Star Kids Referrals and Authorizations Frequently Asked Questions

When do members need a referral/prior authorization?

Superior providers are required to refer members for specialty services within the Superior network. Referrals to out-of-network providers will be made when medically-necessary to do so. Primary Care Provider (PCPs) must document the coordination of referrals and services provided between the PCP and specialist. Providers should work closely with specialists to coordinate services and make sure members are getting the care they need.

Do members need a referral to see a specialist?

A PCP is required to refer a member to a specialist when medically-necessary care is needed beyond the scope of the PCP. A specialist cannot refer to another specialist. All member care should be coordinated through the PCP.

When is a prior authorization required?

All out-of-network services require an authorization, as well as some other services and treatments provided in a specialist's office. To view all prior authorization and notification requirements, please reference Superior's Prior Authorization page or the Superior HealthPlan Medicaid Provider Manual.

Will Superior honor existing prior authorizations?

Existing authorizations for acute services (ex. physical, occupational, speech therapy) will be honored for six (6) months, until the authorizations expires or until Superior conducts a new assessment.

Existing authorizations for long-term services and supports (ex. private duty nursing, personal care services) will be honored six (6) months or until Superior conducts a new assessment.

What if a member's specialist is not in Superior's network?

For 12 months following STAR Kids implementation (November 1, 2016), members can continue to see a Medicaid out-of-network provider/specialist with whom they have an existing relationship, including providers outside their service delivery area. Please note that all providers must be Medicaid-approved providers and the services provided must be Medicaid covered services. Authorizations for office visits are not required, however authorizations for services and treatments may still be required. If a member receives services from a specialist who is not a Superior or Medicaid provider and/or doesn't accept the member's primary insurance plan, the member might be responsible for the bill.

Superior will work with members and specialists to ensure members continue to receive care until the specialist joins the Superior network or members are transitioned to an in-network provider.

What if a member needs emergency or urgent services from a specialist?

No referral or authorization is needed for emergent or urgent services as long as the specialist is in Superior's network or accepts Medicaid. If the specialist is not a Superior or Medicaid provider, members may receive a bill. *Please note: If emergent or urgent services were provided in an office setting, providers should contact Superior as soon as possible after the visit, as some services require an authorization.*

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What if a member already has a specialist or PCP and has Medicare/private insurance?

If a member has Medicare or private insurance, they do not need a referral or authorization from Superior to continue seeing a specialist or PCP. Members can continue to see their specialist or PCP as long as they are accepted by their Medicare plan or private insurance. If the member's provider leaves the network, Superior can help the member find a new provider.