eligibility before considering a member as eligible or ineligible.

A member can request disenrollment from Superior. Their request will require medical documentation from the PCP, or documentation that indicates sufficiently compelling circumstances that merit disenrollment. The member's request must be submitted to HHSC for review and a final decision.

Superior and network providers are expressly prohibited from taking any retaliatory action against a member who requests disenrollment either from the plan or from their care, respectively.

Renewal

Members who receive SSI benefits from the Social Security Administration (SSA) are categorically eligible for SSI Medicaid and, therefore, do not have to re-certify with HHSC each year. To maintain SSI benefits, the SSA may require information from the member related to their SSI benefits. The member or their representative payee may call the SSA. Neither the Department of Aging and Disability Services (DADS) nor HHSC plays 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 [6] months or less) for Medicaid, but regains Medicaid eligibility within the six (6) month time frame and resides in the same service area, the member will be automatically re-enrolled by HHSC 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.

Members Who Move to a Facility Outside of the Service Area

Members may transfer to another Nursing Facility at any time. Members are required to notify the State Enrollment Broker of their change of address. The member may transfer to a Nursing Facility in a different geographic area. For MMP members that transfer from one Nursing Facility to another – the member must elect to enroll in MMP in that new county (Bexar, Dallas, Hidalgo). If Superior is approved by HHSC in the area the Nursing Facility resident is transferred to, the member may remain enrolled with Superior. If the member is transferred to a Nursing Facility that is not in a geographic area that HHSC has approved Superior to provide services, then the member will be asked to select a new Managed Care Organization (MCO). The effective date of the new MCO will be prospective will follow the member's admission to the new Nursing Facility. Superior will be responsible for providing and coordinating services for the member until the enrollment with the new MCO is completed.

SECTION 4

COVERED BENEFITS AND SERVICES

Direct Access to Care - Medicaid Members Only

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

- Obstetric or gynecologic services for female members.
- Routine vision services, to include eye exams and eyewear.
- Behavioral health services.
- Network ophthalmologists or therapeutic optometrists to provide health-care services other than surgery.

Members with special health-care needs can access specialist services as needed. If the specialist is of a specialty which requires prior authorization (PA), per the current Superior Prior Authorization List, an authorization will be provided as appropriate for the member's condition.

Nursing Facility Add-On Services

Nursing Facility add-on services are the types of services provided in the facility setting by a provider or another network provider but are not included in the Nursing Facility Unit Rate. Nursing Facility add-on services are emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs and augmentative communication devices.

All add-on services require PA and are limited to the following:

- **Ventilator care add-on service:** To qualify for supplemental reimbursement, a Nursing Facility member must require artificial ventilation for at least six (6) consecutive hours daily and the use must be prescribed by a licensed physician.
- **Tracheostomy care add-on service:** To qualify for supplemental reimbursement, **a Nursing Facility member must be less than twenty-two (22) years of age;** require daily cleansing, dressing and suctioning of a tracheostomy; and be unable to do self-care. The daily care of the tracheostomy must be prescribed by a licensed physician.
- **PT, ST, OT add-on services:** Rehabilitative services are physical therapy, occupational therapy and speech therapy services not covered under the Nursing Facility Unit Rate, for Medicaid Nursing Facility members who are not eligible for Medicare or other insurance. The cost of therapy services for members with Medicare or other insurance coverage or both must be billed to Medicare or other insurance or both. Coverage for physical therapy, occupational therapy, or speech therapy services includes evaluation and treatment of functions that have been impaired by illness. Rehabilitative services must be provided with the expectation that the Member's functioning will improve measurably in 30 days.

The provider must ensure that rehabilitative services are provided under a written plan of treatment based on the physician's diagnosis and orders, and that services are documented in the Member's clinical record.

- Rehabilitative services only include acute benefits. Therapy services for chronic conditions are not a covered benefit for Nursing Facility add-on services.

The provider must ensure that rehabilitative services are provided under a written treatment plan based on the physician's diagnosis and orders and that services are documented in the member's clinical record.

Initial therapy evaluation requests should originate directly from the office of the member's PCP, specialist or Nursing Facility and should include:

- An evaluation order signed and dated within the last 30 days by the member's PCP or other appropriate specialist involved in the member's care. The evaluation order must specify the discipline(s) to be evaluated.
- Correct procedure codes and diagnoses codes corresponding to the service(s) to be provided.
- Documented medical necessity reason for therapy initial evaluation.

Reevaluation request may originate from the Nursing Facility or servicing provider and should include:

- A reevaluation order signed within the last 30 days by the PCP or specialist involved in the member's care.
- If the request is made greater than 30 days from the end of the existing treatment authorization documentation from the PCP or specialist involved in the member's care identifying the medical necessity for reevaluation.

Initial treatment requests should include:

- Date of evaluation.
- Member's age and birthdate.
- For speech therapy only - member's primary language.
- 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 the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, 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.
- Short and long-term treatment goals which are specific to the member's diagnosed condition or impairment. Short and long-term treatment goals must be functional, measureable, attainable and time-based.
- Treatment plan may not be more than 90 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.

Requests for continued treatment should include all of the above elements, in addition to:

- 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 deficits and the severity level documented using objective data. This may include current standardized assessment scores, percentage of functional impairment, 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 short and long-term treatment goal. For all unmet short-term and long-term goals, baseline and current function must be submitted so that the member's progress towards goals may be measured. As the treating therapist has set the short and long-term goals for a specified time period, it would be expected that short and long term goals would be met within the specified time frame. If the short and long-term goals are unmet, it is the treating therapist's responsibility to objectively describe any barriers to progress that were encountered and appropriate modifications to the treatment plan in order to meet the member's needs.
- If the member has not met the expected level of progress, the request must be reviewed by the medical director to determine if there is medical necessity to continue treatment.
- An updated statement of the prescribed treatment modalities and their recommended frequency/duration.
- A brief prognosis with clearly established discharge criteria.
- Updated short and long-term treatment goals which are specific to the member's diagnosed condition or impairment. Short and long-term treatment goals must be functional, measureable, attainable and time-based.
- Updated treatment plan/progress summary may be no older than 90 days old.
- Treatment plan must be signed and dated by the treating therapist.
- Orders for therapy requests for members 21 years of age and over must be signed by a physician, signatures of an advanced practice RN (APRN) or physician assistant (PA) are not accepted. If an APRN or PA is designated as the member's PCP then that clinician may sign therapy orders.

Note: Therapy orders signed by doctors of philosophy are not accepted.

Customized Power Wheelchair (CPWC) add-on services: To be eligible for a CPWC, a resident must be:

- | | |
|---|--|
| • Medicaid eligible. | • Able to safely operate a power wheelchair. |
| • 21 years of age or older. | • Able to use the requested equipment safely in the Nursing Facility. |
| • Residing in a licensed and certified Nursing Facility that has a Medicaid contract with the Department of Aging and Disability Services (DADS). | • Unable to be positioned in a standard power wheelchair. |
| • Eligible for and receiving Medicaid services in a Nursing Facility. | • Mobility status would be compromised without the requested CPWC. |
| • Unable to ambulate independently more than ten (10) feet. | • Certified by a signed statement from a physician that the CPWC is medically necessary. |
| • Unable to use a manual wheelchair. | |

Augmentative Communication Device (ACD) add on services: A speech-generating device system available to Nursing Facility members. A physician and a licensed speech therapist must determine if the ACD is medically necessary

Note: For Nursing Facility add-on therapy services, Superior will accept claims received from: (1) the Nursing Facility on behalf of the employed or contracted therapists; and (2) directly from therapists who are contracted with Superior. All other Nursing Facility add-on providers must contract directly with and directly bill Superior. Nursing Facility add-on providers except Nursing Facility add-on therapy providers, should reference the STAR+PLUS Provider Manual for information on credentialing and re-credentialing.

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. In order to meet this need, Superior provides or coordinates the following:

- A Member Services department that is staffed with bilingual personnel (Spanish and English).
- Trained professional language interpreters, including American Sign Language that can be made available for face-to-face communication in your office, if necessary, or via telephone to assist providers with discussing technical, medical or treatment information with members.
- Provide availability of more than 200 languages to handle calls in the Member Services department.
- TTY access for members who are hearing impaired. This is coordinated through 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 more than 200 other languages.

To coordinate interpreter services for your residents, contact Superior's Member Services department at 1-866-516-4501.

Utilization Management Criteria

Utilization Management decisions are made in accordance with currently accepted medical or health-care practices. The criteria used for review of medical necessity, provider peer-to-peer review takes into account the special circumstances of each case that may require an exception to the standard, as stated in the screening criteria. The medical director may review all potential adverse determinations for medical necessity; and the vice president of medical management, or a designee, assesses the consistency with which reviewers apply the criteria.

