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FQHC Training

Provider Training

Introductions and Agenda

- STAR
- STAR+PLUS
- STAR+PLUS Medicare-Medicaid Plan (MMP)
- STAR Kids
- STAR Health (Foster Care)
- CHIP and CHIP Perinate
- Ambetter from Superior HealthPlan (Health Insurance Marketplace)
- Wellcare By Allwell (Medicare Advantage and D-SNP)
- Medical Management
- Cultural Competency and Disability Sensitivity
- Hospital Billing Guidelines
- Claims and Payment Processing
- Corrected Claims and Appeals (Medicaid/CHIP/MMP)
- Complaints and Appeals (Ambetter and Wellcare By Allwell)
- Secure Provider Portal
- Health Passport
- Superior Departments
- Superior Partners
- Questions and Answers

Superior HealthPlan

- Superior provides Medicaid and CHIP programs in Texas Health and Human Services (HHS) service areas throughout the state. These programs include:
  - STAR
  - STAR Health (Foster Care)
  - STAR Kids
  - STAR+PLUS
  - STAR+PLUS Medicare-Medicaid Plan (MMP)
  - CHIP and CHIP Perinate
- In addition to the products above, Superior also offers the following, in limited service areas:
  - Health Insurance Marketplace (Ambetter from Superior HealthPlan)
  - Medicare Advantage (Wellcare By Allwell [HMO and HMO DSNP])

NCQA Accreditation

- National Committee for Quality Assurance (NCQA) awards accreditation to participating health plans.
  - NCQA is a private, non-profit organization. It was founded in 1990 to help improve health-care quality.
  - Superior is among the top-rated Medicaid plans in Texas, earning a score of 3.5 out of 5 in the National Committee for Quality Assurance's (NCQA) Medicaid Health Insurance Plan Ratings NCQA Accreditation ratings are based on:
    - Health Effectiveness Data and Information Set (HEDIS) scores.
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
    - NCQA Accreditation standard scores.

Verify Eligibility (Medicaid/CHIP)

- Texas Medicaid Benefits Card
- TexMed Connect – www.YourTexasBenefits.com
- Superior's ID Card
- Secure Provider Portal – Provider.SuperiorHealthPlan.com
- Contacting Superior's Member Services department at:
  - STAR 1-800-783-5386
  - STAR+PLUS: 1-877-277-9772
  - STAR Kids: 1-844-590-4883
  - STAR Health: 1-866-912-6283
  - CHIP/CHIP Perinate 1-800-783-5386
  - STAR+PLUS MMP: 1-866-896-1844
  - Ambetter: 1-877-687-1196
  - Wellcare By Allwell (HMO): 1-844-796-6811
  - Wellcare By Allwell (HMO DSNP): 1-877-935-8023

Provider Roles and Responsibilities

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 or care and referrals to specialists
- Enroll as a Texas Health Steps provider or refer members to a participating Texas Health Steps provider
- Ensure accurate information in provider directories by updating contact information
- Report all encounter data on CMS-1500 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-hours 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 the 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 call outside of 30 minutes.

PCP Access to Care Requirements

Appointment Type	Access Standard – Medicaid/CHIP	Access Standard – Wellcare By Allwell	Access Standard - Ambetter	Access Standard - MMP
Routine Care	14 Calendar Days	30 Calendar Days	3 weeks	14 Calendar Days
Urgent Care	24 hours	Immediately; for services that are not emergencies or urgently needed, but in need of medical attention within 1 week	24 hours	24 hours
Emergent Care	Immediately (same day)	Immediately	Upon arrival	Upon arrival

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.
- 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 SuperiorHealthPlan.com/ProviderManuals.

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.
  - Ambetter Value and Virtual members will require a referral* to be submitted through the secure provider portal.
- Specialist may not refer to another specialist.
- Members may also self-refer for several services

**Referrals are not required for OB/GYN, Mental Health/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia*

Texas Health Steps

Texas Health Steps

For Medicaid-eligible children, adolescents and young adults under 21 years old, 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: www.dshs.state.tx.us/thsteps/providers.shtm
  - Members under 3 years old 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 Calendar 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).

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 old 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 is available as a free continuing education course on the Texas Health Steps website at: www.txhealthsteps.com
- 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

Missed Appointments and Refusal of Exam

- 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.).
  - Missed Appointment is found on the HHS Texas Health Steps Forms form is available at: THSteps Provider Outreach Referral Form
- Refusal of Exam:
  - Superior is required to log all member refusal 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 his or her 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.

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.
- A separate Texas Health Steps Texas Provider Identifier (TPI) number is required.
- 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

STAR Eligibility

Who is covered by the STAR Program in Texas?

- Families, children and pregnant women
  - Based on income level, age, family income and other resources/assets
- Newborns
  - Born to mothers who are Medicaid-eligible at the time of the child's birth are automatically eligible for Medicaid and remain eligible until their first birthday
- Temporary Assistance for Needy Families (TANF) recipients or TANF-related benefits.
- Former children in Foster Care, ages 21-25

STAR Benefits

- Include, but are not limited to:
  - Medical and surgical services
  - Applied Behavioral Analysis (effective 2/1/2022)
  - Hospital services
  - Texas Health Steps
  - Transplants
  - Unlimited prescriptions
  - Durable Medical Equipment (DME)
  - Mental and behavioral health services
  - Maternity services
  - Dental and vision services
  - Therapy – Physical, Speech, Occupational

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STAR+PLUS

STAR+PLUS Eligibility

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

STAR+PLUS Eligibility

- 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 conserved 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
- 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)

STAR+PLUS Eligibility

- Excluded Members
  - 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 Medicaid benefits.
  - Individuals receiving long-term care services through non-Medicaid funded programs.

