STAR, STAR+PLUS and CHIP

Provider Training

Introductions and Agenda

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Who is Superior HealthPlan?

- Superior, a subsidiary of Centene Corporation, manages health care for Medicaid and CHIP members across Texas.
- Superior has been a contracted Managed Care Organization (MCO) for the Medicaid managed care program (STAR program) since December 1999.
- Superior provides Medicaid and CHIP programs in contracted Texas Health and Human Services (HHS) service areas throughout the state. These programs include:
  - Ambetter from Superior HealthPlan
  - CHIP
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - Wellcare By Allwell (HMO and HMO DSNP) Plans

Superior Member ID Cards

- The Member ID Cards contain at least the following information:
  - Member name
  - Primary Care Provider (PCP) (except CHIP Perinate mother)
  - Prescription information
  - Program eligibility
  - Superior HealthPlan contact information

- Images of Member ID Cards can be found in the Superior Provider Manual, found at www.SuperiorHealthPlan.com/providers/training-manuals.html.

Provider Roles and Responsibilities

Provider Roles and Responsibilities

- Eligibility Verification
- PCP Responsibilities
- After-Hours Telephone Arrangements
- PCP Access to Care Requirements
- Referrals
- Member Self-Referral
- Cultural Competency

Primary Care Provider (PCP) Responsibilities

- Serve as a “Medical Home.”
- Physicians and mid-level practitioners contracted as PCPs may be selected as a PCP by the member.
- Be accessible to patients 24/7/365.
- Responsible for the coordination of care and referrals to specialists.
- Enroll as a Texas Health Steps provider or refer member to a participating Texas Health Steps provider.

Primary Care Provider (PCP) Responsibilities

- Ensure accurate information in Provider Directories by updating contact information including:
  - Address.
  - Phone number.
  - Provider listing.
  - Hours of operation.
- Report all encounter data on CMS 1500 (HCFA) or other appropriate documents.
- Maintain Health Insurance Portability and Accountability Act (HIPAA) compliance.

PCP Accessibility

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

After Hours Telephone Arrangements

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

PCP Access to Care Requirements

- Superior requires that a provider's hours of operation for Medicaid and CHIP members be no less than those offered to commercial patients.
- Appointment Access Guide:
  - Routine Care
    - Provided within 2 weeks of request.
  - Urgent Care
    - Provided within 24 hours of request.
  - Emergent Care
    - Provided immediately (same day).

PCP Access to Care Requirements

- Appointment Access Guide (continued):
  - Referrals to Specialists
    - Appointments should be available within 30 days of the request for non-urgent conditions.
  - Preventive Health Services
    - Consistent with the Texas Health Steps Periodicity Schedule for STAR and STAR+PLUS and American Academy of Pediatrics (AAP) periodicity schedule for CHIP.
  - Preventive Health Services for Adults
    - Provided within 90 days of request.

Marketing Guidelines

- Providers must adhere to Marketing Guidelines as outlined by HHS and referenced in their provider contract.
- Providers can educate/inform patients about the CHIP/Medicaid Managed Care programs in which the provider participates.
- Providers can inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate.
- Providers **cannot** recommend one MCO over another MCO.

Marketing Guidelines

- Providers must distribute and/or display health-related materials for all contracted MCOs or choose not to distribute and/or display for any contracted MCO.
- Providers must display stickers submitted by all contracted MCOs or choose to not display stickers for any contracted MCOs.
- More information and a complete list of Marketing Guidelines can be found in the Provider Manual at www.SuperiorHealthPlan.com/providers/training-manuals.html.

Referrals

- All health-care services are coordinated through the PCP.
- PCP is required to refer a member to a specialist when medically-necessary care is needed beyond PCP's scope.
- PCP is not required to issue paper referrals but must obtain a prior authorization to certain specialty physicians and all non-emergent out-of-network providers.
- Specialist may not refer to another specialist.

Referrals

- Members may self-refer for the following services:
  - Family planning.
  - Texas Health Steps.
  - Case management for children and pregnant women.
  - Vision.
  - Behavioral health.
  - True emergency services.
  - Well woman annual examinations.

Verify Eligibility

- Providers should verify member eligibility prior to delivering service at each visit by:
  - Logging on to Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.
  - Viewing the member's Superior issued ID card (Member ID card is not a guarantee of enrollment or payment).
  - Contacting Superior's Member Services Department at:
    - 1-800-783-5386 STAR, CHIP and Perinate
    - 1-877-277-9772 STAR+PLUS
  - Viewing the member's "Your Texas Benefits" Medicaid Card.
  - Visiting TexMedConnect at https://secure.tmhp.com/TexMedConnect.

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STAR

STAR Eligibility

Who is covered in Texas?

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

STAR Benefits

- Include, but are not limited to:
  - Dental and vision services
  - Durable Medical Equipment (DME)
  - Hospital services
  - Maternity services
  - Medical and surgical services
  - Mental and behavioral health services
  - Prescriptions (unlimited)
  - Texas Health Steps
  - Therapy - physical, speech and occupational
  - Transplants

Value-added Services (VAS)

- Superior offers a diverse array of Value-added Services (VAS) for each product line including, but not limited to:
    - A 24-hour nurse advice line.
    - Online mental health resources.
    - Extra vision benefits.
        - Includes $150 toward prescription eyewear.
    - Over the counter (OTC) items.

- A complete listing of current VAS can be found at www.SuperiorHealthPlan.com/VAS.

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Texas Health Steps Program

Overview

- For Medicaid-eligible children, adolescents and young adults under 21 years of age, the comprehensive preventive care program combines:
- Diagnostic screenings
- Communication and outreach
- Medically necessary follow-up care including:
  - Dental
  - Hearing examinations
  - Vision
- Age-appropriate screenings must include, but are not limited to:
  - Autism
  - Developmental
  - Hearing
  - Lead
  - Mental Health
  - Nutrition
  - Sexually Transmitted Diseases
  - Tuberculosis
  - Vision
- For complete Texas Health Steps Exam information, please view the Texas Health Steps Medical Checkups Periodicity Schedule: https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers

Checkup Requirements

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

Checkup Requirements

- Members new to Superior
  - Within first 90 days (unless documentation of previous checkup is provided).
- Existing members
  - Follow periodicity schedule: https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers
  - Members under 3 years of age have multiple checkups within each year; 6 outpatient checkups in the first year.
  - Members over 3 years of age have an annual checkup which must occur within 364 days following their birth date.
- Exceptions (outside of periodicity)
  - Medically necessary: developmental delays, medical concerns, suspected abuse (use modifier code SC).
  - Mandated services: state or federal requirements (use modifier code 32).
  - Unusual anesthesia: procedures which usually require no anesthesia or local anesthesia (use modifier code 23).

Missed Appointments

- Providers should complete a Missed Appointment form and fax it to MAXIMUS at 1-512-533-3867, who will then contact recipients to determine what prevented them from keeping the appointment (lack of transportation, child care, money for gasoline, etc.).
- More information is available through your local regional Texas Health Steps Providers Services Representative: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/health-services-providers/thsteps/ths-regional-contacts.pdf

Superior Outreach and Resources

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

Texas Health Steps Outreach and Informing

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

Refusal of Exam

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

Oral Evaluation and Fluoride Varnish

- This program will allow Medicaid-eligible Texas Health Steps members and Children with Special Health Care Needs (CSHCN) who are 6 to 35 months to receive an oral evaluation and fluoride varnish during medical checkups.
  - Limited to 10 fluoride treatments.
  - Providers must be certified to provide oral evaluations and fluoride varnishes.
  - Once a provider has completed the training, they will need to submit their certification to their Superior Account Manager.
  - The training information is available on the HHS website along with the registration form. The information can be accessed at the following site: https://hhs.texas.gov/doing-business-hhs/provider-portals/health-services-providers/texas-health-steps/medical-providers/oral-evaluation-fluoride-varnish-medical-home
  - Provider should bill with procedure code 99429 and modifier U5 with the diagnosis Z00.129.