InterQual criteria are used to determine medical necessity. InterQual was developed by generalist and specialist physicians representing a national panel from academic as well as community-based practice, both within and outside the managed care industry. These criteria provide a clear and consistent platform for care decisions to appropriately balance resources. A Superior Utilization Management nurse will review clinical documentation to determine medical necessity and the appropriateness for Nursing Facility add-on and acute care services, including setting of care, are met according to the InterQual criteria. Superior also utilizes the Texas Medicaid Provider Manual (TMPPM) as a guideline for Medicaid covered services.

Note: Utilization Management reporting requirements are specified by individual mental health service types.

Coordination with Other State Program Services

Coordination with Public Health

Superior coordinates with other State Health and Human Services (HHS) programs regarding the provision of 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 Tuberculosis (TB) and all confirmed cases of STD/HIV to the public health entity for investigation and evaluation, and preventive treatment of persons whom the member has come into contact within one (1) working day of identification:
 1. Bill all TB-related services to TMHP.
 2. Reporting to the local public health entity for TB contact investigation and evaluation, and preventive treatment of persons whom the member has come into contact within one (1) working day of identification.
 3. Ensure all members who have TB or are at-risk are screened for TB.
 4. Access procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/forms.
- Properly maintaining confidential information about members who have received STD/HIV services.
- Properly 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 HHSC 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 (3) 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 (2) working days from the day the member is identified.
- Using materials from Department of Assistive and Rehabilitative Services (DARS) available on www.dars.state.tx.us/ecis/index.shtml or by contacting 1-800-783-5386.
- Complying with the release of records within 45 days so that screening may be completed.

For coordination of services not directly provided through Superior, all network providers are encouraged to refer to and coordinate services with the agencies listed below. However, if more information or assistance is required, contact Superior's Member Services department or complete and submit a Connections Referral Form located the Superior website.

Access procedures for reporting TB and appropriate DSHS forms from www.dshs.state.tx.us/idcu/disease/tb/ forms or by contacting Superior's Member Services department.

Access required forms for STD/HIV reporting from: <http://www.dshs.texas.gov/hivstd/healthcare/reporting.shtm> by calling Superior's Member Services department.

Refer to the TMPPM for further coordination.

Additional Benefits

Prescriptions

All STAR+PLUS non-dual eligible Medicaid members receive unlimited prescriptions. Members who receive Medicare as their primary health-care insurance coverage will continue to receive their prescriptions through their Medicare Part D.

Roles of a Pharmacy

Superior members receive pharmacy services through Superior's contracted Pharmacy Benefit Manager (PBM). The PBM has a statewide network of contracted pharmacies enrolled in the Texas Vendor Drug Program (VDP), including many long-term care pharmacies such as but not limited to Pharmerica, Omnicare, and Pharmascript and VDP-enrolled independent and chain pharmacies. In addition, in-house pharmacies and/or those affiliated with a Nursing Facility are contracted with the VDP and our PBM. Contracting for in-house or affiliated pharmacies are handled via our PBM. The PBM will also work with any pharmacy provider should there be VDP questions or concerns related to contracting to redirect the concern or facilitate resolution.

Superior HealthPlan is required to adhere to the Preferred Drug List (PDL) which is created and maintained by the Texas VDP. Members have the right to obtain Medicaid 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 state mandated Medicaid formulary PDL. The pharmacy must coordinate the benefits when a member also receives Medicare Part D services or has other benefits.

Behavioral Health

Superior contracts with Cenpatco Behavioral Health, Inc. to manage behavioral health services (mental health and substance abuse) for Superior members. Cenpatco is responsible for the provision of medically necessary behavioral health services and maintains a robust network of behavioral health and substance abuse disorder providers including psychiatrists, nurse practitioners, psychologists, social workers, licensed professional counselors, hospitals and Local Mental Health Authority (LMHA) Facilities.

Cenpatco behavioral health providers agree to:

- Refer members with known or suspected physical health problems or disorders to the PCP for examination and treatment.

- Only provide physical health services if such services are within the scope of the network provider's clinical licensure.
- Schedule outpatient follow up and/or continuing treatment prior to discharge for all members that have received inpatient psychiatric services.
- Ensure outpatient treatment occurs within seven (7) days from the date of hospital discharge, inpatient psychiatric facility discharge or Nursing Facility discharge.
- Contact members who have missed appointments within 24 hours to reschedule appointments.
- Coordinate with LMHA and state psychiatric facilities.
- Complete training and become certified to administer Adult Needs and Strengths Assessment (ANSA).
- Use Department of State Health Services Resiliency and Recovery Utilization Management Guidelines (RRUMG) as the medical necessity criteria for Mental Health Rehabilitative services (MHR) and Mental Health Targeted Case Management (TCM) services.
- As part of the credentialing process, provide an attestation to Superior that provider/facility has the ability to provide, either directly or through sub-contract, Superior members with the full array of MHR and TCM services as outlined in the RRUMG.
- Abide by the Qualified Mental Health Professionals for Community Services (QMHP-CS) the requirement minimums for a QMHP-CS are as follows:
 - Demonstrate competency in the work to be performed; and medical record documentation and referral information must be documented using the Diagnostic and Statistical Manual of Mental Disorders (DSM) classifications.

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 HHSC determines will promote healthy lifestyles and improve health outcomes. Superior contracts with companies to provide VAS. Those companies will bill Superior directly for the services they provide.

For a complete listing of Superior's current VAS, please refer to:

- Superior's Member Handbook.
- Superior's website at www.SuperiorHealthPlan.com.
- Superior's Member Services department by calling 1-866-516-4501.

SECTION 5

SERVICE COORDINATION

The goals of managed care include an emphasis on preventive care, improved access to care, appropriate utilization of services, improved client and provider satisfaction, improved health outcomes, quality of care and cost-effectiveness. Superior Service Coordinators will partner with Nursing Facility staff to ensure a member's care is holistically integrated and coordinated by finding ways to avoid preventable hospital admissions, readmissions and emergency room visits, resulting in shared savings to benefit both the Nursing Facility and Superior, and most importantly the members.

The Service Coordinator participates in person and family-centered¹ service planning² with the Nursing Facility staff, Primary Care Provider, vendors and other state and community agencies to coordinate managed and non-managed services, including non-Medicaid community resources. In addition, the Service Coordinator attends meetings, assists in the development of the Nursing Facility's plan of care for the member, and serves as the primary resource or advocate for the member ensuring that the member, the member's family or representative, Nursing Facility staff and other members of the interdisciplinary team are involved. On a quarterly basis, the Service Coordinator conducts a face-to-face visit with the Nursing Facility member, or more frequently, as determined by the member's condition, situation and level of care.

Service Coordinator Responsibility

The Service Coordinator is responsible for:

- Coordinating services when a member transitions into a Nursing Facility.
- Developing a service plan that includes services provided through the Nursing Facility, add-on services, acute medical services, behavioral health services and primary or specialty care.
- Participating in Nursing Facility care planning meetings telephonically or in person, provided the member does not object.
- Comprehensively reviewing the member's service plan, including the Nursing Facility plan of care, at least annually, or when there is a significant change in condition.
- Visiting members living in Nursing Facilities at least quarterly. Visits should include, at a minimum, a review of the member's service plan and, when possible, a person-centered discussion with the member about the services and supports the member is receiving, any unmet needs or gaps in the member's service plan and any other aspect of the member's life or situation that may need to be addressed.
- Promote a meaningful quality of life and autonomy for members.
- Assisting with the collection of applied income when a Nursing Facility has documented unsuccessful efforts, per the state-mandated Nursing Facility requirements.
- Cooperating with representatives of regulatory and investigating entities including DADS Regulatory Services, the LTC Ombudsman program, Adult Protective Services, the Office of the Inspector General and law enforcement.

- Fulfilling requirements of the Texas Promoting Independence Initiative (PII) as described in UMCC Section 8.3.9.2. The quarterly in-person visits required can include assessments required under the PII, and the Service Coordinator can serve as the designated point of contact for an individual referred to return to the community under PII.
- Coordinating with the Nursing Facility discharge planning staff to plan discharge and transition from the Nursing Facility.
- Notifying the Nursing Facility within ten (10) days of a change to Superior's assigned service coordinator.
- Returning a call from a Nursing Facility within 24 hours after the call is placed by the Nursing Facility.

¹Information on person-centered practices can be found online at: <http://www.learningcommunity.us/> and <http://www.person-centered-practices.org/home.html>.