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.).

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

SNF Benefits for Dual-Eligible Members

- Medicare is the primary payor for all acute care services (e.g. Primary Care Physician [PCP], hospital, outpatient services), skilled nursing facility (SNF) services and skilled nursing stay days 1-20 paid at 100% of the Resource Utilization Group (RUG).
- STAR+PLUS (Superior)
  - Covers Vent and Trach add-on services.
  - Is the primary payor for the co-insurance for the SNF Unit Rate for days 21-100 (if the stay meets qualifying hospital stay criteria and skillable needs) and add-on services.
  - Is the primary payor for the Nursing Facility (NF) Unit Rate starting day 101.

Long Term Services and Supports (LTSS)

- Both dual and non-dual STAR+PLUS members may qualify for Long Term Services and Supports (LTSS). Services include:
  - Day Activity and Health Services (DAHS).
  - Primary Home Care.

- Other services under the STAR+PLUS Home and Community-Based Services (HCBS) waiver include but are not limited to:
  - Personal Assistance Services
  - Adaptive aids
  - Assisted living
  - Emergency response services
  - Home delivered meals
  - Minor home modifications
  - Respite care

STAR+PLUS Medicare-Medicaid Plan (MMP)

STAR+PLUS MMP

- A fully integrated managed care model for individuals 21 years of age and older who are enrolled in Medicare and Medicaid.
  - Eligible members are able to opt out of the MMP program.
- Superior offers this program in Bexar, Dallas and Hidalgo counties only.
- Individuals who meet all of the following criteria are eligible for STAR+PLUS MMP:
  - Age 21 or older at the time of enrollment
  - Entitled to benefits under the Medicare Part A and enrolled under Medicare Part B
  - Required to receive their Medicaid benefits through the Superior STAR+PLUS
  - Reside in Bexar, Dallas or Hidalgo counties
- Superior covers:
  - All Medicare benefits, including parts A, B and D
  - Medicaid benefits, including LTSS
  - Flexible benefits
  - Supplemental Benefits

STAR+PLUS MMP Benefits

- STAR+PLUS MMP offers the same acute care health services members receive through Medicare. These include, but are not limited to:

  - Ambulance services
  - Hospital Services
  - Behavioral health services
  - Birthing center services
  - Cancer screening and treatment
  - Dialysis
  - Durable medical equipment and supplies
  - Emergency services
  - Laboratory
  - LTSS services
  - Medical checkups
  - Podiatry services
  - Prenatal care
  - Radiology, imaging and x-rays
  - Specialty physician services
  - Unlimited prescriptions

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STAR Kids

STAR Kids Eligibility

- STAR Kids integrates the delivery of state plan services, behavioral health services and LTSS benefits for children and young adults age 20 and younger with disabilities.
- The following Medicaid-eligible individuals must enroll in the STAR Kids program:

  - Receive Supplemental Security Income (SSI) and SSI-related Medicaid
  - Receive SSI and Medicare
  - Receive Medically Dependent Children (MDCP) waiver services
  - Receive Intellectual and Developmental Disabilities (IDD) waiver services, including:
    - Community Living Assistance and Support Services (CLASS)
    - Deaf-Blind with Multiple Disabilities (DBMD)
    - Home and Community-Based Services (HCS)
    - Texas Home Living (TxHmL)
  - Members who reside in a community-based intermediate care facility for individuals with intellectual disabilities (ICF-IID) or in a Nursing Facility.

STAR Kids Benefits

- Include, but are not limited to:
  - Medical and surgical services
  - Hospital services
  - Emergency services
  - Transplants
  - Unlimited prescriptions
  - Durable Medical Equipment (DME)
  - Mental and behavioral health services
  - Maternity services
  - Laboratory
  - Radiology, imaging and x-rays

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STAR Health (Foster Care)

STAR Health Eligibility

- Children and young adults under 18 in DFPS conservatorship
- Young adults age 18-22 who choose to remain in foster care placement
- Members in a waiver program will be enrolled in STAR Health but receive waiver services from the waiver program
  - Waivers include CLASS, HCS, DBMD, MDCP and TxHmL
- Young adults who have exited care and are eligible for Medicaid for Former Foster Care Children (FFCC) from age 18 to 22
- Adoption Assistance or Permanency Care Assistance (AAPCA) program members that qualify and choose to remain in STAR Health

STAR Health Benefits

- Include, but are not limited to:
  - Hospital services
  - Dental services
  - Doctor visits
  - Therapy – Physical, Occupational and Speech
  - Personal Care Services (PCS)
  - Mental and behavioral health services
  - Specialty physician services
  - Pregnancy services
  - Transplants

3 in 30

- 3 in 30 is a collaborative effort between the Texas Department of Family and Protective Services (DFPS), HHS and Superior HealthPlan.
- 3 in 30 combines three separate, yet critical, tools for assessing the medical, behavioral, and developmental strengths and needs of children and youth in foster care, when entering DFPS conservatorship.
- Each assessment is a requirement set forth by Senate Bill 11. Together, the three assessments chart the path for ensuring STAR Health members get the care and services they need at the time they enter foster care.