Blood Lead Level Reporting

Texas Childhood Lead Poisoning Prevention Program (TXCLPPP)

- TXCLPPP maintains a surveillance system of blood lead results on children younger than 15 years of age.
- Texas law requires reporting of blood lead tests, elevated and non-elevated, for children younger than 15 years of age.
- Physicians, laboratories, hospitals, clinics and other health-care facilities must report all blood lead tests and re-tests to the Texas Child Lead Registry.
- For more information and forms, visit: www.dshs.state.tx.us/lead/child.shtm
- Centers for Disease Control (CDC) Childhood Lead Poisoning Prevention and Screening guidelines can be found on the Department of State Health Services (DSHS) website:
  - Prevention: www.dshs.state.tx.us/lead/default.shtm
  - Screening: www.dshs.state.tx.us/lead/screening.shtm?terms=lead%20screening

Children of Traveling Farm Workers

- HHS defines a traveling farm worker as “a migratory agricultural worker, whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode.”

- Superior will assess the child’s health-care needs, provide direct education about the health-care system and the services available and arrange appointments and transportation.

- Superior will attempt to accelerate services to these individuals before they leave the area.

- Superior has developed a “Travel Packet” and other helpful pieces of information to ensure these children get the health-care services they need.
- Providers who provide care to Superior members, who are a children of Traveling Farmworkers, can direct the parent to call Member Services for assistance on program benefits or to help schedule an appointment by calling 1-800-783-5386.

Enrollment and Training

- Enrollment as a Texas Health Steps provider must be completed through Texas Medicaid and Healthcare Partnership (TMHP) at www.tmhp.com.
- Training from HHS is mandatory for Texas Health Steps providers.
- Free continuing education hours are available at www.txhealthsteps.com/cms/.

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STAR+PLUS

What is STAR+PLUS?

- The STAR+PLUS program is designed to integrate the delivery of acute care and Long-Term Services and Supports (LTSS) through a managed care system, combining traditional health care (doctors visits) with LTSS, such as providing help in the home with:
  - Daily living activities, home modifications and personal assistance.
- Members, their families and providers work together to coordinate member's health care, long-term care and community support services.
- The main feature of the program is Service Coordination, which describes a special kind of care management used to coordinate all aspects of care for a member.

STAR+PLUS Eligibility

Mandatory Population

- Adults 21 years of age and older who:
  - Have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid because of low income.
  - Qualify for Medicaid because they receive STAR+PLUS Home and Community Based Services (HCBS) waiver services (formerly known as the CBA program).

STAR+PLUS Dual-Eligible Members

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

Medicaid Non-Dual Services

- Members who have Medicaid only and are enrolled with Superior for their STAR+PLUS managed care plan.
- STAR+PLUS covers both Acute Care Services and Long-Term Support Services.
  - Exception: For IDD members, Superior pays for Acute Care Services **only**.
- Superior has contracted with CVS Caremark as the Pharmacy Benefit Manager (PBM).

STAR+PLUS Benefits

- Include, but are not limited to:
  - Ambulance Services
  - Audiology Services
  - Behavioral Health Services
  - Birthing Center Services
  - Chiropractic Services
  - Dialysis
  - DME and Supplies
  - Emergency Services
  - Family Planning Services
  - Laboratory
  - Medical Checkups
  - Physical, Occupational and Speech Therapy (PT/OT/ST)
  - Podiatry Services
  - Prenatal Care
  - Prescription Medications (Unlimited)
  - Primary Care Services
  - Radiology, Imaging and X-rays
  - Specialty Doctor Services
  - Vision Services

STAR+PLUS - LTSS

- PAS
- DAHS
- STAR+PLUS Waiver Services
  - Adaptive Aids
  - Adult Foster Care
  - Consumer Directed Services
  - DME
  - Emergency Response System
  - Home Delivered Meals
  - Minor Home Modification (MHM)
  - Skilled Nursing
  - PT/OT/ST
  - Medical Supplies
  - Residential Care/Assisted Living
  - Transition Assistance Services

Service Coordination

- Dedicated, centralized Service Coordination line: 1-877-277-9772
- Service Coordination:
  - Coordinates care for members with special health-care needs.
  - Utilizes a multidisciplinary approach in meeting member's needs.
  - Is available to all STAR+PLUS members.
- Members are assigned a Service Coordinator who they can call directly.
- Service Coordinators participate with the member, their family or representative, and other members of the interdisciplinary team to provide input for the development of the plan of care.

LTSS Assessments

- Members receiving LTSS services are assessed annually, or as needed, to continue services.
- Service Coordinators review the assessment(s) to identify service needs with the member in developing a plan of care.
- Assessments are also reviewed biannually and upon notification of a change of condition.

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

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

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

- A MN signature is required after the initial assessment for services from the HCBS waiver program. TMHP will grant final approval into the HCBS waiver program upon initial request and annually based on the MNLOC assessment performed by a nurse.
- The MN Form must be signed and obtained from a Physician (MD), Osteopathic Medicine (DO) or Military Physician who has examined the member and reviewed the medical record within the last 12 months.
  - Providers must be Medicaid providers.

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

- The signing physician is certifying that the member meets nursing facility level of care, and that the member would benefit from the additional services provided under the HCBS waiver program.
- These additional benefits will provide the member with a higher level of service coordination, including Registered Nurse care, additional home visits and additional Medicaid benefits that will allow them to stay safe in the community.

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

- Providers have 5 business days from the initial request to submit the form.
  - If not received within the timeframe, Superior will complete additional attempts to obtain the signature.
  - If no response if received, the member is notified and Superior will notify the Program Support Unit at HHS
- Forms can be returned:
  - Electronically, using Adobe Sign e-signature: SHP.Intake@superiorhealthplan.com
  - Via fax: 1-866-703-0502
- For additional information, please call 1-877-277-9772 or reference the Medical Necessity and Level of Care Assessment Physician's Signature FAQs (STAR+PLUS and MMP), found under "Member Management" at www.SuperiorHealthPlan.com/providers/resources/forms.html.

Prior Authorizations

- Services and supplies requiring authorization:
  - Adult Foster Care
  - Assisted Living
  - DAHS
  - DME over $500 – per unit
  - ERS
  - HDM
  - Home Health
  - Incontinence supplies*
  - MHM
  - PAS or Primary Home Care (PHC)
  - PT/OT/ST
  - Skilled Nursing

Prior Authorization Process

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

Value Added Services

- Superior offers a diverse array of VAS for each product line including, but not limited to:
  - 24-hour nurse advice line.
  - Extra dental benefits.
    - STAR+PLUS Non-dual, non-HCBS Waiver and Non-Dual Nursing Facility members may receive $250-$500 annually in dental services depending on their SDA.
  - Extra vision services.
    - STAR+PLUS members are eligible to receive a $150 allowance every 12 months towards a choice of upgraded eyeglass frames and lenses or contact lenses not covered by Medicaid.
- Complete listing of current VAS can be found at www.SuperiorHealthPlan.com/VAS.