²For the purposes of this document, service plan is a comprehensive set of services and supports, including Medicaid-covered services, informal or family supports, and non-Medicaid community resources. The Service Coordinator is responsible for a member's service plan. A Nursing Facility plan of care is the Medicaid-covered services provided in a Nursing Facility. The Nursing Facility is responsible for the Nursing Facility plan of care but the Nursing Facility plan of care may include add-on services authorized by Superior.

Nursing Facility Responsibility

The Nursing Facility staff will partner with Superior's Service Coordinators to ensure the member's plan of care meets the member's needs in the least restrictive setting. The Nursing Facility is responsible for:

- Inviting Superior's Service Coordinator to attend scheduled meetings with the interdisciplinary team and include the Service Coordinator's input on the development of the Nursing Facility care plan which is subject to the member's right of refusal. Nursing Facility care planning meetings should be contingent on Superior's Service Coordinator participation.
- Notifying Superior's Service Coordinator within one (1) business day of unplanned admission or discharge to a hospital or other acute facility, skilled bed or another nursing home.
- Notifying Superior's Service Coordinator if a member moves into hospice care.
- Notifying Superior's Service Coordinator within one (1) business day of an adverse change in a member's physical or mental condition or environment that could potentially lead to hospitalization.
- Coordinating with Superior's Service Coordinator to plan discharge and transition from a Nursing Facility.
- Notifying Superior's Service Coordinator within one (1) business day of an emergency room visit.
- Notifying Superior's Service Coordinator within 72 hours of a member's death.
- Notifying Superior's Service Coordinator of any other important circumstances such as the relocation of members due to a natural disaster.
- Providing Superior's Service Coordinator access to the facility, Nursing Facility staff and member's medical information and records.

SECTION 6

ROUTINE, URGENT AND EMERGENCY SERVICES

Routine, Urgent and Emergency Services Defined

Superior requires that medically necessary health services are safely provided in the most appropriate and least restrictive setting without adversely affecting a member's physical health or their quality of life. Members are encouraged to contact their Primary Care Provider (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

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. Some examples of routine care include immunizations and regular screenings like pap smears or cholesterol checks.

Urgent Condition

A health condition, including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a PCP or practitioner to believe that a member's condition requires medical treatment evaluation or treatment within 24 hours to prevent serious deterioration of the member's condition or health. Medicare members in need of urgent care services should be treated within 12 hours in order to avoid the likely onset of an emergency medical condition.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity including severe pain, such that a PCP or practitioner 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 the Health and Human Services Commission (HHSC) and Texas Department of Insurance (TDI). “Day” is a calendar day, and the standards are measured from the date of presentation or request, whichever occurs first.

Covered Services	Timelines
Routine primary care	14 days
Routine specialty care	30 days
Initial outpatient behavioral health visits	10 days
Urgent care, including urgent specialty care	24 hours
Emergency services, including at non-network out-of-area facilities	Must be provided upon member presentation at the service delivery site

Emergency Pharmacy Services - Medicaid Only

A 72-hour emergency supply of a prescribed drug will be offered when a medication is needed without delay and prior authorization (PA) is not available. This applies to drugs requiring a PA, either because they are non-preferred drugs on the Preferred Drug List (PDL) or because they are subject to clinical edits. Emergency supplies are NOT available for medications that do not appear on the PDL. Emergency supply provision does not apply to Hepatitis C medications.

The 72-hour emergency supply should be dispensed when a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member’s medical condition. This short-term supply does not apply to Drug Efficacy Study Implementation (DESI) drugs, when the drug could be contraindicated to the member’s condition or when starting and abruptly stopping the medication would be medically contraindicated. If the prescribing provider cannot be reached or is unable to request a PA, then the pharmacy should submit an emergency 72-hour prescription as long as the above concerns are not noted.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable such as albuterol inhaler as a 72-hour emergency supply. To be reimbursed for a 72-hour emergency prescription supply, pharmacies should submit pharmacy benefit claims electronically through the PBM’s claims adjudication system. Questions surrounding pharmacy claims should be directed to the PBM. It is the responsibility of the Nursing Facility to notify the pharmacy regarding a member’s eligibility with Superior to ensure timely processing of claims.

For more information about the 72-hour emergency prescription supply policy, please contact the Envolve Pharmacy Solutions 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. Providers may bill for up to 10 ingredients through the on-line system. Payment requests for ingredients exceeding 10 must be submitted to the PBM’s help desk.

Emergency Transportation

An emergency ambulance transport is reimbursable when the member has an emergency medical condition. Nursing Facilities should utilize a participating provider for all emergency transportation.

Reimbursement is limited to basic life support ambulance services. Emergency ground transportation does not require PA; however, air or water transport requires authorization.

Non-Emergency Ambulance Transportation

The Nursing Facility is responsible for providing routine non-emergency transportation services. The cost of such transportation is included in the Nursing Facility unit rate. Transports of Nursing Facility members for rehabilitative treatment (e.g., physical therapy), to outpatient departments or to physicians' offices for recertification examinations for Nursing Facility care are not reimbursable services by Superior.

Superior is responsible for authorizing non-emergency ambulance transportation for a member whose medical condition is such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contra-indicated).

Superior is required to cover emergency and medically necessary non-emergency ambulance services. Non-emergency ambulance transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in 1 TAC §353.2 (relating to definitions), is not available at the first facility and Superior has not included payment for such transports in the hospital reimbursement.

All ambulance transports which do not meet the definition of an emergency medical condition as per 1 TAC §353.2 require PA, 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 PA to 1-800-690-7030. You can use the Texas Department of Insurance Standard Prior Authorization Form or the Superior Prior Authorization Form found at www.SuperiorHealthPlan.com.
- Faxing clinical information establishing medical necessity to 1-800-690-7030.
- Submitting the request and clinical information through our secure web portal at www.SuperiorHealthPlan.com.

Authorization Tips:

Nursing Facility providers must follow the steps below to obtain PAs for non-emergency ambulance transportation for STAR+PLUS members:

1. A physician or physician extender writes an order for non-emergency transport.
2. Nursing Facility staff should contact Superior's Member Services line, Utilization Management department or the

assigned Service Coordinator to find an ambulance company that is in-network.

3. The Nursing Facility staff contacts the ambulance company to get their necessary information to complete the PA form. Necessary information supplied by the ambulance company is limited to company name, fax number, NPI and other business information.
4. The ambulance provider will document the request was initiated by the Nursing Facility staff and include name, time and date.
5. The Nursing Facility must sign and submit the form to Superior for review along with documentation to support medical necessity.
6. The ambulance company and Nursing Facility will coordinate the scheduling of the appointment.

Approvals/Denials

Approved Utilization Management criteria will be used by Superior to review requests for medical necessity. Superior will provide an approval or denial letter for the PA to the requesting entity, as well as the ambulance provider. If a request for recurring transports is approved, Superior will include the number of one-way transports in the approval. Appeals for denials of medical necessity follow the standard provider appeal process, refer to the Appeals section of this manual.

The ambulance provider is ultimately responsible for ensuring that a PA has been obtained prior to transport; non-payment may result for services provided without a PA or when the authorization request is denied.

STAR+PLUS Non-Urgent Transportation

The HHSC Medical Transportation Program (MTP) is designed to serve STAR+PLUS members that have no other means of transportation for medical and dental appointments. The MTP will utilize the most cost effective method of transportation that does not endanger a member's health, to include an ambulance or wheelchair van.

- To request medical transportation services, members in most of Texas should contact MTP at 1-877-633-8747. Calls to MTP are free calls in Texas.
- Members in the Houston / Beaumont Service Delivery Area (SDA) should call Medical Transportation Management at 1-855-687-4786 toll-free to arrange services. Counties in this area include: Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller and Wharton.
- Members in the Dallas / Fort Worth SDA should call LogistiCare at 1-855-687-3255 toll-free to arrange services. Counties in this area include: Collin, Dallas, Denton, Ellis, Erath, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant and Wise.

MTP intake specialists are available to take requests by telephone on weekdays from 8:00 a.m. to 5:00 p.m.

MTP requires at least two (2) business day's advance notice for most requests, but will attempt to accommodate urgent requests. Members should call in their request as far in advance as possible. The MTP may also reimburse mileage for the client, a caregiver/medical consentor, 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. In situations where MTP does not provide transportation, additional transportation assistance may be available to qualifying Superior members. Please refer residents to the Value Added Services section of their member handbook for specific information on transportation-related benefit. Providers can also direct members to contact Member Services to

see if additional benefits are available to them.