3 in 30

- 3 Day Initial Medical Exam
  - Within 3 Business Days, children entering DFPS care must see a doctor to be checked for injuries or illnesses and get any treatments they need.
- CANS 2.0 Assessment
  - Within 30 days, children ages 3 and older must get a CANS 2.0 assessment. The CANS 2.0 is a comprehensive trauma-informed behavioral health evaluation. It gathers information about the strengths and needs of the child and helps in planning services that will help the child and family reach their goals.
- Texas Health Steps Medical Check-Up (also known as Early and Periodic Screening, Diagnosis and Treatment [EPSDT])
  - Within 30 days, children must see a Texas Health Steps doctor for a complete check-up with lab work. This makes sure:
    - Medical issues are addressed early
    - Kids are growing and developing as expected
    - Caregivers know how to support strong growth and development

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CHIP (Children's Health Insurance Program) and CHIP Perinate

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:
  - Hospital services
  - Dental and vision services
  - Durable Medical Equipment (DME)
  - Mental and behavioral health services
  - Medical and surgical services
  - Birthing Center services
  - Prescriptions
  - Laboratory
  - Therapy – Physical, Speech and Occupational
  - Transplants
  - Well-child exams and preventive health services

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 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).

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Ambetter from Superior HealthPlan
(Health Insurance Marketplace)

Ambetter Enrollment

- Annual open enrollment period
- Ambetter offers several levels of plan options, each one representing a different type of coverage.
  - Ambetter Essential/Balanced/Secure
  - Ambetter Value
  - Ambetter Virtual
- All plans have cost shares in the form of copays, coinsurance and deductibles.
  - Some members will qualify for assistance with their cost shares based on their income level.
  - This assistance would be paid directly from the government to Superior.
- Dependent coverage to 26 years of age
- Ambetter coverage is available for members in several counties throughout Texas. For a full list of the counties, visit: Ambetter.SuperiorHealthPlan.com/for-brokers/coverage-area-map.html.

Ambetter Value

- New plan design with a more restrictive yet inclusive and adequate network being offered within a limited set of counties:
  - Bexar, Collin, Dallas, Denton, Fort Bend, Harris, Montgomery, Rockwall, Tarrant, Travis, Williamson
- The Ambetter Value plan design differs in the following:
  - HCA Physicians Groups are the preferred PCP groups in which members will be able to utilize as a medical home.
    - ID Cards will display "**Ambetter Value Medical Group**"
  - Any specialty care rendered by a specialist outside of the HCA Physicians Group will require a referral prior to services being rendered to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia
  - Please Note: The above provider or facility types will still be required to be in-network and prior authorization requirements will continue to apply as applicable.

Ambetter Virtual

- New plan design which most closely mirrors the network offered within Essential/Balanced/Secure.
  - There are a few exceptions most noticeably within our Hospital systems network.
- The Ambetter Virtual Access plan design differs in the following:
  - Teladoc is the preferred PCP group in which members will automatically be assigned to.
    - Members under the age of 18 are the exception as they will be assigned to a local PCP
  - Teladoc (or local PCP) will be responsible to submit a referral to Ambetter from Superior Health Plan in order for any Specialty care provider to render services to our members.
- Referrals are NOT required or applicable to the following specialties or service types:
  - OB/GYN, MH/SUD, Urgent Care, Emergent Care, Labs, Radiology and Anesthesia
  - Please Note: The above provider or facility types will still be required to be in-network and prior authorization requirements will continue to apply as applicable.

Ambetter Benefits

- Essential Health Benefits (EHBs) are the same for every plan within the state. The EHBs outlined in the Affordable Care Act are:
  - Preventive and wellness services (covered at 100%)
  - Maternity and newborn care
  - Outpatient or ambulatory services
  - Emergency services
  - Prescription drugs
  - Laboratory services
  - Pediatric services
  - Mental health and substance abuse services
  - Hospitalization
  - Various therapy services (such as physical therapy) and devices

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Wellcare By Allwell

Medicare Advantage
Medicare Advantage Special Needs Plan (D-SNP)

Wellcare By Allwell (Medicare)

- Wellcare By Allwell (HMO and HMO SNP) is a Medicare federal health insurance program for people ages 65 and older, and those under 65 with qualifying disabilities.
- Eligibility: Who Qualifies?
  - **HMO**: Individuals enrolled in Medicare only
  - **HMO DSNP**: Individuals who qualify for Medicaid coverage through the state of Texas and are eligible for Medicare
  - Enrollees must also live in a county offering their selected plan

Wellcare By Allwell (Medicare)

- Wellcare By Allwell provides complete continuity of care. This includes:
  - Integrated coordination of care
  - Care management
  - Co-location of behavioral health expertise
  - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM)
  - Additional services specific to the member's needs
- Superior's approach to care management facilitates the integration of community resources, health education and disease management.
  - It promotes access to care as the beneficiaries are served through a multidisciplinary team including Registered Nurses (RN), social workers, pharmacy technicians and behavioral health case managers all co-located in a single, locally based unit.
- Members have access to the following provider types:
  - Clinical Social Workers (CSW)
  - Psychiatrists
  - Clinical Psychologists
  - Psychiatric Nurse Practitioners

Wellcare By Allwell Benefits - DSNP

- All Part A and Part B benefits by Medicare
- Part B drugs – such as chemotherapy drugs
- Part D drugs – no deductible at network retail pharmacies or mail order*
- Additional benefits and services such as:
  - Dental
  - Vision
  - No Cost / Low Cost PCP copay*
  - $0 generic prescription drugs
- For a summary of plan benefits, visit: Wellcare.SuperiorHealthPlan.com

**Dependent on plan*

Medicare Covered Services

- Covered Services include, but are not limited to:
  - Ambulance
  - Behavioral Health
  - Hospital Inpatient/Outpatient
  - Lab and X-Ray
  - Medical Equipment and Supplies
  - Physician
  - Podiatry
  - Prescribed Medicines
  - Therapy
  - Wellness Programs
  - 24-Hour Nurse Advice Line

**Specific counties only.*

Behavioral Health Benefits

Behavioral Health Benefits

- Traditional and Day Treatment Outpatient Services
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Medication Management Therapy
  - Individual, Group and Family Therapy
- Inpatient Mental Health Services
  - Inpatient Hospitalization
  - Substance Detoxification
  - 23-Hour Observation
- Substance Use Disorder Treatment
  - Individual and Group Therapy
  - Residential Treatment
  - Outpatient services
- Enhanced Services
  - Targeted Case Management or Rehabilitative Services
- Telemedicine
- Pharmacy Benefits - Prescription Drugs

Please note: The behavioral health benefits referenced above are not available for all products.