Transportation

STAR and STAR+PLUS Transportation Benefits

- Superior's Medical Ride Program (Non-Emergency Medical Transportation [NEMT] Services) provides transportation to covered health-care services for Medicaid members who have no other means of transportation.
- Transportation includes rides to the doctor, dentist, hospital, pharmacy and other places members receive Medicaid services.
- Transportation services are provided by SafeRide.
- Superior's Medical Ride Program will cover the cost of an attendant for patients needing assistance while traveling.
  - Providers may receive a request to provide proof of documentation of medical necessity.
- Children 14 years of age and younger must be accompanied by a parent, guardian or other authorized adult.

Medical Ride Program Services

- Services offered by Superior's Medical Ride Program include, but are not limited to:
  - Passes or tickets for mass transit within and between cities or states.
  - Commercial airlines transportation.
  - Mileage reimbursement for an Individual Transportation Participant (ITP) using their own vehicle to get a covered health-care service.
    - The enrolled ITP can be the patient, the patient's family member, friend or neighbor.
  - Car, van or private bus services, including wheelchair-accessible vehicles, if necessary.
  - Members 20 years of age and younger requiring long-distance trips may be eligible to receive the cost of meals and/or lodging to obtain a covered health-care service.

Requesting NEMT Services

- Superior members should request rides as early as possible, and at least two Business Days before they need the ride.
- It is the responsibility of the member to coordinate all information needed from both the provider and Superior timely, in order for Superior or SafeRide to consider the request.
- Appointments can be requested Monday through Friday, 8:00 a.m. – 5:00 p.m. by calling 1-855-932-2318 (TTY: 7-1-1).

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CHIP (Children's Health Insurance Program)

CHIP Eligibility

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

CHIP Benefits

- Include, but are not limited to:
  - Dental and Vision Services
  - DME
  - Hospital Services
  - Medical and Surgical Services
  - Mental and Behavioral Health Services
  - Prescriptions
  - PT/OT/ST
  - Transplants
  - Well-child Exams and Preventive Health Services
- For a full list of covered benefits, please refer to the Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual, located at www.SuperiorHealthPlan.com/providers/training-manuals.html.

CHIP Cost-Sharing

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

Value-added Services (VAS)

- Superior offers a diverse array of VAS for each product line including, but not limited to:
  - A 24-hour nurse advice line.
  - Help for members with Asthma.
  - Extra vision benefits.
    - Includes $150 toward prescription eyewear.
  - Reward for getting a flu vaccine (up to age 2).
- A complete listing of current VAS can be found at www.SuperiorHealthPlan.com/VAS.

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CHIP Perinate

CHIP Perinate Eligibility

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

CHIP Perinate Benefits

- Covered Services (Professional)
  - Up to 20 prenatal care visits (more if medically necessary with authorization).
  - Prescriptions based on CHIP formulary (DME is not a covered benefit for CHIP Perinate).
  - Case management and care coordination.
  - 3 ultrasounds of the baby when medically indicated.
  - Labor with delivery of child.
  - 2 postpartum visits within 60 days of delivery; first postpartum visit must be after delivery global period (45 days).

CHIP Perinate Benefits

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

Helpful Billing Hints

- Prenatal visits
  - Initial visits bill with Evaluation and Management (E&M) codes (99201 - 99205) with modifier TH to indicate prenatal visit.
  - Subsequent visits bill with E&M codes (99211-99215) with modifier TH to indicate prenatal visits.
- Postpartum visits bill Current Procedural Terminology (CPT) code 59430.
- Three sonograms are allowed per pregnancy. Additional sonograms, with authorization, are covered if the patient has a high risk diagnosis.
- Primary diagnosis for all covered services must be pregnancy-related (all other services are not covered benefits).

OB, Family Planning and Postpartum Programs

OB and Newborn Programs

- Start Smart for Your Baby® consists of Case Management services, education (baby showers*) and orientation for members who are pregnant.
- The program eliminates barriers our pregnant members have in accessing care, and provides information and assistance on benefits.
- Outreach workers with knowledge of community resources and agencies are ready to assist members with housing, transportation, employment and continued education.
- In order for your patients to be eligible to receive these benefits from Superior, please submit a Notification of Pregnancy (NOP) form upon initial prenatal visit for each of your Superior patients.

**In some areas*

Healthy Texas Women

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

Healthy Texas Women

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

Healthy Texas Women Plus

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

HHS Family Planning Program

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

Primary Health Care Program

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

Primary Health Care Program

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

Notification of Pregnancy

- Superior HealthPlan's Notification of Pregnancy (NOP) Incentive Program rewards providers on a quarterly basis for completing and submitting NOP forms in a timely manner.
- This program was implemented to identify Superior members who may have a history of preterm delivery and/or other conditions that may complicate pregnancy.
- Effective January 1, 2017, the only NOP forms that will be accepted for the NOP incentive program must be submitted via the Secure Provider Portal: Provider.SuperiorHealthPlan.com

Notification of Pregnancy

- Quarterly NOP Incentive Program Plan available for completing NOP forms within 60 days of the initial/first provider visit based on number of forms submitted correctly:
  - 5-10 forms = $100 gift card
  - 11-20 forms = $200 gift card
  - 21-30 forms = $400 gift card
  - 31+ forms = $800 gift card
- Contact your Account Manager for further information.

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Medical Management

Prior Authorization

- Procedures and/or services that require authorization can be found at www.SuperiorHealthPlan.com/providers/preauth-check.html.
- Initiating a prior authorization:
  - Must be at least 5 business days prior to requested date of service (for non-emergency services).
  - Log on to your online account at Provider.SuperiorHealthPlan.com.
  - Use the Request for Authorization form found on the website, complete and submit to via fax to the number on the form.
  - If you have an urgent request, indicate “This is urgent and must be treated within 24 hours.”

National Imaging Associates – Radiology Authorizations

- National Imaging Services (NIA) is contracted with Superior to perform utilization review for High-Tech Imaging Services, including:
  - CT/CTA.
  - CCTA.
  - Echocardiography (STAR+PLUS)
  - MRI/MRA.
  - Nuclear Cardiology/MPI.
  - PET Scan.
  - Stress Echo.
- The ordering physician is responsible for obtaining an authorization by:
  - Accessing www.radmd.com, or calling 1-800-642-7554.
- Emergency room, observation and inpatient imaging procedures do not require authorization.
- Servicing providers and imaging facilities may access status of authorizations by:
  - Accessing www.radmd.com, or accessing Integrated Voice Response (IVR) at 1-800-642-7554.

NIA - Interventional Pain Management (IPM) Authorizations

- NIA also manages non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR and STAR+PLUS members 21 years of age and older.
- It is the responsibility of the ordering physician to obtain authorization for all IPM procedures outlined on the following slide.
- Authorizations are valid for 30 days from the date of the request.

NIA - Interventional Pain Management (IPM) Authorizations

- Outpatient IPM procedures requiring prior authorization include:
  - Spinal Epidural Injections
  - Paravertebral Facet Joint Injections or Blocks
  - Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis)
  - Sacroiliac Join Injections
- Note: A separate prior authorization number is required for each procedure ordered.
- To obtain authorization through NIA, visit RadMD.com or call 1-800-642-7554.
- Note: Prior authorization is not required through NIA for services performed in the emergency department or on an inpatient basis.
  - Authorization and/or notification of admission is still required through Superior.

Utilization Review for Physical, Occupational and Speech Therapy Services

- Texas National Imaging Associates (TNIA) is delegated utilization review for outpatient physical, occupational and speech therapy treatment services for Superior Medicaid (STAR, STAR+PLUS non-HCBS waiver) and CHIP members.
- Medicaid STAR Health, STAR Kids, STAR+PLUS HCBS Waiver and STAR+PLUS MMP prior authorization requests continue to be submitted to Superior.
- TNIA responsibilities for utilization review are limited to contracted network provider prior authorization requests; all out of network prior authorization requests should continue to be submitted to Superior.