Emergency Dental Services-Medicaid only

Superior is responsible for emergency dental services provided to Medicaid members in a hospital or ambulatory surgical center setting. Superior will also pay for hospital, physician and related medical services such as anesthesia and drugs for covered emergency dental procedures.

Covered emergency dental procedures include, but are not limited to:

- Alleviation of extreme pain in oral cavity associated with serious infection or swelling.
- Repair of damage from loss of tooth due to trauma (acute care only, no restoration).
- Open or closed reduction of fracture of the maxilla or mandible.
- Repair of laceration in or around oral cavity.
- Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts.
- Incision and drainage of cellulitis.
- Root canal therapy. However, payment is subject to dental necessity review and pre and post-operative x-rays are required.
- Extractions: single tooth, permanent; single tooth, primary; supernumerary teeth; soft tissue impaction; partial bony impaction; complete bony impaction; surgical extraction of erupted tooth or residual root tip.

Non-Emergency Dental Services

Superior is not responsible for paying for routine dental services provided to Medicaid members. However, Superior is responsible for paying for treatment and devices for craniofacial anomalies.

SECTION 7

PRIOR AUTHORIZATION

Prior Authorization Requirements

Requesting providers must initiate a prior authorization (PA) of non-emergency services and all add-on services prior to providing the requested service. It is recommended that requests be submitted five (5) business days prior to the desired start date in order to allow time for processing. All add-on services require PA and should be submitted in one of three ways:

1. Calling the Prior Authorization department at 1-800-218-7508.
2. Faxing the PA form to 1-800-690-7030. The form is available online at www.SuperiorHealthPlan.com.
3. Submitting the request via the Secure Provider Portal at provider.SuperiorHealthPlan.com.

Superior has adopted a PA process for specific procedures and/or services. These procedures and/or services are listed on Superior's PA list. The PA list is available on Superior's website at www.SuperiorHealthPlan.com.

Failure to obtain PA for services that require PA will result in an administrative denial. Incomplete PA requests will be returned as incomplete and not processed.

Radiology Authorizations

For imaging services, Superior uses National Imaging Associates (NIA) to provide PA of high-tech radiology 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 services listed below should verify that the necessary authorization has been obtained because failure to do so may result in claim non-payment. PA is required for the following outpatient radiology procedures:

- CT /CTA.
- MRI/MRA.
- PET scan.
- Cardiac imaging modalities for STAR+PLUS members require an authorization. These include CCTA, stress echo and nuclear cardiology.

Emergency room, observation and inpatient imaging procedures do not require authorization.

To reach NIA and obtain authorization, please call 1-800-642-7554.

SECTION 8

CLAIMS AND ENCOUNTERS ADMINISTRATION

A claim is a request for reimbursement for any health-care service provided. The claims process begins when a member's eligibility for coverage is determined and Superior provides benefits for specific services. Superior providers are encouraged to submit a claim or encounter for each service rendered to a Superior member. However, Superior will not accept claims submitted to an address or through a method not described in this section.

Claim Filing Guidelines

All Nursing Facility providers must follow and meet DADS' criteria for clean claims submissions as described in UMCM Chapter 2.3, "Nursing Facility Claims Manual" and as noted below.

DADS Clean Claim Criteria:

- The Nursing Facility resident must be Medicaid eligible for the dates of service billed.
- The Nursing Facility resident must be in the Nursing Facility for the dates of service billed.
- The Nursing Facility resident must have a current Medicaid necessity determination for the dates of service billed.
- The Nursing Facility provider had to be in good standing for the dates of service billed (i.e., not on vendor payment hold for any reason).

Note: Any claim that does not meet the definition of a clean claim is considered a "non-clean claim." Non-clean claims typically require external investigation or development in order to obtain all information necessary to adjudicate the claim.

Nursing Facility providers are encouraged to participate in Superior's electronic claims/encounter filing program through Centene Corporation, Superior's parent organization, for all daily unit rate billing. This could occur in one of two ways:

1. Centene Corporation has the capability to receive ANSI X12N 837 institutional transactions in addition to having the capability to generate an ANSI X12N 835 electronic explanation of payment (EOP). For a full list of the trading partners who work with Superior (Centene), visit the Superior Secure Provider Portal at <http://www.SuperiorHealthPlan.com/for-Providers/electronic-transactions/>. The EDI Department can also be contacted at EDIBA@centene.com.
2. Providers may also submit claims directly to Superior through the Secure Provider Portal at www.SuperiorHealthPlan.com/providerlogin. To reach the web applications support desk, call directly to 1-866-895-8443 or email them to TXWebApplications@centene.com.

Timely Filing Requirements

Nursing Facilities must file their claim within 365 days from the date of service. If a claim is not received by Superior within the 365 days, Superior will deny the claim unless there is an exception from the filing deadline.

If the Nursing Facility files with the wrong health plan or the wrong HHSC portal within the required 365 days and produces documentation demonstrating timely filing, Superior will honor the initial filing date and process the claim without denying for the sole reason of passed timely filing. The Nursing Facility must file the claim with Superior (1.) 365 days after the date of service, or (2.) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from the other carrier or contractor.

When a service is billed to a third-party insurance resource other than to Superior, the claim must be refiled and received by Superior: (1.) 365 days from the date of service, or (2.) 95 days after the date on the R&S Report or explanation of payment from the other carrier or contractor. Superior will require that the Nursing Facility file their claim with a copy of the third-party payor's R&S Report or explanation of payment.

A claim should not be filed with different RUG or service levels. Each claim must only bill for one RUG or service level which may result in a split claim.

If a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

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 Uniform Managed Care Manual Chapter 2.3. Superior may not directly or indirectly charge or hold a member or network or non-network provider responsible for a fee to adjudicate a claim.

Superior may deny a claim submitted by a provider for failure to file in a timely manner as described in the Uniform Managed Care Manual Chapter 2.3. Superior may withhold all or part of a payment for a claim submitted to a provider:

- Excluded or suspended from Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
- On full or partial payment hold under the authority of HHSC or its authorized agent(s) with debts, settlements, or pending payments due to HHSC or the state or federal government.
- If the provider's claim for Nursing Facility unit rate does not comply with all clean claim criteria.

No later than ten (10) days after the Submission Received Date of a Clean Claim, Superior must: (1.) pay the total amount due of the claim or part of the claim or (2.) deny the entire claim, or part of the claim and notify the provider defining the reasons why the claim will not be paid.

Payment is considered paid on the date of: (1.) the date of issue of a check for payment and its corresponding explanation of Payment or (2.) electronic transmission, if payment is made electronically.

Durable Medical Equipment (DME) and Other Common Pharmacy Products

Superior reimburses for covered DME and products commonly found in a pharmacy and not covered under the Nursing Facility unit rate. DME covered under the Nursing Facility unit rate includes medically necessary items such as:

- Nebulizers, ostomy supplies or bed pans and medical accessories.
- Cannulas, tubes, masks, catheters, ostomy bags and supplies.
- Intravenous (IV) fluids, IV equipment and equipment that can be used by more than one person.
- Wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers and oxygen equipment.
- Tanks, concentrators, tubing, masks, valves and regulators.

Nursing Facility Unit Rate

Nursing Facility Unit Rates will continue to be authorized by DADS. Superior will not reassess or authorize services resulting from the MDS and covered under the Nursing Facility Unit Rate. Nursing Facilities must submit an electronic version of the Medicare Remittances and Advice Form.

The Nursing Facility Unit Rates are the types of services included in the DADS daily rate for Nursing Facility providers, such as room and board, medical supplies and equipment, personal needs items, social services and over-the-counter drugs. This also includes applicable Nursing Facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility add-on services.

It is important to note that DADS will continue to authorize the daily rate as well as make the medical necessity determinations. Nursing Facilities are required to submit the Minimum Data Set (MDS) form to Centers for Medicare and Medicaid Services (CMS) and Long-Term Care Medicaid Information (LTCMI) form to the LTC Online Portal. For additional information, visit the DADS website for Texas Minimum Data Set (MDS) at <http://www.dads.state.tx.us/providers/mds/preparingformedicad.html>.

Providers should contact Superior's Provider Services at 1-877-391-5921 for questions related to claims procedures. The uniform billing requirements can be found in the HHSC Uniform Managed Care Manual (UMCM), Chapters 2 Texas Claims Procedures: <http://www.hhsc.state.tx.us/medicaid/managed-care/umcm/>.