Case Management for Children and Pregnant Women (CPW)

- For dates of service on or after September 1, 2022, Superior HealthPlan is responsible for managing the delivery of Case Management for Children and Pregnant Women (CPW) services for Superior HealthPlan (STAR, STAR+PLUS, STAR Health, STAR Kids) and STAR+PLUS Medicare-Medicaid Plan (MMP) programs.
  - CPW services for STAR Health members are limited to members who are not in Department of Family and Protective Services (DFPS) conservatorship.
  - CPW services are available to STAR Health members who are in categories 3, 4, 5 and 6 of the Target Population.
- Authorization is not required for CPW Case Management Services.
- Specific documentation for the comprehensive visit and follow-up visits, the billable components of case management, are required.
- FQHCs may provide CPW Case Management services; however, must obtain approval from HHSC **and** complete HHSC Case Management Training.
- CPW providers will need to complete a demographic form if they wish to provide these services.
- Additional information on CPW Case Management Services, please review the Quick Reference Guide.

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Medical Management

Prior Authorization Tool

- Medicaid: SuperiorHealthPlan.com/MedicaidPriorAuth
- Ambetter: SuperiorHealthPlan.com/AmbetterPriorAuth
- Medicare: SuperiorHealthPlan.com/MedicarePriorAuth
- MMP: SuperiorHealthPlan.com/MMPPriorAuth

Authorization Request Response Times

Program	Authorization Type	TAT
STAR, STAR+PLUS, STAR Kids and STAR Health	Outpatient, Inpatient Elective	3 Business Days
CHIP	Outpatient, Inpatient Elective	2 Business Days
CHIP and Medicaid	Urgent, Outpatient and Inpatient Elective	3 Calendar Days
CHIP and Medicaid	Inpatient	1 Business Day
STAR+PLUS MMP	Urgent Expedited Authorization/ Concurrent Hospital	1 Business Day
STAR+PLUS MMP	Standard Authorization	3 Business Days

Please note: Timeframes above are not applicable to emergent services.

Authorization Request Response Times

Program	Authorization Type	TAT
Wellcare By Allwell	Standard	Expeditiously as the member's health condition required, but no later than 14 Calendar Days after receipt of request
Wellcare By Allwell	Standard Extension	Up to 14 additional Calendar Days (not to exceed 28 Calendar Days from receipt of original request)
Wellcare By Allwell	Expedited	Expeditiously as the member's health condition requires, but no later than within 72 hours after receipt of request
Wellcare By Allwell	Expedited Extension	Add 11 Days up to 14 additional Calendar Days (not to exceed 17 Calendar Days after receipt of original request)
Wellcare By Allwell	Concurrent	As soon as medically indicated; usually within 1 Business Day of request depending on the plan's policy
Ambetter	Prospective/Urgent and Non-Urgent	3 Calendar Days
Ambetter	Concurrent/Urgent and Non-Urgent	24 Hours
Ambetter	Retrospective	30 Calendar Days

Prior Authorization Requests

- Authorizations for all products may be requested through Superior HealthPlan's web portal at: Provider.SuperiorHealthPlan.com.
- Forms are available on our website: SuperiorHealthPlan.com/ProviderForms or Ambetter.SuperiorHealthPlan.com.
  - Fax numbers:
    - Medicaid/CHIP/MMP:
      - Medical – Inpatient: 1-877-650-6942; Outpatient: 1-800-690-7030
      - Behavioral Health – Inpatient: 1-800-732-7562; Outpatient: 1-866-570-7517
    - STAR+PLUS MMP:
      - Medical – Inpatient: 1-877-259-6960; Outpatient: 1-877-808-9368
      - Behavioral Health – Inpatient: 1-866-900-6918; Outpatient: 1-855-772-7079
    - Ambetter:
      - Medical – Inpatient: 1-866-838-7615; Outpatient: 1-855-837-3447
      - Behavioral Health – Inpatient: 1-844-824-9016; Outpatient: 1-844-307-4442
    - Wellcare By Allwell:
      - Medical – Inpatient: 1-855-837-3535; Outpatient: 1-877-808-9368
      - Behavioral Health – Inpatient: 1-866-900-6918; Outpatient: 1-855-772-7079
- Providers can also call in requests:
  - Medicaid/CHIP/Wellcare By Allwell/MMP – 1-800-218-7508
  - Ambetter - 1-877-687-1196

National Imaging Associates (NIA)

- National Imaging Associates (NIA) is contracted with Superior to perform utilization review for several services, including:
  - Outpatient High-Tech Imaging Services for all products
  - Non-emergent outpatient prior authorizations for Interventional Pain Management (IPM) procedures for STAR and STAR+PLUS members 21 years of age and older
  - Outpatient physical, occupational and speech therapy treatment services for Superior Medicaid (STAR, STAR+PLUS non-HCBS waiver), CHIP and Ambetter members.
- The ordering physician is responsible for obtaining an authorization by:
  - Accessing www.radmd.com
  - Calling 1-800-642-7554 (Medicaid); 1-866-214-1703 (Medicare); or 1-800-424-4916 (Ambetter)
- NIA QRGs and FAQs are available online at: SuperiorHealthPlan.com/PriorAuth

TurningPoint Healthcare Solutions

- Superior partners with TurningPoint Healthcare Solutions to process prior authorization requests for medical necessity and appropriate length of stay for:
  - Musculoskeletal Surgical procedures for Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids), CHIP, Wellcare By Allwell and Ambetter members
  - Cardiac procedures, ENT surgeries and sleep study procedures for Medicaid (STAR, STAR+PLUS, STAR Health, STAR Kids), CHIP, Wellcare By Allwell and Ambetter members
- Emergency related procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization.
- 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: 1-469-310-3104 | 1-855-336-4391
  - Facsimile Intake: 1-214-306-9323

Cultural Competency and Disability Sensitivity

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.