NIA Genetic and Molecular Testing

- Utilization review for genetic and molecular testing services is delegated to NIA for Medicaid, CHIP, and STAR+PLUS MMP members.
- Authorization requests for out-of-network providers should continue to be submitted to Superior.
- Claims should be submitted to Superior for processing
- NIA's Genetic and Molecular Testing clinical guidelines can be found on NIA's Genetic Testing Policies webpage.

TurningPoint Healthcare Solutions – Musculoskeletal Surgical Procedures

- TurningPoint is responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures.
- Prior authorization will be required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Knee Arthroplasty and Arthroscopy	Spinal Fusion Surgeries
Uni/Bi-compartmental Knee Replacement	Cervical
Hip Arthroplasty and Arthroscopy	Lumbar
Acromioplasty and Rotator Cuff Repair	Thoracic
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Osteochondral Defect Repair	Laminectomy/Discectomy

**This is not an all-inclusive list. For a complete list of impacted CPT codes, visit TurningPoint's Web Portal or www.SuperiorHealthPlan.com/providers/preauth-check.html.*

TurningPoint Healthcare Solutions Expansion

- Superior has expanded the partnership with TurningPoint to process prior authorization requests for medical necessity and appropriate length of stay for certain Cardiac procedures, ENT surgeries and sleep study procedures for Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids), CHIP, Wellcare By Allwell (HMO and HMO DSNP) and Ambetter from Superior HealthPlan members.
- Prior Authorization is required for the following Cardiac Surgical Procedures in both inpatient and outpatient settings:
  - Arterial Procedures
  - Coronary Angioplasty/Stenting
  - Coronary Artery Bypass Grafting
  - Implantable Cardioverter Defibrillator (ICD)
  - ICD Revision or Removal
  - Left Atrial Appendage Occluders
  - Loop Recorders
  - Non-Coronary Angioplasty/Stenting
  - Pacemaker
  - Pacemaker Revision or Removal
  - Valve Replacement
  - Wearable Cardiac Defibrillator

TurningPoint Healthcare Solutions Expansion

- Prior authorization is required for the following ENT surgeries and sleep studies performed in the inpatient, outpatient, physician's office and in-home settings:

Sleep Study Procedures
Actigraphy
Home Sleep Study
Multiple Sleep Latency and Maintenance of Wakefulness Testing
Polysomnography

Ear, Nose and Throat (ENT) Surgeries
Balloon Dilation Esophagoscopy
Cochlear Implant Device
Laryngoscopy and Laryngoplasty
Rhinoplasty and Septoplasty
Sinus Surgery
Thyroidectomy and Parathyroidectomy
Tonsillectomy (with or without Adenoidectomy)
Tympanostomy and Tympanoplasty

TurningPoint Healthcare Solutions

- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the services listed on previous slides should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
  - Web Portal Intake: http://www.myturningpoint-healthcare.com
  - Telephonic Intake: 469-310-3104 | 855-336-4391
  - Facsimile Intake: 214-306-9323

Non-emergent Ambulance Transport

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

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

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

Non-emergent Ambulance Transport

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

Utilization Management (UM)

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

Care Management (CM)

- Superior members with identified needs are assessed for CM enrollment.
- Members identified through various ways including, but not limited to:
  - Census.
  - Claims.
  - Clinical rounds.
  - Directly from providers.
  - Hospital.
  - Referrals from Superior staff.
  - Self-referral.
- CM facilitates communication between PCP, member, managing physician and the CM team.
- Refer a member by contacting the Care Management department at 1-800-218-7508.

Disease Management

- Superior partners with Nurtur, a disease management company, for members with asthma, diabetes and other complex health conditions.
- Nurtur’s health coaches coordinate with both the member and providers to focus on disease specific conditions.

Notification of Admissions

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

Medicaid External Appeal Rights - External Medical Review and State Fair Hearing

Medicaid Member New External Appeal Rights

- Senate Bill 1207, 86th Legislature, Regular Session, established new External Medical Review (EMR) processes for:
  - Superior service denials and reductions (Phase I – effective 5/1/2022).
  - Eligibility denials for certain programs based on medical or functional necessity (Phase II implementation date not yet scheduled).
- After exhausting Superior's internal appeal of an adverse benefit determination, a member may request a State Fair Hearing with or without External Medical Review through and Independent Review Organization (IRO).
- The member, member's authorized representative, or a member's LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing within 120 days of Superior's appeal decision letter.
- If requested, the External Medical Review through an IRO is completed before a State Fair Hearing.

Medicaid Member New External Appeal Rights

- There are two types of EMR requests – standard and expedited:
  - Standard EMR Request – IRO Review is completed no later than 10 days following receipt of Superior's records related to the service denial or reduction determination.
  - Expedited EMR Request – IRO review is completed the next business day following receipt of the Superior's record for urgent requests.
- IRO will make one of the following determinations related to the adverse benefit determination to deny, reduce, suspend or terminate services: Upheld, Partially Overturned or Fully Overturned.
- The IRO will send written notification of its EMR decision to the member, the member's authorized representative or member's LAR (if applicable), Superior and the HHSC EMR Intake Team.
- Superior will implement any partial or full overturn by the IRO within 72 hours.

Medicaid Member New External Appeal Rights

- Withdrawal of EMR or State Fair Hearing Requests:

  EMR – The member, the member's authorized representative, or the member's LAR must initiate an EMR request withdrawal communication to Superior before the IRO Review is initiated.

  State Fair Hearing – If the EMR decision is to overturn Superior's adverse determination, the State Fair Hearing will proceed unless the member or member's representative withdraws the request. If the request is not withdrawn, regardless of the EMR decision, the member, the member's authorized representative or the member's LAR is required to attend the State Fair Hearing.

- Provider training on the new EMR process is available at:

  https://attendee.gotowebinar.com/recording/4623254401546558726

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Superior Pharmacy Services

Pharmacy Benefits

- PBM
  - Responsible for timely and accurate payment of pharmacy claims.
  - Provides pharmacy network for Superior members.
  - Responsible for review of prior authorizations for prescriptions, as applicable.
- Vendor Drug Program (VDP) formulary and Preferred Drug List (PDL) has been adopted for Medicaid and CHIP.
  - View VDP formulary and PDL here:

    https://www.txvendordrug.com/formulary

Specialty Drugs

- Specialty medications are typically filled through a specialty pharmacy such as but not limited too: AcariaHealth or CVS Caremark Specialty Pharmacy.
  - Only Synagis is required to be filled through AcariaHealth or CVS Caremark Specialty Pharmacy.
- Contact Information:

AcariaHealth	CVS Caremark
Phone: 1-855-535-1815	Phone: 1-800-237-2767
Fax: 1-877-541-1503	Fax: 1-800-323-2445
Web: www.AcariaHealth.com	Web: www.CVSSpecialty.com

How to Access the Formulary/PDL

- Superior utilizes the VDP formulary which is available on smart phones, tablets or similar technology on the web at: www.epocrates.com
- VDP Website for PDL and clinical authorization criteria: www.txvendordrug.com
- Texas clinical prior authorization criteria for Superior members: www.txvendordrug.com/formulary/prior-authorization/preferred-drugs

72-Hour Prescription

- State and Federal law requires that a pharmacy dispense a 72-hour (3 day) supply of medication to any member awaiting a prior authorization or medical necessity determination.
- If the prescribing provider cannot be reached or is unable to request an authorization, the pharmacy should dispense an emergency 72-hour prescription.
- A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable (e.g., an albuterol inhaler) as a 72-hour emergency supply.