Adjusted Claims-Daily Unit Rate

There may be occasions in which a claim, which is in a paid status, may require a payment adjustment. Superior will monitor and re-adjudicate a claim through the daily Service Authorization (SAS) file. Adjustments are automatic and facility providers are not required to take any action. Some of the reasons a claim may require an adjustment are due to changes in:

- Nursing Facility daily rates
- Provider contracts
- Service authorizations
- Applied income
- Level of service/Resource Utilization Group (RUG)

In each of these instances, Superior will automatically re-adjudicate claims affected by the change. Payment on adjusted claims will be made within 30 days from receipt of the adjustment reason.

When a subsequent claim submission is necessary as result of a SAS related claim denial, please submit as a new claim (vs. “Corrected Claim”).

Applied Income – Nursing Facility Unit

Within three (3) business days after the effective date of the Nursing Facility member, Superior will provide the name and contact information of a Service Coordinator or designated representative who will assist with the collection of applied income from the Nursing Facility member. Superior will notify the provider within ten (10) days of any change to the assigned Service Coordinator or designated representative. The provider must make reasonable efforts to collect applied income, document those efforts. The provider should notify Superior’s Service Coordinator or designated representative when they have made two (2) unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the provider’s existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40 TAC § 19.2316.

Coordination of Benefits for STAR+PLUS Members with Medicare

Dual eligible members have both Medicare and Medicaid health insurance coverage. Medicare is the primary payor and will reimburse for all acute care services including behavioral health as well as the Skilled Nursing Facilities (SNF) approved amounts. The Nursing Facility is responsible for filing claims for Medicare coinsurance. Superior is responsible for paying the Medicare deductibles and coinsurance for services provided by Nursing Facilities. To receive payment on a claim for tracheostomy care or ventilator services, it is not necessary to provide the R&S report from Medicare for the Nursing Facility unit costs. However, for all other services provided by the Nursing Facility, if Superior is not the member’s Medicare payor, then the electronic copy of the R&S Report from Medicare will need to be filed with the claim. In the event Superior is the member’s Medicare carrier no Medicare R&S is required. Claims will deny if services billed that require a copy of the Medicare R&S are not submitted with the initial claim. The denial status of the claim will not change until the Medicare R&S is received. The Nursing Facility must file a claim with Superior: (1.) 365 days after the date of service or (2.) 95 days after the date on the R&S Report or explanation of payment (EOP) from the other carrier or contractor.

Claims for SNF services require that one claim be filed to the Medicare carrier for the SNF allowable and a second, distinct claim be filed to Superior for the Medicaid coinsurance reimbursement. Appropriate and required revenue codes must be used for each separate claim.

Coordination of Benefits for Members Enrolled in the STAR+PLUS Medicare-Medicaid Plan (MMP)

MMP members have their Medicare and Medicaid benefits coordinated under one health plan. Superior STAR+PLUS MMP will reimburse providers for acute care services, including behavioral health (statewide, including Dallas SDA) as well as the SNF approved amounts. In the case of SNF, providers must file two claims: one claim with the standard Medicare revenue code for SNF and a separate claim for the Medicaid coinsurance revenue code 101. It is

not required that providers file their claims for coinsurance with a copy of the Superior (Medicare) EOP. The Nursing Facility must file a claim with Superior: (1.) 365 days after the date of service or (2.) 95 days after the date on the EOP from the Medicare payment.

Acute Care Service

For Superior members that are dual eligible because they receive both Medicare and Medicaid, Medicare is the primary payor for all acute care services (e.g. PCP, hospital and outpatient services), SNF services and skilled nursing stay days one (1) through 20 at 100% of the level of service.

For Superior members that have Medicaid only, Superior covers acute care services (such as hearing aids, orthotics or prosthetics and non-emergent ambulance transportation), add-on services and the Nursing Facility Unit Rate.

Providers that provide acute care services have 95 days from the date of service to submit a claim. Providers are required to bill two separate claims for Medicare Acute Services: (1.) for member compensation and (2.) for Medicaid co-pay. Depending on the member's coverage, additional information may be available in the MMP Provider Manual or the Medicare Advantage Provider Manual which are available at www.SuperiorHealthPlan.com.

Coordination of Benefits

Some members with Medicaid may have other health coverage that must pay before Medicaid pays its share of the bill. These health insurance coverages are always primary to Medicaid coverage. When there's more than one payor, "coordination of benefits" rules decide who pays first. It is important that providers verify if members have health coverage in addition to Medicaid as this will help ensure that claims are submitted to the correct payer to avoid delays. If a member has other insurance, please submit your claim to the primary insurance for consideration. Claims filed to Superior for members who have another insurance carrier should include a copy of the Explanation of Benefits (EOB), an Explanation of Payment (EOP) or a rejection letter from the other insurance carrier. If this information is not received with the initial claim, then the claim will deny until the appropriate documentation is received.

Note: If a member has more than one primary insurance carrier and Medicaid is the third payor, then a claim cannot be submitted through the Electronic Data Interchange (EDI) or the Secure Provider Portal, a paper claim must be submitted.

Out-of-Network Reimbursement

Nursing Facilities that have not signed a contract to provide care for Superior members are considered out-of-network. In such cases where an out-of-network Nursing Facility provides care to a Superior member, Superior will reimburse the out-of-network, in-area service provider the Medicaid fee-for-service (FFS) rate whereby Superior will pay for services rendered, less five percent (5%) per rules found in 1 Texas Administrative Code (TAC) § 353.4 with the exception to the Medicare coinsurance.

Claims Filing Guidelines for Add-On Services

A clean claim must include Superior published requirements for adjudication such as the appropriate Medicaid number, TIN number, NPI and taxonomy or medical records. For additional information on billing guidelines including taxonomy placement, please reference Section 10 - Claims and Encounters Administration of the Superior HealthPlan Provider Manual.

Please use the ANSI ASC X12 837P 5010 format for PT, OT, ST, Customized Power Wheelchairs (CPWC) and Augmentative Communication Devices (ACD) and ANSI ASC X12 837I 5010 format for Ventilator and Tracheostomy Care add-on services. Claims filed for add-on services must conform to national billing standards and Medicaid billing guidelines. Claims may be filed in one of three ways:

1. Submitting an ANSI X12N 837 professional transaction through an EDI partner. For a full list of the trading partners who work with Superior (Centene), visit the Superior Secure Provider Portal at www.superiorhealthplan.com/for-Providers/electronic-transactions/. The EDI Department can also be contacted for assistance at EDIBA@centene.com. *Note: Submission of a claim to the clearinghouse 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. Providers may also submit claims directly to Superior through the Secure Provider Portal at provider.superiorhealthplan.com. To reach the web applications support desk, call 1-866-895-8443 or email them at TXWebApplications@centene.com.
3. Claims for add-on services can be submitted on paper to:
Superior HealthPlan Claims Department
PO Box 3003
Farmington, MO 63640-3803

Note: Paper claims must be filed on the approved claim form UB-04/CMS 1450. The only acceptable claim form is the FLINT OCR Red, J6983, or exact match ink.

Timely Filing Requirements

Claims for add-on services must be filed with Superior: (1.) 95 days after the date of service, or (2.) 95 days after the date on the Remittance and Status (R&S) Report or explanation of payment from another carrier or contractor. However, if a filing deadline falls on a weekend or holiday, the filing deadline shall be extended to the next business day following the weekend or holiday.

Payment Requirements

All clean claims (including professional and institutional claims submissions) will be processed within 30 days of receipt. Each claim payment check will be accompanied by an EOP, which itemizes your charges for services rendered and the amount paid by Superior.

Billing Codes

Please reference to the most current LTSS Crosswalk for the list of codes and modifiers located in the HHSC MMC <http://www.hhsc.state.tx.us/medicaid/managed-care/mmc/carved-in-carved-out-services.pdf>.

Claims Reconsiderations

A corrected claim is the replacement of a previously submitted claim and occurs when a provider has submitted a claim and received a denial due to incorrect or missing information. To submit a claim form on paper, please use the required standard red and white UB-04 or HCFA 1500 claim form.

- Adjustment – An adjustment to a previously finalized clean claim.
- Appeal - In accordance with the appeal process, a clean claim that has been adjudicated where the provider is appealing the disposition through written notification to Superior. Examples of supporting documentation which must be included with an appeal:
 1. A letter from the provider stating why they feel the claim payment is incorrect (required).
 2. A copy of the original claim.
 3. A copy of the Superior EOP (required).
 4. An EOP from another insurance company.
 5. Documentation of eligibility verification such as copy of an ID card, “Your Texas Benefits” Medicaid card (formerly Medicaid form 3087), TMHP documentation or call log, etc.
 6. Overnight or certified mail receipt as proof of filing date.
 7. EDI acceptance reports showing the claim was accepted by Superior.
 8. Prior authorization number and/or form or fax.