How Can Providers Help?

- Know your patients. Capture information about accommodations that might be required.
- Identify patients with limited health literacy.
- Use simple language, short sentences and define technical terms for patients.
- Supplement instructions with appropriate materials (videos, models, graphic materials, translated written materials, interpreting, etc.).
- Ask patients to explain your instructions (teach back method) or demonstrate the procedure.
- Ask questions that begin with “how” and “what,” rather than closed-ended yes/no questions.

How Can Providers Help?

- Organize information so that the most important points stand out and repeat this information.
- Reflect the age, cultural, ethnic and racial diversity of patients.
- Provide information in their primary language (for Limited English Proficiency [LEP] patients) or preferred alternate format, i.e. large print or braille.
- Improve the physical environment in your office by using universal symbols.
- Offer assistance with completing health-care forms.

Resources For Your Practice

Complimentary Interpretation Services

Superior provides interpretation services to our providers at no cost. To obtain access to a telephonic interpreter, follow these steps:

1. Use a phone in the exam room, call the Member Services number located on the back of the patient's Superior member ID card.
2. Tell the representative that you need an interpreter in the desired language.
3. When connected, use the speakerphone function to communicate with the patient.

Cultural Sensitivity & Health Literacy Training

Superior has resources for providers regarding cultural competency and health literacy. This includes, but is not limited to:

- Trainings and resources found at SuperiorHealthPlan.com/Quality
- Superior Provider Manuals found at SuperiorHealthPlan.com/ProviderManuals

FQHC Billing Guidelines

FQHC Claims Filing

- All claims must be submitted on a CMS-1500 or 837P form.
  - Forms can be found at SuperiorHealthPlan.com/ProviderForms.
- All services provided in the FQHC should be billed with location code 50
  - If a service is provided outside of the FQHC, use the location code appropriate to where the service was provided.
- Modifiers:
  - All Evaluation and Management (E&M) services and T1015 must be billed with the modifier indictor that describes the type of provider rendering the service (AH, AJ, AM, SA, TD, TE, U1, U2 or U7).
  - Modifier 25 is not required for multiple encounters on the same day for the same patient; however, it is required with the appropriate vaccine administration codes.
  - Modifier TH must be submitted for all pre- and postnatal services and must be in the first modifier position.
  - Modifier EP must be submitted on the T1015 and the E&M service line for Texas Health Step services and any additional required modifier.

FQHC Claims Filing, continued

- All Medicaid (STAR, STAR Health, STAR Kids and STAR+PLUS) and CHIP services provided in an FQHC must be billed with a T1015 service line.
  - Claims billed with location code 50 without a T1015 service line will not receive the Prospective Payment System (PPS) payment and may result in denial.
- The PPS rate should be entered in the charge field on the T1015 service line.
- National Drug Code (NDC) information is required to be billed on claims containing Clinician-Administered Drugs (CADs).
- Long-Acting Reversible Contraception (LARC) devices may be paid in addition to the provider's PPS encounter rate with the appropriate removal/insertion code.
  - These should be billed with the family planning visit E&M and diagnosis code, T1015 and the LARC device code. 58300 is considered informational.

FQHC Claims Filing – Sports Physicals

- Superior will reimburse sports physicals for eligible members:
  - STAR, STAR Health, STAR Kids and CHIP members only
  - 4-17 years of age (STAR and CHIP) and 4-18 years of age (STAR Health)
  - 1 per Calendar Year
- For prompt claim payment please follow these guidelines:
  - Diagnosis Code: Z02.5
  - Current Procedural Terminology (CPT) Codes: 99382-99385 or 99392-99395
- Billing and payment for sports physicals:
  - Sports physicals must be billed with the appropriate E&M and diagnosis code in the primary position. Sports physical claims should not be billed with T1015. This is an incorrectly billed claim and will result in denial.
- Reimbursement will be $35.00 (there is no co-pay).

Behavioral Health Claims

- Claims must be filed on a CMS-1500 claim form:
  - Using Location Code 50.
  - With a procedure code T1015 and all applicable modifiers (AH, AJ, AM, SA, TD, TE, U1, U2 or U7) in order to receive an encounter payment, and a PPS rate on first service line of the claim form, in addition to the appropriate procedure code: 90791, 90792, 90832, 90833*, 90834, 90836*, 90837, 90838*, 90846, 90847, 90853, 90899, 96116, 96130, 96132 or 96136.
- Behavioral diagnosis needs to be in first position to process to Behavioral Health platform.
- For Superior electronic claim submissions, ensure that your Electronic Data Interchange (EDI) and clearinghouse has the correct payor ID, 68068.

Please note: Providers will not be reimbursed an encounter rate without a face-to-face encounter procedure code on the claim.