DME and Medical Supplies - Pharmacy Providers

- If a pharmacy enrolled in Superior's PBM wishes to provide services that are not on the VDP formulary, the pharmacy must enroll as a DME provider and obtain a separate contract with Superior for medical services.
- Includes medically necessary items such as nebulizers, ostomy supplies or bed pans and other supplies and equipment.
- For children (birth through 20 years of age), this includes items typically covered under the Texas Health Steps program including, but not limited to, prescribed over-the-counter drugs, diapers, disposable or expendable medical supplies and some nutritional products.

Pharmacy Contact Information

- For questions or concerns from prescribers and members:
  - Phone: 1-800-218-7453, ext. 22272
  - Fax: 1-866-683-5631
  - E-forms: www.SuperiorHealthPlan.com/contact-us
- Pharmacy benefit prior authorization requests (PBM – CVS Caremark)
  - Authorization Requests Phone: 1-866-399-0928
  - Authorization Requests Fax: 1-866-399-0929
- Biopharmacy/Clinician Administered Drugs (CAD) Rx administration (Superior Authorizations Department)
  - Authorization Requests Phone: 1-800-218-7453, ext. 22272
  - Authorization Requests Fax: 1-866-683-5631
- Appeal (Superiors Appeals Department)
  - Appeals Requests Fax: 1-866-918-2266
  - Appeals Requests Phone: 1-800-218-7453, ext. 22168

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Quality Improvement

Quality Improvement

- Working with our provider community:
  - Manage and review annual Healthcare Effectiveness Data and Information Set (HEDIS) rates to identify interventions to improve HEDIS scores.
  - Maintain compliance with quality related areas of HHS regulations.
  - Generate, distribute and analyze selected provider profiles.
  - Coordinate office site visits related to complaints regarding physical appearance, physical accessibility, adequacy of wait time and adequacy of treatment record.
  - Conduct provider satisfaction surveys annually.
  - Review, investigate and analyze quality of care concerns (member complaints).

Quality Improvement

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

Cultural Sensitivity

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

Cultural Sensitivity

- More information regarding Cultural Sensitivity can be found in the Superior HealthPlan STAR, CHIP, STAR+PLUS, STAR Health and STAR Kids Provider Manual, located at www.SuperiorHealthPlan.com/providers/training-manuals.html.

Abuse, Neglect and Exploitation

Abuse, Neglect and Exploitation (ANE)

- Abuse
  - Intentional mental, emotional, physical or sexual injury to children, the elderly or people with disabilities, or failure to prevent such injury.
- Neglect
  - Failure to provide a child, the elderly or a person with a disability with food, clothing, shelter and/or medical care, and/or leaving a child in a situation where the child is at risk of harm.
- Exploitation
  - Misuse of a child, the elderly or a person with a disability for personal or monetary benefit. This includes taking Social Security or SSI checks, abusing a joint checking account and taking property and other resources.

How to Report ANE

- Providers must report any allegation or suspicion of ANE to the appropriate entity:
  - Department of Family and Protective Services (DFPS)
    - To report a child who has a disability, receiving services from:
      - Home and Community Support Services Agencies (HCSSAs)
      - An unlicensed foster care provider with 3 or fewer beds.
      - A child with disability or child residing in or receiving services from local authority, Local Mental Health Authority (LMHA), community center or mental health facility operated by DSHS.
      - A child with disability receiving services through the Consumer Directed Services (CDS) option.
    - Call the Abuse Hotline, 24 hours a day, 7 days a week, toll-free at 1-800-252-5400.

How to Report ANE

- Department of Aging and Disability Services (DADS)
  - Report an adult or child who resides in or receives services from:
    - Nursing facilities.
    - Assisted living facilities.
    - HCSSAs (also required to report any HCSSA allegation to DFPS).
    - Day care centers.
    - Licensed foster care providers.
  - Phone: 1-800-647-7418
- Local Law Enforcement
  - If a provider is unable to identify state agency jurisdiction, but an instance of ANE appears to have occurred, report to a local law enforcement agency and/or DFPS.

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Claims – Filing and Payment

Clean Claims

- For electronic pharmacy claim submissions, claims will be paid in 18 days.
- Once a Clean Claim is received, Superior will either pay the total amount of the claim or part of the claim in accordance with the contract, or deny the entire claim or part of the claim, and notify the provider why the claim will not be paid within the 30-day claim payment period.
- Each claim payment check will be accompanied by an Explanation of Payment (EOP), which itemizes a provider's charges for that reimbursement and the amount of the provider's check from Superior.
- Payment is considered to have been paid on the date of issue of a check for payment and its corresponding EOP to the provider by Superior, or the date of electronic transmission, if payment is made electronically.

Claims Filing: Initial Submission

- Claims must be filed within 95 days from the Date of Service (DOS):
  - Filed on CMS 1450/UB-04 or CMS 1500 (HCFA) filed electronically through clearinghouse.
  - Filed directly through Superior's Provider Portal.
- Claims must be completed in accordance with Medicaid billing guidelines.
- All member and provider information must be completed.
- Providers should include a copy of the EOP when other insurance is involved.
- Mailing Address (paper claims)

  Superior HealthPlan
  Attn: Claims
  P.O. Box 3003
  Farmington, MO 63640-3803
- 24(I) Qualifier ZZ, 24J(a) Taxonomy Code, 24J(b) National Provider Identifier (NPI) are all required when billing Superior claims (only applicable for form CMS 1500).

Paper Claims Filing

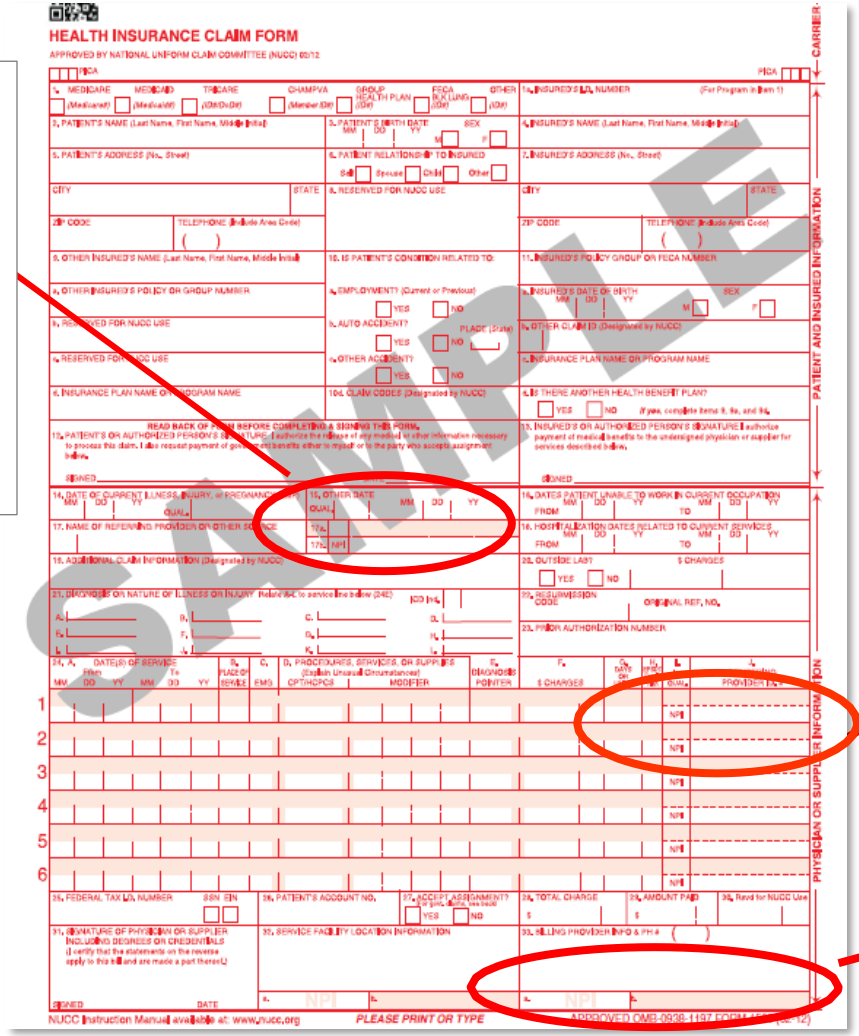
- To help process paper claims quickly and accurately, please take the following steps:
  - Remove all staples from pages.
  - Do not fold the forms.
  - Claim must be typed using a 12pt font or larger and submitted on original CMS 1450 or CMS 1500 red form (not a copy).
    - Handwritten claim forms are no longer accepted.
  - When information is submitted on a red form, Superior's Optical Character Recognition (OCR) scanner can put the information directly into our system. This speeds up the process by eliminating potential errors and allows Superior to process claims faster.