Note: If a provider disputes the disposition of a claim, the provider may appeal the decision.

Submitting a Claim Appeal

A claims appeal is a request for reconsideration of a previous claim denial. This excludes claims for medical necessity or that would require review of medical records to make a determination. Upon receipt of denial, all claim appeals regarding the amount reimbursed or regarding a denial for a particular service must be initiated in writing or through the Secure Provider Portal with the necessary documentation. Any adjustments that result from a claim appeal will be provided by check with an EOP that reflects the claim adjustment. When submitting appeals please follow these guidelines:

- All appeals of claims and adjustment requests must be received by Superior within 120 days from the date of the last denial of and/or adjustment to the original claim.
- Claims appeals must be submitted via the Secure Provider Portal or in writing to:

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

Corrected Claim

A corrected claim is a correction or change of information to a previously finalized clean claim in which corrected information from the provider is required to perform the adjustment and is unrelated to MESAV/SAS changes. A corrected claim can be the result of:

- An original claim that was either denied or rejected as being deficient, as it did not contain all required elements to appropriately process the claim.
- 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 were erroneous.
- Providers may correct, but are not limited to, the following:
 1. Patient control number (PCN)
 2. Date of birth
 3. Place of service (POS)
 4. Quantity billed
 5. Date of service (DOS)
 6. Modifier missing or incorrect

Filing a Corrected Claims

Corrected paper claims should clearly indicate the corrections. Electronic or paper corrected claims must be submitted within 120 days of the initial claim disposition. When a subsequent claim submission is necessary as result of a SAS related claim denial, please submit as a new claim (vs. “Corrected Claim”).

Corrected claims can be submitted electronically or on paper via the Superior Secure Provider Portal or by completing the Corrected Claim Form on the website at www.SuperiorHealthPlan.com. Additionally, corrected claims can be submitted via the EDI or mailed to:

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

SECTION 9

COMPLAINT PROCEDURES

In Medicaid, a complaint is defined as an expression of dissatisfaction expressed by a Complainant, orally or in writing to the MCO, about any matter related to the MCO other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid member's rights.

Filing a Provider Complaint

Providers are able to file a complaint through a variety of mediums.

- Calling Provider Services to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Superior employee.
- Completing the on line Complaint Form found on Superior HealthPlan's website at:
<https://www.superiorhealthplan.com/contact-us/complaint-form-information.html>
- Mailing a written complaint to:
Superior HealthPlan
ATTN: Complaints Department
5900 E. Ben White Blvd.
Austin, TX 78741
- Faxing a complaint to: 1-866-683-5369

Resolving a Complaint

It is Superior's goal to resolve all complaints in a timely manner. Superior has 30 calendar days to investigate and provide response to a complaint. When a complaint is received, written acknowledgement of the complaint is sent to the provider within five (5) business days. The resolution is provided to the complainant in the form of a letter which contains a full explanation of the resolution as well as what further action could be taken if the provider is not satisfied with the resolution of the complaint.

Appealing a Resolution

If a 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 Superior's complaint procedures, Medicaid providers may also file a complaint with HHSC by submitting the complaint to:

Texas Health and Human Services Commission
HPM Complaints
P.O. Box 85200, MC H-320
Austin, TX 78758

Member Complaints

Filing a Complaint

- Calling Customer Service to file a complaint orally.
- Expressing their dissatisfaction during face-to-face contact with a Superior employee.
- Completing the on-line Complaint Form found on Superior HealthPlan's website at:
<http://www.superiorhealthplan.com/contact-us/complaint-hotline/complaint-form/>
- Mailing a written complaint to:
Superior HealthPlan
Complaints Department
5900 E. Ben White Blvd.
Austin, TX 78741
- Faxing a complaint to: 1-866-683-5369

What a Member Can Expect When Filing a Complaint

When a complaint is received, a written acknowledgment letter is sent to the complainant within five (5) business days of receipt of the complaint. Superior then has 30 calendar 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 of 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 the Chief Executive Officer of Superior HealthPlan for a final decision. No later than 30 calendar days from receipt of the complaint appeal panel request, Superior will mail the complaint appeal response letter to the member.

Additional Filing Rights

If a Medicaid member is not satisfied with the outcome of Superior's resolution of the complaint, he or she may file a complaint with the Texas Health and Human Services Commission (HHSC) at 1-866-566-8989 or by mail at the address below.

Texas Health and Human Services Commission
Health Plan Management
Attn: Resolution Services
P.O. Box 85200, MC H-320
Austin, TX 78758

How Superior Can Assist the Member with Filing Complaints or Appeals

Superior Member Advocates are available to assist members with the complaint or appeal process. A Member Advocate may be reached by calling Member Services at 1-866-516-4501.

SECTION 10

ADVERSE DETERMINATIONS, ACTIONS AND APPEALS

An adverse determination is a reduction, suspension, denial or termination of any service based on medical necessity or benefit limitations. Superior's Utilization Management program outlines the process the member or a member's authorized representative must follow when a request for a covered add-on service receives an adverse determination.

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 or the expedited appeal. An appeal resolution letter will be mailed to the member or the member's authorized representative with a decision on the appeal or the expedited appeal. However, if a member or the member's authorized representative disagrees with the appeal decision, they have the right to ask for a state fair hearing from the Health and Human Services Commission (HHSC).

Adverse Determinations

Adverse determinations occur when a request for an add-on service is denied for not meeting medical necessity criteria. Superior will make good faith efforts to obtain all necessary information, including pertinent clinical information and consult with the physician providing treatment as appropriate in making Utilization Management determinations.

A peer-to-peer discussion is available to the ordering physician at any time during the prior authorization, denial or appeal process. A Medical Director will review all potential medical necessity denials and render a final decision. The review may include a discussion with the ordering physician in order to obtain any information that may not have been submitted with the request. If the final decision is to deny the service request, then a denial is rendered.

Superior will notify the member and ordering provider of the denial in writing. The notification describes the services that are being denied, the full clinical explanation for the denial and the steps a member or authorized representative can take to appeal the decision and how to access subsequent steps of the appeal process which includes a state fair hearing.

Appeal of an Adverse Determination on an Add-On Service

Medicaid members have the right to appeal a decision for any of the following reasons:

- They believe the requested services are necessary.
- They believe the services should be authorized.
- When Superior has not paid a hospital bill they feel should be paid.
- When Superior limits a request for a covered service that the member believes should be allowed.

A person authorized by the member to act on their behalf, or their provider or other health-care provider may request an appeal of an adverse determination. All standard appeal requests must be confirmed in writing and signed by the member or the member's authorized representative.

If a member is currently receiving a service that is being terminated, reduced or suspended and wishes to continue receiving these services, the member or their authorized representative must make an appeal request on or before the later of the later of:

- Ten (10) days following Superior's date of the notice of the denial; or
- The intended effective date of the proposed action.

Superior will continue to provide benefits while the appeal is being reviewed, if all of the following criteria are met:

- The member or their authorized representative files the appeal timely.
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.

If the above criteria are met, services will continue until any of the following occurs:

- The member cancels the appeal or fair hearing.
- The denial is upheld through appeal or fair hearing.
- The time period covered by the original authorization has ended.

If the final decision is adverse to the member, then the member may be required to pay the cost of services furnished while the appeal is pending.

Filing a Standard Appeal

Medicaid appeal requests must be received within 30 days from the date of the denial letter. Superior will acknowledge a standard appeal request within five (5) days of receipt. Every oral appeal must be confirmed by a written and signed appeal by the member or the member's authorized representative unless an expedited appeal is requested. The standard appeal process must be completed within 30 days. Any additional information that may be used in consideration of the appeal must be submitted to Superior.

The filing for a standard appeal is similar to the appeal of an adverse determine on an add-on service such that:

- Medicaid members have the right to appeal a decision for the same reasons listed under the Appeal of an Adverse Determination on an add-on service, which includes services the member believes are covered and necessary; and when Superior has not paid a hospital bill they feel should be paid for services in whole or in part, or a request for a covered add-on service is limited.
- All STAR+PLUS standard appeal requests must be confirmed in writing and signed by the member or the member care provider representative.
- MMP enrollees have a right to appeal to an Independent Review Entity.

Appeal requests for add-on services that are being terminated, reduced or suspended yet the member wishes to continue receiving these services, require that the member or the member's authorized representative submit an appeal request on or before ten (10) days following Superior's date of notification of the denial or the intended effective date of the proposed action.

Superior will continue to provide benefits while the appeal is being reviewed based on the following criteria: if the member or their authorized representative files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; and the original period covered by the original authorization has not expired.