Additional Claims Information

- For telehealth services, FQHC providers must bill the appropriate E&M procedure code, along with T1015.
- Claims need to be billed with place of service 50, along with the modifier 95 to indicate the telehealth services.
  - All other applicable modifiers must be billed as well.
- For additional billing information, please access the FQHC Frequently Asked Questions (FAQ) and Quick Reference Guide (QRG) documents, located under “Quick Reference Guides & Contacts” on Superior’s Provider Resources webpage: SuperiorHealthPlan.com/ProviderResources

PaySpan

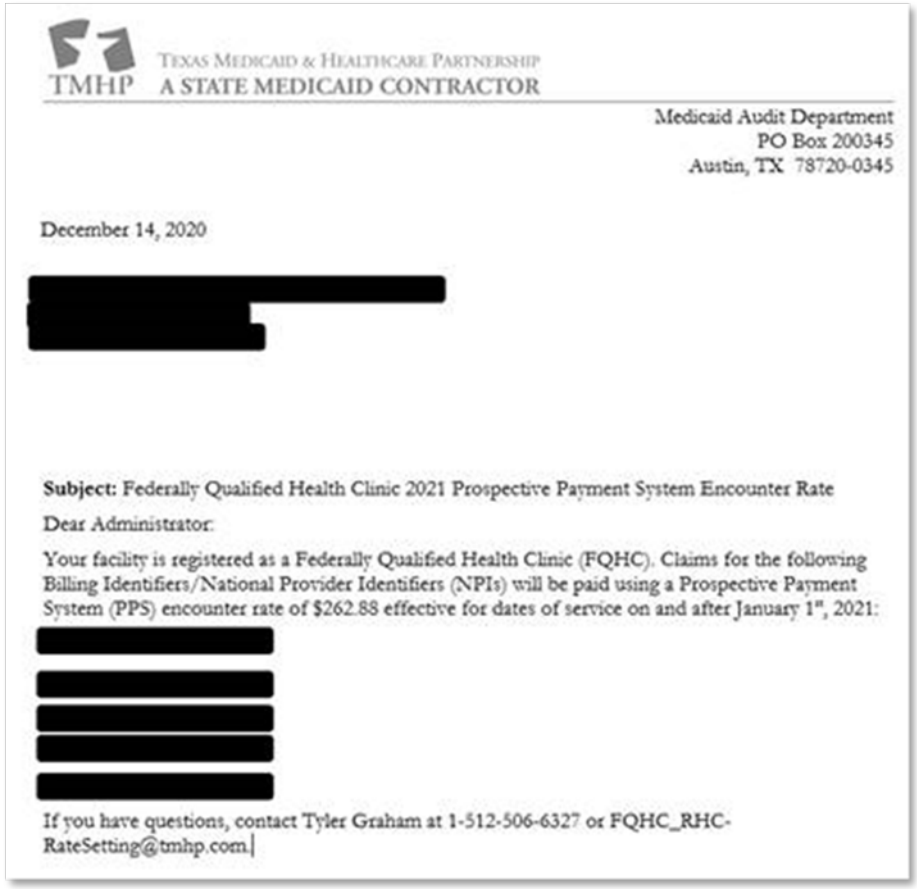
- Superior has partnered with PaySpan to offer expanded claim payment services.
  - Electronic Funds Transfer (EFT)
  - Online remittance advices (ERA's [Electronic Remittance Advice]/EOPs)
  - Health Insurance Portability Accountability Act (HIPAA) 835 electronic remittance files for download directly to HIPAA-compliant Practice Management or Patient Accounting System
- Register at: www.PaySpanHealth.com.
- For further information, contact PaySpan at 1-877-331-7154, or email ProvidersSupport@PaySpanHealth.com.

Encounter Rate Process

Encounter Rate Process

- FQHCs receive a letter from Texas Medicaid & Healthcare Partnership (TMHP) with their encounter rate.
- Once received, the FQHC is responsible for sending a copy of the encounter rate letter to the Superior Account Management team for update.
- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to PPS encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.

Encounter Rate Letter Example



TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Medicaid Audit Department
PO Box 200345
Austin, TX 78720-0345

December 14, 2020

[redacted]

Subject: Federally Qualified Health Clinic 2021 Prospective Payment System Encounter Rate

Dear Administrator:

Your facility is registered as a Federally Qualified Health Clinic (FQHC). Claims for the following Billing Identifiers/National Provider Identifiers (NPIs) will be paid using a Prospective Payment System (PPS) encounter rate of $262.88 effective for dates of service on and after January 1st, 2021:

[redacted]

If you have questions, contact Tyler Graham at 1-512-506-6327 or FQHC_RHC-RateSetting@tmhp.com.

Corrected Claims and Appeals

Medicaid, CHIP and MMP

Corrected Claim

- A corrected claim is a correction or a change of information to a previously finalized clean claim in which additional information from the provider is required to perform the adjustment.
  - Must reference original claim number.
  - Must be submitted within 120 Days of adjudication paid date.
  - Can be submitted electronically, through your clearinghouse/Electronic Data Interchange (EDI) software or through Superior's Secure Provider Portal.
- Corrected or adjusted paper claims can also be submitted with a corrected claim form attached and sent to:

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

Superior HealthPlan STAR+PLUS MMP
Attn: Claims - Correction
P.O. Box 4000
Farmington, MO 63640-4000

Appeals

- 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.
  - Must include Appeal Form:
    - www.superiorhealthplan.com/providers/resources/forms.html
    - Must include applicable documentation and information to support claim appeal.
  - Submit appeal within 120 Days from the date of adjudication or denial.
  - Can be submitted electronically through Superior's Secure Provider Portal or in writing.

- Claims submitted in writing should be sent to:

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

Superior HealthPlan STAR+PLUS MMP
Attn: Claims Appeals
P.O. Box 4000
Farmington, MO 63640-4000

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, Texas Medicaid Benefits Card (TMBC), Texas Medicaid and Healthcare Partnership (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

Member Balance Billing

- Providers may not bill members directly for covered services for Medicaid, CHIP or MMP.
- Superior reimburses only services that are medically necessary and a covered benefit.
- Superior Medicaid and CHIP Perinatal members do not have co-payments.
  - Superior CHIP members may share costs. Cost sharing information is included in the Provider Manual (please see “CHIP Benefits”).
- MMP providers must verify cost share each time a Superior member is scheduled to receive services.