CMS 1500 (HCFA) Form

Referring Provider: [C]

17 Name of the referring provider and

17b National Provider Identifier (NPI)



Rendering Provider: [R]

Place your NPI box 24J (unshaded) and Taxonomy Code in box 24J (shaded).

These are required fields when billing Superior claims.

If you do not have an NPI, place your Atypical Provider Identifier (API) # or LTSS # in Box 33b.

Billing Provider: [R]

Billing NPI# in box 33a and Billing Taxonomy # (or API #, if no NPI) in 33b.

Claims Filing: Submitting Claims

- Secure Provider Portal:
  - Provider.SuperiorHealthPlan.com
- Electronic Claims:
  - Visit the web for a list of our trading partners: www.SuperiorHealthPlan.com/providers/resources/electronic-transactions.html
  - Superior Emdeon ID 68069
- Paper Claims – Initial and Corrected*

  Superior HealthPlan
  P.O. Box 3003
  Farmington, MO 63640-3803
- Paper Claims – Requests for Reconsideration* and Claim Disputes*

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

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

Claims Filing: Deadlines

- First Time Claim Submission
  - 95 days from DOS.
- Adjusted or Corrected Claims
  - 120 days from the date of EOP or denial is issued.
- Claim Reconsiderations and Disputes
  - 120 days from the date of EOP or denial is issued.

Identifying a Claim Number

- Superior assigns claim numbers for each claim received. Each time Superior sends any correspondence regarding a claim, the claim number is included in the communication.
- When calling Provider Services, please have the following ready to expedite handling:
  - Claim number (can be found on the Secure Provider Portal)
  - Electronic Data Interchange (EDI) Rejection/Acceptance reports
  - EOP
  - Rejection letters

Please note: Rejected claims never made it through Superior's claims system for processing. The claim number that is provided on the rejection letter is a claim image number that helps us retrieve a scanned image of the rejected claim.

Identifying a Claim Number

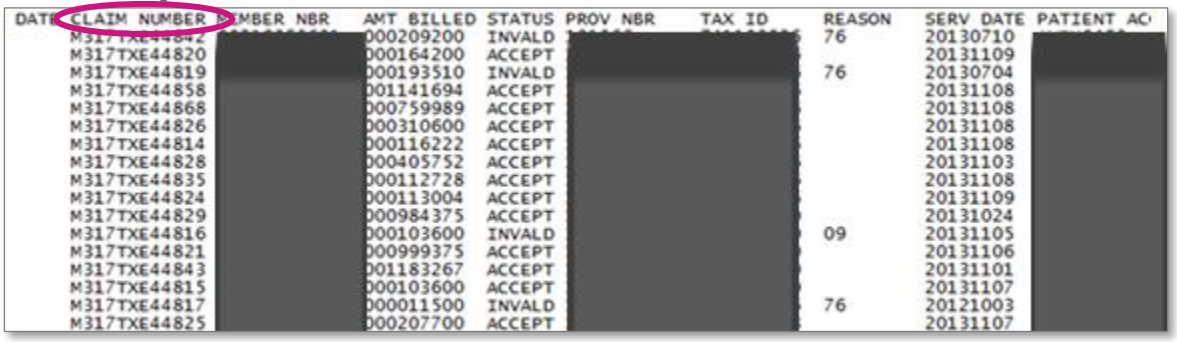
- **Electronic**: Secure Provider Portal or EDI through a clearinghouse.
  - Your response to your submission is viewable through an EDI rejection/acceptance report, rejection letters, Superior Provider Portal and EOPs.
- **Paper**: Mail to our processing center.
  - Your response to your submission is viewable through rejection letters, Superior's Provider Portal and EOPs.

Please note: On all correspondence, please reference either the claim number or control number.

Where do I find a Claim Number?

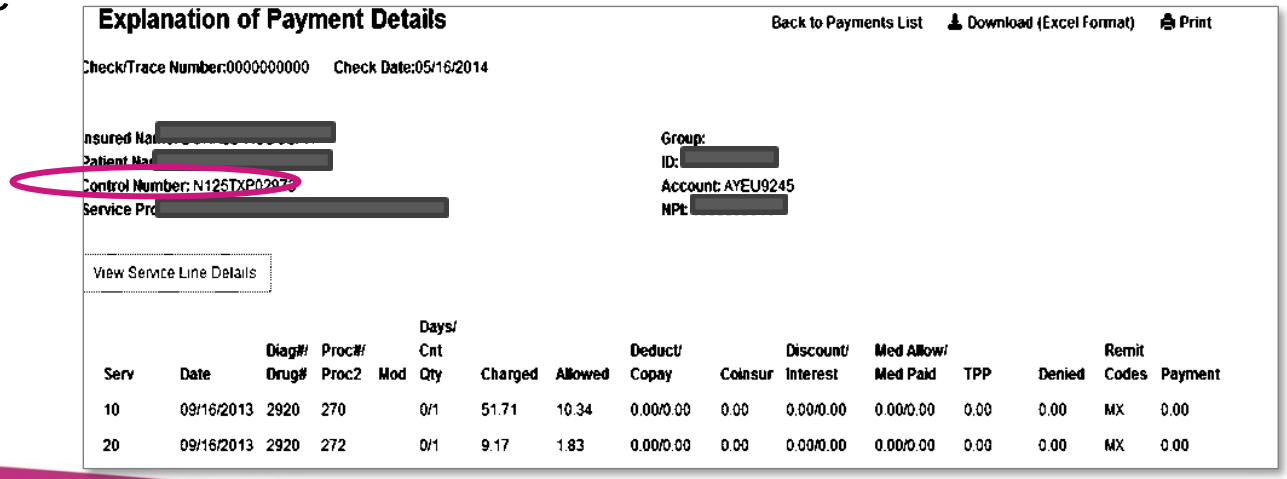
- You can find claim numbers on:
  - EDI reports
  - EOP Details on the Secure Provider Portal