If the criteria are met, then services will continue until any of the following occurs: the member cancels the appeal or fair hearing; the denial is upheld through an appeal or fair hearing; or the time period covered by the original authorization has ended.

Note: If the final decision is adverse to the member, then the member may be required to pay the cost of services furnished while the appeal is pending a final decision.

Resolving a Standard Appeal

Superior will acknowledge a standard appeal request within five (5) days of receipt. The standard appeal process must be completed within 30 days. Any additional information that may be used in consideration of the appeal must be submitted to Superior.

If STAR+PLUS or MMP members or their authorized representative feel an extension beyond 30 days of the appeal timeframe would be in their best interest, then Superior will grant an additional 14 days for review of the appeal. However, if Superior does not agree with the extension, a letter will be sent to the member. Superior can also request an extension by contacting the appellant, to inform them of the reason for the request for an extension and indicate why the extension would be in the best interest of the member. Superior's request for an extension will be confirmed in writing to the member or member's authorized representative.

Expedited Appeals

An appeal will be expedited when a condition or situation is urgent and has the potential to become an emergency in the absence of treatment. This applies if the member and/or their provider believe that the decision or delay in making a decision may have an adverse impact on the member's health and well-being.

Members or their authorized representative may file a request for an expedited appeal if waiting 30 days for a standard resolution could seriously jeopardize the member's life or health. Expedited appeal requests may be submitted verbally or in writing. Superior's Member Advocates can also assist a member in filing an expedited appeal.

STAR+PLUS and MMP members must request an expedited appeal within 30 days from the date of the denial letter. Additional information that may be used in the reconsideration of the denial may be submitted to Superior by the member, their authorized representative or health-care provider. The appellant or member may request an extension of the expedited appeal timeframe, for an additional 14 days, if they feel an extension would be in the best interest of the member. However, if Superior does not agree with the extension, a letter will be sent to the member.

Superior can also request an extension by contacting the appellant informing them of the reason for the request for an extension and indicating why the extension would be in the best interest of the member. Superior's request for an extension will be confirmed in writing to the member or member's authorized representative.

Resolving an Expedited Appeal

An expedited appeal for emergency care or continued hospitalization will be resolved and notification sent of the resolution within one (1) business day but no later than three (3) calendar days from of the receipt of the request. All other expedited appeals will be resolved and notification of the resolution sent within three (3) calendar days of the request. However, if Superior's decision is to uphold the denial, the member or the member's authorized representative can request an expedited fair hearing.

If Superior denies a request to process an appeal as an expedited appeal, Superior will transfer the appeal to the standard appeal timeframe of 30 days and make a reasonable attempt to give the member or the member's authorized representative prompt oral notice followed by a written notice within two (2) days.

State Fair Hearings

Can a Member Ask for a State Fair Hearing?

A member may request a State Fair Hearing (1.) at any time during or after Superior's appeals process and (2.) if the member disagrees with Superior's decision. A fair hearing is an informal proceeding held before an HHSC hearings officer in which a member appeals Superior's decision, such as a denial or limited authorization of a requested service(s). The member may name someone to represent him or her by writing a letter to Superior providing the person's name. A provider may be the member's representative. The member, or the member's representative, must ask for a fair hearing within 90 days of the date on Superior's letter that tells of the decision being challenged. If the member does not request a fair hearing within 90 days, then the member may lose his or her right to fair hearing. To ask for a fair hearing, the member or the member's representative should either send a letter to Superior at the address below or call the Member Services Department at 1-866-516-4501.

Superior HealthPlan
ATTN: Fair Hearings Coordinator
5900 E. Ben White Blvd.
Austin, TX 78741
1-877-398-9461

If the member requests a fair hearing within ten (10) days from the time the member receives the hearing notice from Superior, the member has the right to keep getting any service that Superior has denied, at least until the final hearing decision is made. If the member does not request a fair hearing within 10 days from the time the member gets the hearing notice, the service Superior denied will be stopped.

If the member asks for a fair hearing, the member will get a packet of information letting the member know the date, time and location of the hearing. Most 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.

HHSC will give the Member a final decision within 90 days from the date the Member asked for the hearing.

Expedited Fair Hearings

Medicaid members, or their authorized representatives, may request an expedited fair hearing if they believe that waiting for a standard fair hearing could seriously jeopardize the member's life or health. However, in order to qualify for an expedited fair hearing, the member must exhaust Superior's expedited appeal process before making a request for an expedited fair hearing from HHSC. If the final decision is adverse to the member, it is possible that the member may be required to pay the cost of continued services while the appeal is in progress.

An expedited fair hearing can be requested in one of two ways:

- Verbally or by calling Superior.
- By completing a Fair Hearing Form and attaching the denial letter or the appeal resolution letter to Superior.

Note: Verbally expedited fair hearing requests must be confirmed in writing and signed by the member or the member's authorized representative.

Resolving a Level of Care Determination

Medical necessity determinations for the daily unit rate will continue to be the responsibility of HHSC's administrative services Contractor, Accenture. Accenture will review the information received on the MDS form and use the information to assign a Resource Utilization Groups (RUG) level. The MDS form will provide a comprehensive summary of the member's mental and physical issues which should be completed by the fifth day after admission to a Nursing Facility. The determination of the RUG level is based on facility considerations, including facility needs, nursing care, and the amount of therapy provided per week. The RUG level determines the amount of money per day that Medicare will pay for a member's stay at the Nursing Facility. If a member is informed that medical necessity is denied by an Accenture physician, the member has the right to appeal that decision. The member or the member's licensed authorized representative (LAR) or physician may file an appeal directly to Accenture:

Texas Health and Human Services Commission
HHSC Administrator Contract Management
PO Box 204077, Mail Code 91-X
Austin, Texas 78720-4077

Other Available Provider and Member Resources

Consumer Rights and Services

Consumer Rights and Services (CRS) is an area at the Department of Aging and Disability Services (DADS) that receives complaints regarding long-term care services provided to individuals in any type of facility or setting. Complaints come from a variety of sources and in several formats.

- A complaint allegation is an assertion that a requirement of licensure or certification has been violated. This allegation can be reported orally or in writing and can come directly from individuals or residents, family members, health-care providers, advocates, law enforcement or other state agencies.
- A self-reported incident is an official notification to the state survey and licensing agency from a DADS-regulated provider that the physical or mental health or welfare of an individual or resident has been, or

may be adversely affected by mistreatment, neglect or abuse. These reports may also include injuries of unknown source and exploitation or misappropriation of individual or resident property. In addition, reports are required to be filed on staff drug diversions or situations that pose a threat to residents, employees or the public, including calling the police or the local fire authority to maintain safety.

Contact information:

- CRS website: <http://www.dads.state.tx.us/services/crs/about.html>
- Telephone Number: 1-800-458-9858

Long-Term Care (LTC) Ombudsman

The LTC Ombudsman identifies, investigates and resolves complaints that adversely affect the health, safety, welfare or rights of people who live in nursing facilities and assisted living facilities to ensure they receive optimal quality of care and achieve high quality of life. STAR+PLUS members can file a complaint through the Office of Long Term Care Ombudsman.

Contact information:

- The Office of the LTC Ombudsman can be contacted at 1-800-252-2412.
- LTC Ombudsman website: https://www.dads.state.tx.us/news_info/ombudsman/
- A list and contact information of the 28 Area Agencies on Aging can be found at: <http://www.dads.state.tx.us/contact/aaa.cfm>

Health Plan Management

Health Plan Management (HPM) at the Texas Health and Human Services Commission (HHSC) in the managed care division receives complaints, inquiries or disenrollment requests either directly from providers and members or via secondary sources, such as the Office of the Ombudsman, Legislative offices (External Relations Division), member advocates (family), Vendor Drug Program, DADS, Department of Family and Protective Services or other stakeholders.

HHSC Office of the Ombudsman

The HHSC's Office of the Ombudsman serves as a central point of assistance in identifying appropriate programs and departments for problems and complaints. The Office of the Ombudsman assists the member when the agency's normal complaint process cannot or does not satisfactorily resolve an issue. They also conduct independent reviews of complaints concerning agency policies or practices, ensure policies and practices are consistent with the goals of HHSC, ensure individuals are treated fairly, respectfully and with dignity and make referrals to other agencies as appropriate. If there is a problem or complaint, it is recommended that the person, program or office involved contact the Office of the Ombudsman to see if they can explain a specific policy or correct the problem immediately. If the agency's normal complaint process cannot or does not satisfactorily resolve the issue, there are ways to send a question or file a complaint:

Contact information:

- Online submission form found on their website at <http://www.hhsc.state.tx.us/ombudsman>.
- Telephone: 1-877-787-8999 or Relay Texas/TTY (hearing Impaired) 7-1-1 or 1-800-735-2989.