Complaints and Appeals/Reconsiderations (Ambetter and Wellcare By Allwell)

Ambetter Claims Reconsiderations and Disputes/Appeals

- A Request for Reconsideration is a communication from the provider about a disagreement with the original claim outcome (e.g. payment amount, denial reason, etc.).
  - Medical records are not typically required for a reconsideration, unless it relates to a code audit, a code edit or an authorization denial.
  - Providers may submit reconsiderations:
    - Via Provider Services
    - With the online form: Ambetter.SuperiorHealthPlan.com/content/dam/centene/Superior/Ambetter/PDFs/TX_AMB_Claim_Dispute_Form.pdf
    - By sending a detailed written letter with the request

Ambetter Claims Reconsiderations and Disputes/Appeals

- A Claim Dispute/Claim Appeal is only used when a provider has received an unsatisfactory response to a request for reconsideration.
  - The dispute must be submitted using the online form located at: Ambetter.SuperiorHealthPlan.com/content/dam/centene/Superior/Ambetter/PDFs/TX_AMB_Claim_Dispute_Form.pdf.
  - The completed form should be mailed to:

    Ambetter
    Claim Dispute
    PO Box 5000
    Farmington, MO 63640-5000

  - Providers will receive written notification of the decision within 30 Calendar Days of the dispute being received.

Ambetter Complaints

- A complaint is an expression of dissatisfaction about any aspect of Superior's administration.
  - Complaints can be submitted by members or providers. Ambetter will acknowledge receipt within 5 Business Days of receiving the complaint.
    - Ambetter will research and send a resolution letter with the outcome of the complaint within 30 Calendar Days.
  - No punitive action will be taken against a provider by Ambetter for acting as a member's representative.
  - Full details on Claim Reconsideration, Claim Dispute, Complaints and Appeals processes can be found in our Provider Manual at: Ambetter.SuperiorHealthPlan.com.

Wellcare By Allwell Claims Reconsideration and Disputes

- A Request for Reconsideration is a communication from the provider about a disagreement with the manner in which a claim is processed.
  - Submit requests for reconsiderations to:
    Wellcare By Allwell
    Attn: Request for Reconsideration
    P.O. Box 3060
    Farmington, MO 63640-3822

- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
  - Submit reconsiderations or disputes to:
    Wellcare By Allwell
    Attn: Claim Dispute
    P. O. Box 4000
    Farmington, MO 63640-4400

Ambetter Member Balance Billing

- Ambetter providers are prohibited from billing the member for any covered services except for copayments, coinsurance and deductibles.
- Contracted providers may only bill Ambetter members for non-covered services if the member and provider both sign an agreement outlining the member's responsibility to pay prior to the services being rendered.
- Providers may bill the member a reasonable and customary fee for missing an appointment when the member does not call in advance to cancel the appointment.

Wellcare By Allwell Member Balance Billing

- Providers may not bill members for services when the provider fails to obtain an authorization and the claim is denied by Wellcare By Allwell.
- Providers may not seek payment from members for the difference between the billed charges and the contracted rate paid by Wellcare By Allwell.
- Contracted providers may only bill members for non-covered services if:
  - A request for prior authorization was denied by the plan and member received a written Notice of Denial of Medical Coverage in advance of receiving the service.
  - The member's Evidence of Coverage clearly states the item or service is never covered by the plan.

Secure Provider Portal

Superior Website and Secure Provider Portal

Secure Provider Portal

Submit:

- Claims
- Adjusted claims
- COB claims
- Health Passport Information
- Notification of pregnancy
- Prior authorization requests
- Provider complaints
- Request for EOP

Verify:

- Claim status
- Member eligibility

SuperiorHealthPlan.com

Resources:

- Provider directory
- Provider manual
- Provider training schedule
- Submit provider complaints
- Additional provider resources

How to Register for the Secure Provider Portal

- Visit Provider.SuperiorHealthPlan.com.
- Enter your email address, first and last name, language preference and password.
- Click on Create Account
- You will receive an email to verify your account. You will then need to login to the portal to complete you registration.
- Each user within the provider's office must create his or her own use name and password.

Additional Secure Provider Portal Information

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

Health Passport

Health Passport

- Health Passport is a secure web-based application, for STAR Health providers, built using core clinical and claims information to deliver relevant health-care information when and where it is needed.
  - Providers may access Health Passport on Superior's Secure Provider Portal at Provider.SuperiorHealthPlan.com.
- Using Health Passport, providers can gain a better understanding of a person's medical history and health interactions. This helps:
  - Improve care coordination.
  - Eliminate waste.
  - Reduce errors.

Health Passport: Modules

Health Passport modules include, but are not limited to:

- **Face Sheet**—An easy-to-read summary that includes member demographics, care gaps, Texas Health Steps (TH Steps) and last dental visit dates, active allergies, active medications and more.
- **Contacts**—Easily find a foster child's PCP, medical consenter, caregiver, caseworker and service coordinator contact information in one place.
- **Allergies**—Providers can use interactive fields to add or modify allergies at the point-of-care. Once an allergy is charted, it's instantly checked for medication interactions.
- **Assessments**—Providers can document TH Steps, dental, CANS 2.0 and behavioral health forms directly online. Mailing or faxing in documents critical to patient care for display is still available.
- **Growth Chart**—Providers can chart weight, height, length and head circumference at the point of care to track growth of infants and children.