EDI Reports



DATE	CLAIM NUMBER	MBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT AC
	M317TXE44842		000209200	INVALD			76	20130710	
	M317TXE44820		000164200	ACCEPT				20131109	
	M317TXE44819		000193510	INVALD			76	20130704	
	M317TXE44858		001141694	ACCEPT				20131108	
	M317TXE44868		000759989	ACCEPT				20131108	
	M317TXE44826		000310600	ACCEPT				20131108	
	M317TXE44814		000116222	ACCEPT				20131108	
	M317TXE44828		000405752	ACCEPT				20131103	
	M317TXE44835		000112728	ACCEPT				20131108	
	M317TXE44824		000113004	ACCEPT				20131109	
	M317TXE44829		000984375	ACCEPT				20131024	
	M317TXE44816		000103600	INVALD			09	20131105	
	M317TXE44821		000999375	ACCEPT				20131106	
	M317TXE44843		001183267	ACCEPT				20131101	
	M317TXE44815		000103600	ACCEPT				20131107	
	M317TXE44817		000011500	INVALD			76	20121003	
	M317TXE44825		000207700	ACCEPT				20131107	

Explanation of Payment Details on Provider Portal



Explanation of Payment Details

Back to Payments List | Download (Excel Format) | Print

Check/Trace Number:0000000000 Check Date:05/16/2014

Insured Na[redacted]

Patient Na[redacted]

Control Number: N125TXP02073

Service Pro[redacted]

Group:

ID: [redacted]

Account: AYEU9245

NPI: [redacted]

View Service Line Details

Serv	Date	Diag#/ Drug#	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	09/16/2013	2920	270		0/1	51.71	10.34	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00
20	09/16/2013	2920	272		0/1	9.17	1.83	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	MX	0.00

Electronic Claims Filing

- Claims can be submitted through Superior's Secure Provider Portal.
- Claims can also be submitted by using a Superior-preferred trading partner/clearinghouse.
- If provider uses EDI software but is not set up with a trading partner/clearinghouse, they must bill Superior by submitting paper claims or through the Secure Provider Portal until the provider has established a relationship with a trading partner/clearinghouse listed on our website.
  - For Superior electronic claim submissions, ensure that your EDI and clearinghouse has the correct payor ID: **68069** for medical claims and **68068** for behavioral health claims.
  - Contact EDI: EDIBA@Centene.com

Electronic Claims Filing

- Superior will not pay any claim submitted by a provider if the provider:
  - Is excluded or suspended from the Medicare, Medicaid or CHIP programs for fraud, waste or abuse.
  - Is on payment hold under the authority of HHS or its authorized agent(s).
  - Has provided neonatal services on or after September 1, 2017, if submitted by a hospital that does not have a neonatal level of care designation from HHS.*
  - Has provided maternal services on or after September 1, 2019, if submitted by a hospital that does not have a maternal level of care designation from HHS.*

**In accordance with Texas Health and Safety Code § 241.186, the restrictions on payment identified for neonatal and maternal services above do not apply to emergency services that must be provided or reimbursed under state or federal law.*

Claim Adjustments, Reconsiderations and Disputes

- Submit appeal within 120 days from the date of adjudication or denial.
  - **Adjusted or Corrected Claim**: The provider is changing the original claim.
  - **Correction to a Prior Claim**: Finalized claim that was in need of correction as a result of a denied or paid claim.
  - **Claim Appeals**: Often require additional information from the provider.
    - **Request for Reconsideration**: Provider disagrees with the original claim outcome (payment amount, denial reason, etc.).
    - **Claim Dispute**: Provider disagrees with the outcome of the request for reconsideration.
- Claim adjustments/corrections and submissions can be processed through the Provider Portal or a paper claim.
  - Paper claims require a Superior Corrected Claim or Claim Appeal form.
    - Find claims forms under **Provider Resources > Forms** at www.SuperiorHealthPlan.com/providers/resources/forms.html.

Corrected Claims

- A Corrected Claim is a correction of information to a previously finalized Clean Claim and must be submitted within 120 days of the adjudication date.
  - For example: Correcting a member's date of birth, a modifier, diagnosis (Dx) code, etc.
  - The original claim number must be billed in field 64 of the UB-04 form or field 22 of the CMS 1500 form.
  - The appropriate frequency code/resubmission code should also be billed in field 4 of the UB-04 form or field 22 of the CMS 1500 form.
- A Corrected Claim form may be used when submitting a Corrected Claim and mailing it to:

  Superior HealthPlan
  Attn: Claims
  P.O. Box 3003
  Farmington, MO 63640-3803
- Corrected claims can also be filed through Superior's secure provider portal or through your clearinghouse.

Claims Appeal Form

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

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

Appeals Documentation

- Examples of supporting documentation may include, but are not limited to:
  - A copy of Superior's EOP (required).
  - A letter from the provider stating why they feel the claim payment is incorrect (required).
  - A copy of the original claim.
  - An EOP from another insurance company.
  - Documentation of eligibility verification such as copy of ID card, TMBC, TMHP documentation, call log, etc.
  - Overnight or certified mail receipt as proof of timely filing.
  - Centene EDI acceptance reports showing the claim was accepted by Superior.
  - Prior authorization number and/or form or fax.

Common Billing Errors

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

Billing Reminders

- All institutional claims must contain POA indicators and Superior will utilize the POA information submitted on claims to reduce and/or deny payment for provider preventable conditions.
  - For per diem hospital payments, Superior utilizes a methodology for reduction and/or denial of payment for services related to a provider preventable condition that was not POA.
- If a provider bills for procedure codes not identified as valid services (identified specifically in the TMHP manual, available at www.TMHP.com) the service will not pay, as the services are considered to be informational only.

Billing Reminders

- Superior's Provider Manual provides guidelines on how to submit Clean Claims and highlights the requirements for completing CMS 1450 or CMS 1500 forms.
  - NPI of a referring or ordering physician on a claim.
  - Appropriate two-digit location code must be listed.
  - Appropriate modifiers must be billed when applicable.
  - Taxonomy codes are required on encounter submissions for the referring or ordering physician.
    - ZZ qualifier for CMS 1500 or B3 qualifier for CMS 1450 to indicate taxonomy.

Member Balance Billing

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

PaySpan

- Superior has partnered with PaySpan to offer expanded claim payment services to include:
  - Electronic Claim Payments/Funds Transfers (EFTs)
  - Online remittance advices (Electronic Remittance Advice [ERAs]/EOPs)
  - HIPAA 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at www.PaySpan.com.
- For further information contact 1-877-331-7154, or email ProviderSupport@PayspanHealth.com.

Provider Training

- Superior offers targeted billing presentations depending on the type of services provided and billed for.
  - Example: LTSS Billing Clinics
- There are also product-specific trainings available on STAR, STAR Health, STAR Kids and STAR+PLUS.
  - Access the schedule for face-to-face trainings or webinars at www.SuperiorHealthPlan.com/providers/training-manuals/provider-training-calendar.html.

Claims – Electronic Visit Verification (EVV)*

**For LTSS providers, as applicable*

Electronic Visit Verification (EVV)

- The 21st Century Cures Act Section 12006 is a federal law requiring all states to use EVV for Medicaid personal care services and home health services.
- Service attendants or CDS employees providing covered services to an individual or health plan member must use the EVV system to record visit arrival and departure times.
- The program provider, Financial Management Services Agency (FMSA) or CDS employer will use the time recorded in the EVV system to determine billable units/hours.
- The EVV system:
  - Electronically verifies the occurrence of authorized personal attendant service visits.
  - Electronically documents the precise time a service delivery visit begins and ends.