SECTION 11

QUALITY IMPROVEMENT

Quality Improvement Department

The Quality Improvement (QI) Department performs ongoing monitoring of quality metrics, credentialing reviews, medical record audits, barrier or root cause analysis, data warehouse retrieval and analysis and other activities in an effort to identify areas of concern, health delivery system issues or issues in regards to member and provider services.

Superior utilizes a ten (10)-step methodology recommended by Health Care System for Managed Care: A Guide for States to implement its QI initiatives. However, in the event there are opportunities for improvement where changes are tested in small cycles then, a Plan-Do-Study-Act (PDSA) Model will be implemented. A PDSA Model is an iterative, four-stage problem-solving model for process improvement and change. All QI initiatives (clinical and non-clinical performance improvement projects [PIPs], focus studies, medical record audits) may be selected based on the following:

- To implement health-care initiatives that will have the greatest potential for improving health outcomes or the quality of service delivered to Superior's members and network providers.
- To test an innovative performance improvement strategy for specific populations, age groups, disease management categories or risk status that aligns with the state contract requirements.
- To eliminate health disparities and detect distinctive regional emphasis on populations and cultures.
- To implement improvement strategies that address behavioral health-care issues.
- To conduct medical record reviews and provider audits, which may include a review of specifications and appropriateness of care that is consistent with utilization, compliance practice guidelines, access to care and appointment wait times.

All focus studies and other QI initiatives are designed and implemented in accordance with national QI standards and benchmarks (e.g., NCQA, HEDIS®, CAHPS®, as applicable). These focus studies utilize sound research design and appropriate statistical analysis.

Practice Guidelines

Whenever possible, Superior approves, adopts and promotes preventive and Clinical Practice Guidelines (CPG) to providers from recognized sources for the provision of acute, chronic and behavioral health services relevant to the populations served. Practice Guidelines will be presented to the Quality Improvement Committee (QIC) annually for appropriate provider review and adoption. Practice Guidelines will be updated at least every two (2) years or upon significant new scientific evidence or changes in national standards.

Superior adopts clinical practice guidelines for at least two (2) non-preventive acute and chronic medical conditions; whereas, Centene adopts clinical practices guidelines for at least two (2) behavioral conditions and preventive or non-preventive acute or chronic medical conditions, relevant to the population. Practice Guidelines are based on the health needs of the population or opportunities for improvement as identified in the QAPI

program. These evidence-based guidelines are known to be effective in improving health-care quality outcomes and reducing unnecessary variation in care for Superior membership. The following QIC approved practice guidelines for Superior are:

- Diagnosis and management of asthma.
- Antepartum care.
- Childhood obesity prevention.
- Texas Health Steps: Early, periodic, screening, diagnosis, treatment (EPSDT).
- Diagnosing and treating the child with attention deficit or hyperactivity disorder.
- Treatment of members with major depressive disorder.
- Treatment of bipolar disorder.
- Adult preventive services.
- Diagnosis and management of pharyngitis.
- Coronary artery disease.
- Chronic respiratory disease (CRD) including asthma and Chronic Obstructive Pulmonary Disorder/Disease (COPD).
- Heart failure.

Superior's Quality Assessment and Performance Improvement (QAPI) program assures that Practice Guidelines meet the following:

- Adopted guidelines are approved by Superior's QIC bi-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 bi-annually.
- Guidelines are disseminated to providers in a timely manner via the following appropriate communication settings:
 1. Provider orientations and other group sessions
 2. Provider e-newsletters
 3. Online via the HEDIS Resource page
 4. Online via the Provider Portal
 5. Targeted mailings

Guidelines are posted on Superior's website in the Secure Provider Portal at www.SuperiorHealthPlan.com or paper copies are available upon request by contacting Superior's Quality Improvement Department at:

Superior HealthPlan
ATTN: Quality Improvement Director
5900 E. Ben White Blvd.
Austin, TX 78741
1-800-218-7453

SECTION 12

CULTURAL COMPETENCY IN SERVING SUPERIOR'S MEMBERS

Cultural Sensitivity

Superior places emphasis on the wellness of its members. A large part of quality health-care delivery is treating the whole member and not just the medical condition. Sensitivity to differing cultural influences, beliefs and backgrounds, can improve a provider's relationship with members and, in the long run, the health and wellness of the members themselves.

The following list of principles for health-care providers 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 race, ethnicity and influence.
- Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
- Understanding of the particular psycho-social stressors relevant to minority members including war trauma, migration, acculturation stress and socioeconomic status.
- Understanding of the cultural differences within minority groups.
- Understanding of the minority member within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network.
- Understanding of the differences between culturally acceptable behaviors of psycho-pathological characteristics of different minority groups.
- Understanding indigenous healing practices and the role of religion in the treatment of minority members.
- Understanding of the cultural beliefs of health and help seeking patterns of minority members.
- Understanding of the health service resources for minority members.
- Understanding of the public health policies and its impact on minority members and communities.

Skills

- Ability to interview and assess minority members based on a psychological, social, biological, cultural, political or spiritual model.
- Ability to communicate effectively with the use of cross-cultural interpreters.
- Ability to diagnose minority members with an understanding of cultural differences in pathology.
- Ability to avoid under diagnosis or over diagnosis.

- Ability to formulate treatment plans that are culturally sensitive to the member and family's concept of health and illness.
- Ability to utilize community resources (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 encourages and advocates for providers to provide culturally competent care for its members. Providers are also encouraged to participate in training provided by other organizations. For information on these resources and trainings, visit:

- The United States Department of Health and Human Services, Health Resources and Services Administration (HRSA) site at www.hrsa.gov/healthliteracy. Providers can find free online courses on topics such as addressing health literacy, cultural competency and limited English proficiency.

Your local, state and national provider organizations to which you belong are likely to have information resources available as well. Providers may also request this information by contacting their Superior Account Manager.

SECTION 13

SUPERIOR'S PROVIDER PORTAL

Superior has a Secure Provider Portal that providers can use to access resource information, file claims, request authorizations and verify eligibility. Superior's website and the Secure Provider Portal make your online transactions easier and faster. Superior's website is located at www.SuperiorHealthPlan.com.

Registering for the Provider Portal

In order to use our Secure Provider Portal, you must register at provider.superiorhealthplan.com, you will be asked to enter your tax identification number, first name, last name, email address and 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.

After your email address has been validated, 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 one Account Manager who 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.

Benefits of the Provider Portal

Here are some of the features available to you:

- Verify Member Eligibility: Determine a member's coverage by simply entering the necessary search criteria, such as date of birth, member number and member name.
- Online Claims Submission features:
 - Individual Claim Submissions - Submit both professional claims for add-on services and institutional claims for the daily unit rate.
 - Copy Claim Feature - Recreate claims without entering data twice.
 - Recurring Claims Tool - Quick and easy way to submit repetitive, long-term care claims for multiple members.
 - Corrected Claims - Resubmit through the Secure Provider Portal.
 - Batch Claim Submissions - Avoid paying clearinghouse fees and submit batch claims online. Currently, formatted 837 claims files are only accepted. We apply Health Insurance Portability and Accountability Act (HIPAA) level four (4) edits. Files must be .dat or .edi formats.

- Attachments for Claims: Please attach additional documentation during the online claims process or when submitting a Request for Reconsideration.
- Check Claims Status Online - Confirm the status of submitted claims and easily reconcile to your resident accounts.
- Online Claims Appeal: Submit claim appeals and attach necessary documentation.
- Explanation of Payment (EOP): EOPs are available in the Secure Provider Portal.
- Update Demographic Information - Update provider demographics such as address, phone number and office hours.
- Submit and Review Online Authorizations:
 - Avoid the fax machine and submit acute service and add-on service authorization requests directly to us online.
 - Check on status of authorizations by member, authorization or web reference number and dates of service.

Other valuable content made available at www.SuperiorHealthPlan.com. This website includes a Provider Resources section which contains Frequently Asked Questions (FAQs), a Provider Manual, a Provider Directory, an online look-up feature to find contracted providers, training presentations and other helpful website links.

Provider Portal Help Desk

If you need assistance with accessing the Secure Provider Portal, contact the web applications support desk at 1-866-895-8443 or TxWebApplications@centene.com.



**superior
healthplan™**

5900 E. Ben White Blvd.
Austin, TX 78741

1-877-391-5921
SuperiorHealthPlan.com