Health Passport: Modules

- **Immunizations**—A comprehensive list of a person's immunizations collected from ImmTrac.
- **Labs**—All lab results are made available, where providers typically only have access to the lab results they've requested.
- **Medication History**—A summary of medications filled and access to more detail, including name of the prescription, the prescribing clinician, date filled, and dosage. Indicators representing drug-drug, drug-allergy and drug-food interactions appear, when applicable, as soon as new medications or allergies are added to the member record.
- **Patient History**—Past visits with details that include the description of service, treating provider, diagnosis and the service date.
- **Admit Discharge and Transfer (ADT)** – All users can view a patient's ADT data in real time from Health Information Exchanges (HIEs) services.
- **Appointments**—On this module, users are able to add, modify and cancel their own appointments entries.

Additional Resources

- Please contact the Health Passport Support Desk with any questions:
  - Call: 1-866-714-7996
  - Email: TX.PassportAdministration@SuperiorHealthPlan.com
- For more information on Health Passport and the resources provided, please visit www.FosterCareTX.com/for-providers/health-passport.html.
- Providers can schedule a live demo of Health Passport by reaching out to their local Account Manager.

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Superior HealthPlan Departments

Service Coordinators

- Available to members receiving behavioral and/or physical health services, depending on the level of service coordination assigned.
- Perform in-home assessments with members for LTSS to ensure members are able to live a healthy life in the setting of their choice.
- Coordinate referrals to other programs like Disease Management and Case Management, if necessary.
- Assist with coordinating care and follow-up with members.
- Visit or touch-base telephonically with members at least 2 times a year.

Behavioral Health Care Management

- Superior has experienced nurses, licensed clinical counselors and licensed CSWs who can assist members in coordinating all aspects of their care.
- Care Management services are available for any member.
- Levels of care management include:
  - **Care Coordination** – Lowest level, mostly short-term needs, social assistance, stable chronic conditions.
  - **Care Management** – Intermediate needs, may require additional time or resources to ensure member needs are addressed.
  - **Complex Care Management** – Significant illness burden and complexity. These members require longer term, ongoing assistance to address care gaps and service needs.

Account Management

- Account Managers are here to assist you with:
  - Face-to-face orientations
  - Secure Provider Portal training
  - Assist with inquiries related to administrative policies, procedures, and operational issues
- Access a map with your Superior field office and Account Manager at: SuperiorHealthPlan.com/FindMyAM.

Please note: When doing a search, you must search by your county.

Provider Services

- The Provider Services staff can help you with:
  - Answering questions on claim status and payments
  - Assisting with claims appeals and corrections
  - Finding Superior network providers
- For claims-related questions, be sure to have your claim number, TIN and other pertinent information available as HIPAA validation will occur.
- Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (STAR Health, Ambetter and Wellcare By Allwell until 6:00 p.m.), by calling:
  - Medicaid/CHIP/MMP: 1-877-391-5921
  - Ambetter: 1-877-687-1196
  - Wellcare By Allwell: 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

Member Services

Available Monday-Friday, 8:00 a.m. to 5:00 p.m. local time (Ambetter, MMP and Wellcare By Allwell until 8:00 p.m.), by calling:

– STAR	1-800-783-5386
– CHIP/CHIP Perinate:	1-800-783-5386
– STAR+PLUS:	1-877-277-9772
– STAR+PLUS MMP:	1-866-896-1844
– STAR Kids:	1-844-590-4883
– STAR Health:	1-866-912-6283
– Ambetter	1-877-687-1196
– Wellcare By Allwell (HMO)	1-844-796-6811
– Wellcare By Allwell (SNP)	1-877-935-8023

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 to existing Superior contracts
  - Amendments to existing contracts

- Contract packets can be requested at SuperiorHealthPlan.com/JoinOurNetwork

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.

Provider Re-Credentialing

- 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

- Provider complaints can be submitted in writing, verbally or online.
  - Mail:
    Superior HealthPlan
    Attn: Complaint Department
    5900 E. Ben White Blvd.
    Austin, Texas 78741
  - Fax:
    Attn: Complaint Department
    1-866-683-5369
  - Verbally:
    During a face-to-face interaction/visit or telephone call into any Superior department.
  - Online:
    www.SuperiorHealthPlan.com/contact-us/complaint-form-information.html
- The complaint form can be printed, completed and faxed or mailed to Superior for resolution response.
  - Form can be found under **Filing Provider Complaints:** SuperiorHealthPlan.com/ProviderResources.

Ambetter and Wellcare By Allwell Complaints

Ambetter Complaints

- Medical and Behavioral Claim disputes and appeals must be submitted in writing and mailed to:

  Ambetter
  P.O. Box 5000
  Farmington, MO 63640-5000

- Non-claim related complaints/grievances:

  Ambetter
  ATTN: Appeals
  Complaint Department
  5900 E. Ben White Blvd
  Austin, TX 78741

Wellcare By Allwell Complaints

- Can be submitted in writing or verbally:

  Wellcare By Allwell
  Complaint Department
  5900 E. Ben White Blvd
  Austin, TX 78741

Compliance

Health Insurance Portability Accountability Act (HIPAA) of 1996:

- Providers and contractors are required to comply with HIPAA guidelines found at: http://www.HHS.gov/ocr/privacy.
- Fraud, Waste and Abuse (Claims/Eligibility):
  - Providers and contractors are all required to comply with state and federal provisions.
  - To report Fraud, Waste and Abuse, call the numbers listed below:
    - Texas Office of Inspector General (TX-OIG) Fraud Hotline: 1-800-436-6184
    - Texas Attorney General Medicaid Fraud Control Hotline: 1-800-252-8011
    - Superior HealthPlan Fraud Hotline: 1-866-685-8664

Questions and Answers

Thank you for attending!