Programs Requiring EVV

- STAR Health:
  - PCS
  - CFC-PAS and Habilitation (HAB)
  - In-Home Respite Services
  - Flexible Family Support Services
- STAR Kids:
  - PCS
  - In-Home Respite Services
  - Flexible Family Support Services
  - CFC-PAS and HAB
- STAR+PLUS:
  - PAS
  - In-Home Respite Services
  - CFC-PAS and HAB
  - Protective Supervision

EVV Claims

- Providers, FMSAs or CDS employers will verify EVV visits using their selected EVV vendor system.
- All EVV claims must match to an accepted EVV visit in the EVV Aggregator (the state's centralized EVV database) in order to receive payment.
- Superior will only pay for verified units of service aligning with EVV data.
- To avoid denials, claims for multiple dates of service should be billed on a separate line for each day with the number of units per day.

EVV Claims

- EVV claims must be billed to TMHP and are subject to the EVV claims matching process.
- The info on EVV claims must match EVV transactions along the following data elements:
  - NPI or API.
  - Date of Service.
  - Medicaid ID.
  - HCPCS Codes.
  - Modifier(s), if applicable.
  - Units (a requirement only for program providers, not CDS).
    - All EVV claims lines billed with mismatches between these data elements EVV will result in denials
    - Providers or FMSAs will be required to resubmit any denials to TMHP.

superior healthplan™

Secure Provider Portal

Superior Website and Secure Provider Portal

Visit www.SuperiorHealthPlan.com.

Submit:

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

Verify:

- Member Eligibility
- Claim Status

View:

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

Provider Portal Highlights

- Manage all product lines and multiple Tax Identification Numbers (TINs) from one account.
  - Office Manager accounts available.
- PCP Panel - Texas Health Steps last exam date.
  - View the date of the member's last Texas Health Steps exam on file.
- Eligibility section for providers.
- Authorization detail and history.
  - New display features: Authorization denial reason
- Submit batched, individual or recurring claims.
- Download EOPs.
- Secure messaging.
- Refer members to Case Management.
- Review member alerts/care gaps.

How to Register for the Provider Portal

- Visit Provider.SuperiorHealthPlan.com.
- Enter your provider/group name, TIN, individual's name entering the form, office phone number and email address.
- Create user name and password.
- Each user within the provider's office must create their own user name and password.

Provider Portal: Eligibility

- Search for eligibility using:
  - Member's DOB.
  - Medicaid/CHIP/DFPS ID number or last name.
  - DOS.
- View/print patient list:
  - Member panel.
  - Member care gap alerts.
  - Both can be downloaded in Excel or PDF format.

Provider Portal Highlights

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

- Examples of Care Gap Alert categories and descriptions:
  - Adult Preventive
    - No mammogram in most recent 12 months.
    - No chlamydia test in past 12 months in patient 16-25 years of age.
    - No PAP in past 12 months.
  - Diabetes:
    - DM - Not seen in past 6 months.
    - DM - No retinal eye exam in past 12 months.
    - DM - No HbA1C screening in past 12 months.
  - Cardiac:
    - CAD - Not seen in past 12 months.
    - HTN - Not seen in past 12 months.
    - Flu vaccine.- No flu vaccine in past 12 months.
  - Child Preventive:
    - Immunizations not current for age.

Provider Portal: Authorizations

- Create Authorizations
  - Enter the patient's member ID/last name and DOB and click "Find."
  - Populate the 6 sections of the authorization with the appropriate information starting with the service type section.
  - Follow the prompts and complete all required information.
  - Attach any required documentation, review and submit.
- Check Authorization Status
  - Enter web reference number and click "Search"; please allow at least 24 hours after submission to review status.
  - View authorization status, ID number, member name, DOS, type of service and more.
  - To view all processed authorizations, click "Processed" and to view any authorizations with errors, click "Errors."

Please note: Authorizations update to the web portal every 24 hours.

Provider Portal: Claims

- Claim Status
  - Claims update to the web portal every 24 hours.
  - Status can be checked for a period of time 18 months prior.
- View Web Claims
  - Click on the claims module to view the last 3 months of submitted claims.
- Unsubmitted Claims
  - Incomplete claims or claims that are ready to be submitted can be found under “saved” claims.
- Submitted Claims
  - Status will show “in progress,” “accepted,” “rejected” or “completed.”

Provider Portal: Claims

- Create Claims
  - Professional, institutional, corrected and batch.
- View Payment History
  - Displays check date, check number and payment amount for a specific timeframe (data available online is limited to 18 months).
- Claim Auditing Tool
  - Prospectively access the appropriate coding and supporting clinical edit clarifications for services before claims are submitted.
  - Proactively determine the appropriate code/code combination representing the service for accurate billing purposes.
  - Retrospectively access the clinical edit clarifications on a denied claim for billed services after an EOP has been received.

Additional Provider Portal Information

- Online Assessment Forms
  - NOP
- Resources
  - Practice guidelines and standards
  - Training and education
- Contact Us (Web Applications Support Desk)
  - Phone: 1-866-895-8443
  - Email: TX.WebApplications@SuperiorHealthPlan.com

Superior HealthPlan Departments

We're here to help you!

Account Management

- Field staff are here to assist you with:
  - Face-to-face orientations.
  - Face-to-face web portal training.
  - Office visits to review ongoing trends.
- Superior Account Management offers targeted billing presentations depending on the type of services you provide. For example, we offer general and LTSS billing clinics.

Please note: Visit www.SuperiorHealthPlan.com/providers/resources/find-my-provider-rep.html for a map that can assist you with contact information for your Account Manager.

Provider Services

- Provider Services can help you with:
  - Questions on claim status and payments.
  - Assisting with claims appeals and corrections.
  - Finding Superior network providers.
- For claims-related questions, have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Contact Provider Services, Monday through Friday, 8:00 a.m. to 5:00 p.m. local time:
  - 1-877-391-5921

Member Services

- The Member Services staff can help you with:
  - Verifying eligibility.
  - Reviewing member benefits.
  - Assisting with non-compliant members.
  - Helping to find additional local community resources.
  - Answering questions.
    - Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time, by calling:
      - STAR, CHIP and Perinate: 1-800-783-5386
      - STAR+PLUS: 1-877-277-9772

Provider Contracting

- Network Development and Contracting is a centralized team that handles all contracting for new and existing providers to include:
  - New provider contracts.
  - Adding providers to existing Superior contracts.
  - Adding additional products (i.e. CHIP, STAR, STAR+PLUS) to existing Superior contracts.
  - Amendments to existing contracts.

- Contract packets can be requested at www.SuperiorHealthPlan.com/providers/become-a-provider.html.

Provider Credentialing

- Initial Credentialing
  - Complete a Texas Department of Insurance (TDI) credentialing application form for participation.
  - Complete an electronic application.
  - Provide Council for Affordable Quality Healthcare (CAQH) identification number.
  - Email applications to SHP.NetworkDevelopment-Medicaid@SuperiorHealthPlan.com.
- Re-credentialing
  - Completed every 3 years from date of initial credentialing.
  - Applications and notices are mailed at 180, 120, 90 and 30 days out from the last day of the credentialing anniversary month.
  - Lack of timely submission can result in members being re-assigned and system termination.
  - Email applications to Credentialing@SuperiorHealthPlan.com.
  - Failure to respond timely to requests for information or documentation will result in discontinuation of re-credentialing and termination of contract.
- All credentialing and re-credentialing questions should be directed to Superior's Credentialing department at 1-800-820-5686, ext. 22281 or Credentialing@SuperiorHealthPlan.com.

Provider Complaints

- A complaint is an expression of dissatisfaction, orally or in writing, about any matter related to the Superior. Superior offers a number of ways to file a complaint, as listed below:
  - Mail:

    Superior HealthPlan
    ATTN: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741

  - Fax:

    1-866-683-5369

  - Online:
    www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html

Questions and Answers

Let us know what we can do to help.

Thank you for attending!